
In the ORS 656.327 Medical Treatment Dispute of
STEVEN R. JOHNSON, Claimant

Contested Case No: H04-179

PROPOSED AND FINAL ORDER

MAY 5, 2005

AMERICAN MOTORISTS INSURANCE CO., Petitioner

STEVEN R. JOHNSON, Respondent

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

HISTORY OF THE CASE

Insurer appeals the Administrative Order issued on October 20, 2004 by the Medical Review Unit (MRU) of the Workers' Compensation Division (WCD), Department of Consumer and Business Services (department or director). On December 27, 2004, the department referred the matter to the Office of Administrative Hearings (OAH). On March 4, 2005, Administrative Law Judge (ALJ) Catherine P. Coburn convened and postponed the hearing to allow claimant to obtain counsel. On April 26, 2005, ALJ Coburn conducted a hearing in Beaverton, Oregon. Attorney Brad Garber represented petitioner American Motorist Insurance Company and its claims administrator Broadspire Risk Management Inc. (insurer). Attorney John Oswald represented respondent Steven R. Johnson (claimant). Claimant testified on his own behalf and claims examiner Laura Ellis testified on insurer's behalf. The record closed on the date of hearing.

ISSUE

Whether insurer is liable for reimbursement to claimant for expenses he incurred when he paid for an artificial disc replacement (ADR) elective surgery he underwent at the Stenum Hospital in Germany on March 25, 2004.

EVIDENTIARY RULINGS

WCD Exhibits 1 through 86 were admitted into the record without objection. Insurer's Supplementary Exhibit 66A was admitted into the record over claimant's objection because it is an e-mail exchange between claimant and the claims examiner and does not constitute "medical" evidence within the meaning of ORS 656.327(2)¹ and OAR 436-001-0225(1)².

¹ ORS 656.327(2) provides in pertinent part:

At the contested case hearing, the administrative order may be modified only if it not supported by substantial evidence or if it reflects an error of law. No new medical evidence or issues shall be admitted.

² OAR 436-001-0225(1) provides:

Review of medical service (ORS 656.245 and 656.247(3)(a)) and treatment (ORS 656.327 and 656.260) disputes is for substantial evidence or error of law. New medical evidence or issues may not be considered at the contested-case hearing.

FINDINGS OF FACT

(1) On July 1, 1992, claimant suffered a compensable low back injury while working as an airline pilot. (Exs. 6 and 7.) Insurer accepted a lumbar strain and L4-5 disc herniation. (Ex. 39 and 44-2.)

(2) Claimant underwent lumbar surgeries in 1992, 1996 and 1997. (Exs. 4, 17, and 26.) Claimant's condition became medically stationary in September 1996 and the claim was closed the following month. (Exs. 9, 40 and 43.)

(3) In February 1998, the parties executed a claims disposition agreement to settle the claim, preserving claimant's right to continuing medical services. Claimant was represented by counsel. (Ex. 44.)

(4) In 2004, claimant's designated attending physician was Kenneth Y. K. Leung, MD who practiced in Seattle, Washington. (Exs. 27, 29, 30, 31, 34, 66A; testimony of Ellis.) Claimant also treated with Curtis Hill, MD in Portland, Oregon. (Exs. 35, 49, 52, and 54.)

(5) From January 2004 until the disputed surgery in March, claimant experienced severe lumbar pain. (Testimony of claimant.) In February 2004, claimant sought treatment from David S. Bradford, MD at the University of California at San Francisco, California, listing his insurance carrier as "self-pay". (Exs. 60 and 61.) On February 18, 2004, Dr. Bradford noted that claimant was considering seeking treatment in Europe. (Ex. 63.) Artificial disc replacement (ADR) has not been approved by the United States Food and Drug Administration. (Exs. 63, 71 and 81.)

(6) By e-mail to claimant dated March 2, 2004, the Stenum Hospital in Bremen, Germany confirmed claimant's appointment for surgical ADR on March 25, 2004. The confirmation was sent from the office of Dr. Malte Petersen. The package deal included one day presurgical hospitalization, surgery, 5 to 7 days postsurgical hospitalization, and 7 days postoperative stay in the Hilton Hotel for two people including breakfast buffet. (Ex. 64-2.) The Stenum Hospital required full payment 14 days prior to arrival and claimant prepaid the full amount. (Ex. 64; testimony of claimant.)

(7) By letter dated March 2, 2004, claimant notified insurer that he had scheduled ADR surgery for March 25 at Stenum Hospital in Bremen, Germany. Claimant attached the appointment confirmation from the hospital. (Exs. 64, 65, 66-7.) Insurer received the letter on March 4, 2004. (Ex. 65.)

(8) On or about March 4, 2004, insurer's claims examiner, Laura Ellis, spoke to claimant by telephone. Claimant said that he was going to Germany for surgery. (Testimony of claimant and Ellis.) Ellis indicated that insurer intended to schedule an independent medical consultation concerning the proposed surgery but claimant replied that he had already purchased his plane ticket to Germany for March 22. (Testimony of Ellis.) Ellis asked claimant for the name of the doctor who recommended the ADR. (Testimony of claimant and Ellis.) That day, claimant e-mailed to insurer a list of four physicians who had examined claimant without identifying the doctor who planned to perform the proposed ADR. The list included Malte Petersen and contact

information for the Stenum Hospital in Germany. (Ex. 66A.)

(9) On or about March 4, 2004, Ellis, sent claimant an 827 form to properly request authority to designate a new attending physician. On March 17, she notified him by e-mail that she had not received a completed 827 form. Insurer never received a completed 827 form. (Ex. 66A; testimony of Ellis.) Insurer never received any communication from claimant identifying the name of the out-of-state physician he chose to designate as his new attending physician. (Testimony of Ellis.) Insurer never received any communication from claimant's current attending physician, Dr. Leung, referring claimant to another physician. (Testimony of Ellis.)

(10) On March 22, 2004,³ Dr. Leung opined that claimant may be a candidate for an artificial disk replacement at L4-5. (Ex. 67.)

(11) On March 22, 2004, claimant flew to Germany. (Testimony of claimant.) On March 25, Dr. Zechel performed surgical ADR at L4-5. On March 30, claimant was discharged from Stenum Hospital. (Ex. 69.)

(12) Following ADR surgery, claimant's lumbar pain has been reduced to a mild level occasionally. (Testimony of claimant.)

(13) On September 8, 2004, claimant forwarded the ADR report from Dr. Zechel to insurer. (Ex. 81.) Dr. Zechel never provided insurer with medical information that substantiated the need for surgery. (Testimony of Ellis.)

CONCLUSION OF LAW

Insurer is not liable for reimbursement to claimant for expenses he incurred when he paid for an artificial disc replacement (ADR) elective surgery he underwent at the Stenum Hospital in Germany on March 25, 2004.

OPINION

Jurisdiction lies with the director. ORS 656.327(2). I may modify the administrative order only if it is not supported by substantial evidence in the record or reflects an error of law. ORS 656.327(2) and OAR 436-001-0225(1). The burden of proving a fact or position falls upon the proponent. ORS 183.450(2). As petitioner, insurer bears the burden of proving by a preponderance of evidence that the administrative order is incorrect. *Cook v. Employment Div.*, 47 Or App 437 (1980) (In the absence of contrary legislation, the standard of proof in administrative hearings 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 (1998).

MRU determined that insurer is liable for the disputed elective surgery. As a factual matter, MRU found that claimant notified insurer of his intent to choose an out-of-state attending

³ The letter's date is incomplete but insurer's date stamp is March 30, 2004.

physician and that insurer failed to respond in writing in violation of OAR 436-010-0210. MRU further found that although claimant failed to comply with the elective surgery notice requirement specified in OAR 436-010-0250, that failure was excused because a foreign medical provider is not expected to be aware of Oregon workers' compensation administrative rules but may seek payment from an Oregon workers' compensation insurance carrier. Finally, MRU concluded that the disputed surgery was appropriate medical treatment because claimant's pain was reduced, and therefore, insurer is liable. Insurer contends that the administrative order reflects errors of law because MRU misinterpreted and misapplied OAR 436-010-0210 and OAR 436-010-0250. In contrast, claimant contends that the administrative order is correct and should be affirmed. Having reviewed the record, I find that insurer has met its burden.

Under ORS 656.245⁴ and ORS 656.327,⁵ the insurer is required to provide medical services for a compensable injury unless the treatment is excessive, inappropriate, ineffectual or in violation of the administrative rules. Additionally, ORS 656.245(2)(a) provides in pertinent part:

(2)(a) The worker may choose an attending doctor, physician or nurse practitioner within the State of Oregon. The worker may choose the initial attending physician or nurse practitioner and may subsequently change attending physician or nurse practitioner two times without approval from the director. If the worker thereafter selects another attending physician or nurse practitioner, the insurer or self-insured employer may require the director's approval of the selection and, if requested, the director shall determine with the advice of one or more physicians, whether the selection by the worker shall be approved. The decision of the director is subject to a contested case review under ORS chapter 183. **The worker also may choose an attending doctor or physician in another country or in any state or territory or possession of the United States with the prior approval of the insurer or self-insured employer.**

(Emphasis added.)

OAR 436-010-0210 provides in pertinent part:

⁴ ORS 656.245(1) provides in pertinent part:

(c) Notwithstanding any other provision of this chapter, medical services after the worker's condition is medically stationary are not compensable except for the following:

(L) Curative care provided to a worker to stabilize a temporary and acute waxing and waning of symptoms of the worker's condition.

⁵ ORS 656.327(1)(a) provides: If an injured worker, an insurer or self-insured employer or the Director of the Department of Consumer and Business Services believes that the medical treatment, not subject to ORS 656.260, that the injured worker has received, is receiving, will receive or is proposed to receive is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services, the injured worker, insurer or self-insured employer shall request review of the treatment by the director and so notify the parties.

(1) Attending physicians and authorized nurse practitioners may authorize time loss and manage medical services subject to the limitations of these rules.

(8) 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.**

(Emphasis added.)

Additionally, OAR 436-010-0250 provides in pertinent part:

(1) "Elective Surgery" is surgery which may be required in the process of recovery from an injury or illness but need not be done as an emergency to preserve life, function or health.

(2) Except as otherwise provided by the MCO, when 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, authorized nurse practitioner, 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.**

(3) When elective surgery is recommended, the insurer may require an independent consultation with a physician of the insurer's choice. The insurer shall notify the recommending physician, the worker and the worker's representative, within seven days of receipt of the notice of intent to perform surgery, whether or not a consultation is desired by submitting Form 440-3228 (Elective Surgery Notification) to the recommending physician. When requested, the consultation shall be completed within 28 days after notice to the physician.

(4)(a) Within seven days of the consultation, the insurer shall notify the recommending physician of the insurer's consultant's findings.

(b) When the insurer's consultant disagrees with the proposed surgery, the recommending physician and insurer shall endeavor to

resolve any issues raised by the insurer's consultant's report. Where medically appropriate, the recommending physician, with the insurer's agreement to pay, shall obtain additional diagnostic testing, clarification reports or other information designed to assist them in their attempt to reach an agreement regarding the proposed surgery.

(c) The recommending physician shall provide written notice to the insurer, the worker and the worker's representative when further attempts to resolve the matter would be futile by signing Form 440-3228.

(5) If the insurer believes the proposed surgery is excessive, inappropriate, or ineffectual and cannot resolve the dispute with the recommending physician, the insurer shall request an administrative review by the director within 21 days of the notice provided in subsection(4)(c) of this rule. Failure of the insurer to timely respond to the physician's elective surgery request by submitting Form 440-3228, or to timely request administrative review pursuant to this rule shall bar the insurer from later disputing whether the surgery is or was excessive, inappropriate, or ineffectual.

(6) If the recommending physician and consultant disagree about the need for surgery, the insurer may inform the worker of the consultant's opinion. The decision whether to proceed with surgery remains with the attending physician and the worker.

(7) A recommending physician who prescribes or proceeds to perform elective surgery and fails to comply with the notification requirements in section (2) of this rule, may be subject to civil penalties as provided in ORS 656.254(3)(a) and OAR 436-010-0340.

(Emphasis added.)

The director has held that OAR 436-010-0250 must be strictly applied. *John B. Foster*, 9 CCHR 1 (2004); *on recon* 9 CCHR 256 (2004). *See also Sandra Schneiderman*, 10 CCHR 29 (2005); *Glenn R. Horn*, 9 CCHR 93 (2004), *on recon* 9 CCHR 201 (2004).

In construing the meaning of an administrative rule, I apply the same method of analysis employed in determining the meaning of a statute. *Abu-Adas v. Employment Dept.*, 325 Or 480 (1997); *Perlenfein and Perlenfein*, 316 Or 16 (1993); *Larry Hemenway*, 5 WCSR 33 (2000). *See also PGE v. Bureau of Labor and Industries*, 317 Or 606 (1993) (court's task in determining the legislative intent is to first examine the statute, including text and context, and if the intent is clear, to proceed no further with its analysis.) Where an agency's interpretation of its own rule is plausible and not inconsistent with the wording of the rule itself, the rule's context or with any

other source of law, there is no basis for asserting that the rule has been misinterpreted by the agency. *Don't Waste Oregon Com. v. Energy Siting Council*, 320 Or 132 (1994).

I find several flaws in the administrative order. To begin, MRU determined that insurer violated OAR 436-010-0210(8) because it failed to respond to claimant's March 2 letter indicating that he intended to seek medical treatment outside of Oregon. (Administrative Order p. 5, para. 3 and para 5.) However, based on the record, I find that substantial evidence does not support MRU's factual finding in this regard. Rather, the record establishes that claims examiner Ellis spoke to claimant by telephone within a day after she received his letter. Additionally, she sent claimant an 827 form to enable him to properly request approval of an out-of-state attending physician, and she followed up with him by e-mail a week later when she had not received a completed 827 form.⁶ Nevertheless, insurer never received a completed 827 form or any other communication from claimant identifying the name of the doctor claimant wished to designate as his new attending physician⁷ or any referral from his current attending physician, Dr. Leung, to a physician in Germany. In the absence of a completed 827 form, insurer was unaware of the name of the doctor claimant wished to designate as his new attending physician and, more importantly, whether that doctor agreed to assume the responsibilities incumbent upon an attending physician.⁸ Based on the record, I find that MRU's conclusion that insurer violated OAR 436-010-0210 by failing to respond to claimant's request to designate an out-of-state attending physician is not supported by substantial evidence.

MRU interpreted OAR 436-010-0210 to mean that an injured worker may obtain reimbursable medical services from an out-of-state physician without approval of the insurer or director. This interpretation of the rule conflicts with ORS 656.245(2)(a) which requires either the insurer's or the director's approval of any out-of-state attending physician. Consequently, the administrative order reflects an error of law. Furthermore, based on the record, I find that claimant violated ORS 656.245(2)(a) by failing to obtain approval from either the insurer or the director of his choice of an attending physician in Germany.

Next, MRU found that although claimant failed to comply with the elective surgery notice requirements specified in OAR 436-010-0250, that failure was excused because a foreign medical provider is not expected to be aware of Oregon workers' compensation administrative rules but may seek payment from an Oregon workers' compensation insurance carrier. (Adm. Order p. 5, para 6 and p. 6.) On the contrary, ORS 656.245(2)(a) requires approval by either the insurer or the director of any out-of-state attending physician in order to ensure the orderly provision of medical services in compliance with the statutory scheme. MRU's reasoning that a foreign medical provider may obtain payment from an Oregon insurance carrier without complying with Oregon statutes and administrative rules is faulty. *Aetna Casualty & Surety Company v. Sue Blanton*, 139 Or App 283 (1996) (in order to obtain reimbursement from insurer, a medical provider must comply with Oregon administrative rules). Suffice it to say that

⁶ Claimant's testimony evolved on this point. Initially, he testified that he scanned and e-mailed the 827 form back to insurer the same day he received it. Later, he testified that he may have scanned and e-mailed it to Dr. Leung for the attending physician's signature, but claimant was unaware whether Dr. Leung forwarded it to insurer.

⁷ Claimant's March 2, 2004 letter refers to Dr. Petersen, but in fact, Dr. Zechel performed the disputed surgery.

⁸ See i.e. OAR 436-010-0240 titled "Reporting Requirements for Medical Providers".

the Oregon workers' compensation system does not require insurers to pay for a week in the Hilton Hotel for two people with breakfast buffet.

Next, MRU found that insurer was notified of the proposed surgery three weeks before the appointment but failed to notify claimant whether it intended to obtain an independent medical consultation pursuant to OAR 436-010-0250(3). (Adm. Order p. 6 para 2.) I find that MRU's interpretation of OAR 436-010-0250(3) is inconsistent with the text of the rule and is not plausible, and consequently, I do not defer. The text of the rule requires *inter alia* either claimant's attending physician or surgeon upon referral from the attending physician to notify the insurer of a proposed elective surgery. Here, claimant, rather than any medical provider notified insurer of the proposed surgery. Three days before the disputed surgery took place, claimant's attending physician, Dr. Leung, wrote only that claimant "may" be a candidate for ADR without proposing such a surgery and without referring claimant to any surgeon in Germany. The physician who performed the surgery, Dr. Zechel, has never corresponded with insurer either to provide advance notice of a proposed elective surgery or to provide medical information that substantiates the need for surgery as required by OAR 436-010-0250(3).

Furthermore, based on the record, I find that substantial evidence does not support MRU's factual finding that insurer was notified of the proposed surgery three weeks before the appointment but failed to notify claimant whether it intended to obtain an independent medical consultation pursuant to OAR 436-010-0250(3). (Adm. Order p. 6 para 2.) Insurer first received notice of the proposed surgery on March 4. Within a day of receiving claimant's letter, insurer's claims examiner spoke to him by telephone and indicated that insurer intended to obtain an independent medical consultation concerning the proposed surgery. However, claimant had already purchased his plane ticket to Germany for March 22, effectively depriving insurer of the opportunity to obtain an independent medical consultation. Inasmuch as claimant violated OAR 436-010-0250, which is strictly construed, the disputed elective surgery is not reimbursable.

OAR 436-009-0015 provides in pertinent part:

(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:

(b) When 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.

The Oregon Workers Compensation statutory and administrative scheme does not require insurers to provide medical services upon the injured worker's request. Rather, it is predicated upon the role of the attending physician in authorizing medical services and communication between the attending physician and the insurer. Here, the record establishes that claimant, who was previously represented by counsel, disregarded the Oregon statutory and administrative

requirements in obtaining the disputed surgery. For example, he confirmed the surgical appointment with Stenum Hospital and purchased a plane ticket to Germany before notifying insurer that any surgery was proposed. Moreover, he wrote a letter that insurer received on March 4 and requested full payment to a hospital in Germany by March 10, only 6 days later (fourteen days prior to claimant's hospitalization on March 24). I find it notable that when claimant sought treatment for the same lumbar condition from Dr. Bradford at the UCSF, he listed his insurance carrier as "self-pay". Similarly, when claimant obtained the disputed surgery which was not prescribed by the attending physician or by a specialist physician upon referral of the attending physician, he assumed personal responsibility for the disputed medical expenses.

In conclusion, claimant failed to obtain approval of an out-of-state attending physician as required by ORS 656.245(2)(a) and OAR 436-010-0250(8). Moreover, the disputed surgery was not authorized by claimant's designated attending physician as required by OAR 436-010-0210(1). Furthermore, by failing to provide insurer with adequate notice and information substantiating the need for surgery prior to the disputed elective surgery, claimant failed to comply with OAR 436-010-0250 which is strictly construed. For these reasons, I find that insurer has carried its burden of proving by a preponderance of evidence that the administrative order is not supported by substantial evidence and reflects errors of law. Accordingly, I reverse.

ATTORNEY FEES

Claimant has not prevailed in a contested case hearing and is entitled to no attorney fee. ORS 656.385(1).

ORDER

IT IS HEREBY ORDERED that:

The Administrative Order dated October 20, 2004 is reversed.