



News & Case Notes

BOARD NEWS

- Board Meeting (December 15, 2020) - Biennial Review of Attorney Fee Schedules (For 2020) Concluded - "Fee Award" Data Will Be Compiled/Shared With Public & Considered During "2022" Biennial Review 1
- ALJ Bloom - Tribute 1
- WCB'S 2020 ALJ Anonymous Survey 2
- Adoption of Permanent Rules/ Amendments (Attorney Fees - OAR 438 Division 015) - ("Contingent Hourly Rate" - "015-0010(4)(l)"); "Voluntary Bifurcation of Attorney Fee Award for Certain Cases on Board Review" - "015-0125" - Effective October 1, 2020 2
- Update to Portal Hearing Request Form 3

CASE NOTES

- Consequential Condition: Claimed "New/Omitted" Conditions Resulted From Surgery - Reasonable/ Necessary Medical Treatment Due, In Material Part, to Compensable Condition - "005(7)(a)(A)", "245(1)(a)" 4
- Extent: Impairment Findings - Reduced "ROM" Findings ("Normal" for Claimant) - Not Attributed to "Accepted," "Preexisting," "Combined" Condition - No Permanent Impairment Award Granted - *Caren, Robinette, Johnson* Distinguished 5
- "Recon" Proceeding: Board W/O "Remand" Authority to ARU for Clarification of ARU's "Apportionment" Inquiry to Medical Arbitrator For Supplemental Report - "Apportionment" Inquiry Relevant for "Combined Condition" Claims, "Denied/Superimposed" Conditions, & if Worker's Condition Not Caused, in Any Part, by Compensable Injury 7

BOARD NEWS

Board Meeting (December 15, 2020) - Biennial Review of Attorney Fee Schedules (For 2020) Concluded - "Fee Award" Data Will Be Compiled/Shared With Public & Considered During "2022" Biennial Review

At their December 15, 2020, public meeting, the Members discussed their biennial review of the Board's attorney fee schedules under ORS 656.388(4). Parties, practitioners, and the general public also participated (remotely) in the meeting, offering comments.

The Members reviewed the events related to their 2018 biennial review, which had culminated in several amendments to the Board's attorney fee rules (Division 15) in 2020. The Members observed that the most recent rule changes (*i.e.*, amended OAR 438-015-0010(4) and the adoption of OAR 438-015-0125) had become effective October 1, 2020. Given such circumstances, the Members agreed that the effect of these rule amendments had yet to be evaluated. Accordingly, the Members concluded that, rather than considering further amendments to the Board's attorney fee rules, they would continue to compile information regarding attorney fee awards in preparation for their next biennial review.

Consequently, the Members closed the 2020 biennial review. In doing so, they emphasized that information regarding attorney fee awards would be reviewed on an ongoing basis, which would also be shared with the public. The Members further agreed that such information would be considered for their 2022 biennial review of the Board's attorney fee schedules.

ALJ Bloom - Tribute

By Joy Dougherty, Presiding Administrative Law Judge

It is with great sadness that I share that Administrative Law Judge G. Duffy Bloom passed away in his home in Eugene, Oregon on December 24, 2020.

Many of you have known Judge Bloom for decades. But, for those of you who haven't, Judge Bloom graduated from the University of Washington with BA degrees in Political Theory and Comparative Religion. In the late 80s and very early 90s, he worked at SAIF Corporation as an appellate and special-projects law clerk and certified law student trial counsel. He began representing injured workers, starting in 1991, at the Eugene, Oregon law firm of Coons, Cole and Cary, and then at the firm of Cary, Wing and Bloom. While in private practice,

"Recon" Proceeding: Board W/O
 "Remand" Authority to ARU for
 Clarification of ARU's
 "Apportionment" Inquiry to Arbitrator
 for Supplemental Report -
 "Apportionment" Inquiry Relevant
 for "Combined Condition" Claims,
 "Denied/Superimposed"
 Conditions, & if Worker's Condition
 Not Caused, in Any Part, by
 Compensable Injury - Challenge
 to Arbitrator's Findings (W/O Closing
 Evaluations of Prior/Current
 Injuries) Not Raised to ARU at
 "Recon" Level 8

APPELLATE DECISIONS

Update

TTD: "AP" Authorization -
 Inference, at Claim Closure, from
 Surgery/Hospital/Medical Records
 - "060-0020(4)" 10

he represented his own clients, the Oregon Trial Lawyers Association, the Farmworker Justice Fund, Legal Aid Services of Oregon, Oregon Advocacy Center, and the Oregon Law Center before the Oregon Court of Appeals and Supreme Court.

In 2003, Judge Bloom was appointed as an Administrative Law Judge for the Oregon Workers' Compensation Board, in the Medford office. There, he presided over contested cases and helped parties settle their disputes as a mediator under the Board's and Oregon Supreme Court's mediation programs. Over the years, Judge Bloom's work shifted primarily to conducting mediations, and in November 2012, he moved to be more centrally located in the Eugene office.

In addition to his work, Judge Bloom taught at many seminars and continuing legal education courses for lawyers, administrative law judges, employers and claims adjusters. He was also an avid film enthusiast, he loved to read, was a man of faith, and had a rare-known gift of caring for the children in his world. He was generous and caring of parties to his mediations, as well as his co-workers, by routinely providing food and snacks. Additionally, from my personal observations, he was someone who loved working in the Workers' Compensation field second to none. He would routinely say to me how much his work meant to him. He had a zeal for his work that was nothing short of admirable. His loss will be felt greatly amongst all who knew him.

WCB'S 2020 ALJ Anonymous Survey

Consistent with ORS 656.724(3)(b), attorneys regularly participating in workers' compensation cases will be sent a link, via email, to participate in the annual anonymous survey. So, please watch for your invitation to participate in this important survey tool. Please take a few minutes to complete the survey, which can be completed from your computer, smart phone, or tablet.

Responses will be accepted until February 11, 2021, and results will be posted on WCB's website by March 3, 2021.

Your participation is greatly appreciated.

Adoption of Permanent Rules/Amendments (Attorney Fees - OAR 438 Division 015) - ("Contingent Hourly Rate" - "015-0010(4)(1)"); "Voluntary Bifurcation of Attorney Fee Award for Certain Cases on Board Review" - "015-0125" - Effective October 1, 2020

At their August 19, 2020, public meeting, the Members adopted rules/amendments relating to attorney fees (OAR 438 Division 015). The Members took these actions after considering comments presented at a July 31, 2020, rule-making hearing, as well as discussing submissions from Members Curey and Ousey, and comments presented by attendees at the Board's August 19 meeting. The rule adoptions include (among other rule amendments):

- Allowing the submission and consideration of information regarding a claimant’s attorney’s “contingent hourly rate,” including the calculation of such a rate. (OAR 438-015-0010(4)(I)).
- Establishing a procedure regarding the voluntary bifurcation of an attorney fee award from the merits concerning certain cases on Board Review. (OAR 438-015-0125).

The effective date for the permanent rules/amendments is October 1, 2020, to be applied in the manner prescribed in the Board’s Order of Adoption. The Board’s Order of Adoption can be found here: <https://www.oregon.gov/wcb/legal/Pages/laws-and-rules.aspx>. In addition, copies of the Order of Adoption have been distributed to all parties/practitioners on WCB’s mailing list.

Update to Portal Hearing Request Form

The WCB Portal request for hearing form has been updated with a checkbox for “ongoing” temporary disability. Submitters can now choose between an “end date” for the temporary disability request, or select the option for “ongoing” temporary disability. Below are views of the new Issues tab, and the printable version of the form.

If you have any questions or need assistance on the portal, please contact WCB at portal.wcb@oregon.gov.

List Requests New Hearing Request

Request Claimant information Insurer / TPA Employer Issues Accommodations Attachments

A hearing is requested for the reason(s) checked below

DENIAL (date) Defacto

Compensability - complete claim denial
 Partial Denial after a Claim Acceptance
 Challenge to Notice of Claim Acceptance
 Worker Noncooperation
 Aggravation
 Responsibility
 Medical Services

NONCOMPLYING EMPLOYER ORDER

TEMPORARY DISABILITY

Procedural Temporary Disability

Period sought: 11/09/2020 to Ongoing

Temporary Disability Rate
 Supplemental Disability

Order on Reconsideration Attach a PDF

Classification (disabling/nondisabling)
 Premature Closure
 Substantive Temporary Disability

Period sought: to

Permanent Partial Disability
 Permanent Total Disability

OTHER (Explain and cite ORS)

Director's Order Attach a PDF

PENALTY (Cite ORS)

ATTORNEY FEE (Cite ORS)

COSTS

TEMPORARY DISABILITY OFFSET

A hearing is requested for the reason(s) check below:

A DENIAL (date) Defacto

B Compensability - complete claim denial
 X Partial Denial after a Claim Acceptance
 Z Challenge to Notice of Acceptance
 V Worker Noncooperation
 K Aggravation
 L Responsibility
 C Medical Services (OS 656-245)

M NONCOMPLYING EMPLOYER ORDER

O TEMPORARY DISABILITY

D Period sought 11/9/2020 Ongoing

R Rate

F SUPPLEMENTAL DISABILITY

N ORDER ON RECONSIDERATION attach copy

Y Classification (disabling/nondisabling)
 I Premature Closure
 E Temporary Disability

Period Sought

H Permanent Partial Disability
 G Permanent Total Disability

Q OTHER (Explain and cite ORS)

P DIRECTOR'S ORDER attach copy

S PENALTY (Cite ORS)

T ATTORNEY FEE (Cite ORS)

W COSTS

CASE NOTES

Consequential Condition: Claimed “New/Omitted” Conditions Resulted From Surgery - Reasonable/Necessary Medical Treatment Due, In Material Part, to Compensable Condition - “005(7)(a)(A)”, “245(1)(a)”

Gerald W. Cox, 72 Van Natta 1159 (December 30, 2020). Analyzing ORS 656.005(7)(a)(A), (B), ORS 656.245(1)(a), and ORS 656.266(2)(a), in finding several shoulder conditions compensable as new/omitted medical conditions, the Board determined that, based on a physician’s persuasive opinion that claimant’s “otherwise compensable injury” and accepted rotator cuff tear were the major contributing cause of his disability/need for treatment for a combined condition (which included his currently claimed bursitis and impingement syndrome), the record established that those claimed conditions were compensable and, because his previous shoulder surgery was partially directed at those conditions, he had also proven that other shoulder conditions resulting from that surgery (widening of the coracoclavicular joint, well-corticated ossicle at the joint line, and regrowth of the left distal clavicle resection area) were compensable as “consequential conditions.” In initiating new/omitted medical condition claims for several shoulder conditions, claimant argued that his shoulder bursitis and impingement syndrome conditions were compensable under a “direct injury” theory and that other shoulder conditions (widening of the coracoclavicular joint, well-corticated ossicle at the joint line, and regrowth of the left distal clavicle resection area) were compensable as “consequential conditions” resulting from a shoulder surgery that was partially attributable to the bursitis and impingement syndrome conditions. After the carrier denied the claims, claimant requested a hearing.

The Board agreed with claimant’s contentions. Citing ORS 656.005(7)(a), ORS 656.266(1), *Betty J. King*, 58 Van Natta 977, 977 (2006), and *Maureen Y. Graves*, 57 Van Natta 2380, 2381 (2005), the Board stated that, to be compensable, the claimed bursitis and impingement syndrome must exist and that the work event must be a material contributing cause of the disability/need for treatment of those conditions. Referring to ORS 656.005(7)(a)(B), ORS 656.266(2)(a), *SAIF v. Kollias*, 233 Or App 499, 505 (2010), and *Jack G. Scoggins*, 56 Van Natta 2534, 2535 (2004), the Board noted that when an “otherwise compensable injury” combines with a statutory “preexisting condition,” the carrier must establish that the “otherwise compensable injury” was not the major contributing cause of claimant’s disability/need for treatment of the combined conditions.

Turning to the case at hand, the Board was persuaded by a physician’s opinion that claimant’s “otherwise compensable injury” (and his previously accepted rotator cuff tear) were the major contributing cause of the disability/need for treatment of a combined condition (which included bursitis and impingement syndrome). In doing so, the Board acknowledged that the physician had not expressly opined that the work event was a material contributing cause of the disability/need for treatment of claimant’s bursitis and impingement syndrome. Nonetheless, considering that the physician had attributed the major cause of claimant’s disability/need for treatment to the “otherwise compensable injury” and his accepted rotator cuff, the Board interpreted the opinion as persuasive

Surgery was partially directed at compensable combined shoulder condition and was major cause of other claimed shoulder conditions.

New/omitted shoulder conditions (bursitis/impingement syndrome) found part of compensable “combined condition.”

Carrier did not prove work injury was not major cause of disability/ treatment for “combined condition” because physicians had not sufficiently weighed contribution from the “otherwise compensable injury.”

Surgery for compensable “combined condition” was directed at least in part to the bursitis/impingement syndrome; surgery was also the major cause of the other claimed shoulder conditions.

support for a conclusion that the work event was at least a material contributing cause of the disability/need for treatment of the claimed bursitis and impingement syndrome.

Addressing the carrier’s burden to establish that the “otherwise compensable injury” was not the major contributing cause of the disability/need for treatment of a combined condition, the Board was not persuaded by other physicians’ opinions that did not support the compensability of the claimed conditions. In doing so, the Board reasoned that such opinions had not sufficiently weighed the relative contribution of the “otherwise compensable injury” or address the persuasive theory advanced by the first physician. Under such circumstances, the Board concluded that the carrier had not met its burden of proof under ORS 656.266(2)(a) and, as such, the claimed bursitis and impingement syndrome were compensable.

Next, the Board considered the compensability of the other claimed shoulder conditions (*i.e.*, coracoclavicular joint, ossicle, and distal clavicle conditions) under a “consequential condition” theory. Referring to ORS 656.005(7)(a)(A), *Barrett Bus. Servs. v. Hames*, 130 Or App 190, 193, *rev den*, 320 Or 492 (1994), and *Robert D. Harrington*, 68 Van Natta 496, 498 (2016), the Board stated that claimant must prove that the claimed conditions existed and that his compensable injury (or its reasonable and necessary treatment) was the major contributing cause of the claimed conditions.

Applying those requirements to the record, the Board acknowledged that a prior shoulder surgery had been directed in part to claimant’s preexisting arthritic condition. Nevertheless, the Board reasoned that the record persuasively established that the surgery had also been directed (at least partially) to the claimed bursitis and impingement syndrome. See *Brooks v. D & R Timber*, 55 Or App 688, 692 (1982); *Daniel B. Slater*, 71 Van Natta 962, 966-67 (2019). Because the latter conditions had been found compensable and because it was undisputed that the other claimed shoulder conditions were a direct result of the surgery that was partially for those conditions, the Board concluded that the surgery had been a reasonable and necessary treatment for claimant’s compensable injury and was the major contributing cause of the other claimed shoulder conditions (coracoclavicular joint, ossicle, and distal clavicle). See *Hames*, 130 Or App at 193; *Brooks*, 55 Or App at 692; *Slater*, 71 Van Natta at 966-67. Accordingly, the Board concluded that the claimed conditions were compensable.

Extent: Impairment Findings - Reduced “ROM” Findings (“Normal” for Claimant) - Not Attributed to “Accepted,” “Preexisting,” “Combined” Condition - No Permanent Impairment Award Granted - *Caren, Robinette, Johnson* Distinguished

Kyle A. Klever, 72 Van Natta 1144 (December 17, 2020). Analyzing OAR 436-035-0007(1), (5), and OAR 436-035-0006(3), in rating claimant’s permanent impairment for an accepted groin muscle strain, the Board held that, although a medical arbiter’s findings had noted lost range of motion

Arbiter did not attribute reduced “ROM” lumbar finding to accepted groin muscle strain.

(“ROM”) in his lumbar spine/hip, he was not entitled to a permanent impairment award because those findings were wholly unrelated to his accepted condition and no preexisting/combined condition had been identified. After a reconsideration order did not award permanent impairment based on a medical arbiter’s findings did not attribute his reduced “ROM” to his accepted groin muscle strain, claimant requested a hearing. Relying on *Caren v. Providence Health Sys. Or.*, 365 Or 466 (2019), he contended that, because the carrier had not identified a preexisting condition or issued a “combined condition” denial, he was entitled to a permanent impairment award based on the “ROM” findings.

The Board disagreed with claimant’s contention. Citing OAR 436-035-0007(5) and *SAIF v. Owens*, 247 Or App 402, 414-15 (2011), *recons*, 248 Or App 746 (2012), the Board stated that where a medical arbiter is used, impairment is established based on the medical arbiter’s findings, except where a preponderance of the medical evidence demonstrates that different findings by the attending physician, or impairment findings with which the attending physician has concurred, are more accurate and should be used. Referring to OAR 436-035-0006(3), OAR 436-035-0007(1), OAR 436-035-0013(1), and *Khrul v. Foremans Cleaners*, 194 Or App 125, 130-31 (1994), the Board observed that only findings of impairment that are permanent and caused by the accepted condition or direct medical sequela of the accepted condition may be used to rate impairment.

Turning to the case at hand, the Board acknowledged that the arbiter had noted lost “ROM” in claimant’s lumbar spine. Nonetheless, noting that the arbiter had expressly concluded that this loss was wholly unrelated to claimant’s groin condition.

Under such circumstances, the Board determined that the arbiter’s findings did not establish that claimant’s impairment was caused, in any part, by his compensable injury. Consequently, the Board found no error in the reconsideration process. See ORS 656.283(6); *Marvin Wood Products v. Callow*, 171 Or App 175, 183 (2000).

In reaching its conclusion, the Board distinguished *Caren v. Providence Health Sys. Or.*, 365 Or 466 (2019), *Johnson v. SAIF*, 307 Or App 1 (2020), and *Robinette v. SAIF*, 307 Or App 11 (2020). In contrast to *Caren* (which had held that, because the medical arbiter had found that 70 percent of the claimant’s lumbar impairment was due to a preexisting lumbar condition, the carrier was required to follow ORS 656.268(1)(b) and issue a “combined condition” denial before it could reduce permanent impairment to account for a preexisting condition), the Board noted that, in the present case, the arbiter had not attributed any impairment to claimant’s accepted groin condition nor had the arbiter identified a preexisting groin condition. Similarly, in contrast to *Johnson* (where a medical arbiter had identified hand impairment that the court attributed to a combined condition that included the accepted hand condition) and *Robinette* (where a medical arbiter had identified knee impairment attributable to undenied preexisting knee conditions), the Board reiterated that, in the present case, the arbiter had not identified any groin impairment nor attributed any impairment to a preexisting groin condition.

Caren distinguished because arbiter did not attribute any impairment to accepted or preexisting condition.

“Normal for him” “ROM” finding did not necessarily support permanent impairment due to compensable injury.

Finally, the Board acknowledged that the arbiter had also stated that claimant’s lumbar “ROM” was “normal” for him. Yet, referring to *Marla S. Scanlon*, 66 Van Natta 2060, 2061 (2014), the Board observed that a “normal for him” “ROM” finding does not necessarily support permanent impairment due to a compensable injury. Moreover, the Board reasoned that, although claimant’s reduced “ROM” had been recognized, the record did not establish that such findings had been caused in any part by the compensable injury. See OAR 436-035-0007(1).

“Recon” Proceeding: Board W/O “Remand” Authority to ARU for Clarification of ARU’s “Apportionment” Inquiry to Medical Arbiter For Supplemental Report - “Apportionment” Inquiry Relevant for “Combined Condition” Claims, “Denied/Superimposed” Conditions, & if Worker’s Condition Not Caused, in Any Part, by Compensable Injury

Joel E. Johnson, 72 Van Natta 1113 (December 11, 2020). Analyzing ORS 656.268(8) and OAR 436-030-0165(8), the Board held that it was not authorized to remand a claim to the Appellate Review Unit (ARU) for the issuance of a supplemental report from a medical arbiter, which would be based on ARU’s clarification of its “apportionment” inquiry in light of the Supreme Court’s holding in *Caren v. Providence Health Sys. Oregon*, 365 Or 466 (2019). After claimant sought reconsideration of a Notice of Closure (NOC) that did not award permanent disability for his accepted condition and a medical arbiter examination, ARU referred the claim to an arbiter, along with its “apportionment” letter, which instructed the arbiter to state if the examination findings were due to the accepted conditions, direct medical sequelae, and unrelated factors, and indicated that apportionment was appropriate if the worker had evidence of a preexisting condition, denied condition or other superimposed conditions. Relying on the medical arbiter’s findings that did not support ratable permanent impairment, an Order on Reconsideration affirmed the closure notice. Claimant requested a hearing, asserting that ARU’s “apportionment” inquiry conflicted with the *Caren* holding because the carrier had neither accepted nor denied a “combined condition.” Consequently, he contended that his claim should be remanded to ARU to obtain a second medical arbiter examination.

Claimant asserted that ARU’s “apportionment” inquiry to arbiter conflicted with Caren holding because a “combined condition” was neither accepted nor denied.

Board lacked authority to remand claim to ARU, except for a “special determination” to address disability not addressed by the existing standards.

The Board denied claimant’s remand request. Citing *Pacheco-Gonzalez v. SAIF*, 123 Or App 312, 316-17 (1993), the Board stated that it lacked authority to remand a claim to ARU for a second medical arbiter’s examination or a supplemental or clarifying medical arbiter report. See also *Daniel B. Lukich*, 55 Van Natta 412 (2003); *Robert E. Kobs*, 53 Van Natta 1499 (2001); *Melody R. Ward*, 52 Van Natta 241 (2000); *Randal W. Piper*, 49 Van Natta 543 (1997); *Beverly L. Cardin*, 46 Van Natta 770 (1994). Referring to *Caren*, the Board reiterated that, in the absence of a combined condition denial, a carrier must pay compensation for the full measure of a worker’s permanent impairment if the impairment as a whole is caused in material part by the compensable injury. Nonetheless, citing OAR 436-035-0007(1)(b), the Board reasoned that an ARU “apportionment” inquiry to a medical arbiter remains relevant when

Although ARU's reference to "preexisting condition" in its arbiter inquiry was not relevant, other portion of ARU's inquiry was relevant; i.e., whether any part of worker's impairment was due to compensable injury/medical sequelae.

Concurrence expressed concern that Board's lack of remand authority can leave claimants without a means to obtain benefits to which they are legally entitled.

a carrier has processed a combined condition claim, when there has been a denied/superimposed condition, and if a worker's impairment is not caused in any part by the compensable injury/medical sequelae.

Applying those principles to the case at hand, the Board acknowledged that the reference to a preexisting condition in ARU's "apportionment" inquiry had not been relevant to the claim because the carrier had not accepted/denied a combined condition. Nevertheless, the Board reasoned that ARU's "apportionment" inquiry was relevant to the question of whether claimant's impairment was caused in any part by the compensable injury. See OAR 436-035-0007(1)(b)(B), (C). Furthermore, the Board observed that the medical arbiter had not attributed claimant's permanent impairment findings to his accepted conditions/direct medical sequelae. See OAR 436-030-0165(8).

Finally, relying on *Gallino v. Courtesy Pontiac-Buick-GMC*, 124 Or App 538 (1993) and *Valerie D. Stafford*, 66 Van Natta 2014 (2014), the Board reiterated that it is authorized to remand a claim to ARU for a "special determination" when a disability is not addressed by the existing standards. However, the Board noted that claimant's remand request was not based on such a contention.

Member Ousey specially concurred. Citing *Trujillo v. Pacific Safety Supply*, 336 Or 349 (2004), Ousey recognized that the "reconsideration process" has been found to satisfy the right to due process, in part, because the parties have the opportunity to submit evidence and issues to the Director for the medical arbiter to address, and they have the opportunity to respond to the medical arbiter report. See ORS 656.268(6)(a)(B); OAR 436-030-0115(4), (5), (7); OAR 436-030-0125(10), (11); OAR 436-030-0155(5); OAR 436-030-0165(8). However, Member Ousey expressed concern that the lack of Board authority to remand claims to ARU for a supplemental/clarifying arbiter report can leave claimants without a means of obtaining permanent disability benefits to which they are legally (and sometimes clearly) entitled. See *e.g.*, *Melody R. Ward*, 52 Van Natta 241 (2000); *Randal W. Piper*, 49 Van Natta 543 (1997).

"Recon" Proceeding: Board W/O "Remand" Authority to ARU for Clarification of ARU's "Apportionment" Inquiry to Arbiter for Supplemental Report - "Apportionment" Inquiry Relevant for "Combined Condition" Claims, "Denied/Superimposed" Conditions, & if Worker's Condition Not Caused, in Any Part, by Compensable Injury - Challenge to Arbiter's Findings (W/O Closing Evaluations of Prior/Current Injuries) Not Raised to ARU at "Recon" Level

Tanya M. Jones, 72 Van Natta 1122 (December 15, 2020). Analyzing ORS 656.268(8) and OAR 436-030-0165(8), the Board held that it was not authorized to remand a claim to the Appellate Review Unit (ARU) for the issuance of a supplemental report from a medical arbiter, which would be based on ARU's clarification of its "apportionment" inquiry in light of the Supreme Court's holding

Claimant sought remand to ARU to obtain a second medical arbiter examination based on a clarification of ARU's "apportionment" inquiry under Caren holding.

in *Caren v. Providence Health Sys. Oregon*, 365 Or 466 (2019). After claimant sought reconsideration of a Notice of Closure (NOC) (which had not awarded permanent impairment for her accepted lumbar strain) and a medical arbiter examination, ARU referred the claim to an arbiter, along with its "apportionment" letter, which instructed the arbiter to state if the examination findings were due to the accepted conditions, direct medical sequelae, and unrelated factors, and indicated that apportionment was appropriate if the worker had evidence of a preexisting condition, denied condition or other superimposed conditions. A medical arbiter reported reduced range of motion findings in the lumbar spine, but considered them normal for claimant and also attributed such findings to her underlying lumbar spondylosis. Relying on the medical arbiter's opinion, an Order on Reconsideration affirmed the closure notice. Claimant requested a hearing, asserting that ARU's "apportionment" inquiry conflicted with the *Caren* holding because the carrier had neither accepted nor denied a "combined condition." Consequently, she sought remand of her claim to ARU to obtain a second medical arbiter examination based on a clarification of its "apportionment" inquiry.

After an ALJ set aside the Order on Reconsideration and remanded the claim to the ARU for another medical arbiter examination based on a clarification of its "apportionment" questions in light of the *Caren* holding, the carrier requested Board review. Asserting that the ALJ lacked "remand" authority to ARU for a second medical arbiter examination and that claimant had not sustained permanent impairment attributable to her accepted lumbar strain, the carrier sought affirmance of the reconsideration order.

Board lacked authority to remand claim to ARU for supplemental/clarifying report from arbiter.

The Board agreed with the carrier's contentions. Citing *Pacheco-Gonzalez v. SAIF*, 123 Or App 312, 316-17 (1993), the Board stated that it lacked authority to remand a claim to ARU for a second medical arbiter's examination or a supplemental or clarifying medical arbiter report. See also *Daniel B. Lukich*, 55 Van Natta 412 (2003); *Robert E. Kobs*, 53 Van Natta 1499 (2001); *Melody R. Ward*, 52 Van Natta 241 (2000); *Randal W. Piper*, 49 Van Natta 543 (1997); *Beverly L. Cardin*, 46 Van Natta 770 (1994). Referring to *Caren*, the Board reiterated that, in the absence of a combined condition denial, a carrier must pay compensation for the full measure of a worker's permanent impairment if the impairment as a whole is caused in material part by the compensable injury. Nonetheless, citing OAR 436-035-0007(1)(b), the Board reasoned that an ARU "apportionment" inquiry to a medical arbiter remains relevant when a carrier has processed a combined condition claim, when there has been a denied/superimposed condition, and if a worker's impairment is not caused in any part by the compensable injury/medical sequelae.

Although ARU's reference to "preexisting condition" in its arbiter inquiry was not relevant, other portion of ARU's inquiry was relevant; i.e., whether any part of worker's impairment was due to compensable injury/medical sequelae.

Applying those principles to the case at hand, the Board acknowledged that the reference to a preexisting condition in ARU's "apportionment" inquiry had not been relevant to the claim because the carrier had not accepted/denied a combined condition. Nevertheless, the Board reasoned that ARU's "apportionment" inquiry was relevant to the question of whether claimant's impairment was caused in any part by the compensable injury. See OAR 436-035-0007(1)(b)(B), (C). Furthermore, the Board observed that the medical arbiter had not attributed claimant's permanent impairment findings to his accepted conditions/direct medical sequelae. See OAR 436-030-0165(8).

At ARU, claimant had not challenged arbiter's report (based on absence of closing evaluations). Thus, under Trujillo decision, Board lacked remand authority.

Concurrence expressed concern that Board's lack of remand authority can leave claimants without a means to obtain benefits to which they are legally entitled.

Claimant entitled to TTD benefits despite no express time loss authorization from attending physician.

Finally, relying on *Gallino v. Courtesy Pontiac-Buick-GMC*, 124 Or App 538 (1993) and *Valerie D. Stafford*, 66 Van Natta 2014 (2014), the Board reiterated that it is authorized to remand a claim to ARU for a "special determination" when a disability is not addressed by the existing standards. However, the Board noted that claimant's remand request was not based on such a contention.

In reaching its conclusion, the Board acknowledged claimant's assertion that the medical arbiter's report had not been based on claimant's closing evaluations from her prior and current injuries. Nonetheless, reasoning that there was no indication that claimant had challenged the arbiter's report at the reconsideration level (e.g., attempted to correct the record, or requested that ARU seek clarification from the medical arbiter), the Board concluded that it lacked authority to remand the claim to ARU. See *Trujillo v. Pacific Safety Supply*, 336 Or 349, 373-74 (2004).

Addressing claimant's request for a permanent disability award, the Board noted that the medical arbiter had not attributed any impairment to her accepted lumbar strain and that her attending physician had determined that her compensable injury had resolved without sequela, work restrictions, or impairment findings. Under such circumstances, the Board concluded a permanent disability award was not warranted. See OAR 436-035-0007(1)(b)(C).

Member Ousey specially concurred. Ousey agreed that there is no statutory authority to remand the claim to the ARU for a second or supplemental medical arbiter report, and that neither the medical arbiter nor the attending physician supported an award of permanent disability related to claimant's compensable injury. See *Pacheco-Gonzalez v. SAIF*, 123 Or App 312, 317 (1993). Nonetheless, referring to his special concurrence in *Joel E. Johnson*, 72 Van Natta 1113 (2020), Member Ousey reiterated his concerns regarding the reconsideration process that can leave claimants without a means of obtaining permanent disability benefits to which they are legally entitled.

APPELLATE DECISIONS UPDATE

TTD: "AP" Authorization - Inference, at Claim Closure, from Surgery/Hospital/Medical Records - "060-0020(4)"

Rodriguez v. Keystone RV - Thor Industries, 308 Or App 201 (December 30, 2020). Citing ORS 656.262(4)(a), and OAR 436-060-0020(4), the court affirmed the Board's order in *Jorge A. Rodriguez*, 70 Van Natta 379 (2018), previously noted 37 NCN 3:5, that held that, notwithstanding an express time loss authorization from his attending physician, claimant was entitled to temporary disability (TTD) benefits for his accepted left knee condition based on his attending physician's surgery report and "post-surgery" instructions indicating an inability to work. Asserting that the attending physician had not expressly authorized TTD benefits, the carrier contested the Board's order that had affirmed an Order on Reconsideration's award of such benefits, arguing that he was not statutorily entitled to the award.

The court disagreed with the carrier's contention. Citing ORS 656.262(4)(a) and *Menasha Corp. v. Crawford*, 332 Or 404, 402 (2001), the court reiterated that TTD benefits (either procedural or substantive) must be authorized by the

Timeloss authorization may be inferred from surgery report or hospitalization records that reasonably reflect an inability to work.

“AP’s” “post-surgery” instructions (e.g., elevate/ice knee for 20 minutes every two hours) and the physician’s subsequent release to full duty supported reasonable inference of inability to work.

In the absence of an express “AP” time loss authorization, carrier had legitimate doubt concerning its TTD liability; penalty/fee for unreasonable claim processing not justified.

attending physician/nurse practitioner. Referring to OAR 436-060-0020(4), the court observed that, at claim closure, in the absence of an explicit medical authorization of TTD benefits or time off work, an attending physician’s authorization may be inferred from medical records such as a surgery report or hospitalization record that reasonably reflects an inability to work because of the compensable claim or from a medical report/chart note generated at the time of, and indicating, the worker’s inability to work. See *Lederer v. Viking Freight, Inc.*, 193 Or App 226, 237, *adh’d to as modified on recons*, 195 Or App 94 (2004); see also, *Scott v. Liberty Northwest Ins. Corp.*, 268 Or App 325, 330 (2014).

Turning to the case at hand, the court noted that the Board had considered the entire record of claimant’s attending physician’s treatment of both of claimant’s knees, which included the physician’s previous time loss authorization for a right knee condition, as well as the physician’s “post-surgery” instructions regarding the accepted left knee condition (which included a requirement to keep the knee elevated/iced for twenty minutes every two hours and the physician’s subsequent release to “full duty”). Reasoning that an authorization of TTD benefits could be inferred from the attending physician’s “post-surgery” restrictions for claimant’s accepted left knee condition, the court concluded that the Board’s determination was supported by substantial evidence.

The court also affirmed the Board’s decision that the carrier’s “pre-claim closure” failure to pay TTD benefits following claimant’s left knee surgery was based on a legitimate doubt regarding its liability to pay such compensation and, as such, penalties/attorney fees for unreasonable claim processing under ORS 656.262(11)(a) were not warranted. See *Brown v. Argonaut Insurance Company*, 93 Or App 588, 591 (1988).

In reaching its conclusion, the court acknowledged that the Board had inferred from the entire medical record that claimant’s attending physician had authorized TTD benefits. Nevertheless, the court emphasized that the Board had also emphasized that, in the absence of an explicit work restriction, the opposite inference (*i.e.*, that there had not been a medical authorization) was reasonable. Persuaded that the Board’s reasoning constituted a permissible interpretation of the medical record and concluding that the Board’s interpretation was supported by substantial evidence, the court affirmed the Board’s determination that penalties/attorney fees were not justified.