IN THE COURT OF APPEALS OF THE STATE OF NEVADA

US SECURITY ASSOCIATES HOLDING; AND LIBERTY MUTUAL,
Appellants,
vs.
MARK ARAGON,
Respondent.

No. 75821-COA

FILED

APR 24 2019

ELIZABETH A. BROWN
CLERK OF SUPREME COURT
BY S. Young
DEPUTY CLERK

ORDER OF AFFIRMANCE

US Security Associates Holding and Liberty Mutual ("Insurer") appeal from a district court order denying a petition for judicial review in a workers' compensation matter. Eighth Judicial District Court, Clark County; Mark R. Denton, Judge.

In July 2014, respondent Mark Aragon injured his back at work and sought medical treatment at Sunrise Medical Center. Aragon was diagnosed with low back pain causally correlated with his job and referred to an orthopedic surgeon. Insurer denied that referral and instead referred Aragon to Concentra, where Dr. Anand diagnosed him with lumbosacral strain and lumbar radiculopathy and placed him on modified duty at work.

In August 2014, Aragon saw Dr. Vater with his first complaint of numbness and tingling. Dr. Vater referred Aragon to Dr. Reed for transforaminal epidural steroid injections and Aragon was placed on light duty at work. Dr. Reed agreed with the recommendation for steroid injections and began treatment.

In January 2015, Dr. Reed noted the failed results of the injections and referred Aragon to an orthopedic spine surgeon, Dr. Bassewitz. Insurer, however, notified Aragon that Dr. Bassewitz was not

on its provider list and denied the consultation. In February, Dr. Reed noted that Aragon had still not received a consultation from an orthopedic spine surgeon despite being referred to one at the time of his injury seven and a half months earlier.

In March 2015, Aragon consulted with a neurosurgeon, Dr. Flangas, complaining of spine pain and paresthesias on his outside right foot. Dr. Flangas reported Aragon as a surgical candidate. Dr. Reed agreed that Aragon required surgery and recommended transfer of care to Dr. Flangas for surgery. Dr. Reed also noted that Aragon's light duty work was beyond his capabilities. A few days after seeing Dr. Flangas, Aragon presented at the emergency room for pain alleviation.

In April 2015, Insurer denied spine surgery and instead scheduled an independent medical evaluation for May with Dr. Vater. Again, Aragon's severe pain sent him to the hospital twice in April after the denial of spine surgery.

On Friday, May 1, 2015, Aragon presented to Sunrise Medical's emergency care with symptoms of increased difficulty with ambulation and bowel incontinence. Aragon underwent MRI scans and was admitted with a primary impression of "cauda equina impingement," and it was noted that surgical intervention may be necessary. On Saturday, May 2, a neurologist, Dr. Forage, evaluated Aragon and concluded that emergency surgery was indicated. On Sunday, May 3, Aragon underwent surgery. On Monday, May 4, the hospital advised Insurer about the emergency surgery. On May 9, Insurer notified hospital that it denied payment because the hospital did not obtain prior authorization from Insurer for surgery. Insurer did not assert in its denial letter that the hospital failed to give a reason why prior authorization was impracticable as a basis for denial. On May 22, Insurer

likewise denied Aragon's request for total temporary disability (TTD) benefits only because of the unauthorized May 3 surgery.

Following Insurer's denial of coverage for the hospital bills and the TTD benefits, Dr. Forage reported that Aragon would have suffered irreversible neurologic deficit without emergency surgery and that his return to work worsened him neurologically. Additionally, Dr. Forage reported that Aragon suffered irreversible nerve damage due to the fact that his medical care was delayed.

Aragon administratively appealed, and the appeals officer granted coverage, finding that "the totality of circumstances presented in this case support compensability of the surgery . . . on an emergent basis," and that under Nevada Administrative Code 616C.126(2), "prior authorization was impracticable to obtain over the weekend." Insurer petitioned the district court for judicial review, but the petition was denied. Insurer and Aragon's employer appealed.

On appeal, Insurer argues that NAC 616C.126(2) required the hospital to obtain prior authorization for the surgery, or submit with the initial billing statement the reason why doing so was impracticable. Insurer argues that because the hospital did not meet these regulatory requirements, that it is not responsible for the costs of surgery or benefits requested thereafter. Insurer thus argues that the appeals officer (1) erred by not denying the claim because the hospital failed to show impracticability with the initial bill, and (2) abused his discretion by assuming without supporting evidence that prior authorization was impracticable to obtain over the weekend. We disagree.

"This court's role in reviewing an administrative decision is identical to that of the district court: to review the evidence presented to the

agency in order to determine whether the agency's decision was arbitrary or capricious and was thus an abuse of the agency's discretion." *Installation & Dismantle, Inc. v. SIIS*, 110 Nev. 930, 932, 879 P.2d 58, 59 (1994). "Although a reviewing court may decide pure legal questions without deference to an agency determination, an agency's conclusions of law which are closely related to the agency's view of the facts are entitled to deference and should not be disturbed if they are supported by substantial evidence." *Jourdan v. SIIS*, 109 Nev. 497, 499, 853 P.2d 99, 101 (1993). "Substantial evidence is evidence which a reasonable mind might accept as adequate to support a conclusion." *Schepcoff v. SIIS*, 109 Nev. 322, 325, 849 P.2d 271, 273 (1993).

NAC 616C.126(2) states in relevant part:

> In the case of a medical emergency, a provider of health care or a medical facility that is not able to obtain prior written authorization to treat a person for an industrial injury . . . shall submit to the insurer proof of the emergency and the reasons why prior authorization was impracticable to obtain. The proof must be submitted with the initial billing for the treatment that was rendered.

Insurer argues that the hospital failed to give a reason why prior authorization was impracticable in its initial billing statement. Thus, Insurer argues an alleged deficiency in the initial billing statement, but Insurer did not include an original, a copy or even a summary of the billing statement in the record. Therefore, Insurer's argument fails under the "best evidence" rule. *See Lagrange Const., Inc. v. Kent Corp.*, 88 Nev. 271, 276, 496 P.2d 766, 769 (1972) ("[I]n proving the terms of a writing, where such terms are material, the original writing must be produced, unless it is shown to be unavailable for some reason other than the serious fault of the

proponent." (quoting McCormick on Evidence § 409, at 196 (1st ed. 1954))); *see also* NRS 52.235 ("To prove the content of a writing . . . the original writing . . . is required, except as otherwise provided in this title."). Additionally, this court cannot consider matters that do not properly appear in the record on appeal. *Carson Ready Mix, Inc. v. First Nat'l Bank of Nev.*, 97 Nev. 474, 476, 635 P.2d 276, 277 (1981). Insurer is responsible for making an adequate appellate record, and when "appellant fails to include necessary documentation in the record, we necessarily presume that the missing portion supports the district court's decision." *Cuzze v. Univ. & Cmty. Coll. Sys. of Nev.*, 123 Nev. 598, 603, 172 P.3d 131, 135 (2007).

Furthermore, even if Insurer is correct in its interpretation of NAC 616C.126 that the hospital must have submitted the reason, and failed to submit it with the initial billing statement, and we overlook the missing record, the regulation provides no remedies for its violation. Where an agency has not stated a remedy for a regulation's violation, this court will not create one. *Cf. California v. Sierra Club*, 451 U.S. 287, 297 (1981) ("The federal judiciary will not engraft a remedy on a statute, no matter how salutary, that Congress did not intend to provide."). Therefore, we conclude that the appeals officer did not abuse his discretion.

Lastly, Insurer argues that the appeals officer abused his discretion by assuming without supporting evidence that obtaining prior authorization was impracticable on the weekend. "[A]n agency's conclusions of law which are closely related to the agency's view of the facts are entitled to deference and should not be disturbed if they are supported by substantial evidence." *Jourdan*, 109 Nev. at 499, 853 P.2d at 101. Substantial evidence supported the appeals officer's conclusion that authorization was impracticable because the medical reports showed that

the surgery was emergent and happened over the weekend. Because the agency's view of the facts is entitled to deference and supported by substantial evidence, we conclude that the appeals officer did not abuse his discretion.

For the foregoing reasons, we conclude that the appeals officer neither erred nor abused his discretion. Accordingly, we

ORDER the judgment of the district court AFFIRMED.

_____, C.J.
Gibbons

_____, J.
Tao

_____, J.
Bulla

cc: Hon. Mark R. Denton, District Judge
Lewis Brisbois Bisgaard & Smith, LLP/Las Vegas
Nevada Attorney for Injured Workers/Carson City
Nevada Attorney for Injured Workers/Las Vegas
Eighth District Court Clerk