In the ORS 656.248 Medical Fee Dispute of

Laurelhurst Physical Therapy

Contested Case No: 09-085H

FINAL ORDER ON RECONSIDERATION

April 7, 2011

LAURELHURST PHYSICAL THERAPY, Petitioner
HARTFORD CASUALTY INSURANCE COMPANY,
SPECIALTY RISK SERVICES, Respondent

Before John Shilts, Workers' Compensation Division Administrator

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The Department of Consumer and Business Services (the department) issued a Final Order in this matter on January 28, 2011. That order did not correctly identify the participating parties. The department therefore issues this Amended Final Order.

This is a medical fee payment dispute between medical provider Laurelhurst Physical Therapy (provider) and insurers Hartford Casualty Insurance Company and Specialty Risk Services (insurers). The injured workers are not participating in the dispute. The dispute is whether insurers were authorized to discount their payments to provider for billed fees based on a fee discount contract between provider and First Health Group Corporation (TPA). The parties addressed the dispute as though it involved the application of former temporary rule OAR 436-009-0040.[1] That was not correct. The controlling rule is the preceding, permanent version of that rule. Former OAR 436-009-0040[2] I find the discounts were permitted under that rule.

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[1] Hartford's written argument submitted for the hearing correctly points out the Administrative Order was issued after January 1, 2009, so that the preceding, permanent version of the rule should be controlling. The Hartford Closing Argument, p. 8.The Proposed and Final Order does not address this point.

[2]The current version of OAR 436-009-0040 only applies to disputes where the services were provided on or after the rule took effect on January 1, 2009. OAR 436-009-0003(1). The rule now states: "Insurers must pay for medical services at the provider's usual fee, or according to the fee schedule, whichever is less, unless otherwise provided by contract . . . ." OAR 436-009-0040(1).

The former temporary rule 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 . . . ." Former Temporary OAR 436-009-0003(1); WCD Admin. Order No. 08-060, July 7, 2008. Former Temporary 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.

The permanent rule that preceded the temporary rule stated:

> "The insurer must pay for medical services at the provider's usual fee or in accordance with the fee schedule whichever is less. Insurers must pay for medical services that have no fee schedule at the provider's usual fee. For all MCO enrolled claims, the insurer must pay for medical services at the provider's usual fee or according to the fee schedule, whichever is less, unless otherwise provided by MCO contract."

Former OAR 436-009-0040(1); WCD Admin. Order No. No. 07-055, November 1, 2007

FACTUAL SUMMARY

On July 7, 2008, the department adopted a temporary rule concerning billing and payment of medical fees for services provided to injured workers. The temporary rule permitted fee discount contracts between medical providers and insurers. Former OAR 436-009-0040; WCD Admin. Order No. 08-060, July 7, 2008.

Provider performed medical services for an injured worker between January 2006 and April 2008. At that time, provider had a contract with TPA under which provider agreed to accept discounted fees for specified services. Insurers also had a contract with TPA under which insurers were entitled to apply the fee discounts in the provider/TPA contract. Applying that contract, insurers paid provider less than the full billed amount for provider's services. Provider brought this dispute.

The Workers' Compensation Division's (WCD) Resolution Team (RT) issued an Administrative Order in this dispute on May 12, 2009. The order found provider and insurers were parties to the discount agreement and that insurers had properly applied the discounts stated in the contract. Insurer therefore did not owe any additional payment.

Provider requested a hearing. Administrative Law Judge (ALJ) Monte Marshall held the hearing and issued a Proposed and Final Order on August 9, 2010. The ALJ concluded the provision in the temporary rule that authorized 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). [3] The ALJ reasoned that, since the original treatment and billing in this case occurred before the temporary rule was enacted, applying the temporary rule to those events would extend the operation of the rule beyond the permitted 180 days. The ALJ 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).

Although it appears RT, the ALJ, and the parties focused their dispute on the applicability of the former, temporary version of OAR 436-009-0040(1), that version of the rule is not relevant here. As explained above, the temporary rule had expired at the time RT issued the Administrative Order. By its own terms, the current, permanent rule does not apply where the

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[3] 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."

services were provided before the rule took effect. The controlling version of the rule is therefore the former, permanent version that preceded the temporary rule.

In determining the meaning of the former rule, it is important to bear in mind that the department promulgated the rule and that when an agency interprets its own rules, the court will defer to that interpretation if it is plausible, and not inconsistent with the rule, the rule's context, or other sources of the law. *Coffey v. Board of Geologist Examiners,* 348 Or 494, 509 (2010); *Tualatin Riverkeepers v. Oregon Department of Environmental Quality,* 235 Or App 132, 144 (2010). The courts should interpret rules so as to give effect to the intent of the agency that established the rule. *Safeway Stores, Inc. v. Martinez,* 239 Or App 224, 230 (2010).

I conclude fee discount contracts between providers and insurers were permitted under the prior, permanent version of OAR 436-009-0040(1). That rule stated:

> "The insurer must pay for medical services at the provider's usual fee or in accordance with the fee schedule whichever is less. Insurers must pay for medical services that have no fee schedule at the provider's usual fee. For all MCO [Managed Care Organization] enrolled claims, the insurer must pay for medical services at the provider's usual fee or according to the fee schedule, whichever is less, unless otherwise provided by MCO contract."

Former OAR 436-009-0040(1); WCD Admin. Order No. No. 07-055, November 1, 2007. I reach this conclusion for several reasons.

First, the rule does not expressly prohibit fee discount contracts. Nor does it include exclusive language, such as the word "only." In interpreting rules, it is not proper to add language the rule does not actually contain. ORS 174.010; *Michels v. Hodges,* 326 Or 538, 544 (1998).

Second, the rule must be read in the context of its authorizing statute, ORS 656.248(2). That section provides:

> "Medical fees equal to or less than the fee 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."

The clear intent of this provision is to set an upper limit on what medical fees may be paid, the fee schedule. But the statute expressly states that ". . . [m]edical fees . . . less than the fee schedules . . ." may be paid. Thus, the statute deliberately does not set a minimum or a floor for medical fee payments. This is consistent with the policy of the workers' compensation system to:

> ". . . provide . . . sure, prompt, and complete medical treatment for injured workers . . . [and]
>
> . . . [a] fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversarial nature of the compensation proceedings, to the greatest extent practicable . . . ."

ORS 656.012(2)(a), (b).

Setting maximum fees contains costs. Not setting a floor helps to contain costs, by allowing insurers and providers to negotiate fees less than the fee schedule. Permitting discount contracts allows providers to determine how much less than the fee schedule they can charge while still providing quality medical services. Enforcing fee discount contracts is consistent with the wording of the rule and the statute, and with the policies of the workers' compensation system.

In addition, the rule and statute authorize payment of the provider's "usual fee." When a provider and insurer sign a contract authorizing an agreed-upon discount for a given service, the parties have essentially agreed on what the provider's "usual fee" is for each covered service. The provider is therefore being paid their "usual fee" within the meaning of the statute and rule.

Permitting discount contracts also serves the purposes of the workers' compensation system to reduce litigation and the adversarial nature of the proceedings. If providers and insurers agree in advance what a provider will be paid for a given service through a valid, enforceable agreement, there should be fewer payment disputes.

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, only that fees will only be paid if they are equal to or less than the fee schedule. 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.

In its exceptions, provider cites legislative discussions during the drafting of the workers' compensation statutes 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 Preferred Provider Organizations (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, discount contracts that concern billing and payment, not care management. An agreement under which a provider

accepts specific discounts is not the same as a provider agreeing to allow the insurer to act as an MCO by managing care. The legislative discussions referred to do not support provider's position.

Provider cites to the same legislative debate to assert the legislature intended that ORS 656.248 would 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 656.012(2) provides:

> "[T]he objectives of the Workers' Compensation Law are declared to be as follows:
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> * * * * *
> (e) To provide the sole and exclusive source and means by which subject workers, their beneficiaries and anyone otherwise entitled to receive benefits on account of injuries or diseases arising out of and in the course of employment shall seek and qualify for remedies for such conditions."

ORS 656.018(1)(a) states in part:

> "The liability of every employer who satisfies the duty required by ORS 656.017(1) is exclusive and in place of all other liability arising out of injuries, diseases, symptom complexes or similar conditions arising out of and in the course of employment that are sustained by subject workers . . . ."

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. This is a misconstruction of the exclusive remedy principle. That rule means that, in exchange for receiving guaranteed benefits for work-related conditions, workers can obtain remedies for work-related conditions only through the workers' compensation system. In exchange, employers who properly insure their workers are shielded from other liability for their workers' work-related conditions. 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 regulated structure of the workers' compensation system.

It is true, as provider states, that the workers' compensation system is tightly regulated. But, as discussed above, the controlling statutes permit fee discount contracts, and doing so 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 contracts are one way of doing this. Fee discount agreements are not inconsistent with or outside of the structure of the workers' compensation system.

Alternatively, if provider is arguing allowing fee discount contracts permits the parties to operate outside of the regulated parameters of the workers' compensation system, this is incorrect. Allowing providers and insurers to negotiate payment levels does not remove their interactions from the regulated structure of the workers' compensation system, because that structure permits payment equal to or less than the amounts the fee schedule specifies.

Provider contends fee discount agreements are improper unregulated insurance products. 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. In addition, the injured workers are not parties to the fee discount contracts; they are not contracts through which the worker bargains for a benefit in the case of being injured. The existence of those contracts does not determine whether an injured worker will receive treatment for an accepted condition.

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 is 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.

It is undisputed that there is a contract between TPA and provider that sets the fees to be paid for the services provided in this case. That contract is enforceable under former, permanent OAR 436-009-0040(1).

IT IS HEREBY ORDERED The May 12, 2009, Administrative Order is modified in that its result is affirmed, but the result is properly based on former, permanent OAR 436-009-0040. The August 9, 2010, Proposed and Final Order is modified in that former, permanent OAR 436-009-0040(1) is the controlling rule. However, contrary to the finding in the Proposed and Final Order, that rule does permit the use of fee discount contracts between providers and insurers. Insurers have paid the amounts owes and are not required to pay any additional amounts for the bills at issue in this matter.