

---

In the Matter of the ORS 656.327 Treatment Dispute of  
**Villagrana, Francisco, Claimant**

Contested Case No: H03-017

**PROPOSED AND FINAL ORDER**

May 27, 2003

MISSION INSURANCE COMPANY, Petitioner

FRANCISCO VILLAGRANA, Respondent

Before John L. Shilts, Workers' Compensation Division Administrator

---

**HISTORY OF THE CASE**

Insurer appeals a February 3, 2003 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 fusion of the first metatarsal medial cuneiform joint of the left foot proposed by Timothy Mooney, DMP was appropriate treatment for claimant's compensable condition. The matter was referred to the Hearing Officer Panel (Panel) for hearing on February 27, 2003.

On April 3, 2003, Administrative Law Judge (ALJ) Ella D. Johnson conducted a telephone hearing in this matter in Salem, Oregon. Insurer Mission Insurance Company (insurer or Mission) was represented by attorney Brad Garber. Attorney John Bogardus represented respondent Francisco Villagrana (claimant). WCD waived appearance at the hearing. No witnesses testified. The record closed on following the hearing.

**ISSUES**

(1) Whether MRU erred in failing to characterize the proposed surgery as palliative care and failing to follow the palliative care rules.

(2) Whether substantial evidence supports MRU's decision that the fusion of the first metatarsal medial cuneiform joint of the left foot proposed by Dr. Mooney was appropriate treatment for claimant's compensable condition

**EVIDENTIARY RULING**

The record consists of Exhibits 1 through 77, which were admitted into the record without objection.

**FINDINGS OF FACT**

I adopt the Findings of Fact set forth in the February 3, 2003 Administrative Order, with the following supplementation:

(1) On December 19, 1979, claimant compensably sustained a severe crush injury to his left foot and leg when his right leg fell into a grain auger, pulling his entire leg into the

machinery up to the groin. The injury result in fractures of the third metatarsal and cuboid and substantial loss of soft tissue on the dorsum of the foot, damage to the peroneal nerve, injury to the subtalar joint, and loss of range of motion. Employer accepted the claim and the claim was closed on January 6, 1981 with an award if 50 percent permanent partial disability (PPD) which was later increased by stipulation to 75 percent PPD. Thereafter, claimant experienced ongoing left foot problems that caused pain and made use of the foot difficult. He underwent multiple subsequent surgeries on his left foot, including metatarsal osteotomies, toe joint implants and skin grafts. His claim remains in Own Motion status. (Exs. 1-38, 61.)

(2) On August 30, 1991, Bruce J. Sangeorzan, MD (Orthopedics) found claimant to be stable but noted that a surgical reconstruction of claimant's left foot should be performed in the future. Dr. Sangeorzan recommended surgical correction to reposition the middle phalanx, transfer the FDL tendon, and possibly release the metatarsophalangeal extension contracture. Claimant rejected the recommendation. (Ex. 41.)

(3) In 2000, L. Bruce Ford, DPM recommended that claimant undergo an osteotomy of the first metatarsal head with realignment of the great toe on the first metatarsal phalangeal. Dr. Ford had previously performed two other surgeries to address claimant's foot problems. Ivanhoe B. Higgins, MD (Orthopedics) performed a chart review and stated that the proposed surgery was "ill advised." Dr. Higgins opined that the proposed surgery would fall short of addressing the problems claimant experienced and that anything short of a full alignment of the foot would be futile. He also noted that this realignment might carry a considerable risk of the potential for loss of the foot. (Ex. 50.) Dr. Ford agreed with Dr. Higgins's opinion. (Ex. 51.)

(4) Claimant continued to experience significant foot pain and discomfort when walking. On August 18, 2001, Dr. Mooney examined claimant and proposed a surgical correction of his left foot to lengthen claimant's foot bones, reconstruct his arch, and improve his bunion deformity. The purpose of the surgery was to alleviate the pressure on the plantar 1<sup>st</sup> metatarsal head and place it more in alignment with the rest of the metatarsals. Dr. Mooney would have preferred to address the problems with entire foot but claimant wanted only this problem corrected. (Exs. 52, 53, 56.) Spencer A. Clark, MD (Family Practice) concurred with Dr. Mooney's recommendation. (Ex. 55.) Dr. Higgins opined that Dr. Mooney's proposed surgery was essentially the same procedure recommended by Dr. Ford, and therefore, he would recommend against the proposed surgery for the same reasons as previously stated. (Ex. 54.)

(5) Dr. Mooney disagreed with Dr. Higgins on October 30, 2001 and later clarified that there were two surgical approaches that would benefit claimant. The first surgery would be a rear foot/subtalar joint fusion and Lisfranc's joint fusion of the left foot. The second would be a dorsiflexory wedge osteotomy of the left 1<sup>st</sup> metatarsal with screw fixation to elevate the bone and an arthrodesis of the proximal interphalangeal joint of the left 2<sup>nd</sup> toe. Claimant rejected the first surgical option because of the extensive post operative and rehabilitative process and the fact that the second option would correct his immediate problem. Claimant continued to refuse the more extensive surgery due to concerns about losing toes or his foot. (Ex. 51.)

(6) On November 26, 2001, Alan F. Rothstein, DPM performed an insurer's medical examination on claimant's left foot. Although he did not believe an athroplasty of the second

digit would benefit claimant, Dr. Rothstein concurred with Dr. Mooney's recommendation as to the lengthening of the 2<sup>nd</sup> metatarsal joint and a dorsiflexory of the 1<sup>st</sup> metatarsal were warranted and would provide claimant with some relief. (Ex.58.) Dr. Ford concurred with Dr. Rothstein's opinion. (Ex. 59.)

(7) On August 12, 2002, Dr. Mooney requested authorization to perform fusion of the 1<sup>st</sup> metatarsal medial cuneiform joint and a tentomy/capsulotomy of the 2<sup>nd</sup> metatarsalphalangeal joint of the left foot. (Ex. 62.) The employer requested review of the surgery request by Elias Dickerman, MD (Neurology) who performed a file review and characterized the surgery as a piecemeal "temporizing measure" that would have no long term benefit. He opined that claimant needed a more extensive corrective mid-foot arthrodesis. (Exs. 63, 65.) Dr. Higgins also opined the proposed surgery might create a greater problem of predisposing claimant to greater risk of soft tissue breakdown by making the first Ray more rigid. (Ex. 64.)

(8) On October 2, 2002, the employer requested Director Review of the proposed surgery, arguing that the proposed surgery was not palliative or curative and is excessive, inappropriate, ineffectual and violates the rules regarding the performance of medical services. (Ex. 61.) At MRU's request, Robert C. Stevens, DPM and William Mayhill, MD (Orthopedic Surgery) examined claimant on December 17, 2002. (Ex. 72.)

(9) Dr. Mayhill opined that proposed surgery was reasonable and necessary. He noted that indications for the proposed surgery are consistent with claimant's findings, that his demonstrated clinical evidence was consistent with the indications for the surgery and that claimant met the criteria for someone who would benefit from the proposed surgery. Although Dr. Mayhill also noted that claimant was aware that the surgery would not relieve his foot pain entirely, claimant was not willing to undertake the complete corrective foot surgery previously recommended. (Ex. 73.)

(10) Dr. Stevens also opined that the proposed treatment was "acceptable" but noted as did other physicians that the long term solution was a subtalar or rearfoot fusion to bring the mechanics of the foot back into an anatomically correct position. He recommended that claimant undergo the more extensive surgery and claimant reiterated that he did not want any type of rearfoot or midfoot procedures. (Ex. 74.)

## CONCLUSIONS OF LAW

(1) MRU did not err in failing to characterize the proposed surgery as palliative care because MRU correctly determined that the surgery would

(2) Substantial evidence supports MRU's decision that the fusion of the first metatarsal medial cuneiform joint of the left foot proposed by Dr. Mooney is appropriate treatment for claimant's compensable condition.

## 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).

Under ORS 656.245 and 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. Following the determination that an injured worker is medically stationary, medical treatment ceases to be compensable under a workers' compensation claim with the exception of services specified at ORS 656.245(1)(c). "Palliative care" is compensable following approval by the insurer or director and only if it is "necessary to enable the worker to continue current employment or a vocational training program." ORS 656.245(1)(c)(J). In contrast, "curative care" continues to be fully reimbursable without prior approval, under ORS 656.245(1)(c)(L), when it is "provided to a worker to stabilize a temporary and acute waxing and waning of symptoms of the worker's condition."<sup>1</sup>

In the administrative order, MRU found that claimant has an accepted claim and is entitled to appropriate curative medical care to treat his compensable conditions. MRU noted the agreement of Drs. Mooney, Stevens, Mayhill, Ford, Clark, Rothstein, and Sangeorzan that claimant requires additional surgery and that the proposed surgery may provide some relief to claimant. MRU also noted the disagreement with Dr. Higgins who opined that a more extensive surgery was required because the surgery proposed by Dr. Mooney would not address all of claimant's problems and could create a greater risk of soft tissue breakdown. However, MRU discounted Dr. Higgins's opinion because his opinion was not based on an examination of claimant but rather on a review of claimant's medical records. Consequently, finding that there was no law requiring a procedure eliminate all of the worker's symptoms or requiring the worker to consent to a more extensive surgery in order for it to be considered appropriate treatment, MRU concluded that the proposed surgery was appropriate treatment for claimant's conditions.

At hearing, insurer argued that MRU's decision that the proposed surgery was appropriate treatment for claimant's compensable condition was not supported by substantial evidence or reflected an error of law. Specifically, insurer argued that MRU erred in failing to characterize the proposed surgery as palliative care and failing to follow its rules concerning the provision of palliative care.

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 ALJ is required to:

---

<sup>1</sup> Insurer also argues that it should not be required to pay piecemeal three or four times for surgery, when one more extensive surgery could address all of claimant's foot problems. However, claimant is not willing to undergo the more extensive surgery in view of the risks that he might lose his toes or the entire foot as a result. There is no requirement that he do so and the statute requires the insurer to provide appropriate medical services. Consequently, I do not find the insurer's argument a persuasive basis to overturn MRU's decision.

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 ALJ] 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).

Under the substantial evidence review, 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 decision. See *John J. Rice*, 4 WCSR 173, 176 (1999). Having reviewed the record as a whole, I conclude that MRU's decision that the proposed surgery is appropriate is supported by substantial evidence.

With respect to insurer's argument that MRU failure to characterize the proposed surgery as palliative care and failure to follow the rules concerning the provision of palliative care was an error of law, "palliative care" is defined by ORS 656.005(20) to mean:

medical service rendered to reduce or moderate temporarily the intensity of an otherwise stable medical condition, but does not include those medical services rendered to diagnose, heal or permanently alleviate or eliminate a medical condition.

Generally, curative care is defined as "that which heals or cures." STEDMAN'S MEDICAL DICTIONARY 379 (25<sup>th</sup> ed. 1990). However, that general definition is modified by ORS 656.245(1)(c)(L) which authorizes curative care that "stabilizes a temporary and acute waxing and waning of symptoms." In *William S. Holland*, 4 WCSR 60, 63 (1999), the director examined the meaning of "curative care:"

The statute, by its very terms, addresses symptoms, not conditions. This is certainly consistent with ORS 656.245(1)(c), which applies only to care given after the worker is medically stationary. 'Medically stationary' means that 'no further material improvement would reasonably be expected from medical treatment, or the passage of time.' ORS 656.005(17). The statutory scheme contemplates that healing will occur, if at all, while a claim is open. Thereafter, medical care will treat symptoms rather than the underlying condition. The only question is whether the symptoms are temporary and acute, and treatment is needed to restore the worker to a baseline or medically

stationary level. If so, the care is 'curative.

MRU concluded that the proposed surgery was curative and the record establishes that claimant's foot condition was extremely painful prior to seeking care from Drs. Ford and Mooney, who recommended the fusion of the first metatarsal medial cuneiform joint of the left foot. I find that the proposed surgery was curative in nature inasmuch as claimant was experiencing acute symptoms and the surgery was necessary to provide claimant with some relief. Consequently, I find no error of law and affirm MRU's order.

### **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 \$909.

### **ORDER**

*IT HEREBY ORDERED* that Mission shall be liable for all costs associated with the proposed fusion of the first metatarsal medial cuneiform joint of the left foot surgery. Mission is ordered to pay claimant's counsel an assessed fee of \$909.

Dated this 27<sup>th</sup> day of May 2003 at Salem, Oregon.

---

Ella D. Johnson, Administrative Law Judge  
Hearing Officer Panel