CASE NO. 6170 CRB-3-17-1 CLAIM NO. 800126596	: COMPENSATION REVIEW BOARD
MARK ANTON CLAIMANT-APPELLANT	: WORKERS' COMPENSATION COMMISSION
v.	: DECEMBER 22, 2017

COLORTONE CAMERA
EMPLOYER

and

FIREMAN'S FUND INSURANCE CO.
INSURER
RESPONDENTS-APPELLEES

APPEARANCES:

The claimant and A. Herbert Schwartz, M.D., were represented by Steven D. Jacobs, Esq., Jacobs & Jacobs, L.L.C., 700 State Street, Third Floor, New Haven, CT 06511.

The respondents were represented by Brian L. Smith, Esq., Pomeranz, Drayton & Stabnick, L.L.C., 95 Glastonbury Boulevard, Glastonbury, CT 06033-4412.

This Petition for Review from the December 27, 2016 Finding and Dismissal of Jack R. Goldberg, the Commissioner acting for the Third District, was heard June 30, 2017 before a Compensation Review Board panel consisting of the Commission Chairman John A. Mastropietro and Commissioners Ernie R. Walker and Randy L. Cohen.

OPINION

JOHN A. MASTROPIETRO, CHAIRMAN. The claimant has appealed from a Finding and Dismissal issued by Commissioner Jack R. Goldberg concluding that bills owed to the claimant's authorized treating psychiatrist, A. Herbert Schwartz, M.D., should not be paid. The trial commissioner determined that because the provider failed to adhere to the billing guidelines of the Workers' Compensation Commission ["Commission"], the bills submitted by Dr. Schwartz for the period of January 3, 2013 through January 22, 2015, in the amount of $11,800, were dismissed. The claimant has appealed, arguing that because the trial commissioner found that Dr. Schwartz provided reasonable and necessary medical care during this period, he should be paid. We have reviewed the facts and applicable law. Given that we find nonpayment for authorized necessary medical treatment is not an enumerated remedy for failure to comply with our Commission's billing guidelines, we vacate Order, ¶ 1, of the relief in the Finding and Dismissal. We affirm Order, ¶ 2, and caution Dr. Schwartz, as well as all medical providers, that it is the obligation of an authorized treater to comply with the billing and reporting guidelines promulgated by this Commission.

The trial commissioner reached the following factual findings at the conclusion of the formal hearing. The parties stipulated that Dr. Schwartz was an authorized treating physician, that his treatment had been reasonable and necessary, and that none of his bills were submitted on an HCFA claim form.[1] The claimant was being treated for a January 10, 2000 lumbar injury which led to depression. Dr. Schwartz is seeking

[1] Form HCFA-1500 is the health insurance claim form approved by the Centers for Medicare and Medicaid Services (CMS).

payment for fifty-eight sessions with the claimant during the period from January 3, 2013 through January 22, 2015. The charge sought by the treater is $200 per session, but the bill presented seeks $10,800 in payment.

Dr. Schwartz was the sole witness to testify at the hearing. He testified that he has been in practice for fifty years and has not issued separate invoices in the past for office visits; instead, he has submitted a "bulk billing" invoice with the applicable diagnostic codes. All billing and reports were submitted to claimant's counsel's office and the doctor had never submitted reports to the respondents on an HCFA form. He noted that he had been paid approximately $32,000 by the respondents for treatment provided through January 2013, and his reports and bills were similar to those provided during the period in dispute.

Dr. Schwartz also testified regarding his billing and reporting methods. He indicated that after seeing the claimant and preparing an office note, he did not customarily submit the note and bill within thirty days of treatment. He was not aware that the Commission's guidelines require the use of an HCFA form or that reports are to be sent to the claimant's insurance carrier and the attorneys in the case within thirty days of treatment. He has participated in the workers' compensation system since the tenure of former Chairman John Arcudi and maintained the same reporting and billing practices as he had then; he has not attended any course offered by the Chairman's office during this period. His invoices contained the diagnostic code for a major depressive disorder, and the claimant's diagnosis and code had remained unchanged. On the occasions when he treated the claimant, Dr. Schwartz would not always make handwritten notes at the time of the visit; rather, he would make a summary note later, and these notes often were

illegible. He indicated that he had been asked periodically by claimant's counsel to provide written narrative reports, and on some occasions, the request had to be repeated two or three times. He received requests for updates on the claimant's condition from claimant's counsel or the insurance adjuster in 2009, 2011, 2013 and 2014. The trial commissioner also noted that claimant's counsel had requested payment of Dr. Schwartz' bills in 2014 and 2015.

Based on the evidence, the trial commissioner concluded that "the State of Connecticut workers' compensation statutes, regulations and guidelines require authorized treating physicians to provide contemporaneous medical reports and bills on prescribed forms with applicable diagnostic codes." Conclusion, ¶ d. He concluded that the respondents had acted in good faith in paying Dr. Schwartz, despite not having received such reports from him, and this payment was not a waiver of their right to receive such reports. The trial commissioner did not find persuasive Dr. Schwartz' explanation for his noncompliance with the required reporting guidelines. In addition, the trial commissioner found Dr. Schwartz' noncompliance in reporting to be unreasonable. The commissioner found that the treating physician's failure to report to the respondents impeded their ability to raise a possible objection to the care provided and was in derogation of their due process rights. He concluded that Dr. Schwartz' methods may have been reasonable in past years, but did not meet the standard expected in the system in 2016.

Therefore, the trial commissioner dismissed the claim for $11,800 in invoices for treatment rendered by Dr. Schwartz between January 3, 2013 and January 22, 2015. He further ordered Dr. Schwartz to submit all future invoices for treatment on an HCFA

form within thirty days of providing treatment. The claimant responded to this decision by filing a timely appeal asserting that the trial commissioner had abused his discretion in the Finding and Dismissal and exceeded his authority in dismissing Dr. Schwartz' demand to be paid.

The claimant did not file a Motion to Correct. Therefore, on appeal, we must accept the validity of the facts found by the trial commissioner in this matter. Crochiere v. Board of Education, 227 Conn. 333, 347 (1993); Claros v. Keystone Pipeline Services, 5399 CRB-1-08-11 (October 28, 2009); Stevens v. Raymark Industries, Inc., 5215 CRB 4-07-4 (March 26, 2008), *appeal dismissed*, A.C. 29795 (June 26, 2008). As such, we must limit our review on appeal to whether the trial commissioner appropriately applied the law. In light of the remedy applied herein, we are not persuaded that he did.

We agree with the trial commissioner that Dr. Schwartz failed to comply with the guidelines we have promulgated for providing timely medical reports and bills for authorized treatment. However, we cannot identify where our statutes or regulations state that nonpayment for otherwise reasonable and necessary medical treatment is the appropriate remedy for the submission of deficient or untimely reports or bills. The respondents point to various provisions of Admin. Reg. § 31-280-3 as well as memoranda issued by the Chairman's office which govern the reporting standard for authorized treating physicians. In Admin. Reg. § 31-280-3 (d) (1), we noted that Public Act § 93-228 requires that the Commission publish "Practitioner Billing and Payment Guidelines."[2] In addition, Admin. Reg. § 31-280-3 (d) (3) mandates that "[t]he

[2] Admin. Reg. § 31-280-3 (d) (1) states: "Pursuant to Public Act 93-228, the Chairman shall publish Practitioner Billing and Payment Guidelines. Such guidelines shall govern the billing, claims payment review, and payment process for Practitioners, Reviewers and Payors. The Medical Advisory Board shall assist the Chairman in accordance with Subsection (c) (2) of section 31-280-1."

guidelines shall require that Practitioners submit all bills using the HCFA 1500 form or its current equivalent beginning no later than October 1, 1993." The April 11, 1995 Chairman's Memorandum entitled "WCC CPT Codes/Practitioner Fee Schedule/Billing Guidelines Memorandum" reiterates that "[a]ll billing will be submitted on a HCFA 1500."

Although the requirement for workers' compensation treating physicians to utilize the HCFA billing form has been in place for over two decades, it does not appear that Dr. Schwartz ever used this form to seek payment. In addition, the trial commissioner noted deficiencies with the timeliness and sufficiency of Dr. Schwartz' treatment notes. Medical providers have a statutory obligation to provide timely and complete progress reports on the treatment of injured workers. General Statutes § 31-294f (b) states that "[a]ll medical reports concerning any injury of an employee sustained in the course of his employment shall be furnished within thirty days after the completion of the reports, at the same time and in the same manner, to the employer and the employee or his attorney." Admin. Reg. § 31-279-9 (a) requires treating physicians to ensure that "[t]he employer or its insurance carrier will receive an early original report of injury, and such regular subsequent progress reports from the attending physician as may be reasonably required in each case."

In addition, the "Payor and Medical Provider Guidelines to Improve the Coordination of Medical Services," effective as of July 1, 2010, contain extensive provisions [see Section II (A) (2)] regarding the requirements for medical reports subsequent to providing treatment to workers' compensation patients. Further requirements are delineated in Section III of the "Professional Guide for Attorneys,

Physicians and Other Health Care Practitioners, Guidelines for Cooperation," *revised* October 1, 2008. The trial commissioner could reasonably determine that Dr. Schwartz' medical reports were not submitted in a timely fashion consistent with these protocols and were not substantively sufficient.

In the absence of a Motion to Correct, we can give conclusive effect to the factual finding that Dr. Schwartz' reports were not presented consistent with Commission standards and his failure to comply with these standards was unreasonable. The question presented is whether the trial commissioner's decision to deny payment for reasonable and necessary services rendered was legally appropriate. We note that while the provision of delayed or uninformative medical reports could conceivably impede the due process rights of the respondents, there are no finding of facts indicating that the respondents sustained actual prejudice.[3] On the other hand, we note that the principle of quantum meruit would argue in favor of honoring the invoices for services provided to the claimant by Dr. Schwartz.

Our statutes articulate the appropriate remedies for noncompliance with statutes and regulations. The statute which specially addresses this situation, General Statutes § 31-294f (b), as discussed previously herein, lacks any penalty provision for noncompliance. Presumably, had Dr. Schwartz' untimely and inadequate reports delayed the proceedings, the claimant would potentially be liable for a fine pursuant to General

[3] Had the facts found by the trial commissioner supported the conclusion that the respondents were prejudiced by Dr. Schwartz' lapses in reporting, we would find the balance of the equities potentially supported a denial of some or all of the questioned invoices. Such a determination is factual in nature and the facts as stipulated do not support such a remedy. In the absence of a "factual predicate," a sanction cannot be imposed. See McFarland v. Dept. of Developmental Services, 115 Conn. App. 306, 323 (2009), *cert. denied*, 293 Conn. 919 (2009).

Statutes § 31-288 (b) (2).[4] See Falkowski v. W. E. Bassett Company, 5711 CRB-4-11-12 (December 3, 2012). The trial commissioner did not make such a factual finding in this case, however. General Statutes § 31-300, although often applied as a sanction statute, does not reference the factual scenario in this matter.[5] The statute generally applicable to the conduct of hearings, General Statutes § 31-298, does not specify a remedy for this type of lapse, but does provide broad powers to a trial commissioner to "proceed, so far as possible, in accordance with the rules of equity."[6]

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[4] General Statutes § 31-288 (b) (2) states: "Whenever either party to a claim under this chapter has unreasonably, and without good cause, delayed the completion of the hearings on such claim, the delaying party or parties may be assessed a civil penalty of not more than five hundred dollars by the commissioner hearing the claim for each such case of delay. Any appeal of a penalty assessed pursuant to this subsection shall be taken in accordance with the provisions of section 31-301."

[5] General Statutes § 31-300 states in relevant part: "In cases where, through the fault or neglect of the employer or insurer, adjustments of compensation have been unduly delayed, or where through such fault or neglect, payments have been unduly delayed, the commissioner may include in the award interest at the rate prescribed in section 37-3a and a reasonable attorney's fee in the case of undue delay in adjustments of compensation and may include in the award in the case of undue delay in payments of compensation, interest at twelve per cent per annum and a reasonable attorney's fee. Payments not commenced within thirty-five days after the filing of a written notice of claim shall be presumed to be unduly delayed unless a notice to contest the claim is filed in accordance with section 31-297. In cases where there has been delay in either adjustment or payment, which delay has not been due to the fault or neglect of the employer or insurer, whether such delay was caused by appeals or otherwise, the commissioner may allow interest at such rate, not to exceed the rate prescribed in section 37-3a, as may be fair and reasonable, taking into account whatever advantage the employer or insurer, as the case may be, may have had from the use of the money, the burden of showing that the rate in such case should be less than the rate prescribed in section 37-3a to be upon the employer or insurer. In cases where the claimant prevails and the commissioner finds that the employer or insurer has unreasonably contested liability, the commissioner may allow to the claimant a reasonable attorney's fee. No employer or insurer shall discontinue or reduce payment on account of total or partial incapacity under any such award, if it is claimed by or on behalf of the injured person that such person's incapacity still continues, unless such employer or insurer notifies the commissioner and the employee of such proposed discontinuance or reduction in the manner prescribed in section 31-296 and the commissioner specifically approves such discontinuance or reduction in writing…. Any employee whose benefits for total incapacity are discontinued under the provisions of this section and who is entitled to receive benefits for partial incapacity as a result of an award, shall receive those benefits commencing the day following the designated effective date for the discontinuance of benefits for total incapacity. In any case where the commissioner finds that the employer or insurer has discontinued or reduced any such payment without having given such notice and without the commissioner having approved such discontinuance or reduction in writing, the commissioner shall allow the claimant a reasonable attorney's fee together with interest at the rate prescribed in section 37-3a on the discontinued or reduced payments."

[6] General Statutes § 31-298 states: "Both parties may appear at any hearing, either in person or by attorney or other accredited representative, and no formal pleadings shall be required, beyond any informal notices that the commission approves. In all cases and hearings under the provisions of this chapter, the commissioner shall proceed, so far as possible, in accordance with the rules of equity. He shall not be bound by the ordinary common law or statutory rules of evidence or procedure, but shall make inquiry,

In Falkowski, supra, this tribunal cited Bailey v. State/GHCC, 5144 CRB-1-06-10 (October 15, 2007), wherein the respondent sought to have a claim dismissed due to the claimant's failure to make herself available for a respondent's medical examination which had been approved by the trial commissioner. Upon reviewing the matter, we noted that although Pietraroia v. Northeast Utilities, 254 Conn. 60 (2000), gave the trial commissioner the equitable power to dismiss a claim for noncompliance with a commissioner's orders, the circumstances in Bailey suggested a less onerous statutory remedy was more equitable and appropriate. As General Statutes § 31-294f (a) provides for a specific type of relief for respondents when a claimant fails to attend a medical examination, i.e., the suspension of benefits, we deemed that the preferable form of sanction.[7]

We have reviewed the administrative regulations and find there is a specific sanction for a medical provider who fails to provide documentation of treatment

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through oral testimony, deposition testimony or written and printed records, in a manner that is best calculated to ascertain the substantial rights of the parties and carry out the provisions and intent of this chapter. No fees shall be charged to either party by the commissioner in connection with any hearing or other procedure, but the commissioner shall furnish at cost (1) certified copies of any testimony, award or other matter which may be of record in his office, and (2) duplicates of audio cassette recordings of any formal hearings. Witnesses subpoenaed by the commissioner shall be allowed the fees and traveling expenses that are allowed in civil actions, to be paid by the party in whose interest the witnesses are subpoenaed. When liability or extent of disability is contested by formal hearing before the commissioner, the claimant shall be entitled, if he prevails on final judgment, to payment for oral testimony or deposition testimony rendered on his behalf by a competent physician, surgeon or other medical provider, including the stenographic and videotape recording costs thereof, in connection with the claim, the commissioner to determine the reasonableness of such charges."

[7] General Statutes § 31-294f (a) states: "An injured employee shall submit himself to examination by a reputable practicing physician or surgeon, at any time while claiming or receiving compensation, upon the reasonable request of the employer or at the direction of the commissioner. The examination shall be performed to determine the nature of the injury and the incapacity resulting from the injury. The physician or surgeon shall be selected by the employer from an approved list of physicians and surgeons prepared by the chairman of the Workers' Compensation Commission and shall be paid by the employer. At any examination requested by the employer or directed by the commissioner under this section, the injured employee shall be allowed to have in attendance any reputable practicing physician or surgeon that the employee obtains and pays for himself. The employee shall submit to all other physical examinations as required by this chapter. The refusal of an injured employee to submit himself to a reasonable examination under this section shall suspend his right to compensation during such refusal."

consistent with the standards we have promulgated. Admin. Reg. § 31-279-9 (g) states, "[v]iolation of these regulations shall constitute sufficient cause for a removal from the approved list of physicians maintained by the board of compensation commissioners." If Dr. Schwartz is unwilling to provide medical service to claimants in a manner which complies with our Commission's reporting protocols, he should no longer be an authorized treater. This sanction is clearly authorized and within the power of the trial commissioner to impose.

Order, ¶ 2, of the Finding and Dismissal directs Dr. Schwartz to submit all future reports to the respondents within thirty days of service and submit all future bills on HCFA forms. Should Dr. Schwartz fail to comply with this order, we believe a process to remove Dr. Schwartz as a treating physician should be pursued. Such a sanction is authorized by our statutes and regulations and is proportionate to the circumstances. Given that Order, ¶ 1, of the Finding and Dismissal is not an enumerated sanction and is indeed a "harsh remedy," we vacate Order, ¶ 1. See West v. Heitkamp, Inc., 4587 CRB-5-02-11 (October 27, 2003), *dismissed for lack of final judgment* (February 11, 2004).

Commissioners Ernie R. Walker and Randy L. Cohen concur in this opinion.

CERTIFICATION

THIS IS TO CERTIFY THAT a copy of the foregoing was mailed this 22nd day of December, 2017 to the following parties:

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