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Division II
State of Washington
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No. 52454-6

**COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON**

KATHRYNE CONNER,

Appellant,

v.

HARRISON MEDICAL CENTER,

Respondent.

REPLY BRIEF OF APPELLANT

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I. ADDITIONAL STATEMENT OF THE CASE

The Employer details two claims Ms. Conner filed for industrial injuries before her employment with Harrison hospital as well as her four claims while employed at Harrison. (Br. of Resp. at pp. 1-2).

Kathryne Conner was born November 18, 1950. She graduated from the University of Puget Sound with a Bachelor of Science degree in Occupational Therapy in 1972. (CP 6 Testimony of Conner at p. 17). Her work as an occupational therapist was physically demanding. As Vocational Rehabilitation Counselor Carl Gann put it, “essentially you’re a traveling clinic in a car.” (CP 6 Testimony of Gann at p. 24). After downloading her patients for the day and communicating with staff and patients, Ms. Conner would load her car for visits with five to seven patients who were multi-handicapped with debilitating conditions. Her gear included a standard wheelchair, the mobility device she was using for a particular patient, and equipment to take a full set of vitals. She also had her heavy computer, which she carried (along with its cord and a recharging battery) in a bag, over her shoulder. Layering bags over both her shoulders at a time, Ms. Conner would take her computer, her occupational therapy treatment bag, her gloves/booties/mask/sanitizer bag, specific equipment (e.g., transfer tub bench, walker, thera-band) and an accordion file of paperwork with her to see each patient. This required reaching, twisting, pulling, and squatting. As she did this, the bags would fall off her shoulder down to her arms and elbows. She was also

responsible for patient transfers. This required moving patients weighing anywhere between 84-641 pounds, all of whom required at least 75 percent physical assistance. She'd perform at least five to seven patient transfers each day, more when she was performing multiple transfers with each session. (CP 6 Testimony of Gann at pp. 32, 24, 45-46, 52, 132, 133; and Testimony of Conner at pp. 33-42).

Ms. Conner's work as an occupational therapist for disabled patients was clearly physically demanding with risk of physical injury. Indeed, at times she sacrificed her own body to avoid injury to her patients. (CP 6 testimony of Conner at p. 29). When she was injured over the years, she properly filed claims as provided by the Industrial Insurance Act.

Ms. Conner's "scooter" injury occurred on March 10, 2010, when she attempted to move a 40-pound scooter that had become stuck in the tire well of her car, causing pain in her left shoulder, mid and low back. (CP 6 testimony of Conner at pp. 45-46). Since she thought she required treatment before her claim was allowed, she sought treatment through her private medical insurance at Bremerton Naval Hospital where she had x-rays on March 11, 2010. (CP 6 testimony of Conner at p. 58). The x-rays revealed moderate narrowing of the L5-S1 disk space with end plate sclerosis, which revealed the degeneration that was ultimately ordered allowed by the superior court judgment. (CP 6 testimony of Shuster at p. 48).

II. ARGUMENT

Respondent argues that Appellant did not obtain additional relief in superior court because the court did not specifically direct anything other than to order degenerative disc disease as causally related to her industrial injury and ordered the claim closed effective July 18, 2012. (Br. of Resp. at p 6). The Employer specifically argues that (1) Appellant fails to show how she can get additional relief from a closed claim; (2) that even if it was possible for the Department to act on a closed claim, the payment of any medical bills is based on a Department adjudication as to what is necessary and proper medical treatment (not the superior court judgment); and (3) there is no evidence of any medical bills not covered, so whether there is additional relief in the form of medical treatment is speculative. (Br. of Resp. at p 7).

A. There is Authority and Process for Payment of Medical Treatment Bills Post-Claim Closure.

In Appellant's brief, Ms. Conner cites the Board significant decision, *In re Kimberly Nelson*, BIIA Dec., 00 18243 (2001) that specifically addresses the authority and mechanism for how additional relief shall be granted to Ms. Conner from the superior court judgment. *In re Kimberly Nelson, Id.*, involved a self-insured employer and outstanding medical bills incurred during the pendency of the claim that were payable after claim closure. The Department closed Ms. Nelson's claim on August 19, 1998; Ms. Nelson appealed the claim closure order which, aside from the primary issue of closure, also mentioned some outstanding medical

bills, but nothing specific. Ms. Nelson voluntarily dismissed her appeal after mediation in March 1999. In June 1999, Ms. Nelson's medical provider, Dr. Lance Brigham, wrote the Department seeking help in getting the employer to pay him for medical treatment he provided to Ms. Nelson while her claim was open. In May 2000, the Department ordered the employer to pay Dr. Brigham's bills. The employer appealed arguing that the dismissal of Ms. Nelson's appeal from the closing order precludes the Department from ordering payment of Dr. Brigham's bills. The Board disagreed and held that claim closure does not preclude the Department from ordering payment for bills incurred during the period that the claim was open. This process is legally authorized and procedures are dictated by WAC 296-20-125 of the medical aid rules which provides for payment within 60 days of billing.

Dr. Brigham's bills were not specifically before the Board or the Department at the time of the closing order. Also like the present case, the closing order indicated only that services rendered after the date of closure would not be paid. The Board held that by implication, bills for services rendered during the pendency of the claim would be paid.

B. Payment of Medical Treatment Bills for the Newly Added Condition flows from the Superior Court Judgment and Constitutes Additional Relief.

Citing *Kustura v. Dep't of Labor & Indus.*, 142 Wn. App. 655 175 P.3d 1117 (2008) and *Sacred Heart Med. Ctr. v. Knapp*, 172 Wn. App. 26, 288 P.3d 675 (2012), Respondent argues that the superior court judgment

is a mere corrective order that does not translate into additional relief and that if the Department must adjudicate the additional relief, such cannot be construed as additional relief on appeal as contemplated by RCW 51.52.130. (Br. of Resp. at pp 9-10). The holdings of both cases are factually specific and not controlling or in any way applicable here.

Respondent represents *Kustura, Id.* as holding attorney fees were properly denied when the superior court issued a corrective order changing two workers' marital status and dependents where such order would "inevitably" increase their time loss. By analogy, Respondent reasons that the superior court order adding degenerative disc disease should also be deemed corrective without additional relief – especially where, unlike in *Kustura, Id.* there was no inevitable byproduct to the correction. (Br. of Resp. at p 10). However, this is not a correct representation of the holding in *Kustura*. In fact, while the court's correction of two workers' marital status and dependents would normally result in inevitable additional relief in the form of increased time loss, such was not the case because those two workers allowed their previous wage orders to become final and binding by failing to timely appeal them and the third worker's wage order was correct. In *Kustura Id.*, there was no additional relief let alone "inevitable" additional relief as represented by Respondent.

Here, unlike in *Kustura, Id.*, the superior court's judgment is not a benign corrective order without consequence but a determination that

provides additional relief because there are no previously un-appealed adverse orders here that would preclude the payment of additional relief.

Respondent cites *Sacred Heart v. Knapp*, 172 Wn. App. 26, 288 P.3d 675 (2012) for the general proposition that when the Department must adjudicate whether there is additional value to an appeal, (as in the instant case) such does not constitute additional relief. This is also not an accurate representation of the Court's holding in *Knapp*. The court expressly denied attorney fees on the basis that neither party was a prevailing party. *Knapp* did not sustain her entitlement to vocational services as determined by the Board; the court simply provided the procedural remedy of remanding the case to the Department to adjudicate whether she was entitled to vocational retraining. Here, unlike *Knapp*, the superior court granted additional relief in the form of an additional medical condition and directed the Department to act in conformity with such court judgment and order. The fact that the Department must take action consistent with the superior court judgment by determining what bills are payable or reimbursable does not negate the fact that Appellant's right to additional relief for a new condition came from the superior court.

C. Workers have One Year to Request Payment for Medical Bills for Conditions or Claims Previously Denied but later Reversed.

Respondent argues that whether there are medical treatment bills owing for inclusion of degenerative disc disease is speculative because they are not part of the Board record. (Br. of Resp. at pp 7-8). However,

WAC 296-20-125(7)(b) specifically accommodates medical billing for segregated or rejected claims that are subsequently overturned by providing that medical treatment bills are payable if received within one year of the date the final order is issued which subsequently reopens or allows the claim. See also, *In re Kimberly Nelson, Id.* at 3, lines 27-28.

WAC 296-20-125(7)(b) does not require a reviewing tribunal to direct payment of specific bills to be paid; it requires only that once coverage denial is overturned, the worker or medical provider need only request payment of medical bills within one year from the order reversing a previously denied claim or condition. While we do have evidence in the record regarding the fact Ms. Conner initially sought medical treatment in the form of evaluation and x-rays through her private medical insurance with Bremerton Naval hospital prior to her claim being allowed, (which medical treatment is payable as a matter of law)¹ it is her entitlement to request additional relief for a new condition in the form of medical

¹ While RCW 51.36.010(2)(a) requires that the Department and self-insured employers are responsible for necessary and proper medical treatment at the hands of a physician of the worker's own choosing, at least some of Ms. Conner's prospective bills are exempt from pre-authorization requirements and payable as a matter of law without the usual proper and necessary determination. WAC 296-20-030 lists the type and frequency of treatment not requiring pre-authorization for accepted conditions. These include a maximum of twenty office calls for the treatment of the industrial condition during the first sixty days following the injury, and initial diagnostic x-rays necessary for evaluation and treatment of the condition. Ms. Conner's "scooter" injury occurred on March 10, 2010. Since she wanted treatment before her claim was officially allowed, she sought treatment through her private insurance at Bremerton Naval hospital where she was evaluated and had x-rays on March 11, 2010; the x-rays revealed moderate narrowing of the L5-S1 disk space with end plate sclerosis. The x-rays revealed the degeneration that was ultimately ordered allowed by the superior court judgment. Dep. Shuster, P. 48. Therefore, at the very least, the cost for these initial examinations and x-rays one day after her industrial injury at Bremerton Naval hospital are payable by the self-insured employer as a result of the superior court appeal without regard to the Department's determination that they are reasonable and necessary.

treatment and future reopening relief based on for her degenerative disc disease that is the real additional relief. Appellant is not limited to payment of medical treatment evidenced in the CABR, however, because the Department has original jurisdiction to determine what benefits are owing as a result of the additional medical condition being included in the claim. *Lenk v. Dep't of Labor & Indus.* 2 Wn. App. 977, 982, 478 P.2d 761 (1970).²

The issue presented here where Ms. Conner secured an additional medical condition as causally related to her industrial injury is analogous to an appeal of a wholly rejected claim where the only issue on appeal is claim allowance. In such cases, owing to the Department having original jurisdiction to adjudicate benefit entitlements, the Board and courts do not have authority to determine what specific benefits a worker is entitled to beyond claim or condition allowance. Again, the Board's scope of review is limited to those issues which the Department previously decided. *Lenk, Id. at 982.* Stated otherwise, the only issue that can be adjudicated on appeal from a rejected claim is whether the claim should be allowed. In such cases, even though the court does not delineate what benefits flow from claim allowance, and there may be no evidence in the record as to what benefits are owing, such worker would clearly be entitled to an attorney fee award pursuant to RCW 51.52.130. See *Jackson v. Harvey,*

² "[I]f a question is not passed upon by the department, it cannot be reviewed either by the board or the superior court."

72 Wn. App. 507, 864 P.2d 975 (1994) (Worker obtained additional relief and was entitled to attorney fees pursuant to RCW 51.52.130 in securing claim allowance on appeal). This fee award is based on the worker's undefined entitlement to coverage under the Act which, at the very least presumably will include medical treatment pursuant to WAC 296-20-125(7)(b) discussed above.

Upon remand to the Department, the worker would be entitled to seek all appropriate benefit entitlements for his/her now allowed claim. He or she would not be limited to benefits supported in the CABR because the only issue in the appeal was claim allowance. Similarly, with respect to Ms. Conner's degenerative disc disease, the Board and superior court's scope of review on this condition was limited to causation. The Department has original jurisdiction to adjudicate the precise benefit entitlements flowing from inclusion of this new condition by the superior court.

Upon remand to the Department to issue an order allowing a worker's claim, there is no guarantee that the Department would allow any benefits other than to allow the claim and close the claim. However, in such case, the worker would still have one year to seek payment of medical treatment expenses and would have 7 years from the date of claim closure to seek reopening for all benefits.³

³ To affirm the superior court's denial of fees, this Court must conclude that there is absolutely no value or additional relief in including degenerative disc disease in Ms. Conner's "scooter" claim and that the payment of medical treatment expenses for such condition while the claim was open is worthless. However, this is contrary to one of the

D. Expanding the Scope of Future Reopening Rights is also Additional Relief.

In addition to the medical treatment expenses Ms. Conner secured by her appeal, she also secured the real additional relief in the form of an additional medical condition upon which to seek future claim reopening for all benefits including medical treatment, time loss compensation, retraining, and pension pursuant to RCW 51.32.160.

Her appeal expanded the scope of conditions proximately caused by her industrial injury and, while the superior court deemed such expanded relief theoretical or speculative, such affects the risk to the accident or medical funds of her self-insured employer. This should not be discounted as additional relief affecting the self-insured employer's funds. Workers' Compensation is industrial insurance. Insurance is about transferring risk and underwriting. In Industrial Insurance, workers transfer the losses from work injuries to the Department or self-insured employers in exchange for giving up a private right of action in tort. As a means of insuring ability to pay injured workers, the Department and self-insured employers have reporting requirements. WAC 296-17-870; WAC 296-15-221. WAC 296-15-221 sets forth the reporting requirements for self-insured employers to the Department and requires self-insured

primary objectives of the Act; to minimize suffering and economic loss to injured workers. See, *Pend Oreille Mines & Metals Co. v. Dept. of Labor & Indus.*, 64 Wn.2d 270,391 P.2d 210 (1964). In *Pend Oreille Mines*, the employer sought to classify the worker as permanently totally disabled as a means of terminating his entitlement to further medical care because further treatment would never make him employable. The court wrote that "such a construction would make the Act an absurdity by emasculating one of its primary objectives...." *Pend Orielle Mines, Id.* at 272.

employers to submit reports to the Department to include claim costs which includes “a complete and accurate annual report of all claim costs paid for each year of liability with an estimate of **future claim costs**. WAC 296-15-221(4)(b). This information is used by the Department in its annual determination of each self-insurer’s surety requirement.

Owing to Ms. Conner’s right to reopen her claim for 7 years pursuant to RCW 51.32.160, the outcome of her superior court judgment secured her the additional expanded relief for claim reopening based on an additional medical condition causally related to her industrial injury and increased the self-insured employer’s potential future costs and risk exposure such that it must be reported to the Department. The fact that such additional relief has a reporting requirement underscores the value of this relief as beyond theoretical or speculative. In using these reports to evaluate the solvency of self-insured employers, such acknowledges the fact that her inclusion of degenerative disc disease is additional relief that affects the self-insured employer’s accident and medical funds.

E. Denying Attorney Fees for Securing Inclusion of a Medical Condition and Resulting Medical Treatment Bills Contrary to the Intent of RCW 51.52.130.

In addition to ignoring the value and authority for payment of medical treatment expenses and augmented reopening rights, affirming the superior court’s judgment would remove a whole class of worker appeals from the benefit of the fee-shifting statute contrary to its intent to insure injured workers are able to secure competent legal counsel. Moreover, it would encourage the Department and self-insured employers to segregate

medical conditions from claims and effectively leave injured workers without any effective legal recourse owing to the difficulty in finding competent legal counsel willing to take on such cases because, if there is no additional relief secured by successfully challenging a rejection or segregation order, the fee shifting statute is not triggered and the attorney has no means of reasonable compensation.

The superior court too narrowly construed “additional relief” as set forth in RCW 51.52.130 which is contrary to the mandate that the law be liberally construed (RCW 51.12.010), contrary to the intent of the fee-shifting statute (to insure workers are capable of securing competent legal counsel), and inappropriately expected Appellant to have provided evidence in the CABR of the specific additional relief secured by inclusion of degenerative disc disease to her claim contrary to the Department having original jurisdiction to adjudicate these specific benefits. In *Hilding v. Dep’t of Labor & Indus*, 162 Wash. 168, 175, 298 P. 321 (1931), quoted in *Johnson v. Tradewell Stores*, 95 Wn.2d 739, 630 P.2d 441 (1981), the court wrote:

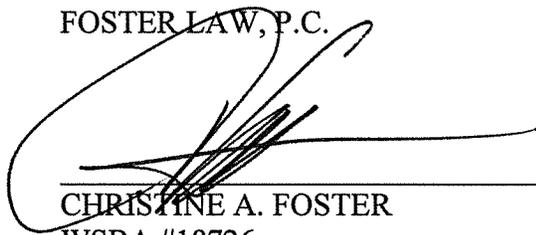
This court is committed to the doctrine that our workmen’s compensation act should be liberally construed in favor of its beneficiaries. It is a humane law and founded on sound public policy, and is the result of thoughtful, painstaking and humane consideration, and its beneficent provisions should not be limited or curtailed by a narrow construction.

V. CONCLUSION

Based on the foregoing points and authorities, Appellant respectfully requests that this Court reverse the decision of the superior court denying her attorney's fee and cost petition in its entirety, remand this matter to the superior court for a calculation of reasonable attorney's fees to be awarded by the superior court, and to further award her fees for this appeal.

RESPECTFULLY SUBMITTED this 18th day of January 2019.

FOSTER LAW, P.C.

A handwritten signature in black ink, appearing to read 'Christine A. Foster', is written over a horizontal line. The signature is stylized and somewhat cursive.

CHRISTINE A. FOSTER

WSBA #18726

Attorney for Ms. Kathyne Conner

CERTIFICATE OF SERVICE

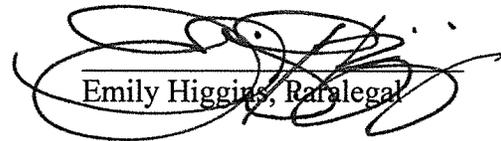
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