

---

In the ORS 656.245 Medical Services of

**Gerardo L. Herrera, Claimant**

Contested Case No: 12-032H

Administrative Order No:

**ORDER ON REMAND**

March 15, 2016

JRP CONSTRUCTION ENTERPRISES, CHARTIS CLAIMS INC., COMMERCE  
AND INDUSTRY INSURANCE COMPANY, Petitioners  
GERARDO L. HERRERA, Respondent

Before Louis Savage, Workers' Compensation Division Administrator

---

Petitioners—JRP Construction Enterprises, Chartis Claims Inc., and Commerce and Industry Insurance Company—filed exceptions in this case to a Proposed Order entered by the Hearings Division of the Workers' Compensation Board on October 3, 2012.

This is a dispute regarding the provision of medical services. Claimant requested Administrative Review by the Workers' Compensation Division's Medical Resolution Team ("MRT") on January 17, 2012, seeking an order directing Commerce and Industry Insurance Company ("insurer") to authorize an evaluation at Craig Hospital "for ongoing [gastrointestinal] problems and neurogenic bowel issues." Administrative Order MS 12-0316 was issued on April 18, 2012, finding that insurer was liable to provide the worker with treatment at Craig Hospital and ordering that attorney fees were due to the claimant's attorney under ORS 656.385(1). Petitioners requested a hearing. ALJ Kekauoha issued a Proposed Order on October 3, 2012, that affirmed the MRT's Administrative Order and concluded that additional attorney fees were due to the claimant's attorney under ORS 656.385(3). Thereafter, petitioners sought the director's review. On February 20, 2013, the director issued a Final Order determining that the dispute was moot because the worker had obtained the desired medical service and insurer had paid all related expenses while the dispute was pending. Petitioners requested that the director abate and reconsider the Final Order. The director issued an Order Abating, dated April 18, 2013, which abated the Final Order pending reconsideration. On July 30, 2013, the director issued an Order After Reconsideration, finding that the Final Order was correct as the substantive issues were moot. Petitioners filed for judicial review of the director's order. On February 25, 2015, the Court of Appeals issued a decision reversing and remanding the director's order. An Appellate Judgment was issued on May 11, 2015.

On review after remand, I affirm the ALJ's Proposed Order, with modification.

### ISSUES

1. Whether the insurer's decision not to grant pre-authorization was a denial of medical services to which claimant was entitled.
2. Whether an insurer has a duty to act to cause medical services to be provided, if the insurer is aware that medical treatment is necessary and that treatment will not be provided without the insurer's intervention.

## FACTUAL AND PROCEDURAL SUMMARY

This medical services dispute comes before me on remand from the Court of Appeals. In that decision, *JRP Construction Enterprises, Inc. v. DCBS*, 269 Or App 372 (2015), the court reversed and remanded a final order of the director that had determined that the dispute was no longer justiciable. I adopt the findings of fact as stated in the MRT's underlying Administrative Order. Those facts and the subsequent procedural history are summarized as follows.<sup>1</sup>

On September 6, 2007, claimant sustained a catastrophic industrial injury. The insurer, through its processing agent, Chartis Claims Inc. ("Chartis"), accepted the following conditions: right wrist distal radius fracture; complete transection of spinal cord at T6-7; T7 complete displegia/paraplegia; and left second, right third, and bilateral fourth, sixth and seventh rib fractures. Claimant saw multiple medical service providers and underwent a battery of tests and treatments for the accepted injury, including treatment at Craig Hospital in Colorado.

The medical services at issue in this case are an evaluation at Craig Hospital "for ongoing [gastrointestinal] problems and neurogenic bowel issues." Claimant's attending physician, Dr. Ugalde, first recommended this evaluation on August 19, 2011, explaining:

"\* \* \* I believe an outpatient rehabilitation followup appointment at Craig Hospital where he was originally rehabilitated would be appropriate at this time. Especially, in light of the fact that his abdominal pain and spine pain is worsening despite treatment. It is preventing him from sitting for extended periods of time. It is also limiting his activities outside of the home. I don't think we can advance him into a work position until we resolve these issues."

On December 20, 2011, claimant, through his attorney, sent a letter to Chartis advising that his attending physician, Dr. Ugalde, had referred him to the Craig Rehabilitation Center and was awaiting approval from Chartis and requesting that Chartis promptly approve the referral or provide a written explanation for its refusal. The letter further requested that Chartis communicate directly with Dr. Ugalde if Chartis had any questions or needed help with the referral.

On January 5, 2012, Chartis, through its attorney, sent a letter to Dr. Ugalde asking her to confirm whether or not she was recommending that claimant seek additional treatment at Craig Hospital. On January 10, 2012, Dr. Ugalde confirmed in writing that she was recommending further treatment at Craig Hospital.

On January 10, 2012, claimant's attorney sent a letter to Chartis' attorney stating that he had received no response to his December 20<sup>th</sup> letter and asking whether the matter needed to be taken to the MRT for resolution. On January 17, 2012, claimant requested Administrative

---

<sup>1</sup> My review of the MRT's order is for "substantial evidence." ORS 656.327(2). I am therefore limited to evaluating the evidence in the record to determine whether, based on that evidence, a reasonable factfinder in the MRT's position could have made the findings that the MRT actually made. *Liberty Northwest Ins. Corp. v. Mundell*, 219 Or App 358, 363 (2008).

Review by the MRT, seeking an order directing Chartis to authorize the requested treatment at Craig Hospital.

On February 6, 2012, in response to claimant's request for Administrative Review, Chartis asserted that claimant's request was moot and should be dismissed. Chartis stated that the treatment recommended by Dr. Ugalde had not been denied and did not require pre-authorization and that claimant was therefore free to pursue the recommended treatment and could then submit any requests for reimbursement, along with any medical bills, for processing by Chartis.

On February 13, 2012, claimant, through his attorney, stated that, although the administrative rules do not require pre-approval of curative medical services, ORS 656.245(1)(a) requires the insurer to "cause to be provided" medical services for conditions caused in material part by the compensable injury. Stating that he was unable to pay for the necessary transportation to the facility or to pay in the event Chartis finds reason not to cover the expenses of the treatment, he asserted that Chartis' failure to indicate whether it will pay for the recommended treatment was effectively preventing him from receiving the treatment in violation of ORS 656.245(1)(a).

On April 18, 2012, the MRT, on behalf of the director, issued Administrative Order MS 12-0316, finding that "Chartis essentially delayed and ultimately denied the worker's treatment" and ordering insurer liable to provide claimant with medical services at Craig Hospital. The MRT found further that claimant was the prevailing party and awarded attorney fees of \$645 to claimant under ORS 656.385(1).

Petitioners then requested a hearing on the matter. ALJ Keith Kekauoha affirmed the MRT's decision, concluding that a request for pre-authorization is a "claim" for "compensation" as those terms are defined under ORS 656.005(6) and (8), that the insurer's refusal to respond to the request was consequently a *de facto* denial of a claim for compensation, and that the insurer had incorrectly denied medical services to the worker. The ALJ further determined that claimant, having established that the compensation awarded under ORS 656.245 (*i.e.*, the aforementioned evaluation at Craig Hospital) should not be disallowed or reduced, was entitled to additional attorney fees of \$2,500 under ORS 656.385(3).

Thereafter, petitioners sought director review of the ALJ's Proposed Order. The director issued a Final Order which determined that the dispute was moot because claimant had obtained the desired medical service and the insurer had paid all related expenses while the dispute was pending.

On judicial review, the Court of Appeals issued a decision that reversed and remanded the director's decision. The court held that "mootness" is an aspect of justiciability concerning the authority of courts to exercise the judicial power conferred by Article VII of the Oregon Constitution. As such, it does not apply to administrative agencies. Alternatively, the court held that if the director dismissed the insurer's request for review under some other concept of mootness created by the agency in the course of carrying out the authority delegated to it by statute, the director failed to articulate a rational connection between the facts of the case and the legal conclusion that was reached. Specifically, in omitting to address whether a ruling in

insurer's favor would require a reversal of the attorney fee awards against insurer, the director's final order failed to articulate a rational connection between the fact that insurer remains subject to those attorney fee awards, and the legal conclusion that the dispute is no longer live.

### CONCLUSIONS OF LAW

Petitioners requests director review of the Proposed Order, contending that the ALJ erred in finding it liable to provide claimant with the recommended treatment at Craig Hospital. Claimant responds that the ALJ's decision is correct and should be affirmed. For the reasons explained below, I affirm the ALJ's decision, with modification.

In the underlying Administrative Order, the MRT noted that after receiving claimant's requests for authorization, Chartis could have (1) designated a doctor of its choice to evaluate the need for further treatment, (2) denied the treatment, or (3) advised Dr. Ugalde that pre-authorization was not needed. Because Chartis only confirmed with Dr. Ugalde that she was still recommending the treatment at Craig Hospital, and otherwise "remained silent," the MRT found that Chartis' response to claimant's request was "unreasonable." The MRT then concluded as follows:

By not responding to [Dr. Ugalde's] and the worker's requests, Chartis effectively denied the worker medical services, as it is well aware the worker is not in the financial position to pay for the necessary transportation to the facility, let alone in the financial position to pay the medical expenses.

The Director finds Chartis essentially delayed and ultimately denied the worker's treatment thereby failing to uphold its statutory obligation, that is, "To provide ... prompt and complete medical treatment for injured workers." The Director further finds Chartis is liable to provide the worker with treatment at Craig Hospital proposed by [Dr. Ugalde].

The Administrative Order was subsequently affirmed. The ALJ concluded that Chartis had *de facto* denied a "claim" for "compensation," reasoning as follows:

An insurer's processing obligation is triggered by the filing of a "claim." A "claim" is defined, in relevant part, as a "written request for compensation from a subject worker or someone on the worker's behalf, \* \* \*." ORS 656.005(6). "Compensation" includes "all benefits, including medical services, provided for a compensable injury \* \* \*." ORS 656.005(8). Based on these statutory definitions, I find that Dr. Ugalde's and claimant's attorney's written requests for approval of the evaluation at Craig Hospital were "claims." Upon receiving notice or knowledge of these claims, Chartis had a statutory duty to timely process the claims, including furnishing written notice of acceptance or denial of the claims, and its refusal to do so constituted a "de facto" denial of the claimed medical service. *SAIF Corp. v. Allen*, 320 Or 192, 211-12 (1994). I therefore conclude that the Director's finding of a "de facto" denial is supported by substantial evidence.

On Director Review, petitioners contend that the ALJ erred in holding the request for pre-approval of treatment as a “claim” for “compensation.” Petitioners assert that the request that Chartis pre-approve the treatment at Craig Hospital was not a “claim” for “compensation” under ORS 656.005(6) and (8), as it is not a bill or a request that the medical service provider be reimbursed for treatment already provided. Consequently, petitioners assert that there is no case law, statute, or rule that required Chartis to issue a formal acceptance or denial in response to a request to pre-approve medical treatment, and that an insurer is permitted to wait to process a claim for medical services until a claimant has obtained medical services and submitted a claim for reimbursement.

Claimant responds that under ORS 656.005(6) and (8) a “claim” is a written request for compensation, and medical services are “compensation.” As a result, claimant contends the ALJ correctly upheld the MRT’s finding that Chartis was obligated to respond to the claimant’s requests for pre-approval of medical services at Craig Hospital, and that by not responding to the requests Chartis effectively denied the requested medical services.

An administrative order in a medical services dispute under ORS 656.245 may be modified at hearing only if it is not supported by substantial evidence in the record or if it reflects an error of law. ORS 656.327(2); *see* OAR 436-001-0225(2). As the party challenging the order, petitioners have the burden to establish that the order is not supported by substantial evidence or reflects an error of law. *E.g.*, *Terry G. Duke*, 17 CCHR 50, 53 (2012). Substantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that finding. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206 (1988).

On review, I affirm the underlying orders but find it unnecessary to address whether a request for pre-approval of medical services is a “claim” for “compensation” under ORS 656.005(6) and (8). Even if it is assumed that claimant’s request for authorization was a “claim” for “compensation” under ORS 656.005(6) and (8), and that Chartis therefore *de facto* denied that claim when it failed to respond within the 60 days required by ORS 656.262(6)(a), I would still be required to determine whether Chartis erred in denying the claimed services. However, Chartis has not conceded the existence of a sufficient causal relationship between the requested medical services and an accepted claim. Ex. 107-1.<sup>2</sup> As a result, I would lack jurisdiction to address the propriety of Chartis’ denial. ORS 656.704(3)(b) (Any dispute that requires a determination of whether a sufficient causal relationship exists between medical services and an accepted claim to establish compensability is a matter concerning a claim to be resolved by the Workers’ Compensation Board). I consequently vacate those portions of the underlying administrative orders addressing Chartis’ alleged *de facto* denial as over-broad.<sup>3</sup>

---

<sup>2</sup> Even though claimant has obtained the desired medical service and the insurer has paid all related expenses, merely paying or providing compensation is not be considered acceptance of a claim or an admission of liability. ORS 656.262(10).

<sup>3</sup> I do not interpret the MRT’s Administrative Order as finding that claimant made a “claim” that was *de facto* denied in violation of the insurer’s claim processing obligations under ORS 656.262(6)(a). When requesting MRT review, the worker specifically cited to the insurer’s duty to cause medical services to be provided under ORS 656.245(1)(a). Ex. 110-1. While the MRT found that Chartis had “effectively denied” the worker medical services, it did not describe claimant’s request for authorization as a claim or state that Chartis had violated its claim processing obligations under ORS 656.262(6)(a).

Rather, the dispute in this case is most appropriately resolved under ORS 656.245(1)(a), as I find that insurer failed to uphold its statutory obligation to “cause” medical services “to be provided.”<sup>4</sup>

ORS 656.245(1)(a), in relevant part, provides as follows:

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, \* \* \*.

(Emphasis added). As a matter of interpretation, I must construe the statute in a way that does not render any terms superfluous or meaningless. *See* ORS 174.010 (rule of statutory construction is not to insert what has been omitted, or to omit what has been inserted; and where there are several provisions or particulars such construction is, if possible, to be adopted as will give effect to all); *see also Crystal Communications, Inc. v. Dept. of Rev.*, 353 Or 300, 311 (2013); *State v. Stamper*, 197 Or App 413, 418 *rev den*, 339 Or 230 (2005).

The verb form of “cause” commonly means “to serve as cause or occasion of; bring into existence; make” or “to effect by command, authority, or force.” Webster’s Third New Int’l 356 (unabridged 2002). As a result, the plain language of ORS 656.245(1)(a) provides that an insurer shall serve as the cause of the provision of medical services, or effect the provision of medical services by command, authority, or force.

As petitioners correctly note, the compensability of a medical service is finally determined only after the service is performed. ORS 656.283 and 656.327 both allow an insurer to raise a challenge to the compensability of a medical service after the service has been performed. ORS 656.283(1) (a party may request “at any time” a request for hearing on any matter concerning a claim, including matters under ORS 656.704(3)(b)(A) and (C)); ORS 656.327(1)(a) (a party may assert that the medical service that the injured worker “has received” is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services). Nevertheless, under both of the potential plain language meanings described above, the duty described by ORS 656.245(1)(a) is prospective and affirmative; the insurer shall

---

The order also stated that Chartis could have responded to claimant’s request by informing Dr. Ugalde that pre-authorization was not needed; if the MRT had concluded that claimant’s request for authorization was a claim, Chartis would have been limited to a choice between acceptance or denial of that claim under ORS 656.262(6)(a). As such, I interpret the MRT’s statement as a factual finding that Chartis’ inaction was effectively preventing the worker from receiving treatment, not a legal conclusion that Chartis had *de facto* denied a claim for compensation. Nevertheless, to the extent that the MRT’s Administrative Order found that Chartis *de facto* denied a “claim” under ORS 656.262(6)(a), it is hereby modified.

<sup>4</sup> For the reasons described in the opinion below, I conclude that ORS 656.245(1)(a) most specifically addresses the dispute before me: whether an insurer has a duty to act to cause medical services to be provided, if the insurer is aware that medical treatment is necessary and that treatment will not be provided without the insurer’s intervention. The resolution of such a dispute is not dependent on a determination of whether claimant’s communications requesting authorization amounted to a “claim” for “compensation” under ORS 656.005(6) and (8).

serve as the cause of the provision of medical services, or effect the provision of medical services by command, authority, or force. In order to give full effect to ORS 656.245(1)(a), 656.283(1), and 656.327(1)(a), and so as to not render the phrase “cause to be provided” meaningless, I interpret ORS 656.245(1)(a) as imposing a duty to facilitate the provision of medical services, separate from and in addition to the duty to accept or deny a “claim” under ORS 656.262(6)(a). Thus, the obligation to cause medical services to be provided under ORS 656.245(1)(a) does not require the insurer to make a final determination as to the compensability of a requested medical service, but it does impose an affirmative and continuing duty to take action, as necessary, to supply an injured worker with medical treatment that is prompt and adequate. To read the insurer’s processing obligations as petitioners suggest, as applicable only to medical services that have already been provided, would render the phrase “cause to be provided” meaningless and superfluous.<sup>5</sup>

The above interpretation of ORS 656.245(1) is consistent with the legislature’s usage of a similar provision in ORS 656.340(1). ORS 656.340(1) states that an insurer “*shall cause vocational assistance to be provided* to an injured worker who is eligible for assistance in returning to work.” (Emphasis added). In furtherance of that purpose, the insurer must contact a potentially eligible worker for evaluation of the worker’s eligibility for vocational assistance and cause an individual certified by the director to determine whether the worker is eligible for vocational assistance. ORS 656.340(1)–(4). As in ORS 656.340(1), I interpret the “cause to be provided” sentence structure in ORS 656.245(1)(a) as an indication of the legislature’s intent to impose an obligation on the insurer to facilitate the provision of workers’ compensation benefits, even before eligibility for the related benefit can be finally determined.

Such a reading of ORS 656.245(1)(a) is also consistent with the legislative policy of ORS chapter 656, as expressed in ORS 656.012. Under ORS 656.012(2)(a), it is the objective of the Workers’ Compensation Law to provide sure, prompt, and complete medical treatment for injured workers. Under ORS 656.012(2)(c), it is the objective of the Workers’ Compensation Law to restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable. A duty to facilitate the provision of medical services helps to accomplish each of those goals; by working with the worker and medical providers to remove hindrances to the provision of medical services, an insurer can help to ensure the provision of prompt medical treatment and the expeditious recovery of injured workers. *Cf. Evans v. State Acc. Ins. Fund Corp.*, 62 Or App 182, 186–87 (1983).<sup>6</sup>

---

<sup>5</sup> Petitioners’ reading of the statute is also inconsistent with traditional concepts of workers’ compensation law, as it would place the obligation to find and procure medical care on the worker. *See* Larson’s Workers’ Compensation, §§ 94.02(4)(a) and (b) (Desk Edition 2003) (employer has affirmative and continuing duty to provide prompt and adequate medical care).

<sup>6</sup> In *Evans*, the Court of Appeals held that a physician’s report that enumerated claimant’s present problems regarding a prior compensable injury and requested insurer pre-authorization for diagnostic medical services constituted a *prima facie* valid claim for medical services. *Evans*, 62 Or App at 186. As a result, the insurer had a duty to authorize the requested diagnostic evaluation, issue a denial of the claim, or have a doctor of its choice evaluate the need of further treatment and the causal relationship to the industrial injury. *Id.* The court concluded that, “Such an interpretation of the duty imposed by ORS 656.245 promotes the policy underlying the Workers’ Compensation law ‘to provide \* \* \* prompt and complete medical treatment for injured workers.’” *Id.* at 187 (omissions in original).

By contrast, petitioners' understanding of an insurer's processing obligations under ORS 656.245(1)(a) creates a catch-22 for a worker in claimant's circumstances: If the worker lacks the means to independently procure recommended medical treatment the worker is reliant on the insurer to cause treatment to be provided, but the insurer need not act to cause treatment to be provided until the worker has received treatment and submitted a claim for reimbursement. Thus, under petitioners' understanding of the statute, claimant is without practical or administrative remedy. I find nothing in the Workers' Compensation Law that would permit such an outcome. *Cf.* ORS 656.012(2)(b) (it is the objective of the Workers Compensation Law to provide a fair and just administrative system for delivery of medical and financial benefits to injured workers).

Finally, interpreting ORS 656.245(1)(a) to impose an obligation on workers' compensation insurers to facilitate the provision of medical services is consistent with the regulatory context. The Workers' Compensation Division's administrative rules state that physicians may request pre-authorization in certain circumstances and the insurer must respond, however, the insurer is not required to make a formal determination as to the compensability of the requested service. Under OAR 436-010-0250, a physician may recommend and request pre-approval of elective surgery. Upon receipt of the request, the insurer must approve the surgery, obtain an independent consultation with a physician of the insurer's choice, or request an administrative review by the director if the insurer believes the proposed surgery is excessive, inappropriate, or ineffectual. When the insurer's consultant disagrees with the proposed surgery, the recommending physician and insurer should endeavor to resolve any issues raised by the insurer's consultant's report. Failure to approve or dispute the recommended surgery bars the insurer from later disputing whether the surgery is or was excessive, inappropriate, or ineffectual. Under *current* OAR 436-010-0230 and 436-010-0270,<sup>7</sup> a physician may recommend and request pre-approval of certain diagnostic imaging studies. The insurer must respond to the provider's request in writing whether the service is pre-authorized or not pre-authorized within 14 days of receipt of the request. However, pre-authorization is not a guarantee of payment. Thus, the administrative rules are consistent with an interpretation of ORS 656.245(1)(a) that imposes an obligation on workers' compensation insurers to facilitate the provision of medical services, as the rules provide that there are circumstances in which an insurer has a duty to take action before medical services are performed and before a formal determination of compensability is required.<sup>8</sup>

---

While *Evans* is factually similar to the current case, and similarly interprets the interaction of an insurer's processing obligations under ORS 656.245 and the legislative policy expressed in ORS 656.012(2), I do not find it dispositive in the resolution of this dispute. Most significantly, in holding that the physician's report constituted a *prima facie* valid claim for medical services, the court found that the claimant had met his burden of proving that the proposed diagnostic service was causally related to his compensable industrial injury. That is not a determination I am authorized to make. ORS 656.704(3)(b).

<sup>7</sup> Pre-authorization requirements for diagnostic imaging studies were added in Administrative Order No. 14-053, effective April 1, 2014. The rules are not offered here as evidence of the administrative rules applicable to this dispute, but rather as an example of the director's understanding of an insurer's duty to provide medical services under ORS 656.245(1)(a).

<sup>8</sup> The administrative rules describe certain circumstances in which this duty exists, but there is no indication that the rules are intended to address all situations in which the insurer has a duty to cause medical services to be provided, to the exclusion of any situation not explicitly identified. Rather, the duty exists as stated in ORS 656.245(1)(a): the insurer has a duty to cause medical services to be provided.

The director's authority to interpret and enforce ORS 656.245(1) is not limited to promulgation of and compliance with administrative rules. The director is statutorily authorized to administer and enforce

In sum, while the statutes do not explicitly require an insurer to pre-authorize medical service, such action may be necessary to “cause to be provided medical services” under ORS 656.245(1)(a). That duty to “cause to be provided medical services” is interpreted, as applicable to specific classes of medical services, in administrative rule at OAR 436-010-0230, 436-010-0250, and 436-010-0270, but may otherwise be applied by administrative order on a case-by-case basis. *Ross v. Springfield School Dist. No. 19*, 294 Or 357, 368-69 (1982) (when applying terms of complete legislative expression, an agency may interpret statutory standards either by an interpretive rule or by order in a contested case); *Springfield Education Association v. Springfield School District*, 290 Or 217, 226 (1982) (same).

In fact, the Workers’ Compensation Division has applied the insurer’s duty to “cause to be provided medical services” on several occasions. See *Agnes K. Foster*, 12 CCHR 115 (2007) (up-front costs required to receive prescription medication; worker was unable to pay up-front costs; insurer had obligation to implement method of payment that did not result in up-front expenses for the worker); *Rena C. Cherrick*, Order MS 15-0080 (up-front costs required to receive prescription medication; worker was unable to pay up-front costs; insurer had obligation to implement method of payment that did not result in up-front expenses for the worker); *Miguel Bello-Arzate*, Order MS 14-0897 (up-front costs required to receive prescription medication, however, worker did not show inability to pay the up-front costs); *Jerry Kirby*, Order MS 10-0627 (up-front costs required to receive prescription medication; worker was unable to pay up-front costs; requested medication was compensable and, if provided, reimbursable); *Andrew May*, Order MS 11-0901 (physician would not proceed with neurosurgical consultation without prior authorization; requested consultation was compensable and, if provided, reimbursable). In reviewing those cases, two principles regarding the application of that duty begin to emerge: First, insurers shall “cause to be provided” medical services, and find alternative solutions, if need arises due to the inability of the worker to receive a recommended and potentially compensable medical service. Second, that if the insurer fails to take action in furtherance of its duty, and fails to take steps to resolve hindrances to the provision of medical services, the director may fashion a remedy to cause the service to be provided.

Turning to the case at hand, I find that Chartis, on behalf of insurer, failed in its obligation to “cause to be provided” medical services. I also find that the MRT appropriately directed Chartis to provide payment for the requested services at Craig Hospital.

In the underlying Administrative Order, the MRT concluded that Chartis’ refusal to respond was effectively preventing the claimant from moving forward with the proposed treatment at Craig Hospital. Ex. 113-5. That finding was supported by substantial evidence. Dr. Ugalde’s chart notes and communications to claimant and Chartis indicate that she continued to recommend the claimant’s evaluation by Craig Hospital but was awaiting approval from Chartis.

---

ORS 656.245(1) on a case-by-case basis in the contested case process. The director may choose to interpret legislative policy already expressed in the statute in a contested case adjudication, without first promulgating an administrative rule for every potential application under the statute. *Ross v. Springfield School Dist. No. 19*, 294 Or 357, 368-69 (1982) (when applying terms of complete legislative expression, an agency may interpret statutory standards either by an interpretive rule or by order in a contested case); *Springfield Education Association v. Springfield School District*, 290 Or 217, 226 (1982) (same).

Exs. 77-6 and 77-8. Chartis was also given sufficient reason to believe that claimant was not able to pay costs for the services or transportation to the facility.<sup>9</sup>

On that factual basis, I conclude that Chartis, on behalf of insurer, failed in its obligation to “cause to be provided” medical services. Chartis was aware that claimant’s efforts to obtain the requested treatment at Craig Hospital had reached an impasse. It was also aware that medical treatment was necessary and that the need for medical treatment was potentially related to claimant’s compensable injury. Under ORS 656.245(1)(a), Chartis had a duty to take action to facilitate the provision of the requested services. Importantly, that action did not need to be a formal acceptance or denial. As noted by the MRT, Chartis could have taken steps to investigate the merits of the referral, such as designating a doctor of its choice to evaluate the need for further treatment. Chartis also could have investigated the obstacles hindering the provision of the proposed services, by contacting Craig Hospital or Dr. Ugalde. It may have even been possible to supply alternative treatment options. Instead, Chartis did nothing. Like the MRT, I find Chartis’ inaction unreasonable, and in violation of its duty to “cause to be provided medical services” under ORS 656.245(1)(a).

Finally, since Chartis did not take action to resolve the issue, I find that the MRT was within its authority to direct Chartis to take appropriate action to facilitate the provision of the requested medical treatment. When requesting administrative review, the worker specifically cited to the insurer’s duty to cause medical services to be provided under ORS 656.245(1)(a). Ex 110-1. Chartis contended that it had no duty to act or respond until services had been rendered and a bill for the services had been submitted. Ex. 104-1. Thus, there was a dispute arising under ORS 656.245, relating to Chartis’ duty to cause medical services to be provided, which the MRT had authority to resolve under ORS 656.704(2) and (3). Since the MRT determined, as I have here, that the insurer violated its duty by taking no action, the logical resolution of the dispute was to direct Chartis to take an action that would comply with its processing obligations. The MRT concluded that it was appropriate to direct Chartis to pay for claimant’s evaluation at Craig Hospital. I agree, as that resolution was reasonably fashioned to facilitate the provision of claimant’s medical treatment. Lastly, contrary to petitioners’ assertions, that resolution did not eliminate the insurer’s rights under ORS 656.283(1) and 656.327(1)(a), because payment for medical expenses does not estop an insurer from later contesting the compensability of the treatment received. ORS 656.262(10); *Evans*, 62 Or App at 187–88.

I reiterate that I do not conclude that an insurer must issue a formal written acceptance or denial in response to a request for pre-approval of medical treatment. Rather, my conclusions are three-fold: (1) ORS 656.245(1)(a) imposes a duty to facilitate the provision of medical services, separate from and in addition to the duty to accept or deny a “claim” under ORS 656.262(6)(a);

---

<sup>9</sup> On February 13, 2012, claimant, through his attorney, stated that he was unable to pay for the necessary transportation to the facility or to pay in the event Chartis found reason not to cover the expenses of the treatment, and that Chartis’ failure to indicate whether it would pay for the recommended treatment was effectively preventing him from receiving the treatment. Ex 110-1. Chartis was also aware of the severity of the claimant’s physical disabilities and of the difficulties he was experiencing in finding a work position. In fact, the treatment at Craig Hospital was requested, in part, to address worsening spine pain and neuropathic pain that was limiting claimant’s activities outside of the home and undermining claimant’s ability to advance into an appropriate work position. Ex. 77-2.

(2) An insurer violates that duty when, as in this case, the insurer fails to act to facilitate the provision of medical treatment, even though the insurer is aware that medical treatment is necessary and that treatment will not be provided without the insurer's intervention; and (3) If the insurer fails to take action in furtherance of its duty, and fails to take steps to resolve hindrances to the provision of medical services, the director may fashion a remedy to cause the service to be provided.

Because this review was initiated by insurer and I have found that the compensation awarded under ORS 656.245 (*i.e.*, payment for the aforementioned evaluation at Craig Hospital) should not be disallowed or reduced, claimant's attorney is entitled to a reasonable attorney fee payable by insurer for time spent for legal representation by an attorney at this level of review. ORS 656.385(3). In a statement of services, submitted February 23, 2016, claimant's attorney states he did no further briefing in this matter. After considering the factors in OAR 436-001-0400(3), and assuming that claimant's attorney spent 1–2 hours on procedural matters and considerations (*see* OAR 436-001-0400(2)), I find that a reasonable attorney fee for claimant's attorney's services is \$500.00.<sup>10</sup> In addition, because I affirm the compensation awarded in the underlying administrative orders, I also uphold the attorney fees awarded by the MRT and Hearings Division. Pursuant to ORS 656.313(1)(b), those fees shall accrue interest at the rate provided in ORS 82.010 from the date of the order appealed from through the date of payment.<sup>11</sup>

### **IT IS HEREBY ORDERED**

1. Petitioners' request for relief is denied, and the Director's Administrative Order MS 12-0316 dated April 18, 2012, and the Proposed Order dated October 3, 2012, are affirmed.
2. Claimant's attorney is awarded an additional assessed attorney fee of \$500.00, to be paid by Chartis, on behalf of the insurer.

---

<sup>10</sup> Because claimant's attorney's statement of services does not address time spent relative to the Final Order issued February 20, 2013, the Order Abating issued April 18, 2013, or the Order After Reconsideration issued July 30, 2013, I do not consider whether it would be appropriate to award attorney fees under ORS 656.385(3) for time spent for legal representation related to those matters.

<sup>11</sup> ORS 656.313(1)(b) was amended by House Bill 2764. That amendment is applicable to orders issued and attorney fees incurred on or after January 1, 2016. 2015 Oregon Laws Ch. 521 (H.B. 2764).