

**Subcommittee on Neel**  
**March 25, 2026**  
**2:00 p.m.**

*Members: Andrew Marcham (Chair), Mark Peterson, Patti Vaughn, Ann Young, Kamerron Slay, Chair Claire Sharp, Director George Gutierrez, Kelli Segroves, John Hummel, and Jamie Arnold.*

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Mr. Marcham outlined the subcommittee's purpose. As an employer representative, he emphasized the importance of reducing expenses and noted specific concerns regarding *Neel*, including its associated costs, ambiguities in its application, complex calculations, and litigation fees. See *Neel v. Western Construction Inc.*, 147 Idaho 146, 206 P.3d 852(2009). He further observed that these issues can delay benefits for injured workers and suggested that greater clarity would benefit all parties involved.

**Proof Required for Claimant Reimbursement.**

Mr. Marcham inquired about the proof required for reimbursement, specifically whether documentation must originate from a particular level of physician or whether a claimant can request surgery without submitting medical records. Chair Sharp clarified that requests for medical treatment should be formal and submitted by a physician and further asked how individuals typically determine their need for medical care.

Mr. Marcham explained that situations arise when an Independent Medical Examination (IME) doctor concludes that surgery is unnecessary, yet the treating physician pursues approval under workers' compensation. He sought clarification regarding standards used to review denials of medical treatment and suggested that input from a treating physician would be appropriate. Mr. Peterson concurred that the medical request should come from the treating doctor, not just a medical provider. Mr. Marcham noted that IMEs do not typically request treatment but rather offer clinical opinions. Mr. Peterson pointed out that it's the treating physician, not the IME doctor, who initiates treatment recommendations, which are then reviewed by the carrier for approval or denial. Even in cases involving occupational diseases or emergency care, a treating physician remains responsible for directing patient care.

Director Gutierrez inquired about the process for an injured worker seeking a second medical opinion after treatment, specifically whether the surety pays or the worker pays out of pocket. Mr. Peterson notes that such decisions may also involve obtaining the treating physician's perspective. Mr. Marcham addresses documentation requirements for claim reimbursement, questioning whether detailed physician invoicing or a Blue Cross printout is necessary. He suggests that documentation should typically originate from the treating physician, but acknowledges that third-party billing can be involved with HMO plans. Generally, relevant details are supplied either by the provider or the insurance company. The Explanation of Benefits (EOB) should indicate the amount billed, but a comprehensive provider invoice is also recommended. Ms. Vaughn adds that the EOB often includes CPT codes, which employers request because services are bundled and affect the fee schedule.

Mr. Marcham noted that the calculation does not come from a medical provider and lacks detailed information, which could prompt requests for further details. Mr. Peterson agreed, but suggested that if there is a provider, then there must be a bill.

### **Payment Clarification.**

Mr. Marcham asked whether reimbursement is required when group health insurance or Medicare has already provided payment, noting that, according to *Neel*, all amounts may still be owed regardless of prior health insurance payments. Mr. Peterson indicated that previous attempts have been made to address this issue, with the most recent case, *Millard v. ABCO Construction Inc.*, involving Medicaid, requiring payment of the full billed charges. Mr. Peterson indicated that *Millard* stated the medical fee schedule rate may be applied, provided the surety makes payment before the Commission renders a compensation decision. Mr. Marcham concluded that this is the current ruling on the matter.

### **Scope of Decision Beyond Neel's Specific Claim.**

Mr. Marcham asked about a denied claim and expressed uncertainty about other case law on situations such as a good-faith surgery denial. He noted that when an IME finds a condition unrelated to the claim, the surety may deny coverage based on the IME's findings. Mr. Marcham inquired at what point *Neel's* exposure begins. Mr. Peterson indicated he was unsure about what the fee schedule under IDAPA specifies regarding when a surety should pay a bill, especially if the bill is not in dispute. He explained that he understood that *Neel* becomes applicable after the surety receives the bill and either pays it or denies it.

Mr. Marcham clarified that the timing has nothing to do with the surety's denial or with when the surety responds, rather, it's simply about when they receive the bill. Mr. Peterson discussed accepted claims and referenced a Commission precedent where there is no ongoing obligation to notify the claimant of every new bill. Mr. Marcham wished that claimants' counsel were present to provide their perspective, but he agreed with Mr. Peterson.

Ms. Martin explained that disputes tend to be somewhat ambiguous; typically, they are resolved through settlement. Only when a claim is denied, a hearing takes place, and responsibility is assigned does *Neel* come into play. She deferred to Mr. Peterson, who is knowledgeable about case law. Ms. Vaughn mentioned the timeline in IDAPA and noted that medical fee disputes do arise under those circumstances. The common practice is to adjust payments according to the fee schedule, but there's a 30% penalty under IDAPA, which is between the provider and payor. Mr. Peterson clarified that these situations assume approval of care and payment amount, not a decision to deny or accept care.

Ms. Vaughn asked whether responses to bills are required. Mr. Peterson believes you must respond. Mr. Marcham pointed out that sometimes bills aren't paid for reasons like a lack of CPT codes. Mr. Peterson added that if the bill is the correct amount but payment is refused outright, that could trigger *Neel's* liability. Mr. Marcham queried when exactly, after a denial based on case facts, the surety should consider *Neel's* exposure. Mr. Marcham indicated that, returning to Ms. Martin's earlier point, if bills are paid before the Commission's fee schedule applies, is further action

needed? Chair Sharp indicated that this is what Millard was looking at and raised the scenario in which payment decisions are reversed just before surgery, inquired about the remaining options other than paying the full invoiced amount, and asked whether such a decision could be reversed at the last minute to avoid that situation.

Mr. Peterson believes that certain actions could be taken the night before surgery, but not in the week leading up to the hearing. He explained that in the case of *Neel*, if the injured worker is essentially left to fend for themselves in the wilderness, financial responsibility for the medical bills remains the surety's responsibility, and those costs will ultimately be addressed, with bills generated accordingly. Chair Sharp referenced Mr. Peterson's example, emphasizing that because the claimant is in the wilderness, they may not receive care due to lack of insurance, rendering them unable to access treatment. As full billing charges are only applicable to incurred medical care, there is no obligation to pay for services that were not actually received. Mr. Peterson reiterated that only incurred medical expenses required payment, not those simply denied.

Mr. Peterson opined that if there's no valid reason to deny a claim, attorney's fees must be paid. If an expert backs your position and verifies that the injuries were unrelated, denial is justified, and *Neel* has no damages. He mentioned that Darin Monroe, Claimant's counsel, sought benefits for denied medical care in *Neel*, but since the treatment hadn't occurred, costs weren't incurred. The ISC clarified that only expenses that are both incurred and denied count. Mr. Peterson indicated that if an individual does not pursue treatment due to lack of resources, personal choice, or other reasons, and the Commission subsequently determines that the back injury is related, the precedent set by *Neel* does not apply. At such a time, should the individual undergo treatment, the resulting expenses would be covered under the medical fee schedule, as the Commission has established a connection between the injury and the claim. Ms. Martin concurred that that was her understanding. Chair Sharp recommended seeking input from the Claimants' bar to potentially address any imbalances but remained impartial. Mr. Peterson explained that Mr. Monroe, representing the claimant, was unhappy with the decision because they wanted certainty for future medicals. A central issue in *Neel* is whether a surety that initially denies a claim, which is later found compensable, should be permanently prevented from reviewing its reasonableness. This was Mr. Monroe's argument, asserting that once the claim is denied and later found compensable, a hundred percent of the invoice amount in perpetuity. Mr. Peterson indicated that if new medical care is presented, the surety can review it and make a determination. In such instances, billing is managed in accordance with the medical fee schedule. Mr. Marcham explained that if acceptance occurs immediately before surgery, that marks the day of acceptance, and claims may be accepted any time up to the day of surgery.

#### **Attorney Fees in Medical Bill Reductions.**

Mr. Marcham asked whether attorney fees are awarded on an hourly basis. Chair Sharp explained that it's more common to invite parties to agree on a specific amount, though in some cases an hourly rate is more appropriate. This approach allows the parties to resolve matters independently and for the Commission to review what has been presented.

Mr. Peterson commented that costs depend on the type of surgery. In many cases, the actual medical fee schedule amount is only one-fifth of the full billed amount. Mr. Marcham pointed out that this can result in a larger payout than what providers typically accept under contract.

Chair Sharp then observed that in this situation, the claimant's counsel had created these additional benefits, and if the claimant's counsel argued that the opposing side was unreasonable, they may request attorney fees on the benefit they earned for their client, noting that earning attorney fees requires substantial effort to overcome such challenges. Mr. Peterson added that the award of attorney fees under Idaho Code 72-804 depends on proving unreasonableness. Mr. Marcham raised a question about good-faith denial and stated that getting a second opinion through an Independent Medical Examination (IME) can be a valuable experience.

Mr. Marcham discussed attorney fees related to understanding the issue. Chair Sharp referenced I.C. 72-804, noting that attorney fee cases vary significantly. These cases had appeared before the ISC and involved distinctions under Idaho Code § § 72-803 and 804, as well as factors such as settlements and adjuster errors. Chair Sharp added that other considerations exist. Chair Sharp suggested the details might be outside of the scope of this subcommittee, but offered to send the relevant document on attorney fees to Mr. Marcham.

Mr. Peterson pointed out that there are consequences for the workers' compensation industry, particularly on the defense side. Adjusters now face situations where, even if there's a strong legal argument or a non-compensable claim, they must still consult with the employer, especially when medical care ratios are high. Mr. Peterson indicated that they are discussing whether there is about an 80% chance they will prevail. Mr. Peterson indicated that it is more than looking at case law or statute to have a reasonable basis; they have to really analyze if they want to risk the *Neel* exposure. Mr. Peterson indicated that there's now an incentive to avoid adjudication when a third-party insurer is paying out, since medical bills incurred before decisions can lead to greater financial gains. Chair Sharp indicated that it would be beneficial to get feedback from the claimant's bar. Mr. Arnold joined the meeting. Mr. Peterson clarified that your medical care is not being delayed due to Medicare coverage; Medicare will pay for services in place of the insurance company, without causing any delays.

Mr. Marcham asked Mr. Arnold his thoughts on a question regarding exposure to *Neel*, suggesting that if the surety authorizes an accepted claim the day before surgery, there may not be *Neel* exposure since costs are not incurred. He invited input on this scenario. Mr. Arnold responded, citing three current cases with significant subrogation claims and upcoming hearings. In his view, when workers' compensation surety authorizes payment before surgery, it resolves concerns about claimants having to pay a portion of expenses. He further explained that various health insurance scenarios and subrogation considerations can affect claimants' out-of-pocket costs, depending on deductibles and whether Medicare or Medicaid is involved. If authorization is not granted before major surgery, even if decided later by workers' compensation surety, it can create complex issues regarding payments and outcome, leading to consequences that could have been avoided with timely authorization.

Mr. Arnold stated that obtaining proper authorization helps avoid issues commonly encountered in Medicare or health insurance cases, particularly those related to billing adjustments. In his recent case before the Idaho Supreme Court (ISC), argued by Matt Vook, the ISC acknowledged concerns about denying authorization, as doing so can incentivize payers to wait for a reduced settlement rate, thereby perpetuating denial of authorization until insurance resolves payment. This approach has been a longstanding concern. While Mr. Arnold is open to discussion, he believes *Neel's* primary role is to advocate for injured workers. Mr. Marcham concurred with this assessment, noting that pre-surgical authorization carries significant implications; if authorization is not obtained, clients may be left responsible for incurred costs that can't be reimbursed after the fact. Mr. Peterson agreed, offering the example of Blue Cross paying a bill, and reiterated that, based on the *Neel* and *Millard* cases, there is no mechanism to retroactively seek reimbursement from providers once another insurer has paid. Attempts to reverse payments or substitute new payers are not permitted once the appropriate timeframe has lapsed.

Mr. Arnold noted that such circumstances can frequently become complex, particularly when payments have been issued but the recipient subsequently attempts to reclaim the funds, prompting efforts to recover them. These issues don't happen in every case, but ERISA claims can be particularly challenging because those involved may not feel obligated to pay attorney fees or offer reductions. This leaves us in a position where negotiation isn't possible, likely leading to a hearing due to subrogation concerns. Mr. Peterson noted that the Commission has already addressed this matter in a decision. Despite federal law, Idaho state law also applies, and the decision was noteworthy for its discussion of federal preemption. Mr. Arnold further emphasized that whether the ERISA plan is subject to preemption under Idaho law adds another layer of complexity to these cases.

### **Adjournment**

Mr. Marcham thanked participants for their time and the discussion. The meeting adjourned at 2:51 p.m.