

In the ORS 656.260 Managed Care Dispute of

Tony M. Larson, Claimant

Contested Case No: 07-066H

PROPOSED & FINAL ORDER

September 27, 2007

TONY M. LARSON, Petitioner

SAIF Corporation, Respondent

Before Geoffrey G. Wren, Administrative Law Judge

Pursuant to notice, a hearing was set for August 22, 2007. Prior to hearing, the parties notified the Hearings Division that this matter could be submitted on the documentary record. James E. Bailey, III, represents claimant. James D. Booth represents SAIF Corporation. The record closed on September 17, 2007.

Exhibits 1-19 are admitted.

ISSUES

Medical Services: Claimant challenges dismissal of his request for administrative review regarding SAIF's nonpayment of a medical service. Claimant contends that the Director erred in dismissing his request for review as untimely.

AGENCY FINDINGS OF FACT

Claimant sustained a compensable injury on October 19, 2005. SAIF accepted a claim for right elbow abrasion, right hip contusion, right elbow non-displaced radial head fracture, right and left knee strains, right hip traumatic bursitis, right knee medial meniscus tear and lateral meniscus tear, left knee ACL tear, medial and lateral meniscus tears, right wrist strain, right wrist central TFCC tear, and ulnar impaction and mild mid-carpal synovitis.

Claimant became enrolled in Oregon Health Systems (OHS), a managed care organization, on November 3, 2005.

On December 3, 2005, claimant sought emergent treatment at St. Charles Medical Center ("St. Charles") for overdose of Percocet. The treating physician noted the clinical impression of 1) accidental overdose, 2) depression, 3) suicidal ideation, 4) IV drug abuser, and 5) status post knee surgery. Claimant was discharged home. The hospital billed SAIF.

On August 8, 2006, SAIF sent St. Charles an Explanation of Benefits ("EOB") stating that SAIF was disallowing benefits for the emergency room visit. The EOB included the following language:

Oregon Administrative Rules (OAR) 436-009-0008(2)(a), (b) and 436-010-0008(6) directs that disputes must be submitted in a timely manner, no later than

90 days from the date of the explanation of benefits form.

On April 23, 2007, claimant's counsel requested administrative review by the Director. The request for review included a cover letter stating that claimant's attorney first inquired about the disputed bill on June 23, 2006, the EOB showing August 25, 2006 as the date it was faxed to claimant's counsel, and a log of emails and letters of communication with SAIF's adjuster.

STATEMENT OF PROCEDURAL FACTS

By Administrative Order of Dismissal dated May 18, 2007, the Director dismissed claimant's request for review as untimely filed. The Director did not address the substance of the parties' dispute. Claimant timely requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Claimant challenges the Director's May 18, 2007 Administrative Order of Dismissal. He contends that the Director erred in dismissing his request for review as untimely filed. On review of a Director's order pertaining to a medical services dispute, I may set aside or modify the order only if it is not supported by substantial evidence in the record or if it reflects an error of law. No new medical evidence or issues may be admitted or considered. ORS 656.247(3)(a); OAR 436-001-0225(2)

The Director reasoned that claimant failed to file his request for review within the time limits set by OAR 426-009-0008(2)(b) and OAR 436-010-0008(6)(b). OAR 426-009-0008(2)(b) pertains to the time in which an aggrieved party must request Director's review regarding a medical services dispute not resulting from a decision by an MCO. That rule provides:

(2) The medical provider, injured worker, or insurer may request review by the director in the event of a dispute about either the amount of a fee or non-payment of bills for medical services on a compensable injury. The following time frames and conditions apply to requests for administrative review before the director under this rule:

...

(b) For all claims not enrolled in an MCO, or for disputes which do not involve an action or decision of the MCO, the aggrieved party must request administrative review by the director within 90 days of the date the party knew, or should have known, there was a dispute over the provision of medical services. This time frame only applies if the aggrieved party other than the insurer is given written notice that they have 90 days in which to request administrative review by the director. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation, the 90 day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. For purposes of this rule, the date the insurer should have known of the dispute is the date action on the bill was due pursuant to OAR 436-009-0030. Filing a request for

administrative review under this rule may also be accomplished in the manner prescribed in OAR Chapter 438, Division 005.

The Director reasoned that claimant had 90 days from August 25, 2006, the date claimant's counsel received the faxed EOB, because the EOB included language stating that disputes must be submitted to the Director within 90 days. As claimant requested review outside that period, the Director found that claimant's request was untimely. (Ex. 18).

Substantial evidence does not support the Director's order. SAIF provided the EOB to St. Charles Medical Center, the medical provider, not to claimant. (Ex. 8). Insofar as the Director found that the medical provider faxed the EOB to claimant's counsel on August 25, 2006, the Director presumably considered notice given to the medical provider and thereafter transmitted by the provider to claimant's counsel an act of giving notice of the 90-day time frame under OAR 426-009-0008(2)(b). The rule, however, does not say that the 90 day period begins running when notice is given to one party, and that party then passes the notice along to another party. Rather, the rule plainly states that the 90 days begin running when "the aggrieved party other than the insurer is given written notice that they have 90 days in which to request administrative review by the director." With respect to nonpayment of a medical bill, the medical provider and the claimant cannot both be the aggrieved party. Either the medical provider accepts nonpayment as its problem and thereby become aggrieved, or the provider seeks to collect the bill from the claimant, making the claimant the aggrieved party. Further, the rule contemplates that the party giving notice is the party whose action creates the dispute. That party here was SAIF. SAIF never gave claimant or claimant's counsel notice of the 90-day time period.

The Director's order leaves unclear whether the Director reasoned that the request for review was untimely because claimant's counsel had "actual knowledge of the dispute" once the provider faxed the EOB on August 25, 2006. The Director did not expressly rely on that rationale, but he highlighted that portion of OAR 426-009-0008(2)(b) in the Dismissal Order. To the extent the Director reasoned that claimant's counsel had actual knowledge of the dispute as of August 25, 2006, substantial evidence does not support the Director's order. Claimant's counsel did write SAIF on June 23, 2006 regarding nonpayment of the disputed bill. (Ex. 7). Rather than confirming SAIF's refusal to pay, that communication resulted in SAIF reviewing the dispute. As late as February 2, 2007, SAIF had not made a final decision. That day, SAIF's adjuster wrote claimant's counsel that she would write a note to claimant's doctor before she would "make a decision on This bill." (Ex. 10). The adjuster did not finally communicate to claimant's counsel that SAIF would not pay the bill until April 5, 2007. (Ex. 14). Until that point, counsel did not have knowledge that there in fact was a disputed medical service.

Claimant requested review on April 23, 2007, well within 90 days from April 5, 2007. Claimant's request was timely.

Because the Director dismissed the request for review as untimely, the Director did not address the merits of the parties' dispute. Substantial evidence review requires a record for review. *See Liberty Northwest Ins. Corp. v. Kraft*, 205 Or App 59, 62 (2006) ("Nothing in our understanding of 'substantial evidence' review comports with an adjudicator rendering findings

of fact.”). Remand of this case is necessary for the Director to determine in the first instance whether the disputed medical service is reimbursable.

ORDER

IT IS HEREBY ORDERED that the May 18, 2007 Administrative Order of Dismissal is set aside, and this matter is remanded for decision on the merits.