

OPINION ENTERED: November 9, 2012

CLAIM NO. 201070107

SUTTON RANKIN LAW, PLC

PETITIONERS

VS.

**APPEAL FROM HON. JOSEPH W. JUSTICE,  
ADMINISTRATIVE LAW JUDGE**

KIMBERLY M. SUTTON, EMPI,  
KY REHABILITATION SERVICES,  
KENWOOD SURGERY CENTER,  
SUMMIT MEDICAL-EDGEWOOD,  
TRI-STATE ORTHOPAEDIC PRODUCTS, INC.,  
UC HEALTH,  
UNIVERSITY OF CINCINNATI PHYSICIANS,  
UNIVERSITY ORTHOPAEDICS & SPORTS MEDICINE,  
and HON. JOSEPH W. JUSTICE,  
ADMINISTRATIVE LAW JUDGE

RESPONDENTS

**OPINION  
AFFIRMING**

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BEFORE: ALVEY, Chairman, STIVERS and SMITH, Members.

**STIVERS, Member.** Sutton Rankin Law, PLC ("Sutton Rankin")  
appeals from the January 5, 2012, opinion, order, and award  
of Hon. Joseph W. Justice, Administrative Law Judge ("ALJ")

awarding income and medical benefits to Kimberly M. Sutton ("Sutton") as a result of a July 21, 2010, work-related injury. The ALJ also resolved a medical fee dispute filed by Sutton Rankin determining the contested medical bills were compensable but the contested treatment was not compensable. Sutton Rankin appeals from that portion of the opinion, order, and award determining the medical bills are compensable. Sutton Rankin also appeals from the February 3, 2012, order denying its petition for reconsideration.

Sutton's Form 101 filed June 6, 2011, alleges a right knee injury occurring on July 21, 2010, while setting up for Sutton Rankin's company picnic. Sutton alleged she was carrying a plastic bin full of soft drinks when she slipped on wet pavement, fell, and injured her right knee. Sutton Rankin's July 25, 2011, Form 111 denied the claim asserting Sutton did not sustain a work-related injury.

The October 4, 2011, benefit review conference ("BRC") order reflects the following contested issues: "benefits per KRS 342.730; work-relatedness/causation; unpaid or contested medical expenses; TTD." Sutton Rankin argued, in its brief to the ALJ, Sutton was not acting in the course and scope of her employment at the time of the injury, sustained no impairment as a result of the injury,

and failed in her burden of proving entitlement to medical benefits.

Sutton testified at an August 2, 2011, deposition and the November 9, 2011, hearing. She is married to one of the partners in the law firm and works as a receptionist at the firm approximately nineteen hours a week. Sutton has a flexible work schedule where she works two days one week and three days the next. She testified she had a previous injury to her left knee in 2007 which necessitated surgery to repair her ACL and a torn meniscus. Sutton testified the doctor also performed a "microfracture."

Sutton testified on the day of the injury she had gotten off work early from work in order to prepare for the company picnic. Sutton was on the committee responsible for the food and setup. She denied having any previous right knee problems before the work incident. After she fell, Sutton immediately knew her knee was injured because she could not walk very well. The next day she called Dr. Colosimo who performed the previous surgery on her left knee and made an appointment. Ultimately, Dr. Colosimo performed surgery on December 8, 2011.

Sutton testified because her family had met a \$6,000.00 yearly deductible, she decided to have the surgery at the end of the year. Sutton testified she did

not consider filing a report of injury and informing KESA of the injury. She explained she "did not want to charge the firm." She believed she would undergo surgery on Wednesday and return to work on Monday and miss no work. However, the surgery was much more extensive and she did not return to work until five weeks after the surgery. Sutton testified that eventually the attorneys in the firm made the determination since this involved workers' compensation, the injury should be reported to the carrier, and the office administrator prepared the first report and reported the claim.

Sutton testified she learned after the surgery a microfracture was performed.<sup>1</sup> Dr. Colosimo informed her after the surgery that her knee was in worse shape than anticipated. Sutton believes a brace would help because her knee is unstable.

Sutton testified when she was seen by the medical providers she gave them her personal insurance information. As a result, she has unpaid medical bills which have not been covered by her health insurance. Her only medical

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<sup>1</sup> The December 8, 2010, operative note reflects an abrasion chondroplasty with microfracture was one of the three procedures performed.

providers were Dr. Colosimo, NovaCare Rehabilitation ("NovaCare"), and Kenwood Surgical Center.<sup>2</sup> Sutton does not know the amount of her out-of-pocket expenses and outstanding balance for the surgery and does not believe KESA was billed by the providers.<sup>3</sup> Sutton insisted she has always maintained the injury was work-related.

Lawrence Hicks, a partner, testified at the hearing in support of Sutton's contention she sustained a work-related injury. Since his testimony is not germane to the issue on appeal, it will not be discussed.

Gayla Pritchard ("Pritchard"), an adjuster with KESA, testified at the hearing. She testified the injury had been reported to KESA on December 10, 2010, by Julia Fronk, the office administrator. After receiving the notice, Pritchard followed the typical KESA protocol in investigating the claim. Pritchard testified as follows:

Q: And in the course of your investigation you said that you did request medical records?

A: Yes.

Q: And did you request records or receive records from NovaCare Rehabilitation?

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<sup>2</sup> Kenwood Surgical Center is also known as Kenwood Surgery Center.

<sup>3</sup> At the time of Sutton's injury, KESA was Sutton Rankin's workers' compensation insurance carrier.

A: We did later on. At that time we were requesting the treatment that she had received up to the point that we'd received the claim. Once we received those medical records it was sent for a medical consultation review and the review physician determined that at the point she had the MRI, which did not confirm a meniscal tear --

[text omitted]

A: So based on the medical consultation report the claim was, from that point forward treatment was denied as not related to the injury.

Q: Okay. So the records that you had at that point were from Dr. Colosimo?

A: Yes.

Q: Okay. You initially in the paperwork that you sent Ms. Sutton to complete, did that include a medical waiver?

A: Yes.

Q: Okay, and that's what you used to request medical records?

A: I did. But Dr. Colosimo's office would not accept that, they required that she complete their medical authorization release.

Q: Okay. And so did you provide a, is that this medical authorization form UC Physicians -

A: Yes.

Q: --and was that Dr. Colosimo's office?

A: Yes.

Q: Okay. And did Ms. Sutton complete one of those authorization forms?

A: Yes.

Q: When did she first complete that authorization form?

A: That was faxed to me on December 20<sup>th</sup>, it was signed December 20<sup>th</sup>. And I faxed back to University Orthopaedics on December 21<sup>st</sup> along with a copy of that signed release requesting past medical records.

Q: Okay. And did you receive records from Dr. Colosimo at that point?

A: Not until January 19<sup>th</sup>.

Pritchard testified the first medical bills from Dr. Colosimo's office were received on September 14, 2011, which included a bill for services rendered on January 18, 2011.<sup>4</sup> Pritchard testified the bills supplied on that date were made a part of the medical fee dispute. She stated the bills go back as early as July 2010 and include a bill for the December surgery. She testified the bills attached to the October 24, 2011, Notice of Addition to Medical Fee Dispute were the bills received from NovaCare

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<sup>4</sup> The record reflects on August 30, 2011, Sutton's attorney mailed a group of bills and statements to Sutton Rankin's attorney. On September 6, 2011, Sutton Rankin filed a medical fee dispute concerning those bills. On October 3, 2011, KESA filed a "Notice of Addition to Medical Fee Dispute" attaching the bills and supporting medical records received by KESA on September 14, 2011.

Rehabilitation ("NovaCare") by Karen Mason ("Mason"), a "utilization review nurse."<sup>5</sup> She explained Mason "was getting the information together to send to the review physician who did the medical consultation review." Pritchard testified at her direction Mason "would request any medical records that they were aware of at that time that they needed to complete the medical consultation." On February 4, 2011, records were sent by facsimile to Mason.

Pritchard testified she received a call from an employee of NovaCare stating it had been advised "by the employee" that "this was work comp," and the bills should be submitted to Pritchard's office. The employee wanted to know if a claim was open. Pritchard advised there was an open claim which was in litigation. Pritchard testified she told the NovaCare employee the injury date was July 21, 2010, and NovaCare could submit the bills but there was no guarantee of payment because there was "a 45-day time for submission." The employee informed Pritchard the bills had been sent to collection or were in the process of being sent to collection, and she would get the information and submit it to Pritchard. Pritchard testified the bills

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<sup>5</sup> The record reflects the second Notice of Addition to Medical Fee Dispute was filed on October 27, 2011. The bills attached to the notice are from Kentucky Rehabilitation Services. Apparently, NovaCare Rehabilitation and Kentucky Rehabilitation Services are the same entity.

covering the period from January 4, 2011, through January 25, 2011, were received from Kentucky Rehabilitation Services on October 7, 2011. The documents she received included "supporting medical records for those billing statements."<sup>6</sup> Pritchard testified the first time she received an HCFA form or some kind of statement for services was on March 28, 2011. That bill came from University Hospital for x-rays of the right knee performed on January 18, 2011.

Pritchard testified she received no Form 114 from Sutton for reimbursement of travel, prescriptions, or out-of-pocket expenses. After receiving the medical consultation review from Dr. Goldman, on February 4, 2011, "treatment was denied as not related to the work injury." She acknowledged since February 2011 "the claim has been considered denied." Pritchard understood the bills had either been paid by the Suttons or their health carrier. Pritchard is unaware of which bills were unpaid. KESA has not paid any medical bills.

In the Form 112 medical fee dispute filed September 6, 2011, Sutton Rankin asserted medical bills had been submitted more than forty-five days after treatment.

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<sup>6</sup> Those bills were the bills attached to the second Notice of Addition to Medical Fee Dispute filed on October 27, 2011.

Sutton Rankin relied upon Dr. Corbett's independent medical examination ("IME") report to contest the reasonableness and necessity of the surgery performed by Dr. Colosimo. It posited most of the bills received relate to the surgery. It asserted there is no purpose in securing utilization review "as the milk is already spilled."

Sutton Rankin recited Sutton's deposition testimony concerning her actions after the injury and asserted that "only when her treatment rolled over into 2011, resetting that \$6,000 annual deductible," did she choose to file this workers' compensation claim.

Sutton Rankin stated the claim was filed on June 6, 2011, and the bills attached to the Form 112 were first submitted for payment on September 1, 2011. Sutton Rankin argued pursuant to 803 KAR 25:096 Section 6 and KRS 342.020(1), the bills are non-compensable since they were not submitted within forty-five days of the date the services were rendered and there are no reasonable grounds for failure to submit the contested medical bills within that time. Sutton Rankin asserted some of these bills were paid, at least in part, by Sutton's major medical provider and it is unclear whether the outstanding balances reflected on the statements "represent balance billing by

the providers, disallowed charges, or amounts owed by the claimant pursuant to her deductible."

Sutton Rankin asserted the tendered bills are not a "statement for services" as defined in 803 KAR 25:096 §1(5)(a). Further, to the extent the bills represent deductibles or out-of-pocket expenses, Sutton Rankin argued Sutton had not filed a Form 114 within sixty days from the date her out-of-pocket expenses were incurred.

Based upon the findings and conclusions of Dr. Corbett, Sutton Rankin maintained the surgery is non-compensable on "grounds of causation and reasonableness and and necessity." Sutton Rankin asserted Dr. Colosimo did not perform a menisectomy. It maintained Sutton testified she believed she sustained a meniscal tear and the primary purpose for the surgery was to repair the tear. However, the records concerning the operation do not reflect a meniscal tear and therefore Dr. Colosimo did not perform surgery to address an acute or traumatic injury. Rather, Dr. Colosimo performed surgery to address advanced osteoarthritic changes. Sutton Rankin maintained Dr. Colosimo performed a microfracture which Dr. Corbett stated was neither indicated nor related to the slip and fall. Sutton Rankin contended there was no request for pre-authorization for any of the procedures and it was not

provided the opportunity to submit the matter to utilization review. It posited Sutton opted to forego her workers' compensation remedy and submit the claim to her health insurance carrier.

Attached to the Form 112 are bills from The University Hospital, University Orthopedics and Sports Medicine, Kentucky Rehabilitation Services, University of Cincinnati Physicians, EMPI, St. Elizabeth Healthcare, Tri-State Orthopedic Products, and Kenwood Surgery Center. Also attached is a "claim detail" for the charges of Kenwood Surgical Center for the December 8, 2010, surgery and numerous documents styled "Your Claim Recap" from Anthem addressed to Michael Sutton which appear to relate to statements for services for treatment of the work injury.

On October 3, 2011, Sutton Rankin filed a Notice of Addition to Medical Fee Dispute attaching the bills received from University Radiology, University of Cincinnati Physicians, and University Orthopedic Consultants. Attached to each bill was a corresponding medical record setting out the service performed on each date. The dates of service for the bills range from July 26, 2010, through June 6, 2011.

On October 27, 2011, Sutton Rankin filed a second Notice of Addition to Medical Fee Dispute attaching the bills received from Kentucky Rehabilitation Services covering services rendered from January 4, 2011, through January 25, 2011. Each bill was submitted on a health insurance claim form.

In his analysis, findings of fact, and conclusions of law, the ALJ determined Sutton sustained a work-related right knee injury and as a result had a 6% impairment. With respect to the issue on appeal, the ALJ determined as follows:

**Medical Benefits.** Defendant argues that Plaintiff has not proven entitlement to medical benefits. It also raises the issue of failure to submit statements for services and failure to request pre-authorization of services. The ALJ is not persuaded by these arguments. Plaintiff pursued conservative treatment for a few months prior to surgery. Defendant was aware of her injury at the picnic, even though the carrier may not have been notified until December. When the physician recommended surgery, Plaintiff made a decision to turn this in on her health insurance in order to take advantage of the deductible provisions of her policy. She had not heard from the carrier. Plaintiff is not precluded from collecting medical benefits when the bills were not submitted to the carrier within 60 days from the time they were incurred. The requirements of KRS 342.020(1) do not apply during the pendency of the claim,

but only after the claim has been adjudicated.

Plaintiff's surgeon requested approval of a knee brace and Synvisc injections. These were not approved by the carrier. Plaintiff has not agreed that the ALJ should rule on these matters, and any need for a brace and injections at this time should properly be resubmitted if a physician requests same and if they are reasonable and necessary. The ALJ could find no reports or statements by Dr. Colosimo in support of the reasonableness or necessity of a knee brace or the injections, and therefore Defendant's dispute as to these items will be sustained.

Accordingly, the ALJ "overruled" that portion of the medical fee dispute regarding the medical bills for the surgery and treatment of Sutton's right knee but "sustained" that portion of Sutton Rankin's medical fee dispute regarding Sutton's entitlement to a knee brace and Synvisc injections.

Sutton Rankin filed a petition for reconsideration, in part, questioning the ALJ's conclusion KRS 342.020(1) applies only after adjudication of the claim. Sutton Rankin asserted if 803 KAR 25:096 Sections 6 and 11 apply, then the ALJ must state the "reasonable grounds" Sutton or her health care providers have established for their failure to timely submit the

contested bills. Based on the ALJ's findings, it maintained as a matter of law the bills are not compensable. Sutton Rankin asserted since the contested medical bills were not submitted within the applicable time frame, they must be found non-compensable pursuant to 803 KAR 25:096 Sections 6 and 11; and Garno v. Solectron USA, 329 S.W.3d 301 (Ky. 2010). Sutton Rankin requested clarification of the ALJ's statement he did not find its argument persuasive.

In response to that portion of Sutton Rankin's petition for reconsideration, in the February 3, 2012, order overruling Sutton Rankin's petition for reconsideration, the ALJ stated as follows:

Whether provider [sic] statements of service must be submitted within 45 day [sic] of service pursuant to KRS 342.020(1) in a pre-award situation? The ALJ became very aware of the 45 day rule in a pre-judgment claim in a claim in which he held otherwise and the Board reversed. Defendant is cited to Board opinion 07-89156, styled *McGeorge v. St. Joseph Healthcare*. In that case the Board cited the case of *R.J. Corman Railroad v. Haddix*, 864 S.W.2d 915 as controlling.

On appeal, citing to 803 KAR 25:096 Section 6 and KRS 342.020(1), Sutton Rankin argues the ALJ erroneously determined "the 45/60 day rule does not apply to the submission of medical bills prior to an award." Sutton

Rankin also asserts the bills attached to its September 2, 2011, Form 112 medical fee dispute do not constitute a statement for services as defined in 803 KAR 25:096 Section 1(5)(a). Sutton Rankin contends the bills were submitted by her attorney many months after treatment was initiated, and Sutton's providers did not establish reasonable grounds for their failure to submit the contested bills in a timely manner.

Sutton Rankin argues that for five months Sutton chose not to pursue a workers' compensation claim. It argues when Sutton realized her treatment would continue into 2012, "resetting that \$6,000 deductible," she elected to pursue a workers' compensation claim.

Sutton Rankin acknowledges some of the bills sent to KESA were paid at least in part by "Sutton's major medical provider" and maintains it is unclear whether many of the bills attached to its Form 112 "represent balance billing by the providers or disallowed charges or amounts owed by [Sutton] pursuant to her deductible." Sutton Rankin posits to the extent the outstanding balances represent deductibles or other out-of-pocket expenses incurred by Sutton, 803 KAR 25:096, Section 11(2) requires her to submit a Form 114 within sixty days from the date she incurred the expense.

Sutton Rankin argues the ALJ erroneously relied upon McGeorge v. St. Joseph Healthcare, WC No. 2007-89156, rendered February 25, 2010, in which the Board cited R.J. Corman R.R. Const. v. Haddix, 864 S.W.2d 915 (Ky. 1993) as controlling. It argues the Supreme Court's decision in Wolford & Wethington Lumber v. Derringer, 2009-WC-000620-WC, rendered August 26, 2010, Designated Not To Be Published, is also inapplicable. Sutton Rankin argues Sutton was "calling the shots" and elected not to pursue her claim until she learned the extent of the surgery performed by Dr. Colosimo and that she would incur medical costs in the new year. Sutton Rankin posits it had not denied Sutton's claim at the time she elected to undergo surgery or for more than sixty days thereafter.<sup>7</sup> Sutton Rankin argues Sutton effectively made an "end-run around" the utilization review process which would have revealed she did not have a meniscal tear and did not need the surgery proposed by Dr. Colosimo. Because Sutton chose to avoid utilization review, Sutton Rankin posits she has

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<sup>7</sup> We find Sutton Rankin's statement that it did not deny the claim for more than sixty days after the surgery, December 8, 2010, to be rather disingenuous given Pritchard's testimony that after learning of the claim KESA followed protocol in investigating the claim and based on the report of Dr. Goodman denied the claim on February 4, 2011, as not being work-related.

undermined its right to question her care for which she now wants to hold Sutton Rankin liable.

Sutton Rankin maintains although it is not required to file a medical fee dispute pre-award, it is required to notify the employee of its denial within thirty days. Sutton Rankin maintains Sutton and the provider's failure to submit the bills and request authorization before the treatment had been undertaken left it in the dark. In essence, it was deprived of the opportunity to utilize the statute and regulations pertaining to treatment plans, utilization review, and medical bill audits. Sutton Rankin requests the ALJ's decision finding the medical bills compensable be reversed.

We feel compelled to address the fact Sutton Rankin does not argue on appeal the medical bills are not reasonable and necessary or causally related to Sutton's work injury. Likewise, Sutton Rankin does not assert Sutton failed in her burden of establishing the medical bills in question were reasonable and necessary and causally related to the work injury. Significantly, in its petition for reconsideration, it argued KRS 342.020(1), 803 KAR 25:096 Section 6 and 11, and Garno v. Solectron USA, supra, required a finding that the medical bills were non-compensable.

KRS 342.020(1) reads, in relevant part, as

follows:

In addition to all other compensation provided in this chapter, the employer shall pay for the cure and relief from the effects of an injury or occupational disease the medical, surgical, and hospital treatment, including nursing, medical, and surgical supplies and appliances, as may reasonably be required at the time of the injury and thereafter during disability, or as may be required for the cure and treatment of an occupational disease.

. . .

The employer, insurer, or payment obligor acting on behalf of the employer, shall make all payments for services rendered to an employee directly to the provider of the services within thirty (30) days of receipt of a statement for services. The commissioner shall promulgate administrative regulations establishing conditions under which the thirty (30) day period for payment may be tolled. The provider of medical services shall submit the statement for services within forty-five (45) days of the day treatment is initiated and every forty-five (45) days thereafter, if appropriate, as long as medical services are rendered.

803 KAR 25:096 Sections 1(5)(a), 6 and 11(2) read, respectively, as follows:

Section 1.

. . .

(5) "Statement for services" means:

(a) For a nonpharmaceutical bill, a completed Form HCFA 1500, or for a hospital, a completed Form UB-92, with an attached copy of legible treatment notes, hospital admission and discharge summary, or other supporting documentation for the billed medical treatment, procedure, or hospitalization; and

Section 6. Tender of Statement for Services. If the medical services provider fails to submit a statement for services as required by KRS 342.020(1) without reasonable grounds, the medical bills shall not be compensable.

Section 11. Request for Payment for Services Provided or Expenses Incurred to Secure Medical Treatment. (1) If an individual who is not a physician or medical provider provides compensable services for the cure or relief of a work injury or occupational disease, including home nursing services, the individual shall submit a fully completed Form 114 to the employer or medical payment obligor within sixty (60) days of the date the service is initiated and every sixty (60) days thereafter, if appropriate, for so long as the services are rendered.

(2) Expenses incurred by an employee for access to compensable medical treatment for a work injury or occupational disease, including reasonable travel expenses, out-of-pocket payment for prescription medication, and similar items shall be submitted to the employer or its medical payment obligor within sixty (60) days of incurring of the expense.

A request for payment shall be made on a Form 114.

Contrary to Sutton Rankin's assertion, we believe McGeorge v. St. Joseph Healthcare, supra, is applicable in the case *sub judice*. In McGeorge, we summarized the dispute regarding contested medical expenses as follows:

Due to the narrow issue on appeal, only a brief recitation of the procedural history is necessary. The record reveals McGeorge filed a claim for benefits on or around July 11, 2007, alleging three separate injuries occurred on November 28, 2006; March 17, 2007; and April 17, 2007. On September 18, 2007, McGeorge filed a motion to bifurcate, requesting the ALJ to make a determination regarding: 1) the work-relatedness of the alleged injury; 2) notice; and 3) the compensability of medical treatment. On November 15, 2007, McGeorge filed a "notice of filing of contested medical expenses" and attached several pages of receipts for meals and medication prescribed by Dr. Ray Hays and Dr. Mark Secor. She also filed several pages of forms entitled "Alternative Insurance Management Services, Inc. Mileage Reimbursement Request." Also attached was a November 5, 2007, notice from Modern Medical regarding Catholic Health Initiatives' denial of reimbursement for the above-noted medication, a \$653.39 invoice from St. Joseph generated on or around October 20, 2007, a \$150.00 invoice for a bone scan from Central Kentucky Radiology dated November 2, 2007, and an invoice for what appears to be a consultation with Dr. James Bean. [footnote omitted] The record reveals McGeorge filed the

\$653.39 invoice from St. Joseph via separate notice on November 12, 2007, as an "unpaid medical bill."

A BRC was held on December 5, 2007, and the BRC order identified the following as contested issues: causation/work relatedness, injury as defined by the act, and reasonableness/necessity of medical treatment. The BRC order also indicates temporary total disability benefits were voluntarily paid in the amount of \$583.71 per week from April 20, 2007, through June 28, 2007, for a total amount of \$5,837.71. A hearing was held on January 29, 2008, and the ALJ rendered his opinion and order on March 31, 2008, resolving the issue of causation in McGeorge's favor and directing "the matter is now set for the taking of proof on the issue of extent and duration." Additionally, the issue of the work-relatedness, reasonableness, and necessity of a proposed diskectomy and fusion surgery were referred to a university evaluator. The matter was placed in abeyance pending the evaluator's review. Neither McGeorge nor St. Joseph filed petitions for reconsideration following the March 31, 2008, order.

A telephonic benefit review conference was held on April 16, 2009, and the final hearing was held on June 23, 2009. On July 17, 2009, St. Joseph filed a "notice of filing of medical bills" and attached several receipts for meals and mileage reimbursement requests "that have been submitted to counsel for the defendant/employer for payment." [footnote omitted] Hand-written notes on the last sheet of mileage reimbursement requests indicate additional medical expenses, including

\$180 for a visit to a Dr. Bean, \$86.14 for a visit to the ER, and \$150 for a bone scan. [footnote omitted] St. Joseph's notice stated the following:

Several of these charges related to alleged medical treatment obtained prior to the original Opinion issued in this case. Therefore, these statements are presented for consideration regarding compensability at this time.

. . .

The ALJ issued his August 21, 2009, "supplemental opinion and order," and this appeal ensued following the above-recounted petitions for reconsideration and October 5, 2009, order on reconsideration.

We reversed the ALJ's determination the medical bills were not compensable holding as follows:

We conclude the ALJ's finding McGeorge was required to submit the expenses at issue on a Form 114 within 60 days of having incurred them, pursuant to 803 KAR 25:096, is erroneous. While this requirement is applicable post-award, it is not applicable pre-award. The case of R.J. Corman Railroad v. Haddix, supra, is instructive here. In R.J. Corman, the Supreme Court held the 30-day rule for the payment of medical bills in KRS 342.0011(1) is only applicable post-award stating the following:

The amendments to KRS 342.020(1) requiring the payment of medical benefits in 30 days is clearly

intended to hasten payment of those medical bills that the employer is obligated to pay. Until an award has been rendered, the employer is under no obligation to pay any compensation, and all issues, including medical benefits, are justiciable. Id. at 918.

This same rationale must apply to the submission of expenses, pre-award, by claimants pursuant to 803 KAR 25:096, otherwise an inequity would result. Even more persuasive is the language used in 803 KAR 25:096, as this regulation pertains only to "expenses incurred by an employee for access to compensable medical treatment." (emphasis added). The language used in this regulation is unambiguous and clearly only applicable in a scenario in which medical expenses have been ruled *compensable*. Indeed, the very case *St. Joseph* has cited in its response brief in support of ALJ Smith's ruling- *Susan Garno v. Solectron-USA, et al*, Claim No. 02-66400- is supportive of our interpretation of 803 KAR 25:096. [footnote omitted] In *Garno*, the ALJ ordered the payment of temporary total disability benefits ("TTD") and medical expenses in an interlocutory opinion and award dated March 24, 2006. Several months after the entry of this award, Garno submitted multiple Forms 114 requesting reimbursement for expenses that were more than 60 days old. A medical fee dispute was filed by Garno's employer asserting the expenses were not submitted in a timely manner pursuant to 803 KAR 25:096, Section 11. The ALJ agreed and ordered the expenses were not compensable. We

affirmed the ALJ's decision on this issue holding as follows:

Further, we reject Garno's contention she had no responsibility or duty, after the interlocutory opinion and order of ALJ Cowden dated March 26, 2006, amended by order of May 4, 2006, to submit her medical bills or Forms 114 requesting reimbursement for medical expenses she paid. ALJ Cowden certainly could have determined what medical expenses were to be paid as required by his Opinion, Order and Award. Pursuant to that order both carriers knew they were obligated to pay TTD, which they did. Garno's claim that she was not required to submit her medical bills and claim for reimbursement in spite of ALJ Cowden's opinion and order rings hollow. The carriers had an obligation to pay Garno's medical bills pursuant to the decision of ALJ Cowden. Likewise Garno and her medical providers were required to comply with the mandates of the statutes and regulations regarding timely submission of medical bills and requests for reimbursement.

In the case *sub judice* we have a different scenario. McGeorge's November 15, 2007, notice of filing of contested medical expenses was filed in the record prior to the ALJ's interlocutory order. More importantly, the ALJ's March 31, 2008, opinion and order

resolved only the issue of causation, noting "the matter is now set for the taking of proof on the issue of extent and duration." The compensability of medical expenses was not ruled on until the ALJ's supplemental opinion and order of August 21, 2009. Therefore, the requirements set forth in 803 KAR 25:096 were inapplicable to all expenses submitted prior to the August 21, 2009, order; thus, McGeorge was not required to submit any of the expenses at issue on a Form 114 within 60 days of when they were incurred. Despite the inapplicability of these requirements, we feel compelled to point out McGeorge submitted her mileage expenses on forms provided by St. Joseph's insurance carrier. This satisfied the purpose of 803 KAR 25:096, Section 11.

We first address the documents attached to the Form 112. Some of these documents are statements received by Sutton for treatment of the work-related injury.<sup>8</sup> The bills are as follows:

- University Hospital- The total charge is \$326.00 for "Radiology Diagnostic" on January 18, 2011. The bill dated March 1, 2011, reflects an Anthem payment of \$188.10 and a balance due of \$137.90.
- University of Cincinnati Physicians- the total charge is \$90.00 for services rendered June 6, 2011. Anthem paid \$40.90 and the balance due is \$49.10.

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<sup>8</sup> Some documents are duplicate bills.

- Kentucky Rehabilitation Services- There are two separate bills for services rendered from December 10, 2010, to January 25, 2011. One reflects a patient balance of \$586.61 and the other lists an insurance balance of \$234.00 with a patient balance of \$489.63.
- EMPI- The statement indicates there is no amount owed due to insurance adjustments and other adjustments.
- St. Elizabeth Healthcare- The total charge is \$272.00 for services on September 9, 2010.
- Tri-State Orthopedic Products, Inc.- The total charge is \$122.95 for a polar care 500 pump. It reflects no balance due because of a payment or credit.
- Kenwood Surgery Center- The total charge is \$6,140.00 for services rendered on December 8, 2010. It reflects an Anthem insurance credit adjustment of \$5,491.00 and a self-pay insurance credit adjustment of \$119.00 leaving a balance of \$529.00.
- University of Cincinnati Physicians- The total charge is \$56.00. After an adjustment of \$39.71, with no payment by Anthem the outstanding balance is \$16.29.

Also included is a document from Anthem relating to Kenwood Surgical Center's charges of \$12,280.00 for the December 8, 2010, surgery.<sup>9</sup> The remaining documents are an

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<sup>9</sup>This appears to be referring to the Kenwood Surgery Center's charges.

explanation of benefits sent by Anthem to Michael Sutton for services rendered between December 8, 2010, and June 6, 2011. Each document sets out the total charge, the amount paid by Anthem, the amount owed by Sutton and what appears to be the remaining balance of the deductible.

Sutton Rankin contends, to the extent these bills represent Sutton's attempt for reimbursement, pursuant to 803 KAR 25:096 Section 11(2), she was required to submit the bills on a Form 114 within sixty days of incurring the expense. We conclude submission of these bills did not constitute an attempt by Sutton to obtain out-of-pocket expenses. Attached to the Form 112 is the August 30, 2011, letter from Sutton's attorney advising Sutton Rankin's attorney the enclosed medical bills were received by Sutton from various healthcare providers pertaining to her slip and fall. Her attorney requested that these invoices be forwarded to KESA for payment. The letter plainly establishes Sutton was not seeking reimbursement but was seeking to have the balance of the bills paid. All of the statements attached to the Form 112 reflect balances due. One statement reflects a zero balance. Thus, 803 KAR 25:096 Section 11(2) is not applicable.

Assuming, *arguendo*, these bills were an attempt by Sutton to obtain reimbursement, Section 11(2) does not

preclude her from seeking reimbursement of these expenses. Section 11(2) pertains to expenses incurred by an employee for access to compensable medical treatment for a work injury. On February 4, 2011, Pritchard testified, pursuant to what clearly appears to be utilization review, KESA refused to pay the bills for the treatment of Sutton's injury because it determined the treatment did not relate to a work injury. Contrary to Sutton Rankin's assertion it did not have the opportunity to submit the bills to utilization review, Pritchard's testimony certainly indicates Sutton Rankin implemented utilization review of Sutton's treatment and denied the claim.<sup>10</sup> Pritchard identified Mason as the "utilization review nurse." Pritchard testified after receiving the report of injury on December 10, 2011, KESA followed its typical protocol in investigating the claim and less than two months later made the determination none of the bills were compensable because the treatment did not relate to a work injury. Thus, no purpose was served by submitting those bills to Sutton Rankin because its carrier had already made the determination the bills were not compensable. The key

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<sup>10</sup> Significantly, we note Sutton Rankin did not file a medical fee dispute within thirty days of February 4, 2012, as required by 803 KAR 25:012(8). Pritchard's testimony establishes KESA's utilization review nurse submitted information to Dr. Goldman and based on his opinion the claim was denied on February 4, 2012.

phrase in Section 11 is "compensable medical treatment." At the time the bills were sent to Sutton Rankin's attorney, KESA had already denied the claim and the ALJ had not determined the bills in question to be compensable.

Long before the claim was filed on June 6, 2011, KESA had already made a determination, on Sutton Rankin's behalf, the bills relating to the treatment of Sutton's right knee were not work-related. Consequently, contrary to Sutton Rankin's assertion, we conclude Wolford & Wethington Lumber v. Derringer, supra, is applicable. There, the Supreme Court discussed this very issue stating as follows:

*Haddix* concerned KRS 342.020(1)'s 30-day payment rule. At issue presently is the statute's 45-day submission rule, which was enacted effective July 14, 1992, shortly before the *Haddix* and *Yates* decisions. 803 KAR 25:096 was adopted in 1993 and has been amended subsequently. The August 9, 2007 version controls this claim.

. . .

The employer asserts that KRS 342.020(1)'s 45-day rule is unambiguous, mandatory, and 'serves several legitimate purposes' that the 30-day rule at issue in *Haddix* did not. Moreover, it applies to statements for pre-award medical services without regard to whether the employer denies liability. The employer concludes that the expenses at issue were not compensable because the providers

failed to submit a statement for services within 45 days. We disagree.

The claimant directed medical providers to bill his health insurance carrier because his employer asserted from the outset that his back condition and herniated disc were not work-related. Like the 30-day rule at issue in *Haddix*, the 45-rule is unambiguous and stated in mandatory language. Nonetheless, 803 KAR 25:096, § excuses a failure to submit a statement for services within 45 days upon a showing of reasonable grounds for failing to do so. Knowledge of an employer's assertion that the condition being treated is non-work-related constitutes reasonable grounds for failing to direct a provider to submit bills for treating the condition to the employer or for failing to seek reimbursement for bills paid personally.

Slip Op. at 12-15.

Because of Sutton Rankin/KESA's denial of the claim, Sutton and the medical providers were not required to submit the bills for payment within the mandated time by KRS 342.020(1) and the applicable regulations. Further, we believe Sutton's direction to the medical providers to submit the bills to her personal health insurance carrier constitutes reasonable grounds for the providers not submitting the bills within forty-five days after treatment was initiated.

The same logic holds true for the medical bills which Sutton Rankin filed in the two Notices of Addition to

Medical Fee Dispute. The first Notice of Addition to Medical Fee Dispute filed on October 3, 2011, contained bills for services rendered from July 26, 2010, through January 18, 2011. A review of those bills establishes they were submitted on the proper form and were accompanied by a corresponding medical record. The second Notice of Addition to Medical Fee Dispute filed on October 27, 2011, contained bills for services rendered from January 4, 2011, through January 25, 2011. Pritchard testified supporting medical records were attached to these bills.

Based on the Supreme Court's holding in Wolford & Wethington Lumber v. Derringer, supra, the ALJ correctly concluded the requirements of KRS 342.020(1) and 803 KAR 25:096 Section 6 did not cause the disputed medical bills to be non-compensable. On behalf of Sutton Rankin, KESA had made the decision on February 4, 2011, it would not pay any of the medical bills. Since Sutton Rankin had already determined the bills were not compensable and Sutton initially directed the medical providers to submit the bills to Anthem, reasonable grounds existed for the medical providers failure to submit the bills within forty-five days of the day treatment was initiated as required by KRS 342.020(1). Pritchard's testimony establishes once the providers learned these bills pertained to a workers'

compensation claim the medical providers sent the appropriate statements to KESA. Therefore, we conclude 803 KAR 25:096 Section 6 and KRS 342.020(1) do not cause those medical bills attached in the Notice of Addition to Medical Fee Dispute filed on October 3, 2011, and the Notice of Addition to Medical Fee Dispute filed on October 27, 2011, to be non-compensable.

Concerning the bills attached to Sutton Rankin's second Notice of Addition to Medical Fee Dispute, we note these bills represent services rendered by Kentucky Rehabilitation Services between January 4, 2011, and January 25, 2011. On February 4, 2011, one month after the services were initiated, KESA determined all of Sutton's bills relating to her knee injury were not compensable.<sup>11</sup> By February 4, 2011, it appears Mason had all of NovaCare's treatment records covering the services NovaCare rendered between January 4, 2011, and January 25, 2011. Thus, submission of the bills after February 4, 2011, would have served no purpose.

Similarly, we believe Sutton Rankin's argument the bills in question are not compensable because they were

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<sup>11</sup> In the hearing transcript, Pritchard refers to the bills attached to the second Notice of Addition to Medical Fee Dispute as the bills from NovaCare Rehabilitation.

not submitted in the proper form as set forth in 803 KAR 25:096(5)(a) has no merit. Significantly, in its brief to the ALJ, Sutton Rankin did not argue the failure to submit a proper statement of services as required by 803 KAR 25:096(5)(a) caused the medical bills in question to be non-compensable. Regarding the medical fee dispute, in the argument section of its brief to the ALJ, Sutton Rankin asserted as follows:

Specifically, the defendant/employer contests liability for past medical treatment on grounds of work-relatedness; reasonableness and necessity; KRS 342.020(1) (45-day rule); 803 KAR 25:096, Section 6 (failure to submit statement for services without reasonable grounds); failure to request pre-authorization; and failure to submit request for reimbursement on Form 114 or within 60 days from the date expense incurred.

Sutton Rankin did not in any manner discuss the issue of failure to submit a proper statement for services. Likewise, in its petition for reconsideration Sutton Rankin did not address this issue. Thus, we believe Sutton Rankin waived its right, on appeal, to argue the bills are non-compensable because a proper statement for services for each of the bills was not submitted.

Finally, Garno v. Solectron USA, supra, is inapplicable. In Garno, during the pendency of the action

the ALJ entered an interlocutory order directing the medical providers to pay the medical bills. Thus, the regulations relating to the submission of bills were applicable. In this case, no interlocutory order was entered. A medical fee dispute was filed in this case and a determination of the compensability of the bills was not made until rendition of the opinion, order, and award. As in R.J. Corman R.R. Const. v. Haddix, supra, the parties litigated the compensability of the medical bills in the claim.

In conclusion, since KESA had determined on February 4, 2011, it would not pay any of Sutton's medical bills, Wolford & Wethington Lumber v. Derringer, supra, is controlling. Therefore, the requirements of KRS 342.020(1) and 803 KAR 25:096(6) were not applicable. Sutton and the medical providers were not required to submit the statement for services within forty-five days of the day treatment initiated and every forty-five days thereafter.

Accordingly, concerning the sole issue raised by Sutton Rankin on appeal, the January 5, 2012, opinion, award, and order and the February 3, 2012, order ruling on the petition for reconsideration are **AFFIRMED**.

ALL CONCUR.

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