

In the Matter of the ORS 656.45 Medical Treatment Dispute of

John D. Foster, Claimant

Contested Case No: H03-086

FINAL ORDER

August 16, 2004

AMERICAN MANUFACTURERS MUTUAL INSURANCE CO., Petitioner

JOHN D. FOSTER, Respondent

Before John Shilts, Administrator, Workers' Compensation Division

This matter comes before the director for issuance of a Final Order. Office of Administrative Hearings Administrative Law Judge (ALJ) Ray Myers issued a Proposed and Final Contested Case Hearing Order on January 14, 2004. The director adopts and affirms with the following supplementation.

On February 4, 2004, petitioner employer filed a Motion for Abatement and Reconsideration of Proposed Order. The Workers' Compensation Division treated employer's motion as a request for further hearing and on February 12, 2004 abated the proposed order and requested that the ALJ conduct further hearing to address the issues discussed in insurer's motion and any responses thereto.

On April 1, 2004, the division withdrew its request for further hearing, treating employer's motion as exceptions instead. The proposed order was reinstated and held in abeyance pending completion of the exceptions process. New appeal rights were given. Written exceptions were to be filed within 30 days of the date of the Withdrawal of Request for Further Hearing, or by Monday, May 3, 2004.

On May 6, 2004, employer submitted Exceptions to Proposed and Final Contested Case Order of January 14, 2004. Employer's exceptions were submitted three days late, and are therefore not considered. However, employer's February 4, 2004 motion was filed within the original time frame for filing exceptions to the proposed order. The issues discussed in employer's motion have not been addressed. Therefore, the director issues this final order to address the issues discussed in employer's February 4, 2004 motion. Claimant did not respond to employer's arguments.

The underlying issue is whether medical treatment proposed by claimant's attending physician is appropriate. Employer denied authorization of the proposed treatment. The Medical Review Unit, in a June 6, 2003 Administrative Order, found that employer was barred from challenging the appropriateness of the treatment under OAR 436-010-0250(5), which provides that failure to timely respond to an elective surgery request bars an insurer from later disputing the surgery. The issue of whether the treatment is appropriate was not addressed. Employer filed a request for hearing.

The ALJ's proposed order stated the issue as whether the director exceeded her authority in adopting OAR 436-010-0250(5). ALJ Myers concluded that the director did not exceed her authority, finding that the rule is within her general statutory authority, that the interpretation of

the rule is plausible, and that the rule is consistent with the objectives of the workers' compensation law.

Employer contends that the proposed order does not address a critical element of its argument. Employer does not challenge the director's general rulemaking authority, or her interpretation of OAR 436-010-0250(5). Rather, employer challenges the validity of the rule.

OAR 436-010-0250 (eff. 1/1/02) provides, in part:

* * * * *

“(2) Except as otherwise provided by the MCO, when the attending physician or surgeon upon referral by the attending physician, believes elective surgery is needed to treat a compensable injury or illness, the attending physician 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 attending 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.

“(c) The recommending physician shall provide written notice to the insurer, the worker and the worker's representative when further attempts to resolve the matter would be futile by signing Form 440-3228.

“(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 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.*

“(6) If the recommending physician and consultant disagree about the need for surgery, the insurer may inform the worker of the consultant's opinion. The decision whether to proceed with surgery remains with the attending physician and the worker.”

* * * * *

(Emphasis added.)

Specifically, employer challenges the director's authority to declare elective surgery conclusively compensable, regardless of whether or not it is appropriate, based on whether the insurer responds to the request for surgery within seven days. Employer disagrees that ORS 656.726(4), discussed below, provides the director authority to adopt this rule.

Claimant's position is that under ORS 656.012(2)(a),¹ a worker is entitled to prompt treatment. An insurer's right to review treatment needs to be balanced with the worker's need for the treatment. The director's rule does provide insurers the opportunity to review and comment on the proposed treatment. While the rule provides a seven-day time frame for the insurer to notify the parties of its intent to obtain a consultation, it allows 28 days to get the consultation.

The Workers' Compensation Division appeared at hearing and agreed with claimant's position. In addition to ORS 656.012(2)(a), the division argued, the authority for the rule is derived from ORS 656.726(4) and 656.252(1).²

¹ ORS 656.012(2)(a) provides: “In consequence of [the findings in ORS 656.012(1)], the 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.”

² ORS 656.252(1) provides:

“(1) In order to ensure the prompt and correct reporting and payment of compensation in compensable injuries, the Director of the Department of Consumer and Business Services shall make rules governing audits of medical service bills and reports by attending and consulting physicians and other personnel of all medical information relevant to the determination of a claim to the injured worker's representative, the worker's employer, the employer's insurer and the Department of Consumer and Business Services. Such rules shall include, but not necessarily be limited to: “(a) Requiring attending physicians and nurse practitioners authorized to provide compensable medical services under ORS 656.245 to make the insurer or self-insured employer a first report of injury within 72 hours after the first service rendered.

Employer argues that the director's authority under ORS 656.726(4) allows her to promulgate rules necessary to accomplish her duties under ORS chapter 656. The director has no duty, employer contends, to impose a forfeiture of an insurer's rights for its failure to respond within seven days. ORS 656.726(4) provides, in part: "The director hereby is charged with duties of administration, regulation and enforcement of * * * [ORS chapter 656]. 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." Contrary to employer's characterization, this language does not provide that the director may only make rules necessary to perform duties that are specifically stated in ORS chapter 656. Rather, the language provides that the director may make all rules reasonably required to perform the director's duties of administration, regulation, and enforcement of ORS chapter 656. The director has adopted OAR 436-010-0250 in administering the Workers' Compensation Law, including its objective to provide prompt medical treatment for injured workers. ORS 656.012(2)(a).

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.").

Employer argues that the director's general authority under ORS 656.726(4) does not allow her to interfere with an insurer's specific rights under ORS chapter 656. Employer characterizes its right to obtain a consultation following an elective surgery request as an insurer medical examination under ORS 656.325, and points out that there is no requirement in statute to notify the other parties of its intent to seek such an exam within seven days. However, the right to obtain a consultation under OAR 436-010-0250 is treated differently than an insurer medical examination under ORS 656.325. *See* OAR 436-010-0265(5)(c).

In a contested case, the burden of presenting evidence to support a position is on the proponent of the position. ORS 183.450(2). Employer's attorney argued at hearing that he was "in a position of arguing a negative." (Tape of hearing.) He stated that he is unable to find specific statutory authority for the rule in dispute, but offered to argue in response to any such authority argued by opposing counsel. This stance is not enough for employer to meet its burden of proving its position that the director's rule is invalid.

"(b) Requiring attending physicians and nurse practitioners authorized to provide compensable medical services under ORS 656.245 to submit follow-up reports within specified time limits or upon the request of an interested party.

"(c) Requiring examining physicians and nurse practitioners authorized to provide compensable medical services under ORS 656.245 to submit their reports, and to whom, within a specified time.

"(d) Such other reporting requirements as the director may deem necessary to insure that payments of compensation be prompt and that all interested parties be given information necessary to the prompt determination of claims.

"(e) Requiring insurers and self-insured employers to audit billings for all medical services, including hospital services."

Employer's remaining arguments are not well taken. Employer argues that the delay here was not significant -- 14 days late, or 21 days total. Regardless, the rule provides specific time frames and employer is bound to follow them. *See Aetna Casualty & Sur. v. Blanton*, 139 Or App 283 (1996). Further, employer points out, timelines for insurer action in cases not involving elective surgery are much longer: 45 days to pay a bill, 90 days to seek administrative review. That the director has established different time frames for different processes does not support employer's argument that this particular time frame is invalid or unreasonable. Moreover, the timeframes in OAR 436-010-0250 do not conflict with other time frames provided in the rules. Elective surgery disputes are specifically excepted from the time frames provided for administrative review, which allow parties 90 days from the date the party knew or should have known there was a dispute over the provision of medical services to request administrative review. OAR 436-010-0008(6)(c). Employer further contends that the rule effectively abrogates an insurer's 60-day time frame to accept or deny a claim if the elective surgery request requires an assessment of the compensability of the condition to which the surgery is directed. The director disagrees. An insurer can question whether the elective surgery is directed at a compensable condition and still comply with its obligation to respond to the elective surgery request pursuant to OAR 436-010-0250.

In sum, OAR 436-010-0250 is valid. Employer 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). ALJ Myers awarded claimant's attorney a fee of \$2,500. Employer has not objected to the award or amount, and the director affirms.

IT IS HEREBY ORDERED the January 14, 2004 Proposed and Final Contested Case Hearing Order is affirmed.

DATED this 16th day of August, 2004.