COMMONWEALTH OF MASSACHUSETTS

DEPARTMENT OF INDUSTRIAL ACCIDENTS **BOARD NO. 028059-97**

Thomas F. Chalifoux	Employee
United Parcel Service	Employer
Liberty Mutual Insurance Co.	Insurer

REVIEWING BOARD DECISION
(Judges Wilson, McCarthy and Smith)

APPEARANCES
Michelle K. Manners, Esq., for the employee
Patricia M. Vachereau, Esq., for the insurer

WILSON, J. The employee, who appeals from an administrative judge's denial of his claim for penalties under §14(1), contends that the insurer unreasonably defended the claim. Finding no error, we affirm the decision.

The case was submitted to the administrative judge on an agreed statement of facts. Thomas Chalifoux, a package truck driver for UPS, reported to his supervisor on July 31, 1997 that he had injured his hip. The employer forwarded a First Report of Injury form to its insurer on August 1, 1997. That same day the insurer's adjuster called the employee's home, but the employee was unavailable, and the adjuster spoke with his wife about the claim. On August 4, 1997, the insurer contacted the office of the employee's physician, Dr. Lobovits, and was informed that on August 1 the doctor had seen the employee but the dictation was not yet prepared. (Dec. 2.) The insurer requested that the information be sent to it when complete. On August 5, an insurer representative met with the employee and received a signed authorization to obtain information. The insurer again contacted Dr. Lobovits' office on August 7, but was unable to get any additional information. On or about the same day, the insurer completed an Insurer's Notification of Denial form and forwarded it to the employee. (Dec. 3) The denial specified:

A. No Personal Injury. Witnesses and documents dispute that the employee sustained an injury.
B. No Injury Arising Out of and in the Course of Employment. Injury was not caused by an incident of the employment.
C. No Disability. No medical reports have been received to substantiate a disability.
D. No Causal Relation Between Personal Injury and Disability. Disability, if any, was caused by a non-employment source.

(Joint Exhibit D.) The insurer once more contacted Dr. Lobovits' office on August 11, 1997, and learned that the employee was to have a bone scan that day. Three days later, the insurer again contacted Dr. Lobovits' office in an attempt to obtain the results of the bone scan, but was told that the report was not yet in. On September 9, 1997, the employee forwarded his claim (Form 110) and the medical reports of his attending physician to the insurer. About two days later, the insurer prepared an Insurer's Notification of Denial (Form 104), listing the same defenses as in its original denial. (Dec. 3, Joint Exhibit H.) The insurer received the results of the employee's bone scan on September 16, 1997, and then scheduled the employee for a medical examination by Dr. John Duff on September 30, 1997. As the employee requested that the examination be rescheduled, it was not held until October 22, 1997. Meanwhile, a conciliation was held on October 8, 1997. Upon receipt of the report of Dr. Duff's examination, the insurer requested an addendum with reference to his opinion on causal relationship, which it received on November 7, 1997. Upon receipt of the addendum, the insurer's adjuster called employee's counsel twice, on November 10, 1997 and November 24, 1997 to review the claim. On or about November 26, 1997, the insurer forwarded to the employee's counsel an agreement to pay compensation, (Dec. 4), which proposed payment of temporary, total incapacity benefits under § 34 from August 1, 1997 through November 2, 1997 at the rate of $513.66, plus a $500 attorney's fee. (Joint Exhibit M.) The employee did not accept the proposed agreement. (Dec. 4.)

A § 10A conference was held before an administrative judge on January 6, 1998, following which an order of payment consistent with the insurer's proposed agreement to pay compensation was awarded, along with a full conference fee. (Dec. 1, 4.) The

administrative judge denied the employee's claim for penalties under §§ 7 and 14. (Dec. 1.) The employee appealed to a hearing *de novo*, at which time the parties waived lay testimony and submitted the case on an agreed statement of facts. (Dec. 2.) The only issues were the penalty claims under §§ 7 and 14, and legal fees under § 13A. (Dec. 1.)

In denying the claim for § 14 penalties at hearing, the administrative judge wrote:

> Not only has the Employee failed to show that the insurer acted in a way to be found "wholly insubstantial, frivolous and not advance[d] in good faith" [Brown v. Massachusetts Correctional Institute-Norfolk, 10 Mass. Workers' Comp. Rep. 58, 60 (1996)], the Employee has failed to show that the insurer's denial was without reasonable grounds. As a result of it's [sic] investigation of the Employee's claim, the insurer had legitimate concerns regarding disability, extent of disability and causal relationship and appropriately issued a denial of the Employee's claim setting forth those defenses . . . .

(Dec. 6.) The administrative judge further found that the insurer had complied with § 7(1) by adequately specifying "the grounds and factual basis for its refusal to commence payment" of compensation, and held that no penalty was warranted.

The employee contends on appeal that he is entitled to double back benefits under § 14(1) because the insurer defended without reasonable grounds. The employee does not directly contest the denial of § 7(1) penalties but, rather, asserts that by violating § 7(1) and the regulations promulgated thereunder in failing to state the factual bases for its denial, the insurer has, by definition, violated § 14. The employee further urges that the lack of good faith requirement articulated by Brown, supra, and invoked by the administrative judge is inappropriate, and that the correct inquiry is whether the insurer acted reasonably in defense of the employee's claim. The employee alleges that the insurer did not act reasonably by withholding benefits to which it knew or should have known the employee was entitled.

Section 14(1) provides in relevant part:

> . . . [I]f any administrative judge or administrative law judge determines that any proceedings have been brought, prosecuted, or defended by an insurer without reasonable grounds:
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> (a) the whole cost of the proceedings shall be assessed upon the insurer; and

> (b) if a subsequent order requires that additional compensation be paid, a penalty of double back benefits of such amount shall be paid by the insurer to the employee[.]

The reviewing board recently revisited the issue of the standard to be applied in determining a § 14 violation and concluded it is a reasonable person standard, i.e., an objective rather than a subjective standard. Gonsalves v. IGS Store Fixtures, Inc., 13 Mass. Workers' Comp. Rep. 21 (1999). Compare Brown v. MCI-Norfolk, 10 Mass. Workers' Comp. Rep. 58 (1996). Nevertheless, "[d]efining 'without reasonable grounds' by an objective standard does not mean that § 14(1) violations will be easy to prove." Gonsalves, supra at 24. The appropriate inquiry is whether the facts available to the actor at the moment would warrant a person of reasonable caution in the belief that the action taken was appropriate. Id., quoting Coblyn v. Kennedy's, Inc., 359 Mass. 319, 325 (1971), in turn quoting Terry v. Ohio, 392 U.S. 1, 21-22 (1968).

In the decision at issue, the administrative judge's findings comport with the objective standard announced in Gonsalves, supra. He made a specific finding that "the employee has failed to show that the insurer's denial was without reasonable grounds." (Dec. 6.) The judge further found that as a result of its initial investigation, the insurer had legitimate concerns regarding disability, extent of disability and causal relationship. Id. The stipulated facts support this conclusion. Immediately after receiving the first report of injury, the insurer made a number of attempts to gain information, which yielded little to no results. It promptly scheduled a medical examination for the employee, which was rescheduled for a later date at the employee's request. Following the examination, it asked for an addendum on the issue of causal relationship. When that was received, it made two attempts to contact the employee's counsel to discuss the case. Within two days after the second conversation, the insurer forwarded a proposed agreement to the employee's counsel containing the same terms as the conference order that issued over a month later. The employee did not accept the proposal. We see no

error in the judge's conclusion that there was nothing unreasonable in the insurer's defense of this claim.[1]

We turn to the employee's primary assertion that an alleged violation of § 7 and the regulations[2] promulgated thereunder constitutes a violation of § 14(1). The employee contends that the operation of 452 Code Mass. Regs. § 1.04, which provides that "no grounds for refusal to pay compensation shall be allowed as a defense unless the insurer's notice of refusal contains a statement of the factual basis supporting such grounds[,]" deprived the insurer of any grounds for defense. We do not agree.

Sections 7 and 14 serve to penalize distinct actions, and a § 7 violation does not necessarily create a § 14(1) violation. Section 7(1) provides in relevant part:

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[1] We have upheld the imposition of § 14(1) sanctions against the insurer where the insurer failed at hearing to introduce any evidence that the employee's disability was not causally related to his employment, MacNeil v. George R. Hall, Inc., 2 Mass. Workers' Comp. Rep. 253 (1988); where the insurer appealed a conference order, but, at hearing "failed to introduce a scintilla of evidence to rebut the employee's claim," Gallagher v. Town of Wellesley, 3 Mass. Workers' Comp. Rep. 29, 31 (1989); where the insurer maintained an appeal to the reviewing board, withdrawing it at oral argument and conceding it did not contest the validity of the claimant's issues on appeal, DiPace v. Ingalls & Cronin, 7 Mass. Workers' Comp. Rep. 125, 126 (1993); where the insurer failed to pay COLA benefits until after the employee filed a claim in violation of § 35F, which mandates payment without application, Graziano v. Polaroid Corp., 9 Mass Workers' Comp. Rep. 729 (1995); Martineau v. Sheaffer Easton/Textron, 11 Mass. Workers' Comp. Rep. 12 (1997). Although we cannot tell whether an objective or subjective standard was applied in all of these cases, certainly the insurer's actions in the instant case do not rise to the level of unreasonableness evinced by the actions of the insurers in the above-cited cases.

[2] 452 Code Mass. § Regs. 1.02 defines "Factual Basis for an Insurer's Refusal to Pay Compensation as used in M.G.L. c. 152, §§ 7 and 8, . . . [as] a short and plain statement of the specific facts supporting the grounds for said refusal."

452 Code Mass. Regs. § 1.04, entitled "Insurer's Notice of Refusal to Pay Compensation", reads in pertinent part:

> Subject to the provisions of M.G.L. c. 152, §§ 7(1) and 8(1), as to newly discovered evidence, no grounds for refusal to pay compensation shall be allowed as a defense unless the insurer's notice of refusal contains a statement of the factual basis supporting such grounds. No ground or factual basis sought to be raised by an insurer on newly discovered evidence shall be allowed as a defense unless the insurer reports each such ground or factual basis to the injured employee and the Department not less than five working days before any conference or hearing. . . .

> Within fourteen days of an insurer's receipt of an employer's first report of injury, or an initial written claim for weekly benefits on a form prescribed by the department, whichever is received first, the insurer shall either commence payment of weekly benefits under this chapter or shall notify the division of administration, the employer, and, by certified mail, the employee of its refusal to commence payment of weekly benefits. The notice shall specify the grounds and factual basis for the refusal to commence payment of said benefits and shall state that if no claim has yet been filed, benefits will not be secured for the alleged injury unless a claim is filed with the department and insurer within any time limits provided under this chapter. Any grounds and basis for noncompensability specified by the insurer shall, unless based upon newly discovered evidence, be the sole basis of the insurer's defense on the issue of compensability in any subsequent proceeding. An insurer's inability to defend on any issue shall not relieve an employee of the burden of proving each element of any case.

Section 7(2) assesses penalties for failing to begin payment or give notice of non-payment, increasing those penalties the longer the violation lasts.

The purpose of § 7(1), which was enacted in 1985, and amended in 1991, is to "deter an insurer from defense of a claim by calculated ambush, from withholding the legal grounds and factual bases for its denial of liability until the eleventh hour." Dennen v. Addison Gilbert Hospital, 5 Mass. Workers' Comp. Rep. 289, 299 (1991). While § 7(1) is intended to motivate the insurer to provide specific reasons for its refusal to pay compensation in a timely manner so that the employee can adequately prepare his or her case, § 14(1) is designed to discourage the insurer from maintaining a posture that has no basis. In summary, § 7(1) is designed to ensure that the employee has notice of the defenses that will be raised, while § 14(1) is intended to discourage the maintenance of defenses without reasonable grounds.

But more to the point, we see no § 7(1) violation in this case. We have held that whether the requirements of § 7 have been met is a question to be determined by looking at the facts of each case. Taylor v. Brockton Hospital, 2 Mass. Workers' Comp. Rep. 304, 310 (1988). We have also held that an insurer response listing liability and causal relationship as grounds for denial of payment was sufficient notice to the employee of the insurer's defenses. Van Nostrand v. Eastern Scale and Packaging Co., 8 Mass. Workers' Comp. Rep. 68, 70 (1994). Here, the administrative judge found that the insurer

conducted an immediate investigation, had issues regarding the claim, and thus properly issued a denial with factual support for the defenses raised. (Dec. 7.) He also found that "the denial . . . was based on available information or lack thereof, at the time such denial was issued . . . ." Id. The stipulated facts reveal that, before issuing its initial denial on August 7, 1997, the insurer made several attempts to obtain information on the injury and medical reports from the employee or his doctors, but was unable either to speak with the employee or to glean any medical information from his physician. Under the circumstances, the insurer cannot be faulted for any lack of specificity in its denial.

The employee seems to argue that the insurer violated § 7 by listing the same defenses in response to the employee's September 9, 1997 claim as were set out in response to the employer's first report. As the insurer had obtained no more definitive information at that point, we see no evidence that the defenses were overinclusive and we find them sufficient to meet the statutory purpose of apprising the employee of the insurer's defenses. See Van Nostrand, supra.

The administrative judge's decision is affirmed.

So ordered.

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Sara Holmes Wilson
Administrative Law Judge

Filed: August 19, 1999

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William A. McCarthy
Administrative Law Judge

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Suzanne E.K. Smith
Administrative Law Judge