

In the ORS 656.248 Medical Fee Dispute of

Michael J. Doud, Claimant

Contested Case No: 08-122H

PROPOSED & FINAL ORDER

March 25, 2009

Eric Long M.D., Petitioner

Empire Risk Management, Respondent

Before Robert A. Davis, Administrative Law Judge

Eric W. Long, M.D., has requested a hearing in response to the Administrative Order that found his fee for responding to an IME report not reasonable. The doctor is represented in this matter by his attorney, Floyd H. Shebley. The employer, Pacific Lumber, and the claims administrator, Empire Pacific Risk Management, have been represented by their attorney, David P. Levine. The record closed in this matter on February 23, 2009, upon receipt by the Hearings Division of the final written argument from counsel.

Exhibits: Counsel for the employer/claims administrator has submitted an exhibit list that contains Exhibits 1 through 19. That submission has not drawn objection. Consequently, Exhibits 1 through 19 are admitted.

FINDINGS OF FACT

Claimant is a male in his middle years. On August 13, 2007, he was compensably injured when he was driving a pickup truck on a highway. He was stopped in traffic, and he was struck from behind by another vehicle.

His claim was accepted as a nondisabling cervical muscle strain. The claims administrator enrolled claimant in the Oregon Health Systems for medical management. Consequently, the care claimant was receiving became subject to the provisions of a managed-care agreement

Claimant was referred by the claims administrator for an insurer-requested medical examination (IME). Claimant saw orthopedist Dr. Peterson on December 7, 2007. Dr. Peterson took a history of the injury and inquired as to the then-current status of claimant's condition. The doctor did a chart review. He also obtained some basic medical history from claimant and socioeconomic data. Dr. Peterson examined claimant. The doctor diagnosed a cervical strain/whiplash injury secondary to the industrial injury. He noted that there were non-physical factors affecting claimant's physical presentation. He also referenced that claimant was status post-C5-6 anterior cervical discectomy and fusion in 1996 and a C4-5 anterior discectomy instrumented fusion in 2001. The doctor noted that claimant has had surgery on the right shoulder three times and one surgery on the left rotator cuff. Claimant had submitted to lumbar decompressive surgery in November of 2007. The doctor responded to a list of questions submitted by the insurer. Dr. Peterson did not believe claimant had sustained a major injury from the motor-vehicle accident. The doctor did not think claimant needed further treatment for the injuries sustained in the accident.

By letter of December 30, 2007, the claims administrator sent Dr. Eric Long a form on which it asked him to concur or dissent from the IME report written by Dr. Peterson. The letter to Dr. Long invited him to check a box if he concurred with the medically stationary date, diagnoses, physical findings, and conclusions of the IME. In the alternative, Dr. Long could check a box if he did not concur. A footnote on the letter advised the doctor that pursuant to administrative rule, a concurrence with the physician's report would be an agreement with every particular, including the medically stationary "impression and date," unless the physician expressly stated to the contrary and explained the reasons for disagreement. The footnote also indicated that if Dr. Long did not concur, or if he wanted to comment, he should send a narrative report.

On January 3, 2008, Dr. Long advised the claims administrator that he did not concur with the IME report and also advised that he would provide a narrative report. On January 10, 2008, Dr. Long produced a five-page report, and he also attached two pages of imaging-study results. Dr. Long indicated that he had reviewed Dr. Peterson's report carefully and he had reviewed his own medical records. He reviewed the images from two CT scans and two MRI scans. In his letter to the claims administrator, Dr. Long paraphrased the questions asked of Dr. Peterson by the claims administrator. Dr. Long also paraphrased the responses provided by Dr. Peterson. Dr. Long then listed a series of items that "shed light on the reliability of Dr. Peterson's findings and conclusions." Dr. Long articulated 20 such "items." Dr. Long then proceeded to answer the questions that the claims administrator asked Dr. Peterson to answer.

On January 12, 2008, the claims administrator modified the claim acceptance to reflect that the claim was disabling. Also on that date, the administrator denied a claim for C6-7 left disc injury with radiculitis and right L4-5 disc protrusion with radiculitis.

Dr. Long submitted a bill for \$7,200 to the claims administrator. The bill was for the work done in reviewing the IME and responding to it. The doctor indicated that he had expended eight hours on record review and producing a report.

The claims administrator sought director's review of the bill. The claims administrator asserted that the charge by Dr. Long was excessive.

On June 6, 2008 the Medical Section of the Workers' Compensation Division issued an Administrative Order. The reviewer noted that information gathered by the director indicated the physicians with Dr. Long's specialty charge between \$250 (not including a report) to \$800 per hour (including the report) to perform the kind of task Dr. Long was asked to do. The order concluded that jurisdiction over the medical-fee dispute resided with the director, and further, payment of the bill by the insurer did not depend on whether the claim that prompted the IME was denied.

In evaluating Dr. Long's activity, the director noted that Dr. Long had properly utilized a billing code and had included information about the actual time he spent reviewing records and reports. Further, the director noted that Dr. Long had summarized the agent's questions to Dr. Peterson and the responses in the IME. The director noted that the claims administrator had not asked for that information. The director concluded that to provide his non-concurrence, Dr.

Long needed to review his own medical records and that the doctor also had to review a long IME report. The director did not doubt that Dr. Long expended time reviewing the IME report, the doctor's own records, the radiological films, and preparing an in-depth report for the claims administrator.

The director concluded, however, that eight hours and a fee of \$7,200 were not reasonable. The order reduced the hours to four and the hourly fee to \$800 with a resulting fee of \$3,200.

CONCLUSIONS AND OPINION

I review this matter *de novo* pursuant to OAR 436-001-0225(1). A medical-fee dispute under ORS 656.248 is not subject to the scope of review (substantial evidence and error of law) articulated in OAR 436-001-0225(2).

As to the doctor's hourly fee, I agree with the Administrative Order that \$800 an hour is appropriate. The best information in the record is that \$800 an hour is the high end of the fees charged by other physicians of Dr. Long's specialty when they review IME reports and records and when they respond to an IME (Exhibit 17-2, -3).

As to an appropriate number of hours, the claims administrator invited the doctor to explain the reasons for his disagreement with the IME report. The doctor was invited to write a narrative report (Exhibit 7, fn1). It would not be reasonable to expect a doctor to articulate his disagreement with a long and detailed IME report without reviewing the report with care and reviewing his own records with care. Further, in this case involving a claim for the spine, it was appropriate for the doctor to review the actual films from four different scans.

It was appropriate for Dr. Long to identify 20 factors he feels "shed light" on Dr. Peterson's findings and conclusions (Exhibit 8-3, -4). Dr. Long's report was more elaborate than it needed to be, however. There was no need for the report to paraphrase the questions asked of Dr. Peterson and the responses Dr. Peterson gave. I note that the questions and answers are not simply copied from Dr. Peterson's report, but restated in slightly different words, which restating was presumably time consuming. The information exists already in Dr. Peterson's report. Further, Dr. Long then recapitulated the many questions asked of Dr. Peterson and provided his own answers to those questions. It appears from the inquiry to Dr. Long concerning the IME that a narrative of several paragraphs would have been an appropriate response.

Dr. Long could not reasonably assume that the administrator was asking him for a full records review and report. If the administrator had wanted that from him, the administrator presumably would have asked him to produce such a project. I conclude that with some streamlining in both records review and formulation of the report, six hours on the project would have been adequate.

Attorney Fee

The doctor's attorney asserts entitlement to an assessed fee. He has not cited to a statute or rule that authorizes such a fee in a case arising out of ORS 656.248. The attorney fees referred to in ORS 656.385 do not appear to apply to cases under ORS 656.248. OAR 436-001-0265 does not appear to authorize a fee in a .248 case. An attorney fee is not authorized by law.

ORDER

The insurer/claims administrator is liable pursuant to statute and rule for a fee of \$4,800, payable to Dr. Long for his response to Dr. Peterson's IME report.