

In the ORS 656.327 Treatment Dispute of

ROBERT SHADDY, Claimant

Contested Case No: H04-200

PROPOSED AN FINAL ORDER

MARCH 29, 2005

RLC INDUSTRIES, Petitioner

ROBERT SHADDY, Respondent

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

HISTORY OF THE CASE

RLC Industries Co. (Petitioner) timely appealed a December 8, 2004 Administrative Order on Remand issued by the Medical Review Unit (MRU) of the Workers' Compensation Division (WCD), Department of Consumer and Business Services. The Order determined that Petitioner was precluded from challenging a proposed surgery for Robert Shaddy (Claimant) because it failed to comply with OAR 436-010-0250(3). On January 21, 2005, Petitioner's appeal was referred to the Office of Administrative Hearings (OAH).

On February 28, 2005, Administrative Law Judge (ALJ) Lawrence S. Smith conducted a telephone hearing. Attorney Ray Heysell represented Petitioner. Attorney Christine Jensen represented Claimant. WCD waived appearance. No witnesses testified. The record closed after the hearing.

ISSUE

Whether WCD exceeded its rulemaking authority in promulgating OAR 436-010-0250(3), which imposes a seven-day time limit for Petitioner to challenge proposed surgery for Claimant.

EVIDENTIARY RULING

The record consists of Exhibits 101, 102, 104, and 107, which were admitted into the record without objection. After hearing, it was determined that Exhibits 108 and 109 are related to Exhibit 107 and are admitted. The parties have 10 days after issuance of this Proposed and Final Order to file an objection with the ALJ.

FINDINGS OF FACT

The Findings of Fact in the December 8, 2004 Administrative Order are adopted and incorporated in this Proposed and Final Order.

CONCLUSION OF LAW

WCD did not exceed its rulemaking authority in promulgating OAR 436-010-0250(3), which imposes a seven-day time limit for Petitioner to challenge proposed surgery for Claimant.

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) when compensability is not at issue. OAR 436-010-0008.² 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

Petitioner concedes that it did not comply with OAR 436-010-0250(3)⁴ because it did not submit a Form 440-3228 (Elective Surgery Notification) to Claimant’s doctor within seven days after receiving notice of the doctor’s proposed surgery. It is therefore barred from “disputing whether the surgery was excessive, inappropriate, or ineffectual.” OAR 436-010-0250(5).⁵ The record contains substantial evidence that Petitioner did not meet the seven-day time limit in section (3) and that, pursuant to section (5), it is barred from disputing whether the proposed surgery was medically appropriate.

Petitioner does not dispute that it failed to respond within the time limit, but instead argues that the Administrative Order on Remand reflects an error of law because WCD exceeded its statutory authority in establishing a short deadline in OAR 436-010-0250(3). Petitioner does not challenge WCD’s general rulemaking authority, but specifically alleges that WCD has exceeded the rulemaking authority granted it in ORS 656.327 by imposing a deadline for insurers to request a second opinion after receiving notice of proposed surgery, citing as support, *Lee v. Oregon Racing Commission*, 142 Or App 114, 117 (1996) (“An agency may not, by rule, expand its power beyond that provided by statute. *See Severy v. Board of Parole*, 318 Or 172, 176 n 7 (1993); [“The Board could not confer on itself, by enactment of an administrative rule, greater authority than that granted to the Board by the legislature.”] *see also Oregon Occupational Safety v. Don Whitaker Logging*, 123 Or App 498, 500-01 (1993), *rev den* 318 Or 326 (1994). [“The Board’s powers are limited to those delegated to it by statute. The Board’s powers are limited to those delegated to it by statute.”]) and *Newport Church v. Hensley*, 161 Or App 12, 29 (1999) [Burden on exercise of religious organization does not outbalance the “state’s important interest in providing for the economic security of its citizens.”] None of these cases supports the conclusion that Petitioner’s interest outweighs WCD’s authority to promulgate OAR 436-010-0250(3), as explained below.

ORS 656.327 states in relevant part:

(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.

⁴ OAR 436-010-0250(3) states in relevant part:

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. * * *

⁵ 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.

Medical review of treatment of worker; findings; review; costs. (1)(a) If an injured worker, an insurer or self-insured employer or the Director of the Department of Consumer and Business Services believes that the medical treatment, not subject to ORS 656.260, that the injured worker has received, is 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.

WCD has general rulemaking authority in ORS 656.726(4), which states in relevant part:

(4) The director hereby is charged with duties of administration, regulation and enforcement of ORS 654.001 to 654.295, 654.750 to 654.780 and this chapter. To that end the director may:

(a) Make and declare all rules and issue orders which are reasonably required in the performance of the director's duties.

The courts have held that a rule promulgated under the director's general authority under ORS 656.726(4) is valid if it is within the range of discretion allowed by the more general policies of the Workers' Compensation Law. *Black v. Dep't of Ins. and Fin.*, 108 Or App 437, 440 (1991) (rule under which fee for deposition testimony was calculated valid under former ORS 656.726(3)). Those policies are found in ORS 656.012, which also provides the director with rulemaking authority. See *SAIF v. Ross*, 191 Or App 212, 219 (2003), *rev'd and rem'd on recon* 192 Or App 200 (2004). That general authority is not unlimited, however. See *Franzen v. Liberty Mutual Fire Ins. Co.*, 154 Or App 503, 507-08 (the broad authority under former ORS 656.726(3) "does not include the power to adopt rules that are inconsistent with statutes.").

The statutory authority for OAR 436-010-0250(3)(a) is found in chapter 656, the Workers' Compensation Law. ORS 656.012 contains the chapter's policy statement:

(2) [T]he objectives of the Workers' Compensation Law are declared to be as follows:

(a) To provide, regardless of fault, sure, prompt and complete medical treatment for injured workers and fair, adequate and reasonable income benefits to injured workers and their dependents;

(b) To provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent practicable;

(c) To restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable[.]"

An insurer's right to review medical treatment needs to be balanced with the worker's need to obtain the treatment. OAR 436-010-0250(3) does provide insurers the opportunity to review and comment on the proposed treatment. Nothing in WCD's interpretation of the rule is inconsistent with the goals of compensating and caring for injured workers within a fairly and expeditiously administered system or any policy in the Workers' Compensation Act.

Furthermore, nothing in this rule exceeds the director's authority to make rules that satisfy those goals. Therefore, WCD did not err as a matter of law.

In sum, OAR 436-010-0250 is valid. Petitioner did not timely respond to the elective surgery request and is therefore barred from disputing whether the surgery was excessive, inappropriate, or ineffectual under OAR 436-010-0250(5).

ATTORNEY FEES

In medical services cases, where a claimant finally prevails in a WCD contested case order, WCD 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). A statement of services is not a prerequisite to a fee award, however. The ALJ may consider any information deemed relevant and appropriate. OAR 436-001-0265(1)(j).

Claimant eventually provided a statement of services, which is considered because it is relevant and appropriate. Petitioner filed no objection to the statement. The amount requested is above the limit of \$2,000, but based on review of the factors in the administrative rule, particularly the benefit to claimant, the complexity of the issue(s) involved, and the quality of the legal representation, the statement of services is accepted. Claimant is entitled to an assessed fee of \$2,562.50, in addition to the attorney fee granted in the Administrative Order.

ORDER

MRU's Administrative Order dated December 8, 2004, is affirmed. Claimant is awarded attorney fees of \$2,562.50.