STATE OF NEW HAMPSHIRE

SUPREME COURT

2019 TERM

NO. 2019-0464

APPEAL OF LAURA LEBORGNE

APPEAL FROM WORKERS' COMPENSATION APPEALS BOARD PURSUANT TO RSA 541:6

RESPONDENT'S BRIEF

Respectfully submitted,

ELLIOT HOSPITAL

By Its Attorneys,

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TEXT OF RELEVANT STATUTES

NH RSA 281-A:23V (b) (c)

(b) The commissioner shall develop a form on which health care providers and health care facilities shall report medical, surgical or other remedial treatment. The report shall include, but is not limited to, information relative to the up-to-date medical status of the employee, any medical information relating to the employee's ability to return to work, whether or not there are physical restrictions, what those restrictions are, the date of maximum medical improvement, and, where applicable, the percentage of permanent impairment in accordance with the "Guides to the Evaluation of Permanent Impairment" published by the American Medical Association and as set forth in RSA 281-A:32, and any other information to enable the employer or insurance carrier to determine the benefits, if any, that are due and payable. In addition to the report required under this section, the health care provider shall furnish a statement confirming that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained. The statement shall read as follows: "I certify that the narrative descriptions of the principal and secondary diagnosis and the major procedures performed are accurate and complete to the best of my knowledge." The health care provider shall date and sign the statement.

(c) The commissioner may assess a civil penalty of up to $2,500 on any health care provider who without sufficient cause, as determined by the commissioner, bills an injured employee or his or her employer for services covered by insurers or self-insurers under this chapter. There shall be no reimbursement for services rendered, unless the health care provider or health care facility giving medical, surgical, or other remedial treatment furnishes the report required in subparagraph (b) to the employer, insurance company, or claims adjusting company within 10 days of the first treatment. First aid treatment is excluded from the 10-day reporting requirement. Additionally, for good cause, a hearing officer may waive the 10-day reporting requirement and order remuneration paid. The employer, claims adjustment company, self-insurer or insurer shall pay the health care provider or health care facility within 30 days of receipt of a bill for services.

NH RSA 281-A:37 II

In no event shall the medical provisions of this chapter be lump summed. The costs of vocational rehabilitation services as provided in RSA 281-A:25 may be lump summed provided the lump sum agreement specifically sets forth the portion of the lump sum amount attributable to vocational rehabilitation services. Such sum shall be held in escrow by the employer or insurance carrier and shall be paid to the provider of the vocational rehabilitation services for services incurred by the claimant. Any lump sum agreement which proposes to include the costs of vocational rehabilitation services shall also specify the nature of the vocational rehabilitation services to be provided to the claimant and shall require the claimant to commence such vocational rehabilitation services within 6 months of the approval of the agreement. The employer and the insurance carrier shall not be liable for vocational rehabilitation services incurred if the claimant fails to commence use of vocational rehabilitation services within 6 months after approval of the lump sum agreement, unless the period is extended by the commissioner for good cause.

NH RSA 281-A:42-a I.

There is established a compensation appeals board. The board shall consist of a pool of 33 members, of which 11 members shall represent labor, 11 members shall represent employers or workers' compensation insurers and 11 members shall be attorneys who shall be neutral. Members of the board shall be appointed by the governor and council from a list of nominees submitted by the commissioner. The commissioner shall submit at least 2 nominees for each vacancy to be filled. Any person appointed by the governor and council who is not qualified or who ceases to be qualified in the capacity in which such person is serving on the appeals board shall be replaced by the governor and council. Terms of board members shall be 3 years,

except the initial appointments shall be staggered so that no more than 1/3 of the members' terms shall expire in the same year. Members of the board shall have at least 5 years' experience in the area of workers' compensation or human resources or administrative law. As a condition to maintaining eligibility to hear appeals, board members shall have at least 10 hours annually of training and briefing in the area of workers' compensation and relevant disciplines. The commissioner, or designee, with the assistance of the attorney general's staff shall supervise and approve the training. The commissioner shall have the authority to suspend the eligibility of any member of the board who is not in compliance with such annual training requirements, and to reinstate such member's eligibility upon compliance. The commissioner may suspend from active participation any board member who fails to render a decision or order within 30 days of the hearing as required by RSA 281-A:43, I(b). The commissioner may rescind the suspension once the board member is in compliance with RSA 281-A:43, I(b). Appeals from a decision of the commissioner or the commissioner's representative shall be heard de novo by a 3-member panel, composed of an attorney who shall serve as chair, one member representing labor and one member representing employers or workers' compensation insurers. At least 2 like votes shall be necessary for a decision by the panel. The board shall hear appeals, in accordance with RSA 281-A:43, I(b), from the decisions of the commissioner made pursuant to RSA 281-A:43. No person who is an interested party or an employee of an interested party shall participate as a member of the panel. The board shall conduct its proceedings in such a manner as to ensure a fair and impartial hearing.

NH RSA 281-A:42-b.

The commissioner shall appoint as many individuals as necessary to carry out the department's responsibilities under this chapter. Such individuals shall have experience in workers' compensation and shall hear workers' compensation cases before the commissioner. The commissioner shall set forth the job qualification necessary to insure that each hearing officer is qualified to hear workers' compensation cases. The salary shall be commensurate with the responsibilities and experience required. The commissioner shall, by rules adopted under RSA 541-A, strengthen the reporting structure and the role of a hearing officer; develop a code of ethics for hearings and hearing officers; develop and require at least 15 hours of continuing education on an annual basis for hearing officers; and require a minimum of an additional 15 hours of annual training and briefing with the attorney general's staff.

NH RSA 541:3 MOTION FOR REHEARING

Within 30 days after any order or decision has been made by the commission, any party to the action or proceeding before the commission, or any person directly affected

thereby, may apply for a rehearing in respect to any matter determined in the action or proceeding, or covered or included in the order, specifying in the motion all grounds for rehearing, and the commission may grant such rehearing if in its opinion good reason for the rehearing is stated in the motion.

NH RSA 541:4 SPECIFICATIONS

Such motion shall set forth fully every ground upon which it is claimed that the decision or order complained of is unlawful or unreasonable. No appeal from any order or decision of the commission shall be taken unless the appellant shall have made application for rehearing as herein provided, and when such application shall have been made, no ground not set forth therein shall be urged, relied on, or given any consideration by the court, unless the court for good cause shown shall allow the appellant to specify additional grounds.

STATEMENT OF THE CASE

Almost nine years ago on May 19, 2011, while employed by Elliot Hospital, the claimant was transitioning a patient from a chair to a bed when she experienced sudden and severe pain in her jaw, neck, shoulder, and upper right side of her body. App. [1] at 15. Elliot Hospital provided the claimant with a light duty desk job. She found it painful to sit at a computer and missed a lot of time from work. The Department of Labor found the claimant eligible for temporary total disability benefits beginning December 19, 2012.

Approximately a year and a half later, on May 1, 2014, the claimant and her employer agreed to a lump sum settlement of her disability benefits, permanent impairment benefits, and vocational rehabilitation benefits. App. at 15. Lump sum settlements in NH workers compensation cases do not include any agreement as to payment of future medical bills. By operation of law, the party's rights with respect to future medical bill payments do not change pursuant to a lump sum settlement. RSA-A:37 II. **Any statement by the claimant to the contrary is false.** Pet.[2] Brief at 9.

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[1] "App." refers to Appendix to Respondent's Brief
[2] "Pet. Brief" refers to Petitioner's Brief filed on January 21, 2020

The Department of Labor approved the lump sum settlement agreement on June 3, 2014. The settlement allocated $15,471.04 for future disability benefits. This represented 78 weeks (1.5 years) of weekly temporary total disability payments. The lump sum settlement approval created no obligations with regard to payment of future medical bills. Claimant's counsel did obligate himself to continue to assist the claimant on follow-up medical bill disputes.

Approximately two years later, on June 17, 2016, the claimant underwent her last treatment with her long time treating physician, Dr. Hsu. He has not prescribed nor commented upon the claimant's treatment since. App. at 16.

On October 31, 2016, the claimant began treating with Dr. Charles Kim, MD at the NYU Langone Health Clinic. She was able to discontinue narcotic use, her pain was improved and she felt more stable. The claimant reported mindfulness training was also helping. App. at 31. In May 2017, Dr. Kim provided the claimant, at her request, a chiropractic referral. App. at 28.

On May 30, 2017, the claimant started receiving massage therapy at the Ettia Holistic Day Spa for massage therapy. She subsequently

submitted a bill for 30 massages to her former employer, Elliot Hospital, asserting that the massages constituted necessary medical treatment required by the nature of May 19, 2011 work injury. The massages cost $110 each and included a 20% tip for the message therapist. The employer's workers compensation administrator denied payment of the bills.

The massage therapists provided the claimant with no notes documenting or describing any treatment provided. No notes were provided to the employer's workers compensation administrator nor were any provided to the Department of Labor Hearing Officer. App. at 16, 24.

Though he had not previously prescribed the claimant's massage therapy, Dr. Kim, six months after the treatment at issue, opined, without apparent benefit of any contemporary therapy notes, that the massages were medically necessary. App. at 27. An independent medical examiner, Dr. Andrew Farber, an osteopath, ultimately determined the massage therapy at issue, for the dates of service, May 30, 2017 through January 2018, was neither reasonable, related, nor medically necessary to the claimant's May 19, 2011 work injury. App. at 36, 38.

The claimant requested, and the Department of Labor scheduled, an initial level hearing before Hearing Officer Sarah Fuller. At the hearing, the employer argued that: 1) Dr. Farber's opinion, 2) the absence of a contemporaneous supporting opinion from Dr. Kim, 3) the absence of treatment notes, and, 4) the failure of the massage therapists to submit the statutorily required N.H. Workers' Compensation Medical forms, precluded the claimant from meeting her burden of proof and from securing reimbursement. App. at 22.

The claimant argued that: 1) Dr. Hsu' 2016 comments, 2) Dr. Kim's retroactive endorsement of massage, 3) the independent medical examiner's application of New York, rather than New Hampshire, criteria, 4) the massage therapist's regular practice of not keeping contemporaneous notes, and, 5) the massage therapist nonresident status sufficiently supported the claim for reimbursement of massage therapy payments. App. at 22.

The Hearing Officer determined the claimant failed to provide evidence that the denied massage treatment was reasonable, necessary, and/or causally related to the work injury. Hearing Officer Fuller noted specifically, the massage therapist provided no notes describing the treatment and no evidence as to the therapist's qualifications. App. at 22,

23. The claimant appealed this decision to the Compensation Appeals Board (hereinafter "CAB").

On appeal, the massage therapy notes, previously declared non-existent, suddenly materialized. App. at 24, 26. There is no way to verify they were prepared contemporaneously, especially given the claimant's original assertion that her massage therapists did not keep such notes. The statutory forms remain outstanding.

On appeal, the employer raised the same arguments presented at the first level hearing and challenged the veracity of the newly submitted massage therapy notes. The employer further relied upon an addendum opinion from Dr. Farber. The claimant, in turn, relied on the 2016 opinion of Dr. Hsu, the retroactive opinion of Dr. Kim, and the out-of-state status of the massage therapists to excuse their failure to comply with NH law. The CAB found the treatment non-compensable. App. at 18.

In a subsequent motion for rehearing, the claimant for the first time argued the statutory requirements applicable to medical bill reimbursement requests do not apply when the claimant pays for services in the first instance. App. at 11.

The CAB issued a decision denying the claimant's RSA 541 motion for rehearing. The CAB's findings and analysis contained in the decision denying the motion for rehearing are part-and-parcel of, and integral to, the original CAB decision. **This Court's review should incorporate the original decision as modified by, and clarified through, the decision addressing the motion for rehearing.**

In denying the claimant's motion for rehearing, the CAB specifically adopted "the reasons asserted by the defendant in the objection to the claimant's motion." Appt. at 3. The reasons articulated in the employer's objection and adopted by the CAB include the following: 1) the claimant failed to prove the massage therapy at issue was reasonable, necessary, and causally related treatment; 2) even with the additional credence afforded the treating physician, Dr. Kim, there was ultimately "insufficient evidence to enable the claimant to meet the preponderance-of-the-evidence threshold"; 3) several of Dr. Kim's own treatment notes fail to reference massage therapy as prescribed medical treatment; 4) Dr. Kim's own contemporaneous medical notes support the CAB's ultimate rejection of Dr. Kim's subsequent narrative opinion; and, 5) "the claimant failed to prove the treatment was reasonable, necessary, and causally related to the

work injury given the disturbing discrepancies between the office notes and the narrative opinion". App. at 4.

The CAB, in its ruling on the Motion for Rehearing, specifically adopted the employer's argument that "beyond the aforementioned deficiencies in proof, the claimant failed to meet the requisite procedural requirements for reimbursement." App. at 4.

Following the CAB's original decision and the CAB's affirmation, expansion, and clarification of that decision in its denial of the claimant's RSA 541 motion for rehearing, the claimant filed a Notice of Appeal with this Court. In her Notice of Appeal, the claimant set forth five issues for review by this Court: 1) whether she failed to prove her massage therapy was necessary medical treatment required by the nature of her injury; 2) whether the CAB properly considered the massage therapists failure to file required forms; 3) whether the massage therapist was required to provide the statutory forms when the patient pays for the treatment in the first instance; 4) whether the CAB properly weighed the evidence before it; and, 5) whether the claimant's hearsay assertion, purporting to explain the massage therapist's failure to provide the statutory forms, compelled the CAB to find good cause to waive the form requirement.

Most recently, in her brief, the claimant added the issue of whether the palliative nature of her massage therapy relieved her massage therapists from statutory reporting requirements. She similarly added the issue of whether language contained on the statutory reporting form relieved the massage therapists from filing the form.

SUMMARY OF THE ARGUMENTS

The CAB identified the appropriate legal standards; the relative weight afforded conflicting medical opinions, and the reasons for accepting, or rejecting in whole, or in part, the opinions of the medical doctors. The CAB found that even affording the treating physician's opinion substantial weight, the opinion failed to support the claimant's contentions. Specifically, the CAB noted Dr. Kim's own treatment notes fail to reference massage therapy as prescribed medical treatment. In this respect, the CAB reasoned that Dr. Kim's own contemporaneous notes favor rejection of Dr. Kim's subsequent narrative opinion. The CAB characterized as "disturbing" the discrepancies between Dr. Kim's office notes and his narrative opinion. App. at 3

Accordingly, the claimant is mistaken when she represents to this Court that the CAB's finding of a lack of medical necessity was "based solely on the fact that her New York providers declined to execute New Hampshire Workers' Compensation forms." NOA[3] at 15. While the CAB did rule separately, that the claimant failed to comply with procedural requirements governing reimbursement requests for medical payments, the

[3] "NOA" refers to Petitioner' Rule 10 Notice of Appeal.

CAB also independently determined on the merits that the claimant failed to meet her medical burden of proof. App. at 3.

Concurrently, as a procedural matter, the failure of the claimant's massage therapists to provide statutorily required documentation is also a stand-alone basis sufficient to support the CAB's refusal to order the claimant be reimbursed for her massage therapy treatments.

Procedurally, New Hampshire statute provides there shall be no reimbursement for services rendered, unless the health care provider or health care facility giving medical, surgical, or other remedial treatment furnishes the report required in subparagraph (b) to the employer, insurance company, or claims adjusting company within 10 days of the first treatment. RSA 281-A: 23 V (c).

The statute does potentially allow relief from the 10-day reporting time limit. It states specifically, "for good cause, a hearing officer may waive the 10 –day reporting requirement and order remuneration paid." RSA 281-A: 23 V (C) (emphasis added). The statute grants no such waiver authority to the CAB, however. The sole exception to the 10-day reporting requirement is the authority of a "hearing officer" to waive the "10 day reporting requirement" for "good cause".

The claimant has failed to set forth in her Notice of Appeal or Brief (and has therefore waived) any argument that the phrase "hearing officer" somehow incorporates the separate, statutorily distinct, "CAB".

Moreover, to the extent, the statute authorizes a waiver; it authorizes a waiver of the 10-day reporting requirement, not a waiver of an absolute refusal to issue the form.

The claimant argues that, in any event, the 10-day requirement for filing the statutory form is inapplicable to reimbursement requests where the claimant pays for the treatment initially and then seeks reimbursement from her employer. The claimant cites no statute or rule, nor any case holding supporting this assertion. The claimant provides no legal analysis as to why this Court would read the statute in such a way as to nullify its terms simply because the claimant pays for the disputed treatment in the first instance. The claimant provides no policy rationale for why such direct payment by the claimant should defeat the mandatory ("shall") language used in the statute.

In her Rule 10 Notice of Appeal, the claimant asserts for the first time that the belatedly produced massage therapist's notes constitute

substantial compliance with the10-day reporting requirement. Grounds not raised in the RSA 541 Motion for Rehearing are waived:

> ". . . no ground not set forth therein shall be urged, relied on, or given any consideration by the court, unless the court for good cause shown shall allow the appellant to specify additional grounds." RSA 541:4

More fundamentally, the CAB has explained that the late-filed information did not sufficiently address, among other things, the causal relationship of the treatment to the work injury.

In her brief, the claimant raises an additional new ground not raised in her notice of appeal nor in her RSA 541 Motion for Rehearing. Specifically, the claimant now asserts the statutory 10-day reporting requirement does not apply to palliative treatment but only to remedial treatment. Grounds not raised in the RSA 541 Motion for Rehearing are waived. More fundamentally, this Court has already held RSA 281-A: 23 applies to palliative, as well as remedial care, a point emphasized in the claimant's own brief.

Finally, in her brief, the claimant raises an additional new ground not raised in her notice of appeal nor in her RSA 541 Motion for Rehearing. Specifically, she asserts an earlier form found in the record does not list LMT's on its face and cites this as evidence massage therapist have no

obligation to comply with the 10-day reporting requirements. Again, grounds not raised in the RSA 541 Motion for Rehearing are waived.

Moreover, as an evidentiary matter, the massage therapist themselves never cited this particular form as deterring them from complying with statutory reporting requirements. As a legal matter, the form states emphatically that it must be completed at each "health professional" visit and filed with the insurance carrier within 10-days of treatment. The massage therapist have forcefully set forth their credentials as "health professionals".

STANDARD OF REVIEW

The CAB's findings of fact will not be disturbed if they are supported by competent evidence in the record, and upon which its decision reasonably could have been made. See Appeal of Northridge Environmental, 168 N.H. 657, 660 (2016). As long as competent evidence supports the CAB's decision, this Court will not reverse a finding supported by evidence in the record even if other evidence would lead to a contrary result. See Appeal of Anheuser Busch Company, 156 N.H. 677, 682 (2008).

ARGUMENT

I. The CAB's original decision, in conjunction with its decision denying the claimant's motion for rehearing, properly addressed the claimant's failure to prove her case on the merits.

As long as competent evidence supports the CAB's decision, this Court will not reverse a finding supported by evidence in the record even if other evidence would lead to a contrary result. See Appeal of Anheuser Busch Company, 156 N.H. 677, 682 (2008). The Court's task is not to

determine whether it would have found differently or to reweigh the evidence, but rather to determine whether the findings are supported by competent evidence in the record. See Appeal of Hillsborough County Nursing Home, 166 N.H. 731, 733(2014).

New Hampshire Worker's compensation law provides, in relevant part, that a trier of fact is free to accept or reject an expert's testimony, in whole or in part, when faced with conflicting expert testimony. Bartlett Tree Experts Co. v. Johnson, 129 NH 703, 706 (1987). As a matter of law, the CAB is free to reject even an un-contradicted medical opinion so long as it states a reason for doing so. Appeal of Kehoe, 141 NH 412, 418-419 (1996).

Conversely, it is only when faced with un-contradicted medical testimony that the CAB must identify the consideration that impelled it to disregard any such un-contradicted medical testimony. Moreover, it is improper for the board, as a matter of law, to automatically favor the claimant's experts over the employer's because the board risks improperly shifting the burden of persuasion to the employer. Appeal of Rockingham County Sheriff's Dep't. 144 NH 194,197 (1999).

The CAB, both in the original decision and in the decision addressing the claimant's motion for rehearing, rendered a series of findings. RSA 541:4 requires a Motion for Rehearing as a prerequisite to an appeal to this Court, in part, to allow the CAB in the first instance to correct any errors within the decision. See Appeal of Briand, 138 N.H. 555, 557-558 (1994). Accordingly, in assessing the validity of the CAB decision this Court must review that decision as expanded upon in the Board's ruling on the Motion for Rehearing.

The Board identified the appropriate legal standards; the relative weight afforded conflicting medical opinions, and the reasons for accepting, or rejecting in whole, or in part, the opinions of the medical doctors. The CAB found that even affording the treating physician's opinion substantial weight, the opinion failed to support the claimant's contentions. Specifically, the CAB noted Dr. Kim's own treatment notes fail to reference massage therapy as prescribed medical treatment. In this respect, the CAB reasoned that Dr. Kim's own contemporaneous notes favor rejection of Dr. Kim's subsequent narrative opinion. The CAB characterized as "disturbing" the discrepancies between Dr. Kim's office notes and his narrative opinion.

The inferences drawn by the CAB from the evidence submitted constitute at least reasonable, and probably the most reasonable, inferences to be drawn therefrom. The claimant has presented no reason why this Court should reweigh the medical opinions, arrive at a different inference, and then substitute such an alternative inference in place of that determined by the CAB. Indeed, the claimant cannot point to a single statement by Dr. Kim explaining the scarcity in his treatment notes of a contemporaneous prescription for massage therapy. The CAB has acknowledged the disturbing discrepancies between the office notes and the opinion letters of Dr. Kim and therefore, has cited a reason for rejecting the treating physician's opinion.

Even if the Court was inclined to weigh the above evidence differently, the Court's task is not to determine whether it would have found differently or to reweigh the evidence, but rather to determine whether the findings are supported by competent evidence in the record. See Appeal of Hillsborough County Nursing Home, 166 N.H. 731, 733 (2014). In this case, the treating physician's own contemporaneous office notes qualify as competent evidence in the record to support the CAB's decision.

Accordingly, the claimant is mistaken when she represents to this Court that the CAB's finding of a lack of medical necessity was "based solely on the fact that her New York providers declined to execute New Hampshire Workers' Compensation forms." NOA at 15. While the CAB did rule separately, that the claimant failed to comply with procedural requirements governing reimbursement requests for medical payments, the CAB also independently determined on the merits that the claimant failed to meet her medical burden of proof.

The claimant's failure to sustain her medical burden of proof is, in and of itself, sufficient support for the CAB's refusal to order the claimant be reimbursed for her massage therapy treatments.

Concurrently, as a procedural matter, the failure of the claimant's massage therapists to provide statutorily required documentation is also a stand-alone basis sufficient to support the CAB's refusal to order the claimant be reimbursed for her massage therapy treatments. The CAB, in its ruling on the motion for rehearing, specifically adopted the employer's argument that "beyond the aforementioned deficiencies in proof, the claimant failed to meet the requisite procedural requirements for reimbursement." App. at 3.

II. The CAB's original decision, in conjunction with its decision denying the claimant's motion for rehearing, properly determined the claimant's failure to establish a right to medical reimbursement on procedural grounds.

The claimant bears the burden of proving the causal connection between the condition for which benefits are sought and the work-related injury. Appeal of Hooker, 142 N.H. 40, 46 (1997)(citing Appeal of Cote, 139 N.H. 575, 582 (1995); Hudson v. Wynott, 128 N.H. 478, 483 (1986). Procedurally, New Hampshire statute provides there shall be no reimbursement for services rendered, unless the health care provider or health care facility giving medical, surgical, or other remedial treatment furnishes the report required in subparagraph (b) to the employer, insurance company, or claims adjusting company within 10 days of the first treatment. RSA 281-A: 23 V (c). In legislative parlance, the word "shall" constitutes a command and therefore the massage therapists' failure to provide the referenced documentation within the 10-day period precludes reimbursement for the treatment at issue.

The Department of Labor has formulated rules that reinforce this statutory requirement. These rules confirm the failure of the practitioner to provide the carrier with medical information necessary in the prompt

processing of a claim, may result in the nonpayment of the medical bill under RSA 281-A:23V(c). See Lab 508.01(B).

In determining the scope of the term "remedial", as used in section 23, this Court noted the term "reasonable" preceded the enumerated compensable items in the statute and therefore modified all of them. The Court, therefore, held particular treatment may be reasonable and required even if not technically remedial. This Court determined the statute is properly read to apply to palliative as well as curative treatment. Appeal of Levesque, 136 N.H. 211, 214 (1992).

The statute does potentially allow relief from the 10-day reporting time limit. It states specifically, "for good cause, a hearing officer may waive the 10 –day reporting requirement and order remuneration paid." RSA 281-A: 23 V (C) (emphasis added). The statute grants no such waiver authority to the CAB. The sole exception to the 10-day reporting requirement is the authority of a "hearing officer" to waive the "10 day reporting requirement" for "good cause". The worker's compensation statute definitively distinguishes between "Hearing Officers", RSA 281-A: 42-b, and the Compensation Appeals Board, RSA 281-A 42-a.

The claimant seeks reimbursement for 30 massages provided by Megan Doolen and Amanda Brewester of the Ettia Holistic Day Spa. She began this therapy on May 30, 2017, almost a year following her discharge form Dr. Hsu's care. Her treating physician at this time was Dr. Kim who had prescribed a variety of treatments other than massage therapy. In rendering the massages, Megan Doolen and Amanda Brewester initially provided no contemporaneous notes detailing the massage therapy rendered. The claimant initially testified no such notes existed.

Both Megan Doolen and Amanda Brewester failed to provide the form required pursuant to RSA 281-A: 23 V (C) and Lab 508.01 (B). Both failed to provide this form within 10 days of first treatment and both have failed to provide the required form to this day.

In her presentation to the Department of Labor Hearing Officer, the claimant asserted the massage therapists' out-of-state status precluded their access to, and knowledge of, the 10-day requirement. The form is actually available to the whole world on the NH Department of Labor website as is the statute and labor rule requiring its submission within 10 days. The claimant's counsel, who agreed at the settlement approval hearing to represent the claimant on future medical bill disputes, is well aware of the

10-day filing requirement and the form's availability on the world-wide-web.

Even if the Hearing Officer had accepted the premise that the 10-day reporting requirement was somehow undiscoverable at the Eitta Holistic Day Spa, or that the form was somehow unavailable at that location, this premise would only explain a delay in providing the form within the required 10-days. This would not explain the spa's failure to issue the form in time for the Department of Labor Hearing.

On appeal to the CAB, the good-cause-waiver of the statutory reporting requirement was beyond the Board's jurisdiction. The statute grants such authority only to a "hearing officer". Because the right to compensation is statutory in its origin, injured worker's rights can be no greater than what the legislature has provided. McKay v. N.H. Comp. App. Bd., 143 N.H. 722 (1999); Hagerty v. Great Am. Indem. Co., 106 N.H. 425 (1965); Desrosiers v. Dionne Brothers Furniture, Inc., 98 N.H. 424 (1953).

In denying the claimant's motion for rehearing, the CAB adopted the employer's argument that the "statute does not expressly grant the Compensation Appeals Board [as opposed to a hearing officer] the

authority to override the 'no reimbursement' rule with a finding of good cause". App. at 4, 3.

The claimant has failed to set forth in her Notice of Appeal or Brief (and has therefore waived) any argument that the phrase "hearing officer" somehow incorporates the statutorily separate and distinct "CAB" within the universe of those entities granted the authority to waive the 10-day reporting requirement.

Indeed, in her Notice of Appeal and in her Brief, the claimant cites the relevant statutory provision and the express reference to "hearing officer" without making any argument that this language should be expanded to include the CAB as well. Pet. Brief at 21. At this juncture, the time for preserving such arguments has passed.

Moreover, no argument based in principles of statutory construction could overcome the plain meaning of the statutory language chosen by the legislature. The familiar axiom of statutory construction, "the expression of one thing in a statute implies the exclusion of another", favors a reading that the legislature intended to authorize "Hearing Officers" only to grant good cause waivers of the 10-day reporting requirement. See Appeal of Cover, 168 N.H. 614, 622 (2016). Any argument the claimant belatedly

attempts at this point would necessarily include a request that this Court, in effect, rewrite the statute.

From a policy perspective, the statute contemplates a waiver of the 10 day filing period with an expectation the statutory form will eventually be submitted. It therefore makes sense that the legislature would not extend the waiver authorization to a tribunal hearing the case de novo after the first level hearing and well after the reasonable time required to correct a late filing.

The claimant offered the CAB no analysis supporting a waiver at the appeal level. Instead, the claimant simply posited that "good cause" flowed from the therapists' New York City licensure, and their purported discomfort with New Hampshire forms. App. at 25. Significantly, the therapists offered no first hand testimony (in person or telephonically) regarding this alleged discomfort. The massage therapist submitted no written report or correspondence asserting any such discomfort. The sole evidence of the alleged discomfort was the claimant's hearsay testimony as to the therapist's state of mind.

Significantly, during the CAB hearing, the massage therapists submitted statements describing their training and qualifications. Nowhere

within these submissions did they express any discomfort with completing New Hampshire forms. The CAB adopted the employer's argument that "the information the providers ultimately did issue to the carrier described their education, training, and experience but failed to fulfill the requirements of RSA 281 – A: 23." App. at 11. (Emphasis added).

To reverse this finding, the Court would have to substitute its judgement for that of the CAB on the issue of whether the information supplied matched the information required on the relevant form. The CAB has explained that the late filed information did not sufficiently address, among other things, the causal relationship of the treatment to the work injury.

The claimant quotes at length from the massage therapists' documents, but cites no actual opinion that the treatment rendered was reasonable, necessary, causally related to, and/or required by the nature of the claimant's specific work injury. NOA at 11-12.

Ultimately, in its ruling on the motion for rehearing, the CAB agreed with the employer that the proffered explanation for the failure to comply with section 23 is unpersuasive. App. at 3. The claimant's testimony before the CAB was that her massage therapists were uncomfortable filling

out an out-of-state form. The CAB was under no obligation to accept this hearsay testimony as supporting a finding of good cause. First, the massage therapists' purported discomfort with complying with New Hampshire law, hardly qualifies *per se* as good cause for their failure to issue the requisite forms. Second, the claimant cannot speak competently to the state of mind of her massage therapists.

Even assuming the admissibility of hearsay evidence in CAB proceedings, the mere admissibility of evidence does not necessarily render it persuasive.

Moreover, to the extent the statute authorizes a waiver, it authorizes a waiver of the 10-day reporting requirement, not a waiver of an absolute refusal to issue the form. One reasonable inference, and probably the most reasonable inference, drawn from the evidence is that the massage therapists lacked good cause for their continued failure to submit the required statutory forms. Indeed, the CAB adopted the employer's reasoning that "no 'good cause' argument was made nor could it be made given the provider's continued failure to furnish the required report." App. at 4 ,3.

The statute specifies the hearing officer's prerogative to waive the "10 day reporting requirement", not to waive the provider's failure to supply the form altogether. The fact that the provider in this case has never submitted the requisite form renders moot any contemplated waiver of the ten day period allowed for filing the form.

In her RSA 541 Motion for Rehearing, the claimant, for the first time, argued the 10-day requirement for filing the statutory form is inapplicable to reimbursement requests where the claimant pays for the treatment initially and then seeks reimbursement from her employer. The claimant cited no statute or rule, nor any case holding for such an assertion. The claimant has yet to cite any statutory or regulatory language or case precedent that recognizes any distinction between reimbursement to the claimant and payment directly to the treatment provider. Indeed, the statute provides, "there shall be no reimbursement for services rendered". The statute does not limit this prohibition to "no reimbursement directly to the provider". The legislature could have easily used such language had it intended to set different rules depending on whether the claimant paid out-of-pocket for the treatment in the first instance.

The claimant provides no legal analysis as to why this Court would read the statute in such a way as to nullify its terms simply because the claimant pays for the disputed treatment in the first instance. The claimant provides no policy rationale for why such direct payment by the claimant should defeat the mandatory ("shall") language contained in the statute. As noted above, the injured worker's rights can be no greater than what the legislature has provided.

Moreover, that the claimant's description of her payment arrangements is somewhat contradictory. The claimant insists in her Notice of Appeal that this "is not a situation where the injured employee was billed directly by a health care provider. . ." NOA at 13. At the CAB hearing, however, the claimant testified that she purchased her massage treatments in blocks of ten because it was cheaper. She testified as well that the unreimbursed bills for massage included the "customary tip". App. at 16.

In any event, whether the claimant was, or was not, billed directly by her massage provider, the statutory prohibition on reimbursement applies equally in either instance. The statute states rather emphatically that <u>there shall be no reimbursement for services rendered</u> unless the health care provider furnishes the required report within 10 days off first treatment.

The claimant concedes in her Notice of Appeal that she paid for the massage therapy after the employer denied reimbursement because she felt the treatment was effective. NOA p 9. The claimant is free to pay for treatment herself, independent of the employer's legal obligation to do so. The claimant's willingness to pay for such treatment does not, by itself create an independent obligation on the part of the employer to pay for such treatment. On the contrary, the statute prohibits reimbursement is if the provider fails to comply with the furnishing of the requisite reports within 10 days of first treatment.

In her Rule 10 Notice of Appeal, the claimant asserts for the first time that the belatedly produced massage therapist's notes constitute substantial compliance with the10-day reporting requirement. The CAB never heard this argument and accordingly there can be no error attributed to the CAB for failing to adopt it. Moreover, grounds not raised in the RSA 541 Motion for Rehearing are waived.

> ". . . no ground not set forth therein shall be urged, relied on, or given any consideration by the court, unless the court for good cause shown shall allow the appellant to specify additional grounds." RSA 541:4

More fundamentally, the claimant's mere insistence that the CAB somehow improperly considered the therapist's late-filed notes, hardly suffices as a basis for overturning the CAB's determination. The CAB has explained that the late filed information did not sufficiently address, among other things, the causal relationship of the treatment to the work injury. In her Notice of Appeal and Brief, while the claimant quotes at length from the massage therapists' documents, she quotes no actual statement therein that the treatment rendered was reasonable, necessary, causally related to, and/or required by the nature of the claimant's specific work injury. NOA at 11-12.

In her brief, the claimant raises an additional new ground not raised in her notice of appeal nor in her RSA 541 Motion for Rehearing. Specifically, the claimant now asserts the statutory 10-day reporting requirement does not apply to palliative treatment but only to remedial treatment. The CAB never heard this argument and accordingly, there can be no error attributed to the CAB for failing to adopt it. Moreover, grounds not raised in the RSA 541 Motion for Rehearing are waived:

> ". . . no ground not set forth therein shall be urged, relied on, or given any consideration by the court, unless the court for good cause shown shall allow the appellant to specify additional grounds." RSA 541:4

The claimant likely failed to raise this argument earlier because it so clearly lacks merit. This Court has already held RSA 281-A: 23 applies to palliative, as well as remedial care, a point emphasized in the claimant's own brief. Pet. Brief at 20-21. The claimant now urges that section 23 allows for palliative treatment but does not require such treatment conform to those measures designed to enable the efficient processing of payment for such treatment. The claimant presents specious arguments in support of this tenuous construct.

For instance, the claimant notes the form includes a section for addressing permanent impairment. The claimant then reasons massage therapists by definition would know nothing of permanent impairment and, ergo, the form is not a requirement for the likes of massage therapists. This argument assumes many things that may or may not be true.

Suffice it to say, the form allows the provider to answer the question about permanent impairment by checking the "undetermined" box. The fact is that many physicians providing remedial treatment have no more ability to apply the AMA Guidelines, 5th Edition, to a determination of permanent impairment than does a massage therapist. Their inability in this

regard does not relieve them from the statutory reporting requirements to secure payment for the treatment they do provide.

Finally, in her brief, the claimant raises an additional new ground not raised in her notice of appeal nor in her RSA 541 Motion for Rehearing. Specifically, she asserts an earlier form found in the record does not list LMT's on its face and cites this as evidence massage therapist have no obligation to comply with the 10-day reporting requirements. The CAB never heard this argument and accordingly there can be no error attributed to the CAB for failing to adopt it. Moreover, grounds not raised in the RSA 541 Motion for Rehearing are waived:

> ". . . no ground not set forth therein shall be urged, relied on, or given any consideration by the court, unless the court for good cause shown shall allow the appellant to specify additional grounds." RSA 541:4

The claimant likely failed to raise this argument earlier because it so clearly lacks merit. As an evidentiary matter, the massage therapist themselves never cited this particular form as deterring them from complying with statutory reporting requirements. As a legal matter, the form states emphatically that it must be completed at each "health professional" visit and filed with the insurance carrier within 10-days of treatment. The

massage therapist statements, submitted for the CAB hearing, proclaim the depth and rigors of their training as "health professionals". App. at 45-46.

The form's parenthetical list of (MD, DO, DC, or DDS) who might serve as such health professionals is not exhaustive. The list omits specialties that regularly qualify to provide medical opinions such as physician assistants, nurse practitioners, physical therapists, and PHDs. Moreover, the statue governing the form's development states, in relevant part, that the form is to provide the information necessary "to enable the employer or insurance carrier to determine the benefits, if any that are due and payable." RSA 281-A: 23 V (b). Those health professionals seeking to qualify their services as reasonable and necessary for workers' compensation reimbursement are necessarily bound to comply with the procedures legislatively established to process such claims.

The claimant has failed to cite any genuine errors of law but has instead misconstrued the original CAB findings and has overlooked the findings adopted by the CAB as part of its denial of the motion for rehearing. As a result, the claimant has overlooked the CAB's stand-alone determination, that as a matter of medical proof, the claimant failed to establish the disputed treatment is required by the nature of the work injury.

Given this context, the claimant's Brief serves merely as a series of disagreements with the CAB's weighing of the evidence.

Similarly, as a procedural matter, the failure of the claimant's massage therapists to provide statutorily required documentation is also a stand-alone basis sufficient to support the CAB's refusal to order the claimant be reimbursed for her massage therapy treatments.

CONCLUSION

For the foregoing reasons we ask this Honorable Court to affirm the decision of the New Hampshire Workers Compensation Appeals Board.

The appellee requests fifteen minutes for oral argument.

CERTIFICATION

Pursuant to New Hampshire Supreme Court 2018 Supplemental Rules of the Supreme Court, the undersigned certifies that copies of this Brief and Appendix have been electronically filed on this day to the Clerk of the Supreme Court of New Hampshire.

Pursuant to New Hampshire Supreme Court 2018 Supplemental Rules of the Supreme Court, the undersigned certifies that on this day

copies of this brief have been electronically filed with Mark D. Wiseman, Esq., and the Office of the Attorney General. One (1) copy has been mailed to the New Hampshire Department of Labor.

CERTIFICATION OF COMPLIANCE

I hereby certify that this brief complies with Rule 16(3)(i) because copies of the appealed decisions are appended to this brief; Rule 16(11) because this brief contains 6250 words exclusive of pages containing the table of contents, table of authorities, text of pertinent statutes, and addendum.

Pursuant to New Hampshire Supreme Court Rule 16(10)(2), the undersigned requests oral argument and designates Eric G. Falkenham, Esquire to be heard. It is estimated that oral argument will require fifteen (15) minutes.

Respectfully submitted,

ELLIOT HOSPITAL

By its Attorneys,

DEVINE, MILLIMET & BRANCH,
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Dated: 2/20/2020 By: Eric G. Falkenham

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