

In the ORS 656.327 Treatment Dispute of

AUDREY CASTILLO, Claimant

Contested Case No: H04-173

PROPOSED AND FINAL ORDER

APRIL 12, 2005

RLC INDUSTRIES, INC., Petitioner

AUDREY CASTILLO, Respondent

Before Lawrence S. Smith, Administrative Law Judge, Administrative Hearings

HISTORY OF THE CASE

RLC Industries Co. (Petitioner) timely appealed an October 7, 2004 Administrative Order issued by the Medical Review Unit (MRU) of the Workers' Compensation Division (WCD), Department of Consumer and Business Services. MRU concluded that Petitioner was precluded from challenging a proposed surgery because it failed to comply with OAR 436-010-0250(3). On December 10, 2004, the matter was referred to the Office of Administrative Hearings (OAH) for hearing.

On March 8, 2005, Administrative Law Judge (ALJ) Lawrence S. Smith conducted a telephone hearing. Attorney H. Scott Plouse represented Petitioner. Attorney Keith Semple represented Audrey Castillo (Claimant). No witnesses testified. The record closed after the hearing.

ISSUE

Whether Petitioner submitted a Form 440-3228 (Elective Surgery Notification) within seven days of receiving notice of a proposed medical procedure, as required by OAR 436-010-0250(3).

EVIDENTIARY RULING

The record consists of Exhibits 1 through 69, which were admitted into the record without objection.

FINDINGS OF FACT

The Findings of Fact in the October 7, 2004 Administrative Order are accepted and incorporated in this Proposed and Final Order, with the following supplementation:

1. Petitioner referred Claimant to an Independent Medical Evaluation by Dr. Richard Matteri, an orthopedic surgeon. Dr. Matteri performed this evaluation on December 9, 2003, and submitted a report the same day. His report states in one part:

It was Dr. Van Pett's impression that because of [Claimant's] low back pain and bilateral lower extremity paresthesia, that surgical intervention would be advisable. Specifically, Dr. Van Pett has recommended an L1 corpectomy with instrumentation through a controvertebral approach with possible posterior stabilization. Dr. Van Pett has sought authorization for this procedure. [Ex. 47 at p. 6-7.]

Furthermore, the surgery proposed [by Dr. Van Pett] is one of an L1 corpectomy with an anterior bone graft and instrumentation done through a costovertebral approach. A posterior approach may also be required. [Ex. 47 at p. 14.]

2. Petitioner referred Claimant to an Independent Medical Evaluation by Dr. Thomas J. Rosenbaum, a neurosurgeon. Dr. Rosenbaum performed this evaluation on December 9, 2003, and submitted a report the same day. His report states in one part:

On November 7, 2003 Dr. Van Pett evaluated the examinee [Claimant] and recommended an L1 corpectomy with a fusion and instrumentation through a transthoracic route. [Ex. 48 at p. 4.]

3. Also in Dr. Rosenbaum's report is this question from Petitioner:

More specifically and importantly, it appears that Dr. Van Pett is contemplating some form of surgery, apparently at L1, apparently to address the supposed radicular type complaints. Do you believe that such surgery is warranted or is reasonable and necessary? Do you believe that is in fact related to the accepted compression fracture or is more likely due to some other problem?

Dr. Rosenbaum concluded that Claimant's radiculopathy was related to her industrial injury. (Ex. 48 at 9.)

CONCLUSION OF LAW

Petitioner did not submit a Form 440-3228 (Elective Surgery Notification) within seven days of receiving notice of a proposed medical procedure, as required by OAR 436-010-0250(3).

OPINION

ORS 656.245(1)(a) and (b)1 provide that an insurer is required to provide medical services for any condition caused in material part by a compensable injury. WCD has jurisdiction over medical disputes arising under ORS 656.245(1) where compensability is not at issue. OAR 436-010-0008.2 MRU's decision is reviewed for substantial evidence and errors of law. Petitioner has the burden of showing that the Administrative Order on Remand is not supported by substantial evidence or that it reflects an error of law. OAR 436-001-0225(1).3

¹ ORS 656.245(1) states in relevant part:

(a) For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions caused in material part by the injury for such period as the nature of the injury or the process of the recovery requires, subject to the limitations in ORS 656.225, including such medical services as may be required after a determination of permanent disability. In addition, for consequential and combined conditions described in ORS 656.005 (7), the insurer or the self-insured employer shall cause to be provided only those medical services directed to medical conditions caused in major part by the injury.

(b) Compensable medical services shall include medical, surgical, hospital, nursing, ambulances and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services. A pharmacist or dispensing physician shall dispense generic drugs to the worker in accordance with ORS 689.515. The duty to provide such medical services continues for the life of the worker.

² OAR 436-010-0008 states in relevant part:

Administrative Review and Contested Cases

(1) Administrative review before the director:

(a) Except as otherwise provided in ORS 656.704, the director has exclusive jurisdiction to resolve all matters concerning medical services arising under ORS 656.245, 656.247, 656.260, and 656.327.

* * *

(3) Except for disputes regarding interim medical benefits, when there is a formal denial of the compensability of the underlying claim, the parties must first apply to the Hearings Division of the Workers' Compensation Board to resolve the compensability issues. After the compensability of the underlying claim is finally decided, any party may request director's review of appropriate medical issues within 30 days after the date the decision becomes final by operation of law.

(4) When there is a denial of the causal relationship between the medical service and the accepted condition or the underlying condition, the issue must first be decided by the Hearings Division of the Workers' Compensation Board.

³ OAR 436-001-0225(1) states:

Scope of Review/Limitations on the Record

(1) Review of medical service (ORS 656.245 and 656.247(3)(a)) and treatment (ORS 656.327 and 656.260) disputes is for substantial evidence or error of law. New medical evidence or issues may not be considered at the contested-case hearing.

“Substantial evidence exists to support a finding of fact when the record viewed as a whole, would permit a reasonable person to make that finding.” ORS 183.482(8)(c). A finding is supported by substantial evidence if it is reasonable in light of countervailing as well as supporting evidence. *Garcia v. Boise Cascade Corp.*, 309 Or 292 (1990). To determine whether substantial evidence exists, a reviewer must:

[L]ook at the whole record with respect to the issue being decided, rather than one piece of evidence in isolation. If an agency’s finding is reasonable, keeping in mind the evidence against the finding as well as the evidence supporting it, there is substantial evidence. ***For instance, and in the context which is likely to occur in workers’ compensation cases, if there are doctors on both sides of a medical issue, whichever way the [director] finds the facts will probably have substantial evidentiary support. [The administrative law judge] would not need to choose sides. The difference between the ‘any evidence’ rule and the substantial evidence test *** will be decisive only when the credible evidence apparently weighs overwhelmingly in favor of the finding and the [director] finds the other without giving a persuasive explanation. *Armstrong v. Asten-Hill Co.*, 90 Or App 200 (1988).

Insurer contends there is no substantial evidence for the conclusion in MRU’s Administrative Order that insurer was notified of Dr. Van Pett’s proposal to perform a L1 corpectomy. Insurer is entitled to receive actual notice of proposed elective surgery at least seven days prior to the surgery. OAR 436-010-0250(2).⁴ Insurer contends it did not receive notice of the proposed surgery until May 2004, but on December 9, 2003, both of its consultants specifically refer to the proposed surgery. Dr. Matteri specifically states Dr. Van Pett’s surgery proposal was sent to Petitioner and that Dr. Van Pett has sought authorization for this procedure. These consultants received their information from Petitioner, so there is at least substantial evidence that Petitioner received actual notice from Dr. Van Pett in December 2003 that she was proposing the surgery in issue. Upon receiving such notice, Petitioner had seven days to submit

⁴ OAR 436-010-0250(2) states:

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.

a Form 440-3228 (Elective Surgery Notification) to Dr. Van Pett. OAR 436-010-0250(3).⁵ Petitioner concedes that it never submitted a Form 440-3228. Its failure to do so within seven days bars it from “later disputing whether the surgery was excessive, inappropriate, or ineffectual.” OAR 436-010-0250(5).⁶

The record contains substantial evidence that Petitioner did not meet the seven-day time limit and it is barred from disputing whether the surgery was appropriate.

ATTORNEY FEES

In medical services cases, where a claimant finally prevails in a contested case order, the director shall require the insurer or self-insured employer to pay a reasonable attorney fee to the claimant’s attorney. ORS 656.385(1). A statement of services may be considered as a factor in assessing the award if submitted within seven days of the hearing date. OAR 436-001-0265(1). Claimant prevailed. Her attorney submitted his Statement of Services within seven days. Petitioner filed no response to the Statement. The statement is accepted as reasonable. Claimant is entitled to an assessed fee of \$862.50.

ORDER

The Administrative Order dated October 7, 2004 is affirmed. Claimant is entitled to an attorney fee of \$862.50.

⁵ OAR 436-010-0250(3) states:

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 attending physician.

⁶ OAR 436-010-0250(5) states:

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 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.