
In the Medical Fee Dispute of
RANDY D. BOYDSTON, Claimant
Contested Case No: 05-127H
PROPOSED AND FINAL ORDER
January 10, 2006
SAIF CORP., Petitioner
JAMES A. COULTER, M.D., Respondent
Before Catherine P. Coburn, Administrative Law Judge, Administrative Hearings

HISTORY OF THE CASE

Insurer appeals the Administrative Order issued on August 10, 2005 by the Medical Review Unit (MRU) of the Workers' Compensation Division (WCD), Department of Consumer and Business Services (department or director). On September 9, 2005, the department referred the matter to the Office of Administrative Hearings (OAH). On December 9, 2005, Administrative Law Judge Catherine P. Coburn conducted a hearing in Beaverton, Oregon. Attorney Jerome B. Larkin represented petitioner SAIF Corporation (insurer). Attorney William L. Ghiorso represented respondent James A. Coulter, M.D. and J.D. (Dr. Coulter or medical provider) who appeared as a limited party pursuant to OAR 137-003-0535. Claimant waived appearance. Attorney Norman Cole testified on insurer's behalf and Dr. Coulter testified on his own behalf. The record closed on the date of hearing.

ISSUE

Whether the fee charged by James A. Coulter, M.D. for a Worker Requested Medical Examination (WRME) provided on October 8, 2004 is excessive.

EVIDENTIARY RULINGS

The following exhibits were admitted into the record without objection: WCD Exhibits 1 through 31, insurer's Supplementary Exhibits 4A through 28B, and 5A through 49, as well as Dr. Coulter's Supplementary Exhibits R4a through 47.

FINDINGS OF FACT

(1) On September 22, 1980, claimant suffered a compensable injury while working as a logging truck driver. He was using an axe to trim branches from the branches on top of a log truck trailer and jumped to the ground, a distance of 12 to 15 feet. (Exs. 1, 3 and 48-2.) Insurer initially accepted cervical and lumbar strains. (Ex. 48-2.) In May 1993, claimant underwent lumbar discectomy, and following litigation in 1994, insurer accepted an L5-S1 disc herniation. (Exs. 4 and 5.)

(2) On September 14, 1994, the claim was closed. (Ex. 25.) From 1995 until 2004, claimant had no medical treatment on the claim. (*Id.*)

(3) On January 19, 2004, Paul G. Amstutz, M.D. performed a C3 through C7 laminectomy with neural foramina decompression. (Ex. 48-3.) On February 9, 2004, insurer received a bill for the surgery. (Ex. 25-1.)

(4) On April 19, 2004, insurer requested William Parsons, M.D. to conduct a record review. (Ex. 5.) Insurer asked the following questions:

1. Based on your review of the records, what is your diagnosis(es)?
 2. Did you identify a re-existing condition (one existing prior to the 1980 injury)?
 3. If there is a pre-existing injury, did it combine with the results of the 1980 work injury to cause or prolong disability or treatment? Please explain.
 4. If there is a combined condition, is the pre-existing condition the major contributing cause (more than 50 percent) of the combined condition and the disability or treatment resulting therefore? Please explain.
 5. If you did not identify a pre-existing condition, is the 1980 work injury a material contributing cause of the current cervical condition? (A material cause is more than a minimal cause, but not necessarily the sole or primary cause.)
- Any additional comments or recommendations you may have will be appreciated. (Ex. 5.)

(5) On April 21, 2004, Dr. Parsons issued a record review report. He opined that the January 2004 cervical surgery was not work related. (Ex. 5A.) On April 30, 2004, Dr. Parsons reviewed imaging studies that claimant provided to him and confirmed his opinion that the surgery was not caused by the 1980 work injury. (Ex. 5B-2.)

(6) On May 25, 2004, insurer denied compensability of the cervical surgery performed by Dr. Amstutz, asserting that it was not related to the work injury. Insurer noted that the denial was based in part on Dr. Parson's record review. (Ex. 7.)

(7) On June 30, 2004, Dr. Amstutz explained that he did not concur with Dr. Parson's opinion. (Ex. 8.)

(8) On August 9, 2004, insurer notified claimant of an independent medical examination (IME) with Robert Staver, M.D. and Jau-Shin Lou, M.D., set for September 25, 2004. (Ex. 9.) Insurer posed the following questions to Drs. Staver and Lou:

1. What history did the worker provide regarding the cervical condition that led to the surgery in January?

2. In your opinion, after reviewing the records, what was the diagnosis of the cervical condition at the time of the 1980 injury?
3. What are the objective findings today?
4. Did you identify a pre-existing condition (one existing prior to the 1980 work injury)?
5. If there is a pre-existing injury, did it combine with the results of the 1980 work injury to cause or prolong the disability or treatment?
6. If there is a combined condition, is the pre-existing condition the major contributing cause (more than 50%) of the combined condition and the disability or treatment resulting therefrom?
7. If you did not identify a pre-existing condition, is the 1980 work injury the major contributing cause of the current cervical condition?
8. Is the cervical diagnosis at the time of the 1980 injury a material contributing cause of the current condition? Please explain.

(9) On August 23, 2004, claimant submitted a written request for an examination by a physician selected by the director. (Ex. 10.)

(10) On September 17, 2004, the director notified claimant that it had selected James A. Coulter, M.D. to perform a Worker Requested Medical Examination (WRME). (Ex. 11.) Dr. Coulter is board certified in Neurology and Legal Medicine. (Ex. 32-2; testimony of Coulter.) The director instructed claimant to schedule the examination with Dr. Coulter within 14 days, and to notify insurer and the Workers' Compensation Board of the examination date. (Ex. 11.)

(11) On September 24, 2004, insurer sent medical records to Dr. Coulter for the WRME. (Exs. 12 and 16-25.) Insurer indicated that claimant was scheduled for an IME on September 25, 2004 and it would send that report if it became available prior to the WRME. (Ex. 12.)

(12) On October 1, 2004, claimant's attorney provided claimant with copies of all hearing exhibits and other medical records. (Ex. 13.)

(13) On October 1, 2004, insurer provided additional medical records to Dr. Coulter, including the list of questions it had submitted to Drs. Staver and Lou for the IME. (Exs. 15 and 16-19.) Insurer sent Dr. Coulter a total of 670 pages of medical records which did not constitute the complete medical record on this claim. (Exs. 14 and 16; testimony of Coulter.)

(14) On October 8, 2004, Dr. Coulter conducted the WRME. (Ex. 16.) When claimant arrived for the appointment, he delivered a laundry basket of containing 13 inches of medical and legal records which were not organized in chronological order and contained duplicates. (Exs. 15, 16-25 and 19; testimony of Coulter.) During the physical examination, Dr. Coulter conducted a standard protocol neurological evaluation, including the low back. (Ex. 16-26; testimony of Coulter.)

(15) In preparing the WRME report, Dr. Coulter reviewed all of the x-rays and medical records provided to him by insurer and claimant, totaling approximately 2,000 pages. He answered the questions that insurer had asked of Drs. Staver and Lou in the recent IME; he did not address any questions posed by claimant. (Exs. 16-19 and 16-26; testimony of Coulter.) Dr. Coulter wrote a 26-page report reviewing claimant's medical history, presenting physical examination findings, and evaluating the current medical condition. Based in part on records provided by claimant, Dr Coulter opined that the 1980 work injury was the major contributing cause of the current cervical condition, including the need for surgery in January 2004 and future treatment including a C4-5 anterior cervical fusion with halo immobilization. (Ex. 16-25; testimony of Coulter.)

(15) On November 22, 2004, insurer received the WRME report with a bill for \$14,075. (Exs. 15 and 25-2.) Under Code W0001, Dr. Coulter billed \$2,000 for a 1½ hour physical examination and travel, \$7,050 for 23½ hours spent reviewing the medical records submitted by insurer and claimant, \$225 for x-ray review, \$4,500 for 18 hours preparing the report, and \$200 for 1½ hours' research. (*Id.*)

(16) SAIF recoded Dr. Coulter's bill as a medical arbiter's report under code A0002 and paid him \$2,877 for the WRME. (Exs. 17, 18 and 21-3.)

CONCLUSION OF LAW

The fee charged by James A. Coulter, M.D. for a Worker Requested Medical Examination (WRME) provided on October 8, 2004 is excessive.

OPINION

Jurisdiction over this medical fee dispute lies with the director. ORS 656.248(12), 656.704(3)(a) and OAR 436-009-0008(1)(a). I review *de novo*. OAR 436-001-0225(3). The burden of proving a fact or position rests with the proponent. ORS 183.450(2); *Harris v. SAIF*, 292 Or 683 (1982). As petitioner, insurer bears the burden of proving by a preponderance of evidence that the administrative order is incorrect. *Cook v. Employment Div.*, 47 Or 437 (1982) (In the absence of contrary legislation, the standard of proof in administrative hearings is preponderance of evidence).

Preponderance of evidence means that the factfinder is persuaded that the facts asserted are more likely true than false. *Riley Hill General Contractors v. Tandy Corp.*, 303 Or 390 (1989).

MRU applied OAR 436-060-0147 and concluded that insurer is liable for the WRME at a reduced cost. MRU first found that claimant was eligible for a WRME. MRU next determined that Dr. Coulter was entitled to payment for reviewing medical records provided by claimant and that the issue concerning questions claimant submitted to Dr. Coulter was moot. MRU further determined that Dr. Coulter was entitled to payment for answering questions that insurer had submitted to Drs. Staver and Lou. MRU next reprimanded Dr. Coulter for late submission of the WRME report and determined that he was entitled to payment for a neurological examination which included the low back. MRU next found that Dr. Coulter charged the usual and customary fee, but MRU deducted the amounts charged for travel and research because the rule does not

provide for those functions. Finally, MRU concluded that insurer was liable to pay Dr. Coulter \$12,975.00 for the WRME.

Insurer does not dispute claimant's eligibility for the WRME¹ and raises no issue concerning timeliness of the report. Furthermore, insurer does not dispute Dr. Coulter's usual and customary hourly rate. Rather, insurer contends that Dr. Coulter devoted excessive time to the WRME because he exceeded the scope of a WRME by reviewing the medical records provided to him by claimant. Insurer next contends that Dr. Coulter is not entitled to payment for time he spent answering the questions insurer submitted to Drs. Staver and Lou rather than the questions it had earlier submitted to Dr. Parsons. Insurer further contends that it is not liable for the full of the cost of the physical examination because Dr. Coulter's examination of the lumbar spine was unnecessary and superfluous to the WMRE. Finally, insurer contends that \$3,000 is an appropriate fee for the WRME.

In contrast, Dr. Coulter contends that he is entitled to full payment for the WRME in the amount of \$14,075.00. In support of his position, Dr. Coulter argues that his fee for a WRME should be commensurate with the fee paid for a report in a longshore case. However, inasmuch as longshore cases arise under a federal rather than state statute, this argument is unpersuasive.

Under ORS 656.245(1)(a),² an insurer is obligated to provide medical services that are materially related to a compensable condition as long as the nature of the injury or the process of recovery requires. Pursuant to ORS 656.325, an injured worker is entitled to a WRME under certain circumstances and the cost is borne by the insurer. ORS 656.325(1)(b) provides:

If the worker has made a timely request for a hearing on a denial of compensability as required by ORS 656.319 (1)(a)³ that is based on one or more reports of examinations conducted pursuant to paragraph (a)⁴ of this subsection and the worker's attending

¹ Insurer does not assert that claimant was ineligible for the WRME because the compensability denial was based on a record review rather than an IME.

² ORS 656.245 provides in pertinent part:

(1)(a) For every compensable injury, the insurer or the self-insured employer 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, ***.

³ ORS 656.319 provides:

(1) With respect to objection by a claimant to denial of a claim for compensation under ORS 656.262, a hearing thereon shall not be granted and the claim shall not be enforceable unless:

(a) A request for hearing is filed not later than the 60th day after the mailing of the denial to the claimant;

⁴ ORS 656.325(1)(a) provides:

Any worker entitled to receive compensation under this chapter is required, if requested by the Director of the Department of Consumer and Business Services, the insurer or self-insured employer, to submit to a medical examination at a time reasonably convenient for the worker as may be provided by the rules of the director. However, no more than three examinations may be requested except after notification to and authorization by the director. If the worker refuses to submit to any such examination, or obstructs the same, the rights of the worker to compensation shall be suspended with the consent of the director until the examination has taken place, and no compensation shall be payable during or for account of such period. The provisions of this paragraph are subject to the limitations on medical examinations provided in ORS 656.268.

physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245⁵ does not concur with the report or reports, the worker may request an examination to be conducted by a physician selected by the director from the list described in ORS 656.268(7)(d).⁶ **The cost of the examination and the examination report shall be paid by the insurer or self-insured employer.**

(Emphasis added.)

Additionally, the director promulgated OAR 436-060-0147 to govern the provision of WRMEs. OAR 436-060-0147 provides in pertinent part:

(2) The director shall determine the worker's eligibility for a Worker Requested Medical Examination (Exam). The worker is eligible for an exam if the worker has made a timely request for a Workers' Compensation Board hearing on a denial of compensability as required by ORS 656.319(1)(a); and the denial was based on one or more Insurer Medical Examination reports with which the attending physician disagreed.

(6) The director will notify all parties in writing of the physician selected, or will provide the worker or the worker's representative a list of appropriate physicians.

(8) The worker and/or the worker's legal representative shall schedule the exam with the selected physician and notify the insurer and the Workers' Compensation Board of the scheduled exam date within 14 days of the notification date in (6) of this rule. An unrepresented worker may consult with the Injured Worker Ombudsman for assistance.

(9) The insurer must send the physician the worker's complete medical record on this claim and the original questions asked of

⁵ORS 656.245(2)(a) provides in pertinent part:

The worker may choose an attending doctor, physician or nurse practitioner within the State of Oregon.

⁶ ORS 656.268(7)(d) provides:

The arbiter, or panel of medical arbiters, shall be chosen from among a list of physicians qualified to be attending physicians referred to in ORS 656.005 (12)(b)(A) who were selected by the director in consultation with the Board of Medical Examiners for the State of Oregon and the committee referred to in ORS 656.790.

the Insurer Medical Examination(s) physician(s) no later than 14 days prior to the date of the scheduled exam.

(10) The worker or the worker's representative shall communicate questions related to the compensability denial in writing to be answered by the physician at the exam to the physician at least 14 days prior to the scheduled date of the exam. An unrepresented worker may consult with the Injured Worker Ombudsman for assistance.

(11) Upon completion of the exam the physician must address the original Insurer Medical Examination(s) questions and the questions from the worker or the worker's representative pursuant to section (9) and send the report to the worker's legal representative, if any, or the worker, and the insurer within 5 working days.

(12) The insurer must pay the physician selected pursuant to this rule in accordance with OAR 436-009. Delivery of medical services to injured workers shall be in accordance with OAR 436-010.

In construing the meaning of an administrative rule, I apply the same method of analysis employed in determining the meaning of a statute. *Abu-Adas v. Employment Dept.*, 325 Or 480 (1997); *Larry Hemenway*, 5 WCSR 33 (2000). *See also PGE v. Bureau of Labor and Industries*, 317 Or 606 (1993) (court's task in determining the legislative intent is to first examine the statute, including text and context, and if the intent is clear, to proceed no further with its analysis.)

The parties dispute the proper fee for the WRME authorized by OAR 436-060-0147. Dr Coulter submitted a bill for \$14,075; insurer paid \$2,877 under the medical arbiter's code.⁷ MRU determined that the appropriate fee was \$12,975. At hearing, insurer took the position that a fee of \$3,000 is warranted. I agree with MRU's conclusion.

Record review:

Dr. Coulter billed insurer \$7,050 for 23½ hours he spent reviewing a total of 2,000 pages of medical records. Of the 2,000 pages, 670, or approximately one third were provided by insurer. MRU determined that the appropriate fee included Dr. Coulter's review of records submitted by claimant as well as those provided by insurer. The text of OAR 436-060-0147 contains no provision authorizing an injured worker to submit records for a WRME. However,

⁷ OAR 436-009-0030(6) provides in pertinent part:

When there is a dispute over the amount of a bill or the appropriateness of services rendered, the insurer shall, within 45 days, pay the undisputed portion of the bill and at the same time provide specific reasons for non-payment or reduction of each medical service code.

OAR 436-060-0147(9) requires the insurer to “send the physician the worker’s complete medical record on this claim”.

Here, Dr. Coulter based the WRME analysis and opinion in part on records provided by claimant. Inasmuch as Dr. Coulter found the records provided by claimant illuminating and useful, I logically infer that the records insurer provided were not complete. Therefore, MRU correctly included the time Dr. Coulter spent reviewing claimant’s records in the fee.

Report Preparation:

MRU determined that Dr. Coulter was entitled to payment for addressing the questions that insurer had submitted to Drs. Staver and Lou for the scheduled IME. I agree.

Insurer contends that the report exceeded the scope of a WRME because Dr. Coulter answered the IME questions rather than the questions insurer had earlier submitted to Dr. Parsons. In support of its position, insurer argues that OAR 436-060-0147(2) limits a WRME to the IME on which a denial was based. Here, the denial of medical services was based on Dr. Parson’s report and not on the report later issued by Drs. Staver and Lou. However, the record contains no evidence that insurer addressed a list of questions to Dr. Coulter or specified which questions he was to answer. Moreover, in preparing for the WRME, insurer initially sent Dr. Coulter medical records, including Dr. Parson’s report and subsequently sent him the IME questions. Based on insurer’s communications, it was reasonable for Dr. Coulter to address the recent IME questions in his WRME report and he is entitled to payment for his services in that regard.

Physical Exam

MRU determined that Dr. Coulter is entitled to the full amount billed for the physical examination. I agree.

Insurer contends that Dr. Coulter is not entitled to payment for examining the lumbar spine because that body part was unnecessary and superfluous to the WRME. However, Dr. Coulter, who is a board certified neurologist, credibly testified that standard protocol for a neurological examination includes the lumbar spine. Therefore, MRU correctly included the full amount charged for the physical examination in the WRME fee.

ATTORNEY FEES

Insurer is liable for attorney fees only in the event that claimant finally prevails in a contested case hearing; no attorney fees are available to a medical provider. *See* ORS 656.385(1).

ORDER

IT IS HEREBY ORDERED that:

The Administrative Order dated August 10, 2005 is affirmed.

Insurer shall pay Dr. Coulter a WRME fee of \$12,975.00.