Workers' Compensation Board

Volume XXXVI, Issue 11

November 2017

News & Case Notes

BOARD NEWS

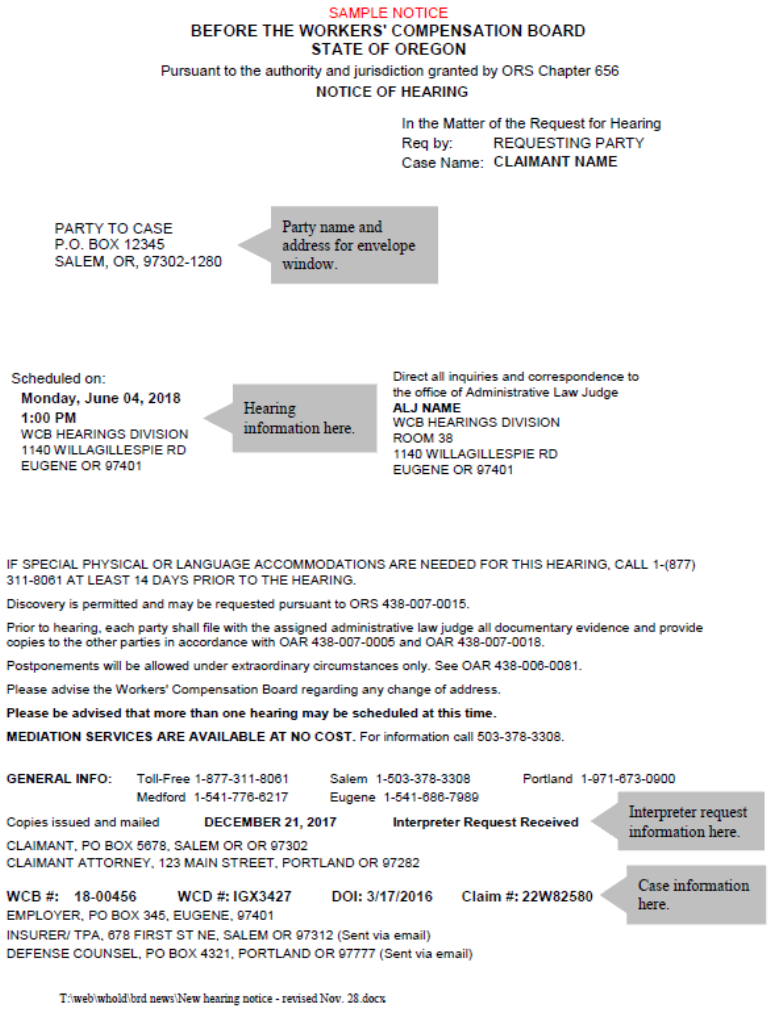
CASE NOTES

BOARD NEWS

Additional Changes Coming to Hearing Notice

In our October issue of the Board's News & Case Notes, we published a mock-up of the new Hearing Notice. This change was prompted by our efforts to reduce mailing costs. The parties' address will now show through a standard window envelope, unlike our previous notice, which required a special mailing envelope that would frequently jam our machinery.

After further testing and the feedback we received, we have made a modification to better highlight the hearing date and contact information. The new version, shown below, is now in use.



SAMPLE NOTICE

BEFORE THE WORKERS' COMPENSATION BOARD
STATE OF OREGON

Pursuant to the authority and jurisdiction granted by ORS Chapter 656
NOTICE OF HEARING

In the Matter of the Request for Hearing
Req by: REQUESTING PARTY
Case Name: **CLAIMANT NAME**

PARTY TO CASE
P.O. BOX 12345
SALEM, OR, 97302-1280

Party name and address for envelope window.

Scheduled on:
Monday, June 04, 2018
1:00 PM
WCB HEARINGS DIVISION
1140 WILLAGILLESPIE RD
EUGENE OR 97401

Hearing information here.

Direct all inquiries and correspondence to the office of Administrative Law Judge
ALJ NAME
WCB HEARINGS DIVISION
ROOM 38
1140 WILLAGILLESPIE RD
EUGENE OR 97401

IF SPECIAL PHYSICAL OR LANGUAGE ACCOMMODATIONS ARE NEEDED FOR THIS HEARING, CALL 1-(877) 311-8061 AT LEAST 14 DAYS PRIOR TO THE HEARING.

Discovery is permitted and may be requested pursuant to ORS 438-007-0015.

Prior to hearing, each party shall file with the assigned administrative law judge all documentary evidence and provide copies to the other parties in accordance with OAR 438-007-0005 and OAR 438-007-0018.

Postponements will be allowed under extraordinary circumstances only. See OAR 438-006-0081.

Please advise the Workers' Compensation Board regarding any change of address.

Please be advised that more than one hearing may be scheduled at this time.

MEDIATION SERVICES ARE AVAILABLE AT NO COST. For information call 503-378-3308.

GENERAL INFO: Toll-Free 1-877-311-8061 Salem 1-503-378-3308 Portland 1-971-673-0900
Medford 1-541-776-6217 Eugene 1-541-686-7989

Copies issued and mailed **DECEMBER 21, 2017** **Interpreter Request Received**

Interpreter request information here.

CLAIMANT, PO BOX 5678, SALEM OR OR 97302
CLAIMANT ATTORNEY, 123 MAIN STREET, PORTLAND OR 97282

WCB #: 18-00456 **WCD #: IGX3427** **DOI: 3/17/2016** **Claim #: 22W82580**

Case information here.

EMPLOYER, PO BOX 345, EUGENE, 97401
INSURER/ TPA, 678 FIRST ST NE, SALEM OR 97312 (Sent via email)
DEFENSE COUNSEL, PO BOX 4321, PORTLAND OR 97777 (Sent via email)

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CDA: "236(1)" - Initially Approved CDA Invalid - "Attorney Fee" Exceeded Board Rule Without "Extraordinary Circumstance" Provision/Finding - Amended CDA Approved

Bryan D. Lewellen, 69 Van Natta 1676 (November 28, 2017). Applying ORS 656.236(1) and OAR 438-015-0052(1), the Board held that a previously approved Claim Disposition Agreement (CDA) was invalid because it provided for an attorney fee that exceeded the Board's rules (without a provision or finding concerning "extraordinary circumstances") and, as such, the Board was authorized to approve an amended CDA which corrected the distribution of proceeds between claimant and his attorney, even though the parties' addendum had been filed more than 10 days after the Board's approval of the initial CDA. More than 10 days after the Board's approval of the parties' initial CDA (which stated that $1,875 of the $2,500 in proceeds were payable to claimant's attorney), the parties submitted an addendum stating that the distribution of proceeds in the initial CDA had been transposed and that their intention was that $625 of the $2,500 proceeds would be payable to claimant's counsel.

If initial CDA was void, Board approval was invalid.

The Board approved the amended CDA. Citing OAR 438-009-0035(1), the Board acknowledged that a motion for reconsideration of an approved CDA must be filed within 10 days of the approval. However, relying on *Korey S. Eubanks*, 68 Van Natta 2031 (2016), the Board stated that, if an initial CDA was void and its approval was invalid, the Board is authorized to approve an amended CDA, even if the addendum is filed more than 10 days after the prior CDA approval.

Because attorney fee in initial CDA exceeded Board rules, CDA was void.

Board authorized to consider and approve CDA addendum that amended attorney fee.

Turning to the case at hand, the Board noted that the initial CDA had provided for an attorney fee that exceeded the standard attorney fee from the $2,500 in proceeds without either including a provision describing "extraordinary circumstances" justifying the proposed attorney fee or a Board finding of "extraordinary circumstances." *See* OAR 438-015-0052(1). Under such circumstances, the Board concluded that the initial CDA was contrary to OAR 438-015-0052(1) and, as such, void. *See Eubanks*, 68 Van Natta at 2032-33. Furthermore, reasoning that its previous approval was invalid, the Board determined that it was authorized to consider, and to approve, the parties' addendum (which provided for an attorney fee payable from the CDA proceeds in an amount consistent with OAR 438-015-0052(1)).

Claim Filing: "265(1), (4)" - "Good Cause" For Untimely Filing Not Established - Claimant's Subjective Belief of "Negative Connotations" Not Supported by Record

Cynthia H. Falk, 69 Van Natta 1634 (November 15, 2017). Applying ORS 656.265(1) and (4)(c), the Board found that claimant had not established "good cause" for her untimely filed claim because her subjective belief of "negative connotations" from her employer for filing a claim was not supported by the record. Although acknowledging that her injury claim had not been filed within 90 days of the alleged work incident, claimant contended that she had "good cause" for the untimely filing because of a "negative connotation" from her employer to the filing of such claims. In response, the carrier asserted that claimant's subjective belief was insufficient to establish "good cause" because the record did not establish an actual occurrence of the employer having threatened her job or other disciplinary action or having taken any such action to any other employee.

The Board found that "good cause" for the untimely filed claim had not been established. Citing ORS 656.265(4)(c), the Board stated that a claim is not barred as untimely filed if the worker establishes "good cause" for failing to give notice within 90 days of the accident. Relying on *Andrew Kuralt*, 67 Van Natta 589 (2015), the Board reiterated that a worker's subjective belief of a negative reaction from an employer to the filing of a claim does not establish "good cause" unless that belief is supported by evidence of an actual occurrence of a threat to the worker's job or other actual negative consequences to the worker or to any other employee.

Worker's subjective belief of negative reaction to claim filing not "good cause" unless corroborated.

Turning to the case at hand, the Board acknowledged claimant's testimony that there were would be "negative connotations" from her employer if she filed her claim. However, after conducting its review, the Board found no supporting evidence of an actual occurrence of a threat to claimant's job or other actual negative consequences to her or any other employee. Under such circumstances, the Board determined that claimant had not established "good cause" for her untimely filed claim.

No supporting evidence to support claimant's testimony of "negative connotations" from claim filing.

Evidence: No Abuse of Discretion in ALJ's Admission of Physician's Report - Admitted For Physician's Medical Expertise (Not For "Accident Reconstruction" Purposes)

Michelle D. Johnson, 69 Van Natta 1607 (November 6, 2017). Applying ORS 656.283(6), the Board found no abuse of discretion in an ALJ's admission of a physician's report, which expressed the physician's medical opinion, rather than that of an accident reconstructionist. At a hearing regarding claimant's denied injury claim arising from a motor vehicle accident (MVA),

Examining physician addressed photographs of accident in providing opinion.

the carrier offered a report from an examining physician, which addressed photographs of the vehicle's damage from the accident. Asserting that the physician was not an accident reconstructionist, claimant objected to the admission of the report. After the ALJ denied the objection and upheld the carrier's denial, claimant requested Board review. In doing so, he contested the ALJ's admission of the report, contending that the physician was not qualified to be an accident reconstructionist. *See* OEC 104(i).

The Board found no abuse of discretion in the ALJ's evidentiary ruling. Citing ORS 656.283(6), the Board stated that an ALJ is authorized to conduct a hearing in any manner that will achieve substantial justice and is not bound by common law or statutory rules of evidence. Relying on *SAIF v. Kurcin*, 334 Or 399, 406 (2002), and *Michael P. Zapel*, 57 Van Natta 1995, 1996 (2005), the Board noted that if the record would support an ALJ's evidentiary ruling, such a ruling does not constitute an abuse of discretion.

Turning to the case at hand, the Board observed that, in admitting the disputed report, the ALJ had relied on *Streight v. Conroy*, 279 Or 289 (1977), where the court had found no abuse of discretion by a trial court judge, who had admitted the testimony of physician witnesses who had responded to hypothetical questions in a back injury claim, which were based on admitted photographs showing damage related to a MVA, because the witnesses had relied not only on the photographs, but also on their expertise as physicians. The Board further acknowledged claimant's assertion that OEC 104(i) had become effective after the *Streight* decision.

Examining physician's opinion offered in the context of a physician, not as accident reconstructionist.

Nevertheless, after conducting its review, the Board noted that the examining physician had offered his opinion in the context of a physician, considering the relevant forces involved in the mechanism of injury. Consequently, the Board reasoned that the physician's report had been presented and considered in the context of an examining physician, not as an accident reconstructionist. Moreover, the Board observed that the record supported the examining physician's representation of "some expertise" in accident reconstruction. Finally, referring to *Tammy G. Dodson*, 46 Van Natta 1895 (1994), the Board reiterated that an expert's qualifications affect the probative weight to be given to an opinion, not its admissibility.

Expert's qualifications affect probative weight of opinion, not admissibility.

Accordingly, based on the aforementioned reasoning, the Board found no abuse of discretion in the ALJ's evidentiary ruling. Concerning the compensability issue, the Board affirmed the ALJ's decision to uphold the carrier's claim denial.

New/Omitted Medical Condition: "267(1)" - Claimed "Cervical Radiculopathy" Not "New/Omitted" - Previously Accepted Via "Cervical Sprain With Radiculopathy" - Prior Acceptance "Reasonably Apprised" Claimant/Providers of Nature of Compensable Conditions

Greg H. Westphal, 69 Van Natta 1693 (November 29, 2017). Applying ORS 656.267(1), the Board held that a carrier had not *de facto* denied claimant's new/omitted medical condition claim for "cervical radiculopathy" because the carrier had accepted "cervical strain with radiculitis," which reasonably apprised claimant and medical providers of the nature of the compensable condition. Following claimant's compensable injury, the carrier accepted a cervical sprain. After claimant initiated a new/omitted medical condition claim for "cervical radiculopathy" (whether by injury, occupational disease, or combined condition), the carrier accepted "cervical sprain with radiculopathy, combined with preexisting cervical degenerative osteoarthritis, spinal stenosis, and neural foraminal stenosis." Thereafter, the carrier issued a "ceases" denial, asserting that the accepted cervical sprain with radiculopathy was no longer the major contributing cause of claimant's need for treatment/disability for his combined condition. After that denial was not appealed and became final, claimant requested a hearing, alleging a *de facto* denial of his previously claimed "cervical radiculopathy," arguing that the carrier had only accepted his "cervical radiculopathy" as a symptom of his cervical sprain, rather than as a separate and independent condition.

Claimant contended acceptance of sprain "with" radiculopathy was just a symptom of his sprain.

The Board disagreed with claimant's contention. Citing ORS 656.262(6)(d), (7)(a), and ORS 656.267(1), the Board stated that a claimant may initiate, at any time, a new/omitted medical condition claim to seek acceptance of conditions that are not included within the scope of a carrier's previous acceptance. Relying on ORS 656.267(1), the Board noted that a carrier's acceptance need not specify each and every medical diagnosis or condition as long as it reasonably apprises the claimant and the medical providers of the nature of the compensable conditions. Referring to *Warren D. Duffour*, 64 Van Natta 619, 623, *recons*, 64 Van Natta 795 (2012), and *Michal A. Fleming*, 52 Van Natta 383, 384 (2000), the Board reiterated that "reasonably apprised" is an objective standard, which does not require that, in every case, the claimant or medical providers subjectively understand what conditions are compensable.

"Reasonably apprised" of nature of compensable conditions is an objective standard.

Turning to the case at hand, relying on claimant's neurosurgeon's opinion, the Board was persuaded that the cervical sprain and cervical radiculopathy conditions constituted the "otherwise compensable injury" component of claimant's combined condition. *See* ORS 656.005(7)(a)(B). Under such circumstances, the Board determined that the carrier's acceptance reasonably apprised claimant and medical providers that the claimed cervical

"Sprain" and "radiculopathy" conditions were the "otherwise compensable injury" component of combined condition.

radiculopathy was accepted as part of the "otherwise compensable injury" component of claimant's "combined" condition. Consequently, because the claimed radiculopathy condition was included within the scope of the carrier's acceptance, the Board concluded that there had not been a *de facto* denial. *See Akins v. SAIF*, 286 Or App 70, 74 (2017).

Cervical radiculopathy had been accepted as separate/ independent condition, not as a symptom.

In reaching its conclusion, the Board disagreed with claimant's assertion that the carrier's prior use of the word "with" signified that it had accepted the claimed radiculopathy condition as a component, or symptom, of the previously accepted cervical sprain, rather than as a separate and independent condition. Consulting the dictionary definition of "with," the Board determined that the word was synonymous with "and," which meant that the cervical radiculopathy had been accepted as a separate and independent condition. Moreover, the Board found no medical evidence supporting the proposition that claimant's radiculopathy was a symptom. Finally, although acknowledging that the unappealed "ceases" denial eliminated the "combined/ preexisting condition" component of the claim, the Board emphasized that the "otherwise compensable injury" component (*i.e.*, the cervical sprain with radiculopathy) remained accepted.

Occupational Disease: "802(1)(a)" - Work Activities Major Cause of Claimed CTS - "Medical Service" Requirement Not Raised at Hearing, Not Considered on Review

Tracy A. Brigham, 69 Van Natta 1600 (November 2, 2017). Applying ORS 656.802(1)(a), the Board held that an occupational disease claim for carpal tunnel syndrome (CTS) was compensable because the record established that the major contributing cause of the claimed condition was her work activities and that the condition had required medical services. While claimant was treating for a compensable thumb condition, a CTS condition was detected. Although no treatment was recommended, an examining physician referred claimant for diagnostic testing to rule out any "nerve compression" issues. Thereafter, claimant filed an occupational disease claim for CTS. The carrier denied the claim, asserting that the claimed CTS was not caused by claimant's work activities. After an ALJ set aside the denial, the carrier appealed, contending that the claimed CTS had not required medical services as required by ORS 656.802(1)(a). In response, claimant argued that the "medical service" issue had not been raised or, alternatively, that her claimed CTS had required medical services under the rationale expressed in *Finch v. Stayton Canning Co.*, 93 Or App 168 (1988).

While treating for compensable thumb condition, CTS was detected.

Carrier contended on review that CTS had not required medical services.

The Board held that the claimed CTS was compensable. Referring to *Fister v. South Hills Health Care*, 149 Or App 214 (1997), *rev den*, 326 Or 389 (1998), the Board observed that it did not appear that a "medical services" contention was raised at the hearing level and, as such, the issue should not be considered on review. *See also Terry Hickman*, 48 Van Natta 1073, 1074-75 (1996) (when "objective findings" requirement regarding claim was not raised at

"Medical services" contention not raised at hearing level; not considered on review.

hearing level, issue could not be raised on Board review). However, the Board considered it unnecessary to conclusively resolve this procedural issue because the record established that the claimed condition required medical services.

Diagnostic testing qualified as medical services.

In reaching its conclusion, the Board acknowledged that claimant had been seeking treatment for a separate compensable thumb condition. Nonetheless, the Board noted that an examining physician had referred claimant for diagnostic testing "to rule out any other issues related to nerve compression." Under such circumstances, the Board reasoned that the diagnostic testing qualified as "medical services" within the meaning of ORS 656.802(1)(a). *See Finch*, 93 Or App at 173; *William N. Jauron*, 58 Van Natta 1045 (2006).

Turning to the medical evidence regarding the cause of the claimed CTS, the Board was persuaded that claimant's work activities were the major contributing cause of her claimed condition. Accordingly, the Board concluded that the claimed CTS was compensable.

Penalties: "268(5)(f)" - Separate Unreasonable Refusals to Close Claim - Three-Month Delays in Seeking Further Information From "AP" and Providing "Job Description"

David A. Vansickle, 69 Van Natta 1642 (November 16, 2017). Applying ORS 656.268(5)(f), the Board assessed separate penalties based on a carrier's unreasonable delays in closing a claim in response to claimant's separate closure requests. Determining that claimant's compensable shoulder injury was medically stationary, his attending physician recommended that his permanent impairment rating be evaluated by an independent medical evaluator. Thereafter, the attending physician did not concur with that evaluation and performed a closing examination. Noting differences between the two evaluations, the attending physician suggested "range-of-motion" findings with a goniometer. A month later, after no response from the carrier, claimant requested claim closure. The carrier refused the request, stating that it did not have sufficient information to close the claim. Some three months later, the carrier's counsel contacted the attending physician, who opined that claimant might have permanent work restrictions and recommended a functional capacity evaluation to rate permanent impairment and assess his work capacity. In the meantime, claimant again requested claim closure. The carrier continued to refuse to close the claim, noting that the attending physician had requested a functional capacity evaluation. A work capacity evaluation (WCE) was performed three weeks later, with which the attending physician concurred. However, noting the absence of a job analysis, the attending physician believed that claimant's job at injury exceeded the work capacity identified in the WCE. Some five weeks later, the job analysis was eventually provided to the attending physician, who confirmed that it exceeded the work capacity identified by the WCE. The claim was eventually closed (some 60 days after the attending physician had concurred with the WCE), awarding permanent impairment and work disability.

Carrier did not respond to AP's suggestion for range of motion evaluation.

Delay in providing job analysis to AP for "work capacity" evaluation.

The Board held that both refusals to close the claim were unreasonable. Citing *Cayton v. Safelite Glass Corp.*, 232 Or App 454 (2009) and *Walker v. Providence Health Sys.*, 254 Or App 676, *rev den*, 353 Or 714 (2013), the Board observed that ORS 656.268(5)(f) provides that if the correctness of a refusal to close is at issue in a hearing and a finding is made that the refusal to close was unreasonable, a penalty of 25 percent of the amount then due, as ultimately determined by the subsequent Notice of Closure (or final appellate decision from that closure notice) is assessed against the carrier. Referring to *Anthony D. Cayton*, 63 Van Natta 54 (2011) (on remand), *recons*, 63 Van Natta 266 (2011), *aff'd without opinion*, 248 Or App 480 (2012), the Board further noted that where a claimant has made multiple requests for claim closure, the carrier's corresponding actions/inactions may result in multiple penalties. Relying on *Scott A. Burns*, 63 Van Natta 1118 (2011), the Board stated that, in evaluating whether a carrier's refusal to close a claim was unreasonable under ORS 656.268(5)(f), all conduct that preceded the claimant's closure request, as well as subsequent conduct, may be considered.

Carrier did not take reasonable action for more than two months after its refusal to close the claim.

Turning to the case at hand, the Board acknowledged the carrier's explanation that its delay in closing the claim in response to claimant's first closure request was due to the absence of a "claimant signed" claim form. Yet, the Board noted that the carrier had not taken any reasonable action to obtain sufficient information to close the claim for more than two months after its refusal to close the claim. Moreover, the Board observed that the carrier had eventually scheduled a conference with claimant's attending physician *before* receiving claimant's signed claim form. Under such circumstances, the Board was not persuaded that the carrier's over two-month delay in gathering sufficient information to close the claim was due to the lack of a signed claim form and that the carrier's delay in obtaining such information constituted an unreasonable delay in closing the claim.

Job analysis not provided to "AP" for 5 weeks.

Regarding claimant's second claim closure request, the Board recognized the carrier's explanation that the attending physician had raised concerns pertaining to the "at-injury" job description. Nonetheless, the Board reasoned that the job description had not been provided to the attending physician until some five weeks after the attending physician had noted the absence of the job description/analysis. Furthermore, the Board observed that the claim had not been closed until nearly a month after the attending physician had opined that the job analysis exceeded the work capacity identified in the evaluation. Based on its review of the record, the Board found that the carrier's delays in providing the job description to the attending physician, and in closing the claim once it received the attending physician's response, constituted an unreasonable refusal to close the claim.

Separate penalties for each unreasonable refusal based on compensation ultimately determined by NOC (or final decision).

Addressing the penalty under ORS 656.268(5)(f), the Board reiterated that it was authorized to assess separate penalties based on the carrier's separate unreasonable refusals to close the claim. *See Cayton*, 63 Van Natta at 54. Relying on *Walker* and *Jose L. Olvera-Chavez*, 67 Van Natta 1455, 1456 (2015), the Board further concluded that those separate penalties would be based on the amount then due, as ultimately determined by the Notice of Closure (or final decision from that closure notice).

Finally, the Board awarded a carrier-paid attorney fee under ORS 656.382(1) based on both of the carrier's unreasonable refusals to close the claim. *See Scott A. Burns*, 63 Van Natta 1118, 1121 (2011). Citing *Cayton v.*

Safelite Glass Corp., 258 Or App 522, 525 (2013), the Board stated that this attorney fee award was for claimant's counsel's services performed at the hearing level and did not extend to services rendered on review.

TTD: "262(4)(a)" - Obligation to Pay TTD - Triggered By Carrier's Receipt of "AP" Verification (Express or Implied) of Inability to Work - Employer Knowledge of Claimant's Hospitalization/Surgery Insufficient

Denial issued within 14 days of receipt of medical verification – no entitlement to interim compensation.

Michael K. Spurgeon, 69 Van Natta 1612 (November 6, 2017). Applying ORS 656.262(4)(a), the Board held that a carrier was not obligated to pay temporary disability (TTD) benefits (interim compensation) because it denied claimant's injury claim within 14 days of its receipt of a medical record which constituted verification from his attending physician of his inability to work due to his claimed back injury. Asserting that his employer knew that he had been hospitalized and undergone back surgery, claimant argued that he was entitled to TTD benefits (interim compensation) commencing with the filing of his injury claim until the carrier's denial some six weeks later.

The Board disagreed with claimant's contention. Citing ORS 656.262(4)(a), the Board stated that a claimant is entitled to TTD benefits (interim compensation) when the carrier has receipt of both notice of a claim and an attending physician's authorization for the payment of temporary disability compensation. *See Jones v. Emanuel Hosp.*, 280 Or App 147 (1977). Relying on *Lederer v. Viking Freight, Inc*., 193 Or App 226, 237, *adh'd to as modified on recons*, 195 Or App 94 (2004), and *Theresa E. Barnes*, 56 Van Natta 3598, 3599 (2004), the Board noted that, under ORS 656.262(4)(a), an express authorization from an attending physician is not required when an objectively reasonable carrier would understand contemporaneous medical reports to signify approval from the attending physician of the worker's inability to work due to a work-related injury.

Employer knew of hospitalization and surgery, but AP's authorization/ medical verification was received a month later.

Turning to the case at hand, the Board acknowledged that the employer knew of claimant's hospitalization and surgery when it received his injury claim. Nevertheless, the Board found that the medical record (which included the attending physician's authorization/medical verification of claimant's inability to work due to the claimed work-related injury) was not received until a month later. Because the carrier denied the claim within 14 days of its receipt of the medical record (containing the attending physician's authorization/ verification), the Board concluded that claimant was not entitled to TTD benefits (interim compensation). *See Daniel F. Yrigollen*, 59 Van Natta 897, 898 (2007); *Michael Winegart*, 54 Van Natta 2376, 2380 (2002).

TTD: "AP" Authorization "Close-Ended" - Subsequent Contemporaneous Record Did Not Support Further "AP" Authorization

Amber R. Frazey, 69 Van Natta 1667 (November 22, 2017). Applying ORS 656.262(4)(a), and (g), the Board held that a carrier was not obligated to pay temporary disability (TTD) benefits beyond the date of claimant's attending physician's "close-ended" authorization because the subsequent contemporaneous record did not establish that the attending physician had authorized, either express or implied, further TTD benefits. While claimant's injury claim was in denied status, claimant's attending physician signed a work release form authorizing modified duty for a 30-day period, which expired on a specified date. After the carrier's denial was set aside, the carrier paid TTD benefits until the specified date and, based on the physician's assistant re-authorization, recommenced the payment of such benefits. Claimant requested a hearing, seeking TTD benefits for a 3-month gap between the aforementioned periods, asserting that the physician's assistant had opined that she had been on light duty throughout that time. In addition, claimant contended that it was reasonable for the carrier to understand the contemporaneous medical reports as signifying her attending physician's approval excusing her from work during the 3-month gap.

While claim was denied, work release form authorized modified duty for 30 days.

The Board disagreed with claimant's contention. Citing *Lederer v. Viking Freight, Inc.*, 193 Or App 226, 237, *modified on recons*, 195 Or App 94 (2004), the Board stated that a carrier is obligated to pay TTD benefits when an objectively reasonable carrier would understand contemporaneous medical reports as signifying an attending physician's approval excusing an injured worker from work. Relying on *Charlene Y. Pearce*, 55 Van Natta 728, 730 (2003), the Board reiterated that a TTD authorization is open-ended, unless it is limited to a specific period or the occurrence of a specific event. Finally, referring to ORS 656.262(4)(g), the Board noted that no authorization of TTD compensation by an attending physician shall be effective to retroactively authorize the payment of TTD benefits more than 14 days prior to its issuance.

TTD authorization retroactively effective for 14 days.

Turning to the case at hand, the Board found that claimant's attending physician had expressly authorized modified duty for a specified 30-day period. Consequently, the Board determined that the attending physician's TTD authorization had not been open-ended. Analyzing whether a subsequent implied TTD authorization existed once the specific authorization ended, the Board was not persuaded that the contemporaneous record would lead a reasonable carrier to infer that the attending physician had released claimant from work during the disputed period.

AP authorization for specified period; not "open-ended."

In reaching its conclusion, the Board acknowledged that a physical therapist's notes had referenced that claimant was working "modified duty" during the period in question and was waiting for a prescribed injection. Nevertheless, the Board reasoned that such references were merely a recitation of claimant's reported history of her work status at that time and, in any event, had not been expressed on behalf of the attending physician. Under such circumstances, the Board was not persuaded that the carrier was statutorily responsible to continue the payment of TTD benefits during the disputed period.

Physical therapist's notes referenced modified duty during disputed period, but references were reported history, not AP authorization.

Subsequent clarification reports were not contemporaneous authorizations.

Finally, the Board recognized that subsequent "clarification" reports from the attending physician (and the physician's assistant) indicated that claimant was on light duty during the period in question. Nonetheless, the Board reasoned that such subsequent recollections did not establish a *contemporaneous* authorization for TTD benefits and, in any event, as "retroactive" authorizations, could only apply to a 14-day period before the authorization, which would not reach back to the disputed period. *See* ORS 656.262(4)(g); *Menasha Corp. v. Crawford*, 332 Or 404, 416 (2001); *Tony L. Clark*, 67 Van Natta 424, 440 (2015), ***aff'd without opinion***, 281 Or App 460 (2016).

APPELLATE DECISIONS UPDATE

Attorney Fees: "262(11)(a)" - Board Authorized to Award Fee on Remand For "Penalty" Determination

Walker v. Providence Health System Oregon, 288 Or App 772 (November 15, 2017). Analyzing ORS 656.262(11)(a), the court reversed the Board's order in *Joy M. Walker*, 68 Van Natta 371 (2016), previously noted 35 NCN 3:3, which had held that it was not authorized to award a penalty-related attorney fee for claimant's counsel's services before the court and on remand because the court's previous decision had expressly remanded the case for a determination of a penalty. In reaching its conclusion, the Board had reasoned that, because claimant had previously prevailed before the court (when the court had decided that she was entitled to a penalty under ORS 656.262(11)(a)) and the court had merely remanded to the Board to take the ministerial action of calculating the penalty, it lacked the authority to award attorney fees pursuant to ORS 656.262(11)(a). In doing so, the Board had relied on *Aguiar v. J.R. Simplot Co.*, 94 Or App 658 (1989).

The court held that the Board had erred in determining that it lacked authority to consider the attorney fee. Noting that the *Aguiar* decision had analyzed ORS 656.388(1) (which provides for carrier-paid attorney fees for every prior forum when a claimant "finally prevails after remand") and had determined that the claimant had finally prevailed before the court (and that the Board's remand decision had been ministerial), the court reasoned that the current case involved ORS 656.262(11)(a) that does not employ language that makes the attorney fee award turn on prevailing "*after* remand" as with ORS 656.388(1).

Attorney fee under "262(11)(a)" predicated on unreasonable refusal or delay in accepting/ denying claim.

Consequently, the court concluded that the case at hand did not involve a procedural twist as presented in *Aguiar*. Instead, after analyzing ORS 656.262(11)(a), the court reasoned that nothing conditions attorney fees on a penalty award being made at a particular procedural stage (such as prevailing "after remand"), but rather turns on the predicate circumstances set forth in the statute (*i.e.*, an unreasonable refusal or delay in accepting or denying claim).

Therefore, the court determined that ORS 656.262(11)(a) does not operate to limit the Board's authority to award an attorney fee even if claimant prevailed on the right to a penalty before the court and the amount was left

Prior court order remanding for penalty determination had not limited Board's authority to conduct related proceedings.

for the Board to determine on remand. Furthermore, noting that nothing in its previous order (which contemplated the determination of a penalty) implied a limitation on the Board's authority to conduct any related proceedings, the court concluded that its prior decision had simply returned the case to the Board to determine a penalty and to complete the case consistently with statutes, rules, and procedures.

Finally, the court observed that the carrier had objected to claimant's attorney fee request because she had not made the request until she sought reconsideration of the Board's order on remand that had determined the penalty. Noting that the Board had not referred to its own rules or practices in addressing claimant's attorney fee request (but rather had erroneously ruled that it lacked authority to award attorney fees), the court concluded that the Board was authorized on remand to consider or reject claimant's request consistent with its rules and practices.

APPELLATE DECISIONS
COURT OF APPEALS

Extent: Impairment Findings - "Apportionment" Rule - Applied to "Unclaimed/Unaccepted" Legally Cognizable "Preexisting Condition"

Caren v. Providence Health System Oregon, 289 Or App 157 (November 29, 2017). The court affirmed, *per curiam*, the Board's order in *Susan Caren*, 67 Van Natta 1636 (2015) that, in evaluating claimant's permanent impairment for an accepted lumbar strain condition, apportioned her impairment between her accepted condition and an unclaimed/unaccepted legally cognizable "preexisting condition" (arthritis). The court cited *McDermott v. SAIF*, 286 Or App 406 (2017).