In the ORS 656.260 Managed Care Dispute of

SHERYL J. BURTCH, Claimant

Contested Case No: H04-194

PROPOSED AND FINAL ORDER

June 23, 2005

SHERYL J. BURTCH, Petitioner

SAIF CORP., Respondent

Before Catherine P. Coburn, Administrative Law Judge, Administrative Hearings

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HISTORY OF THE CASE

Claimant appeals an Administrative Order issued on December 7, 2004 by the Medical Review Unit (MRU) of the Workers' Compensation Division (WCD) Department of Consumer and Business Services (director or the department). On January 12, 2005, WCD referred the matter to the Office of Administrative Hearings (OAH). On June 1, 2005, Administrative Law Judge Catherine P. Coburn conducted a hearing. Petitioner Sharyl J. Burtch (claimant) was represented by attorney Charles R. Mundorff. Respondent SAIF Corporation (insurer) was represented by attorney James D. Booth. Oregon Health Systems, a managed care organization (OHS or MCO) waived appearance. No witnesses testified and the record closed on the date of hearing.

ISSUES

(1) Pursuant to ORS 656.245, whether insurer is liable for medical services obtained outside the MCO panel for a subsequently accepted condition.

(2) Whether MRU incorrectly determined that insurer is not liable for medical services provided by Paul J. Montalbano, MD and H. Neil Sweeten, PA on February 17, 2004.

EVIDENTIARY RULINGS

WCD Exhibits 1 through 58 were admitted into the record without objection.

FINDINGS OF FACT

(1) On December 2, 2002, claimant suffered a compensable injury while working as a mental health technician. A patient grabbed her by the hair and slammed her into a chalkboard. (Ex. 1.) On December 16, 2002, insurer accepted "right knee contusion and right suprascapular muscle strain" and sent claimant a notice of MCO enrollment. (Exs. 3, 4 and 5.)

(2) Jonathan Hitzman, MD, who is an MCO panel member, treated the right knee and right shoulder conditions. (Exs. 8, 9, 11, 14, 16, 18.) Dr. Hitzman referred claimant to Guy Gehling, MD for evaluation of cervical complaints. (Ex. 19-1.) Dr. Gehling recommended surgery and opined that the cervical condition was not work-related. (Ex. 19-6.)

(3) For the cervical condition, claimant sought treatment from her family physician, Julie Wuest, MD, who referred her to Paul J. Montalbano, MD (Neurosurgeon). (Ex. 21.) Neither Dr. Wuest nor Dr. Montalbano are MCO panel members. (*Id.*) Dr. Montalbano recommended C5-6 anterior cervical decompression, fusion and instrumentation. (Ex. 24.)

(4) On February 17, 2004, Dr. Montalbano performed surgery at C5-6, assisted by H. Neil Sweeten, PA. (Ex. 23.) Dr. Montalbano noted, "The patient is an approximately 45-year-old female who presents with evidence of a spinal cord injury secondary to spondylolytic changes after experiencing a traumatic, work-related event." (*Id.*) The bills for the February 17, 2004 cervical surgery total $16,514 ($14,360. + $2,154). (Exs. 30, 31, 32 and 33.)

(5) On March 4, 2004, claimant requested insurer to accept C5-6 spondylosis. (Ex. 26.)

(6) On April 28, 2004, Thomas J. Rosenbaum, MD (Neurosurgeon) conducted an independent medical examination. (Ex. 34.) He opined that claimant suffered preexisting asymptomatic cervical spondylotic changes that combined with the work injury. He further opined that the work injury was the major contributing cause of the need for surgery. (Ex. 34-8.)

(7) On May 3, 2004, insurer issued a Modified Notice of Acceptance to include C5-6 spondylosis as a combined condition. (Ex. 36.)

CONCLUSIONS OF LAW

(1) Pursuant to ORS 656.245, insurer is liable for medical services obtained outside the MCO panel for a subsequently accepted condition.

(2) MRU incorrectly determined that insurer is not liable for medical services provided by Paul J. Montalbano, MD and H. Neil Sweeten, PA on February 17, 2004.

OPINION

The director exercises jurisdiction over MCO disputes. ORS 656.260(6). I review for substantial evidence and error of law. ORS 656.260(16) and OAR 436-001-0225(1). The burden of proving a fact or position rests with the proponent. ORS 183.450(2); *Harris v. SAIF,* 292 Or 683 (1982). As petitioner, claimant bears the burden of proving by a preponderance of evidence that the administrative order is incorrect. *Cook v. Employment Div.,* 47 Or 437 (1982) (In the absence of contrary legislation, the standard of proof in administrative hearings is preponderance of evidence). Preponderance of evidence means that the factfinder is persuaded that the facts asserted are more likely true than false. *Riley Hill General Contractors v. Tandy Corp.,* 303 Or 390 (1989). Having reviewed the record, I conclude that claimant has met her burden.

MRU determined that insurer was not liable for the disputed medical services because claimant was enrolled in an MCO and obtained services outside the panel. MRU did not consider the scope of acceptance in relation to the MCO rules. Citing ORS 656.245(4)(D),

claimant contends that insurer is liable for the disputed cervical surgery because it was directed to a condition that was not accepted at the time of the treatment but was later accepted as a compensable condition based on new medical evidence. In support of her position, claimant argues that MCO rules do not apply to a medical condition until the date insurer accepts that condition as compensable. In contrast, insurer contends that the administrative order is correct and should be affirmed.

Pursuant to ORS 656.245(1)(a),[1] an insurer is required to provide medical services for conditions caused in material part by the work injury for such period as the nature of the injury or the process of recovery requires. This obligation continues for the injured worker's lifetime. ORS 656.245(1)(b). Additionally, pursuant to ORS 656.245(4) and ORS 656.260, an insurer may provide medical services to injured workers through an MCO.

ORS 656.245 provides in pertinent part:

> (4) Notwithstanding subsection (2)(a)[2] of this section, when a self-insured employer or the insurer of an employer contracts with a managed care organization certified pursuant to ORS 656.260[3] for medical services required by this chapter to be provided to injured workers:
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> (a) **Those workers who are subject to the contract shall receive medical services in the manner prescribed in the contract.**
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[1] ORS 656.245(1)(a) provides:
(1)(a) For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions caused in material part by the injury for such period as the nature of the injury or the process of the recovery requires, subject to the limitations in ORS 656.225, including such medical services as may be required after a determination of permanent disability. In addition, for consequential and combined conditions described in ORS 656.005 (7), the insurer or the self-insured employer shall cause to be provided only those medical services directed to medical conditions caused in major part by the injury.

ORS 656.245(1)(b) provides:
(b) Compensable medical services shall include medical, surgical, hospital, nursing, ambulances and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services. A pharmacist or dispensing physician shall dispense generic drugs to the worker in accordance with ORS 689.515. The duty to provide such medical services continues for the life of the worker.

[2] ORS 656.245(2)(a) provides in pertinent part:
The worker may choose an attending doctor, physician or nurse practitioner within the State of Oregon.

[3] ORS 656.260(1) provides:
Any health care provider or group of medical service providers may make written application to the Director of the Department of Consumer and Business Services to become certified to provide managed care to injured workers for injuries and diseases compensable under this chapter. However, nothing in this section authorizes an organization that is formed, owned or operated by an insurer or employer other than a health care provider to become certified to provide managed care.

> (b)(D) If the claim is denied, the worker may receive medical services after the date of 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 656.248 by the insurer or self-insured employer if the claim is finally determined to be compensable.

In interpreting a statute, the court's, and thus my charge is to determine the legislative intent. ORS 174.020[4] *PGE v. Bureau of Labor and Industries,* 317 Or 606 (1993). In order to discern the legislative intent, the first level of analysis is to examine both the text and context of the statute. 317 Or at 610-611. The text of the statute is the best evidence of the legislature's intent. If the legislature's intent is unclear, I consider legislative history, and if still unclear, I apply the general maxims of statutory construction. *Id.* Applying this analysis to ORS 656.245, I find I need progress no further than the text and context.

To begin, ORS 656.245(4)(a) is read in context with ORS 656.245(1) which requires an insurer to provide medical services for conditions caused in material part by a work injury. ORS 656.245(4)(a) reads, "Those workers who are subject to the contract shall receive medical services in the manner prescribed in the contract." Implicit in this language is the requirement that such workers shall receive medical services for accepted, compensable conditions. Certainly, no insurer would concede that it was required to provide medical services for conditions that were outside the scope of acceptance. By the same token, the MCO rules do not apply to medical conditions that are outside the scope of acceptance.

Next, ORS 656.245(4)(a), read in context with ORS 656.245(4)(b)(D) further reflects the legislature's intent to exclude noncompensable medical conditions from the MCO rules. Under subsection (4)(a), an MCO-enrolled injured worker is required to seek treatment within the MCO panel only for those medical conditions that are compensable. Conversely, under subsection (4)(b)(D), denied conditions are not subject to MCO requirements unless and until they become accepted as compensable; at such time when a condition is finally determined to be compensable, then insurer is liable for any medical treatment obtained outside the panel during the period before acceptance.

Here, the disputed surgery was related to a cervical condition that was neither accepted nor denied at that time. In keeping with the contemporaneous medical opinion, no claim for a cervical condition was asserted before the surgery. Pursuant to ORS 656.245(4)(a) and ORS 656.245(4)(b)(D), claimant was not required to seek treatment within the MCO panel for the cervical condition until it became compensable. The cervical condition became subject to the MCO rules on May 3, 2004 when insurer accepted it as a compensable condition. Furthermore, insurer is liable for medical treatment obtained outside the panel before the date of acceptance.

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[4] ORS 174.020(1)(a) provides:
In the construction of a statute, a court shall pursue the intention of the legislature if possible.

Additionally, OAR 436-009-0015 supports the conclusion that MCO rules apply only to accepted medical conditions. OAR 436-009-0015 provides:

> (1) An injured worker shall not be liable to pay for any medical service related to an **accepted compensable injury or illness** or any amount reduced by the insurer pursuant to OAR chapter 436. A medical provider shall not attempt to collect payment for any medical service from an injured worker, except as follows:
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> (d) When the injured worker seeks treatment outside the provisions of a governing MCO contract after insurer notification in accordance with OAR 436-010-0275;[5]

(Emphasis added.)

Under the rule, an injured worker is not liable for medical services related to an accepted, compensable injury or illness. As an exception, an MCO-enrolled injured worker who seeks

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[5] OAR 436-010-0275 provides in pertinent part:

(4) When the insurer is enrolling a worker in an MCO, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical service providers, and the MCO of enrollment. The notice must:

(a) Notify the worker of the eligible attending physicians within the relevant MCO geographic service area and describe how the worker may obtain the names and addresses of the complete panel of MCO medical providers;

(b) Advise the worker of the manner in which the worker may receive medical services for compensable injuries within the MCO;

(c) Describe how the worker can receive compensable medical treatment from a primary care physician or authorized nurse practitioner qualified to provide services as described in OAR 436-015-0070, who is not a member of the MCO, including how to request qualification of their primary care physician or authorized nurse practitioner;

(d) Advise the worker of the right to choose the MCO when more than one MCO contract covers the worker's employer except when the employer provides a coordinated health care program as defined in OAR 436-010-0005(6);

(e) Provide the worker with the title, address and telephone number of the contact person at the MCO responsible for ensuring the timely resolution of complaints or disputes;

(f) Advise the worker of the time lines for appealing disputes beginning with the MCO's internal dispute resolution process through administrative review before the director, that disputes to the MCO must be in writing and filed within 30 days of the disputed action and with whom the dispute is to be filed, and that failure to request review to the MCO precludes further appeal; and

(g) Notify the MCO of any request by the worker for qualification of a primary care physician or authorized nurse practitioner.

(5) Insurers under contract with MCOs who enroll workers prior to claim acceptance must inform the worker in writing that the insurer will pay as provided in ORS 656.248 for all reasonable and necessary medical services received by the worker that are not otherwise covered by health insurance, 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 occurs first.

medical service outside the panel for an accepted, compensable injury or illness is liable. The director promulgated OAR 436-009-0015(1)(d) in order to protect medical providers from the risk of nonpayment when an MCO-enrolled injured worker obtains medical service for a compensable condition outside the panel. Under such circumstances, the rule properly assigns liability to the worker because he, and not the medical provider, possesses knowledge of the critical factors, *viz.*, the fact that he has a workers' compensation claim, what medical conditions are included in that claim, and that he has been enrolled in an MCO. *See Glen Johnston,* 10 CCHR 139 (2005) (Claimant was liable for an MRI obtained outside the MCO panel where he failed to inform medical provider that the body part was accepted in a workers' compensation claim and he was enrolled in an MCO.)

In contrast, at the time claimant obtained the disputed surgery, she had no knowledge that the cervical condition was work-related. The existing medical opinion at that time indicated that it was not work-related. Consequently, claimant properly sought treatment from her family physician and a specialist for a cervical condition that was apparently not work-related. When new medical information came to light, insurer eventually accepted the cervical condition. Under the circumstances, claimant is not liable pursuant to OAR 436-009-0015.

The director has construed ORS 656.245(4)(a) to mean that a worker and not a medical condition is enrolled in an MCO. *Thomas Yoney* 7 CCHR 29 (2002). In *Yoney,* insurer initially accepted a shoulder strain and cervical disc and enrolled claimant in an MCO. Claimant obtained treatment that did not comply with the MCO rules. Several years after the MCO enrollment, claimant requested acceptance of additional medical conditions, insurer denied compensability and was eventually ordered to accept them. At hearing, claimant contended that the MCO enrollment did not apply to the subsequently accepted conditions. The director ruled that, by virtue of the initial MCO enrollment, the MCO rules applied to each medical condition as of the date of acceptance over the life of the claim. Similarly here, the MCO rules apply to the initially accepted knee and shoulder conditions effective on the date of the initial acceptance and MCO enrollment. Additionally, the MCO rules apply to the subsequently accepted cervical condition effective on the later date of acceptance.

In conclusion, it is undisputed that an MCO-enrolled injured worker may obtain medical services outside the panel for a variety of non-work-related, noncompensable medical conditions. Conversely, an MCO-enrolled injured worker is required to obtain medical services within the panel only for accepted, compensable conditions. Where an insurer initially accepts one medical condition and subsequently accepts another, the MCO rules apply upon the date of acceptance for each condition. Furthermore, if an MCO-enrolled injured worker obtains medical service outside the panel for a noncompensable condition, and subsequently, insurer accepts that condition as compensable, then insurer, rather than claimant is liable. Finally, inasmuch as the administrative order reflects an error of law, I reverse.

ATTORNEY FEES

Claimant has prevailed in a contested case hearing and is entitled to a reasonable attorney fee. ORS 656.385(1). Considering the factors listed in OAR 436-001-0265, $700 ($200 x 3.5 hours) is a reasonable fee for claimant's attorney's services in this matter.

ORDER

IT IS HEREBY ORDERED that:

(1) The Administrative Order dated December 7, 2004 is reversed.

(2) Insurer shall pay claimant's attorney a fee of $700.