

McCormick, Fitzpatrick,  
Kasper & Burchard, P.C.

David A. Berman  
Daniel L. Burchard  
John P. Cain  
Jason R. Ferreira  
Eric A. Johnson  
Keith J. Kasper  
Craig S. Matanle  
Robin M. McCormick  
Thomas E. McCormick  
Robert G. Reagan  
Thomas P. Simon

40 GEORGE STREET  
P.O. Box 638  
BURLINGTON, VT 05402

John C. Fitzpatrick  
(1936-2009)

Telephone: (802) 863-3494  
Telefax: (802) 865-9747  
E-mail: [attorney's initials]@mc-fitz.com

March 12, 2015

Trudy Smith  
Vermont Department of Labor  
Workers' Compensation Division  
P.O. Box 488  
Montpelier, VT 05601-0488

Re: VR Rules

Dear Trudy:

Please allow this letter to serve as my written comments relative to the proposed rule changes. As previously stated, I gratefully support the hard work of the Department in reorganizing and updating the workers' compensation rules. However, I do have a few proposed changes.

First, I would add the attached to the end of Rule 12.1120. This proposal is an attempt to alleviate the backlog on Form 27 reviews which is dramatically slowing down the process. Before the statutory change relative to the inclusion of "relevant evidence" the time period for review and approval or rejection of a Form 27 was generally a week or so. Since the statutory change it has been a month or more. It appears the primary reason for this is the need to review vast amounts of irrelevant medical evidence in support of the Form 27. This proposed rule change deals only with represented parties and would not affect the current rule for unrepresented parties. This would greatly diminish the amount of useless paperwork being generated at the Department for review of old and irrelevant medical records merely because the complete medical file was sent to the IME doctor for review. As both parties are represented, if claimant's counsel believes there are additional medical records missing they have the opportunity to supplement the matter in response of the Form 27. That is the practice currently in contested workers' compensation matters whether we call it supplemental or additional or highlighted medical records the effect is the same: Relevant medical evidence is brought to the Department's attention and the irrelevant records do not require months of review and overloading of the Department's storage and personnel resources.

I would also suggest a rule change to 12.1100. The last sentence of that rule states "if the injured worker is represented by counsel, a copy of the notice must also be sent to his or her attorney." If a Form 27 is filed by Defense counsel there is an ethical bar to that attorney communicating directly with a represented party such as the Claimant. 4.2 of the Code of Professional Conduct. I would suggest changing that sentence to read "if the injured worker is represented by counsel, a copy of the notice must be sent to his/her attorney in lieu of service of the injured work of the Form 27."

State of Vermont  
Department of Labor  
MAR 16 2015

Ret. of the  
Workers' Compensation  
Division

A similar issue arises with the notice of independent medical examinations under 6.1200. In such circumstances again notice to the attorney should be sufficient. Therefore, I would suggest amending the first sentence of 6.1200 to read "and if represented, to his or her attorney in lieu of notice to the injured worker."

Thank you for your consideration in this matter.

Sincerely yours,

McCORMICK, FITZPATRICK,  
KASPER & BURCHARD, P.C.



Keith J. Kasper

Enclosure

N:\clients\135207\LETTER\SMIT04.wpd

State of Vermont  
Department of Labor

MAR 16 2018

Received.  
Workers' Compensation

Rule 12.1120 add

Regardless of whether the represented parties stipulate to the effective date of the Form 27, Counsel for the Defendant or insurance carrier may file only those records directly supporting and directly contradicting the factual basis for the Form 27. If the basis of the Form 27 is an Independent Medical Exam report, it shall not be necessary to provide copies of all medical records listed in the Independent Medical Record Report, as reference to those records shall suffice as relevant medical evidence in support of the Form 27. Counsel for Claimant shall be able to supplement the filing within the designated time for a response, if Counsel for Claimant believes any additional or missing information is necessary for a full understanding of the issues involving the approval or rejection of the Form 27.

State of Vermont  
Department of Labor

MAR 18 2008

Received  
Workers' Compensation

## Phillips, Phyllis

---

**From:** Patricia Turley <pturley@zclpc.com>  
**Sent:** Tuesday, March 17, 2015 2:53 PM  
**To:** Phillips, Phyllis  
**Subject:** Comments on Proposed Rule

Dear Phyllis:

I am writing regarding the proposed amended Workers' Compensation rules. I was admitted to the Bar in 1999 and have been practicing workers' compensation law, among other areas, since that time. I regularly represent claimants, and I also provide legal services to employers or health insurers with regard to workers' compensation claims or practices.

I have three comments to submit:

1. Some attorneys commented at public hearing that it would be inappropriate for represented claimants to receive certain notices directly from defense counsel, as specified in proposed Rule 12.1100. The attorneys cited the ethical prohibition on contact with represented parties. In this situation, however, the statute (21 V.S.A. 643a) requires notice to the claimant, which should trump that ethical concern. As a practical matter, a Form 27 is a time-sensitive filing. If a claimant is represented, it may take an additional two or more days for counsel to provide a copy to the client in order to determine what might need to be done, if it is to be challenged. This further limits the ability of counsel to respond to the proposed termination of benefits within the tight timeframe allowed by the statute. The language as proposed should remain.
2. Proposed Rule 10.1300 overturns the holding of the Vermont Supreme Court in *Brown v. W.T. Martin Plumbing & Heating*, 2013 VT 38 (2013). Most claimants rely on treating physicians for a diagnosis. The proposal ignores the reality that treating physicians may not have the training or time to document a diagnosis as required by the AMA Guides. This does not mean the diagnosis is not valid, but that certain data or information may not be retained in the medical record, for example. The new requirement of a diagnosis by a medical expert (rather than a treating physician) will harm claimants and is an unnecessary obstacle in this informal system. AMA-trained experts are very expensive, and this could also raise medical costs in the claim.
3. Proposed Rule 20.1500 relates to an award of attorney fees absent a formal hearing, under 21 V.S.A. 678(d). The rule as proposed decreases the availability of attorney fees in contrast to the legislature's intent when section (d) was added to the statute just seven years ago. The overall goal of the workers' compensation attorney fee law is to avoid diluting the limited remedy paid to claimants where insurers did not take the right action. The addition of these factors is not authorized by the statute, and it changes the meaning of the amended statute. The Vermont Supreme Court affirmed that the attorney-fee benefits were available where a recovery was later made, *Yustis v. Department of Public Service*, 2011 VT 20 (2011) and to restrict their recovery is unwise policy.

Thank you for the opportunity to provide comments on the proposed rules. I know this has been a substantial project, and I commend you and the Department for this comprehensive reform effort.

Sincerely,

*Patricia K. Turley*

Patricia K. Turley

Patricia K. Turley, Esq. | Zalinger Cameron & Lambek, P.C. | 140 Main Street | Montpelier, VT 05602  
phone (802) 223-1000, ext. 24 | fax (802) 223-5271 | [www.zclpc.com](http://www.zclpc.com)

This email and any files transmitted are confidential and intended solely for the use of the individual to whom they are addressed and may contain material protected by the attorney-client privilege. If you are not the intended recipient, be advised that you have received this email in error; please notify us immediately by calling 802-223-1000. Disclosure, forwarding, copying, printing, or distribution is strictly prohibited.

## Phillips, Phyllis

---

**From:** Stephen Cusick <scusick@zclpc.com>  
**Sent:** Thursday, March 12, 2015 12:36 PM  
**To:** Phillips, Phyllis  
**Subject:** Comment - Proposed Rule 20

Dear Phyllis:

This is a comment on Proposed Rules 20.1400 and 20.1500. I believe the proposed rule is not consistent with the Legislature's adoption of 21 V.S.A. § 678(d) or the plain language of § 678(d). More particularly, proposed Rules 20.1510 and 20.1520 requiring the showing of undue delay, denial without reasonable basis, or misconduct and consideration of whether claimant's attorney caused unreasonable delay are beyond what the statute contemplated. The statute sets out the clear requirements for an award of fees at the informal level: "the Commissioner may award reasonable attorney's fees if the claimant retained an attorney in response to an actual or effective denial of a claim and thereafter payments were made to the claimant as a result of the attorney's efforts." § 678(d). The statute does not require a showing of undue delay, denial without reasonable basis or misconduct. There is nothing in the statute that bases the award of fees on bad behavior. But the proposed rule effectively creates a bright-line rule requiring the Commissioner to make such a finding before awarding fees.

The bad-behavior standard existed in the rule prior to the adoption of § 678(d) in 2008. It existed at that time as a means of awarding fees absent a formal hearing based on the conduct of the carrier. In that sense, it was a punitive standard meant to punish the carrier for the bad conduct. The Legislature knows how to speak clearly when adopting a punitive standard, and it did not adopt such a standard in § 678(d). The Legislature also had knowledge of the punitive standard in prior WC Rule 10.1300, but it chose not to incorporate it into the statute.

I recognize that fee awards are discretionary, but that discretion does not extend to applying a bright line rule that contravenes statute. Indeed, by requiring application of the punitive standard, the proposed rule actually limits the Commissioner's discretion in such cases. The plain language of the statute explicitly expands the availability of attorney's fees to cases that are resolved before formal hearing, so long as the requirements of the statute are met. Adding more requirements by rule is not only inconsistent with the statute, but it violates the remedial purpose of the Worker's Compensation Act. *See St. Paul Fire and Marine Insurance Co. v. Surdam*, 156 Vt. 585 (1991) (the Act "is remediate in nature and must be liberally construed to provide injured employees with benefits, unless the law is clear to the contrary").

Thank you.  
Sincerely,  
Steve Cusick

Stephen L. Cusick, Esq.  
Zalinger Cameron & Lambek, P.C.  
140 Main Street | Montpelier, VT 05602  
phone (802) 223-1000 ext. 25 | fax (802) 223-5271 | [www.zclpc.com](http://www.zclpc.com)

This email and any files transmitted are confidential and intended solely for the use of the individual to whom they are addressed and may contain material protected by the attorney-client privilege. If you are not the intended recipient be advised that you received this email in error; please notify us immediately by calling 802-223-1000. Disclosure, forwarding, copying, printing, or distribution is strictly prohibited.

March 16, 2015

Ms. Phyllis Phillips  
Vermont Department of Labor  
5 Green Mountain Drive  
Montpelier, VT 05601-0488

Re: Rule Number 15P007, Vermont Workers Compensation Rules 1-27

Dear Ms. Phillips:

Healthsystems appreciates the opportunity to comment on the proposed rules re-write as noticed via email and on the Vermont Secretary of State's web portal on January 28, 2015. Our comments will focus on matters related to the delivery of medications to injured workers as proposed within 3.2500 **Compensation agreements; medical bill payments**. We support many of the language changes within the rule, and we also have some concerns and questions about some of the language which is being inserted into this new subsection of the rule.

First, we support the existing language and proposed modifications to 3.2511, which currently permits but does not require carriers to arrange for direct billing of pharmaceuticals and medical supplies with their selected vendor when the injured worker will require medications for four months or longer. The new language will require carriers to offer direct billing. It is our experience that most, if not all insurance carriers and TPAs are currently contract with vendors who offer direct billing of pharmaceuticals and medical supplies. Generally speaking most carriers offer this for every injured worker regardless of the duration of the claim as long as the claim is accepted as compensable. In regard to the notice requirement to the injured worker, carriers send informational letters or claims packets to the injured worker at the inception of the claim, and that notification contains the information described within 3.2511. For these reasons, we support the language within subsection 3.2511.

Healthsystems does have some concerns as to other language proposed in 3.2500. In subsection 3.2512 and 3.2513, the Department of Labor proposes:

3.2512 The employer or insurance carrier shall promptly provide both the injured worker and the selected vendor(s) with a list of all approved medications and/or medical supplies covered by the direct billing and payment arrangement, including any maximum limit on the number of authorized refills or units to be supplied. If known, the employer or insurance carrier shall provide the injured worker at least 30 days prior notice that such maximum limit is about to be exceeded.

3.2513 The injured worker shall promptly notify the employer or insurance carrier of any changes to his or her prescribed treatment regimen that will require amending the list of approved



medications and/or medical supplies. Upon receipt, the employer or insurance carrier shall promptly provide both the injured worker and the selected vendor(s) with an updated list incorporating such changes.

We are opposed to the language in both of these subsections based on the increased administrative burden which will be placed on carriers. These new communication standards would be not only difficult to fulfil, they are impractical and do not add any benefit to the outcome of the claim.

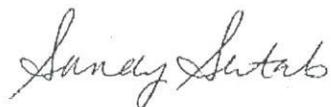
Injured workers are examined by their physician and that physician prescribes medications which are needed to cure or treat their work related injury. The patient is advised verbally in the office about what is prescribed and that information is also contained in the medical records. The patient is also aware of what is authorized by the carrier when they pick up their medications from the pharmacy. In regard to the communication requirements on changes to the "list" of approved medications or supplies, the same reasoning would apply. The injured worker is aware when the physician changes their medication regimen at their office visit and knows which medications are approved when they fill those medications at the pharmacy.

In regard to sending written correspondence to document the number of authorized refills, we also see this as an unnecessary step. The number of refills authorized by the carrier is associated with the prognosis of each individual injured worker. A carrier may choose to authorize only one month at a time, since the injured workers claim status can and often does change from month to month. Physicians often modify dosage and/or strength of existing medications, or will add new medications and discontinue others. The frequency of changes could mean the carrier would be sending a new letter after every doctor's visit. This is an unnecessary and expensive requirement, which would simply replicate what is already documented in the injured workers' medical and pharmacy records. Our objection is that this new requirement would add an inefficient communication requirement to an already streamlined process, without any quantifiable benefit to the injured worker or their medical outcome. For these reasons, we urge the Department of Labor to consider eliminating the language proposed in subsections 3.2512 and 3.2513.

Healthsystems appreciates the opportunity to comment on this rule proposal. If there are any questions which arise out of this correspondence, please do not hesitate to contact me directly.

Best regards,

Sandy Shtab



Director, Regulatory and Legislative Affairs

[sshtab@healthsystems.com](mailto:sshtab@healthsystems.com)

813-868-2264

March 17, 2015

Phyllis Phillips  
Vermont Division of Workers' Compensation  
(Via email: [Phyllis.Phillips@state.vt.us](mailto:Phyllis.Phillips@state.vt.us))

**Re: Proposed Workers' Compensation and Occupational Disease Rules for "Direct Billing"**

Helios (formerly Progressive Medical and PMSI) appreciates this opportunity to provide comments on the proposed Workers' Compensation and Occupational Disease Rules – specifically newly detailed provisions concerning "direct billing" for prescription medications and/or medical supplies. After reading the newly proposed language in comparison with the existing language, as well as the enabling statutory language, we hope the Division of Workers' Compensation may be able to provide clarification as to the intent in proposing the changes and the expansion of regulatory language.

The statute referenced for the authority underlying the Division's direct billing rule language is 21 V.S.A. §640(d), the last sentence of which states, "An employer shall establish direct billing and payment procedures and notification procedures as necessary for coverage of medically-necessary prescription medications for chronic conditions of injured employees, in accordance with rules adopted by the commissioner." To that end, the Division has adopted the provisions under Rule 26.0000. Those existing provisions outline a rather basic process for accomplishing this direct billing arrangement by mutual agreement of employee and employer. Helios has no questions related to the existing regulatory parameters or underlying enabling statutory language and remains neutral on the proposed revisions. Rather, we remain curious as to not only the expansion, and revision, of existing language – but the impetus or need for the expansion of this language.

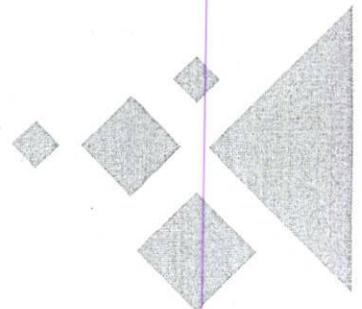
The language in the Division's newly proposed Rules 3.2510 – 3.2515 expands on these provisions by, among other changes, removing the "mutual agreement" reference. Given this, Helios respectfully requests additional clarification as to the intent. Does the Division envision the ability of an employer or insurance carrier to "direct" care provided to the injured worker for these types of prescribed medications or medical supplies to only approved vendors? If so, does this constitute a substantial change in Division policy toward direction of care? And, if so, we would appreciate any additional insight the Division may be able to provide as to why this change is being proposed. Answers to these questions are important as many employers and insurance carriers, today, often use vendors such as pharmacy benefit managers who establish large networks of pharmacies an injured worker **may** go to in order fill their prescribed medications. However, to our knowledge, they do not **require** that the injured worker use only network pharmacies as a condition for reimbursement (lacking any legal authority to do so).

Thank you for your consideration of our comments. Helios looks forward to a continued dialogue with the Division in this and other regulatory efforts. Should you have any questions, please feel free to contact us.

Sincerely,



Kevin C. Tribout  
Executive Director of Government Affairs, Helios  
[Kevin.Tribout@helioscomp.com](mailto:Kevin.Tribout@helioscomp.com)





CompPharma

March 13, 2015

Ms. Phyllis Phillips  
Vermont Department of Labor  
5 Green Mountain Drive  
Montpelier, VT 05601-0488  
Phyllis.Phillips@state.vt.us

Re: Proposed Workers' Compensation Rules

CompPharma would like to thank you for the opportunity to seek clarification and/or changes to the proposed workers' compensation rules, specifically 3.2510 Direct billing for prescription medications and/or medical supplies.

CompPharma is a consortium of pharmacy benefit managers (PBMs) that provide pharmacy care and services in the workers' compensation marketplaces. Our members work on behalf of private insurers, third-party administrators, self-insured employers and state funds to handle workers' compensation pharmacy claims covered under your state workers' compensation regulations and/or insurance laws.

CompPharma remains neutral on the provision in Sub Section 3.2511, which would require the employer or insurance carrier to provide injured workers with written notice of the vendor(s) selected to provide prescribed medications and/or medical supplies, CompPharma respectfully requests clarification from the Department on the need and/or impetus of such a specific revamp of the existing regulatory language, which is aligned with the statute. CompPharma requests the Division expound on its vision of the provision of pharmacy and other ancillary care upon final adoption of the proposed rule changes, specifically Sub Section 3.2511 and 3.2512.

CompPharma specifically seeks clarification on the necessity of Sub Section 3.2512 that would require a carrier to provide the injured worker with a list of approved medications, and update that list as conditions within the claim change. At each injured worker's medical appointment, physicians typically reassess the effectiveness of the current drug therapy. Because the injured workers' condition can improve or worsen over time, medications may be adjusted several times during the course of treatment. These factors make it impractical to provide a list of all approved medications for ALL injured workers. It is practical to establish and disclose a list of medications that are generally found to be medically necessary to treat common workers' compensation injuries, but providing such a specific list to all employees who have received medical treatment for more than four months or longer would not provide any discernable benefit to the injured worker, may stall healing and may add unnecessary administrative costs.



CompPharma

In regard to providing details to the injured worker on how many refills will be authorized, there are many variables which may change over the course of the claim, which make this administratively burdensome, and do not add any benefit to the injured worker or their medical outcome. For these reasons we strongly recommend striking the language in subsection 3.2512 in its entirety.

CompPharma supports initiatives designed to protect the safety of injured workers and ensure appropriate medications are prescribed and dispensed. Initiatives in the marketplace allow pharmacies to receive real-time information from pharmacy benefit managers to ensure injured workers receive prompt notification of approved medications. CompPharma appreciates the Department of Labor considering our comments and concerns.

Sincerely,

Joe Paduda

**Phillips, Phyllis**

---

**From:** Peggy Gates <pegaroo1993@yahoo.com>  
**Sent:** Monday, March 16, 2015 12:55 PM  
**To:** Phillips, Phyllis  
**Subject:** VT WC RULE REVISION - COMMENTS  
**Attachments:** Rule Revision Commentary.docx

Phyllis,

Many thanks to you for addressing the long needed revisions to the WC rules in this state! I truly feel that nothing is going to change regarding compliance and complexity of WC in VT until carriers are held responsible for their individual actions or inactions. Many adjusters may not fully understand the VT Statutes or Rules and do not have the time or training needed due to excessive caseloads and the need to handle claims from multiple jurisdictions. By holding carriers accountable, one could theorize they would have more incentive to avoid penalties and ensure appropriate training and manageable caseloads for their adjusters. That being said, my two cents on the rule changes are attached -

If you could confirm receipt, it would be greatly appreciated - just want to be sure I don't end up in SPAM/Junkmail -  
Thank you :)

Peggy Gates

**Rule 4.1300 for Mileage Reimbursement.** This revised rule removes the deduction for round trip mileage to work. While understood that the calculation format can cause confusion, and likely conflict, it limits the amount due to the employee to be an actual reimbursement for the gas and wear and tear of their vehicle due to the miles driven specifically for the work injury treatment. The principle of indemnification is to indemnify a person for their loss, not to provide a profit due to their loss. In a state like Vermont, it is not unusual for an employee to work in a different town than they reside. Many things are spread out in our state. A very common and modest example would be: A person lives in Waterbury and works in So. Burlington, 50 miles round trip daily mileage. They would travel this each workday whether or not they get injured. Their medical provider is at FAHC/UVM Medical Center, 54 round trip miles from home. If this person has a soft tissue back injury, is out of work, and is to attend physical therapy 3 times per week for 12 weeks (very common treatment practice), the current rule would provide them reimbursement for their mileage over and above what their normal workday commute would be - the loss that they actually suffered - which would be 4 miles per visit x .575 = **\$2.30**. Using the revised rule, by not omitting the travel they would normally incur, the reimbursement would be 54 miles per visit x .575 = **\$31.05** - with the employee PROFITING \$28.75 each visit. Calculate this 3 times per week for 12 weeks - the amounts would be **\$82.80 vs. \$1,117.80**, a very clear difference (1,350% increase in this case) and a very clear profit/windfall to the employee. This is a very limited time frame example of a 3 month treatment plan. Multiply this by the hundreds of cases per carrier and/or months of extended treatment. I don't believe a penalty exists if a carrier wishes to ignore the deduction and pay the mileage in full. They should have that right, however I don't feel that a change in the rule on the way calculation is done benefits anyone other than the employee, as is not truly a reimbursement - it would become a profit, and those funds increase claim expenses and need to be funded from somewhere. Those costs are borne not only by carriers, but by employers, small businesses, and Mod Rate calculations are affected, companies and carriers may become insolvent, etc.

**Rule 4.1340 Timeframe for reimbursement payments.** I agree that the payments should be issued within a timeframe, however feel that there should be additional parameters addressed here. The proposed rule does indicate that a reimbursement request with reasonable documentation needs to be paid within 21 days. The obvious documentation would be receipts for meals, equipment, medication, etc, however, the mileage reimbursements should allow a carrier to pay within 21 days of receipt of supporting documentation that the visit occurred and was related to the work injury. It is very, very common (although not typically intentional) for dates to be on a mileage log that are incorrect. An example would be: an employee receives his/her schedule for doctor's and PT appointments and lists them all on the mileage log before they forget - then changes such as cancellations, no-shows, and rescheduling may occur. Or a spouse writes an appointment date on the log and the appointment was actually for an unrelated issue, not the work injury. If the requirement is implemented that carriers have to pay the request blindly within 21 days, payments may be incorrect, overpayments could be created, etc. If the intention is to pay within 21 days of receiving supporting documentation and verification of relation to the work injury, it should be clarified. This would still allow for an employee to receive prompt payment, while allowing the carrier to ensure that payment is actually due.

**Rule 6.1100 Scheduling and locations for IME.** I don't expect this rule to change significantly, but would be remiss if I didn't express my frustrations on the several limitations imposed upon employers/carriers and the sometimes seemingly endless allowances made for employees. It does seem reasonable not to force someone to have to travel hours and hours to get to an appointment, especially if they are at a time of discomfort or healing from an injury that may make travel uncomfortable. That being said, there are no limitations upon an employee for their choice of medical provider and location, even though specialized expertise may not be needed. Other colleagues, as well as myself, have had cases where an employee chooses to have their treatment at a location of excessive distance, and then reap the benefits of mileage reimbursement. One case file I handled, an employee lived in the northwestern part of the state and chose to treat his soft tissue back injury with a chiropractor in

Massachusetts. It was confirmed with the DOI at the time that an employee has their choice of doctors without limitation, and that we are responsible to pay for any mileage over and above the round trip to work mileage travelled to seek the medically necessary care related to their work injury. This resulted in mileage reimbursement equivalent to **three times** the amount paid of the total of all other benefits combined on that claim. [Again - case for argument on Rule 14.1300 to keep the RTW mileage deduction].

**Rule 6.1300 Notice of intent not to attend.** Further clarification is desired on this. As written, it would seem that an ill-intended employee and/or attorney would be able to endlessly reap TTD benefits by simply writing 3 days before each scheduled IME that the employee plans not to attend. Some treating providers either do not respond to and/or do not feel that they should address MER. Rule 4.1200 provides the right to an employer/carrier being able to have an IME, while this rule as written may allow it to be avoided. I would suggest that the employee must provide a viable reason to support them not being able to attend - and possibly an allowance of being able to file this letter one time without repercussion. Beyond that, language could be added specifying that an employer/carrier is able to file a form 27 suspending applicable benefits until attendance occurs. This would provide the sometimes necessary motivation for the rescheduling and attendance so that the carrier is able to have the IME they are entitled to, and the employee is not unnecessarily punished, as they only lose benefits that are the result of their lack of attendance. Then, if the result of the IME warrants a discontinuance of benefits, a new Form 27 would be filed.

**Rule 6.1400 Right to record examination.** I agree with Dr. Davignon's comments provided during the public discussion, about a professional videographer being utilized to protect all parties within an exam. One small detail can change the entire outcome of a claim, either way. This also seems true with recordings. If only part of a video/audio is available due to batteries dying, equipment malfunction, etc, or if the video is edited or changed from its original format, what information is missing? To be able to rely on that video/audio, it should be complete without alterations or defects. How can a neutral 3rd party be sure that the copy is not edited, or that important information is omitted (intentional or not)? The one sentence spoken when the microphone was disrupted- does it carry weight when parties are in disagreement about what was said? A professional would have appropriate equipment, training, and knowledge to be a neutral person to the process. Unedited copies would be provided to all parties directly from the videographer, and there would be no question about editing, inaudible issues, or whether the entire examination is on the recording. Another thought would be that the employee can record the examination on their own (providing they complied with the requirements of 6.14), with the understanding that the recording cannot be used as evidence in a proceeding unless all parties agree. This allows their attorney, union representative, or family to be able to review the content of the exam if that is the intention, while avoiding the question of quality and fullness of the record.

## Phillips, Phyllis

---

**From:** Greg LeRoy <gleroy@voforeservices.com>  
**Sent:** Wednesday, February 04, 2015 3:08 PM  
**To:** Phillips, Phyllis  
**Subject:** WC rule feedback

Hi Phyllis – Per a quick review of the proposed WC rules, this section caught my attention:

10.1710 Unless the extent to which an injured worker's functional limitations precludes regular, gainful work is so obvious that formal assessment is not necessary, a claim for permanent total disability under the odd lot doctrine should be supported by the following:

10.1711 A functional capacity evaluation (FCE ) that assesses the injured worker's physical capabilities; and

10.1712 A vocational assessment that concludes that the injured worker is not reasonably expected to be able to return to regular, gainful work, either with or without vocational rehabilitation assistance. See Vermont Vocational Rehabilitation Rule 51.1000.

While I think I understand the intent, I'm curious as to what evidence is envisioned that would support a conclusion that the preclusion of regular, gainful work is "obvious". This seems ripe for debate and contention. I've seen numerous PTD cases referred to me for the required vocational assessment where no treating/consulting medical providers have indicated the existence of a work capacity. Would that meet the criteria for being obvious?

What about the oft-seen situation where a physician offers an opinion that a claimant cannot work, yet in many circumstances they are rendering what amounts to a vocational vs. medical opinion? A conclusion that an individual with certain functional impairments (medically determined) cannot perform work that exists in the labor market is a vocational opinion and not within a physician's scope of practice.

A claimant's ability to perform regular, gainful employment often comes down to whether they can meet what I call the general conditions of employment (meeting standards of work quality/productivity, working at a consistent pace, regular attendance, meeting deadlines, etc.). This requires a vocational interpretation using medical input as a foundation.

What about cases where the VR counselor discontinued services due to the severity of the claimant's disability? There continues to be this conflict around "suitable employment" as the relevant criteria for the provision of VR, and "regular, gainful work" that is the criteria for PTD. Additional VR is sometimes suggested as necessary prior to a finding of PTD. If suitable employment couldn't be achieved, how is it that the provision of additional VR in the context of deciding PTD can be supported (the rules indicate that VR services are provided only when suitable employment can be achieved). This conflict creates a double standard around the applicability of VR.

Greg

Gregory LeRoy, M.Ed., CRC, D-ABVE  
Certified Rehabilitation Counselor  
Board Certified Vocational Expert

VOFORE Services  
794 Buck Hill Road West  
Hinesburg, VT 05461  
(802) 482-6093