

In the ORS 656.327 Medical Treatment Dispute of

**STEVEN R. JOHNSON, Claimant**

Contested Case No: H04-179

**FINAL ORDER**

November 10, 2005

AMERICAN MOTORIST INSURANCE CO., Petitioner

STEVEN R. JOHNSON, Respondent

Before John Shilts, Administrator, Workers' Compensation Division

---

Respondent claimant, through attorney James W. Moller, filed exceptions to Office of Administrative Hearings Administrative Law Judge (ALJ) Catherine P. Coburn's May 3, 2005 Proposed and Final Order. Petitioner insurer, through attorney Brad G. Garber, responded. The issue is whether insurer is liable to reimburse claimant for the cost and related expenses he paid for an elective artificial disc replacement he underwent in Germany on March 25, 2004. The Medical Review Unit (MRU), in its October 20, 2004 Administrative Order, concluded that insurer was liable. The ALJ reversed. I affirm on different grounds.

I adopt the ALJ's findings of fact with one correction. Finding of fact (2) states in part that claimant's condition became medically stationary in September 1996 and the claim was closed the following month. The record shows that claimant's condition became medically stationary in September **1997**, and his claim was closed in October 1997. (Ex. 40 and 43.) The ALJ's finding is modified accordingly.<sup>1</sup>

The relevant facts can be summarized as follows. Claimant was injured in 1992. Insurer accepted lumbar strain and L4-5 disc herniation. The claim was closed in 1997. Claimant arranged for an artificial disc replacement in Germany, scheduled for March 25, 2004. Artificial disc replacement has not been approved by the Food and Drug Administration. On March 2, 2004, claimant notified insurer that he had scheduled the surgery, and requested payment. On March 9, 2004, claimant personally paid the full cost and expenses associated with the procedure. Three days before the surgery claimant's attending physician, Dr. Leung, indicated "to whom it may concern" that claimant "may be a candidate for an artificial disc replacement at L4-5." Insurer denied payment. Claimant's pain has reduced considerably after the surgery.

Three primary issues are raised by the ALJ's proposed order and the parties' written arguments. I address each issue separately.

Change of Attending Physician

MRU found that insurer did not comply with OAR 436-010-0210 when it did not respond to claimant's March 2, 2004 letter. The ALJ found that substantial evidence does not support MRU's finding because the record establishes that insurer did respond to claimant's letter. I agree with the ALJ that MRU's finding is not supported by substantial evidence, for different

---

<sup>1</sup> I may modify the ALJ's findings of historical fact if I determine that the finding is not supported by a preponderance of the evidence in the record. ORS 183.650(3); OAR 137-003-0665(4).

reasons. OAR 436-010-0210(7)<sup>2</sup> provides, in part:

“In accordance with ORS 656.245(2)(a), with the approval of the insurer, the worker may choose an attending physician outside the state of Oregon. Upon receipt of the worker's request, or the insurer's knowledge of the worker's request to treat with an out-of-state physician, the insurer shall give the worker written notice of approval or denial of the worker's choice of attending physician within 14 days.”

By its terms, this rule applies when a worker requests an out-of-state attending physician. Language in the second sentence – “the insurer’s knowledge of the worker’s request to treat with an out-of-state physician” – can be read to apply to a request to *treat* with an out-of-state physician, when read in isolation. When read in context, however, it is clear that the rule only applies when the working is wanting to designate an out-of-state physician as his attending physician, under ORS 656.245(2)(a).

Claimant’s March 2, 2004 letter does not indicate that claimant is wanting to change attending physicians or choose an out-of-state attending physician. Rather, it indicates that he has scheduled surgery for March 25 and is requesting confirmation of payment. While insurer’s representative testified that she sent claimant a Form 827<sup>3</sup> in response to his letter, I find that OAR 436-010-0210(7) does not apply.<sup>4</sup> Therefore, insurer did not fail to comply with it.

### Elective Surgery Rule

MRU excused the surgeon in Germany from compliance with OAR 436-010-0250 and found that since claimant notified insurer of the proposed surgery, insurer was obligated to respond under the rule and failed to do so. The ALJ did not defer to MRU’s interpretation of the rule.

OAR 436-010-0250 provides, in part:

“(2) [W]hen the attending physician or surgeon upon referral by the attending physician or authorized nurse practitioner, believes elective surgery is needed to treat a compensable injury or illness, the attending physician or the surgeon shall give the insurer actual notice at least seven days prior to the date of the proposed surgery. Notification shall give the medical information that substantiates the need for surgery, and the approximate surgical date and place if known.”

---

<sup>2</sup> MRU cited to section (8) of OAR 436-010-0210. In March 2004, when this dispute arose, the rule language quoted appeared in section (7). It was renumbered to section (8) effective 4/1/04. The language was not changed. All rule references herein are to the rules adopted effective 1/1/04, WCD Admin. Order 03-069.

<sup>3</sup> *Worker’s and Physician’s Report for Workers’ Compensation Claims*. Used to, among other things, designate a new attending physician.

<sup>4</sup> To the extent the ALJ found that OAR 436-010-0210 does apply and claimant wished to designate an out-of-state attending physician, I do not affirm.

The ALJ found that claimant's attending physician did not propose the surgery or refer claimant to a surgeon. The ALJ further found that the surgeon did not communicate with insurer or provide medical information substantiating the need for surgery. I agree with the ALJ. The rule requires the attending physician, or surgeon upon referral by the attending physician, to provide notice to the insurer. Here, claimant provided notice to the insurer. There is no evidence in the record that Dr. Leung referred claimant to the surgeon in Germany. While the record does show that Dr. Leung believed claimant *may* be a candidate for the surgery, I do not interpret the evidence to mean that Dr. Leung proposed or recommended the surgery. Moreover, insurer was not provided with medical information substantiating the need for surgery as required by the rule. In an e-mail to claimant, insurer stated, "Please contact your physicians to fax us medicals. [W]e still have no medical requesting authoriz[ation] for surgery. We only have your letter. We need a request from a[] physician \* \* \*." (Ex. 66A-1.)

Under OAR 436-010-0250, an insurer may seek an independent consultation when elective surgery is recommended. The insurer must notify the recommending physician of its decision to obtain a consultation, and of the consultant's findings. The insurer and the recommending physician must attempt to resolve any differences of opinion. Here, there is no recommending physician. Dr. Leung did not fail to comply with the rule because he was not recommending elective surgery. While insurer could have obtained an independent consultation, insurer could not have fully complied with the rule under these facts. I find that insurer is not barred from challenging the surgery.<sup>5</sup>

#### Surgery Not Authorized by Attending Physician

The worker's attending physician is primarily responsible for the worker's care. OAR 436-010-0220(1). To be compensable and reimbursable, medical treatment must be authorized in writing by the worker's attending physician. ORS 656.245(2)(b)(A). OAR 436-010-0220(2) provides, in part:

"The worker may have only one attending physician or authorized nurse practitioner at a time. Simultaneous or concurrent treatment by other medical service providers shall be based upon a written request of the attending physician or authorized nurse practitioner, with a copy of the request sent to the insurer. Except for emergency services, or otherwise provided for by statute or these rules, all treatments and medical services must be authorized by the injured worker's attending physician or authorized nurse practitioner to be reimbursable."

---

<sup>5</sup> OAR 436-010-0250(5) provides, in part:

"Failure of the insurer to timely respond to the physician's elective surgery request or to timely request administrative review pursuant to this rule shall bar the insurer from later disputing whether the surgery was excessive, inappropriate, or ineffectual."

In addition, OAR 436-009-0015(1)(b) provides that a provider may seek payment from the worker “[w]hen the injured worker seeks treatment that has not been prescribed by the attending physician or authorized nurse practitioner, or a specialist physician upon referral of the attending physician or authorized nurse practitioner.”

Here, there is no written request or prescription from Dr. Leung for artificial disc replacement. While Dr. Leung indicated that claimant “may” be a candidate, I do not find that sufficient evidence that he requested or prescribed the surgery. For that reason, I find that insurer is not liable to reimburse claimant for the cost and related expenses for the elective artificial disc replacement he underwent in Germany on March 25, 2004.

Attorney fees

Claimant has not prevailed. Accordingly, his attorney is entitled to no fee. ORS 656.385(1).

**IT IS HEREBY ORDERED** the May 3, 2005 Proposed and Final Order is affirmed for the reasons stated above.