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In the ORS 656.327 Medical Treatment Dispute of

**Miller, Thomas E., Claimant**

Contested Case No: HH01-100

**PROPOSED & FINAL ORDER**

March 24, 2002

LIVERTY NORTHWEST INSURANCE CORPORATION, Petitioner

THOMAS E. MILLER, Respondent

Before John L. Shilts, Workers' Compensation Division Administrator

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Insurer appeals an Administrative Order issued on August 22, 2001, by the Medical Review Unit (MRU) of the Workers' Compensation Division (WCD), Department of Consumer and Business Services (director or department). On November 16, 2001, Administrative Law Judge Catherine P. Coburn conducted a contested case hearing in this matter. Petitioner Liberty Northwest Insurance Corporation (insurer) was represented by attorney Scott P. Monfils. Respondent Thomas E. Miller (claimant) was represented by attorney Charles R. Mundorff. No witnesses testified and the record closed on the date of hearing.

The record of this proceeding, consisting of written argument, all evidence received, and all hearing papers filed, has been considered. The findings of fact and conclusions of law are based upon the entire record.

**ISSUE**

Pursuant to OAR 436-010-0250(5), is insurer barred from contesting the medical appropriateness of a proposed surgery?

**EVIDENTIARY RULINGS**

The record consists of WCD Exhibits 1 through 25 which were received into the record without objection.

**FINDINGS OF FACT**

I adopt the findings of fact contained in the Administrative Order dated August 22, 2001 with the following supplementation:

In September 1978, while working for a newspaper, claimant lifted papers and developed low back and left leg pain. (Ex. 4-1). Claimant underwent two lumbar surgeries and his condition was declared medically stationary in November 1980. (*Id.*) Claimant underwent several additional lumbar surgeries and was declared permanently, totally disabled in July 1989. (Ex. 4-3).

In January 2001, claimant sought treatment with John C. Misko, MD. (Ex. 9). Dr. Misko copied insurer with a chart note dated February 24, 2001 that reads, "It was Dr. Slacks' and my

conclusion that Mr. Miller needs a two-level fusion, one at L2-L3 and one at L3-4.\*\*\* In conclusion, we are requesting authorization for a two-level fusion using bilateral Ray cages at L2-L3 and L3-4 from Liberty Northwest.” (Ex. 8). Dr. Misko’s office sent insurer a letter dated February 26, 2001 listing claimant’s name, claim number, date of birth and date of injury. The letter reads, “Dr. John Misko is requesting authorization for bilateral lumbar laminectomy, foraminotomies and facetectomies with cauda equina and nerve root decompression followed by a Ray Cage fusions (sic) using autologous bone graft and Osteoset at L3-L4 and L5-L5(sic)\*\*\*\*”. (Ex. 10) The letter notes CPT codes and indicates that the surgery would be performed at Tuality Community Hospital, assisted by Francis P. Nash, MD on the first available surgery date. Dr. Misko’s staff enclosed copies of his consultation, chart notes and diagnostic reports and invited insurer to call with questions. (*Id.*)

On May 16, 2001, an insurer’s medical examination (IME) was completed recommending against the proposed surgery. (Ex. 11-30). By letter to insurer dated July 2, 2001, Dr. Misko disagreed with the IME and recommended surgery at L2-3 and L3-4. (Ex. 15). On July 2, 2001, claimant requested administrative review of insurer’s failure to authorize surgery. (Ex. 12). On July 11, 2001, insurer contacted Dr. Misko’s office and clarified that the proposed surgery was addressed to spinal levels L3-4 and L4-5. (Ex. 16).

### CONCLUSIONS OF LAW

This case presents a medical treatment dispute arising under ORS 656.327. Jurisdiction lies with the director. ORS 656.245(1)(c)(J) and ORS 656.327(1). I may modify the administrative order only if it is not supported by substantial evidence in the record or if it reflects an error of law. ORS 656.327(2); OAR 436-001-0225(3). The burden of proving a fact or position rests with the proponent. ORS 184.450(2). As petitioner, insurer bears the burden of proving by a preponderance of the evidence that the administrative order is incorrect. *See Cook v. Employment Div.*, 47 Or 437 (1982) (In the absence of contrary legislation, the standard of proof in an administrative hearing is preponderance of evidence).

An insurer is obligated to provide medical services for conditions materially caused by the work injury for such period as the nature of the injury or the process of recovery requires. ORS 656.245(1). This obligation continues over the injured worker’s lifetime. ORS 656.245(1)(b). After the medically stationary date, insurer is obligated to provide medical services to injured workers who are permanently, totally disabled. ORS 656.245(1)(c)(A). However, medical treatment that is excessive, inappropriate, ineffectual or violates administrative rules is not reimbursable. ORS 656.327. The director reviews medical appropriateness questions pursuant to ORS 656.327 and administrative rules promulgated for the purpose of establishing uniform guidelines for provision of medical services to injured workers.

Under the heading “Elective Surgery”, OAR 436-010-0250 provides:

“(1) ‘Elective Surgery’ is surgery which may be required in the process of recovery from an injury or illness but need not be done as an emergency to preserve life, function or health.

“(2) Except as otherwise provided by the MCO, when an attending physician or [consulting physician] surgeon upon referral by the attending physician believes elective surgery is needed to treat a compensable injury or illness, the attending physician or the surgeon, shall give the insurer actual notice at least seven days prior to the date of the proposed surgery. Notification shall give the medical information that substantiates the need for surgery, an estimate of the surgical date and the post-surgical recovery period, and the hospital where surgery is to be performed.”

“(3) When elective surgery is recommended, the insurer may require an independent consultation with a physician of the insurer’s choice. The insurer shall notify the recommending physician, worker and the worker’s representative, within seven days of receipt of the notice of intent to perform surgery, whether or not a consultation is desired. When requested, the consultation shall be completed within 28 days after notice to the attending physician.”

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“(5) If the insurer believes the proposed surgery is excessive, inappropriate, or ineffectual and cannot resolve the dispute with the recommending physician, the insurer shall request an administrative review by the director within 21 days of the notice provided in (4)(c)<sup>1</sup>. Failure of the insurer to timely respond to the physician’s elective surgery request or to timely request administrative review pursuant to this rule shall bar the insurer from later disputing whether the surgery was excessive, inappropriate or ineffectual.” (Emphasis added).

In the administrative order, MRU cited *AETNA Casualty and Surety Company v. Blanton*, 139 Or App 283 (1996) for the proposition that strict compliance with administrative rules is required. (Ex. 23-3). MRU determined that insurer was barred from disputing the medical appropriateness of the proposed surgery because it failed to comply with the requirements of OAR 436-010-0250. Specifically, MRU found that insurer failed to respond within seven days

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<sup>1</sup> OAR 436-010-0250(4)(c) provides:

“The recommending physician shall provide written notice to the insurer, the worker and the worker’s representative when further attempts to resolve the matter would be futile. The director may, by bulletin, prescribe the form and format of such notification.”

of receiving the surgery request as required by subsection (3). Consequently, MRU ruled that insurer was barred from challenging the medical appropriateness of the proposed surgery pursuant to subsection (5). Finally, MRU concluded that insurer is liable for all costs associated with the proposed surgery.

Insurer contends that it received no valid recommendation for surgery, insurer's obligation to respond was not triggered and therefore, insurer is not barred from contesting the medical appropriateness of the proposed surgery. In support of its position, insurer argues that Dr. Misko's chart notes and letter failed to strictly comply with subsection (2), insurer was not required to comply with subsection (3), and therefore, the prohibition against challenging medical appropriateness contained in subsection (5) does not apply to the facts. Insurer further contends that even if strict compliance is not required, Dr. Misko's communications are so flawed that they failed to adequately apprise insurer that he proposed to perform surgery.

In contrast, claimant contends that even if Dr. Misko failed to comply with the notification requirements prescribed in subsection (2), insurer is not excused from complying with the response requirement prescribed in subsection (3) and that therefore, under subsection (5), insurer is barred from contesting medical appropriateness. Claimant further contends that where a recommending surgeon fails to provide adequate notice to the insurer, the proper remedy for a recommending physician who fails to comply with the rule's notification requirements is prescribed by subsection (7)<sup>2</sup>.

Citing *Blanton*, MRU interpreted OAR 436-010-0250 as requiring strict compliance. In *Blanton*, the court held that an administrative agency must apply its own administrative rule as written. The court further held that medical providers must strictly comply with an administrative rule requiring a written treatment plan prior to provision of ancillary medical services. An agency is entitled to deference in interpreting its own administrative rule if the interpretation is plausible and not inconsistent with the wording of the rule itself or with any other source of law. *Hadley v. Cody Hindman Logging*, 144 Or App 157 (1996); *Don't Waste Oregon Comm. v. Energy Facility Siting Council*, 320 Or 132 (1994).

I find that MRU's interpretation of OAR 436-010-0250 is plausible and not inconsistent with any other source of law. *Blanton* and the present case are similar because they present the question whether medical providers are required to strictly comply with certain administrative rules. Moreover, MRU's interpretation requiring strict compliance is consistent with the wording of the rule which uses the mandatory term "shall" in both subsection (2) as applied to the recommending surgeon and in subsection (3) as applied to the insurer. Furthermore, subsection (3) begins with the phrase, "When elective surgery is recommended\*\*\*\*", indicating that the following requirements are triggered only if the recommending physician strictly complied with subsection (2). However, MRU's order reflects a legal error because it imposes strict compliance upon insurer but not upon the medical provider. MRU's decision is

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<sup>2</sup> OAR 436-010-0250(7) provides:

"A recommending physician who prescribes or proceeds to perform elective surgery and fails to comply with the notification requirements in section (2) of this rule, may be subject to civil penalties as provided in ORS 656.254(3)(a) and OAR 436-010-0340(2)."

inconsistent with *Blanton* which requires medical providers to strictly comply with an administrative rule.

I defer to MRU's interpretation of OAR 436-010-0250 requiring strict compliance.<sup>3</sup> However, I apply the principle of strict compliance to the medical provider in accord with

*Blanton* as well as to the insurer. Here, Dr. Misko failed to estimate the post-surgical recovery period as required by subsection (2). Inasmuch as the recommending surgeon failed to strictly comply with the notification requirements, insurer did not receive “actual notice” as defined in subsection (2) and insurer’s obligation to respond by strictly complying with subsection (3) was not triggered. Therefore, subsection (5) does not apply, and insurer is not barred from contesting the medical appropriateness of the proposed surgery pursuant to ORS 656.327. Accordingly, I remand to MRU for consideration of the medical appropriateness issue.

### **ATTORNEY FEES**

Claimant has not prevailed in a contested case hearing, and therefore, he is not entitled to an attorney fee. ORS 656.385(1).

### **ORDER**

IT IS HEREBY ORDERED that:

The Administrative Order dated August 22, 2001 is reversed.

Case Number H01-100 is remanded to MRU.

DATED this \_\_\_\_\_ day of March 2002.

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Catherine P. Coburn, Administrative  
Hearing Officer Panel