

In the Matter of ORS 656.245 of
Mickel M. Crawford, Claimant

Contested Case No: 05-193H

PROPOSED & FINAL ORDER

July 26, 2006

MICKEL M. CRAWFORD, Petitioner
LIBERTY NW INSURANCE CORP, Respondent
Before Elizabeth Fulsher, Administrative Law Judge

A hearing was scheduled for April 5, 2006 in Bend, Oregon before Administrative Law Judge Fulsher. Prior to the scheduled hearing, the parties agreed to submit this matter on the record with written arguments in lieu of a hearing. Claimant is represented by attorney James Bailey. DAGP Associates LP and its insurer, Liberty Northwest Insurance Corporation, are represented by their attorney, Leah Sideras. The record closed on June 26, 2006, 7 days after the receipt of the insurer's argument.

Exhibits 1 through 52 are admitted into evidence.

ISSUE

Claimant seeks review of two Administrative Orders (05-1079 and 05-1104) of the medical review unit (MRU) that found the insurer not liable for chiropractic services from July 2, 2003 through January 25, 2005 and from March 29, 2005 through August 3, 2005.

CONCLUSIONS OF LAW AND OPINION

In medical service disputes under ORS 656.245, the administrative law judge (ALJ) may modify the Director's order only if it is not supported by substantial evidence in the record or if it reflects an error of law. Now new medical evidence or issues may be admitted or considered. OAR 436-001-0225(2). Review by the ALJ is for substantial evidence and the ALJ may not supplement the evidentiary record developed by the medical review unit (MRU). *Liberty Northwest Ins. Corp. v. Kraft*, 205 Or App 59 (2006).

Here, the MRU's findings of fact are summarized as follows. Claimant was compensably injured on December 29, 1987. The insurer ultimately accepted L5-S1 herniated nucleus pulposus, lumbar strain/sprain, L5-S1 disc herniation with surgical fusion, consequential L4-5 facet joint arthrosis with surgical fusion and consequential post-surgical (from the prior surgical fusion of L5-S1 and L4-5) L3-4 stenosis condition.

On September 11, 1995, claimant's claim was closed. On July 1, 2003, Dr. Andrews examined claimant. His clinical impression was chronic worsening back pain, right groin pain, dysesthesias and chronic progressive right heel pain. On August 8, 2003, Dr. Andrews completed an 827 form notifying the insurer of an aggravation. Dr. Hiskey provided chiropractic treatments from July 2 through July 30, 2003 and from August 4 through September 12, 2003.

On September 16, 2003 and November 20, 2003, Dr. Andrews prescribed chiropractic treatment for claimant. Dr. Hiskey provided the chiropractic treatment to claimant.

On January 28, April 9, May 6, June 23 and August 6, 2004 Dr. Hiskey prepared treatment plans listing chiropractic manipulation therapy and strengthening exercises. (Exs. 8-13; 8-17; 8-23; 8-25; 8-32). Dr. Hiskey provided this treatment. On October 13, 2004, Dr. Moore prescribed four to six weeks of chiropractic treatment with Dr. Hiskey which Dr. Hiskey provided. Claimant's claim was reopened on November 17, 2004. On November 29, 2004, Dr. Hiskey prepared a treatment plan listing chiropractic and ultrasound treatment for eight weeks. (Ex. 8-43). Dr. Hiskey provided such treatment through February 20, 2005. On January 25, 2005, claimant was declared medically stationary and his claim was closed.

Dr. Hiskey prepared a treatment plan on February 21, 2005 for chiropractic treatment and ultrasound. He provided such treatment through May 11, 2005. On March 7, 2005, the insurer notified claimant that Dr. Hiskey's treatment was disapproved as he was not a valid attending physician and palliative care had not been requested or approved. Claimant requested administrative review on March 17, 2005. On May 12, 2005, Dr. Hiskey prepared a treatment plan for chiropractic treatment for eight weeks. Dr. Hiskey provided chiropractic treatment from May 16, 2003 through August 3, 2005.

In MS 05-1079, the MRU found that Dr. Hiskey's chiropractic services between July 2, 2003 and January 25, 2005 were not reimbursable because the services did not comply with the treatment plan requirements of OAR 436-010-0230(4)(a).

Specifically, the MRU found that for the period of July 2, 2003 through September 12, 2003, there was no evidence that the chiropractic services were ordered by claimant's attending physician and there was no treatment plan. For the services provided from September 16, 2003 through November 17, 2003, there was no evidence of a treatment plan. For services from November 26, 2003 through November 24, 2004, there were treatment plans, but objectives for treatment were not included. For services provided from November 29, 2004 through January 25, 2005, there were treatment plans, but the plans lacked objectives for treatment and there is no evidence that the treatment was ordered by claimant's attending physician. (Exs. 50; 51). Citing *Aetna Casualty and Surety v. Blanton*, 139 Or App 283 (1996), the MRU reasoned that strict compliance with the rule is mandatory.

In MS 05-1104, the MRU also found that Dr. Hiskey's treatment from March 29, 2005 through August 3, 2005 did not comply with OAR 436-010-0230(4)(a) because his treatment plan did not include objectives.

Claimant argues that Dr. Hiskey's office substantially complied with OAR 436-010-230(4) and OAR 436-010-0290. This argument is contrary to the court's holding in *Aetna Casualty and Surety v. Blanton* that holds that the language of the rule is mandatory. I do not find claimant's argument that Dr. Hiskey substantially complied with the rule persuasive.

Claimant also argues that that insurer did not timely notify Dr. Hiskey of its denial of payment for the disputed services and should be estopped from denying those services.

The only rule cited by claimant that specifically requires the insurer to notify the attending physician, worker and worker's attorney of disapproval of a request for medical services within a specific time is OAR 436-010-0290(1)(D), which requires notification within 30 days of receipt of a palliative care request.¹ However, OAR 436-010-0290 also requires that the physician submit a palliative care request to the insurer that requires, among other things, that the physician describe how the requested care will enable the worker to continue current employment. The record contains no such palliative request for the periods of time identified by claimant. Thus, it appears that the notice requirements of the rule were not triggered.

Claimant also argues that the insurer should be equitably estopped from denying reimbursement of the chiropractic treatments. For equitable estoppel to apply, there must be (1) a false representation, (2) made with knowledge of the facts, (3) with the intent that the other party rely, (4) when the other party was ignorant of the truth, and (5) the other party must have been induced to rely upon the representation to his or her detriment. *Coos County v. State of Oregon*, 303 Or 173, 180-81 (1987).

Here, the record does not establish that the insurer made a "false representation" that was intended to be relied on by Dr. Hiskey or claimant or that Dr. Hiskey or claimant were induced to rely upon a representation to their detriment. Therefore, equitable estoppel does not bar the insurer from denying reimbursement of the chiropractic services.

Because the Director's orders are supported by substantial evidence and do not contain errors of law, the orders should be affirmed.

ORDER

The administrative orders in case numbers MS 05-1079 and MS 05-1104 dated December 5, 2005 are affirmed.

¹ Claimant also cites OAR 436-010-0270(3), but that rule only requires notification when the insurer denies or partially denies a previously accepted claim which did not occur here.