**COMMONWEALTH OF MASSACHUSETTS**

**DEPARTMENT OF INDUSTRIAL ACCIDENTS** **BOARD NO. 060612-93**

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| Joane Estey | Employee |
| Burns International Security | Employer |
| Travelers Insurance Company | Insurer |

**REVIEWING BOARD DECISION**
(Judges Costigan, Carroll and Levine)

**APPEARANCES**
Thomas H. O'Neill, Esq., for the employee at hearing and on brief
Paul G. Lalonde, Esq., for the employee at oral argument
John J. Canniff, Esq., for the insurer

**COSTIGAN, J.** The employee appeals from the decision of an administrative judge rejecting her challenge to the method by which the insurer compensated her for prescription medications causally related to her 1993 industrial injury,[1] and denying her claim for § 14 penalties. Finding merit in the employee's appeal as to the § 30 claim, we reverse the judge's decision. Because the issue presented by that claim was one of first

[1] By way of background, the Board file reflects that on June 20, 1993, the employee, then fifty-one years old, stepped on a rock while performing her rounds as a security guard for the employer. She fractured her left ankle and injured her low back. Based, we assume, on the locus of her contract of hire, the insurer paid her benefits under Connecticut's workers' compensation statute for the left ankle injury only. In 1994, the employee filed a claim in Massachusetts, where she had been injured, for weekly incapacity and medical benefits from and after the injury date. She alleged injuries to her left leg, left ankle and back. By hearing decision filed on November 30, 1995, the administrative judge awarded the benefits sought by the employee for the injuries claimed, allowing the insurer a credit for benefits paid in the other jurisdiction. The employee exhausted the § 34 statutory maximum and in early 1997, she filed a claim for § 34A permanent and total incapacity benefits and medical benefits. By amended hearing decision filed on August 6, 1998, the administrative judge found that the employee was permanently and totally incapacitated based on her left leg, left ankle and low back complaints and a persistent pain syndrome likely due to reflex sympathetic dystrophy. The insurer appealed that decision to the reviewing board but later withdrew its appeal.

impression, however, the insurer's defense was not unreasonable. The employee is not entitled to § 14 penalties.[2]

The claim which is the subject of the hearing decision before us was filed in June 2000.[3] The employee sought payment of her Zoloft and Vioxx prescriptions as well as penalties under §§ 8(1)[4] and 14(1) for the insurer's alleged failure to pay for those prescriptions. Prior to the conference on that claim, the insurer sought to join a complaint for modification or discontinuance of the weekly § 34A benefits the employee was then receiving. By corrected conference order filed on November 8, 2000, the administrative judge denied the employee's claim and indicated that if the order were appealed, the insurer's modification/discontinuance complaint would be joined to the employee's claim for hearing. Both parties appealed the conference order and the employee submitted to another § 11A impartial medical examination. Prior to hearing, based on the § 11A doctor's opinion,[5] the insurer withdrew its appeal of the conference order. (Tr. 33-34; Employee br. 2.)

At the hearing on the employee's appeal, the insurer conceded that the prescriptions at issue -- Vioxx and Zoloft -- were reasonable, necessary and causally related to the industrial injury for which it had accepted liability. (Tr. 9-10.) It maintained, however, that its method of reimbursing the employee for her prescription

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[2] The administrative judge did not list § 14(1) as part of the employee's claim, (Dec. 1), but the employee included it in her statement of claim at hearing, (Employee Ex. 1; Tr. 5-6), and the insurer expressly denied it was liable for the statutory penalty. (Insurer Ex. 1; Tr. 7.)

[3] The employee previously had filed a § 30 claim seeking payment of certain medications prescribed for depression, a condition she claimed was causally related to her injuries. By conference order filed on April 9, 1999, the administrative judge ordered the insurer to pay for the employee's Zoloft prescription. The insurer appealed that conference order but withdrew its appeal after a § 11A impartial psychiatric examiner opined that the employee's depression and the medicines prescribed to treat it were causally related to her physical industrial injuries.

[4] The § 8(1) penalty claim was withdrawn at conference.

[5] In his January 10, 2001 report, Marc A. Linson, M.D., opined that "it is reasonable for [the employee] to be treated indefinitely with Vioxx and/or Zoloft and/or other medications to help reduce the pain and depression that is associated with her injury." (Statutory Ex. I, 2.)

costs satisfied its statutory obligation. (Tr. 7; Insurer Ex. 1.) The administrative judge agreed with the insurer. (Dec. 3.) We do not.

General Laws c. 152, § 30, as amended by St. 1991, c. 398, § 53, provides in pertinent part:

> **The insurer shall furnish to an injured employee adequate and reasonable health care services, and medicines if needed**, together with the expenses necessarily incidental to such services. . . . Where services are provided to employees under this section, **the reasonable and necessary cost of such services shall be paid by the insurer.**

(Emphasis added.) The administrative judge framed the issue presented by the employee's claim as "whether the system adopted by the insurer for payment of medical bills falls within the statutory mandate to 'furnish . . . adequate and reasonable health care services.' " (Dec. 2.) In his opening statement at the hearing, employee's counsel framed the issue somewhat more expansively:

> Your Honor . . . [i]n the almost ninety years that the Workers' Comp system has be [sic] active in Massachusetts, this is possibly the first time that the issue has been raised as to whether an insurer is required to furnish medicine on the same basis that they are required to furnish medical treatment, in terms of whether it can be by providing from the insurer or just reimbursement of payments made by the employee . . . So now they are reimbursing and indicated that she would have to pay first, then be reimbursed. And I believe that does not comply with the statute which says that they must furnish on the same basis as physicians.

(Tr. 5-6.) The administrative judge disagreed and decided that issue in the insurer's favor, supported by the barest of subsidiary findings of fact:

> Joane Estey was injured while at work on June 20, 1993. As a result of her injury, she continues to treat with doctors who prescribe prescription medicines including Zoloft and Vioxx.
>
> Before March of 2000 the insurer used a system in which the medicines were sent to the employee in the mail, after the prescription was called into an 800 number. No direct payment at all was required by the employee.
>
> Around March of 2000 the insurer instituted a new system, wherein the employee must pay out of pocket to obtain her prescription, and that

> amount is later reimbursed. The employee testifies the reimbursements have all been promptly made.
>
> Patricia Brodfuehrer testified that the insurer did switch payment systems at a time when they were questioning the causal relationship of the medicines (they are no longer questioning them).
>
> Under the new system, the employee is required to send in the receipt of any out-of-pocket expenses, which are then promptly paid.

(Dec. 2-3.)

Only two witnesses testified before the judge -- the employee and Patricia Brodfuehrer, the claims adjuster assigned to the employee's case. Both agreed, and the administrative judge found, that prior to March 2000,[6] the insurer used the services of PMSI, located in Florida, to process prescription medication claims from workers' compensation claimants, including the employee. (Dec. 2; Tr. 11-12, 23-26.) Under the PMSI system, either the employee or her doctor would call in the prescription to an 800 number and the medicine would be delivered to the employee's home, at no cost to her. (Tr. 12, 24; Dec. 2.) Ms. Brodfuehrer testified that in March 2000, however, she "pulled" the employee's PMSI prescription card "because they were unrelated medicals at the time and I requested that the medicals be submitted first to me so that I can review it for causal relationship to the original injury." (Tr. 26.) She specifically identified Vioxx as a prescription she considered unrelated to the original injury but conceded that she pulled the employee's prescription card "for everything," including Zoloft, which the administrative judge had ordered the insurer to pay in

[6] The employee testified that "at the beginning . . . we had to pay out of our own pocket. Then the insurance company kicked in and I was getting it delivered directly to me through the mail from PMSI out in Florida." (Tr. 12.) No evidence was introduced as to when (e.g., during a payment-without-prejudice period), why (e.g., liability or causal relationship contested by the insurer) or for how long the employee was first required to pay for her medications out of her own pocket. In any event, Patricia Brodfuehrer testified that she had been handling the employee's claim for about four years prior to the May 31, 2001 hearing, (Tr. 24), and that the insurer's file on the employee had been set up under the PMSI system before she took over the file. (Tr. 25.) Thus, it would appear, as Ms. Brodfuehrer acknowledged, (Tr. 25), that the employee's prescription medications were processed and paid for by the insurer under the PMSI system for two and one-half to three years before the insurer "instituted a new system" in March 2000. (Dec. 2.)

an April 1999 conference order. She maintained that she had to pull the employee's PMSI card for all of her prescriptions and that she could not do it for just one, i.e., the Vioxx. (Tr. 25-26.)

Ms. Brodfuehrer testified that she not only disputed the insurer's responsibility to pay for the Vioxx, (Tr. 26), but she also questioned the causal relationship of the employee's Zoloft prescription, notwithstanding the 1999 conference order[7], based on an independent medical examination commissioned by the insurer. (Tr. 33-34.) That report, which is not in evidence, was the basis of the modification/discontinuance complaint, withdrawn by the insurer after the § 11A impartial medical report, (Statutory Ex. I), was filed. (Tr. 34.) Ms. Brodfuehrer insisted, however, that at no point in time did she fail to pay for the Zoloft. (Id.) She "continued to reimburse" the employee for her prescription payments. (Tr. 35.) The administrative judge's sole finding as to Ms. Brodfuehrer's testimony in this regard is wholly inadequate: "Patricia Brodfuehrer testified that the insurer did switch payment systems at a time when they were questioning the causal relationship of the medicines (they are no longer questioning them)." (Dec. 3.)

The employee and Ms. Brodfuehrer both testified, and the judge found, that after the insurer stopped processing payment of the employee's prescriptions through PMSI, she was required to purchase her medications out-of-pocket and to submit the receipts to the insurer for reimbursement. (Dec. 2-3; Tr. 12, 28; Employee Ex. 3.) The employee testified that she did so, but the financial strain of paying the full cost of her Vioxx and Zoloft (over $100.00 each) prompted her to apply for coverage under a Commonwealth

[7] See footnote 3, infra.

of Massachusetts program,[8] which paid most of the cost of the Vioxx and Zoloft, but required her to make co-payments. (Tr. 12-14; Employee Ex. 2.) Because Vioxx and Zoloft were non-generic drugs, the employee's co-payment per prescription was $10.00. (Tr. 13.) We see only one finding made by the administrative judge which even remotely addresses that testimony:

> While the employee obviously preferred the former system of payment for her medicines, the question is not which method of payment is the easiest for the employee, but only whether the system is a reasonable one.

(Dec. 3.) The judge ruled, "I find this system of direct payment by the employee that is promptly reimbursed is proper under the Act." Id. Insofar as that finding can be read to mean that the reimbursement system at issue satisfied the insurer's dual obligation under § 30 not only to "furnish" the employee's prescription medications but also to pay for them, we disagree and reverse the judge's ruling as a matter of law.

It is well-established that an insurer's obligation under § 30 to ". . . furnish to an injured employee adequate and reasonable health care services, and medicines if needed . . . ," is an affirmative duty. Francis v. Sheraton Tara Hotel, 10 Mass. Workers' Comp. Rep. 161, 163 (1996), quoting Klapac's Case, 355 Mass. 46, 49 (1968). Where the language of a statute is unambiguous and clear, it must be given its plain and ordinary meaning. Joseph v. City of Fall River, 15 Mass. Workers' Comp. Rep. 31, 34 (2001), citing Jinwala v. Bizzaro, 24 Mass. App. Ct. 1, 4 (1987). To "furnish" is "to supply, provide, or equip, for accomplishment of a particular purpose . . . ," Black's Law Dictionary 675 (6th ed. 1990); "[t]o equip with what is needed . . . [t]o supply; give."

[8] According to Employee Ex. 2, the program was entitled "MassHealth Buy-In and The Pharmacy Program." The employee testified that she had been enrolled in the state program for only "a couple of months" as of the May 31, 2001 hearing. (Tr. 21.) From March 2000 until she became covered under the state program, the employee had to pay for her medications out-of-pocket, (Tr. 12), although she did receive free samples of Zoloft from her doctor on occasion. (Tr. 15.) She testified that sometimes she had to choose between purchasing groceries for her family and paying for her prescriptions. (Tr. 12.) Even Ms. Brodfuehrer acknowledged that if an employee could not afford to pay for prescriptions out-of-pocket and could not arrange for a pharmacy to directly bill the insurer, that employee might go without the medicine. (Tr. 29-30.)

American Heritage College Dictionary 552 (3rd ed. 1993). The terms "furnish" and "provide" are synonymous. McQuade v. New York Cen. R.R., 320 Mass. 35, 38 (1946) (Massachusetts statute which mandated that railroad corporation "provide" a uniform hat or cap to certain employees required hat or cap to be furnished without charge).

> "Furnish" means to provide or supply. Its significance may vary with the connection in which it is found. It is used here to describe a duty placed upon an insurer respecting a workman who receives "a personal injury arising out of and in the course of his employment." Such a person manifestly is presumed by the act to be under more or less physical disability and hence not in his normal condition of ability to look out for himself. **The word "furnish" in such connection imports something more than a passive willingness to respond to a demand. It implies some degree of active effort to bring to the injured person the required humanitarian relief.**

Panasuk's Case, 217 Mass. 589, 593 (1914). (Emphasis added.) Even though the employee did not dispute Ms. Brodfuehrer's testimony that her co-pay reimbursements were processed in a timely fashion by the insurer, nor did she disagree that at least as of the hearing date, there were no unpaid medical bills or unreimbursed prescription expenses, (Tr. 17-19, 41-45),[9] the statutory obligation is not expressed in terms of reimbursing the employee for amounts she was required by the insurer to pay. See Klapac's Case, supra at 49. We have said that, "[i]njured employees who 'may be presumed commonly to be somewhat needy', Ahmed's Case, 278 Mass. 180, 187 (1932), should not be forced to pay for what they are entitled to receive under the Act. . . ." Diaz v. Western Bronze Co., 9 Mass. Workers' Comp. Rep. 528, 533 n.4 (1995). As was testified to by the employee in this case, such a system can impose an extreme financial

[9] At the outset of the hearing, counsel for the insurer argued that it might be "inappropriate" to even convene the hearing because there was "no issue outstanding," that is, there were no medical expenses claimed by the employee but unpaid by the insurer. (Tr. 7.) We agree that the employee's claim did not fit neatly into the parameters of 452 Code Mass. Regs. § 1.07(2)(c), cited by the insurer as governing claims for medical benefits, but it plainly qualified as "a complaint from any party requesting resolution of any other issue arising under this chapter . . .," G. L. c. 152, § 10(1), which was entitled to adjudication, the insurer's argument to the contrary notwithstanding.

hardship on the injured worker, even when the turn-around time for the insurer's reimbursement is relatively short.[10]

Nevertheless, we are unwilling to say that the dual obligations imposed on insurers by § 30 -- to "furnish . . . medicines if needed" and to pay for those medicines -- can be satisfied only by direct payment of such costs to pharmacies or vendors such as PMSI. Currently there is nothing in the statute or the regulations which prohibits an insurer from requiring an injured employee to pay for prescription medications out-of-pocket, even if the insurer acknowledges its ultimate responsibility for such costs.[11] That method may suffice to furnish the medicines to the employee, but the insurer's obligation to pay requires timely payment, either directly or by reimbursement, of 100% of the costs of the prescriptions.

Such is not the case here. Based on the uncontroverted evidence that the insurer, at least for the two months prior to the hearing, was not paying -- to anyone -- the *full* costs of the employee's prescription medications, which it conceded were causally related to her accepted work injury, we hold that the insurer is in violation of the statutory mandate that such costs "shall be paid by the insurer." G. L. c. 152, § 30. The word "shall" is plain and unambiguous; it is mandatory, not precatory. See Taylor's Case, 44 Mass. App. Ct. 495. 499 (1998); Hashimi v. Kalil, 388 Mass. 607, 609-610 (1983). We think that the employee framed the issue best:

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[10] Moreover, unlike payments owed directly to a pharmacy, prescription reimbursements owed to an employee but not timely paid may, under certain circumstances, expose the insurer to the penalties provided by § 8(1) and/or § 8(5). Diaz v. Western Bronze Co., supra.

[11] When neither liability nor causal relationship nor the reasonableness and necessity of medical treatment is disputed, no cogent argument can be advanced that an insurer may properly require an injured employee to pay, out-of-pocket, the cost of expensive diagnostic testing, hospitalization or even surgery, and then await reimbursement by the insurer. Given the ever-increasing cost of prescription medicines, there may be no valid reason to distinguish between them and such other forms of medical treatment which insurers usually pay directly. Currently, however, the department's Utilization Review and Quality Assessment regulations, 452 Code Mass. Regs. § 6.00, et seq., do not expressly address the method(s) by which an insurer may furnish and pay for prescription medicines. We think the issue warrants consideration by the health care services board. See G. L. c. 152, § 13(3).

> Well, my thought was the State of Massachusetts is paying full price for my medication and I only have to pay ten dollars with my card to CVS. I am thinking why should they have to pay for it if they are paying the whole - - you know, the whole rest of the bill. I think Travelers, the insurance company, should be paying, not the State of Massachusetts.

(Tr. 18.) She is correct.

We reject the insurer's argument that because it was promptly reimbursing the employee her prescription co-payments, it was in compliance with the provisions of § 30. Those co-payments, as reimbursed by the insurer, represent only approximately ten per cent of the total cost of the medications.[12] Because the "MassHealth Buy-In and The Pharmacy Program," funded by the taxpayers of the Commonwealth, is paying the other ninety per cent, it is beyond dispute that the insurer is not in compliance with that provision of § 30 which mandates that "the reasonable and necessary cost of such [health care] services **shall be paid by the insurer**. . . ." (Emphasis added.)

The insurer should not be allowed to benefit from payments made by a third party, here the Commonwealth of Massachusetts, whether or not it played any role in effecting those payments. See Pina's Case, 40 Mass. App. Ct. 388 (1996) (employee not entitled to reduction of her § 15 statutory excess by the amount of medical expenses paid by Medicare). Moreover, it cannot be said that no unfairness results from the insurer's system of reimbursing the employee only her co-payments, albeit in a timely fashion. Because the Commonwealth is paying ninety per cent of the employee's prescription costs, it has a potential lien against the employee's workers' compensation case under

[12] The record establishes that the insurer knew the employee's Zoloft and Vioxx prescriptions cost over one hundred dollars each. (Tr. 28.) In fact, the insurer paid the full cost, at least of the Zoloft, initially by reimbursement to the employee, (Tr. 12), and then by payment to PMSI. (Tr. 11-12, 24-27.) It could not have been unaware of the savings resulting from reimbursing the employee only her prescription co-payments.

§ 46A[13], which, at a minimum, could prove a hindrance to a future settlement of her claim.[14]

On the facts of this case, we hold that the insurer's payment, by way of reimbursement to the employee, of only a fraction of her total prescription costs, does not satisfy its statutory obligation under § 30 to not only "furnish . . . adequate and reasonable health care services, and medicines if needed . . ." but also pay "the reasonable and necessary cost of such services. . . ." Accordingly, we reverse the

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[13] Section 46A provides in pertinent part:

> If . . . medical assistance is paid to or on behalf of an employee . . . by the . . . division of medical assistance under chapter one hundred and eighteen E, with respect to a claim which is subsequently found compensable under this chapter, the . . . division of medical assistance may, at any time before an award of workers' compensation benefits or approval of a lump sum settlement is paid, file with the division a claim for reimbursement out of the proceeds of such award or lump sum settlement. In those instances in which such a claim is filed . . . the division of medical assistance . . . shall have a lien against the award, or lump sum, and upon satisfactory proof, the division or a member thereof shall order direct payment of the reimbursement to be made from such award or lump sum to the . . . division of medical assistance who paid or furnished such benefits.

[14] The dissent suggests that it is a "common occurrence for employees' work-related medical care to be paid for by outside insurers." Certainly that can happen when a workers' compensation insurer denies an employee's claim at the outset, on liability grounds, or accepts the claim but later disputes that certain modalities of treatment, such as prescription medications, are reasonable, necessary and causally related to the work injury for which it accepted liability. In such circumstances, payment by a private group health insurer, or even a state agency, is preferable to the employee going without needed treatment, or paying the costs out-of-pocket, until the dispute is adjudicated by this department.

Here, however, the insurer did *not* dispute the reasonableness, necessity and causal relationship of the employee's Vioxx and Zoloft prescriptions to the industrial injury for which it had accepted liability. Nevertheless, the dissent would allow the insurer to default on its statutory obligation to furnish and pay for those prescriptions simply because MassHealth's payments are protected by § 46A. We do not agree. Even though, in the context of any future lump sum settlement of the employee's claim, it would fall not to the employee but to the insurer to directly reimburse the lienholder for such prescriptions payments, in addition to the settlement amount to be paid to the employee, the very existence of the § 46A lien could result in significant delays to the finalization of a settlement under § 48, all to the detriment of the employee.

administrative judge's decision in that regard as contrary to law.[15]

So ordered.

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Patricia A. Costigan
Administrative Law Judge

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Martine Carroll
Administrative Law Judge

Filed: February 26, 2003

[15] We leave the practical application of this holding to the determination of the parties. The insurer represents in its brief that it ". . . was also agreeable to set up a direct billing arrangement with a designated pharmacy which the employee has failed to take advantage of. [Tr. p. 49, 51]." (Insurer br. 4.) The cited testimony of Patricia Brodfuehrer confirms that the insurer did have direct billing arrangements with certain pharmacies in other of its workers' compensation claims but that neither the employee nor her attorney had requested such an arrangement. We note, however, that there was in evidence a letter dated March 24, 2000 from Ms. Brodfuehrer to the employee which stated, "I will no longer accept direct billing of prescription medication. Effective immediately reimbursement of prescription medication will be done on a bill by bill basis with proper medical documentation to support the causal relationship with the original injury." (Employee Ex. 3.) It appears that on June 21, 2000, the employee's attorney faxed a letter to Ms. Brodfuehrer submitting some prescription receipts and inquiring as to which pharmacy the employee could use to effect direct billing to the insurer. (Tr. 38-39.) In her letter of that same date to employee's counsel, Ms. Brodfuehrer offered the questionable disclaimer that under the statute, the insurer could not direct the employee as to where to have her prescriptions filled. (Employee Ex. 4.) We are unaware of any such statutory prohibition but even if there were one, we suggest that the insurer would not run afoul of it by simply identifying for the employee which pharmacies in her community have direct billing arrangements with the insurer, and then allowing her to choose.

**LEVINE, J. (dissenting).** The employee's "claim" in this case was essentially for declaratory relief, as there were no prescription bills that had been presented to the insurer that had not been paid. This was made clear to the judge at the outset of the hearing. (Tr. 5-7.) The declaration that the employee sought from the judge was that the insurer's responsibility under § 30 to furnish causally related prescription medications was not met, as a matter of law, by its prompt reimbursement of the employee's out-of-pocket payment for those medications.[16] This, and a meritless § 14 penalty claim for frivolous defense of this declaratory judgment "claim," was all that was before the judge.

The majority has substituted the case tried at hearing with a different one; it has inserted Mass Health's payment of some of the bills as the dispositive factor in the dispute. The judge made no mention or findings regarding the employee's submission of bills to Mass Health, which the employee testified occurred only a couple months prior to the hearing, (Tr. 21), and many months after the claim was filed; the judge apparently did not see that fact as relevant to the question presented: Was the insurer obligated to pay for prescription medications directly or was prompt reimbursement to the employee reasonable? The majority's reliance on the Mass Health factor is a bootstrap and red herring.

Nonetheless, the majority concludes that the insurer violated its obligations under § 30, not by doing what the judge concluded was reasonable -- i.e., promptly paying the bills presented to it -- but by somehow not noticing that the recently submitted bills that it was paying were only for co-payments and not for the whole amounts: "we hold that the insurer's payment, by way of reimbursement to the employee, of only a fraction of her total prescription costs, does not satisfy its statutory obligation under § 30 . . . ."[17]

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[16] It is questionable whether, in the absence of an actual dispute, an employee has standing under c. 152 to bring a claim in the nature of a class action intended to govern the practice of all insurers.

[17] Apparently, the majority takes the position that when an employee only seeks reimbursement from the insurer of an amount that appears to be less than what one would expect the full cost of a drug to be, the insurer should decline to pay and undertake some action to assure that it pays the full amount. That is not realistic.

The judge's decision is sound. Although it is brief, its omissions are telling, and it is not appropriate that it be supplemented by fact finding by the majority. The judge was not obliged to credit the employee's account of financial hardship triggering the filing of her claim. Indeed, the employee testified, (Tr. 12), that at some time in the past she had initially paid for her medication; she expressed no complaint, and this could suggest an acceptable reimbursement arrangement.[18] Furthermore, in its footnote 15, the majority recounts correspondence between the employee's attorney and Ms. Brodfuehrer, the insurer's claims adjuster, regarding the insurer's payment for the medicines. (Employee Ex. 4.) The majority neglects to point out that, in her June 21, 2000 letter to the employee's attorney, Ms. Brodfuehrer invited the attorney to call if any questions. Indeed, Ms. Brodfuehrer testified that an arrangement could have been made in which a pharmacy directly billed the insurer for the employee's medication. (Tr. 48-51.) The employee presented no evidence that she accepted the invitation offered by Ms. Brodfuehrer in her letter. Instead, the next action the employee appears to have taken was to file the present claim dated June 30, 2000. If the employee chose not to follow-up and undertake to have the insurer pay directly the full cost of the medicines, it is unreasonable for the majority to make the finding of fact that the insurer failed in its obligation under § 30 of the act.

It also merits repeating that the claim was filed around June 30, 2000. The employee testified she did not start to receive welfare payments for her medication until about March 2001, nine or ten months later. The majority is incorrect to spin that scenario into a violation of the act.[19] The only matter in dispute at the hearing was whether the insurer was obligated to pay for medications directly or was prompt reimbursement to the employee reasonable. (Tr. 5-6; see employee's post hearing brief to

[18] Because the employee was promptly reimbursed, the employee only had to make one initial payment for the medication from her own funds. Thereafter, she could pay for medication with the promptly reimbursed funds she received from the insurer.

[19] See footnote 17 supra.

the administrative judge, p. 6.) The record in this case simply does not support the result the majority crafts.

Although reimbursements by an insurer of co-payments may be inconsistent with its obligations under the act,[20] in this case such a conclusion can be made only by way of dictum. By deciding the case on a theory different from that tried at the hearing, and where no findings of fact were made by the judge to support the theory, the majority is overstepping its appropriate role as an appellate tribunal and acting as fact finder.[21]

I would affirm the decision. Accordingly, I respectfully dissent.

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Frederick E. Levine
Administrative Law Judge

Filed: February 26, 2003

[20] It is a common occurrence for employees' work-related medical care to be paid for by outside insurers. See, e.g., Kemp v. Victory Mkt., 17 Mass. Workers' Comp. Rep. ___ , ___ (January 16, 2003). General Laws c. 152, § 46A, recognizes that fact and offers protection therefor. The majority is not saying anything that has not already been recognized by the legislature.

[21] The majority thus misapprehends this dissent when the majority states that "the dissent would allow the insurer to default on its statutory obligation. . . ."