

In the ORS 656.245 Medical Services Dispute of

Santa Maria, Pedro, Claimant

Contested Case No: H03-081

PROPOSED AND FINAL ORDER

November 24, 2003

SEDGWICK CLAIMS MANAGEMENT SERVICES, Petitioner

PEDRO SANTA MARIA, Respondent

Before John L. Shilts, Workers' Compensation Division Administrator

HISTORY OF THE CASE

Insurer appeals an Administrative Order issued on May 15, 2003 by the Medical Review Unit (MRU) of the Workers' Compensation Division (WCD), Department of Consumer and Business Services (director or department). On September 2, 2003, Administrative Law Judge Paul Vincent conducted a contested case hearing. Petitioner Sedgwick Claims Management Service (formerly Johnston and Culberson) (insurer) were represented by attorney Mark P. Bronstein. Respondent Pedro Santa Maria (claimant) was represented by attorney William D. Okrent. No witnesses testified and the record closed on the date of hearing.

After the record closed, ALJ Vincent began working in another section of the Office of Administrative Hearings and this matter was transferred to the undersigned. I have listened to the tape of the September 2, 2003 hearing, including the arguments of the parties, and I have reviewed all of the exhibits in the record before making the decision that follows.

MOTION FOR DISMISSAL

On August 15, 2003, claimant filed a Motion for Dismissal or for Transfer Order. On August 26, 2003, insurer responded. At hearing, ALJ Vincent took the matter under advisement.

In the Motion for Dismissal, claimant does not seek dismissal of insurer's request for hearing. Rather, claimant seeks dismissal of insurer's third contention *viz.*, that the disputed medical services are not causally related to the compensable condition. In support of his position, claimant argues that insurer waived the causation issue by failing to raise it before MRU.

ORS 656.704 delineates the jurisdictional boundaries between the Workers' Compensation Board and the Workers' Compensation Division. ORS 656.704(3)(a)(C) provides:

(C) Any dispute that requires a determination of whether a sufficient causal relationship exists between medical services and an accepted claim to establish compensability is a matter concerning a claim.

OAR 436-010-0008(13)(a) provides:

(13) Contested cases before the director: Any party that disagrees with an action or order pursuant to this rule, may request a contested case hearing before the director as follows:

- (a) The party must send a written request to the administrator of the Workers' Compensation Division. **The request must specify the grounds upon which the order or other action is contested**, and include a copy of the administrative order being appealed.

(Emphasis added.)

On March 12, 2003, insurer filed a Specification of Issues listing two grounds for denying reimbursability, which did not include lack of causation. (Ex. 47.) On April 7, 2003, insurer wrote to MRU explaining its reasons for denial but did not mention causation. (Ex. 53.) On May 13, 2003, MRU contacted insurer by telephone to clarify the issues. Insurer stated its grounds for denial without reference to causation. Inasmuch as the causation issue was not presented to MRU, I conclude that insurer waived that argument and is barred from asserting it in the contested case hearing.

ISSUES

1. Whether claimant has exhausted three choices of attending physician.
2. If so, whether the director should approve Frances V. Vervosa, MD as the fourth attending physician.
3. Whether insurer is liable to reimburse Francis V. Vervosa, MD for treatments provided to claimant from August 19, 2002 through November 22, 2002.
4. Whether insurer is liable to reimburse Mark E. Walsh, DC for treatments provided to claimant from August 12, 2002 through October 23, 2002.

EVIDENTIARY RULINGS

WCD Exhibits 1 through 61 were received into the record without objection. Insurer Supplementary Exhibits 1P¹, 4P, 6P, 7P, 9P, 13P, 15P, 16P, 17P, 19P, 20P, 22P, 23P, 24P, 25P, 26P, and 36P were received into the record without objection. Insurer withdrew the remaining supplementary exhibits as duplicative.

FINDINGS OF FACT

1. On December 12, 2000, claimant suffered a compensable injury while working as a landscaper. (Exs. 1, 9 and 25P.) Insurer initially denied compensability, but accepted a

¹ I added "P" for "petitioner" in order to distinguish insurer's exhibits from WCD's.

disabling lumbar strain following litigation. (Exs. 15, 25P, 26P.)

2. On December 22, 2000 claimant sought emergency medical treatment at St. Vincent Hospital Emergency Room. (Ex. 3.) Kenneth Dirk, MD diagnosed lumbar strain, prescribed medication and sent claimant back to work the following day with restrictions. Dr. Dirk referred claimant to the occupational health clinic. (Ex. 3-1.)

3. On December 26, 2000, claimant sought treatment from Richard M. Brown, MD at the Providence Occupational Health Clinic at Tanasbourne. (Ex. 4.) Dr. Brown examined claimant, authorized modified duty with a lifting restriction, prescribed medication and scheduled a return appointment in one week. (Exs. 4 and 4P.) On January 2, 2001, claimant sought treatment from John Seymour, MD at the Tanasbourne Occupational Health Clinic. (Ex. 5.) Dr. Seymour refilled prescriptions, took claimant off work and referred him for a lumbosacral MRI. (Ex. 6P.) An MRI on January 4, 2001 revealed moderate disc disease and a prominent disc bulge at L4-5. (Ex. 7P.) On January 16, 2001, Dr. Seymour authorized time off work, prescribed medication and referred claimant to Jeffrey I. Gerry, MD, PhD (Physical Medicine). (Exs. 5 and 9P.)

4. On January 18, 2001, claimant sought treatment from Dr. Gerry who viewed x-rays, diagnosed muscular lumbar strain, refilled prescriptions, referred claimant to physical therapy and planned a follow-up appointment in two weeks. (Ex. 6.) Claimant designated Dr. Gerry as his attending physician. (Ex. 7.) On February 1, 2001, Dr. Gerry observed significant pain behaviors and planned to see claimant only as needed. (Ex. 8.)

5. On February 26, 2001, claimant returned to St. Vincent Hospital Emergency Room. Dr. Dirk again diagnosed lumbar strain, refilled prescriptions and referred claimant to the occupational health clinic. (Exs. 3-2, 11, 15P, 16P, and 17P.) On April 14, 2001, claimant again sought treatment from St. Vincent Hospital Emergency Room. Caryl Kenworth, FNP refilled prescriptions and referred claimant to the occupational health clinic. (Exs. 19P and 20P.)

6. On July 25, 2002, claimant designated Mark E. Walsh, DC as his attending physician. (Ex. 20.) Dr. Walsh treated claimant from July 20, 2002 through October 11, 2002. (Ex. 19.) Claimant's twelfth visit with Dr. Walsh occurred on August 16, 2002. (Ex. 21-12.) After claimant's fourteenth visit, Dr. Walsh referred claimant to Dr. Vervosa. (Ex. 35.)

7. On August 19, 2002, claimant sought treatment from Francis V. Vervosa, MD who prescribed continued adjustments and manual traction. (Exs. 23-3 and 25.) On September 3, 2002, Dr. Vervosa prescribed continued adjustments and heat three times per week for four weeks for progressive strengthening and stabilization. (Ex. 28-1.) On October 1, 2002, Dr. Vervosa prescribed "cont[inue] adjustment and heat once per week for four weeks" for strengthening, stabilization and decreasing pain. (Exs. 25 and 28-2.)

CONCLUSIONS OF LAW

1. The director properly approved Frances V. Vervosa, MD as the third attending physician.

2. Insurer is liable to reimburse Francis V. Vervosa, MD for treatments provided to claimant from August 19, 2002 through November 22, 2002.
3. Insurer is liable to reimburse Mark E. Walsh, DC for treatments provided to claimant from September 3, 2002 through October 30, 2002.

OPINION

Jurisdiction over this medical services dispute lies with the director. ORS 656.704(3)(a) and ORS 656.245. The burden of proving a fact or position rests with the proponent. ORS 184.450(2). As petitioner, insurer bears the burden of proving by a preponderance of the evidence that the administrative order is incorrect. *See Cook v. Employment Div.*, 47 Or 437 (1982) (In the absence of contrary legislation, the standard of proof in an administrative hearing is preponderance of evidence). Proof by a preponderance of evidence means that the fact finder is persuaded that the facts asserted are more likely true than false. *Riley Hill General Contractors v. Tandy Corp.*, 303 Or 390 (1989).

Attending Physician

The first and second issues are whether claimant has exhausted the three statutory choices of attending physician, and if so, whether the director should approve a fourth choice. These issues arise under ORS 656.245(2)(a) which provides in pertinent part:

The decision of the director is subject to a contested case review under ORS 183.310 to 183.550.

Inasmuch as the Administrative Procedures Act, ORS Ch. 183, does not specify a standard of review, I review *de novo*. *See Archie Ulbrich*, 2 WCSR 152 (1997) (In the absence of a statutory prescription, the standard of review is *de novo*).

Pursuant to ORS 656.245(1)(a), an insurer is obligated to provide medical services that are materially related to a compensable work injury for so long as the nature of the injury or the process of recovery requires. Pursuant to ORS 656.245(2)(a), an injured worker may choose three attending physicians over the life of a claim without approval.

MRU approved Dr. Vervosa, MD as the fourth attending physician because the previous attending physician, Dr. Walsh, DC was disqualified after 12 visits pursuant to ORS 656.005(12)(b)(B)². I agree.

Insurer first contends that claimant has exhausted the three choices of attending physician allowed by statute. In support of its position, insurer argues that Dr. Brown and Dr. Seymour

² ORS 656.005(12)(b)(B) provides:

(12)(a) "Doctor" or "physician" means a person duly licensed to practice one or more of the healing arts in any country or in any state, territory or possession of the United States within the limits of the license of the licentiate.
(B) For a period of 30 days from the date of first visit on the initial claim or for 12 visits, whichever first occurs, a doctor or physician licensed by the State Board or Chiropractic Examiners for the State of Oregon or a similarly licensed doctor or physician in any country or in any state, territory or possession of the United States.

constitute the first choice of attending physician. Insurer next argues that Jeffrey Gerry, MD was the second attending physician. Insurer next argues that several medical providers at St. Vincent Medical Center constitute the third choice of attending physician. Insurer further argues that the director erred by approving claimant's subsequent change from Dr. Walsh to Dr. Vervosa.

In contrast, claimant contends that he has not exhausted the three statutory choices of attending physician. In support of his position, claimant argues that the emergency services at St. Vincent and Dr. Vervosa are not attending physicians. Claimant next argues that he properly designated Dr. Walsh as his third attending physician.

ORS 656.245(2)(a) provides in part:

The worker may choose the initial attending physician and may subsequently change attending physician two times without approval from the director.

The statute is implemented by OAR 436-010-0220(3) Choosing and Changing Medical Providers which provides:

The worker is allowed to change attending physicians by choice two times after the initial choice. Referral by the attending physician to another attending physician, initiated by the worker, shall count in this calculation. The limitations of the worker's right to choose physicians pursuant to this section begin with the date of injury and extend through the life of the claim. For purposes of this rule, the following are not considered changes of physician by choice of the worker:

- (a) Emergency services by a physician;
- (b) Examinations at the request of the insurer;
- (c) Consultations or referrals for specialized treatment initiated by the attending physician;
- (d) Referrals to radiologists and pathologists for diagnostic studies;
- (e) When workers are required to change physicians to receive compensable medical services, palliative care or time loss authorization because their medical service provider is no longer qualified as an attending physician;
- (f) Changes of attending physician required due to conditions beyond the worker's control. This could include, but not be limited to, when the physician terminated practice or leaves the area, when a physician is not longer willing to treat an injured worker, when the worker moves out of the area requiring more than a 50 mile commute to the physician, and when a worker is subject to managed care and compelled to be treated inside an MCO;
- (g) A Worker Requested medical examination; or

- (h) Whether a worker has an attending physician who works in a group setting/facility and the worker sees another group member due to team practice, coverage, or on-call routines.

The medical treatment that claimant sought at St. Vincent Hospital Emergency Room in December 2000 does not count a choice of attending physician. OAR 436-010-0220(3)(a). Next, the record establishes that the medical providers at Providence Occupational Health Clinic at Tanasbourne constitute claimant's first attending physician. OAR 436-010-0220(3)(h). Dr. Seymour and Dr. Brown, who practice in the same clinic, acted as attending physician, rendering medical treatment, authorizing time loss and referring claimant to Dr. Gerry as a specialist. Next, in January 2001, claimant designated Dr. Gerry as the second attending physician.

In February and April 2001, claimant received medical services from St. Vincent Hospital Emergency Room. Insurer argues that these services constitute claimant's third choice of attending physician because claimant complained of persistent back pain and did not seek care for an urgent medical condition. However, OAR 436-010-0220(3)(a) provides that emergency services do not count as a change of attending physician and the rule does not provide an exception concerning the nature of the patient's medical complaints. Therefore, I find that the services claimant obtained from St. Vincent Hospital Emergency Room in February and April 2001 do not count as a change of attending physician.

Next, in July 2002, claimant designated Dr. Walsh, a chiropractor, as the third attending physician. Claimant's twelfth visit with Dr. Walsh occurred on August 16, 2002, and at that point, Dr. Walsh was no longer qualified to serve as attending physician. ORS 656.005(12)(a)(B). At this point, Dr. Walsh referred claimant to Dr. Vervosa who is a medical physician. Pursuant to OAR 436-010-0220(3)(e), when a physician is not longer qualified to serve as attending physician, the change to a physician who is qualified is not considered a change of attending physician. Here, Dr. Walsh, is a chiropractor who was no longer qualified as attending physician after twelve visits and referred claimant to a medical physician. Therefore, MRU properly approved Dr. Vervosa as the third attending physician.

Medical Services

The third and fourth issues are whether insurer is liable to reimburse Dr. Vervosa and Dr. Walsh for medical services. These issues arise under ORS 656.245(1). Pursuant to ORS 656.245(6) and ORS 656.327(2), I review for substantial evidence and errors of law.

MRU determined that Dr. Vervosa's initial treatment plan was inadequate, and therefore, the subsequent chiropractic treatments were not reimbursable. MRU next determined that Dr. Vervosa's second and third treatment plans were adequate, and therefore, the subsequent chiropractic treatments were reimbursable. I agree.

Alternatively to its attending physician argument, insurer contends that Dr. Vervosa's initial treatment plan was inadequate and subsequent chiropractic treatment was not reimbursable. Insurer concedes that the September 3, 2002 and October 1, 2002 treatment plans were adequate and that if Dr. Vervosa is recognized as attending physician, the subsequent

chiropractic treatment is reimbursable. In contrast, claimant contends that all of the treatment plans were adequate, and therefore, all of the chiropractic treatment was reimbursable.

OAR 436-010-0230(4)(a) provides:

Except as otherwise provided by the MCO, ancillary services including but not limited to physical therapy or occupational therapy, by a medical service provider other than the attending physician or specialist physician shall not be reimbursed unless prescribed by the attending physician or specialist physician and carried out under a treatment plan prepared **prior** to the commencement of treatment and signed by the attending physician or specialist physician within 30 days of beginning treatment. The medical service provider shall provide an initial copy of the treatment plan to the attending physician or specialist physician and the insurer within seven days of beginning treatment. A copy of the treatment plan signed by the attending physician or specialist physician shall be provided within 30 days of beginning treatment. The treatment plan shall include objectives, modalities, frequency of treatment, and duration. The treatment plan may be recorded in any legible format including, but not limited to, signed chart notes

(Emphasis added.)

The Court of Appeals has ruled that administrative rules requiring treatment plans are to be strictly applied. When a treatment plan prepared by the attending physician fails to specify the required elements, the treatment is not reimbursable. *Aetna Casualty & Surety Co. v. Blanton*, 139 Or App 283 (1996); *John J. Eggleston*, 4 WCSR 27 (1999); *Jeffrey A. Pugh*, 6 WCSR 62 (2001).

The record establishes that Dr. Vervosa's first treatment plan was untimely. On August 19, 2002, Dr. Vervosa referred claimant for chiropractic treatment. Therefore, any chiropractic treatment Dr. Walsh provided from August 16, 2002 when he no longer qualified as attending physician until Dr. Vervosa provided a valid treatment plan was not reimbursable. Insurer concedes that Dr. Vervosa's September 3, 2002 and October 1, 2002 treatment plans were adequate. In view of my approval of Dr. Vervosa as the fourth attending physician, insurer is liable for the treatment Dr. Walsh provided from September 3, 2002 through October 30, 2002.

ATTORNEY FEES

Claimant has prevailed in a contested case hearing, and therefore, he is entitled to a reasonable attorney fee. ORS 656.385(1). On September 25, 2003, claimant's attorney submitted a statement of services requesting an attorney fee of \$6,750. On October 1, 2003,

insurer objected to the amount requested, arguing that the risk that claimant's attorney would go uncompensated should not be considered as a factor.

OAR 436-001-0265 provides:

- (1) In cases where the director is authorized to assess a reasonable attorney fee by statute, the following factors may be considered:
 - (a) The time devoted to the case;
 - (b) The complexity of the issue(s) involved;
 - (c) The quality of the legal representation;
 - (d) The value of the interest involved;
 - (e) The nature or the proceedings;
 - (f) The benefit secured for the claimant;
 - (g) The risk in a particular case that an attorney's efforts may go uncompensated;
 - (h) The assertion of frivolous issues or defenses;
 - (i) A statement of services, if submitted within seven days of the hearing date, unless the presiding officer instructs otherwise; and
 - (j) Any other relevant consideration deemed appropriate by the presiding officer.

Having considered these factors, I find that \$6,750 is a reasonable fee for claimant's attorney's services in this matter. Therefore, claimant is entitled to an assessed fee of \$6,750.

ORDER

IT IS HEREBY ORDERED that:

The Administrative Order dated May 15, 2003 is modified.

1. Dr. Vervosa is approved as claimant's third choice of attending physician.
2. Insurer is liable to reimburse Francis V. Vervosa, MD for treatments provided to claimant from August 19, 2002 through November 22, 2002.
3. Insurer is liable to reimburse Mark W. Walsh, DC for treatments provided to claimant from September 3, 2002 through October 30, 2002.
4. Insurer is liable for an attorney fee of \$6,750.

DATED this 24th day of November 2003.

Catherine P. Coburn
Administrative Law Judge
Office of Administrative Hearings