In the ORS 656.245 Medical Services Dispute of

GERARD EGAN, Claimant

Contested Case No: H05-022

FINAL ORDER

December 7, 2005

GERARD EGAN, Petitioner

SAIF CORPORATION, Respondent

Before John Shilts, Administrator, Workers' Compensation Division

Petitioner claimant, through his attorney Jeremiah J. Scannell, timely submitted exceptions to Office of Administrative Hearings Administrative Law Judge (ALJ) Lawrence S. Smith's June 2, 2005 Proposed and Final Order. Respondent insurer, through its attorney David L. Runner, responded. This matter comes before the director for a final order. The issue is reimbursement for a doctor's visit. I affirm in part and reverse in part.

Findings of Fact

I adopt the ALJ's findings of fact with the following modifications.[1] Finding of fact (3) states:

> "On August 10, 2004, Claimant sought follow-up treatment for knee pain from Dr. Terlaje in Guam. Dr. Terlaje noted the pain was at the site of Claimant's prosthetic right foot and **prescribed Monetasone and Hydrocodone at a cost of $66.29**. (Exs. 1 and 2.) Claimant had to pay for the medical services at the time of service, or he would not be treated. He submitted a request to SAIF for reimbursement of his payment for the services and his prescriptions. SAIF reimbursed him for his prescriptions, but not for the medical services because it had no record from the doctor regarding the purpose of the services. (Ex. 6.) Claimant wrote to WCD, asking for an order that required SAIF to reimburse him for the medical services. WCD responded by requesting Dr. Terlaje's chart notes. (Ex. 4.)"

(Emphasis added.) The bold language appears to state that the prescriptions cost $66.29. The record shows that the office visit cost $66.29, while the prescriptions cost $58.03. (Ex. 1.) I modify the finding accordingly.

Claimant further takes issue with finding of fact (3) insofar as it states that the reason why insurer did not reimburse claimant for the office visit was because it had no record regarding the purpose of the visit. Rather, claimant argues, insurer's reason for not paying was because the provider did not bill insurer directly. Insurer argues there is no distinction between the two reasons.

[1] I may modify the ALJ's findings of historical fact if I determine that the finding is not supported by a preponderance of the evidence in the record. ORS 183.650(3); OAR 137-003-0665(4).

The best evidence of the reason insurer denied reimbursement is the insurer's own statements at the time. The record shows that insurer told claimant it was not reimbursing him for the office visit "as medical providers are supposed to bill insurers direct. [M]edical providers must bill insurers using current billing form[s] and provide legible chart notes documenting services that have been billed * * *." (Ex. 5.) I modify the finding to be consistent with this statement.

The ALJ's finding of fact (3) is therefore modified to state:

> "On August 10, 2004, Claimant sought follow-up treatment for knee pain from Dr. Terlaje in Guam. Dr. Terlaje noted the pain was at the site of Claimant's prosthetic right foot and prescribed Monetasone and Hydrocodone. (Exs. 1 and 2.) Claimant had to pay for the medical services at the time of service, or he would not be treated. He submitted a request to SAIF for reimbursement of his payment for the services and his prescriptions. SAIF reimbursed him for his prescriptions, but not the $66.29 office visit fee, stating that providers must bill insurers directly. (Ex. 5, 6.) Claimant wrote to WCD, asking for an order that required SAIF to reimburse him for the medical services. WCD responded by requesting Dr. Terlaje's chart notes. (Ex. 4.)"

I otherwise adopt the ALJ's findings of fact.

Evidentiary Issues

On insurer's objection, the ALJ excluded claimant's exhibits P1 and P2 as not relevant. At hearing the ALJ marked claimant's March 27, 2005 Hearing Memorandum, including the attachments, as P1, and claimant's April 6, 2005 Additional Citation of Authority as P2. The memos themselves were timely submitted written argument, and are properly considered.[2] To the extent the ALJ's evidentiary ruling excluded claimant's argument, I reverse.

Insurer objected to the attachments to claimant's March 27, 2005 memo. The attachments were not individually marked at hearing. Consistent with OAR 436-001-0240(2), I have marked them as follows:

Exhibit a	June 17, 2003 letter from insurer to claimant
Exhibit b	July 14, 2003 letter from claimant to WCD
Exhibit c	July 30, 2003 letter from insurer to WCD
Exhibit 17a	December 17, 2004 fax from insurer to WCD

[2] On May 31, 2005, claimant submitted a Post-Hearing Memorandum. The copy in the hearing file was stamped "RECEIVED" by "WCB-SALEM" on June 3, 2005 and by "WCD Policy Section" on June 8, 2005. It does not appear as though it was sent to, received by, or considered by the ALJ. The record closed on May 26, 2005, the date of the hearing, and therefore the post-hearing memo is not considered.

I consider each exhibit separately. Irrelevant, immaterial, or unduly repetitious evidence is properly excluded. OAR 137-003-0610(2) and (3). Exhibit 17a is directly related to this proceeding, and is therefore admitted. Exhibits a, b, and c relate to a prior reimbursement dispute between the parties. Insurer objected to their admission, arguing they are not relevant to this proceeding. Claimant argues they are offered to show that insurer knew Guam providers do not accept SAIF insurance. I find that the exhibits are sufficiently related to this dispute to be admissible and therefore reverse the ALJ's ruling.

Issue

The underlying issue is whether insurer was required to reimburse claimant $66.29 he paid for the August 10, 2004 office visit with Dr. Terlaje in Guam. The Medical Review Unit (MRU), by Administrative Order dated February 16, 2005, found that insurer was not required to reimburse claimant, citing ORS 656.248(2) and OAR 436-009-0010(2) and (3). The ALJ affirmed, finding no legal basis to set aside MRU's order.[3]

Mootness

Insurer ultimately reimbursed claimant the office visit fee of $66.29. Insurer argues, therefore, that this matter is moot. Claimant responds that it is not moot because insurer may now recover that amount as an overpayment under ORS 656.268(13).[4] Further, claimant argues, this issue is capable of repetition yet will escape review, and it is in the interest of judicial economy to address the issue now because it is relevant to the issue of penalties for alleged late payment.

A matter is moot if a decision on it would have no practical effect on the rights of the parties. *City of Eugene v. Public Employees Retirement Bd.*, 330 Or 113, 128 (2005). Oregon courts do not recognize the "capable of repetition, yet evading review" exception to the mootness doctrine. *Yancy v. Shatzer*, 337 Or 345, 363 (2004). For the following reasons, I find that this matter is not moot.

The original dispute arose because insurer did not reimburse claimant for the office visit fee. Before MRU issued its order, insurer reimbursed claimant in full. However, MRU went on to conclude, and the ALJ affirmed, that insurer was not required to reimburse claimant. There are two practical effects of such a decision on the rights of the parties. First, insurer may be liable for a penalty under ORS 656.262(11) for unreasonable delay of payment of compensation if there was compensation then due to claimant. The decision in this case determines whether compensation was due. Second, if insurer was not required to pay, insurer may decide to recover the amount reimbursed as an overpayment under ORS 656.268(13)(a).[5] Therefore, I find that a decision in this matter would have a practical effect on the rights of the parties and this matter is therefore not moot.

---

[3] Under ORS 656.245(7), 656.327(2), and OAR 436-001-0225(1), MRU'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.

[4] ORS 656.268(13)(a) provides, in part: "An insurer * * * may offset any compensation payable to the worker to recover an overpayment from a claim with the same insurer * * *."

[5] The ALJ stated that if insurer does offset the reimbursement paid to claimant from future payments, claimant should request waiver under OAR 436-009-0003(2). That rule provides for director waiver of procedural rules, not statutes.

Applicable Statutes and Rules

As MRU and the ALJ found, the statute and rules require the provider to bill the insurer directly. ORS 656.248(2) provides, in part: "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." OAR 436-009-0010[6] further provides, in part:

> "(2) All medical providers shall submit bills to the insurer or managed care organization, as provided by their contract for medical services, on a current UB92 or HCFA/CMS 1500 form * * *.
> "(3)(a) All original medical provider billings shall be accompanied by legible chart notes documenting services which have been billed, and identifying the person performing the service and license number of person providing the service. * * *"

In addition, OAR 436-009-0030(3) provides, in part:

> "Insurers shall date stamp medical bills and reports upon receipt and pay bills for medical services on accepted claims within 45 days of receipt of the bill, if the billing is submitted in proper form in accordance with OAR 436-009-0010(2) through (4) and clearly shows that the treatment is related to the accepted compensable injury or disease."

Under these provisions, insurers are required to pay for medical services when the provider submits a bill in proper form and including the required information. Insurer received no such bill, and was therefore not required to pay.

Claimant contends insurer is required to pay under ORS 656.245(1)(a) and OAR 436-010-0270(7). ORS 656.245(1)(a) provides: "For every compensable injury, the insurer * * * shall cause to be provided medical services for conditions caused in material part by the injury for such period as the nature of the injury or the process of the recovery requires * * *." While this provision establishes an insurer's liability for compensable medical services, the specific procedural rules must also be followed in order for medical services to be reimbursable. Those rules were not followed here.

OAR 436-010-0270(7)[7] provides, in part, "Insurers shall reimburse workers for actual and reasonable costs for travel, prescriptions, and other claim related services paid by a worker in accordance with ORS 656.245(1)(e), 656.325, and 656.327." Claimant argues the office visit was a "claim-related service," and insurer is therefore required to reimburse claimant under this rule. Insurer argues this language does not apply to medical treatment. I agree. "Claim related

[6] WCD Admin. Order 04-054, effective April 1, 2004.
[7] WCD Admin. Order 04-055, effective April 1,2004.

services" under this rule and OAR 436-009-0025[8] include those out-of-pocket expenses a worker incurs in order to receive compensable medical services. They include such things as travel, mileage, lodging, and meals. The medical services themselves are subject to the rules discussed above, and they must be directly billed to the provider.

Claimant cites *Robert L. Brill*, 9 CCHR 107 (2004) in support of his argument. I find that the case is distinguishable on its facts and therefore does not apply. In *Brill* the worker incurred out-of-pocket expenses, including mileage and private medical insurance deductible payments, during the time his workers' compensation claim was denied. The issue before the ALJ was whether the request for reimbursement was timely submitted under OAR 436-009-0025(3) after compensability of the underlying conditions was finally determined. That fact scenario is distinguishable from this case.

Claimant also argues that OAR 436-009-0015(1) applies here. OAR 436-009-0015(1) provides, in part: "An injured worker shall not be liable to pay for any medical service related to an accepted compensable injury or illness * * *." Generally, a worker is not liable to pay for compensable medical services. However, as discussed above, insurer was also not required to pay.

Public Policy

Claimant argues that the end result in this matter – that a worker who seeks otherwise compensable medical care from a Guam physician who will not bill an Oregon workers' compensation insurer, and who pays for that care out-of-pocket, is not entitled to reimbursement – is contrary to public policy. According to claimant, the worker must either pay for the services himself or go without the services.

Oregon's workers' compensation system allows for medical services provided outside of Oregon. ORS 656.245(2)(a). However, the rules regarding payment for those services remain the same as for services provided in Oregon. The provider must follow the rules, and the insurer's obligation to pay is not triggered unless the rules are followed.

[8] OAR 436-009-0025(1) provides, in part:

> "The insurer shall notify the worker at the time of claim acceptance that actual and reasonable costs for travel, prescriptions and other claim-related services paid by the worker will be reimbursed by the insurer upon request. The insurer may require reasonable documentation to support the request. Insurers shall date stamp requests for reimbursement upon receipt and shall reimburse the costs within 30 days of receiving the worker's written request and supporting documentation, if the request clearly shows the costs are related to the accepted compensable injury or disease. If the insurer cannot determine if the costs are related to the accepted compensable injury or disease, the insurer shall inform the worker what information is needed before the request for reimbursement can be processed."

Penalties

The ALJ did not address the issue of penalties. Claimant contends he raised the issue; insurer responds that penalties are not a part of this proceeding. Before the ALJ, and before me, the issue is whether MRU's Administrative Order is supported by substantial evidence in the record or reflects an error of law. As to the issue of penalties, MRU's order indicates that a copy of it was submitted to the Investigations and Sanctions Unit for a determination of whether insurer is liable for a penalty for late payment. No such determination is before me in this matter.

Attorney Fees

Claimant has not prevailed, so his attorney is entitled to no fee. ORS 656.385(1).

IT IS HEREBY ORDERED the June 2, 2005 Proposed and Final Order is affirmed in part and reversed in part.