
In the Compensation of
Tamara M. Keller, Claimant
Contested Case No: 08-017H
PROPOSED & FINAL ORDER

May 15th, 2008

TAMARA M. KELLER, Petitioner
AIG CASUALTY CO., Respondent

Before Robert Pardington, Administrative Law Judge

ISSUE

1) Jurisdiction. The insurer contends that claimant did not request a hearing for the alleged processing error within two years, as required by ORS 656.319(6).

2) Liability for “interim” medical services, provided by American Medical Response on May 14, 2004. ORS 656.247.

SUMMARY OF FACTS

Making new or supplemental “findings of fact” is not appropriate with a “substantial evidence” standard of review. ORS 656.327(2). *See Liberty Northwest Insurance Corp. v. Kraft*, 205 Or App 259, 262-3 (2006). Accordingly, I offer the following “summary of facts,” as found by the Department, and which I find to be supported by substantial evidence. (*See* Administrative Order, Ex. 14).

On May 14, 2004, claimant filed a form 827 “first medical report,” describing an incident that day as “smelled propane, throat started to burn [and] got dry. Pulled bus over. Got out and changes got tight and started coughing up mucas [*sic*] running nose, gagging, headache.” (Ex. 2).

Also that day, claimant received medical services from the American Medical Response (AMR)

On June 4, 2004, the carrier denied claimants claim. (Ex. 10).

AMR billed the carrier for services, but the carrier did not pay.

On January 2, 2008, after AMR had still apparently not been paid, claimant, through her attorney, requested administrative review by the Workers’ Compensation Division. (Ex. 11).

In a January 17, 2008 response to the Division, the carrier asserted that it would need proof that the bill from AMR was submitted to claimant’s private health carrier, and cited “ORS” 436-009-0035(3) through (8). (Ex. 13-2).

On January 28, 2008, the Division issued an Administrative Order, finding that claimant did not meet the statutory requirements of ORS 656.247, and specifically that claimant did not

have a private health benefit plan in force as of May 14, 2004. (Ex. 14). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The Administrative Order may be modified at hearing only if it is not supported by substantial evidence in the record, or reflects an error of law. ORS 656.327(2).

Initially, I note the insurer's jurisdictional argument based on ORS 656.319(6). However, I need not address that argument, as I find that the Director's order is supported by substantial evidence and does not reflect an error of law.

ORS 656.247 addresses circumstances in which a carrier is required to pay for medical services from the date of the employer's notice or knowledge of the claim until acceptance or denial. ORS 656.247(4)(b) provides:

“If the claim in which medical services are provided under subsection (1) of this section is denied and a health benefit plan provides benefits to the work, the health benefit plan shall be the first payer of expenses for medical services according to the terms, conditions, and benefits of the plan. Except as provided by subsection (2) of this section, after payment by the health benefit plan, the workers' compensation insurer or self-insured employer shall pay any balance remaining for such services subject to the limitations and conditions of this chapter.”

OAR 436-009-0035(6) and (7) provide:

“(6) When the claim is denied, the medical service provider shall first bill the health benefit plan(s) with a copy of the workers' compensation denial letter.

“(7) After payment is received from the health benefit plan(s), the medical service provider may bill the workers' compensation insurer, according to OAR 436-009-0010, for any remaining balance. The provider shall include a copy of the health benefit plan(s)' explanation of benefits with the bill. If the worker has no health benefit plan, the workers' compensation insurer is not required to pay for interim medical benefits.”

Claimant contends that there is no explicit requirement in ORS 656.247 that a worker must have a “health benefit plan” in order for the carrier to pay interim medical benefits, and that the statute only allows the carrier to bill any health benefit plan first, then pay the remainder of the bill. ORS 656.247(4)(b).

After analyzing the terms of ORS 656.247, I find no error of law in the Director's Order. To begin, ORS 656.247(1) provides that payment for medical services prior to claim acceptance or denial "shall be payable in accordance with subsection (4) of this section[.]" Therefore, ORS 656.247(4) sets forth the exclusive procedure for payment of such medical services.

ORS 656.247(4)(a) applies to "accepted" claims, and therefore is not applicable here. ORS 656.247(4)(b), set forth above, states that if the claim is denied, *and* a health benefit plan provides benefits to the worker, then the health benefit plan "shall be the first payer of the expenses," with the carrier paying any "balance remaining." *Id.* The only exception to this procedure listed in subsection (4)(b) is for claims denied within 14 days, in which case "no payment shall be due" from the carrier. ORS 656.247(2); ORS 656.247(4)(b).

In this context, then, the statute requires two things as a precondition to payment of interim medical services by the carrier: 1) that a claim be denied *and* 2) that "a health benefit plan provides benefits to the worker." ORS 656.247(4)(b).

The Division's finding that there is no "health benefit plan [that] provides benefits to [claimant]" is supported by substantial evidence. The statute describes no alternative procedure for payment of "interim" medical services when a claim is denied and there is no "health benefit plan." ORS 656.247(1); ORS 656.247(4)(b).

Reading ORS 656.247(1) and ORS 656.247(4)(b) in context, I disagree with claimant's contention and find that ORS 656.247 *does* require that the worker have a "health benefit plan" as a precondition to payment of interim medical services on a denied claim. The Director, in fact, very recently reached this same conclusion, and I am bound by it. *See Reese Blacknall, Jr.*, 13 CCHR 77 (May 9, 2008).

It follows, and I find, that OAR 436-009-0035(7) (explicitly stating that, if the worker has no health benefit plan, the carrier is not required to pay for interim medical benefits) is consistent with the statute and does not exceed statutory authority.

Accordingly, the January 28, 2008 Administrative Order is affirmed.

IT IS SO ORDERED.