VERMONT WORKERS' COMPENSATION AND OCCUPATIONAL DISEASE RULES
Effective [DATE]

TABLE OF CONTENTS Page

Topical Index iii

Forms Index xi

Purpose and Construction (Rule 1.0000) 1

Definitions (Rule 2.0000) 2

Reporting the Injury and Adjusting Claims (Rule 3.0000) 7

Choice of Physician; Travel and Meals; Wages While Undergoing
Medical Treatment or Examination (Rule 4.0000) 15

Resolving Medical Disputes (Rule 5.0000) 17

Independent Medical Examinations (Rule 6.0000) 18

Pre-Authorization of Proposed Medical Treatment (Rule 7.0000) 20

Calculating Average Weekly Wage and Compensation Rate (Rule 8.0000) 23

Temporary Total and Temporary Partial Disability Benefits (Rule 9.0000) 27

Permanent Partial Disability, Permanent Total Disability
and Death Benefits (Rule 10.0000) 29

Denying Benefits (Rule 11.0000) 33

Discontinuing Benefits (Rule 12.0000) 34

Lump Sum Payments and Compromise Agreements (Rule 13.0000) 38

Requesting a Hearing in a Contested Claim (Rule 14.0000) 40

Representation in a Contested Claim; Assistance by
Bargaining Unit Representative (Rule 15.0000) 41

The Informal Dispute Resolution Process (Rule 16.0000) 43

Formal Hearing Procedure; Appeals (Rule 17.0000) 44

Mediation (Rule 18.0000) 47

Arbitration of Insurance Disputes (Rule 19.0000) 50

Costs and Attorney Fees; Attorney Liens (Rule 20.0000) 52

Third Party Liability Actions (Rule 21.0000) 55
Reporting Benefit and Expense Payments (Rule 22.0000) 56
Compliance Statements (Rule 23.0000) 57
Filing Certificates of Insurance, Notices of Cancellation or Non-Renewal
and Anti-Fraud Reports; Investigating Claims of Fraud (Rule 24.0000) 59
Excluding Corporate Officers and LLC Managers and Members
from Coverage (Rule 25.0000) 61
Self-Insurance (Rule 26.0000) 63
Application and Effect of Rules, Severability, Effective Date (Rule 27.0000) 67

Topical Index Rule

Accident 2

Administrative penalties 3, 18, 19, 22, 23, 24

Aggravation 2

Aggregate claim data, reporting (Form 13-A) 22

Agreement

- For Compensation in Fatal Cases (Form 23) 10
- For Permanent Partial or Permanent Total Disability Compensation (Form 22) 10
- For Temporary Compensation (Form 32) 9

Allocating third party recovery expenses 21

Allocation of damages, third party liability action 21

AMA Guides to the Evaluation of Permanent Impairment 10

Anti-fraud plan 24

Appeals 17

Application for Exclusion (Form 29) 25

Arbitration 19

Attorney

- Fees 20
- Lien 20
- Representation 15, 17
- Withdrawal 20

Average weekly wage 8

Bargaining unit representative, assistance by 15

Benefit payments

- Late payment, penalties for 3
- Lump sum 13
- Method of payment 3
- Payment without prejudice 2, 3
- Voluntary payment 2, 3

Weekly payment day 3
Cancellation, notice of 24
Certificate of Dependency and Concurrent Employment (Form 10) 3, 8, 9
Certificate of Insurance 24
Change in Compensation Rate, Notice of (Form 28) 8
Choice of physician 4
Claim denial 3
Claims adjuster, communication with 3
Claim-specific data, reporting (Form 13) 22
Compliance statement 23
Compensation rate 8
Compromise Agreement (Form 16) 13
Concurrent employment 8
Corporate officers, exclusion 25
Cost of living adjustment (Form 28) 8
Costs, litigation 20

Date of injury 2
Death benefits
Death causally related to compensable injury 8, 10
Death not causally related to compensable injury 10
Discontinuing benefits, change in beneficiary status 12
Denial of Workers' Compensation Benefits (Form 2) 3, 7, 11
Depositions 17
Direct billing, prescription medications and/or medical supplies 3
Disclosure and use of medical information 3
Discontinuing benefits
Employer's Notice of Intention to Discontinue Benefits (Form 27) 12
Objection to, request for extension 12
Review by Commissioner, reinstatement, appeal 12
Vocational rehabilitation screening verification 12

Duty to disclose relevant information 3

Electronic Data Interchange (EDI) 2, 3
Electronic delivery 3
Electronically transmitted forms 3
Employee's Notice of Injury and Claim for Compensation (Form 5) 3
End medical result 2
    Discontinuance on basis of 12
Evidence
    Hearsay 17
    Late-disclosed 17
    Photographic and/or video 17
Exclusion, Application for (Form 29) 25
Expert medical testimony 17
Extension, request for 3

Failure to execute compensation agreement 9, 10
Fatal Accident, Report of (Form 4) 3
Fatal Cases, Agreement for Compensation (Form 23) 10
First-aid only injury 2, 3
First Report of Injury (Form 1) 3
Flare-up 2
Formal hearing
    Appeal from 17
    Attorney representation 17
    Certified questions 17
    Docket referral 16
    Opinion and order 17
    Post-hearing pleadings 17
    Pre-trial conference 17
    Subpoena 17

Fraud, investigating claims of 24
Functional capacity evaluation 2, 10

Health care provider, Notice of Intent to Change (Form 8) 4
Hearing
    Notice and Application for (Form 6) 14
    Response 14
    Service of papers 14
Hearsay 17

Independent medical examination (IME) 4, 6, 7
Informal conference 16
Injury 2
Interest 3, 19
Interim order 3, 7, 11, 12, 16
Investigation 3

Joint medical exhibit 17

Late payment, interest and/or penalty 3
Lien, attorney fees 20
LLC manager or member, exclusion from coverage 25
Lump sum 13

Maximum and minimum compensation rates 8
Meal reimbursement 4
Mediation 18
Medical authorization (Form 7) 3
Medical benefits, discontinuing 12
Medical bill payments 3
Medical case management 2

Medical disputes, resolving 5
Medical end result 2
Medical examination, independent 4, 6, 7
Medical information, disclosure and use 3
Medical treatment or examination
    Choice of physician 4
    Travel and meal reimbursement 4
    Wage reimbursement while undergoing 4
Misclassification or miscoding 2, 24

National Council on Compensation Insurance (NCCI) 24
Notice
    and Application for Hearing (Form 6) 14
    of cancellation or non-renewal 24
    of Change in Compensation Rate (Form 28) 8
    of claimed injury 3
    of Intention to Discontinue Benefits (Form 27) 12
    of Intent to Change Health Care Provider (Form 8) 4
    of independent medical examination 6
    of third party liability action 21

Occupational disease 2, 3
Odd lot doctrine 10
Opinion and order 17

Palliative care 2
Payment without prejudice 2, 3
Penalties, administrative 3, 18, 19, 22, 23, 24, 27
Permanent partial disability
    Agreement for (Form 22) 10
    Calculating compensation weeks 10

Compensation rate 10
Entitlement 10
Payment for impairment evaluation 10
Rating impairment 10
Permanent total disability
Agreement for (Form 22) 10
Compensation rate 10
Discontinuing benefits, change in status 12
Entitlement 10
Odd lot doctrine 10
Post-hearing pleadings 17
Pre-authorization of proposed medical treatment 2, 7
Prescription medications, direct billing 3
Pretrial conference 17

Recurrence 2
Regular gainful work 10
Reimbursement from third party recovery 21
Reimbursement, travel and meal 4
Relevant information, duty to disclose 3
Reporting benefit and expense payments 22
Representation in contested claim 15
Return to work, discontinuance based on failure or refusal to 12
Rules, application, severability and effective date 27

Self-insurance 26
Service of papers 14
Settlement agreement, see Compromise Agreement (Form 16) 13
Social security offset 13
Statute of limitations 3
Subpoena 17

Suitable wage 2
Suitable work 2

Temporary partial disability
- Agreement for Temporary Compensation (Form 32) 9
- Compensation rate 8
- Discontinuing benefits 12
- Waiting period 9

Temporary total disability
- Agreement for Temporary Compensation (Form 32) 9
- Compensation rate 8
- Discontinuing benefits 12
- Extended benefit claims 9
- Partial weeks, payment for 9
- Vocational rehabilitation screening verification 12
- Waiting period 9

Third party liability actions 21
Timeliness, determining 3

Vocational assessment 10
Vocational rehabilitation screening verification 12
Voluntary payments 2
Volunteer public safety officer, average weekly wage 8

Wage, calculating average weekly 8
Wage Statement (Form 25) 3, 8, 9, 10
Wages while undergoing medical treatment 4
Weekly benefits, method of payment 3
Weekly payment day 3
Withdrawal of representation 20
Written communication, notice of appeal rights 3

Workers' compensation law, purpose and construction 1

Forms Index Rule

Aggregate Annual Reporting Form (Form 13A) 22
Agreement for Compensation in Fatal Cases 10
Agreement for Permanent Partial or Permanent Total Disability Compensation (Form 22) 10
Agreement for Temporary Compensation (Form 32) 9
Application for Exclusion (Form 29) 25
Application for Self-Insurance (Form 30) 26
Certificate of Dependency and Concurrent Employment (Form 10) 3, 8, 9
Compromise Agreement (Form 16) 13
Denial of Workers' Compensation Benefits (Form 2) 3, 7, 11
Employee's Notice of Injury and Claim for Compensation (Form 5) 3
Employer's Notice of Intention to Discontinue Benefits (Form 27) 12
First Report of Injury (Form 1) 3
Medical Authorization (Form 7) 3
Notice and Application for Hearing (Form 6) 14
Notice of Change in Compensation Rate (Form 28) 8
Notice of Intent to Change Health Care Provider (Form 8) 4
Report of Benefits and Related Expenses Paid (Form 13) 22
Report of Fatal Accident (Form 4) 3
Wage Statement (Form 25) 3, 8, 9, 10

Rule 1.0000
PURPOSE AND CONSTRUCTION

1.1100 "The purpose of the workers' compensation law is to provide, not only for the employees, a remedy which is both expeditious and independent of proof of fault, but also for employers, a liability which is limited and determinate. It places on business the burden of caring for injured employees, or when killed, their dependents to the extent provided for in the act. ..." *Morrisseau v. Legac*, 123 Vt. 70, 76 (1962).

1.1200 "While the [Workers'] Compensation Act is to be construed liberally to accomplish the humane purpose for which it was passed, a liberal construction does not mean an unreasonable or unwarranted construction." *Herbert v. Layman*, 125 Vt. 481, 485-86 (1966).

Rule 2.0000
DEFINITIONS

For the purposes of these rules:

2.1100 "Accident" means an unlooked-for mishap or an untoward event that is not expected or designed.

2.1200 "Aggravation" means an acceleration or exacerbation of a pre-existing condition caused by some intervening event or events. *Compare with* "flare-up," Rule 2.2300, and "recurrence," Rule 2.3900.

2.1210 In determining whether there has been an aggravation or recurrence, the following factors should be considered:

2.1211 Whether a subsequent incident or work condition has destabilized a previously stable condition;

2.1212 Whether the injured worker had stopped treating medically;

2.1213 Whether the injured worker had successfully returned to work;

2.1214 Whether the injured worker had reached an end medical result; and

2.1215 Whether the subsequent work contributed independently to the final disability.

2.1300 "Commissioner" means the Commissioner of Labor or the Commissioner's designee. 21 V.S.A. §601(20).

2.1400 "Corporate officer" means an officer described in a corporation's bylaws or appointed by the board of directors in accordance with its bylaws, and as further defined and described in the Vermont Business Corporation Act, 11A V.S.A. §§1.01 *et seq*.

2.1500 "Date of injury" means:

2.1510 For purposes of filing a claim and statute of limitations, the point in time when the injury, and its relationship to employment, is reasonably discoverable and apparent. 21 V.S.A. §656(b); *see* Rules 3.1500 and 3.1700.

2.1520 For purposes of calculating average weekly wage pursuant to 21 V.S.A. §650(a) when there are one or more periods of disability, the date(s) on which the injury becomes disabling. *See* Rule 8.1650.

2.1600 "Department" means the Vermont Department of Labor.

2.1700 "EIN" means an employer's federal Employer Identification Number.

2.1800 "Electronic data interchange" (EDI) means the computer-to-computer exchange of the data elements contained in a *First Report of Injury* (Form 1) between an employer's workers' compensation insurance carrier (or if self-insured, the employer's workers' compensation claims administrator) and the Department. 21 V.S.A. §660a. *See* Rule 3.1200.

2.1900 "Employer" means the employer as defined in 21 V.S.A. §601(3) and its workers' compensation insurance carrier.

2.2000 "End medical result" or "medical end result" or "maximum medical improvement" means the point at which a person has reached a substantial plateau in the medical recovery process, such that significant further improvement is not expected, regardless of treatment.

2.2100 "Evidence that reasonably supports" a denial of benefits means relevant evidence that a reasonable mind might accept as adequate to support a conclusion that must be based on the record as a whole, and take into account whatever in the record fairly detracts from its weight. 21 V.S.A. §601(24). *Compare with* "preponderance of the evidence," Rule 2.3700.

2.2200 "First-aid only injury" means an injury for which the injured worker loses no time from work (except for the time, not exceeding one day of work, related to medical treatment and recovery), and which requires only one treatment that generates a bill for less than $750.00. 21 V.S.A. §640(e). *See* Rule 3.1300.

2.2300 "Flare-up" means a temporary worsening of a pre-existing condition caused by a new injury for which a new employer or insurance carrier is responsible, but only until the condition returns to baseline and not thereafter. *Compare with* "aggravation," Rule 2.1200, and "recurrence," Rule 2.3900.

2.2400 "Functional capacity evaluation" (FCE) means testing performed by a registered physical or occupational therapist or other qualified medical provider, in which the injured worker's ability to participate in activities within a work setting is objectively determined. An FCE is used to match physical capabilities to job requirements and should address such activities as bending, lifting, pushing, pulling, balance, reaching, climbing, stooping, standing, sitting, eye-hand-foot coordination, manual finger dexterity and physical endurance. *See* Vermont Vocational Rehabilitation Rule 51.1200.

2.2500 "Health care provider" means a person, partnership, corporation, facility or institution, licensed or certified or authorized by law to provide professional health care service to an individual during the individual's medical care, treatment or confinement. 21 V.S.A. §601(22).

2.2600 "Injury" means any harmful work-related change in the body, whether occurring instantaneously or gradually, and includes a claimed or apparent injury or disease. The term also includes damage to and the cost of replacement of prosthetic devices, hearing aids and eyeglasses when the damage or need for replacement arises out of and in the course of employment. 21 V.S.A. §601(7). Depending on the circumstances, the term "injury" also includes "aggravation," "flare-up" or "recurrence" as those terms are defined in Rules 2.1200, 2.2300 and 2.3900.

2.2700 "Maximum medical improvement" – *see* "end medical result," Rule 2.2000.

2.2800 "Medical bill" means any claim, bill, or written request for payment from a health care provider or injured worker for all or any portion of health care services provided to the injured worker as a consequence of an injury for which he or she has filed a claim under Vermont's Workers' Compensation Act. 21 V.S.A. §601(25). *See also* Vermont Workers' Compensation Rule 40.000.

2.2900 "Medical case management" means the planning and coordination of health care services appropriate to achieve the goal of medical rehabilitation. Medical case management may include medical case assessment, including personal interview with the injured worker, assistance in developing, implementing and coordinating a medical care plan with health care providers in consultation with the injured worker and his or her family, and evaluation of treatment results. The goal of medical case management should be to avail the injured worker of reasonable treatment options to ensure that he or she can make an informed choice. Medical Case Managers shall not provide medical care or adjust claims. *See* Vermont Vocational Rehabilitation Rule 51.1900.

2.3000 "Medical end result" – *see* "end medical result," Rule 2.2000.

2.3100 "Misclassification" means improperly classifying an employee as an independent contractor for the purpose of avoiding workers' compensation insurance coverage.

2.3200 "Miscoding" means improperly categorizing an employee under the National Council on Compensation Insurance (NCCI) workers' compensation classification codes, which account for varying levels of risk attributable to different job types for the purpose of calculating workers' compensation insurance premiums.

2.3300 "Occupational disease" means a disease that results from causes and conditions characteristic of and peculiar to a particular trade, occupation, process or employment, and to which an employee is not ordinarily subjected or exposed outside or away from the employment and which arises out of and in the course of the employment. 21 V.S.A. §601(23).

2.3400 "Palliative care" means medical services rendered to reduce or moderate temporarily the intensity of an otherwise stable medical condition, but does not include those medical services rendered to diagnose, heal or permanently alleviate or eliminate a medical condition. Palliative care is compensable if it is reasonable, medically necessary and offered for a condition that is causally related to a compensable work injury.

2.3500 "Payment without prejudice" means the payment of benefits claimed to be due and payable under the provisions of Vermont's Workers' Compensation Act that are made by an employer or insurance carrier prior to its acceptance of the claim and without waiving its right to contest compensability of the claimed benefit(s). *See* Rule 3.2300.

2.3600 "Pre-authorization" means the process by which, upon written request submitted with supporting medical evidence, the employer or insurance carrier agrees to pay for a proposed medical procedure or treatment. 21 V.S.A. §640b. *See* Rule 7.0000.

2.3700 "Preponderance of the evidence" means the greater weight of the evidence, the more probable hypothesis when all relevant evidence is considered, evidence sufficient to incline an impartial mind to one

side of the issue rather than the other. *Compare with* "evidence that reasonably supports," a denial of benefits, Rule 2.2100.

2.3800 "Reasonable medical treatment" means treatment that is both medically necessary and offered for a condition that is causally related to the compensable work injury. As to the medically necessary component, the determination whether a treatment is reasonable should be based primarily on evidence establishing the likelihood that it will improve the patient's condition, either by relieving symptoms and/or by maintaining or increasing functional abilities. *See also* 21 V.S.A. §601(27), defining "medically necessary care."

2.3900 "Recurrence" means the return of symptoms following a temporary remission. *Compare with* "aggravation," Rule 2.1200, and "flare-up," Rule 2.2300.

2.3910 In determining whether there has been an aggravation or recurrence, the following factors should be considered:

2.3911 Whether a subsequent incident or work condition has destabilized a previously stable condition;

2.3912 Whether the injured worker had stopped treating medically;

2.3913 Whether the injured worker had successfully returned to work;

2.3914 Whether the injured worker had reached an end medical result; and

2.3915 Whether the subsequent work contributed independently to the final disability.

2.4000 "Regular full time employment" means a job that was at the time of hire, or is currently, expected to continue indefinitely. *See* Vermont Vocational Rehabilitation Rule 51.2100.

2.4100 "Successful return to work" means a return to employment that the injured worker has demonstrated the physical capacity and actual ability to perform without imminent risk of re-injury. Where the injured worker was employed in a temporary or part-time capacity prior to his or her injury, "successful return to work" means a return to employment under the same or similar circumstances.

2.4200 "Suitable wage" means a wage that equates as closely as possible to 100 percent of the injured worker's average weekly wage as calculated in Rule 8.0000. *See* Vermont Vocational Rehabilitation Rule 51.2700.

2.4300 "Suitable work" means work:

2.4310 For which the injured worker has the necessary physical capacities, knowledge, skills and abilities, as those terms are defined in Vermont Vocational Rehabilitation Rules 51.2610-51.2630;

2.4320 Located where the injured worker customarily worked prior to his or her injury, or within reasonable commuting distance of his or her residence;

2.4330 Which pays or would average on a year-round basis a suitable wage, as defined in Rule 2.4200; and

2.4340 Which is regular full-time employment, as defined in Rule 2.4000. Temporary or part-time work is suitable if it equates as closely as possible to the injured worker's annual income from a similarly temporary or part-time job held prior to the injury. *See* Vermont Vocational Rehabilitation Rule 51.2600.

2.4400 "Voluntary payments" means payments made by an employer or insurance carrier to an injured worker during the period of disability, or to his or her dependents, that were not due and payable under the provisions of Vermont's Workers' Compensation Act at the time they were made. 21 V.S.A. §651.

RULE 3.0000
REPORTING THE INJURY AND ADJUSTING CLAIMS

3.1100 **First Report of Injury; when filed.** Except for first-aid only injuries, every employer shall file a *First Report of Injury* (Form 1) with its insurance carrier (or if self-insured, with its workers' compensation claims administrator) within 72 hours (Sundays and legal holidays excluded) of receiving notice or knowledge of a claimed work-related injury that either (a) causes an absence of one day or more from work; and/or (b) necessitates medical attention. 21 V.S.A. § 701.

3.1110 The employer shall file a *First Report of Injury* with its insurance carrier or claims administrator even if it disputes the facts surrounding the injury and/or its relationship to the injured worker's employment. Filing the *First Report of Injury* does not in any respect amount to an admission of liability.

3.1120 Upon filing a *First Report of Injury* with its insurance carrier or claims administrator, as promptly as possible the employer shall deliver a copy to the injured worker.

3.1130 If the injury results in death, the employer shall also file a *Report of Fatal Accident* (Form 4) with its insurance carrier or claims administrator.

3.1200 **Electronic Data Interchange (EDI).** Within 30 days after being approved by the Department of Financial Regulation to write workers' compensation insurance in Vermont (or, for self-insured employers, within 30 days after being approved to self-insure), the insurance carrier (or, if self-insured, the employer's workers' compensation claims administrator) shall complete and submit a Department-approved EDI trading partner agreement with an approved EDI vendor. A new trading partner agreement shall be submitted every three years, or sooner in the event of a change in EDI vendor. An updated transmission profile shall be filed in the event of a change in contact information.

3.1210 Immediately upon receipt of an employer's *First Report of Injury*, the employer's insurance carrier or claims administrator shall transmit the data elements contained therein to the Commissioner via EDI. The level of record detail in the electronically submitted report shall be equivalent to that required in a written paper record, and shall be complete, valid and accurate. Each electronic transmission of data shall include appropriate header and trailer records. 21 V.S.A. §660a.

3.1300 **First-aid only injuries.** In the event of a first-aid only injury, within five days of receiving notice of its occurrence the employer shall file a *First Report of Injury* with the Commissioner. As promptly as possible thereafter, the employer shall give a copy of the *First Report of Injury* to the injured worker. 21 V.S.A. §640(e).

3.1310 In the event that the employer contests a claimed first-aid only injury, within five days of receiving notice of its occurrence the employer shall also file the *First Report of Injury* with its workers' compensation insurance carrier.

3.1320 If the employer accepts a first-aid only injury as compensable, it shall pay the associated medical bill within 30 days of receipt.

3.1330 In the event that an accepted injury no longer qualifies as a first-aid only injury, either because (a) the billing for the associated one-time-only medical treatment is $750.00 or more; or (b) the injury necessitates additional medical treatment; and/or (c) the injury causes an absence of more than one day from work, the employer shall promptly report the claim to its workers' compensation insurer, which shall adjust it accordingly.

3.1400 First Report of Injury; complete information required. Whether filed via EDI or otherwise, the employer shall provide all information necessary to complete the *First Report of Injury* in full. An employer who fails to do so may be subject to administrative penalty. 21 V.S.A. §702.

3.1500 Notice of claimed injury. An injured worker must give an employer notice of any claimed work-related injury (including the recurrence, aggravation or flare-up of a prior injury or condition), as soon as practicable after its occurrence, and must file a claim for compensation within six months after the date of injury. The notice and/or claim may be given or made by any person claiming entitlement to compensation or acting on the injured worker's behalf. 21 V.S.A. §656(a).

3.1510 As used in this Rule, "date of injury" means the point in time when both the injury and its relationship to the employment are reasonably discoverable and apparent.

3.1520 When the employer or insurance carrier has paid benefits voluntarily or without prejudice, the injured worker need not file a claim for benefits unless and until payments are denied or discontinued. The injured worker shall have six months from the date of denial or discontinuance within which to file a claim for benefits. 21 V.S.A. §656(c).

3.1600 Failure to give notice. An injured worker who fails to give notice or make a claim for compensation within six months of the date of injury may nonetheless pursue a claim for compensation and benefits, provided he or she can show either that the employer, the employer's agent or representative had knowledge of the accident, or that the employer has not been prejudiced by the delay or want of notice. 21 V.S.A. §660(a).

3.1700 Statute of limitations. Proceedings to initiate a claim for a work-related injury may not be commenced after three years from the date of injury. 21 V.S.A. §660(a). This provision shall not be construed to limit a subsequent claim for benefits stemming from a timely filed work-related injury claim; such claims shall be filed within six years of the date on which they accrue.

3.1800 Occupational disease claims. A claim for occupational disease shall be made within two years of the date when the occupational disease and its relationship to the employment are reasonably discoverable and apparent. 21 V.S.A. §§ 656(b), 660(b).

3.1900 Employee's Notice of Injury. If the employer fails or refuses to file a *First Report of Injury*, the injured worker may file an *Employee's Notice of Injury and Claim for Compensation* (Form 5) directly with the Commissioner. The filing of a *Notice of Injury* shall not absolve the employer or insurance carrier from responsibility either for filing a *First Report of Injury* or for investigating and determining compensability in accordance with this Rule.

3.2000 **Investigation; forms.** Having received notice or knowledge of an injury, the employer or insurance carrier shall promptly investigate and determine whether any compensation is due. In all cases in which the injured worker is alleged to have been disabled from working for at least three calendar days as a result of his or her injury the employer or insurance carrier shall immediately complete a *Wage Statement* (Form 25), and solicit a completed *Certificate of Dependency and Concurrent Employment* (Form 10) from the injured worker. Upon receipt, both forms shall be filed with the Commissioner, with copies to the injured worker. *See* Rule 8.0000.

3.2100 **Disclosure and use of medical information.** The filing of a claim for workers' compensation benefits shall be a waiver of all claims to privilege as between the parties regarding medical information relevant to the specific claim. Therefore, upon request by the employer or insurance carrier in the course of its investigation, the injured worker shall execute *Medical Authorizations* (Form 7) as needed for the release of all relevant medical records and reports regarding his or her diagnosis, condition, treatment, permanent impairment and/or return to work restrictions or limitations. Information that may be requested includes minimum data to justify services and payment, office notes of the examination relating to diagnosis or treatment and any other relevant provider records contained in the file. 21 V.S.A. §655a.

3.2110 Medical information relevant to a specific claim includes records and reports pertaining to a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part. Disputes as to the relevance of particular medical information shall be resolved by the Commissioner. The employer or insurance carrier shall not use medical information that is found not to be relevant to the claim to deny or limit an injured worker's entitlement to benefits.

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.

3.2130 An injured worker's failure or refusal, without good cause, to provide a medical authorization upon request is grounds for the employer or insurance carrier to deny a claim or discontinue benefits by filing the appropriate *Denial of Workers' Compensation Benefits* (Form 2) or *Notice of Intention to Discontinue Payments* (Form 27) with the Commissioner, or for the Commissioner to dismiss the claim without prejudice. *See* Rules 11.0000 and 12.0000.

3.2140 The employer or insurance carrier shall take no negative action with regard to a claim based solely on an oral communication with a medical provider. All substantive communications with an injured worker's treatment provider(s) must be in writing and simultaneously copied to the injured worker or, if represented, to his or her attorney.

3.2200 **Claim denial; request for extension.** The employer or insurance carrier shall have 21 days (measured from the date on which the employer received notice or knowledge of a claimed work-related injury) within which to determine whether any compensation is due. If it determines that no compensation is due, within 21 days after receiving notice or knowledge of the injury, it shall file a *Denial of Workers' Compensation Benefits* (Form 2) with the Commissioner and the injured worker. The *Denial* shall clearly

state the reason(s) for the denial, and shall be accompanied by copies of all relevant documentation, medical or otherwise, relied upon to support it. *See* Rule 11.0000.

3.2210 If, despite good faith efforts, the employer or insurance carrier cannot render a decision within 21 days, it may request an extension in writing. The extension request must be specific as to the reason for the delay and the number of additional days requested (not to exceed an additional 21 days). It must be accompanied by documentation demonstrating that the employer or insurance carrier has made good faith efforts to investigate the claim, and must be received by the Commissioner (with a copy to the injured worker) prior to the expiration of the initial 21-day time limit.

3.2220 An employer or insurance carrier who has denied a claim on the grounds that information relevant to its investigation was appropriately requested but not forthcoming shall have an affirmative obligation to reconsider its denial if the requested information is received within 45 days thereafter.

3.2300 Payment without prejudice. At any time during its investigation, the employer or insurance carrier may elect to pay without prejudice all or a portion of any benefits to which the injured worker claims entitlement. The employer or insurance carrier shall notify both the injured worker and the Commissioner of its election to do so in writing. In the case of medical bills, the notice shall specify the nature and duration of all medical services or supplies to be paid without prejudice. In the case of indemnity benefits, the notice shall specify the type and duration of the benefit(s) to be paid without prejudice, and shall be accompanied by a *Certificate of Dependency and Concurrent Employment* (Form 10) and a *Wage Statement* (Form 25) sufficient to allow calculation of the compensation rate to be used. If the employer or insurance carrier fails to deny compensability of the claimed benefit(s) in accordance with Rule 11.0000 within 90 days of making a payment without prejudice, it shall be deemed to have accepted responsibility for them. In that event, it shall follow the procedures outlined in Rule 12.0000 prior to discontinuing payment.

3.2400 Interim order. If the employer or insurance carrier fails either to commence payment without prejudice or to make a determination whether any compensation is due within the time period specified in Rules 3.2200 or 3.2210 above, upon written request by the injured worker and if the available evidence does not reasonably support a denial, the Commissioner shall issue an interim order that compensation be paid. 21 V.S.A. §662(b). Unless otherwise specified therein, any such payments shall be due and payable upon issuance of the interim order.

3.2500 Compensation agreements; medical bill payments. If the employer or insurance carrier determines that indemnity compensation is due, it shall enter into the appropriate compensation agreement, in accordance with Rules 9.0000 and/or 10.0000. If it determines that medical benefits are due, it shall promptly review, audit and pay the associated medical bills in accordance with Vermont Workers' Compensation Rule 40.000.

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 or local vendor. 21. V.S.A. §640(d). The following rules shall apply to such procedures:

3.2511 The employer or insurance carrier shall provide written notification to the injured worker as to the name, physical and/or email address and telephone number of the vendor(s) it has selected to provide prescribed medications and/or medical supplies.

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.

3.2514 In the event that the employer or insurance carrier elects to change vendor(s), it shall promptly provide written notification to the injured worker in accordance with Rule 3.2511 above, and shall promptly provide the new vendor(s) with a list of approved medications and/or medical supplies in accordance with Rule 3.2512 above.

3.2515 An injured worker who is dissatisfied with a vendor's ability to provide prescription medications and/or medical supplies promptly, accurately and efficiently shall first notify the employer or insurance carrier of his or her concerns. Thereafter, if such concerns are not adequately addressed and for good cause shown, the Commissioner may order that the employer or insurance carrier select a new vendor to service the injured worker.

3.2600 Weekly benefit payments. The following rules shall apply to the payment of benefits, whether made pursuant to agreement or as ordered by the Commissioner:

3.2610 Method of Payment. Weekly benefits shall be paid by check issued to the injured worker. Alternatively, with the injured worker's written consent weekly benefits may be paid by either of the following methods:

3.2611 By electronic funds transfer or direct deposit to a checking, savings or other deposit account maintained by or for the injured worker and which he or she designates in writing for that purpose, 21 V.S.A. §618(f); or

3.2612 By credit to a an electronic prepaid benefit card account, in a manner consistent with the requirements of 21 V.S.A. §342(c)(2).

3.2612.1 The issuer of such a card shall comply with all of the requirements, and provide the injured worker with all of the consumer protections, that apply to a payroll card account under the rules implementing the Electronic Fund Transfer Act, 15 U.S.C. §1693 *et seq.*, as may be amended.

3.2612.2 An electronic prepaid benefit card account may be used only for weekly payment of temporary disability benefits. It shall not be used for payment of a lump sum award or for permanent disability benefits. 21 V.S.A. §618(f).

3.2620 Weekly payment day. When weekly benefits have been awarded or are not in dispute as described in 21 V.S.A. §650(e), the employer or insurance carrier shall establish the weekday on which payment shall be mailed, deposited or credited, and shall notify the injured worker and Commissioner of that day. The employer or insurance carrier shall ensure that each weekly payment is mailed or deposited on or before the day established. 21 V.S.A. §650(f).

3.2621 In the event that the employer or insurance carrier elects to change the originally established weekday on which payment is to be mailed or deposited, it shall give at least seven days' prior notice of the change to the injured worker, his or her attorney if represented, and the Commissioner.

3.2622 If the employer or insurance carrier fails to mail or deposit a weekly benefit payment on the day established (or if no day has yet been established, then on the injured worker's regular pay day), it shall pay to the injured worker a late fee of $10.00 or five percent of the benefit amount, whichever is greater, for each weekly payment that is made after the established day. In the event of a dispute, proof of payment shall be established by affidavit. 21 V.S.A. §650(f).

3.2630 Late payment; interest. If an employer or insurance carrier fails to make payment to an injured worker in accordance with an executed compensation agreement, interim or final order of the Commissioner or arbitration award within 15 days after the payment is due, it shall also pay interest at the statutory rate on any such overdue amount(s). 21 V.S.A. §675(c). For the purposes of this Rule, payment shall be deemed due (a) upon entering into an agreement for compensation in accordance with Rules 9.1400, 10.1800 or 10.1910; (b) upon filing a partially executed compensation agreement with the Department in accordance with Rules 9.1430, 10.1830 or 10.1913; or (c) upon issuance of an interim or final order, whichever occurs first.

3.2640 Late payment; monetary penalty. If weekly compensation benefits or weekly accrued benefits (including benefits paid pursuant to an interim or final order of the Commissioner or an arbitration award) are not timely paid within 21 days after becoming due and payable pursuant to 21 V.S.A. §650(e), the employer or insurance carrier shall be assessed a penalty of ten percent of the overdue amounts(s), which shall be added to the amount due and paid to the injured worker. Interest shall also be assessed and, if justified, late fees under Rule 3.2622 and/or administrative penalties under 21 V.S.A. §688.

3.2650 Late payment; administrative penalty. In appropriate circumstances, an employer or insurance carrier who fails to make timely payment of any benefit due to or on behalf of an injured worker may be subject to administrative penalties in accordance with 21 V.S.A. §688 and Vermont Workers' Compensation Rule 45.

3.2700 **Duty to disclose discoverable information.** The parties to a pending workers' compensation claim have an ongoing, affirmative duty to promptly disclose the following information to all other parties, and if specifically required by these Rules, to the Commissioner as well:

3.2710 All relevant medical information obtained in accordance with Rule 3.2100;

3.2720 The identity of any expert witness that the disclosing party may use to support its claims or defenses, as well as any written report(s) prepared and signed by such witness, provided that:

3.2721 Disclosure shall not be required as to draft reports, regardless of the form in which they are recorded; and

3.2722 Disclosure shall not be required as to communications with a party's attorney, except to the extent that the communications (a) relate to compensation for the expert's study or testimony; (b) identify facts or data that the party's attorney provided and that the expert considered in forming the opinions to be expressed; or (c) identify assumptions that the party's attorney provided and that the expert relied on in forming the opinions to be expressed.

3.2730 Video and/or audio recordings of independent medical examinations, but only to the extent and in the manner required by **Rules** 6.1420 and 6.1500;

3.2740 Surveillance photographs, video and/or written reports, to the extent that the disclosing party's position on a disputed issue relies, in whole or in part, on information gleaned therefrom;

3.2750 Any other records, documents and recorded statements, and/or the identity of any other individual likely to have discoverable information – as well as the subject of that information – that the disclosing party may use to support its claims or defenses, unless the use would be solely for impeachment.

3.2800 **Written communication to injured worker; appeal rights.** Any written communication from an employer or insurance carrier to an injured worker that (a) purports to affect his or her entitlement to benefits, or (b) provides notice of an independent medical examination scheduled in accordance with **Rule 6.0000**, shall include the following statement: "Please contact the Department of Labor's Workers' Compensation Division for further information regarding your right to appeal this action, and the process and procedure for doing so." 21 V.S.A. §602(c).

3.2900 **Communication with employer or insurance carrier.** Upon receipt of a *First Report of Injury* involving lost time from work, the employer or insurance carrier shall provide the injured worker and the Commissioner with written notice of the name and mailing address of the workers' compensation claims adjuster assigned to the claim. This information shall be updated whenever a change occurs.

3.3000 **Determining timeliness; electronic delivery.** The provisions of Vermont Rules of Civil Procedure 6(a) and (e) shall apply to the computation of any time period required or allowed by these Rules. In addition, except for attachments exceeding 20 pages in length, which must be delivered in paper or disc format, any communication required or allowed by these Rules may be sent electronically (a) to the

Department; (b) to the attorney for a represented party; and/or (c) to an unrepresented party provided he or she consents and with delivery confirmation required.

3.3100 **Electronically transmitted forms.** Any form, report or communication required by these Rules to be filed with the Commissioner may be signed and transmitted electronically.

RULE 4.0000
CHOICE OF PHYSICIAN; TRAVEL AND MEALS; WAGES WHILE UNDERGOING MEDICAL TREATMENT OR EXAMINATION

4.1100 **Choice of physician; notice of intent to change.** An employer or insurance carrier may designate a health care facility and/or provider, as those terms are defined in 18 V.S.A. §§9432(8) and (9), to initially treat an injured worker immediately following a claimed work-related injury. 21 V.S.A. §640(b).

4.1110 At or before initial treatment, the employer, insurance carrier or designated health care facility or provider shall provide the injured worker with a *Notice of Intent to Change Health Care Provider* (Form 8). At any time after the initial treatment, the injured worker may select another health care facility and/or provider by filing the completed *Notice* with the employer or insurance carrier. The *Notice* shall include the injured worker's reason(s) for dissatisfaction with the initially designated health care facility or provider and the name and address of the health care facility or provider with whom he or she intends to treat. 21 V.S.A. §640(b).

4.1120 The Commissioner may permit an employer or insurance carrier to refuse to reimburse a health care facility or provider selected by the injured worker upon a showing that he or she failed to provide the notice required by Rule 4.1110, unless the failure was due to excusable neglect or inadvertence. 21 V.S.A. §640(b).

4.1200 **Independent medical examinations.** If the injured worker selects a new health care provider in accordance with this Rule, the employer or insurance carrier shall have the right to require other medical examinations as provided for in 21 V.S.A. §640(c) and Rule 6.0000.

4.1300 **Travel and meal reimbursement.** When an injured worker is required to travel for medical treatment or examination (including independent medical examinations under Rule 6.0000), and/or for vocational rehabilitation-related counseling or assessment, the employer or insurance carrier shall provide reimbursement as follows:

4.1310 Mileage reimbursement at the current U.S. General Services Administration rate for authorized use of a privately owned vehicle;.

4.1320 Meal reimbursement for breakfast, lunch and/or dinner, when those meals must be taken during travel, at the current rate in effect for classified Vermont state employees; and/or

4.1330 Reimbursement for overnight accommodations, and/or for air, rail, bus, taxi, ambulance, rental car or other transportation expense, when reasonable in amount and required as a consequence of an injured worker's medical condition.

4.1340 The injured worker shall be responsible for providing reasonable documentation for any reimbursement request submitted to the employer or insurance carrier. Upon receipt of a properly documented request, the employer or insurance carrier shall make payment within 21 days.

4.1400 Wages while undergoing medical treatment or examination. An employer shall not withhold any wages from an injured worker, or otherwise require him or her to use accumulated leave time, when absence from work is required in order to attend a medical appointment necessitated by a compensable work injury. 21 V.S.A. §640(c). This rule shall apply to an injured worker's current employer, notwithstanding that the injury occurred while he or she was employed by a prior employer. The injured worker and/or insurance carrier shall make every reasonable effort to schedule such appointments at times that do not conflict with the injured worker's regular work schedule. Disputes as to wages that allegedly were improperly withheld under this Rule shall be referred to the Department's Wage and Hour Division for resolution in accordance with its procedures.

Rule 5.0000 RESOLVING MEDICAL DISPUTES

5.1100 Previously promulgated rules relating to the conduct of independent medical examinations under 21 V.S.A. §667 shall be held in abeyance until such time as the pool of examiners contemplated by §667(b) has been established.

Rule 6.0000
INDEPENDENT MEDICAL EXAMINATIONS

6.1100 Scheduling; location. Independent medical examinations requested by the employer or insurance carrier pursuant to 21 V.S.A. §655 shall be scheduled at reasonable intervals and with due regard for the injured worker's schedule and ability to travel. The examination shall be conducted at a location that is within a two-hour driving radius of the injured worker's residence; however, in the Commissioner's discretion an examination outside the two-hour driving radius may be permitted if the injured worker consents, and/or if his or her condition warrants the specialized expertise of a more remotely located provider.

6.1200 Notice. Except in exigent circumstances, written notice of a scheduled independent medical examination shall be provided to the injured worker (and if represented, to his or her attorney as well) at least seven days prior to the scheduled examination date. The notice shall identify the reasons for the examination and the issues to be addressed by the examining medical provider. In addition, the notice shall include information as to the injured worker's and the examining medical provider's respective rights and responsibilities regarding video and/or audio recordings of the examination in accordance with Rules 6.1400 and 6.1500.

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. Depending on the circumstances, if the injured worker fails to provide such notice 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.

6.1400 Injured worker's right to record examination. At his or her own expense, an injured worker may make a video or audio recording of any examination requested pursuant to this Rule, 21 V.S.A. §655, in which case the following rules shall apply:

> 6.1410 At least three business days prior to the scheduled examination date, the injured worker shall give notice of his or her intention to make a video or audio recording of the examination to the employer or insurance carrier, who shall in turn notify the examining medical provider.
>
> 6.1420 To the extent that the injured worker's position on a disputed issue relies, in whole or in part, on information gleaned from a video or audio recording of the examination, he or she shall promptly provide an unedited and un-retouched copy to the employer or insurance adjuster.
>
> 6.1430 An injured worker shall not be penalized in any way for exercising his or her right to make a video or audio recording of an examination in compliance with this Rule.
>
> 6.1440 As an alternative to making a video or audio recording of an examination requested pursuant to this Rule, an injured worker may, at his or her own expense, designate a licensed health care provider to be present at the examination. 21 V.S.A. §655.

6.1500 Examining medical provider's right to record examination. Absent the injured worker's prior written consent, an examining medical provider shall have no right to make a video recording of any examination conducted pursuant to this Rule. However, provided notice is given at the start of the examination, he or she may make an audio recording of the examination, with or without the injured worker's consent. Upon request, the employer or insurance carrier shall, at its own expense, provide the injured worker with an unedited copy of any such audio recording in a timely manner, in accordance with Rule 3.2730. 21 V.S.A. §655.

6.1600 Neutral videographer. Nothing in this Rule shall preclude the parties from agreeing to the selection and payment of a neutral videographer.

6.1700 Recording of examination; admissibility. A video or audio recording of an examination conducted pursuant to this Rule shall be admissible in the context of either informal and/or formal dispute resolution procedures at the Commissioner's discretion, and only upon a showing that (a) it is unedited and unretouched; and (b) it has been provided to the opposing party in a timely manner.

6.1800 Duty to disclose examination report. Upon receipt of the examining medical provider's office notes and/or final report relating to an examination conducted pursuant to this Rule, the employer or insurance carrier shall promptly provide a copy to the injured worker, or if represented, to his or her attorney, in accordance with Rule 3.2720.

6.1900 Refusal to attend; obstruction of examination. Notwithstanding Rule 6.1300, if an injured worker refuses without good cause to submit him- or herself to an examination scheduled pursuant to this Rule, or if he or she in any way obstructs the examination, his or her right to take or prosecute any proceeding under the Workers' Compensation Act shall be suspended until such refusal or obstruction ceases, and compensation shall not be payable for the period during which such refusal or obstruction continues. 21 V.S.A. §655.

Rule 7.0000
PRE-AUTHORIZATION OF PROPOSED MEDICAL TREATMENT

7.1100 **Request for preauthorization.** An injured worker or treating medical provider may submit a request to an employer or insurance carrier that a proposed medical treatment or diagnostic procedure be preauthorized. 21 V.S.A. §640b. The request must be in writing, and must be accompanied by written documentation supporting both the medical necessity of the proposed treatment or procedure and its causal relationship to the injured worker's compensable injury or condition. The request also must clearly delineate the extent of any treatment or diagnostic procedure proposed, in terms of amount, duration and frequency.

7.1200 **Response to request.** The employer or insurance carrier shall have 14 days following the receipt of both the request for preauthorization and the supporting medical documentation within which to respond. 21 V.S.A. §640b(a). It may do so in one of three ways:

> 7.1210 By authorizing the proposed treatment or diagnostic procedure. 21 V.S.A. §640b(a)(1). Once authorized, the employer or insurance carrier shall be obligated to pay all appropriately billed charges related to the proposed treatment or diagnostic procedure in accordance with **Rule** 40.000.
>
> 7.1220 By denying the proposed treatment or diagnostic procedure on one or more of the following grounds:
>
> > 7.1221 That the preauthorization request was not accompanied by the required supporting documentation;
> >
> > 7.1222 That compensability of the injury or condition for which the treatment or diagnostic procedure is sought is disputed, on either legal or factual grounds. This defense shall not be available to an employer or insurance carrier against whom an interim order to pay benefits has been issued, 21 V.S.A. §640b(a)(2)(A);
> >
> > 7.1223 That the proposed treatment or diagnostic procedure (a) is not medically necessary and/or (b) is not causally related to the injured worker's compensable injury or condition. 21 V.S.A. §640b(a)(2)(B).
>
> 7.1230 By ordering a medical record review and/or scheduling an independent medical examination in accordance with **Rule 6.0000** for the purpose of determining whether the proposed treatment or diagnostic procedure is medically necessary and causally related to the injured worker's compensable injury or condition. 21 V.S.A. §640b(a)(3).

7.1300 **Time period for responding after ordering medical record review and/or scheduling independent medical examination.** In claims in which the employer or insurance carrier has responded to a preauthorization request by ordering a medical record review and/or scheduling an independent

medical examination under Rule 7.1230, it shall have 45 days following the receipt of both the request for preauthorization and the supporting medical documentation within which to either approve or deny it. In the Commissioner's sole discretion, an extension of up to ten days may be granted, but only upon a showing of extremely unusual and/or emergency circumstances. 21 V.S.A. §640b(a)(3). Alternatively, if both parties agree in writing an extension of ten or more days may be granted for any reason, provided the time period within which to respond is clearly and specifically stated.

7.1400 **Failure to respond; request for interim order.** If the employer or insurance carrier fails to respond to a preauthorization request within the time periods specified in Rules 7.1200 and/or 7.1300 above, either the injured worker or the treating medical provider may request that the Commissioner issue an interim order authorizing the treatment or diagnostic procedure by operation of law. 21 V.S.A. §640b(b).

> 7.1410 The Commissioner shall notify the employer or insurance carrier of an injured worker's or treating medical provider's request for interim order upon receipt. The employer or insurance carrier shall have five days within which to respond, following which the Commissioner shall have five days within which to rule on the request.
>
> 7.1420 Unless compensability of the injury or condition for which the treatment or diagnostic procedure is sought has been denied or disputed, and provided the initial request for preauthorization conforms to the requirements of Rule 7.1100, absent extraordinary circumstances issuance of an interim order shall be presumed appropriate in all claims in which the employer or insurance carrier has failed to respond within the required time period.
>
> 7.1430 In claims in which compensability of the injury or condition for which the treatment or diagnostic procedure is sought has been denied or disputed, the Commissioner shall consider a request for interim order according to the same criteria applied when reviewing a denial under Rules 3.2200 and 11.0000. 21 V.S.A. §640b(c).

7.1500 **Preauthorization denied; interim order.** If the employer or insurance carrier denies a preauthorization request, either initially under Rule 7.1220 or following a medical record review and/or independent medical examination under Rules 7.1230 and 7.1300, the Commissioner may, either on his or her own initiative or at the injured worker's request, consider whether an interim order authorizing the proposed treatment or diagnostic procedure is appropriate. 21 V.S.A. §640b(c). The burden of proof in such circumstances shall be on the injured worker to establish that the proposed medical treatment or diagnostic procedure is both medically necessary and causally related to the compensable injury or condition for which it is sought.

7.1600. **Required notices; form and content.** When responding to a preauthorization request, the employer or insurance carrier shall provide written notice as follows:

> 7.1610 If it is authorizing the proposed treatment or diagnostic procedure under Rule 7.1210, to the injured worker, the treating medical provider and the Department, 21 V.S.A. §640b(a)(1);
>
> 7.1620 If it is denying the proposed treatment or diagnostic procedure under Rule 7.1220, to the injured worker, the treating medical provider and the Department, 21 V.S.A. §640b(a)(2)(B), by way of a *Denial of Workers' Compensation Benefits* (Form 2), accompanied by (a) the medical

documentation provided in support of the initial preauthorization request; and (b) the medical documentation supporting denial;

7.1630 If it is ordering a medical record review and/or scheduling an independent medical examination under Rule 7.1230, to the injured worker, the treating medical provider and the Department, 21 V.S.A. §640b(a)(3). The notice shall identify the medical provider with whom the record review and/or independent medical examination has been scheduled, and if the latter, the date, time and location at which the examination will occur.

7.1700 Requests not covered. The following requests are not considered preauthorization requests, and therefore are not covered by this Rule, but may instead be pursued in accordance with the provisions of 21 V.S.A. §640a:

7.1710 A demand that the charges for a treatment or diagnostic procedure already undertaken, including prescription medications already purchased, be paid;

7.1720 A request that the charges for medical supplies, including special clothing, footwear or equipment but excluding prescription medications proposed as a course of treatment, be paid or reimbursed.

Rule 8.0000
CALCULATING AVERAGE WEEKLY WAGE AND COMPENSATION RATE

8.1100 **Gross wages; amounts included.** In order to calculate an injured worker's average weekly wage and compensation rate, the employer or insurance carrier shall first file a *Certificate of Dependency and Concurrent Employment* (Form 10) and a *Wage Statement* (Form 25), as required by **Rule 3.2000**. The *Wage Statement* shall include the gross wages paid and/or due the injured worker for each of the 26 weeks preceding the injury, but not including the week of the injury. 21 V.S.A. §650(a). In addition, for each of the 26 weeks preceding the injury, the *Wage Statement* shall also include:

8.1110 Any overtime earnings and/or tips paid, due or received;

8.1120 Any bonuses paid, due or received; and

8.1130 The fair market value of any room, board, food, electricity, telephone, uniforms or similar benefits provided the injured worker; provided, however, that if the injured worker continues to receive any of these benefits during the period of his or her temporary disability, the value of such benefit shall not be included in his or her temporary disability compensation rate.

8.1200 **Total gross wages; weeks excluded.** In determining the injured worker's total gross wages, the following weeks shall not be included:

8.1210 Any week(s) during which the injured worker worked and/or was paid for less than one-half of his or her normally scheduled hours;

8.1220 Any week(s) during which the injured worker did not work at all, regardless of whether he or she was paid for the absence; and

8.1230 Any weeks preceding a raise, promotion and/or transfer as a result of which the injured worker was paid and/or due larger regular wages. 21 V.S.A. §650(a).

8.1300 **Average weekly wage calculation.** An injured worker's average weekly wage shall be determined by dividing the total gross wages, calculated in accordance with **Rule 8.1100** above, by the number of weeks qualifying for inclusion in accordance with **Rule 8.1200** above. However:

8.1310 If the injured worker has been employed for fewer than four weeks at the time of his or her injury, or if fewer than four weeks of includable wages remain after the application of **Rules 8.1210** and/or **8.1220** above, then his or her average weekly wage shall be based instead on the gross wages of a comparable employee working in a similar capacity under like conditions for the 26 weeks prior to the injury. If the wages of a comparable employee cannot be determined, then the injured worker's average weekly wage shall be based instead on his or her agreement with the employer as to both expected hours per week and contract rate of pay. 21 V.S.A. §650(a).

8.1400 **Volunteer public safety worker.** The average weekly wage of a volunteer public safety worker who is covered under 21 V.S.A. §§601(12) and/or 650(a) and who has no other regular employment shall be based on the gross wages of a similarly responsible, paid employee in the same occupation during the 26 weeks prior to the injury. 21 V.S.A. §650(a).

8.1500 **Concurrent employment.** If an injured worker is regularly employed by two or more insured employers at the time of his or her injury (or, in claims in which the disability does not occur concurrently with the injury, at the time of his or her disability), a separate wage statement shall be obtained from each employer, and the injured worker's compensation rate shall be based on the combined average weekly wage from all employers. 21 V.S.A. §650(a).

8.1600 **Compensation rate; temporary total disability.** An injured worker's weekly compensation rate for temporary 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. 21 V.S.A. §642. In addition, the following rules shall apply:

8.1610 The compensation rate shall not be more than the maximum nor less than the minimum weekly compensation rate as set annually in accordance with 21 V.S.A. §650(d) and **Rule 8.2000.** 21 V.S.A. §642.

8.1620 The compensation rate shall be adjusted annually beginning on the first July 1st following the receipt of 26 weeks of indemnity benefits, in accordance with 21 V.S.A. §650(d) and **Rule 8.2000**, provided, however, that it does not exceed the maximum weekly compensation rate.

8.1630 During the period of his or her temporary total disability, the injured worker also shall receive $10.00 per week for each dependent child, as defined in 21 V.S.A. §601(2), who is unmarried and under the age of 21 years, provided that no other injured worker is receiving the same benefits on behalf of the same dependent child or children. 21 V.S.A. §642. The allowance shall be adjusted weekly to reflect the number of dependent children extant during the week of payment.

8.1640 Notwithstanding the provisions of **Rule 8.1610**, in no event shall an injured worker's total weekly wage replacement benefits, including any payments for a dependent child, exceed 90 percent of his or her average weekly wage prior to applying any applicable cost of living adjustment. 21 V.S.A. §§601(19), 642.

8.1650 When temporary disability, either total or partial, does not occur in a continuous period but occurs in separate intervals each resulting from the original injury, the injured worker's weekly compensation rate shall be adjusted for each such recurrence as follows, 21 V.S.A. §650(c):

8.1651 If the average weekly wage has increased since a prior period of disability, the compensation rate for the current period of disability shall be adjusted upward accordingly;

8.1652 If as a consequence of the injury the average weekly wage has decreased since a prior period of disability, the compensation rate for the prior period of disability shall remain in effect;

8.1653 If the average weekly wage has decreased since a prior period of disability for reasons unrelated to the injury, the compensation rate for the current period of disability shall be adjusted downward accordingly.

8.1654 If more than three months have elapsed between separate intervals of disability, the employer or insurance carrier shall submit a new *Wage Statement* (Form 25) and *Agreement for Temporary Compensation* (Form 32) documenting weekly compensation payments in accordance with Rules 8.1651 through 8.1653 above.

8.1660 If more than three months have elapsed between the date of injury and an initial period of temporary disability (whether total or partial) causally related thereto, two *Wage Statements* (Form 25) shall be submitted – one covering the 26-week period prior to the date of injury and one covering the 26-week period prior to the date of disability. Upon comparing them, the employer or insurance carrier shall calculate the injured worker's weekly compensation rate as follows:

8.1661 If the average weekly wage has increased since the date of injury, the compensation rate shall be adjusted upward accordingly;

8.1662 If as a consequence of the injury the average weekly wage has decreased since the date of injury, the compensation rate shall be based on the average weekly wage as of the date of injury;

8.1663 If the average weekly wage has decreased since the date of injury for reasons unrelated thereto, the compensation rate shall be adjusted downward accordingly.

8.1700 Compensation rate; temporary partial disability. An injured worker's weekly compensation rate for temporary partial disability shall be two-thirds (0.667) of the difference between his or her pre-injury average weekly wage, calculated in accordance with 21 V.S.A. §650 and this Rule, and his or her current weekly wage. 21. V.S.A. §646.

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 (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:

8.1810 The compensation rate shall not be more than the maximum nor less than the minimum weekly compensation rate as set annually in accordance with 21 V.S.A. §650(d) and Rule 8.2000. 21 V.S.A. §648(a).

8.1820 The compensation rate shall be adjusted annually on July 1st, in accordance with 21 V.S.A. §650(d) and Rule 8.2000, provided that it does not exceed the maximum weekly compensation rate. Such cost of living adjustments shall begin on the first July 1st following the date on which temporary total disability benefits cease, or if there is no temporary total disability, on the first July 1st following the date of injury.

8.1830 Notwithstanding Rule 8.1810 above, if the injured worker's average weekly wage is lower than the minimum weekly compensation, the weekly compensation rate shall be the full amount of his or her average weekly wage. 21 V.S.A. §601(19).

8.1900 Compensation rate; death benefits. The weekly compensation rate at which death benefits are paid shall be as required by 21 V.S.A. §§632 through 636. In addition, the following rules shall apply:

8.1910 The compensation rate shall not be more than the maximum nor less than the minimum compensation rate as set annually in accordance with 21 V.S.A. §650(d) and Rule 8.2000.

8.1920 The compensation rate shall be adjusted annually on July 1st, in accordance with 21 V.S.A. §650(d) and Rule 8.2000, provided that it does not exceed the maximum weekly compensation rate.

8.2000 Calculating cost of living adjustments and maximum and minimum compensation rates. On or before July 1st annually, the Commissioner shall publish the annual change in compensation rate and new minimum and maximum weekly compensation rates for the coming fiscal year. 21 V.S.A. §650(d).

8.2010 The employer or insurance carrier shall file a *Notice of Change in Compensation Rate* (Form 28) with the Commissioner by July 1st annually as to any injured worker or dependent who is receiving indemnity benefits as of that date and who is entitled to an adjustment of compensation in accordance with this Rule. Concurrent with the filing, the employer or insurance carrier shall mail a copy of the *Notice of Change in Compensation Rate* to the injured worker or if appropriate, to his or her dependent(s).

8.2020 The Commissioner shall maintain a list of current and historical changes in annual compensation rates on the Department's website.

Rule 9.0000
TEMPORARY TOTAL AND TEMPORARY PARTIAL DISABILITY BENEFITS

9.1100 **Temporary total disability benefits; when payable.** If as a result of a compensable injury an injured worker is temporarily disabled from working in any capacity, he or she shall be entitled to temporary total disability benefits as follows, 21 V.S.A. §642:

> 9.1110 **Waiting period.** Temporary total disability benefits are not owed unless and until the injured worker has been totally disabled from working for more than three calendar days, which need not be consecutive. The date of injury shall count as the first day of total disability, unless the injured worker was paid in full for that date. If the injured worker continues to be disabled for seven or more consecutive calendar days after the third day, then he or she shall be entitled to temporary total disability benefits retroactive to the first day of disability. 21 V.S.A. §642.
>
> 9.1120 **Average weekly wage and compensation rate; payment for partial weeks.** Temporary total disability benefits shall be calculated based on the injured worker's average weekly wage and compensation rate as determined in accordance with **Rule 8.0000**. Where the injured worker is entitled to temporary total disability compensation for only a portion of a week, benefits shall be paid at a daily rate based on the number of days per week he or she regularly worked during the 26 weeks prior to the injury.

9.1200 **Temporary partial disability benefits; when payable.** If as a result of a compensable injury an injured worker is temporarily disabled from working in a full time and/or full duty capacity, he or she shall be entitled to temporary partial disability benefits as follows, 21 V.S.A. §646:

> 9.1210 **Waiting period.** Temporary partial disability benefits are not owed unless and until the injured worker has been disabled from working, either totally or partially, for at least eight calendar days, which need not be consecutive. 21 V.S.A. §646. The date of injury shall count as the first day of disability, unless the injured worker was paid in full for that date.
>
> 9.1220 **Compensation rate.** Temporary partial disability benefits shall be calculated in accordance with **Rule 8.1700.**

9.1300 **Evidence required.** An injured worker's claim for temporary total and/or temporary partial disability benefits must be supported by credible medical evidence establishing both the extent of his or her disability and its causal relationship to the compensable injury.

9.1400 **Agreement for Temporary Compensation.** In all cases in which temporary total and/or temporary partial disability benefits are owed, the employer or insurance carrier shall enter into an *Agreement for Temporary Compensation* (Form 32) with the injured worker, and shall begin paying benefits immediately. Once executed by the parties, the completed *Agreement* shall be filed with the Commissioner for review and approval.

9.1410 Any *Agreement for Temporary Compensation* submitted for the Commissioner's review must be accompanied by the necessary supporting documentation, including but not limited to a *Wage Statement* (Form 25) and *Certificate of Dependency and Concurrent Employment* (Form 10). The Commissioner shall not approve an *Agreement* that is inaccurately or insufficiently completed, or that lacks the necessary supporting documentation.

9.1420 The Commissioner shall send a copy of the approved *Agreement for Temporary Compensation* to both the injured worker and the employer or insurance carrier. Once approved, a duly executed *Agreement for Temporary Compensation* constitutes a binding and enforceable contract. Absent evidence of fraud or material mistake of fact, the parties will be deemed to have waived their right to contest the material portions thereof.

9.1430 An injured worker's failure or refusal to execute an *Agreement for Temporary 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 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.

9.1500 Discontinuing benefits. The employer or insurance carrier must fully comply with the requirements of Rule 12.0000 in order to discontinue an injured worker's temporary disability benefits. Absent extraordinary circumstances, if it fails to do so it shall remain responsible for ongoing benefits until such time as full compliance occurs.

9.1600 Extended temporary total disability benefit claims. The employer or insurance carrier shall review every claim for temporary total disability benefits that continues for more than 104 weeks. Within 30 days thereafter, it shall file with the Commissioner and the injured worker medical evidence documenting (a) the injured worker's current medical status; (b) the currently expected duration of his or her disability; and (c) the current likelihood that he or she will be capable of returning to work and if so, when. If the current medical evidence establishes that the injured worker has reached an end medical result, the employer or insurance carrier shall concurrently file an *Employer's Notice of Intention to Discontinue Payment* (Form 27) in accordance with Rule 12.1200. 21 V.S.A. §642a.

Rule 10.0000
PERMANENT PARTIAL DISABILITY, PERMANENT TOTAL DISABILITY AND DEATH BENEFITS

[To calculate the permanent partial disability compensation applicable to injuries occurring before April 1, 1995, please refer to prior Rules 11.1000 through 11.1530, posted on the Department's website.]

10.1100 **Permanency benefits; entitlement.** If as a result of a compensable injury an injured worker suffers a permanent impairment or is deemed to be permanently and totally disabled, he or she shall be entitled to permanent partial or permanent total disability benefits. 21 V.S.A. §§644, 645, 648.

10.1200 **Payment for permanent partial impairment evaluation.** Within 45 days after receiving notice or knowledge that the injured worker has reached an end medical result, the employer or insurance carrier shall take action necessary to determine whether he or she has suffered a permanent impairment as a result of the compensable injury.

> 10.1210 The employer or insurance carrier shall promptly notify the injured worker in writing of his or her right to seek a permanent impairment rating, either from the treating physician or from another physician of his or her choosing. The employer or insurance carrier shall be responsible for paying for at least one such permanent impairment rating, notwithstanding its decision to obtain a rating from another medical examiner as well if it so chooses. At the Commissioner's discretion, the employer or insurance carrier may be ordered to pay for additional permanent impairment evaluations.
>
> 10.1220 Consistent with **Rule 3.2720**, a party who receives a final permanent impairment rating report shall promptly disclose it to all other parties.

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.

> 10.1310 The existence and degree of permanent partial impairment referable to mental and behavioral disorders shall be determined in accordance with the rating methodology described in Chapter 14 of the *American Medical Association Guides to the Evaluation of Permanent Impairment, 6th edition*.
>
> 10.1320 Compensation for other injuries or conditions for which the *AMA Guides* does not provide numerical impairment ratings shall be as determined by the Commissioner and in proportion to the compensation paid for analogous injuries for which numerical impairment ratings are provided.

10.1400 Calculating compensation for permanent partial impairment not referable to spine. Except with respect to the spine, the permanent partial disability compensation due an injured worker as a consequence of permanent impairment to a body part, system or function shall be based on the percentage impairment of the whole person multiplied by 405 weeks. 21 V.S.A. §648.

10.1410 When a compensable injury results in permanent impairment to more than one body part, system or function, not including the spine, the whole person impairment shall be determined in accordance with the *AMA Guides'* combined values chart, and the number of weeks for which compensation must be paid shall be based on the resulting percentage impairment of the whole person multiplied by 405 weeks.

10.1500 Calculating compensation for permanent partial impairment referable to spine. The permanent partial disability compensation due an injured worker as a consequence of permanent impairment to the back or spine shall be based on the percentage impairment of the whole person multiplied by 550 weeks. 21 V.S.A. §648.

10.1510 When a compensable injury results in permanent impairment to more than one body part, system or function, including the spine, the number of weeks for which compensation must be paid shall be determined by adding together:

10.1511 The percentage whole person impairment to the body part, system or function, not including the spine, multiplied by 405 weeks; and

10.1512 The percentage whole person impairment to the spine, multiplied by 550 weeks.

10.1600 Permanent total disability. The disability caused by any of the injuries or conditions enumerated in 21 V.S.A. §644(a) shall be deemed total and permanent. Provided compensability is established, an injured worker who suffers any such injury or condition shall be entitled to permanent total disability benefits in accordance with 21 V.S.A. §645.

10.1700 Odd lot doctrine. An injured worker shall be considered permanently and totally disabled in accordance with the odd lot doctrine if a compensable injury causes a physical and/or mental impairment that renders him or her unable to perform regular, gainful work. In evaluating whether or not an injured worker is permanently and totally disabled under this rule, his or her age, experience, training, education, occupation and mental capacity shall be considered, in addition to physical or mental limitations and/or pain. 21 V.S.A. §644(b).

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.

10.1720 For the purposes of this Rule, "regular, gainful work" refers to regular employment in any well-known branch of the labor market. Work that is so limited in quality, dependability or quantity that a reasonably stable market for it does not exist does not constitute "regular, gainful work."

10.1800 Agreement for Permanent Partial or Permanent Total Disability Compensation. In all cases in which permanent partial or permanent total disability benefits are owed, the employer or insurance carrier shall enter into an *Agreement for Permanent Partial or Permanent Total Disability Compensation* (Form 22) with the injured worker, and shall begin advancing benefits immediately. Once executed by the parties, the completed *Agreement* shall be filed with the Commissioner for review and approval.

10.1810 Any *Agreement for Permanent Partial or Permanent Total Disability Compensation* submitted for the Commissioner's review must be accompanied by the necessary supporting documentation, including but not limited to (a) a *Wage Statement* (Form 25); and (b) medical evidence establishing the date of end medical result and the extent of any permanent impairment and/or disability causally related to the compensable injury. The Commissioner shall not approve an *Agreement* that is inaccurately or insufficiently completed, or that lacks the necessary supporting documentation.

10.1820 The Commissioner shall send a copy of the approved *Agreement for Permanent Partial or Permanent Total Disability Compensation* to both the injured worker and the employer or insurance carrier. Once approved, a duly executed *Agreement for Permanent Partial or Permanent Total Disability Compensation* constitutes a binding and enforceable contract. Absent evidence of fraud or material mistake of fact, the parties will be deemed to have waived their right to contest the material portions thereof.

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 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.

10.1840 Unless separately negotiated in the context of a compromise agreement approved by the Commissioner in accordance with Rule 13.0000, the Commissioner's approval of an *Agreement for Permanent Partial or Permanent Total Disability Compensation* shall not relieve the employer or insurance carrier from its ongoing responsibility to provide medically necessary treatment causally related to the compensable injury in accordance with 21 V.S.A. §640.

10.1900 Death from causes related to compensable injury. If death results from a compensable injury, the employer or insurance carrier shall pay compensation in accordance with 21 V.S.A. §§632 through 637 and Rule 8.1900.

10.1910 In all cases in which death benefits are owed as a consequence of a compensable injury, the employer or insurance carrier shall enter into an *Agreement for Compensation in Fatal Cases* (Form 23) with the injured worker's spouse and/or dependent beneficiaries, and shall begin paying benefits immediately. Once executed by the parties, the completed *Agreement* shall be filed with the Commissioner for review and approval.

10.1911 Any *Agreement for Compensation in Fatal Cases* submitted for the Commissioner's review must be accompanied by the necessary supporting documentation, including but not limited to (a) a *First Report of Injury* (Form 1) and *Report of Fatal Accident* (Form 4), if not already filed; and (b) a *Wage Statement* (Form 25). The Commissioner shall not approve an *Agreement* that is inaccurately or insufficiently completed, or that lacks the necessary supporting documentation.

10.1912 The Commissioner shall send a copy of the approved *Agreement for Compensation in Fatal Cases* to both the injured worker's spouse and/or dependent beneficiaries and the employer or insurance carrier. Once approved, a duly executed *Agreement for Compensation in Fatal Cases* constitutes a binding and enforceable contract. Absent evidence of fraud or material mistake of fact, the parties will be deemed to have waived their right to contest the material portions thereof.

10.1913 Failure or refusal of the injured worker's spouse and/or dependent beneficiaries to execute an *Agreement for Permanent Partial or Permanent Total Disability Compensation* shall not disqualify any of them from receiving benefits otherwise determined to be owed. If despite at least two written requests the injured worker's spouse and/or dependent beneficiaries fail or refuse 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's spouse and/or dependent beneficiaries. Thereafter, the employer or insurance carrier shall pay the amount the Department deems correct in accordance with the partially executed *Agreement*. However, the acceptance of such payments by the injured worker's spouse and/or dependent beneficiaries shall not, by itself, constitute a waiver of their right to contest the amount of benefits due.

10.2000 Death from causes unrelated to compensable injury. If an injured worker dies from causes unrelated to the compensable injury, the employer or insurance carrier shall pay any compensation benefits that already have accrued to his or her surviving spouse and/or dependent beneficiaries in accordance with 21 V.S.A. §§635 and 636. If the injured worker dies without leaving either a surviving spouse or dependent beneficiaries, then any remaining accrued benefits shall be applied to burial, funeral and out-of-state transportation expenses in accordance with 21 V.S.A. §639.

Rule 11.0000
DENYING BENEFITS

11.1100 **Generally.** An employer or insurance carrier who seeks to deny an injured worker's claim for specific benefits causally related to a compensable injury shall file a *Denial of Workers' Compensation Benefits* (Form 2) with the Commissioner and the injured worker. The *Denial* shall clearly state the reason(s) for the denial, and shall be accompanied by copies of all relevant documentation, medical or otherwise, relied upon to support it.

> 11.1110 An employer or insurance carrier who has denied a claim for specific benefits on the grounds that information relevant to its investigation was appropriately requested but not forthcoming shall have an affirmative obligation to reconsider its denial if the requested information is received within 45 days thereafter.

11.1200 **Interim order.** Upon written request by the injured worker and if the available evidence does not reasonably support a denial, the Commissioner shall issue an interim order that the denied benefit(s) be paid pending a formal determination in accordance with **Rule 17.0000.** Unless otherwise specified therein, any such benefit payments shall be due and payable upon issuance of the interim order. If following a formal hearing the Commissioner concludes that some or all of the benefits paid pursuant to an interim order were not in fact owed, the employer or insurance carrier may request that the injured worker be ordered to make repayment, and may enforce such order in any court of law having jurisdiction. 21 V.S.A. §662(b).

11.1300 **Application of rule.** This rule shall apply to claims for an initial or successive period of temporary disability, claims for new or resumed medical services or supplies and claims for permanent disability. An employer or insurance carrier who seeks to terminate its responsibility for ongoing benefits, whether indemnity or medical, must do so in accordance with **Rule 12.0000.**

Rule 12.0000
DISCONTINUING BENEFITS

12.1100 **Generally.** Except as provided in **Rule 12.1500** with respect to successful return to work and/or in **Rule 3.2300** with respect to payment without prejudice, an employer or insurance carrier shall not discontinue an injured worker's compensation benefits until at least seven days after an *Employer's Notice of Intention to Discontinue Payments* (Form 27) is received by both the Commissioner and the injured worker. 21 V.S.A. §643a. If the injured worker is represented by counsel, a copy of the *Notice* must also be sent to his or her attorney.

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 to the specific benefit(s) for which discontinuance is sought, including both supporting and countervailing evidence. Previously filed evidence need not be duplicated, but should be so referenced in the current filing.

12.1111 Relevant evidence may be filed in either paper or disc format. If the latter, the disc must not be encrypted or password-protected, and must be submitted in a searchable format. Whether chronologically or otherwise, the evidence must be organized in such fashion that the specific information upon which the discontinuance is based is readily identifiable and available for review. Failure to comply with this Rule may be grounds for rejecting the proposed discontinuance.

12.1120 If the injured worker is represented by counsel, the parties may stipulate to a discontinuance of benefits as of a specified date, in which case the employer or insurance carrier shall file a copy of the signed stipulation with the *Employer's Notice of Intention to Discontinue Payments*. Relevant evidence in support of the discontinuance shall also be filed, but countervailing evidence need not be included.

12.1200 **Discontinuing temporary disability benefits; end medical result.** An employer or insurance carrier who proposes to discontinue an injured worker's temporary disability benefits on the basis of end medical result shall comply in all respects with the requirements of **Rule 12.1100**. The employer or insurance carrier shall also comply with the requirements of **Rule 10.0000** with respect to evaluating the extent of any permanent impairment referable to the compensable injury and paying permanent disability benefits accordingly.

12.1300 **Discontinuing temporary disability benefits; failure or refusal to return to work.** An employer or insurance carrier who proposes to discontinue an injured worker's temporary disability benefits on the basis of his or her failure or refusal to return to work shall comply in all respects with the requirements of **Rule 12.1100**. In such cases, the *Employer's Notice of Intention to Discontinue Payments* must be accompanied by written documentation establishing:

12.1310 That the injured worker has been medically released to return to work, either with or without restrictions; and

12.1320 That the employer or insurance carrier has notified the injured worker, in writing, that he or she has been medically released to return to work, either with or without restrictions, and either (a) that the employer has made suitable work available; or (b) that the injured worker is obligated to conduct a good faith search for suitable work; and

12.1330 That the injured worker has failed to conduct a good faith search for suitable work and/or has refused an offer of suitable available work once notified.

12.1400 **Discontinuing temporary disability benefits; other grounds.** An employer or insurance carrier who proposes to discontinue an injured worker's temporary disability benefits on other grounds shall comply in all respects with the requirements of **Rule 12.1100**. Such other grounds may include, but are not limited to:

12.1410 The injured worker's failure or refusal to comply with medical treatment recommendations;

12.1420 The injured worker's failure or refusal to cooperate with vocational rehabilitation efforts; and/or

12.1430 The injured worker's failure or refusal to adhere to other obligations imposed by statute or rule.

12.1500 **Discontinuing temporary disability benefits; notice not required.** The provisions of **Rule 12.1100** shall not apply in situations where the employer or insurance carrier seeks to discontinue temporary disability benefits on the grounds that the injured worker has successfully returned to work as defined in **Rule 2.4100**.

12.1510 If the injured worker has returned to work under circumstances that entitle him or her to temporary partial disability benefits in accordance with **Rule 9.1200**, the employer or insurance carrier shall promptly file a new *Agreement for Temporary Compensation* (Form 32), in accordance with **Rule 9.1400**, and shall commence paying weekly benefits immediately.

12.1520 Unless other grounds for discontinuance exist, the employer or insurance carrier shall be obligated to reinstate temporary disability benefits previously discontinued under this Rule upon receiving notice that as a consequence of the compensable injury the injured worker's return to work has proven unsuccessful.

12.1600 **Discontinuing temporary disability benefits; vocational rehabilitation screening verification.** In all cases in which the injured worker has been totally disabled from working for a period of 90 days or more, the employer or insurance carrier shall verify in writing that it has offered vocational rehabilitation services as required by 21 V.S.A. §641(a)(3).

12.1700 **Discontinuing medical benefits.** An employer or insurance carrier who proposes to discontinue payment for specific medical services or supplies previously covered under 21 V.S.A. §640 shall comply in all respects with the provisions of **Rule 12.1100**.

12.1710 The grounds for such discontinuance include, but are not limited to, proof that the specified service or supply is no longer medically necessary and/or causally related to the compensable injury. In appropriate circumstances, an injured worker's documented pattern of non-compliance with prescribed medical treatment may also provide sufficient grounds for discontinuance.

12.1720 If the proposed discontinuance pertains to narcotic or other medications for which a safe taper plan is medically necessary, the employer or insurance carrier shall provide credible medical evidence establishing that the date of its proposed discontinuance comports with such a plan.

12.1800 **Discontinuing permanent partial disability, permanent total disability and death benefits.** The provisions of **Rule 12.1100** shall not apply in situations where the employer or insurance carrier seeks to discontinue permanent partial disability, permanent total disability or death benefits. However, where the employer or insurance carrier seeks to discontinue permanent total disability or death benefits on the grounds of a change in status on the part of the injured worker or his or her dependent beneficiaries, it shall provide notification in accordance with **Rule 3.2800.**

12.1900 **Injured worker's objection to discontinuance; request for extension.** If the injured worker disputes a discontinuance proposed by the employer or insurance carrier, he or she may request that the Commissioner extend its effective date for a period of 14 days. The request must be in writing, and must be filed with the Commissioner, with a copy to the employer or insurance carrier, within 7 days after the injured worker receives the *Employer's Notice of Intention to Discontinue Benefits*. The request must specifically identify the reason(s) why the proposed discontinuance is objectionable and must be accompanied by supporting evidence. The Commissioner shall review the request for extension promptly upon receipt, and shall either approve or deny it, which decision shall not be subject to reconsideration or appeal. 21 V.S.A. §643a.

12.2000 **Commissioner's review of discontinuance.** The Commissioner shall review every *Employer's Notice of Intention to Discontinue Benefits* to determine whether a sufficient basis exists for the proposed discontinuance.

12.2010 If a preponderance of the relevant evidence reasonably supports discontinuance, the Commissioner shall approve it as of its effective date. In that event, the employer or insurance carrier shall be entitled to offset any benefit payments made either during the seven-day notice period required by **Rule 12.1100** and/or during the 14-day extension period granted in accordance with **Rule 12.1900** against any permanent partial disability benefits subsequently determined to be due. 21 V.S.A. §643a.

12.2020 If a preponderance of the relevant evidence fails to reasonably support discontinuance, the Commissioner shall issue an interim order that benefits continue. 21 V.S.A. §643a.

12.2100 **Appeal.** If any party is aggrieved by the Commissioner's decision upon review of a proposed discontinuance, it may request a formal hearing in accordance with **Rule 14.0000.** If following a formal hearing the Commissioner concludes that some or all of the benefits paid subsequent to a proposed discontinuance were not in fact owed, the employer or insurance carrier may request that the injured worker be ordered to make repayment, and may enforce such order in any court of law having jurisdiction. 21 V.S.A. §643a.

12.2110 The injured worker may request that discontinued benefits be reinstated prior to formal hearing by providing sufficient new evidence to the Commissioner establishing that a preponderance of the relevant evidence no longer reasonably supports discontinuance. 21 V.S.A. §643a.

12.2120 Notwithstanding the issuance of an interim order against it under Rule 12.2020, the employer or insurance carrier may at any time seek to discontinue benefits on grounds not previously alleged by filing a new *Employer's Notice of Intention to Discontinue Benefits* in accordance with Rule 12.1100.

Rule 13.0000
LUMP SUM PAYMENTS AND COMPROMISE AGREEMENTS

13.1100 **Lump sum payment; generally.** The employer or insurance carrier shall issue payment of compensation benefits to the injured worker in a lump sum under the following circumstances:

13.1110 Where the amount paid represents retroactive and/or past due compensation;

13.1120 Upon request by the injured worker, and with the Commissioner's approval under **Rule 13.1200**, where the amount paid represents compensation for some or all of the permanent partial and/or permanent total disability benefits to which the injured worker is entitled;

13.1130 Where the amount paid is in accordance with a compromise agreement approved by the Commissioner under **Rule 13.1500.**

13.1200 **Lump sum request; Commissioner's approval.** An injured worker who seeks to have some or all of the permanent partial and/or permanent total disability benefits to which he or she is entitled paid in a lump sum must file a written request with the Commissioner, with a copy to the employer or insurance carrier. The request must specify both the lump sum amount requested and the reason(s) therefor. The Commissioner shall approve the request upon a showing that a lump sum payment is in the injured worker's best interests. 21 V.S.A. §652(b).

13.1210 In determining whether a lump sum payment is in the injured worker's best interests, the following factors shall be considered positive:

13.1211 That the injured worker's household benefits from a regular source of income aside from any workers' compensation benefit(s) currently being paid;

13.1212 That the lump sum payment likely will hasten or improve the injured worker's ability to return to gainful employment; and/or

13.1213 That other specified circumstances justify payment in a lump sum.

13.1220 Unless the employer or insurance carrier consents, the Commissioner shall not approve a lump sum request for benefits awarded pursuant to an interim order or formal hearing decision from which the employer or insurance carrier has appealed.

13.1230 Notwithstanding the above, the Commissioner shall not approve a lump sum request for payment of permanent total disability benefits beyond 330 weeks unless the employer or insurance carrier consents.

13.1240 The employer or insurance carrier shall have 30 days following the Commissioner's approval of a lump sum request within which to issue payment to the injured worker. Upon request, the Commissioner may extend this time period for good cause shown.

13.1300 **Lump sum payment; Social Security offset.** With the exception of lump sum payments of retroactive or past due compensation benefits, and unless the injured worker waives this provision in writing, every request for a lump sum payment to be issued under Rule 13.1100 shall include a provision accounting for excludable expenses and prorating the remainder of the lump sum payment in the manner set forth by the Social Security Administration in order to protect the injured worker's entitlement to Social Security benefits. 21 V.S.A. §652(c).

13.1400 **Lump sum payment; attorney fees.** In appropriate circumstances, and with the injured worker's consent, the Commissioner may approve a lump sum payment by way of a check issued jointly to the injured worker and his or her attorney. Alternatively, with the injured worker's consent, the Commissioner may approve payment of the attorney's associated costs and fees by way of a separate check payable directly to the attorney. An attorney who requests payment in this manner must do so in writing, with a copy to the injured worker, and must specify the amount of costs and attorney fees to be deducted from the lump sum payment.

13.1500 **Compromise agreement; generally.** With the Commissioner's approval, the parties may enter into a compromise agreement to fully and finally resolve all or part of an injured worker's claim for workers' compensation benefits. The Commissioner shall approve the agreement upon a showing that it is in the injured worker's best interests. 21 V.S.A. §662(a).

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;
>
> 13.1620 The parties' respective positions on each of these issues;
>
> 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
>
> 13.1640 The reason(s) why the proposed compromise agreement is in the injured worker's best interests.

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.

Rule 14.0000
REQUESTING A HEARING IN A CONTESTED CLAIM

14.1100 **Notice and Application for Hearing; filing.** When a claim for compensation is contested, any party may file a *Notice and Application for Hearing* (Form 6) with the Commissioner. Upon receipt, the Commissioner shall serve a copy on all other parties, either by first class mail or electronically in accordance with Rule 3.3000.

> 14.1110 The Commissioner may treat any written communication from a party as a *Notice and Application for Hearing*, and make the necessary service of the application on the other party or parties. Any written communication by an unrepresented injured worker that appeals or otherwise questions the denial, discontinuance or miscalculation of any benefit shall be deemed an application for hearing. 21 V.S.A. §662(b).

14.1200 **Contents.** The *Notice and Application for Hearing* shall contain a short and plain statement of the claim and the specific relief sought, and shall be accompanied by all relevant supporting documentation not previously filed. The *Notice and Application for Hearing* shall be signed by the applicant or an authorized representative.

14.1300 **Response.** Within 21 days after the *Notice and Application for Hearing* is served by the Commissioner, the opposing party or parties shall serve an answer upon the applicant, all other parties and the Commissioner. The answer shall specifically respond to each claim asserted, identify the issues in dispute and reference all relevant supporting evidence (copies of which shall be attached if not previously filed). If the injured worker has provided specific facts sufficient to support the claim, failure to answer by the employer or insurance carrier may be treated as an unreasonable denial subject to an order to pay compensation pursuant to 21 V.S.A. § 662(b) and/or an award of attorney fees pursuant to Rule 20.0000. This provision shall not be construed to bar the timely assertion of additional defenses when justice so requires.

14.1400 **Service of papers.** Once a *Notice and Application for Hearing* has been filed, every paper or document subsequently filed by a party shall be served upon all other parties and the Commissioner. Filing with the Commissioner shall occur when a document or paper is received by the Commissioner, whether in paper, disc or electronic format. Except as provided in Rule 6.1200 (notice of independent medical examination) and in Rule 12.1100 (notice of discontinuance), if a party is represented by counsel, service shall be on counsel.

Rule 15.0000
REPRESENTATION IN A CONTESTED CLAIM; ASSISTANCE BY BARGAINING UNIT REPRESENTATIVE

15.1100 **Personal appearance; attorney representation.** Parties to a contested claim before the Commissioner may appear personally or, upon filing of a written notice of appearance, may be represented by a licensed attorney. Upon request and in the Commissioner's discretion, an attorney who is not licensed to practice in Vermont may be permitted to represent a party, provided he or she (a) is in good standing with the bar of another state; and (b) actively associates with a member of the Vermont bar.

15.1200 **Notice to or by party.** Except as provided in **Rule 6.1200** (notice of independent medical examination) and in **Rule 12.1100** (notice of discontinuance), any notice given to or by an attorney of record for a party, or to or by the employer's or insurance carrier's claims adjuster, shall be considered in all respects as notice to or by that party.

15.1300 **Attorney withdrawal.** An attorney who seeks to withdraw from representing a party after he or she has entered an appearance must first request the Commissioner's authorization to do so in writing. In ruling on such a request, the Commissioner shall consider whether the attorney has complied with the requirements of Rule 1.16 of the Vermont Supreme Court Rules of Professional Conduct, particularly with respect to providing notice to the client and alleging sufficient grounds for the withdrawal. If applicable, the Commissioner shall also consider the manner in which any lien for attorney fees granted in accordance with 21 V.S.A. §682 and **Rule 20.1800** is to be addressed.

15.1400 **Assistance by collective bargaining unit representative.** An injured worker who is a member of a collective bargaining unit may identify a bargaining unit representative to provide informal assistance in furtherance of his or her claim for workers' compensation benefits. In order for the Commissioner to discuss any details of the claim with such representative, the injured worker first must sign and submit a written release, identifying the representative's name, title and bargaining unit. The release shall remain effective until (a) the injured worker modifies or withdraws it; (b) the named bargaining unit representative ceases to hold a representative position, or (c) an attorney enters his or her appearance on the injured worker's behalf. The bargaining unit representative's assistance shall not extend to providing legal representation at any stage of the dispute resolution process, but may consist of the following:

> 15.1410 Conveying general information regarding the workers' compensation claims process to the injured worker;
>
> 15.1420 Conveying specific information to the injured worker as to the status of his or her claim;
>
> 15.1430 Assisting the injured worker to prepare forms, letters or other submittals, provided that all such filings shall be signed by the injured worker him- or herself; and/or

15.1440 With the Commissioner's approval, conferring with the injured worker and/or speaking on his or her behalf at an informal telephone conference.

Rule 16.0000
THE INFORMAL DISPUTE RESOLUTION PROCESS

16.1100 **Informal conference; scheduling.** Upon receipt of a *Notice and Application for Hearing* (Form 6), and after notice to the parties in accordance with **Rule 14.1100**, the Commissioner shall review the claim and, if appropriate, may issue an interim order or schedule an informal telephone conference. If necessary, the Commissioner may require that additional supporting documentation be filed before taking further action. The Commissioner shall not be responsible for obtaining records, documents or other evidence, and shall not bear any of the costs associated with doing so.

16.1200 **Purpose.** The purpose of the informal conference is to identify, address and, if possible, resolve the disputed legal and/or factual issues raised by the *Notice and Application for Hearing*. If at any time it becomes apparent that additional information is required in order for this to occur, the Commissioner may continue the matter until such information is received, at which time additional informal conferences may be scheduled.

> 16.1210 Subject to the provisions of **Rule 3.2700**, each party shall provide relevant evidence to the Commissioner and to the other party or parties with sufficient promptness so that it can be adequately reviewed and considered in advance of the informal conference. In the Commissioner's discretion, a party's failure to do so may delay or preclude the issuance of any interim order or other ruling sought by that party.

16.1300 **Formal hearing docket referral.** When it appears that no further progress towards resolution is likely at the informal level, the Commissioner shall forward the claim to the formal hearing docket.

16.1400 **Interim order.** At any time before, during or following an informal conference, if the evidence produced does not support a denial or discontinuance of benefits in accordance with the applicable evidentiary standard, the Commissioner may issue an interim order that payments be made, in whole or in part. 21 V.S.A. §§643a, 662(b); **Rules 11.1200** and **12.2000**. Unless otherwise specified therein, any such benefit payments shall be due and payable upon issuance of the interim order.

Rule 17.0000
FORMAL HEARING PROCEDURE; APPEALS

17.1100 **Purpose.** The purpose of the formal hearing is to determine the rights of the parties by a speedy and inexpensive procedure. To that end, in general hearings shall be conducted in accordance with the Vermont Rules of Civil Procedure and the Vermont Rules of Evidence, but only insofar as they do not defeat the informal nature of the hearing. 21 V.S.A. §§602, 604.

17.1200 **Attorney representation.** An injured worker or uninsured employer who is a party to a formal hearing proceeding may appear *pro se*. An insured employer must appear by way of legal counsel appointed for that purpose by its workers' compensation insurance carrier.

17.1300 **Pretrial conference.** Upon forwarding of a disputed claim to the formal hearing docket, the assigned Workers' Compensation Administrative Law Judge shall schedule a telephone pretrial conference with the parties.

> 17.1310 In advance of the pretrial conference, each party shall file a preliminary disclosure in which it (a) identifies the disputed issue(s); (b) discloses any hearsay evidence upon which it intends to rely at hearing; (c) identifies any exhibits it intends to use and/or introduce; and (d) outlines the proposed testimony of any witnesses it intends to call.
>
> 17.1320 At the pretrial conference, the Administrative Law Judge shall set the date upon which the formal hearing shall occur, the deadline for mandatory mediation under **Rule** 18.0000 and the date by which final disclosures must be filed. In situations where some financial, medical or other emergency requires immediate resolution, every effort shall be made to expedite the pretrial discovery process so that a formal hearing can be scheduled as quickly as possible. Continuances shall be granted at the Administrative Law Judge's sole discretion.
>
> 17.1330 In advance of the formal hearing and by the deadline established at the pretrial conference, each party shall file a final disclosure setting forth (a) a final statement of the disputed issue(s); (b) a joint and final statement of uncontested facts; (c) a final witness list and brief statement as to the substance of each witness' proposed testimony; (d) a final list of exhibits to be used and/or introduced; and (e) a final statement as to any hearsay evidence, not yet disclosed, upon which it intends to rely.

17.1400 **Subpoena.** The Administrative Law Judge may issue a subpoena requiring the attendance of any witness for the purpose of examination either at a deposition and/or at the formal hearing upon the written request of any party filed at least 10 days prior thereto. 21 V.S.A. §603(a). The requesting party shall be responsible for ensuring appropriate service of the subpoena and for paying the appropriate mileage and witness fees.

17.1500 **Photographic and/or video evidence.** A party seeking to introduce photographic and/or video evidence must provide copies to the opposing party in a timely manner prior to the formal hearing, so as to allow sufficient opportunity to review the evidence and verify its accuracy.

17.1600 Joint medical exhibit. The parties shall make every effort to compile a joint medical exhibit, containing legible copies of all relevant medical records and reports, in advance of the formal hearing. Any records or reports that are intended to be offered for admission by one party but are not to be included in the joint medical exhibit shall be produced no later than the final disclosure deadline.

17.1700 Late-disclosed evidence. Notwithstanding the above, at the Administrative Law Judge's discretion a party may be permitted to produce evidence or identify witnesses after the final disclosure deadline upon a showing that doing so will cause no unfair surprise to the opposing party.

17.1800 Hearsay evidence. Hearsay evidence shall be admissible at the formal hearing provided that it (a) is of a type commonly relied upon by prudent people in the conduct of their affairs; (b) conforms to the requirements of this Rule; and (c) is produced with notice sufficient for the opposing party to verify its accuracy.

17.1900 Repetitive material. Repetitive and clearly irrelevant material shall be excluded.

17.2000 Expert medical testimony. At the Administrative Law Judge's discretion, expert medical testimony may be submitted by deposition. Depositions of witnesses, other than depositions of medical experts, shall be admitted by agreement or pursuant to Rule 32 of the Vermont Rules of Civil Procedure. Upon agreement of the parties, or at the Administrative Law Judge's discretion, a witness shall be permitted to testify via telephone, video or other electronic media.

17.2100 Judicial notice. The Administrative Law Judge shall take notice of judicially cognizable facts, generally recognized technical and scientific facts within his or her specialized knowledge and all previously filed workers' compensation forms.

17.2200 Post-hearing pleadings; opinion and order. If ordered by the Administrative Law Judge, proposed findings of fact and conclusions of law shall be submitted within thirty days after the hearing concludes, or longer if the parties agree and/or if good cause is shown. At the Administrative Law Judge's discretion, responsive pleadings also may be allowed. The Commissioner's opinion and order, which may include abbreviated findings of fact and/or conclusions of law when appropriate, shall issue within sixty days after the date the hearing is completed, the evidentiary record is closed and all required submissions are filed. 21 V.S.A. §§663, 664.

17.2300 Appeals; certified questions. Except with regard to transcripts, appeals to the superior court shall be governed by 21 V.S.A. §670 and Rule 74 of the Vermont Rules of Civil Procedure. Appeals to the supreme court shall be governed by 21 V.S.A. §672 and Rule 4 of the Vermont Rules of Appellate Procedure.

> 17.2310 Within 30 days after a notice of appeal is filed with the Department, the Commissioner shall certify the questions on appeal to the appropriate court in accordance with 21 V.S.A. §§671 and 672. In the Commissioner's sole discretion, such questions may be derived, in whole or in part, from those proposed by any party to the appeal.

17.2400 Formal hearing recording or transcript. Upon request by either party, the Commissioner shall produce a digital recording of the formal hearing, the expense of which shall be borne by the requesting

party. The Commissioner shall not be responsible for transcribing all or any portion of the formal hearing, but upon request, may certify the accuracy of any transcript presented by a party.

Rule 18.0000
MEDIATION

18.1100 **Disputes appropriate for mediation.** Unless otherwise provided in this Rule, upon referral to the formal hearing docket the Commissioner may order mediation in any disputed workers' compensation claim not resolved at the informal level. In exercising this discretion, the Commissioner shall consider the extent, if any, to which mediation is likely to speed resolution of the dispute in a cost-effective manner. 21 V.S.A. §663a(a).

18.1200 **Disputes not covered.** The following disputes shall not be subject to mandatory mediation under this Rule:

18.1210 Disputes involving administrative fraud, misclassification and/or penalty proceedings brought under 21 V.S.A. §§688, 689, 692, 702, 704, 705, 708 and/or **Vermont Workers' Compensation Rule 45;**

18.1220 Disputes involving an employer's obligation, if any, to maintain workers' compensation insurance coverage over a putative employee or independent contractor; and/or

18.1230 Insurance coverage disputes between an employer and its insurance carrier.

18.1300 **Waiver.** Upon request by any party, in appropriate circumstances the Commissioner may waive mandatory mediation. In ruling on such a request, the Commissioner shall consider the following factors:

18.1310 Whether the disputed issues are primarily legal or factual in nature;

18.1320 Whether the amount in dispute is small in comparison to the cost of mediation;

18.1330 Whether the cost of mediation is prohibitive given the injured worker's financial circumstances;

18.1340 Whether the injured worker has access to legal representation, and if not, whether he or she is capable of representing him- or herself at mediation;

18.1350 Whether the other party or parties to the dispute concur with the request to waive mandatory mediation; and/or

18.1360 Whether it is unlikely under the circumstances that mediation will be successful.

18.1400 **List of approved mediators.** The Commissioner shall publish and maintain a list of mediators who have been approved to conduct mandatory mediations under this Rule. 21 V.S.A. §663a(c).

18.1410 A person who seeks approval to serve as a mediator shall submit to the Commissioner, in writing, a list of his or her qualifications, which shall include familiarity with Vermont's workers' compensation statute, rules and case law, as well as practical mediation experience, if any.

18.1420 A person need not be a Vermont licensed attorney in order to qualify as an approved mediator. A Vermont licensed workers' compensation adjuster, former Department of Labor Workers' Compensation and Safety Division employee, Vermont licensed physician and /or a currently practicing mediator may qualify, provided he or she can demonstrate practical mediation experience and/or familiarity with Vermont's workers' compensation statute, rules and case law.

18.1430 The Commissioner may remove a mediator from the approved list upon a showing that he or she has violated appropriate standards of competence, ethical conduct, impartiality and/or confidentiality.

18.1500 Selecting a mediator. The parties may mutually agree on a qualified mediator from the Commissioner's list of approved mediators. If they are unable to do so within 14 days after being ordered to mediate, the Commissioner shall assign a qualified mediator from the approved list.

18.1600 Mediation process. Once a mediator is chosen, the mediation shall be scheduled as soon as practicable, but at least 30 days prior to any scheduled formal hearing.

18.1610 The mediation process shall conform to the Vermont Uniform Mediation Act, 12 V.S.A. §5711 *et seq.*

18.1620 Any discussions or admissions made in the course of the mediation process shall be deemed confidential, and shall not be subject to disclosure at formal hearing. However, this provision shall not relieve any party from its obligation to fully and promptly disclose relevant information in accordance with Rule 3.2700.

18.1630 Under no circumstances shall a mediator be called upon to testify or otherwise participate in any workers' compensation proceeding involving the mediated claim.

18.1700 Good faith participation required. The parties to a mediation shall each make a good faith effort to participate fully in the process and endeavor to resolve the disputed issues.

18.1710 All parties shall be fully prepared to discuss the legal and factual bases for their respective positions on the disputed issues.

18.1720 A representative for the employer or insurance carrier, who may be an attorney or Vermont licensed adjuster, shall be present at the mediation. Should such representative lack the full and final authority necessary to settle the claim, a person with such authority shall also participate by telephone for the duration of the mediation session.

18.1730 In the Commissioner's discretion, a party who fails to participate in mediation in good faith may be ordered to pay for all or an additional portion of the costs associated with the mediation. If the offending party is the injured worker, the Commissioner may order that further action on the claim and/or ongoing benefit payments be suspended until such time as good faith participation

occurs. If the offending party is the employer or insurance carrier, the Commissioner may issue an interim order to pay benefits pending formal hearing.

18.1800 Mediator's responsibilities. The mediator shall prepare for and conduct the mediation in such a way as to maximize the likelihood that the disputed issues will be successfully resolved. Within 15 days after mediation is concluded, the mediator shall file a *Workers' Compensation Mediation Report* with the Commissioner.

18.1900 Mediation fees and costs. Unless the parties agree otherwise, all mediation fees and costs shall be split equally among the parties to the mediation.

18.1910 Unless the parties and the mediator agree otherwise, the mediator's fee shall be $600.00 per half-day (4.5 hours) mediation session.

18.1920 If following an unsuccessful mediation the injured worker substantially prevails at formal hearing, he or she may recover his or her share of the mediation fees and costs in accordance with 21 V.S.A. §678(a) and Rule 20.1600. 21 V.S.A. §663a(b).

18.2000 Voluntary mediation. Nothing in this Rule shall preclude the parties to a workers' compensation claim from agreeing voluntarily to mediate at any time during the dispute resolution process.

Rule 19.0000
ARBITRATION OF INSURANCE DISPUTES

19.1100 Claims subject to arbitration. Either upon order of the Commissioner or by mutual agreement of the parties, and after payment to the injured worker, any dispute among employers and/or insurance carriers arising under 21 V.S.A. §§662 (c) or (d) may be resolved through arbitration rather than formal hearing. 21 V.S.A. §662(e). The scope of arbitration shall be limited, and shall not address any claim-related issues or disputes other than those arising under §§662(c) or (d).

19.1200 Qualifications of arbitrator. To be qualified to arbitrate disputes arising under this Rule, an arbitrator must (a) have basic knowledge of Vermont workers' compensation law; (b) be unbiased towards any party; and (c) be free from any financial or other interest in the outcome of the dispute.

19.1300 Selection of arbitrator. Within 21 days after an order or agreement to arbitrate, the parties shall select a qualified arbitrator and notify the Commissioner of their selection. In the event the parties are unable to reach agreement as to an arbitrator, the Commissioner shall assign one. Once selected or assigned, the arbitrator shall provide timely notice of all further proceedings to the parties.

19.1400 Initial arbitration conference. Within 30 days after selection or assignment, the arbitrator shall conduct an initial arbitration conference. In advance of the conference, the parties shall share responsibility for submitting to the arbitrator copies of all relevant records, documents and other evidence upon which they intend to rely at hearing. At the conference, the arbitrator shall establish a discovery schedule and, with due regard for each party's circumstances, shall set the time, place and manner in which the arbitration hearing shall be conducted.

19.1500 Discovery disputes and pretrial motions. The arbitrator shall be responsible for resolving discovery disputes and ruling on pretrial motions.

19.1600 Arbitrated claim settlement. Any proposed settlement of the issues ordered to arbitration shall be submitted to the Commissioner for review and approval in accordance with Rule 13.0000.

19.1700 Arbitration hearing. Unless extended by mutual agreement of the parties, the arbitration hearing shall be held within 90 days after the initial arbitration conference. The arbitrator shall be responsible for maintaining a record of the hearing.

19.1800 Arbitrator's decision; contents. The arbitrator shall issue a written decision, including both findings of fact and conclusions of law, within 45 days after the date the hearing is completed, the evidentiary record is closed and all required submissions are filed. As part of the decision, the arbitrator shall determine apportionment of liability for the claim, including costs and attorney fees, among one or more parties. 21 V.S.A. §662(e)(2)(A). In doing so, the arbitrator shall consider the facts as established at the hearing and/or as stipulated by the parties, and the law as properly applied thereto.

19.1900 Arbitrator's decision; delivery. The arbitrator's decision shall be signed by the arbitrator and delivered to each party, and to the Commissioner, either by first class mail or electronically in accordance

with Rule 3.3000. The arbitrator's decision shall be a part of the record of the arbitration proceeding, but shall not be admissible in other proceedings under this chapter except as between the parties to the arbitration.

19.2000 Arbitrator's decision final. In the absence of fraud, the findings of fact made by the arbitrator acting within his or her powers shall be conclusive. Once signed by the arbitrator, the arbitration decision shall be final. 21 V.S.A. §662(e)(2)(B). An arbitration award may only be modified upon a showing of mathematical miscalculation or other mistake in identifying a person, thing or property referenced therein, and may only be vacated upon a showing of corruption, fraud or partiality.

19.2100 Effective date of award. The arbitrator's award shall be of full force and effect 30 days after issuance.

19.2200 Arbitrator's fee. The arbitrator shall set a reasonable fee for his or her services, which, if not shared by mutual agreement of the parties, shall be apportioned among them in his or her sole discretion.

19.2300 Enforcement of arbitrator's award. If a party against whom an arbitration award is made fails to comply with its terms, the prevailing party may proceed to collect all or any part of the amount owed in any court of law having jurisdiction over the amount involved. If successful, the prevailing party also shall be entitled to interest, costs and reasonable attorney fees.

19.2400 Late payment; interest and penalties. If an employer or insurance carrier fails to make timely payment to an injured worker in accordance with an arbitration award, interest and penalties shall be assessed in accordance with Rules 3.2630 and 3.2640. In the Commissioner's discretion, administrative penalties also may be assessed in accordance with 21 V.S.A. §688 and Rule 3.2650.

Rule 20.0000
COSTS AND ATTORNEY FEES; ATTORNEY LIENS

20.1100 **Award of attorney fees.** In addition to any compensation or other benefits awarded, the Commissioner may award reasonable attorney fees to an injured worker who substantially prevails in either formal or informal dispute resolution procedures. 21 V.S.A. §678.

20.1200 **Request for award.** A request for an award of attorney fees shall be submitted no later than 30 days following the issuance of a decision in which the injured worker substantially prevails. 21 V.S.A. §678(e). The request must be accompanied by an itemized statement of hours billed and work performed, stated with sufficient specificity to determine whether they are reasonable in amount.

20.1300 **Amount.** At the Commissioner's discretion, an award of attorney fees may be based on either an hourly or contingency basis.

20.1310 If based on an hourly fee, the award shall not exceed a charge of $145.00 per hour.

20.1320 If based on a contingent fee, the award shall not exceed 20 percent of the compensation or benefits awarded.

20.1330 The above limitations apply only to an award of fees by the Commissioner, and shall not prohibit an attorney and client from agreeing to a different hourly or contingent fee as between themselves.

20.1400 **Award of fees absent formal hearing.** Attorney fee awards to prevailing injured workers are discretionary, and generally shall be considered only in cases resolved at the formal hearing level. In cases that are resolved prior to formal hearing, the Commissioner may award attorney fees if the injured worker is able to demonstrate the following, 21 V.S.A. §678(d):

20.1410 That a formal hearing was requested;

20.1420 That the injured worker retained an attorney in response to an actual or effective denial of all or part of a claim; and

20.1430 That thereafter payments were made to the injured worker as a result of the attorney's efforts.

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. 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.

20.1600 Costs. Necessary costs awarded under 21 V.S.A. §678(a) shall include, but shall not be limited to, deposition expenses, subpoena fees, expert witness fees and, if itemized, reasonable copy, fax and/or long-distance telephone charges. Necessary costs shall also include mandatory mediation fees and costs incurred in accordance with Rule 18.1900. 21 V.S.A. §663a(b). Costs referable to ordinary office overhead shall not be allowed.

20.1700 Objections; when filed. The employer or insurance carrier shall have 30 days from the date upon which an injured worker's request for an award of costs and attorney fees is filed within which to file any objections thereto. Unless stayed by the Commissioner, the employer or insurance carrier shall pay any awarded costs and attorney fees directly to the injured worker's attorney in a lump sum.

20.1800 Lien for attorney fees. When approved by the Commissioner, a lien for attorney fees may be enforced against an injured worker's compensation as provided in 21 V.S.A. §682. The lien amount must be calculated in accordance with the provisions of Rules 20.1310 and/or 20.1320 above, and if based on a contingent fee agreement, shall not be excessive when considered against the factors listed in Rule 1.5 of the Vermont Supreme Court Rules of Professional Conduct. Absent extenuating circumstances, a lien for attorney fees shall not be approved for so long as a conflicting lien exists.

20.1900 Request for acknowledgment of lien. An attorney's request for acknowledgment of a lien may be made to the Commissioner in writing, with a copy to the injured worker, at any time after a notice of appearance is filed. The request must be accompanied by a copy of the written fee agreement executed by the injured worker.

20.1910 If the lien is acknowledged, the Commissioner shall provide written notice to the employer or insurance carrier and to the injured worker, advising that a lien is claimed against future compensation benefits awarded.

20.1920 Having received written notice of an acknowledged attorney's lien, an employer or insurance carrier shall reserve 20 percent of any permanent disability and/or lump sum retroactive temporary disability compensation owed to the injured worker for the purposes of satisfying the lien. If the employer or insurance carrier fails to do so, in the Commissioner's discretion it shall be liable for payment of the acknowledged lien to the attorney.

20.2000 Notice. Having received written notice of an acknowledged attorney's lien, an employer or insurance carrier shall first notify the injured worker's attorney prior to issuing payment of any compensation benefits subject to the lien.

20.2100 Enforcement. An attorney seeking to enforce an acknowledged attorney's lien must file a written request with the Commissioner, with copies to both the injured worker and the employer or insurance carrier, prior to the date that benefits subject to the lien are due and payable. The request must be

accompanied by an itemized statement detailing both the work performed and the hours billed, in increments sufficient to discern whether the charges are reasonable.

20.2110 If enforcement of the lien is approved, the Commissioner shall direct the employer or insurance carrier to deduct the amount approved and advance it to the attorney against (a) the end of any permanent disability compensation due; (b) any lump sum payment of retroactive temporary disability benefits and/or (c) any lump sum compromise settlement.

20.2120 If an attorney fails to request enforcement of a lien in a timely fashion, in the Commissioner's discretion enforcement may be limited or denied so as not to impede the disbursement of benefit payments due to the injured worker.

Rule 21.0000
THIRD PARTY LIABILITY ACTIONS

21.1100 **Notice of third party liability action.** An injured worker, employer and/or insurance carrier who seeks to enforce the liability of a third party for a compensable work-related injury shall notify the Commissioner by registered mail at least 30 days prior to commencing suit. The notice shall conform to the requirements of 21 V.S.A. §624(a), and shall also include the state file number assigned to the underlying workers' compensation claim.

21.1200 **Process.** The prosecution, settlement and/or resolution of any third party liability claim shall conform to the requirements of 21 V.S.A. §624(b) through (g).

21.1300 **Allocation of damages.** Where the injured worker's recovery against a third party for damages resulting from personal injury or death is less, after deducting the expenses of recovery, than the full value of such claim, any reimbursement due the employer or insurance carrier shall be limited to that portion of the recovery allocated to damages covered by the Workers' Compensation Act. If the court has not allocated the damages, and/or if the parties cannot agree, any party may request that the Commissioner make an administrative determination. 21 V.S.A. §624(e)(2).

> 21.1310 Upon receiving such request, the Commissioner shall order mediation in accordance with Rule 18.0000.
>
> 21.1320 Should mediation prove unsuccessful, the Commissioner shall either adjudicate the dispute or refer it to arbitration in accordance with Rule 19.0000. The determination of the Commissioner or arbitrator shall be final.

21.1400 **Reimbursement from third party recovery.** In determining the extent to which an employer or insurance carrier is entitled to reimbursement from an injured worker's third party recovery under 21 V.S.A. §624(e)(1), credit shall be allowed for any amounts paid for indemnity compensation, medical services and supplies, vocational screening and assessment, and those vocational rehabilitation costs specified on an approved Return to Work Plan. Credit shall not be allowed for claims adjustment, medical management and/or other vocational rehabilitation costs.

21.1500 **Allocating third party recovery expenses; workers' compensation "holiday."** An employer or insurance carrier's share of an injured worker's third party recovery expenses shall be calculated by dividing the total allowable third party recovery expenses by the gross third party proceeds allocable to damages covered by the Workers' Compensation Act. This expense ratio shall be applied to reduce any credit, whether past or future, from which the employer or insurance carrier benefits as a result of a third party recovery. 21 V.S.A. §624(e) and (f).

Rule 22.0000
REPORTING BENEFIT AND EXPENSE PAYMENTS

22.1100 **Reporting claim-specific data.** Within 60 days after the final payment of any claim-related benefits or expenses to or on behalf of an injured worker, the employer or insurance carrier shall file a *Report of Benefits and Related Expenses Paid* (Form 13) with the Commissioner. 21 V.S.A. §§701, 703.

22.1200 **Reporting aggregate claim data.** On or about July 1st annually, the employer or insurance carrier shall file an *Aggregate Annual Reporting Form* (Form 13-A) with the Commissioner. 21 V.S.A. §704.

22.1300 **Penalty for failure to report.** An employer or insurance carrier who fails to file the reports required by this Rule in a timely manner may be subject to administrative penalties in accordance with Vermont Workers' Compensation Rule 45. 21 V.S.A. §§702, 704.

Rule 23.0000
COMPLIANCE STATEMENTS

23.1100 **Generally.** Upon receipt of evidence that an employer has failed to procure and/or maintain workers' compensation insurance in accordance with Vermont law, the Commissioner shall deliver a written request, either in person or by certified mail, that the employer complete a *Compliance Statement*. For the purposes of this Rule, the term "employer" shall include a subcontractor and/or independent contractor. 21 V.S.A. §690(b)(1).

23.1200 **Contents; currently insured employer.** If at the time the *Compliance Statement* is requested the employer has a current workers' compensation policy in force, the following information shall be supplied:

23.1210 The issuing insurance carrier, policy number and policy effective and expiration dates;

23.1220 The insurance agent, if any, through which the policy was procured;

23.1230 The number of employees employed during the policy term, sorted by job site and National Council on Compensation Insurance (NCCI) class code;

23.1240 The number of employee hours for which remuneration was paid, sorted by job site and NCCI class code;

23.1250 A list of all subcontractors and/or 1099 contractors, sorted by job site and including federal employer identification number, function and remuneration paid; and

23.1260 As an attachment, a copy of the insurance policy declaration pages, including the payroll and hours upon which the NCCI classification code(s) and policy premium were based.

23.1300 **Contents; currently uninsured employer.** If at the time the *Compliance Statement* is requested the employer does not have a current workers' compensation policy in force, the following information shall be supplied:

23.1310 The number of employees employed during the twelve-month period immediately preceding the request, sorted by job site; and

23.1320 A list of all subcontractors and/or 1099 contractors, sorted by job site and including federal employer identification number, function and compensation paid.

23.1400 **Response period.** Unless a different time period is specified, and/or if the Commissioner consents in writing to an extension, an employer shall return a completed *Compliance Statement* to the Commissioner within 30 day of receipt.

23.1500 **Penalty for failure to respond; falsified information.** An employer who fails to return a *Compliance Statement* within the appropriate response period, or who falsifies information contained therein, may be assessed an administrative penalty of not more than $5,000.00 for each week during which the noncompliance or falsification occurred, as well as any costs and attorney fees required to enforce this Rule. The Commissioner may also seek injunctive relief in Vermont Superior Court, Washington Unit Civil Division. 21 V.S.A. §690(b)(2). In addition, an employer who knowingly falsifies information contained in a *Compliance Statement* may be subject to further enforcement action and/or prosecution in accordance with 21 V.S.A. §708(b) and (c).

23.1600 **Review; enforcement.** The Commissioner shall review and investigate the information supplied on a completed *Compliance Statement*, and if warranted, shall take appropriate enforcement action in accordance with 21 V.S.A. §692 and **Vermont Workers' Compensation Rule 45**. 21 V.S.A. §690(b)(3).

23.1610 A *Compliance Statement* shall be a public record. The Commissioner shall provide an employer's completed *Compliance Statement* to any person upon request. 21 V.S.A. §690(b)(3).

23.1620 Upon review and investigation of an employer's completed *Compliance Statement*, in the event that the Commissioner finds no evidence of non-compliance, timely written notification of this fact shall be provided to the employer and any other requesting party. 21 V.S.A. §690(b)(4).

Rule 24.0000
FILING CERTIFICATES OF INSURANCE, NOTICES OF CANCELLATION OR NON-RENEWAL AND ANTI-FRAUD REPORTS; INVESTIGATING CLAIMS OF FRAUD

24.1100 NCCI as agent. The National Council on Compensation Insurance (NCCI) is hereby designated the Commissioner's agent for the purpose of receiving the certificates of insurance and notices of cancellation and non-renewal required by 21 V.S.A. §§ 690(a), 696 and 697. The information required shall be filed in whatever format deemed acceptable to NCCI. This designation does not extend to a copy of the insurance contract or policy requested by the Commissioner under 21 V.S.A. §690(a) or to a *Compliance Statement* requested in accordance with 21 V.S.A. §690(b)(1) and Rule 23.0000, which shall be filed directly with the Commissioner.

24.1200 Certificate of insurance. A certificate of insurance must be filed with NCCI no later than 30 days following a policy's issuance, renewal and/or reinstatement. The certificate shall include the insured's name, address and federal identification number, the carrier's name and address, the policy number and the policy effective and expiration dates. 21 V.S.A. § 690(a).

24.1300 Notice of cancellation. An insurance carrier seeking to cancel a policy prior to its expiration date shall provide notice, both to NCCI and to the insured employer, at least 45 days prior to the effective cancellation date. The notice to the insured employer shall be provided by certified mail, and shall clearly and specifically state the date and time at which coverage under the current policy shall be cancelled. 21 V.S.A. §696.

24.1400 Notice of non-renewal. An insurance carrier who does not intend to renew an employer's workers' compensation insurance policy or guarantee contract shall provide notice, both to NCCI and to the insured employer, at least 45 days prior to the current policy or contract expiration date. The notice to the insured employer shall be provided by certified mail, and shall clearly and specifically state the date and time at which coverage under the current policy or contract shall expire. 21 V.S.A. §697.

24.1410 An insurance carrier who fails to give the notice required by this Rule shall continue the insurance policy or guarantee contract in force beyond its expiration date for 45 days from the date on which the notice of non-renewal is received by both NCCI and the insured employer. 21 V.S.A. §697. However, in the following circumstances, notice to the insured employer shall not be required, and coverage under the current policy or contract shall expire upon notice to NCCI alone:

24.1411 If, on or before the expiration date stated in the current policy or guarantee contract the insurance carrier has, by delivery of a renewal contract or otherwise, offered to continue the insurance;

24.1412 If the insured employer notifies the insurance carrier in writing that it does not wish that coverage be continued beyond the expiration date stated in the current policy or guarantee contract; and/or

24.1413 If the employer otherwise secures coverage as required by 21 V.S.A. §687.

24.1500 **Penalty for non-compliance.** In the Commissioner's discretion, an insurance carrier who fails to comply with the requirements of Rules 24.1200 through 24.1400 above may be subject to administrative penalties and other sanctions as provided in 21 V.S.A. §688.

24.1600 **Anti-fraud plan.** Upon request by the Commissioner, a workers' compensation insurance carrier shall file its anti-fraud plan with the Department, which shall include information about fraud investigations, referrals or prosecutions involving Vermont workers' compensation claims, misclassifications and/or miscoding. Information regarding investigations and referrals shall not be public unless the Commissioner or the attorney general commences administrative or criminal proceedings. 8 V.S.A. §4750(b).

24.1700 **Investigating claims of fraud.** Upon receipt of an allegation that an employee has committed fraud for the purpose of obtaining a workers' compensation benefit or payment, the Commissioner shall determine whether further investigation is warranted. 21 V.S.A. §663b.

24.1710 The Commissioner shall require the employer or insurance carrier to promptly investigate specific allegations of fraud and submit a written report.

24.1720 Upon receipt of the employer or insurance carrier's report, the Commissioner shall deliver a copy to the employee, who shall have 30 days within which to respond, either in writing or in person, at a time and in a manner specified by the Commissioner. The Commissioner may order that either the employer or insurance carrier or the employee provide additional information.

24.1730 The Commissioner shall issue a determination on the fraud allegation in a timely manner. An employee who is found to have committed fraud for the purpose of obtaining a workers' compensation benefit or payment shall be ordered to repay all compensation fraudulently received, in addition to administrative penalties and/or other sanctions authorized by 21 V.S.A. §708. The employee may appeal the Commissioner's determination in accordance with the Vermont Administrative Procedure Act, 3 V.S.A. §800 *et seq*.

24.1740 For the purposes of calculating its experience rating, an employer shall not be charged for any compensation benefits or payments determined to have been fraudulently received by an employee.

Rule 25.0000
EXCLUDING CORPORATE OFFICERS AND LLC MANAGERS AND MEMBERS FROM COVERAGE

25.1100 **Definitions.** For the purposes of this Rule, the following definitions shall apply:

25.1110 As applied to a for-profit corporation, the terms "board of directors," "director" and "officer" shall be as defined and/or described in the Vermont Business Corporation Act, 11A V.S.A. §§1.01 *et seq.*

25.1120 As applied to a non-profit corporation, the terms "board of directors," "director" and "officer" shall be as defined and/or described in the Vermont Non-Profit Corporation Act, 11B V.S.A. §§1.01 *et seq.*

25.1130 As applied to a limited liability company, the terms "limited liability company," "manager" and "member" shall be as defined and/or described in 11 V.S.A. §§3001 *et seq.*

25.1200 **Generally.** An executive officer of a corporation, or a manager or member of a limited liability company (LLC), who elects to be excluded from coverage under the Workers' Compensation Act pursuant to 21 V.S.A. §601(14)(H) must file an *Application for Exclusion* (Form 29) with the Commissioner for approval. Up to four corporate executive officers or LLC managers or members may be excluded from coverage. A corporate director who does not hold a corporate office and who is not an employee as defined in 21 V.S.A. §601(14) is considered exempt and does not need to file an application for exclusion.

25.1300 **Application for exclusion.** The *Application for Exclusion* must be accompanied by the following documentation:

25.1310 A sworn statement or affidavit from an officer or director of the corporation, a manager or member of the LLC or the attorney for the corporation or LLC, who is fully familiar with the business entity's organizational documents and who confirms the date on which the corporation's board of directors or LLC's managers and members consented to exclude the individuals listed on the *Application for Exclusion*; or

25.1320 A notarized copy of the minutes of the meeting of the corporation's board of directors, or of the meeting of the LLC's managers and/or members, at which the authority to request exclusion for the individuals listed on the *Application for Exclusion* was granted; and

25.1330 If the individuals listed on the *Application for Exclusion* are not identified as officers, managers and/or members in the organizational documents on file with the Secretary of State, a notarized copy of the minutes of the meeting of the corporation's board of directors, or of the meeting of the LLC's managers and/or members, at which they were appointed or recognized as officers, managers and/or members.

25.1400 **Review and approval.** The Commissioner shall approve a properly documented *Application for Exclusion* upon verifying that the corporation or LLC is properly registered, either with the Vermont Secretary of State or in the state or country in which it is incorporated. Thereafter, the Commissioner shall notify the applicant in writing, either that the requested exclusion has been granted or the grounds upon which it has been denied.

25.1500 **Effect of approved exclusion.** If all of the officers of a corporation, or all of the managers and members of an LLC, receive approval for exclusion, and if the corporation or LLC has no other employees, then it shall not be required to purchase workers' compensation insurance coverage. 21 V.S.A. §601(14)(H).

> 25.1510 If after having been approved for exclusion, a corporate officer, or manager or member of an LLC, suffers a personal injury and files a claim for workers' compensation benefits, the corporation or LLC shall have all of the defenses available in a personal injury claim.
>
> 25.1520 Other than the excluded officer, member or manager, an exclusion election shall not prevent any individual who is found to be an employee of the corporation or LLC from recovering workers' compensation benefits either from the corporation or LLC or from a statutory employer.

25.1600 **New application required.** A new *Application for Exclusion* shall be filed whenever there is a change of business entity, corporate officers or LLC members or managers.

25.1700. **Rescinding exclusion.** An individual who has elected and been approved for exclusion may rescind the election upon written notice to the Commissioner, the corporation's board of directors or LLC's managers and/or members, and if applicable, the corporation's or LLC's current workers' compensation insurance carrier. A rescinded election shall take effect 30 days after the required notice is received, or as soon as insurance coverage is procured, whichever occurs first.

Rule 26.0000
SELF-INSURANCE

26.1100 An employer desiring to self-insure under 21 V.S.A. §687(3) shall annually apply to the Commissioner for approval on a form provided by the Commissioner. The applicant shall submit, for each of the employer's three fiscal years immediately preceding the application:

26.1110 an audited balance sheet and income statement;

26.1120 an annual payroll report, categorized in accordance with the system used by the National Council on Compensation Insurance (NCCI) Occupational Classifications; and

26.1130 the workers' compensation insurance rate including the disease rate for each $100.00 of payroll category above as most recently determined by NCCI and as filed with and approved by the Commissioner of Financial Regulation. Copies of that filing may be obtained from NCCI, One Penn Plaza, New York, NY 10119.

26.1200 Using the information obtained in Rule 26.1100, the Commissioner shall annually determine whether or not the employer meets each of the following tests for each of the preceding three years:

Cash Flow Minimum: Minimum Working Capital:

$$\frac{F}{CL - AEC} > 0.25 \qquad \frac{CA - CL - AEC}{S} > \frac{Cab - CLb}{Sb}$$

and

$$\frac{Ca - CL - AEC}{S} > 0.05$$

Minimum Liquidity: Minimum Net Worth to Debt:

$$\frac{CA - I}{CAb - Ib} > \qquad \frac{A - L}{Ab - Lb} >$$

CA + AEC CLb L + AEC Lb

and and

CA - I A - L

--------- > 0.5 -------- > 0.25

CL + AEC L + AEC

Minimum Profitability:

If E - AEC 0 in not more than one of the three previous years, the employer shall meet the following test:

E - AEC Eb E - AEC

------- > ------ and --------- > 0.03

TA TAb TA

If E - AEC 0 in two of the three years, but not in the most recent year, the employer shall meet the following test:

E - AEC Ea E - AEC

------- > ------ and --------- > 0.03

TA TAa TA

If E - AEC 0 for each of the three years, the employer does not meet the test for minimum profitability.

Turnover Minimum:

A - L - AEC Ab - Lb A - L - AEC

---------- > ------- and ---------- > 0.05

S Sa S

26.1300 For the purposes of Rule 26.1200:

26.1310 AEC = Average Expected Claims = the sum of the products of the actual payroll as determined by category under Rule 26.1120, multiplied by the rate for each payroll category as determined in Rule 26.1130, divided by 100.

26.1311 F = cash flow = net income after taxes plus allowances for depreciation and depletion.

26.1320 E = earnings = net income before taxes and extraordinary items.

26.1321 A = total assets.

26.1330 L = total liabilities.

26.1331 CA = current assets.

26.1340 CL = current liabilities.

26.1341 I = inventory.

26.1350 TA = tangible assets = total assets less intangible items.

26.1351 S = net sales = gross sales less returns and allowances.

26.1360 W = net worth = assets less liabilities (A-L).

26.1361 a = subscript denoting industry median data.

26.1370 b = subscript denoting lower base quartile industry data.

26.1371 c = subscript denoting upper quartile industry data.

26.1400 If the Commissioner finds that an employer fails one or more of the tests enumerated in Rule 26.1200, the Commissioner shall disapprove the application for self-insurance unless the Commissioner finds that a test is inappropriate to a particular employer because of the nature of that employer's business, in which case the Commissioner may waive that test. If the Commissioner finds that the employer passes each of the tests enumerated in Rule 26.1200, the Commissioner may approve the application for self-insurance and require the employer to do one or more of the following:

26.1410 Establish a cash reserve fund, held in trust in this state, from which claim payments can immediately be made. The fund should be equal to 25% of AEC as defined in Rule 26.1300. Payments from the fund must be able to be made by the Commissioner; and

26.1420 Hold a surety bond in an amount determined by the Commissioner written by a company licensed to do business in this state guaranteeing the payment of claims in the amount of that bond. The bond must require notice to the Commissioner at least 90 days before cancellation; and

26.1430 Hold excess insurance issued by a company authorized to do business in the State of Vermont for claims in excess of the amount of the surety bond under which claims are payable regardless of the financial bond under which claims are payable regardless of the financial condition (including bankruptcy) of the employer; and

26.1400 Identify a person or claims adjusting agency who is skilled in workers' compensation claims adjustment and who has a demonstrated knowledge of the Vermont Act. That person must have the full power and authority to act for the self-insurer in any matter respecting workers' compensation; and

26.1500 Have sufficient assets located in this state that are readily available to satisfy claims.

Rule 27.0000
APPLICATION AND EFFECT OF RULES, SEVERABILITY, EFFECTIVE DATE

27.1100 Procedures under these rules, not affecting the substantive rights of a party, shall apply to pending and future claims and cases. Nothing contained in these rules shall be construed to limit the Commissioner's authority under Vermont's Workers' Compensation Act, 21 V.S.A. §§601 *et seq.*

27.1200 Except for Vermont Workers' Compensation Rules 40.000 (medical fee schedule) and 45 (administrative penalties), Vermont Vocational Rehabilitation Rules 50.0000-58.0000, the rules relating to Bennington Sarcoidosis Claims and the Workers' Compensation Administrative Fund rules, all previously promulgated rules under Vermont's Workers' Compensation Act, 21 V.S.A. §§601 *et seq.*, are hereby repealed.

27.1300 In the event that any part or provision of these rules is modified, limited or invalidated by either court decision or statute, all other parts and provisions shall remain in full force in effect.

27.1400 These rules shall take effect 15 days after adoption.

~~STATE OF VERMONT – Department of Labor~~
~~Workers' Compensation Alternative Dispute Resolution Report~~
~~Report due from mediator within 15 days of completion of mediation~~

~~Claimant name~~		~~State File No.:~~	
~~Defendant name~~			

~~Date of ADR Session~~		~~Starting Time~~		~~Finishing Time~~	

~~1. Please indicate the names and addresses of all persons participating in the ADR Session. (If additional space is needed, please attach an additional sheet.) If any party is a corporation or other entity, please indicate the name and title of the representative. Identify with an asterisk the representative of each party who had decision-making authority.~~

~~Participants~~	**~~Name~~**	**~~Mailing Address~~**	**~~City, State & Zip Code~~**
~~Claimant~~			
~~Claimant's Counsel~~			
~~Defendant/Insurer~~			
~~Defendant/Insurer Counsel~~			
~~Employer representative~~			
~~Interested party~~			
~~Interested party~~			

~~2. Were all appropriate parties in attendance? _____. If not, who failed to appear?~~
~~List and summarize any substitute arrangement made regarding attendance at the ADR Session.~~

~~3. Was full or partial settlement reached at the session? ____~~
~~If so, please summarize and append any agreement of the parties.~~

_____ _____
~~Mediator~~ ~~Date~~