

INVESTIGATING THE CLAIM

Index

[Reports of Injury/Determining Compensability](#) [Denials](#)

OVERVIEW:

This section outlines the insurer's obligations when a claim for compensation has been filed, and discusses some problems involving denials. The adjuster has an obligation to promptly investigate a claim to determine, within 21 days of notice to the employer, whether the claim is compensable and whether benefits are due. The Department recommends that initial contact with an injured worker be by letter. The Department has developed an outline ([Initial Contact Letter](#)), which provides guidance that may make the investigation and life of the claim run more smoothly. When a claim is denied, whether in whole or in part, the adjuster must notify the injured worker and the Department via a Form 2 denial and must attach evidence, such as medical records or other evidence, providing reasonable support for its position..

REPORTS OF INJURY/DETERMINING COMPENSABILITY:

An employer is required to file an Employer's First Report of Injury (Form 1) within 72 hours of receiving notice or knowledge of an injury (Sundays and legal holidays excluded). First Reports of Injury must be filed via the Electronic Data Initiative, as required by [21 VSA §660a](#). The statute specifies that all injuries that require medical attention or cause an absence from work of one day or more **must** be reported [[see 21 V.S.A §656\(a\)](#)]. The Department will accept the report only from the employer's insurer, with the exception of first aid only injuries [[21 VSA§640\(e\)](#)].

The filing of a First Report of Injury does **not** mean that the claim is accepted. The employer should be reassured that the filing of the Form 1 is a statutory obligation. The injured worker still has the burden of proof of establishing his or her claim.

An injury is defined as any harmful work-related change in the body, whether occurring instantaneously or gradually. The term also includes damage to and the cost of replacement of prosthetic devices, hearing aids and eyeglasses when the damage or need for replacement results from an incident arising out of and in the course of employment. The Department has interpreted the term “personal injury” to include a mental injury. The two types of mental injury claims recognized under Vermont’s Workers’ Compensation Act are “physical-mental” and “mental-mental” claims.

A **physical-mental claim** is a claim that one’s work-related physical condition led to a psychological problem. It is an injured worker’s burden to prove a causal connection between the two. *Blais v. Church of Jesus Christ of Latter Day Saints*, *Opinion* No. 30-99WC (September 28 and July 30, 1999).

A **mental-mental claim** does not involve any work-related physical injury at all. Instead the claim is that work-related stress or emotional injury arose out of and in the course of employment. An injured worker must meet a higher standard of proof in order for a mental-mental claim to be found compensable by demonstrating the following:

- A. Some condition of work created an actual stressful situation. This need not be sudden or immediate but may take place over a period of time (gradual onset); it cannot be a reaction to normal employment events such as a job transfer, disciplinary action or job termination; and the stressful situation must actually exist and not merely be the injured worker’s subjective impression or perception;
- B. The work situation was the proximate cause of the mental injury rather than some other stress in the injured worker’s life (e.g., divorce, financial ruin, legal problems, family illness or death, etc.); and
- C. The stress created by the work situation was greater than the day-to-day stress and tensions which all employees must experience and/or greater than that experienced by employees in a similar occupation.

NOTE: Stress from bona fide personnel actions, such as transfers or disciplinary action is not compensable. *Wilson v. Quechee Landowners Assoc.*, Opinion No. 9-87WC (November 4, 1987); *Crosby v. City of Burlington*, Opinion No. 43-99WC (December 3, 1999).

If an employer fails or refuses to file a First Report of Injury, the injured worker may file a Notice of Injury and Claim for Compensation (Form 5). The filing of a Form 5 does not relieve the employer of its responsibility to file a First Report of Injury (Form 1). Upon receipt of a Form 5, Department staff will put all parties on notice of the injury in writing.

The injured worker making a claim for compensation must notify the employer within six months of the date of injury. An injured worker who fails to give notice or to make a claim within six months may still pursue a claim if sufficient evidence is presented that the employer had knowledge of the injury or that the employer is not prejudiced by the delay. An injured worker cannot, however, initiate a claim more than three years from the date of injury.

A personal injury need not be instantaneous to be compensable as a work-related injury under Vermont's Workers' Compensation Act. It can be an injury that occurs over a period of time. For example, consider a machinist who has performed the same duties for several years with some pain and numbness in his hands and wrists. The pain steadily worsens to the point that he seeks medical treatment. The doctor takes a history and determines that the symptoms are directly related to injured worker's machinist duties. The "date of injury" is "the point in time when the injury and its relationship to the employment is reasonably discoverable and apparent." In the above example, the date of injury would be the date when the injured worker's doctor first determined that his symptoms were causally related to his work.

If the insurer commences payment of a claim on a voluntary without prejudice basis (without accepting or denying the claim) the adjuster **MUST** notify both the Department and the injured worker in writing. If the claim is ultimately discontinued, the injured worker may appeal the discontinuance and proceed through the informal process.

Notice of an injury begins with the employer: the adjuster has 21 days from receipt of the notice of injury to accept or deny the claim. If within that 21-day period the insurer, despite good faith efforts, cannot determine whether compensation is due, an **extension** may be requested. The request for an extension must be made to the Department in writing. In the request, the adjuster must specify the reason(s) why the extension is needed. The request must be copied to the injured worker and received by the Department **prior to the end** of the 21-day limit. If the Department grants an extension it is routinely for an additional 21-day period, unless stated otherwise.

Upon notice of a claim, the adjuster should immediately send out an initial contact letter (see [Initial Contact Letter](#)) to the injured worker with an explanation of benefits. The adjuster should also request that the injured worker provide a Workers' Compensation Medical Authorization (Form 7) for the release of all relevant medical records. Medical records relating to prior injuries or pre-existing conditions may be requested if they are relevant to the injury for which benefits are being claimed. If the injured worker refuses to provide a medical authorization, the insurer may deny the claim for benefits.

NOTE: We recommend that to the extent possible the insurer request that the employer have the injured worker sign a Form 7 as soon as the injury is reported to it. The employer can then fax or send the Form 7 to the insurer to expedite the receipt of medical records.

Having received notice or knowledge of an injury, the employer must promptly investigate and determine whether or not compensation is due. In all cases in which the injured worker is alleged to have been disabled from working for at least three calendar days as a result of his or her injury the employer shall complete and file a Certificate of Dependency and Concurrent Employment (Form 10) and a Wage Statement (Form 25) with the Department. (For information on how to calculate an injured worker's average weekly wage and compensation rate, see Rule. 15.0000).

A Wage Statement (Form 25) must be filed regardless of whether or not the claim has been accepted.

If a lost time claim is determined to be compensable, an Agreement for Temporary Compensation (Form 32) must be completed and signed by both

parties (the injured worker and the adjuster). The adjuster then sends the Form 32 to the Department for review and approval. Compensation must be paid pending review and approval by the Department.

DENIALS:

If the adjuster determines that no compensation is due, within the 21-day time frame following notice of the injury to the employer he or she must notify **both** the injured worker and the Department in writing. A Form 2 (Denial of Workers' Compensation Benefits by Employer or Insurer) must be submitted when a claim is being denied, with evidence attached that reasonably supports the denial.

Form 2 Denial Examples:

- 1. A Form 2 denial from the insurer filed with NO EVIDENCE attached will be rejected.** A letter or explanation from the insurer does not constitute evidence. The adjuster **must** provide documentation and/or other evidence supporting the denial.
- 2. A Form 2 denial from the insurer stating that the injury did not arise out of and in the course of employment.** If the adjuster denies a claim because the injury occurred at home and not at work, the adjuster must submit **proof** supporting the denial. The proof may consist of medical records documenting the injury at home or other evidence. The denial must support the conclusion that the injury did not “arise out of and in the course of employment.” Any evidence that is relied upon for the denial must be attached.
- 3. A Form 2 denial from the insurer stating that there is no medical evidence to support a work-related injury.** A denial issued on this basis requires further evidence and explanation. If the medical records have been requested, but not yet received or if the injured worker has not signed or returned the medical authorization the adjuster must provide a copy of his or her letter documenting the request. If the medical records that are available do not support the claim, that medical evidence must be attached to the denial. **If a claim is denied on these grounds, the adjuster must revisit**

notify both the injured worker and the Department of his or her decision.

4. **A Form 2 denial from the insurer stating that the claim is denied on the basis that the injured worker has a pre-existing, non-work related condition.** If an injury at work or a work condition has accelerated or hastened the pre-existing condition, it will be found compensable. In order to support a denial on this basis the insurer must submit medical evidence that supports its position. Please review the section in this manual on aggravation versus recurrence for more information.