Preauthorization of medical treatment in Oregon: Your obligation is now clear as mud

By Matthew Fisher ■ July 7, 2016

In the last few years, the Department has provided conflicting information about a carrier's obligation to preauthorize medical treatment other than for diagnostic imaging, elective surgery and palliative care. An Oregon Administrative Law Judge's (ALJ) Proposed and Final Order based on a 2009 decision[1], which cited a 1993 Department case, had confirmed the insurer was "not required to preauthorize curative medical services unless the requested service involves a [service specifically requiring a response]." Another 2009 case[2] confirmed an insurer does not need to preauthorize imaging studies, although this case was decided prior to the Department's more recent rule requiring preauthorization for this specific medical service.

Contradicting these decisions, a complex procedural dispute through the Court of Appeals resulted in the Director issuing a March 2016 decision in *Gerardo L. Herrera.*[3] Here, claimant's attending physician requested preauthorization for an evaluation by a different medical provider. This secondary provider refused to perform this evaluation unless it was preauthorized by the insurer. Furthermore, claimant stated he was unable to travel to the evaluation without assurance of reimbursement for travel.

The Medical Resolution Team pointed to language in ORS 656.245(1)(a) stating a carrier has an obligation to "cause to be provided" medical services for a worker. An ALJ took the argument one step further on appeal and concluded such requests constitute a "claim" and therefore required a formal acceptance or denial within 60 days. The Director's final Order on Remand disavowed the statement that such requests are considered "claims" for the purpose of necessitating a formal acceptance or denial under ORS 656.262(6)(a). However, the Director nonetheless concluded a carrier has an affirmative obligation to ensure a worker is not prevented from obtaining necessary medical treatment.

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The problem lies in the Director's suggestion that such situations may be evaluated on a case-by-case basis. The Director does not provide clear direction about what a carrier must do upon receipt of requests for preauthorization of certain services for which preauthorization is not otherwise specifically required. Language in this decision suggests a carrier must, at a minimum, advise the physician he or she is not obligated to preauthorize treatment and will process bills upon receipt. However, this leaves two critical questions: what

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Preauthorization is as clear as mud (continued)

if the provider states she will not provide treatment or evaluation without specific preauthorization (or even guarantee of payment)? What if a worker demands prepayment of travel expenses for travel to his pharmacy, physician or physical therapist?

The Director's recent order skirts these questions by simply saying the carrier must work to fashion an alternative remedy if refusing preauthorization means the worker will not be able to obtain the treatment. Presumably, this is why the Director then concludes such situations will be evaluated on a case-by-case basis. The dilemma is that carriers are left with very little direction and making the "wrong" choice could expose carriers to thousands of dollars in assessed attorney fees and litigation costs.

Herrera was not appealed further; there is a decent probability the issue will need to be revisited on narrower facts with a different case. We therefore recommend that claims examiners contact their defense counsel to discuss requests for preauthorization when not otherwise mandatory.

The attorneys at Reinisch Wilson Weier PC are available to discuss these situations as they arise in hopes of navigating this new potential minefield. ■

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[1] Janine D. Jones, 14 CCHR 36 (2009)

[2] Augosto Sanchez-Lopez, 14 CCHR 131 (2009)

[3] Gerardo L. Herrera, 21 CCHR 13 (March 15, 2016)