COMMONWEALTH OF MASSACHUSETTS

DEPARTMENT OF INDUSTRIAL ACCIDENTS	**BOARD NO. 007176-96**
George Rivera	Employee
Department of Corrections	Employer
Commonwealth of Massachusetts	Self-Insurer

REVIEWING BOARD DECISION
(Judges Horan, Koziol and Harpin)

The case was heard by Administrative Judge Sullivan.

APPEARANCES
Deborah G. Kohl, Esq., and Ryan Benharris, Esq., for the employee
Patricia G. Noone, Esq., for the self-insurer

HORAN, J. The self-insurer appeals from a decision awarding the employee § 34A[1] benefits from March 13, 2012, to June 18, 2012, additional benefits pursuant to §§ 14(1)(a) and (b),[2] and an enhanced attorney's fee pursuant to § 13A(5). We

[1] General Laws c. 152, § 34A, provides, in pertinent part:

> While the incapacity for work resulting from the injury is both permanent and total, the insurer shall pay to the injured employee, following payment of compensation provided in sections thirty-four and thirty-five, a weekly compensation equal to two-thirds of his average weekly wage before the injury. . . .

[2] General Laws c. 152, § 14(1), provides, in pertinent part:

> [I]f any administrative 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
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> (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. . . .

reverse the decision, and vacate the § 34A, § 14(1)(a) and (b), §§ 13 and 30,[3] and § 13A(5) awards. We recommit the case for further findings on whether an attorney's fee is due.

We recite the facts and procedural history pertinent to the issues on appeal. In so doing, we take judicial notice of the board file.[4] Rizzo v. M.B.T.A., 16 Mass. Workers' Comp. Rep. 160, 161 n.3 (2002).

The employee has been employed as a corrections officer for the Department of Corrections (DOC) since 1989. His primary job duties include the care, custody and control of inmates. On February 25, 1996, the employee injured his knees while breaking up a fight between inmates. The employee had surgery on both knees. The self-insurer accepted the case and eventually paid the maximum weeks of total and partial incapacity benefits under §§ 34 and 35. (Dec. 6-7, 12; Tr. I, 30; Tr. II, 12-13.)

The employee "worked continuously as a correctional officer, regular duty and on a full-time basis, during the period from January 8, 2006 into 2011." (Dec. 7.) In April, 2011, owing to his sore left knee, the employee filed a claim for §§ 13 and 30 benefits, requesting the self-insurer to authorize an evaluation by his treating physician, Dr. Henry Toczylowski. Based on the August 16, 2011 report of Dr. William C. Donahue, who opined the employee did not need further medical treatment, the self-insurer denied the claim. On November 4, 2011, the judge issued a conference order authorizing further medical evaluation and treatment of the employee's knees. The self-insurer appealed the order.

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[3] The self-insurer challenges the award of §§ 13 and 30 benefits, contending that the employee's entitlement to medical treatment was not an issue at the commencement of the hearing. We agree. (Ex. 5; Tr. I, 4-5, 17-20.)

[4] The hearing took place on May 9, 2013, July 18, 2013, and September 6, 2013; we refer to the transcripts of those hearings as Tr. I, Tr. II and Tr. III, respectively. Unfortunately, myriad status conferences took place off the record; we have repeatedly advised against this practice, as it frequently produces an incomplete record which, in turn, complicates our judicial function.

On January 13, 2012, the employee was examined by Dr. James T. McGlowan, the impartial medical examiner. See G. L. c. 152, § 11A(2). In his January 20, 2012 report, Dr. McGlowan opined the employee's "treatment appears to be reasonable and medically necessary. He should follow up with Dr. Toczylowski. An MRI of the left knee is not unreasonable due to his ongoing discomfort." (Ex. 1.) On January 13, 2012, the employee also underwent an MRI on his left knee, which demonstrated a "nondisplaced longitudinal horizontal tear involving [the] anterior horn and body of the medial meniscus." (Ex. 2.) Michael Bishop, the self-insurer's claims adjuster, finding no reason to question the causal relationship between the employee's injury and the proposed surgery, and relying on the judge's conference order, forwarded the request for surgical approval to the self-insurer's utilization review (UR) department. (Tr. III, 9-12.) On February 21, 2012, UR authorized,[5] as reasonable and necessary, the proposed surgery on the employee's knee. (Ex. 10.) Relying on UR's authorization, on March 13, 2012, Dr. Toczylowski performed arthroscopic surgery to repair the employee's torn meniscus "with chondroplasty of his patella and medial femoral condyle of his left knee." (Ex. 18; March 26, 2012 report.) On March 26, 2012, the self-insurer issued a notification of denial accompanied by a letter to the employee denying his request to be placed on weekly incapacity benefits following surgery. (Exs. 11 and 12.) In its denial, the self-insurer raised, inter alia, the issue of causal relationship.

On April 3, 2012, the employee filed a motion to join a claim for payment of the employee's March 13, 2012 surgery, a claim for § 34A benefits from the date of that surgery, and a claim for § 14 penalties for the self-insurer's failure to pay for the surgery that UR authorized. (Ex. 13.) On April 10, 2012, the self-insurer sent a letter

[5] As set forth in 452 Code Mass. Regs. § 6.02, for UR purposes:

> Authorization means a determination by the utilization review agent that a health care service has been reviewed, and based on the information provided, meets the clinical requirements for medical necessity and reasonableness of said service in accordance with medical guidelines.

to Lakeville Physical Therapy denying payment for the employee's prescribed physical therapy, questioning "the causal relationship between the request for treatment and the original injury." (Ex. 15.) On April 18, 2012, the judge allowed the employee's motion to join the aforementioned claims.

Following a status conference on June 6, 2012, the judge suggested, and the parties agreed, to ask Dr. McGlowan to conduct another examination of the employee and to issue a second report addressing the medical aspects of the pending claims. (Tr. I, 4.) The next day, the judge sent a letter to Dr. McGlowan, enclosing a copy of the doctor's first impartial medical report "as well as the subsequent records of Henry Toczylowski, M.D., . . . and the related objective testing." (Ex. 18.) The self-insurer did not forward any new medical information to the doctor, as indicated by the judge's letter, and the second impartial report.[6] The second impartial report issued on December 21, 2012, the date of the second examination. (Ex. 18.) In that report, Dr. McGlowan opined the employee's treatment, including the March 13, 2012 arthroscopy, was reasonable, necessary *and* related to the 1996 industrial accident. (Ex. 2.) The doctor also opined the employee could "work full duty." Id. In fact, on June 19, 2012, the employee had returned to work full duty − over six months prior to the date of his second examination with Dr. McGlowan. (Dec. 7-8.)

On February 15, 2013,[7] the self-insurer withdrew its appeal of the conference order, which had authorized further medical treatment of the employee's knees. (Dec. 2.) On March 11, 2013, the self-insurer offered to pay for the surgery that its UR department had authorized on February 21, 2012; it did not offer to pay weekly incapacity benefits. (Dec. 9.)

[6] Dr. McGlowan, in his December 21, 2012 report, noted the "[d]ocuments available for review" included his January 13, 2012 report, lab reports dated March 13, 2012 – the employee's date of surgery – and "documents from Orlando Orthopedic Associates." (Ex. 2.) The reference to "Orlando" is obviously a transcription error, as Exhibit 18 reveals that Dr. Toczylowski's reports issued from Longwood Orthopedic Associates.

[7] The decision lists this date as February 26, 2012; the board file reveals this is a scrivener's error.

The hearing to address the employee's claims for permanent and total incapacity benefits and § 14 penalties commenced on May 9, 2013. (Tr. I, 4-5, 14-15.) Because the employee exhausted his entitlement to §§ 34 and 35 benefits for his 1996 injury, the employee moved to join two new dates of injury: April 4, 2011, and November 28, 2011. Over the self-insurer's objection, the judge allowed the motion. (Tr. I, 17.) The self-insurer defended the employee's amended claims by denying: 1) liability and causal relationship for the new injury dates; 2) § 14 penalties; and 3) the employee's entitlement to permanent and total incapacity benefits. (Ex. 5.)

To summarize, the issues remaining in dispute at the May 9, 2013 hearing were: 1) the employee's entitlement to permanent and total incapacity benefits from the date of his surgery, March 13, 2012, until his June 19, 2012 return to full duty work; 2) the employee's entitlement to total incapacity benefits during that time, owing to the new dates of injury claimed; and 3) whether the self-insurer's delay in paying for the employee's surgery and post-operative physical therapy violated § 14.

After three days of hearing, the judge issued his decision, in which he found the employee was "totally" incapacitated from March 13, 2012, through June 18, 2012, as "that period was reasonable given the nature of the surgery involved . . . and the opinions of Dr. McGlowan."[8] (Dec. 14.) Finding that the employee "suffered no particular aggravation of [his] left knee condition due to any event on either April 4, 2011, or November 28, 2011," the judge concluded "there was no new industrial accident for which I am able to award" weekly incapacity benefits.[9] (Dec. 16.) Because the employee had exhausted his statutory entitlement to § 34 benefits for his 1996 injury, the judge, reasoning there was nothing in the statute to prohibit an award of a closed period of § 34A benefits, awarded the employee permanent and total

[8] Dr. McGlowan's opinions, expressed in his reports and at his deposition, were the only medical opinions in evidence at the hearing.

[9] In fact, the employee, on direct examination, was asked if he could recall anything happening to him on April 4, 2011, or November 28, 2011; in both instances, he replied, "No." The judge observed "that [the employee] on direct testimony said that he had no traumatic event on either of the two dates that were joined today." (Tr. I, 57-58.)

incapacity benefits for the period claimed. (Dec. 15-16.) He then found the self-insurer "expressed no reasonable basis for defending against" the claim for surgery, "for denying a typical post-surgical course of physical therapy or for denying payment of Section 34A benefits during his recovery following that procedure." (Dec. 17.) Accordingly, under § 14(1)(a), he assessed the whole cost of the proceedings against the self-insurer, awarded the employee double back § 34A benefits pursuant to § 14(1)(b), and an enhanced attorney's fee pursuant to § 13A(5). (Dec. 19-20.)

On appeal, the self-insurer raises several issues. In light of our decision to recommit the case for further findings, we address three.

First, the self-insurer contends the judge erred by awarding the employee permanent and total incapacity benefits for a closed period of total disability. On this record, we agree. When the § 34A claim was joined, the employee failed to produce any medical evidence that his incapacity from his surgery would "continue for an indefinite period which is likely never to end, even though recovery at some remote or unknown time is possible." Yoffa v. Metropolitan Life Ins. Co., 304 Mass. 110, 111 (1939). Because permanency is "the opposite of temporary or transient," more was required to warrant the employee's entitlement to § 34A benefits. Id. Moreover, Dr. McGlowan's opinions, expressed after the employee had returned to work, are insufficient to satisfy the employee's burden of proof on permanency. Stickney v. Greyhound Lines, 3 Mass. Workers' Comp. Rep. 134 (1989)(once § 34 benefits exhausted, burden of proof on employee to prove permanency of incapacity). But here, the judge, based on the only medical opinion in evidence, found only that the employee's incapacity from March 13, 2012, through June 18, 2012, "was reasonable given the nature of the surgery involved. . . ." (Dec. 14.) Had the employee *not* exhausted his statutory entitlement to total incapacity benefits, an award for same would have been in order. See, e.g., Maraia v. M.B.T.A., 25 Mass. Workers' Comp. Rep. 401 (2011)(presumptive validity of award of total incapacity benefits for a reasonable time following surgery). To award a higher amount of weekly

compensation[10] benefits to an employee, because his entitlement to a lesser amount has exhausted, is contrary to the statutory scheme and cannot be justified solely on the general beneficent design of the workers' compensation statute.[11] Compare Bracchi v. Ins. Auto Auctions, 22 Mass. Workers' Comp. Rep. 287 (2008)(permissible to award "lesser included" unclaimed § 35 benefits after exhaustion of § 34 benefits). Because we find error in the award of § 34A benefits, we vacate that award, and the award of double back benefits pursuant to § 14(1)(b).

Next, the self-insurer contends the judge erred in finding that it violated § 14 by failing to articulate a reasonable basis for: 1) denying the employee's claim for permanent and total incapacity benefits; 2) denying prompt authorization and payment for the employee's physical therapy; and 3) failing to pay for the employee's surgery following UR authorization.

We agree with the self-insurer that it had reasonable grounds to deny the employee's § 34A claim. The employee did not produce any medical evidence supporting his claim for permanent and total incapacity when he filed his motion to join that claim. The employee's argument that a reasonable period of total incapacity may be presumed after surgery is correct, see Maraia, supra, but we do not accept the general premise that permanent *and* total incapacity may be reasonably presumed following a surgical procedure. Considering the lack of medical evidence supporting it, the self-insurer had a plausible basis to deny the § 34A claim. DiFronzo's Case, 459 Mass. 338 (2011)(no § 14 violation where insurer has objectively plausible defense of claim); Litchfield's Case, 79 Mass. App. Ct. 1117 (2011)(Memorandum and Order Pursuant to Rule 1:28)(no § 14 violation where insurer fails to present

[10] The statutory rate for total incapacity benefits is sixty percent of the employee's average weekly wage; the statutory rate for permanent and total incapacity benefits is two-thirds of the employee's average weekly wage, plus a cost of living benefit. Benefits are also capped by the state average weekly wage. See §§ 34, 34A and 34B.

[11] The judge framed the § 34A issue as presenting whether it would be appropriate to award such benefits for a closed period. We do not suggest that it is never appropriate to do so. We only decide that, on this record, the claim for permanency is not supportable.

medical evidence to rebut § 34A claim; employee retains burden of proof); Stickney, supra.

While it is true the judge also based his § 14 finding on the self-insurer's failure to authorize the employee's post-operative physical therapy, that finding was based, in part, on a faulty analysis of the record. When Mr. Bishop, on April 10, 2012, denied the employee's post-surgical physical therapy claim, the judge found that "[i]n the course of denying that benefit claim, Mr. Bishop did not read the second Impartial report of Dr. McGlowan (Exhibit 2)." (Dec. 11.) In fact, Dr. McGlowan's second impartial report did not yet exist; it would not issue until December 21, 2012, eight months later. (Ex. 2.)

Lastly, while the judge found that Mr. Bishop initially discerned no reason to question whether the employee's proposed surgery was causally related to his 1996 injury, both Mr. Bishop, and Kelly Correira,[12] the director of workers' compensation for the self-insurer, testified they questioned the causal relationship between the employee's left knee injury and the need for the proposed surgery. Mr. Bishop testified receiving information from a co-worker, after UR authorized surgery, that the employee had injured his knee playing softball. (Tr. III, 13-17, 21-23.) Ms. Correira noted that while Dr. McGlowan, in his first report, found the employee's treatment of his left knee to be causally related to his work injury, the doctor did not address the surgery issue. (Tr. II, 48-49.) That is true. When asked why she had denied the request for surgery after UR authorization, she explained that since the employee's 1996 industrial accident, "a lot of time had passed . . . we wanted another impartial to look at the . . . request for surgery." (Tr. II, 22.) She testified further that it was her understanding the parties agreed to seek permission to schedule a second impartial examination specifically addressing the need for surgery, and whether it was causally

[12] Ms. Correira testified she was responsible for deciding whether to pay or deny claims for medical treatment and incapacity benefits. (Tr. II, 9.) In his decision, the judge noted that claims decisions "were made jointly between [Mr. Bishop] and the Department of Corrections." (Dec. 11.) But he also credited Ms. Correira's testimony that "she retained the right to make the final decision as to all payments." (Dec. 8.)

related to the employee's 1996 work injury. (Tr. II, 19, 22-24.) That is also true. The judge acknowledged the parties did agree to arrange a second impartial examination to address the surgery issue. (Tr. II, 26.) And when the self-insurer received Dr. McGlowan's second report, it offered, on March 11, 2013, to pay for the employee's surgery. (Dec. 9.) The self-insurer subsequently paid for the surgery. (Dec. 10.)

The employee, in essence, maintains that once the self-insurer's UR agent authorized the proposed surgery, the self-insurer could not contest the causal relationship between the surgery and the employee's 1996 injury. We disagree. The issue of the reasonableness and necessity of surgery is different from the issue of causal relationship.[13] We cannot say authorization by the self-insurer's UR agent respecting the reasonableness and necessity of the surgery operated to bar the self-insurer from raising the issue of the causal relationship between the employee's 1996 injury and the proposed 2012 surgery. There is nothing in the statute, or the regulations, to support such a ruling. In fact, the regulations,[14] and case law, indicate otherwise. See Burnette's Case, 60 Mass. App. Ct. 1118 (2004)(Memorandum and Order Pursuant to Rule 1:28)(UR authorization for treatment of psychiatric condition did not prevent judge from finding that causal relationship between the employee's work injury and the need for said treatment ended as of a date certain). And the self-insurer's failure to issue a formal denial, on causation grounds, in response to the joined claim for surgery did not prevent it from litigating that issue. This is because there is nothing in the statute, or the regulations, which requires an insurer or self-insurer to file a denial of a claim for benefits other than an *initial* claim for incapacity

[13] In fact, had UR determined the proposed surgery was not reasonable and necessary, and that determination went unchallenged, the causal relationship issue would be moot.

[14] 452 Code Mass. Regs. § 6.04(1), provides, in pertinent part:

> Insurers and self-insurers are required to undertake utilization review for health services rendered to injured employees . . . . *Said utilization review program must remain separate and distinct from case management and all other claim functions.* (Emphasis added.)

benefits. See G. L. c. 152, § 7; Cicerano v. Home Parenteral Care, Inc., 18 Mass. Workers' Comp. Rep. 158, 160 n.3 (2004). The employee's claim for surgery was not an initial claim for benefits.

Due to the passage of time between the employee's injury, his return to full-time work in 2006, and his 2011 claim for medical services, we conclude the judge erred by finding that the self-insurer defended the employee's subsequent claim for surgery without reasonable grounds. See DiFronzo, supra; Mahoney's Case, 81 Mass. App. Ct. 1142 (2012)(Memorandum and Order Pursuant to Rule 1:28)("significant passage of time" part of legitimate rationale for concluding that insurer had reasonable basis for denying claim for medical treatment; no § 14 found). Furthermore, we conclude the employee conceded the self-insurer's right to litigate the surgery issue by agreeing to permit Dr. McGlowan to address it following the second impartial examination. See footnote 8, supra. Accordingly, we vacate the § 14 finding.

We are left with the issue of whether an attorney's fee is due under § 13A(5). The employee has not prevailed on his § 34A and § 14 claims, and his §§ 13 and 30 claims were not before the judge when the hearing commenced on May 9, 2013. See footnote 3, supra. The self-insurer maintains it made an offer to pay for the employee's medical treatment, including his surgery, more than five days prior to the date set for the hearing. See G. L. c. 152, § 13A(5).[15] But what was the "date set for a hearing pursuant to section eleven"? That subject was broached at oral argument. The following exchange ensued:

Judge Harpin: Doesn't our case law . . . refer to the fact that if the original

[15] This statute provides:

> Whenever an insurer . . . contests a claim for benefits and then . . . (i) accepts the employee's claim . . . within five days of the date set for a hearing pursuant to section eleven; or (ii) the employee prevails at such hearing the insurer shall pay a fee to the employee's attorney in an amount equal to three thousand five hundred dollars plus necessary expenses. An administrative judge may increase or decrease such fee based on the complexity of the dispute or the effort expended by the attorney.

> hearing date has been put over either by request of the employee or by mutual request of the parties that the five-day period really doesn't attach until the next hearing date?
>
> Attorney Kohl: That may be so. This case is so convoluted in its . . . history that it's hard to tell at some junctures where the hearing dates start and when they don't because the – although it was scheduled for March 13th, the actual first hearing date wasn't 'till May []9th of 2013.

(O.A. Tr. 27.) We agree with employee's counsel that the procedural history of this case is convoluted. Based on the record, we cannot determine, with any degree of confidence, when the "date set for the hearing" occurred for § 13A(5) purposes. See Perry v. Chaves Heating & Air Conditioning, 25 Mass. Workers' Comp. Rep. 289 (2011)(where employee is cause of postponement of hearing, "date set for hearing," for fee purposes, is the continued hearing date).

Accordingly, we reverse the decision and vacate the benefits awarded, including the attorney's fee. We recommit the case to the judge to determine, consistent with our case law, the "date set for the hearing" for § 13A(5) purposes, and, once done, to further determine whether an attorney's fee is due owing to the timing of the self-insurer's offer to pay the employee's §§ 13 and 30 claims.[16]

So ordered.

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Mark D. Horan
Administrative Law Judge

[16] See 452 Code Mass. Regs. § 1.19(3), which provides, in pertinent part:

> When an insurer, at least . . . five days before a hearing, serves on a claimant . . . or the representative of such claimant . . . a written offer to pay . . . compensation under MGL c. 152, §§ 30 . . . and such offer is not accepted, the insurer shall not be required to pay any fee under MGL c. 152, § 13A, for such . . . hearing, unless the order or decision rendered directs a payment of said . . . compensation in excess of that offered.

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Catherine Watson Koziol
Administrative Law Judge

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William C. Harpin
Administrative Law Judge

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