

No. 50130-9-II

COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

DEPARTMENT OF LABOR & INDUSTRIES
OF THE STATE OF WASHINGTON,
Appellant,

v.

RONALD V. MA'AE,
Respondent.

BRIEF OF RESPONDENT

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I. INTRODUCTION

A.) The Industrial Insurance Act

This case arises out of a workplace injury and thus the Industrial Insurance Act of the State of Washington (Hereinafter "Act") applies by and through RCW Title 51. The Act, enacted in 1911, differs substantially from other administrative laws in that it essentially did away with the common-law system governing the remedy of workers against employers for injuries received in the course of their employment.

The common law system governing the remedy of workers against employers for injuries received in employment is inconsistent with modern industrial conditions. In practice it proves to be economically unwise and unfair. Its administration has produced the result that little of the cost of the employer has reached the worker and that little only at large expense to the public. The remedy of the worker has been uncertain, slow and inadequate. Injuries in such works, formerly occasional, have become frequent and inevitable. The welfare of the state depends upon its industries, and even more upon the welfare of its wage worker. The state of Washington, therefore, exercising herein its police and sovereign power, declares that all phases of the premises are withdrawn from private controversy, and sure and certain relief for workers, injured in their work, and their families and dependents is hereby provided regardless of questions of fault and to the exclusion of every other remedy, proceeding or compensation, except as otherwise provided in this title; and to that end all civil actions and civil causes of action for such personal injuries and all jurisdiction of the courts of the state over such causes are hereby abolished, except as in this title provided.

RCW 51.04.010 Declaration of police power-Jurisdiction of courts abolished

Because injured workers gave up any other remedy in this “grand bargain,” the Courts have liberally construed the provisions of the Act since its inception.

RCW 51.04.010 embodies these principles, and declares, among other things, that "sure and certain relief for workers, injured in their work, and their families and dependents is hereby provided [by the Act] regardless of questions of fault and to the exclusion of every other remedy." To this end, the guiding principle in construing provisions of the Industrial Insurance Act is that the Act is remedial in nature and is to be liberally construed in order to achieve its purpose of providing compensation to all covered employees injured in their employment, with doubts resolved in favor of the worker.

Dennis v. Dep't of Labor & Indus., 109 Wn.2d 467, 745 P.2d 1295, (1987) citing RCW 51.12.010; *Sacred Heart Med. Ctr. v. Carrado*, 92 Wash.2d 631, 635, 600 P.2d 1015 (1979); *Lightle v. Dep't of Labor & Indus.*, 68 Wash.2d 507, 510, 413 P.2d 814 (1966); *Wilber v. Dep't of Labor & Indus.*, 61 Wash.2d 439, 446, 378 P.2d 684 (1963); *State ex rel. Crabb v. Olinger*, 196 Wash. 308, 311, 82 P.2d 865 (1938); *Gaines v. Dep't of Labor & Indus.*, 1 Wash.App. 547, 552, 463 P.2d 269 (1969). See also *Montoya v. Greenway Aluminum Co.*, 10 Wn. App. 630, 634, 519 P.2d 22 (1974).

It is not any particular portion of Title 51 that is to be liberally construed. Rather, it is the entire statutory scheme that receives the benefits of liberal construction. Each statutory provision should be read in reference to the whole act. “We construe related statutes as a whole, trying to give

effect to all the language and to harmonize all provisions.” *Guijosa v. Wal-Mart Stores, Inc.*, 101 Wn. App. 777, 792, 6 P.3d 583 (2000), *aff’d*, 144 Wn.2d 907, 32 P.3d 250 (2001).

“Ambiguous statutory language ... should be construed in the manner ‘best advanc[ing] the perceived legislative purpose.’ Title 51’s overarching objective is ‘reducing to a minimum the suffering and economic loss arising from injuries and/or death occurring in the course of employment.’ ... Also, on a practical level, this court has recognized that the workers’ compensation system should continue ‘serv[ing] the goal of swift and certain relief for injured workers.’” *Cockle v. Dep’t of Labor & Indus.*, 142 Wn.2d 801, 16 P.3d 583, (2001), *citing* *Wichert v. Cardwell*, 117 Wash.2d 148, 151, 812 P.2d 858 (1991), RCW 51.12.010 & *Weyerhaeuser Co. v. Tri*, 117 Wash.2d at 138, 814 P.2d 629 (1991).

B.) The Provider Network

In the century after the grand bargain of 1911 the courts of Washington have reiterated liberal construction of Title 51 in order to provide swift and certain relief to injured workers. In 2011 the legislature passed Senate Bill 5801 (hereinafter SB5801) which created the provider network. In its preamble the bill states, “high quality medical treatment and adherence to occupational health best practices can prevent disability and reduce loss of family income for workers and lower labor and insurance

costs for employers. Injured workers deserve high quality medical care in accordance with current health care best practices. To this end, the department shall establish minimum standards for **providers who treat workers** from both state fund and self-insured employers. The department shall establish a health care **provider network to treat injured workers**, and shall accept providers into the network that meet the minimum standards. *SB 5801, 2011 Regular Session* (emphasis added).

Prior to consideration of SB5801, injured workers were able to see a doctor of their choice. In the original version of the bill, the legislature proposed requiring injured workers to see only network providers for all medical examinations. S-1390.1 Sec. 1 (2)(a) (CP 73). However, in the bill that passed the senate and amended RCW 51.36.010 the wording was changed to allow an injured worker to see a non-network provider for an initial office or emergency room visit. S-1771.1 Sec. 1 (2)(a) (CP 81). The bill went on to task the Department with establishing the network, including allowing it to promulgate rules related to the new network. S-1771.1 Sec. 1 (10) (CP 86). While establishing the new provider network, the Department of Labor and Industries (hereinafter Department) amended WAC 296-14-400 (Reopenings for Benefits) to require that only a network provider could provide documentation for a reopening application. (CP 91). It is this amendment to WAC 296-14-400 that is at the crux of this appeal.

II. STATEMENT OF ISSUES

1. Whether the provision in WAC 296-14-400 that limits the filing of an application to reopen to network providers is a Department interpretive rule and, therefore, not binding on the courts or the public?
2. Whether RCW 51.36.010 prohibits a non-network provider from completing and filing an application to reopen a claim for aggravation?
3. Whether Mr. Ma'ae submitted medical evidence with his application to reopen?

III. STATEMENT OF THE CASE

Ronald V. Ma'ae (hereinafter Mr. Ma'ae) sustained an industrial injury on January 19, 2007. (CP 101). Following the injury, he sought medical attention and filed an application for benefits with the Department (CP 101). The Department allowed the claim on February 5, 2007. (CP 101). Finding Mr. Ma'ae was at maximum medical improvement, the Department issued an Order closing the claim on July 24, 2009. (CP 101).

Believing that his condition had worsened, on April 14, 2014, Mr. Ma'ae filed an application to reopen his claim for aggravation of his industrial injury. (CP 102). On September 5, 2014, the Department issued an Order denying the reopening application on the basis that no medical documentation had been provided to the Department. (CP 102). On that same date, the Department sent a letter to Mr. Ma'ae advising him that his

reopening application had been denied because the doctor listed on his reopening application, Dr. H. Richard Johnson, was not a member of the Department's provider network. (CP 102). Mr. Ma'ae appealed on September 30, 2014 to the Board of Industrial Insurance Appeals (hereinafter Board). (CP 102).

The Department filed a Motion for Summary Judgment dated March 6, 2015, arguing that there was no issue of material fact because it was uncontested that Dr. Johnson was not a network provider. (CP 102 & 120). The Department further argued that the Board did not have the authority to determine the validity of the rules promulgated by the Department under the authority of the legislature. (CP 121).

Mr. Ma'ae argued that the promulgation of WAC 296-14-400 conflicted with the underlying statute, RCW 51.36.010, and therefore, the Department had exceeded its authority when it determined that reopening applications could only be completed by network providers. (CP 121). Mr. Ma'ae also argued that there was an issue of material fact in that he was contending that his industrial injury had become aggravated and he had provided adequate medical documentation to support his claim and, therefore, liberal construction of Title 51 called for his case to be heard on its merits. (CP 121).

Oral arguments were heard by Industrial Appeals Judge Kathleen Stockman (hereinafter IAJ) on April 6, 2015. (CP 100). On June 25, 2015, the IAJ issued her Proposed Decision and Order granting the Department's motion for Summary Judgment, and holding that because Dr. Johnson was not a member of the provider network he could not complete and file a reopening application pursuant to WAC 296-14-400 and RCW 51.36.010. (CP 122).

Mr. Ma'ae appealed the IAJ's decision to the Board. (CP 100). On November 23, 2015, the Board reversed and remanded, holding that WAC 296-14-400 was an interpretive rather than a legislative rule, and therefore, not a binding determination by the Department regarding who may file an application to reopen. (CP 25) The Board found that RCW 51.36.010 and RCW 51.32.160 did not limit the authority to file an application to reopen to Department network providers. (CP 25). The Board further found that the reopening application filed by Mr. Ma'ae was a valid application and remanded it to the Department to consider the medical information, including the information received from Dr. Johnson, and to issue a further order allowing or denying the reopening application. (CP 26). The Department appealed that decision to Pierce County Superior Court. (CP 1)

Concurrent to his Petition for Review to the Board, Mr. Ma'ae also filed a Petition for Judicial Review and Declaratory Judgment with

Thurston County Superior Court. (CP 43). Mr. Ma'ae contended that WAC 296-14-400 conflicts with RCW 51.36.010 in that it exceeds the authority granted the Department under the statute and interferes with and impairs his rights under RCW 51.36.010 to seek care from a non-network provider for an initial office or emergency room visit. (CP 46).

The Department filed a motion to change venue in their appeal of the Board's decision to Pierce County Superior Court to consolidate that case with Mr. Ma'ae's Petition for Judicial Review and Declaratory Judgment in Thurston County Superior Court. Mr. Ma'ae opposed the motion, arguing that the cases involved two separate and distinct issues. (Not included in Clerk's Papers).

Mr. Ma'ae argued that the issue before the Pierce County Superior Court was whether the Board was correct in determining that the requirement that reopening applications be completed by network providers in WAC 296-14-400 was an interpretive rule and, therefore, the Board had the discretion to disregard it. Because the Board, as stated in its November 23, 2015 decision, (CP 25-26) did not have the authority to determine the legality of the Department's legislative rules, any decision made in Pierce County Superior Court would not reach the validity of WAC 296-14-400.

Mr. Ma'ae argued that the issue before the Thurston County Superior Court was whether the Department overstepped the authority

granted it in RCW 51.36.010 in promulgating WAC 296-14-400? But a determination by the Thurston County Superior Court that the Department had indeed overstepped its bounds in promulgating WAC 296-14-400, would not reach the issue of whether the Board was correct in determining that the rule was interpretive and that the Board had the authority to disregard it.

Arguments in Thurston County were heard by the Honorable Judge Mary Sue Wilson on September 23, 2016. Judge Wilson entered an order finding that (1) WAC 296-14-400 did not exceed the statutory authority of the Department under RCW 34.05.570(2)(c), (2) WAC 296-14-400 was not arbitrary and capricious under RCW 34.05.570(2)(c), and (3) that WAC 296-14-400 was a valid rule, and an order was so entered on October 20, 2016. (CP 315-316). Mr. Ma'ae has appealed that decision to this Court under Cause No. 49659-3.

The Honorable Judge Frank E. Cuthbertson in Pierce County Superior Court denied the Department's Motion for a Change of Venue. After briefing and oral arguments were made before Judge Cuthbertson, he affirmed the Board's decision on December 20, 2016 in Pierce County Superior Court. (CP 323-325). The Department appealed that decision to this Court and it is the issues raised by the Board's November 23, 2015 decision and the Pierce County Superior Court's December 20, 2016

affirmation of that decision that are before this tribunal in this appeal. (CP 331).

IV. SUMMARY

As stated by Judge Cuthbertson in his decision on the Department's appeal of the Board's November 23, 2015 Decision and Order in favor of Mr. Ma'ae: "This is a very tough case. I think it will ultimately be decided in the appellate courts. I think there's some policy considerations here that are significant and need to be balanced. One is the need for quality providers to take care of injured workers. The other is access to care for injured workers, and those policy considerations have to be reconciled." *Dep't of Labor and Indus. v. Ma'ae*, Verbatim Report of Proceedings, P. 47 L22-25 & P. 48 L. 1-4.

Mr. Ma'ae asserts that when the legislature created the provider network under the auspices of ensuring high quality care for injured workers, it never intended to restrict workers' access to the workers' compensation system. That is why it amended the bill to allow a worker to see a non-network provider for an initial office visit. The Department interpreted that wording to mean that initial office visit meant for the original opening of a claim and not for a reopening of a claim and, consequently, restricted claimants from seeing a non-network provider for an initial visit to reopen a claim. The Board disagreed and found not only

that the new rule was an interpretive rule and therefore, not binding on the courts and public, but that the underlying statute, RCW 51.36.010, did not prohibit a non-network provider from completing and filing an application to reopen a claim for aggravation. Judge Cuthbertson of Pierce County Superior Court affirmed the Board, and the Department appealed to this Court.

V. STANDARD OF REVIEW

By appealing the Board's decision, the Department assumes the burden of producing "sufficient, substantial, facts, as distinguished from a mere scintilla of evidence" which must overcome the presumption of correctness attributed to the Board's Decision and Order to warrant reversing that decision. *Cyr v. Dep't of Labor & Indus.*, 47 Wn.2d 92, 96, 286 P.2d 1038 (1955).

When reviewing a decision of the Board, the superior court presumes the correctness of the Board's decision. RCW 51.52.115; *Dep't of Labor & Indus. v. Rowley*, 185 Wn.2d 186, 200, 378 P.3d 139 (2016). If the superior court decides that the Board "has acted within its power and has correctly construed the law and found the facts," the superior court confirms the Board's decision in its entirety: In all court proceedings under or pursuant to this title the findings and decision of the board shall be prima facie correct and the burden of proof shall be upon the party attacking the same. If the court shall determine that the board has acted within its power and has correctly construed the law and found the facts, the decision of the board shall be confirmed; otherwise, it shall be reversed or modified. RCW 51.52.115. When the Board's decision is confirmed, it is unnecessary for

the superior court to make its own findings. The superior court can make its own findings or reach a different result only if the judge finds by a preponderance of the evidence that the Board's findings and decision are erroneous. *Gorre v. City of Tacoma*, 184 Wn.2d 30, 36, 357 P.3d 625 (2015).

Harder Mechanical, Inc. v. Tierney, 196 Wn.App. 384, 384 P.3d 241, (2016).

In a case of this type, the appellate court examines the record "to see whether substantial evidence supports the findings made after the superior court's de novo review, and whether the court's conclusions of law flow from the findings." *Ruse v. Dep't of Labor & Indus.*, 138 Wn.2d 1, 5-6, 977 P.2d 570 (1999) (quoting *Young v. Dep't of Labor & Indus.*, 81 Wn.App. 123, 128, 913 P.2d 402 (1996)), quoted in *Gorre*, 184 Wn.2d at 36. When the superior court concludes the Board's findings and decision are erroneous, the findings we review for substantial evidence are those made by the court. *Watson v. Dep't of Labor & Indus.*, 133 Wn.App. 903, 909, 138 P.3d 177 (2006). But when the superior court confirms the Board's findings and decision, the Board's findings survive and provide the basis for substantial evidence review by the appellate court. Here, because the superior court confirmed the decision of the Board, our review--like the superior court's--examines the legal and factual sufficiency of the Board's decision.

Id at 384.

A.) Motion to Strike

As stated above, the issues before this Court are limited to those decided by the Board and affirmed by the Superior Court. Mr. Ma'ae moves to strike any statistics cited by the Department in its Brief as to current numbers of doctors in the provider network (Dep't Br. P. 4 Fn 1 & 2) for two reasons. First, the data is irrelevant because the issue before this Court

is not how many doctors are currently members of the network, but whether the Department had the authority to restrict the filing of reopening applications to only those members. Second, the data was not considered by the Board or the Superior Court and therefore is not a part of the record under review by this Court. Should this Court consider that data, Mr. Ma'ae requests an opportunity to dispute the information presented.

VII. LEGAL AUTHORITY AND ARGUMENT

A.) The Board was correct when it found that the provision in WAC 296-14-400 that limits the filing of an application to reopen to network providers is a Department interpretive rule and, therefore, not binding on the courts or the public.

“Administrative agencies do not have the power to promulgate rules that would amend or change legislative enactment.” *Green River Cmty. Coll. v. Higher Educ. Pers. Bd.*, 95 Wash.2d 108, 112, 622 P.2d 826 (1980).

In the case of an interpretative rule, the inquiry is not into validity but is into correctness or propriety. The legislative body has not delegated power to make a rule which will be binding upon the court if it is valid. The statute does not prevent the reviewing court from substituting its judgment on questions of desirability or wisdom. The law is embodied in the statute, and the court is free to interpret the statute as it sees fit." *Bonfield*, supra, at 281 (quoting 1 Kenneth Culp Davis, *Administrative Law Treatise* § 5.05, at 315 (1958)). Therein lies the true difference between interpretive and legislative rules: their effect on the courts. Legislative rules bind the court if they are within the agency's delegated authority, are reasonable, and were adopted using the proper procedure. *See Weyerhaeuser Co. v. Dep't of Ecology*, 86

Wash.2d 310, 314-15, 545 P.2d 5 (1976). Interpretive rules, however, are not binding on the courts at all: "Reviewing courts are not required to give any deference whatsoever to the agencies' views on that subject [correctness and desirability of the agencies' interpretations]. Legislative rules therefore have greater finality than interpretive rules because courts are bound to give some deference to agency judgments embodied in the former, but they need not defer to agency judgments embodied in the latter." Bonfield, *supra*, at 281-82. We have said as much. Technically, interpretive rules are not binding on the public. They serve merely as advance notice of the agency's position should a dispute arise and the matter result in litigation. The public cannot be penalized or sanctioned for breaking them. They are not binding on the courts and are afforded no deference other than the power of persuasion. Accuracy and logic are the only clout interpretive rules wield. If the public violates an interpretive rule that accurately reflects the underlying statute, the public may be sanctioned and punished, not by authority of the rule, but by authority of the statute. This is the nature of interpretive rules.

Ass'n. of Wash. Bus. v. State of Wash., Dept. of Revenue, 155 Wn.2d 430, 446-447, 120 P.3d 46, (2005).

Nowhere in the language of the Senate Bill that created the provider network does it say that the legislature intended to restrict a person's access to the benefits afforded under Title 51. The Legislature is quite clear that the purpose of the amendment to RCW 51.36.010 is "to establish minimum standards for providers who treat workers from both state fund and self-insured employers. The department shall establish a health care provider network to treat injured workers..." S-1771.1 Sec. 1 (1) (CP 80).

“This [use of "may" and "shall" in the statute] indicates that the Legislature intended the two words to have different meanings: "may" being directory while "shall" being mandatory. *State v. Krall*, 881 P.2d 1040, 125 Wn.2d 146, (1994). Throughout SB 5801, which became the amended RCW 51.36.010, the legislature stated what the Department “shall” do with regard to creating the new provider network. It stated the Department “shall” establish minimum standards for providers who treat workers, shall convene an advisory group, shall restrict providers based upon certain criteria, shall work with self-insurers, etc. All of these instructions surround the Department’s requirements for creating a provider network and setting the rules for how providers can apply to the network. The statute, however, when citing the Department’s authority to make rules other than those specifically set out in the amendment states, “(10) The department **may** adopt rules related to this section.” S-1771.1 Sec. 1 (10) (CP 86) (emphasis added).

The grant of authority for creating legislative rules extended to all of the aspects of the creation of the provider network, and what criteria would be used to grant entry to that network. This is evident from the Legislature’s use of the word “shall” when setting out the duties that were mandatory for the Department. However, when it came to the other rules that the Department felt it needed in order to implement the provider

network, the Legislature used the word “may.” These are the interpretive rules that the Department created in order to meld the new provider network with the existing system. They are interpretive because the Department was not given a specific mandate for each of those rules. It was up to the Department to determine which rules it thought were necessary to integrate the provider network into the system, but interpretive rules “are not binding on the courts at all: “Reviewing courts are not required to give any deference whatsoever to the agencies' views on that subject [correctness and desirability of the agencies' interpretations].” *Ass’n of Wash. Bus. v. State of Wash., Dep’t. of Revenue*, 155 Wn.2d 430, 446-447, 120 P.3d 46, (2005).

When talking about the role of the injured worker in seeing a doctor for medical care for an injury the Legislature did not change the majority of the wording in Section 1 (2)(a) which states: “Upon the occurrence of any injury to a worker entitled to compensation under the provisions of this title, he or she shall receive proper and necessary medical and surgical services at the hands of a physician *or licensed advanced registered nurse practitioner* of his or her own choice, if conveniently located, *except as provided in (b) of this subsection*, and proper and necessary hospital care and services during the period of his or her disability from such injury.” S-1771.1 Sec. 1 (2)(a) (CP 81). (Changes made by the Legislature are italicized.)

The wording of the paragraph reveals that proper and necessary medical treatment upon the occurrence of an industrial injury is a mandatory requirement placed upon the Department through the use of the word "shall." The words stating the injured worker "shall receive" medical treatment are directed at what the Legislature is requiring from the Department, not what the Legislature is requiring of the injured worker because the injured worker has no control over what type of medical treatment the Legislature chooses to provide. In the exception in paragraph (b) the Legislature reverts to the word "may." "(b) Once the provider network is established in the worker's geographic area, an injured worker **may** receive care from a nonnetwork provider only for an initial office or emergency room visit. However, the department or self-insurer **may** limit reimbursement to the department's standard fee for the services. The provider must comply with all applicable billing policies and must accept the department's fee schedule as payment in full." S-1771.1 Sec. 1 (2)(b) (CP 81) (emphasis added). The use of the word "may" makes it permissive rather than mandatory; the injured worker can choose to see a network provider for an initial office or emergency room visit, or can see a doctor of his or her choosing that is not a member of the provider network.

The wording of the statutory amendment shows that there were many requirements that the Legislature placed upon the Department when

creating the provider network. The amendment set out specific rules for the medical providers and the Department that were mandatory. However, the rule promulgated by the Department that requires only network providers to file reopening applications (WAC 296-14-400) was not one of the mandatory requirements set out by the Legislature, and was, therefore, interpretive.

Additionally, the new rule promulgated by the Department does not require a penalty or sanctions if it is violated, which statutorily defines an interpretive rule. "An 'interpretive rule' is a rule, the violation of which does not subject a person to a penalty or sanction, that sets forth the agency's interpretation of statutory provisions it administers." *Ass'n of Wash. Bus. v. State of Wash., Dep't. of Revenue*, 155 Wn.2d 430, 120 P.3d 46, (2005).

As an interpretive rule, the Board had the authority to look at the underlying statute to determine if the interpretive rule promulgated by the Department was correct. "In the case of an interpretative rule, the inquiry is not into validity but is into correctness or propriety. The legislative body has not delegated power to make a rule which will be binding upon the court if it is valid. The statute does not prevent the reviewing court from substituting its judgment on questions of desirability or wisdom. The law is embodied in the statute, and the court is free to interpret the statute as it sees fit." *Ass'n of Wash. Bus. @ 447*. The Board correctly found that the

amendment to WAC 296-14-400 that restricted the filing of reopening applications to only network providers was an interpretive rule and, therefore, open to the Board's review of its correctness or propriety.

B.) The Board was correct when it found that RCW 51.36.010 does not prohibit a non-network provider from completing and filing an application to reopen a claim for aggravation.

A court interprets a statute so as to give effect to the Legislature's intent in creating the statute. If the statute is unambiguous, its meaning is to be derived from the language of the statute alone. If, however, the intent of the statute is not clear from the language of the statute by itself, the court may resort to statutory construction. Such construction may include the consideration of legislative history.

Food Services of America v. Royal Heights, Inc., 123 Wn.2d 779, 871 P.2d 590, (1994).

It has been noted that it is not any particular portion of Title 51 that is to be liberally construed. Rather, it is the entire statutory scheme that receives the benefits of liberal construction. Each statutory provision should be read in reference to the whole act. For instance, "We construe related statutes as a whole, trying to give effect to all the language and to harmonize all provisions." *Guijosa v. Wal-Mart Stores, Inc.*, 101 Wn. App. 777, 792, 6 P.3d 583 (2000), *aff'd*, 144 Wn.2d 907, 32 P.3d 250 (2001).

In the case of RCW 51.36.010, the intent of the amendment is evident because it is written in the statute itself:

The legislature finds that high quality medical treatment and adherence to occupational health best practices can prevent disability and reduce loss of family income for workers, and lower labor and insurance costs for employers. Injured workers deserve high quality medical care in accordance with current health care best practices. To this end, the department shall establish minimum standards for providers who treat workers from both state fund and self-insured employers. The department shall establish a health care provider network to treat injured workers, and shall accept providers into the network who meet those minimum standards.

RCW 51.36.010 (1)

However, the intent of the amendment to Section 2, paragraph (b) is not quite as unambiguous. It states, “Once the provider network is established in the worker’s geographic area, an injured worker may receive care from a nonnetwork provider only for an initial office or emergency room visit.” RCW 51.36.010 (2)(b). It’s the intent behind the language, “initial office or emergency room visit” that is at the crux of this appeal. It seems straightforward on its face until one considers that injured workers sometimes have numerous “initial” visits.

When a worker is injured on the job, the worker applies for access to the benefits under Title 51. That application includes a portion that must be filled out by a medical provider. The medical provider must examine the worker, make a diagnosis, and give an opinion as to whether the provider believes the worker’s physical condition is causally related to the mechanism of injury reported. Each time a worker has a new injury, the

worker must file an application for benefits that includes the same requirement for medical information. After the worker's condition has stabilized and the worker has reached maximum medical improvement, the Department closes the claim. Under the law, if the worker's industrially related condition worsens, the worker can apply to reopen the closed claim within seven years of the first closure by filing an application for benefits under Title 51. The worker must be examined by a medical provider and the provider must make a diagnosis, and give an opinion as to whether the worker's current condition is causally related to the original mechanism of injury, directly or indirectly. The only difference between an application for benefits and an application for reopening is that the doctor filing a reopening application must also opine that the worker's causally related condition has worsened since the claim closed.

The ambiguity in the statute is what constitutes "an initial office or emergency room visit?" Is it only the very first time the worker applies for benefits? Or does the worker get an "initial office or emergency room visit" for each time the worker has a new injury? Does the worker get an "initial office or emergency room visit" when the worker is applying to reenter the system after the original claim is closed? Mr. Ma'ae contends, and the Board and Superior Court of Pierce County agree, that each of those instances is an "initial visit" because an initial visit is defined as an initial

visit to attempt to access the benefits accorded to injured workers under Title 51.

First, the language of the statute shows that the legislature's use of the terms "worker" and "treatment" in the statute show that the initial officer or emergency room visit exception was meant to apply to reopening applications.

a.) The Term "Injured Worker"

The language says the Department shall create a provider network to treat "injured workers." Until a person is accepted into the workers' compensation system, he or she is not an injured "worker" but an injured person. "Injured worker" is a term of art that applies to people who have applied and had their claims allowed by the Department. When the grand bargain was struck injured workers gave up their constitutional right to sue their employers in exchange for swift and certain relief under the Act. In that bargain, they also accepted various rules and regulations they would have to follow as a part of the administrative process of ensuring that relief. But until a claim is accepted, that person is not an injured worker, but an injured person who has the right to see the medical provider of their choice. Once they have their claim allowed and the Department has said it will be responsible for their treatment, then the Department has the right to

determine which medical providers the injured worker will see, but not before.

b.) The Term “Treatment”

Additionally, the Legislature is very specific in what it is telling the Department to do. “The department shall establish a health care provider network to **treat** injured workers...” RCW 51.36.010 (emphasis added). A “treating” provider is much different than a one-time visit for the purposes of filing an application. WAC 296-20-01002 defines an “attending provider as one who “actively treats an injured or ill worker.” Under the definition of Doctor, it states, “An attending doctor is a treating doctor.” Under the definition of Physician, it states, “An AP is a treating physician.” The Courts have consistently made a distinction between a treating doctor and a one-time examiner. The Supreme Court of the State of Washington just held that a jury instruction known as a “Hamilton instruction” **must** be given in cases where there is a treating provider or the Court **must** explain why it was unnecessary. *See Street v. Weyerhaeuser* 391 P.3d 457 (2017); *Hamilton v. Dep’t of Labor & Indus.*, 111 Wn.2d 569, 761 P.2d 618 (1988). Once again, a “treating provider” is a term of art that case law has stated is defined by seeing an injured worker at least twice. Therefore, a one-time examiner for the purposes of filing a reopening application cannot be what the Legislature meant when it created the network to “treat injured workers.”

Second, the first version of SB5801 did not set out an exception for “an initial office or emergency room visit.” However, prior to passage, the Bill was amended to allow the injured worker to see a doctor of the worker’s choosing for an initial office or emergency room visit. Mr. Ma’ae contends that the reason for this change is that the Legislature was concerned about maintaining swift relief by not limiting access to the workers’ compensation system. The liberal construction of Title 51 is not only written into the Act itself, but reiterated in over a century of case law that holds:

RCW 51.04.010 embodies these principles, and declares, among other things, that “sure and certain relief for workers, injured in their work, and their families and dependents is hereby provided [by the Act] regardless of questions of fault and to the exclusion of every other remedy.” To this end, the guiding principle in construing provisions of the Industrial Insurance Act is that the Act is remedial in nature and is to be liberally construed in order to achieve its purpose of providing compensation to all covered employees injured in their employment, with doubts resolved in favor of the worker. RCW 51.12.010;

Dennis v. Dep’t of Labor & Indus., 109 Wn.2d 467, 745 P.2d 1295, (1987).

The Legislature maintained swift access to the workers’ compensation system by protecting an injured worker’s right to see any doctor for an initial office or emergency room visit. That swift access should not be denied to a person because their new condition is related to a previous injury rather than a new injury.

Third, “Statutes should be construed to effect their purpose and unlikely, absurd or strained consequences should be avoided.” *State v. Stannard*, 109 Wn.2d 29, 742 P.2d 1244, (1987). There are many times when what was originally thought to be a new injury is later determined to be an aggravation of a previous injury. In this instance the doctor, who is not a member of the provider network, is doing his best to comply with Title 51, and protect his patient’s interests by reporting the injury. By the Department’s interpretation, the doctor can file the report of injury, but if it is later determined to be an aggravation of a previous injury as well or instead, the worker would then have to go to a separate doctor to file a reopening application even though case law says that an application for benefits can be construed to be a reopening application and vice versa. *See In re John Svicarovich*, BIIA Dec., 08,205 (1957).

Sometimes, it takes several months and doctor’s visits to determine if something is or is not an aggravation of a previous injury. In this case, if, several months after the doctor’s visit, it is determined that the worker suffered an aggravation of an old injury, the injured worker will have to worry about whether the doctor will be paid by the Department or if the injured worker will have to pay out of pocket for that initial visit. But even more importantly, the injured worker will lose all those benefits between the time he originally applied for the new injury and the time he reapplies

for an aggravation using a network provider, even though the worker would have no way of knowing if it was a new injury or an aggravation of an old injury until the determination was made months later by the Department.

The Department has maintained that only the very first visit to a doctor to file an application for benefits is to be considered an "initial visit" that falls within the scope of the exception to the requirement of a provider network doctor. However, the Department has built in many exceptions to that exception. The Department has determined that all services related to a hospitalization directly from the emergency department initial visit are considered as part of the initial visit. So, if a worker ends up in the hospital for a month or two after the initial visit on the day of injury, anyone who treats that worker is considered to be a part of that initial visit, and able to render "treatment" whether that doctor is a member of the provider network or not. The Department goes further to determine that a second visit with the same non-network provider is also considered part of the initial visit when there is no added payment due to the provider for that second visit. Obviously, the consideration in this instance is not whether the doctor meets the Department standards, but whether or not the Department has to pay for it.

Emergency Room doctors that see the worker only once can file reopening applications if the person comes into the hospital in an emergent

situation, but the doctor that a worker may have been seeing for his entire life and knows that persons condition better than anyone else, cannot file that application if not a member of the provider network. Out of state doctors can file reopening applications even though they are not members of the provider network, but in state doctors, over whom the State has much more control, cannot. These are all constructions of RCW 51.36.010 that lead to an absurd result.

Fourth, the Legislature never changed the Aggravation statute. RCW 51.32.160 Aggravation, diminution, termination, sets out the parameters for reopening a claim for aggravation of an industrial injury. This statute establishes that a reopening application must be filed within seven years of the date of the first closure of the claim to receive compensation, but that a reopening application for proper and necessary medical services can be made at any time. It explains that the seven-year statute of limitations does not apply if the claim was closed without medical certification, and that the time limitation is ten years for cases where there is a loss of vision or hearing. It also establishes that if the Department does not deny a reopening application within ninety days it will be deemed admitted.

In 1973 when the time limit was changed from five to seven years for filing a reopening application, and ten years for issues with vision or

hearing loss, the legislature amended this statute. In 1986, when “closing order” was defined to mean an order based upon medical recommendation, advice or examination the legislature amended this statute. In 1988 when the termination date for filing a reopening application was linked to the date of the first closing order rather than the date of establishment of compensation, the legislature amended this statute. In 1995 when requirement to mail a copy of the reopening application to the employer was added, the legislature amended this statute. It only makes sense that if the legislature had intended to, once again, change the parameters for filing a reopening application, it would have, once again, amended this statute.

Finally, the Department has argued that initial visit was defined prior to the amendment to RCW 51.36.010 and so that is the definition the Legislature intended. However, the wording is different. Initial visit is defined in WAC 296-20-01002 “The first visit to a health care provider during which the Report of Industrial Injury or Occupational Disease is completed and the worker files a claim for workers compensation.” In RCW 51.36.010 the legislature said, “only for an initial office or emergency room visit.” If it had meant to follow the definition in the WAC why didn’t it simply state that? It could easily have said, “only for an initial visit as previously defined by the Department,” or “only for an initial visit as

defined in WAC 296-20-01002. But instead it used separate wording that listed both an office or emergency room visit.

The Department has also argued that Mr. Ma'ae is incorrect in asserting that the wording of "an" initial visit as opposed to "the" initial visit means that the Legislature contemplated more than one. The Department states that only the very first time a person visits a doctor when reporting an injury is "an initial office or emergency room visit." Yet the Department allows numerous visits to count as "first visits" contrary to that argument in that follow-up visits to a health care provider, or hospital stays that last days to weeks can all be codified as an initial visit even if the provider is not a member of the provider network.

For all of these reasons, the Board was correct when it determined that the term "initial office or emergency room visit" in RCW 51.36.010 was meant to encompass the visit to file a reopening application. The Superior Court affirmed the Board, but also commented that it believed the filing of a reopening application by non-network providers fell within the statutory exception.

C.) Mr. Ma'ae submitted medical evidence with his reopening application.

Throughout the history of Title 51, the courts of Washington and the Board of Industrial Insurance Appeals have continually upheld liberal construction of the Industrial Insurance Act in finding that substance carries more weight than form. The issue is not whether an injured worker used a proper form, but whether notice was given to the Department that the worker has sustained an injury or an aggravation of that injury. In 1957 the Board held that a report of accident should have been construed as an application for reopening. *In re John Svicarovich*, BIIA Dec., 08,205 (1957). A couple of years later the Board found that an application to reopen a claim for a prior injury, filed within one year of a new injury, may properly be construed as a claim for that new injury where information concerning the new incident has been supplied to the Department. *In re Stanley Lee*, BIIA Dec., 09,425 (1959).

“An application to reopen must be in writing, be individual in nature, and give the Department information regarding the reason for the application (*Donati v. Department of Labor & Indus.*, 35 Wn.2d 151, 211 P.2d 503 (1949)), but the Department may not require a worker to submit an application to reopen by using a particular form (WAC 296-14-400). Where worker's physician submitted office notes recommending further

treatment, the Department should have treated the same as an application to reopen. *In re Wallace Hansen*, BIIA Dec., 90 1429 (1991).

Mr. Ma'ae's application included the proper medical documentation. Dr. H. Richard Johnson is a Board Certified, licensed orthopedic surgeon in the state of Washington. He is duly certified to examine patients and render diagnoses. In WAC 296-20-01002, the very rule that the Department has cited to argue that initial visit means only that visit to file an opening application, also defines Doctor. "Doctor or attending doctor: For these rules, means a person licensed to independently practice one or more of the following professions: Medicine and surgery; osteopathic medicine and surgery; chiropractic; naturopathic physician; podiatry; dentistry; optometry. An attending doctor is a treating doctor." WAC 296-20-01002. Dr. Johnson fulfills those requirements. Dr. Johnson examined Mr. Ma'ae, read the medical history of his injury, reached a diagnosis that Mr. Ma'ae's industrially related condition had worsened and filed the reopening application on Mr. Ma'ae's behalf. There was the requisite medical information on the form to put the Department on notice that Mr. Ma'ae was applying to reopen his claim. When the Department is put on notice that a worker has been injured or that a previous injury may

have worsened, the Department is required to investigate and determine if that worker needs treatment.

In determining that only network providers can file reopening applications the Department has effectively overturned over five decades of precedent in workers' compensation law. The law is clear that liberal construction of the Act is required. Further, that construction favors putting less, not more restrictions on a worker's access to Title 51 benefits. There is no indication that when it decided to create a provider network to ensure "high quality medical treatment," it intended to restrict access. On the contrary, the fact that the legislature initially considered forcing workers to see network providers for anything to do with workers' compensation, and then changed its mind and created an exception where injured workers could see non-network providers for an initial visit shows that its intent was to maintain, rather than restrict access to the workers' compensation system.

VII. REQUEST FOR ATTORNEYS' FEES AND EXPENSES

Mr. Ma'ae requests attorneys' fees and expenses on this appeal pursuant to RCW 51.52.130, and RAP 18.1

RCW 51.52.130 Attorney and witness fees in court appeal.

(1) If, on appeal to the superior or appellate court from the decision and order of the board, said decision and order is reversed or modified and additional relief is granted to a worker or beneficiary, or in cases where a party other than the worker or beneficiary is the appealing party and the worker's or beneficiary's right to relief is sustained, a reasonable fee for the services of the worker's or beneficiary's attorney shall be fixed by the court. In fixing the fee the court shall take into consideration the fee or fees, if any, fixed by the director and the board for such attorney's services before the department and the board. If the court finds that the fee fixed by the director or by the board is inadequate for services performed before the department or board, or if the director or the board has fixed no fee for such services, then the court shall fix a fee for the attorney's services before the department, or the board, as the case may be, in addition to the fee fixed for the services in the court. If in a worker or beneficiary appeal the decision and order of the board is reversed or modified and if the accident fund or medical aid fund is affected by the litigation, or if in an appeal by the department or employer the worker or beneficiary's right to relief is sustained, or in an appeal by a worker involving a state fund employer with twenty-five employees or less, in which the department does not appear and defend, and the board order in favor of the employer is sustained, the attorney's fee fixed by the court, for services before the court only, and the fees of medical and other witnesses and the costs shall be payable out of the administrative fund of the department. In the case of self-insured employers, the attorney fees fixed by the court, for services before the court only, and the fees of medical and other witnesses and the costs shall be payable directly by the self-insured employer.

Rule 18.1 of the Rules of Appellate Procedure provides that if “applicable law grants to a party the right to recover reasonable attorney fees or expenses on review, the party must request the fees or expenses

provided in this rule, unless a statute specifies that the request is to be directed to the trial court.” RAP 18.1.

Should he prevail in this appeal, Mr. Ma’ae is entitled to attorneys’ fees and expenses pursuant to these authorities.

VIII. CONCLUSION

For the reasons stated above, Mr. Ma’ae respectfully requests that the Court affirm the Pierce County Superior Court’s December 20, 2016 ruling that affirmed the Board’s November 23, 2015 Decision and Order that held that a non-network provider can file a reopening application.

Respectfully submitted this 6th day of October, 2017.

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