
In the Matter of the Compensation of
FRANCISCO VARGAS, Claimant
WCB Case No. 13-06146
ORDER ON REVIEW
Schoenfeld & Schoenfeld, Claimant Attorneys
Gilroy Law Firm, Defense Attorneys

Reviewing Panel: *En Banc*. Members Lanning, Johnson, Somers, Curey, and Weddell.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that affirmed an Order on Reconsideration's temporary disability award. On review, the issues are claim processing and temporary disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant filed a low back injury claim in February 2010. Before determining the compensability of the claim, the insurer enrolled claimant in a managed care organization (MCO) for medical care related to the work injury. The insurer informed claimant that he was required to receive treatment under the terms and conditions of the MCO contract.

In March 2010, the insurer accepted the injury claim for lumbar and thoracic strains. In October 2011 and February 2012, the insurer denied new/omitted medical conditions claims for bilateral lumbar radiculopathy and facet arthropathy/syndrome. Claimant requested a hearing, contesting the denials.

On December 14, 2011, claimant began treating with Dr. Miller, who was not an MCO medical provider. Dr. Miller began authorizing temporary disability and did not release claimant to return to regular work.

In a January 2013 order, an ALJ set aside the denials of the new/omitted medical conditions. The insurer provisionally accepted the claim for those conditions. The insurer notified claimant, however, that Dr. Miller was not an MCO provider and was not authorized to provide treatment for the work injury. Claimant was also advised that he was required to change medical providers to

one from the MCO directory. Finally, if he continued to seek treatment from a non-MCO provider, claimant was warned that any temporary disability benefits would stop seven days after the mailing date of the insurer's notification letter. (Ex. 115).

Thereafter, claimant began treating with Dr. Gerry, an MCO physician, who authorized temporary disability benefits beginning March 12, 2013.

In August 2013, a "provisional" Notice of Closure issued, awarding temporary partial disability from March 12, 2013 through June 25, 2013.¹ Claimant requested reconsideration.

A December 2013 Order on Reconsideration affirmed the closure notice, determining that claimant was not substantively entitled to temporary disability benefits from December 14, 2011 to March 12, 2013 due to the absence of an "attending physician" authorization during that period. Claimant requested a hearing, seeking the aforementioned temporary disability benefits.

The ALJ affirmed the reconsideration order, reasoning that Dr. Miller, as a non-MCO medical provider, did not qualify as an "attending physician" and, therefore, could not validly authorize temporary disability benefits while claimant was enrolled in an MCO. The ALJ relied on *David N. Hood*, 53 Van Natta 1589 (2001), *on remand*, 54 Van Natta 1021 (2002); *Laura J. Golden*, 53 Van Natta 1463 (2001); and *William I. Sergeant*, 53 Van Natta 231 (2001), for the proposition that a non-MCO provider who did not qualify as an "attending physician" could not authorize temporary disability benefits.

On review, claimant requests that we reexamine the aforementioned decisions and apply the reasoning expressed in the dissenting opinion in *Darlene Sparling*, 63 Van Natta 281 (2011), *aff'd Sparling v. Providence Health System Oregon*, 258 Or App 275 (2013).² Specifically, he argues that his non-MCO physician's temporary disability authorization during the "denied status" period of his new/omitted medical condition claim was valid because that denial has been overturned and the claim is currently compensable. Based on the following reasoning, we agree with claimant's contention.

¹ Because the insurer had appealed the ALJ's compensability decision, and was responsible for processing the claim during that appeal, it designated the Notice of Closure as "provisional."

² The *Sparling* court affirmed our order on grounds that did not require discussion of the current issue.

The *Golden* decision holds that a non-MCO physician's temporary disability authorization for a new/omitted medical condition claim was not valid while the claim was in denied status. Concluding that the claimant was subject to the MCO contract (notwithstanding the carrier's denial), the *Golden* Board reasoned that, under ORS 656.245(2)(b), only an "attending physician" can authorize temporary disability benefits, and that pursuant to ORS 656.262(4)(i), a carrier may unilaterally suspend payment of all compensation if a worker enrolled in an MCO continues to seek care from an attending physician not authorized by the MCO. *Golden*, 53 Van Natta at 1465.³

After further analysis of the statutory scheme, we reach a conclusion different from the one expressed in *Golden* and its progeny. Our reasoning follows.

The pivotal question is whether a worker enrolled in an MCO remains "subject to" an MCO contract once the worker's new/omitted medical condition claim has been denied. Pursuant to ORS 656.245(4)(b)(D), reasonable and necessary medical services received from sources other than the MCO after the date of the claim denial must be paid by the carrier. The logical conclusion from this statutory directive is that, upon issuance of a carrier's denial of a new/omitted medical condition claim, the worker is no longer "subject to" an MCO contract for medical services attributable to the conditions subject to the denial. A further analysis of the phrase "subject to" supports this conclusion.

"Subject to" is not defined in the statute. In analyzing the text of the statute in context, we look to the application of relevant rules that pertain to word usage, including the presumption that words of common usage typically should be given their plain, natural, and ordinary meaning, and that terms that have acquired specialized meanings and have become recognized "terms of art" are given the specialized meaning that they have acquired. *See State v. Gaines*, 346 Or 160, 175 (2009); *PGE v. BOLI*, 317 Or 606, 611 (1993); *Tharp v. PSRB*, 338 Or 413, 423 (2005); *see also Oregon State Denturist Ass'n v. Bd. of Dentistry*, 172 Or App 693, 701-02 (2001) (resorting to medical dictionary and dictionary of ordinary meaning to determine meaning of statutory reference to "dentures").

³ The *Hood* and *Sergeant* decisions are consistent with the *Golden* rationale. In addition, the *Sparling* decision did not address the *Golden* holding.

The word “subject” is a common term and used in ordinary discourse. See *Karjalainen v. Curtis Johnston & Pennywise, Inc.*, 208 Or App 674, 682 (2006), *rev den*, 342 Or 473 (2007); *Antonio L. Martinez*, 61 Van Natta 1892, 1895 (2009). “Subject,” as pertinent here, means “falling under * * * the power or dominion of another < children ~ to their parents” or “subjected” or “submissive <be ~ to the laws>.” *Webster’s Third New Int’l Dictionary* 2275 (unabridged ed 2002). “Subjected” means “brought into a state of subjection,” with “subjection” meaning “the quality or state of being subject and esp. under the power, control, or government of another.” *Id.*

Thus, to be “subject to” an MCO contract, a worker must “fall under * * * the power or dominion” of that contract, or be “under the power, control, or government” of that contract. Applying that definition to ORS 656.245(4)(b)(D), the statute provides that once a “claim is denied,” the worker is no longer under “the power,” “control,” or “dominion” of an MCO contract; rather, that “worker may receive medical services * * * from sources other than the MCO until the denial is reversed.” See *Id.* Stated another way, if a worker is statutorily entitled to receive medical services not authorized by the MCO (or its contract) while a claim is in denied status, it cannot be said that the worker is under the power or control of that contract.

Consequently, the text of ORS 646.245(4)(b)(D) supports a conclusion that, once the insurer denied claimant’s new/omitted medical condition claim, he was no longer “subject to” the MCO contract for purposes of that denied claim. Instead, the physician primarily responsible for the treatment of a worker’s compensable condition was entitled to function as claimant’s “attending physician” without regard to his relationship to the MCO. See ORS 656.005(12)(b).

Legislative history provides further support for this conclusion. Specifically, that history shows that the MCO provisions were meant to ensure that, once a denial is issued, “the worker is on notice that the claim is not considered to be covered by the system and then, of course, the worker is free to go outside the system * * *.” Tape Recording, Senate Labor and Government Operations, meeting jointly with House Labor, SB 396, January 30, 1995, Tape 15, Side B (statement of Rep. Kevin Mannix). Representative Mannix elaborated that “when the denial goes out, the worker is then released from the obligation to treat with the [MCO] and can treat wherever the worker wants. If that denial is later overturned so [that] the claim is compensable, wherever that care was, that still has to be paid for, too. * * * [I]f the claim is denied, then the worker knows that the worker is free to go elsewhere.” Tape 45, Side A. Finally, in summarizing the MCO provisions of ORS 656.245(4), Representative Mannix reiterated the “dramatic”

and “almost revolutionary * * * guarantee that when an employer tells the worker, ‘you must go into a [MCO] for your medical services on a claim,’ that until a denial is issued, the worker is going to be guaranteed that the employer has to pay those medical bills,” and that when workers initially subject to an MCO contract “get a denial letter, * * * *they’ll know that they’re on their own.*” Tape 217, Side B (emphasis added).

Thus, our analysis of ORS 656.245(4)(b)(D), as well as the legislative history, establishes that, as of the date of a carrier’s denial of a new/omitted medical condition claim, the MCO can no longer dictate the worker’s “attending physician” or restrict the medical services obtained by the worker insofar as that physician and those services concern the denied claim. Under such circumstances, a worker is no longer “subject to” the MCO contract (insofar as the physician and medical services pertain to the denied claim); *i.e.*, the worker is no longer under the “power,” “control,” or “dominion” of the MCO contract.

To summarize, we draw the following conclusions from our examination of the statutory scheme insofar as it concerns a claimant’s entitlement to temporary disability for a compensable new/omitted medical condition claim that was authorized by a non-MCO physician during the period that the claim was in denied status. Once enrolled in an MCO, a worker remains subject to the MCO contract so long as the claim remains in accepted status. However, where a new/omitted medical condition claim is in denied status, the MCO requirements do not apply to the claim for those particular conditions. Moreover, when a denial of the new/omitted medical condition claim is subsequently set aside, the carrier becomes obligated to pay temporary disability benefits for that particular claim during the period that the claim was in denied status provided that there was an “attending physician’s” authorization during that period (regardless of that physician’s affiliation with an MCO). Because this rationale conflicts with the *Golden* reasoning, *Golden* and its progeny are disavowed.

Applying our analysis to the present case, we make the following determinations. Once the insurer denied claimant’s new/omitted medical condition claim, he was entitled to treat with and select an “attending physician” regarding those particular claimed conditions, unencumbered by any restrictions in the MCO contract. Furthermore, once the insurer’s denial was set aside, it was required to pay temporary disability benefits for those particular compensable conditions (*see* OAR 436-060-0020(10)), as well as to pay for all reasonable and necessary medical services provided by his attending physician during the period his new/omitted medical condition claim was in denied status. *See* ORS 656.245(4)(b)(D).

Accordingly, we conclude that Dr. Miller (the physician who was primarily responsible for claimant's treatment for the new/omitted medical conditions while the claim was in denied status) was statutorily permitted to authorize temporary disability benefits for that claim for the period in question. Pursuant to Dr. Miller's temporary disability authorization, we find that claimant was entitled to temporary disability benefits during the disputed period.⁴ Therefore, we award the requested temporary disability benefits.

For services at hearing and on review, claimant's attorney is awarded an "out-of-compensation" attorney fee equal to 25 percent of the increased temporary disability compensation created by this order, not to exceed \$5,000, payable directly to claimant's counsel. ORS 656.386(4); OAR 438-015-0055.

ORDER

The ALJ's order dated March 21, 2014 is reversed. In addition to the Order on Reconsideration's award, claimant is granted temporary disability benefits from December 14, 2011 to March 11, 2013. Claimant's counsel is awarded an "out-of-compensation" attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed \$5,000, payable directly to claimant's counsel.

Entered at Salem, Oregon on October 22, 2014

⁴ Apart from its challenge to Dr. Miller's status as an attending physician, the insurer does not otherwise contest that Dr. Miller's temporary disability authorizations entitle claimant to the disputed temporary disability.