



# News & Case Notes

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**BOARD NEWS**

## CDAs: “Full” Release of “Agg Rights,” “Own Motion Relief,” “Penalties/Fees” - No Effect on “Medical Service-Related” Benefits

The Board has been receiving proposed Claim Disposition Agreements (CDAs), which indicate (in the ‘summary page’ and/or in the text of the agreement) that “aggravation rights,” “own motion relief,” “penalties/attorney fees” and/or “new/omitted medical condition claims” have been *fully* released. These dispositions initially received Board approval by means of an order, which clarified that a CDA cannot release any “medical service-related” benefits for an “aggravation,” “worsening,” or “new/omitted medical condition” claim. See *Merritt Hopson*, 67 Van Natta 1426 (August 6, 2015); *Chandra Lee-Bloomer*, 67 Van Natta 1218 (July 7, 2015). As such, the Board interpreted the CDA as confirming that the claimant’s future claims were limited to “medical services-related” benefits.

The Board recognizes that several carriers and their counsels submit CDAs, which include provisions (in the “summary page” and/or in the text of the CDA) that contain “full” releases of claims for aggravation or new/omitted medical conditions, as well as Own Motion relief such as those described above. (Some CDAs also include provisions describing “full” releases of “penalties/attorney fees,” which would conflict with the rationale expressed in the *Watkins* decision. See *Liberty Northwest Ins. Corp., Inc. v. Watkins*, 347 Or 687 (2010); *David S. Sheerin*, 67 Van Natta 1489 (2015).) Thus, those parties/practitioners are encouraged to immediately revise any proposed CDA provision that expressly addresses the release of future “aggravation rights,” “new/omitted medical condition claims,” “own motion relief” rights, and penalties/attorney fees (whether in the “summary page” or in the text of the CDA) to clarify that such a release is “partial” because the claimant remains entitled to any “medical service-related” benefits related to such rights.

Effective September 1, 2015, the Board no longer approves proposed CDAs containing any of these aforementioned provisions. Instead, the Board issues a letter, which will seek an amendment of the agreement to confirm the claimant’s retention of “medical service-related” benefits for such rights. Because this “addendum” process will delay the review of the proposed dispositions, parties/practitioners should revise their agreements in advance of September 1.

Finally, to further assist parties/practitioners in modifying their CDAs, a sample form has been posted on WCB’s website.

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*Board obligated to review record to determine appropriate legal standard to evaluate compensability.*

*Because persuasive opinion was consistent with "occupational disease" theory of compensability, "injury" denial for same condition upheld.*

## CASE NOTES

## Claim Processing: Injury/O.D. Claim for Same Condition - Apply Appropriate "Compensability" Standard

*Jeffery L. Miller*, 67 Van Natta 1497 (August 14, 2015). In analyzing the compensability of claimant's shoulder condition, the Board held that it was obligated to determine the appropriate legal standard (injury or occupational disease) to evaluate the compensability of the denied claim. Claimant initiated both an injury and occupational disease claim for his right shoulder condition. After an ALJ found that his condition was compensable under both theories and set aside both of the carrier's denials, the carrier requested review, contending that it should be held responsible for only one claim for the same condition.

The Board agreed. Citing *Dibrito v. SAIF*, 319 Or 244, 248 (1994), and *Jeffrey F. Durant*, 65 Van Natta 1182 (2013), the Board reiterated its obligation as fact finder to review the medical evidence and record to determine the appropriate legal standard to evaluate the compensability of a claim. Relying on ORS 656.802(1)(a)(C), the Board stated that an occupational disease includes "any series of traumatic events or occurrences which requires medical services or results in physical disability or death. Furthermore, referring to *Hunter v. SAIF*, 246 Or App 755, 760 (2011), the Board noted that work injuries may be considered among "employment conditions" for purposes of evaluating the major contributing cause of an occupational disease.

Turning to the case at hand, the Board observed that a physician had opined that claimant had sustained an acute injury superimposed on his occupational disease, which consisted of rotator cuff tears due to overuse from performing his apartment maintenance work activities. Finding that persuasive opinion consistent with an "occupational disease" theory of compensability (rather than an "injury" theory), the Board set aside the "occupational disease" denial, but upheld the "injury" denial for the same condition. See *Randy W. Collins*, 55 Van Natta 641, 645 n 3 (2003) (upholding aggravation denial when record established a compensable occupational disease); *Troy A. Edmonds*, 50 Van Natta 1093, 1094 (1998) (upholding injury denial when record established compensable occupational disease).

## Combined Condition: "Ceases" Denial - "262(6)(c)" - Not Precluded By Prior Litigation Order Regarding "Initial" Claim - "Combined Condition" Analysis Was "Alternative" Reasoning

*Donelle Applegate*, 67 Van Natta 1537 (August 21, 2015). Applying ORS 656.262(6)(c), in upholding a carrier's "ceases" denial of a claimant's combined low back condition, the Board held that an alternative finding in a

prior litigation order regarding the initial injury claim (*i.e.*, that the carrier would not have successfully met its burden of proving under ORS 656.266(2)(a) that the otherwise compensable injury was not the major contributing cause of the disability/need for treatment for a combined condition) did not preclude the carrier from subsequently issuing its “ceases” denial of the subsequently accepted combined condition. In a prior litigation order (which had set aside the carrier’s denial of claimant’s low back injury claim), the Board had reasoned that, even if a combined condition existed, the carrier had not carried its burden, under ORS 656.266(2)(a) to prove that the work injury was not the major contributing cause of claimant’s disability/need for treatment. After the carrier accepted a low back strain, it eventually also accepted a combined lumbar spondylosis condition (effective as of the date of claimant’s injury) and denied the combined condition (effective as of the date of its denial). After an ALJ upheld the carrier’s denial, claimant requested Board review, contending that the carrier’s “combined condition” acceptance was contrary to the “law of the case” and was barred by the principles of issue preclusion.

The Board rejected claimant’s contention. To begin, noting that claimant had not raised a “procedural” challenge to the carrier’s denial at the hearing level, the Board declined to consider the issue for the first time on review. *Richard G. Boyce*, 63 Van Natta 2024, 2027 (2011).

In any event, the Board noted that its initial order decided only the compensability of claimant’s injury claim, not the scope of the carrier’s subsequent acceptance or other subsequent claim processing matters. Moreover, the Board observed that its prior order expressly considered the possible existence of a combined condition by means of reasoning that it was alternative in nature.

Under such circumstances, the Board concluded that the carrier was not precluded from issuing its “ceases” denial of claimant’s combined condition. Turning to the merits of the denied claim, the Board found that a physician’s opinion persuasively established a change in claimant’s condition between the effective date of the “combined condition” acceptance (the injury date) and the effective date of the denial (the issuance of the denial). *See Oregon Drywall Sys. v. Bacon*, 208 Or App 205, 210 (2006). Further persuaded by that physician’s opinion that the undisputed preexisting arthritic condition had become the major contributing cause of claimant’s disability/need for treatment by the effective date of the carrier’s denial, the Board determined that the combined condition was no longer compensable.

*Because initial litigation order decided only compensability of injury claim (not scope of acceptance/subsequent claim processing), carrier not precluded from issuing “ceases” denial.*

## Consequential Condition: Treatment for Compensable Back Condition Not Major Cause of Claimed Abdomen Condition - *Hames Applied, Robinson Distinguished*

*Jane E. Birdsong*, 67 Van Natta 1429 (August 6, 2015). Applying ORS 656.005(7)(a)(A), the Board held that claimant’s new/omitted medical condition claim for an abdomen condition was not compensable because the medical

treatment for her compensable low back condition was not the major contributing cause of the claimed abdomen condition. After undergoing physical therapy for her accepted lumbar strain, claimant experienced abdomen complaints, which prompted her file a claim for her abdomen condition. The carrier denied the claim, contending that the compensable medical treatment was not the major contributing cause of claimant's abdomen condition. Claimant requested a hearing, asserting that she need only establish that the medical treatment was a material contributing cause of her abdomen condition.

The Board disagreed with claimant's assertion. Citing *Barrett Business Services v. Hames*, 130 Or App 190, rev den, 320 Or 492 (1994), the Board stated that when reasonable and necessary medical treatment of a compensable injury is the major contributing cause of the new injury, the compensable injury itself is deemed the major contributing cause of the consequential condition under ORS 656.005(7)(a)(A). Referring to *Robinson v. Nabisco, Inc.*, 331 Or 178 (2000), the Board noted that, when a claimant's injury was sustained during a carrier-arranged medical examination for a compensable injury, the court analyzed whether the "examination" injury arose out of and in the course of employment without applying the "major contributing cause" standard of ORS 656.005(7)(a)(A).

Turning to the case at hand, the Board reasoned that, unlike *Robinson*, claimant was not contending that her "physical therapy" injury was a compensable injury. Instead, the Board determined that claimant was contending that the prescribed medical treatment associated with her accepted lumbar strain had caused her claimed abdomen condition.

Under such circumstances, consistent with the *Hames* rationale, the Board concluded that the "consequential condition" analysis under ORS 656.005(7)(a)(A) applied. Because the medical evidence did not persuasively establish that the physical therapy was the major contributing cause of claimant's abdomen condition, the Board upheld the carrier's denial.

*Because claimant contended that prescribed medical treatment for accepted lumbar condition had caused claimed abdomen condition, "consequential condition" analysis of "005(7)(a)(A)" applied.*

## Course & Scope: "On Call" Nurse - Fall in Walkway at Home - Returning From Work Assignment - Intending to Send "Notes" to Employer's Computer - Arose Out Of/Within Course Of" Employment

*Cami Bean*, 67 Van Natta 1391 (August 4, 2015). The Board held that claimant's ankle injury, which occurred when she fell in the walkway of her home while returning from her work assignment as an "on call" nurse, arose out of and in the course of her employment because she was authorized to work from home and intended to send her computer notes to her employer's server when she returned home (which was consistent with the employer's expectations). After returning from her "on call" assignment with a patient, claimant parked her car in her driveway and was walking on her private walkway (carrying her computer), with the intention of immediately "sync[ing]" her notes to the employer's server

when she got into her house. Before she could do so, claimant tripped and fell on the walkway, injuring her ankle. Claimant did not recall tripping on any hazard. Asserting that claimant was not performing any work duties when she was injured and contending that her fall did not result from a risk inherent in her work environment or connected to her work activity, the carrier denied her injury claim.

The Board set aside the carrier's denial. Citing *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366 (1994), the Board stated that whether an injury arose out of employment concerns the causal relationship between the injury and employment, and whether the injury occurred in the course of employment concerns the time, place, and circumstances of the injury. Relying on *U.S. Bank v. Pohrman*, 272 Or App 31, 44 (2015), the Board noted that the "going and coming" rule is not implicated when a worker has not left work, such as when a worker is still "on duty" or otherwise "subject to the employer's direction or control." Referring to *Halsey Shedd RFPD v. Leopard*, 180 Or App 332, 338 (2002), the Board observed that a worker's "on call" status, particularly when combined with other employment-related circumstances, may satisfy the requirement that an injury occur "in the course of" employment.

Turning to the case at hand, the Board found that claimant was walking where and when she was injured because had answered a work-related call from a patient. In addition, the Board determined that she was proceeding to "sync" her notes to her employer's server (when she arrived at her house), which was a task required by her employment. Under such circumstances, the Board concluded that claimant was not only "on duty" when she was injured, but was otherwise "subject to the employer's direction or control."

Addressing the "arising out of" employment prong, the Board acknowledged that claimant's injury had occurred on her private driveway/walkway. Nonetheless, reasoning that she was returning from a work assignment with the intention of uploading her notes to the employer's system (so that other nurses would have access to such information), the Board determined that her injury resulted from a risk to which she was exposed by her work environment. See *Sandberg v. JC Penney Co., Inc.*, 243 Or App 342 (2011).

Member Curey dissented. Reasoning that claimant's fall resulted from simply tripping as she walked on her own premises (and noting that she was not required to immediately "sync" her notes), Curey asserted that there was no "employment" risk to her injury because her job did not require her to do anything at the time of her injury and her personal sidewalk was not part of her work environment. Furthermore, Member Curey rejected claimant's reliance on the "traveling employee" doctrine, determining that, once she had parked her car in her private driveway and left the vehicle, her travel had concluded.

*Because "on-call" nurse was returning home from a work assignment intending to upload her notes to the employer's system (so that other nurses had access to the information), her injury from a fall in her driveway arose out of and in the course of her employment.*

*Dissent argued that there was no "employment" risk to claimant's injury because her job did not require her to do anything at the time of her injury and her personal sidewalk was not part of her work environment.*

## Extent: Impairment Findings - “Apportionment” Rule (“035-0013”) “Grip Strength” Findings - Accepted Finger/Hand Conditions and “Denied” & Post-Closure” Accepted Shoulder Conditions

*Marisela Johnson*, 67 Van Natta 1458 (August 12, 2015). The Board held that in evaluating claimant’s permanent impairment for an accepted hand condition, the “apportionment” rule (OAR 436-035-0013) was applicable because a portion of her impairment was attributable to a shoulder condition (which was either in denied status at the time of the reconsideration proceeding or had been accepted after claim closure). Following closure of claimant’s accepted left fingers claim (which did not award permanent impairment), the carrier accepted left shoulder/trapezius strains, but denied a rotator cuff tear, as well as forearm/elbow/upper arm strains. After claimant requested reconsideration of the Notice of Closure, a medical arbiter related range of motion findings concerning her left fingers to her accepted finger conditions and attributed 50 percent of her grip strength loss to her accepted finger/hand condition and 50 percent to her shoulder condition. When the reconsideration order awarded permanent impairment (but apportioned 50 percent of claimant’s grip strength findings to her finger/hand condition), claimant requested a hearing, contending that she was entitled to the entire grip strength loss because her shoulder condition did not constitute a legally cognizable “preexisting condition.” *Schleiss v. SAIF*, 354 Or 637 (2013).

The Board disagreed with claimant’s contention. Relying on ORS 656.268(15), the Board stated that conditions that are a direct medical sequela to the original accepted conditions shall be included in rating permanent disability of the claim unless they have been denied. Citing *Schleiss*, the Board stated that, when a portion of claimant’s impairment findings were related to non-legally cognizable “preexisting conditions,” the application of the “apportionment” rule would not be appropriate. Nonetheless, referring to ORS 656.268(15), and *Jonathan E. Ayers*, 56 Van Natta 1103, *recons*, 56 Van Natta 1470, 1472 (2004), the Board noted that, when a condition is in denied status during the reconsideration process, it is not appropriate to rate impairment due to that condition. Finally, based on ORS 656.262(7)(c) and *Ayers*, the Board observed that, if a condition is found compensable after claim closure, the claim must be reopened and reclosed, at which time the previously raised condition will be rated.

Turning to the case at hand, the Board found that the left shoulder/trapezius strains had been accepted *after* claim closure. In addition, the Board noted that claimant’s other left shoulder conditions were in denied status during the reconsideration proceeding. Under such circumstances, the Board concluded that the reconsideration proceeding was limited to the accepted finger/hand conditions and that any impairment attributable to the subsequent accepted shoulder conditions (or denied shoulder conditions, if subsequently found compensable) would be rated in a separate claim closure proceeding.

*Because reconsideration proceeding was limited to the accepted finger/ hand conditions, any impairment attributable to the “post-closure” accepted shoulder conditions and denied conditions were not ratable and subject to the “apportionment” rule.*

Likewise, the Board determined that apportionment of claimant's "grip strength" impairment between her accepted finger/hand condition and her left shoulder condition was appropriate. See OAR 436-035-0013; OAR 436-035-0007(1); *Talbot D. Christensen*, 64 Van Natta 1247, 1249 (2012); *Jonathan E. Ayers*, 56 Van Natta 1103, *recons*, 56 Van Natta 1470 (2004).

In reaching its conclusion, the Board distinguished *Leonard L. Seeger*, 67 Van Natta 263 (2015), where application of the "apportionment" rule was not considered appropriate when 50 percent of the claimant's impairment findings had been attributed to a legally cognizable condition and two non-legally cognizable conditions. The Board noted that the *Seeger* holding was based on the proposition that, in the absence of ratable impairment findings that apportioned only legally cognizable "preexisting conditions," application of the "apportionment" rule was not appropriate.

In contrast to *Seeger* (where it was unable to discern "apportionable" impairment from "unapportionable" impairment) the Board reasoned that the arbiter's impairment findings in the present case had expressly apportioned claimant's "grip strength" impairment between her accepted finger/hand condition (which was ratable) and her "post-closure" accepted/denied shoulder conditions (which were not ratable). Consequently, the Board determined that claimant's "grip strength" impairment findings were subject to the "apportionment" rule.

## Extent: Impairment Findings - No Findings Due to Accepted Conditions - "Apportionment" Rule ("035-0013") Not Applicable

*Eugene Walters*, 67 Van Natta 1439 (August 10, 2015). In rating the extent of claimant's permanent impairment for accepted cervical/lumbar strains, the Board held that the "apportionment" rule (OAR 436-035-0013) did not apply because, even though the impairment findings attributed his permanent impairment to a "non-legally cognizable condition," those findings did not relate any of claimant's permanent impairment to his accepted conditions. During a reconsideration proceeding regarding the closure of claimant's accepted cervical/lumbar sprain claim, a medical arbiter attributed his reduced range of motion (ROM) findings "entirely" to a preexisting arthritic condition. When the Order on Reconsideration did not award permanent impairment for his cervical and low back conditions, claimant requested a hearing, contending that the record did not establish that the so-called "arthritis" was an inflammation of the joints and, as such, was not a legally cognizable "preexisting condition." Consequently, claimant argued that the arbiter's "ROM" findings should be attributed to his compensable conditions.

The Board disagreed with claimant's contention. Citing ORS 656.268(15), the Board stated that a worker is entitled to an impairment value for permanent impairment caused by the accepted condition and direct medical sequela. Relying on OAR 436-035-0007(1), the Board noted that unrelated or

*Because impairment findings did not attribute any impairment to claimant's accepted conditions, a permanent impairment award was not warranted, even in the absence of a statutorily qualified "preexisting condition."*

noncompensable impairment findings are excluded and not valued under the Director's permanent disability standards. Referring to *Paula Magana-Marquez*, 66 Van Natta 1300, 1302 (2014), the Board reiterated that, if impairment is entirely due to causes that are not related to the compensable injury, a permanent impairment award is not appropriate. Finally, based on *Stuart C. Yekel*, 67 Van Natta 1279 (2015), the Board observed that the "compensability" rationale expressed in *Brown v. SAIF*, 262 Or App 640 (2014) (which provides that a "work-related injury incident" constitutes an "otherwise compensable injury") does not extend to the rating of permanent disability.

Turning to the case at hand, the Board acknowledged that the record did not establish the existence of a statutorily qualified "preexisting condition." See *Staffing Services, Inc. v. Kalaveres*, 241 Or App 130, 137-38, *rev den*, 350 Or 423 (2011). Nevertheless, reasoning that neither the medical arbiter's findings nor those from claimant's attending physician had attributed any cervical or lumbar impairment to his accepted conditions, the Board concluded that a permanent impairment award was not warranted.

In reaching its conclusion, the Board disagreed with claimant's argument that the *Schleiss v. SAIF*, 354 Or 637 (2013) holding meant that all permanent disability must be rated unless there was a combined condition. Citing *Claudia S. Stryker*, 67 Van Natta 1003, 1005 (2015), the Board reiterated that permanent impairment may be apportioned between the accepted condition and any unclaimed/unaccepted legally cognizable "preexisting condition." In any event, in contrast to *Schleiss* (where the record established impairment due to the compensable injury, as well as related to a non-legally cognizable "preexisting condition"), the Board reasoned that none of claimant's permanent impairment was attributable to his compensable injury. In the absence of such impairment findings, the Board determined that a permanent disability award was not justified.

Finally, regarding claimant's accepted left shoulder condition, the Board disagreed with his assertion that the Order on Reconsideration had improperly apportioned his permanent impairment between his accepted conditions and several denied conditions. Reiterating that claimant was entitled to a permanent impairment award based on the accepted conditions and their direct medical sequela, the Board concluded that, consistent with the "apportionment" rule, his permanent impairment must be apportioned between his compensable shoulder condition and his denied conditions.

## Own Motion: PPD - Carrier "Arbiter" Request Granted

*Kevin T. Kinnamore*, 67 Van Natta 1505 (August 18, 2015). Citing ORS 656.278(6), and OAR 438-012-0060, on review of a claimant's appeal of an Own Motion Notice of Closure, the Board granted a carrier's "arbiter" request because it was disagreeing with the impairment findings used to rate claimant's new/omitted medical condition. After claimant requested review of an Own Motion Notice of Closure, the carrier requested the appointment of a medical arbiter to evaluate his permanent impairment. In response, claimant contended that the carrier was not authorized to request an arbiter examination.

*Because claimant had requested review of an Own Motion Notice of Closure, carrier was authorized to request a medical arbiter exam.*

*Penalty for unreasonable failure to accept/deny a claim was based on "amounts then due" as of the date of hearing regarding the compensable claim.*

The Board disagreed with claimant's contention. Relying on *Ray W. Bluemer*, 61 Van Natta 991, 995-96 (2009), the Board noted that, under ORS 656.278(6), a carrier is not authorized to request review of an Own Motion Notice of Closure or to seek a medical arbiter examination. However, citing *James G. Earnest*, 58 Van Natta 2226 (2006), the Board stated that a carrier is authorized to request a medical arbiter examination when, after a claimant requests review of an Own Motion Notice of Closure, it objects to the impairment findings used to rate impairment regarding "post-aggravation rights" new/omitted medical conditions and requests an arbiter exam.

Turning to the case at hand, the Board found that claimant had requested review of the Own Motion Notice of Closure. Under such circumstances, the Board held that the carrier was authorized to request a medical arbiter examination. Consequently, the Board granted the carrier's request.

## Penalty: "De Facto" Denial - Amounts "Then Due" as of Hearing Date

*Jesse R. James*, 67 Van Natta 1508 (August 18, 2015). Applying ORS 656.262(11)(a), the Board held that the penalty for a carrier's *de facto* denial of a new/omitted medical condition claim was based on "amounts then due" as of the date of the hearing. In response to claimant's new/omitted medical condition claim for cervical radiculitis and radiculopathy, the carrier neither issued a written acceptance nor denial. Claimant requested a hearing, raising as issues a *de facto* denial, penalties, and attorney fees. An ALJ found the claim compensable and assessed a penalty based on the compensation due as a result of the ALJ's order.

Citing *Wacker Siltronic Corp. v. Satcher*, 91 Or 654 (1988), the carrier argued that the penalty must be based on the amounts due through the date of the denial, which for purposes of the *de facto* denial, was the date the denial of the claim should have issued; *i.e.*, 60 days after the claim's filing. See ORS 656.262(7)(a). Consequently, the carrier challenged the ALJ's penalty assessment.

The Board disagreed with the carrier's contention. In contrast to *Satcher* (where the carrier had issued an untimely *written* denial and the "amounts then due" were based on the date of the written denial), the Board reasoned that the carrier had neither issued an acceptance nor a denial at any time before the hearing. Relying on *Nichole M. Robinson*, 63 Van Natta 1475 (2011), the Board assessed a penalty for the carrier's unreasonable claim processing based on any "amounts then due" "as of the date of hearing."

## TTD: Board Not Authorized to Create “Administrative Overpayment” - Could Not Award “Procedural” TTD Where Subsequent NOC Had Not Awarded TTD - Penalty Available if Carrier’s Claim Processing Unreasonable

*Jackie A. Scott*, 67 Van Natta 1375 (August 4, 2015). On remand from the court, *Scott v. Liberty Northwest Ins. Corp.*, 268 Or App 325 (2014), the Board held that, although an attending physician’s comments were sufficient to constitute an authorization of temporary disability (TTD) benefits, such benefits could not be granted because claimant’s claim had subsequently been closed without a temporary disability award. After accepting a new/omitted medical condition claim for “surgical scarring,” the carrier did not pay TTD benefits. It asserted that claimant’s attending physician had previously reported that claimant’s condition was medically stationary before a prior claim closure and considered claimant’s disability to be “permanent.” Claimant requested a hearing, seeking TTD benefits, penalties, and attorney fees. While this litigation was pending, a Notice of Closure (NOC) had subsequently closed the “surgical scarring” claim without a TTD award. The NOC was not appealed.

On remand from the court, the Board found that claimant’s attending physician’s references to pain-related work restrictions, in conjunction with diagnoses of arachnoiditis and surgical scarring, were sufficient to establish that the physician had authorized TTD benefits for the accepted surgical scarring. Citing *Vincent O. Robison*, 67 Van Natta 938, 939 (2015), the Board reiterated that a TTD authorization is still valid if it concerns unclaimed or unaccepted conditions, provided that the authorization is due in part to the accepted condition. Furthermore, relying on the court’s decision in *Scott*, the Board stated that the attending physician’s references to permanent disability did not preclude claimant’s entitlement to TTD disability benefits on the “surgical scarring” claim.

Notwithstanding these findings, the Board determined that it lacked authority to award the requested “procedural” TTD benefits. Noting that while the litigation regarding this procedural matter was pending the claim had been closed by an unappealed NOC (which did not award TTD benefits), the Board concluded that it lacked authority to award TTD benefits beyond those granted by the final NOC. See *Lebanon Plywood v. Seiber*, 113 Or App 651 (1992). Relying on the *Seiber* rationale, the Board reasoned that it could not create an “administrative overpayment.”

Nevertheless, also consistent with the *Seiber* reasoning, the Board stated that, if a carrier has unreasonably delayed or refused to pay TTD benefits it would be subject to penalties, which would be the appropriate way to induce compliance with its claim processing responsibilities. See *Pascual Zaragoza*, 45 Van Natta 1221, 1223 (1993), *aff’d without opinion*, *Zaragoza v. Liberty Northwest Ins. Co.*, 126 Or App 544 (1994). Addressing that question, the Board acknowledged that the court had eventually rejected the carrier’s position that

*Because claim was subsequently closed by an unappealed NOC (which did not award TTD benefits), Board lacked authority to award “procedural” TTD benefits.*

*Despite lack of authority to award TTD benefits, Board was authorized to address whether claim processing was unreasonable.*

the attending physician's "medically stationary/permanent disability" comments were insufficient to constitute a TTD authorization. Nonetheless, in light of such information (which was the basis for the Board's earlier decision that claimant was not entitled to TTD benefits), the Board found that the carrier had a legitimate doubt regarding its obligation to pay TTD benefits. Consequently, the Board concluded that penalties/attorney fees were not warranted under ORS 656.262(11)(a). See *International Paper Co. v. Huntley*, 106 Or App 107 (1991); *Brown v. Argonaut Ins. Co.*, 93 Or App 588, 591 (1988).

## TTD: "Emergency Room" Physician's TTD Authority - Limited to 14-Days - "245(2)(b)(B)" - No "Open-Ended" Authorization

*"Emergency room" physician is allowed to authorize TTD benefits for a maximum of 14 days.*

*Jason Osborne*, 67 Van Natta 1410 (August 5, 2015). Applying ORS 656.245(2)(b)(B) and ORS 656.262(4)(h), the Board held that a carrier was not obligated to pay temporary disability (TTD) benefits beyond 14 days because an "open-ended" authorization had been provided by an "emergency room" physician, whose authority was limited to 14 days. Following a knee injury at work, claimant sought emergency room treatment. The emergency room physician limited him to modified work and directed him to an orthopedist, who became his attending physician. That physician did not address claimant's work restrictions, but eventually recommended surgery. After paying interim compensation benefits for approximately one month, the carrier denied the claim. While claimant's hearing request regarding that denial was pending, the carrier asked the attending physician whether the physician could verify claimant's inability to work, noting that he had not been examined for several months. The physician responded that such verification could not be provided, but that the physician was awaiting authorization for the surgery. After its denial was set aside and the claim was accepted, the carrier paid TTD benefits, effective with the litigation order finding the claim compensable, but did not pay TTD benefits for the "unpaid" period preceding the litigation order. Claimant requested a hearing, contending that the "emergency room" physician's TTD authorization was "open-ended" and had not been terminated by his eventual attending physician.

The Board held that claimant was not entitled to the disputed TTD benefits. Citing ORS 656.005(12)(c), the Board stated that a hospital emergency room physician who provides care and refers a worker to a primary care physician for follow-up care and treatment is not authorized to serve as an attending physician. However, relying on ORS 656.245(2)(b)(B), the Board noted that an emergency room physician is allowed to authorize TTD benefits for a maximum of 14 days. Finally, referring to ORS 656.262(4)(h), the Board observed that a carrier may unilaterally suspend the payment of TTD benefits at the expiration of the 14-day period until such benefits are reauthorized by an attending physician.

*Although attending physician recommended surgery, because no work restrictions had been imposed on claimant, Board did not find any TTD authorization.*

*Dissent considered that most reasonable interpretation of attending physician's surgery recommendation and responses to carrier's inquiries was that TTD benefits had been authorized and that claim processing had been unreasonable.*

Turning to the case at hand, the Board found that, as an emergency room physician, the physician's TTD authorization was statutorily limited to 14 days. Consequently, the Board determined that the emergency room physician was not authorized to issue an "open-ended" or "ongoing" work release. See *Ana Galvan*, 67 Van Natta 1055, 1057 (2015) (physician assistant unable to authorize TTD benefits beyond 30 days under ORS 656.245(2)(b)(B)).

The Board acknowledged that the attending physician had recommended surgery. Nonetheless, noting that the physician had not imposed any restrictions on claimant's activities or made any references to his work status, the Board did not consider the physician to have issued a TTD authorization. See *Lederer v. Viking Freight, Inc.*, 193 Or App 226, *mod on recons*, 195 Or App 94 (2004).

In reaching its conclusion, the Board acknowledged that the carrier had not first obtained confirmation from the attending physician of an inability to verify claimant's inability to work. See ORS 656.262(4)(d); OAR 436-060-0020(3). Nonetheless, reasoning that the emergency room physician's TTD authority was statutorily limited, the Board determined that the carrier was allowed under ORS 656.262(4)(h) to unilaterally suspend claimant's TTD benefits without following the procedures prescribed in OAR 436-060-0020(3).

Member Weddell dissented. Based on the attending physician's surgery recommendation and responses to the carrier's "verification of inability to work" request, as well as the carrier's processing actions in response to the physician's reply, Weddell reasoned that the most reasonable interpretation of the physician's comments was that TTD benefits had been authorized. Furthermore, because the carrier had not asked claimant whether there was a reason beyond his control that prevented him from receiving treatment *before* suspending such benefits, Member Weddell asserted that the carrier had not fully complied with its claim processing obligations and, as such, was not authorized to suspend claimant's TTD benefits. See *Fairlawn Care Center v. Douglas*, 108 Or App 698 (1991); *Michael Arnold*, 62 Van Natta 2854, 2856 (2010). Finally, considering the carrier's claim processing to have been unreasonable, Weddell believed that penalties and attorney fees were warranted.

## APPELLATE DECISIONS COURT OF APPEALS

### Attorney Fees: "262(11)(a)" - Claimant's Successful Defense of Board's "Penalty-Related" Attorney Fee Award - Entitled to Attorney Fee on Appeal

*SAIF v. Traner*, 273 Or App 310 (August 26, 2015). Analyzing ORS 656.262(11)(a), the court held that claimant's counsel was entitled to a carrier-paid attorney fee for services performed on judicial review regarding the successful defense against a carrier's appeal of a Board order that awarded an

attorney fee under ORS 656.262(11)(a) for the carrier's unreasonable failure to timely issue an acceptance/denial of a new/omitted medical condition claim. See *SAIF v. Traner*, 270 Or App 67 (2015).

Citing *Cayton v. Safelight Glass Corp.*, 257 Or App 188, 195 (2013), and *Saxton v. SAIF*, 80 Or App 631, *rev den*, 302 Or 159 (2000), the court reiterated that, in the absence of an award of "compensation," an attorney fee award *under ORS 656.382(2)* is not justified for either a claimant's counsel's successful appellate defense of an attorney fee award or for successfully obtaining on appeal penalties and attorney fees for a carrier's unreasonable conduct pursuant to ORS 656.262(11)(a). Nevertheless, the court reasoned that such case precedent did not address whether ORS 656.262(11)(a) independently authorized an attorney fee award on appeal.

After reviewing ORS 656.262(11) (as well as its legislative history), the court found that an attorney fee award under the statute was not dependent upon satisfying any precondition of any other statute. Instead, the court reasoned that the statute was only conditioned on a finding that the carrier unreasonably delayed payment, acceptance, or denial of a claim.

Turning to the case at hand, the court determined that claimant had successfully defended the Board's conclusion that the carrier should have responded to the new/omitted medical condition and its failure to do so was unreasonable. Under such circumstances, the court concluded that it was expressly authorized by ORS 656.262(11)(a) to require the carrier to compensate claimant's counsel for attorney fees on appeal.

In reaching its conclusion, the court noted that its analysis of ORS 656.262(11)(a) was consistent with the legislative history surrounding the 2003 amendments to the statute, which supported a conclusion that the intent was to address a concern that workers were unable to find willing lawyers and that their lawyers could not be paid even when prevailing. In addition, referring to 2015 statutory amendments to ORS 656.262 and ORS 656.382 (which would become effective January 1, 2016), the court observed that its conclusions will not prove to be out of step, in the future, on the question of attorney fees where only penalties and attorney fees are at issue.

Finally, the court rejected claimant's request for an "extraordinary" attorney fee in excess of the statute's "soft cap" of \$3,334. Although acknowledging the novelty of the questions demonstrated by its principal opinion, the court did not consider the matter extraordinary "all in all." Describing the legal issues as "routine" and noting that claimant was not deprived of receiving any compensation, the court considered the carrier's disagreement to be reasoned and in good faith and, as such, allowed an attorney fee of \$3,334.

*Because claimant successfully defended Board's unreasonable claim processing conclusion, "262(11)(a)" independently authorized an attorney fee award on appeal.*

*Because legal issues were "routine" and claimant was not deprived of receiving any compensation, the court did not find that "extraordinary" attorney fee under "262(11)(a)" was allowed.*