

In the Medical Fee Dispute of

Alisha M. Ard, Claimant

Contested Case No: 07-051H

CORRECTED PROPOSED & FINAL ORDER

September 4, 2007

ALISHA M. ARD, Petitioner
SAFEWAY INC., Respondent

Before Robert Pardington, Administrative Law Judge

NOTE: This Order was originally issued on August 31, 2007 with the pages miscopied. Accordingly, that August 31, 2007 order is withdrawn, and a full and correct version of the Order is being reissued this date. The parties' rights of appeal shall begin to run from the date of this Order.

The above-captioned matter was originally scheduled for July 20, 2007, in Portland, Oregon, before Administrative Law Judge Robert Pardington. Claimant is represented by Daniel Spencer. The self-insured employer, Safeway Stores, Inc., is represented by Ronald Bohy. The medical provider, Good Shepherd Medical Center, and the Workers' Compensation Division, both waived appearance.

Prior to hearing, the parties arranged for submission of written arguments. The record closed on receipt of claimant's reply argument on August 8, 2007.

Exhibits 1 through 26 are hereby admitted.

ISSUES

1) Jurisdiction. Whether the Director has jurisdiction over the medical provider's attempt to collect medical bills beyond those covered in a Disputed Claim Settlement (DCS).

2) (Potentially). Whether the medical provider may collect medical bills beyond those covered in the DCS.

SUMMARY OF FACTS

Claimant injured her low back in an incident at work on May 15, 2006. (Exs. 1, 6). On July 13, 2006, the employer issued a denial of the claim. (Ex. 15).

On January 4, 2007, another ALJ approved a Disputed Claim Settlement (DCS), in which claimant accepted a sum of money, but agreed that the employer's denial would stay in effect. (Ex. 18). Pursuant to ORS 656.313(4), medical bills from various providers were summarized in the DCS, including all of the bills from Good Shepherd Medical Center ("the medical provider") totaling \$2,934.15, which were "audited" to \$1,649.73. (Ex. 18-7). The parties agreed that the audited amounts would be paid directly to the medical providers. (*Id.*)

The medical provider then attempted to collect the remaining amounts of the medical bills from claimant. (Exs. 19-21). Claimant requested that the Director review the dispute. (Exs. 22, 23).

On April 4, 2007, the Director issued an “Administrative Order of Dismissal,” finding that it lacked jurisdiction over the matter; *i.e.*, that it “lacked authority to prevent medical service providers from billing workers at rates beyond that permitted by the Workers’ Compensation Fee schedule for care outside of the Workers’ Compensation Act.” (Ex. 24-2). Claimant requested a hearing, which was referred to the Board’s Hearings Division. (Exs. 25, 26).

CONCLUSIONS OF LAW AND OPINION

Finding no specific standard of review for medical fee disputes under ORS 656.248, I review the Director’s Order *de novo*. OAR 436-001-0225(1).

I) Jurisdiction

Generally, cases at the Hearings Division are those involving “matters concerning a claim.” [ORS 656.704\(3\)\(a\)](#) provides:

“For the purpose of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under this chapter, and for determining the procedure for the conduct and review thereof, matters concerning a claim under this chapter are those matters in which a worker’s right to receive compensation, or the amount thereof, are directly in issue. However, subject to paragraph (b) of this subsection, such matters do not include any disputes arising under [ORS 656.245](#), 656.248, 656.260, 656.327, any other provisions directly relating to the provision of medical services to workers or any disputes arising under [ORS 656.340](#) except as those provisions may otherwise provide.”

However, in this “H-file” case, which has been referred by the Director, I essentially “step into the shoes of” the Director for purposes of jurisdiction. (Ex. 26); ORS 656.704(2)(a). Therefore, in this case, I have jurisdiction over, *inter alia*, disputes arising under ORS 656.248 (*i.e.*, medical fee disputes). ORS 656.704(2)(a); (3)(a).

ORS 656.248(12) provides:

“When a dispute exists between an injured worker, insurer or self-insured employer and a medical service provider regarding either the amount of the fee or nonpayment of bills for compensable medical services, notwithstanding any other provision of this chapter, the injured worker, insurer, self-insured employer or medical service provider shall request administrative review by the

director. The decision of the director is subject to review under ORS 656.704.”

Currently, this is a dispute over bills for a claim that has been settled in a DCS, not for “compensable medical services.” ORS 656.248(12). Specifically, the medical provider seeks to collect from claimant the balance of bills over the audited amounts paid in the DCS. Both claimant and the employer contend that ORS 656.248(12) gives the Director jurisdiction over this dispute, reading the statute as applying to disputes regarding the “amount of the fee” (for *any* medical services including noncompensable ones), or “nonpayment of bills for compensable medical services.” *Id.* In other words, they contend that the phrase “compensable medical services” modifies only “nonpayment of bills,” and not “the amount of the fee.” I disagree.

Although I agree with claimant that ORS 656.248(12) could have been drafted more artfully, I still find that the Director has jurisdiction regarding the following disputes for compensable medical services only: the amount of the fee and the nonpayment of bills. In other words, the term “compensable medical services” applies to both “the amount of the fee” and “the nonpayment of bills.” ORS 656.248(12). In reaching this conclusion, I note that the amount of the fee and the nonpayment of bills are two subcategories of disputes that might arise regarding compensable medical services. *Id.*

ORS 656.248(1), which gives the Director authority to promulgate rules for developing and publishing fee schedules “for medical services provided under this chapter [ORS 656]” is consistent with this interpretation. Medical services on a denied claim are not “medical services provided under this chapter.”

Claimant’s entering into a DCS, approved by an ALJ, was a final determination that her medical services on this claim are “noncompensable.” (Ex. 18); ORS 656.289(4)(a). I can locate no authority for the Director to decide such a dispute regarding fees for medical services on a noncompensable claim.

Beverly M. Helmken, 55 Van Natta 3174 (2003), cited by the employer, is distinguishable. There, the Board affirmed an ALJ’s order upholding a denial, and, citing ORS 656.248(12) and OAR 436-010-0008(1)(a), noted that the Director had jurisdiction over a dispute regarding nonpayment of *interim* medical services under ORS 656.247. 55 Van Natta at 3178. The Board did not hold that the Director had jurisdiction over fees for noncompensable medical services generally.

Accordingly, the Director’s April 4, 2007 Order, dismissing the case for lack of jurisdiction, is affirmed. In these circumstances, I do not reach the parties’ contentions on the “merits,” including policy considerations.

IT IS SO ORDERED.