MARK A. MAY, Employee/Appellant, v. CITY OF RICHFIELD, SELF-INSURED/BERKLEY RISK ADM'RS, Employer/Cross-Appellant.

WORKERS' COMPENSATION COURT OF APPEALS
JUNE 4, 2001

No. [REDACTED SSN]

HEADNOTES

APPEALS - SCOPE OF REVIEW; JURISDICTION - SUBJECT MATTER. Where the employee did not raise equitable estoppel as an issue at the compensation hearing or in his notice of appeal, the workers' compensation court of appeals was without authority to rule on the issue. Malinoski v. North Am. Cable Sys., slip op. (W.C.C.A. Dec. 14, 1989) (an issue raised for the first time on appeal is not properly before the court and will not be addressed); Minn. Stat.§ 176.421, subd.6 ("the workers' compensation court of appeals' review is limited to the issues raised by the parties in the notice of appeal or by a cross-appeal").

MEDICAL TREATMENT & EXPENSE - TREATMENT PARAMETERS. Where the employee's treating chiropractor acknowledged that he was aware of the prior notification requirements of the treatment parameters, that he did not provide notification, and that he made no attempt to do so, and where the employee's other treating physician's records clearly documented the employer's past efforts to accommodate the employee's work injury, the compensation judge did not err in denying payment of the chiropractic expenses at issue on grounds that the provider had not complied with notice provisions of the treatment parameters. A good faith effort to comply with the parameters is essential to their effectiveness, and parties affected by them must be able to rely upon consistent application of their requirements.

Affirmed.

Determined by Pederson, J., Rykken, J., and Johnson, J.
Compensation Judge: Joan G. Hallock

OPINION

WILLIAM R. PEDERSON, Judge

The employee appeals from the compensation judge's determination that the healthcare provider did not provide prior notification of a departure from the medical treatment parameters as required by Minnesota Rules 5221.6050, subpart 9, and from the judge's consequent denial of chiropractic treatment expenses. The self-insured employer cross-appeals on grounds that documentation in the medical record does not support a departure from the treatment parameters under Minnesota Rules 5221.6050, subpart 8D, as determined by the compensation judge. We affirm.

BACKGROUND

On January 25, 1996, Mark May sustained an admitted work-related injury to his low back when he slipped and fell while stepping out of a truck in the course of his employment with the City of Richfield's Parks and Recreation department. The City of Richfield [the employer] was self-insured against workers' compensation liability, with claims administered by Berkley Risk Administrators [Berkley]. Mr. May [the employee] later testified that he felt immediate stiffness and soreness in his low back at the time of the incident but was able to continue working without medical treatment.

About six months later, the employee visited his family doctor at HealthPartners. He received a diagnosis of low back sprain/strain and was advised to perform exercises at home and to take Tylenol as needed. Low back symptoms persisted, however, and on August 26, 1997, the employee sought chiropractic treatment with Dr. Timothy DeVries. Dr. DeVries diagnosed lumbar disc displacement and treated the employee with manual traction, spinal adjustments, and hot moist packs. Treatment was provided daily for the first week and then gradually decreased as the employee's symptoms decreased. On November 18, 1997, Dr. DeVries wrote that the employee reported almost 100 percent relief with treatment and that his symptoms were dependent on his activities of daily living. The doctor indicated that he believed at that time that treatment on a PRN basis was appropriate.

On December 4, 1997, Berkley notified Dr. DeVries that it intended to invoke the provisions of the medical treatment parameters, limiting use of passive treatment modalities in a clinical setting to twelve calendar weeks. Dr. DeVries was advised that payment would not be made for any additional passive treatment beyond December 4, 1997, except as provided by Minnesota Rules 5221.6200, subpart 3.B., which provides for an additional twelve visits for the use of passive treatment modalities over an additional twelve-month period under specified circumstances. Berkley evidently paid for an additional twelve visits in accordance with this rule, between December 5, 1997, and January 28, 1998. On February 4, 1998, the employee returned to Dr. DeVries with complaints of low back stiffness and soreness. Dr. DeVries provided ten additional treatments to the employee between February 4, 1998, and April 22, 1998. The doctor did not notify Berkley of his intent to provide additional treatment. On June 17, 1998, Berkley notified Dr. DeVries that treatment beyond February 4, 1998, was being denied under the medical treatment parameters.

On April 28, 1999, the employee was seen for evaluation by physical medicine specialist Dr. Paul Biewen. Dr. Biewen noted the employee's history of persistent low back pain following a slip and fall at work. The employee advised Dr. Biewen of his treatment with Dr. DeVries and that he felt the treatment was helpful in reducing his pain. The employee reported an increase in his pain at work over the past two or three months, perhaps associated with increased driving duties and related jarring. Dr. Biewen concluded that the employee's physical exam was indicative of right SI joint malpositioning and made a referral to physical therapy, both to address that problem and to advance a home exercise program. Dr. Biewen also stated that "treatment with chiropractic care may be indicated," commenting that, depending on how the employee responded to therapy, "[i]f he i[s] not improved and could benefit from a couple manipulative treatments, this may be reasonable."

The employee returned to Dr. Biewen on June 2, 1999, complaining of increased back pain, which he associated with jarring that he experienced while operating tractors and lawn mowers that had minimal suspension and no back support. Dr. Biewen noted that the employee's work activity was inhibiting his response to physical therapy and provided written restrictions limiting his use of the tractors and mowers. Additional therapy was recommended, along with home exercises and a lumbar support.

On July 20, 1999, Dr. Biewen ordered an MRI of the lumbar spine that was interpreted as showing very mild dehydration at L4-5 and L5-S1 and a small central disc protrusion at L4-5 without any neural compromise. On August 3, 1999, the employee advised Dr. Biewen that he had completed his physical therapy but that he still had pain on a daily basis. He indicated that it was helpful that his employer had not been assigning him to the more physically demanding tractors. Dr. Biewen concluded that the employee's symptoms and findings were most consistent with discogenic low back pain. He did not believe that this represented a surgical problem and opined that the employee "appears to be at MMI." Dr. Biewen released the employee to work without restrictions, but he also stated, "Hopefully he can work with his employer to avoid an excessive amount of pounding on the tractors."

On September 28, 1999, Dr. Biewen completed a Health Care Provider Report, on which he opined that the employee attained maximum medical improvement [MMI] on August 3, 1999, having sustained a 7% permanent partial disability of the whole body under Minnesota Rules 5223.0390, subpart 3C(1). On October 20, 1999, Berkley wrote to the employee to advise him of the permanency rating and how payment would be made. The employee later testified that, shortly after receiving this letter from Berkley, he contacted Berkley's claim representative to discuss his continuing symptoms and to make sure that medical treatment remained available. The employee testified that he was advised that treatment was available but "just don't go do anything weird like some kind of herbal . . . treatment."

About a month later, after setting up the ice rinks for the season and driving a blower used to clear snow from the rinks, the employee noted an increase in his lower back symptoms. On December 6, 1999, the employee returned to Dr. DeVries for the first of six treatments concluding December 23, 1999. At no time did Dr. DeVries notify Berkley of his intent to provide this additional treatment. On January 26, 2000, Berkley denied payment for the chiropractic treatment as being unauthorized under the treatment parameters.

On March 29, 2000, the employee filed a Medical Request, seeking payment of an unpaid balance at DeVries Chiropractic. An administrative conference was held on May 18, 2000, and on June 8, 2000, a compensation judge issued a decision under Minn. Stat. § 176.106, denying the employee's Medical Request. On June 14, 2000, the employee filed a Request for Formal Hearing.

On August 16, 2000, the employee's claim for chiropractic treatment expenses incurred between February 4, 1998, and December 23, 1999, came on for a hearing. The specific issues presented to the compensation judge were (1) whether the treatment in dispute was causally related to the January 25, 1996, low back injury and (2) whether that treatment was "consistent

with the treatment parameters or fit[] within a specific departure from the treatment parameters." Evidence presented at trial included testimony of the employee and Dr. DeVries, Dr. Biewen's medical records from Fairview Spine Care & Rehabilitation Clinic, and records of the treatment from DeVries Chiropractic.

In a Findings and Order issued September 13, 2000, the compensation judge determined that the employee's chiropractic treatment from February 4, 1998, to December 23, 1999, was causally related to his January 25, 1996, low back injury. She also determined that the employee received twelve weeks of chiropractic treatment plus an additional twelve visits prior to February 4, 1998. She concluded that the treatment in dispute was necessary to enable the employee to keep working, that the treatment was also medically necessary, and that a departure from the treatment parameters was necessary for the employee to obtain proper treatment. However, because Dr. DeVries did not provide prior notification to Berkley as required by the treatment parameters for a departure, the judge denied the employee's claim. The employee appeals and the employer cross-appeals.

STANDARD OF REVIEW

In reviewing cases on appeal, the Workers' Compensation Court of Appeals must determine whether "the findings of fact and order [are] clearly erroneous and unsupported by substantial evidence in view of the entire record as submitted." Minn. Stat. §176.421, subd. 1 (1992). Substantial evidence supports the findings if, in the context of the entire record, "they are supported by evidence that a reasonable mind might accept as adequate." Hengemuhle v. Long Prairie Jaycees, 358 N.W.2d 54, 59, 37 W.C.D. 235, 239 (Minn. 1984). Where evidence conflicts or more than one inference may reasonably be drawn from the evidence, the findings are to be affirmed. Id. at 60, 37 W.C.D. at 240. Similarly, "[f]actfindings are clearly erroneous only if the reviewing court on the entire evidence is left with a definite and firm conviction that a mistake has been committed." Northern States Power Co. v. Lyon Food Prods., Inc., 304 Minn. 196, 201, 229 N.W.2d 521, 524 (1975). Findings of fact should not be disturbed, even though the reviewing court might disagree with them, "unless they are clearly erroneous in the sense that they are manifestly contrary to the weight of the evidence or not reasonably supported by the evidence as a whole." Id.

"[A] decision which rests upon the application of a statute or rule to essentially undisputed facts generally involves a question of law which [the Workers' Compensation Court of Appeals] may consider de novo." Krovchuk v. Koch Oil Refinery, 48 W.C.D. 607, 608 (W.C.C.A. 1993).

DECISION

Equitable Estoppel

In his brief, the employee contends that, shortly after receiving Berkley's letter in October 1999 regarding his permanency award, he contacted the claim representative to discuss the need for future medical care. The employee testified that he understood from the conversation that he was authorized to return to the chiropractor for treatment. On appeal, the employee argues

that, as a matter of equity, the employer should be estopped from asserting the prior notification provisions of the treatment parameters as a defense against payment of reasonable and necessary medical treatment that was in fact authorized by the employer.

Estoppel is an equitable doctrine "intended to prevent a party from taking unconscionable advantage of his own wrong by asserting his strict legal rights." Northern Petrochemical Co. v. United States Fire Ins. Co., 277 N.W.2d 408 (Minn. 1979). Whether equitable estoppel is applicable depends on the facts of each case and is a question for the trier of fact. O'Donnell v. Continental Casualty Co., 263 Minn. 326, 331, 116 N.W.2d 680, 684 (1962). Because the employee did not raise equitable estoppel as an issue at the compensation hearing or in his notice of appeal, this court is without jurisdiction to rule on this issue. Minn. Stat. § 176.421, subd. 6 ("the workers' compensation court of appeals' review is limited to the issues raised by the parties in the notice of appeal or by a cross-appeal"); see also Bradford v. Bureau of Engraving, 459 N.W.2d 697, 698, 43 W.C.D. 279, 280 (Minn. 1990). Moreover, an appealing party's brief on appeal may address only issues raised in that party's notice of appeal. Minn. R. 9800.0900, subp. 1.

We have carefully reviewed the judgment roll and the transcript of the proceedings before the compensation judge and find no reference to an issue of equitable estoppel. In her Statement of Issues, contained within her Findings and Order, the compensation judge set forth the only two issues submitted to her for determination by the parties. The issue of equitable estoppel was not listed by the judge, nor did the judge issue any findings relative to this alleged issue. Because equitable estoppel requires a specific factual analysis not performed by or requested of the judge, and because this court may not consider matters not contained within the record before the judge, there is no basis for a review by this court. See also Malinoski v. North Am. Cable Sys., slip op. (W.C.C.A. Dec. 14, 1989) (an issue raised for the first time on appeal is not properly before the court and will not be addressed); Hartman v. 3M Co., slip op. (W.C.C.A. Sept. 8, 1992) (an issue raised for the first time in a party's appellate brief is beyond the scope of the Workers' Compensation Court of Appeals' review).

Medical Treatment Parameters

In Jacka v. Coca Cola Bottling Co., 580 N.W.2d 27, 58 W.C.D. 395 (Minn. 1998), the supreme court held that the medical treatment parameters are to be used by compensation judges as standards that establish the limits of compensable treatment. The court further held that the treatment parameters meet the requirements of the enabling statute, Minnesota Statutes § 176.83, and are validly promulgated administrative rules to be given the respect, force, and effect accorded other properly promulgated administrative rules. The court also explained that the "rules are substantial enough to establish standards and procedures based on good medical practice that can be used to regulate provider abuses and reduce litigation over compensable treatment." Jacka, 580 N.W.2d at 36, 58 W.C.D. at 410.

Minnesota Rules 5221.6200, subpart 3, places limits on the duration of passive treatment modalities by providing that use of such modalities is generally not indicated beyond twelve calendar weeks after any of the care is initiated. Under certain conditions, an additional twelve visits over an additional twelve months may be provided. Minn. R. 5221.6200, subp. 3B(1).

It is undisputed that the employee's chiropractic care after January 1998 exceeded the durational limits on passive care, including the additional twelve visits beyond the initial twelve weeks. The issue presented to the compensation judge was whether the disputed treatment between February 4, 1998, and December 23, 1999, qualified for a departure under Minnesota Rules 5221.6050, subpart 8.

Minnesota Rules 5221.6050, subpart 8, provides, in part, that "[a] departure from a parameter that limits the duration or type of treatment . . . may be appropriate" based on evidence of progressive improvement in the employee's subjective complaints, objective clinical findings, and functional status. Id., subp. 8D. In her Findings and Order, the compensation judge essentially determined that, based on documentation in the medical record and the testimony of the employee and Dr. DeVries, the employee had established grounds for a departure under subpart 8D.[1] But the judge denied payment for the treatment because Dr. DeVries did not provide prior notification to Berkley of the treatment rendered.[2]

Minnesota Rules 5221.6050, subpart 8, specifies that "[t]he health care provider must provide prior notification of the departure as required by subpart 9" (emphasis added). Minnesota Rules 5221.6050, subpart 9, provides that "[p]rior notification is the responsibility of the health care provider who wants to provide the treatment" listed in that subpart, including "treatment that departs from a parameter limiting the duration or type of treatment . . . ." Id., subp. 9A(4).

The employee argues that the judge's rigid application of the parameters effectively precludes, on a technicality, treatment that the judge herself found to be reasonable and necessary to assist the employee to continue working. As a matter of equity, he contends, there should be exceptions to the technicalities set forth in the treatment parameters. We are not persuaded.

At trial, Dr. DeVries acknowledged that he did not provide prior notification to Berkley of a proposed departure from the parameters in either February of 1998 or December of 1999. He testified:

> I know that prior notification is in the treatment parameters. I will say that this practitioner has been frustrated with the Work Comp system, and I'm going to be just quite frank -- well, why haven't I done this prior notification -- because a lot of paperwork with managed care system -- I can't do this on every case and I've had

[1] The judge's findings, although containing no reference to subpart 8D, are arguably directed toward improvement in the employee's subjective complaints, objective clinical findings, and functional status. Clearly, the employee did not claim an "incapacitating exacerbation" under subpart 8E.

[2] The employee did not claim that prior notification was unnecessary because emergency treatment was required under Minnesota Rules 5221.6050, subpart 9, nor because this was a "rare case" exception under Asti v. Northwest Airlines, 588 N.W.2d 737, 59 W.C.D. 59 (Minn. 1999).

> not -- not any success with doing written prior notifications with any insurer, and that's my experience.

At the heart of Dr. DeVries' testimony, and the employee's appeal, is the reasonable question of whether the prior notification provisions of the parameters are essentially a meaningless exercise. In other words, if the insurer denies authorization for a departure after receiving prior notification and the employee subsequently files a medical request to determine compensability, are the parties in any different position than they would be had the healthcare provider not provided prior notification before the employee filed the medical request? The compensability issues presented to a compensation judge for review are ultimately the same under either scenario. Therefore, in the instant case, should treatment otherwise determined to be appropriate by the compensation judge be denied based on a technicality?

This court previously considered the prior notification requirements of the treatment parameters in Olson v. Allina Health Sys., 59 W.C.D. 37 (W.C.C.A. 1999). The court held that the notification requirement is not a mere technicality that may be ignored, reasoning as follows:

> The apparent intent of the notification rules . . . is to avoid unnecessary disputes by requiring a certain level of communication, between a healthcare service provider and an insurer, concerning proposed care that is beyond that care ordinarily deemed reasonable and necessary under the treatment standards established by the parameters. Notification sets in motion a process intended to allow the insurer to reasonably evaluate proposed treatment and to request additional information, if necessary, without causing undue delay in the provision of services to an injured worker. The insurer, too, has various responsibiltiies under the notification rules; for example, an insurer that fails to respond to provider notification in a timely manner may not later refuse to pay for the treatment covered by the notification. Minn. R. 5221.6050, subp. 9C(1). Other safeguards exist to insure that payment for proposed treatment is not denied arbitrarily by nonmedical personnel. Id., subp. 9C (an insurer's review of its denial of authorization for proposed treatment must be made by a currently licensed healthcare provider). We would also observe that the notification requirement of the rules places only a minimal burden on a provider who wishes to provide additional treatment. What is required here is only notification and the provision of pertinent information; under most circumstances, the provider need not obtain the insurer's prior approval.

Olson, at 46-47. See also Stillson v. Holiday Co., slip op. (W.C.C.A. Aug. 11, 2000) (an insurer that fails to comply with Minnesota Rules 5221.6050, subpart 9C(3), requiring a review, on request, of a denial of treatment authorization, may not use the limits set by the treatment parameters as a defense against a claim for treatment).

Dr. DeVries acknowledged that he was aware of the prior notification requirements of the treatment parameters, that he did not provide notification, and that he made no attempt to do so. Dr. Biewen's records clearly document the employee's varying symptoms related to activity and the employer's efforts to accommodate those symptoms with less physically demanding duties. Had Dr. DeVries notified Berkley of proposed treatment, authorization may have been granted for additional treatment. In such a case, the employer would have had an opportunity to evaluate beforehand the proposed treatment and its costs and reduce the likelihood of litigation. Even if authorization had been denied, the chiropractor could have requested that the employer review its denial or, instead of requesting a review, filed a medical request. Under any circumstance, however, a good faith effort to comply with the parameters is essential to their effectiveness. Those affected by the treatment parameters must be able to rely upon consistent application of their requirements. The rules were designed to promote uniformity and certainty as to the compensability of treatment. Under the facts presented here, we affirm the judge's denial of the chiropractic treatment expenses at issue.

Because we have affirmed the judge's denial of the expenses at issue, we need not address the issues raised by the employer's cross appeal.