
In the ORS 656.327 Medical Treatment Dispute of

ERIK J. MORGAN, Claimant

Contested Case No: H04-176

PROPOSED AND FINAL ORDER

June 3, 2005

ROSEBURG FOREST PRODUCTS, Petitioner

ERIK J. MORGAN, Respondent

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

HISTORY OF THE CASE

Insurer appeals the Administrative Order issued on November 3, 2004 by the Medical Review Unit (MRU) of the Workers' Compensation Division (WCD), Department of Consumer and Business Services (department or director). On December 29, 2004, the department referred the matter to the Office of Administrative Hearings (OAH). A hearing was set for February 16, 2005 before Administrative Law Judge Catherine P. Coburn and the parties agreed to submit written argument only. Attorney H. Scott Plouse represented petitioner Roseburg Forest Products (RFP or insurer). Attorney Gerald C. Doble represented respondent Erik J. Morgan (claimant). The record closed on April 27, 2005 following submission of the parties' briefs.¹

ISSUES

1. Pursuant to OAR 436-010-0250, whether insurer is barred from contesting the medical appropriateness of a proposed elective surgery.
2. Whether a diagnostic left wrist arthroscopy and possible fusion, proposed by Scott C. Young, MD, are appropriate medical treatment for the compensable conditions.

EVIDENTIARY RULINGS

WCD Exhibits 1 through 75, as well as insurer's Supplementary Exhibits 78 through 80 are admitted into the record without objection. Insurer's Supplementary Exhibit 81 is admitted into the record over claimant's objection and claimant's motion to reopen the record for a deposition is denied. Claimant's Supplementary Exhibits 29, 33A through 77, 75A, 75a, 75b, and 76 are admitted into the record without objection.

FINDINGS OF FACT

(1) On November 5, 2002, claimant suffered a compensable injury while working as a millwright. (Ex. 8.) A piece of metal tubing weighing approximately 700 pounds fell on his left hand. (Ex. 6-2.) Insurer accepted "crush injury left hand, with laceration of first web space and transection of the thenar muscle." (Ex. 12.)

¹ I allow claimant's motion to strike insurer's final brief for untimely submission.

(2) On December 6, 2002, Douglas A. Bitter, MD, performed surgical repair of the left trapezoid fracture dislocation. (Ex. 14.)

(3) On February 3, 2004, claimant sought treatment from Scott C. Young, MD. (Ex. 40). Dr Young discussed the possibility of surgery pending further testing. Dr. Young's office addressed the letter to several physicians who had treated claimant, but not to insurer. (Ex. 40-3 and 4.)

(4) Claimant designated Dr. Young as his new attending physician. (Ex. 41.) On June 3, 2004, MRU approved Dr. Young as claimant's attending physician. (Exs.49A and 74A.)

(5) On June 18, 2004, Dr. Young informed insurer that he proposed arthroscopic examination of the left wrist with possible fusion. (Ex. 44.) Dr. Young stated,

“[Claimant]’s pain is in the left radial wrist dorsally, left ulnar wrist dorsally and left second CMF joint. He also has aching in the left thumb MP joint. It is not so significant. In reviewing his x-rays, he has torn triquetral lunate and scapholunate ligaments, as well as the damaged trapezoid where the fracture was. He has arthritis around the trapezoid.

“We plan a wrist arthroscopy to determine the next procedure. It will probably be four-corner fusion and trapezoidal fusion. The second CMC joint in particular would need fusion, then other joints around it PRN. We will see what it looks like at surgery. STT fusion was also considered, but we saw a problem with the lunotriquetral joint. Complete wrist fusion is also a possibility if he has radiocarpal arthritis. There was no sign of it.

“We will do this in August. I will see him again a couple of weeks before the surgery.” (Ex. 44-2.)

Dr. Young copied this chart note to insurer and insurer received it on June 30, 2004. (Insurer's opening brief, p. 9.)

(6) On August 19, 2004, insurer sent a letter to Dr. Young acknowledging the surgical request and seeking additional information. (Ex. 51.) On August 31, 2004, insurer verbally informed Dr. Young's office that it disputed the proposed surgery. (Ex. 52.)

(7) On September 3, 2004 insurer sent a Form 440-3228 to Dr. Young stating that it did not request a consultant examination and did not authorize the proposed surgery. (Exs. 54 and 55.) On September 16, 2004, Dr. Young returned the Form 440-3229 indicating his belief that further efforts to reach agreement would be futile. (Ex. 54.)

(8) On September 9, 2004, claimant requested administrative review. (Ex. 59.)

CONCLUSION OF LAW

Pursuant to OAR 436-010-0250, insurer is barred from contesting the medical appropriateness of the proposed left wrist arthroscopy.

OPINION

Jurisdiction lies with the director. ORS 656.327(2). I may modify the administrative order only if it is not supported by substantial evidence in the record or reflects an error of law. ORS 656.327(2) and OAR 436-001-0225(1). The burden of proving a fact or position falls upon the proponent. ORS 183.450(2). As petitioner, insurer bears the burden of proving by a preponderance of evidence that the administrative order is incorrect. *Cook v. Employment Div.*, 47 Or App 437 (1980) (In the absence of contrary legislation, the standard of proof in administrative hearings is preponderance of evidence). Proof by a preponderance of evidence means that the fact finder is persuaded that the facts asserted are more likely true than false. *Riley Hill General Contractors v. Tandy Corp.*, 303 Or 390 (1998).

MRU determined that insurer is liable for the disputed elective surgery. MRU found that Dr. Young perfected the surgery request on June 18, 2004, insurer failed to timely respond, and therefore, insurer was barred from contesting the medical appropriateness of the proposed surgery. Finally, MRU did not reach the question whether the proposed surgery was inappropriate medical treatment.

Insurer contends that it is not barred from contesting medical appropriateness of proposed surgery. In support of its position, insurer argues that Dr. Young was not claimant's attending physician and was not authorized to recommend surgery. Insurer further argues that Dr. Young's June 18, 2004 chart note does not constitute a valid surgical authorization request under OAR 436-010-0250(2). In contrast, claimant contends that the administrative order is correct and should be affirmed. Having reviewed the record, I agree with claimant's position.

Under ORS 656.245² and ORS 656.327,³ the insurer is required to provide medical services for a compensable injury unless the treatment is excessive, inappropriate, ineffectual or in violation of the administrative rules. Additionally, OAR 436-010-0250 provides:

² ORS 656.245(1) provides in pertinent part:

(c) Notwithstanding any other provision of this chapter, medical services after the worker's condition is medically stationary are not compensable except for the following:

(L) Curative care provided to a worker to stabilize a temporary and acute waxing and waning of symptoms of the worker's condition.

³ ORS 656.327(1)(a) provides: 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.

(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 must give the insurer actual notice at least seven days prior to the date of the proposed surgery. Notification must provide 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 must 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 a completed Form 440-3228 (Elective Surgery Notification) to the recommending physician. If the form is not completed the physician is not required to respond. When requested, the consultation must be completed within 28 days after notice to the physician.

(4)(a) Within seven days of the consultation, the insurer must notify the recommending physician of the insurer's consultant's findings.

(c) The recommending physician must notify the insurer, the worker and the worker's representative by signing Form 440-3228 or providing other written notification that further attempts to resolve the matter would be futile.

(5) If the insurer believes the proposed surgery is excessive, inappropriate, or ineffectual and cannot resolve the dispute with the recommending physician, the insurer must 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 a completed Form 440-3228, or to timely request administrative review under this rule shall bar the insurer from later disputing whether the surgery is or was excessive, inappropriate, or ineffectual.**

(Emphasis added.)

The director has held that OAR 436-010-0250 must be strictly applied. *John B. Foster*, 9 CCHR 1 (2004); *on recon* 9 CCHR 256 (2004). See also *Sandra Schneiderman*, 10 CCHR 29 (2005); *Glenn R. Horn*, 9 CCHR 93 (2004), *on recon* 9 CCHR 201 (2004).

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); *Perlenfein and Perlenfein*, 316 Or 16 (1993); *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, Dr. Young was approved as claimant's attending physician on June 3, 2004. Later that month, on June 18, he notified insurer that he proposed to perform surgery, providing medical information substantiating the need for surgery and identifying the approximate date of the surgery as required by OAR 436-010-0250(2).⁴ Insurer received this chart note on June 30. On August 19, insurer sent a letter Dr. Young acknowledging the surgical request and seeking additional information. However, insurer failed to submit a Form 440-3228 to Dr. Young within seven days of receiving the surgical request as required by OAR 436-010-0250(3). Then on September 3, 2004, insurer sent a Form 440-3228 to Dr. Young, more than seven days after it received the surgical request on June 18. Moreover, insurer failed to request administrative review within 21 days of receiving the surgical request as required by OAR 436-010-0250(5). Claimant, rather than insurer, requested administrative review. Consequently, pursuant to OAR 436-010-0250(5), insurer is barred from disputing whether the proposed wrist arthroscopy and possible fusion is excessive, inappropriate or ineffectual. In conclusion, I find that insurer has failed to carry its burden of proving that the administrative order is incorrect, and therefore, I affirm. Finally, inasmuch as insurer's challenge is barred, I do not reach the medical appropriateness question.

ATTORNEY FEES

Claimant has prevailed in a contested case hearing and is entitled to a reasonable attorney fee. ORS 656.385(1). Considering the factors listed in OAR 436-001-0265, I find that \$2,000 is a reasonable fee for claimant's attorney's services in this case.

ORDER

IT IS HEREBY ORDERED that:

1. The Administrative Order dated is affirmed.
2. Insurer shall pay claimant's attorney a fee of \$2,000.

⁴ OAR 436-010-0250(2) does not require the attending physician to submit any particular form when requesting surgical authorization.