
In the Matter of the Compensation of
TIMOTHY TROUPE, Claimant
WCB Case No. 00-01864
ORDER ON REVIEW
Ernest M Jenks, Claimant Attorneys
Bostwick Et Al, Defense Attorneys

Reviewing Panel: Members Haynes, Bock, and Phillips Polich. Member Phillips Polich dissents.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Thye's order that declined to award an attorney fee pursuant to ORS 656.386(1). On review, the issue is attorney fees.

We adopt and affirm the ALJ's order with the following supplementation and correction.

Claimant compensably injured his left shoulder on September 29, 1999. The claim was accepted as a left shoulder strain. Claimant's attorney wrote the insurer on February 2, 2000 and requested acceptance of claimant's left shoulder tendinitis. The letter contended that the condition had been incorrectly omitted from the Notice of Acceptance.

On March 2, 2000, claimant's attending physician concurred with a statement from the insurer to the effect that the doctor believed that the diagnoses of tendinitis were encompassed within the medical term "strain" and that the insurer's acceptance of a "disabling left shoulder strain" reasonably apprised the claimant and medical providers of the nature of his compensable condition.

On March 3, 2000, the insurer wrote claimant's attorney and stated, in part: "We hereby decline to amend the acceptance of this claim as the current acceptance of a disabling left shoulder strain encompasses and reasonably apprises [claimant] and his medical providers of the nature of his compensable condition." Thereafter, claimant requested a hearing alleging a "de facto" denial of left shoulder tendinitis and rotator cuff tendinitis.

The ALJ concluded that the Notice of Acceptance should be amended to include tendinitis. The ALJ also declined to award an attorney fee pursuant to ORS 656.386(1) on the ground that there was no statutory basis on which to award an attorney fee.

On Board review, claimant contends that the insurer failed to properly revise the Notice of Acceptance or provide clarification of its acceptance for the condition. Claimant argues that he is entitled to an attorney fee under ORS 656.386(1). The insurer asserts that the claim processing requirements of ORS 656.262(6)(d) and ORS 656.386(1) were satisfied by its March 3, 2000 letter, stating that the tendinitis condition was encompassed within the acceptance of a strain. The insurer further contends that there is no “denied claim” and thus no entitlement to an attorney fee under ORS 656.386(1). We agree.

Unless specifically authorized by statute, the Board has no authority to award attorney fees, even though an inequity could result. *Stephenson v. Meyer*, 150 Or App 300, 303 (1997). Attorney fees under ORS 656.386(1) are awarded for prevailing over a “denied claim,” as that term is defined in ORS 656.386(1)(b). *William F. Davis, Jr.*, 52 Van Natta 915 (2000).

ORS 656.386(1)(b) defines a “denied claim” as:

“(A) A claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation;

“(B) A claim for compensation as a condition omitted from a notice of acceptance, made pursuant to ORS 656.262(6)(d), which the insurer or self-insured employer does not respond to within 30 days; or

“(C) A claim for an aggravation or new medical condition, made pursuant to ORS 656.262(7)(a), which the insurer or self-insured employer does not respond to within 90 days.”¹

ORS 656.262(6)(d) provides that the insurer “has 30 days from receipt of the communication from the worker to revise the notice or to make other written clarification in response.” The insurer in this case responded within 30 days of

¹ There is no contention that this claim involves an aggravation or new medical condition claim. Thus, we conclude that ORS 656.386(1)(b)(C) does not apply.

receipt of claimant's communication by stating that the acceptance of a left shoulder strain "encompasses and reasonably apprises" claimant and "his medical providers of the nature of his compensable condition." We conclude that this response satisfies the statute's requirement of written clarification. *See e.g., Myron O. Rasmussen*, 52 Van Natta 1827 (2000); *Carrie L. Eller*, 52 Van Natta 625 (2000). Thus, we agree with the ALJ that this record does not establish a "denied claim" pursuant to ORS 656.386(1)(b)(B).

In reaching this conclusion, we find the facts of the present case similar to those in *Lato E. Hamilton*, 51 Van Natta 724 (1999). There, the claimant requested that the employer accept L5-S1 facet dysfunction and L5-S1 disc bulge/protrusion/herniation. Within 30 days, the employer responded by amending the notice of acceptance to include L5-S1 facet dysfunction. The employer also wrote the claimant and explained that the previously accepted disc bulge encompassed the disc protrusion diagnosis. The insurer further indicated that it was seeking clarification from the claimant's attending physician regarding the disc herniation diagnosis.

We held that, although the employer did not accept the disc herniation, as a distinct condition, until receiving clarification from the claimant's attending physician, its clarification and response to the claimant's request complied with the claim processing requirements of ORS 656.262(6)(d).

Here, as in *Hamilton*, the insurer responded within the 30 day period to claimant's request for amendment of the Notice of Acceptance by stating that the tendinitis condition was encompassed within the acceptance of the left shoulder strain. In addition, prior to responding, the insurer had sought clarification from claimant's attending physician, who opined that the strain diagnosis accepted by the insurer encompassed the diagnoses of tendinitis. Although the ALJ ultimately did not agree that the strain diagnosis encompassed the tendinitis diagnosis, we conclude that the insurer's clarification complied with the claim processing requirements of ORS 656.262(6)(d).

Accordingly, we conclude that the insurer's response complied with ORS 656.262(6)(d).²

² We distinguish the facts of this case from those in *Cynthia J. Thiesfeld*, 51 Van Natta 984 (1999). There, the insurer did not respond within 30 days to a request from the claimant's counsel to accept additional conditions. After expiration of the 30 day period and after the claimant filed a hearing request alleging a "de facto" denial, a physician opined that the conditions were encompassed within the insurer's prior acceptance. The insurer then denied the conditions. We concluded that, since the insurer

A “denied claim” also includes a claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation. ORS 656.386(1)(b)(A).

Here, we are not persuaded that the insurer’s response amounted to a refusal to pay on the express ground that the condition is not compensable or does not give rise to an entitlement to compensation. Instead, the insurer’s communication was an acknowledgment that the condition is part of its accepted claim.

For the reasons expressed above, we are not persuaded that the record establishes a “denied claim” under ORS 656.386(1)(b)(A) or (B).

Finally, we note that the “order” section of the ALJ’s order directs the insurer to amend its Notice of Acceptance to include “left rotator cuff tear.” The “order” language is corrected to direct the insurer to amend its acceptance to include left shoulder tendinitis rather than a rotator cuff tear.

ORDER

The ALJ’s order dated March 12, 2001 is affirmed, as corrected above.

Entered at Salem, Oregon on January 16, 2002

Board Member Phillips Polich dissenting.

I disagree with the majority’s conclusion that the insurer’s response to claimant’s request for amendment of the Notice of Acceptance did not amount to a denied claim for purposes of ORS 656.386(1). The insurer, in this case, attempted to avoid accepting *tendinitis* by stating that the *tendinitis* condition was already encompassed within the acceptance of the left shoulder *strain*. The ALJ did not agree, however, that the evidence established that the tendinitis condition was encompassed within the acceptance. Under such circumstances, I would

did not respond within 30 days to the claimant’s request to accept the conditions as required by ORS 656.262(6)(d), the insurer’s inaction resulted in a “denied claim” under ORS 656.386(1)(b). Furthermore, we noted that, when the insurer issued its denial, it did not clarify its position that the claimed conditions were subsumed within its prior acceptance. Under such circumstances, we concluded that there was a denied claim. Here, in contrast, the insurer responded as required within 30 days after receiving clarification from claimant’s attending physician that the strain diagnosis accepted by the insurer encompassed the diagnoses of tendinitis.

conclude that this matter involves a “denied claim” and that an attorney fee is due under ORS 656.386(1). Any other interpretation would allow a carrier to “respond” to a request for amendment of an acceptance notice within 30 days, falsely state that the condition was encompassed within the accepted claim, and avoid any liability for an attorney fee when an ALJ concludes that a condition was not actually encompassed within the prior acceptance. Such an interpretation allows carriers to utilize a “loophole” in ORS 656.386(1) to avoid liability for an attorney fee in cases where one would otherwise be justified.