STATE OF VERMONT
DEPARTMENT OF LABOR

Brian Wiggins

v.

Ben & Jerry's Homemade, Inc.

Opinion No. 03-20WC

By: Beth A. DeBernardi
Administrative Law Judge

For: Michael A. Harrington
Interim Commissioner

State File No. T-20194

OPINION AND ORDER

Hearing held in Montpelier on August 26, 2019
Record closed on December 20, 2019

APPEARANCES:

Ronald A. Fox, Esq., for Claimant
Erin J. Gilmore, Esq., for Defendant

ISSUE PRESENTED:

Does Claimant's current regimen of prescription opioid medications constitute reasonable medical treatment for his June 23, 2003 compensable work injury?

EXHIBITS:

Claimant's Exhibit A:	Medical records from December 2015 through August 2019
Claimant's Exhibit B:	Controlled Substance Treatment Agreements
Defendant's Exhibit 1:	Medical records from June 2003 through October 2019
Defendant's Exhibit 2:	*Curriculum Vitae* of Andrea Wagner, MD
Defendant's Exhibit 3:	Record of Dr. Jeffrey Haddock's Conditioned License
Defendant's Exhibit 4:	Dr. Haddock's Temporary Voluntary Limitation of Practice Agreement dated December 5, 2018

CLAIM:

Medical benefits pursuant to 21 V.S.A. § 640(a)
Costs and attorney fees pursuant to 21 V.S.A. § 678

FINDINGS OF FACT:

1. At all times relevant to these proceedings, Claimant was an employee and Defendant was his employer as those terms are defined in the Vermont Workers' Compensation Act.

2. I take judicial notice of all forms and correspondence in the Department's file relating to this claim.

Claimant's June 2003 Work Injury and Claim for Benefits

3. Claimant is a 45-year-old man who lives in Fairfax, Vermont, with his wife and two children.

4. On June 23, 2003, Claimant was working in Defendant's warehouse. He tried to lift a freight elevator door, but the door was jammed in its tracks. When he forced the door open, he felt a sharp pain in his lower back.

5. Claimant sought immediate medical treatment and was diagnosed with a lumbar strain. He was released to return to work on restricted duty the next day and continued to work for Defendant for five months.

6. Defendant accepted Claimant's injury as compensable and began paying workers' compensation benefits accordingly.

7. In November 2015 the parties entered into a Compromise Agreement (Form 16) and Addendum, which the Commissioner approved on November 13, 2015. The agreement provides for a full and final settlement of all workers' compensation benefits except for medical benefits, which remain open. The Addendum provides in relevant part as follows:

> Within 60 days of the Commissioner's approval of the Form 16 and Addendum, Defendant shall present a plan to Claimant for narcotic rehabilitation. The parties shall work together collaboratively in good faith in order to engage Claimant in this narcotic rehabilitation plan, however the Form 16 and Addendum shall proceed forthwith.

Addendum, para. 9.

8. Despite agreeing to engage in a narcotics rehabilitation plan, Claimant did not do so. Accordingly, on January 16, 2018, Defendant filed a Notice and Application for Hearing (Form 6) on whether he is required to enter into such a program, either pursuant to the Compromise Agreement or pursuant to the statutory provision governing reasonable medical services and Workers' Compensation Rule 12.1720, which requires a safe taper plan for the discontinuance of opioid medications.

Claimant's Medical Course

9. When he was injured in June 2003, Claimant received a prescription for a short-acting opioid pain medication and a physical therapy referral. Over the following weeks and months, he participated in physical therapy and chiropractic treatment.

10. In October 2003 an MRI study identified two herniated discs and a sequestered disc fragment in Claimant's lumbar spine. He began taking OxyContin in addition to his short-acting opioid medication. In November 2003 he saw orthopedic surgeon Warren Rinehart, MD. Dr. Rinehart recommended epidural injections, but they did not provide significant pain relief.

11. In May 2004 Claimant underwent a lumbar disc excision by orthopedic surgeon William Abdu, MD, at Dartmouth-Hitchcock Medical Center. At his five-week follow up appointment, Claimant reported considerable overall improvement. Accordingly, Dr. Abdu implemented a narcotic weaning schedule for Claimant's OxyContin. In September 2004 Dr. Abdu noted that Claimant's spinal symptoms had "completely resolved," with no leg pain or low back pain, and that he had successfully weaned off his opioid medications.

12. In March 2005 Claimant saw rehabilitation physician Mark Bucksbaum, MD. Dr. Bucksbaum placed Claimant at an end medical result for his work injury with a 12 percent whole person impairment. He also prescribed an opioid medication for Claimant's reported back pain flare ups.

13. In June 2006 Claimant reported to Dr. Rinehart that weaning off his OxyContin in 2004 made him sick and left him with sleep-disrupting pain, causing him to feel "upset" and "mean." *Defendant's Exhibit 1*, at 287. Dr. Rinehart recommended physical therapy and an eight-week course with clinical psychologist Neil Jepson. Mr. Jepson reported that Claimant was working full time in property maintenance but was experiencing significant irritability and anxiety.

14. In July 2007 Claimant visited the Spine Institute of New England. The Spine Institute recommended medial branch blocks for his low back pain, but they did not provide significant relief. Claimant continued to take opioid medications prescribed by pain management physician William Roberts, MD. Dr. Roberts prescribed 10 mg of Lorcet twice per day, alternating with 5 mg of Lorcet twice per day, for a total hydrocodone exposure of 30 mg per day.[1]

15. On January 17, 2008, Dr. Roberts noted surprise that Claimant was back for a Lorcet refill, as his prescription should have lasted through the month. Rather than requiring Claimant to bring his medication to the office for a pill count, Dr. Roberts sent him home. *Defendant's Exhibit 1*, at 335. On October 6, 2008, Dr. Roberts noted that Claimant admitted to using the majority of his higher dose opioid pills at the beginning of the month, rather than alternating his 10 mg and 5 mg pills, as prescribed. *Defendant's Exhibit 1,* at 357. They made plans for a narcotics "holiday" in January 2009 to reduce his tolerance, but the holiday never took place.

[1] Lorcet is a combination of hydrocodone and acetaminophen.

Claimant's Treatment with Opioid Pain Medications by Jeffrey Haddock, MD

16. In May 2010 Claimant began treatment with family medicine physician Jeffrey Haddock, MD, at the Thomas Chittenden Health Center. Dr. Haddock prescribed 10 mg of Lorcet every four to six hours, which was twice the daily dose of hydrocodone prescribed by Dr. Roberts. In January 2011 Dr. Haddock added a 25-mcg fentanyl patch to the regimen, but Claimant could not tolerate this medication. Thereafter, Dr. Haddock continued to increase Claimant's opioid medications significantly over time.

17. In March 2014 Dr. Haddock was prescribing 10 mg of oxycodone, one to two tablets every four to six hours *and* 80 mg of OxyContin, two tablets three times per day. He noted: "We have discussed that maybe [Claimant] is getting to a point where he may need to reset his tolerance and while not looking forward to this he recognizes this." *Defendant's Exhibit 1*, at 542. Not only did Dr. Haddock fail to impose a narcotics holiday, however, but in 2015, he increased Claimant's oxycodone tablets to 15 mg.

18. In July 2017 Dr. Haddock noted in Claimant's chart that his morphine equivalent dose (also known as Morphine Milligram Equivalent or MME) was 990 mg per day. *Defendant's Exhibit 1*, at 623. Dr. Haddock continued to prescribe this level of opioid medications through December 2018. The Centers for Disease Control (CDC) considers 50 MME per day a "higher dose" requiring careful reassessment. It further recommends that physicians avoid increasing a patient's dose to 90 MME or carefully justify a decision to do so.[2]

19. In 2018 the Vermont Board of Medical Practice investigated Dr. Haddock. Effective December 5, 2018, the Board and Dr. Haddock entered into a Temporary Voluntary Limitation of Practice Agreement under which Dr. Haddock voluntarily agreed to cease and desist from the prescribing of opioid medications after December 31, 2018 in exchange for the Board's not initiating a summary suspension of his medical license. Dr. Haddock's medical license is currently subject to this condition. *Defendant's Exhibits 3 and 4.*

Claimant's Treatment with Opioid Pain Medications by Pamela Dawson, MD

20. In January 2019 family practice physician Pamela Dawson, MD, took over Claimant's care from her partner, Dr. Haddock. Dr. Dawson continued Claimant's opioid prescriptions at the level prescribed by Dr. Haddock as she reviewed his chart over the next several months.

21. In June 2019 Dr. Dawson began a slow taper of Claimant's opioid medications. In July 2019 she documented an overall reduction from 990 MME to 877.5 MME, a reduction of approximately ten percent.

22. On August 9, 2019, Claimant attended a consultation with the UVM Medical Center's Comprehensive Pain Program. Erin Bingham, the program's nurse practitioner, noted

[2] *CDC Guideline for Prescribing Opioids for Chronic Pain*, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report (March 18, 2016), at 22.

that he did not have increased pain with his recent taper. She endorsed a slow taper of no more than ten percent of his total MME per month, as well as group therapy, acupuncture and yoga.

23. In September 2019 Dr. Dawson tapered Claimant's opioid dose to 798.75 MME per day, a reduction of another ten percent from July 2019.

24. On October 28, 2019, Dr. Dawson noted that she would not further taper Claimant's opioid medications until he continued his involvement with the Comprehensive Pain Program. She noted that he cancelled his first appointment with the program on July 29, 2019 and was a "no show" for his rescheduled appointment on July 31, finally meeting with them on August 9. Dr. Dawson further noted that the pain program had contacted Claimant to complete part two of his intake, but "[h]e has been 'too busy' since he met with them in August to find time to meet with them again." *Defendant's Exhibit 1*, medical record dated October 28, 2019 (emphasis in original).

Claimant's Current Status on Opioid Medications

25. Claimant and his wife have two children, ages 8 and 12, whom they home school. Claimant does significantly less home schooling than his wife but helps the children with math and music. The children also learn through gardening and trips to the ECHO Leahy Center for Lake Champlain and the Discover Jazz Festival.

26. Claimant testified that before he began treatment with Dr. Haddock, he was "real miserable." He had a short temper, trouble sleeping, and difficulty interacting with other people. When Dr. Haddock increased his opioid medications, he was able to sleep better and be more "human" at home. I find this testimony credible.

Expert Medical Opinions as to the Reasonableness of Claimant's Opioid Medications

(a) Andrea Wagner, MD

27. Andrea Wagner, MD, is a board-certified physical medicine and rehabilitation physician. She graduated from the University of Massachusetts Medical School and completed her residency at the Albert Einstein College of Medicine. Dr. Wagner worked as an attending physician at Somerville Hospital for over 30 years and currently has a private practice in physical medicine and rehabilitation in Cambridge.

28. Dr. Wagner's specialty is rehabilitating patients with neurological and musculoskeletal conditions to improve their overall function. Pain management is a chief focus of her practice. She treats a large number of chronic pain patients, with chronic low back pain being the most prevalent condition.

29. At Defendant's request, Dr. Wagner reviewed Claimant's medical records in July 2014 and March 2017. *See Defendant's Exhibit 1*, at 552-72, 614-15. She testified by preservation deposition on September 18, 2019.

30. In Dr. Wagner's opinion, opioid medications are not a reasonable treatment for Claimant's work injury. First, his treatment regimen has not significantly improved his function, as he has not returned to any gainful employment, even at a light level, nor is he otherwise particularly active in his daily life. He also continues to complain of considerable subjective pain. Thus, in her opinion, opioid treatment is not effective for his condition. Second, opioid medications place him at risk for opioid abuse, cognitive impairment, respiratory depression and fatal overdose.

31. More broadly, based on her review of the current medical literature and the CDC guidelines published in the *Journal of the American Medical Association*, Dr. Wagner testified that opioid medications are generally not effective for chronic pain conditions with certain exceptions not applicable to Claimant, like late-stage cancer. Further, she has concluded based on her own clinical experience that the use of opioids for chronic pain is not helpful, either subjectively or objectively.

32. Therefore, in Dr. Wagner's opinion, opioids are not a reasonable medical treatment for Claimant, and he should wean off them following a sound taper plan.

33. As a rehabilitation physician, Dr. Wagner is knowledgeable about pain management and its effect on function. She is also well informed about the serious risks associated with opioid pain medications. Her opinion that opioids are not a reasonable treatment for Claimant's low back pain is based on her medical training, her experience with her own patients, her collaboration on the care of colleagues' patients, and on her understanding of the CDC Guidelines and the current scientific literature. I therefore find her opinion well supported and credible.

34. Finally, in Dr. Wagner's opinion, the tapering and discontinuance of Claimant's opioid medications should be overseen by an addiction medicine specialist, as they are experts in the tapering of opioids in a manner that is safe and comfortable for the patient.

(b) Pamela Dawson, MD

35. Dr. Dawson is Claimant's current treating physician. She graduated from McGill University Medical School and completed her residency in family medicine in 1998. She currently practices family medicine at the Thomas Chittenden Health Center in Williston. Dr. Dawson testified by preservation deposition on September 18, 2019.

36. Dr. Dawson estimated that ten percent of her patients have chronic pain and that she treats 75 percent of them with opioid medications. In her opinion, opioid treatment is appropriate for Claimant because "[m]any people do not necessarily respond to all the other ways we have to treat chronic pain and therefore need narcotics." *Dawson deposition,* at 25. Further, she testified that opioid medications control Claimant's pain and make him functional. She defined "functional" as having a quality of life that is pleasing to the patient.

37. Dr. Dawson acknowledged that the prescribing of opioid medications has changed over time. In past years, Claimant's opioid regimen might have been considered reasonable, but today his dosage is considered dangerously high. In her opinion, Claimant should taper his dose to the extent he can, at a rate of no more than ten percent per month, as a faster taper might cause psychological and physical decompensation. Dr. Dawson does not think that Claimant will be able to discontinue opioid medications completely, however.

38. Dr. Dawson's opinions are based on her experience as a family practice physician, as well as on her relatively recent treating relationship with Claimant. Based on her experience as an opioid prescriber and her knowledge of Claimant's high dosage, I am persuaded by her opinion that the taper of his opioid medications should proceed slowly. However, I am not persuaded by her opinion that Claimant requires ongoing opioid medications, as she did not address his underlying mechanism of injury, his pain levels, alternative treatments that could replace opioids in his regimen, or the general efficacy of opioid medications for chronic pain. These omissions significantly weaken her opinion.

39. Finally, in Dr. Dawson's opinion, Claimant should taper his opioid medications under her supervision, rather than attending a rehabilitation facility, because he trusts her. Local outpatient tapering would also allow him to attend the Comprehensive Pain Program and receive the continued support of his family during the tapering process.

CONCLUSIONS OF LAW:

1. In workers' compensation cases the claimant has the burden of establishing all facts essential to the rights asserted. *King v. Snide*, 144 Vt. 395, 399 (1984). Once a claim is accepted and benefits are paid, however, the burden shifts to the employer to establish a sufficient basis for terminating compensation. *Merrill v. University of Vermont*, 133 Vt. 101, 105 (1974).

2. Vermont's workers' compensation statute obligates an employer to furnish "reasonable" medical services and supplies to an employee who has suffered a compensable work-related injury. 21 V.S.A. § 640(a). When an employer seeks to discontinue payment for a medical benefit, it has the burden of proving that the treatment at issue is no longer reasonable. *Nelson v. Federal Express Freight*, Opinion No. 19-16WC (November 1, 2016), citing *Richards v. Mack Molding*, Opinion No. 34-07WC (December 11, 2007). A treatment may be unreasonable either because it is not medically necessary or because it is not related to the compensable condition or injury. *Baraw v. F.R. Lafayette, Inc*., Opinion No. 01-10WC (January 20, 2010); *Brodeur v. Energizer Battery Mfg, Inc.,* Opinion No. 06-14WC (April 2, 2014).

Applicability of Workers' Compensation Rules 11.1400 and 12.1730

3. In 2015 the Vermont Department of Health (VDOH) promulgated its first rule governing the prescribing of opioids for chronic pain. Effective July 1, 2017, the rule

was amended to encompass both acute and chronic pain.[3] The VDOH Opioid Rule established various "best practices" for opioid prescribers, including a mandatory risk assessment, consideration of non-opioid alternatives, patient compliance testing, and consultations with appropriate specialists. *Id.*

4. In 2016 this Department incorporated the VDOH Opioid Rule as its best practices guideline for determining the reasonableness of treatment in the workers' compensation context. *See Workers' Compensation Rules 11.1400 and 12.1730.* These rule amendments created a rebuttable presumption that opioid medications as prescribed are not reasonable medical treatment if the prescribing physician has failed to comply with the VDOH Opioid Rule. In such cases, the injured worker shall have the burden of proving that the treatment is reasonable notwithstanding the prescribing provider's failure to comply. *See id.*

5. Claimant here was injured in 2003, well before the rule amendments were adopted. Accordingly, I must determine whether the amendments apply to his claim.

6. Vermont law provides that the amendment of a statutory provision "shall not affect any right, privilege, obligation, or liability acquired, accrued, or incurred" prior to the amendment's effective date. 1 V.S.A. § 214(b)(2); *see also Myott v. Myott,* 149 Vt. 573, 575-76 (1988). This general rule of statutory construction prohibits legislative amendments that affect substantive rights and responsibilities from being applied retroactively.[4]

7. In contrast, amendments that are solely procedural can be given retroactive effect. *See, e.g., Agency of Natural Resources v. Towns*, 173 Vt. 552, 555 (2001); *Myott,* 149 Vt. at 575-76. Generally, provisions are procedural in nature if they "control only the method of obtaining redress or enforcement of rights and do not involve the creation of duties, rights, and obligations." *Smiley v. State of Vermont,* 2015 VT 42, ¶ 18.

8. Our Supreme Court has applied this well-established rule of statutory construction to workers' compensation claims. For example, in *Montgomery v. Brinver Corp.*, 142 Vt. 461, 463 (1983), the Court ruled that "[t]he right to compensation for an injury under the Workmen's Compensation Act is governed by the law in force at the time of occurrence of such injury." Later, in *Sanz v. Douglas Collins Construction*, 2006 VT 102, the Court clarified what constitutes the "right to compensation" in the *Montgomery* context. A post-injury statutory amendment that "fundamentally changes the right to benefits or the obligation to pay those benefits," it declared, is substantive, and cannot be applied retroactively. An amendment that does not fundamentally change pre-existing rights and responsibilities is procedural, and can be applied retroactively in a pending action. *Id.* at ¶ 12.

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[3] *Rule Governing the Prescribing of Opioids for Pain*, Code of Vermont Rules 13-140-076. The VDOH updated the rule effective March 1, 2019.
https://www.healthvermont.gov/sites/default/files/documents/pdf/REG_opioids-prescribing-for-pain.pdf

[4] This rule of construction applies equally to rule amendments. *Smiley v. State of Vermont,* 2015 VT 42, ¶ 16.

9. Specifically, in the *Sanz* case, the Court considered an amendment to the Vermont Workers' Compensation Act that allowed payment of an injured worker's permanent total disability benefits in a lump sum without the employer's consent. The *Sanz* claimant, who was injured two years prior to the amendment's adoption, sought such a payment. The Court held that the change in the method of payment alone substantially affected an injured worker's right to compensation and an employer's obligation to pay it. Therefore, the amendment was substantive and not retroactive. 2006 VT 102, ¶ 13. *See also Ford Motor Credit Co. v. Welch,* 2004 VT 94, ¶ 14 (addition of a rebuttable presumption rule to secured party transactions held substantive); *Bergeron v. City of Burlington,* Opinion No. 14-18WC (October 15, 2018) (amendment to workers' compensation act adopting presumption that post-traumatic stress disorder in first responders was incurred in the line of duty held substantive).

10. The VDOH Opioid Rule includes numerous prescribing requirements, all of which must be strictly met and carefully documented. *See* Conclusion of Law No. 3 *supra*. By itself, the incorporation of this rule into the workers' compensation scheme is a significant change. Further, the amendment's rebuttable presumption operates to shift the burden of proof to the injured worker when the treating prescriber fails to comply with the VDOH Opioid Rule. This burden shifting provision substantially affects the legal analysis of an injured worker's entitlement to medical treatment. As such, the amendments go beyond merely specifying the procedural steps an injured worker must take to establish entitlement to a particular medical treatment.

11. Applying the Court's analysis in *Sanz*, I conclude that the November 2016 amendments to Workers' Compensation Rules 11.1400 and 12.1730 affect an injured worker's entitlement to benefits and an employer's obligation to pay them. Thus, the amendments are substantive and may not be applied retroactively. Accordingly, Defendant here retains the burden of proof on the discontinuance of Claimant's opioid medications.

Reasonableness of Prescription Opioid Medications as Treatment for Claimant's Work Injury

12. The parties have offered conflicting expert medical opinions as to the reasonableness of prescription opioid medications for treatment of Claimant's work injury. In such cases, the commissioner traditionally uses a five-part test to determine which expert's opinion is the most persuasive: (1) the nature of treatment and the length of time there has been a patient-provider relationship; (2) whether the expert examined all pertinent records; (3) the clarity, thoroughness and objective support underlying the opinion; (4) the comprehensiveness of the evaluation; and (5) the qualifications of the experts, including training and experience. *Geiger v. Hawk Mountain Inn*, Opinion No. 37-03WC (September 17, 2003).

13. Relying primarily on the third and fifth factors, I find Dr. Wagner's opinion the most persuasive. As a rehabilitation physician, Dr. Wagner has significant experience working with injured patients to improve their condition and function. She is also well versed in the latest scientific literature on the prescribing of opioids for chronic pain. Further, her opinion that opioid medications are not an appropriate treatment for

Claimant is supported by her understanding that his pain is not sufficiently controlled by these medications to allow him to work even light duty or otherwise participate more actively in his life. In contrast, Dr. Dawson based her opinion on her assumption that Claimant probably cannot discontinue his opioid medications. However, she did not explain the basis for her assumption, nor did she explain the efficacy of opioid medications as a treatment for his chronic pain.

14. I therefore conclude that opioid medications are not a reasonable medical treatment for Claimant's June 2003 compensable work injury.

The Vermont Workers' Compensation Rules on Opioid Discontinuance

15. Workers' Compensation Rule 12.1720 provides:

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

16. In turn, Workers' Compensation Rule 12.1730 provides in pertinent part:

> [T]he Commissioner shall not approve a proposed discontinuance under this Rule unless credible medical evidence establishes that the effective date thereof comports with a safe taper plan as required by Rule 12.1720.

17. Defendant has not proposed a discontinuance date for Claimant's opioid medications, as required by Workers' Compensation Rule 12.1720. Although Claimant's opioid regime is not reasonable treatment for his work injury, the treatment cannot be discontinued until Defendant proposes a safe taper plan and a discontinuance date that comports with the plan. When Defendant submits those two items, the Department will review them and take appropriate action.

18. Defendant has offered to send Claimant to an out-of-state narcotics rehabilitation program. Claimant prefers to taper his opioids on an outpatient basis under Dr. Dawson's supervision. Both parties offered evidence on the reasonableness of their preferred plans. *See* Finding of Fact Nos. 34 and 39 *supra*. However, it is not my role to order an injured worker to undergo any particular medical treatment. Having found Claimant's opioid medications unreasonable, my role is to determine when Defendant may discontinue paying for them. Claimant may avail himself of one of the programs offered by Defendant, or he may taper his medications under Dr. Dawson's supervision. Whatever he decides, he should be mindful that Defendant will no longer pay for his medications after the approved discontinuance date.

19. Not every patient responds to the discontinuance of medications in the same way. Thus, in fashioning a safe taper plan and proposed discontinuance date, employers and their insurance carriers must be mindful of the injured worker's specific medical

history and circumstances and should build a reasonable amount of flexibility into the taper plan and the discontinuance date.[5]

Conclusion

20. I conclude that Claimant's current regimen of opioid medications is not a reasonable treatment for his June 2003 work-related injury. Defendant has therefore sustained its burden of proof that it is not liable under 21 V.S.A. § 640(a) to continue to pay for these medications.

21. Before the medications may be discontinued, however, Defendant must submit a proposed discontinuance date and credible medical evidence that the proposed date comports with a safe taper plan.

22. As Claimant has not prevailed on his claim for benefits, he is not entitled to an award of costs and attorney fees.

ORDER:

Based on the foregoing Findings of Fact and Conclusions of Law:

1. Claimant's claim for workers' compensation medical benefits under 21 V.S.A. § 640(a) to cover his prescription opioid medications is **DENIED**;

2. Before Defendant may discontinue payment for those medications, however, it must obtain approval of a proposed discontinuance date, as provided in Workers' Compensation Rules 12.1720 and 12.1730.

DATED at Montpelier, Vermont this 11th day of February 2020.

_____
Michael A. Harrington
Interim Commissioner

[5] When an employer or insurance carrier submits a taper plan and a proposed discontinuance date to the Department, it cannot know in advance how long the approval process will take. If the proposed discontinuance goes to formal hearing, for example, the proposed date might pass before a decision is rendered. Thus, an employer or carrier may specify the proposed discontinuance date as a specific number of days into the future after the discontinuance is approved, rather than specifying a date certain.