

In the ORS 656.248 Medical Fee Dispute of  
**Back in Action Physical Therapy, Claimant**

Contested Case No: 08-163H

**AMENDED FINAL ORDER**

January 21, 2011

BACK IN ACTION PHYSICAL THERAPY, Petitioner  
LIBERTY NORTHWEST INSURANCE CORPORATION, Respondent  
Before John Shilts, Workers' Compensation Division Administrator

---

The Final Order in this matter was initially issued on January 6, 2011. A clerical error in the heading was subsequently discovered, in that the identification of the petitioner and respondent were reversed. This Amended Final Order is therefore being issued to correct the heading. That correction is the only change from the January 6, 2011 Final Order.

Medical provider Back in Action Physical Therapy (provider) brought this medical fee dispute when insurer Liberty Northwest Insurance Corporation (insurer) discounted its payments to provider for treatment provided to an injured worker. On August 8, 2008, the Workers' Compensation Division's Resolution Team (RT) issued an Administrative Order finding no further payment was owed, because the discounts had been authorized by contract, under temporary former rule OAR 436-009-0040(1).<sup>1</sup> Following a hearing, Administrative Law Judge (ALJ) Monte Marshall issued a Proposed and Final Order on April 12, 2010. That order found the temporary rule could not be applied to this case, that the former permanent rule did not authorize discounting payment under individual contracts, and held that insurer owed additional payment towards the amounts billed. I affirm the Administrative Order and disagree with the Proposed and Final Order.

**FACTUAL SUMMARY**

In 2004, insurer entered into a contract with Medrisk (TPA). TPA agreed to arrange for rehabilitative treatment for injured workers being treated under the workers' compensation system and to process the billings for that treatment from medical providers.

In 2006, TPA entered into a contract with provider. Provider agreed to accept specified rates of payment for specified services provided to workers being treated under the workers' compensation system.

Between January 23, 2007, and June 17, 2007, provider performed treatment for an injured worker. Provider submitted bills for this treatment to insurer, which in turn sent the bills to TPA. Insurer paid provider at discounted rates as set out in the agreement with TPA. Provider brought this dispute, asserting it was entitled to be paid the amount it had billed.

---

<sup>1</sup> Former OAR 436-009-0040(1) stated: "Unless otherwise provided by contract, insurers must pay providers at the providers' usual fee, or the amount set by fee schedule, whichever is less."  
WCD Admin. Order No. 08-060, July 7, 2008.

On July 8, 2008 the Department of Consumer and Business Services (the department) adopted a temporary rule concerning billing and payment of medical fees for services provided to injured workers. The temporary rule enforced fee discount contracts between medical providers and insurers. Former OAR 436-009-0040; WCD Admin. Order No. 08-060, July 7, 2008. RT then issued its administrative order, finding the discounted payment was proper according to the contract between provider and TPA, and that the contract was enforceable under the temporary rule.

Following a hearing, ALJ Marshall concluded the provision in the temporary rule relating to fee discount contracts, former OAR 436-009-0040(1), could not be applied in this case. The Proposed and Final Order notes that a temporary rule can only be in effect for 180 days. ORS 183.335(6)(a).<sup>2</sup> ALJ Marshall reasoned that, since the original treatment and billing in this case occurred in 2007, applying the temporary rule to those events would extend the operation of the rule beyond the permitted 180 days. ALJ Marshall therefore applied the previous permanent rule which he concluded did not authorize fee discount agreements. Former OAR 436-009-0040(1); WCD Admin. Order No. 08-051; June 12, 2008.

### CONCLUSIONS OF LAW

In this medical fee dispute, I review de novo. OAR 436-001-0225(1).

There is a preliminary evidentiary issue to address. Insurer attempted to subpoena records from provider concerning its charging, billing, and receipts. ALJ Marshall concluded that this was new evidence that had not been offered during the administrative review, and that new evidence was not admissible at hearing. OAR 436-001-0225(1), (2).<sup>3</sup> He also found the evidence was irrelevant. ALJ Marshall declined to enforce the subpoena or to admit this evidence on both grounds. Insurer contends ALJ Marshall's ruling is erroneous.

Insurer's subpoena requested any and all discounted fee agreements, contracts, and/or PPO contracts entered into by provider for therapy services; documentation of provider's usual and customary rates from 1/23/02 to 1/23/07 for physical therapy for specified CPT codes; billing records from 1/23/02 to 1/23/07 showing the amounts provider billed under those CPT

---

<sup>2</sup> ORS 183.335 provides in part:

“(5) Notwithstanding subsections (1) to (4) of this section, an agency may adopt, amend or suspend a rule without prior notice or hearing or upon any abbreviated notice and hearing that it finds practicable . . . .

\* \* \* \* \*

(6)(a) A rule adopted [or] amended . . . under subsection (5) of this section is temporary and may be effective for a period of not longer than 180 days.”

<sup>3</sup> OAR 436-001-0225 provides in part:

“(1) Except for the matters listed in sections (2) and (3), the administrative law judge reviews all matters within the director's jurisdiction de novo, unless otherwise provided by statute or administrative rule.  
(2) In medical service and medical treatment disputes under ORS 656.245, 656.247(3)(a), and 656.327, and managed care disputes under ORS 656.260(16), the administrative law judge may modify the director's order only if it is not supported by substantial evidence in the record or if it reflects an error of law. New medical evidence or issues may not be admitted or considered.”

codes; and accounts receivable records showing the amounts provider was paid under those CPT codes.

Insurer cites *Michael J. Doud*, 14 CCHR 40 (2009) as authority for the position that new evidence is admissible in a hearing on a medical fee dispute. That decision is not persuasive authority. The issue of whether new evidence can be admitted at the hearing on a medical fee dispute was not raised, addressed, or decided in *Doud*. The order merely refers to the rule that review is de novo in such a case. OAR 436-001-0225(1), (2). A legal decision is only authority for issues that are actually raised and decided in that decision. *State v. McDonnell*, 343 Or 557, 567 (2007).

Even if *Doud* was entitled to precedential weight, it is irrelevant here because the disputed contractual discounts are proper and provider's usual fee is therefore irrelevant. Insurer contends this evidence supports its position that it paid provider's "usual fee" regardless of the validity of the temporary rule and the existence of the TPR contract. Because I find the temporary rule valid and enforceable I need not address whether insurer paid provider's "usual fee" and whether this evidence should have been admitted.

RT applied the temporary rule that was in effect when the dispute was before it, found the contract between TPA and provider was enforceable under that rule, and found the discounted payments were proper under the contract. ALJ Marshall found the temporary rule had been improperly retroactively applied, and that its application in this case improperly allowed the temporary rule to operate beyond 180 days. I find that the rule can properly be applied retroactively, and that its application to the events in this case does not improperly extend its life.

A rule is being applied retroactively when it affects existing rights or obligations that arise from prior transactions or occurrences. *U.S. Bancorp v. Dept. of Revenue*, 337 OR 625, 636-637 (2004). Given that the rule here was enacted in 2008, and the services were provided and billed for in 2007, applying the temporary rule would be a retroactive application.

An agency is allowed to apply a rule retroactively if that was the agency's intent in enacting the rule. *U.S. Bancorp v. Dept. of Revenue*, 337 Or 625, 637-638 (2004); *Delehant v. Board on Police Standards and Training*, 317 Or 273, 278-279 (1993); *May Trucking Co. v. DOT*, 203 Or App 564, 573-574 (2006); *see also Whipple v. Howser*, 291 Or 475, 480-481 (1981). There is some authority that suggests that, in determining whether to apply a rule retroactively, it must be determined whether doing so would impair existing rights. *May, supra*, *Joseph v. Lowery*, 261 Or 545, 547 (1972).

Temporary OAR 436-009-0003(1) stated, in part: "(1) These rules apply to: . . . (b) all payments made under a contract with a medical provider, regardless of the date of service . . ." WCD Admin. Order No. 08-060, July 7, 2008. This is an express, overt, and intentional expression by the department that the temporary rule would operate retroactively and be applied to payments that were made before the rule was enacted.

In addition, enforcing fee discount agreements under the temporary rule does not prejudicially impair provider's pre-existing rights. Applying the rule here results in enforcing the terms of a contract that provider signed. Provider's rights are not harmed by the enforcement of a contract to which provider agreed. It is therefore permissible under the legal precedent cited above to apply the temporary rule to events that occurred before the rule's enactment.

Provider contends applying the rule retroactively violates its due process rights because it reasonably expected to be paid the amount it billed. I disagree. Retroactively applying the rule does not prejudicially affect provider's rights because the rule simply provides for the enforcement of a contract to which provider had already agreed. Provider should have reasonably expected to be paid the amounts it had agreed to in the fee discount contract.

ALJ Marshall also found applying the temporary rule retroactively would improperly extend its operation beyond the 180 days that are permitted for a temporary rule. ORS 183.335(6)(a). ORS 183.335(6)(a) does establish a limited life for a temporary rule. However, the statute provides that a temporary rule "may be effective for a period of not longer than 180 days." The temporary rule was in effect from July 1, 2008, through January 1, 2009. WCD Admin. Order No. 08-060, July 7, 2008; WCD Admin. Order No. 08-063, December 15, 2008. The administrative order here issued on August 8, 2008. The order issued during the 180 days in which the temporary rule was properly in effect and therefore did not improperly extend the life of the rule.

The temporary rule can properly be applied retroactively, and it was in effect at the time this dispute was before RT. RT was therefore correct in applying the temporary rule to resolve this dispute, and was correct in finding the discounts insurer applied were valid and permissible.

Provider also asserts the temporary rule is invalid because the department exceeded its statutory authority by adopting a rule that permitted payment to medical providers under a contractual discount, rather than according to the amount billed or the fee schedule. An administrative rule is invalid if it exceeds the agency's statutory authority. ORS 183.400(4); *Planned Parenthood Association v. Department of Human Resources*, 297 Or 562, 565 (1984). The temporary rule was adopted under the authority of ORS 656.012; 656.248; and 656.726(4)(a). WCD Admin. Order No. 08-060, July 7, 2008. ORS 656.726(4) states in part:

"The director hereby is charged with the duties of administration, regulation and enforcement of . . . this chapter. To that end the director may:

(a) Make and declare all rules . . . which are reasonably required in the performance of the director's duties.

ORS 656.012 provides in part:

(2) . . . [T]he objectives of the Workers' Compensation Law are declared to be as follows:

(a) To provide, regardless of fault, sure, prompt and complete medical treatment for injured workers . . .;

(b) To provide a fair and just administrative system for delivery of medical . . . benefits . . .

ORS 656.248 provides in part:

(1) The Director of the Department of Consumer and Business Services . . . shall

promulgate rules for developing and publishing fee schedules for medical services provided under this chapter . . . .

\* \* \* \* \*

(2) Medical fees equal to or less than the fees schedules published under this section shall be paid when the vendor submits a billing for medical services. In no event shall that portion of a medical fee be paid that exceeds the schedules.

\* \* \* \* \*

(6) Notwithstanding subsection (1) of (2) of this section, such rates or fees provided in subsections (1) and (2) of this section shall be adequate to insure at all times to the injured workers the standard of services and care intended by this chapter.

\* \* \* \* \*

(11) Notwithstanding any other provision of this section, fee schedules for medical services and hospital services shall apply to those services performed by a managed care organization certified pursuant to ORS 656.260, unless otherwise provided in the managed care contract.”

Provider contends the controlling statutes permit the department to authorize only three methods of calculating payments to medical providers: the fee schedule; the amount billed; or amounts specified by MCO contracts. Provider contends the statutory language cited above sets both a ceiling and a floor for payments. Provider’s argument seems to be that, since the statute expressly mentions fee schedules, provider bills, and MCO contracts, but not individual provider discount agreements, the statute does not authorize individual contracts between medical providers and insurers. Adopting this interpretation would require adding restrictive language to the statute that is not present.

The statute need not expressly authorize the use of discount contracts for them to be permissible. The statute expressly permits payments of amounts less than the fee schedule. It does not specify how those reduced amounts are to be determined. The statute does not state it has set out the only permitted methods of calculating fees, as long as there is not an attempt to charge more than the fee schedule allows. The language of the statute does not prohibit the parties from agreeing to rates less than the fee schedule. If a provider is permitted to voluntarily bill an amount lower than the fee schedule, there is not a logical reason to prohibit providers and insurers from agreeing in advance that the provider will accept a payment that is also less than the fee schedule. The statute therefore also does not prohibit the director from adopting rules that enforce fee discount contracts.

ORS 656.248(2) expressly permits payment of amounts lower than the fee schedule. “Medical fees equal to or less than the fee schedules . . . shall be paid when the vendor submits a billing . . . .” ORS 656.248(2) (emphasis added). The statute also explicitly sets the fee schedule as a maximum, or ceiling. “In no event shall that portion of a medical fee to be paid that exceeds the schedules.” *Id.* On its face, the statute sets a ceiling but not a floor.

This interpretation is consistent with the policies of the workers’ compensation system stated in ORS 656.012. Setting the fee schedule as a maximum helps maintain the system’s economic viability. Allowing the parties to voluntarily agree to fees that are lower than the fee

schedule also supports the system by helping to contain costs. If providers agree to contractual discounts, they should have determined they can provide proper care at that price. The use of contractual discounts does not inherently conflict with maintaining an acceptable quality of care.

In its exceptions, provider cites legislative discussions during the drafting of this statute that purportedly show the legislature intended or chose not to allow discount contracts. The matter under discussion in the text provider cites concerns the development of PPO's and MCO's, and their role in the workers' compensation system. The issue was primarily about who would be allowed to manage care. This is a different subject than the one under examination here, individual discount contracts between providers and insurers. An agreement under which a provider accepts specific discounts is not the same as a provider agreeing to allow the insurer to manage care. The legislative discussions referred to do not support provider's position.

Provider cites to the same legislative debate to assert the legislature intended ORS 656.248 to establish a floor for payments. The legislative statements that provider refers to address topics having absolutely nothing to do with the present issue of fee discount contracts. One reference is to benefit payments to disabled workers, another is to workplace safety, and the third concerns cost issues related to MCO's. (Ex. 10. pp. 3, 8-9, 10, 12-13, 16).

Provider next argues allowing fee discount contracts between providers and insurers violates the exclusive remedy concept of the workers' compensation system. ORS 656.018. The argument seems to be that allowing providers and insurers to set fees by contract is somehow setting up a compensation system outside of the workers' compensation laws and rules. First this is a misconstruction of the exclusive remedy principle. That rule means that workers can obtain remedies for work-related injuries only through the workers' compensation system. Allowing providers and insurers to mutually agree on medical fees less than the fee schedule does not alter the fact the injured worker is obtaining medical treatment, and any other benefits, through the workers' compensation system. It is true, as provider states, that the workers' compensation system is tightly regulated. But, as discussed above, allowing fee discount contracts is permitted by the authorizing statutes, and is consistent with the goals and policies of the workers' compensation system. The authorizing statute permits providers to charge less than the fee schedule. Fee discount agreements are not inconsistent with or outside of the structure of the workers' compensation system.

Provider contends fee discount agreements are unregulated insurance products within the workers' compensation system. A fee agreement between an insurer and provider is not an insurance product. The statutes define insurance as "a contract whereby one undertakes to indemnify another or pay or allow a specified or ascertainable amount or benefit upon determinable risk contingencies." ORS 731.102(1). Fee discount agreements are not agreements that concern indemnification or paying benefits upon the occurrence of specified contingencies. A fee discount contract is an agreement to pay a specified price for a specified service.

Provider also contends the rules concerning MCO's prohibit fee discount contracts outside of MCO's. The rules and statutes that establish parameters for MCO's address the operation of MCO's. They do not set the limits or requirements for care within the workers' compensation system outside of the MCO setting. It appears that provider is arguing that because

ORS 656.248(11) specifically authorizes the use of contracts in the MCO context, but does not use the word “contract” outside of the MCO setting, fee discount agreements are not permitted anywhere else. This argument fails because there cannot be an MCO without a care contract. An MCO is a contractual structure that defines how an enrolled worker will receive care. As an MCO cannot exist or provide worker care without being based in a contract, workers’ compensation statutes and rules that address MCO’s necessarily must address the issue of contracts. That contracts are addressed in the section of the statute concerning MCO’s therefore says nothing about whether fee discount contracts are permitted elsewhere in the workers’ compensation system.

Provider argues allowing fee discount agreements is comparable to improperly allowing insurers to act as PPO’s or MCO’s. Provider similarly argues TPA was improperly acting as an MCO without certification. A contract that sets a price for services does not create a PPO or MCO. MCO’s and PPO’s regulate the provision of care beyond simply setting the price for services. See ORS 656.245(4)(a); 656. 260. There has been no proof here that insurer or TPA actually are regulating care rather than simply bargaining over the price of services.

Provider contends that the contract between itself and TPA is not valid because TPA was acting as an uncertified MCO. The only evidence in this case concerns the payment of fees. Regardless of the terms of the contract, there is no proof in this case that TPA attempted to manage care concerning the patient treatment that gave rise to this fee dispute.

For the reasons stated above, I find the Proposed and Final Order contains legal errors. Applying the temporary rule to this dispute is a retroactive application. However, that is permitted because the rule clearly manifests the intent of the department that the rule should be applied retroactively and because retroactive application does not prejudicially affect provider’s rights. Applying the temporary rule in this dispute also does not extend the effective period of the rule beyond 180 days. The rule was only in effect for the authorized period and this dispute came before RT during the time the temporary rule was in effect. The temporary rule therefore should be applied to resolve this dispute.

It is undisputed that there is a contract between TPA and provider which sets the fees to be paid for the services provided in this case. The temporary rule enforcing such contracts was in effect at the time this dispute came before the department for resolution. RT was therefore correct in finding insurer acted properly in paying the amounts the contract authorized.

**IT IS HEREBY ORDERED** The August 8, 2008, Administrative Order is affirmed. The April 12, 2010 Proposed and Final Order is modified. Insurer has paid the amounts it owes and is not required to pay any additional amounts for the bills at issue in this matter.