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In the ORS 656.260 Managed Care Dispute of

**Gayle J. Williams, Claimant**

Contested Case No: 10-029H, 10-047H

**PROPOSED & FINAL ORDER**

August 5, 2010

SAIF CORPORATION, Petitioner

GAYLE J. WILLIAMS, Respondent

Before Bruce D. Smith, Administrative Law Judge

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This matter is before the undersigned Administrative Law Judge on the requests for hearing of SAIF Corporation and Oregon Health Systems, Inc. (OHS), appealing the Administrative Order dated February 17, 2010. Claimant is represented by attorney Christopher D. Moore. Employer South Coast Lumber Company and its insurer SAIF Corporation are represented by their attorney Michael G. Fetrow. OHS is represented by attorney Arden J. Olson. The documentary record consists of Exhibits 1 through 118, as identified in the Division's March 29, 2010 exhibit list (for WCB Case No. 10-00029H), plus Exhibit 119, which was originally submitted by the Division (for WCB Case No. 10-00047H) on April 2, 2010 as Exhibit 2. Also included in the record are Exhibits 30A through 100A, as identified in SAIF's May 11, 2010 submission.

The record closed on July 6, 2010, the date of receipt of closing reply argument from OHS.

**ISSUES**

Issues are: (1) evidence/procedure (claimant's objection to Ex. 73A; motions to compel discovery, dismiss OHS request for hearing); (2) substantial evidence; (3) error of law; and (4) attorney fees.

**FINDINGS OF FACT**

Claimant suffered a compensable injury to her spine on March 24, 1986 (Ex. 3); and the claim was accepted for disabling mid-low back sprain. (Ex. 3). Claimant underwent L2-3 laminectomy on June 18, 1986 (Ex. 10); and L5 microlumbar discectomy on April 22, 1987. (Ex. 22). These procedures, however, did not provide lasting benefit.

On October 13, 1998 claimant was enrolled in OHS, SAIF's managed care organization (MCO). (Ex. 57).

After years of extensive treatment for chronic back pain claimant came under the care of Dr. Ross on October 21, 2008. Following a detailed examination Dr. Ross concluded that claimant's pain was probably due to bilateral L3 foraminal stenosis, in association with a spondylolisthesis; and that she would likely need an L3-4 fusion. (Ex. 72-4).

On January 8, 2009 Dr. Berselli saw claimant for an IME. Although Dr. Berselli agreed that she had a failed back syndrome, he did not believe that claimant's L3-4 retrolisthesis was

related to the work injury or treatment; and did not feel that her back and leg pain were due to that condition. (Ex. 74-13, and -14). Dr. Berselli did not believe that surgery would be helpful. (Ex. 74-14).

At the request of Dr. Ross, on April 7, 2009 Dr. Peterson saw claimant for a second surgical opinion. He agreed that surgical treatment was a reasonable option, although he favored a somewhat different approach than that proposed by Dr. Ross. (Ex. 77-2).

On July 15, 2009 SAIF accepted thoracic/lumbar strain, and retrolisthesis at L3-4 as part of the claim. (Ex. 82).

On July 17, 2009 Dr. Ross submitted a precertification request to OHS, seeking authorization to perform an L3-4 fusion. (Ex. 83). On July 20, 2009 OHS responded, indicating that the request for surgical authorization had been deferred, pending receipt of additional medical information. (Ex. 84). On July 30, 2009 OHS wrote again to Dr. Ross, to the same effect. (Ex. 85).

OHS wrote a second July 30, 2009 letter to Dr. Ross, informing him that the proposed surgery did not meet OHS criteria, and asking him to withdraw the request. In a hand-written response Dr. Ross reiterated his request for authorization to proceed with surgery, as follows: "This is best way to repair bilateral L3 foraminal stenosis in association with a spondylolisthesis. Bilateral foraminotomies will exacerbate spondylolisthesis." (Ex. 86).

On August 7, 2009 OHS wrote to Dr. Ross, indicating that his request for precertification of L3-4 fusion surgery had been disapproved. (Ex. 88). Claimant's attorney promptly requested administrative review on August 18, 2009. (Ex. 90-1). On August 21, 2009 the director issued an Administrative Order of Dismissal, finding that WCD was without jurisdiction to consider claimant's appeal, as claimant had not exhausted the MCO's dispute resolution process. (Ex. 90).

On August 26, 2009 OHS wrote to claimant's attorney, acknowledging his appeal of the August 7, 2009 decision disapproving the proposed surgery; and informing him that the issue would be reviewed in accordance with its dispute resolution procedures. (Ex. 91). OHS informed the attorney, "[y]ou will be notified of *the final outcome* of our review by 10/26/09." (*Id.*). (Emphasis added).

On October 16, 2009 claimant saw Dr. Ross to discuss surgical options. After a detailed summary of claimant's problem Dr. Ross noted that she was continuing to complain of back pain radiating into the anterior thighs bilaterally as far as the knees, with occasional numbness in the top of her right foot. (Ex. 92-1) Claimant had trouble on stairs due to leg weakness; and could only walk one block without stopping. (*Id.*). On exam Dr. Ross noted that claimant could perform only a partial deep knee bend, and had difficulty arising. (Ex. 92-2). Deep tendon reflexes were trace at right knee, 1+ on the left; and 1+ at the right ankle, with absent reflex on the left. (*Id.*). Dr. Ross diagnosed back pain and bilateral L3 radiculopathies due to a retrolisthesis of L3 on L4, resulting in bilateral foraminal stenosis. (*Id.*). Dr. Ross recommended fusion; and felt that there were no contraindications to surgery. (*Id.*).

On October 20, 2009 OHS wrote again to claimant's attorney, informing him that its Medical Review Committee had met on October 13, 2009; and had "voted unanimously to uphold the disapproval of the request from Dr. Ross for L3-4 fusion surgery." (Ex. 93-1). Accompanying the letter was a copy of the detailed, seven-page report of the Committee, explaining its decision. (Ex. 93-2 through -8). The letter and report were separately signed by OHS Medical Director Charles P. Moore, MD.

The October 20, 2009 letter itself was short and to the point; and concluded with the following:

**"NOTICE TO THE WORKER AND ALL OTHER PARTIES: If you want to appeal this decision, you must notify the director of the Department of Consumer and Business Services (DCBS) in writing within 60 days of the mailing date of this notice. Send written requests for review to: Department of Consumer and Business Services, Workers' Compensation Division, Medical Section, 350 Winter Street NE, PO Box 14480, Salem, OR 97309-0405. If you do not notify DCBS in writing within 60 days, you will lose all rights to appeal the decision. For assistance, you may call the Workers' Compensation Division's toll-free hotline at 1-800-452-0288 and ask to speak with a Benefit Consultant."** (Ex. 93-1). (Bold in original).

On October 23, 2009 claimant's attorney sent a copy of the decision to DCBS at the address indicated, and requested review in accordance with the notice provided by the MCO. (Ex. 94).

On October 26, 2009 Dr. Ross took claimant to surgery for L3-L4 pedicle screw fusion, and L3-L5 intertransverse fusion. (Ex. 95).

On October 27, 2009 the director's Medical Resolution Team sent SAIF a Notice of Required Action on a Medical Dispute; and sent copies to claimant, her attorney, and OHS. (Ex. 96). SAIF delivered its response the same day by courier, indicating in the Specification of Disputed Medical Issues form that the only issue was that the disputed medical service is "excessive, inappropriate, [or] ineffectual." (Ex. 97). SAIF sent a copy of its response to OHS. (*Id.*).

Dr. Golden saw claimant on December 16, 2009 at the request of the medical reviewer. He summarized claimant's current symptoms as follows:

"[Claimant] claims that as a result of the operation by Dr. Ross, she no longer has any significant back pain, leg pain in either extremity, or any numbness in the right lower extremity. She feels that she has had some return of strength in her right lower extremity. The only symptom that she is complaining of now is tenderness in the region of the surgery and occasional discomfort if she does too much bending or twisting in her lower back." (Ex. 104-2).

On physical exam claimant was able to do a squat and rise “100 percent without discomfort.” (Ex. 104-7). Deep tendon reflexes were 3 at right knee, 2 on the left; and 1 at the ankles bilaterally. (*Id.*). Waddell’s tests were negative. (Ex. 104-6). Dr. Golden initially agreed that in light of the apparently successful outcome the procedure performed by Dr. Ross was had been appropriate. (Ex. 104-8). After reviewing the operative report, however, Dr. Golden felt that without pre-surgical evidence of instability, and no evidence that the procedure itself had caused instability (because Dr. Ross had not performed foraminal decompression), “there was no instability as an indication for performing a fusion procedure.” (Ex. 110-2). Dr. Golden noted that claimant’s favorable outcome was “difficult to explain[;]” and questioned whether the outcome could be used to support a retrospective analysis. (*Id.*).

Dr. Golden concluded that the disputed L3-4 spine fusion procedure was not appropriate treatment here, summarizing his opinion as follows:

“Dr. Ross has advanced indications for a procedure that was never performed, namely bilateral L3 foraminotomies for L3 radiculopathy. The procedure performed by Dr. Ross, without decompression of the L3 foramina having produced a significant degree of instability was not indicated. In my opinion, neither was there an indication for foraminal decompression.” (Ex. 110-2, and -3).

On February 11, 2010 Dr. Ross wrote to the medical reviewer, noting that he had found Dr. Golden’s remarks “defamatory.” (Ex. 114). Dr. Ross explained:

“If Dr. Golden has (*sic.*) read my operative note carefully or if he had an understanding of spine anatomy, he would have seen that distraction of the pedicle screws resulted in significant opening of the L3 foramina and, therefore, this procedure directly, intentionally, and safely treated the symptoms resulting from L3 foraminal stenosis. The proof of this is that the patient is better.” (*Id.*).

On February 17, 2010 the director issued an Administrative Order, framing the issue as, “whether SAIF Corporation (SAIF), is liable for L3-4 fusion, as proposed by Donald Ross, MD.” (Ex. 117-1). Concluding that SAIF was liable for the disputed procedure, the director wrote:

“The court of appeals found [in *Linn Care Center v. Cannon*, 74 Or App 707 (1985)] the fact that a medical treatment was beneficial is evidence that the treatment was reasonable and necessary, additionally that subsequent improvement was relevant, and was to be considered in determining compensability of medical services. Considering the above referenced court of appeals decision, and Dr. Golden’s report that post surgically his evaluation of [claimant] was ‘near normal,’ and that her primary symptoms had resolved, the director finds that [claimant] has shown improvement in her symptoms subsequent to the surgery performed, and concludes that the L3-4 fusion performed by Dr. Ross, is appropriate for [claimant], and that SAIF is liable.” (Ex. 117-3).

On March 1, 2010 SAIF timely requested a hearing, specifying the issues in dispute as medical services under ORS 656.245; and managed care dispute under ORS 656.260. (Ex. 118).

On March 17, 2010 OHS also timely requested a hearing, contending that when claimant sought administrative review on October 26, 2009 the MCO had not yet completed its “internal dispute process,” and had not issued its final decision. (Ex. 119).

Claimant considers her surgery to have been successful, with sufficient resolution or reduction of her symptoms to allow her to more fully participate in the activities of daily living, and her improvement continues to the present. (Stipulation of the parties).

## CONCLUSIONS OF LAW AND OPINION

### Evidence/Motion to Compel

Claimant objects to the six-page excerpt from the Provider Manual used by OHS in its medical review process (Ex. 73A), which was offered by SAIF. In the alternative, claimant reiterates her motion to compel production of the entire MCO contract,<sup>1</sup> and to reopen the proceedings for additional briefing. For the reasons that follow I admit the exhibit, and deny claimant’s motion to reopen.

Claimant asserts that she is entitled to production of the Provider Manual used by OHS to determine whether to approve the proposed surgery. Claimant argues that, since SAIF has offered a portion of the manual, she is entitled to the entire document, “to see if there is anything relevant in the rest of the manual.” (Rec.).

SAIF and OHS contend that the manual is protected as confidential “data” under ORS 656.260(6); and argue that they cannot be compelled to produce it absent a showing of necessity. I agree.

Under ORS 656.260(6),

“[d]ata generated by or received in connection with [provision of medical services to injured workers] \* \* \* or of any review thereof, shall be confidential, and shall not be disclosed except as considered necessary by the director in the administration of this chapter.”

“Data,” as used in this section, has been interpreted to include, *inter alia*, “all documents” relating to a claim, including the MCO contract. *Thompson-Springer v. SAIF Corp.*, 205 Or App 568 (2006) (affirming without opinion Proposed and Final Contested Case Hearing Order in DCBS No. H03-084). Without having seen the manual in question I cannot determine whether it contains any arguably relevant “data,” much less whether the director might consider any such material “necessary \* \* \* in the administration of [ORS Chapter 656].” The only substantive

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<sup>1</sup> This motion was originally denied by Interim Order dated May 13, 2010.

questions before me are whether the director erred in finding SAIF liable for the disputed medical services, and whether the director's decision is supported by substantial evidence.

Under ORS 656.260(16), and OAR 436-001-0225(2) new *medical* evidence or issues may not be admitted or considered at the contested case hearing. The MCO contract is certainly not medical evidence (and neither are any of the other exhibits offered by SAIF), so I find that it is generally admissible. I also find that it is relevant on the question of the surgery precertification procedures followed by OHS here. Nonetheless, although the medical reviewer does mention the internal dispute resolution process, and summarizes the reasons given by OHS for disapproval of the surgery request (Ex. 117-2), he does not specifically refer to the Provider Manual in his analysis; nor does he cite the MCO contract or OHS surgery guidelines as a basis for his decision. Accordingly, I find that the entire manual, which is protected, is irrelevant.

In any event, it is difficult to imagine how production of the manual would advance claimant's case. Although the director the OHS reliance upon the MCO's "evidence based guidelines for lumbar fusion" (Ex. 117-2), it is SAIF and OHS that bear the burden of proof. Whether the director's decision is supported by substantial evidence does not depend on anything that might be found in the Provider Manual; it depends on the evidence that was in the record before the director.

Further, the principal basis for the legal challenge advanced by SAIF and OHS is that the director erred in failing to require compliance with the MCO's contractual provision requiring precertification for elective surgery, contrary to ORS 656.245(4)(a). The part of the Provider Manual dealing with precertification for elective surgical procedures, and dispute resolution procedures, however, is now in the record. (Ex. 73A). No other part of the manual is relevant to the claim of error; and I deny claimant's motion for its production.

#### Motion to Dismiss Request for Hearing

Claimant moves for an order dismissing the request for hearing of insurer's Managed Care Organization (MCO), OHS. For the reasons set forth below, I deny claimant's motion.<sup>2</sup>

Claimant contends that the request for hearing by OHS should be dismissed, based upon two<sup>3</sup> jurisdictional challenges: (1) lack of OHS standing as a "party" to appeal the director's February 17, 2010 Administrative Order; and (2) failure of OHS to exhaust its administrative remedies.

Claimant first argues that OHS does not have standing to dispute the director's decision. Citing the definition found in ORS 656.005(21), claimant contends that an MCO is not a "party" with regard to Workers' Compensation matters covered under ORS Chapter 656. Claimant notes

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<sup>2</sup> The order denying claimant's motion to dismiss was originally published on May 13, 2010 as part of an Interim Order.

<sup>3</sup> Claimant asserts a third argument, which is a factual dispute over whether the MCO had completed its internal dispute resolution process. Both because this argument does not go to jurisdiction, and because it underlies claimant's second jurisdictional challenge, I do not address it separately.

that under ORS 656.260(14) only “a worker, insurer, self-insured employer or the attending physician” has standing to seek administrative review of an action of the MCO; and argues that, by extension, only those parties can challenge the director’s resulting order under ORS 656.260(15).

OHS responds that under OAR 436-010-0005(31) the MCO *is* designated (together with the worker, insurer and medical providers) as a “party;” and is therefore entitled under OAR 436-010-0008(13) to challenge the director’s Administrative Order here. That rule reads as follows:

“(13) Any party who disagrees with an action or administrative order under these rules may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of an order under ORS 656.245, 656.260, or 656.327, or within 60 days of the mailing date of an order under ORS 656.247. OAR 436-001 applies to the hearing.”

Claimant is correct that under ORS 656.260(14) only the worker, insurer (or self-insured employer) or attending physician can seek administrative review of an MCO’s treatment decision. Why, after all, would the MCO want the director to review the MCO’s own decision? Once the director has completed review of the disputed issues, however, under OAR 436-010-0008(13) “[a]ny party,” including the MCO, is entitled to request a hearing.

Finally, the ORS 656.005(21) definition cited by claimant for “party” is subject to the limitation stated in ORS 656.003: “*Except where the context otherwise requires*, the definitions given in this chapter govern its construction.” (Emphasis added). I agree with OHS that here the context requires what the above-cited administrative rules hold – namely, that the MCO whose medical judgment is at issue is entitled to participate in the contested case hearing as a party.

The second prong of claimant’s argument has its basis in a factual dispute: OHS contends that claimant’s October 23, 2009 request for administrative review should have been dismissed as premature, because its own internal review process had not yet run its course; and that claimant had therefore failed to exhaust her administrative remedies. Claimant disagrees, and argues that, by not raising this issue before the director, it is OHS that has failed to exhaust *its* administrative remedies. Claimant points out that under OAR 436-001-0225(2) no new issues can be raised at hearing in medical treatment disputes and managed care disputes; and contends that the Hearings Division is without jurisdiction to address the exhaustion issue raised by OHS for the first time here.

OHS does not deny that its exhaustion issue was not explicitly before the director; but does deny that this is a “new issue” here. Instead, OHS argues that the director simply erred in failing to dismiss claimant’s request for review *sua sponte*, on the grounds that claimant had not exhausted her rights under the MCO’s internal dispute resolution process. Noting that OAR 436-010-0008(4) requires the worker to “complete the internal dispute resolution process within the MCO before requesting an administrative review,” OHS contends that the director should have dismissed claimant’s request for review for lack of jurisdiction. This, indeed, is what the director had done in the Administrative Order of Dismissal it issued on August 21, 2009 (Ex. 90), in

response to claimant's earlier (premature) request for review. I agree with OHS that it has not waived the jurisdiction issue.

While I agree with claimant that under OAR 436-001-0225(2) – and indeed under ORS 656.260(16) – no new (substantive) issues are admissible at the contested case hearing, it is well settled that lack of subject matter jurisdiction cannot be waived. *See, e.g., Evalyn V. Stevens*, 59 Van Natta 1925, 1926 (2007). Accordingly, OHS is entitled to raise the jurisdiction issue at any stage of the proceedings, including the contested case hearing. *Jerry W. Breazeale*, 55 Van Natta 2051, 2053 (2003).

#### Scope of ALJ Review (Substantive Dispute)

This matter arises under ORS 656.260(12) and OAR 436-010-0008 for resolution of a dispute over the compensability of medical services. The hearing is conducted under OAR 436-001.<sup>4</sup> Review of this managed care dispute is for substantial evidence and error of law. OAR 436-001-0225(2). Because the date of precertification request for the proposed service at issue here is July 17, 2009, the applicable Division 10 rules are found in WCD Admin. Order 09-051 (eff. July 1, 2009).

As the moving parties in these consolidated cases, SAIF and OHS respectively bear the burden of proof. The Administrative Order here “may be modified only if it is not supported by substantial evidence in the record or reflects an error of law.” ORS 656.260(16).

#### Substantial Evidence

SAIF and OHS contend that because the director did not discuss the competing medical opinions the resulting Administrative Order is not supported by substantial evidence. They are especially critical of the director for going against the opinion of Dr. Golden, who had reviewed the case at the request of the medical reviewer. OHS also contends that claimant's self-serving *post hoc* testimony about post-surgical improvement is not substantial evidence.

Claimant contends that the administrative order is supported by substantial evidence. She notes that Dr. Ross and Dr. Peterson both felt that surgery was appropriate; and that claimant's outcome supported their judgment. For the reasons that follow I agree with claimant that the director's decision is supported by substantial evidence.

Whether a decision is supported by substantial evidence depends upon whether it is reasonable, in light of the evidence both for and against it. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206 (1988). The *Armstrong* court explained:

“The difference between the ‘any evidence’ rule and the substantial evidence test in ORS 183.482(8)(c) will be decisive only when the credible evidence apparently weighs overwhelmingly in favor of one finding *and* the Board finds the other without giving a persuasive explanation.” *Id.* (Emphasis added).

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<sup>4</sup> See OAR 436-009-0008(6).

First, I do not find the credible evidence against the proposed treatment here to be overwhelming. Dr. Peterson, a neurosurgeon, had performed a careful examination of claimant; and had agreed that surgical treatment of claimant was a reasonable option, even though he favored a somewhat different approach than Dr. Ross. (Ex. 77). When Dr. Ross thereafter met with claimant he carefully reviewed Dr. Peterson's recommendation, and explained to claimant why he recommended a posterior, minimally invasive pedicle screw fusion, rather than the two-stage procedure advocated by Dr. Ross. (Ex. 79-2).

It is clear from all of Dr. Ross' records that he understood claimant's problem from the beginning; and that he carefully developed an ultimately successful plan to deal with it. Further, Dr. Ross cogently and persuasively responds to the criticism of Dr. Golden, who questioned whether the surgical procedure had been appropriate. (Ex. 114).

In short, the medical evidence supporting the denied procedure is not overwhelmed by evidence against it. Thus, the director's alleged failure to give a persuasive explanation does not automatically result in a finding that his order is not supported by substantial evidence. For the reasons that follow, I find that the decision is in fact supported by substantial evidence.

SAIF and OHS rely on the decision reached by the OHS Medical Review Committee (Ex. 93), and upon the opinion of Dr. Golden. (Exs. 104, 110). In its written argument SAIF cites the Medical Review Committee's decision, which is set forth here in its entirety:

"Oregon Health Systems' Medical Review Committee met to consider the appeal of the disapproval of Dr. Ross' request for L3-4 fusion surgery for [claimant]. After reviewing the medical record and viewing the appropriate imaging studies, the Committee voted unanimously to uphold the disapproval. The Committee agreed with the original reviewer that the clinical findings do not meet Oregon Health Systems' evidence based guidelines for lumbar fusion surgery. Nor do they meet Official Disability Guidelines for lumbar fusion. Lumbar flexion/extension x-rays of 10/21/2008 did not reveal evidence of instability at L3-4. Also, there are multiple levels of degenerative disc disease. The Committee believes fusion at L3-4 would be unlikely to improve [claimant]'s pain and ability to function and might well actually result in further morbidity." (Ex. 93-8).

The Committee does not describe its evidence based guidelines for lumbar fusion surgery, or the Official Disability Guidelines for lumbar fusion. Nor does the Committee explain why multiple levels of degenerative disc disease present a surgical problem here. In fact, the only finding the Committee describes with specificity is the lack of evidence of instability at L3-4. This sparse analysis, however, does not address Dr. Ross' October 16, 2009 chart note, apparently because the Committee did not have it. (See Ex. 93-7). In that last pre-surgery treatment record Dr. Ross acknowledges that claimant's films "did not appear to show any major pathologic motion" (Ex. 92-1), but states that the proposed surgery was nonetheless indicated for claimant's ongoing L3 radiculopathies, which he felt were due to L3 foraminal stenosis, caused by L3-on-L4 retrolisthesis. (Ex. 92-2).

In reviewing Dr. Ross' July 30, 2009 response (Ex. 86) the Committee had, in fact, noted that Dr. Ross had felt that his proposed approach was the best way to repair claimant's condition, and was superior to bilateral foraminotomies, which Dr. Ross believed would exacerbate the spondylolisthesis. (Ex. 93-7). The Committee, however, did not directly respond to this view, either in the chart review (*Id.*), or in its summary decision. (Ex. 93-8).

Further, Dr. Golden's criticism of Dr. Ross' surgical procedure (Ex. 110) is forcefully rebutted by Dr. Ross. (Ex. 114). I find that Dr. Ross, as the attending surgeon, is entitled to deference. *See Argonaut Ins. Co. v. Mageske*, 93 Or App 698 (1988) (special deference is owed to a treating surgeon due to the unique opportunity to view the claimant's condition firsthand); *Kevin L. Nofziger*, 58 VN 2519, 2520 (2006). This is particularly so in light of the fact that Dr. Golden's disagreement with Dr. Ross is based principally upon the operative note itself. In any event, I find Dr. Ross more persuasive, because he explains how the procedure (successfully) addressed claimant's L3 foraminal stenosis problem.

As importantly, I find that the evidence supporting the director's decision is itself substantial. Dr. Ross had first examined claimant in October 2008 (Ex. 72), and had been following her closely for more than a year before he operated on her back. (Exs. 79, 86, 89, 92, 95, 114). I find no persuasive reason not to accord him the customary deference accorded an attending physician. *Weiland v. SAIF*, 64 Or App 810, 814 (1983).

Finally, I note that claimant not only reported symptomatic improvement following the surgery, but her objective physical exam improved as well, with restoration of ability to squat and rise, and partial return of deep tendon reflexes. (*Cp.* Exs. 92-2, 104-7). This, along with the records and opinions of Drs. Ross and Peterson, constitutes substantial evidence that the denied surgery was both appropriate and effective.

In sum, I find that SAIF and OHS have failed to prove that the director's order is not supported by substantial evidence.

#### Error of Law

SAIF and OHS contend that the director erred in failing to require compliance with the MCO's contractual provision requiring precertification for elective surgery, contrary to ORS 656.245(4)(a). OHS argues further that the director erred in proceeding with administrative review, because claimant had mooted her request for precertification review by proceeding to surgery without prior approval. OHS contends that, "[c]laimant's request for precertification review is moot because a decision from WCD that OHS should authorize the surgery will have no practical effect on whether the surgery should be precertified." (Oregon Health System's Closing Argument, page 5). (Emphasis added).

Claimant responds that her appeal (Ex. 94) was from a final disapproval of the proposed surgery (Ex. 93), rather than simply from denial of precertification. Because I find that the issue before the director was medical appropriateness, rather than precertification, I agree with claimant.

The Provider Manual in evidence here does not make reimbursement contingent upon precertification. What the Manual requires is precertification *review*: “All non-emergency hospitalizations and elective surgical procedures require precertification review by the OHS Medical Director or Physician Advisor.” (Ex. 73A-2). Precertification review was done here, in accordance with the contract. Although the section describing precertification review is captioned “Services Requiring Precertification” (*Id.*), the manual itself states only that “failure to obtain precertification for [elective surgical procedures] *may* result in non-payment of fees to the provider.” (*Id.*). (Emphasis added). Further, even *approval* of a precertification request does not guarantee reimbursement, according to the manual. (*Id.*). For these reasons, I find that the issue before the director was not precertification, but appropriateness of the proposed medical treatment.

The matter came before the director on claimant’s request for review of OHS’s disapproval of L3-4 fusion surgery; and her request that the director “determine whether SAIF Corporation is responsible to pay for the surgery.” (Ex. 94). In its October 27, 2009 Specification of Disputed Medical Issues, SAIF indicated that the disputed medical service was disapproved because it was “excessive, inappropriate, [or] ineffectual.” (Ex. 97). SAIF did not contend that the service was not a compensable medical service, or was in violation of medical service rules. (*Id.*). Though SAIF might not yet have learned that claimant had undergone surgery the preceding day, it never thereafter amended its Specification of Disputed Medical Issues; and neither did OHS.

The medical reviewer obviously understood the issue, and asked the reviewing physician to indicate whether the proposed procedure was appropriate. (Ex. 103-1). Further, the basis stated by OHS in its Provider Manual for precertification review is “medical appropriateness.” (Ex. 73A-2). Accordingly, I find that the issue before the director was not moot; and that it was proper for the director to proceed with review.

OHS also argues that the director improperly treated claimant’s request for administrative review of the MCO’s precertification denial as a request for review of the MCO’s *retrospective* review/denial, pointing out that claimant had not first sought retrospective review in accordance with the MCO contract. I disagree.

The Provider Manual does not require the patient to seek retrospective review once her request for precertification has been denied. Indeed, discretion whether to undertake retrospective review appears to lie in the hands of OHS, not the patient. (Ex. 73A-4). Again, the issue before the director (and before me) was/is not precertification or retrospective review, but appropriateness of the proposed surgery.

SAIF notes that ORS 656.245(4)(a) requires compliance with the MCO contract; and contends that claimant’s “failure to obtain preauthorization of a medical service when it is required by the contract is a valid reason for not paying for the service.” (SAIF Closing Argument, page 5). Again, however, I find that the Provider Manual excerpts in evidence here do not make reimbursement contingent upon preauthorization. In any event, I find no evidence in this record upon which to find that the administrative order at issue here is in derogation either of the MCO contract or the provisions of ORS 656.245 or 656.260.

Further, SAIF and OHS argue that the director erred in citing *Linn Care Center v. Cannon*, 74 Or App 707 (1985) as a basis for the administrative decision, noting that *Cannon* was a pre-MCO case, and has no bearing on the disputes under ORS 656.260(14). In *Cannon* the issue was whether proposed surgery was reasonable and necessary, and therefore compensable, under Workers' Compensation law. The court found as follows:

“The fact that medical treatment is beneficial is an indication that the treatment was reasonable and necessary. Subsequent improvement is relevant and can and should be considered in determining the compensability of medical services.” *Id.*, at 710.

OHS argues,

“[W]ith respect to MCO disputes, the Board makes no determination concerning ‘reasonable and necessary’ medical procedures, rather medical services disputes are handled first through the MCO processes, subject to the Director’s oversight and review based on whether the MCO proceeded appropriately under its contract.” (Oregon Health System’s Reply, page 6).

I disagree. OHS essentially invites me to hold that whenever an MCO has “proceeded appropriately under its contract” the director must affirm its decision regarding the compensability of medical services. I decline to do so. OHS points out that, under ORS 656.245(4)(a), “the statutory standard for the provision of medical services is the ‘manner prescribed in the [MCP] contract.’” (Oregon Health System’s Reply, page 7).

What OHS overlooks is that this provision deals with the *manner* of provision of medical services, not the substance thereof. Under ORS 656.245(1) appropriate medical services must be provided “[f]or *every* compensable injury” (emphasis added), regardless of whether the injured worker has been enrolled in an MCO. In any event, I find that the director’s decision does not hinge upon whether the court’s reasoning *Cannon* applies to MCO disputes. The director did not err in finding that the proposed treatment was appropriate.

Finally, although OHS has not explicitly pursued its original contention that the MCO had not yet completed its “internal dispute process” when claimant brought the matter to the director (Ex. 119), I agree with claimant that the denial letter itself (Ex. 93-1) belies this argument. I find that the matter was ripe for review; and that the dispute was properly before the director on the issue of appropriateness of the denied treatment.

In sum, I find that SAIF and OHS have failed to prove that the director erred with regard to the Administrative Order dated February 17, 2010.

#### Attorney Fees

Claimant’s attorney is entitled to an assessed attorney fee for services at hearing under ORS 656.385(1). After considering the factors set forth in OAR 438-015-0010(4) and applying

them to this case, I find that a reasonable fee for claimant's counsel's services is \$7,500, payable by employer. In reaching this conclusion, I have particularly considered the time devoted to the case (as represented by the size and content of the record; the complexity of the issues; the skill and extensive experience of the three lawyers involved; the significant value of the interest involved; and the significant risk that claimant's counsel could go uncompensated.

**ORDER**

**IT IS THEREFORE ORDERED** that claimant's motion to compel discovery of the OHS Provider Manual of is denied.