WORKERS' COMPENSATION MEDICAL FEE SCHEDULE

RULE 40.000

40.000 Workers' Compensation Medical Fee Schedule

The five-digit numeric codes and descriptions included in Rule 40.000, Medical Fee Schedule, are obtained from the *Physicians' Current Procedural Terminology*, Copyright 2005 and any updates thereto, by the American Medical Association (CPT). Appendix I of Rule 40.000 shall be updated on April 1 of each consecutive year to reflect any additions, deletions and modifications of the CPT Codes contained in any update to the *Physicians' Current Procedural Terminology*, Copyright 2005. CPT is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians.

This publication includes only CPT numeric identifying codes and modifiers for reporting medical services and procedures that were selected by the Vermont Department of Labor . Any use of CPT outside the fee schedule should refer to the *Physicians' Current Procedural Terminology*, copyright 2005 American Medical Association and any update thereto. These CPT publications contain the complete and most current listing of CPT descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures.

40.010 General Provisions

40.011 Authority and Purpose

This rule is promulgated by the Vermont Department of Labor under the authority of 21 V.S.A. § 640(d). It establishes that the liability of an employer to pay for medical, surgical, hospital and nursing services provided to an injured employee shall not exceed the maximum fee for a particular service as provided for in this rule.

40.012 Definitions

(A) "Charge" shall mean the amount billed by the health care provider or health care facility to all payers for the same service, whether under workers' compensation or not. Hospitals shall provide an electronic copy of their charge master to the department within 45 days of the effective date of this rule.

(B) "CPT code" means a numeric code, included in the *Current Procedure Terminology* manual, used to identify a specific medical service, article or supply. The *Current Procedure Terminology* manual is published by and may be purchased from the American Medical Association, Order Department: OP054194HA, P.O. Box 10950, Chicago, Illinois 60610.

(C) "Commissioner" means the Commissioner of the Vermont Department of Labor.

(D) "Follow-up Days (FUD)" means the maximum number of days of care following a surgical procedure that are included in the procedure's maximum allowable payment but does not include care for complications, exacerbations, recurrent, or other diseases or injuries.

(E) "Health care facility" shall mean the same as defined in 18 V.S.A. § 9432(7).

(F) "Health care provider" shall mean the same as defined in 18 V.S.A. § 9432(8).

(G) "Hospital" shall mean the same as defined in 18 V.S.A. § 1902(a) and shall be licensed in its state of domicile.

(H) "Incidental Surgery" means a surgery which is performed on the same patient, on the same day, by the same doctor but is not related to the diagnosis.

(I) "Maximum Allowable Payment" means the maximum fee for a procedure listed in Appendix I, subject to the provisions of section 40.020 of this rule, or the health care facility's or health care provider's charge whichever is less. For those procedures having no code listed in Appendix I of this fee schedule, payment shall not exceed 83% of the charge for the service. This percentage shall be adjusted annually to consider any increase or decrease in the total operating expense of all hospitals based on hospital budget submissions to the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA). The change shall be calculated using the ratio of the new cost-to-charge ratio to the prior year cost-to-charge ratio.

(J) "Modifier" means a two-digit number that is added to a procedure code to indicate that the service rendered differs in some material respect from the service described in this rule or in the *Current Procedure Terminology* manual in effect on the date the service was rendered.

(K) "Nursing home", "residential care home", and "therapeutic community residence" shall mean the same as defined in 33 V.S.A. § 7102 and shall be licensed in its state of domicile.

(L) "Health Insurer", means any health insurance company, nonprofit hospital and medical service corporation and managed care organizations.

(M) "Employer", includes any body of persons, corporate or unincorporated, public or private, and the legal representative of a deceased employer, and includes the owner or lessee of premises or other person who is virtually the proprietor or operator of the business there

carried on, but who, by reason there being an independent contractor or for any other reason, is not the direct employer of the worker there employed. If the employer is insured, "employer" includes the carrier so far as applicable. (21 V.S.A. §601(3) and §687).

(N) "Insurance Carrier", includes any corporation from which an employer has obtained workers' compensation or guaranty insurance in accordance with the provisions of 21 V.S.A. §601.

(O) "Medical Necessity", Workers' compensation insurers are only responsible for paying for services or items that are medically necessary. Medically necessary is defined as health care services that "are appropriate, in terms of type, amount, frequency, level, setting, and duration to the beneficiary's diagnosis or condition". Medically necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or a similar general specialty as typically treat or manage the diagnosis or condition, and help restore or maintain the claimant's health; or prevent deterioration or palliate the claimant's condition.

40.013 Interpretation

It is the intention of the Vermont Department of Labor that this rule be generally interpreted and administered based on the conventional practices of the licensed health insurers in Vermont, e.g. following the practice of reimbursing for certain procedures based on time increments or specific units.

40.020 Reimbursement

40.021 General Reimbursement Requirements

(A) An employer is not liable for reimbursement for health care services provided to an injured employee in excess of the maximum allowable payment provided for in this rule. The maximum allowable payment is the maximum fee for a procedure listed in Appendix I of this rule or, subject to the other provisions of this rule, or the health care facility's or health care provider's charge whichever is less. For those procedures having no code listed in Appendix I of this fee schedule, the maximum allowable payment shall not exceed 83% of the charge for the service. This percentage shall be adjusted annually to consider any increase or decrease in the total operating expense of all hospitals based on hospital budget submissions to the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA). The change shall be calculated using the ratio of the new cost-to-charge ratio to the prior year cost-to-charge ratio.

(1) Reimbursement for an amount less than the maximum allowable payment in Rule 40.000 is allowed, but only in

those instances where there is a contract for workers' compensation related services between the employer or insurance carrier and the health care provider that provides for a lower amount.

(B) In accord with 21 V.S.A. §640(a), the employer/insurance carrier is responsible for payment of reasonable and necessary medical treatment for a work-related injury. Billing for treatment of a work-related injury shall be directed to the employer/insurance carrier. In no event shall the employee be required to provide payment to the medical provider for treatment of a work-related injury deemed compensable nor is the employee required to pay additional reimbursement for medical services which are subject to this fee schedule.

(1) Pre-payment under this schedule is prohibited.

(C) The employer/carrier shall pay the health care provider's charge or the maximum allowable payment under this fee schedule, whichever is less, within 30 days of receipt of the bill and legible, supporting documentation. If the claim is held for more than 30 days without payment, then the employer/carrier must notify the provider in writing as to the status of the claim. When payment for a procedure is denied, the employer/carrier must provide an "Explanation Of Benefits" (EOB)/Remittance Advice to the medical provider within 30 days of receipt of the bill. If the employer/carrier disagrees with the appropriateness of a procedure code billed, it shall request a hearing, in writing, before the Commissioner within 30 days of receipt of the bill. An employer/carrier may not change a billed procedure code unless the medical provider agrees.

(D) Reimbursement shall be limited to duly licensed health care providers for services provided within the scope of their practice. Payment for a service provided by a para-professional operating under the supervision of another health care professional may be paid either to the para-professional or the supervising health care professional, but not both, subject to the provisions of paragraph 40.040 (F) of this rule.

(E) The health care provider shall maintain documentation for each service provided which is sufficiently detailed to allow for the review of the medical necessity of the service and the appropriateness of the fee charged. This documentation shall include but is not necessarily limited to progress or chart notes, test results, and billing information (HCFA 1450 and/or HCFA 1500 – documentation to determine appropriateness of the fee charged is sufficient if a line item detail bill is provided with these forms). Individual invoices are not required. Failure to provide documentation when requested may result in delays and/or, with the approval of the commissioner, denial of reimbursement.

(F) Separate charges for procedure(s) which are normally performed as part of another procedure shall generally not be permitted (i.e. no unbundling).

Appendix III lists procedures that have been assigned as component parts of a more comprehensive procedure. Payment for the major procedure includes any separately identified component parts of the procedure which are to be denied.

(G) Bills submitted by health care providers or health care facilities to carriers or employers for reimbursement of medical services must specify the date and type of service, the appropriate procedure code from the CPT manual in effect at the time of service or the appropriate facility revenue code, the condition treated, and the charges for each service. Health care providers are required to properly bill on form HCFA 1500, form HCFA 1450 (UB-92), or the ADA claim form and provide patient's Social Security Number, to comply with this requirement. Uncoded bills may be returned for coding.

(H) Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) as defined under the Medicare program, shall be reimbursed at 83% of billed charge and adjusted annually thereafter or 150% of cost whichever is less. Individual invoices are not required, but documentation allowing a reasonable determination of what the provider paid for the DMEPOS must be submitted.

40.022 Hospital Reimbursement

(A) Hospital reimbursement for services provided to an employee who is an inpatient or outpatient at a hospital shall be paid at 83% of the charge and adjusted annually thereafter for services identified by the appropriate revenue codes on the HCFA-1450 (UB-92) uniform billing claim form.

(B) Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) as defined under the Medicare program, shall be reimbursed at 83% of billed charge and adjusted annually thereafter or 150% of cost whichever is less. Individual invoices are not required, but documentation allowing a reasonable determination of what the provider paid for the DMEPOS must be submitted.

(C) Emergency room. When professional components are billed on the HCFA 1500 form by a hospital or emergency care facility for an emergency unscheduled initial visit or an emergency follow-up visit, as supported by medical records, both the professional and the facility fees will be reimbursed at 83% of the charge and adjusted annually thereafter.

(D) Professional components, other than noted in (C) above, billed by a hospital or emergency care facility, irrespective of treatment setting, shall be identified by their appropriate CPT code and submitted to the payer on a HCFA-1500 claim form. The payment for these professional components shall be the lesser of the amount listed in Appendix I of Rule 40.000 or the claim chargeamount.

40.023 Nursing Home Reimbursement

Nursing home reimbursement, residential care home reimbursement, and therapeutic community residence reimbursement shall not exceed 83% of the charge and adjusted annually thereafter for the services.

40.024 Prescription Drug Reimbursement

(A) Prescription drug reimbursement shall be the lower of the charge for the prescription drug or the average wholesale price (AWP), as determined by the Red Book manual or its equivalent, plus a $3.15 dispensing fee.

(B) The provisions of 18 V.S.A., Chapter 91. Generic Drugs, shall apply.

(C) Intravenous Drugs/Infusion Therapy. The provider must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a home care provider of intravenous services under the *Standards for Accreditation of Home Care* and can provide the following services at a Per Diem Rate (all inclusive):

- Intravenous Solutions;
- Pharmacy Professional Services including compounding, dispensing, clinical management, consultations and 24 hour 7 day a week availability;
- Ancillary Medical Supplies including all syringes, tubing, bags, cassettes, supplies necessary to maintain IV catheter patency;
- Durable Medical Equipment (DME) delivery, set-up, instruction, maintenance (24 hour, 7 day a week availability), replacement and removal as appropriate;
- Waste disposal.

1. **Per Diem Rates** are billable for the dates on which home infusion therapy is administered.

2. **Drug Costs** will be paid on the basis of the AWP less 10%.

3. **Nursing Services** will be coordinated through a Home Health Agency by the Infusion Therapy Provider. If services for Initial Patient Assessment and claimant/care giver education and training is billed by the Home Health Agency, no reimbursement will be

provided to the Infusion Therapy Provider for these services. These services are reimbursed on an hourly basis.

WASTAGE POLICY

When an unanticipated change in a patient's condition requires a change in treatment plan, carrier will pay the listed per diem rates plus 83% of AWP for delivered but unutilized supplies and drugs per the following guidelines:

Pain Therapy Drugs
Antibiotics
Chemotherapy Drugs
All other therapies

PRIOR AUTHORIZATION

All services must be preauthorized by the carrier. Per Diem Rates are billable for the dates on which home infusion therapy is administered.

40.025 Reimbursement for Procedures, Articles, and Supplies not listed in Appendix I

For those procedures, articles, and supplies having no code listed in Appendix I, or not otherwise addressed by written sections of this rule, the maximum allowable payment shall not exceed 83 % of the charge and adjusted annually thereafter for the service.

40.030 Modifiers

(A) The modifier codes recognized by these rules are defined in accord with the AMA CPT Manual.

(B) A modifier code shall be used to describe any unusual circumstances or services that arise in the treatment of a work related injury or illness. The modifier codes recognized by these rules are defined in accord with the AMA CPT Manual.

40.040 Anesthesia Guidelines

(A) Reimbursement to the health care provider applies only when anesthesia care is provided by or under the medical directions of a physician anesthesiologist.

(B) To be eligible for reimbursement, the anesthesia service shall include: performance of a pre-anesthetic examination and evaluation; prescription of the anesthesia care required; personal participation in, or medical direction of, the entire plan of care; continuous physical presence of the anesthesiologist or, in the case of medical direction, of the qualified individual (one who is qualified to perform those tasks not personally performed by the anesthesiologist, such as a CRNA, resident or other individual authorized by the hospital or facility to perform such services) being medically directed; proximate presence or (in the case of medical direction) availability of the anesthesiologist for diagnosis or treatment of emergencies; and medical direction of not more than four concurrent anesthesia procedures.

(C) Reimbursement will be determined by the addition of the base unit value, time units and modifying units (if any) and multiplying this sum by a conversion factor of $34.25 per unit. The definition of the unit components will follow. Base unit values are listed in Table A of Appendix I.

(D) The anesthesia care may include, but is not limited to general, regional, monitored anesthesia care, supplementation of local anesthesia, or other supportive services in order to afford the patient the optimal anesthesia care prescribed by the anesthesiologist during any procedure.

(E) Specialized forms of monitoring (e.g., intra-arterial, central venous, and Swan-Ganz) are not included and will be reimbursed separately based on the appropriate medical or surgical fee schedule.

(F) With respect to anesthesia care team payments for claims from two separate billing entities, the total payment to the anesthesia care team is the same as the payment level for an individually performing anesthesiologist or health care provider, with 50 % of the total payment paid to each of the billing entities.

(G) Definition of the Unit Components.

1. **Relative Unit Value**: The relative unit value (RUV) includes usual pre and post-operative visits, the administration of fluids and/or blood incident to the anesthesia care and interpretation of non-invasive monitoring (ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry). When multiple surgical procedures are performed during a single anesthetic administration the highest relative unit value should be used. The relative unit value will be applied to each CPT anesthesia code as outlined at the conclusion of this section.

2. **Time Units**: Anesthesia time begins when the anesthesiologist, or other qualified individual, physically starts to prepare the patient for induction of anesthesia in the operating room (or its equivalent) and ends when the anesthesiologist, or other qualified individual, is no longer in constant attendance (when the patient may be safely under postoperative supervision).

One time unit is allowed for each 15 minute time interval, or fraction thereof.

3. **Reimbursement for Pain Management Services**: Reimbursement for pain management services (evaluation and management, medical or surgical services) will be separate from any reimbursement for anesthesia services. Reimbursement for services for pain management will be based on the appropriate evaluation and management, medical or surgical fee schedule.

4. **Modifying Units**: Physical status modifying units will be reimbursed if the patient is ranked in one of the following three categories:

RANK	UNIT VALUE
P-3 - A patient with severe systemic disease	1
P-4 - A patient with severe systemic disease that is a constant threat to life	2
P-5 - A moribund patient who is not expected to survive without the operation.	3

Other modifying units will be available for the following qualifying circumstances described in the CPT:

CPT	UNIT VALUE
99100 - Anesthesia for a patient of extreme age, under one year and over seventy.	1
99116 - Anesthesia complicated by utilization of total body hypothermia.	5
99135 - Anesthesia complicated by utilization of controlled hypotension.	5
99140 - Anesthesia complicated by emergency conditions (an emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part).	2

40.050 Radiology Guidelines

(A) The maximum fee for a radiology procedure is either the global or, where appropriate, the professional component (-26) or the technical component (-27). These are found in Appendix I under the radiological maximum fee.

(B) When two bills are submitted for a radiological procedure, the professional component shall be identified by using modifier code -26. The technical component, identified by modifier code -27, covers materials and facilities/space for the diagnostic or therapeutic service.

(C) Billings for radiologic procedures are not reimbursable without a report of findings.

40.060 Surgical Guidelines

(A) For surgical procedures that usually mandate a variety of attendant services, the reimbursement allowances are based on a global reimbursement concept. Global reimbursement covers the performance of the basic service and the normal range of care required before and after surgery. The normal range of post-surgical care is indicated at the right-hand column under follow-up days (FUD) in Appendix I. There are two ranges established: on the same day as a surgical procedure; and 30-day global reimbursement policy.

Same day visits (S or I): Surgical procedure codes that are followed by the letter S or I in Appendix I allow for reimbursement for a medical service by the surgeon on the same day as the procedure.

The letter S indicates that an office visit, new patient or established patient, may be allowed. The letter I indicates that only a new patient visit is allowed in addition to the procedure. In the case of an accident-related procedure, the new patient visit with a -WF modifier may be reimbursed in addition to the surgical procedure.

30-day global reimbursement policy: For all surgical procedure codes listed in Appendix I, with **30** follow-up days indicated in the right column under FUD, any medically necessary care related to that procedure may be allowed during the 30-day period following the procedure and may be billed in addition to the procedure.

For those surgical procedure codes in Appendix I that do not have a 30, S or I indicated, all professional routine pre-operative care and post operative care, for 30 days following the surgical procedure, are included as a part of the global fee for that surgery, and medical follow-up visits for the same or a related condition within 30 days of the procedure should be denied.

A surgical procedure shall include all of the following:

1. All office and hospital visits which occur on the day of or day prior to major surgery.

2. Surgery.

3. Post surgical care. The number of follow-up days (FUD) is indicated in the fee schedule which will determine the normal range of post surgical care for that particular procedure.

4. Removal of sutures.

(B) An evaluation and management (E&M) service will not be billed in addition to a minor procedure unless the E&M service was for a significant, separately identified reason. In this instance, Modifier -25 should be reported with the appropriate E&M CPT procedure code.

(C) The following four exceptions to the global reimbursement policy may warrant additional reimbursement for services provided before surgery:

1. When a preoperative visit is the initial visit and prolonged detention or evaluation is necessary to prepare the patient or to establish the need for a particular type of surgery.

2. When the preoperative visit is a consultation.

3. When preoperative services are provided that are usually not part of the preparation for a particular surgical procedure, for example, bronchoscopy prior to chest surgery.

4. When a procedure would normally be performed in the office, but circumstances mandate hospitalization.

(D) Additional charges and reimbursement may be warranted for additional services rendered to treat complications, exacerbation, recurrence, or other diseases and injuries. Under such circumstances, additional reimbursement may be requested. Documentation substantiating the medical necessity of the additional services rendered must be submitted with the medical bill.

(E) An incidental surgery which is not part of the primary procedure performed, and for which there is no diagnostic evidence relating it to the injury, shall not be paid under the Workers' Compensation system.

(F) Reimbursement for the concurrent services of two or more health care providers may be warranted for:

1. Identifiable medical services provided preoperatively, during the surgical procedure or in the postoperative period.

2. Surgical Assistants - Modifier code -80 shall identify the procedure or the procedures which may be performed by the Surgical Assistant. Reimbursement for surgical assistants is limited to health care providers who assist the surgery and must not exceed 25% of the total surgical procedure.

3. Two Surgeons

(a) Certain circumstances where the skills of two surgeons (usually with different specialties) may be required to complete a surgery.

(b) Reimbursement will be made according to the information on the provider's medical bill and the substantiating documentation submitted. Each provider must submit an individual claim for services.

4. A Surgical Team. Some highly complex procedures require the concomitant services of several physicians, often of different specialties. Such complex services may also involve other highly skilled and specially trained personnel, as well as various types of sophisticated equipment. This type of complicated

procedure may be carried out under the "surgical team" concept with a single, global reimbursement for the total service. The charges should be supported by a written report and include itemization of the physician services, paramedical personnel and equipment included in the charge.

(G) Multiple or Bilateral Procedures

1. When multiple or bilateral procedures are provided at the same operative session, the first major procedure should be coded as listed on one line of the HCFA -1500 claim form and the additional procedure(s) on the following line(s) with modifier -50 or -51.

2. The total reimbursement for all services shall be the maximum reimbursement allowance of the major procedure in addition to 50% for the secondary procedure, 25% for the tertiary procedure and 10% for each lesser procedure thereafter. The lesser procedure(s) should be coded using the appropriate modifier -50 (bilateral procedure) or -51 (multiple procedures).

Those services listed in Appendix II of this rule, which can be billed with the -50 modifier, do not have the usual payment adjustment for bilateral procedures. For these services, payment is based on 100% for each side, organ or site.

3. Except when specifically stated, initial dressings, immobilization, or casting is included in the basic allowance for the basic procedure.

40.070 Medical Advisory Committee

Repealed May 15, 2006.

40.080 Good Cause Exception

If an employee or medical provider demonstrates to the satisfaction of the Commissioner that reasonable and necessary treatment, or a related medical service, is not reasonably available at a fee consistent with this fee schedule, the Commissioner may authorize reimbursement for those procedures at a rate higher than that permitted in the fee schedule.

40.090 Psychotherapy Services

CPT Codes 90801 through 90889 may be used for psychotherapy by M.D. level Psychiatrists, Clinical Psychologists and Clinical Social Workers, with the exception of codes 90820, 90862, 90870, and 90871, which may be billed by M.D. level Psychiatrists only.

The reimbursement policy for the practitioner performing the services is as follows:

- M.D. level Psychiatrists shall receive the maximum fee for a procedure, listed in Appendix I, or the practitioner's charge, whichever is less;

- Clinical Psychologists shall receive 80% of the maximum fee for a procedure listed in Appendix I, or the practitioner's charge, whichever is less;

- Clinical Social Workers shall receive 60% of the maximum fee for a procedure listed in Appendix I, or the practitioner's charge, whichever is less.

The level of licensure of the practitioner providing the service shall be indicated on the billing form.

40.100 Fee Adjustments for Physical Medicine and Rehabilitation Modalities; Applicable Only To Supervised and Constant Attendance Modalities

Maximum fees for physical medicine and rehabilitation modalities **that require supervised or constant attendance only** are determined according to the following payment schedule when one or more modalities are provided to the patient on the same day. (This section does not apply to hospital reimbursement.)

100 % of the fee for the most expensive modality;

75 % of the fee for the second most expensive modality;

50 % of the fee for the third most expensive modality; and

10 % of the fee for all other modalities

All modalities after the first most expensive shall be coded by adding modifier -51 to the appropriate procedure code.

All other therapeutic procedure codes shall be paid in accord with Appendix I or, if the procedure code is not listed in Appendix I, reimbursement shall be 83% of the provider’s charge.

40.110 Fees for Depositions, Mileage and Supplemental Reports

40.111 Fees for Depositions and Mileage

(A) Any health care provider who gives a deposition shall use code 99075. Reimbursement shall be $300.00 for one hour or less. Additional time shall be reimbursed at $75.00 for each additional 15 minutes.

(B) The party requesting the deposition assumes responsibility for payment of the witness fee and any related mileage unless the costs of the deposition is included as a part of an award. The costs for witness fees and any related mileage shall be considered inclusive of an award of the deposition cost.

(C) Health care providers shall receive a maximum of $150.00 for a canceled deposition. The party canceling the deposition is responsible for the incurred costs. No charge will be paid if the deposition is canceled

and the health care provider is notified at least three business days before the scheduled date.

(D) Round trip mileage may be charged by the health care provider for travel related to the deposition at the maximum rate allowed for deductions by the internal revenue service.

40.112 Fees for Supplemental Reports

(A) Health care providers shall be reimbursed for providing supplemental reports that are in addition to the documentation required under paragraph 40.021(E) of this rule. Supplemental reports shall be identified by using CPT Code 99080 and appropriately billed on a HCFA 1500 form.

(B) Reimbursement for supplemental reports is limited to $10.00 per page with the total not to exceed $70.00. The party requesting the supplemental reports assumes responsibility for payment.

40.120 FRAUD

Workers' compensation insurers are only responsible for paying for services that are actually provided and that are medically necessary. In filing a claim for reimbursement, the CPT code should be chosen that most accurately describes the service that was provided. It is a felony under Vermont law knowingly to do, attempt, or aid and abet in any of the following when seeking or receiving reimbursement from a workers' compensation insurer:

- File a claim for services which were not rendered
- File a false claim
- File a claim for unauthorized items or services
- Bill the beneficiary, or the beneficiary's family for an amount in excess of that allowed by law or regulation
- Fail to credit the state or its agent for payments received from social security, insurance or other sources
- Receive unauthorized payment

Suspected fraud should be reported to the Workers' Compensation and Safety Division of the Vermont Department of Labor.