In the Managed Care Dispute of

JAVIER GARCIA, Claimant

Contested Case No: H05-122

PROPOSED AND FINAL ORDER

January 12, 2006

JAVIER GARCIA, Petitioner

SAIF CORPORATION, Respondent

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

HISTORY OF THE CASE

Claimant appeals the Administrative Order issued on July 15, 2005 by the Medical Review Unit (MRU) of the Workers' Compensation Division (WCD), Department of Consumer and Business Services (department or director). On August 26, 2005, the department referred the matter to the Office of Administrative Hearings (OAH). On December 14, 2005, Administrative Law Judge Catherine P. Coburn conducted a hearing in Beaverton, Oregon. Attorneys Adriana Ortega and Constance L. Wold represented petitioner Javier Garcia (claimant). Attorney Jerome B. Larkin represented respondent SAIF Corporation (insurer). Managed Healthcare Northwest Managed Care Organization (MCO) waived appearance. Katelin Mathers served as Spanish interpreter and Robert Pfaff served as sign language interpreter. Claimant and his wife, Silvia Garcia, testified on his behalf and the record closed on the date of hearing.

ISSUE

Whether MRU incorrectly determined that claimant has exhausted three choices of attending physician.

EVIDENTIARY RULINGS

WCD Exhibits 1 through 61 as well as claimant's Supplementary Exhibit 22A were admitted into the record without objection.

FINDINGS OF FACT

1. On May 15, 2003, claimant suffered a compensable lumbar sprain while detailing automobiles for a dealership. (Exs.1 and 9; testimony of claimant.) On May 16, 2003, at the employer's suggestion, claimant sought treatment from Jerome B. Brem, M.D., who is not a managed care organization (MCO) panel member. (Exs. 2 and 3; testimony of claimant.)

2. On May 22, 2003, claimant sought treatment from David Mihelic, M.D. who prescribed medications, physical therapy and return to light duty work. (Ex. 6.)

3. On May 28, 2003, insurer accepted a lumbar sprain and enrolled claimant in Care-Mark Comp (MCO). (Exs. 9 and 29-7.)

4. An MRI dated June 2, 2003 revealed degenerative disc disease at L4-5 and L5-S1. (Exs. 22-1 and 30.) On June 5, 2003, claimant followed up with Dr. Milhelic who prescribed physical therapy and light duty, stressing compliance. (Ex. 30-2.)

5. On June 16, 2003, claimant sought treatment from Thomas P. Anderson, M.D., (Occupational Medicine), who is an MCO panel member. Dr. Anderson prescribed medications and physical therapy. (Exs. 15 and 16.) On July 9, 2003, Dr. Anderson examined claimant and referred him to John DiPaola, M.D. for an orthopedic evaluation. (Ex. 17.)

6. On July 14, 2003, claimant sought treatment from Dr. DiPaola (Orthopedic Surgeon) and signed an 827 form designating him as the new attending physician. (Exs. 18 and 19.) Dr. DiPaola's impression was that claimant suffered a work-related lumbar sprain and pre-existing degenerative disc disease. (Exs. 19 and 30-2.)

7. On July 23, 2003, claimant returned to Dr. Anderson, who assessed "low back pain superimposed on degenerative disc disease, slow to respond to treatment." (Ex. 20-1.)

8. On August 12, 2003, claimant treated with Kyle Pirtle, P.A. in Dr. DiPaola's office. (Ex. 22.) Claimant indicated that his low back pain was not relieved by medication or physical therapy and that he was unable to perform any type of work. (Exs. 22-2 and 22-5.) Pirtle noted that the MRI showed no disc symptoms and obtained authorization for acupuncture. (Exs. 22-2 and 22-4.) Claimant underwent one acupuncture treatment and declined to continue. (Ex. 22-4.) Associated Physical Therapy indicated that claimant did not tolerate exercises and they had nothing further to offer him. (Exs. 22-4 and 30-3.) On August 25, 2003, claimant returned to Pirtle and Dr. DiPaola. (Ex. 22-4.) Noting that claimant did not need surgery and that conservative measures had failed to alleviate claimant's pain complaints, they had no further treatment options to offer and referred claimant to Dr. Franklin Wong, M.D. who is the MCO medical director. (Ex. 22-5.)

9. The MCO scheduled claimant for a Disability Prevention Consultation (DPC) with Jennifer K. Lawlor, M.D. (Physical Rehabilitation). (Exs. 22A and 23.) On September 12, 2003, Dr. Lawlor examined claimant and formulated a treatment plan. She wrote, "It is noteworthy to mention that he is already fairly decided upon the need for vocational rehabilitation. This may or may not affect his progress." (Ex. 23-4.) Claimant signed an 827 form designating Dr. Lawlor at his new attending physician. (Ex. 24.) On October 6, 2003, claimant followed up with Dr. Lawlor. (Ex. 25.) Claimant reported a different pain pattern and Dr. Lawlor decided to continue the current treatment plan. (Ex. 25-2.) Dr. Lawlor noted, "I have the sense the patient is convinced of the need for vocational retraining regardless of treatment outcome here." (Ex. 25-2.) On November 3, 2003, claimant followed up with Dr. Lawlor. (Ex. 26.) On November 6, 2003, claimant had an SI joint injection with no clear benefit. (Exs. 26 and 27.)

10. On November 26, 2003, Dr. Lawlor declared claimant's condition medically stationary and released him to regular work with no restrictions due to the accepted lumbar strain. (Ex. 27.)

11. On December 9, 2003, the claim was closed without permanent partial disability

award. (Ex. 29.)

12. On February 9, 2004, medical arbiter Bradford B. Lorber, M.D. (Physiatrist) examined claimant and found no restrictions in the use of the lumbar spine and no work restrictions. (Ex. 30.)

13. In an Order on Reconsideration dated March 11, 2004, the department affirmed the medically stationary date and claim closure without permanent disability award. (Ex. 31.)

14. On July 20, 2004, claimant reported to an urgent care clinic. (Exs. 36, 37 and 38.) On July 21, 2004, claimant sought treatment from Stephen Piepgrass, M.D. who discussed the medical history in detail and prescribed medication, physical therapy and light duty. (Ex. 39.)

15. On September 3, 2004, insurer notified claimant that he had selected three attending physicians and any further change would require the director's approval. (Ex. 51.)

16. On April 5, 2005, Dr. Lawlor examined claimant and noted that the accepted condition remained medically stationary. (Ex. 52-1.) She noted, "I have nothing else to offer him since he did not respond to therapy." (Ex. 52-2.) On May 16, 2005, Dr. Lawlor indicated that she is willing to continue as claimant's attending physician. (Ex. 54.)

CONCLUSION OF LAW

MRU correctly determined that claimant has exhausted three choices of attending physician.

OPINION

The director has jurisdiction over medical service and managed care disputes. ORS 656.704(3), ORS 656.245(6) and ORS 656.260(16). I review for substantial evidence or error of law. OAR 436-001-0225(1). The burden of proving a fact or position falls upon the proponent. ORS 183.450(2). 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 legislation adopting a different standard, the standard of proof in an administrative hearing is preponderance of evidence). Proof by a preponderance of the 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 (1989).

MRU disapproved claimant's request to change attending physicians. Claimant contends that the administrative order is not supported by substantial evidence. In support of his position, claimant argues that he is entitled to choose a new attending physician because he has communication difficulties and he did not intend to designate new attending physicians. In contrast, insurer contends that claimant has exhausted the statutory choice of three consecutive attending physicians.

Substantial evidence exists to support a finding "when the record, viewed as a whole, would permit a reasonable person to make that finding." ORS 183.482(8)(c). To determine whether substantial evidence exists, an ALJ is required to:

> [L]ook at the whole record with respect to the issue being decided, rather than one piece of evidence in isolation. If an agency's finding is reasonable, keeping in mind the evidence against the findings as well as the evidence supporting it, there is substantial evidence. *** For instance, and in the context which is likely frequently to occur in workers' compensation cases, if there are doctors on both sides of a medical issue, whichever way the (director) finds the facts will probably have substantial evidentiary support. The ALJ would not need to choose sides. The difference between the "any evidence rule" and the substantial evidence test *** will be decisive only when the credible evidence apparently weighs overwhelmingly in favor of the finding and the (director) finds the other without giving a persuasive explanation.

Armstrong v. Asten-Hill Co., 90 Or App 200, 206 (1998).

Pursuant to ORS 656.245(1)(a), an insurer is obligated to provide medical services that are materially related to a compensable condition for so long as the nature of the injury or the process of recovery requires. ORS 656.245(a) provides in pertinent part:

> *The worker may choose an attending doctor or physician within the State of Oregon. The worker may choose the initial attending physician and may subsequently change attending physician two times without approval from the director. If the worker thereafter selects another attending physician, 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.*

Additionally, OAR 436-010-00220(3) provides in pertinent part:

> The worker is allowed to change his or her attending physician or authorized nurse practitioner by choice two times after the initial choice. Referral by the attending physician or authorized nurse practitioner to another attending physician or authorized nurse practitioner, initiated by the worker, will count in this calculation. The limitations of the worker's right to choose physicians or authorized nurse practitioners under this section begin with the date of injury and extend through the life of the claim. For purposes of this rule, the following are not considered changes by choice of the worker:
>
> (a) Emergency services by a physician;
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> (b) Examinations at the request of the insurer;

(c) Consultations or referrals for specialized treatment or services initiated by the attending physician or authorized nurse practitioner;

(d) Referrals to radiologists and pathologists for diagnostic studies;

(e) When workers are required to change medical service providers to receive compensable medical services, palliative care, or time loss authorization because their medical service provider is no longer qualified as an attending physician or authorized to continue providing compensable medical services.

(f) Changes of attending physician or authorized nurse practitioner required due to conditions beyond the worker's control. This could include, but not be limited to:

(A) When the physician terminates practice or leaves the area;

(B) When a physician is no longer willing to treat an injured worker;

(C) When the worker moves out of the area requiring more than a 50 mile commute to the physician;

(D) When the 90 day period for treatment or services by an authorized nurse practitioner has expired;

(E) When the nurse practitioner is required to refer the worker to an attending physician for a closing examination or because of a possible worsening of the worker's condition following claim closure; and

(F) When a worker is subject to managed care and compelled to be treated inside an MCO;

(g) A Worker Requested Medical Examination;

(h) Whether a worker has an attending physician or authorized nurse practitioner who works in a group setting/facility and the worker sees another group member due to team practice, coverage, or on-call routines; or

(i) When a worker's attending physician or authorized nurse practitioner is not available and the worker sees a medical provider who is covering for that provider in their absence.

Here, claimant has treated with Drs. Brem, Anderson, Di Paola and Lawlor. Claimant changed from Dr. Brem to Dr. Anderson when he was enrolled in the MCO. Thus, under OAR 436-010-0220(3)(f)(F), that change is not included in the attending physician calculation. However, claimant subsequently treated with three physicians consecutively. Moreover, he

signed 827 forms designating Drs. Di Paola and Lawlor as his attending physicians. Furthermore, these changes do not qualify for any of the exceptions listed in OAR 436-010-0220(f). Finally, Dr. Lawlor is willing to continue as claimant's current attending physician. Therefore, substantial evidence in the record supports MRU's determination that claimant has exhausted three choices of attending physician. Accordingly, I affirm the administrative order disapproving a fourth choice.

ATTORNEY FEES

Claimant has not prevailed in a contested case hearing and is not entitled to an attorney fee. ORS 656.385(1).

ORDER

IT IS HEREBY ORDERED that:

The Administrative Order dated July 15, 2005 is affirmed.