



1 **ISSUE**

2 The issue is whether WCD erred by discontinuing review of medical treatment issues in  
3 this matter.

4 **EVIDENTIARY RULING**

5 WCD Exhibits 1- 71 were entered into the record without objection.

6 **FINDINGS OF FACT**

7 Claimant was compensably injured during a motor vehicle accident on October 1, 1997.  
8 Claimant sought treatment from Charles Close, DC, at Keizer Family Chiropractic (Keizer).  
9 Claimant received services at Keizer from October 1, 1997 through October 15, 1997. Keizer  
10 billed insurer for its services and insurer paid all bills except those for x-rays on October 3, 7 and  
11 9, 1997.

12 On September 30, 1998, insurer requested an administrative review of Keizer’s services  
13 by WCD’s Medical Review Unit (MRU). Insurer alleged that the treatment provided by Keizer  
14 was excessive, ineffectual and inappropriate and requested a finding on that issue. Insurer also  
15 requested sanctions under ORS 656.245(3) and forfeiture of all previously paid fees. At the time  
16 of the request for review, all of claimant’s medical bills in this matter had been paid except for  
17 services provided on October 3, 7 and 9, 1997.

18 On July 14, 1999, MRU issued an order that stated:

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20 “SAIF requested that MRU review services provided by Dr. Close from  
21 October 3 through October 15, 1997. When there is a dispute over the amount of  
22 a bill, or the appropriateness of services provided, the insurer is required to pay  
23 any undisputed portion of the bill and provide specific reasons for non-payment.  
24 See OAR 436-009-0030(6). Since the insurer has paid for services provided by  
25 Dr. Close from October 3 to October 15, 1997, the director concludes the insurer  
has not disputed the appropriateness of these services. Therefore, the director will  
limit this review to the x-rays provided on October 3, 7, and 9, 1997.” (Ex. 66-3).

1 **CONCLUSIONS OF LAW AND REASONING**

2 The claimant was treated at Keizer Family Chiropractic Clinic (Keizer) and insurer has  
3 paid most or all of Keizer’s bills. Nonetheless, insurer challenges the appropriateness of all  
4 treatment provided by Keizer in this case, whether paid or unpaid, and has requested review by  
5 MRU pursuant to ORS 656.327. Insurer’s contention is that “[Keizer] \*\*\* has established a  
6 pattern of treatment that is excessive, inappropriate and harmful to workers in that it does not  
7 reflect individual assessment or tailoring of the treatment plan to the patient’s specific condition  
8 or injuries.” (Petitioner’s Hearing Memorandum and Motion to Remand at 1). MRU relied on  
9 OAR 436-009-0030(5), since amended, to conclude that because insurer had paid for certain of  
10 the services, insurer did not dispute the appropriateness of the remunerated treatment<sup>2</sup>. After so  
11 finding, MRU ceased its review of the appropriateness of those treatments. Because MRU’s  
12 order was issued under authority of ORS 656.327, I review for substantial evidence and errors of  
13 law. ORS 656.327(2).

14 Appropriateness of Treatment under ORS 656.327

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16 Petitioner advanced several arguments concerning MRU’s refusal to proceed with an  
17 administrative review, the first of which is that petitioner has a statutory right under ORS  
18 656.327(1)(a) to an administrative review of this matter, regardless of whether the bill has been  
19 paid or not. To the extent that OAR 436-009-0030(5) requires a different result than ORS  
20 656.327(1)(a), argues insurer, it should not be applied.

21 Former OAR 436-009-0030(5) stated:

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23 “When there is a dispute over the amount of a bill or the appropriateness of  
24 services rendered, the insurer shall, within 45 days, pay the undisputed portion of  
the bill and at the same time provide specific reasons for non-payment or

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25 <sup>2</sup> The current rule, OAR 436-009-0030(6), is substantially the same as the version upon which MRU relied.

1 reduction of each medical service code. Resolution of billing disputes shall be  
2 made in accordance with OAR 436-009-008, 436-010-0008 and 436-015.”

3 Insurer argues, and I agree, that MRU appears to interpret this rule to say that there can  
4 be no dispute over the appropriateness of treatment once an insurer has paid a submitted bill. I  
5 agree with the insurer’s argument that MRU’s interpretation of this rule places it in conflict with  
6 the governing statute, ORS 656.327.<sup>3</sup> That statute provides in relevant part:

7 “(1)(a) If an injured worker, an insurer or self-insured employer or the Director of  
8 the Department of Consumer and Business Services believes that the medical  
9 treatment, not subject to ORS 656.260, that the injured worker has received, is  
10 receiving, will receive or is proposed to receive is excessive, inappropriate,  
ineffectual or in violation of rules regarding the performance of medical services,  
the injured worker, insurer or self-insured employer shall request review of the  
treatment by the director and so notify the parties.

11 “(b) Unless the director issues an order finding that no bona fide medical  
12 services dispute exists, the director shall review the matter as provided in this  
13 section.”

14 The statute requires the director to review contentions by any party (or the department)  
15 that any treatment, past, present or future, is inappropriate. The only exception is where the  
16 director finds that there is no bona fide medical services dispute, and that circumstance does not  
17 exist here<sup>4</sup>. The statute does not say that the director shall review disputes over the  
18 appropriateness of treatment except where the insurer has already paid for the treatment except  
19 where the insurer has already paid for the treatment. MRU’s interpretation of OAR 436-009-  
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21 <sup>3</sup> Insurer’s written argument on this point is persuasive, and much of the following argument is  
22 adopted from insurer’s Hearing Memorandum.

23 <sup>4</sup> This is not a case in which MRU found that there was no bona fide medical services dispute.  
24 The Workers’ Compensation Board has clarified the circumstance in which there is no bona fide  
25 medical services dispute: “Although the statute does not contain a definition of “no bona fide  
medical dispute,” we construe the statute as providing that no bona fide medical services dispute  
exists if the medical services the claimant is receiving is not being challenged on one or more of  
the bases provided in ORS 656.327(1). *George E. Smith, Sr.*, 45 Van Natta 2268 (1991). In

1 0030(5) is inconsistent with the statute. "An administrative agency may not, by its rules, amend,  
2 alter, enlarge or limit the terms of a statute." *Cook v. Workers' Compensation Dept.*, 306 Or  
3 134, 138 (1988). An erroneous agency interpretation of a rule is an error of law. Accordingly,  
4 because there has been an error of law, these cases shall be remanded to MRU to make the initial  
5 determination of whether any of the disputed treatment is excessive, inappropriate, ineffectual, or  
6 in violation of rules.

7 Payment as Admission of Liability

8 MRU's interpretation OAR 436-009-0030(5) to prevent further consideration of  
9 appropriateness where a bill has been paid is also in direct contravention of the well-founded  
10 principle of law that mere payment of compensation cannot admit or establish liability on a  
11 claim. Indeed, ORS 656.262(10) states this principle explicitly:  
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13 "Merely paying or providing compensation shall not be considered  
14 acceptance of a claim or an admission of liability, nor shall mere acceptance of  
15 such compensation be considered a waiver of the right to question the amount  
16 thereof. Payment of permanent disability benefits pursuant to a determination  
17 order, notice of closure, reconsideration order or litigation order shall not preclude  
18 an insurer or self-insured employer from subsequently contesting the  
19 compensability of the condition rated therein, unless the condition has been  
20 formally accepted."

21 The statute specifically prohibits WCD from finding that insurer has incurred liability  
22 based merely on the fact that insurer paid claimant's medical bills. For further discussion of this  
23 basic principal in regards to medical services see: *Gloria T. Olson*, 44 Van Natta 2519, 2520-21  
24 (1992)(neither the employer's approval of payment for surgery nor its failure to challenge a  
25 Determination Order which awarded benefits for the residuals of the surgery constituted  
26 acceptance of the degenerative condition which the surgery was designed to treat); *William T.*

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27 these cases, SAIF is challenging the treatment on all the bases listed in the statute. Therefore,  
28 there is a bona fide dispute.

1 *Smith*, 46 Van Natta 2169 (1994)(mere payment of medical bills not an admission of liability).  
2 These prior decisions should guide MRU in any future interpretation of OAR 436-009-0030(5).

3 Dismissal of Issues

4 The dismissal of these issues was also in opposition to the director’s well-established  
5 policy that matters should not be dismissed where a decision has been made on the merits. The  
6 director has previously cautioned MRU that when the parties have raised a substantive issue  
7 requiring a decision on the merits, the matter should not be summarily dismissed without review.  
8 By refusing to address insurer’s allegations of inappropriate medical treatment, MRU has in  
9 effect dismissed insurer’s request for review on these issues. The director has previously stated  
10 the argument against such a course of action in clear terms:  
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12 “When MRU decides a case on its merits the parties need the opportunity to  
13 dispute MRU's decision. Generally, MRU is right, as it was in this matter.  
14 Nevertheless, MRU could make a mistake. If MRU dismisses the matter, the  
15 parties are required to litigate an additional issue because first the party must fight  
16 the dismissal and then the party must argue the merits of the case. This results in  
17 more expensive litigation, which was contrary to the intent of the legislature when  
18 it gave the director jurisdiction over medical disputes. Therefore, when MRU  
19 decides an issue based on the merits of the case, the order should not dismiss the  
20 matter.” *Teresa Spurgeon*, 3 WCSR 14 (1997).

17 Petitioner's Requests for Sanctions and Penalties

18 ORS 656.254(3)(c) states:

19 “(3) In accordance with the provisions of ORS 183.310 to 183.550, if the  
20 director finds that a health care practitioner has:

21 “(a) Been found, pursuant to ORS 656.327, to have failed to comply with  
22 rules adopted pursuant to this chapter regarding the performance of medical  
23 services for injured workers or to have provided medical treatment that is  
24 excessive, inappropriate or ineffectual, the director may impose a sanction that  
25 includes forfeiture of fees and a penalty not to exceed \$1,000 for each occurrence.  
If the failure to comply or perform is repeated and willful, the director may  
declare the health care practitioner ineligible for reimbursement for treating  
workers' compensation claimants for a period not to exceed three years.

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1 “(c) Engaged in any course of conduct demonstrated to be dangerous to the  
2 health or safety of a workers' compensation claimant, the director may impose a  
3 sanction that includes forfeiture of fees and a penalty not to exceed \$1,000 for  
4 each occurrence. If the conduct is repeated and willful, the director may declare  
the health care practitioner ineligible for reimbursement for treating workers'  
compensation claimants for a period not to exceed three years.”

5 Additionally, OAR 436-010-0340(6) states that if an insurer believes sanctions are  
6 appropriate, it “may submit a complaint in writing to the director.”

7 In each of these cases, insurer submitted such a complaint as part of its request for MRU  
8 review and requested that the director impose sanctions pursuant to ORS 656.254(3)(c).  
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10 Petitioner is correct that these issues were not dealt with in MRU's order, nor does the record  
11 reflect any action by WCD to examine the request for penalties. However, the WCD  
12 Compliance Section, Sanctions Unit is the appropriate unit within WCD to examine requests for  
13 sanctions based on the inappropriate conduct of a claimant, claimant's attorney or medical  
14 provider. While it was advisable in this instance to resolve the medical issues prior to the  
15 resolution of sanctions, it remains the director's practice to refer the initial determination of  
16 sanction requests to the Sanctions Unit. *Jaymie Reynolds*, 2 WCSR 332 (1997); *John Reid*, 2  
17 WCSR 209 (1997). Because the issues of sanctions and penalties were not addressed in MRU's  
18 order, on remand they should be referred to the Sanctions Unit for further proceedings upon the  
19 completion of MRU's review.  
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21 **ORDER**

22 IT IS HEREBY ORDERED that:

- 23 1) MRU's administrative order in this matter, TX 99-302, is abated. This matter is  
24 remanded to MRU for further consideration in accordance with this order.  
25 2) Upon completion of MRU's administrative review, this matter is to be referred to

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the Compliance Section, Sanctions Unit to determine whether sanctions or penalties are appropriate.

DATED this \_\_\_\_ day of April, 2000.

By: \_\_\_\_\_  
Paul Vincent, Hearing Judge  
Hearing Officer Panel