

In the ORS 656.327 Medical Treatment Dispute of

STEVEN G. HUMBERT, Claimant

Contested Case No: H05-021

FINAL ORDER

September 30, 2005

ROSEBURG FOREST PRODUCTS, Petitioner

STEVEN G. HUMBERT, Respondent

Before John Shilts, Administrator, Workers' Compensation Division

Respondent claimant, through his attorney Christine Jensen, submitted exceptions to Office of Administrative Hearings Administrative Law Judge Catherine P. Coburn's June 10, 2005 Proposed and Final Order. Petitioner employer, through its attorney R. Ray Heysell, responded. This matter comes before the director for a final order. The issue is whether OAR 436-010-0250(5) is a valid exercise of the director's rulemaking authority under ORS 656.726 and 656.327.¹ Having reviewed the proposed order and the parties' arguments, I reverse.

I adopt the ALJ's findings of fact.

The underlying dispute between the parties is whether a surgery proposed by Christopher Miller, MD -- decompression and fusion revision of L4-5 and L5-S1 -- is appropriate medical treatment for claimant, under ORS 656.327. The Medical Review Unit (MRU), by Administrative Order dated January 31, 2005, found that because employer did not follow the procedure for elective surgery under OAR 436-010-0250, employer was barred from disputing the appropriateness of the surgery under section (5) of that rule. MRU did not make a finding regarding whether the surgery is appropriate, leaving the decision whether to proceed with the surgery with claimant and Dr. Miller, and ordered employer liable for the surgery if performed.

Employer requested a hearing. Concluding that MRU's order reflected an error of law, the ALJ reversed MRU, finding that OAR 436-010-0250 contravenes ORS 656.327 and is invalid.

The statute that applies when the appropriateness of medical treatment is at issue is ORS 656.327. The relevant provisions are as follows:

“(1)(a) If an injured worker, an insurer or self-insured employer or the [d]irector * * * 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.

¹ The relevant portions of the rule and statute are set out below.

“(b) Unless the director issues an order finding that no bona fide medical services dispute exists, the director shall review the matter as provided in this section. * * *

“(c) The insurer or self-insured employer shall not deny the claim for medical services nor shall the worker request a hearing on any issue that is subject to the jurisdiction of the director under this section until the director issues an order under subsection (2) of this section.

“(2) The director shall review medical information and records regarding the treatment. The director may cause an appropriate medical service provider to perform reasonable and appropriate tests, other than invasive tests, upon the worker and may examine the worker. * * * Review of the medical treatment shall be completed and the director shall issue an order within 60 days of the request for review. The director shall create a documentary record sufficient for purposes of judicial review. If the worker, insurer, self-insured employer or medical service provider is dissatisfied with that order, the dissatisfied party may request a contested case hearing before the director pursuant to ORS chapter 183. At the contested case hearing, the administrative order may be modified only if it is not supported by substantial evidence in the record or if it reflects an error of law. No new medical evidence or issues shall be admitted. * * * Review of the director’s order shall be by the Court of Appeals pursuant to ORS chapter 183.”

The process the parties are required to follow when elective surgery is recommended is described in OAR 436-010-0250,² which is as follows:

“(1) "Elective Surgery" is surgery which may be required in the process of recovery from an injury or illness but need not be done as an emergency to preserve life, function or health.

“(2) 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.

“(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

² Effective 4/1/04, WCD Admin. Order 04-055.

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 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 by submitting Form 440-3228, or to timely request administrative review pursuant to this rule shall bar the insurer from later disputing whether the surgery is or 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.

“(7) A recommending physician who prescribes or proceeds to perform elective surgery and fails to comply with the notification requirements in section (2) of this rule, may be subject to civil penalties as provided in ORS 656.254(3)(a) and OAR 436-010-0340.

“* * * * *”

At issue is OAR 436-010-0250(5), insofar as it provides that if the insurer fails to timely respond to the elective surgery request or fails to timely request administrative review the insurer is barred from later disputing whether the surgery was excessive, inappropriate, or ineffectual under ORS 656.327. The ALJ concluded that the rule contravened ORS 656.327(1)(b) and (2), reasoning that those provisions of the statute require MRU to either issue an order finding no

bona fide dispute, or review the medical information and issue an order on the merits. The ALJ stated,

“Implicit in the language of [ORS 656.327] subsection (2) is the requirement that the director make a ruling on the question whether the disputed medical treatment is appropriate, based on the medical information and records. In contrast, under OAR 436-010-0250(5), if an insurer fails to meet certain deadlines, then the director will not make a ruling on the medical appropriateness question. However, ORS 656.327 is mandatory and contains no provision excusing the director from its duty to rule on medical appropriateness disputes. Inasmuch as OAR 436-010-0250 directly contravenes ORS 656.327, the rule is invalid.”

The ALJ remanded the question of whether the proposed surgery is appropriate to MRU.

In response to the ALJ’s proposed order, claimant argues OAR 436-010-0250 does not contravene ORS 656.327. Rather, the rule balances the insurer’s right to review medical treatment with the worker’s need to obtain treatment. Employer argues OAR 436-010-0250 does contravene ORS 656.327 and is invalid.

Contrary to the way in which the ALJ and the parties framed the issue, I find that the issue is better stated as whether OAR 436-010-0250(5) is a valid exercise of the director’s rulemaking authority under ORS 656.726(4) and 656.327. ORS 656.726(4) provides, in part:

“The director hereby is charged with duties of administration, regulation and enforcement of * * * [the Workers’ Compensation Law]. 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.”

Under ORS 656.726(4), the director is charged with administering the workers’ compensation law, and is given the express authority to adopt all rules, including procedural rules, which are reasonably required for the director to exercise her duty of administering the law. ORS 656.327 provides for director review of medical treatment disputes. OAR 436-010-0250 lays out the process the parties are required to follow in order to initiate that review in disputes regarding elective surgery the worker is proposed to receive. Section (5) provides that the insurer in effect defaults if it fails to comply with procedural requirements. As discussed below, such requirements are reasonably required in the administration of ORS 656.327.

Rules adopted under ORS 656.726(4) have been found valid if 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 provides in part:

“(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 * * * ;

“(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 * * *.”

Rules reasonably related to the objectives stated in ORS 656.012 have been upheld. *Rager v. EBI Companies*, 107 Or App 22 (1991), *reconsidering* 102 Or App 457 (1990) (medical services rule did not conflict with ORS 656.012 or 656.245, but was reasonably related to statutory objective and established a reasonable standard). OAR 436-010-0250 is such a rule.

Under the rule, the attending physician³ must give the insurer notice, including medical information substantiating the need for surgery and approximate date and place if known, at least seven days prior to the date of surgery. The insurer may require an independent consultation. The insurer must notify the attending physician and the worker, by submitting a Form 3228 to the attending physician, within seven days of receiving the notice whether or not it desires an independent consultation. The consultation must be completed within 28 days of submitting the form. Within seven days of the consultation, the insurer must notify the attending physician of the consultant’s findings. If the consultant disagrees with the proposed surgery, the attending physician and the insurer must try to resolve areas of disagreement. If appropriate, additional information may be obtained. If the attending physician believes further attempts to resolve the matter with the insurer would be futile, the attending physician must notify the insurer and the worker by returning the Form 3228. If the insurer believes the proposed surgery is excessive, inappropriate, or ineffectual and cannot resolve the dispute with the attending physician, the insurer must request review by the director within 21 days of the physician signing the Form 3228. The insurer may also simply inform the worker of the consultant’s opinion. If the insurer does not request administrative review within 21 days or does not submit Form 3228 within seven days of receiving notice of proposed surgery, the insurer is barred from later disputing whether the surgery was excessive, inappropriate, or ineffectual. If the physician does not give the insurer the required notice at least seven days prior to the proposed surgery, the physician may be subject to civil penalties.

The intent of the rule is to keep the process moving forward, and it provides time frames for each step of the process. The process is reasonably related to the objectives of the Workers’ Compensation Law “[t]o provide * * * sure, prompt and complete medical treatment for injured workers * * *” and “[t]o restore the injured worker physically * * * to a self-sufficient status in an expeditious manner * * *.” ORS 656.012(2)(a), (c).

³ Surgery may be proposed by the attending physician, authorized nurse practitioner, or surgeon upon referral by the attending physician. OAR 436-010-0250(2). This discussion refers only to the attending physician for the sake of simplicity.

The rule allows an insurer the opportunity to get a second opinion. While the insurer only has seven days from the date it receives the elective surgery request in which to decide whether it wants an independent consultation, it has 28 days to obtain the consultation.

Section (4) of the rule also provides for a collaborative process between the parties to attempt to informally resolve any disagreements regarding elective surgery prior to bringing a dispute to the director. This encouragement of collaboration between the parties is reasonably related to the objective of “provid[ing] a fair and just administrative system for delivery of medical * * * benefits to injured workers that reduces litigation and eliminates the adversary nature of * * * proceedings, to the greatest extent practicable.” ORS 656.012(2)(b).

The rule protects the parties while keeping the process in motion. Injured workers get compensable treatment as expeditiously as possible; insurers have the right to challenge that treatment; and physicians are protected against having no one pay for the surgery. The rule does not alter the parties’ rights under the statute; it provides a process for exercising those rights.

Nothing in ORS 656.327(1)(b) and (2) suggests that the director lacks authority to adopt procedural requirements in medical treatment disputes. ORS 656.327 charges the director with the duty to review medical treatment disputes. ORS 656.327 does not, however, provide the procedural parameters for how to bring such a dispute before the director. The director retains the authority and responsibility under ORS 656.726(4) to adopt procedural rules reasonably required to review disputes and reasonably related to the objectives of the workers’ compensation law. OAR 436-010-0250(5) is within the director’s authority and is valid.⁴

Claimant also argues that because insurer failed to follow the rule, no bona fide dispute exists. Claimant’s argument is based on the ALJ’s conclusion that the Medical Review Unit must either issue an order finding that no bona fide dispute exists or issue an order on the merits of the proposed treatment. Because I reject the ALJ’s conclusion, I do not address claimant’s argument.

Dr. Miller recommended elective surgery on September 21, 2004. OAR 436-010-0250(3) required a response within seven days. Employer did not respond until November 17, 2004. Under OAR 436-010-0250(5), employer is now barred from disputing whether the proposed surgery is excessive, inappropriate, or ineffectual.

Claimant has prevailed and his attorney is entitled to a fee under ORS 656.385(1). The Medical Review Unit awarded \$1,460 for prevailing at administrative review. Because claimant did not prevail at hearing, the ALJ awarded no fee.

⁴ The validity of OAR 436-010-0250(5) has been challenged before, and the rule has been upheld. *John D. Foster*, 9 CCHR 1, *aff’d*, 9 CCHR 256 (2004) (in proposed order, ALJ held OAR 436-010-0250 consistent with goals and policy of Workers’ Compensation Law and does not exceed director’s authority to make rules reasonably required to satisfy those goals; in final order, director held OAR 436-010-0250 a valid administration of the Workers’ Compensation Law, including its objective to provide prompt medical treatment for injured workers under ORS 656.012(2)(a)); *Linda C. Richter*, 9 CCHR ___ (2004), *aff’d*, 10 CCHR 252 (2005) (OAR 436-010-0250 does not exceed director’s authority); *Robert A. Shaddy*, 10 CCHR 81 (2005), *exceptions filed* (in proposed order, ALJ held OAR 436-010-0250 does not exceed director’s authority to make rules that satisfy goals of Workers’ Compensation Law).

Claimant's attorney sought \$2,000 for services before MRU, \$2,000 for services at hearing, and seeks \$1,000 for services before the director. However, attorney fee awards under ORS 656.385(1) are limited. They must be proportionate to the benefit to the injured worker, and primary consideration must be given to the results achieved and the time devoted to the case. The director has adopted a matrix that factors in estimated results and time devoted. OAR 436-001-0265, 436-010-0008(13). The total attorney fee award for services at all levels may not exceed \$2000 nor fall outside the ranges in the matrix absent a showing of extraordinary circumstances or agreement of the parties.

Although claimant's attorney argues in favor of her fee request, she does not specifically argue why the limits imposed by ORS 656.385(1) should not apply here. Therefore, I apply the matrix. Claimant's attorney has devoted a total of 12.3 hours to this matter (5.05 before the Medical Review Unit, 4.75 before the ALJ, and 2.5 hours before the director), and the estimated benefit to claimant is in excess of \$10,000. Accordingly, I award the maximum fee of \$2,000 for services at all levels.

IT IS HEREBY ORDERED the June 10, 2005 Proposed and Final Order is reversed and the January 31, 2005 Administrative Order is affirmed. OAR 436-010-0250 is valid.