



# News & Case Notes

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## BOARD NEWS

### Rulemaking Hearing: November 21, 2014 - "Acknowledgment of Hearing Request" (OAR 438-006-0020)/"Expedited Claim Service - Notice of Hearing Date" (OAR 438-013-0025) - Amending "Mail"/"Mailing" to "Distribute"/"Distribution"

At its September 16 meeting, the Members proposed amendments to OAR 438-006-0020 (Acknowledgment of Hearing Request) and OAR 438-013-0025 (Expedited Claim Service - Notice of Hearing Date). Specifically, their proposal is to replace the terms "mail" and "mailing" in those rules with the terms "distribute" and "distribution." Such a rule change (in conjunction with further development of WCB's website portal, would eventually allow the Board to electronically distribute Notices of Hearing to portal users.

Notice of this rulemaking action has been filed with the Secretary of State's office. Electronic copies of these rulemaking materials are available on WCB's website (under the category "Laws & Rules"): [www.wcb.oregon.gov](http://www.wcb.oregon.gov). Copies have also been distributed to parties and practitioners on WCB's mailing list.

A rulemaking hearing for these proposed rule amendments has been scheduled for November 21, 2014, at 10 a.m. at the Board's Salem office (2601 25<sup>th</sup> St. SE, Ste. 150, Salem, OR 97302-1280). Any written comments submitted in advance of the hearing may be directed to Debra Young, the rulemaking hearing officer. Those comments may be mailed to the above address, faxed to 503-373-1684, e-mailed to [rulecomments.wcb@state.or.us](mailto:rulecomments.wcb@state.or.us) or hand-delivered to a permanently staffed Board office (Salem, Portland, Eugene, Medford).

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*Claimant's counsel was instrumental in obtaining a "pre-hearing" rescission of medical services denial by initiating new/omitted medical condition claim that was subsequently accepted and resulted in the payment of the medical services.*

## CASE NOTES

## Attorney Fees: "Pre-Hearing" Rescission of Medical Services Denial - "386(1)" - Carrier Paid For Medical Services Based on Acceptance of Subsequently Claimed New/Omitted Medical Condition

*Ronald V. Packer*, 66 Van Natta 1715 (October 15, 2014). Applying ORS 656.386(1), the Board held that claimant's counsel was entitled to a carrier-paid attorney fee when a carrier rescinded its opposition to a medical service claim before a hearing based on its acceptance of a new/omitted medical condition claim that had been initiated after the medical service claim. After accepting a C5-6 disc extrusion, the carrier denied claimant's medical service claim for a C7-T1 epidural steroid injection, contesting the causal relationship between the service and the accepted C5-6 disc condition. Following the Workers' Compensation Division's (WCD's) order transferring the causation dispute to the Hearings Division, claimant sought acceptance of a C6-7 disc protrusion. Before the hearing was held, the carrier accepted the C6-7 condition and paid for the steroid injection. When claimant's counsel sought an attorney fee award for securing the "pre-hearing" rescission of the medical service denial, the carrier opposed such a request.

The Board granted a carrier-paid attorney fee. Citing *Guy E. Bales*, 65 Van Natta 1376 (2013), the Board stated that a claimant's attorney is entitled to a fee under ORS 656.386(1)(a) when the record establishes that the attorney was instrumental in obtaining the rescission of a carrier's medical services denial before an ALJ's decision, even if that rescission was based on the carrier's acceptance of a new/omitted medical condition claim that was initiated after the medical services claim.

Turning to the case at hand, the Board found that the disputed medical services had been paid by the carrier based on its acceptance of the subsequently claimed new/omitted medical condition. Furthermore, the Board was persuaded that claimant's counsel had been instrumental in obtaining the rescission of the medical services denial before the hearing by initiating the new/omitted medical condition claim that had resulted in the carrier's acceptance and payment of the medical service. Under such circumstances, the Board concluded that a carrier-paid attorney fee award was warranted.

In reaching its conclusion, the Board acknowledged the carrier's argument that the only "attorney fee-related" statute regarding medical services was ORS 656.385(1), which only authorized WCD to grant such an award. Citing *Antonio L. Martinez*, 58 Van Natta 1814, 1822 (2006), the Board stated that it lacked jurisdiction to award an attorney fee under ORS 656.385(1). Nevertheless, relying on *Stephen H. Moore*, 66 Van Natta 1003, 1006 (2014), the Board reiterated that it is authorized to award an attorney fee under ORS 656.386(1) in a medical service dispute.

Finally, the Board disagreed with the carrier's contention that no attorney fee award under ORS 656.386(1) was authorized because it had not expressly denied any claim for a condition or expressly alleged that the injury or a condition was not compensable. Noting that the carrier had explicitly asserted that the requested medical service was not causally related to the accepted C5-6 disc condition, the Board reasoned that the carrier's position was that the condition for which compensation was claimed did not give rise to an entitlement to compensation. Inasmuch as claimant's counsel had been instrumental in obtaining the carrier's "pre-hearing" rescission of that medical service denial, the Board determined that an attorney fee award under ORS 656.386(1) was justified.

Member Johnson concurred. Expressing her agreement with the dissenting opinion in *Bales*, Johnson noted that a petition for judicial review in *Bales* was pending before the court. Nevertheless, consistent with the principles of *stare decisis*, Member Johnson adhered to the *Bales* holding.

## CDA: Reconsideration Denied - "009-0035(1), (2)" - Proposed Amendment Submitted More Than 10 Days After Board Approval of Initial CDA

*Because a request to approve a CDA addendum was filed more than 10 days after the initial CDA was approved, the Board was not authorized to alter the final CDA.*

*Dana Roger*, 66 Van Natta 1751 (October 17, 2014). Applying OAR 438-009-0035(1), and (2), the Board declined to reconsider a previously approved Claim Disposition Agreement (CDA) to address the parties' proposed amendment to the agreement because more than 10 days had elapsed since the Board's approval of the initial CDA. Over two months after the Board's approval of a CDA, the parties submitted a proposed "addendum" to the agreement.

The Board held that it was not authorized to reconsider its previous approval of the CDA. Citing OAR 438-009-0035(1), and (2), the Board stated that it may reconsider its CDA approvals, provided that the motion is filed within 10 days of the approval's issuance.

Turning to the case at hand, the Board found that the request to approve the CDA "addendum" had been filed more than two months after the CDA's approval. Because the submission was untimely filed, the Board concluded that it lacked authority to alter the previously approved and final CDA.

*The carrier was not prohibited from paying compensation beyond the statutory requirements.*

In reaching its conclusion, the Board emphasized that, in accordance with ORS 656.018(6), nothing in Chapter 656 prohibited the carrier from paying, voluntary or otherwise, payments in excess of the compensation required under the chapter. Therefore, although it was not authorized to reconsider its prior CDA approval, the Board noted that the carrier was not prohibited from paying compensation beyond that prescribed in the CDA.

## Course & Scope: “Social/Recreational” Activity/“Primarily for Personal Pleasure” - “005(7)(b)(B)” - Jumping to Touch Backboard Following Basketball Game During “Break”

*Adam J. Greenblatt*, 66 Van Natta 1696 (October 6, 2014).

Applying ORS 656.005(7)(b)(B), the Board held that claimant’s knee injury, which occurred during a work break in his employer’s courtyard while he was jumping to touch the backboard of a basketball hoop following a game with his co-workers, was excluded from coverage because the injury was incurred as a result of his engaging in or performing a recreational activity primarily for his personal pleasure. Asserting that he had stopped playing basketball and had started to return to work when he jumped to touch the backboard as an expression of happiness and excitement regarding his work performance, claimant contended that his injury had not resulted from his recreational basketball activity.

The Board disagreed with claimant’s contention. Citing *Roberts v. SAIF*, 341 Or 48 (2006), the Board recounted that the statutory exclusion of ORS 656.005(7)(b)(B) raises three questions: (1) whether the worker was engaged in or performing a “recreational or social activity”; (2) whether the worker incurred the injury “while engaging in or performing, or as a result of engaging in or performing,” that activity; and (3) whether the worker engaged in or performed the activity “primarily for the worker’s personal pleasure.” Relying on *Pamela S. Langley*, 60 Van Natta 1098, 1102 n 2 (2008), the Board stated that it looked to the reason(s) claimant “engaged in” or undertook the activity, not whether, in the moment of the game itself or its aftermath, he subjectively found the activity to be “pleasurable.”

Turning to the case at hand, the Board found no dispute that the basketball activity was a recreational activity and that claimant had engaged in that activity primarily for his personal pleasure. Consequently, the Board identified the determinative issue as whether claimant had incurred his injury while engaged in or as a result of performing that activity.

The Board acknowledged claimant’s testimony that he had been motivated by his happiness and excitement about his job performance when he jumped to touch the backboard. Nevertheless, the Board noted that he was still on the employer’s basketball court where he had engaged in a recreational activity primarily for his personal pleasure when he sustained his injury. Furthermore, even if the game had ended shortly before claimant’s leap, the Board reasoned that he was still within the boundaries of the court and that his injury was ultimately the *result* of his engaging in the recreational activity of basketball, which had put him in the position where he could jump to touch the backboard before leaving the court to return to work.

Under such circumstances, the Board concluded that claimant’s injury was excluded from compensability under ORS 656.005(7)(b)(B). Consequently, the Board upheld the carrier’s denial.

*Because claimant’s injury was ultimately the result of engaging in recreational activity of basketball primarily for his personal pleasure, his injury was excluded from compensability.*

## New/Omitted Medical Condition: “Fusion Hardware at L4-5” - Constituted “Condition” - “Physical Status of Body Part”

*Milton D. Restoule*, 66 Van Natta 1731 (October 16, 2014). Applying ORS 656.267(1), the Board set aside a carrier’s denial of claimant’s new/omitted medical condition claim for “fusion with retained hardware at L4-5” because the medical evidence established that the “fusion/retained hardware” constituted the physical status of a body part. Following claimant’s compensable low back injury and the carrier’s acceptance of a left L4-5 disc herniation, claimant underwent surgery, which included a L4-5 fusion, including screw placement and a rod. Several years later, claimant initiated several new/omitted medical condition claims, including one for the fusion/retained hardware at L4-5. The carrier denied that claim, contending that the request was not for a “condition.”

The Board disagreed with the carrier’s contention. Citing *Carl R. Hale*, 65 Van Natta 2316, 2319 (2013), and *Maureen Y. Graves*, 57 Van Natta 2380, 2381 (2005), the Board stated that, in initiating a new/omitted medical condition claim, claimant must establish the existence of a medical “condition.” Relying on *Young v. Hermiston Good Samaritan*, 223 Or App 99, 105 (2008), the Board noted that a “condition” in ORS 656.267(1) is defined as “the physical status of the body as a whole \* \* \* or of one of its parts.” Finally, referring to *Armenta v. PCC Structural, Inc.*, 253 Or App 682, 692 n 7 (2012), the Board observed that whether a claim is for a medical “condition” is a question of fact to be decided based on the medical evidence in individual cases.

Turning to the case at hand, the Board was persuaded by the opinion expressed by claimant’s attending physician, who had explained that as long as the hardware remained in the body, it was a condition of the body. The Board further noted that the physician who expressed a contrary position had acknowledged that the fusion hardware could be a condition, but it was not in the present case because it was not causing symptoms. Reasoning that the attending physician’s opinion more closely addressed and was more conversant with the *Young* standard (*i.e.*, “the physical status of the body as a whole \* \* \* or of one of its parts”), the Board concluded that the medical record supported a conclusion that the claimed fusion/hardware constituted a medical “condition.”

In reaching its conclusion, the Board distinguished *Linda A. George*, 62 Van Natta 663 (2010), where it had upheld a new/omitted medical condition denial because no medical evidence rebutted a medical opinion that a “retained foreign body” was not a separate medical condition. In contrast to *George*, the Board reasoned that the opinion in the present case indicating that the “fusion/hardware” was not a “condition” was persuasively rebutted by the attending physician’s opinion.

Finally, the Board declined to consider the carrier’s alternative argument that there was no objective evidence that the “fusion/hardware” required any treatment. Noting that the carrier’s denial had not included such a contention and finding no indication that the carrier had amended its denial at the hearing, the Board concluded that the issue was confined to whether the claimed “fusion/hardware” was a “condition.”

*A medical opinion persuasively established that “fusion hardware” was a “physical status of the body” and, as such, constituted a “condition.”*

## Own Motion: Penalties - Unreasonable Claim Closure - Carrier Relied on Inapplicable WCD Rule & Did Not Strictly Comply

*Anthony D. Cayton*, 66 Van Natta 1678 (October 7, 2014). Applying ORS 656.262(11)(a), the Board held that a carrier's closure of an Own Motion claim had been unreasonable because it had attempted to apply a Workers' Compensation Division (WCD) rule (which was not applicable) and, in any event, had not fully complied with the rule. Following a Board order reopening claimant's Own Motion claim for a "post-aggravation rights" new/omitted medical condition, the carrier issued a Notice of Closure, relying on OAR 436-030-0034(3) (which concerns claims closed under ORS 656.268(1) where a worker fails to attend a mandatory closing examination for reasons within his control). Claimant requested Board review, challenging the carrier's representation that he had received notice of the scheduled examination by certified mail at least 10 days before the exam, and seeking penalties and attorney fees for unreasonable claim processing. In response, the carrier acknowledged that the claim did not qualify for closure, but opposed claimant's penalty and attorney fee request. After setting aside the claim closure by means of a separate order, the Board addressed the penalty and attorney fee issues.

The Board held that the carrier's claim closure actions had been unreasonable. Citing *Billy J. Arms*, 59 Van Natta 2927, 2928 (2007), the Board stated that, because closure of an Own Motion claim is subject to ORS 656.278 (rather than ORS 656.268), penalties for an unreasonable claim closure pursuant to ORS 656.268(5) are not applicable to Own Motion claims. Nevertheless, relying on *David J. Swanson*, 57 Van Natta 885, 887 (2005), the Board noted that penalties and attorney fees for a carrier's unreasonable processing of an Own Motion claim are available.

Turning to the case at hand, the Board acknowledged the carrier's assertion that the basis for its claim closure had been ORS 656.268(1)(c) and OAR 436-030-0034, which provide for claim closure if the worker fails to attend a mandatory closing examination. Yet, the Board reiterated that claim closure was governed by ORS 656.278(6), not ORS 656.268.

In any event, even assuming that the aforementioned statute and rule regarding claim closure under ORS 656.268 were applicable to an Own Motion claim, the Board found no support in the record that the carrier had sent the "closing exam" notice to claimant by certified mail as required by the rule. Relying on *Paniagua v. Liberty Northwest Ins. Corp.*, 122 Or App 288 (1993), the Board noted that, for an administrative closure to be proper, the notice must be in strict compliance with the applicable rule.

Determining that the carrier had not strictly complied with the rule on which it based its actions in closing the claim, the Board concluded that the carrier's claim closure had been unreasonable. Consequently, the Board awarded penalties and attorney fees under ORS 656.262(11)(a).

*Because the carrier had not strictly complied with the rule on which it relied to close an Own Motion claim (even though the rule was not applicable), closure was unreasonable.*

Finally, the Board disagreed with claimant's contention that the carrier had unreasonably terminated the payment of his temporary disability (TTD) benefits. Citing ORS 656.278(1)(b), OAR 438-012-0035(2), and *Catherine A. Skinner*, 55 Van Natta 3766 (2003), the Board stated that the payment of TTD benefits on an Own Motion claim continues until claimant's condition becomes medically stationary.

After reviewing the record, the Board found that the carrier had received the attending physician's "check-the-box" response to its inquiry, which indicated that claimant's conditions were medically stationary. Noting that the carrier had terminated claimant's TTD after receiving the physician's response, the Board did not consider the carrier's termination of his TTD benefits to have been unreasonable.

### Own Motion: TTD - "AP" Authorization for Hospitalization/Surgery for "New/Omitted Medical Condition" - For Period Preceding Prior "NOC"

*Hallie E. Holland*, 66 Van Natta 1723 (October 16, 2014). Applying ORS 656.278(1)(b), the Board awarded temporary disability (TTD) benefits for claimant's reopened Own Motion claim for a "post-aggravation rights" new/omitted medical condition (hip osteomyelitis), finding that his attending physician's authorization for such benefits was for his surgery/hospitalization for the condition and that he was entitled to such an award even though the beginning period for the physician's authorization preceded previous Notices of Closure. After the carrier voluntarily reopened claimant's Own Motion claim for a number of "post-aggravation rights" new/omitted medical conditions (including hip osteomyelitis), the carrier eventually closed the claim, with an award of permanent total disability (PTD) benefits, effective as of a date shortly before claim closure, but without a TTD award. Claimant requested Board review, seeking TTD benefits payable from the date the carrier had stopped his TTD benefits under a prior claim closure (which was some three years before the current Notice of Closure), until the effective date of his PTD award.

The Board granted claimant's TTD request. Citing ORS 656.278(1)(b), *Butcher v. SAIF*, 247 Or App 684, 689 (2012), and *David L. Hernandez*, 56 Van Natta 2441, 2448 (2004), the Board stated that TTD benefits are payable from the date an attending physician authorizes temporary disability related to a hospitalization, surgery, or other curative treatment, which may be the date the requisite treatment is recommended, until the worker's condition becomes medically stationary. Relying on *Hernandez*, the Board noted that the obligation to pay TTD benefits on an Own Motion "new/omitted medical condition" claim begins when an objectively reasonable carrier would understand medical reports to signify an attending physician's contemporaneous approval excusing an injured worker from work "for the hospitalization, surgery, or other curative treatment."

Turning to the case at hand, the Board found that the diagnosis of claimant's osteomyelitis had been confirmed before he was hospitalized and underwent surgery and other curative treatment to address the condition. The Board further determined that the attending physician had opined several months after the hospitalization/surgery that claimant could not work and would not be able to work for "at least a couple of years."

Reasoning that the attending physician's work release had specifically mentioned claimant's surgery (which took place during a month-long hospitalization) and had recommended further surgical evaluation, the Board concluded that the work release related to hospitalization, surgery, or other curative treatment for claimant's osteomyelitis. Moreover, the Board interpreted the physician's "couple of years" reference to constitute an "open-ended" or "ongoing" work release due to the osteomyelitis condition. See *SAIF v. Camerena*, 264 Or App 400, 405-06 (2014); *Willie V. Bell*, 62 Van Natta 1157, 1165 (2010). Finally, the Board determined that the attending physician's subsequent "time loss/inability to work" comments since the "couple of years" statement constituted a reiteration of the prior "open-ended" TTD authorization and represented an authorization until claimant's condition became medically stationary shortly before the claim was closed.

Under such circumstances, the Board concluded that claimant was entitled to TTD benefits payable from the date that the carrier had previously stopped paying such benefits until his medically stationary date. In reaching its conclusion, the Board acknowledged that the attending physician's "open-ended" TTD authorization had preceded previous Notices of Closure for a "worsened condition" and another new/omitted medical condition. Nonetheless, citing *Glenn R. Horn*, 56 Van Natta 2924, 2928 (2008), and *Candice Marsden*, 50 Van Natta 1361, 1363 (1998), the Board reasoned that because the Own Motion claim for the new/omitted "osteomyelitis" condition had been reopened, the carrier was obligated to pay TTD benefits under that claim for the osteomyelitis condition, subject to the authorization to offset any TTD benefits paid under the previous claims for the same period.

*Claimant was entitled to TTD benefits on a reopened Own Motion claim payable from the date the carrier stopped paying such benefits on a previously closed claim until the condition became medically stationary.*

## TTD: "Non-MCO" Physician "Time Loss" Authorization - During Denial Period for New/Omitted Medical Condition - Denial Overturned/Authorization Valid

*Francisco Vargas*, 66 Van Natta 1777 (October 22, 2014). Analyzing ORS 656.005(12)(b), and ORS 656.245(4)(b)(D), the Board, *en banc*, held that a worker was entitled to temporary disability (TTD) benefits during the period he was treating with a physician (who was not affiliated with a Managed Care Organization (MCO)) for a denied new/omitted medical condition because the carrier's denial of that claim had subsequently been overturned and the physician had authorized such benefits while treating the worker during the "denial" period. After claimant's work injury, the carrier accepted lumbar and thoracic strains. Claimant was also enrolled in an MCO for treatment of his accepted conditions. Thereafter, the carrier denied claimant's new/omitted

medical condition claim for bilateral radiculopathy and facet arthropathy. Claimant appealed the denial and began treatments for the denied conditions with a non-MCO physician, who authorized temporary disability. Eventually, the carrier's denial was set aside by a litigation order. While the carrier appealed the compensability decision, it issued a provisional NOC, which awarded TTD benefits effective as of the date claimant returned to an MCO physician, who authorized such benefits. After an Order on Reconsideration affirmed the NOC TTD award, claimant requested a hearing, seeking TTD benefits based on the "non-MCO" physician's authorization during the period that the claim had been denied.

The Board granted claimant's request. Citing (among other decisions) *Laura J. Golden*, 53 Van Natta 1463 (2001), and *Darlene Sparling*, 63 Van Natta 281 (2011), *aff'd*, *Sparling v. Providence Health System Oregon*, 258 Or App 275 (2013), the Board acknowledged previous rulings that a "non-MCO" physician did not qualify as an "AP" during the pendency of a subsequently overturned denial of a new/omitted medical condition and, as such, could not validly authorize TTD benefits.

After further analysis of the statutory scheme, the Board reached a different conclusion and disavowed the *Golden* rationale. Relying on ORS 656.245(4)(b)(D), the Board stated that reasonable and necessary medical services received from "non-MCO" sources after the date of the claim denial must be paid by the carrier if the denial is subsequently overturned. The Board reasoned that the logical conclusion from this statutory directive is that, upon issuance of a denial of a new/omitted medical condition claim, the claimant is no longer "subject to" an MCO contract for medical services attributable to the denied condition.

Under such circumstances, the Board concluded that the physician primarily responsible for the treatment of a claimant's subsequently found compensable condition was entitled to function as the attending physician without regard to the MCO relationship. See ORS 656.005(12)(b). The Board noted that the legislative hearing regarding ORS 656.245(4) supported the conclusion that, upon the issuance of a claim denial, workers who were initially subject to an MCO contract were "on their own."

Based on its analysis of ORS 656.245(4)(b)(D) and the statute's legislative history, the Board reached the following determinations regarding the statutory scheme concerning a claimant's entitlement to TTD benefits for a compensable new/omitted condition claim that was authorized by a "non-MCO" physician during the period that the claim was in denied status. Specifically, the Board clarified that when a new/omitted medical condition claim is in denied status, the MCO requirements (which apply to the accepted conditions) do not apply to the claim for those denied conditions. Moreover, the Board reasoned that, when a new/omitted medical condition denial is set aside, the carrier becomes obligated to pay TTD benefits for that particular claim during the "denial" period provided that there was an "AP" authorization during that period (regardless of the physician's "MCO" affiliation).

Turning to the case at hand, the Board found that the "non-MCO" physician was primarily responsible for claimant's new/omitted medical conditions during the period of the carrier's denial. Further determining that the

*When a new/omitted medical condition denial is set aside, the carrier is obligated to pay TTD benefits for that claim based on a "non-MCO" physician's authorization during the claim's "denial" period.*

“non-MCO” physician authorized temporary disability during this denial period, the Board held that, once the carrier’s denial was set aside, the carrier was obligated to pay TTD benefits for those particular compensable conditions. See OAR 436-060-0020(1).

## APPELLATE DECISIONS UPDATE

### Compensable Injury: “Air Pressurization” Event - Hyperbaric Treatment - “Medical Services” Required Due to Work Event

*Horizon Air Industries, Inc. v. Davis-Warren*, \_\_ Or App \_\_ (October 15, 2014). The court affirmed the Board’s order in *Lisa R. Davis-Warren*, 63 Van Natta 2396 (2011), previously noted 30 NCN 12, that found claimant’s (a flight attendant’s) injury claim for the effects from an “in-flight” “air pressurization” work event was compensable because she required medical services (hyperbaric treatments) to diagnose her symptoms. Reasoning that claimant was not required to establish a particular diagnosis, the Board was persuaded by a physician’s opinion that, regardless of a precise diagnosis, claimant’s work exposure to a change in ambient pressure, her resulting symptoms and responses to clinical tests, necessitated a “standard of care” treatment with hyperbaric oxygen, which established that she required medical services. See *K-Mart v. Evenson*, 167 Or App 46, *rev den*, 331 Or 191 (2000). On appeal, the carrier contended that the Board had erroneously: (1) relied on a physician’s opinion that was stated in terms of “possibility” rather than “probability”; and (2) found the physician’s opinion persuasive when contrasted with countervailing medical evidence.

The court disagreed with the carrier’s contentions. Citing ORS 656.005(7)(a), the court stated that to establish a compensable injury claimant must prove that: (1) she suffered an “injury” in the course of her employment; and (2) the injury either resulted in disability or death, or was at least severe enough to “require[e] medical services.” Relying on *Evenson*, the court reiterated that “injury” means “hurt, damaged, or loss sustained.” Finally, referring to *Evenson*, *Collins v. Hygenic Corp. of Oregon*, 86 Or App 484, 488 (1987), and *Finch v. Stayton Canning Co.*, 93 Or App 168, 170 (1988), the court observed that because the statute “makes no distinction between diagnosis and treatment,” a claimant can meet her burden of proof by demonstrating that “medical services [were] required to determine what [was] wrong with her.”

Turning to the case at hand, the court determined that there was ample evidence from which a reasonable person could conclude that claimant sustained “hurt, damage, or loss” as a result of the cabin in her aircraft failing to fully pressurize. For example, the court noted that claimant had difficulty breathing, felt dizzy, and became nauseous, causing her to sit down on the floor and request oxygen. Consequently, the court concluded that claimant’s symptoms represented an “injury,” which occurred while she was at work.

*Because claimant had difficulty breathing, felt dizzy, and nauseous, her symptoms represented an “injury.”*

*Hyperbaric treatment prescribed to help a physician confirm or refute an initial diagnosis of decompression sickness established that claimant's injury required medical services.*

Identifying the real question as whether claimant's injury "requir[ed] medical services," the court acknowledged the carrier's argument that claimant had to demonstrate that it was "medically probable" that her workplace exposure was the cause of "her symptoms and the need for treatment." See *Queen v. SAIF*, 61 Or App 702 (1983); *Gormley v. SAIF*, 52 Or App 1055 (1981). Reasoning that the claimants in *Queen* and *Gormley* had both sought medical treatment for a disability, the court distinguished those cases from the present claim, which involved medical services that were necessary to diagnose claimant's symptoms. Noting that the Board had relied on a physician's explanation that the medical treatment had been prescribed to help confirm or refute an initial diagnosis of decompression sickness, the court determined that the Board's conclusion that the treatments were necessary was consistent with both the *Finch* and *Collins* opinions.

Addressing the carrier's challenge to the Board's decision to defer to the opinion of the aforementioned physician, the court reiterated that ordinarily the question of how to resolve competing expert medical opinions is within the discretion of the Board. See *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206 (1988). Furthermore, the court noted that, in reviewing a medical expert's opinion, it "do[es] not substitute [its] judgment for that of the board; rather, [it] must determine whether the board's evaluation of that evidence was reasonable." *SAIF v. Pepperling*, 237 Or App 79, 85 (2010).

After conducting its review, the court could not say that it was unreasonable for the Board to have accepted the physician's opinion, rather than the opinion expressed by another physician, and to have reasonably concluded that a test of pressure with hyperbaric oxygen was necessary based on claimant's exposure to a change in pressure, her symptoms, the results of her physician's examination, and the relative difficulty of diagnosing decompression sickness. Consequently, the court affirmed.

## **APPELLATE DECISIONS COURT OF APPEALS**

### Combined Condition: "Ceases" Denial - "262(6)(c)" - "Otherwise Compensable Injury"

*Roble v. SAIF*, 266 Or App 228 (October 8, 2014). The court, *per curiam*, reversed the Board's order in *Felix V. Roble*, 65 Van Natta 206 (2013), that had upheld a carrier's "ceases" denial under ORS 656.262(6)(c) of a combined low back condition. Citing *Brown v. SAIF*, 262 Or App 640 (2014), the court remanded.

## Extent: Impairment Findings - “Chronic Condition” Award - “Significant Limitation” in “Repetitive Use” - “035-0019”

*Spurger v. SAIF*, 266 Or App 183 (October 8, 2014). The court reversed the Board’s order in *Angelica M. Spurger*, 63 Van Natta 2372 (2011), which found that claimant was not entitled to a “chronic condition” impairment value for a hip condition because the record did not establish that she was “significantly limited in the repetitive use” of that body part. Applying OAR 436-035-0019, the Board had reasoned that neither claimant’s attending physician’s own report, nor a report from another physician from which the attending physician had concurred, supported a conclusion that claimant was significantly limited in the repetitive use of her hip. On appeal, claimant argued that the Board had not identified a proper interpretation of the term “significantly limited,” but rather had inappropriately relied entirely on the physician’s refusal to label her repetitive use limitations as “significant.”

The court held that the Board’s order was not supported by substantial reason. Citing *Wal-Mart Stores, Inc. v. Young*, 219 Or App 410, 413-14 (2008), the court stated that the Board’s opinion must include a sufficient explanation to allow a reviewing court to examine its action; *i.e.*, it must be supported by substantial reason. Furthermore, relying on *Weckesser v. Jet Delivery Systems*, 132 Or App 325, 328 (1995), the court noted that, under a former version of OAR 436-035-0019, the Board was permitted to award “chronic condition impairment” even if the record contains no express medical finding that the condition is “chronic,” provided that the record contains a medical opinion *from which it can be found* that the worker is unable to repetitively use a body part “due to a chronic and permanent medical condition.”

Turning to the case at hand, the court reasoned that the *Weckesser* principle applied equally to the current rule. In other words, the court explained that what is relevant is whether the *limitations* described in the medical opinion shows that claimant is significantly limited, not whether a physician *described* the limitations as “significant” according to the physician’s understanding of that term.

After reviewing the Board’s order, the court determined that the Board’s only explicit attempt to explain why, as a legal matter, claimant had failed to show that she was “significantly limited” was wholly centered on the physicians’ refusal to call her limitations “significant” under either a “major loss of function” or an “important, weighty or notable” definition of the term. Reasoning that the physicians’ opinions do not drive the legal standard announced in the administrative rule (but rather the legal meaning of the rule drives the significance of the physicians’ opinions), the court considered such opinions to be of little use in a circumstance where the Board had not identified a legal principle by which to gauge their evidentiary weight.

After separating the physicians’ *labels* of claimant’s repetitive use limitations from their opinions, the court noted all that was left insofar as a *description* of those limitations was the statement that she “would have difficulty

*Physician’s opinion of “significant limitation” did not drive the legal standard for a “chronic condition” impairment value; rather the Board must identify a legal principle to gauge evidentiary weight of the physician’s opinion.*

*The Board order had not explained why claimant's described limitations were not considered "significant" enough to qualify for a "chronic condition" impairment value.*

with repetitive squatting, walking long distances and static standing for long periods of time." Observing that the Board's order stated that the medical opinions had been considered "as a whole and in the context in which they were rendered," the court found nothing in such a recital to tell it (as the reviewing body) why the Board had considered the described limitations not "significant" enough to qualify for a "chronic condition" impairment value under OAR 436-035-0019.

Under such circumstances, the court concluded that it was appropriate to remand the case to the Board to correct the aforementioned deficiency. In doing so, the court declined claimant's request that it provide a judicial interpretation of the term "significantly limited"; e.g., "significantly" refers to any repetitive use limitation that is more than a *de minimus* one. Although the Board did not promulgate OAR 436-035-0019, the court reasoned that its function was to review an agency's interpretation of an administrative rule, rather than for the court to formulate an interpretation in the first instance. See *Springfield Education Assn. v. School Dist.*, 290 Or 217, 233-34 (1980).

## Medical Services: "245(1)" - Caused in Material Part By Compensable Injury

*Schaffer v. SAIF*, 266 Or App 227 (October 8, 2014). The court, *per curiam*, reversed the Board's order in *Jeremy Schaffer*, 65 Van Natta 292 (2013), that had upheld a carrier's denial of claimant's medical services claim for a right hand condition because the medical treatment was for his accepted conditions. Citing *SAIF v. Carlos-Macias*, 262 Or App 629 (2014), the court remanded.

## Penalty/Attorney Fees: "262(11)(a)" - Board's "Legitimate Doubt" Determination Concerning Carrier's Termination of TTD - Lacked Substantial Reasoning

*Hamilton v. Pacific Skyline, Inc.*, \_\_\_ Or App \_\_\_ (October 29, 2014). The court reversed the Board's order in *Carl W. Hamilton*, 65 Van Natta 966, *recons*, 65 Van Natta 1121 (2013), that declined to award penalties and attorney fees under ORS 656.262(11)(a) for a carrier's termination of claimant's temporary disability (TTD) benefits. In reaching its conclusion, the Board had reasoned that the carrier had not received claimant's then-attending physician's time loss authorization until after it had retroactively reinstated claimant's TTD benefits and that the carrier's delay in paying such benefits was not unreasonable because its disapproval of the physician as the "attending physician" had been affirmed by the Workers' Compensation Division (WCD). On reconsideration, the Board further determined that, despite the carrier's claim examiner's notation in a claim ledger (recorded before the carrier's termination of TTD benefits) indicating that the attending physician had reported that claimant remained disabled and required more physical therapy, the carrier still had a legitimate doubt regarding claimant's entitlement to TTD benefits when it subsequently

terminated such benefits because there was no written verification from the then-attending physician received by the carrier. On appeal, claimant contended that the Board's determination was not supported by substantial reasoning.

The court agreed with claimant's contention. Citing *Walker v. Providence Health System Oregon*, 254 Or App 676, 686, *rev den*, 353 Or 714 (2013), the court stated that in determining whether a Board order is supported by substantial reason, it considers whether the order articulates the reasoning that leads from the facts found to the conclusion drawn. Relying on *Cayton v. Safelite Glass Corp.*, 257 Or App 188, 192 (2013), the court reiterated that a carrier does not act unreasonably if it has a "legitimate doubt" about its obligation to pay temporary disability benefits.

Turning to the case at hand, the court noted that the Board's conclusion was based on the following facts and principles: (1) the carrier did not receive the then-attending physician's written verification of disability until after the carrier reinstated claimant's benefits and apparently only had oral notice of the physician's disability determination before then; (2) WCD had ultimately upheld the carrier's disapproval of the physician as claimant's "attending physician"; and (3) if a carrier's conduct comports with a validly enacted rule or statute, the carrier acts reasonably.

After examining the aforementioned determinations, the court found no explanation from the Board's orders that would lead to the conclusion that the carrier had a legitimate doubt about its obligations to pay temporary disability benefits at the time it terminated such benefits. In reaching its decision, the court reasoned that, absent further explanation from the Board, it could not discern from the orders whether: (1) the Board had construed ORS 656.262(4)(a) and (g) to require *written* time loss authorization as a matter of law (notwithstanding OAR 436-060-0020(4), which provides that authorization may be oral or in writing); (2) the Board had found that the carrier had relied on a reasonable, albeit mistaken, interpretation of that statute; (3) the Board had concluded that, although written authorization was not necessarily statutorily required, the lack of a written authorization in this particular case provided the carrier with a legitimate doubt regarding its obligation to pay temporary disability benefits; or (4) the Board had concluded something else altogether.

Because it was unable to tell from the Board's orders how the facts it had found connected to its conclusion that the carrier had a legitimate doubt regarding its liability to provide temporary disability benefits during the relevant period, the court remanded for reconsideration.