

In the ORS 656.260 Managed Care Dispute of

**Matthew A. Walters, Claimant**

Contested Case No: 09-051H

**FINAL ORDER**

September 25, 2009

AIG CLAIM SERVICES, INCORPORATED, Petitioner

MATTHEW A. WALTERS, Respondent

Before John Shilts, Workers' Compensation Division Administrator

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Insurer AIG Claim Services Incorporated (insurer) refused to authorize a referral for claimant Matthew A. Walters (claimant) to a pain management program for evaluation and consideration for epidural and nerve block injections. Insurer asserted claimant was medically stationary and that this was palliative care for which authorization had not been properly requested. ORS 656.245(1)(c)(J).<sup>1</sup> The Workers' Compensation Division Resolution Team (RT), following administrative review, issued an Administrative Order on March 23, 2009 holding the evaluation was a compensable diagnostic procedure and that the injections could be compensable as proper substitutes for prescription medications. ORS 656.245(1)(c)(B), (C), (H), (J). Administrative Law Judge (ALJ) Robert Brazeau held a hearing on the matter and issued a Proposed and Final Order on July 9, 2009 affirming the RT's order. Insurer requested director review of the ALJ's order and I affirm.

**FACTUAL SUMMARY**

I adopt the facts as found by the ALJ. Claimant injured himself at work in October 2004. In February 2006 insurer declared claimant had been medically stationary as of August 2005. In August 2007 the Workers' Compensation Board approved a Claim Disposition Agreement between the parties. The agreement established the accepted claims as cervical strain, right shoulder strain and T7-8 disc protrusion.

Claimant was initially evaluated in October and November 2004 by a physician's assistant and a physical therapist. They found right shoulder strain, thoracic strain, possible thoracic disc issues, and established a physical therapy plan.

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<sup>1</sup> ORS 656.245(1)(c) provides in part:

[M]edical services after the worker's condition is medically stationary are not compensable except for the following:

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(B) Prescription medications.

(C) Services necessary to administer prescription medications or monitor the administration of prescription medication.

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(H) Services that are necessary to diagnose the worker's condition.

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(J) With the approval of the insurer . . . palliative care that the worker's attending physician . . . prescribes and that is necessary to enable the worker to continue current employment or a vocational training program.

Dr. Walter George saw claimant in December 2004 and found reduced range of motion in the spine and pain on the right side in the neck, mid-back and low back. He diagnosed cervical, thoracic, and lumbrosacral strains with mild right L5 radiculopathy and rule-out right C8 radiculopathy.

In December 2004 Dr. Ben Taylor examined claimant. Dr. Taylor referred claimant to a rehabilitation specialist.

On referral from Dr. Taylor, Dr. Jeffrey Gerry examined claimant in January 2005. Dr. Gerry diagnosed a muscular strain from the work injury. Dr. Gerry recommended a thoracic MRI because of the persistence of the thoracic symptoms.

Claimant underwent an MRI on February 2, 2005 and was diagnosed with a disc protrusion at T7-8. Dr. Gerry then referred him to Dr. Thomas Rosenbaum. Dr. Rosenbaum diagnosed cervical, thoracic, and lumbar strains but found that claimant was not a candidate for surgical intervention.

On August 23, 2005, Dr. Steven Schilperoort performed an Independent Medical Examination (IME). Dr. Schilperoort diagnosed right shoulder strain resolved without permanent impairment of function; cervical strain resolved without permanent impairment of function; low grade degenerative changes in the thoracic and lumbar spine, pre-existing, possibly contributory to symptoms; and substantial discrepancies in stated level of pain and objective findings. Dr. Schilperoort believed that claimant was medically stationary from his accepted strains without permanent residuals. He felt that any ongoing symptoms were due to degenerative changes in the thoracic and lumbar spine. He recommended no additional treatment, except for anti-inflammatory medication for the thoracic and lumbar degenerative changes. Dr. Gerry concurred with Dr. Schilperoort's report and opinion on September 19, 2005.

Dr. Lorber saw claimant on referral from Dr. Gerry on September 19, 2005. He recommended additional medication for claimant's symptoms but could offer no specific treatment modalities for his thoracic spine symptoms. Dr. Lorber took over claimant's care at that time.

Claimant returned to Dr. Lorber on March 14, 2006, complaining of ongoing symptoms in his mid-back. Dr. Lorber recommended that claimant obtain additional medications from his Kaiser Health provider.

On May 21, 2008, claimant was seen by Dr. Miller, complaining of mid-back pain. Dr. Miller completed a Form 827 and checked the box advising that claimant had reported an aggravation of his original injury. Dr. Miller saw claimant again on July 11, 2008 and found that although claimant's ongoing mid-back complaints appeared real, there were no specific areas to treat. Dr. Miller therefore completed a referral to a pain management clinic for possible therapies such as epidural injections for pain relief. Claimant visited Dr. Miller again on November 24, 2008, complaining of significant pain in his mid-back.

On December 12, 2008, Dr. Rosenbaum performed another IME. Dr. Rosenbaum diagnosed right shoulder strain, cervical strain, and T7-8 disc protrusion secondary to the October 28, 2004, injury. Dr. Rosenbaum suggested that claimant had subjective symptom increases without an objective basis as well as unrelated carpal tunnel syndrome symptoms. Dr. Rosenbaum believed that epidural injections or nerve blocks would be strictly palliative in nature and not of long-term benefit.

On January 5, 2009, Dr. Miller responded to an inquiry from the employer's counsel, disagreeing with Dr. Rosenbaum's report and opinion. He advised that steroid injections would be "at least palliative and possibly curative." Dr. Miller also recommended that a pain management program include education, disability prevention and perhaps a psychological evaluation.

When insurer refused to authorize evaluation at the pain clinic claimant sought administrative review. RT reviewed the matter and issued its Administrative Order on March 23, 2009. RT found the recommended evaluation was not compensable as curative or palliative care ORS 656.245(1)(c)(J), (L).

RT did find the initial pain management evaluation would be compensable as a diagnostic procedure to determine the relationship of claimant's present condition to the accepted conditions. ORS 656.245(1)(c)(H). RT's order specifically stated: "If the pain symptoms were unrelated to the accepted conditions, [insurer] would not be responsible for paying any additional expense past the initial evaluation. . . . [Claimant] is entitled to prescription medications and the services necessary to administer and monitor if directed to his accepted conditions."

ALJ Brazeau concluded substantial evidence did support RT's finding the requested care constituted diagnostic services and services related to prescription medications. The ALJ pointed out Dr. Miller's referral was for an evaluation into the cause of claimant's pain and that Dr. Miller had suggested considering the injections as a substitute for the prescription medications claimant was already receiving.

### CONCLUSIONS OF LAW

I may modify the Administrative Order only if it is not supported by substantial evidence or contains an error of law. ORS 656.260(16); OAR 436-001-0225(2). Substantial evidence supports a finding where the record, viewed as a whole, would allow a reasonable person to make that finding. ORS 183.482(8)(c). An administrative finding reviewed under the substantial evidence standard may only be overturned where the credible evidence overwhelmingly favors one finding and the fact finder makes a different finding without giving a persuasive explanation. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206 (1988). Substantial evidence supports a finding where it is reasonable viewing both the supporting and contradicting evidence. *Garcia v. Boise Cascade Corp.*, 309 Or App 292 (1990).

After an injured worker is medically stationary the employer is liable for the costs of prescription medications, services necessary to administer or monitor the administration of prescription medications, and diagnostic services. Palliative care is only compensable if

necessary to enable the worker to remain in employment or a training program and only after it is approved by the insurer in response to a proper request. ORS 656.245(1)(c)(B), (C), (H), (J).

Substantial evidence supports the finding the referral for a pain program evaluation is diagnostic. The referral is expressly for an “evaluation” to determine whether treatment is possible for claimant’s pain resulting from his compensable injury. An evaluation is not treatment. It is an inquiry conducted to determine the cause of a condition and possible treatment for that condition. An evaluation cannot be palliative because an evaluation does not “reduce or moderate temporarily the intensity of an otherwise stable medical condition . . . .” ORS 656.005(20). In fact, the statutory definition of palliative care specifically “does not include those medical services rendered to diagnose . . . a medical condition.” ORS 656.005(20). The RT order expressly states insurer would not be liable for any further expenses should the evaluation determine that claimant’s medical issues are not related to the accepted conditions. Dr. Miller’s referral for a pain management services evaluation is a referral for diagnostic services and is compensable

Substantial evidence also supports the finding that if injections were recommended as treatment for the accepted conditions they could be compensable as prescription medications or services necessary to administer or monitor the administration of prescription medications. As is clearly stated in the RT order, Dr. Miller’s referral does not mandate, and the RT order does not mandate, the provision or application of any specific medication or treatment. The referral is for an evaluation in part to determine whether treatment with injections is appropriate. In disagreeing with Dr. Rosenbaum’s December 12, 2008 IME report, Dr. Miller expressly stated the referral to a pain management program was in conjunction with attempting to limit prescriptions for narcotic medications. It is not yet known whether injections will be recommended or what substances will be injected, if any. If the evaluation determines that injections should be performed in connection with claimant’s accepted injuries, and if those injections contain prescription medications, the medications and the services necessary to administer them will be compensable at that time. ORS 656.245(1)(c)(B), (C). See *Manuel O. Rivera*, 10 CCHR 123 (2005).

Insurer argues the Administrative Order “inappropriately orders the insurer to preauthorize a medical procedure . . . .” without adequate explanation. The order does not require the insurer to preauthorize any medical procedure. The order only states claimant is entitled to diagnostic services and possibly to injections and that if those services are provided in compliance with the applicable rules and statutes insurer would be liable for the costs. The order nowhere states insurer must preauthorize any procedure.

Insurer’s exceptions misstate the record in asserting the Administrative Order “included a dubious finding that Dr. Miller prescribed epidural injections for diagnostic and curative reasons other than the mere provision of palliative care.” Dr. Miller did not prescribe injections. The order does not state Dr. Miller prescribed injections. The order states:

Dr. Miller suggested consideration of epidural injections and nerve block injections. Usually these types of injections contain drugs not readily available to the worker without a prescription and have to be administered

and monitored by a medical professional. I find [claimant] is entitled to prescription medications and the services necessary to administer and monitor if directed to his accepted conditions.

Dr. Miller did not prescribe injections. The RT did not find that Dr. Miller prescribed injections or that he prescribed injections for either diagnostic or curative reasons.

Insurer argues the ALJ used an incorrect standard of review by applying the substantial evidence standard because insurer asserts the issue of whether a treatment is palliative is a question of law. Insurer waived this argument by failing to raise it at the hearing. At the hearing claimant's counsel expressly argued the substantial evidence standard of review applied. Insurer's counsel did not disagree. In any event, insurer is wrong on this issue.

Two "procedures" are at issue; the evaluation and the potential injections. As discussed above, given the legal definitions, the evaluation simply cannot be anything other than diagnostic. That leaves the issue of whether the potential injections are curative, palliative, or prescription medications.

Insurer contends that determining whether a proposed modality of treatment is palliative is a question of law and that the matter must therefore be remanded for application of the correct legal standard. A question of fact is one that concerns determining what events occurred or what circumstances exist without reference to their legal significance. An issue of law exists in stating or determining the legal effect of the facts. See *McPherson v. Employment Division*, 285 Or 541, 548 (1979); *State of Oregon v. Mendez*, 211 Or App 311, 318-319 (2007). The question of whether a certain form of care is palliative or constitutes prescription medication is a question of fact, not law. See *Amber Powers*, 14 CCHR 26, 29 (2009)(issue of whether Botox injections were palliative care or prescription medication is a question of fact); *Young v. Hermiston Good Samaritan*, 223 Or App 99, 107 (2008). The ALJ did not apply an incorrect standard of review.

Claimant's attorney seeks a fee award of \$2000.00 for his participation in this review. Insurer asserts a fee of \$500.00 is appropriate. Total attorney's fees of \$1860.00 have already been awarded in previous stages of this proceeding. Claimant's attorney did not submit a statement of hours worked or offer any explanation or justification for the amount sought. Absent a showing of extraordinary circumstances, \$2000.00 is the greatest total fee that can be awarded for all stages of the dispute. ORS 656.385(1). Claimant's counsel has not argued or provided a showing that extraordinary circumstances do exist. I am therefore only authorized to award a fee of \$140.00 for this review, bringing the total fee award to \$2000.00.

**IT IS HEREBY ORDERED** the RT's March 31, 2009 order and the ALJ's July 9, 2009 orders are affirmed. For his work in this review claimant's attorney is awarded a fee of \$140.00 in addition to the \$1860.00 previously awarded in this matter, for a total fee of \$2000.00, to be paid by insurer.