In the ORS 656.327 Medical Treatment Dispute of

LINDA C. RICHTER, Claimant

Contested Case No: H04-063

PROPOSED AND FINAL ORDER

December 28, 2004

LUMBERMEN'S MUTUAL CASUALTY CO., Petitioner

LINDA C. RICHTER, Respondent

Before Ella D. Johnson, Administrative Law Judge, Administrative Hearings

HISTORY OF THE CASE

Insurer appeals a March 25, 2004 Administrative Order issued by the Medical Review Unit (MRU) of the Workers' Compensation Division (WCD), Department of Consumer and Business Services (the director or the department), which determined that insurer was barred from contesting the appropriateness of the proposed surgery because it failed to comply with the notice requirements set forth in OAR 436-010-0250(5). On May 25, 2004, the matter was referred to the Office of Administrative Hearings (OAH) for hearing. On July 6, 2004, Administrative Law Judge (ALJ) Ella D. Johnson conducted a telephone hearing in this matter in Salem, Oregon. Attorney Jerald P. Keene represented petitioner Lumbermen's Mutual Casualty Company (insurer). Attorney Randy Elmer represented respondent Linda C. Richter (claimant). The parties requested that this matter be submitted on the record with written argument. Following the parties' submissions, the record was reopened to allow WCD to respond to the parties' arguments. Assistant Attorney General Carol Parks filed a written argument on behalf of WCD and the record closed on October 26, 2004 following WCD's submission.

ISSUE

Whether OAR 436-010-250(3), which bars insurers from contesting the merits of an elective surgery if they fail to comply with the notice requirements, exceeds the department's statutory authority.

EVIDENTIARY RULING

The record consists of WCD's Exhibits 1 through 93, which were admitted into the record without objection.

FINDINGS OF FACT

I adopt MRU's Findings of Fact with the following supplementation:

(1) Claimant compensably injured her low back on February 22, 2001. (Ex. 8.) Insurer accepted claimant's claim for right lumbar strain and right posterior paracentral disc herniation at L5-S1. (Ex. 16.)

(2) Claimant entered into a claim disposition agreement (CDA) with insurer on June 10, 2002, releasing all compensation, attorney fees and penalties, except for medical services.

(3) On October 28, 2003, after numerous medical tests and consultations, Alexis Norelle, MD (Neurological Surgery) requested approval by FAX from insurer to perform a postformaminal lumbar fusion at L5-S1 to treat claimant's compensable condition. (Ex. 70.)

(4) Insurer did not send form 440-3228 in response to Dr. Norelle's request advising her of the need to obtain consulting examination. Insurer obtained a consulting examination from Paul Williams, MD (Neurological Surgery) that the surgery was not reasonable or necessary. Based on his opinion, insurer denied authorization for the proposed surgery. (Exs. 71, 73.)

(5) Claimant requested administrative review. Insurer argued that the surgery was inappropriate and unreasonable. (Ex. 79.) MRU approved the surgery concluding that insurer was barred from contesting the propriety of the surgery because it had failed to comply with the administrative rule concerning elective surgery. (Ex. 84.)

CONCLUSIONS OF LAW

OAR 436-010-250(3), which bars insurers from contesting the merits of an elective surgery if they fail to comply with the notice requirements, does not exceed the department's statutory authority.

OPINION

This dispute arises under ORS 656.327, and therefore, jurisdiction lies with the director. ORS 656.245(6), 656.704(3). I review for substantial evidence or error of law. ORS 656.245(6), ORS 656.327 and OAR 436-120-0225(3). The burden of proving a fact or position falls upon the proponent. ORS 183.450(2). As petitioner, insurer bears the burden of proving by a preponderance of evidence that the administrative order is incorrect. *Cook v. Employment Div.,* 47 Or 437 (1982) (In the absence of legislation adopting a different standard, the standard of proof in an administrative hearing is preponderance of evidence) Proof by a preponderance of evidence means that the factfinder is persuaded that the facts asserted are more likely true than insurer has failed to meet its burden. *Riley Hill General Contractors v. Tandy Corp.,* 303 Or 390 (1989).

MRU found that insurer failed to comply with the notice requirements set forth in OAR 436-010-0250. Consequently, MRU concluded that insurer was barred from contesting the appropriateness of the proposed surgery. On appeal, insurer argues that OAR 436-010-250(5) is *ultra virus* because it exceeds the department's statutory authority and seeks a remand to MRU to address the merits of the proposed surgery.

OAR 436-010-0250 states in material part:

> (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 the attending physician or surgeon upon referral by the attending physician or authorized nurse practitioner, believes elective surgery is needed to treat a compensable injury or illness, the attending physician, authorized nurse practitioner, 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, and the approximate surgical date and place if known.

(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, the 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 by submitting Form 440-3228 (Elective Surgery Notification) to the recommending physician**. When requested, the consultation shall be completed within 28 days after notice to the physician.

(4)(a) Within seven days of the consultation, the insurer shall notify the recommending physician of the insurer's consultant's findings.

(b) When the insurer's consultant disagrees with the proposed surgery, the recommending physician and insurer shall endeavor to resolve any issues raised by the insurer's consultant's report. Where medically appropriate, the recommending physician, with the insurer's agreement to pay, shall obtain additional diagnostic testing, clarification reports or other information designed to assist them in their attempt to reach an agreement regarding the proposed surgery.

** * * *

(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 subsection (4)(c) of this rule. Failure of the insurer to timely respond to the physician's elective surgery request by submitting Form 440-3228, or to timely request administrative review pursuant to this rule shall bar the insurer from later disputing whether the surgery is or was excessive, inappropriate, or ineffectual.

(Emphasis added.

While insurer acknowledges that the department possesses broad general authority under ORS 656.726(4) to promulgate administrative rules, it notes that this authority is not unconstrained and must comport with the substantive statutes. It argues that OAR 436-010-0250(5) exceeds the department's statutory authority. In support of its argument, insurer contends that, in the absence of any specific statutory authority, the department lacks the power to impose upon an insurer a waiver, forfeiture or constructive consent to benefits sought as a result of failing to timely respond to a physician's request for authorization and using the proper form to do so. Insurer further argues that, although the department can assess a penalty for untimely processing, it is without authority to implement and enforce timelines not contained in the substantive statute.

WCD responds that the intent of subsection (3) and (5) is to balance the worker's right to prompt medical treatment with the insurer's right to obtain a second medical opinion. The applicable statute, ORS 656.327, does not contain a timeframe related to this process. Therefore, WCD argues, pursuant to the director's broad authority contained in ORS 656.726(4)(a) to promulgate rules which are reasonably required in the performance of her duties, the director has provided the missing timelines by rule in OAR 436-010-0250.

In support of its argument, WCD points to the one of the goals of the workers' compensation system as set forth in ORS 656.012(2)(a), which is to provide "sure, prompt and complete medical treatment for injured workers." OAR 436-010-0250 furthers that goal because it addresses the problem encountered by physicians when insurers delayed in responding to requests for authorization to perform elective surgery. It also protects medical providers when insurers deny payment and protects insurers by providing a process for the insurer to obtain its own medical opinion concerning the surgery.

Finally, WCD argues that ALJ Myers in *John D. Foster,* 9 CCHR 1 (2004), which was adopted and affirmed by the director by Final Order in 9 CCHR 256 (2004), has already addressed insurer's arguments. There, ALJ Myers concluded, applying the analysis of *Don't Waste Oregon Com. v. Energy Facility Siting*, 320 Or 132 (1994), that MRU did not exceed the director's authority by precluding the insurer from challenging the appropriateness of the proposed surgery because the insurer failed to comply with OAR 436-010-250.[1] I find WCD's arguments persuasive and adopt and incorporate by this reference its reasoning into this Proposed and Final Order.

Applying the same analysis as applied by ALJ Myers, I conclude that insurer has not met its burden of proving that MRU erred as a matter of law by relying on OAR 436-010-0250. In interpreting an agency rule for legal error, I defer to the agency's interpretation of its own rule if its interpretation is plausible and is not inconsistent with the rule's wording, its context, or any other source of law. *Don't Waste Oregon Com.*, 320 Or at 142. Like ALJ Myers, I find that MRU's interpretation of OAR 436-010-0250 is consistent with the language and context of the rule and, therefore, is plausible and is not inconsistent with any other provision of law, including

[1] Claimant responds that the rule is presumptively correct but declines to provide a response to insurer's argument, noting that the dispute is primarily between insurer and WCD.

ORS 656.726(4), 656.327 and 656.012(2)(a). Accordingly, I conclude that OAR 436-101-0250 does not exceed the director's statutory authority and finding no error of law, I affirm.

ATTORNEY FEES

Claimant has successfully defended MRU's order on appeal, and is therefore, entitled to an assessed attorney fee both on administrative review and at hearing. ORS 656.385(1). Applying the factors set forth in OAR 436-001-0265, I find that claimant's counsel is entitled to an assessed fee in the amount of $500.

ORDER

IT HEREBY ORDERED that:

(1) MRU's March 25, 2004 Administrative Order is affirmed.

(2) Insurer shall pay claimant's counsel an assessed fee of $500.