

In the Matter of the ORS 656.260 Managed Care Organization Dispute of  
**Curtis, Michelle, Claimant**

Contested Case No: HH01-107

**FINAL ORDER**

October 21, 2002

MICHELLE CURTIS , Petitioner

TRAVELERS INDEMNITY OF ILLINOIS AND PROVIDENCE VANTAGE MCO.,  
Respondent

Before John L. Shilts, Workers' Compensation Division Administrator

On August 23, 2001, the Medical Review Unit (MRU) of the Workers' Compensation Division (WCD) issued an administrative order determining that: (1) claimant was properly notified and enrolled in a managed care organization (MCO); (2) Travelers Indemnity was not liable for the disputed medical services provided outside the MCO; and (3) claimant was liable for the disputed medical bills.

On April 3, 2002, Hearing Officer Ella Johnson conducted a telephone hearing. Petitioner, Michelle Curtis (claimant), was represented by attorney Glen Shearer. Attorney Jerry Keene represented respondent, Travelers Indemnity of Illinois (insurer). Providence Vantage MCO and the WCD waived appearance. No witnesses testified.

On February 8, 2002, Hearing Officer Johnson issued a Proposed and Final Contested Case Hearing Order, which affirmed MRU in part and reversed in part. The hearing officer determined that: (1) claimant received proper notice to treat within the MCO; (2) claimant was entitled to treat outside the MCO between the date of the aggravation denial (January 24, 2000) and the date compensability of the aggravation claim was determined (April 27, 2001) and, thus, the insurer was liable for medical services incurred between those dates; and (3) claimant's counsel was entitled to an assessed fee in the amount \$5,500. The hearing officer affirmed MRU as to unpaid medical billings prior to January 24, 2000 and after April 27, 2001.

The insurer filed a Motion for Abatement and Reconsideration of the order on February 15, 2002, to which claimant responded. On February 22, 2002, the WCD requested the hearing officer to conduct further hearing pursuant to OAR 137-003-0650.

On May 9, 2002, Hearing Officer Johnson conducted further hearing to address the arguments raised by the insurer in its motion. The insurer filed exceptions to Hearing Officer Johnson's June 10, 2002 Amended Proposed and Final Contested Case Hearing Order, which reaffirmed her prior decision. Claimant timely responded to the exceptions. Before the Director, the issue is whether the aggravation denial exempted claimant from seeking medical treatment within the MCO pursuant to ORS 656.245(4)(b)(D) and attorney fees. The entire record, consisting of a tape recording of the hearing, all evidence received, and all documents filed, has been considered.

The director adopts and affirms the hearing officer's order regarding the findings of fact and the sections regarding authorization to treat and notice. The remainder of the order is

corrected and modified as follows.

Claimant has an accepted claim for herniated discs at C5-6 and C6-7. Her condition resulted in surgery, including interbody fusion at C5-6 and C6-7, which had been performed by Dr. Brett. On April 15, 1999, the insurer enrolled claimant into the MCO. Claimant was initially allowed to treat with Dr. Brett, a non-MCO neurosurgeon, following her enrollment. Dr. Brett declared claimant medically stationary on May 7, 1999. The claim was closed pursuant to Notice of Closure dated May 27, 1999. Dr. Brett subsequently retracted his opinion that claimant's condition was medically stationary. Rather, he felt that claimant had developed a non-union at C5-6 and recommended a repeat fusion. Dr. Brett submitted a claim for aggravation on August 10, 1999. On November 23, 1999, the insurer advised claimant that she was enrolled in the MCO, that she could not treat with Dr. Brett as her primary care physician, and that the insurer would not reimburse Dr. Brett for services rendered after 7 days from the date of the letter. Claimant did not appeal this decision. Claimant began treating with Dr. Calhoun, neurosurgeon. Claimant did not treat with Dr. Brett from November 1999 until December 7, 2000. The insurer denied the aggravation claim on January 24, 2000 on the ground that claimant's accepted condition had not worsened. On February 7, 2000, the MCO advised claimant that a change to a MCO neurosurgeon would not be medically detrimental. Claimant failed to timely appeal this decision. On December 7, 2000, claimant returned to Dr. Brett for treatment. Dr. Brett performed the repeat fusion on December 22, 2000. WCB Administrative Law Judge (ALJ) Kekauoha issued an April 27, 2001 Opinion and Order which found, based on the opinion of Dr. Brett, that claimant's condition was not medically stationary at the time of claim closure and, thus, her claim was prematurely closed. This decision rendered the aggravation denial moot.

Hearing Officer Johnson determined that the claim that was in denied status was the aggravation claim, that the disputed medical services were directed to claimant's aggravated condition, and thus under ORS 656.245(4)(b)(D), the denied claim was the aggravation claim. Therefore, claimant was entitled to seek treatment outside the MCO.<sup>1</sup>

ORS 656.245(4)(b)(D) provides:

“If the claim is denied, the worker may receive medical services after the date of denial from sources other than the [MCO] until the denial is reversed. Reasonable and necessary medical services received from sources other than the [MCO] after the date of claim denial must be paid as provided in ORS 656.248 by the insurer or self-insured employer if the claim is finally determined to be compensable.”

The insurer contends that claimant has an accepted claim, that she was enrolled in an MCO and, thus, she was not entitled to treat outside the MCO with Dr. Brett, notwithstanding the

---

<sup>1</sup> The hearing officer's finding, that the repeat fusion was reasonable and necessary, was premature. The reasonableness and necessity of the surgery was not raised by the parties nor addressed on administrative review. Thus, the hearing officer's determination regarding that finding is vacated.

aggravation denial. The insurer argues that not every claim constitutes a “denied claim” under ORS 656.245(4)(b)(D). Rather, it argues that the phrase “if the claim is finally determined to be compensable” qualifies the phrase “if the claim is denied” and thus, ORS 656.245(4)(b)(D) only applies when compensability of the claim is denied. The insurer thus argues that ORS 656.245(4)(b)(D) is inapplicable here because it never contested compensability. In essence, the insurer seeks to limit the meaning of the term “the claim” to those claims where compensability is at issue; or stated another way, to denials that deny compensability of the claim. The insurer would define “compensability” to mean causation or the underlying condition itself is in dispute.

To establish an aggravation claim, a claimant must prove two elements: (1) an “actual worsening” (2) of the compensable condition. ORS 656.273(1); *see Gloria T. Olson*, 47 Van Natta 2348, 2350 (1995) (if the allegedly worsened condition is not a compensable condition, then compensability must first be established). The insurer argues that its aggravation denial did not deny “compensability of the claim” because it only denied whether claimant’s accepted condition had worsened and did not deny the causal element. Because the underlying accepted condition had not been denied, claimant was still required to treat within the MCO for that accepted condition. Although the insurer’s argument has appeal, ORS 656.245(4)(b)(D) does not distinguish between the different possible permutations on which a denial of an aggravation claim may be based. *See Reid v. SAIF*, 160 Or App 383 (1999) (the term “claim” in ORS 656.245(4)(b)(D) applies to any type of claim); *accord SAIF v. Jensen*, 183 Or App 439 (2002).

In *SAIF v. Reid*, *supra*, the court interpreted the term “the claim” in ORS 656.245(4)(b)(D) to apply to any type of claim, in that case, a new medical condition claim. The court reasoned that “claim” was an inexact statutory term that could have different meanings from the definition contained in ORS 656.005(6).<sup>2</sup> The court concluded that the statutory definition applied to the word “claim” in ORS 656.245(4)(b)(D) and was not limited to initial or aggravation claims. The court relied on its decision in *Johansen v. SAIF*, 158 Or App 672 (1999) that there were different types of claims, that could be distinct from each other because each required different elements. The court believed that the legislature intended ORS 656.245(4)(b)(D) applied to any type of claim to avoid rendering the requirement to treat with a MCO illusory for certain types of claim. *Reid*, 160 Or App at 387. In *Reid*, the insurer was required to pay for psychological services that the claimant received outside a MCO during the time the insurer had *de facto* denied the psychological claim. The claimant had been receiving medical services for his accepted physical condition from the MCO.

As the court recognized in *Reid* and *Johansen*, there are different types of claims with different required elements. Thus, the basis to deny claims, even the same category of claims such as aggravation claims, can be different and distinct. Nothing in *Reid* or *Johansen* indicates that the legislature intended to further segregate the various forms of claims and denials of those claims. The insurer does not dispute that ORS 656.245(4)(b)(D) applies to aggravation claims. Under the court’s interpretation of “claim” in *Reid*, ORS 656.245(4)(b)(D) would apply to the insurer’s denial of the aggravation claim. Therefore, claimant could receive medical services from outside the MCO after the date of the insurer’s aggravation denial until that denial was set aside.

<sup>2</sup> ORS 656.005(6) defined claim as “a written request for compensation \*\*\*.”

### Attorney Fee

The hearing officer determined that claimant had prevailed on a portion of the medical billings and, thus, was entitled to an attorney fee. Claimant's counsel had provided a statement of services requesting a fee of \$5,500 for an estimated 20 hours of work. Applying the factors set forth in OAR 436-001-0265, the hearing officer found that the requested fee was reasonable in light of the quality of legal representation and the benefits secured for claimant.

The insurer requests a reduction of the attorney fee awarded, contending that the hourly rate was unreasonable, that the time expended was excessive, and that the only benefit secured for claimant was payment for the disputed surgery. The insurer further asserts that because the statement of services is not itemized and unclear, any time expended before MRU should not be considered.

Pursuant to OAR 436-001-0265, the factors to be considered in determining an appropriate attorney fee are: 1) time devoted to the case; 2) the complexity of the issues; 3) the value of the interest involved; 4) the nature of the proceedings; 5) benefit secured for the claimant; 6) risk in a particular case that an attorney's efforts may go uncompensated; 7) assertion of frivolous issues or defenses; 8) a statement of services; and 9) any other relevant consideration deemed appropriate.

On September 20, 2001, claimant filed a request for hearing to appeal MRU's administrative order and raised three issues—insurer's withdrawal of Dr. Brett as claimant's attending physician, notice, and claimant's entitlement to treat outside the MCO. The initial contested case hearing convened on December 15, 2001. At WCD's request, further hearing was held on May 9, 2002. The parties appeared by telephone. The evidentiary record consisted of 100 exhibits. The hearing consisted of oral argument. In addition, claimant's counsel prepared a five page Hearing Brief. Most of the brief dealt with the insurer's/MCO's disapproval of Dr. Brett as claimant's attending physician and the process of this disapproval. Claimant only prevailed over the issue of her entitlement to treat outside the MCO. This issue, however, was a legally complex issue. Claimant also received a significant benefit in obtaining medical treatment. Both parties were represented by skilled attorneys, who vigorously litigated their respective positions.

The statement of services was not specific as to the time expended on the services performed. Given the lack of specificity, a broader range of discretion is assumed in awarding a fee in this case. *Clyde Keeland*, 6 WCSR 342 (2001) (citing *SAIF v. Bacon*, 160 Or App 596 (1999)). Although fees cannot be awarded for much of the time requested by counsel regarding issues on which claimant did not prevail, significant weight is placed on the complexity of the remaining issue and the risk that claimant's counsel's efforts could go uncompensated. OAR 436-001-0265(1)(f). Taking into account the factors set forth in OAR 436-001-0265(1), the director finds that the \$5,500 attorney fee award is unreasonable and awards a reasonable attorney's fee of \$2,500 to be paid by the insurer.

IT IS HEREBY ORDERED that the June 10, 2002 Amended Proposed and Final Contested Case Hearing Order is modified in part and affirmed in part, as follows:

1. Claimant was properly enrolled in the MCO and was properly notified that Dr. Brett did not qualify as a primary care physician.

2. Claimant was entitled to receive treatment outside the MCO from the period of January 24, 2000 through April 27, 2001.

3. The employer shall pay claimant's attorney an assessed fee in the amount of \$2,500.

DATED this    day of October, 2002.

**MARY NEIDIG, DIRECTOR  
DEPARTMENT OF CONSUMER  
AND BUSINESS SERVICES**

By: \_\_\_\_\_

John Shilts, Administrator  
Workers' Compensation Division