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SUPREME COURT
STATE OF WASHINGTON
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No. 95251-5

IN THE SUPREME COURT
FOR THE STATE OF WASHINGTON

MICHAEL MURRAY, Petitioner,

v.

DEPARTMENT OF LABOR AND INDUSTRIES, Respondent.

ON REVIEW FROM THE SUPERIOR COURT OF THE
STATE OF WASHINGTON FOR KITSAP COUNTY

#15-2-00566-1

**PETITIONER MICHAEL MURRAY'S
CONSOLIDATED ANSWER TO AMICI**

PALACE LAW OFFICES

PATRICK A. PALACE
WSBA #21396
JORDAN L. COUCH
WSBA #49684
P.O. Box 65810
University Place, WA 98464
(253) 627-3883

BURI FUNSTON MUMFORD &
FURLONG, PLLC

PHILIP J. BURI
WSBA #17637
1601 F Street
Bellingham, WA 98225
(360) 752-1500

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INTRODUCTION

Washington's Industrial Insurance Act entitles appellant Michael Murray to necessary and proper medical care. "Upon the occurrence of any injury to a worker entitled to compensation under the provisions of this title, he or she *shall receive proper and necessary medical and surgical services...*" RCW 51.36.010(2)(a) (emphasis added). But this is an empty promise when the Department of Labor and Industries refuses to consider any evidence of what is medically necessary and proper for him.

Amici Washington State Association for Justice (WSAJ) and Workers Injury Law & Advocacy Group (WILG) identify how the Health Technology Clinical Committee (HTCC), with the Department of Labor and Industries' acquiescence, overrides the Department's medical aid rules and the individual consideration they once protected. One Committee now makes mass coverage decisions that affect thousands of injured workers. In this consolidated answer to Amici, Mr. Murray confirms that the Department's acquiescence violates a fundamental principal of the grand compromise: necessary and proper medical care requires individualized consideration. The HTCC's uniform coverage decrees violate the Industrial Insurance Act.

I. MR. MURRAY HAS A STATUTORY RIGHT TO INDIVIDUAL REVIEW.

In two published cases, the Court of Appeals has upheld the Department's ability, through the HTCC statute, to terminate individual review of a worker's claim for medical treatment. Joy v. Dep't of Labor & Indus., 170 Wn. App. 614, 285 P.3d 187 (2012); Murray v. Dep't of Labor & Indus., 1 Wn. App. 2d 1, 403 P.3d 949 (2017). In Joy, the court noted that the HTCC statute withdrew coverage without review, but considered it a problem for the Legislature. "The absence of remedies under RCW 70.14.120 for workers denied coverage by L & I due to HTCC determinations is, nonetheless, a legislative problem that must be addressed by the legislature, not the courts." Joy, 170 Wn. App. at 627 n.13.

In Murray, the court approved withdrawal of individual consideration, subject only to a constitutional writ of review.

[W]e hold that individualized review of discretionary decisions delegated to an administrative body is not required for the legislature to constitutionally delegate authority to an administrative body. Barry & Barry only requires that "procedural safeguards exist to control arbitrary administrative action and any administrative abuse of discretionary power." Barry & Barry, 81 Wash.2d at 159, 500 P.2d 540 (emphasis omitted).

Murray v. State, Dep't of Labor & Indus., 1 Wn. App. 2d at 9. As Amici detail, both courts chose to enforce the HTCC's unilateral

decisions under RCW 70.14.120(3) rather than uphold claimants' appeal rights under RCW 70.14.120(4). (WILG Brief at 15) (WSAJ Brief at 15-16).

Contained within the HTCC statute is the ambiguity that animates this case. On the one hand, RCW 70.14.120(3) suggests that HTCC decisions are inviolable — “shall not be subject to a determination in the case of an individual patient as to whether it is medically necessary, or proper and necessary treatment”. Yet the next section of the statute preserves a claimant's right to appeal an adverse decision.

Nothing in chapter 307, Laws of 2006 diminishes an individual's right under existing law to appeal an action or decision of a participating agency regarding a state purchased health care program. Appeals shall be governed by state and federal law applicable to participating agency decisions.

RCW 70.14.120(4). Which section controls? Does Mr. Murray retain his right under State law to prove FAI surgery is proper and necessary in his case?

As Amici correctly point out, the Governor's veto message and the Legislature's subsequent actions prove the Legislature did not intend the HTCC statute to override Mr. Murray's appeal rights. He

retains the right to prove that FAI surgery, although controversial, is necessary and proper in his case.

A. Before Joy, The Department Upheld And Required Individual Review

The Department's medical aid rules protect an injured worker's right to prove that a medical procedure is necessary and proper. Under WAC 296-20-01002, medical care must be either curative or rehabilitative for the individual worker.

Care must be of a type to cure the effects of a work-related injury or illness, or it must be rehabilitative. Curative treatment produces permanent changes, which eliminate or lessen the clinical effects of an accepted condition. Rehabilitative treatment allows an injured or ill worker to regain functional activity in the presence of an interfering accepted condition. Curative and rehabilitative care produce long-term changes.

WAC 296-20-01002. The focus is on the individual. Even if a treatment has helped others, to obtain approval, an injured worker must show the treatment either cures or rehabilitates his or her specific workplace injury.

The same is true for controversial treatments. Where the Department has concluded that a procedure is categorically excluded from coverage, the Board of Industrial Appeals and reviewing courts applied a presumption against coverage. WAC 296-20-3002. The claimant still has an opportunity to overcome the

presumption and prove the controversial procedure is necessary and proper.

For example, claimant Duane Bolton sought approval for lumbar fusion to address his disabling low back pain.

The Department's major objection to a lumbar fusion for intractable low back pain is that it is "controversial." This characterization was agreed to by all of the doctors who testified. WAC 296-20-01002(4), -02850, and -03002 together state that the Department shall authorize controversial treatments under very limited circumstances. As we noted in Pleas, any treatment deemed "controversial" is presumed not to be "proper and necessary" treatment. Since the regulations allow the Department to authorize it in certain circumstances, that presumption is rebuttable.

In Re: Duane A. Bolton, 04 14031, 2005 WL 2386294, at *3 (June 23, 2005). Although he or she must rebut the presumption against coverage, an injured worker always had the right to present evidence and receive individual consideration.

As Amicus WSAJ discusses, the Board of Industrial Appeal's decision in In re: Susan M. Pleas, established the analytical framework for deciding whether any treatment is necessary and proper. In Re: Susan M. Pleas, 96 7931, 1998 WL 718232 (Aug. 31, 1998) (Attached as Appendix A); (WSAJ Brief at 6-8). The Board identified why coverage decisions for worker's compensation are unique.

The phrase “proper and necessary medical and surgical services” is not defined within Title 51, RCW. The duration of treatment is discussed within RCW 51.36.010, but only in generalities. The Legislature gave the director of the Department the authority to make rules that include determinations about the types of treatment to be provided to injured workers to enable him to properly administer the provision of medical and surgical services to injured workers. *These determinations must take into consideration the remedial nature of the Industrial Insurance Act.* RCW 51.04.010.

Pleas, 1998 WL 718232, at *3 (emphasis added).

And like Mr. Murray, Susan Pleas proved that the medical treatment she paid for, a spinal cord stimulator, was rehabilitative.

Ms. Pleas has proven that the implantation of a SCS unit has been rehabilitative treatment in her case. As of the date of her testimony, Ms. Pleas' SCS unit had functioned for 18 months without complication. She experienced a marked decrease in pain and an increase in functioning. The rehabilitative effect of the treatment can be verified by the decrease in prescriptions sought, decrease in the use and cost of medical services, and the increase in the claimant's activity level and ability to work....**In this case**, the presumption that SCS is not proper and necessary medical treatment has been rebutted.

Pleas, 1998 WL 718232, at *5. “[A] determination that surgical treatment was medically proper and necessary may be based on ‘20-20 hindsight’ provided from findings of the surgery itself.” Pleas, 1998 WL 718232, at *6. The Department’s medical aid rules upheld a claimant’s right to individual consideration.

Although it has yet to rule on medical coverage, in related worker's compensation cases, this Court has also required the Department to consider the individual circumstances of an injured worker. First, the Court requires special consideration for the opinion of the worker's treating physician.

The industrial insurance act is a unique piece of legislation; it is remedial in nature and the beneficial purpose should be liberally construed in favor of the beneficiaries. The case law allowing special consideration of the attending physician's testimony supports the purpose of the act which is to promote benefits and to protect workers.

Hamilton v. Dep't of Labor & Indus. of State of Wash., 111 Wn.2d 569, 572–73, 761 P.2d 618 (1988) (citations omitted); Clark Cty. v. McManus, 185 Wn.2d 466, 372 P.3d 764 (2016) (instruction is mandatory).

Second, when evaluating disability, the Department must focus on an individual worker's injuries and ability.

[T]he purpose of workers' compensation, *and the principle which animates it*, is to insure against the loss of wage earning capacity. Adherence to this principle focuses disability hearings on the particular claimant's ability to work in the competitive labor market.

Leeper v. Dep't of Labor & Indus., 123 Wn.2d 803, 814, 872 P.2d 507 (1994).

In exchange for providing employers immunity from suit, injured workers received a statutory right to proper and necessary medical care. The unique provisions of industrial insurance – reflected in statute, caselaw and Departmental regulations – require individual consideration of an injured worker’s need for medical treatment. Before the Department and on appeal, a claimant has the right to present competent medical evidence that an unusual or controversial treatment is appropriate.

B. Joy and Murray Enabled The Department To Avoid Individual Review.

The HTCC statute quietly eroded individual consideration. The 2006 HTCC statute had only one reference to workers’ compensation: “Participating agency’ means the department of social and health services, the state health care authority, and the department of labor and industries.” RCW 70.14.080(6). By placing the Department within the HTCC’s jurisdiction, the Legislature set in motion events that ultimately allowed the Department to deny medical coverage without individual review. As Amici detail, that was neither the Legislature’s or Governor’s intent. (WSAJ Brief at 13-16); (WILG Brief at 15-18).

Once the HTCC withdrew coverage for controversial treatments, both the Department and the courts had to choose between RCW 70.14.120(3) (not subject to individual review) and RCW 70.14.120(4) (appeal rights preserved). Both chose to abandon individual review. The practical effect of the Department's acquiescence -- which Joy and Murray accepted -- was to eliminate the rebuttable presumption for controversial treatment.

Returning to the spinal cord stimulator, on October 20, 2010 the HTCC announced that the treatment is not a covered benefit. The Department argued to the Board of Industrial Appeals that it could no longer approve the treatment, even if an individual claimant had sufficient proof. The Board agreed. "Based on the October 22, 2010 HTA and Joy, we have no alternative but to affirm the October 30, 2013 Department order" denying coverage. In Re: Ladonia M. Skinner, 14 10594, 2015 WL 4153105, at *4 (June 12, 2015) (Attached as Appendix B).

The Department has ceded its statutory authority – and the rights of injured workers – to the HTCC. Under RCW 51.04.030(1), "medical coverage decisions shall be adopted by rule after consultation with the workers' compensation advisory committee established in RCW 51.04.110." By advocating for HTCC

jurisdiction, rather than protecting its delegated authority to make coverage decisions, the Department violates its statutory obligations. In addition, by refusing to defend the statutory appellate process in RCW ch. 51.52, the Department abandons substantive review for the workers it should protect.

The Court of Appeals in Joy and Murray concluded that HTCC decisions under RCW 70.14.120(3) trump Mr. Murray's appellate rights under Title 51 and the Department's regulations. The Department compounds this error by advocating for the HTCC rather than the program it administers.

II. One Size Does Not Fit All.

Amici raise a second flaw in the Court of Appeal's and Department's rulings: that an injured workers' right to medical care is no different or greater than that of a Medicare recipient or an insured under a State health plan. (WILG Brief at 7-8) (WSAJ Brief at 19-20). To the contrary, workers' compensation is unique, reflecting the presumption in favor of coverage.

RCW 51.04.010 embodies these principles, and declares, among other things, that "sure and certain relief for workers, injured in their work, and their families and dependents is hereby provided [by the Act] regardless of questions of fault and to the exclusion of every other remedy." To this end, the guiding principle in construing provisions of the

Industrial Insurance Act is that the Act is remedial in nature and is to be liberally construed in order to achieve its purpose of providing compensation to all covered employees injured in their employment, with doubts resolved in favor of the worker. RCW 51.12.010; Sacred Heart Med. Ctr. v. Carrado, 92 Wn.2d 631, 635, 600 P.2d 1015 (1979); Lightle v. Department of Labor & Indus., 68 Wn.2d 507, 510, 413 P.2d 814 (1966); Wilber v. Department of Labor & Indus., 61 Wn.2d 439, 446, 378 P.2d 684 (1963); State ex rel. Crabb v. Olinger, 196 Wash. 308, 311, 82 P.2d 865 (1938); Gaines v. Department of Labor & Indus., 1 Wn. App. 547, 552, 463 P.2d 269 (1969).

Dennis v. Dep't. Labor & Indus., 109 Wn.2d 467, 470, 745 P.2d 1295 (1987).

As WSAJ documents, Title 51 and its guarantees do not bind the HTCC. "The HTCC is not required in ch. 70.14 RCW to resolve all doubts regarding benefits coverage in favor of compensating injured workers when making its determinations regarding which benefits are covered under the IIA." (WSAJ Brief at 20). Furthermore, the generic criteria the HTCC uses to evaluate treatment – "safety, efficacy, and cost-effectiveness" differs substantially from the Department's more specific requirement that treatment be curative or rehabilitative. Compare RCW 70.14.110(2)(a) with WAC 296-20-01002. For at least two treatments, FAI surgery and spinal cord stimulators, the HTCC has forbid reimbursement for what the Department once approved.

Upholding the Department's position will erase any distinction between workers' compensation and discretionary, need-based State programs. But workers' compensation is not discretionary. The Fifth Amendment of the United States Constitution and Article I Section 3 of the Washington State Constitution both provide that "no person shall be deprived of life, liberty, or property, without due process of law."

Here, Michael Murray has a property interest in proper and necessary medical care because he has a vested right to benefits under the Industrial Insurance Act. Willoughby v. Dep't of Labor and Indus., 147 Wn.2d 725, 733, 57 P.3d 611 (2002) ("all workers who suffer an industrial injury covered by the Industrial Insurance Act, Title 51 RCW, have a vested interest in disability payments upon determination of an industrial injury"). Proper and necessary medical care, like disability payments, is a vested benefit under the Act. Willoughby, 147 Wn.2d at 732 ("legitimate claims of entitlement generally entail vested liberty or property rights").

The State can deprive Mr. Murray of his vested right only with due process of law.

Whether a statute deprives one of life, liberty, or property without due process depends on "(1) whether the [statute] is aimed at achieving a legitimate public

purpose; (2) whether it uses means that are reasonably necessary to achieve that purpose; and (3) whether it is unduly oppressive.

Willoughby, 147 Wn.2d at 733. The HTCC statute's complete denial of individual consideration and substantive judicial review violates the second and third factors of the test.

By depriving him of the ability to prove what necessary and proper medical treatment is, the Department has effectively denied Mr. Murray his statutory right to care. The HTCC statute insulates the Committee's decisions from any substantive review. Under federal and State constitutional decisions, this is below the minimum due process required. In Matthews v. Eldridge, 424 U.S. 319, 96 S.Ct. 893, 47 L.Ed.2d 18 (1976), the United States Supreme Court provided the standard for deciding what process is due.

First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.

Mathews v. Eldridge, 424 U.S. at 335.

Here, Mr. Murray should have at least one opportunity to challenge the HTCC's decision. The private interest at stake –

proper medical care through Industrial Insurance – is compelling. As noted above, injured workers like Mr. Murray *have no alternative* to Industrial Insurance. They have given up their right to sue. “There must eventually come a “tipping point,” where the diminution of benefits becomes so significant as to constitute a *denial* of benefits—thus creating a constitutional violation.” Westphal v. City of St. Petersburg, 194 So. 3d 311, 323 (Fla. 2016).

Second, the risk of erroneous deprivation is high. The HTCC did not examine whether FAI surgery would benefit individual patients; it considered the cost of the procedure versus the available evidence of efficacy. The Committee did not conclude FAI surgery was unsafe or ineffective, only that current evidence is insufficient.

Third, allowing claimants to seek review of HTCC coverage decisions – like the Department’s decisions – creates no additional administrative burdens. The Governor’s veto message assumed that current appeal procedures would correct any errors in HTCC determinations. By allowing workers’ compensation claimants to challenge a blanket HTCC decision, the State will pay only for what it has already promised – proper and necessary medical care.

No reasonable dispute should exist that insulating the HTCC from any form of review is unreasonable. The State can achieve the

goal of uniform health care policies without depriving claimants of their right to an individual determination of what is necessary and proper care.

Finally, prohibiting review of HTCC decisions is unduly oppressive. No one intended this outcome, but HTCC statute now presumes that eleven unelected individuals will never make a mistake, will never fail to review important information, and will never be swayed by evidence that others find insufficient. Administrative and judicial review exists because this presumption is never true. Even the HTCC will err.

III. BECAUSE THE LEGISLATURE NEVER INTENDED TO DIVEST CLAIMANTS OF INDIVIDUAL CONSIDERATION, THE HTCC STATUTE DOES NOT CONTAIN THE PROCEDURAL SAFEGUARDS TO DO SO.

Amici both detail how the vetoed version of the HTCC statute lacks the necessary procedural safeguards to make mass coverage decisions. (WILG Brief at 9-13); (WSAJ Brief at 17-20). Both also explain how neither the Open Meetings Act nor the constitutional writ of review salvages the HTCC statute. (WILG Brief at 12) (“constitutional writ of certiorari does not enable an injured worker to challenge an HTCC determination *as applied* to his or her case”) (WSAJ Brief at 19) (“form of review lies entirely within the trial court’s discretion”). Since the Legislature never intended to divest injured

workers, it is no surprise that the HTCC statute fails constitutionally delegate that power.

As originally conceived, the HTCC had power to limit or deny coverage subject to two avenues of review. First, under the vetoed section 6 of the HTCC bill, patients, providers and stakeholders could appeal HTCC determinations directly. Laws of 2006, ch. 307 § 6. Second, workers compensation claimants could appeal a determination under RCW ch. 51.52, which both the Governor and Legislature assumed would include coverage. (WILG Brief at 15-16); (WSAJ Brief at 8-9). By vetoing the first avenue of review, the Governor did not intend to divest workers of the right to individual consideration.

At issue in this appeal is the right of injured workers to obtain necessary and proper medical care. The Department has infringed that right by enforcing HTCC edicts as unreviewable and final. If the Department's position is correct, the Legislature has unconstitutionally delegated unreviewable authority to the HTCC. Neither the Open Meetings Act nor a discretionary writ of review saves the statute.

CONCLUSION

As Amici Workers' Injury Law & Advocacy Group and Washington State Association for Justice show, this Court has two methods to uphold Appellate Michael Murray's right to necessary and proper medical care. First, the Court as a matter of statutory construction can conclude that his appellate rights under RCW 70.14.120(4) limit the HTCC's decision under RCW 70.14.120(3). Second, the Court can conclude that the Governor's veto created an unconstitutional delegation of authority to the HTCC. At stake is Mr. Murray's right to prove that FAI surgery rehabilitated his hip and is therefore necessary and proper care.

Appellant Michael Murray respectfully requests the Court to reverse the Court of Appeals, remand his case to the Department for a hearing on the merits, and award him reasonable attorneys' fees on appeal.

DATED this 16 day of May, 2018.

BURI FUNSTON MUMFORD & FURLONG, PLLC

By 

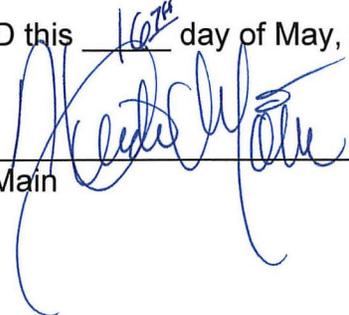
Philip J. Buri, WSBA #17637
1601 F. Street
Bellingham, WA 98225
360/752-1500

DECLARATION OF SERVICE

The undersigned declares under penalty of perjury under the laws of the State of Washington that on the date stated below, I mailed or caused delivery of Appellant Michael Murray's Supplemental Brief to :

Anastasia R. Sandstrom
Attorney General's Office
800 5th Ave Ste 2000
Seattle WA 98104-3188

DATED this 16th day of May, 2018.



Heidi Main

APPENDIX A

IN RE: SUSAN M. PLEAS, 1998 WL 718232 (1998)

1998 WL 718232 (Wash.Bd.Ind.Ins.App.)

Board of Industrial Insurance Appeals

State of Washington

IN RE: SUSAN M. PLEAS

Claim No. J-746527

Docket No. 96 7931

August 31, 1998

SIGNIFICANT DECISION

Appearances:

*1 Claimant, Susan M. Pleas

by Law Office of William D. Hochberg, per William D. Hochberg

Employer, Advanced Technology Labs

None

Department of Labor and Industries

by The Office of the Attorney General, per Beverly Norwood Goetz, Assistant

DECISION AND ORDER

The claimant, Susan M. Pleas, filed an appeal with the Board of Industrial Insurance Appeals on September 25, 1996, from an order of the Department of Labor and Industries dated August 14, 1996. The order affirmed a prior order dated June 3, 1996, that denied authorization and payment for a spinal cord stimulator. **REVERSED AND REMANDED.**

DECISION

Pursuant to RCW 51.52.104 and RCW 51.52.106, this matter is before the Board for review and decision on a timely Petition for Review filed by the Department of Labor and Industries to a Proposed Decision and Order issued on December 31, 1997, in which the order of the Department dated August 14, 1996, was reversed and remanded to the Department with direction to issue an order authorizing payment for the claimant's spinal cord stimulation treatment.

The Board has reviewed the evidentiary rulings in the record of proceedings and finds that no prejudicial error was committed, and the rulings are affirmed.

Upon thorough review, we feel that the disposition of this appeal by our industrial appeals judge was correct. However, we have granted review in order to provide an analytical framework for determining what constitutes "proper and necessary medical and surgical services" to which injured workers are entitled pursuant to RCW 51.36.010. Such a framework is important to aid in uniformity in analysis of the facts and the applicable law.

The issue in this appeal is whether in this case a specific treatment service, referred to at various times as a spinal column stimulator, epidural spinal column stimulator or a dorsal column stimulator (and hereinafter referred to by the acronym SCS), is "proper and necessary" medical service within the meaning of RCW 51.36.010. This is the fourth time we have been called upon to determine whether, and under what circumstances, the Department should authorize a spinal column stimulator. The past Decision and Orders, none of which have been classified by us as a "Significant Decision," are *In*

re Larry Morefield, Dckt. No. 90 5663 (May 5, 1992); *In re Jerry Albaugh*, Dckt. No. 91 1481 (November 12, 1992); and *In re Kim O. Machado*, Dckt. No. 94 1240 (August 2, 1995). The first two of these decisions affirmed the Department's denial of authorization of the SCS implant, while the last one reversed the Department and ordered that the treatment be provided. The result in each of these decisions was heavily dependent on the facts presented at hearing. This is true in this appeal as well.

SCS is a "treatment of last resort" for patients with intractable neuropathic pain in the extremities. It is used in cases of intractable pain and hypersensitivity caused by injured nerve roots in the spine or peripheral nerves to modify or block nerve activity that the brain interprets as pain. The Department refuses to authorize SCS implants in all cases, basing its decision on a recommendation from its Medical Advisory Industrial Insurance Committee (MAIIC). Dr. Gary Franklin, the Department's medical director and a neurologist, and Dr. John Loeser, the neurosurgeon member of the MAIIC, testified that there is insufficient medical literature, meeting appropriate scientific standards, to show that SCS is effective or that it leads to functional improvement of patients. Dr. Franklin believes that SCS is palliative treatment only and does not meet the accepted standards of good practice of neurosurgery and pain management. Dr. John Oakley, the claimant's attending neurosurgeon, and Mr. Starckenbaum, a biomedical engineer for a company that makes SCS units, testified that SCS is approved by the U.S. Food and Drug Administration and that the Department of Labor and Industries is virtually alone among insuring entities in its refusal to authorize its usage in appropriate cases.

*2 Ms. Pleas is a 55-year-old woman who, as a proximate result of an industrial injury of May 29, 1986, sustained Failed Back Surgery Syndrome (FBSS) that manifests itself through severe, continuous and intractable leg pain that is neuropathic in nature. No treatment modality, including surgery, physical therapy, chiropractic manipulation, acupuncture, naturopathic treatment, various medications, including anti-depressants, and a pain clinic, helped curtail or alleviate her neuropathic leg pain. Ms. Pleas attempted to start a fabric business, designing garments with a computer that she operated while reclining in a chaise lounge at her home. However, she found that she could work in this way only one-half to two hours per day and many days not at all. Dr. Oakley, her attending neurosurgeon, testified that Ms. Pleas was totally unable to perform all work due to her back condition. Her mental state was deteriorating.

Dr. Oakley suggested to Ms. Pleas that implantation of a SCS might provide her with pain relief. Before implanting the device, Dr. Oakley used a screening protocol to determine if she was a good candidate for this treatment. As part of the protocol, Dr. Oakley had the claimant examined by Dr. Ray Baker, an anesthesiologist and specialist in pain management, who implants SCS devices as part of his practice. Dr. Baker concluded that SCS was indicated in her situation. On February 29, 1996, Dr. Oakley surgically implanted the device, on a temporary basis, to see if and to what extent Ms. Pleas actually obtained pain relief. Ms. Pleas noted immediate, dramatic and continuous relief of her leg pain. On March 18, 1996, Dr. Oakley performed the procedure necessary to make the implant permanent. In the year since the implant has become permanent, Ms. Pleas has not needed to see Dr. Oakley (she has seen his nurse four or five times to make sure she was receiving the optimal stimulation from the unit) and no longer takes pain medication. She will require a minor surgical procedure every 3.2 years in order to replace the internal battery powering the SCS unit. Ms. Pleas now works at home at least two hours per day and plays golf four or five times per week, walking the course.

Decisions of the Department either to authorize or deny authorization of a treatment service are reviewed *de novo*, by a preponderance of the evidence, inasmuch as neither RCW 51.36.010 nor WAC 296-20-01002 categorize treatment authorization decisions as within the "sole discretion" of the director of the Department. *Morefield*.

Appeals from denial of treatment authorization usually are tried before us as if the issue was one of classification of the proposed treatment within a dichotomy as either "curative" treatment to be authorized or "palliative" treatment to be denied. This sort of analysis is an oversimplification and has no legal basis in the statutes, regulations or case law. *In re Terri Tollie*, Dckt No. 85 3932 (December 17, 1987). The term "curative" is contained within the definition of "medically necessary" found in WAC 296-20-01002, but that regulation also indicates that treatment provided for diagnosis and rehabilitative treatment may also be medically necessary. The word "palliative" does not appear in industrial insurance

statutes and is found in the regulations promulgated thereunder only three times. In WAC 296-20-03001(13) it appears in the context of provision of long-term prescription of medication. WAC 296-20-03003(8) refers to a “rule prohibiting palliative treatment,” but no such rule appears anywhere in Chapters 296-20, 296-21, or 296-23, WAC. In WAC 296-23-260(1)(b) doctors performing medical examinations for the Department are required to state whether proposed treatment is curative or palliative. None of these regulations is applicable here. Maintenance or supportive care, [see, e.g., WAC 296-20-03002(4) and WAC 296-23-190(3)(h)] generally is not authorized, but it still is erroneous to decide authorization of treatment questions merely by determining which descriptive term best applies.

*3 Statutory guidance on this issue is scanty and very general. RCW 51.36.010 establishes an injured worker's entitlement to “proper and necessary medical and surgical services” as well as to “proper and necessary hospital care and services.” These phrases are not defined. RCW 51.36.015 includes chiropractic care and evaluation as a service available to injured workers under RCW 51.36.010. Additionally, RCW 51.36.020 authorizes a few specific types of treatment, equipment and treatment-related appliances, but SCS is not one of these.

The phrase “proper and necessary medical and surgical services” is not defined within Title 51, RCW. The duration of treatment is discussed within RCW 51.36.010, but only in generalities. The Legislature gave the director of the Department the authority to make rules that include determinations about the types of treatment to be provided to injured workers to enable him to properly administer the provision of medical and surgical services to injured workers. RCW 51.04.030(1); RCW 51.04.020(4). These determinations must take into consideration the remedial nature of the Industrial Insurance Act. RCW 51.04.010.

The “Medical Aid Rules,” Chapter 296-20, WAC, do not contain a definition of “proper and necessary medical and surgical services.” But a definition of “medically necessary” is contained within WAC 296-20-01002. That regulation states, in part:

Medically necessary: Those health services are medically necessary which, in the opinion of the director or his or her designee, are:

- (a) Proper and necessary for the diagnosis and curative or rehabilitative treatment of an accepted condition; and
- (b) Reflective of accepted standards of good practice within the scope of the provider's license or certification; and
- (c) Not delivered primarily for the convenience of the claimant, the claimant's attending doctor, or any other provider; and
- (d) Provided at the least cost and in the least intensive setting of care consistent with the other provisions of this definition.

In no case shall services which are inappropriate to the accepted condition or which present hazards in excess of the expected medical benefits be considered medically necessary. Services which are controversial, obsolete, experimental, or investigational are presumed not to be medically necessary, and shall be authorized only as provided in WAC 296-20-03002(6).

The vast majority of treatment authorization decisions require an individualized analysis to ascertain if the proposed treatment is medically necessary. However, WAC 296-20-01002 is not the only regulation that may be applicable when conducting such an analysis. The Department has promulgated other, more specific regulations that may apply concurrently or in its stead. Some specific treatment modalities and services are the subject of specific regulations found within Chapters 296-20, 296-21 and 296-23, WAC. One such specific regulation, WAC 296-23-175, applies to the provision of SCS treatment. Many common kinds of treatment require prior authorization before being provided to the injured worker. WAC 296-20-03001.

*4 A case-by-case analysis is not necessary when certain types of treatment are proposed. WAC 296-20-030 lists certain treatments that the Department has determined to be proper and necessary in all cases so that they are authorized even without prior application. WAC 296-20-03002 (1)-(5) lists treatments that the Department has determined never to be proper and necessary in any case and, therefore, never will authorize.

The Department contends that SCS cannot be authorized in any case, including this one, because it is “maintenance care” within the meaning of WAC 296-20-03002(4) and, because based on the recommendation of the MAIIC, it has a policy that SCS is never to be authorized. However, in Ms. Pleas' case the SCS treatment was not mere maintenance care inasmuch as it was intended to increase her physical functioning and end her total disability status by enabling her to return to work, an outcome that appears very close to being achieved. The recommendation of the MAIIC does not permit the Department to prohibit all authorizations of SCS treatment. That committee is advisory only. Furthermore, when Department policy conflicts with a validly promulgated regulation, the policy is not given effect. See, e.g., *In re State Roofing & Insulation Inc.*, BIIA Dec., 89 1770 (1991), and *In re Howard Sells*, Dckt. No. 95 4334 (December 20, 1996).

Authorization of SCS treatment must be determined on a case-by-case basis. WAC 296-23-165 and WAC 296-23-175, regarding miscellaneous services and appliances in general and stimulators in particular, do not contain an absolute prohibition of such treatment services, but instead set requirements for its authorization on a case-by-case basis. WAC 296-23-165(1) and (3) reiterate the requirement that provision of a stimulator must be medically necessary for it to be authorized. Thus, this specific regulation requires SCS treatment to meet the WAC 296-20-01002 definition of “medically necessary.”

The Department argues that pursuant to WAC 296-20-01002, SCS treatment must be presumed **not** to be medically necessary because it is controversial and/or experimental. While we do not believe SCS to be experimental, we agree that it is “controversial” within the meaning of WAC 296-20-01002. SCS treatment has been available for over 20 years. The three surgical experts who testified all use it as treatment in selected cases of failed back surgery syndrome (FBSS), the condition from which Ms. Pleas suffers. It only is used when virtually all other possible treatments have been tried and failed. The FDA has approved the device. Most entities providing medical insurance authorize it in appropriate cases. On the other hand, Dr. Franklin and Dr. Loeser testified that the medical literature has not proven SCS to be efficacious or cost effective, the methodology of other studies has been poor, and the results often are only anecdotal. However, the value of Dr. Loeser's study itself is questionable since it is no more than a survey of earlier studies and did not attempt to give weight to more recent studies that more likely reflect positive results from the better technology that Dr. Loeser admits exists currently.

*5 The evidence discussed above shows that while SCS is not experimental, it is controversial. Since SCS is controversial it must be presumed not to be medically necessary. Nonetheless, it still can be authorized as provided by WAC 296-20-03002(6). Since such treatment can be approved in certain cases, it follows that the presumption that it is not medically necessary can be rebutted. This regulation requires the Department to use a case-by-case analysis based on the definition of medically necessary found in WAC 296-20-01002.

In examining this individual case, we believe that Ms. Pleas has shown that the permanent implant of the SCS was rehabilitative treatment and thus medically necessary within the meaning of WAC 296-20-01002 and “proper and necessary medical and surgical services” within the meaning of RCW 51.36.020. “Rehabilitative” and “rehabilitation” are not defined in the statutes or regulations. *Webster's II New College Dictionary* 934 (1995) defines “rehabilitate” as: “to restore to good health or useful life, as through education or therapy.” Thus, treatment that improves functioning, even if it does not improve the underlying pathology, is rehabilitative. Drs. Loeser and Franklin testified that rehabilitation had three components. Return to work was the primary measure of rehabilitation, but others include improved physical functioning and pain relief. However, we have held that mere pain relief is not enough to prove that treatment is improving functioning. *In re Calvin Leslie*, Dckt. No. 93 1261 (May 2, 1994). While the literature reviewed by Dr. Loeser

included individual case histories where SCS resulted in markedly improved functioning and even return to work by injured workers due to the relief of pain, his study and Exhibit No. 2 show that the only finding that can be made about the efficacy of SCS is that approximately 50 percent of the patients receiving the implant will have pain relief of 50 percent or greater. This is a very subjective finding and does not itself justify authorization of SCS. Dr. Oakley believes that soon to be published studies will more clearly show the rehabilitative effects of SCS. But until those studies are published, Dr. Loeser's survey of the literature remains unrebutted.

Notwithstanding the above observations, Ms. Pleas has proven that the implantation of a SCS unit has been rehabilitative treatment in her case. As of the date of her testimony, Ms. Pleas' SCS unit had functioned for 18 months without complication. She experienced a marked decrease in pain and an increase in functioning. The rehabilitative effect of the treatment can be verified by the decrease in prescriptions sought, decrease in the use and cost of medical services, and the increase in the claimant's activity level and ability to work. Adding time spent golfing to the amount of time she works each day, it is likely that she has become physically capable of performing gainful employment. **In this case**, the presumption that SCS is not proper and necessary medical treatment has been rebutted.

*6 Dr. Franklin pointed out that the evidence that SCS had a rehabilitative effect in this case originated after the treatment had been provided. Authorization of treatment is not dependent on a good result from that treatment in any one particular case. Nor should treatment authorization be delayed until after the treatment has been provided and proven to be effective. Such a delay harms the Department as well as the injured worker. Nonetheless, in situations where the treatment has been provided prior to it being authorized, the Board has held that a determination that surgical treatment was medically proper and necessary may be based on "20-20 hindsight" provided from findings of the surgery itself. *In re Zbigniew Krawiec*, BIIA Dec., 90 2281 (1991) and *In re Rebecca Armack*, Dckt. No. 68,368 (October 21, 1985).

The Department also contends that SCS treatment is not medically necessary treatment because it is not reflective of accepted standards of good practice. WAC 296-20-01002(b) requires treatment to be reflective of the standard of good practice within the scope of the provider's license or certification. In this case, the scope of the provider's license in question is that of neurosurgery and surgical pain management. Dr. Franklin, the Department's medical director, has concluded that because the MAIIC, which advises the Department on medical matters, (see WAC 296-20-01001) has recommended that SCS treatment not be authorized, that necessarily means that such treatment does not meet the accepted standard of good practice.

Dr. Franklin's conclusion is erroneous. The testimony of Dr. Loeser, the neurosurgeon member of MAIIC, makes it clear that the committee's rejection of SCS was due to an inability to prove to its satisfaction that such treatment is rehabilitative and cost effective. Dr. Loeser, Dr. Oakley, and Dr. Baker, who perform surgical procedures in these fields, **all** provide SCS implants to their patients who meet their screening criteria. Dr. Franklin, on the other hand, is not a surgeon and treats patients only irregularly. His opinion about what constitutes the standards of good practice of neurosurgery and pain management is entitled to less weight.

The Board, in *Morefield* and *Albaugh*, concluded that implantation of SCS was not reflective of accepted standards of good practice based on Dr. Franklin's interpretation of the MAIIC advisory opinion. In this case, evidence from the neurosurgeon member of the committee was presented, which rebutted Dr. Franklin's views. Because more complete information from a first-hand source was available in this case, the Board can distinguish those two non-leading decisions and reject their holdings under the facts of this case.

The Department contends that SCS should not be authorized because it is not cost effective. However, information from one of the latest studies (Exhibit No. 2) indicates otherwise. In Ms. Pleas' case, it has clearly been cost effective. Her consumption of medication and medical services has dropped to almost nothing, there have been no complications, and she has improved from likely permanent and total disability status to a person whose activity levels are consistent

with some amount of gainful employment. The Department maintains that future costs of maintenance of the SCS unit and battery replacement may prove that this form of treatment may yet prove not to be cost effective in this case. The evidence in the record, especially Exhibit No. 2, suggests that this is a possibility; however, to say that it will occur in this case is mere speculation that cannot justify denial of authorization of this treatment.

*7 Of course, the Department must consider factors related to future costs when determining if proposed treatment is medically necessary. RCW 51.04.030; WAC 296-20-01002(d). The Department is justifiably concerned about the costs of SCS treatment, especially since authorization of such treatment, while initially cost effective, might prove not to be cost effective due to future implant revisions, battery changes, etc. There is no way to accurately forecast future need for treatment in any one individual case. Ms. Pleas may need the stimulator the rest of her life, it may cease to be effective some time in the future, or she may be able to function without the SCS unit at some time in the future. Because of the uncertainties in the treatment of individual cases, the Department routinely reserves claim costs in vast numbers of cases in order to protect the solvency of the medical aid and other funds to which it is entrusted. This decision does not prevent the Department from continuing to use those practices. Rules are in place that the Department can use to manage the continued care that may be necessary due to the SCS unit. See WAC 296-23-175 and WAC 296-20-1102. Dr. Oakley testified that a second type of SCS unit, one that does not require an internal battery, is available. The Department may mandate the use of that type of unit if it proves itself to be less costly and/or a less invasive form of treatment than the unit Ms. Pleas currently uses.

The Department argues that even if permanent implantation of a SCS meets the definition of “medically necessary,” it should not be responsible for payment for that treatment service since the implantation took place without prior authorization as required by WAC 296-20-03002(6) and WAC 296-20-1102(3), as well as without prior medical consultation as required by WAC 296-20-045. The implant took place prior to the authorization required by WAC 296-20-03002(6). Moreover, even though Dr. Baker's examination of the claimant may have been consistent with the WAC 296-20-03002(6) and WAC 296-20-045 requirement of a consultation prior to treatment, it did not meet all of the requirements of WAC 296-20-045 or WAC 296-20-051. However, the failure to comply with these regulations prior to receiving the treatment does not necessarily mean that the authorization of the SCS implant must be denied in this case. In regard to the lack of prior authorization for treatment, the Court of Appeals held, in *Boise Cascade Corp. v. Huizar*, 76 Wn. App. 676, 686 (1994):

if a claimant can establish that he or she notified L&I or the self-insured of the need for medical treatment and supplied information pertinent to a determination of whether the treatment was causally connected to the industrial injury, neither L&I nor the self-insured can use its lack of prior authorization as a basis for denying payment for services later found to be medically necessary and causally connected to the industrial injury. To conclude otherwise would be contrary to the express purpose and intent of the Industrial Insurance Act.

*8 In this case, Ms. Pleas met the requirements listed in *Huizar*. Dr. Oakley could not remember if he sought authorization on behalf of Ms. Pleas for SCS treatment from the Department. However, it is clear that he did seek such authorization inasmuch as he testified that he obtained alternative coverage from another source once the Department denied his authorization request. SCS treatment was intended to treat the residuals of the claimant's low back condition, and the intractable leg pain therefrom, which the Department had already accepted under this claim. Finally, the claimant's dramatic post-implant improvement and the testimony of Dr. Oakley provide sufficient proof that SCS was medically necessary treatment for a condition proximately related to the industrial injury.

Prior to the *Huizar* case, we held in *Krawiec* and *Armack* that failure to follow the regulations requiring prior authorization of treatment and a second medical opinion did not prohibit authorization of treatment if, once the treatment was provided, it proved itself to be rehabilitative in some verifiable fashion. In this case, as stated earlier, there is no doubt that the SCS implant has proven to be rehabilitative for Ms. Pleas.

In summary, authorization of SCS treatment must be determined by the Department on a case-by-case basis. In this case, Ms. Pleas has proven that SCS treatment is rehabilitative and reflective of the accepted standards of good practice within the scope of her provider's license. Therefore, in her case, SCS is "medically necessary" treatment within the meaning of WAC 296-20-01002 and also "proper and necessary medical and surgical services" within the meaning of RCW 51.36.010. The Department order dated August 14, 1996, must be reversed and the Department directed to authorize and pay for SCS treatment in this individual case.

FINDINGS OF FACT

1. On May 29, 1986, while in the course of her employment as a secretary for Advanced Technology Laboratories, the claimant, Susan M. Pleas, caught her foot in a pallet and fell, striking her back on a desk, for which she required medical and surgical treatment. On June 4, 1986, the claimant filed an application for benefits with the Department of Labor and Industries. The claim was allowed and benefits were paid. On June 3, 1996, the Department issued an order denying authorization or payment for a spinal cord stimulator. The claimant filed a timely request for reconsideration with the Department. On August 14, 1996, the Department issued an order affirming its June 3, 1996 order. On September 25, 1996, the claimant filed a Notice of Appeal with the Board of Industrial Insurance Appeals. On November 13, 1996, this Board issued an order granting the claimant's appeal, assigning it Docket No. 96 7931, and directing that further proceedings be held.

2. As a proximate result of the May 26, 1986 industrial injury and surgical treatment therefor, the claimant sustained failed back surgery syndrome, which manifested itself primarily through severe, continuous, and intractable leg pain that was neuropathic in origin. No treatment modality, including surgery, physical therapy, chiropractic manipulation, acupuncture, naturopathic treatment, various medications, including anti-depressants, and a pain clinic, helped curtail or alleviate her neuropathic leg pain. As of February 29, 1996, the claimant was unable to perform any form of reasonably continuous gainful employment.

*9 3. As of February 29, 1996, the claimant was a good candidate for implantation of a spinal column stimulator. On that date, a temporary stimulation unit was implanted and attached to an external pulse generator. The implant provided immediate, dramatic, and continuous relief of the claimant's neuropathic leg pain. On March 18, 1996, the stimulator implant was made permanent. Since that time, the claimant has experienced marked relief of leg pain, her physical functioning and ability to tolerate activity have improved significantly, and she is able to engage in activity consistent with sedentary employment.

4. Implantation of a spinal column stimulator in carefully screened cases of failed back surgery syndrome, such as this one, is rehabilitative in nature. Such treatment is controversial, but is not obsolete, experimental, or investigational. Implantation of a spinal column stimulator is within the standards of good practice of neurosurgery and pain management.

5. As of February 29, 1996, the claimant's attending neurosurgeon had requested, but not obtained, authorization from the Department of Labor and Industries to implant a spinal column stimulator in the claimant as treatment for her failed back surgery syndrome proximately caused by the May 29, 1986 industrial injury and surgical treatment therefor. As part of the screening protocol prior to implanting the spinal column stimulator in the claimant, her attending neurosurgeon had her evaluated by a medical doctor who specialized in anesthesiology and pain management.

CONCLUSIONS OF LAW

1. The Board of Industrial Insurance Appeals has jurisdiction over the subject matter and the parties to this appeal.

2. In this case, implantation of a spinal column stimulator was “medically necessary” within the meaning of WAC 296-20-01002 and also “proper and necessary medical and surgical services” within the meaning of RCW 51.36.010.

3. In this case, failure to comply with the prior authorization requirements of WAC 296-20-03002(6) and WAC 296-20-1102(3) and with all of the WAC 296-20-03002(6) and WAC 296-20-045 requirements for consultation prior to treatment do not relieve the Department from the responsibility to authorize and pay for implantation of a spinal column stimulator.

4. The order of the Department of Labor and Industries dated August 14, 1996, that affirmed an order dated June 3, 1996, that denied authorization and payment for a spinal column stimulator, is incorrect and is reversed. This claim is remanded to the Department with direction to authorize and pay for the implantation of the claimant's spinal column stimulator.

It is so ORDERED.

Dated this 31st day of August, 1998.

Thomas E. Egan
Chairperson
Frank E. Fennerty, Jr.
Member

DISSENT

I dissent. While I am glad Ms. Pleas has relief from her pain as a result of her SCS implant, I must disagree with the majority's opinion that she has met her burden of proof by showing that the SCS implant was medically necessary because of its rehabilitative effect for her. Rather, her burden of proof must be to first show that the Department's denial of authorization of SCS procedures for industrially injured workers is incorrect. She has not met this burden. This record, as the majority notes, makes it clear that the SCS implantation procedure is still significantly controversial within the medical community, and therefore presumed not to be medically necessary under WAC 296-20-01002.

*10 The Department has broad supervisory authority granted by the Legislature to determine types of treatment provided to injured workers through the workers' compensation system. To accomplish this, the Department relies on the Washington State Medical Association (WSMA) committee to specifically advise them on acceptable community standards of treatment for the industrial insurance system. Medical policy coverage decisions are based on available data about clinical outcomes and proven efficacy of treatments. Dr. Franklin explained in his testimony that Dr. Oakley and Dr. Loeser were asked to participate on the WSMA subcommittee formed to look at SCS coverage because of their experience performing SCS implants. After being presented with Dr. Oakley's data and Dr. Loeser's review of available research, the committee unanimously voted to advise the Department not to cover SCS implants as an acceptable standard of care. The majority accords Dr. Franklin's opinion less weight due to the fact that he is not a surgeon. In fact, Dr. Franklin's training in epidemiology is far more critical to the evidence of whether methodologically sound scientific evidence exists to support the effectiveness of SCS. Dr. Franklin's opinion that current studies do not support SCS as an accepted standard of good practice is persuasive. It is not rebutted by the anecdotal opinions of the surgeons who have performed the procedure, the fact that the appliance has FDA approval, or the fact that other insurance programs may pay for the procedure. The expert medical testimony in this record is in agreement that existing research is weak and does not shed light on which individuals are likely to benefit, predictable clinical outcomes, or even the appropriate length of time necessary to ascertain whether a positive outcome has been realized. Dr. Franklin's and Dr. Loeser's testimony clearly show that SCS remains a controversial procedure.

The majority applies the “20-20 hindsight” holdings of *Krawiec* and *Armack* to determine the SCS implant was medically necessary based on testimony the implant resulted in functional improvement for Ms. Pleas. In fact, this case is distinguishable from both *Krawiec* and *Armack* which involved medical procedures routinely accepted by the medical community without controversy, and noncompliance of the treating physicians with Department preauthorization regulations. In contrast, this case involves a controversial medical procedure that is not accepted by the Department as a matter of policy, even if the physician complies with preauthorization requirements. As such, the majority's opinion that the Department must perform a retrospective case-by-case assessment and decide coverage based on the worker's response to the treatment is legally incorrect. It is unreasonable to require the Department to conduct a retrospective analysis of each case on which a controversial procedure has been denied and to pay for treatment based on the treatment result. As a matter of public policy, entitlement to industrial insurance benefits should not be decided on the basis of the worker's response to a particular form of treatment. To do so will encourage physicians and patients to proceed in hopes of achieving results sufficient for coverage, and opens up virtually all unauthorized treatments for later consideration and litigation. Further, this would undermine the Department's authority and statutory role in supervising treatment for injured workers “with the intent that it be in all cases efficient and up to the recognized standard of modern surgery.” RCW 51.04.020(4)

*11 The Department order dated August 14, 1996, denying authorization of Ms. Pleas' March 18, 1996 surgery is correct and should be affirmed.

Dated this 31st day of August, 1998.

Judith E. Schurke
Member

1998 WL 718232 (Wash.Bd.Ind.Ins.App.)

APPENDIX B

IN RE: LADONIA M. SKINNER, 2015 WL 4153105 (2015)

2015 WL 4153105 (Wash.Bd.Ind.Ins.App.)

Board of Industrial Insurance Appeals

State of Washington

IN RE: LADONIA M. SKINNER

Docket No. 14 10594

Claim No. SE-96996

June 12, 2015

***1** Appearances:

Claimant, Ladonia M. Skinner,
by Walthew Law Firm, per Robert Heller
Self-Insured Employer, Seattle School District #1,
by Eims Graham, P.S., per Jonathan James
Department of Labor and Industries,
by the Office of the Attorney General, per Penny L. Allen

DECISION AND ORDER

The claimant, Ladonia M. Skinner, filed a protest with the Department of Labor and Industries on December 30, 2013. The Department forwarded the protest to the Board of Industrial Insurance Appeals as a direct appeal. The claimant appeals an October 30, 2013 Department order in which the Department affirmed an April 18, 2013 order. In the April 18, 2013 order the Department closed the claim with time-loss compensation benefits as paid through January 23, 2013, and directed the self-insured employer to pay a permanent partial disability award equal to Category 2 of WAC 296-20-280 for dorso-lumbar and lumbosacral impairments, less an overpayment in the amount of \$7,630.61 for time-loss compensation benefits paid for March 22, 2012, through January 23, 2013. The Department order is **AFFIRMED**.

PROCEDURAL/EVIDENTIARY MATTERS AND OVERVIEW

As provided by RCW 51.52.104 and RCW 51.52.106, this matter is before the Board for review and decision. The self-insured employer and the Department filed timely Petitions for Review (PFR) of a January 26, 2015 Proposed Decision and Order in which the industrial appeals judge (IAJ) reversed the October 30, 2013 Department order and remanded for further treatment in the form of a spinal cord stimulator (SCS). The claimant filed a Response on April 9, 2015.

The Board has reviewed the evidentiary rulings in the record of proceedings and finds that no prejudicial error was committed. The rulings are affirmed.

We have granted review primarily to address whether an SCS is a covered benefit under RCW 51.36.010. However, there is a preliminary matter that must be addressed first. In its PFR, the Seattle School District challenged the IAJ's finding that the industrial injury aggravated Ms. Skinner's degenerative disc disease. We agree that the medical evidence does not support that finding. However, the evidence establishes that Ms. Skinner suffers from post-laminectomy syndrome (or lumbar failed-back-surgery syndrome) and chronic back pain because of the injury. We have modified the Findings of Fact to reflect that.

Regarding the issue of whether an SCS is a covered benefit, the IAJ relied on *In re Susan Pleas*¹ to find that the Board has the authority to direct the Department to authorize such treatment. He reversed the order in which the Department closed Ms. Skinner's claim and remanded the matter to the Department "to order the self-insured employer to provide proper and necessary treatment of a spinal cord stimulator."

The Department did not participate in the hearing process but has now filed a PFR contending that *Joy v. Department of Labor & Indus.*, 170 Wn. App. 614 (2012) precludes the Department from authorizing such treatment. The Department has attached a copy of the October 22, 2010 Health Technology Assessment (HTA) adopted by the Health Technology Clinical Committee (HTCC) under the process in RCW 70.14. Under ER 201, we take judicial notice of the HTA published on the Health Care Authority (HCA) website as required by WAC 185-55-040. The Seattle School District echoed the Department's argument in its PFR.

*2 The IAJ's reliance on *Pleas* is misplaced. *Pleas* is no longer an accurate statement of the law regarding the Department's authority to authorize the use of an SCS. Those devices have been excluded from coverage since October 22, 2010, when the HTA on spinal cord stimulators was adopted under the process in RCW 70.14. Because the treatment Ms. Skinner is seeking is not a covered benefit, the October 30, 2013 order closing her claim is affirmed.

DECISION

What conditions are covered under this claim? Ms. Skinner injured her back on January 19, 2011, during the course of her employment with the Seattle School District when she and a co-worker were attempting to move a large C-shaped table top using a hand truck. Ms. Skinner bore the weight of the table and they could not move it with the hand truck. They positioned the table top on its side and pushed it down the hall. Because of this activity, Ms. Skinner suffered a lumbosacral strain. A February 26, 2011 MRI revealed multi-level degenerative disc disease, primarily at the L4/5 and L5/S1 levels. After conservative treatment was unsuccessful, Rod Oskouian, M.D., recommended surgery and on August 9, 2012, Ms. Skinner underwent a laminectomy and foraminotomy at L5-S1. The IAJ determined that: "The Department examined these facts and accepted that Ms. Skinner's industrial injury aggravated her degenerative spine condition. Further, it authorized the low back surgery to reduce her pain."² In proposed Finding of Fact No. 2, the IAJ found that the industrial injury caused a lumbosacral strain and aggravated the degenerative disc disease. The employer challenges the latter in its PFR.

The stipulated Jurisdictional History reveals no Department orders determining what conditions were caused or aggravated by the industrial injury, nor does there appear to have been an order directing the self-insured employer to authorize the August 9, 2012 surgery. Ms. Skinner presented the testimony of two medical experts, Thomas S. Yang, M.D., and Sarah B. Hufbauer, M.D. Neither doctor offered an opinion regarding how the industrial injury affected the underlying degenerative disc disease, but both diagnosed post-laminectomy syndrome (or lumbar failed-back-surgery syndrome) and related that condition to the industrial injury. Dr. Yang also said the injury had caused chronic pain.

The employer presented the testimony of Lee Robertson, M.D., and James Champoux, M.D. Dr. Robertson's diagnoses were lumbar strain; chronic radicular symptoms; and status post L5/S1 laminectomy. He apparently determined that Ms. Skinner's permanent impairment was equal to Category 2 of WAC 296-20-280. The claim was closed with a permanent partial disability (PPD) award equal to that impairment rating. Dr. Robertson offered no opinion regarding causation or whether the industrial injury had affected the underlying degenerative disc disease.

The employer's other witness, Dr. Champoux, said the only condition related to the industrial injury was a lumbar strain that had resolved long ago. He was the only doctor who directly addressed whether the injury affected the degenerative disc disease and he said it had not. Dr. Champoux testified that the August 9, 2012 surgery was not proper and necessary treatment for the industrial injury.

*3 However, “[i]t is well-established that when ... the worker reasonably relies on the advice of her doctors, the consequences of treatment are compensable, even if the treatment later turns out to be ill-advised or not necessitated by a condition covered under the claim.”³ There is an exception: When the worker has been placed on notice that the treatment she wishes to pursue has been denied, she proceeds at her own risk and is not entitled to any resulting benefits.⁴ But the exception does not apply here because there is no evidence that the self-insured employer or the Department denied authorization for the surgery or that Ms. Skinner proceeded against the recommendations of her doctors. Even though the employer's experts did not believe the surgery was warranted, the evidence shows it was recommended by Dr. Oskouian.

In addition, both Ms. Skinner's medical experts related post-laminectomy syndrome or lumbar failed-back-surgery syndrome to the industrial injury, and the Department closed the claim with a Category 2 PPD award presumably based on more than a completely resolved lumbar strain. The employer did not appeal the PPD award, so it has conceded that Ms. Skinner has a permanent low back disability because of the industrial injury. While the record supports no specific finding that the industrial injury aggravated the underlying degenerative disc disease in the low back, we accept the opinions of Dr. Yang and Dr. Hufbauer that Ms. Skinner's post-laminectomy syndrome or lumbar failed-back-surgery syndrome was related to the injury. Under *Anderson* and *Silva*, the Seattle School District is responsible for the consequences of the recommended surgery. We have modified the findings of fact to reflect that.

Are spinal cord stimulators a covered benefit? In 2006, the Legislature established the Health Care Authority (HCA) to “study all state purchased health care ... and make recommendations aimed at minimizing the financial burden which health care poses on the state, its employees, and its charges, while at the same time allowing the state to provide the most comprehensive health care options possible.”⁵ As part of that process, a health technology clinical committee (HTCC) was established under the aegis of the HCA.⁶ The committee reviews selected health technologies and issues health technology assessments (HTAs) that are published on the HCA website.⁷

For each health technology selected for review, the committee must determine “[t]he conditions, if any, under which the health technology will be included as a covered benefit in health care programs of participating agencies.”⁸ “Based on the evidence regarding safety, efficacy, and cost-effectiveness of the health technology, the committee shall” determine whether a technology is a covered benefit and may decide that “[c]overage is not allowed because either the evidence is insufficient to conclude that the health technology is safe, efficacious, and cost-effective or the evidence is sufficient to conclude that the health technology is unsafe, ineffectual, or not cost-effective.”⁹

*4 Under RCW 70.14.080(6), the Department of Labor and Industries is one of the participating agencies governed by the committee's coverage determinations that decide “the circumstances, if any, under which a health technology will be included as a covered benefit in a state purchased health care program.”¹⁰ Under RCW 70.14.120:

(1) A participating agency shall comply with a determination of the committee under RCW 70.14.110 unless:

(a) The determination conflicts with an applicable federal statute or regulation, or applicable state statute; or

(b) Reimbursement is provided under an agency policy regarding experimental or investigational treatment, services under a clinical investigation approved by an institutional review board, or health technologies that have a humanitarian device exemption from the federal food and drug administration.

On October 22, 2010, the HTCC adopted an HTA precluding the coverage of spinal cord stimulators by any participating agency. On September 11, 2012, the Court of Appeals addressed the applicability of this HTA to an industrial insurance

claim and whether an injured worker could appeal the Department's denial of medical treatment that the HTCC has determined is not a covered benefit. RCW 70.14.120(3) provides:

A health technology not included as a covered benefit under a state purchased health care program pursuant to a determination of the health technology clinical committee under RCW 70.14.110, or for which a condition of coverage established by the committee is not met, shall not be subject to a determination in the case of an individual patient as to whether it is medically necessary, or proper and necessary treatment.

But Ms. Joy argued that she retained the right to challenge the Department's decision not to provide a spinal cord stimulator under RCW 70.14.120(4), which provides: "Nothing in chapter 307, Laws of 2006 diminishes an individual's right under existing law to appeal an action or decision of a participating agency regarding a state purchased health care program. Appeals shall be governed by state and federal law applicable to participating agency decisions." The court disagreed with Ms. Joy's argument she could challenge the Department's denial of an SCS, holding "that RCW 70.14.120(3) controls over RCW 70.14.120(4), and Joy may not obtain relief on appeal from L&I's denial of coverage for treatment, when L&I's denial is based on the HTCC's determination of noncoverage for such treatment under all state health care plans."¹¹

In her Response, Ms. Skinner argues that *Joy* did not address the question of "whether such a non-appealable process is constitutional. It is not."¹² The court did not reach Ms. Joy's due process argument because it was raised too late. This Board has no authority to resolve constitutional issues.¹³ Ms. Skinner's constitutional arguments must await resolution by a tribunal authorized to address them. Based on the October 22, 2010 HTA and *Joy*, we have no alternative but to affirm the October 30, 2013 Department order.

FINDINGS OF FACT

*5 1. On March 25, 2014, an industrial appeals judge certified that the parties agreed to include the amended Jurisdictional History in the Board record solely for jurisdictional purposes.

2. Ladonia Skinner injured her back on January 19, 2011, during the course of her employment with the Seattle School District #1 when she and a co-worker were attempting to move a large C-shaped table top using a hand truck. Ms. Skinner bore the weight of the table and they could not move it with the hand truck. They positioned the table top on its side and pushed it down the hall.

3. As a proximate result of the industrial injury, Ms. Skinner suffered a lumbosacral strain. A February 26, 2011 MRI revealed multi-level degenerative disc disease, primarily at the L4/5 and L5/S1 levels. After conservative treatment was unsuccessful, Rod Oskouian, M.D., recommended surgery. On August 9, 2012, Ms. Skinner underwent a laminectomy and foraminotomy at L5-S1.

4. As of October 30, 2013, Ms. Skinner suffered from post-laminectomy syndrome or lumbar failed-back-surgery syndrome and chronic pain as a proximate result of the January 19, 2011 industrial injury.

5. On October 22, 2010, the Washington Health Care Authority adopted a Health Technology Assessment Finding (HTA) on spinal cord stimulators that prohibits the Department of Labor and Industries from authorizing the use of a spinal cord stimulator as treatment for an industrial injury.

6. Because the Department is not permitted to authorize a spinal cord stimulator as treatment for the January 19, 2011 industrial injury, Ms. Skinner's conditions proximately caused by the injury were fixed and stable as of October 30, 2013, and she was not entitled to further proper and necessary treatment.

CONCLUSIONS OF LAW

1. The Board of Industrial Insurance Appeals has jurisdiction over the parties and subject matter in this appeal.
2. The October 22, 2010 Health Technology Assessment Finding (HTA) on spinal cord stimulators adopted under RCW 70.14 and WAC 182-55 precludes the Department from authorizing a spinal cord stimulator as treatment for the January 19, 2011 industrial injury.
3. Ms. Skinner's conditions proximately caused by the industrial injury were fixed and stable as of October 30, 2013, and she was not entitled to further proper and necessary treatment under RCW 51.36.010, RCW 70.14, and WAC 182-55.
4. The October 30, 2013 Department order is correct and is affirmed.

Dated: June 12, 2015.

David E. Threedy
Chairperson
Frank E. Fennerty, Jr.
Member
Jack S. Eng
Member

Footnotes

- 1 *In re Susan Pleas*, BIIA Dec., 96 7931 (1998).
- 2 Proposed Decision and Order, at 11.
- 3 *In re Alejandra Silva*, Dckt. No. 08 13990 (August 4, 2009), citing *In re Arvid Anderson*, BIIA Dec., 65,170 (1986).
- 4 *In re Iva Labella*, BIIA Dec., 89 3586 (1991).
- 5 RCW 41.05.006(2)(b).
- 6 RCW 70.14.090.
- 7 n RCW 70.14.100; RCW 70.14.110; WAC 182-55-050; WAC 182-55-055; WAC 182-55-040.
- 8 RCW 70.14.110(1)(a).
- 9 WAC 182-55-035(1)(c).
- 10 RCW 70.14.080(4).
- 11 *Joy*, 170 Wn. App. at 627.
- 12 Response, at 8.
- 13 *In re James Gersema*, BIIA Dec., 01 20636 (2003).

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BURI FUNSTON MUMFORD, PLLC

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