

In the Matter of the ORS 656.327 Treatment Dispute of

Davidson, Mark, Claimant

Contested Case No: H02-127

PROPOSED AND FINAL ORDER

May 14, 2003

SAIF CORPORATION, Petitioner

MARK DAVIDSON, Respondent

Before John L. Shilts, Workers' Compensation Division Administrator

HISTORY OF THE CASE

Insurer appeals a November 12, 2002 Administrative Order issued by the Medical Review Unit (MRU) of the Workers' Compensation Division, Department of Consumer and Business Services (WCD or the department) which determined that the L2-S1 multilevel fusion with pedicle screw fixation provided by Jeffrey Bert, MD (Orthopedic Surgery) was appropriate treatment for claimant's compensable condition. The matter was referred to the Hearing Officer Panel (Panel) for hearing on December 23, 2002.

On February 20, 2003, Administrative Law Judge (ALJ) Paul Vincent conducted a telephone hearing in this matter in Salem, Oregon. Trial Counsel John Motley represented petitioner, SAIF Corporation (SAIF or insurer). Attorney at Law Jon C. Correll represented respondent Mark Davidson (claimant). Claimant testified on his own behalf. The record closed on following the hearing.

ISSUES

- (1) Whether substantial evidence supports MRU's decision that the L2-S1 multilevel fusion with pedicle screw fixation provided by Dr. Bert was appropriate treatment for claimant's compensable condition
- (2) Whether MRU's reliance on the opinion of Dr. Brett reflects an error of law.

Evidentiary Ruling

The record consists of Exhibits 1 through 268, which were admitted into the record without objection.

FINDINGS OF FACT

I adopt the Findings of Fact set forth in the November 12, 2002 Administrative Order, with the following supplementation:

- (1) Beginning in 1982, claimant began experiencing a progressive onset of low back pain. He filed a claim for occupational disease on November 17, 1995. (Exs. 1 – 89.) Claimant began treating with Dr. Bert on December 28, 1995. (Exs. 79, 81.) SAIF subsequently accepted

claimant's claim for post-traumatic at L3-4 and L4-5 with significant mechanical pain and instability. (Ex. 212, 254.) Claimant was treated conservatively for his significant low back pain for over 15 years. (Ex. 244.)

(2) In 1996 and 1997, Dr. Bert requested approval of an interbody fusion surgery at L3-4 and L4-5. SAIF denied that surgical request, and MRU affirmed, because of the potential for stress on the two level fusion and the lack of instability or neurological deficit at L3-4 or L4-5. (Exs. 85, 128, 152, 154, 172.)

(3) On September 13, 1999, Timothy Keenen, MD (Orthopedic Surgery) examined claimant at Dr. Brett's request. (Ex. 165.) In a follow-up on January 11, Dr. Keenen noted that claimant was in extreme pain and opined that fusion was an appropriate treatment for claimant's back and that a four-level fusion would be appropriate if L5 spondylolysis was present. (Ex. 173.).

(4) A July 24, 2001 MRI had revealed degenerative changes at L2-3, L3-4, and L4-5. (Ex. 208.) On August 21, 2001, Dr. Bert proposed an L2-S1 fusion surgery with pedicle screws and autograft to treat the pain associated with his L2-S1 degenerative disc disease. (Ex. 210.) This surgery added additional levels to the fusion surgery and noted that the surgery was to address claimant's pain. (Exs. 212, 220, 221.)

(5) On October 29, 2001, Paul C. Williams, MD (Neurosurgery) and Edward A. Grossenbacher, MD (Orthopedic Surgery) performed an insurer medical examination (IME) and examined claimant and reviewed his medical records. Without explanation, they opined that the proposed surgery was not indicated because of the lack of instability or neurological deficits. (Ex. 221.) Based on the opinion of Drs Williams and Grossenbacher, SAIF denied authorization of the L2-S1 fusion surgery with pedicle screws. (Ex. 223.)

(6) On January 29, 2002, Dr. Bert performed the L2-S1 fusion surgery with pedicle screws and bone graft. (Ex. 228.) A scrivener's error in the operative report stated that the fusion was from L1 through L5, instead of from L2 through L5. (Exs. 228, 244.)

(7) Prior to surgery, claimant was losing the ability to walk and was in constant agonizing pain. Postoperatively, claimant's back pain improved 95 percent. He has no loss of movement, uses minimal pain medication and his condition has consistently improved. (Test. of claimant.)

(8) On February 17, 2002, claimant requested review of SAIF's denial of the fusion surgery. (Ex. 231.) On April 3, 2002, William S.T. Mayhall, MD (Orthopedic Surgery) evaluated claimant at MRU's request and opined that claimant did not present any indications for fusion surgery because there was no indication of spinal instability, or neurologic deficit due to disc herniation or impingement or other neurological conditions. Dr. Mayhall erroneously thought that this was a fusion of the entire spine from L1 though S1 levels. He was also concerned that claimant would be unable to stand straight and that the fusion would be ineffective. (Ex. 241.)

(9) Dr. Brett disagreed with Dr. Mayhall's opinion. While acknowledging that Dr. Mayhall's opinion represented the traditional approach to spinal fusion, recent studies in the *Journal of Musculoskeletal Medicine* written by Drs. Kim and Hochschuler supported his opinion that fusion surgery may be useful treating chronic back pain. In Dr. Bert's opinion, claimant's disc degeneration resulted in a narrowing of the intervertebral disc space causing laxity of the anterior ligamentous complex. The laxity resulted in the formation of osteophytes and facet hypertrophy as the spine attempted to stabilize itself. Ultimately, degenerative instability occurred. For claimant, the only alternative to fusion surgery was to provide him with narcotic pain relief. (Exs. 244, 265, 268.)

(10) On August 8, 2002, Stanley Donahoo, MD (Orthopedic Surgery) disagreed with Dr. Bert's opinion in an almost illegible check the box questionnaire. Apparently referring to the article by Drs. Kim and Hochschuler, Dr. Donahoo stated that a minimum of two years was required to determine the efficacy of a peer-reviewed publication. (Ex. 250.)

CONCLUSIONS OF LAW

(1) Substantial evidence supports MRU's decision that the L2-S1 multilevel fusion with pedicle screw fixation provided by Dr. Bert was appropriate treatment for claimant's compensable condition.

(2) MRU's reliance on the opinion of Dr. Brett does not reflect an error of law.

OPINION

Jurisdiction lies with the director. ORS 656.327(2). I may modify the administrative order only if it is not supported by substantial evidence in the record or reflects an error of law. ORS 656.273(2) and OAR 436-001-0225(3). The burden of proving a fact or position falls upon the proponent. ORS 183.450(2).

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 (1990). To determine whether substantial evidence exists, an administrative law judge is 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).

It is not for an ALJ to decide which medical opinions are more persuasive. I am authorized only to determine whether the record contains substantial evidence to support MRU’s order. See *John J. Rice*, 4 WCSR 173, 176 (1999). Under substantial evidence review standard, an ALJ is not obligated to defer to the opinion of the attending physician. *Dillon v. Whirlpool Corp.*, 172 Or App 484 (2001).

Under ORS 656.245 and ORS 656.327, the insurer is required to provide medical services for a compensable injury unless the treatment is excessive, inappropriate, ineffectual or in violation of the administrative rules. The court generally defers to the opinion of the attending physician unless the record reflects persuasive reasons to do otherwise. *Weiland v. SAIF Corp.*, 64 Or App 810 (1983); *Timothy Krushweitz*, 45 Van Natta 158 (1993). Where the medical dispute involves expert analysis, rather than expert external observation, the court does not give special deference to the attending physician’s opinion as opposed to other doctors. *Hammons v. Perini*, 43 Or App 299 (1979).

In the administrative order, MRU concluded that the proposed surgery was appropriate medical treatment under ORS 656.327. MRU found that claimant’s improved condition, which confirmed the opinion Dr. Bert that the multilevel fusion surgery was appropriate to address claimant’s pain complaints, to be the most persuasive. Relying on *Linn Care Center v. Cannon*, 74 Or App 707 (1985), MRU reasoned that claimant’s improved condition following surgery was evidence that the surgery was reasonable and necessary.

As petitioner, SAIF contended that MRU committed an error of law by “deferring” to Dr. Bert’s opinion as the attending physician and by taking into consideration claimant’s much improved condition following the surgery. In support of its contention, SAIF argued that *Weiland* has been superceded by *Dillion*. SAIF also contended that MRU “abused its discretion” because a reasonable decision-maker would not have reached the same conclusion. As noted by claimant, the “abuse of discretion” standard is usually applied in determining errors in the admission of evidence, not in the weighing of evidence. Consequently, I interpret SAIF’s argument to mean that MRU’s decision is not supported by substantial evidence in the record. I reject SAIF’s contentions and find that SAIF has failed to meet its burden of proof.

To begin, MRU did not “defer” to Dr. Bert merely because he was claimant’s attending physician. In *Dillion*, the court held that when the divided medical opinion leaves the forum in the position of evaluating the evidence; the forum properly may or may not give greater weight to the opinion of the treating physician, depending on the record in each case. Here, MRU found Dr. Bert’s opinion more persuasive because of his treatment of claimant since 1995, his opportunity to observe what treatment worked with claimant and what did not, and the success of the surgery at issue. Notwithstanding the divergent medical opinions, a reasonable decision-maker could have concluded the same after reviewing all of the medical records and the results of the surgery. It is hard to argue with success. Prior to surgery, claimant was losing the ability to walk, and was in constant severe pain; postoperatively, claimant’s back pain improved 95 percent, he had no loss of movement, used minimal pain medication and his condition

consistently improved.

Moreover, Dr. Bert proposed two fusion surgeries for claimant. The first surgery proposed was in 1996 and 1997 for a two level interbody fusion surgery at L3-4 and L4-5. SAIF denied that request because of the potential for stress on the fusion and the lack of instability or neurological deficit at L3-4 or L4-5. Several physicians found the two level fusion to be inappropriate treatment and MRU affirmed. Much of the contrary medical evidence and opinions in the file relate to Dr. Bert's first surgery proposal. The L2-S1 fusion surgery with pedicle screws and bone graft at issue here was proposed by Dr. Bert on August 21, 2001 following a July 24, 2001 MRI which revealed degenerative changes at L2-3, L3-4 and L4-5. This surgery added additional levels to the fusion surgery and noted that the surgery was to address claimant's pain, not any instability.

The medical opinion concerning the surgery at issue is divided between Drs. Williams, Grossenbacher, Mayhall, and Donahoo who opposed the surgery, and Dr. Keenen who supported the surgery, and Dr. Brett who supported and performed the surgery. My task is not to decide which medical pinions are more persuasive but rather to determine whether the record contains substantial evidence to support MRU's order. Consequently, I find based on the record as a whole, substantial evidence supports MRU's decision that the surgery was reasonable and necessary.

ATTORNEY FEES

Claimant has prevailed in defending MRU's decision and is, therefore, entitled to attorney fees. ORS 656.385(1). Applying the factors set forth in OAR 436-001-0265, I find that claimant's counsel is entitled to an assessed fee in the amount of \$1,050.

ORDER

IT HEREBY ORDERED that MRU's November 12, 2002 Administrative is affirmed. SAIF is ordered to pay to claimant's counsel an attorney fee in the amount of \$1,050.

Dated this 14th day of May 2003 at Salem, Oregon.

Paul Vincent, Administrative Law Judge
Hearing Officer Panel