
In the ORS 656.260 Managed Care Dispute of

J.M. Doud, Claimant

Contested Case No: 10-095H

PROPOSED & FINAL ORDER

March 17, 2011

ALLIANT SPECIALTY INSURANCE SERVICES, Petitioner

J.M. DOUD, Respondent

Before Elizabeth Fulsher, Administrative Law Judge

Pursuant to notice, a hearing was held and the record close on February 16, 2011 in Portland, Oregon before Administrative Law Judge Fulsher. Claimant was present and was represented by his attorney, Ernest Jenks. Pacific Lumber Co. and Alliant Specialty Ins. Services were represented by their attorney, David Levine.

Exhibits 1 through 38 were admitted into evidence.

ISSUE

Whether Dr. Keenen's bills for services on November 14 and 19, 2007 are reimbursable. The carrier has appealed the May 26, 2010 Administrative Order.

SUMMARY OF FINDINGS OF FACT

Claimant was compensably injured on August 13, 2007 in a motor vehicle accident. His claim was accepted on October 11, 2007 as a cervical muscle strain. The claims administrator at that time was Empire Pacific Risk Management. (Ex. 3). Claimant was treated by Dr. Keenen on November 14, 2007. Dr. Keenen diagnosed an L4-5 herniated nucleus pulposus on the right that was post-traumatic. Dr. Keenen recommended surgery. (Ex. 4). Dr. Keenen performed surgery at L4-5 on November 19, 2007. (Ex. 9). Claimant paid for the November 14 and 19, 2007 medical services by Dr. Keenen himself.

On January 12, 2008, the employer denied a C6-7 left disk injury with radiculitis and right L4-5 disc protrusion with radiculitis. (Ex. 15). On June 10, 2008, the employer denied a C3-4 disc protrusion. (Ex. 19). On February 13, 2009, an Administrative Law Judge issued an Order Approving a Settlement stipulation in which the employer agreed to rescind its denials and accept a C6-7 disc protrusion, a C3-4 right sided disc protrusion combined with a preexisting and noncompensable cervical spondylosis as a combined condition and an L4-5 lumbar disc combined with preexisting and noncompensable degenerative disc and facet disease of the lumbar spine as a combined condition. (Ex. 22). A modified notice of acceptance was issued on February 27, 2009. The acceptance letter contained a "cc" to Dr. Keenen. (Ex. 24).

The Director's order found that Dr. Keenen submitted documentation explaining that he was not informed of the change of insurers (from Empire Pacific Risk Management to Alliant) and did not receive written notification of the final litigation from the insurer, but was notified by telephone when he received a phone call on January 26, 2010 notifying him that the lumbar area was accepted and that the carrier, Alliant, should be billed for the disputed dates of medical

services. In March 2010, Dr. Keenen requested administrative review regarding the payment for medical services on November 14 and 19, 2007. (Ex. 30). In the May 26, 2010 order, the Director found the carrier liable for Dr. Keenen's bills for November 14 and 19, 2007. (Ex. 36).

CONCLUSIONS OF LAW AND OPINION

The employer has appealed the May 26, 2010 Administrative Order that found the carrier liable for services provided by Dr. Keenen on November 14 and 19, 2007. Pursuant to OAR 436-001-0225(2), the director's order may be modified 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.

The applicable administrative rule cited by the Director's order is OAR 436-009-0010(5) (WCD Admin. Order 07-051). Subsection (a) of the rule provides that medical providers must submit billings for medical services within: 60 days of the date of service; 60 days after the medical provider has received notice or knowledge of the responsible workers' compensation insurer or processing agent; or 60 days after any litigation affecting the compensability of the service is final, if the provider receives written notice of the final litigation from the insurer. Subsection (b) of the rule provides that medical service billings submitted later than the time frames in subsection (a) may be payable in full if the provider establishes good cause for submitting the bill late. Under the rule, good cause may include, but is not limited to, such issues as extenuating circumstances or circumstances considered outside the control of the provider. Pursuant to OAR 436-009-0010(5)(c), a bill rendered over twelve months after the date of service is not payable, except when a provision of subsection (a) of this section is the reason the billing was rendered after twelve months.

In the May 26, 2010 order, the Medical Reviewer found that extenuating circumstances existed that were out of Dr. Keenen's control and he had good cause to bill more than 12 months from the dates of service. In reaching this decision, the reviewer found that Dr. Keenen was not informed of the change of insurers and did not receive written notification of the final litigation from the insurer but was notified by phone of the final litigation on January 26, 2010 and that the doctor billed the carrier for the disputed services on February 3, 2010. Therefore, relying on OAR 436-009-0010(5)(a), (b) and (c), the Director found the carrier liable for Dr. Keenan's bills.

The employer contends that it is not liable for the disputed medical services because the bills were submitted more than a year after the dates of service. It argues that Dr. Keenen received the February 27, 2009 Notice of Acceptance of the lumbar disc condition and had received notice that the conditions were accepted. Claimant argues that it is not known when the doctor received the Notice of Acceptance and that the notice is not notice of final litigation. Claimant argues that the Director's order is supported by substantial evidence.

I agree with claimant's arguments and conclude that the Director's order is supported by substantial evidence. See *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206 (1988) ("substantial evidence" exists to support a finding when the record, viewed as a whole, would permit a reasonable person to make that finding). Although the Notice of Acceptance was copied to Dr. Keenen, there is no indication of when or if he actually received the document. Moreover, it is

unclear whether the Notice of Acceptance constituted “written notice of the final litigation from the insurer.” The Director’s order found that Dr. Keenen did not receive written notice of final litigation but received notice by telephone and submitted the bills soon thereafter to the carrier. Substantial evidence supports this finding that Dr. Keenen did not receive written notice of final litigation from the insurer.

Claimant’s attorney is entitled to an attorney fee pursuant to ORS 656.385(3). After considering the factors in OAR 436-001-0400, I conclude that \$2,000 is a reasonable attorney fee.

ORDER

The May 26, 2010 Administrative Order is affirmed. Claimant’s attorney is awarded a fee of \$2,000, payable by the carrier.