

In the ORS 656.340 Vocational Services Dispute of

JEFF E. BENNING, Claimant

Contested Case No: H04-088

PROPOSED AND FINAL ORDER

September 22, 2004

LIBERTY NORTHWEST INSURANCE CORPORATION, Petitioner

JEFF E. BENNING , Respondent

Before Catherine P. Coburn, Administrative Law Judge

HISTORY OF THE CASE

Insurer appeals the Director's Review and Order issued on April 26, 2004 by the Rehabilitation Review Unit (RRU) of the Workers Compensation Division (WCD), Department of Consumer and Business Services (director or department). On July 19, 2004, the department referred the matter to the Office of Administrative Hearings (OAH). On August 24, 2004, Administrative Law Judge Catherine P. Coburn conducted contested case hearing. Petitioner Liberty Northwest Insurance Corporation (insurer) was represented by attorney Phillip L. Nyberg. Respondent Jeff E. Benning (claimant) was represented by attorney James L. Edmundson. Rehabilitation Consultant Jan Plummer testified on insurer's behalf and the record closed on the date of hearing.

ISSUE

Whether RRU incorrectly determined that claimant remains eligible for vocational assistance pursuant to OAR 436-120-0350(1).

EVIDENTIARY RULINGS

WCD Exhibits 1 through 18 as well as insurer's Supplementary Exhibits 1A through 9A, 19 and 20 were admitted into the record without objection. The parties stipulated that Anthony L. Glassman, M.D. has not seen claimant since January 19, 2004 and served as attending physician until May 2004. The parties further stipulated that Gary Dandy, M.D. was designated as claimant's attending physician on May 5, 2004.

FINDINGS OF FACT

On October 19, 2001, claimant suffered a low back injury while working as an automobile mechanic. (Exs. 1 and 3A.) On November 6, 2001, insurer accepted a lumbosacral strain. (Exs. 2 and 5-4.) On January 8, 2002, Joseph S. Sacamano, MD, examined claimant at insurer's request. He found no evidence of any pre-existing condition and stated that the work-related lumbosacral strain was medically stationary without permanent impairment. (Ex. 3D.) On February 25, 2002, attending physician Matthew Driver, MD concurred. (Ex. 4A.) On September 20, 2002, insurer closed the claim without permanent partial disability (PPD). (Ex. 5-4.)

(2) On January 6, 2003, medical arbiter Patrick F. Golden, MD, examined claimant and noted that he suffered a congenital anomaly at L-5. (Exs. 6-4 and 1A.) Dr. Golden found some physical impairment and stated, “In my opinion, the percentage of findings that are due to the accepted condition is 60%.” (Ex. 6-5.) On February 7, 2003, the department issued an Order on Reconsideration awarding 11 percent PPD. (Ex. 7-4.)

(3) On June 4, 2003, insurer notified claimant that he was eligible for vocational assistance. (Ex. 8.) On August 29, 2003, insurer notified claimant that he was eligible for authorized training services. (Ex. 9.) Claimant began a vocational rehabilitation program for orthotic/prosthetic technical training. (Ex. 10-1.)

(4) On December 8, 2003, Anthony L. Glassman, MD examined claimant and noted that he suffered lumbar degenerative disc disease. (Ex. 10-2.) He opined, “At this point, I do not feel that the patient has a lumbosacral strain as these are usually expected to heal within 12 weeks. Nonetheless the patient does have chronic low back pain that would have been expected to have been healed except for the pre-existing degenerative changes.” (Ex. 10-2.) Insurer submitted Dr. Glassman’s report to attending physician Driver and on January 16, 2004, Dr. Driver marked both boxes indicating concurrence and nonconcurrence. Dr. Driver wrote, “Mr. Benning was dismissed from this practice in September 2002. I have no reason to doubt Dr. Glassman’s observations, but really have no further comment.” (Ex. 11.)

(5) On January 26, 2004, insurer notified claimant that his eligibility for vocational assistance had ended. (Ex. 12.)

OPINION

Jurisdiction lies with the director. ORS 656.340(4). Pursuant to ORS 656.283(2)(c), I may modify the administrative order if it (A) violates a statute or rule, (B) exceeds the statutory authority of the agency, (C) was made upon unlawful procedure, or (D) was characterized by abuse of discretion or clearly unwarranted exercise of discretion. OAR 436-001-0225(5). The burden of proof falls upon the proponent of a fact or position. ORS 183.450(2). In that regard, insurer bears the burden of proving by a preponderance of the evidence that the administrative order is incorrect. *Harris v. SAIF*, 292 Or 683 (1982) (general rule regarding allocation of proof is that burden is on the proponent of the fact or position); *Cook v. Employment Div.*, 47 Or App 437 (1980) (in the absence of legislation adopting a different standard, the standard of proof in an administrative hearing is by a preponderance of the 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).

Pursuant to ORS 656.340, employers are liable to provide vocational services to injured workers who are eligible. OAR 436-120-0350(1) defines the conditions under which an insurer may withdraw a notice of eligibility after issuance. OAR 436-120-0350(1) appears under the heading, “Ineligibility and End of Eligibility for Vocational Assistance” and provides:

The worker does not or no longer meets the eligibility requirements as defined in OAR 436-120-0320. The insurer must have obtained **new information** which did not exist or which the insurer could not have discovered with reasonable effort at the time the insurer determined eligibility.

(Emphasis added.)

RRU applied OAR 436-120-0350(1) and determined that claimant remained eligible because insurer based the notice of ineligibility on medical reports that did not constitute “new information” within the meaning of the rule. Insurer contends that it properly ended claimant’s eligibility based on Dr. Glassman’s report and Dr. Driver’s concurrence. (Exs. 10 and 11.) In contrast, claimant contends that the administrative order is correct. In support of his position, claimant argues that before insurer issued the notice of eligibility, it was aware that claimant suffered a pre-existing condition and it could have discovered the nature and extent of the pre-existing condition then. Claimant next argues that the medical reports in question reflect only a reassessment of medical information previously in the medical record and not new information. Claimant further argues that Dr. Driver’s note dated January 16, 2004 does not clearly express concurrence. Finally, claimant argues that such an eligibility termination is similar to a “back-up denial” which is disfavored for stability and predictability reasons.¹ I find claimant’s arguments persuasive.

argues that Dr. Driver’s note dated January 16, 2004 does not clearly express concurrence. Finally, claimant argues that such an eligibility termination is similar to a “back-up denial” which is disfavored for stability and predictability reasons.² I find claimant’s arguments persuasive.

¹ ORS 656.262(6)(a) provides in pertinent part:

Once a claim is accepted, the insurer or self-insured employer shall not revoke acceptance except as provided in this section. The insurer or self-insured employer may revoke acceptance and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal activity by the worker. ***** If the insurer accepts a claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the worker, and later obtains evidence that the claim is not compensable or evidence that the insurer or self-insured employer is not responsible for the claim, the insurer or self-insured employer may revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of acceptance and denial is issued no later than two years after the date of the initial acceptance. If the worker requests a hearing on such revocation of acceptance and denial, the insurer or self-insured employer must prove, by a preponderance of evidence that the claim is not compensable or that the insurer or self-insured employer is not responsible for the claim.

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In construing the meaning of an administrative rule, I apply the same method of analysis employed in determining the meaning of a statute. *Abu-Adas v. Employment Dept.*, 325 Or 480 (1997); *Larry Hemenway*, 5 WCSR 33 (2000). See also *PGE v. Bureau of Labor and Industries*, 317 Or 606 (1993) (court's task in determining the legislative intent is to first examine the statute, including text and context, and if the intent is clear, to proceed no further with its analysis.) Where an agency's interpretation of its own rule is plausible and not inconsistent with the wording of the rule itself, the rule's context or with any other source of law, there is no basis for asserting that the rule has been misinterpreted by the agency. *Don't Waste Oregon Com. v. Energy Siting Council*, 320 Or 132 (1994). Here, RRU interpreted OAR 436-120-0350(1) to mean that under the circumstances, Dr. Glassman's subsequent report of a pre-existing condition did not constitute "new information." I agree.

To begin, in January 2003, five months before the notice of vocational eligibility, medical arbiter Dr. Golden noted that claimant suffered a congenital lumbar anomaly. At this point, insurer could have explored and discovered the nature and extent of claimant's pre-existing condition before issuing a notice of eligibility. Moreover, in December 2003, Dr. Glassman noted that claimant suffered a pre-existing condition after claimant had begun the vocational training program. Based on the record, I find that Dr. Glassman and Dr. Driver's reports do not provide any new information, because insurer was previously aware that claimant suffered a pre-existing condition. On the contrary, the reports provide only a reevaluation of medical evidence previously contained in the record and not new information.

In conclusion, I find that RRU's interpretation of OAR 436-120-0350(1) is plausible and not inconsistent with its wording, context or any other source of law. Furthermore, finding no basis for modifying the administrative order, I affirm.

ATTORNEY FEES

Claimant has prevailed in a contested case, and is entitled to a reasonable attorney's fee. ORS 656.385(1). Considering the factors listed in OAR 436-001-0265, I find that \$1,237.50 is a reasonable fee for claimant's attorney's services in this case.

ORDER

IT IS HEREBY ORDERED that:

- (1) The April 26, 2004 Director's Review and Order is affirmed.
- (2) Insurer shall pay an assessed fee of \$1,237.50 to claimant's attorney.