COMMONWEALTH OF MASSACHUSETTS

DEPARTMENT OF INDUSTRIAL ACCIDENTS **BOARD NO. 024465-95**

Glenn P. Thibeault	Employee
Johnson Construction	Employer
Eastern Casualty Insurance Co.	Insurer

REVIEWING BOARD DECISION
(Judges Maze-Rothstein, Carroll[1] & Levine)

APPEARANCES
Glenn P. Thibeault, Pro Se
Peter M. Bancroft, Esq., for the Insurer

MAZE-ROTHSTEIN, J. The underlying issues in this case have been previously addressed by the reviewing board and the administrative judge's decision was summarily affirmed. (Summary disposition filed on December 22, 1997, regarding decision dated January 8, 1997 [hereinafter "Dec. I"]). While the matter was pending before the reviewing board, the employee filed claims with the administrative judge who heard the original case for § 14 penalties against the insurer alleging a failure to comply with § 25 and a claim pursuant to 452 Code Mass. Regs. § 7.04.[2] These claims were

[1] Administrative Law Judge Martine Carroll recused herself from this case as she had a prior involvement in this matter while serving in her former capacity as an administrative judge for the Department.

[2] General Laws c. 152, § 14, states in pertinent part:

> (1) . . .[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
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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 . . . .

> If any administrative judge or administrative law judge determines that any proceedings have been brought or defended by an employee or counsel without reasonable grounds, the whole cost of the proceedings shall be assessed against the employee or counsel, whomever is responsible.
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> (2) If it is determined that in any proceeding within the division of dispute resolution, a party, including an attorney or expert medical witness acting on behalf of an employee or insurer, concealed or knowingly failed to disclose that which is required by law to be revealed, knowingly used perjured testimony or false evidence, knowingly made a false statement of fact or law, participated in the creation or presentation of evidence which he knows to be false, or otherwise engaged in conduct that such party knew to be illegal or fraudulent . . . the party shall be assessed, in addition to the whole costs of such proceedings and attorney's fees, a penalty payable to the aggrieved insurer or employee, in an amount not less than the average weekly wage in the commonwealth multiplied by six.

General Laws c. 152, § 25, reads as follows:

> If an insured person who has complied with the rules, regulations and demands of the insurer is required by a judgment of the court to pay to an employee any damages on account of personal injury sustained by such employee during the period covered by insurance, the insurer shall pay to the insured the full amount of such judgment and the cost assessed therewith if the insured shall have given the insurer written notice of the bringing of the action in which the judgment was recovered and an opportunity to appear and defend the same.

452 Code Mass. Regs. § 7.04 reads in pertinent part as follows:

> 7.04: Questionable Claims Handling Techniques/Patterns of Unreasonably Controverting Claims
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> (1) Pursuant to M.G.L. c. 23E, § 3(b)(8), the Department's Division of Administration shall receive for investigation, on a form prescribed by the Department, written allegations of questionable claims handling techniques or patterns of unreasonably controverting claims by insurers, group self-insurers, self-insurers, third party administrators, employers, or other entities, including agents and brokers, handling workers' compensation claims.
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> (2) The Division of Administration shall conduct an investigation, and shall provide the party against whom the allegation is made an opportunity to respond in writing to the written allegations within 30 days. The findings of said investigation shall be reported to the Commissioner of Insurance, to the party making the allegation, and to the respondent party . . . .

(3) Questionable claims handling techniques or patterns of unreasonably controverting claims shall include, but not be limited to, techniques or patterns of practice which involve the following:

(a) misrepresenting pertinent facts or policy provisions relating to coverage, entitlement to benefits under M.G.L. c. 152, or any other material facts or provisions pursuant to M.G.L. c. 152, or for any other purpose;

(b) failing to adopt and utilize reasonable standards for the handling of claims consistent with the provisions of M.G.L. c. 152, § 7;

(c) failing to effectuate prompt, fair, and equitable adjustments of claims in which liability, causal relationship, and/or extent of disability have become reasonably clear;

(d) failing to make payment or to provide the written reason(s) for not doing so to a provider, as defined in 452 CMR 6.02, who has submitted a request for reimbursement for payment in accordance with the provisions of M.G.L. c. 152, §§ 13 and 30 and regulations promulgated thereunder within 45 days of receipt of the request for reimbursement;

(e) prosecuting complaints or defending against claims without reasonable grounds, including, but not limited to, engaging in practices found violative of M.G.L. c. 152, § 14;

(f) delaying or prolonging the processing or payment of requests for reimbursement, including, but not limited to, engaging in repetitive, unnecessary, or otherwise unreasonable requests for the submission of reimbursement or medical information;

. . . .

(h) failing to undertake utilization review pursuant to 452 CMR 6.00 et seq., including, but not limited to, failing to:

1. become a Department-approved utilization review agent or, alternatively, contract with a Department-approved utilization review agent;

2. maintain and utilize adequate standards and procedures to monitor and coordinate utilization review practices; or

3. comply with the reporting requirements of 452 CMR 6.05(2);

(i) failing to conform with the time frames and notice requirements set forth in M.G.L. c. 152 and regulations promulgated thereunder;

(j) misrepresenting facts or law to an experienced modified insured concerning settlement of a claim in order to obtain the insured's written consent, or otherwise failing to obtain

denied following a § 10A conference and the employee appealed to a hearing de novo. Prior to addressing the employee's claim at the de novo hearing, the judge vacated her position to assume the duties of an administrative law judge with the reviewing board. The matter was reassigned to a different administrative judge who conducted the de novo hearing and issued a decision. (Dec. 2, dated November 17, 1988 [hereinafter "Dec. II."]) We affirm the latter decision.

At the outset of the hearing, the judge ruled that he would not entertain the claims brought under § 25 and 452 Code Mass. Regs. § 7.04. (Dec. II, 2.) He based his ruling on the fact that "Mr. Thibeault was not an 'insured person' under § 25 and that § 25 was not applicable to him . . .[and] that claims regarding 452 CMR 7.04 were to be directed to the Division of Claims Administration within the Department of Industrial Accidents and

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such consent when so required by M.G.L. c. 152;

(k) failing to submit a revised statistical unit report to the appropriate rating bureau within 60 days of a finding of non-compensability, a recovery of previously paid workers' compensation benefits from a third party, or reimbursements from the Workers' Compensation Trust Fund for payments made pursuant to M.G.L. c. 152, § 65(2).

(l) failing to pay, in a timely manner, referral fees due under the provisions of M.G.L. c. 152, § 10(5).

(4) The submission of evidence of any questionable claims handling techniques or patterns of unreasonably controverting claims, including but not limited to, the techniques or patterns of practice set out in 452 CMR 7.04(3), may be sufficient to support a finding by the Division of Administration that an insurer, group self-insurer, third party administrator, or agent or broker has, or is, engaging in questionable claims handling techniques or patterns of unreasonably controverting claims. The Division of Administration shall refer its findings to the Commissioner of Insurance to undertake such enforcement, license revocation, and/or other actions as may be applicable by law.

(5) The submission of evidence of any questionable claims handling techniques or patterns of unreasonably controverting claims, including but not limited to, the techniques or patterns of practice set out in 452 CMR 7.04(3), may be sufficient to support a finding by the Division of Administration that a self-insurer, vocational rehabilitation provider, or utilization review agent has, or is, engaging in questionable claims handling techniques or patterns of unreasonably controverting claims. The Division of Administration shall refer its findings to the Commissioner of the Department to undertake such enforcement, fine, license revocation, and/or other actions as may be applicable by law.

that [the judge] lacked jurisdiction to address those allegations." (Dec. II, 2.) The employee's motions for further discovery and postponement of the hearing in the interim were also denied.[3] (Tr. 33, dated October 26, 1998 [hereinafter "Tr. II."]) Nevertheless, the employee was allowed to pursue his § 14 claim against the insurer. (Dec. II, 2.)

The administrative judge determined that there was no merit to the employee's assertions that the insurer had acted unreasonably in defending against the claim or that it knowingly offered false evidence as to employee status or his average weekly wage. (Dec. II, 2-3.) Although the judge did acknowledge that the insurer failed to issue a utilization review card after the conference order, he found that the failure to issue the card did not result in a denial of medical treatment ordered pursuant to the first hearing decision.[4] (Dec. II, 2-3.) Accordingly, the administrative judge dismissed the employee's claim for penalties pursuant to G.L. c. 152, § 14. (Dec. II, 4.)

Glenn Thibeault, the employee, raises numerous issues on appeal. His claims are very fact intensive and, at times, incorporate issues raised elsewhere in his thirty page brief creating an overlapping effect. Each issue raised shares the common element that the insurer mishandled the claim and acted in a manner that mandates an assessment of § 14 penalties. Our best effort in segregating the issues leads us to identify five reviewable concerns. We address them in turn.

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[3] The employee stated that the purpose of the discovery request was to obtain employer documentation that would establish employee-employer relationship rather than subcontractor status. Additionally, the employee sought access to all workers' compensation claims denied by the insurer for the years 1993 through 1995 "to prove a pattern of deliberately and willfully 'Unreasonably Controverting Claims, 452 C.M.R., § 7.04'." (Employee's motions dated September 25, 1998 and October 12, 1998.) The administrative judge denied the motions on October 19, 1998 and the employee resubmitted them at hearing on October 26, 1998. The judge stated that where nothing had been presented to change his opinion, he would not rule again on the same motions. (Tr. II, 33.)

[4] In the first hearing decision, the insurer was ordered to pay "Sections 13 and 30 benefits for the causally related diagnosed [neck and related shoulder] condition." (Dec. I, 15.)

First, the employee argues that the judge erred in denying his motion for discovery. (Employee brief, 5-9.) We disagree. It was proper for the judge to deny the employee's requests for two reasons: 1) the insurer had previously stipulated to an employer-employee relationship and that matter was therefore moot (Dec. I, 4);[5] and 2) as the judge correctly ruled, the appropriate means to address the insurer's handling of claims, is provided in 452 Code Mass. Regs. §7.04, see footnote 2, supra and is not a matter within the judge's jurisdiction. (Dec. II, 2.) Further, the judge rightly stated that the only issue before him was how the insurer acted towards the employee's claim, not the insurer's conduct as to previous unrelated claims. (Tr. II, 33-34.)

Next, the employee asserts that he brought a claim for § 14 penalties against the employer, the insurer and insurer's counsel, but that the judge only referred to the insurer in his decision. Despite the employee's assertion of § 14 penalties on appeal, (Employee Br., 9- 12), it appears that § 14 penalties was never clearly sought against anyone other than the insurer.[6] It was not until the submission of the appellate brief that Mr. Thibeault

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5 The judge correctly stated that "[e]ven had the motion been allowed, the insurer was entitled to argue the terms upon which the employee was hired and the legal conclusion to be drawn regarding 'employee status.' A finding that an individual is an employee is not conclusive that the insurer's contrary position is fraudulent." (Dec. II, 3.)

6 The employee's claim form states the issues of law as "M.G.L. 152 sections 14; 13A, 25, 50[.]" (Employee claim form, dated July 10, 1998). Additionally, the employee sent a letter to the Department, dated July 5, 1998, along with his claim form. His letter, addressed to the Claims Department, indicated that the insurer is the only party from whom the employee sought § 14 sanctions: "This claim by Employee 'Glenn Thibeault' for M.G.L. 152, § 14 against Eastern Casualty Ins. . . . ." (Employee letter to Claims Department, dated July 5, 1998, accompanying the July 10, 1998 claim form).

At the hearing, the judge stated at the outset: "So here today Mr. Thibeault raises a claim under Section 14. That claim is denied by Eastern Casualty. . . what I have that is pertinent is there is a claim under Section 14 being raised and Eastern Casualty takes issue as to that claim, denies that claim." (Tr. II, 6.) The employee never corrected the judge as to other parties against whom § 14 claims were made nor does the employee raise any such issues throughout the October 26, 1998 hearing.

Also worthy of note, in the employee's conference memo submitted to the judge at hearing, the only relief requested by the employee with regard to § 14 sanctions is against the insurer. (Employee conference memo dated February 25, 1998).

alleged § 14 against the employer and insurer's counsel.[7] Therefore, it was appropriate for the judge to address § 14 penalties solely against the insurer. We cannot address § 14 against the employer or insurer's counsel raised for the first time on appeal. See Bracey v. Hogan Regional Center, 13 Mass. Workers' Comp. Rep. 161, 163 (1999); Billert v. Rainbow Nursing Home, 13 Mass. Workers' Comp. Rep. 360, 363-367 (1999)(error to find fraud against a person who was not a party).

On the underlying claim for § 14 penalties as against the insurer, the judge concluded that he could not find that it acted unreasonably in denying or contesting aspects of the claim. Further, the judge did not find that the insurer offered, much less knowingly offered, false evidence. (Dec. II, 2-3.) The evidentiary record provides ample support for the judge's findings. See Moskovis v. Polaroid Corporation, 13 Mass. Workers' Comp. Rep. 273, 278 (1999).

Also incorporated in the employee's second issue is the assertion that his average weekly wage was incorrectly calculated. (Employee brief, 11.) We disagree. The issue of average weekly wage was addressed at length in the first hearing. There the employee raised the same points made here on appeal. As this issue was addressed and affirmed, in the first appeal to the reviewing board, we do not address the finding further. (Summary disposition dated December 22, 1997.)

The third contention is that the judge's refusal to re-address §§13, 30, 34, 35 issues in the context of his § 14 claim was arbitrary and capricious. This argument seems to be based on a misapprehension of how § 14 works. While the judge did examine the insurer's actions in the context of the first hearing and found it did not act unreasonably or falsely in defending against the law, it was not the judge's job to re-decide the extent of the employee's entitlement under other provisions of the Act absent a finding of § 14. See Murphy v. Trans World Airlines, 11 Mass. Workers' Comp. Rep. 94, 97-102 (1997)

[7] The employee did, however, in a response letter dated March 9, 1998 and sent by the employee to insurer's counsel (Dec. II, Exhibit N) allude to improper activity on the part of insurer's counsel. However, this in and of itself, is not a sufficient basis to establish that a formal claim was filed with the Department as to insurer's counsel.

(for a discussion of the mechanics of § 14). There was no error in the judge's application of §14 to the actions of the insurer in the underlying claim.

Next the employee maintains that the second hearing de novo should have been scheduled within twenty-eight days of the conference, pursuant to G.L. § 10A,[8] and as a result his due process rights have been violated. We note that the eight-month delay in scheduling the second hearing de novo resulted, in part, from the need to reassign the case to a different administrative judge. (See, p. 4, supra.) This delay, however, did not result in any perceptible prejudice to the employee nor does he proffer any compelling argument on this point.

A final argument presented by the employee is that the insurer failed to provide a utilization review card in accordance with 452 Code Mass. Regs. § 6.00[9] and that the employee was thereby denied necessary medical treatment. The insurer's failure to timely issue the card, argues the employee, should result in § 14 penalties. Although the judge acknowledged that the insurer did not issue the card timely, he explained that this

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[8] General Laws c. 152, § 10A, states in pertinent part:

> (3) Any party aggrieved by an order of an administrative judge shall have fourteen days from the filing date of such order within which to file an appeal for a hearing pursuant to section eleven. Such hearing shall be held within twenty-eight days of the department's receipt of such appeal.

[9] 452 Code Mass. Regs § 6.00 deals with Utilization Review and Quality Assessment. Section 6.02 defines utilization review as follows:

> a system for reviewing the appropriate and efficient allocation of health care services given to a patient or group of patients as to necessity, for the purpose of recommending of determining whether such services should be covered or provided by an insurer . . . . Utilization review services include, but are not limited to . . . second opinion programs; pre-hospital admission certification; pre-inpatient service eligibility certification; and concurrent hospital review to determine appropriate length of stay.

Although a utilization review card was not issued immediately to the employee, a card was issued on March 20, 1997 and that at all times prior, some form of review was implemented by the insurer. (Tr. II, 22-23).

failure to issue the card did not result in denial of ordered medical treatment. (Dec. II, 3.) The judge concluded that the only medical coverage denied the employee was for matters other than the work-related injury to his neck.[10] (Dec. II, 3). Therefore, it was appropriate for the judge to deny the employee's claim for § 14 penalties against the insurer as to this issue.[11]

Accordingly, the decision is affirmed.

So ordered.

Susan Maze-Rothstein
Administrative Law Judge

Frederick E. Levine
Administrative Law Judge

Filed: June 2, 2000

[10] "Mr. Thibeault made allegations that any number of body parts were injured, symptomatic, and in need of treatment. [The prior judge] found only his neck to have been injured and only his neck and left shoulder symptoms to be related to that injury. Eastern was not unreasonable in taking issue with the broad-ranging treatment that it was being asked to assume responsibility for." (Dec. II, 3.)

[11] The judge held that although the utilization review card had not been issued, the treatment sought by the employee was for matters other than those authorized via the prior judge's conference order and final decision and that someone somewhere had reviewed the requests to determine whether the requests were reasonable and necessary. At hearing the employee claimed that the treatment he was denied, as a result of the insurer's failure to comply with utilization review, was for a neurological exam for the head and hand, neither of which was found to be the responsibility of the insurer. (Tr. II, 13-23.)