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In the ORS 656.248 Medical Fee Dispute of

**Robert S. Fry, Claimant**

Contested Case No: 10-079H

**PROPOSED & FINAL ORDER**

February 1, 2011

RLC INDUSTRIES, Petitioner

OHSU MEDICAL GROUP, Respondent

Before Bruce D. Smith, Administrative Law Judge

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This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to Workers' Compensation Division's Administrative Order dated April 9, 2010. The parties waived hearing and submitted the matter on written argument. Claimant is not represented, and does not appear. Self-insured employer RLC Industries (RLC) is represented by attorney H. Scott Plouse. Wendy Williams, authorized representative for OHSU Medical Group, appears on behalf of medical service provider OHSU, where medical services were provided by Dr. Vigeland. The documentary record consists of Exhibits 1 through 46, as identified in the Division's July 15, 2010 exhibit list. The record closed on January 21, 2011, the last day allowed for receipt of supplemental exhibits and written argument.

**ISSUES**

The only issue is whether RLC is liable for the December 7, 2007 medical services provided to the worker by Dr. Vigeland and OHSU.

**FINDINGS OF FACT**

Claimant suffered a compensable left knee injury on July 11, 2002, while stepping down from a platform; and he promptly sought treatment from Dr. Tran at Evergreen Urgent Care. (Exs. 7, 8).

On July 30, 2002 claimant signed a Form 801 for the left knee injury. (Ex. 9-2). He identified Dr. Black as his regular doctor. (*Id.*).

On August 6, 2002 claimant came under the care of Dr. McCart. (Ex. 10).

An MRI obtained on August 19, 2002 revealed a small tear in the posterior horn of the medial meniscus. (Ex. 12). On November 19, 2002 claimant saw Dr. Van Horne for diagnostic laparoscopy with partial medial meniscectomy, with findings of grade IV degenerative changes in the medial aspects and patellofemoral groove. (Exs. 13-3, 14).

On April 28, 2003 the claim was accepted as a disabling left medial meniscus tear. (Ex. 19). On October 16, 2003 the claim was closed with an award of 5 percent permanent partial disability (PPD) for the left knee. (Ex. 21). Dr. Van Horne was listed as the attending physician at time of claim closure. (Ex. 21-3).

Over the next three years claimant had ongoing problems with the both knees, and continued to receive medical treatment for the knees from various providers in Dr. Van Horne's office. (Ex. 23). On July 12, 2005 claimant was seen by Dr. Van Horn for left knee pain (Ex. 23-55), which led to a series of three left knee steroid injections, the last one done on August 17, 2005. (Ex. 23-59, -65, and -71). On November 16, 2005 Dr. Keys aspirated fluid from claimant's swollen left knee. (Ex. 1-6). There is no further documentation in this record of treatment for claimant's left knee until September 13, 2007, when claimant saw his family physician, Dr. Black.

On September 13, 2007 Dr. Black saw claimant for left knee pain, and diagnosed synovitis. (Ex. 5-14). He gave claimant a corticosteroid injection in the knee. (*Id.*).

Dr. Black saw claimant again on November 16, 2007, noting that he was using a brace for the left knee, which was now "bone-on-bone." (Ex. 5-15). Dr. Black noted that claimant wanted to go to OHSU. (*Id.*). Apparently at Dr. Black's behest, a left knee x-ray was carried out on November 20, 2007, showing degenerative changes in the knee joint. (Ex. 41).

On December 7, 2007 claimant was seen at OHSU Orthopaedics by Dr. Vigeland, on referral from Dr. Black. (Ex. 42). Dr. Vigeland felt that claimant would eventually require a knee replacement, but that he should delay the procedure as long as possible, given that claimant was only 57 years old. (*Id.*). Dr. Vigeland billed Regence, claimant's private medical insurer. (Ex. 43-6).

Claimant returned to Dr. Black on December 21, 2007, reporting that the steroid injection had helped for a month. (Ex. 5-16). Dr. Black gave claimant another injection in the left knee. (*Id.*).

On December 27, 2007 claimant's private health carrier Regence paid OHSU for the December 7, 2007 services that Dr. Vigeland had provided. (Ex. 43-2, and -7).

On February 1, 2008 Dr. Black saw claimant again, noting that the injections were providing only temporary relief. (Ex. 5-17). He recommended orthopedic consultation with Dr. Coon. (*Id.*).

On January 20, 2009 Regence sought reimbursement from Dr. Vigeland for the December 7, 2007 charges that it had paid, informing the provider that the services had been related to a previously denied workers' compensation claim that had now been accepted. (Ex. 43-8).

On February 12, 2009 OHSU, in response to the notice from Regence, submitted the billing claim for the December 7, 2007 services to RLC. (Ex. 43-2). RLC admits that it received the billing statement, along with Dr. Vigeland's December 7, 2007 treatment record, on February 17, 2009. (Rec.).

On January 13, 2010 OHSU requested administrative review, noting that they had received no response from RLC in response to the February 12, 2009 billing. (Ex. 43-2). OHSU also re-billed RLC for the December 7, 2007 medical services. (Ex. 43-13).

On February 12, 2010 Dr. Vigeland withdrew the request for administrative review, apparently believing that the workers' compensation claim was in litigation. (Ex. 45-3). On February 16, 2010 the director issued an Administrative Order of Dismissal. (Ex. 45-3). That same day however, Dr. Vigeland, apparently in response to a phone conversation with someone at RLC, requested reinstatement of the request for administrative review. (*Id.*).

On February 18, 2010 RLC responded to the request for review by contending that the December 7, 2007 bill was not payable, because it had been submitted to RLC more than a year after the date of service. (Ex. 45-3). In addition, RLC noted that claimant had not been referred to Dr. Vigeland by his attending physician. (*Id.*).

On March 2, 2010 the director issued an Administrative Order of Abatement, and resumed review. (Ex. 45-3).

The director issued an Administrative Order on April 9, 2010. Finding that Dr. Vigeland's office had received conflicting information regarding the status of the claim, the director concluded that the provider had good cause for submitting the bill more than twelve months after the disputed services were rendered. (Ex. 45-4).

The director also found that Dr. Black had assumed the role of attending physician, and was acting in that capacity when he referred claimant to Dr. Vigeland:

“In this case, Dr. Black referred [claimant] to Dr. Vigeland. The record supports that [claimant] had a long standing patient physician relationship with Dr. Black. The record further supports that Dr. Black's chart notes reflect he treated primarily non-compensable conditions through August 2007. \* \* \* [In] September 2007 Dr. Black began treating and directing care for [claimant]'s left leg condition. The record submitted for review lacked signed 827 noting change of attending physician to any physician treating [claimant]'s left leg. OAR 436-010-0220(1)(d) provides, in relevant part, that an attending physician or authorized nurse practitioner is determined by the fact[s] of the case and the actions of the physician, not whether a Form 827 is filed. The record supports that Dr. Black was primarily responsible for treatment of [claimant]'s left leg at the time of the referral to Dr. Vigeland. Therefore the director concludes that Roseburg is liable for the December 7, 2007, medical services Dr. Vigeland provided.” (Ex. 45-4).

RLC timely requested a hearing. (Ex. 46).

## CONCLUSIONS OF LAW AND OPINION

### Scope of ALJ Review

This matter arises under ORS 656.248(12) and OAR 436-009-0008 for resolution of a dispute over payment of fees for medical services. The hearing is conducted under OAR 436-001.<sup>1</sup> Scope of ALJ review for this medical fee dispute is *de novo*. OAR 436-001-0225(1). Because the date of service at issue here is December 7, 2007, the applicable Division 9 rules are found in WCD Admin. Order 07-051 (eff. July 1, 2007). Applicable Division 10 rules are found in WCD Admin. Order 07-053 (eff. December 4, 2007).

In concluding that the disputed services were reimbursable the director found that the medical services claim at issue was timely submitted; and that Dr. Black was the attending physician at the time he made the referral to OHSU where claimant received services from Dr. Vigeland. As the appealing party, RLC must prove that the director erred. ORS 40.105; ORS 656.283(6); OAR 436-001-0170(1). I will address the director's two findings in turn.

### *Untimely Submission Issue*

With limited exceptions, a provider of medical services is required to submit the bill for those services within 60 days. *Former* OAR 436-009-0010(5)(a). Under *former* OAR 436-009-0010(5)(c), bills submitted more than 12 months after the date of service are not payable unless the reason for delay was one of those outlined in *former* OAR 436-009-0010(5)(a).

RLC contends that it is not responsible for the disputed charges because it was not billed within 12 months of the date of service.

OHSU responds that the bill was presented to RLC promptly once the provider became aware that the left knee was covered under a workers' compensation claim.

The director found that the provider had good cause for late submission of the bill, because it had received conflicting information regarding the status of the claim. (Ex. 45-4). Although on slightly different grounds, I agree with the director that the disputed bill was timely submitted.

It is undisputed that the bill for Dr. Vigeland's December 7, 2007 service was not submitted to RLC until February 12, 2009, some 14 months after the date of service. Accordingly, the service is not reimbursable unless the reason for late submission is one of those outlined in *former* OAR 436-009-0010(5)(a),<sup>2</sup> which reads as follows:

“(5) Medical providers must submit billings for medical services in accordance with this section.

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<sup>1</sup> See OAR 436-009-0008(6).

<sup>2</sup> This is identical to current OAR 436-009-0010(5)(a).

- (a) Bills must be submitted within:
- (A) 60 days of the date of service;
  - (B) 60 days after the **medical provider has received notice or knowledge** of the responsible workers' compensation insurer or processing agent; or
  - (C) 60 days after any litigation affecting the compensability of the service is final, if the provider receives written notice of the final litigation from the insurer.”  
(Emphasis added).

RLC contends that in its written argument OHSU admits that it knew of the compensable left knee claim in August 2006. (Rec.). In response, OHSU denies that it was aware at the time of the disputed referral that the left knee claim was compensable. OHSU represents that the private health carrier, after having informed OHSU in August 2006 that it would not pay for left knee services to claimant until a worker's compensation compensability issue had been resolved, did in fact thereafter pay the bill in question. (Rec.). OHSU further represents that, when claimant returned for the December 7, 2007 services now at issue, no questions arose regarding workers' compensation coverage; and the health carrier promptly paid for the service. (Rec.). The record before me supports the provider's account. Indeed, I have found nothing in the record to suggest that the provider had notice or knowledge of the responsible workers' compensation processing agent until it received the January 20, 2009 letter from Regence. (Ex. 43-8).

I find that on February 12, 2009 the provider submitted the disputed bill to RLC (Ex. 43-2), well within the 60 days contemplated by OAR 436-009-0010(5)(a)(B). Accordingly, the director did not err in finding that the bill for services provided to claimant by Dr. Vigeland/OHSU was timely submitted.

#### *Attending Physician Issue*

At issue is whether Dr. Black was the attending physician. The answer to this question determines whether Dr. Black's referral to OHSU was proper, which in turn determines whether services provided by Dr. Vigeland are reimbursable. (Ex. 45-4).

RLC contends that Dr. Black was not the attending physician at the time of his referral of claimant to OHSU, both because Dr. Black had not provided significant treatment for claimant's left knee, and because he failed to follow administrative rules requiring him to communicate his involvement to the employer and others.

OHSU contends that since the services it furnished were for a condition that had not yet been accepted as part of a workers' compensation claim at the time of the referral, it was acceptable for claimant's family physician to make the referral.

*Former* OAR 436-010-0220(2), governing medical services by an attending physician, reads as follows:

“(2) The worker may have only one attending physician or authorized nurse practitioner at a time. Simultaneous or concurrent treatment by other medical service providers must be based upon a written request of the attending physician or authorized nurse practitioner, with a copy of the request sent to the insurer. Except for emergency services, or otherwise provided for by statute or these rules, **all treatments and medical services must be authorized by the injured worker’s attending physician or authorized nurse practitioner to be reimbursable.** When the attending physician or authorized nurse practitioner refers the worker to a specialist physician, the referral must be written. An attending physician must specify any limitations regarding the referral within such document. Unless the documented referral limits the referral to consultation only, the referral is deemed to include attending physician authorization for the specialist physician to provide or order all compensable medical services and treatment he or she determines appropriate. Nothing in this rule diminishes the attending physician’s responsibility to fulfill all their duties under ORS chapter 656, including authorizing temporary disability. Fees for services by more than one physician at the same time are payable only when the service is sufficiently different that separate medical skills are needed for proper care.” (Emphasis added).

Noting that under OAR 436-010-0220(1)(d) the attending physician is determined by the facts of the case and the actions of the physician, rather than the filing of a Form 827, the director found that Dr. Black had assumed the role of attending physician when he began treating claimant’s left knee condition in September 2007; and was acting in that role when he made the referral to OHSU. (Ex. 45-4). Again, I agree with the director.

Dr. Black’s chart notes reveal that he had begun to treat claimant’s left knee condition on September 13, 2007. (Ex. 5-14). Over the ensuing four and a half months Dr. Black saw claimant three additional times regarding the left knee (Ex. 5-15 through -17); and during that time he made a referral for an x-ray (Ex. 41), and two orthopedic referrals (Exs. 42, 5-17), including the one to OHSU that is the subject of the current dispute. During this same period of time no other physician was fulfilling the role of attending physician with regard to treatment of claimant’s left knee. Further, at the time Dr. Black took over claimant’s left knee care in September 2007 it had been more than two years since claimant had seen anyone in Dr. Van Horne’s office (Ex. 23-71); and the only physician in this record who had treated the left knee in the meantime was Dr. Keys, who had aspirated the knee on one occasion in November 2005. (Ex. 1-6). On this record I find that Dr. Black was claimant’s attending physician for the left knee condition from September 13, 2007 through at least February 1, 2008.

In sum, I find that the subject referral to OHSU was properly made by Dr. Black, who was in fact claimant's attending physician at the time. Having found that OHSU's billing statement for claimant's December 7, 2007 medical services was timely submitted to RLC for payment, I affirm the director, and find that the disputed charges are payable by the employer.

**ORDER**

**IT IS THEREFORE ORDERED** that the director's Administrative Order dated April 9, 2010 is affirmed in its entirety.