
In the ORS 656.248 Medical Fee Dispute of

KAY HART, Claimant

Contested Case No: H04-145

AMENDED PROPOSED AND FINAL ORDER

JANUARY 4, 2005

ARDELL CARLSON, Petitioner

OIGA for RELIANCE NATIONAL INDEMNITY CO & CAMBRIDGE
INTEGRATED SERVICE GROUP, INC., Respondent

Before Ella D. Johnson, Administrative Law Judge, Administrative Hearings

HISTORY OF THE CASE

Provider appeals the Administrative Order issued on July 29, 2004 by the Medical Review Unit (MRU) of the Workers' Compensation Division (WCD), Department of Consumer and Business Services (department or director). On September 17, 2004, the department referred the matter to the Office of Administrative Hearings (OAH). On October 21, 2004, Administrative Law Judge (ALJ) Ella D. Johnson conducted a contested case hearing. Petitioner Ardell Carlson (provider) represented herself without benefit of counsel. Attorney Delbert Brenneman represented respondent OIGA for Reliance National Indemnity Company and its service company Cambridge Integrated Service Group, Inc. (insurer). Provider testified on her own behalf and called claimant Kay L. Hart as a witness. The record closed on the date of hearing.

ISSUES

Whether MRU's determination that insurer properly reduced payment for massage therapy provided to claimant by Ardell Carlson from April 10, 2003 through February 7, 2004 was incorrect.

EVIDENTIARY RULINGS

WCD Exhibits 1 through 28 were admitted into the record without objection.

FINDINGS OF FACT

(1) Claimant was compensably injured on August 8, 2002. Insurer accepted her claim for right shoulder strain on October 16, 2002. (Ex. 4.) On June 4, 2003, insurer amended its claim acceptance to include right cervical, thoracic and lumbar strains. (Ex. 8.)

(2) On August 18, 2002 and again on September 16, and October 17, 2002, Charles Roese, MD with the Myrtle Point Medical Center prescribed massage therapy two times a week for four weeks. (Ex. 1) Massage therapist Ardell Carlson evaluated claimant for treatment on August 22, 2002. (Ex. 2). Carlson treated claimant during 19 sessions from August 28, 2002 through November 18, 2002 and submitted claim forms to insurer. (Ex. 3.)

(3) On November 4, 2002, insurer paid Carlson \$561.00 for services rendered from August 22 through September 27, 2002. (Exs. 4-6.) On February 5, 2003, Carlson called insurer concerning unpaid billings for the period of September 30, 2002 through November 11, 2002 and then sent a handwritten note detailing the unpaid billings. On May 13, 2003, insurer paid Carlson \$726.00 for the unpaid billings. (Ex. 6.)

(4) On April 8, 2003, claimant sought treatment from Jerry Boggs, MD who prescribed massage therapy two times a week for a month and referred claimant to Carlson. Carlson provided massage therapy services to claimant 40 times on referral from Dr. Boggs from April 10, 2003 through February 7, 2004 and billed insurer \$2,394.00. Insurer reduced payment to \$860.29. (Exs. 3, 6, 21.) Insurer paid the billing at a reduced rate based on its determination that the frequency of the service exceeded that which is typically provided on a single date of service or the service was duplicative of previously reviewed charges. (Ex. 21.)

(5) Carlson requested administrative review. MRU determined that insurer was not liable for any additional payment to Carlson.

CONCLUSION OF LAW

MRU correctly determined that insurer is not liable for additional payment amount for massage therapy provided to claimant by Ardell Carlson from April 10, 2003 through February 7, 2004.

OPINION

This dispute arises under ORS 656.248, and therefore, jurisdiction lies with the director. ORS 656.248(12). Inasmuch as no standard of review is specified in the statute, I review *de novo*. OAR 436-001-0225(2); *Archie M Ulbrick*, 2 WCSR 152 (1997). The burden of proving a fact or position falls upon the proponent. ORS 183.450(2). As petitioner, provider bears the burden of proving by a preponderance of evidence that the administrative order is incorrect. *Cook v. Employment Div.*, 47 Or App 437 (1980) (In the absence of legislation adopting a different standard, the standard of proof in an administrative hearing is preponderance of evidence). Proof by a preponderance of evidence means that the factfinder is persuaded that the facts asserted are more likely true than false. *Riley Hill General Contractors v. Tandy Corp.*, 303 Or 390 (1989).

Pursuant to ORS 656.245, an insurer is obligated to provide medical services for compensable medical condition for so long as the nature of the injury or the process of recovery requires. However, OAR 436-010-230(4)(a) requires ancillary services, including massage therapy, provided by a medical service provider other than the attending physician or specialist physician shall not be reimbursed unless: (1) prescribed by the attending physician; (2) carried out under a treatment plan prepared prior to commencement of treatment; and (3) signed by the attending physician or specialist physician within 30 days of the beginning of treatment.

Additionally, the medical service provider is to provide an initial copy of the treatment plan to the attending physician or specialist physician within seven days of beginning treatment.

The attending physician or specialist physician is then to provide a copy of the signed treatment plan to insurer within 30 days of beginning treatment. The treatment plan must contain objectives, modalities, frequency of treatment, and duration. The treatment plan may be recorded in any legible format, including, but not limited to, chart notes. OAR 436-010-0230(4)(a).

MRU found, and I agree, that the treatment plans submitted by Drs. Roesel and Boggs did not comply with the requirements of the administrative rule. Although the plan signed by the two physicians contained modality, frequency of treatment and duration, the plans failed to include the objectives of the treatment. The application of these requirements is mandatory for the department and can result in denial of reimbursement for the ancillary medical service provided. *See Aetna Casualty & Surety v. Blanton*, 139 Or App 283 (1996) (when an agency adopts administrative rules, it must follow them); *Adalbert Herman*, 9 CCHR ____ (2004) (strict compliance with the rule is mandatory and where a medical provider of ancillary services fails to comply with the rule, insurer is not required to pay the disputed billing).

Provider argues that Exhibit 26 sets forth the objective of the treatment, which was apparently to reduce claimant's pain so she could work a full day. Although this document is signed by Dr. Boggs, there is no date indicating when it was signed and there is no indication that it was sent to insurer within 30 days of beginning treatment. Consequently, I do not find it persuasive. Provider also argues that she acted in good faith in continuing the massage therapy after insurer told claimant that the bills would be paid. However, insurer did pay the bills but at a reduced rate based on its determination that the frequency of the service exceeded that which is typically provided on a single date of service or the service was duplicative of previously reviewed charges. Moreover, as noted by insurer, even if the requirements of the treatment plan were met, insurer had the authority to reduce payment according to the fee schedule promulgated by the department. Accordingly, MRU's order is affirmed.

ATTORNEY FEES

Provider has not prevailed in a contested case hearing and was not represented by an attorney, and therefore, is entitled to no attorney fee. ORS 656.385(1).

ORDER

IT IS HEREBY ORDERED that:

The Administrative Order dated July 29, 2004 is affirmed.