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In the ORS 656.245 Medical Services of  
**Juvenal Gonzales, Claimant**  
Contested Case No: 09-132H  
**PROPOSED & FINAL ORDER OF DISMISSAL**  
January 6, 2010  
JUVENAL GONZALES, Petitioner  
MATRIX ABSENCE MANAGEMENT INC., Respondent  
Before Kirk Spangler, Administrative Law Judge

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The original dispute in this case concerned the administrator's (*i.e.*, Matrix Absence Management, Incorporated) refusal to pay for claimant's physical therapy services rendered by Marquis Physical Therapy and Spine Rehabilitation from February 12, 2008 through March 13, 2008.<sup>1</sup> As a result, claimant's attorney requested administrative review before the Medical Review Unit of the Workers' Compensation Division. By way of a May 8, 2009 Administrative Order, the MRU concluded that the administrator was not liable for payment of the disputed services. Shortly thereafter, claimant's attorney requested reconsideration. Thus, the MRU abated its May 8, 2009 Order. Then, on July 8, 2009, the MRU issued an Administrative Order on Reconsideration, which upheld its earlier conclusion (that the administrator was not liable) and speculated that claimant "may be [personally] liable for the services."

Subsequently, claimant's attorney appealed the July 8, 2009 Order and the case was referred to the Hearings Division of the Workers' Compensation Board. Prior to the hearing, however, the parties moved to submit the case on the documentary record. Their motion was granted. Written arguments were then submitted. Significantly, in her argument, claimant's attorney indicated that claimant was not contesting the MRU's conclusion that claimant's treating doctor had not submitted a proper palliative care request.<sup>2</sup> Instead, she indicated that claimant was appealing solely that portion of the May 8, 2009 Order that concluded "claimant may be liable for the medical services."

As a result, the administrator's attorney moved to dismiss claimant's appeal of the May 8 Order, inasmuch as there allegedly was no longer a "justiciable controversy." Claimant's attorney responded and opposed the dismissal.

### **Conclusion and Opinion**

This case is an example of bureaucracy at its worst. Claimant sustained a compensable injury in 2004, and the law entitles him to lifetime medical services. ORS 656.245. Such services, including palliative care that enables a worker to continue working or training, are the responsibility of the administrator and are supposed to be paid so long as the services are (1) causally related to the accepted injury, and (2) reasonable and necessary.

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<sup>1</sup> The total amount of the unaudited physical therapy bills is \$1,303. Exs. 11-1 & 11-2.

<sup>2</sup> ORS 656.245(1)(c)(J) provides (in part): "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. If the insurer \* \* \* does not approve, the attending physician or the worker may request approval from the Director of the Department of Consumer and Business Services for such treatment."

Here, there is no assertion by the administrator that the disputed physical therapy services did not allow claimant to continue working. In fact, claimant was working at the time and Dr. Power *prescribed* the physical therapy in response to *the employer's request for confirmation of his work restrictions*. Ex. 14-2. Likewise, there is no assertion by the administrator that the services were either not casually related or not reasonable and necessary.

This entire dispute arose because Dr. Powers did not jump through all the bureaucratic holes set forth in OAR 436-010-0290(1).<sup>3</sup> Instead, to his credit, he focused on his patient and on prescribing some medical treatment that would help him.

The administrator could have simply “overlooked” Dr. Powers’ apparent inadvertence and paid the audited amount of \$1,303. Instead, it chose to not pay for the services given the unmet bureaucratic requirements of OAR 436-010-0290(1), and to defend its refusal to pay through the cost of litigation.

To make this sad tale worse, the MRU engaged in unnecessary speculation in its July 8 Order by implying that claimant might be *personally* liable for the \$1,303 in medical services. As the administrator’s attorney correctly points out, however, that portion of the Order was premature, unnecessary, and pure *dictum*. The MRU has no authority to decide whether an injured worker is personally liable for the payment of a medical service. Moreover, to do so was premature, speculative, and outside the scope of this case – given that it would take a future event of the medical service provider (a non-party to this proceeding) billing claimant for the rendition of services.

It follows that the administrator’s attorney is absolutely correct in his position that the present case has no “justiciable controversy” and should, therefore, be dismissed. While I empathize with claimant’s attorney’s argument to the contrary, and her desire to negate the unfortunate *dictum* in the MRU’s July 8 Order, it does not present a justiciable controversy for resolution under ORS 656.245, 656.704(2), and OAR 436-010-0290(1). Consequently, I have no choice but to propose that the current case should be dismissed.

### **IT IS SO ORDERED.**

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<sup>3</sup> In its July 8 Order, the MRU referred to OAR 436-010-0290(1) stating: “Subsection (a) provides that the request must: (A) describe any objective findings; (B) identify by ICD-9-ICM diagnosis, the medical condition for which palliative care is requested; (C) detail a treatment plan which includes the name of the provider who will render the care, specific treatment modalities and frequency and duration of the care, not to exceed 180 days; (D) explain how the requested care is related to the compensable condition; and (E) describe how the requested care will enable the worker to continue current employment, or a current vocational training program, and the possible adverse effect if the care is not approved. Subsection (b) provides that the insurer must date stamp all palliative care requests upon receipt. Within 30 days of receipt, the insurer must send written notification to the attending physician, worker, worker’s attorney approving or disapproving the request as prescribed.”

The MRU you then concluded that Dr. Powers’ prescription “did not contain the elements required by rule for a palliative care request.”