Workers' Compensation Board

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News & Case Notes

BOARD NEWS

Retirement - ALJ Donnelly

Closing out her career at the position she always aspired to, Eugene Administrative Law Judge Kate Donnelly is retiring in December.

Kate was hired as a staff attorney at WCB in 2002, and later became an ALJ in 2005. She is known for her well-explained opinions and strong analytical skills. Her career in workers' compensation spans more than 30 years.

"This was my favorite job," she said. "Being an ALJ was my goal from the beginning." She added with a laugh, "You can see that, by how many times I switched sides."

She clerked at SAIF while in her third year at University of Oregon Law School. After graduation, she began her career at the Eugene firm of Jaqua & Wheatley as a research associate. She later accepted a trial attorney position at SAIF's Eugene office. When SAIF consolidated legal operations in Salem, Kate decided to stay in Eugene and went to work for a claimant's firm, Coons & Cole. "I didn't want to commute to Salem every day," she said. "Little did I know."

After stints at Liberty Northwest and a return to Coons & Cole in the 1990s, Kate ended up commuting to Salem after all, when she went to work for WCD in the Appellate Review Unit. She then came to WCB as a staff attorney in 2002. "It helped me doing cases from both sides," she said. "I always knew where the other side was coming from. I was good at trial work, but having everything riding on a win or loss was difficult."

Before becoming an attorney, Kate worked as a teacher. She obtained undergraduate degrees in history and secondary education at Millersville University in Pennsylvania, and later earned a degree in art history from Buffalo State University in New York. She drove across country to Oregon in a Volkswagen camper, and then began law school. She was part of a group of law students at Oregon that ended up becoming longtime leaders in Oregon workers' compensation, including James Egan, Christine Jensen, Roger Ousey, Brad Garber, Mike Fetrow, Vera Langer and Brent Wells.

She plans to spend the first couple of months of retirement catching up on all of the unread books on her shelf. After that, she plans to return to art, after that 30-year detour into law.

Permanent Rule Amendments: Division 015 (Attorney Fee) Rules - Effective November 1, 2016

At their October 11 meeting, the Members adopted permanent amendments to the Board's Division 015 (Attorney Fee) rules. This action is a culmination of a process that included consideration of an Advisory Committee report, which addressed several attorney fee-related concepts, as well as advised the Board concerning its biennial review of attorney fee schedules as prescribed in ORS 656.388(4). The Members wish to extend their grateful appreciation to the Advisory Committee (Martin L. Alvey, Matthew M. Fisher, Jennifer Flood, Philip H. Garrow, Julie Masters, Graham Trainor, Sheri Sundstrom, and ALJ Mark Mills (facilitator)).

Among the notable changes, these amendments: (1) increase the "thresholds/caps" for attorney fees payable from DCS and CDA proceeds from $17,500 to $50,000; (2) eliminate the "caps" for attorney fees payable from increased permanent partial disability awards; (3) increase the "caps" for attorney fees payable from permanent total disability awards from $12,500 (hearing)/$16,300 (Board review) to $20,000 (hearing)/$30,000 (Board review); (4) eliminate the "cap" for attorney fees payable from "Own Motion" temporary disability awards; (5) include the "contingent nature of the practice" of workers' compensation in the "risk of going uncompensated" factor for determining a reasonable attorney fee award; (6) include consideration of legal services performed by a claimant's attorney's legal staff in the determination of a reasonable attorney fee award; and (7) reduce the time for payment of an assessed attorney fee award from a final order from 30 days to 14 days.

These amendments became effective November 1, 2016 and apply in the manner described in the Board's Order of Adoption. Electronic copies of these amended rules, along with the Board's Order of Adoption, are available on WCB's website at www.wcb.oregon.gov (under the category "Laws and rules"). Copies have also been distributed to parties and practitioners on WCB's mailing list.

CASE NOTES

CDA: Attorney Fee - Amended Version of "015-0052" - Not Applied to Agreement With "Pre-November 1, 2016" Signature

Donald A. Sims, 68 Van Natta 1815 (November 10, 2016). In approving a Claim Disposition Agreement (CDA) and clarifying an ambiguity concerning a proposed attorney fee, the Board held that the former version of OAR 438-015-0052(1) applied because at least one of the signatures on the agreement was dated before November 1, 2016 (the effective date of the amended version of the attorney fee rule). The Board received a proposed CDA, which granted an attorney fee of $4,652 from proceeds totaling $20,000. Not all of the signatures on the CDA were dated on or after November 1, 2016

and the CDA did not identify extraordinary circumstances justifying a fee which would exceed that allowable under the former version of OAR 438-015-0052(1) (*i.e.*, $4,625).

The Board noted that, effective November 1, 2016, OAR 438-015-0052(1) (WCB Admin. Order 2-2016, eff. November 1, 2016) allows a CDA-related attorney fee of up to 25 percent of the first $50,000 of agreement proceeds, plus 10 percent of any amount in excess of $50,000, in the absence of extraordinary circumstances. Nevertheless, relying on *Sharon M. Carothers*, 48 Van Natta 172 (1996), the Board reiterated that, when a CDA contains at least one signature dated before the effective date of the rule amendment, the former version of the rule applies.

Because one of signatures on CDA was dated before November 1, 2016, former version of "015-0052" applied.

Turning to the case at hand, the Board determined that, because at least one of the signatures on the CDA was dated before November 1, 2016, the former version of OAR 438-015-0052(1) applied. Furthermore, because the CDA did not set forth extraordinary circumstances justifying an attorney fee in excess of the standard fee allowable under the rule, the Board reasoned that the proposed fee was a typographical error. Consequently, the Board approved the CDA based on the allowance of an attorney fee consistent with the *former* version of OAR 438-015-0052(1).

Claim Preclusion: Prior Unappealed Denial Expressly Limited to Specific Conditions - No Preclusive Effect on Subsequent Claim for Different Condition

Sanoma Papadopoli, 68 Van Natta 1752 (November 2, 2016). The Board held that claimant's injury claim for a left forearm condition was not precluded by the carrier's prior denial of a left hand and thumb condition because the previous denial had not been "all-inclusive," but rather had been specifically limited to the denied conditions. In response to claimant's initial injury claim arising from a work incident, the carrier's previous denial identified the claim as "an injury to [the claimant's] left hand and thumb," without suggesting that any other condition was included in the denial. That denial was not appealed and became final. Thereafter, claimant filed an injury claim for a left forearm condition arising from her work incident. When the carrier contended that the claim had already been denied and that the current claim was precluded, claimant requested a hearing, contending that her left forearm condition was compensable.

Prior denial of hand and thumb. New claim made for forearm condition.

The Board determined that claimant's forearm condition was not precluded by the previous unappealed denial. Citing *Mills v. Boeing Co*., 212 Or App 678 (2007), the Board stated that the scope of a carrier's denial is a question of fact. Referring to *Longview Inspection v. Snyder*, 182 Or App 530, 536 (2002), the Board observed that a general denial will put at issue all relevant medical conditions of which the carrier was aware. However, relying on *Jimmie C. Hudson*, 57 Van Natta 243 (2005), and *Jeremy J. Hawkins*,

53 Van Natta 566 (2001), the Board reiterated that, when a denial is limited to a specific condition, claim preclusion did not bar subsequent claims for conditions that were not the subject of earlier denials.

Because previous denial was specifically limited to hand/thumb condition, later wrist claim was not precluded.

Turning to the case at hand, the Board acknowledged that the carrier's prior denial had disputed both legal and medical causation for the denied conditions. However, consistent with the *Hudson/Hawkins* rationale, the Board found that the previous denial had been specifically limited to claimant's left hand and thumb conditions. Because claimant's current claim concerned her left forearm condition, the Board concluded that her claim was not precluded by the prior unappealed claim denial.

In reaching its conclusion, the Board distinguished *Deborah V. Hernandez*, 59 Or App 2096 (2007), which had held that a claimant's subsequent claim had been precluded by a carrier's previous denial. The Board recognized that, as in the present case, the prior denial in *Hernandez* had denied both legal and medical causation. Nevertheless, the Board reasoned that, in contrast to the case at hand, the prior denial in *Hernandez* had denied a "compensable injury," whereas the previous denial in the current case had specifically addressed claimant's claim for left hand and thumb conditions without suggesting that any other conditions could be at issue.

Combined Condition: "Ceases" Denial ("262(6)(c)") - No "Change in Condition/ Circumstances" Since "Effective Date" of Acceptance

Claim Preclusion: Previous Litigation Order Based on "Independent" Claim - Carrier's Subsequent "Combined Condition" Acceptance Inconsistent With Prior Litigation Order

Brynn Larson, 68 Van Natta 1847 (2016). Applying ORS 656.262(6)(c), the Board set aside a carrier's "ceases" denial, finding that the medical evidence did not show a change in claimant's condition or circumstances such that the otherwise compensable injury ceased to be the major contributing cause of claimant's combined cervical condition. After a carrier initially accepted a left shoulder strain, claimant initiated a new/omitted medical condition claim for a C5-6 disc herniation, which the employer denied. That denial was set aside by a previous ALJ's order, which rejected the existence of a preexisting/combined condition and found that claimant's cervical disc condition was compensable. Eventually, the carrier accepted a cervical disc herniation combined with

Prior order rejected existence of preexisting/combined condition.

preexisting cervical spondylosis and issued a "ceases" denial, contending that the compensable injury was no longer the major contributing cause of the combined condition.

The Board disagreed with the carrier's contention. Citing ORS 656.262(6)(c) and *Brown v. SAIF*, 262 Or App 640, *rev allowed*, 356 Or 397 (2014), the Board stated that a carrier may deny an accepted combined condition if the claimant's condition or circumstances have changed between the acceptance of the combined condition and the denial such that the otherwise compensable injury (*i.e.*, the work-related injury incident) is no longer the major contributing cause of the disability or need for treatment of the combined condition.

Turning to the case at hand, the Board found that the effective date of the carrier's "combined condition" acceptance was the injury date referred to in the carrier's initial acceptance. Reviewing the medical evidence concerning claimant's cervical condition between the effective date of the carrier's acceptance and denial of her combined condition, the Board was not persuaded that claimant's condition or circumstances had changed. Among other reasons for its determination, the Board noted that the physicians' opinions on which the carrier had relied had not addressed the contrary opinion of an attending surgeon that claimant's current symptoms had been present since her work injury. In the absence of a persuasive medical opinion supporting the carrier's position, the Board set aside the carrier's "combined condition" denial. *Benz v. SAIF*, 170 Or App 22 (2000); *SAIF v. Calder*, 157 Or App 224 (1998).

Experts did not address that claimant's symptoms had been present since injury.

In a special concurrence, Member Weddell addressed the preclusive effect of the Board's prior order. Noting that the prior ALJ had set aside the carrier's initial denial of the C5-6 disc herniation (finding the absence of a legally cognizable preexisting condition and that claimant had established the compensability of her cervical disc condition as an independent condition), Weddell reasoned that those findings (which had been adopted in a final Board order) were conclusive. Relying on *George B. Furst*, 65 Van Natta 1664 (2013), Member Weddell asserted that the carrier's acceptance of a combined condition did not change the finding that claimant's cervical disc herniation was an "independent" (not a "combined") condition, and, as such, the carrier's "ceases" denial was procedurally invalid.

Because prior litigation had found disc herniation compensable as "independent" claim, concurrence argued that carrier's later "combined condition" acceptance was procedurally invalid.

Hearing Request: "319(6)" - Timely Filing - "Two-Year" Limitation/Claim Processing Action/Inaction - TTD Benefit "Installments" - Each "Installment" Constitutes Separate "Action/Inaction"

Armando Morin, 68 Van Natta 1760 (November 3, 2016). Applying ORS 656.319(6) and OAR 436-060-0150(5)(h), the Board held that the statutory two-year limitation in filing a hearing request regarding a carrier's failure to pay temporary disability (TTD) benefits following its acceptance of a new/omitted

medical condition claim (after a prior ALJ's compensability decision) applied to each of the carrier's ongoing claim processing obligations to provide two-week installments of TTD benefits. Some two years after a carrier's acceptance of a new/omitted medical condition claim (which had been found compensable by a prior unappealed ALJ's order), claimant requested a hearing, contending that the carrier had neglected to pay any TTD benefits. In response, the carrier did not dispute that a valid authorization for TTD benefits existed. However, the carrier sought dismissal of the hearing request, arguing that claimant's hearing request was untimely filed under ORS 656.319(6) because the alleged claim processing inaction had occurred more than two years before the filing of the hearing request.

The Board disagreed with the carrier's contention, except to the extent that the hearing request pertained to the carrier's obligation to make its first installment of TTD benefits following the prior ALJ's order. Citing *French-Davis v. Grand Central Bowl*, 186 Or App 280, 285 (2003), the Board stated that "inaction" under ORS 656.319(6) refers to "affirmative inaction," or a failure to perform a time-specific duty, request, or obligation. Relying on OAR 436-060-0150(5) and (6), the Board noted that a carrier has a time-specific obligation to pay "prospective" TTD benefits accruing from the date of a litigation order within 14 days from the issuance of the order, as well as a continuing obligation to pay such benefits at least once every 14 days thereafter. Furthermore, referring to OAR 436-060-0150(5)(h), the Board observed that "retroactive" TTD benefits become due within 14 days from the date a litigation order awarding such benefits becomes final.

Carrier's continuing obligations to make TTD payments arose within two years of hearing request.

Addressing claimant's TTD benefits accruing from the date of the prior ALJ's order, the Board found that the carrier was obligated to begin the payment of these benefits 14 days after the issuance of the prior ALJ's order (which arose more than two years before the filing of claimant's hearing request). Under such circumstances, the Board concluded that claimant's hearing request (insofar as it pertained to the carrier's specific 14-day installment arising from the date of the prior ALJ's order) was untimely filed. However, because the carrier's continuing obligations to make ongoing "two-week" installments had all arisen within two years from the filing of claimant's hearing request, the Board determined those "inactions" were not subject to the "two-year" limitation under ORS 656.319(6).

In reaching its conclusion, the Board acknowledged that, in *Randall E. Kelley*, 54 Van Natta 1645, 1646 (2002), it had held that ORS 656.319(6) did not apply individually to each period of TTD benefits that a carrier had previously paid before later asserting an "overpayment" based on a recalculation of the claimant's TTD rate. However, the Board reasoned that, in *Kelley*, the carrier's recalculation of the claimant's TTD rate and assertion of an overpayment was the triggering event for the application of the two-year time limitation of ORS 656.319(6), whereas, in the current case, each specific "installment payment" obligation was a separate "inaction" under the statute.

Medical Services: "Pre-Hearing" Retraction of AP's "Injection" Request - Dispute "No Longer Live" - Dismissal Justified

Jaime Jimenez, 68 Van Natta 1864 (November 21, 2016). The Board dismissed claimant's hearing request regarding a medical service claim for steroid injections because, before the scheduled hearing, his attending physician had retracted the request for authorization of the injections. After the attending physician sought authorization to administer steroid injections for claimant's accepted condition, the carrier disputed the causal relationship between the injections and the accepted condition. After claimant filed a hearing request seeking resolution of the medical service dispute, his attending physician reported that he was no longer pursuing the injection because he was no longer treating claimant. Based on the physician's retraction of the injection authorization request, the carrier moved to dismiss claimant's hearing request as "moot."

Attending physician no longer treating claimant.

The Board dismissed claimant's hearing request. Citing *JRP Const. Enters. v. DCBS*, 269 Or App 372 (2015), the Board acknowledged that the concept of "mootness" is a judicial, rather than an administrative, term. Nevertheless, again referring to the *JRP* court's reasoning, the Board noted that an agency may dismiss a request for review based on some other concept of mootness created by the agency to carry out its statutory authority. Finally, the Board observed that, in reviewing the propriety of an agency's dismissal order, the *JRP* court focused on the agency's conclusion that "the dispute [was] no longer live." 269 Or App at 375-76.

Turning to the case at hand, the Board found that the causation dispute regarding claimant's medical service claim (which was initially raised in his hearing request) was "no longer live" once his attending physician retracted the authorization request regarding the proposed injections. Under such circumstances, the Board concluded that, although the precise concept of "mootness" did not apply, dismissal of claimant's hearing request was justified.

"Mootness" did not apply, but dismissal of hearing request was justified.

Mental Disorder: "802(3)" - "Independent" Claim - Pertained to "Injury-Related" Incident

Bennanico Rosales, 68 Van Natta 1827 (November 14, 2016). Applying ORS 656.802(3), the Board held that, because claimant was seeking to establish the compensability of his new/omitted medical condition claim for a post-traumatic stress disorder as directly related to his work event (a motor vehicle accident in which he observed a dead body), his claim must be analyzed as a "mental disorder" occupational disease claim. Following claimant's work-related MVA and the acceptance of several physical conditions, he initiated a new/omitted medical condition claim for PTSD (which he attributed to the effects of witnessing a dead body resulting from the MVA). When the carrier denied the claim, claimant requested a hearing, contending that his PTSD condition was compensable under either an "injury" or "mental disorder" theory.

Must be analyzed as mental disorder occupational disease.

"Mental disorder" includes condition arising directly from work-related event.

The Board held that the claim was compensable as a mental disorder under ORS 656.802(3). Citing *Dibrito v. SAIF*, 319 Or 244, 248 (1994), the Board stated that its first task is to determine the applicable law. Relying on *Fuls v. SAIF*, 321 Or 151 (1995), the Board noted that, because ORS 656.802(1)(b) specifically includes "any mental disorder" within the definition of "occupational disease" whether sudden or gradual in onset, a claimant has to establish the compensability of a mental disorder arising directly from a work-related event under ORS 656.802(3) and not as an "injury" under ORS 656.005(7). Finally, referring to *Aetna Casualty Co. v. Robinson*, 115 Or App 154 (1992) and *Boeing Co. v. Viltrakis*, 112, Or App 396 (1992), the Board observed that if a mental condition resulted from a compensable injury (rather than directly from the work event), the claim is analyzed as a "consequential condition" under ORS 656.005(7)(a)(A).

Turning to the case at hand, the Board determined that claimant's PTSD condition was based on the effects of his witnessing a dead body as a result of his work-related MVA. Under such circumstances, the Board concluded that the claim was subject to the "major contributing cause/clear and convincing evidence" requirements of ORS 656.802(3) as a "mental disorder." Finding that the medical evidence persuasively established all of the statutory requirements for a "mental disorder," the Board concluded that the claimed PTSD condition was compensable.

Own Motion: "015-0080" - Attorney Fee - TTD Award - "Out-of-Comp" Fee

Ford A. Cheney, 68 Van Natta 1899 (November 28, 2016). In an Own Motion order, the Board applied OAR 438-015-0080(1) and held that, when it directed a carrier to pay temporary disability (TTD) benefits arising from claimant's reopened new/omitted medical condition claim, his counsel was entitled to an "out-of-compensation" attorney fee, payable from the TTD benefits, rather than a carrier-paid attorney fee award. In reaching its conclusion, the Board disagreed with claimant's contention that his counsel was entitled to a carrier-paid fee under ORS 656.386(1).

2005 legislation changed Own Motion jurisdiction.

Citing *Sherlee Samel,* 55 Van Natta 2634 (2003), *rev dismissed*, *Liberty NW Ins. Corp. v. Samel*, 199 Or App 540 (2005), the Board acknowledged that it had awarded a carrier-paid attorney fee under ORS 656.386(1)(a) (1997), based on the issuance of an Own Motion order reopening a new/omitted medical condition claim under ORS 656.278(1)(b) (2001) and ORS 656.267(3) (2001). However, relying on House Bill 2294 (2005) (HB 2294), the Board noted that the 2005 legislature had amended ORS 656.267, which changed the statutory scheme regarding its Own Motion jurisdiction.

Referring to *amended* ORS 656.267(2), (3), and *James W. Jordan*, 58 Van Natta 34, 36 (2006), the Board explained that, under the current statutory scheme, whether or not the claimant's aggravation rights have expired, new/omitted medical condition claims are processed under ORS 656.262, which include the issuance of an acceptance or denial of such a claim that are first litigated before the Hearings Division under ORS 656.283 and then before the Board on appellate review pursuant to ORS 656.295. Thus, under the current statutory scheme, the Board reiterated that a carrier's responsibilities regarding

Own Motion claim processing does not arise until condition is determined to be compensable.

an Own Motion claim for a new/omitted medical condition do not arise until the condition has been "determined to be compensable." *See* ORS 656.267(3); OAR 438-012-0030(1).

Attorney fee award from increased "Own Motion-related' temporary disability award is "out-of-comp" (not carrier-paid).

Turning to the case at hand, the Board found that claimant's Own Motion claim had been reopened by a Board Own Motion order based on the Board's affirmance of an ALJ's order setting aside the carrier's denial of his new/omitted medical condition claim. Furthermore, noting that claimant had subsequently requested Own Motion relief, seeking TTD benefits on the reopened claim, the Board stated that it had directed to pay such benefits. Relying on ORS 656.386(5), and OAR 438-015-0080(1), the Board concluded that claimant's counsel was entitled to an "out-of-compensation" attorney fee, payable from the increased TTD benefits.

In reaching its conclusion, the Board acknowledged that the 2015 legislature had added ORS 656.383, which provides for assessed attorney fees for temporary disability benefits pursuant to ORS 656.210, 656.212, 656.262, 656.268 or 656.325. The Board noted that it had amended OAR 438-015-0045 and OAR 438-015-0055(1) to apply ORS 656.383 to provide for assessed attorney fees for temporary disability benefits awarded by an ALJ or the Board, respectively, for services rendered at the hearing level or on Board review. However, citing WCB Admin. Order 1-2015 (eff. January 1, 2016), the Board explained that OAR 438-015-0080 was not amended because a majority of Members had concluded that ORS 656.383 did not authorize the Board to award assessed fees in Own Motion-related temporary disability claims.

Member Lanning specially concurred, noting that he had disagreed with the majority's conclusion that ORS 656.383 did not apply to TTD awards concerning Own Motion claims. However, Lanning adhered to the majority's decision and applied OAR 438-015-0080.

Finally, based on her dissenting opinion that claimant was not entitled to TTD benefits, Member Johnson considered it unnecessary to address the attorney fee issue.

Penalty: "268(5)(f)" - Carrier's Refusal to Close Claim Not Unreasonable - Attempting to Obtain Information from "AP" - Carrier's "Pre-Request" Actions Considered - No Separate "262(11)(a)" Penalty For Same Conduct

Kevin S. Tucker, 68 Van Natta 1930 (November 28, 2016). Applying ORS 656.268(5)(f), the Board held that a carrier had not unreasonably refused to close a claim where the attending physician had failed to respond in a timely manner to multiple requests for concurrence with another physician's impairment findings and the carrier had waited for the attending physician's response before obtaining a job analysis to determine claimant's entitlement to a work disability

Attending physician did not respond to carrier's repeated inquiries for three months.

award. After requesting that claimant attend a carrier-arranged medical examination for purposes of determining permanent work restrictions, the attending physician did not respond to the examiner's report for some three months. During that period, the carrier made four requests to the attending physician for a response. About one month after receiving the attending physician's concurrence (which supported additional permanent impairment), the carrier sought a job analysis, to which the employer and claimant responded approximately one month later. Some two weeks after the carrier's "job analysis" request, claimant requested claim closure. Four days later (and some two weeks before it eventually received claimant's response to its "job analysis" request), the carrier refused to close the claim, explaining that it was awaiting information that would determine whether claimant was entitled to a work disability award. A week after receiving the job analysis, the carrier referred it to the attending physician, who immediately responded that claimant was able to perform his "at-injury" job. Some three weeks later, the carrier issued a Notice of Closure, which awarded permanent impairment. Claimant requested a hearing, seeking penalties and attorney fees for an unreasonable refusal to close the claim and unreasonable claim processing. Asserting that there were two separate acts of misconduct, claimant contended that he was entitled to penalties under both ORS 656.268(5)(f) and ORS 656.262(11)(a).

The Board disagreed with claimant's contentions. First, the Board explained that because the issue involved whether the carrier acted unreasonably in refusing to close and process the claim to closure, ORS 656.268(5)(f) and ORS 656.382(1) were the applicable statutes, not ORS 656.262(11)(a). Moreover, reasoning that there was only one request for closure, and the carrier's closure processing actions/inactions were in response to that request, the Board concluded that there were not two separate acts of misconduct warranting multiple penalties. Consequently, citing ORS 656.268(5)(f) and *Red Robin Int'l v. Dombrosky*, 207 Or App 476, 481 (2006), the Board stated that a determination of whether a penalty under ORS 656.268(5)(f) is warranted is based on a factual inquiry into the reasonableness of the refusal to close a claim under the particular circumstances.

Not unreasonable to wait for "AP's" permanent restrictions before obtaining job analysis.

Turning to the case at hand, the Board acknowledged an approximately three-week delay between the carrier's receipt of the attending physician's concurrence and its request for the job analysis, a three-week delay between the carrier's receipt of the attending physician's response to the job analysis and the issuance of the Notice of Closure, and a five-week delay between claimant's request for closure and the closure notice. Nevertheless, the Board did not find the delays to constitute an unreasonable refusal to close the claim, particularly considering the carrier's difficulties in obtaining the requested information from claimant's attending physician.

Finally, in response to claimant's assertion that the examining physician's report should have alerted the carrier of the need to obtain a job analysis to secure sufficient information to close the claim, the Board explained that when another physician performs the examination for purposes of determining impairment and work restrictions, a concurrence by the attending physician is required for the purposes of evaluating a claimant's disability. ORS 656.245(2)(b)(C); OAR 436-015-0007(6); *SAIF v. Owens*, 247 Or App 402, 409 (2011), *adh'd to on recon*, 248 Or App 746, *rev den*, 352 Or 170 (2012). Under such circumstances, the Board did not consider it unreasonable for the carrier to

wait to obtain a job analysis until the attending physician had concurred with the examining physician's permanent restrictions. Accordingly, the Board concluded that the carrier's refusal to close the claim was reasonable and that penalties/attorney fees were not warranted.

Member Weddell dissented. While not disagreeing that the attending physician contributed to the delay in processing the claim to closure, Weddell considered the carrier's approximately 4 month delay in requesting a job description from the employer to have been unreasonable, which had delayed the closure of the claim. Accordingly, Member Weddell considered a penalty under ORS 656.268(5)(f) and an attorney fee pursuant to ORS 656.382(1) justified.

APPELLATE DECISIONS UPDATE

Standards: "BFC" - Based on "DOT" Code(s), Specific Job Analysis, or "Party-Agreed" Job Description - Claimant's Affidavit Probative for Corroborative Purposes

Claimant's affidavit concerning "at-injury" job used to corroborate BFC in the DOT code.

Chase v. SAIF, 282 Or App 369 (November 16, 2016). The court affirmed without opinion the Board's order in *Charles L. Chase*, 67 Van Natta 1205 (2015), previously noted 34 NCN 7:10, which in calculating claimant's work disability under OAR 436-035-0012(9), considered his affidavit regarding the physical demands of his "at-injury" job in determining his "Base Functional Capacity" (BFC), but only as corroborative evidence in identifying the appropriate Dictionary of Occupational Titles (DOT) codes that most resembled his "at-injury" job because the record lacked either a specific job analysis or the parties' agreement regarding a job description for the "at-injury" job.

APPELLATE DECISIONS COURT OF APPEALS

Temporary Disability: "262(4)(a), (g)" - "AP" Authorization Not Directed to Compensable Condition - No Temporary Disability Benefits Awardable

Halton Company v. Nacoste, 282 Or App 420 (November 30, 2016). Applying ORS 656.212 and ORS 656.262(4), the court reversed the Board's order in *Murry Nacoste*, 65 Van Natta 2449 (2013), that awarded temporary partial disability (TPD) benefits for a period that preceded a surgery for claimant's compensable right knee condition because his attending physician's TPD authorization for that period pertained to the condition that was subject to

a previous aggravation denial. In reaching its conclusion, the Board had noted that, in previously denying claimant's aggravation claim for his accepted medial meniscal tear, the carrier had also stated its intention to accept an aggravation claim once he underwent a proposed surgery. Because the surgery had subsequently been performed, the Board determined that an Order on Reconsideration award of TPD benefits (which commenced as of a date before the surgery, as authorized by an attending physician for the meniscal tear condition) was appropriate. On appeal, the carrier contended that the "pre-surgery" disputed TPD benefits were neither awardable for the aggravation of claimant's medial meniscal tear nor for an accepted new/omitted medical condition (chondromalacia).

"AP" authorization must relate to compensable condition.

The court agreed with the carrier's contention. Citing ORS 656.212 and ORS 656.262(4), the court stated that temporary disability benefits are payable when authorized by an attending physician as due to a compensable injury. Relying on *Scott v. Liberty Northwest Ins. Corp.*, 268 Or App 325, 330 (2014), the court noted that an attending physician's authorization must relate to a compensable condition.

Intention to reopen aggravation claim after surgery did not entitle claimant to TPD before surgery, where prior aggravation denial had been upheld.

Turning to the case at hand, the court acknowledged that, in previously denying claimant's aggravation claim regarding his medial meniscal tear condition, the carrier had noted that it would reopen the claim for an aggravation *after* his surgery. Yet, the court observed that the carrier's aggravation denial had been upheld by a prior Board order, which the court had affirmed. *Nacoste v. Halton Co.*, 275 Or App 600 (2015). Moreover, noting that the carrier's prior aggravation denial had also indicated an intention to reopen the aggravation claim once claimant underwent the surgery, the court reasoned that such a statement did not support an entitlement to TPD benefits for a period *preceding* the surgery.

In addition, the court rejected claimant's assertion that the TPD benefits were awardable based on his chondromalacia condition (which was accepted after his attending physician's TPD authorization). Noting that the physician's TPD authorizations were directed to claimant's medial meniscal tear (a condition that was denied at that time pursuant to the prior aggravation denial), the court concluded that claimant was not entitled to a TPD award for the disputed period. *See* ORS 656.262(4)(g); *Webb v. Glenbrook Nickel Co.*, 189 Or App 251, 256 (2003).