Dr. Garber's

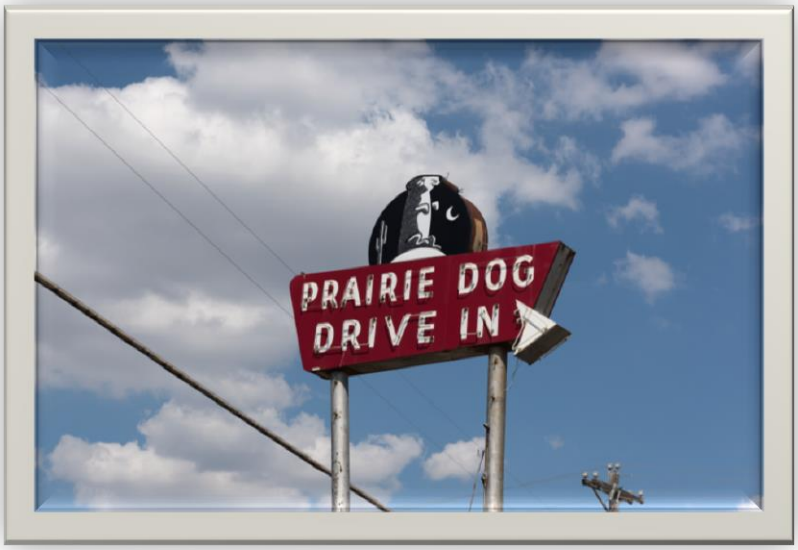
DISPENSARY OF COUGH SYRUP, BUFFALO LOTION, PLEASANT PELLETS, PURGATIVE PECTORAL, SALVE & WORKERS' COMPENSATION CASES

Bradley G. Garber's Board Case Update: 11/16/2015

Charles D. Leffler, 67 Van Natta 1997 (2015) (Own Motion Order)

Claimant requested review of a May 13, 2015 Notice of Closure that did not award additional scheduled permanent partial disability (PPD) for his "post aggravation rights" new/omitted medical conditions. On review, Claimant sought "rescission" of the Notice of Closure because SAIF Corporation did not request permanent impairment findings from the attending physician.OAR 438-012-0055 provides for closure of claims reopened under ORS 656.278 and states, in part, that "[w]hen a claim has been voluntarily reopened or ordered reopened by the Board and the medical reports indicate to the insurer that the claimant's condition has become medically stationary, the claim shall be closed by the insurer without issuance of a Board order." It was SAIF's position that this language provides no requirements regarding the medical information that a carrier is required to rely on, including no requirement to have permanent impairment measured or attending physician approval of permanent impairment findings.

In *Michael P. Hannen*, 55 Van Natta 1508, 1517 (2003), the Board held that, when a record lacked "sufficient information" to rate the claimant's "post-aggravation rights" new/omitted medical condition under the Director's standards, and the claimant asserts that he/she has ratable impairment, it was authorized to refer the claim to the Director for appointment of a medical arbiter to evaluate permanent impairment attributable to the "post-aggravation rights" new/omitted medical condition. The Board applied this rationale on several occasions. *See, e.g., Robert B. Reese*, 60 Van Natta 431 (2008); *Sandra L. Sanchez*, 59 Van Natta 1937 (2007); *Charles Crowe*, 58 Van Natta 2453 (2006); *Muriel E. Dexter*, 55 Van Natta 1907 (2003).



After splitting hairs, the Board decided to disavow its holdings in these cases. It stated, "After further considering this claim processing matter, we conclude that an adjustment of our previous rationale is required." They held: "[W]e hold that an Own Motion Notice of Closure regarding a 'post-aggravation rights' new/omitted medical condition claim may be found invalidly issued due to a carrier's failure to obtain permanent impairment findings from the attending physician or the attending physician's ratification of such impairment findings from other providers." **Notice of Closure set aside.**

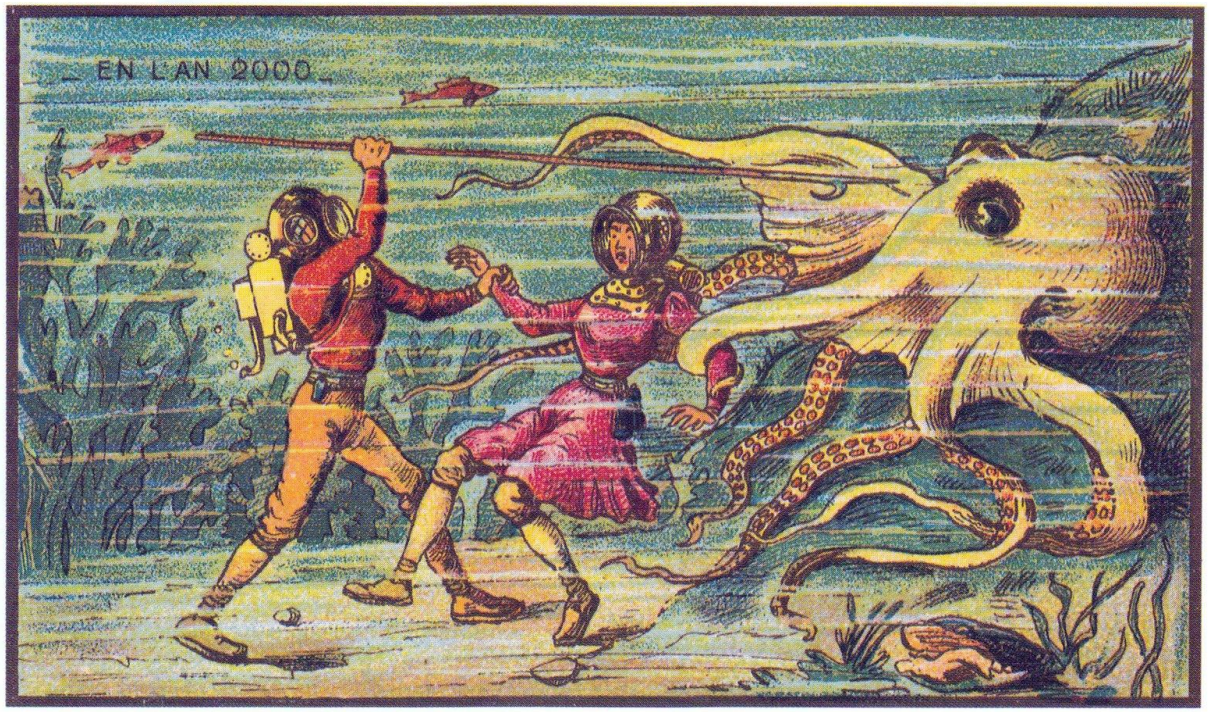
NOTE: So, prior to this decision, closure could be based on an IME report and the claimant's option was to request an arbiter exam. Now, the IME report findings must be blessed by the attending physician before the "post-aggravation rights" claim may be closed.

Steven G. Hall, 67 Van Natta 2012 (2015)
(ALJ Riechers)

Claimant requested review of the Opinion & Order that affirmed an Order on Reconsideration that awarded 5% permanent impairment for a left wrist condition.

Claimant filed an occupational disease claim for progressive left thumb, finger, wrist and elbow pain. SAIF accepted her claim for the condition of **left lateral epicondylitis**. Subsequently, SAIF denied new/omitted condition claims for left median nerve entrapment, left ulnar neuropathy and left wrist arthritis.

After a closing examination, a November 7, 2012 Notice of Closure awarded no permanent impairment for the epicondylitis. A February 19, 2013 reconsideration order affirmed the Notice of Closure. The Order on Reconsideration was not appealed.



A Monster of the Abyss

On March 4, 2014, SAIF's denial of the new/omitted conditions claim for left median nerve entrapment and left ulnar neuropathy was set aside, but the denial of Claimant's left wrist arthritis condition was upheld. Upon claim closure, Claimant's left wrist impairment was apportioned. Claimant requested reconsideration and, by Order on Reconsideration, the apportionment of Claimants

left wrist impairment was affirmed. Claimant requested a hearing, arguing that, because SAIF did not accept or deny a combined condition, under *Schleiss* he was entitled to an "unapportioned" permanent impairment value for his left wrist findings.

The Board summarily disposed of this contention by stating, "The *Brown* holding does not extend to the rating of permanent disability. *See Stuart C. Yekel*, 67 Van Natta 1279, 1284 (2015)(finding that 'statutory and administrative authority make clear that impairment is awarded based on the accepted **conditions** and the direct medical sequelae of the accepted **conditions'**)."

In this case, the claim closure concerned impairment due to newly-claimed and accepted conditions. Therefore, permanent disability had to be "redetermined," under OAR 436-035-0007(3). Under that rule, "impairment values for conditions that are not actually worsened or changed retain the same impairment values established at the prior closure and are not 'redetermined'." OAR 436-035-0007(3)(b).

In support of its holding, the Board discussed a previous decision, as follows:

"In *Marisela Johnson*, 67 Van Natta 1458, 1462, *recons*, 67 Van Natta 1666, 1669 (2015), we concluded that, under *Schleiss*, a denied condition is a legally cognizable condition to which the 'apportionment' rule applies. There, we apportioned the claimant's permanent impairment between her accepted and her denied conditions."

Consistent with *Marisela*, the Board apportioned impairment in this case.
Affirmed

And from the Court of Appeals:

SAIF v. Bales, 1106366; A154979 (November 4, 2015)

Here is the recap:

"Employer Coffman Excavation-Intel OCIP and its workers' compensation insurance carrier, SAIF Corporation, seek review of an order of the Workers' Compensation Board affirming the administrative law judge's (ALJ) order

awarding claimant attorney fees under ORS 656.386(1)(a). That statute requires the insurer to pay the claimant's attorney fees in various circumstances, including, as pertinent here, when the insurer denies a claim for compensation and the claimant's attorney is instrumental in obtaining rescission of the denial. We conclude that SAIF's decision to pay for medical services it previously denied constituted a rescission of the denial. We conclude that SAIF's decision to pay for medical services it previously denied constituted a rescission of a denied claim for purposes of ORS 656.386(1), even though SAIF never withdrew the theory on which it based its original denial."

Here is the back story:

Claimant suffered a compensable left knee injury in 2007, which SAIF accepted as a disabling medial meniscus tear. In 2010, Claimant's attending surgeon opined that the meniscus tear caused a worsening of preexisting arthritis in the knee. He performed a second surgery and administered Synvisc injections into the knee. SAIF closed the claim but rescinded the closure when Claimant became enrolled in an authorized training program.

A few month later, Claimant's attending physician requested authorization to administer more Synvisc injections. The MCO that Claimant and the employer were enrolled in declined to grant authorization, reasoning that the injections were directed at the arthritis in Claimant's knee, and not the accepted medial meniscus tear. After Claimant requested medical director review, the matter was transferred to the Hearings Division, to resolve the underlying compensability issue.

Several months later, Claimant's attending surgeon responded to an inquiry from SAIF, expressing his opinion that the injections were intended to treat arthritis that the meniscal tear had made worse. Claimant then sent SAIF a written request to

add the arthritis to the scope of claim acceptance. SAIF issued a modified notice of acceptance that did just that, and paid for the injections.

By the time the issues reached the ALJ, for hearing, all issues were essentially moot, but the ALJ concluded that SAIF's denial of medical services entitled Claimant's attorney to an assessed fee under ORS 656.386(1), because the attorney had been instrumental in overcoming a compensability denial. The Board affirmed. SAIF appealed.

ORS 656.386(1) provides, in part, that, "[i]n all cases involving denied claims * * * where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the [ALJ], a reasonable attorney fee shall be allowed." On appeal, SAIF argued that a denial of authorization for medical services is not synonymous with a denial of a "claim." The Court disagreed, reasoning that a claim for a medical service is a "claim for compensation," as defined in ORS 656.005(8). ORS 656.386(1)(b)(A) defines a "denied claim" as "[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 in not compensable or otherwise does not give rise to an entitlement to any compensation[.]" So, the Court found that a denial of a medical service was tantamount to a compensability denial.

The Court went on to find that SAIF's subsequent payment for the Synvisc treatments constituted a rescission of its denial of compensation and that, therefor, Claimant's attorney was entitled to an assessed fee, even though compensability of the arthritic condition had been conceded in a timely fashion, after the claim for that condition had been filed. **Affirmed**

Another terrible decision by the Court. Even though the insurer/employer tries to do the right thing, based on developing medical evidence, it is punished for questioning compensability of a medical service directed at a seemingly noncompensable condition. So, if you deny a medical service, don't change your mind.