

In the ORS 656.248 Medical Fee Dispute of

Lloyd R. Wilkins, Claimant

Contested Case No: 11-015H

PROPOSED & FINAL ORDER

August 25, 2011

THOMAS PURTZER, MD, INTRACTABLE PAIN CENTERS, Petitioner

LIBERTY NORTHWEST INSURANCE CORPORATION, Respondent

Before Bruce D. Smith, Administrative Law Judge

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to the request for hearing filed by Intractable Pain Centers (IPC), appealing the Administrative Order of Dismissal dated January 10, 2011 of the Workers' Compensation Division (WCD). Authorized representative Regina Purtzer appears on behalf of medical service provider Dr. Purtzer and IPC. Liberty Northwest Insurance Corporation is represented by attorney Meg Carman. The parties waived in-person hearing and submitted this matter based on the following documentary record: Exhibits 1 through 45, as identified in the director's February 22, 2011 exhibit list.

Exhibits offered by IPC as "Exhibits 1-5," are excluded as duplicative.

The record closed on August 5, 2011, the due date for IPC's reply argument.

ISSUE

The only issues are jurisdiction, and standing.

FINDINGS OF FACT

Claimant suffered a compensable injury on October 28, 2004; and the claim was ultimately accepted for disabling closed head concussion, left traumatic pneumothorax, ruptured spleen, left clavicular fracture, pulmonary contusion, fractured ribs left #2 & #3, fracture of the left transverse process at L4 & L5, left transverse process fractures L1-3, T2-10 costochondral fractures, lumbar strain, thoracic strain and sacroiliac strain. (Ex. 22-1).

Claimant came under the care of Dr. Purtzer and IPC. On August 9, 2010 Purtzer saw claimant (Ex. 26), and billed Liberty a total of \$945.00 for the visit. (Ex. 28). IPC listed three separate diagnostic codes¹ on the standard CMS 1500 billing form² (Ex. 28): (1) 724.2, which is

¹ These standardized diagnostic and procedural codes are commonly referred to as ICD-9 codes. According to OAR 436-009-0005(6)(h), "ICD-9-CM means International Classification of Diseases, Ninth Revision, Clinical Modification, Vol. 1, 2 & 3 by US Department of Health and Human Services."

² See OAR 436-009-0010(2).

the code for lumbago or low back pain;³ (2) 715.90, apparently intended here to indicate degenerative joint disease;⁴ and (3) 729.1, which is for “Myalgia and myositis, Fibromyositis[.]”

On September 30, 2010 Liberty denied payment, citing the following reason on the explanation of benefits form: “Information on the bill/chart does not clearly show this treatment as being related to an accepted condition.” (Ex. 31-1). On October 16, 2010 IPC sought administrative review. (Ex. 32).

On October 20, 2010 the Workers’ Compensation Division’s Resolution Team (hereinafter the director) notified claimant of the medical billing dispute (Ex. 34); and sent Liberty a document entitled Notice of Required Action on a Medical Dispute. (Ex. 35).

On November 2, 2010 Liberty responded with its Specification of Disputed Medical Issues (Ex. 40-3), accompanied by a cover letter explaining the reasons for the denied reimbursement. (Ex. 40). According to Liberty, the disputed service covered conditions that had not been requested by the worker, including chronic pain syndrome, degenerative joint disease, myofascial pain, stress and anxiety. (Ex. 40-1).

On December 20, 2010 the director wrote to IPC, informing the provider that Liberty was contending that payment had been denied “because the medical services provided were for a new or omitted condition in which [claimant] has not asked for acceptance.” (Ex. 41). The director informed IPC that because compensability was in dispute the issue would have to be addressed by the Workers’ Compensation Board (the board); and indicated that the director would take no further action. (*Id.*). Finally, the letter informed IPC that claimant would have to file a request for hearing with the board if he believed the medical services to be compensable. (*Id.*). A copy of the letter was sent to claimant.⁵ (*Id.*).

On December 23, 2010 IPC responded to the director’s December 20, 2010 letter. IPC informed the director that the chart note for the disputed date of service had been “corrected to reflect the actual medical service provided related to [claimant’s] workers compensation claim.” (Ex. 42). Asserting that Dr. Purtzer had provided medical services for claimant’s accepted conditions on the date in question, IPC asked the director to review the matter further. (*Id.*). IPC faxed the director a “corrected” CMS 1500 form (Ex. 43-2), replacing the 729.1 code with 840.4, which is the diagnostic code for rotator cuff (capsule).

On January 10, 2011 the director issued an Administrative Order of Dismissal, denying IPC’s request for reconsideration. (Ex. 44). Finding that compensability of medical services was

³ Information regarding diagnostic codes is taken from *Wikipedia*, List of ICD-9 codes, found online at wikipedia.org. Administrative notice is taken of the information found in these diagnostic codes.

⁴ No ICD9 code match was identified for 715.90, but 715.09 is the diagnostic code for osteoarthritis, degenerative arthritis or degenerative joint disease. Dr. Purtzer’s chart note includes degenerative joint disease as one of claimant’s diagnoses. (Ex. 26-5).

⁵ Because claimant is unrepresented here, he may want to contact the Workers’ Compensation Ombudsman’s office whose job is to assist injured workers in such matters. He may contact the office free of charge at 1-800-927-1271.

at issue, the director concluded that WCD did not have jurisdiction, and dismissed the matter without prejudice. (*Id.*). IPC timely requested a hearing. (Ex. 45).

CONCLUSIONS OF LAW AND OPINION

First, I agree with the director that this matter involves compensability of the disputed medical services. Accordingly, subject matter jurisdiction is with the board. *See, e.g., AIG Claim Services v. Cole*, 205 Or App 170, 173-74 (2006) (explains which agency has jurisdiction in the three types of medical services disputes). Because I find that medical provider IPC does not have standing, however, I find that there is no case or controversy properly before the Hearings Division, and dismiss IPC's request for hearing. I reason as follows.

In its response to the director's inquiry regarding the disputed medical issues, Liberty represented on the check-the-box form that the issue did not involve formal denial of the underlying condition, or a dispute over whether the medical service was causally related to the accepted condition. (Ex. 40-3). The only box the insurer checked was the one that reads, "The service is for a new/omitted condition which the worker has not asked (*sic.*) for acceptance." (*Id.*). In its accompanying letter, however, the insurer's case manager reiterated the statement found on the original explanation of benefits form: "Information on the billings and chart notes still do not clearly show this treatment as being related to an accepted condition." (Ex. 40-3). This is the kind of relevant information contemplated by OAR 436-010-0008(7); and shows that the insurer was questioning the relationship between the medical services and the accepted claim. Accordingly, I find that ORS 656.704(3)(b)(C) is potentially implicated here. Because claimant is not a party, however, I find that his right to receive compensation is not directly in issue here. See ORS 656.704(3)(a). Further, for the reasons that follow I find that IPC does not have standing to challenge Liberty's denial of medical services.

According to ORS 656.283(1), "[s]ubject to ORS 656.319,⁶ any party * * * may at any time request a hearing on any matter concerning a claim, except matters for which a procedure for resolving the dispute is provided in another statute, including ORS 656.704." Under OAR 436-001-0019(1) and (2)(b) a medical provider may be considered a "party" to disputes that are "within the director's jurisdiction." Various types of medical services disputes fall into this category.⁷ ORS 656.704(3)(b)(B). Where the dispute involves compensability of medical services broadly,⁸ however, jurisdiction lies not with the director, but with the Hearings Division. ORS 656.704(3)(b)(A) and (C). In such cases it is the *claimant* who must file a timely request for hearing to challenge the denial of a claim for compensation. ORS 656.319. Further, it is the *worker* whose burden it is to establish compensability of a claim. ORS 656.266(1). Finally, it is the *worker* who is entitled to initiate a new medical or omitted condition claim. ORS 656.267(1) and (3).

⁶ Under ORS 656.319 there are time limitations upon when a hearing may be requested.

⁷ This category includes disputes over whether treatment is excessive, inappropriate, ineffective, or otherwise in violation statutes or rules governing the provision of medical services. See OAR 436-010-0008.

⁸ Not including disputes relating to efficacy or propriety of treatment. (See fn 9, *supra*).

Although a medical provider is entitled under ORS 656.248(12) to challenge nonpayment of bills for *compensable* medical services, there is no provision in Oregon Workers' Compensation Law for a medical provider to directly challenge the denial of an injured worker's claim for compensation on grounds that the claim is not compensable. Under these circumstances, I find that IPC does not have standing to challenge the director's order of dismissal here. Accordingly, its request for hearing must be dismissed.

ORDER

IT IS THEREFORE ORDERED, the Administrative Order of Dismissal dated January 10, 2011 is affirmed; and IPC's request for hearing is dismissed.