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In the ORS 656.245 Medical Services Dispute of

**ADELINA RODRIGUES, Claimant**

Contested Case No: H04-181

**PROPOSED AND FINAL ORDER**

February 18, 2005

ADELINA RODRIGUES, Petitioner

SAIF CORP., Respondent

Before Catherine P. Coburn, Administrative Law Judge, Administrative Hearings

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### **HISTORY OF THE CASE**

Claimant appeals the Administrative Order issued on October 21, 2004 by the Medical Review Unit (MRU) of the Workers' Compensation Division (WCD), Department of Consumer and Business Services (director or department). On December 29, 2004, the department referred the matter to the Office of Administrative Hearings (OAH). On February 16, 2005, Administrative Law Judge Catherine P. Coburn conducted a hearing in this matter. Petitioner Adelina Rodrigues (claimant) was represented by attorney Gary Borden. Respondent SAIF Corporation (insurer) was represented by attorney David L. Runner. No witnesses testified and the record closed on the date of hearing.

### **ISSUE**

Whether insurer is liable for physical therapy provided to claimant from March through September 2002 under the terms of a Disputed Claim settlement (DCS).

### **EVIDENTIARY RULINGS**

WCD Exhibits 1 through 17 as well as insurer's Supplementary Exhibits R1<sup>1</sup> through R42 were admitted into the record without objection

### **FINDINGS OF FACT**

(1) On February 18, 2002, claimant suffered a compensable injury while working as an office clerk. (Exs.2, R7 and R15.) On April 1, 2002, insurer accepted right rotator cuff tendonitis. (Exs. 5 and R18.) On July 1, 2002, claimant underwent surgical repair. (Ex. R12.) Claimant's condition became medically stationary on November 22, 2002 and the claim was closed on December 19, 2002. (Ex. R19.)

(2) On March 3, 2003, insurer accepted a combined condition to include preexisting right shoulder conditions and denied the current combined condition. (Ex. R21.)

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<sup>1</sup> I renumbered respondent's supplementary exhibits with initial "R" to distinguish them from the WCD exhibits.

(3) From March 15 through September 23, 2002, John Arthur, PT provided physical therapy to claimant on referral from Michael Tso, M.D.. (Exs. 2, 3 and 7.) Insurer received these bills on or before March 13, 2003.<sup>2</sup> (Ex. 8-2.)

(4) Insurer drafted and the parties executed a \$3,500 DCS which was approved on July 13, 2003. The text of the settlement agreement reads:

Medical Provider Reimbursement

The parties agree that SAIF Corporation has fully paid, within amounts set by Administrative Rules, all medical billings received by SAIF Corporation on or before June 13, 2003. Therefore, there are no unpaid medical billings subject to reimbursement from the proceeds of this settlement.

(Ex. 27-3.)

(5) On July 1, 2004, insurer denied reimbursability of the disputed medical bills, asserting that they were not approved by the attending physician through a treatment plan. (Ex. 8.)

**CONCLUSION OF LAW**

**Insurer is liable for physical therapy provided to claimant from March through September 2002 under the terms of a DCS.**

**OPINION**

Jurisdiction over this medical services dispute lies with the director. ORS 656.704(3)(a). I review for substantial evidence or error of law. ORS 656.245(6) and OAR 436-001-0225(1). The burden of proving a fact or position falls upon the proponent. ORS 183.450(2). As petitioner, claimant bears the burden of proving by a preponderance of evidence that the administrative order is incorrect. *Cook v. Employment Div.*, 47 Or 437 (1982) (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 the 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).

MRU determined that insurer was not liable for the physical therapy provided in March and April 2002 because the services were not rendered under a treatment plan as required by OAR 436-010-0230(4).<sup>3</sup> MRU further determined that insurer was liable for the physical

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<sup>2</sup> OAR 436-009-0030(3) provides in pertinent part:

(3) Insurers shall date stamp medical bills and reports upon receipt \*\*\*\*\*.

<sup>3</sup> OAR 436-010-0230(4)(a) provides:

therapy provided in July and September 2002 because those services were rendered under an adequate treatment plan. MRU did not consider the question whether insurer was liable under the terms of the DCS. Pursuant to OAR 436-001-0225(1),<sup>4</sup> no new medical issues may be raised at the contested case hearing. However, interpretation of a settlement agreement is a legal issue and not medical, and therefore, I address it.

Claimant contends that insurer is liable for all of the disputed medical services under the terms of the DCS. In support of her position, claimant argues that insurer had received the disputed medical bills before the parties entered into the settlement agreement and that insurer represented that the disputed bills had been paid. In contrast, insurer contends that the administrative order is correct and should be affirmed. In support of its position, insurer argues that the disputed physical therapy is not reimbursable because it was not approved by the attending physician through a treatment plan as required by OAR 436-010-0230(4)(a).

Pursuant to ORS 656.245(1)(a), an insurer is obligated to provide medical services that are materially related to a compensable condition for so long as the nature of the injury or the process of recovery requires. Pursuant to ORS 656.289(4)(a), the parties may execute a DCS. ORS 656.289(4)(a) provides:

Notwithstanding ORS 656.236, in any case where there is a bona fide dispute over compensability of a claim, the parties may, with approval of an Administrative Law Judge, the board or the court, by agreement make such disposition of the claim as is considered reasonable.

Here, the parties executed a DCS which was approved on July 15, 2003. Under the terms of the parties' agreement, insurer represented that it had paid all medical bills that it had received prior to June 13, 2003. Insurer further represented that there were no unpaid bills that would reduce claimant's proceeds from the settlement. The record establishes that, in fact, insurer had

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(4)(a) Except as otherwise provided by an MCO, ancillary services including but not limited to physical therapy or occupational therapy, by a medical service provider other than the attending physician, authorized nurse practitioner, or specialist physician shall not be reimbursed unless prescribed by the attending physician, authorized nurse practitioner, or specialist physician and carried out under a treatment plan prepared prior to the commencement of treatment and sent by the ancillary medical service provider to the attending physician, authorized nurse practitioner, or specialist physician, and the insurer within seven days of beginning treatment. The treatment plan shall include objectives, modalities, frequency of treatment, and duration. The treatment plan may be recorded in any legible format including, but not limited to, signed chart notes. Treatment plans required under this subsection do not apply to services provided pursuant to ORS 656.245(2)(b)(A).

<sup>4</sup> OAR 436-001-0225(1) provides:

Review of medical service (ORS 656.245 and 656.247(3)(a)) and treatment (ORS 656.327 and 656.260) disputes is for substantial evidence or error of law. New medical evidence or issues may not be considered at the contested case hearing.

not paid all bills that it had received prior to June 13, 2002. Insurer received the disputed bills on March 13, 2003, three months before the date specified in the DCS and has not paid them to date.

At the time the parties negotiate a settlement, insurer and not claimant is in a position to determine which bills insurer has received and which bills insurer has paid. Claimant agreed to settle the case for \$3,500 based on insurer's representation that no medical bills were outstanding. Consequently, claimant is entitled to rely on insurer's representation of fact concerning the status of medical bills. Furthermore, contrary to insurer's argument, it would be patently unfair for claimant to incur the cost of medical bills<sup>5</sup> based on insurer's misrepresentation of fact that they had already been paid at the time the parties agreed on a settlement amount. Finally, under the terms of the parties' agreement, insurer assumed liability for all bills it had received on or before June 13, 2003. By its own admission, insurer had received the disputed bills three months earlier, on or before March 13, 2003. For these reasons, I conclude that insurer is liable for the disputed physical therapy treatment. Accordingly, I modify the administrative order.

### **ATTORNEY FEES**

Claimant has prevailed in a contested case hearing and is entitled to a reasonable attorney fee. ORS 656.385(1). Considering the factors listed in OAR 436-001-0265, I find that \$800 is a reasonable fee for claimant's attorney's services in this matter.

### **ORDER**

IT IS HEREBY ORDERED that:

1. The Administrative Order dated October 21, 2004 is modified.
2. SAIF is liable for physical therapy provided to claimant by John Arthur, PT from March through September 2002.

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<sup>5</sup> OAR 436-009-0015 provides in pertinent part:

(1) An injured worker shall not be liable to pay for any medical service related to an accepted compensable injury or illness or any amount reduced by the insurer pursuant to OAR chapter 436. A medical provider shall not attempt to collect payment for any medical service from an injured worker, except as follows:

(b) When the injured worker seeks treatment that has not been prescribed by the attending physician or authorized nurse practitioner, or a specialist physician upon referral of the attending physician or authorized nurse practitioner. This would include, but not be limited to, ongoing treatment by non-attending physicians in excess of the 30 day/12 visit period or by nurse practitioners in excess of the 90 day period, as set forth in ORS 656.245 (§3, ch. 811, OL 2003) and OAR 436-010-0210;

(c) When the injured worker seeks palliative care that is either not compensable or not authorized by the insurer or the director pursuant to OAR 436-010-0290, after the worker has been provided notice that the worker is medically stationary;