

**ORDER**

Injury No. 10-085912  
Medical Fee No. 10-01232

Employee: Tina Watt  
Employer: Houghton Mifflin Harcourt Publishing Company  
Insurer: AIG Property Casualty Company  
Health Care Provider: Midwest Special Surgery

On February 9, 2016, an administrative law judge issued an award denying health care provider Midwest Special Surgery's (HCP's) application for additional reimbursement of medical fees. HCP filed an application for review. Employer/insurer filed a motion asking us to dismiss the application for review for failing to comply with the specificity requirement set forth in 8 CSR 20-3.030(3)(A). HCP filed his response opposing the employer's motion.

8 CSR 20-3.030(3)(A) reads, as follows:

An applicant for review of any final award, order or decision of the administrative law judge shall state specifically in the application the reason the applicant believes the findings and conclusions of the administrative law judge on the controlling issues are not properly supported. It shall not be sufficient merely to state that the decision of the administrative law judge on any particular issue is not supported by competent and substantial evidence.

By its application, HCP identifies the findings and conclusions of the administrative law judge HCP believes are erroneous and specifies the reasons HCP believes the findings and conclusions are in error.

The application for review is sufficient. We deny employer/insurer's motion asking us to dismiss HCP's application for review.

Given at Jefferson City, State of Missouri, this 11<sup>th</sup> day of April 2016.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

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John J. Larsen, Jr., Chairman

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James G. Avery, Jr., Member

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Curtis E. Chick, Jr., Member

Attest:

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Secretary

## MEDICAL FEE DISPUTE AWARD

Employee: Tina Watt (Settled) Injury No.: 10-085912  
MFD No.: 10-01232  
Healthcare Provider: Midwest Special Surgery, P.C. Before the  
**Division of Workers'**  
Employer: Houghton Mifflin Harcourt Publishing Company **Compensation**  
Department of Labor and Industrial  
Additional Party: Second Injury Fund (Settled) Relations of Missouri  
Jefferson City, Missouri  
Insurer: AIG Property Casualty Company c/o Chartis Claims, Inc.  
Hearing Date: January 15, 2016 Checked by: EJK/sb

### FINDINGS OF FACT AND RULINGS OF LAW

1. Are any benefits awarded herein? No
2. Was the injury or occupational disease compensable under Chapter 287? Yes
3. Was there an accident or incident of occupational disease under the Law? Yes
4. Date of accident or onset of occupational disease: September 29, 2010
5. State location where accident occurred or occupational disease was contracted: Lincoln County, Missouri
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes
7. Did employer receive proper notice? Yes
8. Did accident or occupational disease arise out of and in the course of the employment? Yes
9. Was claim for compensation filed within time required by Law? Yes
10. Was employer insured by above insurer? Yes
11. Describe work employee was doing and how accident occurred or occupational disease contracted:  
The employee developed lateral epicondylitis in her left elbow from lifting boxes overhead at work.
12. Did accident or occupational disease cause death? No Date of death? N/A
13. Part(s) of body injured by accident or occupational disease: Left elbow
14. Nature and extent of any permanent disability: 20% Permanent partial disability of the left elbow
15. Compensation paid to-date for temporary disability: \$9,746.52
16. Value necessary medical aid paid to date by employer/insurer: \$38,122.37

- 17. Value necessary medical aid not furnished by employer/insurer? None
- 18. Employee's average weekly wages: \$522.13
- 19. Weekly compensation rate: \$348.09
- 20. Method wages computation: Per settlement

**COMPENSATION PAYABLE**

- 21. Amount of compensation payable: Settled
- 22. Second Injury Fund liability: Settled
- TOTAL: N/A
- 23. Medical Fee Dispute Additional Compensation for Medical Fees awarded: None

Said payments to begin immediately and to be payable and be subject to modification and review as provided by law.

The compensation awarded to the claimant shall be subject to a lien in the amount of N/A of all payments hereunder in favor of the following attorney for necessary legal services rendered to the claimant: N/A

Employee: Tina Watt

Injury No.: 10-085912

MFD No.: 10-01232

## **FINDINGS OF FACT and RULINGS OF LAW:**

Employee: Tina Watt (Settled)

Injury No.: 10-085912

Dependents: N/A

MFD No.: 10-01232

Before the

Employer: Houghton Mifflin Harcourt Publishing Company

**Division of Workers'  
Compensation**

Department of Labor and Industrial

Additional Party: Second Injury Fund (Settled)

Relations of Missouri

Jefferson City, Missouri

Insurer: AIG Property Casualty Company c/o Chartis Claims, Inc.

Checked by: EJK/sb

### **SUMMARY OF FACTS**

On September 29, 2010, the employee sustained a compensable work injury to her left elbow. The Healthcare Provider in this case rendered medical treatment to the employee between November 15, 2010, and April 27, 2011. On November 15, 2010, Dr. Sudekum performed an initial evaluation. See Exhibit 1. He performed an initial and revision surgery for right lateral epicondylitis early in the course of treatment. See Exhibit 1. Later, in the course of authorized treatment, Dr. Sudekum treated the employee for left-sided symptoms, and performed an epicondylar release and a left radial tunnel release. See Exhibit 1. The accident occurred in Lincoln County, Missouri, but the parties waived venue.

#### **Medical Fees**

The Healthcare Provider submitted itemized medical billing statements showing medical fees in the total amount of \$15,432.00 charged for medical services provided to the employee from November 15, 2010, to September 15, 2011. See Exhibit 1. The itemized billing statements show the Employer/Insurer made payments to the Healthcare Provider, leaving the amount in dispute at \$8,443.86 for which the Healthcare Provider is seeking additional reimbursement. See Exhibit 1.

On June 3, 2015, Midwest Special Surgery, P.C., filed its application for payment of additional reimbursement of medical fees with the Division of Workers' Compensation. The application asserts that the above captioned employer and insurer bear liability for an additional \$8,443.86 for authorized medical services rendered to the employee in the underlying workers' compensation case. On September 16, 2015, the Healthcare Provider filed an Application for Evidentiary Hearing with the Division of Workers' Compensation.

In October 2015, and on November 30, 2015, the Employer and Insurer in this medical fee dispute filed an answer to the application, alleging that it had paid all reasonable and customary expenses to the Healthcare Provider, that all remaining charges were not reasonable and customary and that the statute of limitations had run before the Healthcare Provider filed its

application. On November 13, 2015, the Division of Workers' Compensation sent a notice of evidentiary hearing to the parties. On December 1, 2015, the Employer and Insurer filed a letter requesting an Award on Undisputed Facts without hearing. No response was received within thirty days.

On January 15, 2016, the parties appeared by counsel pursuant to Notice of Hearing issued by the Division of Workers' Compensation. The injury in this case occurred in Lincoln County, Missouri, but the parties waived venue at the hearing. The procedure for proceedings in Medical Fee Dispute cases is provided by law:

The division shall, by regulation, establish methods to resolve disputes concerning the reasonableness of medical charges, services, or aids. This regulation shall govern resolution of disputes between employers and medical providers over fees charged, whether or not paid, and shall be in lieu of any other administrative procedure under this chapter. The employee shall not be a party to a dispute over medical charges, nor shall the employee's recovery in any way be jeopardized because of such dispute. Any application for payment of additional reimbursement, as such term is used in 8 CSR 50-2.030, as amended, shall be filed not later than:

- (1) Two years from the date the first notice of dispute of the medical charge was received by the Healthcare Provider if such services were rendered before July 1, 2013; and
- (2) One year from the date the first notice of dispute of the medical charge was received by the Healthcare Provider if such services were rendered after July 1, 2013.

Notice shall be presumed to occur no later than five business days after transmission by certified United States mail.

At the hearing, the Healthcare Provider submitted a complete medical report stating that Dr. Sudekum reviewed the medical records and bills generated for the employee's treatment, and works closely with all departments of the Healthcare Provider and has knowledge of its billing practices and protocol, that all fees and charges contained in the billing records are attributable to authorized medical services provided for the employee's work injuries, and that the fees and charges are fair and reasonable and are not greater than the usual and customary fee this Healthcare Provider receives for the same treatment or service when the payer for such treatment or service is a private individual or a private health insurance carrier. See Exhibit 1. Dr. Sudekum testified, by affidavit, that no notice of dispute of the medical charges has been received by the Healthcare Provider. See Exhibit 1.

The Healthcare Provider also submitted affidavits from Mary Ellen Richardson, the healthcare provider's director of billing and collection supervisor, stating that all fees and charges contained in the billing records are attributable to authorized medical services provided for the employee's work injuries, and said fees and charges are fair and reasonable and are not greater

than the usual and customary fee this Healthcare Provider receives for the same treatment or service when the payer for such treatment or service is a private individual or a private health insurance carrier. See Exhibit 1. The Affidavit also states that Ms. Richardson reviewed the disputed items which led to an adjustment or underpayment and did not find any of the charges to be outlandish, high, or unreasonable. See Exhibit 1. The second Affidavit states that she personally identified the attached medical bills as being those of the employee and that they were personally prepared by her staff and kept in the regular course of business, and were complete copies of all the patient charges during this applicable time period. See Exhibit 1. Dr. Sudekum and Ms. Richardson swore in their affidavits that no notice of dispute of the medical charges has been received by the healthcare provider. See Exhibit 1.

The Employer and Insurer submitted a copy of its Application for Award on Undisputed Facts and five explanations of benefits directed to the Healthcare Provider. See Exhibits A, B.

### **ISSUES**

The issues to be resolved in this proceeding are:

1. Whether an evidentiary hearing should have been held in light of Request for Award on Undisputed Facts;
2. Whether the Healthcare Provider is entitled to additional reimbursement of medical fees for medical treatment and services provided to Employee to cure and relieve the effects of the compensable work injury dated 9/29/2010;
3. Whether any "statute of limitations" as defined by RSMo 287.140.4(1)&(2) constitutes *Ex Post Facto*, and is prohibited by Article 1, Section 13 of the Missouri Constitution and other Missouri Law.

### **FINDINGS OF FACT**

Based upon the evidence:

The Healthcare Provider in this case rendered medical treatment to the employee between November 15, 2010, and April 27, 2011. In addition, the Healthcare Provider examined the employee and prepared a medical report on September 15, 2011. Under the above statute, the Healthcare Provider had two years to have filed its application from the date of the first notice of dispute.

The first charge for services rendered pertaining to this application was on November 15, 2010, in the amount of \$800.00. See Exhibit 1. On December 14, 2010, the Employer and Insurer directed payment and an explanation of benefits to the Healthcare Provider showing a reduction of the Healthcare Provider's billing for services rendered to \$407.01, and stated that the charge for the procedure "exceeds the fee schedule or usual and customary allowance". See Exhibit B. The payment was reflected in the Healthcare Provider's billing statement on December 20, 2010. See Exhibit 1.

The medical provider had notice of the Employer and Insurer's dispute of the charges as of that date.

The second charge for services rendered pertaining to this application was also on November 15, 2010, in the amount of \$607.00. See Exhibit 1. On December 15, 2010, the Employer and Insurer directed payment and an explanation of benefits to the Healthcare Provider showing a reduction of the Healthcare Provider's billing for services rendered to \$407.01, and stated that the charge for the procedure "exceeds the fee schedule or usual and customary allowance". See Exhibit B. The payment was reflected in the Healthcare Provider's billing statement on December 20, 2010. See Exhibit 1.

The second date of services rendered pertaining to this application was on January 17, 2011, in the amount of \$140.00. See Exhibit 1. On April 22, 2011, the Employer and Insurer directed an explanation of benefits to the Healthcare Provider showing a reduction of the Healthcare Provider's billing for services rendered to \$98.53, and stated that the "contracted provider ... has agreed to this charge below fee schedule or usual and customary charges for your business. Any reduction is in accordance with the FOCUS Beech Street contract. ... The charge exceeds the fee schedule or usual and customary allowance". See Exhibit B. The Healthcare Provider reflected the payment as of February 11, 2011. See Exhibit 1.

The final charge for services rendered pertaining to this application was on April 27, 2011, in the amount of \$12,432.00. See Exhibit 1. On August 23, 2011, the Employer and Insurer directed an explanation of benefits to the Healthcare Provider showing a reduction of the Healthcare Provider's billing for services rendered to \$4,739.64 alleging that the "contracted provider has agreed to this charge below fee schedule of usual and customary charges for your business, any network reduction is in accordance with the Beech Street Contract, this multiple procedure was reduced 50% according to fee schedule or FAIR Health Benchmark Database, the charge for this procedure exceeds the fee schedule or FAIR Health Benchmark Database." See Exhibit B. The Healthcare Provider reflected the payment as of June 13, 2011, and August 26, 2011. See Exhibit 1.

### **EMPLOYER/INSURER REQUEST FOR AWARD ON UNDISPUTED FACTS**

The Employer and Insurer contend that it emailed a "Request for Award on Undisputed Facts" to the Healthcare Provider Attorney on December 1, 2015, and that this document was accompanied by "EOB's." The Employer and Insurer argue that pursuant to 8 CSR 50-2.030, that no hearing on the merits of the case should have been held and, due to no response by the Healthcare Provider attorney being filed, the facts contained in the "Request" as follows should be deemed as admitted and an Award should be issued upon same (of note is that each below referenced exhibit letter "A-D" constituted one page of EOB):

*"The attached EOBs show that the provider found out in 2010 and 2011 that these charges were being disputed. The Application for this matter was not filed until almost 5 years later in 2015. SEE ATTACHED EXHIBITS A, B, C and D, which correspond to the charges referenced on the Application for Payment of Additional Reimbursement of Medical Fees." See Exhibit A.*

The request is denied, because there are questions of material fact to be determined based on the Application for Payment of Additional Reimbursement of Medical fees and the Request for Award on Undisputed Facts as submitted. For instance, the exhibits do not reveal the date the explanations of benefits were received by the Healthcare Provider and whether they constitute a notice of dispute. However, the first issue is moot, because this award is written based on the exhibits received at the hearing.

### **FAIR AND REASONABLE MEDICAL FEES**

The Healthcare Provider submitted itemized medical billing statements showing medical fees in the total amount of \$15,432.00 charged for medical services provided to the employee from November 15, 2010, to September 15, 2011. See Exhibit 1. The itemized billing statements show that the Employer and Insurer made payments to the Healthcare Provider, leaving the amount in dispute at \$8,443.86 for which the Healthcare Provider is seeking additional reimbursement. See Exhibit 1.

The Healthcare Provider submitted a complete medical report signed by Dr. Anthony Sudekum stating that Dr. Sudekum reviewed the medical records and bills generated for the employee's treatment, and works closely with all departments of the Healthcare Provider and has knowledge of its billing practices and protocol. See Exhibit 1. The complete medical report states that all fees and charges contained in the billing records are attributable to authorized medical services provided for the employee's work injuries, and said fees and charges are fair and reasonable and are not greater than the usual and customary fee this Healthcare Provider receives for the same treatment or service when the payer for such treatment or service is a private individual or a private health insurance carrier. See Exhibit 1. Dr. Sudekum testified in his affidavit that no notice of dispute of the medical charges has been received by the Healthcare Provider. See Exhibit 1.

As additional support of the medical fees, the Healthcare Provider submitted Affidavits from Mary Ellen Richardson, the director of billing and collection supervisor for Midwest Special Surgery. See Exhibit 1. The first Affidavit signed by Ms. Richardson on May 27, 2015, states that all fees and charges contained in the billing records are attributable to authorized medical services provided for the employee's work injuries, and said fees and charges are fair and reasonable and are not greater than the usual and customary fee this Healthcare Provider receives for the same treatment or service when the payer for such treatment or service is a private individual or a private health insurance carrier. See Exhibit 1. The Affidavit also states that Ms. Richardson reviewed the disputed items, which led to an adjustment or underpayment and did not find any of the charges to be outlandish, high, or unreasonable. See Exhibit 1. The second Affidavit signed by Ms. Richardson on May 27, 2015, stated that she personally identified the attached medical bills as being those of the employee and that they were personally prepared by her staff and kept in the regular course of business, and were complete copies of all the patient charges during this applicable time period. See Exhibit 1. Ms. Richardson swore in her Affidavit that no notice of dispute of the medical charges has been received by the Healthcare Provider. See Exhibit 1.

In reviewing the second issue, the Healthcare Provider submitted Affidavits from Mary Ellen Richardson, its director of billing and collection supervisor, and Dr. Sudekum swearing that the “fees and charges are fair and reasonable and are not greater than the usual and customary fee this Healthcare Provider receives for the same treatment or service when the payer for such treatment or service is a private individual or a private health insurance carrier.” See Exhibit 1.

The defense submitted no contrary evidence regarding whether the additional compensation was fair and reasonable leaving a conclusion that the additional compensation is fair and reasonable based on the evidence submitted in the record.

### **STATUTE OF LIMITATIONS**

In this case, the Healthcare Provider provided medical services in 2010 and 2011, billed the Employer and Insurer for services provided and received compensation for same in 2011. The Employer and Insurer contends that it sent explanations of benefits to the Healthcare Provider in 2010 and 2011 stating the reasons that the compensation paid was less than the billed amount. No statute of limitations specifically dealt with this type of proceeding before 2013. In 2013, the legislature enacted a two-year statute of limitations barring actions initiated more than two years from the date the first notice of dispute of the medical charge was received by the Healthcare Provider if such services were rendered before July 1, 2013. The Healthcare Provider did not initiate this proceeding until June 3, 2015. The first question is whether the Healthcare Provider received first notice of dispute of the medical charges before or after June 3, 2013. The second question is how to apply the 2013 act to medical services provided in 2010 and 2011.

Looking at the first question, the medical provider had notice of the Employer and Insurer’s dispute of the charges as of the date that the Healthcare Provider credited the account of the injured employee with the payment from the Employer and Insurer. The Healthcare Provider had sufficient information to determine that the Employer and Insurer had not paid the full amount charged and had to review the explanation of benefits with the payment to determine how to credit the account.

The defense exhibits, a business records affidavit, infer that the Healthcare Provider received notice of the Employer and Insurer’s dispute of medical charges shortly after the dates of the explanation of benefits. See Exhibit B. Although the Healthcare Provider submitted a sworn statement that it had never received any notice that the Employer and Insurer disputed the charges stated in the Healthcare Provider’s billing statement, the billing statement attached to the affidavit shows receipt of payments shortly after the date of the Employer and Insurer’s explanation of benefits leaving an implication that the Healthcare Provider received notice that the Employer and Insurer disputed the charges, because the payments were less than the charges stated on the Healthcare Provider’s billing statement. See Exhibits 1, B.

It is certainly logical to conclude that if the Healthcare Provider received the checks sent by the Employer and Insurer, it would have received the Employer and Insurer’s explanation of benefits with the check. How else could the Healthcare Provider apply the payment to the

account of the patient assuming that the Healthcare Provider serves more than one patient at a time.

Looking at the second question regarding application of the 2013 enactment of a statute of limitations to prior events, all of the events pertaining to medical services, billing for the services provided, and notice of dispute occurred in 2010 and 2011. On July 10, 2013, the Governor of Missouri signed into law an act to impose the statute of limitations described above with an effective date of January 1, 2014. Thus, if the Healthcare Provider did not take advantage of the five plus month interval between the Governor's approval of the act and the effective date of the act, the new statute of limitations would bar the administrative proceeding.

It is possible to shorten the statute of limitations applicable to an existing claim since there is no vested right in the maintenance of the statute in effect at the time a claim accrues. Goodman v. St. Louis Children's Hosp., 687 S.W.2d 889, 891 (Mo. banc 1985). However, if an attempt is made to shorten the time for suing on existing claims, "those who have pending and unbarred claims at the time the new statute becomes effective must be afforded a reasonable time within which to file suit." *Id.* What constitutes a "reasonable time" under a statute shortening the limitation period can vary. See 51 Am.Jur.2d Limitation of Actions § 39 (1970) ("The reasonableness of each limitation prescribed by a statute shortening the period of limitation must be separately judged in the light of the circumstances surrounding the class of cases to which it applies...."). Swartz v. Swartz, 887 S.W.2d 644, 650 (Mo. Ct. App. 1994).

On June 3, 2015, the Healthcare Provider filed its application for payment of additional reimbursement of medical fees with the Division of Workers' Compensation. The dispositive issue in this case regarding the Statute of Limitations revolves around "the date the first notice of dispute of the medical charge was received by the health care provider". The Healthcare Provider submitted Affidavits from Mary Ellen Richardson, its director of billing and collection supervisor, and Dr. Sudekum swearing "that no notice of dispute of the medical charges has been received by Healthcare Provider." See Exhibit 1. On the other hand, the Employer and Insurer argues in its brief:

The Healthcare Provider's own exhibit proves that they knew or should have known there was a dispute back in 2010. The first charge they list is for services on 11/15/10, in the amount of \$607.00 and \$800.00. On page 10 of Exhibit 1, it shows that the Healthcare Provider received payments in the amount of \$289.98 and \$407.01, on 12/20/10. Exhibit B consists of EOBs, that show that the Healthcare Provider was informed of the disputes to the charges and the reasons those amounts were paid. The same holds true for the other charges. See Employer and Insurer Brief.

The notices of dispute for the charges listed in the application were communicated to the Healthcare Provider by August 23, 2011, but the application for payment of additional reimbursement of medical fees was not filed until June 3, 2015. The statute of limitations provides that the Healthcare Provider has two years to file an application from the "first notice of

dispute of the medical charge was received by the health care provider”. In this case, the application was not filed until over three years after the last notice of dispute. The Healthcare Provider did not take advantage of the time between the enactment of the new provision and the effective date of the new provision. For those reasons, the application for payment of additional medical fees is denied.

### **RULINGS OF LAW**

**Now, therefore, pursuant to 8 CSR 50-2.030(2)(I), the application of the above Healthcare Provider for payment of additional reimbursement of medical fees is denied, because the statute of limitations ran before the Healthcare Provider filed its application for payment of additional reimbursement of medical fees. The legislature did not eradicate the liability of the Employer and Insurer, it merely removed this administrative remedy to determine the extent, if any, that the Employer and Insurer may have to the Healthcare Provider. Having exhausted its administrative remedies, the Healthcare Provider will have to determine what other remedies may be available.**

**In addition, the Employer and Insurer’s “Request for Award on Undisputed Facts” is denied, because there are questions of material fact to be resolved by the evidence.**

**Finally, the fair and reasonable compensation for the Healthcare Provider would require payment of an additional \$8,443.86 for authorized medical services rendered to the employee in the underlying workers’ compensation case.**

### **APPEAL**

Pursuant to 8 CSR 50-2.030(2)(I)4, the Healthcare Provider may file an application for review with the Labor and Industrial Relations Commission within twenty days from the date of this award.

Made by: \_\_\_\_\_  
EDWIN J. KOHNER  
*Administrative Law Judge*  
*Division of Workers' Compensation*