
In the Matter of the ORS 656.260 Managed Care Dispute of

Heer, Mary K., Claimant

Contested Case No: HH02-009

2nd AMMENDED ORDER

August 22, 2002

MANAGED HEALTHCARE NORTHWEST, Petitioner

MARY K. HEER, Respondent

Before John L. Shilts, Workers' Compensation Division Administrator

HISTORY OF THE CASE

The managed care organization appeals an administrative order issued on January 8, 2002 by the Medical Review Unit (MRU) of the Workers' Compensation Division (WCD) Department of Consumer and Business Services (director or the department). On April 5, 2002, Administrative Law Judge Catherine P. Coburn conducted a hearing in this matter. Petitioner Caremark Comp/Managed Healthcare Northwest (MCO) was represented by attorney Jerald P. Keene. SAIF Corporation (insurer) was represented by attorney Mary G. Adams. Mary K. Heer (claimant), who was *pro se*, waived appearance. WCD also waived appearance. No witnesses testified and the record closed on April 18, 2002, following receipt of the MCO's Hearing Memorandum, joined by insurer.

The director issued an Amended Proposed and Final Contested Case Hearing Order Remanding on August 1, 2002. Upon reconsideration, the director withdraws and abates the August 1, 2002 Amended Order and re-issues the form of Proposed and Final Contested Case Hearing Order issued by the Hearing Officer on July 3, 2002. No substantial modifications to the Hearing Officer's proposed order have been made. The parties' review and appeal rights begin to run on the date of this order.

The record of this proceeding, consisting of all evidence received, and all hearing papers filed, has been considered. The findings of fact set out below are based upon the entire record.

ISSUE

The issue is whether MRU correctly determined that a trigger point injection administered by Joan M. Takacs, DO, on July 25, 2001 was reimbursable.

EVIDENTIARY RULINGS

WCD Exhibits 1 through 41 as well as the MCO's Supplementary Exhibit 42 were admitted into the record without objection.

FINDINGS OF FACT

In February 2001, claimant filed an occupational disease claim while working as a data entry clerk. (Exs. 1 and 2). Listing the date of injury January 20, 2001, insurer accepted as compensable conditions “right trapezius muscle strain, bilateral forearm muscle strain and bilateral carpal tunnel syndrome”. (Ex. 5-1). In April 2001, insurer enrolled claimant in the MCO. (Ex. 6-1). On May 23, 2001, claimant designated Dr. Takacs as her attending physician. (Ex. 13).

The MCO’s Treatment Standards and Protocols, require precertification of trigger point injections. (Exs. 32-5 and 42-2). The standards prescribe acceptable injection solutions and treatment frequency “every four to seven days for up to three times in a six month period to allow for focused rehabilitation.” (*Id.*)

From April through June 2001, Dr. Takacs administered seven trigger point injections and the MCO disapproved three of the procedures because the injection consisted of a homeopathic solution. (Exs. 3 and 15). On July 25, 2001, Dr. Takacs administered a trigger point injection consisting of normal saline solution. (Ex. 3-13).

The MCO disapproved the July 25, 2001 trigger injection because the treatment frequency exceeded the MCO’s standards. (Ex. 25). The MCO Joint Medical Committee (JMC) met on September 13, 2001 and voted unanimously to uphold the disapproval because the frequency of claimant’s trigger point injections exceeded the MCO’s treatment standards. (Ex. 28). The panel included an occupational medicine specialist, a plastic surgeon, a psychiatrist, a psychologist, an addictionologist, a chiropractor, a neurosurgeon and a physical therapist.¹ (Ex. 32-3). Franklin Wong, MD, MCO Medical Director participated in the discussion but did not vote. (*Id.*) David Silver, MD, JMC Chair noted, “It was the consensus of the Joint Medical Committee that trigger point injections, while possibly providing palliative or placebo benefit, have not been proven to demonstrate curative value in current medical literature.” (Ex. 28).

On August 13, 2001, Dr. Takacs appealed the denial noting that she had changed from homeopathic solution to normal saline solution for claimant’s trigger point injection. (Ex. 26). On September 19, 2001, Dr. Takacs requested director’s review, noting, “The patient reports the treatment has made a significant impact on her pain level.” (Ex. 29).

¹ The Joint Medical Committee did not include a Doctor of Osteopathy. See OAR 436-015-0020(7)(b)(B).

In response to MRU’s notice, Dr. Wong submitted a Dispute Resolution Report dated October 30, 2001. (Ex. 32). In support of the disapproval, Dr. Wong noted that the frequency of claimant’s trigger point injections exceeded the MCO’s treatment standards. (Ex. 32-2). Dr. Wong stated,

The physician members of the panel directed their attention to the medical records obtained to date and their clinical

findings. Of concern to the committee was the number of injections the worker had received without documentation of any significant pain relief. Studying the literature search of recent articles regarding trigger points and myofascial pain syndrome, every author reviewed referred to trigger point therapy being useful in the acute stages of treatment. (Footnotes omitted). The therapy is directed toward reducing pain so the patient may participate in active treatment such as physical medicine, exercise and other conservative care.

Ms. Heer has demonstrated some of the complicating factors listed. There is no evidence in the medical records to support that other modalities were in use to help the injured worker cope. Early in the treatment the worker was instructed in 'spatial dynamic concepts' by Dr. Takacs, but the records fail to document compliance, or other relief of pain as a result of those instructions.

The medical documentation by Dr. Takacs fails to document objective long-term benefit of trigger point injections for this worker. There is no evidence to support that her activity level, rest or mood is positively impacted by the use of the injections. The JMC members recognized that continuing an invasive procedure of trigger point therapy, with attendant risk of infection, as well as their cost, is not medically indicated. The treatment standards proposed by CareMark Comp have been exceeded and there is no supporting evidence that they have been beneficial to this worker. (Ex. 32-3 and 4).

On November 28, 2001, MRU requested K. Annette Weller, MD to serve as physician reviewer of the medical appropriateness dispute. (Ex. 37). On December 6, 2001, Dr. Weller reviewed the medical records and noted the absence of a comprehensive physical rehabilitation program. (Ex. 38-4). She opined that the July 25, 2001 trigger point injection was not appropriate medical treatment based on the frequency and duration of treatment without documentation of clear objective improvement. (*Id.*)

CONCLUSION OF LAW

MRU incorrectly determined that a trigger point injection administered by Joan M. Takacs, DO on July 25, 2001 was reimbursable.

OPINION

This managed care dispute arises under ORS 656.260, and therefore, jurisdiction lies with the director. ORS 656.260(6). I review for substantial evidence and error of law. ORS 656.260(16). The burden of proving a fact or position rests with the proponent. ORS 183.450(2). *Harris v. SAIF*, 292 Or 683 (1982). As petitioner, MCO bears the burden of proving that the administrative is incorrect.

Pursuant to ORS 656.245(1), an insurer is obligated to provide medical services for compensable conditions for such period as the nature of the injury or the process of recovery requires. ORS 656.260(4)(a) authorizes insurers to provide medical services to injured workers through a contract with a state-certified managed care organization.

MRU determined that the disputed trigger point injection was not excessive within the meaning of ORS 656.327, and therefore, reimbursable even though it was rendered outside the MCO treatment guidelines. In reaching this conclusion, MRU disagreed with the opinion of the WCD physician reviewer and did not consider the opinion of the MCO medical review committee.

As petitioner, MCO does not appeal for lack of substantial evidence. Rather, MCO contends that the administrative order reflects several errors of law. MCO contends that MRU erred by applying ORS 656.327 rather than ORS 656.245(4)(a), by applying an incorrect legal standard and by failing to apply OAR 436-010-0230(1).

A. Errors of Law:

1. Applicable Statute: MCO contends that the administrative order is faulty because MRU relied on ORS 656.327 and failed to apply ORS 656.245(4)(a) in evaluating whether the disputed treatment was medically appropriate. I agree. By its terms, ORS 656.327 does not apply to MCO disputes.² On the other hand, ORS 656.245(1)³ contains the general requirement that insurers in every workers'

² ORS 656.327(1)(a) provides:

"If an injured worker, an insurer or self-insured employer or the Director of the Department of Consumer and Business Services believes that the medical treatment, **not subject to ORS 656.260**, that the injured worker has received, is receiving or is proposed to receive is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services, the injured worker, insurer or self-insured employer shall request review of the treatment by the director and so notify the parties." (Emphasis added).

³ ORS 656.245(1)(a) provides:

For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions caused in material part by the injury for such period as the nature of the injury or

compensation claim provide reasonable and necessary medical services that are related to a compensable claim. More specifically, ORS 656.245(4)(a)⁴ authorizes insurers to provide such medical services according to a contract with a managed care organization. Where, as here, claimant is enrolled in an MCO and the director addresses a medical appropriateness dispute, the relevant inquiry is whether insurer provided reasonable and

necessary medical services within the terms of the MCO contract. Inasmuch as MRU applied an incorrect statute, the administrative order reflects an error of law.

Similarly, MRU cited *West v. SAIF*, 74 Or App 317, 320 (1985) for the proposition, “The law requires provision of medical services*** so long as they are reasonable and necessary.” (Administrative Order p. 4). However, *West* is inapposite because it was not an MCO dispute.⁵

2. Legal Standard: MCO’s main contention is that MRU erred by applying an incorrect legal standard in reviewing the MCO’s medical appropriateness decision. MCO contends that MRU is obligated to defer to the MCO’s medical appropriateness decision where the MCO JMC bases its recommendation upon MCO-adopted treatment standards. In support of its position, MCO asserts several arguments. MCO first argues that ORS 656.260(4)(c) and (d)⁶ require MCO’s, as a condition for state-certification, to formulate and enforce procedures, including treatment standards and a medical review committee comprised of medical experts to determine the appropriateness of treatment provided under its contract, and therefore, the legislature intended MRU to defer to MCO medical appropriateness decisions. MCO next argues that ORS 656.260(4)(c) and

process of the recovery requires, subject to the limitations in ORS 656.225, including such medical services as may be required after a determination of permanent disability. In addition, for consequential and combined conditions described in ORS 656.005(7), the insurer or the self-insured employer shall cause to be provided only those medical services directed to medical conditions caused in major part by the injury. ORS 656.245(4)(a) provides in part:

(4) Notwithstanding subsection (2)(a) of this section, when a self-insured employer or the insurer of an employer contracts with a managed care organization certified pursuant to ORS 656.260 for medical services required by this chapter to be provided to injured workers:

(a) Those workers who are subject to the contract shall receive medical services in the manner prescribed in the contract.*****

⁵ The court decided *West* in 1985, five years before the legislature enacted ORS 656.260 authorizing workers compensation insurers to contract with state-certified MCO’s.

⁶ ORS 260(4)(c) and (d) provide:

(4) The director shall certify a health care provider or group of medical service providers to provide managed care under a plan if the director finds that the plan:

(c) Provides appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of service.

(d) Provides adequate methods of peer review, service utilization review, quality assurance, contract review and dispute resolution to ensure appropriate treatment or to prevent inappropriate or excessive treatment, to exclude from participation in the plan those individuals who violate these treatment standards and to provide for the resolution of such medical disputes as the director considers appropriate. A majority of the members of each peer review, quality assurance, service utilization and contract review committee shall be physicians licensed to practice medicine by the Board of Medical Examiners.***

(d) charge MCO’s with the task of preventing excessive or inappropriate treatment and anticipate “outliers”, *viz* MCO medical providers who render services that are outside the parameters of MCO treatment standards, and therefore, MRU should defer to MCO medical appropriateness decisions. MCO next argues that vague terms such as “appropriate” and “excessive” contained in ORS 656.260(4)(d) indicate that the legislature authorized WCD to adopt specific treatment standards and where WCD

declined to do so, WCD is obligated to defer to MCO treatment standards. MCO further argues that ORS 656.260(14)⁷ and OAR 436-015-0008⁸ require parties to submit medical appropriateness questions to the MCO dispute resolution process before seeking MRU's review, and therefore, MRU should to defer to MCO medical appropriateness decisions.

ORS 656.260(6), ORS 656.260(14), and OAR 436-015-0008 prescribe the statutory and administrative scheme for appeal of an MCO medical appropriateness decision.

ORS 656.260(6) provides:

Any issue concerning the provision of medical services to injured workers subject to a managed care contract and service utilization review, quality assurance, dispute resolution, contract review and peer review activities as well as authorization of medical services to be provided by other than an attending physician pursuant to ORS 656.245(2)(b) shall be subject solely to review by the director or the director's designated representatives, or as otherwise provided in this section. Data generated by or received in connection with these activities, including written reports, notes or records of any such activities, or of the director's review thereof, shall be confidential, and shall not be disclosed except as considered necessary by the director in the administration of this chapter. The director may report professional misconduct to an appropriate licensing board.

⁷ ORS 656.260(14) provides:

If a worker, insurer, self-insured employer or the attending physician is dissatisfied with an action of the managed care organization regarding the provision of medical services pursuant to this chapter, peer review, service utilization review or quality assurance activities, that person or entity must first apply to the director for administrative review of the matter before requesting a hearing before the director. Such application must be made not later than the 60th day after the date the managed care organization has completed and issued its final decision.

⁸ OAR 436-015-0008 provides:

Administrative review before the director: The process for administrative review of such matters shall be as follows:

(a) Any party that disagrees with an action taken by an MCO pursuant to these rules shall first use the dispute resolution process of the MCO.

ORS 656.260(14) provides:

If a worker, insurer, self-insured employer or the attending physician is dissatisfied with an action of the managed care organization regarding the provision of medical services pursuant to this chapter, peer review, service utilization

review or quality assurance activities, that person or entity must first apply to the director for administrative review of the matter before requesting a hearing before the director. Such application must be made not later than the 60th day after the date the managed care organization has completed and issued its final decision.

OAR 436-015-0008(2)(b), (c) and (d) provide:

(2) Administrative review before the Director: The process for administrative review of such matters shall be as follows:

(b) The aggrieved party shall file a written request for administrative review with the administrator of the Workers' Compensation Division within 60 days of the date the MCO issues a final decision under the MCO's dispute resolution process. If a party has been denied access to an MCO dispute resolution process because the complaint or dispute was not included in the MCO's dispute resolution process or because the MCO's dispute resolution process was not completed for reasons beyond a party's control, the party may request administrative review within 60 days of the failure of the MCO to issue a decision. The request must specify the grounds upon which the action is contested.

(c) The director shall create a documentary record sufficient for judicial review. The director may require and allow the parties to submit such input and information appropriate to complete the review.

(d) The director shall review the relevant information and issue an order. The order shall specify that it will become final and not subject to further review unless a written request for hearing is filed with the administrator within 30 days of the mailing date of the order.

In construing either a statute or an administrative rule, my task is to discern the intent of the enacting body, beginning with an examination of the text and context. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-611 (1993); *Perlenfein and Perlenfein*, 316 Or 16, 20 (1993). The best indication of legislative intent is in the words of the statute. *Lane County v. LCDC*, 325 Or 569, 577 (1997). I am prohibited from inserting or omitting any language. ORS 174.010. Here, neither the statute nor the rule contains the term "defer". Furthermore, neither the statute nor the rule defines the legal standard that MRU exercises in reviewing a MCO decisions concerning medical appropriateness.

The director has held that in contested cases, where the statute defines no legal standard, the applicable legal standard is *de novo*. *Archie Ulbrich*, 2 WCSR 152 (1997). Even though *Ulbrich* defines the legal standard for contested cases rather than for MRU's review, I apply the same reasoning by analogy. Inasmuch as the legal standard is not defined by statute or rule, I find that MRU exercises *de novo* review of MCO medical appropriateness decisions. Thus, despite the statutory requirement of primary MCO internal review and dispute resolution processes involving medical experts, MRU is not obligated to defer to the MCO's decision concerning medical appropriateness.

3. Applicable Rule: MCO further contends that MRU erred by failing to apply OAR 436-010-0230(1). In support of its position, MCO argues that its treatment standard constitutes "accepted professional standards" as the term is used in OAR 436-010-0230(1), and therefore, MRU was required to defer to the MCO decision concerning medical appropriateness.

OAR 436-010-0230(1) provides:

Medical services provided to the injured worker shall not be more than the nature of the compensable injury or the process of recovery requires. Services which are unnecessary or inappropriate according to accepted professional standards are not reimbursable.

In construing a rule, I apply the same method of analysis employed in determining the meaning of a statute; I determine the meaning of the words used, giving effect to the intent of the enacting body, which in this case is the department. *Abu-Adas v. Employment Dept.*, 325 Or 480, 485 (1997). Here, OAR 436-010-0320(1) is written in the passive voice and does not identify professional standards "accepted" by whom. I find that the department intended the term "accepted professional standards" to mean professional standards accepted by the department, or in the present case, accepted by MRU. This conclusion comports with MRU's *de novo* review of MCO medical appropriateness decisions. Furthermore, the department is not required to make every conceivable policy decision by a rule adopted in advance, but rather, is permitted to make policy decisions as they arise through orders in contested cases. *Forelaws on Board v. Energy Facility Siting Council*, 306 Or 205, 214 (1988); ORS 183.355.⁹

⁹ ORS 183.355(5) provides:

Therefore, the department is not obligated to adopt specific treatment plans for trigger injections but may define "accepted professional standards" through an administrative order.

B. Substantial Evidence: Pursuant to ORS 656.260(16), I review for substantial evidence. Substantial evidence exists to support a finding of fact "when the record, viewed as a whole, would permit a reasonable person to make that finding." ORS 183.482(8)(c). The "substantial evidence" standard of review can be overcome only

when “credible evidence apparently weighs overwhelmingly in favor of one finding and the [director] finds the other without giving a persuasive explanation.” *Armstrong v. Asten-Hill Co.*, 90 Or App 292, 295 (1998). A finding is supported by substantial evidence if it is reasonable in light of countervailing as well as supporting evidence. *Garcia v. Boise Cascade Corp.*, 309 Or 292, 295 (1990). Upon substantial evidence review, my role is not to re-weigh the evidence; rather, I am required to:

“look 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 finding as well as the evidence supporting it, there is substantial evidence. ***For instance, and in the context which is likely 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 Administrative Law Judge] 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 (1988).

Here, the record contains conflicting medical opinions concerning the medical appropriateness of the disputed trigger injection. MRU failed to weigh these conflicting medical opinions; rather, MRU summarized the course of treatment provided by Dr. Takacs and concluded that the disputed treatment was appropriate. MRU noted that Dr. Weller, the WCD medical reviewer, found the disputed medical services inappropriate and MRU disagreed without explanation. Furthermore, MRU did not address the reasoning and opinion of the MCO’s medical review committee. Finally, MRU failed to explain its conclusion that medical treatment that exceeded the MCO treatment standards was appropriate. To use *Armstrong* language, I find that the evidence weighs overwhelmingly in favor of a finding that the disputed medical service was not

No rule of which a certified copy is required to be filed shall be valid or effective against any person or party until a certified copy is filed in accordance with this section. However, if an agency, in disposing of a contested case, announces in its decision the adoption of a general policy applicable to such case and subsequent cases of like nature, the agency may rely upon such decision in disposition of later cases. appropriate while MRU reached the opposite conclusion without giving an explanation. Based on the record, I find that the administrative order is not supported by substantial evidence.

In conclusion, I find that the administrative order reflects errors of law because MRU incorrectly relied on ORS 656.327 and failed to apply ORS 656.245(4)(a) in an MCO dispute. Furthermore, based on ORS 656.260 and OAR 436-010-0320(1), I find MCO’s contention that MRU is required to defer to MCO medical appropriateness

decisions unpersuasive; MRU reviews MCO medical appropriateness decisions *de novo*. However, as a matter of substantial evidence, MRU is not free to disregard MCO medical appropriateness decisions without explanation. I find that the administrative order is not supported by substantial evidence because MRU reached a conclusion that was contrary to the MRU's physician reviewer's opinion and the MCO decision concerning medical appropriateness without persuasive explanation. In particular, MRU failed to explain its reasoning in reaching the conclusion that treatment rendered outside the parameters of the MCO treatment standards was appropriate. For these reasons, I reverse.

IT IS HEREBY ORDERED:

The Amended Proposed and Final Contested Case Hearing Order Remanding dated August 1, 2002 is withdrawn and abated. The administrative order dated January 8, 2002 is reversed.

DATED this _____ day of August 2002.

John Shilts
Administrator
Workers' Compensation Division