

In the Medical Treatment of  
**Ashley M. Olsen, Claimant**  
Contested Case No: 06-201H  
**PROPOSED & FINAL ORDER**

July 17, 2007

ASHLEY M. OLSEN, Petitioner  
FEDERAL INSURANCE COMPANY, Respondent  
Before Geoffrey G. Wren, Administrative Law Judge

---

Pursuant to notice, hearing was convened on March 22, 2007 in Portland, Oregon before the undersigned administrative law judge. Claimant was present and was represented by counsel Scott McNutt, Jr. The employer, PF Chang's China Bistro, Inc., and its insurer Gallagher Bassett Insurance Services, Inc., were represented by Daniel J. Sato. The record closed on July 9, 2007.

Exhibits 1-33 were admitted.

### ISSUES

*Medical Services:* Claimant challenges dismissal of her request for Director's review of a proposed medical service, a surgery proposed by Dr. Butler.

*Attorney Fee:* In the event claimant prevails, she seeks award of an assessed attorney fee.

### STATEMENT OF FACTS

Claimant sought treatment for her right shoulder following an incident in June 2004 when she felt a pop followed by pain in the shoulder after she threw a ball. Her right arm briefly went dead. (Exs. 1, 3). An MRI scan on July 7, 2004 was reported as showing tendinopathy of the right rotator cuff, fluid in the subacromial/subdeltoid bursa, and mild flattening of the posterior lateral humeral head suspicious for a Hill-Sachs deformity and previous anterior dislocations. There also was abnormal appearance of the anterior glenoid labrum suspicious for a Bankart deformity (labral tear). (Ex. 2). On August 9, 2004, Dr. Butler assessed right shoulder tendonitis. He told the claimant that she probably had a combined problem of rotator cuff dysfunction and instability. (Ex. 3).

On April 8, 2006, while working as a server for PF Chang's China Bistro, Inc., claimant's left foot slipped on water, and she fell backwards. She ended up on her buttocks with her right arm behind her. Some part of claimant's right hand or wrist struck the floor. During the fall, claimant heard and felt a pop in her right shoulder and felt immediate pain in the anterior and superior aspects. She also felt her shoulder "shift." (Exs. 3, 22).

Claimant sought treatment from Dr. Darling, her primary care physician. The doctor referred claimant for an MRI and orthopedic consultation. (Ex. 8).

A right shoulder MRI scan on May 9, 2006 revealed subacromial and subdeltoid bursitis, predominantly anterior to the shoulder joint, and evidence suggestive of muscle strain. Dr. Bocchi, a radiologist, stated that the scan did not reveal evidence of a rotator cuff tear or fractures. With regard to the glenohumeral region, Dr. Bocchi stated:

The glenohumeral ligaments are somewhat difficult to evaluate although the middle glenohumeral ligament is visualized and is unremarkable. There is no excess fluid in the shoulder joint and no articular cartilage thinning is present. The visualized portions of the glenoid labrum are unremarkable. There is no abnormality of the biceps anchor or superior labrum.

(Ex. 9).

Claimant consulted Dr. Kayser, an orthopedic surgeon, on June 26, 2006. She complained of continuous right shoulder and upper arm pain and subluxing of the shoulder. Dr. Kayser noted that claimant had seen Dr. Butler in 2004, but that she had “got[ten] over her episode” and that Dr. Butler had not recommended surgery. Claimant said that she had done well until the April 8, 2006 accident. Dr. Kayser noted the reports of the July 7, 2004 and May 9, 2006 MRI scans, and he reviewed the May 9, 2006 scan. He read the May 9, 2006 scan as showing what looked like a superior labral deformity, but he did not think that condition was claimant’s main problem. He assessed a subluxable shoulder. (Ex. 12).

On June 6, 2006, the employer accepted a claim for right shoulder subacromial and subdeltoid bursitis. (Ex. 16).

Following a course of physical therapy, claimant returned to Dr. Kayser on June 26, 2006. She had not made much progress and still had chronic aching in her right shoulder, discomfort with activity, and a sense of instability. On examination, claimant again was globally tender and guarded a “fair amount.” The doctor stated that he could not really demonstrate significant anterior and posterior instability, but her apprehension sign definitely was positive. Her sulcus sign was about 1+. Her biceps tendon seemed unremarkable. Dr. Kayser looked at claimant’s MRI scans. He stated that he did not see an obvious labral tear. He referred claimant to Dr. Butler. (Ex. 12).

Claimant consulted Dr. Butler on July 21, 2006. Claimant complained that her right shoulder “shift[ed]” at work and that she felt constant pain, mostly achy with intermittent sharp pains. Dr. Butler reviewed claimant’s MRI scans and stated that they did not show changes in the anterior labrum. On examination, claimant had a positive relocation sign and apprehension on crank testing. Dr. Butler assessed anterior instability with some impingement features. (Ex. 3).

Dr. Butler sought authorization for a Bankart repair and possible capsular shift surgery. (Ex. 21; *see* discussion). He explained that the surgery would treat the instability portion of claimant’s presentation, distinguishing the surgery from possible future surgery for impingement. (Ex. 3).

Claimant saw Dr. Woodward for an independent medical examination on August 23, 2006. Claimant told the doctor that her right shoulder had “shifted” four or five times since the April 8, 2006 accident, but she had not had shifting or dislocation episodes involving her left shoulder. Claimant complained of pain in her right cervical paraspinal muscles, in the superior and posterior aspects of the right shoulder, and in the right scapular area. Her shoulder pain was constant and aggravated by sleeping or activity. Following examination and review of claimant’s medical records, Dr. Woodward assessed possible strain of the right shoulder girdle muscles from the April 8, 2006 accident and possible chronic instability of the right shoulder from 2004. He attributed the instability to “an episode in 2004” and explained that any shoulder girdle strain caused by the work accident had resolved. That being the case, he opined that the major contributing cause for any need for surgery would be claimant’s “pre-existing condition.” (Ex. 22).

After reviewing Dr. Woodward’s report, Dr. Butler agreed that claimant had a preexisting condition, but he considered the work injury the major contributing cause of a combined condition. Dr. Butler explained that at surgery, he would perform a Bankart reconstruction if claimant in fact had a Bankart lesion. If he instead found capsular laxity, a cause of instability, he would repair that laxity. (Ex. 24).

The insurer did not authorize the surgery Dr. Butler proposed. On November 2, 2006 claimant, by counsel, sought Director’s review. (Ex. 26). The insurer responded, by counsel, on November 14, 2006. The insurer asserted that the proposed surgery appeared related to conditions not currently accepted, namely a Bankart lesion and right shoulder instability. (Ex. 29).

On November 16, 2006, the Director issued an Administrative Order of Dismissal. The Director noted that the insurer had responded that the surgery Dr. Butler proposed was directed to a condition that the insurer had not accepted. The Director did not consider whether the insurer had to pay for the surgery as a diagnostic service. (Ex. 32).

### **ULTIMATE FINDING OF FACT**

The surgery proposed by Dr. Butler would be directed at right shoulder instability, a noncompensable condition.

### **CONCLUSIONS OF LAW AND OPINION**

Claimant challenges the Director’s November 16, 2006 Administrative Order of Dismissal. She contends that she is entitled to the surgery proposed by Dr. Butler as a service to treat a compensable condition. Under ORS 656.247(3)(a) and OAR 436-001-0225(2), I may set aside or modify a director’s order only if it is not supported by substantial evidence in the record or if it reflects an error of law. No new medical evidence or issues may be admitted or considered.

Resolution of this matter begins with determination what the surgery proposed by Dr.

Butler would entail. Dr. Butler explained that the surgery would enable him to find out whether claimant in fact has a Bankart lesion. If so, he would repair that condition. If instead claimant has capsular instability, he would perform a capsulorrhaphy. (Ex. 24). Dr. Butler explained that the surgery would treat the instability portion of claimant's presentation. He distinguished claimant's need for surgery for instability from need for possible future surgery for impingement. (Ex. 3).

By Opinion and Order of this date, the undersigned administrative law judge has determined that right shoulder instability is not a compensable condition. (Administrative Record). Insofar as claimant has sought authorization for surgery to treat instability, the surgery is a noncompensable medical service.

Claimant alternatively contends that she is entitled to the proposed surgery as a diagnostic medical service. In *Hazel M. Hand*, 59 Van Natta 1028 (2007), the Board held that jurisdiction lies with an administrative law judge to determine compensability of diagnostic medical services. By Opinion and Order of this date, the undersigned administrative law judge has determined that the surgery is not compensable as a diagnostic medical service. No basis lies to remand this matter to the Director to consider compensability of the surgery as a diagnostic medical service.

#### **ORDER**

*IT IS HEREBY ORDERED* that the November 16, 2006 Administrative Order of Dismissal is affirmed.

*IT IS FURTHER ORDERED* that all other relief is denied.