BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

FREDERICK "TONY" ASPIAZU, Claimant, v. HOMEDALE TIRE SERVICE, Employer, and SELECT MARKETS INSURANCE COMPANY, Surety, Defendants.	)	**IC 1984-477235** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** Filed January 18, 2012

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Rinda Just, who conducted an expedited hearing in Boise, Idaho, on September 21, 2011. Bradford S. Eidam of Boise represented Claimant. Mark C. Peterson of Boise represented Defendants. The parties submitted oral and documentary evidence, took post-hearing depositions, and filed post-hearing briefs. The undersigned Commissioners have chosen not to adopt the Referee's recommendation and hereby issue their own findings of fact and conclusions of law.

ISSUES

The issues to be decided in this proceeding are:

1. Whether and to what extent Claimant is entitled to medical care;

2. Whether Claimant should be permitted a change of treating physician to Howard Kunz, M.D.; and

3. Whether Claimant is entitled to an award of attorney fees pursuant to Idaho Code § 72-804.

CONTENTIONS OF THE PARTIES

It is undisputed that Claimant suffered a back injury in an industrial accident in 1984. Subsequent to and as a result of the accident, Claimant had six low back surgeries, the last of which occurred in 2009. Despite, or perhaps because of, the multiple spinal surgeries, Claimant has chronic low back pain with radiculopathy. Claimant asserts that the pain is debilitating and has virtually destroyed his quality of life. When Claimant reached medical stability following his 2009 back surgery, Surety terminated coverage of Claimant's workers' compensation claim, leaving Claimant without access to medical care, including payment for prescription medications, access to a physician, or pain management. Claimant contends that he is entitled to designation of a treating physician, compensation for medical care he required after Surety terminated access to his treating physician, and compensation for medications (tramadol, Cymbalta, and Neurontin) prescribed by his treating physician, that Surety refused to cover. Finally, Claimant asserts that Surety's termination of his claim was wrongful and in violation of Idaho Code § 72-432, which requires an employer or a surety to provide medical care that is reasonably necessary as a result of an industrial injury.

Defendants assert that they did not terminate Claimant's workers' compensation claim, but merely denied additional treatment at that time after an independent medical evaluation (IME) determined that, as of November 9, 2009, Claimant had reached medical stability from his last surgery, and that he did not need and should not take prescription pain medication on a long-

term basis. Similarly, Surety argued that Claimant's request for a change of physician was unnecessary, because Surety had provided Claimant with physicians for treatment of his back, but no physician had recommended further treatment, medication, or referral.

Surety argues that it is not obligated to pay for treatment Claimant received from Terry Reilly Health Services or Dr. Kunz, because those providers were outside the chain of referral and Claimant had not sought authorization for or provided notice of his intent to seek care outside the referral chain. Additionally, Surety asserts that Claimant has failed to provide evidence in support of the amount he is owed.

Finally, Surety denies that it unreasonably denied Claimant any medical benefits, because there was no recommended or prescribed treatment for the Surety to provide; therefore, Surety is not liable for attorney fees under Idaho Code § 72-804.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant, taken at hearing;
2. Claimant's Exhibits 1 through 10 and 12 through 19, admitted at hearing;
3. Defendants' Exhibits 4 through 9, admitted at hearing; and
4. Post-hearing depositions of Dr. Cox, taken October 6, 2011, and Dr. Wilson, taken October 13, 2011.

FINDINGS OF FACT

1. In 1984, when Claimant was twenty-two years of age, a fluid-filled tractor tire fell on him, aggravating a pre-existing spondylolisthesis at L5-S1. Surety accepted the claim, and paid benefits, including Claimant's first back surgery in June 1989—an L5-S1 fusion with hardware. Claimant improved after the surgery, but he was never pain free, despite changing to

a lighter-duty job.

2. As the years passed, Claimant's lumbar pain and symptoms increased. In February 1999, Christian Zimmerman, M.D., performed a partial fusion takedown and hardware removal.[1] The hardware removal resolved a part of Claimant's pain, but a dull aching pain remained and worsened.

3. In August 2001, Claimant's original surgeon, Dr. Bishop, performed a laminectomy and decompression of L4-5 with pedicle fixation of L4 and S1, bilaterally, and an L4 to S1 fusion with iliac crest graft and pedicle stable fixation. Claimant re-entered the hospital about ten days after his surgery for repair of a dural leak. Surety paid for the care. Claimant initially had some relief from the 2001 surgery, but by 2006, he was experiencing low back pain and radicular symptoms.

4. After more than two years of conservative treatment, Joseph Verska, M.D., performed a decompression and fusion at L3-4 in late 2008. Surety paid for the care. Claimant's condition did not improve following the fifth surgery; in fact, his pain was worse and more intractable following the surgery.

5. From the date of his injury in 1984, until the day before his surgery with Dr. Verska, Claimant continued to work full time as a fuel truck driver for various companies, with time off for recovery from his surgeries. Following each surgery, Claimant used various prescription pain medications, including opioids, but never for more than a few months. In the spring of 2008, prior to his fifth surgery, Dr. Verska prescribed Norco and Neurontin, and by the time of the surgery, Claimant was also using OxyContin for pain relief.

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[1] Surety initially denied the requested surgery on the basis that the need for the surgery was not causally related to the industrial accident. The Commission determined otherwise in *Aspiazu v. Homedale Tire Service,* 2001 IIC 058 (February 9, 2001).

6. Following the L3-4 fusion by Dr. Verska, Claimant returned to see Paul Montalbano, M.D., who had given Claimant a second opinion prior to his L3-4 fusion. Dr. Montalbano found a pseudoarthrosis at L3-4, and opined that the failed fusion was causing Claimant's increased pain complaints in his low back, groin, and both legs.

7. In preparation for Claimant's contemplated anterior/posterior fusion at L3-4, psychologist Dr. Robert Calhoun conducted a psychological evaluation of Claimant. Dr. Calhoun opined that, based on psychological testing, Claimant was "somatically preoccupied and likely having significant depression and anxiety," exhibited no indication that he was motivated by secondary gain, and was a "reasonable candidate for spine surgery." Defendants' Ex. 4, p. 39.

8. In November 2009, Dr. Montalbano, together with Michael Tullis, M.D., a cardiothoracic and vascular surgeon, performed a complex two-stage surgery to address the pseudoarthrosis. The surgery required both posterior and anterior surgical approaches and included:

- Removing the Stryker instrumentation from L3-S1;
- Redoing the L3 to S1 laminectomy, including bilateral partial L3 to L5 medial facetectomy;
- Performing a bilateral L3-S1 foraminotomy for decompression of an L3-4 to L4-5 posterolateral arthrodesis;
- Performing a complete discectomy at L3-4; and
- Installing L3-S1 instrumentation.

Surety paid for the care. Claimant's left lower extremity pain resolved with Dr. Montalbano's surgery, but he continued to have right lower extremity pain. Following the surgery, Claimant continued taking Zoloft, Oxycodone, OxyContin, and Neurontin.

9. Claimant began physical therapy in late December 2009, and continued with therapy through early March 2010. Claimant showed steady improvement in performing

therapeutic exercises, but continued to complain of low back and right lower extremity pain. In January 2010, Dr. Montalbano suggested adding Cymbalta to aid with residual pain and recommended Claimant wean himself off of the OxyContin.

10. In early March 2010, Dr. Montalbano recommended Claimant for a work-hardening program. Kevin Krafft, M.D., of Boise Physical Medicine and Rehabilitation, (BPM & R) and Dr. Calhoun evaluated Claimant to determine whether he was a suitable candidate for the work-fit program, but found Claimant was not a good candidate because of his reliance on narcotic pain medication and his lack of vocational goals. Dr. Krafft left BPM & R, and gave Claimant the option of following him to his new practice or remaining with the practice and seeing Dr. Cox. Claimant opted to remain at the practice and see Dr. Cox.

11. Claimant returned to Dr. Cox for follow-up in early May, 2010. Dr. Cox noted that Claimant continued to complain of right lower extremity pain, and was taking Neurontin, Cymbalta, Soma, and an anti-inflammatory. Dr. Cox noted that Claimant had discontinued use of OxyContin and hydrocodone. Dr. Cox concluded that since Claimant was not a suitable candidate for work-hardening, there was little to offer him apart from medications. Dr. Cox opined:

> In terms of medication management, he may benefit from a trial of some trazodone to help with sleep. He may also benefit for consideration for some tramadol for pain management in lieu of the hydrocodone. I do feel that it would be reasonable to continue with the Neurontin 600 mg three times a day. Beyond that I do not have much else to offer him.

Claimant's Ex. 9, p. 6. Dr. Cox did write prescriptions for Claimant for Neurontin, Cymbalta, and Ultram (tramadol). Claimant returned to see Dr. Cox in mid-June, and Dr. Cox reiterated that, apart from writing some prescriptions, there was nothing more he could do for Claimant.

12. Claimant believed that he was to schedule a follow-up appointment for six or seven weeks after the June 2010 appointment, and did so before he left the office. Claimant's assertion that Surety cancelled the appointment was not rebutted, though Defendants had the opportunity to depose the claims examiner after the hearing. Claimant attempted to schedule an appointment with Dr. Cox at a later time, but was denied an appointment. Neither would Dr. Cox speak with Claimant on the phone.

13. In November 2010, Claimant participated in a panel IME conducted by Richard Wilson, M.D., and R. Tyler Frizzell, M.D. Drs. Frizzell and Wilson concluded that Claimant was at maximum medical improvement following his November 2009 spinal surgery. They opined that the treatment he had received up to the date of the IME was reasonable. The panel offered no further treatment recommendations, and concluded that Claimant could return to gainful employment in a sedentary to light-duty capacity with a 20 lbs. maximum lifting limit, 10 lbs. on a regular basis. In reaching their conclusions, the panel relied on and referred to Dr. Calhoun's pre- and post-surgical evaluations of Claimant, particularly those related to Claimant's use of narcotic pain medication.

14. When one of Claimant's prescriptions ran out in December 2010, he sought care at Terry Reilly Health Services for his low back pain. Claimant received a prescription for Norco for break-through pain, and amitriptyline for sleep.

15. In January 2011, Surety advised Claimant that "no further medical treatment would be authorized under this claim." Claimant's Ex. 14, p. 1. Claimant, through counsel, requested authorization to see Dr. Cox. Claimant's Ex. 14, p. 2. Surety replied on March 17, 2011, stating: "Therefore, our answer to your request for the claimant to see Dr. Cox, is no, as

he has been found to be at maximum medical improvement with regards to the above industrial injury." *Id.,* p. 8.

16. Surety was uncertain whether the panel intended for Claimant's medication management to continue, and made further inquiries in that regard. In March 2011, Dr. Wilson responded that Claimant "should no longer" require treatment with tramadol, Neurontin or Cymbalta, and should rely on OTC NSAIDs, such as ibuprofen, at doses of 400 to 800 mg. per day. Ex. 4, p. 36. In his deposition, Dr. Wilson testified that he believed that by April of 2011, Claimant should have had sufficient time to wean himself off the remaining medications; however, the original panel report did not include any such recommendation, nor is there any evidence suggesting that Dr. Wilson verbally instructed Claimant to taper his medications.

17. On April 4, 2011, Surety notified Claimant that it would no longer pay for the medications prescribed by Dr. Cox. At the time Surety stopped paying for Claimant's medications, the prescriptions had refills remaining.

18. When Claimant's prescription for tramadol ran out in April 2011, he sought care from his primary care provider, Harold V. Kunz, M.D., at Saltzer Medical Group. Dr. Kunz wrote a new prescription for the tramadol. In September 2011, Dr. Kunz wrote a letter "To Whom It May Concern," concerning Claimant's pain medication management. Dr. Kunz opined that Claimant would have a continuing need for pain management, noting:

> [Claimant] continues to have significant pain that does not respond to non-steroidal anti-inflammatory drugs such as ibuprofen, and he has been taking tramadol as well which does not offer *sufficient* relief from his pain. His condition is not likely to change or improve and he will require long term medications, most likely to include narcotics in dosage and duration that should be managed by a specialist in a pain management clinic.

Claimant's Ex. 12, p. 3 (emphasis added).

DISCUSSION AND FURTHER FINDINGS

MEDICAL CARE

19. At issue is whether Surety is responsible for payment of medical services that Claimant received at Terry Reilly Health Services and from Dr. Kunz and for payment for medications prescribed by Dr. Cox.

20. To provide medical care for a claimant following a compensable industrial injury is at the heart of the obligations an employer or surety undertakes in the Idaho workers' compensation system. Idaho Code § 72-432 (1) requires an employer to provide for an injured employee such reasonable medical, surgical or other attendance or treatment, nurse and hospital service, medicines, crutches and apparatus, as may be required by the employee's physician or needed immediately after an injury or disability from an occupational disease, and for a reasonable time thereafter. If the employer fails to provide the same, the injured employee may do so at the expense of the employer.

21. Defendants argue that Claimant never made a specific request for medical care, that his treating physician concluded that Claimant did not need long-term pain management, and that Defendants never denied Claimant medical care. The record does not support these assertions—it directly contradicts them. Surety cancelled Claimant's appointment with his treating physician, advised Claimant that no further medical treatment would be authorized, denied a written request for Claimant to see his treating physician, and stopped paying for medication prescribed by his treating physician.

Dr. Cox

22. As Claimant's treating physician, Dr. Cox concluded that Claimant required on-going medical pain management. Pursuant to Idaho Code § 72-432 and the case law that has

interpreted this provision, the Commission's role is limited to determining whether the needed care was reasonable. Because the required care is prospective, reasonableness is measured in terms of "whether the proposed care is likely to be efficacious, and is of a type that finds support and acceptance in the medical community." *Richan v. Arlo G. Lott Trucking, Inc.,* 2011 IIC 8, 8.7 (February 7, 2011). Dr. Cox's testimony is convincing on both points.

23. Dr. Cox opined that Claimant "definitely has a painful stimulus in his back" (*Id.*, at p. 38) that was relatable to his underlying grade II spondylolisthesis, which was aggravated by his 1984 industrial injury and led to six back surgeries and chronic low back pain. Dr. Cox discussed at length the reasons that he prescribed tramadol. In doing so, he addressed an issue that had been of particular concern to Drs. Calhoun and Wilson—that any future treatment be based on objective findings, not Claimant's subjective pain complaints. When asked by Defendants if there were objective findings that would warrant ongoing pain medication, Dr. Cox answered in the affirmative. Dr. Cox Deposition, p. 11.

24. Dr. Cox testified that he prescribed tramadol because he believed it was likely that Claimant would be on it long-term, and that if the tramadol, Neurontin and Cymbalta were helpful to Claimant, they constituted reasonable treatment. Dr. Cox explained that in his practice, if a patient needed on-going medical management following acute care, then he would recommend that a primary care physician provide such care. In Claimant's case, that was Dr. Kunz. Dr. Cox stated, "[t]ypically, I don't do the long-term medication management for the workers' compensation patients." Dr. Cox Deposition, p. 18. Dr. Cox was firm in his opinion that Claimant needed on-going medical management for his chronic pain, noting even the long term use of OTC analgesics requires medical monitoring and supervision. Claimant testified that the prescription medications did help his pain. He stated that ibuprofen provided some relief,

that Neurontin, Cymbalta, and tramadol provided additional relief; OxyContin provided the best relief, followed by Norco and related narcotic medications, but Claimant had chosen not to use those drugs on a regular basis.

25. In light of Dr. Cox's testimony, Defendants' assertion that Claimant's treating physician concluded that Claimant did not need long-term pain management (Defendants' Brief, pp. 2, 6, 13) is indefensible. Defendants point out that they were not aware of Dr. Cox's opinion until the post-hearing deposition. There was no bar to Defendants' engaging in a substantive discussion with Dr. Cox at any time before the hearing. Further, Dr. Cox's opinion could hardly have come as a surprise since he wrote the refillable prescriptions based on his opinion that such treatment was reasonable to provide Claimant a modicum respite from his pain.

Dr. Wilson[2]

26. While Dr. Wilson was dismissive of Claimant's pain complaints, referring to Claimant's *perceived* pain or his *subjective complaints* of pain, he utimately agreed that Claimant had both a physiological basis for his pain as well as objective evidence of his pain, and conceded that he had no way of disputing Claimant's pain complaints:

> Q. [By Mr. Eidam] The way I read your note is you believe he has pain?
>
> A. He has pain as his subjective complaint, and he says he has pain, and we have no reason to question that.
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> ***
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> Q. And for [Claimant] there's really no reason to question the fact that he has pain, what's of concern is how he's handling the pain?
>
> A. Right. And to what extent he amplifies his complaints of pain based upon his personality structure and his proclivity to take medication for whatever reason.

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[2] As noted elsewhere, Dr. Wilson was one of two physicians on the panel that evaluated Claimant. Because it is impossible to tease out the individual views of each physician, and because Dr. Wilson was deposed on behalf of the panel, the Commission chose this heading for clarity and brevity.

Dr. Wilson Deposition, p. 26.

27. Dr. Wilson was clear that he disagreed with the treatment proposed by Dr. Cox, and *had he been the treating physician*, he would have treated Claimant differently. But Dr. Wilson ultimately had to agree that Dr. Cox's treatment was not *unreasonable*.

28. Claimant's primary care physician, Dr. Kunz, and the last treating physician on his industrial claim, Dr. Cox, are both of the opinion that Claimant has a need for continuing medical management. Dr. Cox opined that such continuing medical management may include a continuation of his prescription drugs, trials of new or different OTC or prescription medications, or simply monitoring his long-term use of OTC NSAIDs.

29. Claimant's treating physician concluded that Claimant required on-going medical care, and the record makes it clear that the required treatment was reasonable. When Surety blocked Claimant's access to his treating physician, he had no way to get a referral to Dr. Kunz, or anyone else, and was no longer required to remain within the chain of referral or seek permission to change physicians. *Reese v. V-1 Oil Co.,* 141 Idaho 630, 634, 635, 115 P.3d 721 (2005). Claimant and/or his third-party insurer are entitled to compensation for medical visits to Terry Reilly Health Services in December 2010 and Dr. Kunz in April 2011.

30. Dr. Cox prescribed Claimant's medications and after Surety denied Claimant access to Dr. Cox, Dr. Kunz wrote the prescriptions. Surety acted improperly when it refused to pay for valid prescriptions written by Drs. Cox and Kunz. Claimant and/or his third-party insurer are entitled to compensation for prescriptions for tramadol, Cymbalta, and Neurontin from April 4, 2011 forward.

31. Claimant's Exhibits 16 and 17 contain the medical bills which Claimant contends were incurred subsequent to April 4, 2011. Claimant has synopsized those bills at page 10 of his opening brief as follows:

Date of Service	Medication	Qty	Physician	Refills	Price*
4/25/11	Tramadol	240	Kunz		$83.09
4/30/11	Cymbalta	60	Cox	1	$343.99
5/02/11	Cymbalta	60	Cox		$343.99
5/04/11	Gabapentin	180	Cox	2	$189.99
5/21/11	Tramadol	240	Kunz	0	$83.09
5/29/11	Cymbalta	60	Cox	0	$343.99
6/23/11	Gabapentin	180	Cox	1	$35.57 (co-pay)
6/23/11	Tramadol	160	Cox	1	$16.09 (co-pay)
7/18/11	Ultram	32	Kunz		$558.29
7/18/11	Ultram	208	Kunz		$483.85
8/13/11	Ultram	60	Kunz		$141.99
8/19/11	Ultram	180	Kunz		$418.69
9/12/11	Ultram	12	Hlavinka		$33.19

*(*Medication costs computed by adding the noted "price" in addition to amount identified as saved by insurance – Claimant Exh. 17, ps. 17 – 19.)*

Date of Service	Provider	Price
12/22/10	Terry Reilly Health Services	$109.00
04/25/11	Saltzer Medical Group	$30.00 (co-pay)

C. Brf., p.10.

32. Review of Claimant's Exhibits 16 and 17 demonstrate that Claimant's synopsis is based on a number of assumptions, which may or may not be accurate. For example, Claimant asserts that the bill incurred in connection with his December 22, 2010 visit to Terry Reilly Health Services is for $109.00. The actual bill reflects that the charge for services that date was $109.00, but that $91.50 of that bill was charged to Claimant's insurance, leaving Claimant with a payment of $17.50. On December 27, 2010, a "sliding fee adjustment from sliding fee scale" was made with respect to the amount payable by Claimant's insurance, reducing this amount to

zero. From the actual bill, it is unclear whether Claimant's insurance was billed in the amount of $91.50, and if so, whether Claimant's insurance paid this amount. On the other hand, it seems just as likely, as suggested by Defendants, that Claimant's insurance was not billed, and that Terry Reilly simply "wrote off" the $91.50. However, it does seem clear that the original invoiced amount of the bill was $109.00, and that Claimant paid $17.50 towards this bill.

33. More ambiguous is the April 25, 2011 "receipt of payment" from Saltzer Medical Group in the amount of $30.00 (*See*, C. Ex. 16). That receipt reflects that Claimant made a $30.00 payment toward satisfying the bill incurred in connection with the visit of April 25, 2011. Although Claimant maintains that the $30.00 payment was merely Claimant's "co-pay," thus suggesting that the total bill was higher, the receipt of payment does not reflect that any unpaid balance remained following the $30.00 payment, although the receipt, as well, reflects that Claimant could expect to be billed for any remaining balance. In short, it is unclear whether the total bill for the April 25, 2011 visit was $30.00, or some greater amount.

34. That Claimant has some type of non-occupational group health coverage is made clear by the documents contained at Claimant's Exhibit 17, representing purchases of prescription medication subsequent to April 4, 2011. Claimant's synopsis shows, for example, that on April 30, 2011, Claimant filled a prescription for Cymbalta written by Dr. Cox. Per Claimant, the bill for filling this prescription was $343.99 calculated as follows: Claimant paid $35.00 out-of-pocket when he filled this prescription, and the Walgreens' records reflect that his insurance saved him $308.99 in that particular transaction, from which we are left to guess whether Claimant's health carrier actually paid $308.99, or some lesser amount based on negotiation with Walgreens. From the bills collected at Claimant's Exhibit 17, although it is possible to calculate the total invoiced amount for most of Claimant's prescriptions, as well as

Claimant's out-of-pocket payments for each of the prescriptions, it is impossible to understand what portion of the prescription cost was billed to Claimant's non-occupational carrier, much less what that carrier paid to satisfy the amount billed.

35. The record is also silent on the question of whether or not Claimant's non-occupational group carrier has a contractual right of subrogation to any workers' compensation recovery that Claimant might make, and if so, whether it intends to exercise that right.

36. Certain of Claimant's prescriptions were evidently filled at Costco. On or about June 23, 2011, Claimant filled a prescription for 180 300mg Gabapentin capsules, for which Claimant paid $35.57. Claimant asserts that this payment was Claimant's "co-pay," implying that the actual bill for the prescription was higher. However, nothing in the Costco documentation contained at Claimant's Exhibit 17 reflects the amount of the actual bill, if different from $35.57. Similarly, on June 24, 2011 Claimant filled a prescription at Costco for 160 capsules of Tramadol, 50 mg. For this he paid $16.09. Although Claimant has characterized this payment as a "co-pay," the documentation does not reflect whether the total bill was higher, or whether some portion of the charges were paid by Claimant's insurance.

37. Therefore, for some of the medical services obtained by Claimant subsequent to April 4, 2011, there is some difficulty in ascertaining the actual invoiced amount for those services/prescriptions.

38. *Neel v. Western Construction, Inc.*, 147 Idaho 146, 206 P.3d 852 (2009), has been generally cited for the proposition that where a surety has denied responsibility for medical treatment, surety is responsible for the payment of 100% of the invoiced amount of the bills in question upon the Industrial Commission's subsequent determination that surety is responsible for that care. The underlying premise of *Neel* is that where the workers' compensation surety

has denied responsibility for the payment of medical benefits, claimant is in the wilderness: He must go out and strike his own bargain with providers, and is potentially liable for 100% of the invoiced amount of bills for services. For this reason, once the Industrial Commission determines that the denied care is the responsibility of surety, surety is obligated to pay claimant 100% of the invoiced amount of the bills in question, this sum representing the injured worker's exposure on the bills he incurred outside the Workers' Compensation system. What happens, however, where the evidence establishes that Claimant does not have an obligation to pay the full invoiced amount of the bill in question? What happens, in the case of an injured worker with non-occupational health insurance, when the carrier satisfies the provider's bill for a sum much lower than the invoiced amount, under terms which protect the injured worker from balance billing by the provider? In both cases, Claimant's obligation is finite, and represents an amount considerably less than 100% of the invoiced amount of the bills.

39. A careful review of *Neel* demonstrates that the Court considered these scenarios in arriving at its decision. In *Neel*, the evidence suggested that certain of the medical bills in question were paid by Neel's non-occupational group health coverage, while some of the bills were paid by Neel, personally, after the expiration of his health insurance. The Court was therefore aware that there was an insurance payor for some portion of the disputed care. The Court's opinion also makes it clear that it was aware that non-occupational group health providers typically pay much less than the invoiced amount of medical bills due to certain contractual adjustments that such carriers make with providers. The Court was also aware that these contractual adjustments typically protect the insured from balance billing:

> The workers' compensation system is comparable to the system used by private insurers in which they enter into agreements with health care providers for contractual adjustments of the provider's bills. The provider then agrees that it will not seek to recover the contractually adjusted amount from the insured.

The Court then discussed the injured worker's options where surety has declined responsibility for certain medical bills which claimant believes are in fact related to a compensable condition:

> When an injured worker seeks medical treatment, and knows that his claim has been denied, he/she will most likely inform the physician that the case is not a workers' compensation claim and will either rely on his/her private insurance or inform the provider that there is no insurance. Under those circumstances, the provider is justified in assuming that it is not barred by any contractual adjustment or workers' compensation regulations from charging its usual and customary charge. In those cases, the injured worker is potentially liable for the entire charge because there is no prohibition against balance billing.

40. There is some difficulty in understanding what is the logical antecedent of "those circumstances." Under what circumstances is the provider justified in assuming that it is not barred by any contractual adjustment of medical bills? The only answer that makes sense is the circumstance of claimant having no applicable non-occupational group coverage. Only then is a claimant potentially liable for the full invoiced amount of the bill. Therefore, it seems that the Court was well aware that an injured worker's potential exposure for 100% of the amount of an invoiced bill ordinarily arises only in the case of an injured worker who is without non-occupational health insurance. Nevertheless, in making its ruling, the Court did not distinguish between medical bills subject to contractual adjustment, and medical bills which are wholly the responsibility of the injured worker. The Court's ruling unambiguously applies to <u>all</u> medical bills incurred during a period of denial:

> Thus, we hold that sureties, having denied a claim subsequently deemed compensable by the Commission, are only permitted to review a claimant's medical bills incurred after the claim is deemed compensable to determine whether such bills are reasonable in accordance with the workers' compensation regulatory scheme. [4] Any medical bills incurred during the time from when the accident occurred to the time when the claim was deemed compensable fall outside the workers' compensation regulatory scheme and may not be reviewed for reasonableness and must be paid in full by the surety.

> Accordingly, Surety is obligated to pay Mr. Neel the full invoiced amount for all medical bills he incurred for his industrial accident prior to June 8, 2007, the date that his claim was deemed compensable by the Commission. (Footnote omitted)

41. Assuredly, this rule has the potential to result in a windfall to Claimant in certain situations. For example, assume that claimant has been billed for medical services in the amount of $1,000.00. The workers' compensation carrier has denied responsibility for these services. Claimant has non-occupational health insurance, which satisfies the bills for $250.00, under terms which protect the claimant from balance billing. The bills are subsequently found to be compensable by the Industrial Commission and claimant is eventually paid the sum of $1,000.00 by the workers' compensation carrier, representing the invoiced amount of the bills in question. The third party health insurer exercises its contractual right of subrogation, and claimant pays the carrier the sum of $250.00, potentially leaving claimant with $750.00 in reimbursement for medical expenses for which he has no responsibility to pay. We believe the Court was aware of the possibility of an outcome like this, yet felt its ruling was necessary to prevent other kinds of mischief which would be more damaging to the Workers' Compensation system. For example, it is common knowledge that reimbursement rates paid by the State's largest non-occupational group carriers are considerably lower than the medical reimbursement rates established by the Industrial Commission fee schedule. In the scenario under discussion, were workers' compensation sureties only required to reimburse claimant for the amount of the third party carrier's subrogation claim (plus the claimant's co-payment and deductible obligations) workers' compensation sureties would have an incentive to deny responsibility for medical bills, and allow payment for the same to be made by claimant's other insurance. The irony would be that following a finding of compensability by the Industrial Commission, surety would be able to satisfy its obligation for the payment of the bills for a sum considerably less than it would have

paid had it originally accepted responsibility for the claim. This could encourage sureties to deny responsibility for medical care knowing that if proved wrong, the surety's exposure would be less than it would be for an accepted claim.

We believe that the Court considered these, and other scenarios, in striking the balance that would avoid "awarding unearned incentives or windfalls to sureties or claimants." *Neel*, 147 Idaho at 149.

42. As applied to the facts of the instant case, we think it is clear that Claimant has the initial burden of coming forward with evidence establishing the invoiced amount of the medical bills in question. Though not without some ambiguity, as noted above, we believe that the evidence does establish the invoiced amounts of the prescriptions Claimant filled at Walgreens. Pursuant to *Neel*, we do not deem it important to know what Claimant's insurance company actually paid to satisfy its obligation under whatever contractual arrangement it had with Walgreens.

With respect to the prescriptions Claimant filled at Costco, the Commission is unable to ascertain the invoiced amounts, and therefore, limits Claimant to recovering $35.57 and $16.09 for those two prescriptions.

43. Similarly, with respect to the $30.00 payment made by Claimant at Saltzer Medical Group, the record is bereft of evidence supporting a conclusion that there was a higher invoiced amount, therefore limiting Claimant to a recovery of the $30.00 he paid.

44. Finally, with respect to services Claimant received at the Terry Reilly Health Services, the evidence, although, again, not without ambiguity, suggests that the full invoiced amount for services rendered was $109.00. Even though that bill may have been adjusted by Terry Reilly, the reasoning of *Neel*, which made irrelevant contractual adjustments between a

non-occupational group health insurer and a medical provider, strongly suggests that we should likewise ignore the fact that Terry Reilly may have "written off" a portion of the bill equaling $91.50.

CHANGE OF PHYSICIAN

45. Although Dr. Cox stated in May and June 2010 that he did not have much more to offer Claimant, it is clear that he actually did have something more to offer: He continued to write prescriptions for Claimant. Inexplicably, and before it could develop any medical predicate to support its action in the form of a report from the medical panel, Surety contacted Dr. Cox's office to cancel the appointment that Claimant had scheduled, and to (presumably) tell Dr. Cox that it would no longer be responsible for the payment of any care rendered by Dr. Cox to Claimant. Faced, as he was, with these actions in the early summer of 2010, Claimant did the only thing he could do, which was to seek care from the Terry Reilly Health Services and Dr. Kunz, on his own. As noted above, Claimant's actions fall squarely within the ambit of the rule discussed in *Reese v. V1 Oil, supra*. Surety blocked Claimant's access to care, and Claimant was entitled to seek care on his own, as anticipated by I.C. § 72-432(1), without the need of prior written authorization of his intentions to Surety. Based on the facts known as of the date of Surety's cancellation of Claimant's scheduled appointment with Dr. Cox, one need go no further than *Reese* to require Surety to pay for the care rendered by the Terry Reilly Health Services and Dr. Kunz.

46. However, additional facts emerged via the depositions of Drs. Cox and Wilson. The parties concede that Dr. Cox is one of Claimant's treating physicians. Dr. Cox has testified that it is not his usual practice to follow chronic pain patients on a long term basis. It is his practice to refer such individuals back to a primary care physician for a long term follow up.

One can suppose that had Surety not interfered with Dr. Cox's care of Claimant, he would, at some point, have made a referral back to Dr. Kunz, or some other primary care physician for Claimant's long term follow up. At any rate, he clearly expressed the view at the time of his deposition that this would be his course. Under I.C. § 72-432(6), Surety is responsible for the payment of medical expenses incurred by physicians in the chain of referral. Dr. Cox has expressed his desire to refer Claimant for follow up to a primary care physician, and although he has not made specific reference to Dr. Kunz, the Commission finds it reasonable to require Surety to accept responsibility for the services rendered by Dr. Kunz, or such other physician to whom Dr. Kunz may, in turn, refer Claimant for further treatment/evaluation.

ATTORNEY FEES

47. Attorney fees are not granted to a claimant as a matter of right under the Idaho workers' compensation law, but may be recovered only under the circumstances set forth in Idaho Code § 72-804, which provides in relevant part:

> Attorney's fees - Punitive costs in certain cases. - If the commission or any court before whom any proceedings are brought under this law determines that the employer or his surety . . . without reasonable grounds discontinued payment of compensation as provided by law justly due and owing to the employee or his dependents, the employer shall pay reasonable attorney fees in addition to the compensation provided by this law. In all such cases the fees of attorneys employed by injured employees or their dependents shall be fixed by the commission.

The decision that grounds exist for awarding a claimant attorney fees is a factual determination that rests with the Commission. *Troutner v. Traffic Control Company*, 97 Idaho 525, 528, 547 P.2d 1130, 1133 (1976).

48. The Commission finds that an award of attorney's fees is appropriate in this matter. Claimant has asserted that the follow up appointment he scheduled for mid-summer of

2010 with Dr. Cox was cancelled by the Surety. This testimony stands unrebutted in the record, though Surety was afforded every opportunity to contest Claimant's assertions. It is this action by the Surety that is of the most concern to the Commission. Ms. Hill's later correspondence with Claimant's counsel in which she affirmed her disinclination to authorize any care by Dr. Cox has, at the very least, an underlying medical predicate on which to rely in the form of the opinions generated by the panel. However, the same cannot be said with respect to the actions Surety evidently took in the early summer of 2010 in canceling Claimant's scheduled appointment with Dr. Cox.

49. Surety could argue that because Dr. Cox's notes reflect that he really did not have much more to offer Claimant, this means that Dr. Cox, himself, was signaling that Claimant required no further care. However, this interpretation is belied by the fact that Dr. Cox continued to write prescriptions for Claimant, even while suggesting that he had not much more to offer. At the very least, Dr. Cox's actions and statements required further inquiry on the part of Surety, and there is no indication that such inquiry was made prior to cutting Claimant off from further medical treatment. It does appear that Surety was more interested in closing an old claim than it was in assuring Claimant's well being. For these reasons, the Commission finds that an award of attorney's fees under I.C. § 72-804 is appropriate.

CONCLUSIONS OF LAW

1. Claimant is entitled to reimbursement for visits to Terry Reilly Health Services and Dr. Kunz, and his prescriptions for tramadol, Neurontin, and Cymbalta from April 4, 2011, consistent with paragraph 31 of this decision.

2. Dr. Howard Kunz is designated as Claimant's treating physician, which includes the authority to make referrals as he deems reasonably medically necessary to assure appropriate

care for Claimant.

3. Claimant is entitled to an award of attorney fees related to the cost of these proceedings.

ORDER

Based upon the foregoing reasons, IT IS HEREBY ORDERED that:

1. Claimant is entitled to reimbursement for visits to Terry Reilly Health Services and Dr. Kunz, and his prescriptions for tramadol, Neurontin, and Cymbalta from April 4, 2011, consistent with paragraph 31 of this decision.

2. Dr. Howard Kunz is designated as Claimant's treating physician, which includes the authority to make referrals as he deems reasonably medically necessary to assure appropriate care for Claimant.

3. Claimant is entitled to an award of attorney fees related to the cost of these proceedings. Unless the parties can agree on an amount for reasonable attorney fees, Claimant's counsel shall, within twenty-one (21) days of the entry of the Commission's decision, file with the Commission a memorandum of attorney fees incurred in counsel's representation of Claimant in connection with these benefits, and an affidavit in support thereof. The memorandum shall be submitted for the purpose of assisting the Commission in discharging its responsibility to determine reasonable attorney fees in this matter. Within fourteen (14) days of the filing of the memorandum and affidavit thereof, Defendants may file a memorandum in response to Claimant's memorandum. If Defendants object to the time expended or the hourly charge claimed, or any other representation made by Claimant's counsel, the objection must be set forth with particularity. Within seven (7) days after Defendants' counsel files the above-referenced memorandum, Claimant's counsel may file a reply memorandum. The Commission,

upon receipt of the foregoing pleadings, will review the matter and issue an order determining attorney fees.

4. Pursuant to Idaho Code § 72-718, this decision is final and conclusive as to all matters adjudicated.

DATED this _18th_____ day of __January_____, 2012.

INDUSTRIAL COMMISSION

_/s/_____
Thomas E. Limbaugh, Chairman

_/s/_____
Thomas P. Baskin, Commissioner

_/s/_____
R.D. Maynard, Commissioner

ATTEST:

_/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the _18th__ day of __January_____, 2012, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW,** and **ORDER** were served by regular United States Mail upon each of the following persons:

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MARK C PETERSON
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amw

_/s/_____