Vermont

State Employer's Guide

To

Workers' Compensation and

Injury Prevention

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PREFACE

The information contained in this manual is intended to be general information regarding the procedures for Workers' Compensation for State of Vermont Executive, Judicial, and Legislative Branch Employees. It is not intended to be a legal interpretation of Workers' Compensation Law under the Vermont Statutes Annotated (Title 21, Chapters 9 and 11) or any Department of Labor Workers' Compensation Rules and Regulations. This manual should not be considered a substitute for legal advice.

About This Manual

This manual describes the procedures for handling State of Vermont Employees Workers' Compensation claims. Workplace injuries/illnesses, and the accompanying rights of the employee can be complicated issues. The goal of this guide is to provide help in the processing of claims and in quickly resolving claims.

Target Audience

This guide is written for State of Vermont Human Resource Administrators responsible for handling workers' compensation claims on a department level.

Related Publications

This manual contains information about a statutorily mandated benefit and process. Therefore you may also want to reference the following related publications:

- Vermont Statutes Annotated, Workers' Compensation Law: Title 21, Chapters 9 and 11, § 601-§1206
- Department of Labor & Industry Workers' Compensation and Occupational Disease Rules

Contact Information

As a customer of the State, your opinion is very important to us. We encourage you to contact us with any comments or suggestions about this manual or with any questions concerning workers' compensation or injury prevention.

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INTRODUCTION TO THE STATE OF VERMONT WORKERS' COMPENSATION PROGRAM (WCP)

What is Workers' Compensation?

Workers' compensation is "no-fault" insurance coverage that provides medical and disability benefits for injury/illness, disability, or death that occurs in the course of employment. This insurance pays for medical expenses and partial wage replacement during periods of temporary disability. It may also provide permanent disability benefits for those employees that qualify. In certain circumstances, workers' compensation may provide coverage for pre-existing conditions aggravated by work activities.

The State assumes its own workers' compensation liability through a program of self-insurance. A dedicated fund has been established to handle benefit costs, claims, and medical and legal expenses. Departments are back-charged workers' compensation premiums by the Office of Risk Management.

Who Administers Workers' Compensation?

The Office of State Employee Workers' Compensation and Injury Prevention (WCP) of the Department of Buildings and General Services administers the State of Vermont Workers' Compensation Program. That office is comprised of Workers' Compensation Claims Adjusters, Medical Case Managers and Workplace Safety Coordinators.

Who is Eligible for Workers' Compensation?

Any employee of the Executive, Judicial, or Legislative branch of Vermont State Government is eligible for coverage under the State Workers' Compensation Program. Temporary employees and authorized volunteers are also eligible. Independent contractors, self-employed, and self-insured contractors employed by the State to execute a specific contracted service would not be eligible.

What is an Injury/Illness?

An injury/illness is any harmful work-related change in the body, whether occurring instantaneously or gradually, which includes a claimed or apparent injury or occupational disease. Injury, as defined in the Vermont Statutes Annotated, Title 21: Chapter 9, Section 601 (7), can include damage to prosthetic devices, hearing aids, and eyeglasses, as well as death occurring within two (2) years of original injury. Injury can include an aggravation (acceleration or exacerbation) of a pre-existing condition caused by some intervening event or events and/or a recurrence of symptoms following a temporary remission.

What is an Occupational Disease?

An occupational disease, as defined in the Vermont Statutes Annotated, Title 21: Chapter 9, Section 601 (23), is a disease that results from causes and conditions characteristic of and peculiar to a particular trade, occupation, process or employment, and to which an employee is not ordinarily subjected or exposed outside of or away from his/her employment, and arises out of and in the course of such employment.

AFTER AN INJURY/ILLNESS HAS OCCURRED

What Are the Initial Procedures Following A Workplace Injury/Illness?

- The injury/illness should be assessed. **IF IMMEDIATE MEDICAL ATTENTION IS NEEDED THE EMPLOYEE SHOULD GO STRAIGHT TO THE NEAREST EMERGENCY ROOM!** If the injury/illness does not need immediate medical attention, then the following steps must be completed.

- **INSTRUCT THE EMPLOYEE TO REPORT THE INJURY/ILLNESS TO HIS/HER SUPERVISOR IMMEDIATELY.**

- The employee, supervisor, or department HR Administrator must complete a ***Vermont State Employee's Workers' Compensation Incident Report*** online as soon as possible, but no later than 72 hours (Sundays and legal holidays are excluded) following the injury. This form can only be completed by and for an individual who is a current State of Vermont employee with a valid State Employee ID number. *If the injured employee does not have a State Employee ID number, please call WCP at (802) 828-2899.* If the injured employee receives medical treatment or loses time from work, an ***Employee's Claim And Employer First Report Of Injury (Form 1)*** will electronically be forwarded to the Vermont Department of Labor by WCP with a copy to the employee's HR Representative and to the employee. **Please be sure that only one report is created to avoid duplicate claims. MICROSOFT INTERNET EXPLORER MUST BE USED WHEN COMPLETING THIS FORM. IT IS NOT SUPPORTED BY MODZILLA FIREFOX.**

- Instructions for the ***Vermont State Employee's Workers' Compensation Incident Report*** can be found at http://bgs.vermont.gov/workers_comp/injury. This page contains a link to the form which will open in a separate window so that the user can refer back to the instruction page while completing the Report.

- **PLEASE NOTE: If the injured worker is a new hire, his/her Employee ID number may not be in our database and the system will not allow completion of the *Vermont State Employee's Workers' Compensation Incident Report* on line. In this case, please complete an *Employer First Report of Injury (Form 1)* and fax it to WCP at (802) 828-0410. The form can be found at http://labor.vermont.gov/Portals/0/WC/Form01.pdf. DO NOT FORWARD THE FORM TO THE VERMONT DEPARTMENT OF LABOR; IT WILL BE ELECTRONICALLY TRANSMITTED TO THEM ONCE ENTERED INTO OUR DATABASE.**

What If Death Results From an Injury/Illness?

If the injury/illness results in death, call WCP immediately to report the death. The supervisor or department HR Administrator must complete a ***Vermont State Employee's Workers' Compensation Incident Report*** online as soon as possible, but no later than 72 hours (Sundays and legal holidays are excluded) following the death. An ***Employer's Report Of Fatal Accident (Form 4)*** must also be completed. This form can be found online at http://labor.vermont.gov/Portals/0/WC/rules%201-46%20new%20without%20annotate.pdf Please complete and forward to WCP via fax at (802) 828-0410 or by e-mail to riskhelp@state.vt.us as well as to VDOL as instructed (labor-wccomp@state.vt.us; fax (802) 828-2195)

Failure to File Could Result in Fines

Timely filing of the ***Vermont State Employee's Workers' Compensation Incident Report*** is critical. Failure to report an injury could result in administrative fines.

What Happens After WCP receives the *Vermont State Employee's Workers' Compensation Incident Report* Online Filing?

After the ***Vermont State Employee's Workers' Compensation Incident Report*** is submitted, the WCP will affirm receipt by sending an email notification to the Human Resource Administrator. A claim number will also be assigned and provided to the Human Resource Administrator. If an injured employee does not seek medical attention or lose time from work due to the injury, an initial packet will be sent to the employee providing the claim number, identifying the assigned workers' compensation claims adjuster and medical case manager, and providing information regarding the workers' compensation process. The packet also includes a ***Workers' Compensation Medical Authorization (Form 7)*** to be used should the injured worker need to seek medical attention. If the employee does seek medical attention or loses time from work, two reference

documents: The TMESYS Pharmacy Benefits Manager insert and the Vermont State Employee's Guide to Workers' Compensation and Injury Prevention will also be included in the contact packet along with the ***Workers' Compensation Medical Authorization (Form 7)*** and a ***Claim Questionnaire Form.*** Both of these documents assist with the claim compensability processing.

NOTICE OF INCIDENT ONLY (NO MEDICAL TREATMENT-NO LOST TIME FROM WORK)			
FORM	**INJURED EMPLOYEE**	**HR ADMINISTRATOR**	**VDOL**
INITIAL CONTACT LETTER	X	X	N/A
MED AUTH (VDOL FORM 7)	X	N/A	N/A
COPY OF INCIDENT REPORT	X	X	N/A
VDOL FORM 1	N/A	N/A	N/A
CLAIM QUESTIONNAIRE	N/A	N/A	N/A
EMPLOYEE GUIDE TO WORKERS' COMPENSATION	N/A	N/A	N/A
TMESYS PRESCRIPTION CARD	N/A	N/A	N/A

WORKERS' COMPENSATION CLAIM--(HAD MEDICAL TREATMENT OR LOST TIME FROM WORK)			
FORM	**INJURED EMPLOYEE**	**HR ADMINISTRATOR**	**VDOL**
INITIAL CONTACT LETTER	X	X	N/A
MED AUTH (VDOL FORM 7)	X	N/A	N/A
COPY OF INCIDENT REPORT	X	X	N/A
VDOL FORM 1	X	X	X
CLAIM QUESTIONNAIRE	X	N/A	N/A
EMPLOYEE GUIDE TO WORKERS' COMPENSATION	X	N/A	N/A
TMESYS PRESCRIPTION CARD	X	N/A	N/A

What is a Medical Release Authorization?

A medical release authorization is the permission from the claimant to access their injury related medical records. The WCP requests that the employee complete a ***Workers' Compensation Medical Authorization (Form 7)*** for the release of such relevant medical records. To expedite the process you can provide this necessary form to the employee when they report the injury and encourage them to provide WCP and the medical provider with a copy.

What If the Claimant Refuses to Sign the Medical Release Authorization?

If the claimant refuses to provide a medical release authorization form without good reason he/she waives their right to workers' compensation benefits. In accordance with VDOL Rule 3.08, a workers' compensation claim can be denied if the claimant does not comply by signature on the release.

What if the Claimant has a prior injury or pre-existing condition?

Medical records relating to prior injuries or pre-existing conditions may be requested by WCP using a specialized version of the ***Workers' Compensation Medical Authorization (Form 7)*** if relevant to the injury for which benefits are being claimed as per VDOL Rule 3.0820.

What Happens in the First 21 Days?

- "Initial Contact Package" is mailed to claimant containing letter of introduction and Medical Case Manager (MCM)/Adjuster contact information, and medical authorization form, and if appropriate, the employee guide to WC, initial claim questionnaire form, and TMESYS Pharmacy Benefits card
- The Workplace Safety Coordinator (WSC) talks to claimant to assess safety issues surrounding the injury
- Medical Case Manager (nurse) talks to claimant to assess injury and discuss medical treatment
- Medical records are requested from medical provider (repeatedly if necessary)
- If claimant loses time from work, adjuster calls claimant to take statement, discuss claims process, etc.

What is Compensability?

Compensability is the determination of the requirement to compensate an employee for their work-related injury/illness; acceptance or denial of the workers' compensation claim. The workers' compensation claims adjuster is responsible for this determination. WCP has twenty-one (21) days from the date that the employee notifies his/her employer of the injury to determine the compensability of the claim. Timely filing of the ***Vermont State Employee's Workers' Compensation Incident Report*** online is critical in preserving the decision making period.

If the claim is accepted, the claims adjuster sends a letter of notification to the claimant affirming the compensable diagnosis(es). The MCM calls the claimant to notify of claim acceptance, address treatment plan and current medical status, confirm next appointments, etc. Also, the MCM calls medical providers to set up direct billing.

If the claim is denied, the adjuster completes a ***Denial Of Workers' Compensation Benefits by Employer or Carrier (VDOL Form 2)***, attaches supporting documentation, and files the decision with VDOL and the claimant. The adjuster also contacts the claimant to alert him/her to the determination and inform him/her of the VDOL appeals process.

How is the Human Resource Administrator Informed of a Compensability Determination?

The claims adjuster sends an email to the Human Resource Administrator to confirm the compensability determination.

Why Do Claims Get Denied?

- Employee fails to complete and /or return medical records authorization form
- Injury did not arise out of and in the course of employment
- No medical evidence to support a work-related injury
- Pre-existing condition which was not aggravated by work activities

What if An Employee Disagrees With A Compensability Determination?

The employee can appeal any compensability determination to the Vermont Department of Labor. They are encouraged to initiate the appeal within six (6) months following the denial. The Vermont Department of Labor hears the appeals at two levels: The Informal Hearing and the Formal Hearing.

What is Payment Without Prejudice?

The claim adjuster may make a determination to pay a claim or a benefit without prejudice to avoid an interim order of benefits, or if the cost of litigation will exceed the value of the dispute. Payment without prejudice does not waive the determination that a claim is not compensable.

CLAIM TYPES

What Is A Medical Only (Med-Only) Claim?

A Med–Only claim is one in which the employee has sought medical treatment for a work-related injury/illness. A Med-Only claim exists when the employee has not lost time from work **in excess of the three (3) full day, or seven (7) partial day waiting period**, with the exception of the time spent at the medical care provider.

What Is An Indemnity Claim?

Indemnity claims refer to those claims in which an employee has presented a note from the treating physician indicating he/she may not work due to a work-related injury/illness. There are two types of Indemnity Claims: Temporary Total Disability (TTD), and Temporary Partial Disability (TPD).

Temporary Total Disability (TTD)

Temporary Total Disability (TTD) is when an employee loses more than three (3) calendar days of work following the date of injury/illness, regardless of whether or not the employee is scheduled to work. The first three (3) full calendar days an employee is out of work is considered a waiting period. These days do not have to be consecutive and include the date of injury unless the employee has been paid for that day. Workers' compensation payments for initial three (3) days will not be paid unless disability continues to the minimum of ten (10) days. If the employee continues to be totally disabled, beyond the third (3rd) calendar day for an additional period of seven (7) consecutive calendar days or more, he/she shall be entitled to retroactive compensation for the first three (3) days.

Temporary Partial Disability (TPD)

Temporary Partial Disability (TPD) is when a medical provider has released the employee to work less than full-time. There is a waiting period of seven (7) calendar days before the employee is eligible for this benefit. If the employee has previously collected Temporary Total Disability (TTD) benefits, the employee is immediately eligible for Temporary Partial Disability (TPD) benefits. However, if the employee has not been totally disabled previously for the claim for which benefits are being sought, the employee becomes eligible for Temporary Partial Disability (TPD) benefits on the eighth (8th) day. These days need not be consecutive, but, unlike Temporary Total Disability (TTD) benefits, Temporary Partial Disability (TPD) benefits are not retroactive to the first seven (7) days regardless of how long the employee is partially disabled.

What Medical Treatment is Covered?

Regardless of claim type, workers' compensation benefits provide payment for medical benefits that are reasonable, necessary and causally related to the work-injury. Furthermore, Rule 12(c) Vermont Workers' Compensation & Occupational Disease Rules, requires an employer to allow an injured/ill employee to go to medical treatment, evaluation or examination without use of the employee's regular leave. However, any medical evaluation, testing or treatment should be scheduled, where possible, outside the employee's normal workday. When this is not possible, the appointment should be scheduled with minimal disruption to the workplace, early in the morning or late in the day. The employee should notify his/her supervisor in advance of any known upcoming absences from work.

EMPLOYEE REIMBURSEMENT, MEDICAL BILLS & PHARMACY FILL PROGRAM

What Employee Expenses Can Be Reimbursed?

An employee may receive reimbursement for medical bills, accrued mileage, as well as meals and lodging (in cases in which the claimant must travel extensively for medical attention). Expenses that may result from extensive travel for medical attention must be approved in advance by the workers' compensation claims adjuster.

The employee must sign all requests and submit original receipts for medical bills, mileage, meals, and lodging to WCP to be reimbursed for those expenses. If you receive any requests for reimbursement expenses please forward to WCP.

- **Mileage:** The injured/ill employee must fill out a ***Request For Mileage Reimbursement Form*** when requesting reimbursement for workers' compensation medical mileage. Mileage that is accrued to and from medical appointments/treatments is reimbursable. Reimbursement for mileage is limited to trips to and from the hospital, rehabilitation sessions, and physical therapy sessions. Trips to a pharmacy or drugstore **are not** eligible for reimbursement. The rate of mileage reimbursement is subject to change and is paid in accordance with the current rate that classified State employees receive for mileage. Note: Only mileage exceeding the distance normally traveled to the work place is covered.

- **Meals:** An injured/ill employee is entitled to the reimbursement of meals taken during extended travel for treatment or examination of a work-related injury/illness. If the trip involves staying overnight and is approved by WCP in advance, dinner and breakfast may also qualify for reimbursement.

- **Lodging:** Lodging may qualify for reimbursement if the trip involves staying overnight, it must be approved by the WCP in advance.

Medical Bills

It is unlawful for a medical provider to charge a workers' compensation patient a co-pay or balance bill for treatment related to a workers' compensation injury. If you receive reimbursement requests for medical bills, forward them to WCP. Please direct any questions concerning these bills to WCP who will arrange for direct billing of future invoices with the employee's physician. Medical invoicing is processed in accordance with the VT Fee Schedule (Rule 40).

Pharmacy Fill Program

TMESYS Pharmacy Benefits Manager:
The WCP is now providing benefits through Tmesys, an online Pharmacy Benefits Manager. The Tmesys Prescription Card makes the process of obtaining medications for an injury easier and more convenient. The ease of use benefits the employee and reduces the employee's out-of-pocket expenditures. The discount in prescription costs benefits the employer.

To locate a TMESYS PHARMACY:

- Call Tmesys at 866-599-5426
- Visit pharmacy locator at www.pmsionline.com

TREATMENT PROVIDER CHOICE & INDEPENDENT MEDICAL EXAMINATIONS (IME)

Who Chooses the Medical Provider?

Once the employee notifies the employer of an injury/illness, the employer may designate the physician or facility that initially treats the employee. After the initial treatment, the employee has the option to discontinue treatment with the initial doctor and choose to treat with another physician. If the employee makes this choice, then he/she must complete the ***Notice Of Intent To Change Health Care Provider (Form 8)*** prior to changing health care provider. However, if the employer uses this right at injury/illness occurrence and the employee remains with this provider they can't direct care elsewhere in the future through the independent medical examination process. For this reason the WCP does not generally direct the initial visit; instead the employee is allowed to select their own health care provider.

What is an independent medical examination (IME)?

AN IME IS A CARRIER DIRECTED EVALUATION. THE IME IS SCHEDULED BY THE WCP. IME'S ARE CONDUCTED BY EXAMINER'S WHO HAVE NOT PREVIOUSLY TREATED AN EMPLOYEE FOR THE INJURY OF RECORD. THEY ARE SCHEDULED FOR A VARIETY OF REASONS; SUCH AS:

- TO QUANTIFY THE LEVEL OF PERMANENT IMPAIRMENT
- TO CLARIFY CAUSATION
- TO PROVIDE A "SECOND OPINION" ON A TREATMENT PLAN
- TO ASSESS THE APPROPRIATENESS OF CARE

WHAT IF AN EMPLOYEE REFUSES ATTENDANCE AT THE IME?

THE EMPLOYEE'S WORKERS' COMPENSATION BENEFITS CAN BE DISCONTINUED UNTIL SUCH TIME AS THEY PRESENT TO A CARRIER DIRECTED EVALUATION.

EMPLOYMENT BENEFITS

How Might a Workers' Compensation Disability Period Impact an Employee's Benefits?

The following outlines the effect that workers' compensation may have on the benefits of an employee of the State of Vermont who is covered by a Collective Bargaining Unit Agreement or Extension of Benefits.

Benefits

Medical Insurance:

If an employee wishes to continue coverage for his/her family and his/herself, and is receiving an indemnity payment, normal payroll deduction of premiums will occur.

If an employee's workers' compensation ends and they remain out of work on an unpaid medical or administrative leave, it is his/her responsibility to arrange for payment of his/her health insurance premium contributions with the Employee Benefits Unit. Questions can be directed to (802) 828-3455.

Retirement:

If an employee has been absent from work in an approved workers' compensation status, he/she should contact the Retirement Division at (802) 828-2305 as soon as final payment has been received and advise the Retirement Division of the claim. He/she should experience no loss of salary credit or service credit for purposes of determining his/her State of Vermont Retirement Benefits as a result of his/her injury/illness. Verification of the workers' compensation benefits including beginning and ending dates will be required in order to restore full salary and service credit for the period of absence. Retirement deductions will not be taken from his/her workers' compensation payment.

Death Benefits:

If a fatality results from a work-related injury/illness, the employer shall pay compensation to the spouse or to any dependents as defined in the statute as children, dependent parents, dependent grandparents, dependent brothers and sisters, or dependent grandchildren. In addition, the workers' compensation fund would also pay up to $5,500 of the funeral and burial expenses.

If the employee is enrolled in the life insurance plan, a copy of the death certificate needs to be sent to Employee Benefits who will file a claim with the life insurance carrier. Once the claim has been filed the carrier will make direct contact with the employee's beneficiary to obtain necessary information for claim payment. Questions about life insurance claims should be directed to (802) 828-0648.

Annual Leave (AL) and Sick Leave (SL):

Employees should continue to earn annual leave and sick leave while on workers' compensation at the appropriate accrual rate, if the number of hours off payroll is not equal to or in excess of twenty (20) hours per pay period.

Personal Leave:

Employees should experience no loss to their personal leave accrual as a result of a work-related injury/illness.

Tuition Reimbursement:

A work-related injury/illness usually would not adversely affect the tuition reimbursement benefit. One exception would be if the employee were unable to satisfactorily meet the requirements of the program.

Compensation

Holiday Pay (Including Floating Holiday):

If an employee is absent on an official state holiday, he/she will receive his/her regular base pay without charge to his/her leave balance.

Emergency Closing/Reduced Workforce Situations:

Employees will receive regular workers' compensation for that day. If supplementing the workers' compensation benefit with accrued leave, employees may not be required to charge leave balances for those hours that offices were closed or operating with reduced staffing levels.

Snow Season:

Agency of Transportation employees who are absent during snow season due to a work-related injury/illness are not eligible for snow season compensation during the time they are not at work.

Assault Pay:

For an injury/illness resulting from an assault or other event as defined by the labor contracts, an employee will be paid the difference between base salary and the workers' compensation benefit without charge to leave accruals.

Seniority

Reduction in Force (RIF) Seniority:

Time spent on paid medical leave of absence for workers' compensation reasons is considered for Service Date and Reduction in Force (RIF) seniority purposes.

Time spent on unpaid medical for health reasons or unpaid administrative leaves of absence is NOT considered for Service Date and Reduction in Force (RIF) seniority purposes.

Shift Bidding For Corrections Employees:

For the purpose of Shift and Post Bidding, leaves of absence or time "off payroll" shall not be considered an interruption in an employee's seniority when computing their length of "Continuous Departmental Service". Correctional officers absent on workers' compensation may be able to participate in the shift/post bidding process. Affected employees should contact their facility to inquire about the detail well in advance of the shift/post bidding process.

Shift Bidding For State Police:

A trooper's time out on workers' compensation is considered for his/her seniority for shift bidding.

VOCATIONAL REHABILITATION

What Are Vocational Rehabilitation Benefits?

When an employee suffers from an injury/illness which prevents him/her from performing work for which he/she has previous training or experience, the employee may be entitled to vocational rehabilitation benefits. The purpose of vocational rehabilitation is to provide the services necessary to assist the injured/ill employee in his/her return to suitable employment. If an employee is found eligible, these services may include resume development, vocational testing, counseling, training, job development, and assistance with job placement. Although the vocational counselor is responsible for assisting the injured/ill employee with all aspects of the job search, the employee is responsible for seeking his/her own employment. Vocational rehabilitation services are provided by contracted vendors.

The employer (or insurance carrier) may select the initial VR counselor. The injured worker has a right to change counselors if they are not satisfied with the one selected for them. The worker must file a VDOL Form VR-8 requesting a change in counselors.

Eligibility

Individuals who have filed an accepted workers' compensation claim and have been out of work for at least ninety (90) days or are clearly unable to return to their usual work duties may be entitled to these services. Eligibility is determined on a case by case basis by the vocational rehabilitation counselor. Not everyone will be eligible for vocational rehabilitation. Eligibility is based on a number of factors including the employee's work history, educational background, skills, and experience.

Referral Process

Referral for vocational rehabilitation shall be made within fifteen (15) days after it is reasonably apparent, by way of a medical provider's report or otherwise, that a claimant is or may be eligible for vocational rehabilitation services regardless of whether the claimant has reached medical end result. Referral can also be made when an individual has been out of work for ninety (90) days, a ***Vocational Rehabilitation Referral Form (VR 1 Form)*** is completed by the claims adjuster and forwarded to all parties.

Collaboration with Employer

There are times that the Vocational Rehabilitation Counselor (VRC) will request information from the employer to clarify an employee's job duties or to discuss return to work planning. The workers' compensation claims adjuster should alert you in advance if the VRC plans to visit a work-site or communicate with you. If the VRC contacts you directly without prior notification from the WCP please alert the adjuster.

FROM TIME REPORT TO PAYCHECK

Workers' Compensation Payroll Processing

The purpose of this chapter is to outline some administrative payroll aspects of dealing with an employee out on workers' compensation. The procedures outlined within this chapter are subject to change without notice. Please contact the Payroll Division (802) 828-2314 for the latest procedures if you have not recently processed any claims. You may also contact the Payroll Division for any questions related to the payments issued or deductions taken in workers' compensation cases.

Completing the Time Report

Code 01 should be coded on the date of injury. The time that an employee is absent on the actual date of a work related injury/illness should be coded on the time report as if he/she was working.

Code 24 should be coded on the time report for the hours an employee medically disabled from work. Beginning with the day after the injury/illness, all time missed from work due to job related injury/illness should be coded with an earnings **Code 24** and showing the number of hours absent from duty. **Note:** this is applicable even if a decision to accept or deny a workers' compensation claim is still pending. However, an employee will not receive any pay (or will not receive full pay once a workers' compensation claim is approved) for this period of absence unless (s)he **also** chooses to request the use of accrued leave (see Supplementing below).

Code 27 should be coded on the time report after the claim has been accepted and the employee is absent from work for the purpose of attending a medical appointment related to their workers' compensation claim. Earnings **Code 27** will pay them for the time absent for a medical appointment without charging it to their leave time.

Supplementing: If the employee desires to supplement his/her workers' compensation payment he/she may use accrued leave balances. Supplementing with leave allows the employee to receive a paycheck equal to his/her regular base salary. To do this, the employee should enter the statement, "Supplement With Leave Time" on **each** time report that has a **Code 24** entry. The Payroll Division will then charge the employee's absence to sick leave (or other accrued leave if there is insufficient sick leave) to the extent of the difference between any approved workers' compensation benefit and the employee's base salary. Employees who enter a **Code 24** earnings code on their time reports and do not supplement with sick leave (or other leave if they do not have sick leave), will be carried "off-payroll" for those hours not covered by workers' compensation.

Submitting The Time Report

The Department's Time Keeper should submit the original time report to the Payroll Division and fax a copy to WCP (802) 828-0410 anytime he/she sees a **Code 24** on a time report, no later than by noon on the last Friday of each pay period.

Calculation Of The Workers' Compensation Payment

The adjuster uses the information provided on the ***Wage Statement (Form 25)*** to calculate the average weekly wage by averaging wages, overtime, stipends, etc. for the twenty-six (26) weeks prior to the injury/illness. The employee's weekly workers' compensation benefit rate represents 66 2/3% percent of the employee's average weekly wage (Note minimum and maximum rates apply). The adjuster will request a ***Form 25*** as soon as time loss is apparent. These forms should be completed as soon as possible when requested to ensure timely payment of replacement wage benefits.

Authorizing of the Payment

If an indemnity claim is approved by WCP, a voucher will be issued by the claims adjuster to the Payroll Division authorizing payment for the period of disability.

Payroll Deductions

Workers' compensation payments are non-taxable income and therefore are not subject to the normal payroll deductions. **Employees must make special requests to the Payroll Division to maintain normal payroll deductions.** However, the Payroll

Division can't accept requests to continue pre-taxed deductions unless the employee's workers' compensation is supplemented with sufficient leave to prevent taxable wages from going into the negative. If the deduction for insurance premiums is stopped the employee must send the premiums to the Employee Benefit and Wellness Division to keep his/her coverage active. An employee may not deduct deferred income from his/her workers' compensation payment

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Issuance Of Workers' Compensation Payments

If the claim is approved for workers' compensation, the indemnity payment will be posted to the employee's Earnings Statement.

CLAIM TIMELINES

What Timelines Are Applicable In Workers' Compensation?

Timelines?	When the Clock Starts?	What is happening?	Consequences for Non-Compliance?
Vermont State Employee's Workers' Compensation Incident Report : Incident Report must be submitted online within 72 hours of the injury/illness	Employee verbally advises a supervisor or HR Administrator of the injury/illness	Employee, Supervisor, or HR Administrator has 72 hours from date of notice of the injury/illness to complete the Incident Report online and submit to WCP	The employer is assessed penalty by VDOL: $100.00 for each violation
Compensability Determinations "21 day Rule": Claim Determination is due within 21 days of notice of claim	Employee verbally advises a supervisor Employee completes a Vermont State Employee's Workers' Compensation Incident Report Adjuster has knowledge of the injury/illness	Medical records collected and reviewed Claim is investigated Employee and witness statements collected	Adjuster loses initial rights to adjudicate the claim Claim is automatically accepted regardless of facts
Form 25 - WAGE STATEMENT	As soon as employee is losing more than three days from work Or, adjuster requests completion of a Form 25	Form 25 reviewed AWW calculated by adjuster Form 32 is completed by adjuster and submitted to employee and VDOL	Employee will not be paid lost time benefits Employer is subject to interest for late payments Employer subject to fines and penalties up to $5,000.00

Timelines?	When the Clock Starts?	What is happening?	Consequences for Non-Compliance?
Work Capabilities Note/ VDOL Form 20	As soon as employee is losing more than three days from work Or, when the prior OOW note expires	Adjuster requests confirmation that employee work restrictions cannot be accommodated Claimant returns to work at accommodated capacity for as long as accommodation exists or work capabilities change	Employee will not be paid lost time benefits
Time Reports	All time reports with Code 24 must be submitted to WCP no later than noon on the Friday prior to the close of the payroll cycle. Note: Earlier deadlines apply in holiday situations.	Adjuster confirms lost time benefits are related to claim Adjuster assures medical disability note has been secured and corresponds to time sheet	Employee will not be paid lost time benefits Employer is subject to interest for late payments Employer subject to fines and penalties up to $5,000.00
Reconsiderations	5 days from receipt of new evidence on the file Adjuster has 30-days from receipt of medical billing and all supporting documents to process payments to the provider	Adjuster reviews additional evidence "Reconsiders" the claim and determines if benefits are now due Processes payments to the provider Processes benefits due to the employee	Delays result in decreased effectiveness of medical management Employer subject to fines and penalties up to $5,000.00
Vocational Rehabilitation Referral	When it becomes apparent that the employee may not be able to return to his/her prior job. Or, has received 90 days of continuous indemnity benefits	Adjuster completes referral to Vocational Rehabilitation Counselor	Employer subject to administrative penalties in addition to other sanctions

CLAIMS ADJUSTER ROLE & RESPONSIBILITIES

What is the Adjuster's Role?

A Workers' Compensation Claims Adjuster is responsible for the coordination of the financial, medical and legal aspects of a workers' compensation claim in adherence with Vermont Department of Labor guidelines and Vermont State Statute.

What are the Adjuster's Responsibilities?

- Promptly reviews and investigates each claim
- Determines compensability and ongoing eligibility of benefits
- Issues timely medical, temporary and permanent benefits
- Tracks work status and facilitates return to work planning
- Reviews medical services/utilization
- Completes and processes Vermont Department of Labor forms
- Participates in dispute resolution process with the Vermont Department of Labor with claimant or claimant counsel
- Coordinates information exchange

MEDICAL CASE MANAGER (MCM) ROLE & RESPONSIBILITIES

What is the Medical Case Manager's Role?

The medical case managers assigned to a State of Vermont employee's claim are registered nurses with broad experience in orthopedics, rehabilitation, occupational health, and injury management as well as other fields of nursing. As workers' compensation claims revolve around medical issues, the medical case manager can provide invaluable assistance to the injured worker.

What are the Medical Case Manager's Responsibilities Once the Claim is Accepted?

- assisting in developing, implementing, and coordinating of the medical care plan with the injured employee and his/her health care providers
- assessing care
- evaluating treatment results
- facilitating return-to-work as soon as it is medically safe

VERMONT DEPARTMENT OF LABOR (VDOL) ROLE & RESPONSIBILITIES

What is the VDOL's Role?

The Vermont Department of Labor serves as the regulator that monitors the administration of all workers' compensation claims filed by employers in Vermont.

What Are VDOL's Responsibilities?

- Ensure that the law is correctly applied and claimants receive benefits that are due
- Review files to ensure compliance with all benefit and reporting requirements including vocational rehabilitation, medical, temporary, and permanent benefits
- Investigate fraud referrals and issue administrative citations on confirmed violations
- Help to resolve misunderstandings and clarify interpretation of the statute for any issues that arise in a claim
- Informal Hearing process: Attempt to resolve disputes when they arise by mediating between insurance carriers and claimants. Issue Interim Orders to the parties if they find there is sufficient evidence.
- Formal Hearing process: Conduct formal hearings only when disputes are not resolved through the informal hearing process
- Issue citations to insurance carriers that fail to properly adjust Vermont claims in accordance with the statute and rules

EMPLOYEE RESPONSIBILITIES

What Are the Employee's Responsibilities?

- Immediately reporting the injury/illness to the supervisor and to WCP via online reporting
- Completing and returning all WCP forms promptly
- Providing claim number and billing information to medical providers
- Adhering to work restrictions
- Addressing return to work plan with the doctor at each appointment. If disabled from usual duties, securing a completed Work Capabilities Form (VDOL Form 20) from the doctor at every evaluation. Providing the documentation to supervisor, human resources, and WCP
- Notifying the medical case manager of all changes in the medical condition, the medical treatment plan, and any changes in the work capacity
- Contacting medical case manager after each medical assessment
- Notifying WCP, supervisor and human resources office when released to part-time or full-time work
- Seeking and accepting employment if released to modified duty
- Contacting the medical case manager and supervisor at least every 2 weeks if receiving workers' compensation wage replacement benefits
- Cooperating with human resources, supervisor, and WCP staff in workers' compensation process

SUPERVISOR RESPONSIBILITIES

How Do Report the Injury/Illness?

- If you believe the injury is serious, call for an ambulance immediately. NEVER MOVE AN INJURED PERSON.
- If the injury does not require emergency attention, provide any necessary first-aid
- The employee, supervisor, or Department HR Representative must complete a ***Vermont State Employee's Workers' Compensation Incident Report*** online as soon as possible, but no later than 72 hours (Sundays and legal holidays are excluded) following the injury. Provide any additional information to WCP that may pertain to the injury/illness or cause of the injury/illness, such as pictures and witness statements

What if the Employee is Medically Excused from Work or Placed on Restricted Duty?

- Request that the employee provide a written work status note from the medical provider at each medical appointment. Use of the ***Work Capabilities Form*** **(FORM 20)** is recommended
    - The electronic form is located at: **www.state.vt.us/labind/wcomp/wcforms.htm**
    - The employee is responsible for providing a copy of the work status note to the supervisor, human resources, and to the office of Workers' Compensation and Prevention
    - The work status note must have an expected return to work date on it. If the date is omitted you may ask the employee to contact the medical provider to have the date completed
- If the employee is able to return to work with restrictions, the work status note should list work restrictions. Review the work restrictions with the Human Resource Administrator to address whether a work accommodation is available
    - If a work place accommodation is available, you are encouraged to complete a **Modified Duty Agreement** with the employee. Contact your Human Resource Administrator for additional guidance

What Do I Do with Worker' Compensation Related Documents?

- Forward any medical bills to WCP
- Forward requests for mileage reimbursement, meals and lodging to WCP
    - Please note, all such requests **cannot** be submitted on the State Expense Reimbursement Form
- Forward all medical documentation to WCP

What are the Supervisor's Rights?

- The Supervisor has the right to contact the employee to keep the employee informed of current operations at the work site
- The Supervisor may call the employee to attend meetings, trainings and any work-related activities provided it does not exceed work restrictions
    - While participating in work related activities, the employee's time is coded **CODE 01**
- The Supervisor has the right to enforce adherence to work restrictions
- The Supervisor has the right to request reasonable ongoing contact from the employee

What Can't the Supervisor's Do?

- The Supervisor cannot discuss the medical status of the employee with other employees
- The Supervisor cannot contact the medical providers directly to discuss the employee's medical status
    - Any questions regarding the medical status of the employee should be addressed to The Office of Workers' Compensation and Injury Prevention or to the Human resources Administrator

HUMAN RESOURCE ADMINISTRATOR RESPONSIBILITIES

What are the Human Resource Administrator's Responsibilities?

- The employee, supervisor, or Department HR Representative must complete a ***Vermont State Employee's Workers' Compensation Incident Report*** online as soon as possible, but no later than 72 hours (Sundays and legal holidays are excluded) following the injury. Provide any additional information that you have relative to the injury (i.e. witness statements, pictures)by fax at (802) 828-0410 or email to riskhelp@state.vt.us

- Submit the twenty-six (26) week ***Wage Statement (Form 25)*** to WCP once the employee has been absent, or you know that he/she will be absent for more than three (3) full or seven (7) partial days.

  The ***Wage Statement (Form 25)*** must be completed as soon as you know that the employee has lost or will lose more than three (3) full days or seven (7) partial days. A ***Wage Statement (Form 25)*** is a report, which includes stipends, of the employee's wages over the twenty-six (26) weeks prior to the injury/illness. This is necessary in order for the claims adjuster to calculate the employee's average weekly wage, and for the employee to be paid for time missed as a result of a workers' compensation claim. Be sure to follow the instructions at the top of the form and specify the total dollar amount of any "extras" including what the monies were paid for (i.e. stipend, clothing, etc.).

  Send the completed form to WCP. In the event that an employee's first date of disability (DOD) is greater than six (6) months from the date of injury (DOI) a second ***Wage Statement (Form 25)*** is required for the twenty-six (26) week period prior to the week of disability. The higher of the two rates will be used to calculate the benefit amount.

  Note: The week that the employee is injured/ill should not be included as one of the twenty-six (26) weeks.

Wage Statement (Form 25)	
State File No.	Leave blank.
Ins. Co. File No.	Insert claim number provided by the WCP
Date of Accident	Complete.
Employer	Employer's name. (Department/Division)
Employee	Employee's name and Employee ID #
Wage Rate	• Employee's hourly wage. Note any changes in rate of pay and the effective date of the change • Fill in accompanying table as described in the instructions. Be sure to label any "extras" payment (ie. Snow season status, tool allowance), do not include reimbursements to the employee for expenses.
When did the employee begin losing time?	Date when employee's disability began
Was employee paid in full for the day of the accident?	Yes (Employee should Code 01 for day of injury)
Are the employee's wages subject to any child support withholding order?	Yes or No.

If yes, in what amount?	Enter dollar amount and frequency of withholding
Day of the week the check will be mailed to the claimant or deposited in the claimant's account?	Thursday
By	Enter your name. Enter the date.

- Complete ***Personnel Action Form*** each time the employee's work-related injury/illness impacts his/her ability to work a regular schedule. Each time the employee returns to work full or part-time or is going out of work full or part-time, a ***Personnel Action Form*** should be completed.

- Ensure that any work capacity information on file with your office is also provided to the WCP and to the employee's supervisor. Initial phone calls are acceptable; but please follow up with written notification including the employee's full name, work status (full or part-time), return date. Indicate any medical restrictions regarding the employee's return to work.

- Work with supervisors in drafting and tracking Modified Duty Agreements. Ensure that no employee's period of absence and/or restriction exceeds a 90 day period. The 90 day period can be extended with a new formal Modified Duty Agreement.

- Forward WCP work status updates to the appropriate supervisor.

- If the employee does not return to his/her pre-injury position keep the WCP informed of the employee's employment status and effective date(s) following medical end result. Alert the WCP if the employee terminates employment with State Government or is Medically RIF'ed.

RETURN TO WORK

What is the Return to Work (RTW) Program?

The Return to Work (RTW) program is a means to return employees to meaningful productive employment following a work related injury/illness. The primary goal of the program is to assist employees in their return to full duty, which may include a short term change in assigned duties. This will allow the employee to remain a productive member of the state workforce while recuperation and rehabilitation take place.

Experience indicates the longer an employee is away from work, the more difficult it can be to return the individual to employment. Studies indicate that more than 50% of injured/ill employees who are away from work for more than 6 months never return to work. An RTW Program is a valuable loss control measure and is one component of a successfully managed Workers' Compensation Program.

It is important to note that the State is self-insured for Workers' Compensation. Therefore, regardless of whether or not the employee is working modified duty or receiving workers' compensation benefits, the State is paying the employee. It is in the Agency's best interest to utilize the skills of the employee and provide transitional work options rather than have the injured employee stay home and receive workers' compensation benefits.

Program Objectives:

- Assist the employee in his/her return to regular employment
- Reduce workers compensation costs
- Help to maintain employee's income closer to pre-injury level
- Minimize work delays and business interruptions associated with the loss of an experienced employee

- Enhance communication between employer and employee
- Avoid the stress, boredom, and depression sometimes associated with being out of work
- Allay any employee concerns about continued employment opportunities following injury

Modified Duty: This is a short term alteration of an employee's regular full duty job in order to accommodate temporary limitations during recovery from a work related illness/injury. The Modified Duty arrangement is for a defined time period. This can consist of a modification of duties, or a simple restriction in the number of hours worked.

Alternate Duty: This is a short term change in work duties, for a defined time period, that recognizes an employee's limitations during recovery and rehabilitation. Alternate Duty consists of meaningful productive work and presumes an eventual return to full duty position. The assignment may or may not be in employee's original department.

Work Capabilities Form: Employees should ask their medical providers to complete the ***Work Capabilities Form (VDOL Form 20)*** at every appointment. This form specifies any restrictions the employee may have as a result of his/her injury. The employee should provide the form to his/her HR Administrator immediately following each medical appointment. The HR Administrator should fax a copy of the form to the WC Adjuster responsible for that employee's claim. If the Adjuster receives the form directly from the medical provider he/she will fax a copy of the form to the HR Administrator.

Eligibility: Any employee with a compensable injury/illness is eligible to participate in the RTW program. Failure to accept a medically approved modified duty or alternate duty job may result in the termination or reduction of workers' compensation wage replacement benefits.

Offering Modified or Alternate Duty: When the HR Administrator receives the ***Work Capabilities Form*** or a physician's note, he/she should discuss modified duty with the supervisor to determine which return to work options are available. The HR Administrator should confirm with the Adjuster whether the restrictions can be accommodated. The HR Administrator should promptly alert the claims adjuster if the employee refuses or fails to report for a modified or alternate duty assignment.

Return to Work Options:

1. **Modify current job.** This allows the employee to maintain contact with peers and maintain much of the regular job position routine and familiarity. If the modification consists of a shortened workday, it is important that the employee report at the beginning of his/her regular shift.

2. **An alternate job within the same division or department.** Again, this option allows the employee to remain within the familiar structure of his/her original department.

3. **An alternate job in a different department but same location.** Even if the alternate duty opportunity is in a different department, it is less disruptive for the employee to remain in the same geographic location and hopefully the same schedule.

4. An **alternate job in a different location** is the least preferable option. If an employee has to commute for a short-term alternate duty job, the distance will not be greater than thirty-five (35) miles unless special arrangements are provided.

Modified Duty Agreements: The drafting of a formal Modified Duty Agreement is encouraged. This agreement will comply with all necessary physical or medical restrictions and will be for a defined time period, typically not to exceed ninety (90) days. It is important that the supervisor closely and frequently monitor an employee assigned to a modified duty. The supervisor or employee should contact WCP anytime there is a change in the employee's work status or there is a proposed change to the employee's duties, as defined in the Modified Duty Agreement.

The Modified Duty assignment will end when the employee is authorized to return to full duty, circumstances require the Modified Duty Agreement to be discontinued, or ninety (90) days have elapsed without a formal agreement approving an extension.

A RTW placement is not intended to be in effect for more than ninety (90) days. In some situations, an extension beyond ninety (90) days is possible for a defined time period and with the approval of all parties. There are situations that do not allow for a return to full-duty or regular employment due to permanent restrictions; these are dealt with under a separate process of rehabilitation. The HR Administrator should provide the WC Adjuster and Supervisor with a copy of the written modified duty agreement.

MEDICAL END RESULT

What Is Medical End Result?

When an individual's medical condition has reached a plateau in recovery and is no longer expected to make any further significant medical/functional improvement, regardless of treatment, that individual is said to be at a "Medical End". The terms Medical End, Medical End Result, and Maximum Medical Improvement all mean the same thing. A determination of Medical End Result can be made by any health care provider as defined in Vermont Statutes Annotated, Title 21: Chapter 9, Section 601 (22). The workers' compensation claims adjuster will alert you once your employee is declared at a Medical End Result.

The Significance Of A Medical End Result

The Workers' Compensation Program is designed to provide wage replacement until a ***Notice To Commissioner & Employer Of Intention To Discontinue Payments (Form 27)*** has been approved by the Vermont Department of Labor. When a medical professional declares a worker to be at a Medical End Result, a number of things may happen. First, a worker is no longer eligible for Temporary Total Disability (TTD) Benefits (upon approval by the Department of Labor and Industry). Second, the worker may become eligible for a Permanency Award Settlement based on the percentage of physical impairment rating he/she may have as measured by a physician. Third, in the event that an employee has a physical impairment great enough to preclude return to his/her original job, other employment options must be considered by the employee.

Permanent Disability Benefits

When an employee has a permanent physical impairment as a result of a work-related injury/illness, he/she is eligible for an award settlement. The amount of this settlement is based upon the extent (percentage of loss of function) of the permanent physical impairment, as determined by the physician and the amount of the employee's earnings at the time he/she was injured/ill. Established formulas, outlined in the American Medical Association: Guides to the Evaluation of Permanent Impairment - Fifth Edition, are used to calculate how much a worker should receive for a permanency. Since all employees and all injuries/illnesses are different, all award settlements are different. The injured worker, the WCP, and the Vermont Department of Labor must agree to each permanency award.

When an employee reaches medical end result and a health care provider determines that there is some permanent impairment of a physical function, he/she may be entitled to further benefits. There are two types of permanent disability benefits: Permanent Total Disability (PTD) and Permanent Partial Disability (PPD).

If the employee returns to full-time employment, then the Permanent Partial Disability (PPD) benefits are payable from the date of the return to work. If the employee has not yet returned to employment, then the benefits are paid from the date the temporary benefits cease. If a health care provider determines that the employee has a permanent partial impairment, then the claims adjuster must complete an ***Agreement For Permanent Partial Disability Compensation (Form 22).*** In addition, medical documentation is required to substantiate the extent of the claimant's impairment. It also must include a permanency rating completed in accordance with Vermont Statutes Annotated, Title 21 Sec. 648 and Rule 11 or 11a.

Permanent Work Restrictions

If an employee has reaches Medical End Result with permanent work restrictions the WCP will provide formal notification of those limitations to the employee, the Department's HR Administrator, and the Department of Human Resources

EMPLOYMENT AFTER MEDICAL END RESULT – AS OUTLINED IN THE COLLECTIVE BARGAINING AGREEMENTS

NOTE: Individual situations will vary. It is important to read bargaining agreements and policy language and to contact your HR Representative and/or Labor Relations with all questions concerning the specifics of the situation you are reviewing.

Returning To Work With A Reasonable Accommodation:

If an employee can return to his/her current position but believes that he/she has an physical or mental impairment, which substantially limits a major life activity, that affects his/her ability to perform the essential functions of that position he/she may request an accommodation in accordance with the State's Reasonable Accommodation Policy (Personnel Policy 3.2). If a reasonable accommodation is granted that allows the employee to perform the essential functions of his/her current position, the employee returns to that position.

Use Of Sick Leave:

If an employee is unable to perform the essential functions of his/her current position due to a work-related injury/illness, he/she may use accrued sick leave to remain out of work, whether he/she can reasonably be expected to return to work, or not. At the employer's request, the employee must provide acceptable medical documentation establishing the inability to perform the essential functions of the job. Any such granted leave will, if applicable, count toward the leave that an employer is required to provide in accordance with the Vermont Parental and Family Leave Act (PFLA) and the Federal Family Medical Leave Act (FMLA).

Use Of Annual, Personal, Or Compensatory Leave:

If an employee is unable to perform the essential functions of his/her current position, because of a work-related injury/illness, he/she may request and use other accrued leave with the employer's approval. Any such granted leave will, if applicable, count toward the leave that an employer is required to provide in accordance with the Vermont Parental and Family Leave Act (PFLA) and the Federal Family Medical Leave Act (FMLA).

Request An Unpaid Medical Leave Of Absence:

If an employee is unable to perform the essential functions of his/her position, for more than a full pay period, has exhausted all but one hundred and twenty (120) hours of sick leave, and chooses not to use annual, personal, or compensatory time, then he/she may request and may be granted up to six (6) months of unpaid medical leave of absence. Then he/she must provide, upon the employer's request, medical documentation establishing the inability to perform essential job functions. Such a leave of absence cannot be granted for more than six (6) months at a time, but may be extended for up to a total of twenty-four (24) months in a five (5) year period. Any such granted leave will, if applicable, count toward the leave that an employer is required to provide in accordance with the Vermont Parental and Family Leave Act (PFLA) and the Federal Family Medical Leave Act (FMLA).

Medical Reduction In Force (RIF):

When an employee reaches a medical end result, and if he/she is unable to perform the essential functions of his/her current position (with or without a reasonable accommodation), and is not eligible for or has exhausted their rights under Attachment A (Accommodation Through Reclassification) of Policy 3.2, then the employer may choose to begin the layoff (RIF) process, as described in the applicable collective bargaining agreement. An employee will not be "Riffed", or laid off, while on approved sick leave or while on an approved medical leave of absence.

Retirement (Disability Or Standard):
If an employee believes an injury/illness renders him/her unable to work and wishes to consider retirement, he/she should call the Retirement Division of the State Treasurer's Office at (802) 828-2305 for information regarding retirement benefits.

WORKPLACE SAFETY

What Services Are Offered By Workplace Safety?

Workplace Safety investigates incidents to identify causes and appropriate corrective actions while providing health and safety regulatory interpretation to assist state agencies/departments in meeting those requirements.

Additionally Workplace Safety works with state agencies/departments to develop trainings, monitoring injury trends and working to establish injury prevention programs to reduce injury rates and work-related illnesses. This is done through comprehensive Building Safety Inspections, making recommendations for hazard mitigation, working to establish agency/department Safety and Health Committees, performance of Job Safety Analysis's, and Ergonomic valuations.

What is an Ergonomic Evaluation?

Ergonomics is the science of designing tools and equipment, the layout of the workplaces, and the overall organization of work to improve employee well-being and workplace efficiency.

Workplace Safety's Ergonomic Evaluation is a service provided to guide employees on proper workstation adjustments and equipment selection; to preventing repetitive injuries and cumulative trauma. All State Employee's are eligible to receive a Workplace Safety Ergonomic Evaluation.

What is the Ergonomic Evaluation Process?

Employees, HR Administrators, and Supervisors may request an ergonomic evaluation by completing an ergonomic evaluation request form online at http://bgs.vermont.gov/sites/bgs/files/pdfs/BGS-Workplace-Ergo-Assmt-Request.pdf and submitting it to WCP. Ergonomic request forms will be accepted by e-mail (bgs.ergo@state.vt.us) or fax (802-828-0410). Ergonomic evaluations are automatically scheduled for employees who have filed a Workers' Compensation claim for a repetitive injury.

The Workplace Safety Coordinator (WSC) will call the supervisor directly to schedule the evaluation. Evaluations for Workers' Compensation claimants will be given top priority. Preventative evaluations will be grouped by region and completed in order of receipt. The WSC will conduct multiple ergonomic evaluations in each specific location if possible. Group requests are encouraged.

The WSC will provide the completed evaluation report to the employee, the supervisor, the HR Administrator, and the adjuster (if applicable) within 7 calendar days of the evaluation. The Supervisor should review the recommendations and notify the WSC once any recommendations are implemented.

Supervisors and HR Administrators are encouraged to contact Workplace Safety in advance of any scheduled office relocations as a proactive measure for setting up new workspaces.

What Are Workplace Safety Assessments?

Workplace Safety Coordinators review and conduct a Workplace Safety Evaluation of all Vermont State Employee's Workers' Compensation Incident Reports received through our online reporting. Nearly every first report of injury presents the possibility of preventing a similar injury or incident from reoccurring in the future. Unsafe acts, workplace hazards, supervisory factors, and organizational influences contribute to workplace injuries. WSCs view all workplace injuries as being preventable.

Factors that determine the level of investigative response are as follows:

- Anticipated safety value of an investigation, including the likelihood of furthering the understanding of the scope and impact of any safety system failures
- Likelihood of safety action arising from the investigation, particularly of state-wide significance
- Existence and extent or potential for serious injuries
- Relevance to an identified and targeted safety initiative or program

A Workplace Safety Evaluation (WSE) Report will be prepared by the WSC following the site visit. The report shall contain the following:

- Background Information
  - Where and when the incident occurred
  - Who and what were involved
  - Operating personnel and other witnesses
- Account of the Incident
  - Sequence of Events
  - Extent of Damage
  - Procedures associated with Task (if applicable)
- Conclusion
  - Direct Causes (energy sources, hazardous materials)
  - Indirect Causes (unsafe acts or conditions)
  - Basic Causes (policies, personal or environmental factors)
  - Recommendations

The WSE Report will be distributed to the HR Administrator and the Supervisor. The analysis of Agency/Department action or inaction in regards to WS recommendations will only serve to strengthen a workplace climate that is safety oriented. The Supervisor should review the recommendations and notify the WSC once any recommendations are implemented. The WSC will follow up with the Supervisor ninety (30) days after recommendations have been provided. Follow-up may take the form of phone call, e-mail, and/or onsite re-inspection visit.

ANALYSIS TYPE	ACTIONS	RESPONSE PROTOCOL
Telephone Contact	Report of Incident reviewed. Injured worker contacted for details of injury circumstances within 5 days of receipt of Incident Report on line. Voice message left requesting call back if injured worker unavailable.	Following contact with the injured worker, a Workplace Safety Assessment is generated within 5 business days. If information received from injured worker indicates a need for an on-site evaluation of the injury cause, this is scheduled with the injured worker and his/her supervisor. If no return call is received from the injured worker, his/her supervisor is contacted by telephone.
	Telephone call to injured worker's supervisor for details of injury circumstances. If no return call received after two business days, telephone call to supervisor of injured worker. Voice message left requesting call back if supervisor unavailable.	Following contact with the injured worker's supervisor, a Workplace Safety Assessment is generated within 5 business days. If information received from injured worker's supervisor indicates a need for an on-site evaluation of the injury cause, this is scheduled. If no return call is received from the injured worker's supervisor, a "Failed Contact" letter is sent to the Agency HR person with a request for assistance in getting the injured worker/supervisor to contact the Workplace Safety Coordinator.
	Failed Contact letter is sent to the Agency HR person.	Analysis actions ended, no Workplace Safety Assessment performed.

On-site Visit	Based primarily on the details provided on the incident report and injured worker and/or supervisor contact indicating that a safety issue may exist, an appointment will be made to continue the injury investigation with a meeting onsite.	Following the on-site visit with the injured worker/supervisor, a Workplace Safety Assessment is generated within 5 business days.
Workplace Safety Assessment	If recommendations are suggested as a result of the telephone or on-site contact, the WSC must complete the Workplace Safety Evaluation Report The Report will then be completed and distributed within 5 business days from the analysis date to: The employer Human Resource contact, building owners if indicated (SOV owners or BGS Property Mgmt), and others as appropriate	Workplace Safety Coordinator sets a diary to self to follow up with all parties as indicated.
	If injury prevention recommendations have been made as part of the injury analysis, the Workplace Safety Coordinator follows up with the Department 30 days after recommendations have been provided to see if they have been implemented.	Although there currently are no adverse consequences for not implementing Assessment recommendations, if hazards continue to remain that could lead to similar employee injuries a request through the HR contact for making management aware of the continued problem is generated.

How do I request Workplace Safety services?

To request Workplace Safety services or to learn more about the Workplace Safety Program, please contact us via the following:

WCP web page: http://bgs.vermont.gov/workers_comp

E-Mail: riskhelp@state.vt.us

Phone: (802) 828 - 2899

DIRECT AND INDIRECT COSTS

What Are the Direct Costs?

- Salary continuation
- Costs of Benefits
- Overhead Costs
- Supervision, work space, administrative
- Building/Tool Damage
- Production Delays

What Are the Indirect and Hidden Costs?

- Overtime (co-workers)/temps
- Training/Retraining
- Reduced output/Re-work
- Turnover
- Work outsource
- Employee morale/unsatisfied customers
- Lost time by fellow employees
- Loss of efficiency due to break-up of crew
- Lost time by supervision
- Cost of breaking in a new worker
- Damage to tools and equipment
- Spoiled work
- Loss of production
- Failure to fill orders
- Overhead cost (while work was disrupted)
- Workers' compensation costs
- Production loss/worker distraction
- Loss of skill/efficiency - slowed production
- Paperwork
- Time spent in accident investigation
- Supervisor administrative time
- Human resources administrative time
- Loss of morale
- Legal issues
- Fines
- Equipment replacement
- Customer dissatisfaction / lost customers

What is the Ratio Between the Indirect and Direct Costs – "The Iceberg Theory"?

Total accident costs can be compared to an iceberg. The part of the iceberg that can be seen above the surface is like the smaller, direct portion of the total accident costs.

Conservative estimate: For every $1 of direct accident costs = $3 of indirect costs & $4 - $10 of hidden costs

How Are State Workers' Compensation Claims Funded?

A separate fund has been established to support the workers' compensation program. The fund is supported by premiums billed to Agencies/Departments across State Government. Therefore, regardless of whether or not the employee is working modified duty or receiving workers' compensation wage replacement; the State is paying the employee.

How Are Premiums Calculated?

The total premium is based on an annual actuarial review of our losses, reserves, and claims handling procedures. It consists of:

Estimated cost of claims anticipated during the upcoming year
Overhead costs of the Office of Workers' Compensation
Any surcharge (or discount) necessary to calibrate the reserve fund

To spread the premium costs equitably across state government we utilize two methods: exposure and experience -- raising half of the necessary premium by each method.

What Is Exposure?

Exposure: the theoretical risk that each department is exposed to based on the number and type of employees

Calculated by multiplying the payroll for each position class by the federal workers' compensation rate for that class; overall rates are then modified to reflect our experience.
Payroll (by position class)
x WC rate (for each class)
x modification factor

What is Experience?

Experience is a department's loss history.

This half of the premium is simply pro-rated by department to reflect each department's share of the overall losses (i.e. if AOT represents 25% of the state's claims costs, they pay 25% of the premium)

How Are Premiums Contained?

- Education, training and communication
- Loss prevention strategies
- A solid safety program
- Claims investigation and timely reporting
- Medical control/provider management
- Return-to-work programs
- Safety Awareness
- "Accidents are preventable"
- Supervisor Management
- Early medical intervention
- Early return to work programs
- Open communication
- Health and Safety Management
- Safety programs/manuals
- Safety Training
- Hazard assessments
- Equipment maintenance programs
- Safety meetings
- Incident and Accident Investigation
- Health and Safety Committees
- Ergonomics Awareness

FORMS & PUBLICATIONS

There are numerous forms involved with the handling of workers' compensation claims, because each case is different, different sets of forms are generated. It is not likely that you would see all of these forms for a specific individual. So that you are familiar with the appearance of workers' compensation related paperwork the following list and some samples are provided.

We have included copies of those forms you are most likely to encounter on a regular basis. These forms are prefaced with the word "**SAMPLE**" **Note:** Many of the forms below can be found on the Department of Labor website: www.state.vt.us/labind/wcindex or on the WCP website: http://bgs.vermont.gov/workers_comp/forms

- Denial Of Workers' Compensation Benefits by Employer or Carrier (VDOL Form 2)
- Report Of Fatal Accident (VDOL Form 4)
- Employee's Notice Of Injury And Claim For Compensation (VDOL Form 5)
- Notice And Application For Hearing (VDOL Form 6)
- Medical Authorization (VDOL Form 7)
- Notice Of Intent To Change Health Care Provider (VDOL Form 8)
- Certificate Of Dependency And Concurrent Employment (VDOL Form 10)
- Settlement Agreement (VDOL Form 16)
- **SAMPLE** - Work Capabilities Form (VDOL Form 20)
- Agreement For Permanent Partial or Permanent Total Disability Compensation (VDOL Form 22)
- Agreement For Compensation In Fatal Cases (VDOL Form 23)
- **SAMPLE** - Wage Statement (VDOL Form 25)
- Employer's Notice Of Intention To Discontinue Payments (VDOL Form 27)
- Notice of Change in Compensation Rate (VDOL Form 28)
- Agreement For Temporary Compensation (VDOL Form 32)
- Vocational Rehabilitation Referral Form (VDOL Form VR-1)
- Memorandum of Payment (VDOL Form 25M)
- Vocational Rehabilitation Entitlement/Plan/Amendment/ProgressReport/Closure/Suspension/Extension (VDOL)
- Vocational Rehabilitation Disclosure Statement (VDOL)
- Notice of Intention to Change Vocational Rehabilitation Provider (VDOL Form VR-8)
- Denial/Discontinuance of Vocational Rehabilitation by Employer or Carrier (VDOL Form VR-227)
- **SAMPLE** – Ergonomic Assessment Request (WCP)
- **SAMPLE** – Initial Contact Packet – Non-Reportable Claim (WCP)
- **SAMPLE** – Initial Contact Packet – Reportable Claim (WCP)
- **SAMPLE** – Mileage Reimbursement Request Form (WCP)
- **SAMPLE**–Modified Duty Agreement (DHR)
- **SAMPLE** – Extended Modified Duty Agreement (DHR)
- **SAMPLE** – Modified Duty Agreement Has Expired (DHR)
- **SAMPLE** - Tmesys First Fill Program (WCP)

VERMONT

www.labor.vermont.gov

State of Vermont
Department of Labor
Workers' Compensation Division
PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286

Form 20 Rev. 12/10

State File No.**: _____
Ins. Co. File No.: _____
Date of Injury: _____

Work Capabilities Form

Form recommended for use by medical providers in assessing work capabilities of patients with work injuries

Employee's Name: _____ Based on my examination of this patient on: _____

☐ May **Return to Work** with **NO RESTRICTIONS**
☐ May **Return to Work** on _____ with the following capabilities:

Stand/Walk:
☐Not at all ☐1-3 hours ☐3-5 hours ☐5-8 hours ☐Unrestricted

Sit:
☐Not at all ☐1-3 hours ☐3-5 hours ☐5-8 hours ☐Unrestricted

Drive:
☐Not at all ☐1-3 hours ☐3-5 hours ☐5-8 hours ☐Unrestricted

Lift:
☐Not at all
☐No more than **10** lbs. ☐Occasionally ☐Frequently
☐No more than **20** lbs. ☐Occasionally ☐Frequently
☐No more than **50** lbs ☐Occasionally ☐Frequently
☐No more than **100** lbs. ☐Occasionally ☐Frequently
☐Unrestricted

Bend:
☐Not at all ☐Occasionally ☐Frequently ☐Unrestricted

Squat:
☐Not at all ☐Occasionally ☐Frequently ☐Unrestricted

Climb:
☐Not at all ☐Occasionally ☐Frequently ☐Unrestricted

Twist:
☐Not at all ☐Occasionally ☐Frequently ☐Unrestricted

Reach above shoulders:
☐Not at all ☐Occasionally ☐Frequently ☐Unrestricted

Specific work capabilities not listed above: _____

Employee has limited use of: _____

Employee ☐can ☐cannot perform repetitive activities for more than _____ min/hrs.

Employee ☐can ☐cannot work more than 8 hours a day.
Work capabilities are in effect until: _____ ; or ☐until further evaluation.

☐ May **NOT RETURN TO WORK** Estimated duration of total disability: _____

Scheduled for a follow-up appointment on: _____

Referred to: _____ for follow-up care.

_____ _____
Medical Provider's Name (Print) Date

_____
Medical Providers Signature

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize this medical provider to release any information acquired in the course of my examination or treatment for the above injury to my employer or its representative.

Patient Signature: _____ Date: _____

** If you do not have the state file number please contact the Department of Labor at (802) 828-2286.

VERMONT

STATE OF VERMONT
Department of Labor
Workers' Compensation
5 Green Mountain Drive, PO Box 488
Montpelier, VT 05601-0488

DOL FORM 25 (Rev. 6/10)

State File No.** _____
Ins. Co. File No. _____
Date of Injury _____
Fed. ID No. _____

WAGE STATEMENT – For Injuries on or after July 1, 2008

Employee: _____

Employer: _____

Wage Rate: $ _____ per _____ Number of Days Hired to Work: _____ Number of Hours Hired to Work: _____

	Week Ending			Number of Hours or Days Worked	Gross Wages	Extras (as in 6 or 7) Please indicate what the extra is, for example, $1000.00 bonus
	Month	Day	Year			
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						

INSTRUCTIONS:
Read Carefully

1. Enter **GROSS** wages of employee for 26 weeks before date of accident **(NOT take home pay).**
2. Do not include the week of the accident.
3. Leave blank those weeks where the employee had excused absences for which he/she was not paid for more than ½ of a work week.
4. Leave blank those weeks where you had reduced operations or a shutdown of the plant for which he/she was not paid for more than ½ of a work week.
5. Do not enter those weeks where an employee was on vacation for more than ½ of a work week.
6. If room, board, lodging or other "extras" (electricity, fuel, etc.) are provided in addition to monetary wages, break it down into a weekly value, include and describe this income in column marked "EXTRAS." This includes tips if not included in gross wages.
7. Include any bonuses and commissions paid to the employee in addition to wages in the column marked "EXTRAS."
8. Enter the dates when your normal work week ends (not the date a check is given to the employee) and the number of hours or days worked.

When did the employee begin losing time? _____ Was the employee paid in full for the day of the accident? _____

Are employee's wages subject to any child support withholding order? ☐Yes ☐No
If yes, in what amount? $ _____ per _____

Day of the week the check will be mailed to the claimant or deposited in the claimant's account _____

This is a correct statement of the employee's earnings as taken from the employer's payroll records.

By: _____ Position Title: _____
Signature of Preparer

Print Name: _____ Date: _____

VERMONT

Office of State Employee Workers' Compensation and Injury Prevention Ergonomic Intake Form

Today's Date:

Form Completed By:

Employee's First & Last Name:

Employee's e-mail Address:

Employee's SOV ID #:

Employee's Phone Number:

Employee's Job Title:

Employee's (Physical) Address:

Department:

Division:

Street Address:

City:

Location (i.e. Floor #, Building name...etc.):

Supervisor's First & Last Name:

Supervisor's e-mail address:

HR Administrator's First & Last Name:

HR Administrator's e-mail address:

What type of work environment are you using? Computer/Office☐ Vehicle☐ Maintenance☐ Other☐

How many months have you been at this workstation?

Have you ever had an ergonomic evaluation done before? No☐ Yes☐ - Date: _____

Describe your ergonomic concern:

Please email this form to: BGS.ERGO@state.vt.us or fax it to: (802) 828-0410

Submit Form

VERMONT

INITIAL CONTACT LTR-NONREPORTABLE

Department of Buildings & General Services
State Employee Workers' Compensation and Prevention
6 Baldwin Street
Montpelier, VT 05633-3801

[phone] 802-828-2899
[fax] 802-828-0410
[Email] riskhelp@state.vt.us

Agency of Administration

June 01, 2012

Bruce Chenail
Any Road
Anytown, VT 05850-9417

Claim No.: WC120916
State File No.:
Injury Date: 05/01/2012

Dear Bruce Chenail:

We have received notice of an incident which occurred on 05/01/2012 during the course of your employment with the State of Vermont. Since it appears that you did not seek medical treatment or lose time from work, this incident does not currently represent a workers' compensation reportable injury. If you do seek medical treatment, please contact us immediately and return the enclosed medical authorization form so we can consider your claim.

We do appreciate you reporting this incident so that we can use the information to try to prevent future injuries.

If you have any questions, please call me at (802)828-2897.

Sincerely,

Andrew Leicher
Claims Adjuster

Cc: HR Administrator - BGS Financial Operations
File

Vermont State Employee's Workers' Compensation Incident Report

Claim Number: WC120916 05/02/2012

Reporter

Employee Number: [redacted]
Employee Last Name: Chenail
Form completed by: Workers Comp Admini
Name of reporter: Bruce Chenail

Employee

Employee Number: 16447000
Employee Last Name: Chenail
Position No./Job Title: 000 16447000
Social Security Number: ***-**-7731
Email Address: bchenail@state.vt.us
Home Phone: [redacted]
Work Phone: (802)828-0615
Cell Phone: [redacted]
Number of Dependents: 0
Marital Status: Married

Employer

Division: BGS Financial Operations
Supervisor Last Name: Stratton
Supervisor First Name: Lisa
Supervisor Phone: (802)828-0714
Supervisor Email: lisa.stratton@state.vt.us
Did you notify supervisor of injury? Yes
Are you also self-employed? Yes
Is the SOV your only employer? No
Name of other employer(s): Julie's Honeydew Services

Incident

Date of Injury: 05/01/2012
Time of Injury: 08:00
Time Shift Began: 07:00
Date Employer Notified: 05/02/2012
Who was injury reported to? Supervisor
Location of Injury (Postal Code): Montpelier 05633
Did injury occur on employer's premises? Yes
Nature of Injury: Multiple Physical Injuries Only
Body Part(s) Injured: Ears(s)
Additional Body Part information: Ears(s)-right, Facial Bones-right, Hand-left

Was injury gradual? No

Describe the events leading up to the accident or injury:
Came to the realization that I had to test iVOS yet another time

What work process was being performed?
Database testing

How did the injury occur?
I got so frustrated that I hit the right side of my face with my left hand, injuring the hand, my ear, and my cheek bone.

Object causing the injury: None

Machine or tool involved in accident: None
Was it defective? No
Was safety equipment provided? Yes
If yes, was it being used? Yes
Could your employer prevent this type of accident? Yes
If yes, describe how:
Don't make me test iVOS no more

Were you performing usual work duties? Yes
Were other worker(s) injured? Yes
Did you miss time from work other than the date of injury? Yes
Date disability began: 05/02/2012
Have you returned to work?
Date returned to work:
Were there any witnesses to your injury? Yes

Witness

Witness First Name: John
Witness Last Name: Dough
State employee? No
Witness Daytime Phone Number: (802)555-5555
Comment:
He tried to stop me

Medical Treatment

Did you seek treatment for injury?
Is this a report-only (no medical treatment anticipated)?
Physician Name: Dr. Doolittle
Physician Phone Number: (802)888-8888
Emergency Room Treatment? Yes
Overnight In-Patient? Yes
Hospital Name & Address:
CVMC Berlin, VT

State of Vermont
Department of Labor Workers' Compensation Division PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286

State File No.: _____

Ins. Co. File No.: WC120916

VERMONT WORKERS' COMPENSATION MEDICAL AUTHORIZATION

NOTE: Title 21 VSA §655a requires all providers to utilize and comply with this medical release authorization form when seeking or providing medical information relative to a workers' compensation claim. Workers Compensation claims are expressly exempted from the terms and provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), *45 CFR 164.512(1).*
A copy of 21 VSA §655a is included with this form (see Page 2 of 2).

TO: **Health Care Provider(s)**
(Physician, Hospital or other medical practitioner)

This, or a photocopy, will authorize you to release to **State of Vermont; Office of State Employee Workers' Compensation and Injury Prevention**
(Department, Insurance Company, or Employer)

at the following address: 6 Baldwin Street, Montpelier, VT 05633-3801

All medical information you may have relating to the treatment or diagnosis of my injury which occurred on or

about **05/01/2012**, 20 _____

Medical information relevant to the specific claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part. Information that may be requested includes:

(1) Minimum data to justify services and payment, including that on the standard paper 1500 form or electronic 837 form.

(2) Office notes of the examination relating to the injury diagnosis or treatment.

(3) Any other relevant provider records contained in the file.

Name: **Bruce Chenail**

Date of Birth: _____

Date _____ Signature _____

Title 21: Labor

Chapter 9: EMPLOYER'S LIABILITY AND WORKERS' COMPENSATION

21 V.S.A. § 655a. Release of relevant medical records by health care providers; department to oversee release and use of relevant medical information

§ 655a. Release of relevant medical records by health care providers; department to oversee release and use of relevant medical information

(a) Health care providers examining or attending the examination of an injured worker pursuant to this chapter shall provide relevant medical records and reports as requested by the injured worker, the employer, or the department regarding the diagnosis, condition, or treatment of the worker, permanent impairment, or any restrictions or limitations on the worker's ability to work upon receiving a written medical release authorization from the injured worker. The authorization shall be on a form approved by the department. If the relevance of any medical information is disputed, the department shall determine whether the requested medical information is relevant.

(b) Medical information relevant to the specific claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part. Information that may be requested includes:

(1) Minimum data to justify services and payment, including that on the standard paper 1500 form or electronic 837 form.

(2) Office notes of the examination relating to the injury diagnosis or treatment.

(3) Any other relevant provider records contained in the file.

(c) An injured worker shall only be obligated to sign a medical record release authorization approved by the department.

(d) Any medical information received by the employer or the insurance carrier that is found not to be relevant to the claim may not be used to deny or limit a claim. The commissioner may order that specific disclosure requests be denied or rescinded and may make such other interim orders as are appropriate.

(e) Any medical information received in conjunction with a claim shall be used only for the purpose of advancing or defending a claim relating to the injury or of investigating a claim of false representation or of ensuring compliance with the workers' compensation statutes and rules. (Added 2011, No. 50, § 4.)

VERMONT

INITIAL CONTACT LETTER-REPORTABLE

Department of Buildings & General Services
State Employee Workers' Compensation and Prevention
6 Baldwin Street
Montpelier, VT 05633-3801

[phone] 802-828-2899
[fax] 802-828-0410
[Email] riskhelp@state.vt.us

Agency of Administration

May 24, 2012

Bruce Chenail
Any Road
Anytown, VT 05850

WORKERS' COMPENSATION CLAIM NO.: WC120916

DATE OF INJURY: 05/01/2012

CLAIM STATUS:
We have received notice of your injury. Your claims adjuster will make a decision regarding your claim within 21 days.

EMPLOYEE GUIDE:
Please refer to the enclosed booklet, "A State of Vermont Employee's Guide to Workers' Compensation," for further information on the claims process and benefits.

CERTIFICATE OF DEPENDENCY AND EMPLOYEE EXEMPTION REPORT:
Please sign and return the enclosed "Certificate of Dependency and Employee Exemption Report" form. Failure to do so may affect future benefits.

CLAIM QUESTIONNAIRE:
Please complete, sign and return the enclosed "Claim Questionnaire" form.

MEDICAL RELEASE AUTHORIZATION:
Please sign and return the enclosed "Medical Release Authorization" form. Your claim will be denied if we do not receive this form promptly. A second copy is included and should be signed and presented at all claim-related medical appointments.

MEDICAL RECORDS:
Your claim will be denied if we do not receive necessary medical records promptly. Medical providers will not send us your records without a signed medical release. Please advise your medical providers to forward claim-related invoices and medical records to this office at the address or fax number listed above.

TMESYS FIRST FILL PROGRAM:
This office is now providing benefits through Tmesys, an online Pharmacy Benefits Manager. The attached "cut-out" Tmesys First Fill Prescription card will make the process of obtaining medications for your injury easier and more convenient. A permanent prescription card will be mailed to you once your claim has been accepted. Please be sure to read the enclosed letter explaining this program.

CONTACT INFORMATION:
Please feel free to contact this office if you have any questions.

Medical Case Manager: Alexis McLean - (802)828-1274

Claims Adjuster: Andrew Leicher – (802)828-2897

Cc: Human Resources - BGS Financial Operations

VERMONT

DEPARTMENT OF LABOR – ATTN: WORKERS' COMPENSATION
PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286

Form 1 (Rev. 9/11)
(Approved for use as OSHA 101 and 301)

State File No. _____

EMPLOYER FIRST REPORT OF INJURY

Answer every question fully and report promptly to avoid a penalty. Employer's Federal ID Number and Employee Social Security Number MUST be provided.

NOTE

EMPLOYER

1. Legal Name: ALL INFORMATION WILL AUTOFILL FROM INFORMATION
2. Business Name: RECEIVED ON THE INCIDENT REPORTING FORM
3. Mail Address: No. and Street | City | State | Zip
4. Location (if different from Mail Address):
5. Telephone Number, Extension and Contact Person.:
6. Nature of Business (list principal products or service of concern):
7. Do you regularly employ 10 or more employees? ☐ Yes ☐ No
8. Federal ID No.:

EMPLOYEE

9. Name: First Name | Middle Initial | Last Name
10. Social Security No.:
11. Date of Birth:
12. Home Address: No. and Street
13. Home Phone No.:
14. Work Phone No:
15. Age:
City | State | Zip
16. Job Title:
17. Sex: ☐ M ☐ F
18. Wages $ Per | Hours Per Day Days Per Week
19. If board, lodging, etc. were furnished in addition to wages, state estimated value: $
20. Was employee hired in VT? ☐ Yes ☐ No
21. Date of Hire

ACCIDENT

22. Date of Accident:
Accident Time: AM PM
Began Shift: AM PM
23. Location of Accident: Town or City | State
24. Machine, tool, object, motor vehicle or substance directly causing injury:
25. On employer's premises? ☐ Yes ☐ No If yes, name of department:
26. Describe what employee was doing:
Was this the employee's regular occupation? ☐ Yes ☐ No
27. How did accident occur? Describe events leading up to the accident:

INJURY

28. Describe the injury and the part of the body injured.
29. **Was this a first-aid only injury:** ☐ Yes ☐ No
30. Any Lost Time? ☐ Yes ☐ No
If yes, date disability began
Last date paid in full:
31. Employee returned to work? ☐ Yes ☐ No
If yes, date
Medical Only Incident: Yes ☐ No ☐
32. Did injury result in death? ☐ Yes ☐ No
If yes, date of death.
33. Name and address of Physician:
34. Name and address of Hospital:
Remained Overnight ☐ Yes ☐ No

INS

35. Insurance Company Named on Workers' Compensation Policy
Name in full: _____
Policy No.
35A. Claim Administrator
Company Name _____
Phone Number
Signed by:
Employer or Representative | Title | Date

Equal Opportunity is the Law

Vermont State Employee's Workers' Compensation Incident Report

Claim Number: WC120916 05/02/2012

Reporter

Employee Number: [redacted]
Employee Last Name: Chenail
Form completed by: Workers Comp Admini
Name of reporter: Bruce Chenail

Employee

Employee Number: 16447000
Employee Last Name: Chenail
Position No./Job Title: 000 16447000
Social Security Number: ***-**-7731
Email Address: bchenail@state.vt.us
Home Phone: [redacted]
Work Phone: (802)828-0615
Cell Phone: [redacted]
Number of Dependents: 0
Marital Status: Married

Employer

Division: BGS Financial Operations
Supervisor Last Name: Stratton
Supervisor First Name: Lisa
Supervisor Phone: (802)828-0714
Supervisor Email: lisa.stratton@state.vt.us
Did you notify supervisor of injury? Yes
Are you also self-employed? Yes
Is the SOV your only employer? No
Name of other employer(s): Julie's Honeydew Services

Incident

Date of Injury: 05/01/2012
Time of Injury: 08:00
Time Shift Began: 07:00
Date Employer Notified: 05/02/2012
Who was injury reported to? Supervisor
Location of Injury (Postal Code): Montpelier 05633
Did injury occur on employer's premises? Yes
Nature of Injury: Multiple Physical Injuries Only
Body Part(s) Injured: Ears(s)
Additional Body Part information: Ears(s)-right, Facial Bones-right, Hand-left

Was injury gradual? No

Describe the events leading up to the accident or injury:
Came to the realization that I had to test iVOS yet another time

What work process was being performed?
Database testing

How did the injury occur?
I got so frustrated that I hit the right side of my face with my left hand, injuring the hand, my ear, and my cheek bone.

Object causing the injury: None

Machine or tool involved in accident: None
Was it defective? No
Was safety equipment provided? Yes
If yes, was it being used? Yes
Could your employer prevent this type of accident? Yes
If yes, describe how:
Don't make me test iVOS no more

Were you performing usual work duties? Yes
Were other worker(s) injured? Yes
Did you miss time from work other than the date of injury? Yes
Date disability began: 05/02/2012
Have you returned to work?
Date returned to work:
Were there any witnesses to your injury? Yes

Witness

Witness First Name: John
Witness Last Name: Dough
State employee? No
Witness Daytime Phone Number: (802)555-5555
Comment:
He tried to stop me

Medical Treatment

Did you seek treatment for injury?
Is this a report-only (no medical treatment anticipated)?
Physician Name: Dr. Doolittle
Physician Phone Number: (802)888-8888
Emergency Room Treatment? Yes
Overnight In-Patient? Yes
Hospital Name & Address:
CVMC Berlin, VT

VERMONT

www.labor.vermont.gov

Vermont Department of Labor
Workers' Compensation
PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286

Form 10 (rev 9/11)

State File #
Ins. Co. File # WC120916
Date of Injury 05/01/2012

Certificate of Dependency and Concurrent Employment

Employee: Bruce Chenail

Employer: State of Vermont

TO THE EMPLOYEE: This form MUST be completed in every workers' compensation case in which an injured worker has lost time from work as the result of a work-related injury. The form must be completed even when the injured worker has no dependents. The information must be supplied and the form signed by the injured worker. This information is required to determine the employee's right to additional weekly compensation of $10.00 for each dependent child under the age of twenty-one (21) years.

List below your dependent child(ren) up to 21 years old that have not already been declared by your spouse on his/her current workers' compensation claim.**

Name of Dependent	Date of Birth	Relationship

Concurrent employment: If you were working for more than one employer on the date of injury indicated above please provide the following information.**

Name of Employer	Employer's Address	Employer's Phone Number	Date of Hire

I hereby certify that the above is a true, complete and accurate statement of my dependents and concurrent

Employee Signature Date Signed

3020 Gilman Rd
Address

(802)274[redacted]
Telephone Number

Lyndon Center VT 05850
City/State/Zip

**Attach additional sheets if necessary and return this to the insurance carrier

Vermont Office of State Employee Workers' Compensation & Prevention

CLAIM QUESTIONNAIRE

Name: Bruce Chenail Claim#: WC120916 Adjuster: Andrew Leicher

(1.) Division: BGS Financial Operations (2.) Email address: _____

(3.)Supervisor : _____ (4.)Supervisor's phone: _____

(5.) Regular work schedule: S M T W TH F S Hours: _____ (6.) Are you self-employed? Yes No

(7.) Is the State of Vermont your only employer? Yes No

(8.) Additional employer & phone#: _____

NOTE: If you miss time from work due to this injury, any and all income received from any additional employers or self-employment during your period of disability must be reported to your adjuster.

(9.) Name of Primary Care Provider: _____

(10.) How long have you treated with this provider? _____

(11.) Describe in detail the events that led to your injury, including where and how the injury occurred:

_____

_____

_____

_____

_____

_____

(12.) Were there witnesses? Yes No (13.) Name & phone#: _____

(14.) Specific body part(s) injured and symptoms: _____

_____

(15.) Do you still have these symptoms? _____

(16.) List all medical providers who have treated you for this injury: _____

_____

(17.) Have you lost time from work beyond the date of injury? Yes No (18.) Do you have an out of work note? Yes No

(19.) Are you currently working? Yes No (20.) Date you returned to work: _____

(21.) List any prior injuries, symptoms or treatment for the same body part(s), and all treating providers:

_____

_____

(22.) Please list any other medical conditions for which you are treating and all medications you are taking:

_____

_____

_____

(23.) Hobbies and other activities in which you regularly participate: _____

_____

I hereby affirm that the above statements are true:

Signature: _____ Date: _____

DOL FORM 7 (Rev. 1/12)

State of Vermont
Department of Labor Workers' Compensation Division PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286

State File No.: _____

Ins. Co. File No.: WC120916

VERMONT WORKERS' COMPENSATION MEDICAL AUTHORIZATION

NOTE: Title 21 VSA §655a requires all providers to utilize and comply with this medical release authorization form when seeking or providing medical information relative to a workers' compensation claim. Workers Compensation claims are expressly exempted from the terms and provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), *45 CFR 164.512(1).*
A copy of 21 VSA §655a is included with this form (see Page 2 of 2).

TO: **Health Care Provider(s)**
(Physician, Hospital or other medical practitioner)

This, or a photocopy, will authorize you to release to **State of Vermont; Office of State Employee Workers' Compensation and Injury Prevention**
(Department, Insurance Company, or Employer)

at the following address: 6 Baldwin Street, Montpelier, VT 05633-3801

All medical information you may have relating to the treatment or diagnosis of my injury which occurred on or about **05/01/2012**, 20 _____

Medical information relevant to the specific claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part. Information that may be requested includes:

(1) Minimum data to justify services and payment, including that on the standard paper 1500 form or electronic 837 form.

(2) Office notes of the examination relating to the injury diagnosis or treatment.

(3) Any other relevant provider records contained in the file.

Name: **Bruce Chenail**

Date of Birth: [redacted]

Date _____ Signature _____

Title 21: Labor

Chapter 9: EMPLOYER'S LIABILITY AND WORKERS' COMPENSATION

21 V.S.A. § 655a. Release of relevant medical records by health care providers; department to oversee release and use of relevant medical information

§ 655a. Release of relevant medical records by health care providers; department to oversee release and use of relevant medical information

(a) Health care providers examining or attending the examination of an injured worker pursuant to this chapter shall provide relevant medical records and reports as requested by the injured worker, the employer, or the department regarding the diagnosis, condition, or treatment of the worker, permanent impairment, or any restrictions or limitations on the worker's ability to work upon receiving a written medical release authorization from the injured worker. The authorization shall be on a form approved by the department. If the relevance of any medical information is disputed, the department shall determine whether the requested medical information is relevant.

(b) Medical information relevant to the specific claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part. Information that may be requested includes:

(1) Minimum data to justify services and payment, including that on the standard paper 1500 form or electronic 837 form.

(2) Office notes of the examination relating to the injury diagnosis or treatment.

(3) Any other relevant provider records contained in the file.

(c) An injured worker shall only be obligated to sign a medical record release authorization approved by the department.

(d) Any medical information received by the employer or the insurance carrier that is found not to be relevant to the claim may not be used to deny or limit a claim. The commissioner may order that specific disclosure requests be denied or rescinded and may make such other interim orders as are appropriate.

(e) Any medical information received in conjunction with a claim shall be used only for the purpose of advancing or defending a claim relating to the injury or of investigating a claim of false representation or of ensuring compliance with the workers' compensation statutes and rules. (Added 2011, No. 50, § 4.)

EMPLOYEE COPY- PLEASE KEEP FOR YOUR RECORDS DOL FORM 7 (Rev. 1/12)

State of Vermont
Department of Labor Workers' Compensation Division PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286

State File No.: _____

Ins. Co. File No.: WC120916

VERMONT WORKERS' COMPENSATION MEDICAL AUTHORIZATION

NOTE: Title 21 VSA §655a requires all providers to utilize and comply with this medical release authorization form when seeking or providing medical information relative to a workers' compensation claim. Workers Compensation claims are expressly exempted from the terms and provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), *45 CFR 164.512(1).*
A copy of 21 VSA §655a is included with this form (see Page 2 of 2).

TO: **Health Care Provider(s)**
(Physician, Hospital or other medical practitioner)

This, or a photocopy, will authorize you to release to **State of Vermont; Office of State Employee Workers' Compensation and Injury Prevention**
(Department, Insurance Company, or Employer)

at the following address: 6 Baldwin Street, Montpelier, VT 05633-3801

All medical information you may have relating to the treatment or diagnosis of my injury which occurred on or

about **05/01/2012**, 20 _____

Medical information relevant to the specific claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part. Information that may be requested includes:

(1) Minimum data to justify services and payment, including that on the standard paper 1500 form or electronic 837 form.

(2) Office notes of the examination relating to the injury diagnosis or treatment.

(3) Any other relevant provider records contained in the file.

Name: **Bruce Chenail**

Date of Birth: [redacted]

Date _____ Signature _____

Title 21: Labor

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MILEAGE REIMBURSEMENT REQUEST

Please note only mileage beyond the distance normally traveled to the workplace is allowed {WC Rule 12(b)(1)}. In other words, if you regularly commute 25 miles ROUND-TRIP *to work each day, only mileage above that amount will be reimbursed*

Date and Time	Who/Where VISITED (Official Name)	Traveled FROM (City/Town)	Traveled TO (City/Town)	MILEAGE (Round-trip)	Less mileage traveled to the workplace (Round-trip)	Reimbursable mileage

I hereby affirm that all mileage listed above was for travel required for treatment or examination regarding a valid worker's compensation claim.

NAME John Doe WC Claim # WC999999

Home Address _____

Worksite Address _____

SIGNED _____ Dated _____

MODIFIED DUTY AGREEMENT LETTER

Date

Mr. John Doe
PO Box 99999
Sample, VT 999999

Dear :

This document is intended to be a joint agreement between you and the workplace Supervisor [Name], or someone serving as Acting Supervisor. The agreement is intended to provide an appropriate work environment for you during your recovery from a work related injury/illness. The job modifications and workplace accommodations utilize the Vermont State Position Description as the basis for a return to full, unrestricted duties. This agreement was intended to start on [Date], and will be applied for **not more then 90 days**, but may be adjusted for a longer period of time if necessary for additional recovery and upon agreement of all parties. Your inability to perform the essential functions of the regular full duty job due to a work related injury/illness shall not be considered in your performance evaluation while working under this agreement.

Job Activity Modifications:

You are currently assigned to the [Agency or Department & Division], in the job position of [Job Title] . Due to medical limitations associated with your current work related injury you are not able to perform all the Essential Job Functions of your position at this time.

The [Agency or Department & Division] is willing to accommodate you during your recovery by providing this modified duty as follows:

List modified duties being assigned:

Before this Modified Duty assignment is over you will need to supply a medical note from your physician releasing you to full duty with no restrictions.

This is not disciplinary action and should not be construed as such; however, your failure to follow the instructions in this agreement could lead to disciplinary action.

Signatures of Acknowledgement

I have read, understand, and accept this modified assignment. If I have any questions I will notify my supervisor immediately. I also understand that I will need to submit a release from my physician stating that I may return to full duty without restrictions or limitations.

Employee Signature Date

I understand and will support [employee name] modified duty assignment and will monitor his/her progress. I also understand that before the he can return to full duty, [employee name] must submit a release from his Physician.

_____

, Supervisor Date

Cc: Personnel Administrator
Signed copy to employee

EXTENDED MODIFIED DUTY AGREEMENT LETTER

Date

Employee name
Address

Extended Modified Duty Agreement

Dear:

This letter shall serve to function as an Extended Modified Duty Agreement which is intended to provide you with a work environment conducive to your recovery from your work related injuries. Modified Duty Agreements are normally in effect for no more than 30 days but may be extended upon agreement by all parties. Please be advised that your inability to perform the functions of your regular full duty job due to a work related injury shall not be considered in your performance evaluation while working under this Agreement. Please be further advised that job modification agreements and workplace accommodations utilize Vermont State Position Descriptions as the basis for return to full and unrestricted duties (a copy of the Position Description relative to your regularly assigned duties is attached).

As you are aware, you are currently assigned to the _____ in the position of _____ Due to medical limitations associated with your current work-related injury to your _____ however, you are unable to perform the essential functions typically associated with your assigned.

The following **work-related** restrictions pertain to the _____injury:

The aforementioned restrictions relative to your _____ injury shall remain in effect until medical documentation states otherwise.

Please continue to provide me with copies of any medical information (i.e., work restrictions, surgery schedules, medical appointments) related to your work- and non-work-related injuries.

The Extended Modified Duty Assignment is as follows:

Your work day shall begin at _____ and shall end at _____. You shall have an unpaid mid-tour meal break consisting of 30 minutes.

Your temporary duty work hours and days will be _____ (excepting holidays). There may be occasions when your workload at one of the aforementioned duty stations is such that it would be beneficial for you to work at the alternate duty station

Your temporary duties will include, but may not be limited, to the following:

Please be advised that if you are asked to any job which will require the use of your **(injury)** that you must ask for assistance so that you do not use your _____ in a manner that is contrary to the above-described medical restrictions.

You must be supervised at all times to ensure you are working within the parameters of the medical restrictions.

Prior to the conclusion of the Extended Modified Duty Agreement, you may be required to provide a note from your physician that states you may safely resume your regularly assigned duties.

Please be advised that the Extended Modified Duty Agreement does not constitute disciplinary action. Your failure, however, to abide by the Agreement and any related medical restrictions may lead to disciplinary action.

I have read, understand, and agree to abide by this Extended Modified Duty Assignment. I agree to notify my supervisor immediately should I believe that I have been asked to perform any duty that may be outside the parameters of my medical restrictions. I understand that this Extended Modified Duty Agreement shall remain in effect until such time as the Employer notifies me otherwise and/or medical documentation is provided that states I may safely return to full duty. I understand that I may be asked to provide medical documentation relative to my ability to safely perform my regularly-assigned duties and agree to do so.

_____

Employee Signature Date

I understand and agree to support this Extended Modified Duty Assignment. I agree to monitor the progress of the employee. I understand that the employee may not return to his/her regularly assigned duties until medical document is received that states he/she may safely return to his/her regularly assigned duties.

_____

Manager Date

cc: Personnel Administrator
Signed copy to employee

MODIFIED DUTY AGREEMENT HAS EXPIRED LETTER

Date

Employee address

Dear:

After reviewing your latest Work Capability Form submitted by your physician on [Date] , it has been determined you no longer require a modified duty agreement in order to carry out your job duties as a .

As of [Date], you are to return to your normal duties at the [Normal work location]. Please note that the Agency must be notified by your physician should your work capabilities change.

Sincerely,

Supervisor

Cc: Personnel Administrator

tmesys®

Tmesys First Fill Program

tmesys®

INJURED WORKER
PRESCRIPTION CARD

CARRIER
State of Vermont BGS Office of Workers' Compensation

INJURED WORKER NAME

SOCIAL SECURITY NUMBER DATE OF INJURY

Notice to Cardholder: This prescription card should be presented to your pharmacy to receive medication for your injury. For information regarding our program or participating pharmacies in your area contact the Tmesys Injured Worker Information Group at 1.866.599.5426.

Processing Instructions to Pharmacist on back

Single Source Solution for Workers' Compensation

Your workers' compensation claims administrator, State of Vermont BGS Office of Workers' Compensation is providing prescription benefits through Tmesys, an online Pharmacy Benefits Manager.

The attached peel-off Tmesys First Fill Prescription card will make the process of obtaining medications for your injury easier and more convenient. Simply present this card to any of our more than 60,000 participating pharmacies nationwide, including Hawaii and Puerto Rico, and your prescription will be filled at no out-of-pocket expense. Your use of this card is limited to those prescriptions medically related to an injury that is considered to be covered under the applicable state workers' compensation law.

Should you have any questions regarding our program or for the locations of a participating network pharmacy near you, please contact Tmesys at **866.599.5426.**

Sincerely,

Tmesys

HOW TO LOCATE A TMESYS PHARMACY:

1. **Call Tmesys at 866.599.5426.** A Tmesys representative will be more than happy to assist you with the location of a participating pharmacy in your area.
2. **Visit our Pharmacy Locator** in the **Pharmacy Center** on the internet at **www.pmsionline.com.**

tmesys®

PO Box 152539
Tampa, FL 33684-2539
PH: 800.964.2631
FX: 800.774.4111
www.tmesys.com