DR. GARBER'S

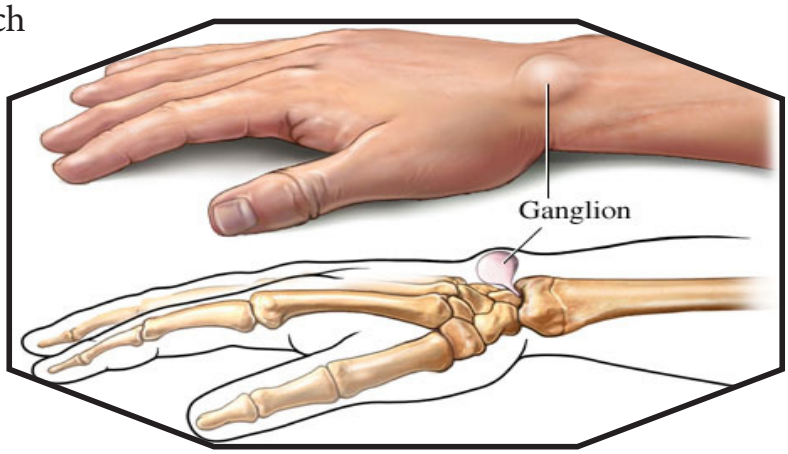
Dispensary of Cough syrup, Buffalo Lotion,
Pleasant Pellets, Purgative Pectoral, Salve
& Workers' Compensation Cases

Bradley G. Garber's Board Case Update: 01/31/12

Allison Wilson, 64 Van Natta 117 (2012)
(ALJ Rissberger)

The self-insured employer requested review of an Opinion & Order that set aside its denial of claimant's new/omitted condition claim and awarded an attorney fee under ORS 656.386(1).

After claimant injured her right wrist in September of 2006, her claim was accepted for the conditions of right thumb contusion, right wrist scapholunate ligament tear, and right dorsal wrist ganglion. A Claim Disposition Agreement was entered into, and approved on March 3, 2008. The CDA provided that claimant released all rights to workers' compensation benefits, including attorney fees, arising out of the claim and any subsequent new medical condition claim, except medical service claims.



In October of 2010, claimant filed a new/omitted condition claim for a left wrist ganglion cyst, which the employer denied. Claimant requested a hearing. After hearing, the ALJ set aside the denial and awarded claimant's attorney a fee under ORS 656.386(1). Employer requested review.

The Board affirmed the ALJ with regard to the disposition of the new condition claim denial. Moving on to the attorney fee issue, the Board started by quoting the language of the CDA, as follows: "By the terms of the March 3, 2008 CDA, claimant released her rights to 'all workers' compensation benefits allowed by law, including * * * attorney fees * * * potentially arising out of this claim and any subsequent claim for new medical conditions, except for medical services." (emphasis original). The employer contended that the CDA barred the award of an attorney fee under ORS 656.386(1). The Board disagreed. Let's see how they found a way around the clear language of the CDA!

Under ORS 656.236(1), a claimant may release "all matters and all rights to compensation, attorney fees and penalties potentially arising out of claims, except medical services." The employer contended, logically, that the issue at hearing was not a medical service issue, but a compensability issue. Claimant, after all, prevailed over a compensability denial of a new/omitted condition claim. The Board analyzed the situation as follows:

"Here, the CDA released all of claimant's rights to compensation other than medical services. Thus, by virtue of the CDA, the present claim is essentially a claim for medical services in the context of a new/omitted medical condition claim."

HUH? So, a CDA will not insulate an employer from the assessment of attorney fees if a claimant successfully overcomes a new/omitted condition denial, even though it says it will. Nearly every new/omitted condition claim involves some sort of medical service. **Affirmed**

Query: If claimant's new/omitted condition claim was a medical service claim, in sheep's clothing, did the Board have jurisdiction ?

Joyce A. Dietrich, 64 Van Natta 153 (2012)
(Order on Reconsideration)

Just another one of those claims in which the Board awards attorney fees because an employer or insurer does not accept or deny an alleged new/omitted condition claim, even though there is no medically-verified "new" medical condition. The Board relied on its precedent, as follows:

"We have assessed penalties for a carrier's unreasonable claim processing in similar

circumstances. E.g., Patsy M. Sanborn, 63 Van Natta 2214, 2216 (2011)(because the carrier did not accept or deny the claim within the statutorily required 60-day period, its claim processing was unreasonable); Nicholas Otzoy-Mejia, 61 Van Natta 2555, 2556 (2009) (regardless of whether the carrier had legitimate doubt for its liability for a new/omitted medical condition claim, it was required to accept or deny the claim within 60 days of its receipt); Peter D. Bass, 60 Van Natta 2936,2939 (2008)(when the carrier did not offer an explanation for its failure to accept or deny a new/omitted medical condition claim, its conduct was unreasonable)."

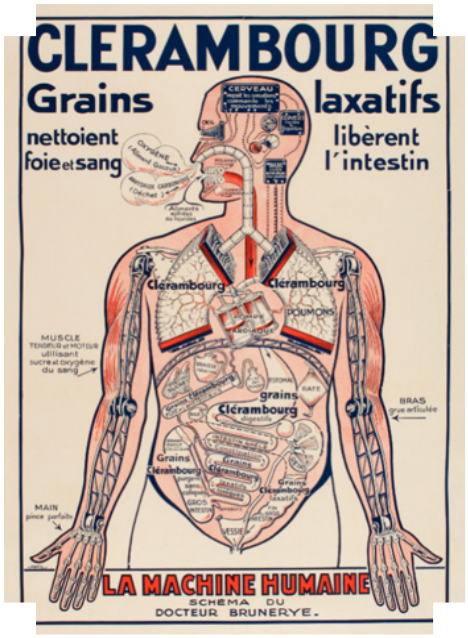
WARNING: *It doesn't matter what "explanation" is offered, if the insurer or employer does not, either, deny or accept a "new" condition claim within 60 days, it will be deemed unreasonable. The worker's attorney will get a penalty and fee under ORS 656.262(11). Even if the alleged "new" medical condition is not medically new, the Board does not care; it is not the "condition" that matters, but the "claim." So, if a "claim" is made, you are obligate to, either, accept it, or deny it. If the alleged "new" condition is really NOT a new condition from a medical standpoint (lumbar strain vs. lumbosacral strain, for example) and you deny it, your denial may be found to be an unreasonable back-up denial.*

And now, from the Court of Appeals:

Butcher v. SAIF, 070158M; A139877 (January 25, 2012)

The claimant compensably injured her low back in 1986. Nineteen years later, after her aggravation rights had, clearly, expired, she filed a claim for a "new" condition. Claimant asked that the scope of claim acceptance be expanded to include a "lumbar sacral strain/sprain." SAIF accepted the "own mo-

tion" claim, but did not award claimant temporary total disability benefits. Claimant requested Board review.



In its "Own Motion Order," the Board found that claimant had obtained a reopening of her claim for acceptance of a new medical condition and that her attending physician had authorized temporary total disability for "other curative treatment" as required by ORS 656.278(1). The board ordered SAIF to pay claimant TTD. SAIF requested reconsideration, however, and the Board changed its mind, agreeing that, while claimant was entitled to receive "other curative treatment," it was not prescribed "in lieu of hospitalization." The Board upheld SAIF's notice of closure. Claimant appealed to the Court of Appeals.

Claimant's argument was, essentially, as follows: ORS 656.278(1)(b) applies when a worker obtains a reopening of a claim for a new or omitted condition, and the worker is entitled to time loss benefits, if authorized, for "curative treatment until the worker's condition becomes medically stationary." This is different than ORS 656.278(1)(a), which applies to the Board's "own motion" authority, in the context of a "worsening," does not require that the curative treatment be "in lieu of hospitalization."

The Court agreed with claimant. In short, if you accept a post-aggravation "new" or "omitted" condition, and the attending physician authorizes time loss benefits, you're on the hook until the worker is declared medically stationary. Whether hospitalization is **involved makes no difference.**