

DISPUTE RESOLUTION - INFORMAL RESOLUTION PROCESS (Rule 6.0000)

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OVERVIEW:

Dispute prevention and resolution constitutes the major component of the work of the Workers' Compensation Division. Disputes may include, but are not limited to: compensability of a claim, in whole or in part; calculation of the compensation rate; correct impairment; reasonableness and necessity of medical treatment; and vocational rehabilitation.

The dispute resolution process begins upon receipt of a Notice and Application for Hearing (Form 6), or comparable written notice, from the injured worker or the insurance adjuster, or their legal representatives, and in some instances, a medical provider.

PURPOSE OF THE INFORMAL RESOLUTION PROCESS: To identify and discuss disputed issues in an attempt to resolve the dispute(s). It's an opportunity for the parties to ensure they have complete information, clear up any misunderstandings or miscommunication involving factual issues and allow the parties to identify the specific evidence they are relying on to support their respective positions. Evidence may include, but is not limited to, specific medical records, a medical opinion, witness statements, affidavits, reference to specific law or rule, or reference to prior hearing decisions by the Commissioner or the Vermont Supreme Court that may be applicable and set precedent on the particular issues in dispute.

ROLE OF THE SPECIALIST: To review the evidence submitted by the parties and make a determination as to whether the insurer is responsible for payment of workers' compensation benefits under the Vermont's Workers'

Compensation Act. This office does not request medical records from medical providers. **It is the parties' responsibility to identify the issues, and identify and provide the evidence they rely upon.** The Specialist will take one or more of the following steps to address a hearing request based on the evidence presented and the information already on file with the Department:

- schedule an informal telephone conference;
- request that additional information be submitted before scheduling an informal telephone conference;
- make a recommendation to the insurer to pay benefits and set a deadline for response;
- issue an Interim Order requiring an insurer to pay benefits at any time before, during or after an informal conference.
- schedule additional conferences if it appears additional conferences may lead to the resolution of the dispute;
- send the parties a letter briefly outlining the results of the conference and the Specialists decision based on the information that was available at the time of each conference held; which may include upholding the insurer's position or issuing an Interim Order requiring payment of benefits in whole or in part.
- refer the matter to the formal hearing docket if it is apparent that no progress towards resolution is likely at the informal level.

STANDARDS OF REVIEW AT THE INFORMAL LEVEL: There are two standards of review at the informal level, identified below. The standard of review applied depends on:

- the date of injury;
- if the dispute involves a denial of the entire claim;
- if the dispute involves a denial of a particular benefit;
- if the dispute involves a denial of a medical provider's request for preauthorization;
- if the dispute involves a discontinuance of a benefit that the insurer had previously accepted and paid.

Reasonable support standard is applied to a denial of an entire claim, a denial of a particular benefit or to a Form 27 (Notice of Intention to Discontinue Payments) in cases having a date of injury prior to 6/1/10. Pursuant to [21 VSA §601\(24\)](#), "reasonable support" means "Evidence that reasonably supports an action", which in turn is defined as "relevant evidence" that a reasonable mind might accept as adequate to support a conclusion that must be based on the record as a whole, and take into account whatever in the record fairly detracts from its weight."

Preponderance of the evidence standard is applied to the denial of a medical provider's request for preauthorization in all cases, regardless of the date of injury, and to Form 27 (Notice of Intention to Discontinue Payments) in cases having a date of injury June 1, 2010 and after. The burden of proof the injured worker has to meet is a **preponderance of the evidence**. **This means** the inference from the facts in the case must be **the more probable hypothesis**. *Burton v. Holden & Martin Lumber Co.*, 112 Vt. 17 (1941). In *Wheeler v. Central Vermont Medical Center*, 155 Vt. 85, 94 (1990), the court equated the preponderance standard with "more likely than not", which is essentially what "the more probable hypothesis means."

The evidence is extremely crucial to a determination as to liability for benefits. Evidence may include, but is not limited to, medical documentation, witness statements and/or statements of how the injury occurred from the injured worker and/or the employer. The injured worker has the burden of proof to show entitlement to a benefit and the insurer has the burden of proof to discontinue a benefit.

The basic difference between the reasonable support standard and the preponderance of evidence standard is when the evidence weighs equally in favor of the injured worker and the insurer. Applying the reasonable support standard would result in a determination that favors the insurer, whereas applying the preponderance of the evidence standard the determination would be in favor of the injured worker.

REPRESENTATION: The parties are not required to be represented during the informal resolution process but may choose to be. It is entirely the decision of the injured worker and the insurance adjuster to retain counsel. **The Department does not represent the injured worker, the**

employer or the insurer. Experience has shown that disputes can often be resolved informally without the involvement or the expense of having legal representation. If a claim proceeds to formal hearing the insurer **must** have legal representation, whereas the injured worker does not need to be represented but it is recommended.

DIFFERENCE BETWEEN THE INFORMAL PROCESS AND FORMAL HEARING: The informal conference is conducted over the telephone and is not recorded. The formal hearing requires in-person attendance of the parties, or their legal representatives. During the informal conference, the parties are not placed under oath and verbal testimony of witnesses and medical experts is not taken. The formal hearing is recorded, the parties' testimony is under oath, witnesses and experts testify and are cross-examined.

INTERIM ORDERS are governed by [21 VSA §662\(b\)](#) and are in effect from the date of issuance until a Stay of the Interim Order is granted or a hearing decision is rendered.

NOTE: The insurer is not precluded from filing a Form 27 (Notice of Intention to Discontinue Payments) in accordance with [21 VSA §643a](#) and Rule 18.0000 after an Interim Order is issued as long as the request is for a reason that is different from the issue addressed in the Interim Order. For example, the order was issued based on the issue of compensability and required payment of medical benefits and temporary total disability. Subsequent to the Interim Order being issued, the insurer received medical evidence supporting the injured worker has reached medical end result. The insurer may file a Form 27 to discontinue payment of the ordered temporary total disability compensation but it would continue to be responsible for ordered medical benefits.

SETTLEMENT OR MEDIATION: At any time in the dispute resolution process, the parties may attempt to resolve the dispute through settlement negotiation. This office does not get involved in settlement negotiation but if the parties do reach a settlement agreement, the agreement is subject to the Division Director's review and approval. We strongly recommend that the adjuster and the injured worker have any settlement agreement reviewed by an attorney **BEFORE** signing it. Once the settlement

agreement is signed by both parties and approved by the Director, it becomes a legal binding contract and absent fraud or material mistake of fact the parties shall be deemed to have waived their right to contest its material portions. Rule 17.0000.

Additionally, Rule 27.0000 allows the parties to agree voluntarily to mediate the dispute at any time in the dispute resolution process. It also gives the Department the authority to order the parties to participate in mediation under Rule 27.3300.

ADDITIONAL NOTES:

Wage calculation disputes can be avoided by the adjuster completing and submitting to the Department all of the following required, applicable forms: Certificate of Dependency (Form 10), Wage Statement (Form 25), Agreement for Compensation (Form 32), and Agreement for Permanent Partial Disability Compensation (Form 22). Upon receipt of these forms a Specialist I will review them for accuracy.

Pre-existing injuries - The adjuster should provide the injured worker with a Medical Authorization (Form 7) to sign that will allow the insurer (or its legal representative) to obtain copies of the relevant pre-existing treatment records. In reviewing the claim for compensability, you should BE AWARE of the well-established principal that a pre-existing condition does not bar recovery where an accident at work aggravates, accelerates or combines with it to produce a greater disability than otherwise would have resulted. *Jackson v. True Temper*, 151 Vt. 592 (1989).

Where a claim dispute involves ONLY employer and/or insurer liability issues. [21 VSA §662\(c\)](#) puts the burden on the most recent employer and/or insurer to prove another employer's or insurer's liability. When an employer/insurer liability dispute arises, the Specialist, after notice to interested parties and a review of the claim, but in no event later than 30 days, shall order that payments be made by one employer or insurer until a hearing is held and a decision is rendered. In addition, the Specialist may order the employers/insurers to arbitrate the employer/insurer liability dispute. [21 VSA §662\(e\)](#), Rule 8.0000.

If an employer/insurer is paying benefits and wishes to assert liability against a subsequent employer/insurer, we recommend the current employer/insurer continue to pay benefits and submit a request to the Department, copied to the injured worker, requesting the Department place the subsequent employer/insurer on notice of possible liability under [21 VSA §662\(c\)](#). If the employer/insurer intends to deny liability for a claim based on the position that a prior employer/insurer is responsible, we recommend the current employer/insurer voluntarily begin paying benefits on a without prejudice basis and submit a request to the Department that it place the former employer/insurer on notice of possible liability under [21 VSA §662\(c\)](#). ALL REQUESTS asserting liability against another employer and/or insurer MUST identify and include the evidence relied upon to support its position that the liability for the injury is with another employer and/or insurer.