VERMONT WORKERS' COMPENSATION RULES 1-27

RESPONSIVENESS SUMMARY

The Department of Labor held a public hearing on proposed changes to Workers' Compensation Rules 1-27 on March 10, 2015 at Vermont Interactive Television sites around the state. Public comment was invited, both by notice published by the Secretary of State and as posted on the Department's website. The deadline for public comment was March 17, 2015.

The Department received eight written comments, all of which are attached to this filing, and five verbal comments, which were recorded at the public hearing. The Department's response to each of the comments received is addressed **in bold print** below.

Summary of Proposed Rules

The Workers' Compensation Rules govern all aspects of Vermont's workers' compensation program. The proposed rules incorporate legislative changes enacted since 2001. The rules also have been reorganized for better readability and ease of reference.

Summary of Public Comments and Department's Response

Table of Contents –

The Table of Contents has been reformatted to more clearly delineate the Rules Index from the Topical Index. The Forms Index remains unchanged.

Rule 3.2120 –

As proposed, this rule restricts the employer or insurance carrier's use of medical information received in conjunction with an injured worker's claim for workers' compensation benefits solely "for the purpose of advancing or defending the injured worker's claim for benefits, investigating a claim of false representation, and/or ensuring compliance with the workers' compensation statute and rules." As such, the proposed rule incorporates *verbatim* the language of the statute, 21 V.S.A. §655a(e).

Speaking at the public hearing, attorney Ron Fox voiced concern that insurance carriers sometimes upload medical records received in one claim to a central database, where they become available to other adjusters in unrelated claims. **To address this valid concern, the proposed rule has been amended as follows:**

> 3.2120 The employer or insurance carrier shall use any medical information received in conjunction with a claim solely for the purpose of advancing or defending the injured worker's claim for benefits, investigating a claim of false representation, and/or ensuring compliance with the workers' compensation

statute and rules. In all other circumstances, the employer or insurance carrier shall be prohibited from disclosing medical information (including but not limited to uploading such information to a central claims database), for use in conjunction with other claims, whether work-related or not, involving the same injured worker.

Rules 3.2510-2515 –

The purpose of these rules is to clarify the parties' respective rights and responsibilities, under 21 V.S.A. §640(d), with respect to direct billing for prescription medications and/or medical supplies that the injured worker is expected to require for four months or longer. Department staff reported having to mediate disputes when the parties could not agree on a mutually acceptable vendor, as is required under current Rule 26.3000. Staff also reported having received complaints from injured workers who were unaware that the employer or insurance carrier had failed to approve a prescribed medication, with the result that access to necessary treatment was delayed.

Recognizing that direct billing is intended primarily as a cost-saving and efficiency device, proposed Rule 3.2510 eliminates the "mutual agreement" requirement, and instead allows the employer or insurance carrier to select "an appropriate mail order or local vendor." Under Rule 3.2515, an injured worker who is dissatisfied with the selected vendor's ability to provide prompt, accurate and efficient service may seek redress first by advising the carrier of his or her concerns, and if that effort fails, by requesting that the Commissioner order the carrier to select a new vendor.

As for the second issue deemed problematic by staff, proposed Rules 3.2511-3.2514 clarify and expand the employer or insurance carrier's obligation to provide written notice to the injured worker of pertinent information relative to the direct billing arrangement, such as the vendor's contact information and a list of the medications and/or supplies that have been approved for direct billing.

The Department received written comments from three pharmacy benefit managers – CompPharma, HealtheSystems and Helios (formerly Progressive Medical and PMSI).

In its comments, Helios expressed concern that by removing the "mutual agreement" reference in the current rule, the Department may be signaling its intent to move to a system whereby only an "approved vendor" will be allowed to fill direct bill prescriptions. This might conflict with the pharmacy benefit management system, which typically allows the injured worker access to a large network of pharmacies.

The Department did not intend to limit an injured worker's access in this manner. As noted above, the "mutual agreement" requirement was deleted in order to facilitate an insurance carrier's ability to establish cost-effective and efficient direct billing arrangements. Such arrangements benefit both employer and injured worker alike. Furthermore, the language of Rule 3.2511 already recognizes the possibility that a carrier might identify multiple vendors to fulfill its direct billing obligation, by requiring written notification to the injured worker as to the

"vendor[s]" it has selected. However, to provide further clarification, proposed Rule 3.2510 has been amended as follows:

> 3.2510 **Direct billing for prescription medications and/or medical supplies.** Where medically necessary treatment for a compensable injury includes prescription medications and/or medical supplies that the injured worker is expected to require for four months or longer, the employer or insurance carrier shall establish direct billing and payment procedures with an appropriate mail order, chain or local vendor(s). 21. V.S.A. §640(d). The following rules shall apply to such procedures:

In their comments, both CompPharma and HealtheSystems expressed concern that the enhanced notice requirements of proposed Rule 3.2512, particularly those pertaining to the list of medications and supplies that have been approved for direct billing, are unduly burdensome.

Proposed Rule 3.2512 places responsibility on the employer or insurance carrier for providing written notice to the injured worker as to the medications and supplies that have been approved for direct billing. Notably, the Department did not receive any negative comments on the proposed rule from employers or insurance carriers directly. As noted above, the enhanced notice requirement addresses concerns raised by injured workers, who sometimes encounter difficulty filling prescriptions because an adjuster has failed to convey an updated list of approved medications to the direct billing vendor in a timely manner. For these reasons, the Department recommends against deleting most of the enhanced notice requirements from the proposed rule.

However, the Department acknowledges that it may be unduly burdensome for an employer or insurance carrier to provide prior notice to the injured worker that a prescription is due to expire. Every prescription label includes information as to the maximum number of refills to be allowed, and therefore the injured worker has ready access to this information. For that reason, proposed Rule 3.2512 has been amended as follows:

> 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.~~

Rule 4.1310 –

Proposed Rule 4.1310 replaces current Rule 12.2100, which pertains to mileage reimbursement when an injured worker is required to travel "for treatment or to attend an employer's independent medical examination." Under the current rule, the injured

worker is entitled to reimbursement only for mileage traveled "beyond the distance normally traveled to the workplace."

In keeping with longstanding practice, the proposed rule clarifies that in addition to medical appointments, mileage reimbursement also is payable for vocational rehabilitation-related counseling or assessment. The proposed rule also eliminates the "normal commute distance" exception, and thus requires the employer or insurance carrier to reimburse for the full amount of mileage an injured worker must travel to attend a covered appointment.

The Department received a written comment from Peggy Gates, an adjuster for the Vermont League of Cities and Towns. Ms. Gates opposed eliminating the "normal commute distance" exception on the grounds that it will result in an unjustifiable windfall to the injured worker.

According to Department staff, the "normal commute distance" exception has resulted in an inordinate amount of time spent mediating disputes as to when, how and to what extent the exception should apply in a particular case. The dollar value of these disputes is minimal. The Department feels strongly that limited staff resources are better allocated to adjudicating more significant claims-related disputes, such as those relating to denied or discontinued indemnity or medical benefits. For that reason, the Department recommends against any change to proposed Rule 4.1310.

Rule 4.1340 –

The proposed rule clarifies the timeframe within which the employer or insurance carrier is obligated to make a travel reimbursement payment – within 21 days after receipt of a properly documented request.

The Department received a written comment from Peggy Gates, an adjuster for the Vermont League of Cities and Towns, and also a verbal comment at the public hearing from attorney Wesley Lawrence. Both expressed concern that the 21-day reimbursement timeframe is inadequate, because the 30-day deadline for reviewing and paying the medical bill for whatever appointment necessitated the travel may not have passed yet.

The proposed rule adequately addresses this concern. It specifically states that the 21-day reimbursement timeframe does not begin to run until a "properly documented request" is received. This would include receipt of the medical bill (and associated treatment notes) from the medical provider whose appointment necessitated the travel in question. Consequently, the Department recommends against any change to proposed Rule 4.1340.

Rule 6.1100 –

The proposed rule incorporates the 2014 amendment to 21 V.S.A. §655, which limits the employer or insurance carrier's right to schedule an independent medical examination to locations that are within a two-hour driving radius of the injured worker's residence.

The Department received a written comment from Peggy Gates, an adjuster for the Vermont League of Cities and Towns. Ms. Gates expressed frustration with "the limitations imposed upon employers/carriers and the sometimes seemingly endless allowances made for employees." Because the two-hour driving distance limitation does not apply to the injured worker's own choice of treating provider, a situation might arise whereby the employer or insurance carrier must provide mileage reimbursement for travel far in excess of what the statute allows for an independent medical examination.

According to both current law and Department precedent, an employer or insurance carrier is only responsible for "reasonable and necessary" medical expenses. If an injured worker cannot establish a credible basis for treating with a remote provider rather than a more local one, this may in some cases be sufficient grounds to deny a mileage reimbursement claim. Beyond that, the proposed rule incorporates the legislative amendment to §655. Any resulting inequity will have to be addressed legislatively, therefore. For that reason, the Department recommends against any change to proposed Rule 6.1100.

Rule 6.1300 –

Proposed Rule 6.1300 requires an injured worker to notify the employer or insurance carrier at least three business days prior to a scheduled independent medical examination "if he or she plans not to attend."

The Department received a written comment from Peggy Gates, an adjuster for the Vermont League of Cities and Towns, and also a verbal comment at the public hearing from attorney Wesley Lawrence. Both expressed concern that the above-quoted language might be interpreted to suggest that an injured worker's attendance at a properly noticed independent medical examination is discretionary rather than mandatory. Attorney Lawrence suggested that the proposed rule should require the injured worker to state the reason(s) for his or her inability to attend. Ms. Gates concurred, and suggested as well that the rule include a provision allowing for benefits to be suspended if the injured worker opts not to attend an examination that already has been rescheduled once.

The Department concurs that the quoted language conveys the erroneous impression that attendance at a properly noticed independent medical examination is discretionary rather than mandatory. Thus, the proposed rule has been amended as follows:

> 6.1300 **Notice of intent not to attend.** An injured worker shall notify the employer or insurance carrier at least three business days prior to an examination

scheduled pursuant to this Rule if he or she plans not to attend, and the reasons therefor. Depending on the circumstances, if the injured worker fails without good cause to provide such notice, and/or fails to establish good cause for his or her inability to attend, the Commissioner may assess all or a part of the cost of the examination against him or her, and/or may suspend payment of compensation benefits to which he or she otherwise might be entitled.

The proposed rule already includes a provision allowing for benefits to be suspended if the injured worker fails to show good cause for his or her inability to attend, and therefore already addresses Ms. Gates' suggestion. The Department recommends no further change to the rule as proposed.

Rule 6.1400 –

Proposed Rule 6.1400 clarifies the parties' respective rights and responsibilities regarding video- and/or audiotaping an independent medical examination. It thus incorporates the provisions of 21 V.S.A. §655.

The Department received a written comment from Peggy Gates, an adjuster with the Vermont League of Cities and Towns, and a verbal comment at the public hearing from Philip Davignon, M.D. Dr. Davignon suggested that the rule be amended to require that a "professional videographer" be retained to perform all videotaping, so as to ensure an "unedited copy and true rendition" of the examination. Ms. Gates concurred, and also suggested as an alternative that a video recording produced by the injured worker him- or herself not be admissible as evidence unless all parties agree to its quality and completeness.

The Department anticipates that requiring injured workers to pay for a professional videographer would create an undue hardship, one significant enough to dissuade many of them from exercising their statutory right to record an independent medical examination. Proposed Rule 6.1700 already provides that a video or audio recording is admissible only upon a showing that it is "unedited and unretouched." In addition, proposed Rule 6.1600 allows for the parties to agree to the selection and payment of a neutral videographer. These safeguards adequately address the concerns raised by both Dr. Davignon and Ms. Gates. For that reason, the Department recommends against amending the proposed rule.

Rule 8.1800 (also Rules 8.1600 and 8.1700) –

Proposed Rule 8.1800 specifies that an injured worker's weekly compensation rate for permanent partial and/or permanent total disability shall be "two-thirds (0.667) of his or her average weekly wage, calculated in accordance with 21 V.S.A. §650 and this Rule [8.0000]."

The Department received a verbal comment at the public hearing from attorney Wesley Lawrence. Attorney Lawrence questioned the 0.667 multiplier as not equivalent to "two-

thirds." Instead, he suggested calculating the compensation rate by multiplying the average weekly wage by two and then dividing by three.

By statute, the weekly compensation rate for temporary total and temporary partial disability benefits is equal to "two-thirds" of the injured worker's average weekly wage. 21 V.S.A. §§642 and 646. Interestingly, for permanent partial and permanent total disability benefits, the statute requires a slightly higher multiplier, "66-2/3 percent" of the average weekly wage. 21 V.S.A. §§645 and 648.

The 0.667 multiplier reflected in proposed Rule 8.1800 is mathematically equivalent to 66-2/3 percent, and therefore yields an accurate calculation for permanent disability benefits. If the issue raised by Attorney Lawrence's comment merits consideration at all, it is in the context of calculating temporary disability benefits, as reflected in proposed Rules 8.1600 and 8.1700.

The Department has long used 0.667 as the multiplier for both temporary and permanent disability benefits. The difference is minor ($.16 applied to a $500.00 average weekly wage, $.25 applied to a $750.00 average weekly wage). Using two different multipliers will create confusion and delay the review process.

The Department recommends against changing the multiplier as reflected in proposed Rules 8.1600, 8.1700 or 8.1800. However, the Department has amended proposed Rule 8.1800 so as to be consistent with the specific language of 21 V.S.A. §§645 and 648, as follows:

> 8.1800 **Compensation rate; permanent partial and permanent total disability.** An injured worker's weekly compensation rate for permanent partial and/or permanent total disability shall be ~~two-thirds~~ 66-2/3 percent (0.667) of his or her average weekly wage, calculated in accordance with 21 V.S.A. §650 and this Rule. 21 V.S.A. §648(a). In addition, the following rules shall apply:

Rule 8.2000 –

In keeping with the statute, 21 V.S.A. §650(d), Rule 8.2000 requires the Commissioner to publish the annual change in compensation rate (more commonly referred to as the cost of living adjustment) and new minimum and maximum weekly compensation rates for the coming fiscal year "on or before July 1st annually."

Speaking at the public hearing, attorney Wesley Lawrence suggested that the rule be amended to require that the Department provide employers and insurance carriers with the updated cost of living adjustment at least two weeks prior to July 1st annually, so that they can prepare accordingly.

The annual change in compensation rate is derived from the state average weekly wage, which the Department's Unemployment Compensation Division calculates annually in accordance with 21 V.S.A. §1338(g). As soon as that calculation process

is completed, the Department's Workers' Compensation and Safety Division endeavors to determine and announce the new cost of living adjustment and maximum and minimum compensation rates as quickly as possible. Typically this occurs no later than mid-June. It is not necessary to mandate a specific deadline by rule. For that reason, the Department recommends against amending proposed Rule 8.2000.

Rule 9.1400 –

Proposed Rule 9.1400 is derived from current Rule 3.1000. It requires the employer or insurance carrier to enter into an *Agreement for Temporary Compensation* (Form 32) in all cases in which temporary total and/or temporary partial disability benefits are owed. Once executed by the parties and approved by the Commissioner, the *Agreement* is considered to be a binding and enforceable contract.

Speaking at the public hearing, attorney Ron Fox expressed concern that employers and insurance carriers sometimes pay benefits on a claim without filing the required *Agreement*. This leaves the door open for them, some months or even years later, to discontinue benefits on the grounds that the claim was never formally accepted. Attorney Fox suggested amending proposed Rule 9.1400 to impose a penalty when the employer or insurance carrier fails either to formally accept a claim (by filing the required *Agreement*) or to formally deny it (by filing the required *Denial of Workers' Compensation Benefits*, Form 2).

Proposed Rule 3.2300, the "payment without prejudice" rule, effectively addresses Attorney Fox's concerns. It requires the employer or insurance carrier to provide notice that is it paying a claim for benefits without prejudice, and limits the period during which it can do so to 90 days. If the employer or insurance carrier fails to formally deny the claim within that period, it will be deemed accepted, whether or not an *Agreement* has been filed.

As for imposing a penalty for non-compliance, the Commissioner already has the power, under Administrative Penalty Rule 45.5500, to issue an administrative citation and $100.00 penalty if an employer "fails to submit any form required by law to be filed with the Department."

For these reasons, the Department recommends against any amendment to proposed Rule 9.1400.

Rule 10.1220 –

Consistent with proposed Rule 3.2720 (pertaining to disclosure of expert witnesses and reports), proposed Rule 10.1220 requires a party who receives a final permanent impairment rating report to promptly disclose it to all other parties.

Speaking at the public hearing, attorney Ron Fox suggested clarification as to whether the disclosure required under proposed Rule 10.1220 applies as well to draft reports.

Proposed Rule 10.1220 specifically requires disclosure only of a "final" permanent impairment rating report. In addition, proposed Rule 3.2721 specifically states that disclosure "shall not be required as to draft [expert witness] reports, regardless of the form in which they are recorded." The language of these rules clearly exempts draft reports from disclosure, therefore. No further amendment to proposed Rule 10.1220 is necessary.

Rule 10.1300 –

As proposed, Rule 10.1300 mandates that where the treatise identified in 21 V.S.A. §648(b) as the basis for any determination of permanent impairment, that is, the *American Medical Association Guides to the Evaluation of Permanent Impairment, 5th edition*, requires a specific diagnosis as part of the process of doing so, no impairment will be found unless the diagnostic criteria specified therein are established by credible medical evidence.

In her written comments, attorney Patricia Turley objected to the proposed rule on the grounds that it conflicts with the Vermont Supreme Court's majority opinion in *Brown v. W.T. Martin Plumbing and Heating*, 2013 VT 38. Specifically, Attorney Turley expressed concern that, lacking the "training or time to document a diagnosis under the *AMA Guides*," a treating physician's impairment rating might be improperly discarded as invalid. As a result, the injured worker might be forced to retain a medical expert with more training in the *AMA Guides*, thus creating an unduly expensive obstacle to establishing his or her right to permanency benefits.

In its majority opinion in *Brown*, the Supreme Court interpreted broadly the legislature's mandate that the *AMA Guides* be used as the authoritative treatise for rating permanent impairment. At the same time, it specifically acknowledged the Commissioner's discretion to determine which of conflicting expert permanency opinions is the most credible in a particular case, as follows:

> **However, by deferring to the AMA Guides with respect to the methodology for rating an impairment, the Vermont Legislature has not purported to remove from the Commissioner the discretion to consider conflicting competent expert opinions concerning the presence of an impairment.**

Brown, supra **at ¶35. The Department's intent in proposing Rule 10.1300 was merely to clarify the manner in which the discretion thus granted would be exercised. The proposed rule was not intended to limit in any way an injured worker's right to rely on a treating physician's proffered impairment rating, so long as it is credibly based on the diagnostic criteria to which the *AMA Guides* require all raters to adhere.**

Having duly considered Attorney Turley's comments, and in keeping with the Supreme Court's interpretation of §648(b) as enunciated in *Brown*, the Department has amended proposed Rule 10.1300 as follows:

> 10.1300 **Rating permanent partial impairment.** Except for mental and behavioral disorders, the existence and degree of an injured worker's permanent partial impairment shall be determined in accordance with the whole person determinations as set out in the *American Medical Association Guides to the Evaluation of Permanent Impairment, 5th edition (AMA Guides)*. 21 V.S.A. §648(b). ~~Where the *AMA Guides* require a specific diagnosis as part of the process of determining an impairment rating, no impairment will be found unless the diagnostic criteria specified therein are established by credible medical evidence.~~ In doing so, the Commissioner shall have discretion to consider competent expert opinions concerning the existence of an impairment notwithstanding that such opinions are based on diagnostic criteria different from those specified in the *AMA Guides*.

Rule 10.1700 –

Proposed Rule 10.1700 reiterates the requirements for making a claim of permanent total disability in accordance with the "odd lot doctrine," as set forth in current Rule 11.3100. To establish such a claim, the injured worker must suffer from a compensable injury resulting in "a physical and/or mental impairment that renders him or her unable to perform regular, gainful work."

In his written comments, Gregory LeRoy, a certified vocational rehabilitation counselor, expressed frustration with the conflicting criteria for determining entitlement to vocational rehabilitation services, on the one hand, and the criteria for determining permanent total disability as reflected in both the current and proposed rules, on the other.

The conflict Mr. LeRoy noted is real, but it is grounded in the workers' compensation statute and therefore not amenable to resolution by rule. Under 21 V.S.A. §641, the goal of vocational rehabilitation is to "restore the [injured worker] to suitable employment." In contrast, the standard for establishing permanent total disability under 21 V.S.A. §644 is that the injured worker be "totally disabled for gainful employment." *Fleury v. Kessel/Duff Construction*, 148 Vt. 415 (1987). There are cases in which an injured worker's limitations are severe enough to preclude his or her return to "suitable" work (with "suitable" wages as compared to his or her pre-injury job), but not so severe as to preclude any "gainful employment" whatsoever. If this benefit gap is to be addressed, it must be done legislatively. For this reason, the Department recommends against any amendment to proposed Rule 10.1700.

Rule 10.1710 –

Proposed Rule 10.1710 clarifies Department precedent regarding the use of functional capacity evaluations to assess the injured worker's physical capabilities in certain permanent total disability claims. While in most cases a functional capacity evaluation should be undertaken to support such a claim, there are occasions when the injured worker's limitations so obviously preclude regular, gainful work that formal assessment is not necessary.

In his written comments, Gregory LeRoy, a certified vocational rehabilitation counselor, expressed concern that the proposed rule does not identify with sufficient specificity the basis for a finding that an injured worker's limitations are so "obvious" as to preclude the need for formal assessment.

As proposed, Rule 10.1710 recognizes that credible proof of an injured worker's permanent total disability typically includes a functional capacity evaluation. There are rare instances where formal assessment is not necessary, however. For injured workers who suffer from poorly controlled, intractable pain that is exacerbated by any activity, for example, undergoing such an assessment is debilitating, unnerving and stressful. The proposed rule protects these individuals from having to endure such pain unnecessarily.

It is impossible to specify the particular findings necessary to establish that the injured worker's limitations are so "obvious" as to preclude the need for formal assessment. Workers' compensation claims are notoriously fact-specific. Each case succeeds or fails on the basis of its own peculiar set of circumstances and the credibility of its expert witnesses. As proposed, Rule 10.1710 acknowledges these unique characteristics. For this reason, the Department recommends against any amendment.

Rule 10.1830 (also Rules 9.1430 and 10.1913) –

Proposed Rule 10.1830 incorporates longstanding Department practice with respect to the process for paying permanent partial or permanent total disability benefits when an injured worker fails or refuses to execute a proffered *Agreement for Permanent Partial or Permanent Total Disability Compensation* (Form 22). Proposed Rules 9.1430 and 10.1913 mandate the same process for paying indemnity benefits when the injured worker fails or refuses to execute either a proffered *Agreement for Temporary Compensation* (proposed Rule 9.1430) or a proffered *Agreement for Compensation in Fatal Cases* (proposed Rule 10.1913). All three rules direct the employer or insurance carrier in such situations to file the partially executed *Agreement* with the Department, and then to pay the amount the Department "deems correct" in accordance therewith. All three rules further specify that the injured worker's acceptance of such payments "shall not, by itself, constitute a waiver of his or her right to contest the amount of benefits due."

In his verbal comments, attorney Ron Fox expressed concern that the Department's review of a partially executed *Agreement* might be mistaken as approval of its material terms. As a result, the injured worker might later be precluded from contesting an agreement to which he or she never truly consented.

The Department agrees that further clarification is necessary. To that end, proposed Rule 10.1830 has been amended as follows:

> 10.1830 An injured worker's failure or refusal to execute an *Agreement for Permanent Partial or Permanent Total Disability Compensation* shall not disqualify him or her from receiving benefits otherwise determined to be owed. If despite at least two written requests the injured worker fails or refuses to execute an *Agreement*, the employer or insurance carrier shall promptly notify the Commissioner in writing of this fact, by filing (a) the partially executed *Agreement* (signed by the employer or insurance carrier); (b) the necessary supporting documentation; and (c) copies of its written requests to the injured worker. Thereafter, the employer or insurance carrier shall pay the amount the Department deems correct in accordance with the partially executed *Agreement*. However, the Department's review shall not constitute approval of the *Agreement*, and the injured worker's acceptance of any ~~such~~ payments made thereunder shall not, by itself, constitute a waiver of his or her right to contest ~~the amount of benefits due~~ its material terms.

Proposed Rules 9.1430 and 10.1913 have been amended to incorporate the same language. Proposed Rule 10.1913 also has been amended to correct an erroneous reference to the relevant *Agreement*.

Rule 12.1100 (also Rule 6.1200) –

Proposed Rule 12.1100 generally pertains to the procedure to be followed when an employer or insurance carrier seeks to discontinue an injured worker's benefits. In keeping with current Rule 18.1100, the proposed rule requires that the *Employer's Notice of Intention to Discontinue Payments* (Form 27) must be provided to the injured worker, and if he or she is represented by counsel, to his or her attorney as well. Proposed Rule 6.1200, which pertains to independent medical examinations, similarly requires that the written notice of a scheduled exam be provided "to the injured worker (and if represented, to his or her attorney as well)." This too is in keeping with current practice, as reflected in current Rule 13.1000.

The Department received written and/or verbal comments from four attorneys – Keith Kasper, Patricia Turley, Wesley Lawrence and Heidi Groff. Attorneys Kasper and Lawrence expressed concern that for a defense attorney to correspond directly with an injured worker who has retained an attorney violates the ethical prohibition against contact with a represented party. Both recommended that where the injured worker is represented by counsel, the notices at issue be given solely to the attorney.

Attorneys Turley and Groff commented in favor of the dual notice requirement. Given the time-sensitive nature of the notices at issue, they expressed concern that even a minor delay in the attorney's handling of a notice could substantially inconvenience the injured worker, and might even affect his or her entitlement to ongoing benefits.

Professional Conduct Rule 4.2 allows for an exception to the general prohibition against contact with a represented party if the lawyer "is authorized to do so by law . . ." With that in mind, the Department considers the concerns raised by Attorneys Kasper and Lawrence to be invalid. The notices at issue are indeed time-sensitive, and there is little risk that the attorney/client relationship will be disrupted in any way by requiring that they be sent to both the injured worker and the attorney. For this reason, the Department recommends against amending either proposed Rule 12.1100 or proposed Rule 6.1200.

Rule 12.1110 –

Proposed Rule 12.1110 clarifies the statutory requirement that an *Employer's Notice of Intention to Discontinue Payments* (Form 27) must be accompanied by "[a]ll relevant evidence, including evidence that does not support discontinuance in the possession of the employer not already filed." 21 V.S.A. §643a. The statute's intent was to ensure that an employer or insurance carrier seeking to discontinue benefits could not unfairly skew the Department's review process, by filing only evidence in support of its position and purposely omitting evidence that might justify continuing benefits instead.

In practice, however, in their efforts to comply with the "all relevant evidence" requirement, employers, insurance carriers and defense attorneys have adopted an "err on the side of caution" approach. They routinely file all of the evidence in their possession, whether previously filed and/or relevant or not, for fear that if they fail to do so the Department might reject their proposed discontinuance. As a result, the Department is inundated with vast amounts of medical records, all of which must be reviewed in order to identify those that are relevant to the specific issues at hand. This has caused substantial delay in Department staff's ability to rule on proposed discontinuances in a timely manner, to the detriment of injured workers, employers and insurance carriers alike.

The Department received written and verbal comments from attorney Keith Kasper, and verbal comments at the public hearing from attorney Heidi Groff. To reduce the flow of duplicate and/or irrelevant medical records and thereby streamline the Department's review process, Attorney Kasper suggested amending proposed Rule 12.1120 to allow defense counsel, in cases where the injured worker is represented by an attorney, to comply with the "all relevant evidence" requirement by filing "only those records directly supporting and directly contradicting the factual basis" for the proposed discontinuance. Thereafter, the injured worker's attorney would be allowed to supplement the filing with "any additional or missing information" believed to be necessary for a full understanding of the relevant issues.

Attorney Kasper also suggested language clarifying that if the basis for a proposed discontinuance is an independent medical examination report, "it shall not be necessary to provide copies of all medical records listed [therein], as reference to those records shall suffice as relevant medical evidence" in support of the proposed discontinuance.

Attorney Groff concurred with both the need for revisions to the current practice and with Attorney Kasper's suggested amendments to the proposed rule.

The Department concurs that the unintended consequences related to the addition of the "all relevant evidence" language to 21 V.S.A. §643a have been both significant and adverse. Prior to the statutory change, Department staff was routinely able to review proposed discontinuances within a week of receipt, whereas currently the timeframe for review is four weeks or more. Streamlining the process is essential to the Department's ability to perform this important function in a timely manner. This is true whether the injured worker is represented by counsel or not.

The Department concurs that the solution lies in clarifying the meaning of the term "relevant." Clarification also is necessary with respect to the necessity (or not) of refiling medical records referenced in an independent medical examination report or medical records review.

As for Attorney Kasper's suggestion that language be added to allow for an opposing party to file "additional or missing information," proposed Rule 12.1900, which incorporates the most recent legislative amendment to 21 V.S.A. §643a, already allows for this.

The Department has amended proposed Rule 12.1110 as follows:

> 12.1110 Notwithstanding the provisions of **Rule 3.2700**, the *Employer's Notice of Intention to Discontinue Payments* must be accompanied by all relevant evidence in the employer's or insurance carrier's possession that pertains directly to the specific benefit(s) for which discontinuance is sought, including both supporting and countervailing evidence. Previously filed evidence, including medical records referenced in an independent medical examination report or medical records review, need not be duplicated, but should be so referenced in the current filing.

Rule 13.1640 –

Proposed Rule 13.1640 clarifies the review process with respect to negotiated compromise agreements. Typically these agreements result in a full and final settlement of some or all of an injured worker's claimed entitlement to benefits. By statute, 21 V.S.A. §662(a), the Commissioner must review any such settlement, and will approve it only upon a showing that it is in the injured worker's best interests.

The proposed rule clarifies the information the parties must submit in conjunction with a proposed compromise agreement, most of which already is required under current Rules 17.5000 and 17.6000.

Although no comments were submitted with respect to the proposed rule, the Department has amended it to further protect the rights of injured workers, especially unrepresented ones, as follows:

13.1600 **Compromise agreement; process.** The parties to a negotiated compromise agreement shall submit a *Compromise Agreement* (Form 16) to the Commissioner for review. The form must be accompanied by a letter, signed by both parties, that contains the following additional information:

> 13.1610 The disputed issues, if any, that the proposed compromise agreement is intended to resolve;
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> 13.1620 The parties' respective positions on each of these issues, with supporting medical documentation if necessary;
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> 13.1630 A full explanation of the proposed compromise agreement's terms, including an itemized breakdown of the settlement monies to be paid and the extent, if any, to which the injured worker's entitlement to Social Security disability and/or Medicare benefits will be affected thereby; ~~and~~
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> 13.1640 A plainly worded statement identifying (a) the specific benefits to which the injured worker is relinquishing his or her rights and (b) the specific benefits to which he or she might still claim entitlement;
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> 13.1650 If the injured worker is unrepresented, a list compiled by the employer or insurance carrier detailing any outstanding bills, invoices and/or other charges for medical services or supplies, vocational rehabilitation services or other claims-related expenses that remain unpaid, and clearly identifying which party to the compromise agreement shall be responsible for making payment; and
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> 13.1660 The reason(s) why the proposed compromise agreement is in the injured worker's best interests.

Rule 13.1700 –

Proposed Rule 13.1700 establishes a 30-day timeframe within which an employer or insurance carrier must issue payment following the Commissioner's approval of a proposed compromise agreement.

Speaking at the public hearing, attorney Wesley Lawrence expressed concern about a possible discrepancy between the proposed rule's 30-day deadline and the 21-day timeframe within which to issue payment of weekly compensation benefits under 21 V.S.A. §650(e). Attorney Lawrence suggested removing the inconsistency by imposing

the same 21-day deadline in the proposed rule for payment pursuant to an approved compromise agreement.

Particularly with respect to large settlements, insurance adjusters often require additional time to obtain supervisory authority prior to issuing payment. With that in mind, the Department proposed a 30-day payment timeframe. The 21-day deadline imposed by §650(e) applies only to "weekly compensation benefits or weekly accrued benefits," furthermore. To the extent that a compromise agreement represents an aggregate payment of past, present and future benefits, payment thereunder is not covered by §650(e). The Department has added clarifying language to that effect, as follows:

> 13.1700 **Compromise agreement; payment of amount due.** The employer or insurance carrier shall have 30 days following the Commissioner's approval of a proposed compromise agreement within which to issue payment to the injured worker. Upon request, the Commissioner may extend this time period for good cause shown. Payments made in accordance with this rule shall not be subject to interest or penalties under 21 V.S.A. §650(e) and/or Rule 3.2640.

Rule 20.1310 –

Proposed Rule 20.1310 specifies a $145.00 hourly rate for attorney fee awards. This rate is unchanged from current Rule 10.1210.

Speaking at the public hearing, attorney Ron Fox suggested that the hourly rate be reviewed and adjusted regularly.

The statute, 21 V.S.A. §678(c), requires that the Department review the hourly rate at least every five years. The current rate became effective June 15, 2010. The Department acknowledges that the rate is due to be reviewed. It intends to conduct a survey of currently prevailing rates in the near future, following which it will propose amending the current rate, if necessary. The Department recommends no change to the proposed rule at the present time.

Rule 20.1500 –

Proposed Rule 20.1500 lists the criteria the Commissioner shall consider prior to awarding attorney fees in claim disputes that are resolved short of a formal hearing.

The Department received written comments from attorneys Patricia Turley and Steven Cusick. Both expressed dissatisfaction with the proposed rule on the grounds that it did not properly reflect the legislative intent embodied in the 2008 amendment to 21 V.S.A. §678(d).

Even as amended, the language of 21 V.S.A. §678(d) is discretionary, not mandatory, and thus the Commissioner retains discretion whether to award

attorney fees at the informal dispute resolution level. Current Rule 10.1300, which was promulgated after §678(d) was added, left intact the general requirement that "in most instances" attorney fees will only be considered in formal hearing proceedings. Awards at the informal level continue to be the exception rather than the rule, therefore.

That said, the Department acknowledges that proposed Rule 20.1500 is unduly restrictive. Therefore, it has amended it as follows:

> 20.1500 **Exercise of discretion.** The discretion to award attorney fees in cases that are resolved prior to formal hearing is intended to be exercised in limited circumstances and not as a general rule. When considering a fee request under **Rule 20.1400,** the Commissioner shall also consider whether an award of fees will further the goals of (a) maintaining appropriate standards of employer and adjuster conduct; (b) discouraging excessive delay or unnecessarily adversarial conduct; and/or (c) encouraging the parties to make effective use of the informal dispute resolution process. ~~Thus, in addition to considering whether the requirements of **Rule 20.1400** have been met, prior to awarding attorney fees in such cases the Commissioner shall also consider the following:~~
>
> > ~~20.1510 Whether the employer or insurance carrier was responsible for undue delay in adjusting the claim, denied all or part of the claim without reasonable basis and/or engaged in misconduct or neglect; and~~
> >
> > ~~20.1520 Whether the injured worker or his or her attorney was responsible for any unreasonable delay in resolving the disputed claim issues.~~

General Comment –

Speaking at the public hearing, attorney Wesley Lawrence suggested that the proposed rules be reviewed to ensure consistent terminology, specifically when referring to the "injured worker." Attorney Lawrence recommended that a more appropriate reference might be either to the "employee" or to the "injured employee," depending on the context.

The Department has reviewed the proposed rules, and finds no inconsistencies other than those required by context. The workers' compensation statute primarily uses the term "injured worker," and the proposed rules have adopted that term as well. The Department recommends against any amendment.