Case Study

A Brave New World: ORS 742.538
Prerequisites Apply to Health Insurers
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Claims Pointer: Subrogation under ORS 742.538 is only available to a health insurer if subrogation recovery through inter-insurer reimbursement under ORS 742.534 or lien under ORS 742.536 is not available. Further, any provision in a health insurance policy that requires the insured must reimburse the health insurer is void.

Health insurers, like PIP providers, often seek subrogation reimbursement. In Providence Health Plan v. Winchester, the court required health insurers to satisfy the prerequisites of ORS 742.538 to obtain subrogation reimbursement, regardless of policy language. Providence Health Plan v. Winchester, in the Court of Appeals of the State of Oregon, A142272, --- P3d ---- (September 12, 2012). The net effect of this case is unclear – but in the short term, liability insurers should be aware that health insurers may have forfeited any right to reimbursement unless they made a timely and proper demand for inter-insurer reimbursement.

Lindsey Winchester was walking down a street when she was stuck by a motor vehicle. She suffered extensive injuries to her head and leg, incurred $116,219.73 in medical expenses, and sustained $422,000 in other economic damages. Lindsey subscribed to Providence Health Plan. Under its policy with Lindsey, Providence paid $86,417.25 in medical expenses on her behalf. The driver who struck Lindsey had a liability insurance policy with State Farm that provided $25,000 liability coverage. Lindsey also had a policy with State Farm with limits of $15,000 in PIP and $100,000 in UIM coverage. In December of 2006, Providence notified Lindsey in writing that under the “Third Party Liability/Subrogation” policy provision Lindsey should hold recovery from State Farm in trust for Providence. In 2008, Lindsey reached a settlement with State Farm for the policy limits of both the driver's and her UIM policy.

Providence filed for a judgment declaring that Lindsey was obligated under her health insurance policy to repay it. Lindsey counterclaimed seeking a declaration that ORS 742.538 controlled Providence’s reimbursement rights and Providence was not entitled to recover under its policy. Both parties filed cross-motions for summary judgment with the trial court and Providence’s was granted while Lindsey’s was denied.

Lindsey appealed arguing that ORS 742.534, ORS 742.536 and ORS 742.538 provided methods for Providence to seek reimbursement and that those statutory provisions trumped any inconsistent language found in Providence’s policy. Regarding ORS 742.538, Lindsey contended Providence had not met two of the statute’s prerequisites to reimbursement, namely that Providence had failed to pursue inter-insurer reimbursement through ORS 742.534. Providence argued that it could require reimbursement from Lindsey because its policy provided a remedy in addition to the one provided in ORS 742.538 and that it had met the statutory prerequisites.

The Oregon Court of Appeals concluded that ORS 742.538 superseded any contrary insurance policy provisions under which Providence sought reimbursement. The Court agreed with Lindsey that Providence failed to satisfy at least one prerequisite to recovery under ORS 742.538: that the inter-insurer reimbursement benefit of ORS 742.534 be unavailable. The Court found that when Providence asserted its right to subrogation, nearly two years prior to Lindsey settling her claim with State Farm, inter-insurer reimbursement was still available to it. Thus, the Court held, Providence did not properly assert its subrogation rights and was not entitled to reimbursement.

— Full case available at: www.publications.ojd.state.or.us/Publications/A142272.pdf

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This article is to inform our clients and others about legal matters of current interest. It is not intended as legal advice. Readers should not act upon the information without seeking professional counsel.
There is a maxim, “Do not believe in everything you read”, which certainly holds true for orthopedics. As patients’ charts multiply exponentially with prolonged care and a multitude of diagnostic studies, it is easy to believe what is written in the chart. Some radiologists opine about traumatic rotator cuff tears in the face of minimal fender-bender motor vehicle accidents or some orthopedists remark about traumatic meniscal tears from a moderate direct knee impact into the dashboard. Sometimes it is a spine surgeon or physiatrist relating a disk bulge or an annular tear to the trauma of a slip and fall. Beware! Although these examples of inaccuracies are but a few of many which exist, they are particularly noteworthy for their frequency and their repercussions. Words have strength and the term tear is a powerful catch word, which requires education of injured patients to do away with false assumptions.

**Rotator Cuff Tears:**
**Injury or Degenerative Process?**
The rotator cuff tear is a tear of the power assembly of the shoulder. The scapula is attached to the rotator cuff muscles, which in turn meld to form a sheath-like tendon (the rotator cuff). This in turn attaches to the proximal humerus. Suffer a rotator cuff tear and one loses the potential to fully guide the shoulder through its full arch of motion with normal muscle strength. The rotator cuff tear is typically in the supraspinatus tendinous portion, which is the most superior aspect of the rotator cuff. It is not a coincidence that this happens; often the rotator cuff tear is secondary to a degenerative bone spur at the end of undersurface of the acromion or the distal clavicle inexorably rubbing at the tendon and progressively fraying it. On other occasions, with middle-aged patients, there is an intrinsic degeneration within the substance of the tendon predisposing the tendon to a complete tear without the need of trauma. In reality, the rotator cuff tear is really a “wear and tear” phenomenon and not a rip and tear circumstance. Think of the analogy of someone wearing a pair of jeans. Jeans can be suddenly torn while playing tackle football, but they will inevitably rip as well if they are worn daily for a prolonged period of time. The word tear conjures up images of trauma and injury when in reality time is usually the only etiology of rotator cuff tears. Nevertheless, if one dislocates a shoulder or suffers a proximal humeral fracture including an attachment point for the rotator cuff such as the greater tuberosity, a rotator cuff tear may very well be part of the injury pattern. This is the exception and not the rule. Furthermore, there is sometimes a disconnect between a layman’s perception and the reality regarding shoulder pathology. Many of you who are weekend warriors, fighting the aging process, may have had MRIs of the shoulder secondary to a chronic nagging pain. Often, the MRI comes back revealing a partial thickness rotator cuff tear. The natural response is to ask, “How did I injure it?” in light of not recalling any trauma. The partial thickness rotator cuff tear is part of the language orthopedists and radiologists use to communicate a thinning of the rotator cuff, literally a loss of thickness of this tendon. This is due to gradual attrition and degeneration and not as a result of an injury. Nevertheless, there are countless patients undergoing innumerable shoulder arthroscopies and subacromial decompressions with debridement of the rotator cuff who are deemed accident victims when in reality, they are only victims of a natural history of a wearing process of the shoulder.

**Meniscal Tears:** Slow Twist or Trauma?!
The meniscal tear of the knee suffers a similar fate. The meniscus is a cushion between the articular surface of the femur and the tibia. It lubricates the knee as it serves as a shock absorber. Furthermore, it provides added stability in the knee assisting the prime stabilizing function of the knee ligaments. There is a very specific mechanism for traumatic meniscal tears other than in the face of overwhelming bony trauma. A moderate direct blow to the anterior knee without a twisting component is not going to lead to a meniscus tear, although a major hematoma may still ensue. The twisting component is critical. The meniscal architecture is clearly visible in an MRI as well as intraoperatively. All too often, the MRI radiologist or the orthopedic surgeon neglects to appropriately characterize the architecture of the tear. In reality, not all meniscal tears are
created equal. There are degenerative, longstanding, horizontal cleavage tears, which when seen en face look like a fish mouth with its lips separated. Other times, there is a bucket-handle tear or a vertical tear as a result of a traumatic event to the knee.

There is typically no surprise at the time of surgery as to the nature of the meniscus tear as the MRI is typically sufficient to characterize the nature of the torn meniscus. Although treatment for these varied meniscal tears may be comparable, a false association between an accident and a meniscal tear can lead to disastrous and expensive repercussions. The menisci guard against wear of the articular surface. Thus, when a partial meniscectomy is performed, there is a loss of part of this cushioning mechanism. As a result, there is more wear on the cartilage caps of the involved bones. Over time, this can lead to further potential meniscectomies or even a total knee replacement if the articular surfaces are irreparably damaged. Deciding accurately as to the true etiology of a meniscal tear in the beginning of an injury history is critical and could avoid wrongly attributing the need for a total knee replacement to a traumatic event instead of a natural, degenerative process.

**Disk Herniations: The Degenerative Process**

The neck is particularly predisposed to trauma from sudden flexion and extension. Nevertheless, herniated disks are not automatically traumatically induced and a fair number of asymptomatic individuals go through life with one or more unrecognized herniated disks. The clinical situation is critical to assisting in determining the likelihood of a herniated disk etiology. The remainder of disk pathology is more simply characterized. Disk bulges are a presentation of degenerative disk disease and are not traumatically induced. Similarly, disk annular tears are not likely to be traumatically induced either. Instead, they are more likely to be a snapshot in time of a degenerative herniated disk, which after sufficient protrusion, ruptures the outer lining (annulus) of the disk. Lastly, many MRIs of the neck describe disk/osteophyte complexes and there is frequent talk of the herniated disk component of this complex being demonstrative of a traumatic event. By putting on blinders, one gains the luxury of ignoring the total true picture. A disk/osteophyte complex is always a very slow growing situation whereby a bone spur grows along the outer border of a disk herniation with its origin being the adjacent vertebral bodies.

This complex is akin to the majestic stalactites and stalagmites in a cave; they both require an extraordinary length of time to develop and neither is secondary to a recent origin no matter how severe the accident may be.

Once one gains knowledge of the diagnosed musculoskeletal pathology following an injury, then one can justifiably attribute a true etiology to that pathology. Both patients and the medical-legal system are better served with the truth. Injured parties gain a more realistic estimate of their injuries, and thus, expectations can potentially become more appropriate. As often is the case, teaching one’s patient is the key towards a fair assessment of one’s injuries. ✤