Workers' Compensation Rules Index

Rule 1.0000 PURPOSE AND CONSTRUCTION

1.1000 "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 at 76 (1962).

1.1100 The act is to be construed liberally to accomplish the humane purpose for which it was passed, but a liberal construction does not mean an unreasonable or unwarranted construction. *Herbert v. Layman*, 125 Vt. 481 (1966).

Rule 2.0000 DEFINITIONS

For the purposes of these rules:

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

2.1110 "Aggravation" means an acceleration or exacerbation of a pre-existing condition caused by some intervening event or events.

2.1120 "Assessment", for the purpose of vocational rehabilitation, means selecting, administering, scoring, and interpreting instruments designed to assess an individual's attitudes, abilities, achievements, interests, personal characteristics, disabilities and mental, emotional, or behavioral disorders as well as the use of methods and techniques for understanding human behavior in relation to coping with, adapting to, or changing life situations.

2.1130 "Commissioner" means the Commissioner of Labor and Industry or designee.

2.1140 "Corporate officer" means members of the directors of a corporation defined by the bylaws or designated by the Board of Directors of the corporation.

2.1150 "Department" means the Department of Labor and Industry.

2.1160 "Division" means the Workers' Compensation Division of the Vermont Department of Labor and Industry.

2.1170 "Director" means the Director of the Workers' Compensation Division or designee.

2.1180 "EIN" means Employer's Identification Number assigned by the federal government.

2.1190 "Employer" means the employer as defined in 21 V.S.A. 601 and its workers' compensation insurance carrier.

2.1200 "End Medical Result" or "Medical End Result" 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.

2.1210 "Functional Capacity Evaluation" may also be known as (FCE); (PCA); (PCE); (FCA); (RFE); or (QFE), is defined as the objective determination of the claimant's ability to participate in activities within a work setting. The 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. The FCE shall be performed by a registered physical or occupational therapist or other qualified medical provider.

2.1220 "Identifying information" refers to the employee's name, current mailing address, social security number, date of injury, date of birth, employee's phone number, education level, average weekly wage, vocational rehabilitation referral date, Department of Labor and Industry's file number, insurer's name, insurer's current mailing address, claims adjuster's name, phone number, insurer's file number, employer's name and phone number, vocational rehabilitation counselor's name, counselor's current address, and the counselor's registration number.

2.1230 "Individual Written Rehabilitation Plan" (IWRP) means a written document completed by a rehabilitation counselor and an injured worker which describes the manner and the means by which the injured worker will be returned to suitable employment through the use of vocational rehabilitation services. The IWRP documents the agreed upon vocational goal(s); the responsibilities of each party in achieving the goal and the time frame in which the plan will be completed.

2.1240 “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 eye glasses when the damage or need for replacement arises out of and in the course of employment.

2.1250 “Job Analysis” means a systematic study that reports work activity as follows:

2.1251 What the worker does in the job being analyzed in relation to data, people and things;
2.1252 What methods and techniques are employed by the worker;
2.1253 What machines tools and work aids are used;
2.1254 What materials, products, subject matter, or services result; **AND**
2.1255 What traits are required by the worker.

2.1260 “Job Development” means a systematic contact of prospective employers resulting in opportunities for interviews and employment that might not otherwise have existed. Job development facilitates a prospective employer's consideration of a qualified employee for employment.

2.1270 “Job Modification” means altering of the work environment to accommodate physical or mental limitations by making changes in equipment, in the methods of completing tasks, or in job duties.

2.1280 “Job Placement” means the activities of the counselor and the injured employee that support an employee's search for work, including, but not limited to:

2.1281 The identification of job leads;
2.1282 Arranging for job interviews;
2.1283 The preparation of a claimant to conduct an effective job search;
2.1284 Communication of information about, but not limited to, the labor market conditions.

2.1290 “Labor Market Survey” is information compiled, or the compiling activity, to determine the wages, hiring practices and availability of suitable employment with regard to a specific worker, obtained from direct contact with employers.

2.1295 “Medical Case Management” refers to the planning and coordination of health care services appropriate to achieve the goal of medical rehabilitation. Medical case management may include, but not be limited to, case assessment, including personal interview with the injured employee, and the assistance in developing, implementing and coordinating a medical care plan with health care providers, as well as the employee and his/her family and evaluation of treatment results. Medical Case Management is not the provision of medical care. The goal of medical case management should be to avail the disabled individual of all available treatment options to ensure that the client can make an informed choice.

2.1300 “On-The-Job-Training” (OJT) means training given to the claimant who under agreement is hired by the OJT employer, with training to occur while the claimant is engaged in productive work. Such training is designed to provide knowledge or skills essential to the satisfactory performance of the job. Specific vocational preparation levels will be used as a guide in determining the length of training on OJT; however, the actual needs of the participant is the determining factor.

2.1310 “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.

2.1312 “Recurrence” means the return of symptoms following a temporary remission.

2.1320 “Regular Full Time Employment” means a job which at the time of hire was, or is currently expected to continue indefinitely with no projected end date.

2.1330 “Rehabilitation Conference” means a conference conducted for the purpose of addressing disputed issue(s) regarding adequacy, feasibility and sufficiency of the vocational rehabilitation services.

2.1335 “Rehabilitation Professional” is defined as a Vocational Rehabilitation Supervisor; Independent Vocational Evaluator; Vocational Rehabilitation Counselor; Vocational Job Developer/Intern; Medical Case Manager and Medical Case Manager Intern.

2.1340 “Rehabilitation Services” means both medical rehabilitation services and vocational rehabilitation services designed to return an individual to "suitable employment" as defined by these rules. The program begins with the first in-person visit with the claimant. The program consists of the sequential delivery and coordination of services by rehabilitation service providers. Specific services under this plan may include, but are not limited to:

2.1341 Medical management by a nurse; counselor or other qualified professional.
2.1342 Counseling and guidance by a certified rehabilitation counselor;
2.1343 Ergonomic modifications, lifting devices and other reasonable accommodations which would enhance the employability of the injured employee;
2.1344 Assistance in job placement by a certified rehabilitation counselor with emphasis on matching the job most closely to the skills, abilities and functional capacity of the injured employee;
2.1345 Vocational Testing;
2.1346 Other rehabilitation services that may include, job analysis, job modification, labor market survey, transferable skills analysis, work adjustment, job seeking skills training, on-the-job training, retraining and coordination of other activities as necessary to return an injured worker to suitable employment.

2.1350 “Suitable Employment”, means employment:

2.1351 For which the worker has the necessary physical capacities, knowledge, skills and abilities;
2.1352 “Knowledge” an organized body of factual or procedural information derived from the worker’s education, training and experience.
2.1353 “Skills” the demonstrated mental and physical proficiency to apply knowledge.
2.1354 “Abilities” the mental and physical capability to apply the worker’s knowledge and skills.
2.1355 Located where the worker customarily worked, or within reasonable commuting distance of the worker’s residence;
2.1356 Which pays or would average on a year-round basis a suitable wage; **AND**
2.1357 Which is regular full-time work. Temporary work is suitable if the worker’s job at injury was temporary and it can be shown that the temporary job will duplicate his/her annual income from the job at injury.

2.1360 “Suitable Wage” means for the purpose of determining entitlement to vocational rehabilitation services, a wage at least 80 percent of the average weekly wage calculated as described in Rule **15.0000** and for the purpose of providing vocational assistance, a wage as close as possible to 100 percent of the average weekly wage as described in Rule **15.0000**. If the goal of 100% of the AWW is not reasonably attainable then the new wage may be considered suitable if it is no less than 80 percent of the average weekly wage.

2.1370 “Transferable Skills” means the knowledge and skills demonstrated in the past training or employment which make a worker employable in suitable new employment. More general characteristics such as aptitudes or interests do not, by themselves, constitute transferable skills.

2.1380 “Vocational Evaluation” means the comprehensive assessment of vocational aptitudes and potential, using information about a claimant's past history, medical and psychological status, and information from appropriate vocational testing, which may use paper and pencil instruments, work samples, simulated work stations, or assessment in a real work environment.

2.1385 “Vocational Rehabilitation” refers to the delivery and coordination of services designed to achieve the goal of returning the injured employee to suitable employment as quickly as possible. Specific services may include, but would not be limited to, collection of relevant medical information; vocational assessment; counseling; job analysis; job modification; job development and placement; labor market survey; vocational testing; analysis of transferable skills; job-seeking skills training; coordination of on-the-job training and retraining; and follow-up after reemployment.

2.1390 “Vocational Rehabilitation Counselor” is an individual that counsels, interviews and evaluates injured employees and confers with medical and professional personnel to determine entitlement to vocational rehabilitation services and feasibility of vocational rehabilitation. A counselor determines what is an appropriate job with the injured employee’s desires, aptitudes, physical, mental and emotional limitations and the Department’s definition of suitable employment.

2.1400 “Vocational Testing” means the measurement of vocational interests, aptitudes, and ability using standardized, professionally accepted psychometric procedures;

Rule 3.0000 REPORT OF INJURY AND ADJUSTMENT OF WORKERS' COMPENSATION CLAIMS

3.0500 Every employer shall file a First Report of Injury (Form 1) with the Division within 72 hours (Sundays and legal holidays excluded) of receiving notice or knowledge of each injury for which an employee loses time from work or requires medical attention. Simultaneously, the employer shall give a copy of the First Report to the claimant. If the injury results in death, a Report of Fatal Accident (Form 4) shall also be filed. A First Report of Injury shall be filed even if the employer disputes the facts surrounding the injury and/or its relationship to the claimant's employment. If the employer is insured by a workers' compensation insurance carrier, the employer shall notify the carrier immediately of the injury.

3.0540 An employee must give an employer notice of the injury, a recurrence or aggravation, as soon as practicable, and must file a claim for compensation within six months after the date of injury, recurrence or aggravation. The date of injury, recurrence or aggravation shall be the point in time when the injury, recurrence or aggravation and its relationship to the employment is reasonably discoverable and apparent. The notice and/or claim may be given or made by any person claiming entitlement to compensation or acting on the employee's behalf.

3.0550 If payments of compensation or benefits have been made voluntarily, no claim for compensation need be filed unless and until payments are denied. An employee shall have six months from the date of denial in which to file a claim.

3.0560 An employee who fails to give notice or make a claim within six months of the date of injury, recurrence or aggravation may nonetheless pursue a claim for compensation and benefits, provided the employee 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, but in no event may proceedings for an initial claim for compensation or benefits be commenced more than six years from the date of injury, recurrence or aggravation.

3.0600 If the employer fails or refuses to file a First Report of Injury, the claimant may file a Notice of Injury and Claim for Compensation (Form 5) directly with the Division, with a copy to the employer. The filing of a Form 5 shall not absolve the employer from responsibility for filing a First Report of Injury in accordance with Rule **3.0560** above.

3.0700 Having received notice or knowledge of an injury, the employer shall promptly investigate and determine whether or not compensation is due. In all cases in which the claimant is alleged to have been disabled from working for at least three calendar days as a result of his or her injury the employer shall complete and file a Certificate of Dependency (Form 10), an Employee Exemption Report (Form 10 S), a Wage Statement (Form 25) and a Weekly Net Income Worksheet (Form 25 S) with the Division. (For information on how to calculate an employee's average weekly wage and compensation rate, see Rule. **15.0000**)

3.0800 The filing of a claim for workers' compensation shall be a waiver of all claims to privilege as between the parties regarding relevant medical records and reports. Therefore, upon request by the employer in the course of its investigation, the claimant shall execute a Workers' Compensation Medical Authorization (Form 7) for the release of all relevant medical records.

3.0810 The carrier or employer shall take no negative action with regard to a claim based solely on an oral communication with a claimant's treating provider.

3.0820 The release of medical reports relating to prior injuries and/or pre-existing conditions shall be required only if relevant to the employer's investigation of the injury for which benefits are claimed.

3.0830 With the commissioner's approval, benefits may be suspended or a claim maybe dismissed without prejudice if a claimant fails or refuses, without good cause, to provide a medical authorization upon request.

3.0900 The employer shall have 21 days from receiving notice or knowledge of an injury within which to determine whether any compensation is due. If it determines that no compensation is due, it shall, within 21 days of notice or knowledge of the injury, notify the commissioner and the claimant in writing of its denial and the reasons therefore. The denial shall be accompanied by copies of all relevant documentation, medical or otherwise, relied upon to support the denial. If, despite good faith efforts, the employer/carrier can not render a decision within the 21day time limit the employer/carrier must request, in writing to the commissioner, an extension of the 21day limit.

This extension must be specific as to the number of days needed and the reason for the delay and must be received by the commissioner prior to the end of the 21 day limit. A copy of the request for an extension must be provided to the claimant at the time the request is provided to the commissioner.

3.1000 If the employer determines that compensation is due it shall enter into a Compensation Agreement (Forms 21, 22, 23 and/or 24) with the claimant, to be approved by the Director, and shall commence paying compensation immediately.

3.1100 The original and two copies of each executed compensation agreement and supporting forms shall be filed with the Director. The agreement shall not be approved unless all copies of the compensation agreement, the Certificate of Dependency (Form 10), the Employee Exemption Report (Form 10 S), the Wage Statement (Form 25) and the Weekly Net Income Worksheet (Form 25 S) have been filed.

3.1200 The employer shall pay the agreed upon compensation pending approval by the commissioner. When agreement with the claimant cannot be reached on the amount of compensation due, the employer shall notify the commissioner, and shall pay the amount deemed correct by the employer pending the commissioner's determination. In the commissioner's discretion, interest may be assessed on any amounts not so paid.

3.1300 If payment or notice of denial is not made within 21 days as provided by sections **3.0900, 3.1000** and/or **3.1200** of this Rule, the commissioner may order that compensation be paid, either with or without prejudice.

3.1400 All parties have an ongoing duty to disclose all information relevant to a pending workers' compensation claim with reasonable promptness.

Rule 4.0000 NOTICE AND APPLICATION FOR HEARING; FILING OF PAPERS IN A CONTESTED CLAIM

4.1100 When a claim for compensation is contested, either party may file a Notice and Application for Hearing (Form 6) with the Division. Upon receipt of a Notice and Application for Hearing (Form 6), or comparable written notice, the commissioner or commissioner's designee shall serve a copy on all other interested parties by first class mail.

4.1200 The Notice and Application for Hearing shall contain a short and plain statement of the claim and the specific relief sought. Whenever possible, it shall be accompanied by relevant supporting documentation. The Notice shall be signed by the applicant or an authorized representative.

4.1300 The opposing party shall serve an answer specifically stating the defenses to each claim asserted, accompanied by copies of all relevant supportive evidence, upon the applicant and the commissioner within 21 days from the date the Notice and Application for Hearing is mailed by the Division. If specific facts sufficient to support the claim have been provided by an employee, failure to answer by the employer may be treated as an unreasonable denial subject to an order to pay compensation pursuant to 21 V.S.A. § 662(b). This provision shall not be construed to bar the timely assertion of additional defenses when justice requires.

4.1400 Every paper or document filed by a party after the Notice and Application for Hearing shall be served by that party upon all other parties and the commissioner. Service shall be made by personally delivering a copy to the other party or by mailing it, first class mail, to the other party at its last known address. Filing with the commissioner shall occur when a document or paper is received by the commissioner. If a party is represented by counsel, service shall be on counsel.

4.1500 The commissioner or director may treat any written communication as a Notice and Application for Hearing, and make the necessary service of the application on the other party.

Rule 5.0000 REPRESENTATION IN A CONTESTED CLAIM

5.1100 Parties to a contested claim before the commissioner may appear personally or may be represented by a licensed attorney. At the commissioner's discretion, if the attorney is not licensed to practice in Vermont, he or she may be permitted to represent a party by filing a request to do so and demonstrating a knowledge of Vermont's Workers' Compensation Laws.

5.1200 Except as otherwise provided in these Rules, all notice given to or by an attorney of record for a party shall be considered in all respects as notice to or from that party.

5.1300 When an attorney has entered an appearance for a party, he or she may not withdraw from such representation without the commissioner's prior authorization, which shall be requested in writing. In ruling on such a request, the following factors shall be considered:

5.1310 Whether the client agrees to the withdrawal;

5.1320 The likelihood that the client will be able to obtain substitute representation without substantial delay and/or prejudice to his or her position; and

5.1330 Whether good cause is shown in support of the request for withdrawal.

Rule 6.0000 INFORMAL RESOLUTION PROCEDURE

6.1100 Within 14 days of receipt of a Notice and Application for Hearing, the Director shall review the claim and if appropriate, shall schedule an informal telephone conference. If necessary, the Director may require that additional supporting documentation be filed before an informal conference will be scheduled.

6.1200 At the informal conference, the parties will identify all disputed legal and/or factual issues and explain their respective positions. If it is determined at the informal conference that additional information is required for final resolution, the Director may continue the matter until such information is received.

6.1300 When it appears to the director that no further progress towards resolution is likely at the informal conference level, the claim may be placed on the formal hearing docket.

6.1400 At any time before, during or following the informal conference, if the evidence produced does not reasonably support a denial of compensation, the commissioner's designee may issue an interim order that payments be made, in whole or in part. Payments made pursuant to such an interim order shall be credited against any subsequent decision entitling the claimant to further compensation. In addition to the authority provided in 21 V.S.A. § 688, at the commissioner's discretion, interest may be awarded for failure to comply with an interim order issued pursuant to this section.

Rule 7.0000 FORMAL HEARING PROCEDURE

7.1000 The purpose of the formal hearing is to determine the rights of the parties by a speedy and inexpensive procedure. The Vermont Rules of Civil Procedure and the Rules of Evidence as applied in Superior Court shall, in general, apply to all hearings conducted under 21 V.S.A. § 663, except as provided in these Rules, and only insofar as they do not defeat the informal nature of the hearing. In addition:

7.1010 Hearsay is admissible provided that it is of a type commonly relied upon by prudent people in the conduct of their affairs, conforms to the requirements of this Rule, and the opposing party has had sufficient notice of it to verify its accuracy.

7.1020 Repetitive and clearly irrelevant material will be excluded.

7.1100 All hearings will be preceded by a pretrial conference before the commissioner or the commissioner's designee at which the parties will frame the issues, agree in writing to uncontested facts, disclose any hearsay evidence upon which they intend to rely and outline the proposed testimony of witnesses they intend to call.

7.1200 Continuances will be granted by the commissioner or the commissioner's designee only for extraordinary circumstances, or where all parties stipulate in writing to a continuance and the stipulation is approved by the commissioner or the commissioner's designee.

7.1300 All relevant medical records and reports will be admitted into evidence if legible copies of the reports are produced for both the opposing party and the commissioner at or before the pretrial conference. Notwithstanding the above, when such evidence is produced after the pretrial conference, it may nonetheless be admitted if it causes no unfair surprise to the other party.

7.1400 Upon the written request of any party filed no later than 10 days before hearing or deposition, the commissioner may issue a subpoena requiring the attendance of any witness for the purpose of examination at the hearing or deposition. The requesting party shall be responsible for ensuring appropriate service of the subpoena and for paying the appropriate mileage and witness fees.

7.1500 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 by discretion of the commissioner or hearing officer, telephonic testimony and/or transcription of telephonic depositions may be admitted.

7.1600 The commissioner or the commissioner's designee may, at his or her discretion, order that an independent medical examination be performed by a health care provider selected from the I.M.E. pool, where the commissioner determines that an opinion would assist the commissioner in resolving disputed testimony. See Rule **14.0000**.

7.1700 A party seeking to introduce photographic and/or video evidence must provide copies to the opposing party in a timely manner prior to hearing, so as to allow sufficient opportunity to review the evidence and verify its accuracy.

7.1800 Notice may be taken of judicially cognizable facts, generally recognized technical and scientific facts within the commissioner's specialized knowledge, and all Workers' Compensation Division forms previously filed.

7.1900 Briefs and requests for findings of fact and conclusions of law, if any, shall be filed within the time period specified by the commissioner.

7.2000 Decisions are to be issued within sixty days from the date the hearing is completed. The hearing shall be deemed completed on the date the evidentiary record is closed.

7.4000 OPPORTUNITY FOR EXPEDITED HEARING

7.4100 The director may set a claim for an expedited formal hearing within 30 days upon written certification by the requesting party of the following:

7.4200 That some financial, medical or other emergency requires immediate resolution; and

7.4300 That the requesting party is fully prepared with all necessary evidence to proceed to immediate hearing; and

7.4400 That the opposing party has had adequate opportunity to obtain the evidence necessary to support its position; and

7.4500 That at least one informal conference has been held and despite reasonable good faith efforts by the requesting party has been proven ineffective in resolving the disputed issue(s).

Rule 8.0000 ARBITRATION OF INSURANCE DISPUTES

Insurance disputes arising under 21 V.S.A. §662 (c) or (d) may be arbitrated either by order of the commissioner or by mutual agreement of the parties. Request and arbitration shall occur after an award of benefits to the claimant.

8.1110 Arbitration shall address insurance or employer disputes but shall not resolve other disputes that may arise in a claim.

8.1120 Request for arbitration:

8.1121 The parties may submit an arbitration request form or comparable written notice to the department requesting arbitration.

8.2000 Qualifications Of Arbitrators shall be as follows:

8.2110 An arbitrator shall have basic knowledge of workers' compensation law.
8.2111 An arbitrator shall be unbiased toward the parties and free of financial or other interest in the claim or the outcome.
8.2112 The department shall maintain a list of qualified arbitrators.

8.3000 Arbitration Process

8.3110 The parties may mutually select an arbitrator.
8.3111 In the event the parties cannot mutually agree upon an arbitrator the commissioner shall assign one.
8.3112 The arbitrator shall timely notice all proceedings to the parties.
8.3113 The arbitrator shall set the time, place and manner of the arbitration which shall be fair and reasonably convenient to all parties.
8.3114 The initial arbitration conference shall be held within 30 days of the arbitrator's receipt of the file.
8.3115 The arbitration hearing shall be held within 90 days of the initial arbitration conference.
8.3116 The arbitrator may order depositions, medical exams or other items of discovery as he or she sees fit.
8.3117 The arbitrator shall be responsible for maintaining a record of the hearing.
8.3118 Any proposed settlements shall be submitted to the arbitrator in writing by the parties for approval. The arbitrator shall approve settlements consistent with the relevant law and facts and which are in the best interests of the claimant.
8.3119 The arbitrator shall apportion liability for the claim, including costs and attorney fees among the respective employers or insurers, or both. Apportionment may be limited to one or more parties.

8.4000 Arbitration Decision

8.4110 The arbitrator shall render the arbitration decision within 45 days after the close of the arbitration proceeding. In the event briefs are filed, within 45 days of receipt of briefs.
8.4111 The decision must be in writing, signed by the arbitrator and shall include the arbitrator's findings of fact and conclusion of law.
8.4112 The findings of fact made by the arbitrator acting within the arbitrator's powers, in the absence of fraud, are conclusive.
8.4113 The arbitrator shall base the decision on the facts established at the arbitration hearing, including stipulation of the parties and on the law as properly applied to those facts.
8.4114 An arbitrator's work shall not be admissible in other proceedings under this chapter.
8.4115 The arbitrator shall deliver a copy of the award to each party by first class mail.
8.4116 The arbitrator's decision is part of the record of the arbitration proceeding.

8.5000 Arbitration Fees

8.5110 The arbitrator shall set a reasonable fee.
8.5111 The arbitrator shall apportion the arbitrator's fee to one or more parties.

8.6000 Arbitration Decision Final

8.6110 The arbitrator shall issue a written decision which shall be final.
8.6211 The arbitration decision may only be vacated by either a showing of corruption, fraud or partiality.

8.7000 Modification of Arbitration Award

8.7110 An arbitration award may only be modified if there is a miscalculation of figures or mistake describing any person, thing or property referred to in the award.

8.8000 Enforcement Of Award

8.8110 If an arbitration award is made under the provisions of this chapter and one employer or insurance carrier fails to comply with the award, the other party may proceed to collect all or any part of the amount owed in any court of law having jurisdiction over the amount involved. The prevailing party is entitled to interest, reasonable attorney fees and costs.
8.8111 An arbitration award shall be of full effect within 30 days of the date issued.
8.8112 An employer who fails to make payment due an employee under this chapter pursuant to an arbitration award or decision, within 15 days after the payment is due, shall also pay the employee interest on the unpaid compensation at the statutory rate.

Rule 9.0000 APPEALS

9.1000 Except with regard to transcripts, appeals to the Superior Court shall be governed by 21 V.S.A. § 670 and Vt. Rule of Civil Procedure 74, and appeals to the Supreme Court shall be governed by 21 V.S.A. § 672 and Vt. Rule of Appellate Procedure 4.

9.2000 Upon request by either party for a transcript of the formal hearing, the commissioner shall either produce a duplicate tape, the expense of which is to be borne by the requesting party, and upon filing of the transcription, certify its accuracy, or hire a court reporter, the expense of which is to be borne by the requesting party, to prepare the transcript for certification. No transcript will be prepared by or at the Department's expense.

Rule 10.0000 ATTORNEY'S FEES AND COSTS

10.1000 In addition to any compensation or other benefits awarded, the commissioner may award reasonable attorney fees to a prevailing claimant.

10.1100 Any amount awarded shall be paid by the employer directly to the claimant' s attorney in a lump sum unless the commissioner stays such award.

10.1200 At the commissioner' s discretion, an award may be based on either an hourly or contingency basis. Awards of attorney's fees to a prevailing claimant shall not exceed:

10.1210 a charge of not more than $90.00 per hour, supported by an itemized statement, or

10.1220 a contingency fee to cover all legal services not to exceed 20% of the compensation awarded, $9000.00, whichever is less.

10.1300 Awards to prevailing claimants are discretionary. In most instances awards will only be considered in proceedings involving formal hearing resolution procedures. In limited instances an award may be made in a proceeding not requiring a formal hearing where the claimant is able to demonstrate that:

10.1310 the employer or insurer carrier is responsible for undue delay in adjusting the claim, or
10.1320 that the claim was denied without reasonable basis, or
10.1330 that the employer or insurance carrier engaged in misconduct or neglect, and
10.1340 that legal representation to resolve the issues was necessary, and,
10.1350 the representation provided was reasonable, and,
10.1360 that neither the claimant nor the claimant' s attorney has been responsible for any unreasonable delay in resolving the issues.

10.2000 This provision applies only to awards of attorney's fees under 21 V.S.A. §678(a) and is not intended to prohibit an attorney and client from agreeing to a different reasonable hourly or contingent fee.

10.3000 Necessary costs to be considered under 21 V.S.A. §678(a) shall include, but shall not be limited to, deposition expenses, subpoena fees and expert witness fees.

10.4000 Evidence establishing the amount and reasonableness of any attorney's fees and/or costs for which the claimant seeks reimbursement shall be offered no later than the date upon which the proposed findings of fact and conclusions of law are filed with the Department. Failure to comply with this subsection may result in denial of an award for attorney's fees and/or costs.

10.5000 In addition, liens against compensation for attorney's fees under 21 V.S.A. § 682 shall not exceed the limit established in subsection (a) above. A request for a lien must be made to the Director in writing, with a copy to the claimant, and must include a copy of the written fee agreement executed by the claimant and an itemized statement detailing both the work performed and the hours billed. If approved, the lien shall be deducted and advanced against the end of any permanent disability compensation due, and/or against any lump sum payment of retroactive temporary disability benefits.

10.6000 A claimant's check for workers' compensation benefits may not be made payable either solely or jointly to the claimant's attorney unless approved, in writing, by the Director.

10.7000 The fee agreement, including a contingency fee agreement, must be submitted before a request for fees will be considered. In the case of a fee agreement other than a contingency fee agreement, an itemized statement of attorney hours and work performed must be submitted before a request will be considered. A contingency fee agreement must include a statement in writing giving the circumstances that make a contingency fee agreement a reasonable alternative to an itemized statement of hours and work performed.

Rule. 11.0000 BENEFITS FOR PERMANENT LOSS OF PHYSICAL FUNCTIONS NOT SCHEDULED IN THE ACT WHERE THE INJURY OCCURRED PRIOR TO 4/1/95

11.1000 In addition to the scheduled compensation set forth in 21 V.S.A. § 648, the following compensation is adopted under 21 V.S.A. § 648(18) and (20):

11.1100 Teeth. In the event of injury resulting in the loss of teeth, the employer shall pay as permanent partial disability compensation, in addition to the cost of acquisition of artificial teeth, the following number of weeks for each lost tooth:

Each of the eight incisors	4 weeks
Each of the four canine or eye teeth	6 weeks
Each of the four first bicuspids	8 weeks
Each of the four second bicuspids	8 weeks
Each of the twelve molars	8 weeks

11.1200 Certain Organs. In the event of injury resulting in the loss of one of the following organs the employer shall pay as permanent partial disability compensation the following number of weeks:

Kidney	100 weeks
Spleen	100 weeks
Single testicle	30 weeks

11.1300 Fingers. In the event of injury resulting in multiple finger loss or loss of use or fractional multiple losses, the employer shall pay as permanent partial disability compensation the following number of weeks:

Thumb	62.949 weeks
Index Finger	40.287 weeks
Middle Finger	31.473 weeks
Ring Finger	25.180 weeks
Little Finger	15.107 weeks

Compensation for loss of less than one-half of the first phalange shall be for one-fourth the period of payment specified for loss of the whole finger. Any Permanent Partial Disability Agreement (Form 22) involving the fractional or total loss or loss of use of one or more fingers or a thumb on the same hand shall be accompanied by a dismemberment chart diagramming the extent of the loss.

11.1400 The Back or Spine. In the event of injury resulting in impairment to the back or spine, not amounting to permanent total disability under 21 V.S.A. § 644, the employer shall pay that percentage of 330 weeks of compensation representing the percentage of permanent partial loss of function to the back or spine. Any whole person impairment rating derived from the AMA Guides to the Evaluation of Permanent Impairment which is referable to an injury to the back or spine shall be converted to a spinal impairment rating in accordance with the following conversion table:

IMPAIRMENT OF WHOLE		IMPAIRMENT OF WHOLE		IMPAIRMENT OF WHOLE	
SPINE	PERSON	SPINE	PERSON	SPINE	PERSON
0%	0%	35%	21%	70%	42%
1%	1%	36%	22%	71%	43%
2%	1%	37%	22%	72%	43%
3%	2%	38%	23%	73%	44%
4%	2%	39%	23%	74%	44%
5%	3%	40%	24%	75%	45%
6%	4%	41%	25%	76%	46%
7%	4%	42%	25%	77%	46%
8%	5%	43%	26%	78%	47%
9%	5%	44%	26%	79%	47%
10%	6%	45%	27%	80%	48%
11%	7%	46%	28%	81%	49%
12%	7%	47%	28%	82%	49%
13%	8%	48%	29%	83%	50%
14%	8%	49%	29%	84%	50%
15%	9%	50%	30%	85%	51%
16%	10%	51%	31%	86%	52%
17%	10%	52%	31%	87%	52%
18%	11%	53%	32%	88%	53%
19%	11%	54%	32%	89%	53%
20%	12%	55%	33%	90%	54%
21%	13%	56%	34%	91%	55%
22%	13%	57%	34%	92%	55%
23%	14%	58%	35%	93%	56%
24%	14%	59%	35%	94%	56%
25%	15%	60%	36%	95%	57%
26%	16%	61%	37%	96%	58%
27%	16%	62%	37%	97%	58%
28%	17%	63%	38%	98%	59%
29%	17%	64%	38%	99%	59%
30%	18%	65%	39%	100%	60%
31%	19%	66%	40%		
32%	19%	67%	40%		
33%	20%	68%	41%		
34%	20%	69%	41%		

11.1500 Cardiovascular, Respiratory, Hematopoietic, Psychological or Nervous System. In the event of injury resulting in impairment to the cardiovascular, respiratory, hematopoietic, psychological or nervous system, not amounting to permanent total disability under 21 V.S.A. § 644, the employer shall pay that percentage of 330 weeks of compensation representing the percentage of permanent partial loss of function to that system.

11.1510 The injuries and compensation set forth in part **11.1000** of this Rule shall not limit the commissioner's authority under 21 V.S.A. § 648 (20) to determine compensation for permanent loss to other physical functions not specified in the Act.

11.1520 In resolving disputes about degrees of impairment to specific body parts, the Guides to the Evaluation of Permanent Impairment of the American Medical Association and similar recognized and accepted treatises may serve as authority in appropriate cases.

11.1530 It shall be the employer's responsibility to pay for at least one permanency examination and impairment rating from the claimant's treating physician, notwithstanding its decision to obtain a rating from an independent medical examiner as well if it so desires. All impairment ratings received by the employer shall be copied to the claimant or his or her attorney.

Rule. 11.2000 COMPENSATION FOR PERMANENT PARTIAL IMPAIRMENT TO A BODY PART, SYSTEM, OR FUNCTIONS / USE OF THE A.M.A. GUIDES. (FOR INJURIES OCCURRING AFTER 4/1/95)

11.2100 The Vermont Legislature directed the commissioner to determine the impact of using the A.M.A.'s whole person rating system on the overall payment of permanent partial disability awards, and, if using that system would result in more than a 2% reduction in the overall payment of permanent partial disability compensation, to adjust the method of awarding permanent partial disability compensation to offset the reduction. See, 1993, No. 225 (Adj. Sess.) sec. 27. The commissioner, with the assistance of independent experts, has determined that using the A.M.A. whole person system will result in an estimated 9.1% reduction in the overall payment of permanent partial disability compensation based on currently available information. This rule is consistent with the requirements of Public Act No. 225 and is effective for injuries occurring after April 1, 1995. The Department anticipates undertaking further analysis of the impact of using the A.M.A. whole person rating system as additional information becomes available.

11.2200 All permanent partial disability compensation for permanent partial impairment to a body part, system, or function, other than the spine, which is addressed in paragraph **11.2300** of this rule, shall be based on the employee's percentage of impairment of the whole person multiplied by 405 weeks.

11.2210 When a compensable injury results in permanent impairment to more than one body part, system or function, not including the spine, the whole person rating shall be determined using the conversion chart in the most recent edition of the A.M.A. Guides to the Evaluation of Permanent Impairment.

11.2220 When a compensable injury results in permanent impairment to more than one body part, system or function including the spine, the whole person rating shall be determined by:

11.2221 determining the whole person rating without the spine and converting it to the percentage of 405 weeks as provided above;

11.2222 determining the impairment to the spine as provided in paragraph **11.2300**of this rule below;

11.2223 adding the weeks determined in paragraphs **11.2221** and **11.2222** together.

11.2300 The Back or Spine. In the event of injury resulting in permanent impairment to the back or spine, not amounting to permanent total disability under 21 V.S.A. § 644, the employer shall pay compensation based on the employee's percentage of impairment to the whole person multiplied by 550 weeks.

11.2400 It shall be the employer's responsibility to pay for at least one permanency examination and impairment rating from the claimant's treating physician, notwithstanding its decision to obtain a rating from another medical examiner as well if it so desires. All impairment ratings received by the employer shall be copied to the claimant or his or her attorney. At the commissioner's discretion, the employer may be ordered to pay for additional permanent impairment evaluations.

11.2500 Compensation for injuries which are not rated by the most recent edition of the American Medical Association Guides To The Evaluation Of Permanent Impairment shall be determined by the commissioner, and shall be in proportion to the compensation paid for similar injuries rated by the Guides.

Rule 11.3000 PERMANENT TOTAL DISABILITY- Injuries Enumerated

A claimant with an injury enumerated under 21 V.S.A. § 644 shall be considered permanently and totally disabled.

Rule 11.3100 PERMANENT TOTAL DISABILITY – ODD LOT DOCTRINE

A claimant shall be permanently and totally disabled if their work injury causes a physical or mental impairment, or both, the result of which renders them unable to perform regular, gainful work. In evaluating whether or not a claimant is permanently and totally disabled, the claimant's age, experience, training, education, occupation and mental capacity shall be considered in addition to his or her physical or mental limitations and/or pain. In all claims for permanent total disability under the Odd Lot Doctrine, a Functional Capacity Evaluation (FCE) should be performed to evaluate claimant's physical capabilities and a vocational assessment should be conducted and should conclude that the claimant is not reasonably expected to be able to return to regular, gainful employment.

A claimant shall not be permanently totally disabled if he or she is able to successfully perform regular, gainful work. Regular, gainful work shall refer to regular employment in any well-known branch of the labor market. Regular, gainful work shall not apply to work that is so limited in quality, dependability or quantity that a reasonably stable market for such work does not exist.

Rule 12.0000 CHOICE OF PHYSICIAN; TRAVEL AND MEALS; WAGES WHILE RECEIVING MEDICAL TREATMENT OR EXAMINATION

12.1000 Choice of Physician

12.1100 An employer may designate the treating health care provider to initially treat an injured employee immediately following a compensable injury. For the purposes of this Rule, a health care provider shall mean the same as defined in 18 V.S.A. § 9432(11), and may include a health maintenance organization.

12.1200 After the initial treatment, an employee may select another health care provider upon giving the employer written Notice of the employee's reasons for dissatisfaction with the health care provider designated by the employer and the name and address of the health care provider selected by the employee. The "Notice of Intent to Change Health Care Provider" (Form 8) is available through the Department, and shall be given to the employee by the employer, its insurance carrier, or the employer's health care provider at or before initial treatment.

12.1300 The commissioner may permit an employer to refuse to reimburse a health care provider selected by the employee if the notice required in this section is not provided to the employer unless the failure to provide notice is due to excusable neglect or inadvertence.

12.1400 If the employee selects a new health care provider in accordance with this section, the employer shall have the right to require other medical examinations as provided for in Chapter 9 of 21 V.S.A..

12.2000 Travel and Meals.

An injured worker required to travel for treatment, or to attend an employer's independent medical examination, shall be paid:

12.2100 Mileage beyond the distance normally traveled to the workplace, at the current rate in effect for classified employees of the State of Vermont; and

12.2200 Meal allowances for breakfast, lunch or dinner when those meals must be taken during travel for treatment or examination, at the current rate in effect for classified employees of the State of Vermont; and

12.2300 Air, rail, bus, taxi, ambulance, rental car or other transportation expense, and overnight accommodations, when reasonable in amount and when required due to an injured worker's condition and/or medical needs.

12.3000 An employer shall not withhold any wages from an employee for an employees absence from work for treatment of a work injury or to attend a medical examination related to a work injury.

Rule 13.0000 MEDICAL EXAMS REQUESTED BY THE EMPLOYER OR INSURER

13.1000 Medical exams which are requested by the employer or workers' compensation insurer shall be scheduled with due regard for the injured worker's schedule and ability to travel. Except in exigent circumstances, notice of medical exams shall be given to the injured worker in writing, at least 7 days prior to the scheduled examination date. If the injured worker is represented by counsel, written notice of the medical exam shall be sent both to the injured worker and to his/her attorney.

13.2000 Upon receipt of the medical examiner's office notes and/or report, the employer shall send a copy to the claimant or, if represented, to his or her attorney.

Rule 14.0000 RESOLVING MEDICAL DISPUTES

14.1000 This rule is promulgated by the Department of Labor and Industry under the authority of 21 V.S.A. § 667. It establishes the following for independent medical examiners: a selection process; training requirements; provisions for the use of independent medical examiners; examination fees; guidelines for conducting examinations and filing reports; and the medical records policy.

14.1500 A pool of independent medical examiners shall be established by the commissioner from a list of health care providers developed by the following processes:

14.1510 **t**he common names submitted to the commissioner by the management and labor representatives of the Governor's Advisory Council on Workers' Compensation established by executive order #02-93;

14.1520 if the Governor's Advisory Council is not available, the common names submitted to the commissioner by other representatives of management and labor; and

14.1530 additional names added at the discretion of the commissioner to ensure a sufficient list and range of health care providers, provided however that no names shall be added until seven days after notice of the proposed additions has been provided to the members of the Governor's Advisory Council, or if unavailable, to other members of management and labor.

14.2000 A health care provider is not eligible to be assigned as an independent medical examiner to a particular workers' compensation case, in the following circumstances:

14.2010 the provider is the employee's treating health care provider and has treated the employee with respect to the injury for which benefits are being paid; or

14.2020 the provider has examined the employee at the request of the insurance company or employer preceding the request for the examination; or

14.2030 the independent medical examiner has been designated by the employer as a health care provider, pursuant to Rule **12.1000**, or has been closely affiliated with a provider so designated, at any time during the preceding 52 weeks. This subsection shall not apply where no other health care provider is reasonably available.

14.2500 All independent medical examiners shall complete courses approved by the commissioner relating to the nature and purpose of workers' compensation, the use of the A.M.A.'s Guide to the Evaluation of Permanent Impairment, and shall follow guidelines for conducting examinations and filing reports, as indicated in paragraph **14.6500** of this rule.

14.3000 The commissioner may appoint an independent medical examiner whenever a dispute exists regarding:

14.3010 the reasonableness and necessity of treatment for an injury;
14.3020 the claimant's ability to perform suitable work, including light duty work; or
14.3030 any other medical issue.

14.3500 The commissioner shall appoint an independent medical examiner whenever a dispute exists regarding the nature and extent of any permanent partial impairment which involves permanent partial disability ratings which differ by more than 10 percent.

14.3510 The examiner shall examine the employee and report to the commissioner the examiner's opinion regarding the nature and extent of any permanent partial impairment.

14.3520 The opinion of the independent medical examiner as to the degree of impairment shall be binding on the parties absent a showing of substantial error or omissions, fraud or a gross departure from generally accepted medical practices.

14.3530 The independent medical examiner shall use the most recent edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment, or the supplement provided by the commissioner, in determining the degree of permanent partial disability.

14.4000 If the dispute involves permanent partial disability ratings which differ by 10 percent or less, the rating shall be determined by the commissioner.

14.4500 If the commissioner appoints an independent medical examiner, the commissioner shall first submit to the employee and the employer a list containing the names of three independent medical examiners. Within seven days of the date of submission of the list, the parties shall have the right to each strike the name of one examiner or reach agreement on an examiner from the names submitted. The commissioner shall appoint an independent medical examiner from the remaining names submitted, unless both parties have agreed on an examiner, in which case the commissioner shall appoint the agreed on examiner as the independent medical examiner.

14.4501 Upon appointment by the commissioner of the independent medical examiner, the commissioner shall issue a notification of the examiner's name, date, time, and location of the independent medical exam, by certified mail to the examiner, employee, insurance company, and employer.

14.5500 If a claimant fails or refuses to undergo an independent medical examination without good cause, the commissioner may assess all or a part of the cost of the examination or any missed appointments against the claimant or may suspend payment of compensation to which the claimant may be entitled, or both.

14.6000 The examiner shall report the findings of the examination to the commissioner within three weeks of the examination or receipt of test results, whichever is later.

14.6500 Independent medical examiners, appointed by the commissioner, will receive a maximum payment of no more than $450.00 for an examination. This payment does not include any diagnostic testing that may be necessary. The employer shall pay for the examination, as well as for necessary diagnostic testing. Exceptions to this maximum payment amount may be granted by the commissioner for unusually complex evaluations.

14.7000 If the employee fails to attend the independent medical examination without good cause, a maximum fee of $150.00 may be charged by the examiner. No charge will be paid if the examination is canceled and the examiner is notified at least three business days before the scheduled date. The commissioner may assess all or a part of the cost of any examinations missed without good cause against the claimant. Any fees under this paragraph not assessed against the claimant will be paid by the employer.

14.7500 Modifier 32 shall be added to diagnostic testing procedure codes required for the independent medical evaluation. (See Rule 40.0000).

14.8000 The adequacy of the examination fees shall be reviewed at least annually by the medical advisory committee created under the provisions of section 40.070 of Department Rule 40.0000.

14.8500 If an independent medical examiner is appointed, all parties to the dispute shall immediately provide the examiner with copies of all relevant medical records in their possession and shall assist the examiner in obtaining any other medical records deemed relevant to the proceedings.

14.9000 Independent medical examiners, appointed by the commissioner under the provisions of paragraph **14.3000** or paragraph **14.3500** of this rule, shall comply with the following guidelines for: conducting examinations; reporting independent medical examinations; and evaluating permanent impairment.

14.9100 Conducting Examinations. Independent medical examiners (IMEs), appointed by the commissioner under the provisions of this rule, shall receive an independent medical examination request letter and forms from the commissioner that will: identify the condition and issues to be addressed; provide background information; provide clinical information and any other relevant information; and indicate who should receive copies of the report. The commissioner shall assure that pain and psychiatric factors are examined where they appear relevant to the claim.

14.9110 The following general guidelines should be followed in conducting examinations:

14.9111 Examinations should take place as soon as possible after receiving the relevant medical records. The examiner's report shall be completed within 40 days from receipt of the IME request letter, unless an extension is granted by the commissioner.

14.9112 The examiner should not evaluate an IME claimant if the appearance of or an actual conflict of interest exists. A conflict of interest exists if any of the provisions of paragraph **14.2000** of this rule apply or if any other conditions or circumstances exist which would affect the independent nature of the examination. Examiners with questions about possible conflicts should consult with the commissioner.

14.9113 At the beginning of the visit, the examiner should explain the nature of the evaluation to the claimant. The examiner should advise the claimant that an independent evaluation will be conducted, but no treatment will be provided. The examiner should refer the claimant to his or her claims manager or attorney for questions about the claim, and to the treating physician for medical advice outside the scope of the examination.

14.9114 Medical findings, not related to the condition identified in the request letter, may come to light during the examination. Comments on these unrelated conditions should be directed to the treating physician and/or claimant and should not be included in the IME report.

14.9120 The following guidelines should be followed relating to relevant records and accompaniment during examinations:

14.9121 No party shall communicate with the IME examiner other than the commissioner or the claimant during the examination, except when setting the appointment, by deposition, or as approved by the commissioner. The only exceptions to this are when: the commissioner receives written consent signed by both parties attached to written communication for the IME examiner, which then may be forwarded to the examiner by the commissioner; if all parties, including the commissioner and the examiner, agree on oral communication; or in cases in which the claimant is represented by counsel, the parties submit written information to the commissioner to be transmitted to the examining physician, who may then forward it to the examining physician.

14.9122 Family members of the claimant, or friends of the claimant with the approval of the commissioner, are allowed to attend the independent medical examination, with the exception of psychiatric interviews or examinations. The accompanying individual must cooperate with the examiner and must not interfere with the examination. The use of electronic recording equipment by the claimant or an accompanying person is not allowed without prior permission of the commissioner.

14.9123 The non-insured employer, self-insured employer, insurance company or their representative shall forward to the IME examiner and the opposing parties, including a pro se claimant, a complete copy of all relevant medical records at least ten business days prior to the IME appointment. The medical file shall be bound, in reverse chronological order (i.e., most recent document on top), appropriately tabulated. Relevant supplemental medical records, not previously submitted, shall be prepared according to the above, and shall be submitted prior to the IME examination. The file shall include the workers' compensation number and a written index of all medical reports within the file.

Medical bills, adjuster notes, surveillance tapes, admissions, denials or commentaries to the IME examiner shall not be submitted as part of the medical records or otherwise without written agreement of all parties or prior permission of the commissioner.

Additional information and questions shall be submitted by agreement of the parties in writing to the commissioner. The commissioner may then submit relevant information to the IME examiner.

14.9200 Reporting Independent Medical Examinations. The examiner's role is to provide documentation of the medical facts, so that they can be applied correctly. The examiner should clearly define and discuss the issues in the report that are identified in the IME request letter from the commissioner. These may include: diagnoses, causal relationship, prognosis, end medical result, permanent impairment, work capability, appropriateness of care and recommendations.

Consistent with the time frame established in paragraph **14.9111** of this rule, the examiner shall submit a report of the independent medical examination, with all attachments, to all parties identified in the request letter from the commissioner.

14.9210 The report of an independent medical examination must include the following items:

14.9211 A record review with a detailed chronology of the injury or condition including: mechanism of injury or exposure; diagnostic studies and results; and treatments and outcomes.

14.9212 A history from the claimant describing both the course of the injury or treatment and his or her present status (to be reported separately and distinctly from the record review).

14.9213 A statement from the claimant about whether he or she is working at the time of the examination, and if not working, the reasons why.

14.9214 The results of the physical examination. The examiner should give sufficient detail of both positive and negative findings to support examination conclusions.

14.9215 Answers to each of the questions asked in the examination request letter from the commissioner. If the examiner cannot address a question, the examiner should explain why it cannot be answered and, if appropriate, identify the additional information needed to answer the question in the report.

14.9216 Conclusions and a summary statement of the findings used to make conclusions. The examiner should tie conclusions to findings actually made.

14.9220 If non-invasive diagnostic testing is needed to respond adequately to the request letter, the examiner should arrange for the needed test and complete the report. If invasive testing (myelogram, biopsies, etc.), or an additional physician specialist is required, the examiner should contact the commissioner for authorization. Invasive testing should be performed by the treating physician or as referred by the treating physician. Per paragraph **14.6500** rule, the employer is liable for the cost of necessary diagnostic testing. Reimbursement for necessary diagnostic testing shall not exceed the maximum allowable payment provided for in the workers' compensation fee schedule, Rule 40.000.

14.9230 Specific diagnoses should be presented in the following way: the condition identified in the IME request letter; relevant pre-existing conditions, and a statement as to whether they are worsening on their own or are worsening as a result of the identified condition; and conditions acquired after the injury or exposure, their effects on the identified condition and whether they are caused by the identified injury or disease.

14.9240 The significance of medical problems should be discussed in the report. The relationship between the extent of symptoms (subjective complaints) and signs (objective findings) must be noted. It is necessary to identify which problems are acute and which are chronic or degenerative in nature. Problems which predated an injury and may relate to current dysfunction directly or indirectly should be determined when relevant to issues raised in the IME request letter. The aggravation or recurrence of a medical problem should be noted in the report.

14.9241 Aggravation means an acceleration or exacerbation of a pre-existing condition caused by some intervening event or events.

14.9242 Recurrence means the return of symptoms following a temporary remission.

14.9250 In situations where the injury has an effect on pre-existing conditions, the examiner should:

14.9251 interview the claimant and review medical reports describing the claimant's prior condition;

14.9252 document the claimant's symptoms and any impairment that existed before the injury or exposure, if possible; and

14.9253 give an opinion, if possible, about the extent of any increased impairment due to the injury or exposure.

14.9300 Evaluating Permanent Impairment. The evaluation and the report shall follow the process outlined in the most recent edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. As appropriate, the examiner should include copies of tables from the Guides depicting the data specific to the assessment and use the forms available in the Guides.

14.9400 The examiner should be familiar with and follow additional Workers' Compensation and Occupational Disease Rules when conducting the examination and completing the report, including:

14.9410 Rule **11.0000** Benefits for Permanent Loss of Physical Functions Not Scheduled in the Act Where the Injury Occurred Prior to 4/1/95; and

14.9420 Rule **11.2000** Compensation for Permanent Partial Impairment to a Body Part, System, or Functions / Use of the A.M.A. Guides. (For Injuries Occurring after 4/1/95).

Rule 15.0000 AVERAGE WEEKLY WAGE; CALCULATING TEMPORARY TOTAL AND PERMANENT PARTIAL COMPENSATION RATE

15.1000 The compensation rate for permanent partial or permanent total disability compensation shall be 2/3rds of the claimant's average weekly wage, taking into account any annual adjustments in compensation rate required by 21 V.S.A. § 650(d) from the date of injury. The compensation rate for permanent partial disability shall not be limited by the employee's weekly net income.

15.2000 A claimant's compensation rate for temporary total disability compensation shall be 2/3rds of his or her average weekly wage but at no time shall the claimant receive temporary total disability compensation that exceeds the maximum weekly compensation rate or his or her weekly net income.

15.3000 A claimant's weekly net income shall mean the average weekly wage, less the amount of state and federal income tax and FICA which the claimant would pay or have withheld if the standard state and federal deductions or credits (including Earned Income Credit) to which the claimant is entitled were taken (see Forms 10S, 25 and 25S).

15.4000 To determine the claimant's average weekly wage, pursuant to 21 V.S.A. § 50, the total gross wages, as reported by the employer on the Wage Statement (Form 25), is divided by the number of weeks used to determine the total gross wages. In determining the total gross wages the following rules shall apply:

15.4100 The Wage Statement (Form 25) shall be filed and will include the wages paid and/or due the claimant for each of the twelve weeks preceding the injury not including the week of the injury. In addition, the Wage Statement shall also include the following for each of the twelve weeks preceding the injury:

15.4110 any overtime earnings and /or tips paid, due or received;

15.4120 any bonuses paid, due or received; and

15.4130 the fair market value of any room, board, food, electricity, telephone, uniforms or similar benefits provided the claimant. If the claimant continues to receive any of these benefits during the period of temporary total disability , the value of that benefit shall not be included in calculating the compensation rate.

15.4200 The following shall not be included when determining the gross wages:

15.4210 any week(s) during which the claimant worked and/or was paid for fewer than one-half of his or her normally scheduled hours;

15.4220 any week(s) during which the claimant did not work at all, regardless of whether or not he or she was paid for this time off; and

15.4230 any weeks preceding a promotion and/or transfer as a result of which the claimant is receiving larger regular wages.

15.4240 If the claimant has been employed for fewer than 4 weeks at the time of his or her injury, such that by the reason of the shortness of the time during which he/she has been in the employment it is impracticable to compute his or her average weekly wage in accordance with subsections **15.4210** and **15.4220** above, then the gross wages of a comparable employee working in a similar capacity under like conditions for the twelve weeks prior to the injury shall be used instead. If wages of a comparable employee are not available, the claimant's agreement with the employer as to both expected hours per week and rate of pay shall be used to determine the average weekly wage.

15.4250 If the claimant is a volunteer public safety worker covered under 21 V.S.A. § 601(12) and/or § 650(a) who has no other regular employment, his/her average weekly wage shall be based on that of a similarly responsible, paid employee in the same occupation.

15.4260 If a claimant is regularly employed for 2 or more insured employers at the time of the injury a separate wage statement shall be obtained from each employer, and the claimant's compensation rate shall be based on the combined average weekly wage from all the employers.

Rule 16.0000 MINIMUM AND MAXIMUM COMPENSATION RATES; ANNUAL CHANGE

16.1000 The following compensation rates have been determined under 21 V.S.A. §§ 601(18)-(19) and 650:

Workers' Comp. Year	Maximum Weekly Compensation 21 V.S.A. §601(18)	Min. Weekly Compensation 21 V.S.A. §601(19)	Dependency Benefits 21 V.S.A. §642(a)	Annual Comp. Adjust. Rate Multiplier 21 V.S.A. §650(d)
7/1/72 to 7/1/73	$ 68.00	$ 34.00	$ 5.00	
7/1/73 to 7/1/74	$ 81.00	$ 41.00	$ 5.00	
7/1/74 to 7/1/75	$ 86.00	$ 43.00	$ 5.00	1.06%
7/1/75 to 7/1/76	$ 91.00	$ 46.00	$ 5.00	1.06%
7/1/76 to 7/1/77	$127.00	$ 64.00	$ 5.00	1.05%
7/1/77 to 7/1/78	$170.00	$ 85.00	$ 5.00	1.07%
7/1/78 to 7/1/79	$181.00	$ 91.00	$ 5.00	1.06%
7/1/79 to 7/1/80	$192.00	$ 96.00	$ 5.00	1.06126%
7/1/80 to 7/1/81	$208.00	$104.00	$ 5.00	1.08334%
7/1/81 to 7/1/82	$225.00	$113.00	$ 5.00	1.08173%
7/1/82 to 7/1/83	$243.00	$122.00	$10.00	1.08%
7/1/83 to 7/1/84	$262.00	$131.00	$10.00	1.0782%
7/1/84 to 7/1/85	$278.00	$139.00	$10.00	1.0611%
7/1/85 to 7/1/86	$293.00	$147.00	$10.00	1.054%

Note: Beginning July 1, 1986 there were two maximum compensation rates - one for injuries occurring before July 1, 1986 and one for injuries occurring on or after July 1, 1986.

	Before 7/1/86	After 6/30/86			
7/1/86 to 7/1/87	$310.00	$465.00	$155.00	$10.00	1.058%
7/1/87 to 7/1/88	$324.00	$486.00	$162.00	$10.00	1.0452%
7/1/88 to 7/1/89	$343.00	$514.00	$172.00	$10.00	1.0576%
7/1/89 to 7/1/90	$363.00	$544.00	$182.00	$10.00	1.0583%
7/1/90 to 7/1/91	$373.00	$559.00	$187.00	$10.00	1.0275%
7/1/91 to 7/1/92	$395.00	$592.00	$198.00	$10.00	1.0590%
7/1/92 to 7/1/93	$407.00	$611.00	$204.00	$10.00	1.0304%
7/1/93 to 7/1/94	$429.00	$644.00	$215.00	$10.00	1.0540%
7/1/94 to 7/1/95	$432.00	$648.00	$216.00	$10.00	1.006%
7/1/95 to 7/1/96	$437.00	$655.00	$219.00	$10.00	1.011%
7/1/96 to 7/1/97	$450.00	$674.00	$226.00	$10.00	1.028%
7/1/97 to 7/1/98	$468.00	$699.00	$233.00	$10.00	1.038%
7/1/98 to 7/1/99	$485.00	$727.00	$242.00	$10.00	1.041%
7/1/99 to 7/1/00	$507.00	$760.00	$253.00	$10.00	1.045%
7/1/00 to 7/1/01	$527.00	$790.00	$263.00	$10.00	1.040%

16.2000 Pursuant to 21 V.S.A. § 650(d), annually on or before July 1 the commissioner shall announce the annual change in compensation rate and new minimum and maximum rates for the coming fiscal year. Any claimant receiving temporary total, temporary partial, permanent total or permanent partial disability compensation on July 1 shall be entitled to an increase in his or her compensation rate in accordance therewith, PROVIDED THAT in no event may a claimant's compensation rate for temporary total disability exceed his or her average weekly wage or his or her weekly net income.

16.3000 Notwithstanding the above, the annual adjustment in compensation rate for claimants whose injuries occurred between July 1, 1973 and June 30, 1977 and who were entitled to the maximum compensation rate at the time shall be computed so that the percentage relationship at the time of injury between the maximum weekly compensation and the state average weekly wage remains the same. The percentage relationship for each year is as follows:

Year	Max. Weekly Comp.	Avg. Weekly Wage	% Relationship
7/1/73-6/30/74	$81.00	$134.17	60.37%
7/1/74-6/30/75	86.00	142.23	60.47%
7/1/75-6/30/76	91.00	150.89	60.31%
7/1/76-6/30/77	127.00	158.65	80.05%

From July 1, 1977 through June 30, 1986 the state average weekly wage was equal to the maximum compensation rate. Beginning July 1, 1986 the State average weekly wage is equal to the maximum compensation rate for injuries occurring before July 1, 1986. See Rule **16.1000** above.

Thus, for example, a claimant whose injury occurred on July 15, 1975 and who was entitled to the maximum compensation rate at the time, or $91.00, would be entitled to an annual adjustment of compensation rate on July 1, 1976 equal to 60.31% of the new state average weekly wage ($158.65), or $95.68 ($158.65 x .6031). Beginning July 1, 1977 the compensation rate would be increased to $102.53 ($170.00 x .6031). If the claimant was still receiving benefits on July 1, 1986, the new compensation rate would be $186.96 ($310.00 x .6031).

Rule 17.0000 COMPENSATION AGREEMENTS

The following forms shall be used to satisfy the requirements of 21 V.S.A. §§ 662(a) and 703. Once executed by the parties and approved by the Division, these forms shall become binding agreements and absent evidence of fraud or material mistake of fact the parties shall be deemed to have waived their right to contest the material portions thereof. A claimant's failure or refusal to sign a compensation agreement offered by the employer shall not preclude his or her right to continuing compensation benefits. Before any of these forms can be approved, a Certificate of Dependency (Form 10), an Employee Exemption Report (Form 10 S), a Wage Statement (Form 25) and a Weekly Net Income Worksheet (Form 25 S) must be filed with this office. In addition, any medical documentation to substantiate the extent of the claimant's disability and its causal relationship to the work injury must be filed with the workers' compensation division.

17.1000 Form 21 - Temporary Total Disability Agreement. This form shall be used in all cases in which the employee has been disabled from working for at least three calendar days as a result of a work-related injury or occupational disease. If there has been a gap of more than 6 months between successive periods of disability related to the same injury, a new Form 21 shall be filed.

17.2000 Form 22 - Permanent Partial Disability Agreement. This form shall be used in all cases in which the employee is deemed to have suffered a permanent impairment as a result of a work-related injury or occupational disease. The medical documentation required to substantiate the extent of the claimant's disability shall include a permanency rating completed in accordance with 21 V.S.A. §648 and Rules **11.0000** or **11.2000** above.

17.3000 Form 23 - Fatality Compensation Agreement. This form shall be used in all cases in which death results from a work-related injury or occupational disease.

17.4000 Form 24 - Temporary Partial Disability Agreement. This form shall be used in all cases in which the employee has missed at least 8 days or parts of days from work as a result of a work-related injury or occupational disease and whose average weekly wage is now lower as a result than his pre-injury average weekly wage.

17.5000 Form 14 - Settlement Agreement (Medical Benefits Open). This form may be used to settle a genuine dispute over the compensability of a claim and/or the extent of benefits due. Once executed by the parties and approved by the commissioner, this form shall relieve the employer of all further liability for compensation benefits causally related to the injury, EXCEPT FOR liability for medical benefits, which shall continue in accordance with 21 V.S.A. § 640 and Rule **12.0000** above. This form must be accompanied by a letter identifying the disputed issue(s), detailing the parties' respective positions (supported by adequate medical documentation if necessary), and fully explaining the terms of the proposed settlement. The agreement shall not be approved unless the commissioner is convinced that the best interests of the claimant are served thereby, and under no circumstances should a claimant be promised that this will occur.

17.6000 Form 15 – Settlement Agreement (Full and Final). This form may be used to settle a genuine dispute over the compensability of a claim and/or the extent of benefits due. Once executed by the parties and approved by the commissioner, this form shall relieve the employer of all further liability for compensation benefits related to the injury. This form must be accompanied by a letter identifying the disputed issue(s), detailing the parties' respective positions (supported by adequate medical documentation if necessary), and fully explaining the terms of the proposed settlement. The agreement shall not be approved unless the commissioner is convinced that the best interests of the claimant are served thereby, and under no circumstances should a claimant be promised that this will occur.

17.7000 Form **23**- Fatality Settlement Agreement. This form shall be used to close a work-related fatality claim at the time that final payment is made.

Rule 18.0000 TERMINATION OF COMPENSATION

18.1000 Termination of Temporary Disability Compensation

18.1100 Unless the claimant has successfully returned to work, temporary disability compensation shall not be terminated until a Notice of Intention to Discontinue Payments (Form 27), adequately supported by evidence, is received by both the commissioner and the claimant. If the claimant is represented by counsel, a copy of the notice shall also be sent to his or her attorney. The employer (insurer) shall take action necessary to determine whether an employee has any permanent impairment as a result of the work injury at such time as the employee reaches a medical end result.

18.1200 Termination of temporary disability compensation on the basis that claimant has reached a medical end result shall be prohibited in the absence of a Form 27 accompanied by adequate, written medical documentation. A determination as to whether the claimant has any permanent impairment shall be made within 45 days of filing the notice of termination.

18.1300 In the case of termination on the basis of the claimant's failure or refusal to return to work, the notice must be accompanied by written documentation establishing the following:

18.1310 That the claimant has been medically released to return to work, either with or without restrictions; AND

18.1320 That the claimant has been notified both of the fact of his or her release and his or her obligation to conduct a good faith search for suitable work; AND

18.1330 That the claimant has either failed to conduct a good faith search for suitable work and/or has refused an offer of suitable available work once notified.

18.1400 For the purposes of this subparagraph,

18.1410 a claimant shall be deemed to have returned to work successfully when he or she demonstrates the physical capacity and actual ability to perform the duties of the job, without disabling pain and/or imminent risk of re-injury.

18.1420 Provided that a discontinuance (Form 27) on the basis of end medical result has not been filed properly in accordance with Rule **18.1000** above, a claimant shall be entitled to a resumption of temporary total disability benefits upon notice to the carrier that his or her return to work has proven unsuccessful, despite reasonable good faith efforts.

18.2000 Termination of Medical Benefits

18.2100 If an employer/insurer intends to discontinue payment of medical benefits, a Form 27 (Notice of Intention to Discontinue Payments) shall be filed with supporting reasons or documentation. The sufficiency of the proposed termination shall be reviewed by the commissioner in the same manner as proposed terminations of temporary disability benefits pursuant to 21 V.S.A. § 643a.

18.2200 If an employer/insurer intends to deny payment of any medical bills presented in connection with a workers' compensation claim, written notice of the denial shall be provided in the same manner as for any other denial in accordance with Rule **3.0900**. The commissioner shall review the sufficiency of the basis for the denial in the same manner as the denial of other benefits as provided by statute and rules governing claims.

Rule 19.0000 LUMP SUM PAYMENTS

19.1000 Retroactive compensation shall be paid in a lump sum.

19.2000 Permanent disability compensation may be paid in a lump sum upon request to and approval by the commissioner. The claimant's request for a lump sum payment must be in writing and must state the amount and the reason(s) for the lump sum request. All parties must have notice and an opportunity to be heard before a lump sum payment may be ordered.

19.3000 The commissioner may approve a lump sum payment if it is in the best interests of the claimant. In evaluating the claimant's request the following are considered positive factors in approving a lump sum:

19.3010 The claimant and/or the claimant's household receives a regular source of income aside from any workers' compensation benefit;
19.3011 The lump sum payment is intended to hasten or improve claimant's prospects of returning to gainful employment;
19.3012 The lump sum payment is intended to hasten or improve claimant's recovery or rehabilitation;
19.3013 The claimant presents other evidence that the lump sum award is in their best interests.

19.4000 A lump sum payment of permanent total disability benefits beyond three hundred and thirty weeks may only be granted with the agreement of all interested parties and approval by the commissioner.

19.5000 A lump sum payment shall not be approved if:

19.5010 The award was based upon a hearing decision for which an appeal has been filed and the employer or insurer objects to the payment of the lump sum; or
19.5011 The claimant is best served by receipt of periodic income benefits; or
19.5012 The payment is intended to pay everyday living expenses; or
19.5013 The lump sum payment is intended to pay past debts.

Rule 20.0000 ANNUAL REPORTS CONCERNING PAYMENT OF COMPENSATION

Within 60 days after the final payment of medical or indemnity benefits to an injured worker, the employer shall file a Report of Benefits and Related Expenses Paid (Form 13) with the Division and provide a copy to the injured worker. On or about July 1 each year the employer shall file a Report of Benefits and Related Expenses Paid. It shall specifically state the amounts paid to date for compensation including, amount paid by contract for vocational rehabilitation services, for contracted adjustment services, for medical services and supplies, for medical management, for medical consultation, for contract legal consultation and representation, and for any other services required for the resolution of the claim. Filing of this form shall satisfy the reporting requirements of 21 V.S.A § 701 and § 703.

Rule 21.0000 REIMBURSEMENT FROM THIRD PARTY RECOVERY

In determining the extent to which an employer is entitled to reimbursement from a claimant's third party recovery pursuant to 21 V.S.A. § 624(e), credit shall be allowed for any amounts paid for indemnity compensation, medical services and supplies, and only those vocational rehabilitation costs specified on an approved individual written rehabilitation plan. Credit shall not be allowed for adjustment, medical management and/or other vocational rehabilitation costs.

Rule 23.0000 CERTIFICATES OF INSURANCE; NOTICES OF CANCELLATION OR NON-RENEWAL

The National Council of Compensation Insurance (NCCI) is hereby designated the Department's agent for the purpose of receiving the notices required by 21 V.S.A. §§ 690, 696 and 697. The information required shall be filed in whatever format deemed acceptable to NCCI and shall include the insured's federal identification number. Certificates of insurance must be filed with NCCI no later than 30 days following a policy's issuance, renewal and/or reinstatement. Notices of cancellation and/or non-renewal must be filed at least 45 days prior to a policy's effective cancellation date. The commissioner may exercise authority granted under 21 V.S.A. § 688 in the event a carrier fails to comply with this requirement.

Rule 24.0000 EXCLUSION APPLICATIONS

A corporate officer who wishes to be excluded from the Workers' Compensation Act under 21 V.S.A. §601(14)(F) must file an Application for Exclusion (Form 29) with the commissioner. Corporate directors not holding a corporate office and who are not actively involved in the management of the business or organization are considered exempt and do not need to file an application. All applications are subject to verification from the records of the Vermont Secretary of State's Office.

An application must be accompanied by a notarized copy of the minutes of the board meeting of the Board of Directors of the corporation where at the authority was granted to request exclusion for specific offices positions. Those positions may include, President, Vice President, Secretary of the Corporation, Clerk and Treasurer.

Rule 25.0000 SELF INSURANCE

25.1000 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:

25.1100 an audited balance sheet and income statement

25.1200 an annual payroll report, categorized in accordance with the system used by the National Council on Compensation Insurance Occupational Classifications (NCCI),

25.1300 the workers' compensation insurance rate including the disease rate for each $100.00 of payroll category above as most recently determined by NCCI and filed with and approved by the commissioner of Banking, Insurance and Securities. Copies of that filing may be obtained from NCCI, One Penn Plaza, New York, NY 10119.

25.2000 Using the information obtained in subsection **25.1000** of this section 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:

$$\frac{F}{CL - AEC} > 0.25$$

Minimum Working Capital:

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

and

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

Minimum Liquidity:

$$\frac{CA - I}{CA + AEC} > \frac{CAb - Ib}{CLb}$$

and

$$\frac{CA - I}{CL + AEC} > 0.5$$

Minimum Net Worth to Debt:

$$\frac{A - L}{L + AEC} > \frac{Ab - Lb}{Lb}$$

and

$$\frac{A - L}{L + AEC} > 0.25$$

Minimum Profitability:

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

$$\frac{E - AEC}{TA} > \frac{Eb}{TAb} \quad \text{and} \quad \frac{E - AEC}{TA} > 0.03$$

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

$$\frac{E - AEC}{TA} > \frac{Ea}{TAa} \quad \text{and} \quad \frac{E - AEC}{TA} > 0.03$$

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

Turnover Minimum:

$$\frac{A - L - AEC}{S} > \frac{Ab - Lb}{Sa} \quad \text{and} \quad \frac{A - L - AEC}{S} > 0.05$$

25.3000 For the purposes of subsection **25.2000** of this section:

25.3100 AEC = Average Expected Claims = the sum of the products of the actual payroll as determined by category under subsection **25.1200** of this section multiplied by the rate for each payroll category as determined in subsection **25.1300** of this section divided by 100.

25.3150 F - cash flow = net income after taxes plus allowances for depreciation and depletion.

25.3200 E - earnings = net income before taxes and extraordinary items.

25.3250 A = total assets.

25.3300 L = total liabilities.

25.3350 CA = current assets.

25.3400 CL = current liabilities.

25.3450 I = inventory

25.3500 TA = tangible assets = total assets less intangible items.

25.3550 S = net sales = gross sales less returns and allowances

25.3600 W = net worth = assets less liabilities; A-L

25.3650 a = subscript denoting industry median data.

25.3700 b = subscript denoting lower base quartile industry data.

25.3750 c = subscript denoting upper quartile industry data.

25.4000 If the commissioner finds that an employer fails one or more of the tests enumerated in subsection **25.2000** of this section, the commissioner shall disapprove the application for self-insurance unless the commissioner finds that a test is inappropriate to a particular employee 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 subsection **25.2000** of this section, the commissioner may approve the application for self-insurance and require the employer to do one or more of the following:

25.4100 Establish a cash reserve fund, held in trust in this state, from which claims payments can immediately be made. The fund should be equal to 25% of AEC as defined in subsection **25.3000** of this section. Payments from the fund must be able to be made by the commissioner; and

25.4200 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

25.4300 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

25.4400 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

25.4500 Have sufficient assets located in this state which are readily available to satisfy claims.

Rule 26.0000 Direct Billing Of Prescription Drugs & Medical Supplies

26.1000 This rule is promulgated by the Department of Labor & Industry under the authority of 21 V.S.A. § 640(d);

26.2000 Unless waived for the convenience of the employee and pursuant to the guidelines of Workers' Compensation Rule 40.000, the employer shall arrange for the direct billing of reasonable and necessary prescription and medical supplies prescribed by a licensed physician for work related medical conditions anticipated to last 4 months or more;

26.3000 These arrangements may include, but are not limited to, mail order, local or chain pharmacies, and shall be established by mutual agreement of employee and employer;

26.4000 This section shall be effective upon receipt of medical documentation and written prescription by a licensed physician substantiating the medical necessity and anticipated duration of the requested items.

Rule 30.0000 IDENTIFICATION AND REFERRAL

30.1000 A vocational rehabilitation referral shall be made within 15 days of identifying an employee who either receives temporary total disability benefits for 90 days or when medical evidence identifies the employee as being unable to return to suitable employment due to their work injury. In the event the insurer identifies the employee, then the insurer shall promptly notify the employer of such identification.

30.2000 The Rehabilitation Referral Notification Form (VR-1) must be completed on forms designated by the department and a rehabilitation counselor must be named from the department's list.

30.3000 If an employer does not designate a rehabilitation counselor within 15 days, the employee may choose their own counselor by filing a VR-8.

30.4000 If the employee is not satisfied with their rehabilitation counselor, they may change their counselor at any time by filing a VR-8.

30.5000 If a change in rehabilitation counselor occurs for a reason other than party selection, the party who chose the counselor has first choice in designating a replacement counselor.

30.6000 The commissioner may order a change in a rehabilitation counselor if presented evidence that the current counselor is not complying with the law or the rules, does not hold current certification, and/or claimant and counselor are unable to engage in an effective working relationship.

30.7000 Any request for change of a rehabilitation service provider shall be directed to the commissioner. The commissioner (designee) may then schedule an informal conference to discuss the concerns of the requesting party.

30.8000 A party may appoint an independent vocational evaluator (IVE) to provide their opinion concerning a rehabilitation plan proposed by a rehabilitation counselor appointed by the opposing party. A counselor who has provided rehabilitation services to an employee for a given work injury may not be an IVE for that claim.

Rule 31.0000 QUALIFYING CRITERIA FOR REHABILITATION PROFESSIONALS

An applicant seeking certification as a Vermont Certified Rehabilitation Professional shall submit an application to the Commissioner of the Department of Labor & Industry. The commissioner may require rehabilitation professionals to regularly report information describing their services, including the geographic areas served by the professionals and the nature, cost and outcome of services provided to employees under these rules. After evaluating the application and all supporting documents the commissioner may certify the person as a Vermont registered vocational rehabilitation supervisor; evaluator; counselor; job developer, intern, medical case manager, or medical case manager intern, if the applicant has completed the following minimum education and experience. The education must have been received from an accredited school.

31.0010 All vocational rehabilitation services shall be provided by a certified vocational rehabilitation supervisor, counselor, evaluator or job developer/intern. Those individuals certified as a Job Developer/Intern shall be supervised by a certified vocational rehabilitation supervisor who shall co-sign and assume all responsibility for all of the intern's determinations, evaluations, rehabilitation plans, reports and billing. Those individuals certified as a Medical Case Manager Intern shall be supervised by a certified Medical Case Manager or a certified Vocational Rehabilitation Supervisor who shall assume all responsibility for the intern's determinations, reports, billing.

31.0015 Vocational Rehabilitation Supervisor, defined as anyone directly supervising either vocational rehabilitation counselors, interns or job developers.

Education: Master's in Rehabilitation Counseling from an accredited institution; Completion of the Vermont Rehabilitation Professional's Orientation workshop no later than six months after submission of an application for Vermont registration as a rehabilitation professional. **or**

Master's in Counseling from an accredited institution with documentation that the following courses had been successfully completed:

One graduate course with a primary focus on the Theories and Techniques of Counseling; and

One graduate course with a primary focus on Assessment; and

One graduate course with a primary focus on Occupational Information; and

One graduate course with a primary focus on medical or psychosocial aspects of disability **and**

Completion of the Vermont Rehabilitation Professional's Orientation workshop no later than six months after submission of an application for certification as a Vermont certified rehabilitation professional.

Experience: Thirty-six months of acceptable experience including a minimum of 12 months working with Vermont Workers' Compensation claimants, within the past 60 months.

31.0020 Independent Vocational Evaluator:

Education: Same as that required of the Vocational Rehabilitation Supervisor.

Experience: Sixty months of acceptable employment experience including 24 months working with Vermont Workers' Compensation claimants.

31.0025 Vocational Rehabilitation Counselor:

Education: Same as that required of the Vocational Rehabilitation Supervisor.

Experience: Twelve months of acceptable employment experience including six months of the past 24 months working with Vermont Workers' Compensation claimants.

31.0030 Vocational Job Developer/Intern:

Education: Baccalaureate degree in any field. Completion of the Vermont Rehabilitation Professional's Orientation workshop no later than six months after submission of an application for certification as a Vermont certified rehabilitation professional.

Experience: None.

31.0035 Medical Case Manager

Education: Post-secondary degree in a field that promotes the physical, psychosocial, or vocational well-being of the injured worker and hold a valid current license or certification as defined below.

Licensure: A process by which a government agency grants permission to an individual to engage in a given occupation, provided that person possess a minimum degree of competency to reasonably protect public health safety and welfare.

Certification: A process by which a government or non-government agency grants recognition to an individual who has met certain predetermined qualifications set by a credentialing body.

Experience: Twenty-four months of acceptable full-time medical case management employment experience under the supervision of a Vermont Certified Medical Case Management, including a minimum of 12 months working with Vermont Workers' Compensation claimants, within the past 24 months.

NOTE: All part-time employment experience will be pro-rated based on a 40 hour full-time work week.

31.0040 Medical Case Manager Intern

Education: Same as that required of a Medical Case Manager.

Experience: None

31.0100 Continuing Education: All of the above mentioned positions, shall attend an annual Rehabilitation Professionals Workshop.

31.0200 Required knowledge: Each applicant applying for approval as a Vermont certified rehabilitation professional shall have a working knowledge of the Vermont Department of Labor & Industry's rules and regulations. The commissioner may require an examination as proof of that knowledge.

31.0300 Education criteria. The burden of proof concerning education shall be borne by the applicant. Proof of education shall include an official transcript from any accredited school or college.

31.0400 Experience criteria. The burden of proof concerning experience shall be borne by the applicant. School internships shall not be acceptable as employment experience. Supporting documents shall consist of signed statements, regarding the applicant's work by present and previous employers which shall include, but not be limited to, the specifications of services, the applicant's position description including caseload, and amount of time spent in vocational rehabilitation or medical case management work.

31.0500 Professional Conduct. All rehabilitation professionals with the exception of medical case managers shall comply with Code of Professional Ethics as published by the Commission on Rehabilitation Counselor Certification (CRCC) until such time the Department of Labor & Industry publishes their own.

31.1000 Grand-fathering

All rehabilitation professionals who have been registered with the Department of Labor & Industry prior to July 1, 2000 and are employed as a vocational rehabilitation supervisor, counselor / consultant or medical case manager as of the effective date of this rule may apply for certification as a Vermont Rehabilitation Professional and may be granted such designation upon verification that he/she has met the following minimum education requirements:

31.1100 Vocational Rehabilitation Supervisor; Counselor or Consultant.

Education: A baccalaureate degree in any field from an accredited institution and a signed agreement to complete, within the next 36 months, the following courses:

One graduate course with a primary focus on the Theories and Techniques of Counseling; and

One graduate course with a primary focus on assessment; and

One graduate course with a primary focus on Occupational Information; and

One graduate course with a primary focus on Medical or Psychosocial Aspects of Disability.

31.1200 The commissioner may issue an Interim certificate pending receipt of verification from an accredited school that the four graduate level courses have been completed. If the applicant requesting consideration under the "grand-father" clause fails to complete the required graduate level courses within the three year period he/she will no longer qualify under the grand-father clause.

31.1250 Medical Case Manager

Education: Post-secondary degree in a field that promotes the physical, psychosocial, or vocational well-being of the injured worker and hold a valid current license or certification as defined below.

Licensure: A process by which a government agency grants permission to an individual to engage in a given occupation, provided that person possess a minimum degree of competency to reasonably protect public health safety and welfare.

Certification: A process by which a government or non-government agency grants recognition to an individual who has met certain predetermined qualifications set by a credentialing body.

Applicants must also be able to demonstrate that, as part of their employment, they apply the six essential activities (assessment; planning; implementation; coordination; monitoring; and evaluation) within each of the following six core components: Processes and relationships; Health Care Management; Community Resources and Support; Service Delivery; Psychosocial Intervention; Rehabilitation Case Management.

31.1255 If the individual requesting consideration under the "grand-fathering" clause fails to complete the required education within a three year period he/she will no longer qualify under the grand-father clause.

31.1300 The commissioner may grant exceptions to the above mentioned grand-fathering provisions on a case by case basis. All requests for exception must be written and accompanied by an application for certification.

31.2000 The Vermont certification shall be valid for three years from the date of the certification. Written application for renewal shall be received by the commissioner no earlier than one hundred twenty days, but not later than seventy-five days prior to the current certification's expiration date. If the certification has lapsed or has been withdrawn by the commissioner the applicant must follow the procedures established for new applicants. All renewals shall only submit a new application.

31.2100 The department shall maintain a current listing of all Vermont certified rehabilitation professionals, including the areas served, and shall provide the list at no charge to employees, employers and insurers.

31.3000 Each Vermont certified rehabilitation professional offering rehabilitation services to workers' compensation claimants shall be evaluated periodically by the Vocational Rehabilitation Unit of the Department of Labor & Industry. The evaluation shall focus on the quality of the services provided, the costs of such services, the results achieved by such services and the professionals compliance with any Department of Labor & Industry established standards of performance. The Department of Labor & Industry shall notify in writing any rehabilitation professional who fails to attain a satisfactory rating. Such notice shall state specifically the reasons for the unsatisfactory rating. The commissioner may suspend or revoke the professional's certification based on the results of the evaluation.

31.4000 Rehabilitation professionals who provide services to employees without obtaining prior certification from the commissioner shall be required to terminate those services immediately, and shall not be considered for certification for a period of two years from the date of the infraction.

31.5000 The commissioner may revoke the certification of a rehabilitation professional for a period, not to exceed three years if following an investigation, to include an opportunity for the professional to respond, the commissioner finds that the professional failed to:

31.5100 Comply with the Department of Labor & Industry's established rules and regulations; or

31.5200 Fulfill any obligation in providing the rehabilitation services prescribed in an approved rehabilitation plan; or

31.5300 Comply with the established Vermont rehabilitation professional's standards of performance; or

31.5400 Comply with any state or federal laws relating to employment practices; or

31.5500 Comply with the established continuing education requirements.

Rule 32.0000 ENTITLEMENT

Vocational rehabilitation shall be provided by an employer when, as a result of a compensable injury or occupational disease, an injured worker is unable to return to suitable employment using his/her previous training or experience. Any training or experience not utilized in the last fifteen years should not be considered when determining entitlement.

32.1000 Prior to completing an entitlement assessment the assigned rehabilitation counselor will contact the employer and discuss the possibility of any light duty work program(s) or positions available or the possibility of job modifications that would assist the injured worker in their return to a job.

32.2000 An assessment as to the entitlement for vocational rehabilitation services shall be made and a report filed with the workers' compensation division within sixty days of the filing of the VR 1. An entitlement assessment must include a face to face interview between the employee and a vocational rehabilitation counselor. The written report shall include, at a minimum, the following:

32.2100 A summary of current medical status, secondary conditions affecting recovery, treatment, prognosis and estimate of time frames if possible;

32.2200 A vocational profile that includes an educational background and work history;

32.2300 A summary of positive and negative indicators for return to work; and

32.2400 A statement of the counselor's conclusion regarding the claimant's entitlement for vocational rehabilitation services.

32.3000 A request for an extension of the sixty day time frame, accompanied by sufficient documentation supporting the inappropriateness of such an assessment at this time, may be made to the commissioner prior to the deadline. If the commissioner denies the request to delay the entitlement assessment, the assessment must be completed in thirty days from receipt of the denial.

Rule 33.0000 INDIVIDUAL WRITTEN REHABILITATION PLAN

33.1000 Within 45 days of completing the entitlement assessment, the rehabilitation service provider shall submit an Individual Written Rehabilitation Plan (IWRP) (VR 2) for a claimant that has been determined eligible entitled for vocational rehabilitation services. The IWRP shall have a plan of action for a specific vocational objective which will result in suitable employment for the injured worker. This plan shall clearly establish steps and a time table for attainment of the objective.

33.2000 The department shall assume a higher likelihood of successful return to work based on the following hierarchy of vocational options which are listed in descending order of preference.

33.2100 Return to the same employer in a modified job or a different job requiring the application of vocational rehabilitation services;

33.2200 Return to a different employer in a modified or different job requiring the application of vocational rehabilitation services;

33.2300 On-the-Job Training:

33.2400 New Skill Training or Retraining;

33.2500 Educational / Academic Program;

33.2600 Self-Employment.

33.3000 The IWRP shall include such information as is necessary to assess the proposal and to track the claim. The department shall provide rehabilitation counselor with a list of the required information. In addition the following information shall be included in the plan.

The IWRP shall include a return to work, training, or self employment plan. This plan shall contain specific vocational outcomes and associated milestones or output measures and a firm time frame for completion.

33.3200 The IWRP shall include the vocational plan justification with information on the claimant's current and projected medical status and functional capacities.

33.3300 The IWRP shall define specific responsibilities of the claimant; counselor; and the employer/carrier.

33.3400 The IWRP shall include an itemization of the projected costs associated with the vocational plan, including but not limited to total equipment costs, travel, training, and the projected costs of services provided by the rehabilitation service providers. The actual costs associated with this plan shall be included on the VR 5 (Closure Report) when submitted.

Failure to provide required information may result in the IWRP being denied.

33.5000 The IWRP shall be forwarded to the employer/carrier and the division after the claimant and the counselor have completed the plan and have signed the plan. In the event that any party fails or refuses to sign the IWRP, the IWRP as proposed shall be filed with a written explanation, by the refusing party, of the reasons for failure or refusal to sign the document.

33.6000 The IWRP shall be reviewed for the feasibility of the vocational objective and the plan of action. The IWRP shall be approved by the commissioner (designee) and vocational rehabilitation services shall be provided in accordance with the plan. A properly documented plan shall be deemed approved if it is not rejected within 45 days of its receipt by the department. The commissioner (designee) may extend his/her review period for an additional 45 days by informing all parties of the extension. If the proposed plan is denied the Vocational Rehabilitation provider shall submit a revised plan within 30 days of the date of denial.

If any party has failed or refused to sign the IWRP, and/or if the commissioner (designee) has found the vocational objective or plan of action not to be practicable an informal conference and/or formal hearing shall be scheduled in accordance with the Workers' Compensation Rules **5.0000 & 6.0000**. The commissioner (designee) may issue an interim order requiring or suspending further vocational rehabilitation services pending such a conference and/or hearing in accordance with 21 V.S.A. Sec. 641(b) and/or 662 (b).

33.7000 Prior to the termination of vocational rehabilitation services pursuant to Rule **38.0000** either party to an IWRP may propose amendments (Form VR 2) under the following circumstances:

33.7100 When it is apparent that the original vocational objective and/or plan has become inappropriate because of the claimant's medical condition as documented by medical reports or,
33.7200 When it is apparent that the claimant is not able to obtain the objective.
33.7300 When the vocational objective is no longer a reasonable goal because of economic changes.

33.8000 Any amendment to an IWRP must be submitted to this office a minimum of 30 days prior to the expiration of the current approved plan. All amendments must have the claimant's, counselor's and insurance adjuster's signatures affixed to the document prior to the submission of the document to the Department of Labor and Industry. Proposed amendments shall be reviewed by the commissioner (designee) in accordance with section **29.5000** above.

33.9000 The rehabilitation service provider shall file progress reports with the claimant or his/her attorney and the division, evaluating progress toward the vocational objective of the approved IWRP. These reports shall be filed every 30 days, at minimum.

Rule 34.0000 SELF-EMPLOYMENT

34.1000 Self-employment is the least favored vocational goal because of the capital usually required to undertake it, the time it usually takes to achieve an appropriate wage level and the inherent risks associated with any new business venture. For this reason, an IWRP that proposes self-employment as the means of returning a claimant to suitable employment must be carefully considered to ensure that this is in fact the most appropriate vocational goal and that no other vocational goal is as likely to lead to suitable employment as this one. This may include returning to Step 2 of the hierarchy of vocational objectives as identified in Rule **33.2000** with the goal of returning the claimant to a job within his/her physical capabilities and a salary no less than 75% of his/her average weekly wage.

34.2000 An IWRP that proposes self-employment as the claimant's vocational goal shall be accompanied by a Self-Employment Workbook (Form VR 4) completed by the claimant with the rehabilitation services provider's assistance. In addition to the workbook, the claimant, if she or he is seeking any financial assistance from the insurance carrier/employer, must submit documentation that she/he has contacted and discussed the business plans with a qualified small business consultant with a written evaluation including recommendations to be completed by the consultant.

34.3000 In determining the required extent of an employer's financial contribution to an approved self-employment plan, the following factors shall be considered:

34.3100 The total amount required to adequately finance the business' start-up, as itemized in the Self Employment Workbook; and

34.3200 The extent to which the claimant has or will incur extraordinary costs as a result of his or her injury that are distinguishable from the ordinary costs associated with the proposed business venture, such as the cost of modified equipment and/or assistive technology; and

34.3300 The availability of financing from other sources.

Rule 36.0000 VOCATIONAL REHABILITATION SETTLEMENT AGREEMENTS

Rehabilitation services pursuant to an approved rehabilitation plan are mandatory for eligible employees. An eligible employee's right to vocational rehabilitation services shall not be subject to compromise and shall not be convertible into cash or other benefits by settlement and release agreement or otherwise, except in extraordinary circumstances.

Rule 37.0000 VOCATIONAL REHABILITATION DISPUTE RESOLUTION

In the case of any dispute involving rehabilitation, the commissioner (designee) either on his/her own motion or upon request of the employer, counselor or employee, may schedule an informal conference to resolve the issue(s) in dispute. A party dissatisfied with the results of an informal conference(s) may request a formal hearing but shall comply with the directives of the informal conference until a formal hearing is held and a decision rendered.

Rule 38.0000 TERMINATION OF VOCATIONAL REHABILITATION SERVICES

38.1000 Vocational rehabilitation services may be suspended and/or terminated under the following circumstances:

38.1100 When it becomes apparent, either because of the claimant's refusal to cooperate or because of a change in his or her current medical condition, that the provision of further vocational rehabilitation services would serve no useful purpose at this time; or

38.1200 Upon successful completion of an approved IWRP, documented by the claimant's successful return to suitable employment, not including any on-the-job training period, for at least 60 days.

38.2000 An employer's/carrier's decision to suspend or terminate the claimant's vocational rehabilitation benefits because of refusal or failure to cooperate with the rehabilitation process shall be filed with the department at least 10 days prior to the discontinuance of vocational rehabilitation services. The notice shall be given to the claimant at the same time it is filed with the department. Evidence of a claimant's refusal or failure to cooperate with rehabilitation may include but is not limited to the following:

38.2100 Failure to cooperate with the initial assessment to determine entitlement within the time limitations specified in these rules;

38.2200 Failure to follow through with the responsibilities of an approved IWRP without good cause;

38.2300 Failure to maintain contact with the rehabilitation counselor;

38.2400 Failure to follow employment leads provided by the rehabilitation counselor in a reasonable and timely manner; or

38.2500 Failure to accept and perform suitable employment, unless refusal is justified.

38.3000 Prior to suspending or terminating vocational rehabilitation services, a Vocational Rehabilitation Closure Report (Form VR 5) shall be filed with the Division, with a copy to the claimant. Upon review, the commissioner may either approve or deny the closure. If the closure is denied, the commissioner (designee) may order the prompt resumption of vocational rehabilitation services. At either party's request, or at the commissioner's discretion, an informal conference and/or formal hearing may be scheduled to resolve any dispute concerning the continuation, modification or termination of vocational rehabilitation services.

Rule 45Rules for Administrative Citations and Penalties

45.1000 Scope

These rules establish the procedure for issuing administrative citations, assessing penalties and requesting hearings concerning citations or penalties.

The commissioner or a representative of the commissioner may, after notice and an opportunity for a hearing, assess an administrative penalty against any person who violates the laws or rules relating to workers' compensation or compensation for occupational disease and against any person who fails to comply with any order issued by the commissioner or the workers' compensation division.

45.2000 Authority

These rules are adopted pursuant to:

45.2100 21 V.S.A. Sections 688, 689, 692, 702, 704, 705, 708.
45.2200 8 V.S.A. Chapter Section 4793(d) and Section 4803 (Adjusters, Workers' Compensation Adjusters).
45.2300 3 V.S.A. Section 809 - 815.

45.3000 Issuance of Administrative Citation

45.3100 The director of the workers' compensation division may issue an administrative citation to any person, including an employee, employer, attorney, insurer or any of their representatives, if the director determines, after investigation by the division, that the person has:

45.3110 refused or neglected to comply with the provisions of the Workers' Compensation Act;
45.3120 refused or neglected to comply with the rules promulgated pursuant to the Act;
45.3130 refused or neglected to file in a complete and timely fashion any reports required by the Act or the rules;
45.3140 refused or neglected to comply with any interim or final order issued by the Commissioner or a representative of the Commissioner; or,
45.3150 willfully made a false statement or representation for the purpose of obtaining any benefit or payment for either her or himself or any other person.

The administrative citation shall be served on the person by certified mail or personal service. Each citation shall be in writing and shall specifically describe the nature of the violation and include a reference to the particular section of the Act, rule or order alleged to have been violated. The citation shall also state the amount of the administrative penalty and the process for requesting a hearing.

45.3200 The person alleged to have committed the violation shall have twenty days from the date of service to notify the director, in writing, of any intent to contest the citation and administrative penalty. If no notice of contest is filed the citation and penalty shall be deemed a final order of the commissioner.

45.3300 Administrative citations and penalties issued under these rules shall not limit the authority of the commissioner or a representative of the commissioner to issue orders or seek injunctive relief and penalties through the court system, or to take other appropriate enforcement action permitted by law.

45.3400 Whenever the commissioner or a representative of the commissioner has reason to believe that an employer has willfully made a false statement or representation for the purpose of obtaining a lower workers' compensation premium, written notice and any supporting documentation shall be provided to the commissioner of Banking, Insurance and Securities with a request for hearing on the matter. The commissioner of Banking, Insurance and Securities may assess an administrative penalty not to exceed $5000.00. See 21 V.S.A. Section 708(b).

45.4000 Hearing on Citation and Proposed Penalty

45.4100 A person who contests a citation and proposed penalty issued by the director, pursuant to 45.3000 of this rule shall be entitled to a hearing before the commissioner or designee within 45 days of filing the notice of contest. The 45 day time frame may be extended if the person requests, in writing, additional time to prepare for the hearing.

45.4200 The hearing notice sent to the person shall include the following information:

45.4210 A statement of the time, place, and nature of the hearing;
45.4220 A statement of the legal authority and jurisdiction under which the hearing is to be held;
45.4230 A reference to the sections of the statutes, rules or order(s) involved;
45.4240 A short and plain statement of the matters at issue.

45.4300 The commissioner may appoint a hearing officer to hear the evidence and prepare findings and recommend a decision. The procedures set forth in 3 V.S.A. Section 809 - 813 and Section 815 shall apply all hearings under these rules.

45.4400 The person may appear at the hearing with Counsel, present evidence and cross-examine witnesses.

45.4500 Evidence shall be admitted as provided in 3 V.S.A. Section 810.

45.4600 The hearing officer may compel, by subpoena, the attendance and testimony of witnesses and the production of books and record in accordance with 21 V.S.A. Section 603(a) and 3 V.S.A. Section 809a and 809b.

45.4700 Nothing in this section shall prohibit the informal disposition of a citation by stipulation, agreed settlement, consent order or default. Informal disposition may proceed with clear and simple documentation without complete adherence to this section.

45.5000 Administrative Penalty

Penalties shall be assessed on a per violation basis and shall not exceed the following:

45.5100 An employer who fails to comply with 21 V.S.A. Section 687 (providing workers' compensation insurance (or self insurance as permitted by law) shall be assessed a penalty of $50.00 per day for every day that the employer neglected to insure workers' compensation liability prior to receiving notice from the commissioner or a representative of the commissioner, but not to exceed $5,000.00. An employer who fails to comply with 21 V.S.A. Section 687 within 5 days of receipt of notice from the commissioner or representative shall be assessed a penalty of $150.00 per day for every day after 5 days from receipt of notice. The commissioner may reduce the assessed penalty if the employer demonstrates:

45.5110 that failure to obtain or maintain insurance was inadvertent or the result of excusable neglect and was promptly corrected;
45.5111 that the penalty amount exceeds the amount of any premium expenditures that would have been paid if a policy was properly obtained or maintained; or
45.5112 the small size of the employer and the non hazardous nature of the employment presented minimal risk to employees

45.5200 A person who willfully makes a false statement or representation for the purpose of obtaining any benefit or payment either for her or himself or another shall be assessed a penalty of $1,000.00. The commissioner may reduce the penalty if the person demonstrates:

45.5210 that the person has repaid or entered into an agreement to repay benefits or amounts received as a result of the false statement or representation; and
45.5215 that the benefit or payment to be gained was less than the amount of the penalty; or

45.5220 the person has agreed to forfeit any claim for additional workers' compensation benefits based on the alleged workplace injury. The commissioner shall not reduce the penalty if:

45.5221.1.1 the false statement or representation was made to establish compensability of the claim; or

45.5221.1.2 the false statement or representation involved falsifying medical records; or

45.5221.1.3 the false statement or representation was sworn testimony.

45.5230 The employee may forfeit only a portion of their workers' compensation benefits if:

45.5231.1 the employee has repaid or entered into an agreement to repay the benefit amount received as a result of the false statement or representation; or

45.5231.2 the benefit or payment to be gained was less than $1,000.00; or

45.5231.3 benefit or payment to be gained was limited to only one benefit then the other workers' compensation benefits the employee was otherwise entitled to shall not be affected.

In addition an employee who willfully makes a false statement or representation of a material fact for the purpose of obtaining workers' compensation shall forfeit all or a portion of her or his right to any workers' compensation.

45.5300 An employer or workers' compensation insurance carrier which refuses or neglects to comply with an interim or final order of the Commissioner shall be assessed a penalty of $500.00 per occurrence. An additional penalty of $100.00 per day shall be assessed for each day the employer or worker's compensation carrier failed to comply after the date set for compliance. The total penalty shall not exceed $5,000.00 per occurrence. The commissioner may reduce the penalty if the insurer demonstrates that noncompliance was the result of inadvertence or excusable neglect.

45.5400 An employer or workers' compensation insurance carrier which fails to ensure that any of its agents or subcontractors complies with the Act or rules of the Department or with an interim or final order of the Department shall be assessed a penalty of $500.00 for a first offense. A first offense shall be defined as one instance of failing to comply with one act or one rule in one claim. The employer or a workers' compensation insurance carrier shall be assessed an additional penalty of $500.00 for each additional instance of failing to comply but shall not be assessed a penalty in excess of $5000.00. In addition, the agent or subcontractor of the employer or insurer who refuses or neglects to comply shall be assessed a penalty of $50.00 for each instance of refusing or neglecting to comply with the Act, but shall not be assessed a penalty in excess of $5000.00.

45.5500 An employer which refuses or neglects to submit a First Report of Injury within 72 hours of learning of an alleged injury, shall be assessed a penalty of $100.00 for each violation.

An employer which fails to submit any form required by law to be filed with the department shall be assessed a penalty of $100.00 for each violation. Forms which are required to be filed with this department include, but are not limited to wage forms (Form 10, Form 10S, Form 25 and Form 25S) and compensation agreements (Form 21, Form 22, Form 23 and Form 24).

45.5510.1 An employer which refuses or neglects to provide an employee a copy of the claimant's First Report Of Injury (Form 1) promptly, on or about the same time as filing a First Report Of Injury shall be assessed a penalty of $50.00 for each violation.

45.5600 An employer or workers' compensation insurer which refuses or neglects to file any interim or

final report required by 21 V.S.A. Section 701, 702, or 703 shall be assessed a penalty of $100.00 for each violation.

45.5700 An employer or workers' compensation insurer which refuses or neglects to file any statistical report requested by the commissioner or designee pursuant to 21 V.S.A. Section 704 shall be assessed a penalty of $1000.00. In addition, they shall be assessed an additional $1,000.00 per occurrence.

45.5800 An employer which refuses or neglects to register with the department when commencing or ceasing business operations in the state as required by 21 V.S.A.§ 705 shall be assessed a penalty of $50.00.

45.5900 The penalty for any administrative or technical violation not otherwise noted in this section shall be fined $500.00.

45.6000 Severability Clause

In the event any part or provision of these rules is held to be illegal, this shall not have the effect of making void or illegal any of the other parts or provisions of these rules.

45.7000 Effective Date

Amended rule effective upon approval.

Rule 46.0000 APPLICATION AND EFFECT OF RULES, AUTHORITY OF COMMISSIONER, REPEAL OF PREVIOUS RULES

46.1000 Procedures under these rules, not affecting the substantive rights of a party, shall apply to pending and future claims and cases. In the event that any part or provision of these rules is modified, limited or invalidated by court or statute, all other parts and provisions shall remain in full force and effect.

46.2000 Nothing contained in these rules shall be construed to limit the authority of the commissioner under the Act.

46.3000 All previous rules under the Act are repealed.

46.4000 Any person failing to comply with these rules may be subject an administrative penalty as provided in the workers' compensation rules governing administrative penalties. See Rule 45.0000