

In the ORS 656.245 Medical Service Dispute of

**DARRELL G. LEWIS, Claimant**

Contested Case No: H04-126

**PROPOSED AND FINAL ORDER**

JANUARY 13, 2005

DARRELL G. LEWIS, Petitioner

LIBERTY NORTHWEST INS. CO., Respondent

Before Catherine P. Coburn, Administrative Law Judge, Administrative Hearings

---

### **HISTORY OF THE CASE**

Claimant appealed an administrative order issued on July 23, 2004 by the Medical Review Unit (MRU) of the Workers' Compensation Division (WCD), Department of Consumer and Business Services (director or department). On September 3, 2004, the department referred the matter to the Office of Administrative Hearings (OAH). On December 8, 2004, Administrative Law Judge Catherine P. Coburn conducted a contested case hearing. Petitioner Darrell G. Lewis (claimant) was represented by attorney James Kirkpatrick. Respondent Liberty Northwest Insurance Corporation (insurer) was represented by attorney Leah Sideras. Claimant testified on his own behalf and Senior Claims Manager Christine James testified on insurer's behalf. Upon receipt of supplementary exhibits, the record closed on December 29, 2004.

### **ISSUE**

Whether a medical service claim for prescription medication is barred for untimely appeal.

### **EVIDENTIARY RULINGS**

WCD Exhibits 1 through 38 as well as insurer's Supplementary Exhibit 39 and claimant's Supplementary Exhibit 40 were admitted into the record without objection. Insurer withdrew proposed Supplementary Exhibit 15A as a duplicate.

### **FINDINGS OF FACT**

(1) On November 11, 1990, claimant suffered a right knee injury while working as a carpet cleaner and living in Lincoln City, Oregon. (Exs. 1 and 16.) Insurer initially accepted right knee effusion and later accepted a right medical meniscus tear. (Exs. 2 and 3.)

(2) In November 1992, the parties settled an aggravation claim though a disputed claim settlement. (Ex. 4.) In December 1993, the parties entered into a claims dispositions agreement. (Ex. 5.)

(3) Subsequently, claimant moved to California. In approximately 1995, claimant began

treating with Jeffrey C. Reinking, MD in Auburn, California. (Testimony of claimant.) Dr. Reinking prescribed hydrocodone 70 mg with acetaminophen 150 mg, taking 3 every 4 hours. This opiate prescription continued into 2004. (Exs. 6, 6-15 and 35-2.)

(4) In 2003, claimant moved from California to Tillamook, Oregon and insurer paid mileage reimbursement for his appointments with Dr. Reinking in Auburn, California, thirty miles east of Sacramento. (Ex. 40; testimony of claimant.)

(5) In March 2003, Senior Claims Manager Christine James became responsible for claimant's file. (Testimony of James.) On May 27, 2003, insurer sent Dr. Reinking Oregon workers' compensation information and requested his agreement to comply with Oregon regulations. The letter reads, "Failure to respond within the required fourteen (14) days will be considered a refusal to become the attending physician of record for this claim." (Ex. 7.) Dr. Reinking did not reply. (Testimony of James.) On May 27, 2003, insurer wrote to claimant requesting current contact information. (Ex. 8.) Claimant did not reply. (Testimony of James.)

(6) On July 28, 2003, insurer sent a second request to Dr. Reinking and to claimant, notifying them that it would no longer authorize medical services without adequate documentation. (Exs. 9 and 10.) Neither Dr. Reinking nor claimant responded. (Testimony of James.)

(7) On August 15, 2003, insurer notified Dr. Reinking and claimant that it would no longer authorize medical services. (Exs. 11 and 12.) The notices read, "If you disagree with this decision, within 90 days from the date of this letter, you, the patient or the patient's representative, may request approval for the treatment from the Director, Worker's Compensation Division, Labor and Industries Building, Salem, OR 97310. If you have any questions regarding the above, feel free to contact this office or the Workers' Compensation Division for clarification." (Exs. 11 and 12.)

(8) On August 28, 2003, claimant contacted insurer by telephone and provided a temporary mailing address. (Ex. 13; testimony of claimant and James.) On August 29, 2003, sent copies of all previous correspondence to claimant. Insurer notified claimant that Dr. Reinking had not responded and that unless he agreed to comply with Oregon regulations, he would not be recognized as the attending physician. Insurer invited questions and provided the Ombudsman's telephone number. (Ex. 13.)

(9) In September 2003, claimant telephoned insurer and was directed to contact the Ombudsman's office. (Testimony of claimant and James.)

(10) In mid-September 2003, Dr. Reinking telephoned insurer and agreed that claimant should designate an attending physician located closer to his home in Oregon. Insurer referred Dr. Reinking to the Ombudsman's office. (Testimony of James.) In an undated letter, Dr. Reinking notified insurer that he agreed to comply with Oregon worker's compensation regulations and fee schedule. Dr. Reinking recommended that claimant designate an attending physician and a pharmacy closer to his home in Oregon. (Ex. 40; testimony of James.)

(11) Insurer authorized payment of prescription medications and Dr. Reinking's services for appointments in October 2003, January and April 2004 with the understanding that claimant would designate an attending physician in Oregon. (Testimony of James.)

(12) On May 14, 2004, insurer denied medication reimbursement because it was not prescribed by the attending physician. Insurer noted that claimant had not appealed the August 15, 2003 denial. (Ex. 21.)

(13) Brad Lorber, MD declined to serve as claimant's attending physician because he had previously conducted an independent medical examination. (Ex. 16; testimony of James.)

(14) On October 28, 2004, Jennifer K. Lawlor, MD examined claimant for the purpose of designating a local attending physician. She prescribed a chronic pain treatment plan that differed from the medications prescribed by Dr. Reinking. Claimant declined Dr. Lawlor's treatment and she provided the following names as potential local attending physicians: Eric Long, MD, Vladimir Fiks, MD and Ashok Jaymar, MD. (Ex. 29-3.)

### CONCLUSION OF LAW

The medical service claim for prescription medication is barred for untimely appeal.

### OPINION

Jurisdiction over this medical services dispute lies with the director. ORS 656.245(6); OAR 436-010-0008(1). I review *de novo*. OAR 436-001-0225(1). The burden of proving a fact or position rests with the proponent. ORS 184.450(2). As petitioner, claimant bears the burden of proving by a preponderance of the evidence that the administrative order is incorrect. See *Cook v. Employment Div.*, 47 Or App 437 (1980) (In the absence of contrary legislation, 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 false. *Riley Hill General Contractors v. Tandy Corp.*, 303 Or 390 (1989).

MRU determined that claimant failed to timely appeal, and therefore, the claim is barred. Claimant contends that he understood from a telephone conversation with insurer's claims manager that no appeal was necessary. In contrast, insurer contends that the administrative order is correct and should be affirmed.

OAR 436-009-0008 provides in pertinent part:

(2) The medical provider, injured worker, or insurer may request review by the director in the event of a dispute about either the amount of a fee or non-payment of bills for medical services on a compensable injury. The following time frames and conditions apply to requests for administrative review before the director under this rule:

(b) For all claims not enrolled in an MCO, or for disputes which do not involve an action or decision of the MCO, the aggrieved party must request administrative review by the director within 90 days of the date the party knew, or should have known, there was a dispute over the provision of medical services. This time frame only applies if the aggrieved party other than the insurer is given written notice that they have 90 days in which to request administrative review by the director. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation, the 90 day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. For purposes of this rule, the date the insurer should have known of the dispute is the date action on the bill was due pursuant to OAR 436-009-0030. Filing a request for administrative review under this rule may also be accomplished in the manner prescribed in OAR chapter 438, division 005.

MRU determined that the claim for medical services is barred because claimant failed to timely appeal. I agree. On August 15, 2003, insurer denied continuing medical services and provided notice of the 90-day appeal period. Under 436-009-0008(2)(b), Dr. Reinking and claimant were required to file a request for administrative review with the director by November 15, 2003 and both failed to do so. Claimant and Dr. Reinking had some contact with insurer but failed to timely appeal the denial. Therefore, the claim is barred.

#### **ATTORNEY FEE**

Claimant has not finally prevailed in a contested case hearing and is entitled to no attorney fee. ORS 656.385(1).

#### **ORDER**

IT IS HEREBY ORDERED:

The Administrative Order dated July 23, 2004 is affirmed.