

In the Matter of the ORS 656.260 Managed Care Organization Medical
Services Dispute of

Curtis, Michelle, Claimant

Contested Case No: H01-107

PROPOSED & FINAL ORDER

February 8, 2002

MICHELLE CURTIS, Petitioner

TRAVELERS INDEMNITY OF ILLINOIS AND PROVIDENCE VANTAGE MCO,

Respondent

Before John L. Shilts, Workers' Compensation Division Administrator

Claimant appeals an administrative order issued by the Medical Review Unit (MRU) of the Workers' Compensation Division (WCD), Department of Consumer and Business Services (department or director) finding her liable for certain medical services. Administrative Law Judge Ella D. Johnson conducted a telephone hearing in this matter. Petitioner Michelle Curtis (claimant) was represented by attorney Glen Shearer. Travelers Indemnity of Illinois (insurer) was represented by attorney Jerald Keene. Providence Vantage managed care organization (MCO) waived appearance. No witnesses testified.

The record of this proceeding, consisting of all evidence received and all hearing papers filed, has been considered. The findings of fact and conclusions of law are based upon the entire record.

ISSUES

1. Whether insurer's denial of claimant's aggravation claim and non-medically stationary status allowed her to obtain treatment outside the MCO panel.
2. Whether claimant received proper notice that she was to treat within the MCO prior to the revision surgery (hereinafter second surgery) performed by Dr. Brett on December 22, 2000.
3. Whether claimant is entitled to an assessed attorney fee if she prevails only on the issue of whether she is liable for the unpaid bill of Dr. Brett and the Portland Adventist Hospital for the second surgery.¹

EVIDENTIARY RULING

WCD submitted Exhibits 1 through 100, which were admitted without objection. The record closed on the date of hearing.

¹ Claimant also raises the following additional "issues:" (a) whether insurer properly "withdrew" its consent for Dr. Brett to act as claimant's attending physician; (b) whether claimant was given proper notice of the decision to terminate Dr. Brett as her attending physician; and (c) whether this matter should be remanded to MRU for a full review of the MCO's records concerning why Darrell Brett, MD (Neurosurgery) was "removed" as claimant's attending physician. I view these "issues" as claimant's arguments, which will be addressed below.

FINDINGS OF FACT

I adopt by this reference the findings contained in MRU's August 23, 2001 Administrative Order "Findings of Fact" with the following supplementation.

On June 15, 1998, claimant compensably injured her neck while transferring a nursing home resident from the bed to a wheel chair. (Ex. 4). Insurer denied claimant's claim and claimant appealed. (Exs. 10, 27).

On July 15, 1998, Dr. Brett became claimant's attending physician. (Ex. 16). He diagnosed cervical disk herniation at C5-6 and C6-7 and recommended an anterior cervical discectomy, foraminotomy and neural decompression, followed by interbody fusion at C5-6 and C6-7 which was performed on July 29, 1998. (Exs. 14, 15 and 17). Following surgery, claimant's complaints resolved. (Ex. 21).

A March 5, 1999 Opinion and Order (O & O) by Workers' Compensation Board (WCB) Administrative Law Judge (ALJ) Albert W. Hoguet set aside insurer's denial of claimant's cervical condition. (Ex. 27). On March 25, 1999, insurer accepted claimant's claim for herniated

disk right C5-6, herniated disk left C6-7. (Ex. 29). On April 15, 1999, insurer notified claimant that she was enrolled in insurer's MCO. Dr. Brett is not a member of the MCO panel. Insurer voluntarily allowed Dr. Brett to continue to treat claimant's cervical condition provided he agreed to comply with all terms and conditions of the MCO regarding service delivery. (Ex. 30).

On May 8, 1999, Dr. Brett declared claimant to be medically stationary. (Ex. 32). Claimant's claim was closed by a May 27, 1999 Notice of Closure awarding 10 percent (32 degrees) of unscheduled permanent partial disability. (Ex. 33).

In June 1999 following a sneezing episode, claimant experienced on-going neck discomfort and radicular arm complaints. Dr. Brett opined that claimant suffered from a non-union at C5-6 with recurrent osteophyte and spinal canal encroachment. (Ex. 21). On August 10, 1999, Dr. Brett filed a claim for aggravation on claimant's behalf. (Exs. 39). Dr. Brett also requested authorization to perform a second surgery to correct the non-union at C5-6. (Ex. 42).

On November 23, 1999, insurer notified claimant by letter that she was required to treat with an MCO physician and that medical services provided by Dr. Brett would not be reimbursed for medical services seven days from the date of the letter because as a neurosurgeon he no longer qualified as a primary care physician pursuant to the administrative rules. The letter contained appeal rights to the MCO's dispute resolution process, including the telephone numbers for the MCO's Dispute Resolution Coordinator. The appeal rights indicated that any complaint must be filed within 30 days of the disputed action. Dr. Brett was copied on the letter. (Ex. 43). Claimant did not appeal the decision.

A December 15, 1999 insurer's medical examination opined that there was a solid fusion

at C5-6 and there was no indication for a second surgery at that level. (Exs. 45, 46). On January 24, 2000, insurer denied claimant's aggravation claim but noted that medical benefits would continue to be provided for claimant's accepted claim. The denial contained no notice that claimant was required to treat within the MCO and that payment for reasonable and necessary services received from the MCO not covered by health insurance was guaranteed to be paid for by insurer. (Ex. 48). Claimant appealed the denial to WCB's Hearings Division. (Ex. 87).

By letter dated February 7, 2000, the MCO notified claimant that it would not be medically detrimental for claimant to change attending physicians from Dr. Brett to an MCO physician at this time. The letter was issued after review by an MCO neurosurgeon and with the agreement of the MCO's Associate Medical Director. The letter provided appeal rights to the MCO dispute resolution process requiring claimant to appeal the decision within 30 days. The appeal rights noted that, if there was no appeal filed, all appeal rights would be lost. (Exs. 49, 91). Claimant did not appeal the decision.

An August 10, 2000 Order on Reconsideration affirmed claimant's medically stationary date of April 1, 1999 and her unscheduled permanent partial disability. (Ex. 63).

Dr. Brett performed a second surgery to address what he opined was a non-union at C5-6 on December 22, 2000. (Ex.74). An April 27, 2001 O & O by WCB ALJ Keith Kekauoha (Kekauoha) found that claimant's claim had been prematurely closed and reopened claimant's claim.² (Ex. 87).

Dr. Brett submitted medical service billings, including the billing for the second surgery, to insurer for claimant's care during the period of December 7, 2000 through June 4, 2001. Two of the billings, which were for services rendered on June 4, 2001 occurred after ALJ Kekauoha's O & O, was issued. (Ex. 67). Portland Adventist Hospital (Adventist Hospital), where Dr. Bret performed the second surgery, also submitted billings for the medical care provided in relation to the surgery totaling \$10, 020.79. (Exs. 67, 77). One Adventist Hospital billing which was for services rendered on June 4, 2001 occurred after ALJ Kekauoha's O & O was issued. (Ex. 72). Insurer refused to pay all of the billings because the surgery had been performed by a physician outside of the MCO panel. (Exs. 88, 92).

On March 27, 2001, claimant filed a complaint with the MCO disputing insurer's decision to remove Dr. Brett as claimant's attending physician. (Exs. 81, 91).

FINDINGS OF ULTIMATE FACT

Prior to the denial of claimant's aggravation claim, claimant received proper notice that she was required to treat within the MCO and that services provided by Dr. Brett would not be reimbursed.

Insurer is liable for payment of the costs associated with claimant's second surgery incurred between the date the aggravation claim was denied and the date the compensability of

² I note that the O & O did not specifically set aside the insurer's aggravation denial but rather found the closure was premature.

her aggravation claim was resolved by ALJ Kekauoha's April 27, 2001 O & O.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction lies with the director. ORS 656.260(6). The issue arises under ORS 656.245(4)(a), which governs enrollment of workers into MCOs. I review *de novo*. OAR 436-001-0225(1). The burden of proving any fact or position falls upon the proponent. ORS 183.450(2).

In its administrative order, MRU found that insurer was not liable for payment of the billings submitted by Dr. Brett and Adventist Hospital for claimant's second surgery because claimant was properly enrolled in the MCO and properly notified prior to the surgery that she was required to receive future medical services within the MCO panel. Consequently, MRU concluded that claimant was responsible under OAR 436-009-0015(1)(d) for payment of Dr. Brett's and Adventist Hospital's unpaid medical bills. I reverse in part and affirm in part.

Authorization to treat

Claimant first argues that insurer improperly "withdrew" its consent for Dr. Brett to act as claimant's attending physician. In support of her argument, she contends that Dr. Brett was authorized to treat claimant outside the MCO and did so for seven months. She further contends that insurer terminated Dr. Brett's status as attending physician because it did not like Dr. Brett's opinion that claimant required a second surgery to correct a non-union at C5-6.³ I do not find claimant's argument in this regard to be persuasive.

Under ORS 656.260(3)(a), an MCO may limit the medical providers from whom an injured worker may seek treatment. Additionally, under ORS 656.245(4), which governs the provision of medical services to injured workers through MCOs, the insurer has the authority to enforce the requirement that the claimant treat within the MCO. When an insurer contracts with an MCO, the insurer may require the claimant to receive all medical treatment for the accepted claim from the MCO panel of physicians. ORS 656.245(4)(a).⁴ If an MCO determines that it would be medically detrimental for the claimant to change attending physicians, the claimant shall not become subject to the contract until the claimant is found to be medically stationary, the claimant changes attending physicians or the MCO determines that a change in attending physician is no longer medically detrimental, whichever first occurs. *Id.*

³ Claimant argues that this matter should be remanded to MRU for a full review of the documents concerning the MCO's reasons for "withdrawing" its approval for Dr. Brett to continue treating claimant outside the MCO panel. I decline to do so because such information is confidential pursuant to ORS 656.260(6). Moreover, I find the reasons for the MCO's decision to require claimant to obtain future treatment within the MCO are fully explained in the record.

⁴ ORS 656.245(4)(a) provides in relevant part:

Those workers who are subject to the contract shall receive medical services in the manner prescribed in the contract. ***A worker becomes subject to the contract upon the worker's receipt of actual notice of the worker's enrollment in the managed care organization, or upon the third day after the notice was sent by regular mail by the insurer or self-insured employer, whichever event first occurs.

Here, following acceptance of her claim, insurer properly notified claimant that she was enrolled in insurer's MCO. Although Dr. Brett was not a member of the MCO panel, insurer voluntarily allowed Dr. Brett to continue to treat claimant's cervical condition provided he agreed to comply with all terms and conditions of the MCO regarding service delivery. In May 1999, Dr. Brett found claimant to be medically stationary and her claim was closed with an award of permanent partial disability (PPD). Thereafter, the department found that claimant's medically stationary date and her PPD award were correct. In November 1999, insurer notified claimant and Dr. Brett by letter that she was required to treat within the MCO panel and that medical services provided by Dr. Brett would no longer be reimbursed. Despite this notice from insurer to both claimant and Dr. Brett, Dr. Brett performed the second surgery on claimant on December 22, 2000. Consequently, I conclude that, because insurer is authorized by the ORS 656.245(4)(a) to require claimant to treat within the MCO after she is found to be medically stationary, insurer did not improperly "withdraw" its consent or "terminate" Dr. Brett⁵

Notice

Claimant next argues that insurer's notice that she was to treat within the MCO following Dr. Brett's finding that she was medically stationary was inadequate and ineffective because insurer failed to provide the claimant with proper notice. In support of her argument, she contends that the letter informing her that medical services provided by Dr. Brett would no longer be reimbursed was defective because it did not contain proper appeal rights.⁶ However, I do not find claimant's argument persuasive.

The letter notifying claimant that she was required to treat within the MCO because Dr. Brett did not qualify as a primary care physician contained a notice that claimant could appeal the decision by filing a complaint with the MCO's dispute coordinator by calling the coordinator at the telephone numbers listed and indicated that any complaint must be filed within 30 days of the disputed action. Although claimant failed to file a complaint challenging the decision, I find that the notice of appeal rights was sufficient.

Claimant argues that the administrative rules governing disapproval of non-MCO physicians are not helpful and urges me to find the administrative rule, OAR 436-010-0210(7)(a)⁷, concerning disapproval of out of state attending physicians to be analogous to the

⁵ Although the insurer's MCO notified claimant of its decision that it would not be medically detrimental for claimant to change attending physicians from Dr. Brett to an MCO physician, it was issued after Dr. Brett performed the second surgery. I also note that that decision was issued only after review by an MCO neurosurgeon and agreement of the MCO's Associate Medical Director.

⁶ Claimant also argues that she was prohibited from appealing insurer's decision to require her to treat within the MCO because her medically stationary status and the compensability of her aggravation claim was in denied status pending litigation at WCB. However, I do not find claimant's argument persuasive because the MCO appeal process is separate from the claim appeal process. At a minimum, her attorney should have preserved her rights by filing a compliant as instructed by the letters' appeal rights.

⁷ *Former* OAR 436-010-0210(7)(a) (Admin. Order 99-055), which governs disapproval of out of state physicians outside of an MCO, states in relevant part:

If the insurer does not approve the worker's out-of-state physician, notice to the

insurer's disapproval of Dr. Brett. These rules, claimant argues, require notice of appeal rights and an opportunity to be heard. Citing *Jahnke v. US West Communication*, 161 Or App 44 (1999), insurer argues that the statute's requirement that the claimant be notified of enrollment in the MCO is clear and unambiguous. I agree. Neither the statute nor rules require the type of notice required by OAR 436-010-0210(7)(a). Consequently, inasmuch as the rule concerning disapproval of out of state physicians does not apply to MCOs, I decline to find it instructive as to the what information must be contained in the appeal rights for insurer's decision to require claimant to treat within the MCO.⁸

Claimant argues that because her aggravation claim was in denied status, she was entitled to treat outside the MCO. She also contends in her Hearing Brief at 5 that the non-union at C5-6 was "causing her severe and unrelenting pain" and that she could not wait for the litigation concerning the compensability of her aggravation claim to be resolved.

ORS 656.245(4)(b)(D) states

If the claim is denied, the worker may receive medical services after the date of the denial from sources other than the managed care organization until the denial is reversed. Reasonable and necessary medical services received from sources other than the managed care organization after the date of claim denial must be paid as provided in ORS 656.248⁹ by the insurer or self-insured employer if the claim is finally determined to be compensable. (Emphasis added).

The facts are not in dispute. Claimant filed an aggravation claim on August 10, 1999. On January 24, 2000, insurer denied the aggravation claim without a guarantee that services obtained through the MCO would be paid by insurer. While claimant's aggravation was in denied status, claimant sought treatment from Dr. Brett and he performed the second surgery on December 22, 2000. The compensability of the aggravation claim was resolved on April 22, 2001 by O & O, which found that the claim was prematurely closed and reopened the initial claim. On this record, I find that the second surgery was a reasonable and necessary medical service given claimant's extreme pain complaints. I also find under ORS 656.245(4)(b)(D) that, absent a requirement that claimant treat within the MCO during the period the aggravation claim was in denied status and a guarantee from insurer that it would pay for the services provided within the MCO pursuant to ORS 656.245(4)(b)(B),¹⁰ claimant was entitled to treat outside the

worker shall clearly state the reason(s) for the denial, identify at least two other physicians of the same healing art and specialty whom it would approve, and reasons for the insurer denial which may include but are not limited to the out-of-state physician's refusal to comply with OAR 436-009 and 436-010. The notice shall also inform the worker that if the worker disagrees with the denial, the worker may refer the matter to the director for review under the provisions of OAR 436-010-0220

⁸ I also decline to find the provisions of OAR 436-015-0009 cited by claimant in her Hearing Brief to be applicable to the issue of notice inasmuch as they appear to deal with the requirements of an MCO plan.

⁹ ORS 656.248 concerns fee schedules for payment of medical services.

¹⁰ ORS 656.245(4)(b)(B) states in relevant part:

If the insurer or self-insured employer gives notice that the worker is required to receive treatment from the managed care organization, the insurer or self-insured

MCO with Dr. Brett between the date that the aggravation claim was denied by insurer and the date the O & O resolved the compensability of the aggravation claim. Consequently, inasmuch as claimant was entitled to treat outside the MCO during the time her claim was in denied status, I conclude that insurer is liable for costs of claimant's second surgery incurred between the date of denial on January 24, 2000 and the date compensability was determined on April 27, 2001.

Attorney Fee

Insurer argues that claimant is not entitled to an attorney fee if she prevails only on the issue of whether she is liable for payment of the costs of her second surgery. However, she has prevailed on that portion of the billings incurred between January 24, 2000 and April 27, 2001. Inasmuch as claimant has finally prevailed in this dispute concerning these billings, she is entitled to payment of her attorney fees. Claimant's counsel has provided a statement of services requesting payment of \$5,500 for approximately 20 hours of work devoted to this case following administrative review. Applying the factors set forth in OAR 436-001-0265, I find that the amount requested by claimant's counsel is reasonable in light of the quality of legal representation and the benefit secured by counsel for claimant.. Accordingly, insurer shall pay claimant's counsel \$5,500 for services rendered in this matter.

ORDER

IT IS HEREBY ORDERED that MRU's Administrative Order number MMS01-817 dated August 23, 2001 is affirmed in part with respect to the unpaid billings from Dr. Brett and Adventist Hospital incurred prior to January 24, 2000 and after April 27, 2001 and reversed in part with respect to the billings incurred between January 24, 2000 and April 27, 2001. Insurer shall also pay claimant's counsel a reasonable attorney fee of \$5,500.

DATED this 8TH day of February 2002.

Ella D. Johnson, Administrative Law Judge
Hearing Officer Panel

employer must guarantee that any reasonable and necessary services so received, that are not otherwise covered by health insurance, will be paid as provided in ORS 656.248, even if the claim is denied, until the worker receives actual notice of the denial or until three days after the denial is mailed, whichever event first occurs. The worker may elect to receive care from a primary care physician who agrees to the conditions of ORS 656.260 (4)(g). However, guarantee of payment is not required by the insurer or self-insured employer if this election is made.