

In the Matter of an ORS 656.327 Medical Treatment Dispute of

Lusby, Judy M., Claimant

Contested Case No: HH02-026

PROPOSED & FINAL ORDER

June 21, 2002

LIBERTY NORTHWEST INSURANCE CORPORATION, Petitioner

JUDY M. LUSBY, Respondent

Before John L. Shilts, Workers' Compensation Division Administrator

PROCEDURAL HISTORY

The petitioner, insurer Liberty Northwest Insurance Corporation (insurer), appeals an administrative order finding certain medical care medically reasonable or necessary. On May 15, 2002, Hearing Officer Paul Vincent conducted a telephone hearing in this matter. Petitioner appeared was represented by attorney Barbara Woodford. Respondent, claimant Judy M Lusby (claimant) appeared and was represented by attorney Joe Di Bartolomeo. The Workers' Compensation Division (WCD) waived appearance.

The record of this proceeding, consisting of a tape recording of the hearing, 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.

ISSUE

Pursuant to the Notice of In-Person Hearing dated April 3, 2002, the issue is the appropriateness of a bilateral lumbar laminectomy, foraminotomies, facetectomies and disectomies with cauda equina and nerve root decompression followed by Ray Cage fusion using autologous bone graft and Osteoset at L4-5, as proposed by John Miski, MD (Neurological Surgery) and Francis Nash, MD (Neurological Surgery), for Judy M Lusby's compensable condition under ORS Chapter 656 and OAR Chapter 436.

EVIDENTIARY RULINGS

WCD Exhibits 1-45 were received without objection. Petitioner's P1-2 were received over Respondent's objection that P1 was new medical evidence. Exhibit P1, a January 9, 2002 report from Paul Williams, MD, is a further response from insurer's medical expert to a report submitted to MRU and therefore is supplemental to medical reports received in WCD Exhibits 1-45. Accordingly, it is not new medical evidence.

FINDINGS OF FACT

Claimant sustained a compensable injury on April 12, 1986 while working in a restaurant. The accepted condition was low back strain. The claim closed on October 30, 1986 and was reopened for an aggravation on August 12, 1991. The accepted condition was updated to include L3-4 and L4-5 disc herniation on August 12, 1999. The claim remains open. (Exs. 1, 3,

42).

Claimant received conservative treatment initially, with no decrease in back pain. A lumbar laminotomy, lumbar canal decompression at L4-5, lateral recess decompression with total facetectomy, foraminotomy and neurolysis at L3-4 and L4-5 were performed in 1990. (Ex. 2).

Claimant's pain continued and she underwent a right subtotal facetectomy, foraminotomy and neurolysis at L3-4 and L4-5 in January 1993. (Ex. 2)

Claimant underwent a transverse process and interpedicular fusion with Steffee plates at L4-5 in July 1993. (Ex. 2).

Claimant's Steffee plates fusion was removed from L3 to L5 and a laminectomy to remove a protruded L3-4 disc on the left was performed in January 1994. (Ex. 2).

Claimant underwent an anterior lateral fusion with left iliac bone crest graft at L3-4 and implantation of a spinal fusion stimulator in January 1996. The stimulator was removed in August 1996. (Ex. 2).

Claimant underwent a lumbar laminotomy, bilateral foraminotomies with medical facetectomy, cauda equinas decompression, and bilateral fusion with Ray cage placement, all at L5-S1, in June 1998. (Ex. 2).

On June 29, 1999, Paul Williams, MD (Neurosurgery) and Stephen Fuller, MD (Orthopedic Surgery) performed an insurer's medical examination (IME) on June 29, 1999. They opined that further surgery would not decrease claimant's pain or increase her ability to function, and that claimant remained capable of performing light-duty work. (Ex. 2).

Claimant was evaluated for continued back pain by John Misko, MD (Neurological Surgery) in September 2000. He opined that claimant had L4-5 instability with bilateral foraminal stenosis requiring surgical intervention. (Ex. 6).

On October 19, 2000, claimant's attending physician, Francis P Nash, MD (Neurological Surgery), reviewed with claimant the potential that the surgery, including a Ray cage fusion at L4-5, might suppress her pain but not return her to work. (Ex. 8) On the same date, Dr. Nash requested permission from insurer to proceed with surgery by Dr. Misko. (Ex. 7).

On March 5, 2001, Dr. Nash opined that claimant's current diagnosis was L4-5 lumbar instability with associated bilateral foraminal stenosis. He further opined that the attempted fusion at L4-5 must be considered a pseudoarthrosis and the patient a candidate for surgical stabilization. (Ex. 12).

On March 9, 2001, a lateral flexion and extension lumbar spine x-ray was performed. The radiologist, Nate D Quilici, MD, interpreted degeneration at L4-5, showing intervertebral cage devices at L5-S1, stability at L5-S1, and stability at L4-5 with widening of the posterior

aspect of the disc spaces on flexion with no subluxation. L3-5 had narrowed disc spaces of between 2-3 mm of anterior subluxation, forward motion, at L3-4, with flexion. (Ex. 13).

On April 24, 2001, Dr. Nash notified insurer that although he had previously considered claimant a candidate for a pain clinic, the claimant's pain had degenerated to the point that he believed that claimant should again be offered additional surgery on a humanitarian basis. (Ex. 15).

On May 6, 2001, examined claimant. He noted that claimant's pain complaints had become progressively severe, to the point that she was having difficulty sleeping, sitting or walking. Dr. Misko opined that upon review of the studies ordered by Dr. Nash, including a CT scan and x-rays including flexion/extension views of the lumbar spine, he agreed with Dr. Nash that there was a pseudoarthrosis at L4-5 and that there was "considerable motion" at that level which was the likely cause of claimant's pain symptoms. He recommended that a surgical authorization be requested by Dr. Nash. (Ex. 16).

On May 9, 2001, Dr. Misko requested authorization for a bilateral lumbar laminectomy, foraminotomies, facetectomies, and discectomies with cauda equina and nerve root decompression followed by Ray cage fusion using autologous bone graft and Osteoset at L4-5 to be performed by Dr. Misko with the assistance of the attending physician, Dr. Nash. The indication for the surgery was pseudoarthrosis as well as instability at L4-5 causing significant back and leg pain. (Ex. 17).

On May 21, 2001, Dr. Misko opined that the proposed surgery could possibly lead to a return to productive employment once the pseudoarthrosis at L4-5 was repaired. He further opined that claimant would not be medically stationary until the pseudoarthrosis was resolved. (Ex. 18).

On June 18, 2001, Drs. Williams and Swanson performed an IME. They opined that claimant's lumbar ranges of motion were not normal due to her previous back surgeries. They did not believe claimant capable of return to regular work and found claimant's chronic medical condition attributable to previous back surgeries. They found no objective findings to warrant surgery and recommended conservative treatment and pain center management of claimant's pain symptoms.

On June 28, 2001, insurer notified Dr. Misko that it was not authorizing the requested procedure. (Ex. 20).

On July 2, 2001, Dr. Misko responded to the IME, noting in particular his objection to the conclusion that there was no motion seen at L4-5 in the most recent diagnostic studies:

Everyone that has seen the films, including Dr. Nash, a radiologist and myself describes the abnormal motion at L4-5. *** The radiologist stated in his report "the L4-5 level seems fairly stable although the posterior aspect of the disk space widens out somewhat with flexion[.]" This proves that there is motion there and this was the level of previous fusion and she has a pseudoarthrosis and I believe

that we should proceed with a fusion at this level. (Ex. 22).

On September 26, 2001, Dr. Nash again opined that the claimant had a pseudoarthrosis at L4-5, as evidenced by the March 9, 2001 studies, "which demonstrates not only a narrowing of the foramen, bilaterally, but also supports the instability and marked widening of the interspace at L4-5 noted with flexion." He noted further that a 4/11/00 diagnostic imaging report had stated that "the L4-5 fusion is probably not intact." (Ex. 23).

On October 2, 2001, claimant requested administrative review of the proposed surgery by the Workers' Compensation Division, Medical Review Unit (MRU). (Ex. 24).

Drs. Williams and Swanson opined in a report of October 25, 2001 that a lack of motion at L4-5 demonstrates that fusion is not indicated:

On 06/18/01 Dr. Swanson and I examined Ms. Judy Lusby. That report is available for review. The films, personally reviewed by Dr. Swanson and myself, were flexion/extension lateral views of Ms. Lusby's lumbar spine, dated 03/09/01. It was our opinion there was no significant motion at L4-5. The American Academy of Orthopedic Surgeons has defined segmental instability at the L4-5 level as a minimum of 4 mm anterior displacement. Dr. Swanson and I did not feel the L4-5 level demonstrated this amount of movement and did not feel, by AAOS definition, there was segmental instability. Without demonstration of AAOS definition of segmental instability, fusion is not indicated. (Ex. 28-1).

On December 21, 2001, Curtis L Hill, MD (Neurological Surgery) examined claimant and reviewed the file at MRU's request. Dr. Hill noted that claimant was suffering severe back pain, taking lots of pain pills, and is essentially disabled. He concluded that the requested surgery was appropriate:

It would appear that this patient is going nowhere the way she is now. She is having a lot of pain and is taking a lot of pain medication and is essentially disabled. I think that there is certainly a chance that she could be helped by stabilizing the L4-5 level and I am in agreement with at least giving this a try. I talked to the patient and her husband and indicated to her that there is still a chance that she will continue to have pain after surgery, but there is also a chance that a good amount of her pain could be relieved and she could get off the chronic narcotics. I would be in favor of authorizing the procedure on that basis. (Ex. 39).

CONCLUSIONS OF LAW

A bilateral lumbar laminectomy, foraminotomies, facetectomies and disectomies with cauda equina and nerve root decompression followed by Ray Cage fusion using autologous bone graft and Osteoset at L4-5, as proposed by John Miski, MD (Neurological Surgery) and Francis

Nash, MD (Neurological Surgery), is appropriate for Judy M Lusby's compensable condition under ORS Chapter 656 and OAR Chapter 436.

OPINION

I may modify the director's administrative order in this matter only if it is not supported by substantial evidence in the record, or reflects an error of law. ORS 656.327(2).

Error of Law

Pursuant to ORS 656.245(1) an insurer is obligated to provide medical services for compensable conditions for such period as the nature of the injury or the process of recovery requires. This obligation continues for the life of the injured worker. OAR 436-010-0230(1) governs the provision of these medical services and provides:

“Medical services provided to the injured worker shall not be more than the nature of the compensable injury or the process of recovery requires. Services which are unnecessary or inappropriate according to accepted professional standards are not reimbursable.”

Insurer believes that the record demonstrates that there is an error of law and that MRU's findings were not supported by substantial evidence in the record. Insurer points out that MRU found the disputed surgery appropriate based on the lack of documentation showing that conservative treatment would reduce pain symptoms, MRU's determination that Drs. Misko and Nash provided a well-reasoned interpretation of diagnostics, the supporting opinion of Dr. Hill, and a finding that claimant's current narcotic medication regimen is not significantly decreasing her pain. Insurer finds error in this analysis, arguing that MRU's analysis failed to address the requirements of administrative rule 436-010-0230(1). Insurer claims that MRU failed to apply “accepted professional standards” as established by Drs. Williams and Swanson in their discussion of a definition by the American Academy of Orthopedic Surgeons of the term “segmental instability.” *See* Ex. 28.

Claimant, in response, argues that insurer has provided no proof that the academy standard cited by insurer is the “accepted professional standard” which must be the basis for MRU's decision. What insurer is asking for, argues claimant, is for the hearing officer to substitute his own judgement for that of the medical reviewer's and grant what amounts to a *de novo* review.

The recent case of *Dallas Hall*, WCSR (2001), analyzed the director's interpretation of OAR 436-010-0230(1) and the term “accepted professional standards.” As in the case before me, the record in *Hall* contained opposing medical opinions regarding the appropriateness of a proposed surgery. MRU found the surgery appropriate and the managed care organization (MCO) and insurer argued that MRU's order committed an error of law by disregarding OAR 436-010-0230(1). In particular, the MCO argued that MRU was obligated to rely upon “nationally accredited surgical indications” as cited by the MCO's joint medical committee. The

claimant, on the other hand, contended that “accepted professional standards,” as that term is used in OAR 436-010-0230(1), were inherent in the medical opinions relied upon by MRU. Claimant argued that MRU was not required to independently apply medical community standards, but only to weigh the relative persuasiveness of the medical opinions presented. The hearing officer found no error of law in a discussion that I find well reasoned, persuasive and determinative of the issue presented here:

In interpreting the meaning of a rule, I apply the same method employed in determining the meaning of a statute. *Abu-Adas v. Employment Dept.*, 325 Or 480 (1997); *Larry Hemenway*, 5 WCSR 33 (2000). In construing a rule, the task is to discern the intent of the enacting body. The first level of analysis is to examine both the text and context of the rule. If the agency’s intent is clear, no further inquiry is necessary. See *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-611 (1993). ORS 174.010 prohibits inserting or omitting any language. OAR 436-010-0230 contains the phrase “accepted professional standards” which is not defined by statute or rule. The MCO contends that the phrase refers to nationally accredited surgical indications that are listed in various publications. On the other hand, claimant contends and I agree that “accepted professional standards” are inherent in each medical opinion contained in the record. In workers’ compensation medical disputes, the parties consult medical experts in recognition of their training and experience including their knowledge of accepted professional standards. When medical experts disagree, more weight is given to those medical opinions that are both well-reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259 (1986). Medical opinions which explicitly cite nationally accredited surgical indications may be considered more well-reasoned. However, OAR 436-010-0230 does not require MRU to defer to medical opinions which cite such publications. Furthermore, an agency is entitled to deference in interpreting its administrative rule if the interpretation is plausible and not inconsistent with the wording of the rule itself or with the rule’s context or with any other source of law. *Hadley v. Cody Hindman Logging*, 144 Or App 157 (1996); *Don’t Waste Oregon Comm. v. Energy Facility Siting Council*, 320 Or 132 (1994). Here, MRU interpreted the rule to mean that “accepted professional standards” are incorporated into each expert medical opinion. This interpretation is plausible and is not legally inconsistent. Therefore, I defer to MRU’s interpretation of OAR 436-010-0230(1). Accordingly, I find that MRU’s application of the rule does not reflect an error of law.

Here, the insurer is asking that I apply “nationally accredited surgical indications” in the form of the representation of Drs. Williams and Swanson that the AAOS had established governing standards for segmental instability. I agree with the opinion in *Hall* that while medical opinions which cites such publications may be considered more well reasoned, MRU’s failure to cite them does not constitute legal error.

Substantial Evidence

In order to determine whether substantial evidence exists, I am required to:

"[L]ook at the whole record with respect to the issue being decided, rather than one piece of evidence in isolation. If an agency's finding is reasonable, keeping in mind the evidence against the finding as well as the evidence supporting it, there is substantial evidence. For instance, and in the context which is likely frequently to occur in workers' compensation cases, if there are doctors on both sides of a medical issue, whichever way the [director] finds the facts will probably have substantial evidentiary support. *** The difference between the 'any evidence' rule and the substantial evidence test * * * will be decisive only when the credible evidence apparently weighs overwhelmingly in favor of one finding and the [director] finds the other without giving a persuasive explanation." *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206 (1988).

In *SAIF Corp. v. Leland*, 160 Or App 480 (1999), the court considered a post-surgical report and held that a back surgery was appropriate medical treatment under ORS 656.327. Exercising substantial evidence review, the court stated, "Generally, where the record merely reflects a difference in medical opinion, substantial evidence in the record may support either a finding of appropriate medical treatment or of inappropriate medical treatment." *Id* at 487. Here, MRU considered the conflicting medical opinions and concluded that those recommending the proposed surgery were more persuasive. Drs. Nash, Misko and Hill opine that the proposed surgery is appropriate. Drs. Williams and Swanson opine that the proposed surgery is inappropriate. On this record, I cannot say that the evidence cited by insurer weighs overwhelmingly in favor of the insurer. Therefore, I find that the administrative order is supported by substantial evidence and, accordingly, I may not modify it.

ORDER

IT IS HEREBY ORDERED that the Medical Review Unit Order dated January 31, 2002, Administrative Order TX 02-060, is affirmed.

DATED this _____ day of June, 2002.

Paul Vincent
Hearing Officer
Hearing Officer Panel