

# MEDICAL BENEFITS

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Medical benefits are governed by [21 VSA §640](#).

## **Overview**

The insurer must furnish to an injured worker medical benefits that are reasonable to treat the work injury, including:

- hospital services and supplies;
- surgical, medical and nursing services and supplies;
- prescription drugs;
- durable medical equipment;
- assistive devices;
- modifications to vehicles and residences when reasonably necessary for an injured worker who suffers an injury that substantially and permanently prevents or limits the him or her from continuing to live at home or perform basic life functions.

## **Medical Payments**

The Department has established a Workers' Compensation Medical Fee Schedule that sets a maximum allowable fee for medical services and supplies. See the section in this manual on Workers' Compensation Medical Fee Schedule (Rule 40.000).

An insurer is responsible for establishing direct billing, payment procedures and notification procedures as necessary for coverage of medically necessary prescription medications for chronic conditions related to the work injury. A chronic condition is a medical condition anticipated to last 4 months or more. [21 VSA §640\(d\)](#) and Rule 26.0000.

### **PREAUTHORIZATION OF MEDICAL TREATMENT:**

**EFFECTIVE July 1, 2011** - [21 VSA §640b](#) was enacted, which governs requests for pre-authorization of medical treatment.

**WITHIN 14 DAYS** of receipt of the medical provider's written request and supporting documentation, the adjuster must do one of the following:

1. authorize the proposed treatment; or
2. schedule a medical records review or Independent Medical Exam; or
3. deny the treatment

**DO NOT ISSUE A DENIAL** in the initial 14 days unless:

- a. You have evidence to show the entire claim is disputed and the Department has not issued an Interim Order to pay benefits; or
- b. You have credible medical evidence that specifically addresses the proposed treatment and supports it is not medically necessary or is unrelated to the work injury.

**NOTE:** Remember, a copy of your denial must be sent to the injured worker (and his or her attorney if represented), the requesting medical provider and the Department with copies of the request and medical documentation you received. Be aware that the standard of review for denials concerning pre-authorization requests is based upon the "preponderance of the evidence." The Department may render an order requiring the insurer to pay for the proposed treatment if the records on file and presented to the Department do not support the denial.

If you authorize treatment, you must send written notice to the injured worker (and his or her attorney if represented), the requesting medical provider and the Department *with copies of the request and medical documentation you received*.

If you take the step of scheduling a records review or IME, you must notify the injured worker (and his or her attorney if represented), the Department and the requesting medical provider, in writing within the initial 14 days that you have done so. You must include copies of the request and medical records you received and indicate the date it was received. Additionally, you should include a copy of the IME scheduling notice or date that you ordered the records review. You have 45 days from the date you received the request to file your decision with the Department, copying the medical provider and injured worker (attorney if represented).

What happens if the adjuster fails to respond to a pre-authorization request within 14 days?

Answer: Either the injured worker (or his or her attorney) or the requesting health care provider can submit a request to the Department for an Interim Order. Upon receipt of such request, the Department will:

1. immediately place the insurer on notice and give it 5 days to respond;
2. at the end of the 5 day response period, if either no response is received and/or if the denial is not supported, the Department will issue the Interim Order requiring payment of the proposed medical treatment covered under [21 VSA §640](#).

FOR ADDITIONAL GUIDANCE, see [Director's Memoranda](#) dated October 17, 2011 and November 3, 2011.

## **Choice of Physician**

The employer has the right to designate the initial treating physician or facility to treat the injured worker. IF the employer exercises this right, the employer must provide the injured worker with a Form 8 (Notice of Intention to Change Health Care Providers) at the time of the initial visit. After the initial visit, the injured worker may switch to a medical provider of his or her choosing FOR ANY REASON by completing the Form 8 and sending copies to the insurer and the Department. The ONLY time an injured worker is required to file the Form 8 is the first time he or she elects to change from the employer's selected physician or facility to another one.

If the employer **did not** exercise its right to select the initial treating physician or facility, the injured worker may seek to have the initial treatment with a medical provider or facility of his or her choosing.

## **Independent Medical Examination** (See [21 VSA §655](#) and Rule 13.0000)

The insurer may exercise its right to schedule an Independent Medical Exam (IME) with a medical expert of its choice to address any issue related to the work injury, such as causation, medical end result, reasonableness and necessity of treatment, work capacity, impairment, etc.

The IME must be scheduled at reasonable times and places and with due regard to the injured worker's schedule. Vermont's workers' compensation statutes and rules do not impose a limit on the distance traveled for a scheduled IME. However, when reasonable in amount and when required due to the injured workers' condition and/or medical needs, transportation and overnight accommodations must be provided to an injured worker who is required to travel for treatment or to attend an IME. See Rule 12.2300.

**WHILE YOU HAVE THE RIGHT TO CHOOSE THE EXPERT AND LOCATION OF THE EXAMINATION** we encourage you to schedule the examination with a medical professional who is located as close as possible to injured worker's home or work address.

Written notice of the scheduled IME must be given in writing to the injured worker at least 7 days in advance of the scheduled examination. If

represented, the injured worker's counsel must also receive a copy of the scheduling notice.

You are responsible for providing the chosen examiner with complete copies of all relevant medical records and other discoverable information applicable to the questions you are asking the examiner to address. You may request that the injured worker bring diagnostic films to the examination.

Upon receipt of the IME report, the adjuster **MUST IMMEDIATELY** provide a copy to the injured worker. If the injured worker is represented, a copy must also be provided to his or her attorney.

If the injured worker drives him- or herself to the IME, the insurer is responsible for providing mileage reimbursement at the rate in effect for classified State of Vermont employees. When breakfast, lunch or dinner must be taken during travel for the examination, the insurer must provide reimbursement for meal allowances as well, also in accordance with the rate in effect for classified State of Vermont employees. [See Mileage and Meals Reimbursement Rates.](#)

In addition, when reasonable in amount and when required due to an injured worker's condition and/or medical needs, the insurer may be required to provide air, rail, bus, ambulance, rental car or other transportation expenses.

The employer cannot withhold wages for time missed from work to attend the IME.

In some instances, more than one IME may be scheduled. The following hearing decision outlines what will be taken into consideration by the Department if a dispute arises concerning whether the insurer is entitled to another IME.

As discussed in *P.B. v. The Store at Sugarbush*, Opinion No. 10-07WC, (February 23, 2007):

... in cases in which the employer has requested multiple IMEs, striking the appropriate balance between the parties' competing interests requires

that a number of factors be considered. How many IMEs has the injured worker already attended? How much time has passed since the most recent IME? Has the injured worker commenced treatment with a new medical provider in the interim, and/or have new treatments been proposed? Is there a legitimately “new” medical question to be addressed, or is the employer simply searching for a second IME opinion that is more favorable to its position than its first one? Each of these questions must be considered in order to determine what is a “reasonable” request for an IME in any particular claim. Without making a blanket pronouncement on the issue, Department precedent establishes that the final question – whether the employer is simply searching for a more favorable opinion to buttress its position – carries great weight. A “yes” answer to that question means that the employer might be doctor-shopping. Absent other legitimate reasons to bolster its IME request, the Department should discourage that practice.

**IF AN INJURED WORKER FAILS TO ATTEND AN IME WITHOUT GOOD CAUSE**, the adjuster may file a Notice of Intention to Discontinue Payments (Form 27) with evidence showing the injured worker received notice of the scheduled examination at least 7 days prior to the examination, evidence to support that the injured worker failed to attend, and if known, the reasons why. **REASONABLE EXPLANATIONS** for an injured worker’s request that an IME be rescheduled and/or failure to attend may include:

- illness;
- inclement weather;
- previously scheduled medical or other appointment;
- work schedule;
- medical or other emergency situation;

WE STRONGLY RECOMMEND YOU MAKE PHONE CONTACT WITH THE INJURED WORKER TO INFORM HIM OR HER THAT YOU HAVE SCHEDULED AN IME, THE PURPOSE FOR THE IME, WHEN IT WILL OCCUR AND THAT WRITTEN NOTICE IS BEING SENT. This gives the adjuster the opportunity to know ahead of time whether there are any scheduling issues or transportation needs. It also allows the adjuster to remind the injured worker to keep a record of roundtrip mileage and receipts for travel expenses and meals.

### **DENIAL OF MEDICAL BENEFITS:**

A Denial of Workers' Compensation Benefits (Form 2) is filed (with supporting documentation) when you HAVE NOT previously paid for the treatment and you have evidence that supports the treatment is not related to the work injury and/or is not medically necessary.

### **DISCONTINUANCE OF MEDICAL BENEFITS:**

A Notice of Intention to Discontinue Benefits (Form 27) is filed (with supporting documentation) when you have been paying for a specific treatment (or medical supply) and have evidence that it is either no longer related to the work injury and/or is no longer medically necessary. This applies to claims that you have been paying on a without prejudice basis as well.

**Effective June 1, 2010** the standard of review for discontinuances (Form 27) changed.

The "reasonable support" standard will be applied to all claims involving a date of injury PRIOR to June 1, 2010.

The "preponderance of evidence" standard will be applied to all claims with a date of injury of June 1, 2010 and after.

“Reasonable support” is defined under [21 VSA §601\(24\)](#) as “evidence that reasonably supports an action” and for the purposes of [21 VSA §643a](#), it is evidence that a reasonable mind might accept as adequate to support a

conclusion that must be based on the record as a whole, and take into account whatever in the record fairly detracts from its weight.

“Preponderance of the Evidence” is defined as “greater weight of evidence, or evidence which is more credible and convincing to the mind.”

**GENERAL EXPECTATIONS AND REQUIREMENTS BY LAW THAT WILL IMPACT WHETHER A FORM 27 WILL BE FOUND SUPPORTED:**

The Form 27 and supporting documentation **MUST BE MAILED** both to the Department and to the injured worker. If the injured worker is represented, a copy must be sent to his or her attorney.

Payment of benefits **MUST CONTINUE** for 7 DAYS AFTER THE Form 27 IS RECEIVED by the Department, the injured worker and if represented, the injured worker’s attorney. Therefore, the proposed effective date **MUST** account for both the 7 day payment requirement **AND** the estimated mailing time. **DO NOT FAX** or **EMAIL** the FORM 27.

The Form 27 **MUST** be completed in its entirety and **SIGNED** by either a **VERMONT LICENSED WORKERS’ COMPENSATION ADJUSTER** or by an attorney who is licensed to practice law in Vermont.

Supporting documentation must be in hard copy or on a disk that is unencrypted and non-password protected. The specific information relied upon **MUST** be identified. Medical records must either be in chronological order or organized by medical provider/facility and in chronological order. If you are submitting records on a disk, we recommend that the specific evidence you rely upon is presented in hard copy as well and attached to the Form 27. Putting the records in order will help the Specialist to review your request in a timely manner. It also helps to ensure that **ONLY** records pertaining to the injured worker are included and that the filing includes copies of all relevant discoverable evidence.

**REMEMBER DO NOT SUBMIT ENCRYPTED CD’S OR DVD’S. DO NOT SUBMIT PASSWORD PROTECTED CD’S WITHOUT SUBMITTING THE PASSWORD.**



## **FREQUENTLY ASKED QUESTIONS:**

### 1. When is a Form 27 required?

A Form 27 is required to be filed when you are discontinuing TTD or TPD (whether accepted or paid on a without prejudice basis) on other than successful return-to-work grounds, or when you are discontinuing specific medical treatments. **THE ONLY TIME** a Form 27 is not required to stop temporary disability compensation is when an **INJURED WORKER HAS SUCCESSFULLY RETURNED TO WORK**. “Successful return to work” is defined under Rule 18.1410. In those instances, TTD/TPD payments would end as of the date the injured worker successfully returned to work.

**DO NOT** rely upon a medical record that indicates the injured worker is working. You must follow up to confirm that he or she has successfully returned to work.

**NOTE:** Keep in mind that if the injured worker returns to work but is not earning his or her pre-injury average weekly wage and a Form 27 has not been filed based on medical end result s/he is entitled to temporary partial disability compensation.

In some instances, you may have evidence to support that the reduction in wages upon returning to work is due to other factors and not related to the work injury, e.g., economic decline in business or voluntary decision by injured worker to take a lesser paying job to work fewer hours when full time hours were offered. In such circumstances, you will need to file a Form 27 or a Form 2. The Form 2 is appropriate only if you had not been paying any temporary total or temporary partial disability compensation at the time these circumstances arise.

**Example 1:** A Form 27 would be appropriate if the injured worker has been on temporary total disability, the employer offers his or her regular job back, but he or she chooses to take a lesser paying job (either there or elsewhere) instead, for reasons unrelated to the work injury.

Example 2: A Form 2 would be appropriate if the injured worker did not lose time from work because his or her work related injury restrictions were being accommodated. The employer has an economic set back that requires it to reduce all employees' hours from full time to part time. A denial should be filed with evidence showing it was not the work injury that led to the reduced wages.

2. What legal implications does a Form 27 have that a Form 2 denial doesn't?

With a Form 27, the insurer is **REQUIRED** to continue payments for 7 days after the Department and the injured worker receive the Form 27. With a Form 2 you are confirming that you never paid for the denied benefit and informing the Department and the injured worker the reasons why you are not going to.

3. Can medical benefits be discontinued based on medical end result?

**NO.** Medical benefits must continue as long as the treatment is related to the work injury and is medically reasonable and necessary.

4. Does a full duty return to work release without restrictions mean the same thing as medical end result? Does a release from care mean medical end result?

**NO.** You must take the steps to determine if work is available and inform the injured worker of his or her obligation to accept a suitable offer of work. If suitable work has not yet been offered, you must notify the injured worker of his or her obligation both to look for work **AND** to provide you with **verifiable job search information**. If the injured worker has been discharged from care with a full duty work release with no restrictions, **WE RECOMMEND** that you send a request to the medical provider asking them to specifically address medical end result.

## EXAMPLES OF SUPPORTED Form 27's

Always complete the Form 27 in its entirety.

EXAMPLE 1: Injured worker failed to accept a suitable offer of work (only applies to TTD/TPD compensation).

You must include the following evidence with your Form 27:

- a. A copy of the medical release to return to work, with or without restrictions.
- b. A copy of your letter showing that the injured worker was provided with a copy of the release, you advised him or her of the obligation to accept a suitable offer of work and provided notice that the employer has a job offer in accordance with the release. **WE HIGHLY RECOMMEND** that any job offer give a specific date of expected return and include a complete description of the work being offered. Your notice letter also should include a warning to the injured worker that failure to accept the job may result in benefits being discontinued.
- c. Written evidence that the injured worker failed to accept the job offer and/or failed to return to work (e.g. something in writing from employer confirming injured worker refused the job and/or did not show up).

NOTE: all discoverable evidence in this situation may include, but is not limited to, additional treatment records showing conflicting information as to whether the injured worker can return to work, or a medical note indicating he or she cannot do the job that was offered.

EXAMPLE 2: Injured worker failed to provide verifiable job search information (only applies to TTD/TPD compensation).

You must include the following evidence with your Form 27:

- a. A copy of the medical release, with or without restrictions.

- b. A copy of your letter showing that the injured worker was provided with a copy of the release, you advised him or her of the obligation to perform job searches as the employer had no work available, of his or her obligation to accept a suitable offer of work and of what you expected in terms of **verifiable job search information**. The letter also should have indicated when the job search information was due (e.g. the date first job search information is due and every “Friday” thereafter), and how many contacts per week needed to be submitted. See – [Job Search Log](#) (a tool created for your use).
- c. Written verification from you of the fact that the injured worker has failed to provide job search information or that the information provided was not verifiable. If the latter, you must show through evidence that the contact info was incomplete and/or your follow up with the prospective employer resulted in no verification of the contact.

Both of the above examples are governed by Rule 18.1300.

EXAMPLE 3: Medical End Result/Maximum Medical Improvement (only applies to TTD/TPD compensation).

You must include the following evidence with your Form 27:

- a. Medical documentation that specifically indicates injured worker has reached MER/MMI for the work-related injury.
- b. If a multiple injury claim, the injured worker **must** be at MER/MMI for ALL disabling injuries.

**IMPORTANT:** You cannot stop payment of medical benefits on the basis of MER/MMI.

EXAMPLE 4: Non-compliance with treatment (may apply to both TTD/TPD and medical benefits).

You must include the following evidence with your Form 27:

- a. Evidence supporting a **pattern** of non-compliance (not just one missed appointment)
  - medical documentation showing pattern of injured worker canceling or not showing for appointments
- b. Evidence from the treating provider(s) supporting that as a result of the failure to treat there is no evidence of ongoing disability.

**IMPORTANT NOTE:** You should be aware that a Form 27 based on non-compliance does not relieve you from the responsibility of reinstating benefits once the injured worker resumes treatment. **FOR THIS REASON,** if you have a pattern of non-compliance, we strongly urge you to schedule an IME to have issues such as reasonableness/necessity of treatment, medical end result, work capacity, etc. addressed.

EXAMPLE 5: Failure to attend a scheduled Independent Medical Exam (applicable to all benefits).

You must include the following evidence with your Form 27:

- a. Copies of the scheduling notice showing it was sent to the injured worker, and his or her attorney if represented, at least 7 days prior to the scheduled examination;
- b. Evidence showing the injured worker received the notice at least 7 days prior to the examination;
- c. Evidence that the injured worker failed to attend or refused to attend without good cause (e.g., written verification from you that you took the steps to determine why the injured worker did not attend and that the reason was without good cause).

NOTE: WE STRONGLY recommend that you contact the injured worker by telephone to let him or her know the IME has been scheduled, the date and time, the issues being addressed and to confirm that a written notice of the examination is being sent. This allows you to know ahead of time whether there are any scheduling conflicts. It also allows you the opportunity to confirm with the injured worker whether he or she will require transportation to or from the examination. REMEMBER, IMEs must be scheduled with due regard for the injured worker's schedule and ability to travel.

ALL DISCOVERABLE EVIDENCE may include, but is not limited to, any notice you (or the IME doctor received) from the injured worker advising of a conflict in the date or time of the exam, information supporting the reasons why he or she may have called and canceled the examination and/or documentation that may support a cancellation for good cause, such as inclement weather or illness.

#### **MOST COMMON REASONS FOR A FORM 27 TO BE REJECTED:**

1. No Vocational Rehabilitation Verification as required by [21 V.S.A §643a](#), [21 V.S.A §641](#) and Vocational Rehabilitation Rules 52.3000 and 53.0000 et seq. Please note it is the Department's position that the filing of a Form 25M does not meet the vocational rehabilitation verification requirement. The submission of the medical records to the Department of Vocational Rehabilitation for a screening, or the filing of a vocational rehabilitation referral form, referring the injured worker to a certified vocational rehabilitation counselor for an entitlement assessment would meet the requirement.
2. Failure to notify the injured worker of his or her obligation to conduct a good faith work search that is within his or her restrictions and/or release to work as the employer does not have a suitable position available.
3. Incomplete submission of **all relevant discoverable evidence** as required by [21 VSA §643a](#). **This would include, but not be limited to, all medical records reviewed by the independent medical examiner or treating physician whose opinion you rely on to**

- discontinue benefits.** See [Director Monahan's interpretive memorandum](#) regarding the changes to [21 VSA §643a](#) which became effective June 1, 2010.
4. Alleged failure to Return to Work; Rule 18.1300 supporting evidence not filed:
    - a. Medical release to work, with or without restrictions.
    - b. Written evidence that medical release to work was provided *by the insurer to the injured worker*.
    - c. Written evidence of employer's job offer was provided to the injured worker.
    - d. Employer's written confirmation that injured worker did not accept job offer.
  5. Allegation of Failure to do Work Search, Rule 18.1300 supporting evidence not filed:
    - a. Proof of insurer's written NOTICE to injured worker of release to work and obligation to conduct work search with explanation of good faith work search and expectations regarding verifiable reporting of contacts and filing requirements.
    - b. Supporting proof that injured worker did not contact potential employers as required.
  6. Failure to Attend IME noticed in accordance with Rule 13.1000 supporting evidence not filed:
    - a. Proof of insurer's written Rule 13.1000 NOTICE to injured worker of IME examination appointment.
    - b. Written confirmation from IME doctor of the failure to attend IME appointment. If insurer is requesting an Order directing the injured worker to pay a "No-Show" fee charged to the insurer under Rule 14.5500, the doctor's invoice must be submitted.
  7. Outdated Form 27. See <http://labor.vermont.gov/forms/#comp> for current forms.
  8. Benefits cannot terminate retroactively. Benefits must continue for 7 days **after** the Department received the notice as required by [21 VSA](#)

§643a. **You must reinstate Temporary Total Disability Benefits retroactively**, unless the injured worker successfully returned to work on that date. If you have been making weekly advance payments of permanent partial disability benefits, you must re-classify those payments as temporary total benefits.

9. Failure to identify specifically what medical benefits are being discontinued. Medical End Result does not terminate reasonable, necessary, and related medical treatment.
10. Form 27 not required if injured worker successfully returned to work pursuant to Rule 18.1100.

If you are not clear whether a Form 27 or a Form 2 should be filed, we urge you to contact the Department for clarification of the proper form to file.