
In the ORS 656.245 Medical Services Dispute of

Monforton, Stephen P., Claimant

Contested Case No: H03-026

FINAL ORDER

November 26, 2003

TIMOTHY GROTHMAN, DC, Petitioner

FIRST NATIONAL INSURANCE CO., Respondent

Before John L. Shilts, Workers' Compensation Division Administrator

Respondent insurer timely filed exceptions to Administrative Law Judge (ALJ) Ella D. Johnson's August 13, 2003 Proposed and Final Contested Case Hearing Order. Petitioner provider responded. The director issues this Final Order declining to adopt the proposed order and affirming the February 7, 2003 Administrative Order.

If exceptions to a proposed order are filed, the director issues a final order. The director may adopt the proposed order as the final order or may modify the proposed order. OAR 137-003-0655, 436-001-0275(3). If the director modifies the proposed order in any substantial manner, the agency must identify and explain the modifications. OAR 137-003-0665(3). The director may only modify the ALJ's findings of historical fact if the director determines that the finding is not supported by a preponderance of the evidence in the record. OAR 137-003-0665(4).

The entire record of this matter has been reviewed, including the exhibits in evidence, the audiotape of the hearing, and the parties' written arguments.

The exceptions raise both factual issues and legal issues. Except as explained below, the director accepts the ALJ's findings of fact. The director believes, however, that the facts compel a different legal conclusion.

Insurer takes issue with several of the ALJ's findings of fact. After consideration of insurer's arguments and on her own motion, the director modifies two of the ALJ's findings of fact that are not supported by a preponderance of the evidence in the record. In finding of fact (6) and in footnote 4 (proposed order, pgs. 2-3), the ALJ refers to a January 1, 2002 phone conversation. The record shows that the phone conversation took place on January 9, 2002, and the finding is so corrected. In footnote 5 [finding of fact (11)] (proposed order, pg. 4), the ALJ states, "The copy of the denial in the record does not indicate that a copy was sent to Dr. Grothman." The June 11, 2002 denial letter (Ex. 25) does indicate that a copy was sent to Dr. Grothman; near the top of page one, to the right of the addressee is a list of parties copied with the letter. Accordingly, the ALJ's statement to the contrary is not adopted. The director does not, however, disturb the ALJ's finding that Dr. Grothman was not in fact copied with the letter. The director declines to further modify the remainder of the ALJ's findings of fact, including her findings as to the credibility of the claims examiner's testimony. Accordingly, the ALJ's findings of fact are adopted except as modified above.

On request of provider and on behalf of the director, the Medical Review Unit reviewed this matter and issued an Administrative Order on February 7, 2003. The unit found that insurer was not liable for services provided by provider between March 13, 2001 and August 7, 2002. The unit reasoned that provider no longer qualified as claimant's attending physician under ORS 656.005(12)(b)(B), and could therefore no longer prescribe palliative care under ORS 656.245(1)(c)(J). Provider requested a contested case hearing, arguing that he relied on the claims examiner's oral statements that his bills would be paid. While the unit's order focused on the attending physician requirements and palliative care rules, the bulk of the argument and testimony at hearing was devoted to the issue of equitable estoppel.

ALJ Johnson reversed the unit's order, finding that insurer was equitably estopped from denying payment. Insurer takes exception to the ALJ's order, contending first¹ that ORS 656.262(10) bars application of the doctrine of equitable estoppel in this case. Alternatively, if the doctrine does apply, insurer is, at most, liable for services provided between January 9, 2002 and April 1, 2002. Further, insurer had no duty to inform provider that it was not authorizing payment.

Provider responds, emphasizing his understanding of the January 9, 2002 phone conversation with the claims examiner was that insurer authorized and would pay for all prior services, as well as all subsequent services until an IME report was received. He relied on the claims examiner's representations in how he managed the services he provided to claimant. Further, insurer never expressly denied authorization or payment.

Insurer's arguments are addressed in turn. First, it contends that ORS 656.262(10) prohibits the application of equitable estoppel in this case. No supporting argument is provided. ORS 656.262(10) provides, in part:

“Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability, nor shall mere acceptance of such compensation be considered a waiver of the right to question the amount thereof.”

The director disagrees that this language prohibits the application of equitable estoppel here. At issue is the effect of representations made by insurer's claims examiner, not the effect of insurer's paying or providing compensation.

Next, insurer contends that under the doctrine of equitable estoppel, insurer is at most liable for payment from January 9, 2002 to April 1, 2002.

“ ‘The doctrine of equitable estoppel * * * is that a person may be precluded by his act or conduct, or silence when it was his duty to speak, *from asserting a right* which he otherwise would have had.’ (Emphasis added.) *Marshall v. Wilson*, 175 Or 506, 518, 154 P2d 547 (1944). ‘The doctrine of estoppel is only intended to protect those who materially change their position in reliance upon another's acts

¹ Insurer's exceptions as to the ALJ's findings of fact and credibility findings are addressed above.

or representations.’ *Bash v. Fir Grove Cemeteries, Co.*, 282 Or 677, 687, 581 P2d 75 (1978).”

Meier & Frank Co. v. Smith-Sanders, 115 Or App 159, 163 (1992), *aff’d on recon.*, 118 Or App 261 (1993), *quoting Stovall v. Sally Salmon Seafood*, 306 Or 25, 34 (1988). Insurer argues that provider did not materially change his position in reliance on insurer’s acts or representations or, if he did, it was not before January 9, 2002. The director agrees and finds that provider did not materially change his position in reliance on insurer’s representations.

In *Meier & Frank*, the employer was found to have provided oral authorization for surgery to both claimant and the surgeon. The surgery was then performed. Employer subsequently denied the claim and attempted to deny payment for the surgery. The court found that employer’s act of telling the claimant and her doctor that the surgery was authorized caused claimant to materially change her position in reliance on employer’s conduct. *Meier & Frank*, 115 Or App at 163.

In contrast, the court found that the provider did not materially change his position in *SAIF Corporation v. Jensen*, 183 Or App 439 (2002). There, insurer represented that it was denying payment because the claim was denied or in litigation. In fact, the services were not compensable because the provider no longer qualified as the claimant’s attending physician. The director found that the insurer represented through its actions that the bills would be paid if the claim were to be accepted. *Id.* at 445. While the court recognized that the insurer may have led the provider to believe his bills would be paid upon claim acceptance, the court found that the provider did not materially change his position in reliance on insurer’s actions. *Id.* at 446. Each time insurer made a representation, it was in response to billings for past services. Unlike in *Meier & Frank*, neither the provider nor the claimant requested or received authorization for continued or future services. *Id.* Further, the court noted that the provider cannot assert that he relied on the insurer’s silence in continuing to provide services. “Silence may be grounds for equitable estoppel only when there is a duty to speak.” *Id.* Because there was no requirement in the statute that insurer notify the provider of the statutory requirements regarding attending physicians, insurer had no duty to speak. *Id.*

Here, provider argues that he relied to his detriment on a January 9, 2002 conversation. The ALJ found the facts here to be inapposite to *Jensen*. However, like in *Jensen*, provider could not have materially changed his position in relation to past billings. Provider contends, “I interpreted [the claims examiner’s January 9, 2002] statement as a verbal authorization for all the prior services rendered to [claimant].” Provider cannot argue that he relied to his detriment in relation to services already provided. If provider materially changed his position in reliance on insurer’s January 9, 2002 representation, it could only have been subsequent to January 9, 2002 and estoppel could not apply before that date.

However, the director finds that the record does not support a conclusion that provider materially changed his position after January 9, 2002. As insurer pointed out at hearing, provider testified that he would have continued to treat claimant even if insurer denied payment. Indeed, the ALJ found that “he still would have continued to treat claimant but would have made arrangements for claimant to pay for the treatment.” (Proposed order, pg. 4). The only difference

would have been that provider would have sought payment from claimant rather than from insurer. The ALJ concluded: “* * * Dr. Grothman materially changed his position because, although he would still have continued to treat claimant but not with the expectation that [insurer] would pay the billings and not without making arrangements with claimant to pay his own bills.” (Proposed order, pg. 6.) The director disagrees that this amounts to a *material* change in position. Provider would have incurred the cost of the services regardless.

The ALJ found the facts of *Jean M. Lewis*, 2 WCSR 33, *aff’d* 2 WCSR 143 (1997) to be similar. There, the insurer explicitly preauthorized the services, and was held to be estopped from later denying payment based on the ancillary treatment rules. The difference between *Lewis* and this case, however, is in how the provider changed positions in reliance on insurer’s representations. In *Lewis*, the provider “changed his long-standing practice of not treating injured workers because of the representations of [insurer]. Therefore, [insurer]’s representations coupled with [provider’s] change in his treatment policy satisfy the requirements of the doctrine of equitable estoppel.” *Lewis*, 2 WCSR at 36. What is missing in this case is the provider’s material change in position.

For the reasons stated above, the director concludes that equitable estoppel does not apply on these facts. Provider may have relied on insurer’s representations. Provider could not, however, have relied on insurer’s representations in relation to services already provided, and provider did not materially change his position in relation to future services - he would have provided them anyway.

Insurer further contends that “Claimant’s chiropractic care did not meet the definition of palliative care because claimant was medically stationary and his need for treatment was not the result of an acute exacerbation of his compensable condition.” The director relies on the unit’s statement in its order: “The record indicates that Mr. Monforton has not experienced any acute exacerbation of his compensable condition. Therefore, the director concludes that the disputed medical services *meet* the definition of palliative care.” (Emphasis added.) Ex. 35-2.²

Finally, insurer contends that the services are not compensable because provider was not qualified to be an attending physician beyond the 30-day or 12-visit limit. Under ORS 656.245(1)(c)(J) the worker’s attending physician must prescribe palliative care; under 656.005(12)(b)(B) a chiropractor can only function as the worker’s attending physician for 30 days from the date of first visit or for 12 visits. Provider no longer qualified as claimant’s attending physician on the dates in dispute. This is the basis on which the unit denied liability, and provider does not dispute it. The director affirms the unit’s conclusion.

IT IS HEREBY ORDERED that the August 13, 2003 Proposed and Final Contested Case Hearing Order is not adopted. The February 7, 2003 Administrative Order is affirmed.

² The ALJ, on page 5 of the proposed order, also states, “MRU also determined that the care did not meet the definition of palliative care because claimant was medically stationary and his need for treatment was not the result of an acute exacerbation of his compensable condition.” The face of the Administrative Order indicates that this is not what MRU determined. However, in light of the director’s modification of the proposed order, it is not necessary to address this error further.

Insurer is not liable for payment of medical services provided by Timothy W. Grothman, DC, between March 13, 2001 and August 7, 2002.

DATED this 26th day of November, 2003.

CORY STREISINGER, DIRECTOR
DEPT. OF CONSUMER AND BUSINESS SERVICES

By: _____
John Shilts, Administrator
Workers' Compensation Division