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BOARD NEWS

WCB Welcomes New Board Members - Judy Johnson and Sally Curey

Judy is a graduate of Willamette University College of Law and has been a member of the Oregon State Bar since 1980. After law school, she practiced for several years as a deputy district attorney and public defender before shifting her focus to workers' compensation law. During the course of her career, she has worked as in-house counsel for SAIF Corporation (1985 to 1987), in private practice at Stoel Rives (1987 to 1990) and for Liberty Mutual (1992 to 2006). From 2006 to 2012, she operated her own practice representing self-insured employers on workers' compensation matters and advising employers on employment law. In addition to her legal work, she has spoken on Workers' Compensation law at legal seminars, and co-authored chapters for the Oregon State Bar's publication on Workers' Compensation Law. Judy joined the Workers' Compensation Board on June 1, 2014.

Sally Anne Curey was confirmed as a Workers' Compensation Board Member on April 29, 2014. Sally graduated from Oregon State University in 1984 with a Bachelor of Science degree in Political Science. Thereafter, she obtained her J.D. from Willamette University College of Law in 1988. Following law school, Sally worked for the Workers' Compensation Board as a Staff Attorney. Thereafter, she started working for Liberty Northwest/Liberty Mutual and had a full-time insurance defense litigation practice which focused on workers' compensation law. While at Liberty, she also practiced some civil litigation. After 25 years of workers' compensation experience, she joined the Workers' Compensation Board as a Board Member.

Bulletin 1 (Revised) - Annual Adjustment to Attorney Fee Awards - Effective July 1, 2014

On June 12, 2014, "WCB Bulletin No. 1 (Revised)" published the annual adjustment to attorney fee awards under ORS 656.262(11)(a) and ORS 656.308(2)(d). See OAR 438-015-0038; OAR 438-015-0055(5); OAR 438-015-0110(3).

Effective July 1, 2014, an attorney fee awarded under ORS 656.262(11)(a) may not exceed \$3,334, absent a showing of extraordinary circumstances. OAR 438-015-0110(3). Also effective July 1, 2014, an attorney fee awarded under ORS 656.308(2)(d) shall not exceed \$2,778, absent a showing of extraordinary circumstances. OAR 438-015-0038; OAR 438-015-0055(5).

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These adjustments apply to all attorney fee awards under these statutes granted by orders beginning July 1, 2014. The bulletin can be found on the Board's website at:

http://www.cbs.state.or.us/wcb/wcbbulletin/bulletin1_2014.pdf

WCB Portal Update

WCB Portal Users who file Requests for Hearings may notice a new feature on the WCB Portal. A date field has been added to provide a defacto denial date. Previously, this information was placed in the comments field, and we implemented this enhancement based on user feedback. Thank you for using the WCB Portal and please continue providing us with suggestions on how the Portal can work best for you.

CDA Provisions: Amount of PPD Awards - "009-0022(4)(c)"

The Board periodically receives Claim Disposition Agreements (CDAs), which include ambiguous provisions regarding the amount of a claimant's previous permanent disability (PPD) awards. Because such ambiguities can delay the processing of the CDA and require an addendum to clarify prior PPD awards, the following comments are offered.

In accordance with OAR 438-009-0022(4)(c), a proposed CDA must include a provision describing the "amount of any permanent award(s), if any." The parties routinely list both the total whole person impairment and total work disability. Occasionally, a CDA will describe a claimant's "whole person impairment" award in an amount less than the total "work disability" award.

Because a claimant's total "work disability" award is computed by adding the "whole person permanent impairment" value to the values for age, education and adaptability to perform a given job (work disability award), if there is any "work disability" award, such an award will always be larger than the "whole person permanent impairment" award. Therefore, those CDAs submitted identifying a work disability award less than the impairment award would be understating the value of claimant's awards.

Because this inaccurate description of a claimant's PPD award can delay the processing and approval of a CDA, parties and practitioners are encouraged to describe the previous "whole person permanent impairment" and "work disability" awards in an accurate manner.

CASE NOTES

Claim Preclusion: “DCS” Concerning “Psychological Condition” - Precluded Later “PTSD” New/Omitted Medical Condition Claim - Continuation of Same Condition

Jose Jimenez, 66 Van Natta 1041 (June 3, 2014). The Board held that claimant’s new/omitted medical condition claim for post-traumatic stress disorder (PTSD) was precluded by a prior Disputed Claim Settlement (DCS), which had resolved his earlier new/omitted medical condition claim for his “current psychological condition” because the record established that his PTSD was a continuation of the previously settled condition. Following his compensable arm and shoulder injury, claimant entered into a DCS, which resolved the compensability of his current psychological condition, as unrelated to his accepted claim. Over ten years later, claimant sought treatment for emotional problems, which resulted in a diagnosis of PTSD and anxiety. The carrier denied his new/omitted medical condition claim, asserting that it was precluded by the prior DCS. Claimant requested a hearing, arguing that his current PTSD and anxiety conditions were separate and distinct from the “current psychological condition” that had been settled in the DCS.

The Board disagreed with claimant’s assertion. Citing *Evangelical Lutheran Good Samaritan Society v. Bonham*, 176 Or App 490, 498 (2001), the Board stated that new/omitted medical condition claims are generally not subject to “claim preclusion” because they can be initiated at any time. See ORS 656.262(6)(d); ORS 656.267(1). However, relying on *Wasson v. Evanite Fiber Corp.*, 117 Or App 246, 248 (1992), and *Proctor v. SAIF*, 68 Or App 333 (1984), the Board noted that a DCS may preclude a new/omitted medical condition claim unless the claimed condition is different from the denied condition that was resolved in the DCS.

Turning to the case at hand, the Board acknowledged that, at the time of the DCS, the record did not indicate that claimant had treated for, or was diagnosed with, a specific psychological condition. The Board further recognized that claimant’s attending physician had initially opined that claimant’s presently claimed PTSD and anxiety were “new” and “different” from the “current psychological condition” that had been resolved by the DCS. Nevertheless, the Board noted that claimant’s attending physician had subsequently concurred with another physician’s opinion that claimant had developed his PTSD and other conditions shortly after his work injury and that these psychological conditions existed when the DCS resolved his “current psychological condition.”

Finding the latter physician’s opinion to be persuasive, and considering the attending physician’s concurrence with that opinion, the Board concluded that claimant’s presently claimed psychological conditions were a continuation of the same “current psychological condition” that had been resolved by the DCS. Under such circumstances, the Board held that claimant’s new/omitted medical condition claim for his psychological condition was precluded. See *Wasson*, 117 Or App at 248; *Proctor*, 68 Or App at 336.

Because medical opinions established that claimant’s presently claimed psychological conditions existed when a prior DCS resolved his “current psychological condition,” the Board held that his present claim was precluded.

Combined Condition: “Ceases” Denial - “262(6)(c)” - Carrier Did Not Prove “OCI” (Work-Related Injury/Incident) Was Not Major Cause of “Combined Condition”

Rebecca Littlefield, 66 Van Natta 1048 (June 3, 2014). Applying ORS 656.262(6)(c), the Board set aside a carrier’s “ceases” denial of claimant’s combined condition because the medical evidence did not persuasively establish that her “otherwise compensable injury” (her work-related injury/incident) was not the major contributing cause of her combined left shoulder condition. Following claimant’s compensable left shoulder injury, the carrier accepted a shoulder strain combined with preexisting bursitis, impingement syndrome, and a partial rotator cuff tear. Thereafter, the carrier denied the combined condition, asserting that claimant’s accepted shoulder strain had ceased to be the major contributing cause of the combined condition. Claimant requested a hearing, asserting that the carrier had not persuasively established that her work injury was not the major contributing cause of her combined shoulder condition.

The Board agreed with claimant’s assertion. Citing *Brown v. SAIF*, 262 Or App 640 (2014), the Board stated that the correct inquiry under ORS 656.262(6)(c) was whether a claimant’s “work-related injury incident” (rather than the accepted condition) remained the major contributing cause of the disability/need for treatment of the combined condition. Relying on *Washington County-Risk v. Jansen*, 248 Or App 335, 345 (2012), and *Wal-Mart Stores, Inc. v. Young*, 219 Or App 410, 419 (2008), the Board noted that a carrier must prove a change in a claimant’s condition or circumstances such that the “otherwise compensable injury” is no longer the major contributing cause of the disability/need for treatment of the combined condition. Referring to *Vigor Industries, LLC v. Ayres*, 257 Or 795, 806 (2013), the Board observed that the “combined condition” consists only of the “otherwise compensable injury” and statutory preexisting conditions.

Turning to the case at hand, the Board acknowledged that a physician had initially referred to claimant’s “work injury” when opining that claimant’s injury had ceased to be the major contributing cause of her need for treatment for her combined shoulder condition. Nonetheless, the Board noted that the physician had subsequently clarified that his opinion was based on the premise that claimant’s “compensable shoulder strain” had resolved.

Reasoning that the physician’s remarks indicated that the accepted strain had been considered as the “otherwise compensable injury” when analyzing the compensability of the combined condition, the Board concluded that the physician had not evaluated the overall contribution from the work-related injury/incident to claimant’s combined condition. In the absence of such an assessment, the Board determined that the physician’s opinion did not persuasively meet the carrier’s burden of proving its “ceases” denial under ORS 656.262(6)(c).

Because the physician’s opinion on which the carrier relied had not evaluated the overall contribution from the work-related injury/incident to the combined condition, the Board held that the carrier had not met its burden of proving its “ceases” denial under “262(6)(c).”

In contrast to the aforementioned physician's opinion, the Board found that the other physician had weighed the overall contribution of claimant's injury/incident (including the worsening of her preexisting conditions and the continued effects of the shoulder strain), in concluding that the work injury remained the major contributing cause of her combined condition. Persuaded by this physician's well-reasoned opinion, the Board concluded that the carrier had not met the requirements for establishing its "ceases" denial pursuant to ORS 656.262(6)(c).

[Editor's Note: The Board has abated its order in *Littlefield* to consider the carrier's motion to remand for further development of the record in light of the *Brown* holding.]

Evidence: Carrier's Receipt of "Claim Closure" Request - Testimony That Request Was "Sent" - Evoked Presumption That Request Was Received by Mail

David J. Lampa, 66 Van Natta 1052 (June 3, 2014). In awarding penalties and attorney fees under ORS 656.268(5)(d) and ORS 656.382(1) for a carrier's unreasonable refusal to close a claim, the Board found that the un rebutted testimony from claimant's counsel's legal assistant established that a "claim closure" request was mailed to the carrier and triggered the presumption under ORS 40.135(1)(q) that the request was received by the carrier in regular course. At a hearing regarding claimant's contention that the carrier had unreasonably refused to close his claim, his counsel's legal assistant identified a letter (which was dated and addressed to the carrier) and testified that it was "sent" to the carrier on a particular date. The carrier did not cross-examine the legal assistant nor offer rebuttal evidence. However, in closing argument, it asserted that the "claim closure" letter did not contain a "date stamp" from the carrier and that, therefore, claimant did not establish that the "claim closure" request had been mailed to it.

The Board disagreed with the carrier's assertion. Citing ORS 40.165(1)(q), the Board stated that there is a presumption that a "letter duly directed and mailed was received in the regular course of the mail." Relying on *Rickey A. Stevens*, 49 Van Natta 1444, 1445 (1997), the Board noted that testimonial evidence may be sufficient to prove the date on which a letter was mailed.

Turning to the case at hand, the Board found that the legal assistant's testimony was sufficient to establish that claimant's claim closure request was "mailed" to the carrier on the date of the letter. In reaching this conclusion, the Board observed that the carrier had not challenged the assistant's testimony nor presented any evidence indicating that the letter was not properly addressed, returned as undeliverable, or never received by the carrier. Under such circumstances, the Board determined that, when viewed in context of the particular record, the assistant's testimony that the letter was "sent" was sufficient to establish that the claim closure request was mailed to the carrier on the date set forth in the letter.

Testimony that claim closure request was "sent" to carrier, in absence of rebuttal evidence, was sufficient to establish that request was "mailed" to carrier and sufficient to evoke presumption under ORS 40.165(1)(q) that duly mailed request was received in the regular course of mail.

Applying the presumption prescribed in ORS 40.135(1)(q), the Board found that the carrier received the claim closure request in the regular course of the mail. Because the carrier had not responded to that request, the Board further determined that the carrier had refused to close the claim. See ORS 656.268(5)(b); *Joy M. Walker*, 66 Van Natta 325, 329 (2014).

Turning to the penalty issue under ORS 656.268(5)(d), the Board acknowledged the carrier's contention that there was insufficient information to close the claim. Nonetheless, noting that there was no indication that the carrier had attempted to gather further information to close the claim (nor had the carrier provided any explanation for not doing so), the Board determined that the carrier had unreasonably refused to close the claim. Consequently, the Board awarded penalties and attorney fees under ORS 656.268(5)(d) and ORS 656.382(1), respectively.

Member Lowell dissented. Noting that there were other methods for claimant to prove the carrier's receipt of the claim closure request (e.g., certified mail, seek discovery from the carrier of the "date-stamped" copy of the request, or provide testimony from the carrier at hearing), Lowell believed that those alternative measures would have avoided the uncertainty inherent in the use of the presumption under ORS 40.135(1)(q).

Moreover, observing that the legal assistant was never asked the relevant and dispositive question of when was the "letter duly directed and mailed," Member Lowell considered the assistant's testimony insufficient to establish that the claim closure request was mailed. In the absence of such evidence, Lowell disagreed with the majority's application of the statutory presumption of receipt under ORS 40.135(1)(q).

Because legal assistant was never asked whether claim closure request was "duly directed and mailed" to the carrier, dissent argued that the testimony was insufficient to establish "mailing" and, as such, the statutory "receipt presumption" was not evoked.

New/Omitted Medical Condition: "CRPS" Claim - "Condition" (Whether Type 1 or 2) Found To Be "In Existence"

Gerald W. Mogensen, 66 Van Natta 1074 (June 4, 2014). The Board held that claimant's new/omitted medical condition claim for complex regional pain syndrome (CRPS) was compensable because the medical record established that the claimed condition existed, regardless of which particular "type" of CRPS (Type 1 or 2) would best describe his condition. Following claimant's compensable finger injury (which resulted in a partial amputation of the finger), he was treated for CRPS/reflex sympathetic dystrophy (RSD). He then initiated a new/omitted medical condition claim for CRPS, which the carrier denied, relying on a physician's opinion that he did not have CRPS. Subsequent physicians opined that claimant was not suffering from CRPS/RSD (which they described as CRPS Type 1, but rather described his condition as CRPS Type 2. Based on these latter opinions, the carrier contended that claimant had claimed CRPS Type 1, which the medical evidence established did not exist and, as such, its denial should be upheld.

The Board disagreed with the carrier's argument. Citing *Maureen Y. Graves*, 57 Van Natta 2380, 2381 (2005), the Board stated that the claimed new/omitted medical condition must exist. Relying on ORS 656.005(7)(a)(A), the Board further noted that claimant's compensable injury must be the major contributing cause of his claimed CRPS condition.

Turning to the case at hand, the Board noted that, in specifically requesting acceptance of a "CRPS," claimant had not described a particular type. Consequently, the Board reasoned that the question before it was not what "type" of CRPS would best describe his claimed condition, but rather whether the claimed "CRPS" existed as a new/omitted medical condition and, if so, whether his compensable finger injury was the major contributing cause of the claimed condition. See *Jeremy Schaffer*, 65 Van Natta 2191 (2013); *April L. Shabazz*, 60 Van Natta 2475 (2008).

After reviewing the physicians' opinions, the Board found that the record supported the existence of a "CRPS" condition (whether described as Type 1 or 2). Because claimant had not further particularized his claimed condition to include Type 1 or 2, and because the physicians' opinions persuasively established the requisite causal relationship between that claimed condition and his compensable finger injury and accepted amputation, the Board concluded that the claim was compensable.

In reaching its conclusion, the Board commented that any dispute as to which "Type" of CRPS would be accepted by the carrier was a claim processing matter that might arise when the carrier issued its Modified Notice of Acceptance, at which time claimant could submit an objection to the notice under ORS 656.262(6)(d). The Board further reasoned that, to engage in an analysis concerning the particular "Type" of CRPS at this initial stage of the claim would be premature.

Finally, the Board considered claimant's request for penalties and attorney fees based on the carrier's allegedly unreasonable failure to modify its acceptance to include CRPS Type 2 once that condition was diagnosed as related to the compensable injury/accepted finger amputation. See ORS 656.262(6)(b)(F). Assuming without deciding that the statute applied while a carrier's denial of a new/omitted medical condition claim was in litigation, the Board determined that the carrier had a legitimate doubt regarding its responsibility to modify the acceptance notice. Referring to a physician's opinion that claimant did not have the claimed "CRPS," the Board did not consider it unreasonable for the carrier to have denied the claim and to have maintained that denial while awaiting a determination of the disputed issues. See *Randy L. Carter*, 48 Van Natta 1271 (1996).

Member Lanning dissented from the Board's determination that the carrier's claim processing had not been unreasonable. Relying on ORS 656.262(6)(b)(F), Lanning noted that a carrier is obligated to modify its acceptance "from time to time as medical or other information changes a previously issued notice of acceptance."

Referring to Member Weddell's concurring opinion in *Mai K. Moua*, 66 Van Natta 848, 852 (2014), Member Lanning agreed that, although a claimant has a right to pursue a new/omitted medical condition claim under

Because claimant had not particularized claimed condition to include either Type 1 or 2 "CRPS," and because medical evidence supported the existence of the claimed "CRPS" condition and its causal relationship to the accepted condition, the Board held that the claimed condition was compensable.

Reasoning that any legitimate doubt regarding the carrier's statutory responsibility to modify its acceptance notice was extinguished by subsequent medical opinions, dissent believed that carrier's claim processing had been unreasonable.

ORS 656.262(6)(d) and (7)(a), such a right does not relieve a carrier of its independent duty to initially determine what conditions are compensable and, pursuant to ORS 656.262(6)(b)(F), to modify its acceptance based on changes in its knowledge of a compensable condition. Applying that analysis to the present case, Lanning considered the subsequent "medical information" (*i.e.*, the opinions from other physicians that claimant was suffering from CRPS Type 2, which was causally related to his work-related finger amputation) to have extinguished any legitimate doubt regarding the carrier's statutory responsibility to modify its acceptance notice. Under such circumstances, Member Lanning believed that penalties and attorney fees for unreasonable claim processing were warranted.

New/Omitted Medical Condition: "Lumbar Disc @ L5-S1" - Record Did Not Establish That Claimed "Condition" Was "In Existence"

Bradley R. Madrid, 66 Van Natta 1080 (June 4, 2014). Applying ORS 656.267(1), the Board upheld a *de facto* denial of claimant's new/omitted medical condition claim for "lumbar disc @ L5-S1" because the medical record did not establish that the claim concerned the "physical status of the body" and, as such, was not "in existence." After claimant sustained a compensable injury, the carrier accepted a lumbar strain. Subsequently, he filed a new/omitted medical condition claim for "lumbar disc @ L5-S1." In response, the carrier modified its acceptance including a combined condition of preexisting facet degenerative arthritis at L4-5 and L5-S1, as well as preexisting disc degeneration and mild protrusion at L5-S1. Thereafter, claimant requested a hearing, asserting that the carrier had *de facto* denied his new/omitted medical condition claim. In response, the carrier contended that its "combined condition" acceptance encompassed the claimed "condition" and, alternatively, that the claim was not for a "condition."

The Board found that there had been a *de facto* denial, but held that the claimed "condition" did not exist. Citing *Rose v. SAIF*, 200 Or App 654, 662 (2005), the Board stated that, on receipt of a clear request for formal written acceptance of a new/omitted medical condition, a carrier must respond within 60 days by a written acceptance or denial. Relying on *SAIF v. Stephens*, 247 Or App 107, 112 (2011), the Board noted that the absence of a timely acceptance or denial constitutes a procedural deficiency that gives rise to a *de facto* denied claim. Finally, the Board referred to *Young v. Hermiston Good Samaritan*, 223 Or App 99, 105 (2008), for the proposition that a "condition" constitutes "the physical status of the body as a whole * * * or of one of its parts."

Because the carrier had not specifically accepted or denied the purported "condition" that had been claimed ("lumbar disc @ L5-S1"), Board found a de facto denial.

Turning to the case at hand, the Board acknowledged that the carrier's modified acceptance referred to "L5-S1." Nevertheless, reasoning that the carrier did not specifically accept or deny the purported "condition" that had been claimed (*i.e.*, "lumbar disc @ L5-S1"), the Board determined that the claim had been *de facto* denied.

*Because “lumbar disc @ L5-S1” did not describe a “physical status of the body as a whole * * * or of one of its parts,” the Board was not persuaded that the claimed “condition” existed.*

Addressing the denial, the Board recognized that chart notes from claimant’s physician referred to an L5-S1 disc bulge and facet degeneration, as well as inflammation. Nonetheless, observing that claimant’s claim specifically sought acceptance of “lumbar disc @ L5-S1,” the Board concluded that the medical record did not establish that such a claim described “the physical status of the body as a whole * * * or of one of its parts.”

Consequently, the Board was not persuaded that the claimed condition existed. See *Carl R. Hale*, 65 Van Natta 2316, 2319 (2013); *Emma R. Traner*, 64 Van Natta 1207, 1208 (2012). Under such circumstances, the Board upheld the carrier’s *de facto* denial. In reaching its conclusion, the Board did not address the causal relationship between any conditions mentioned in the medical record and claimant’s work injury. Instead, pursuant to ORS 656.267(1), the Board noted that claimant may “initiate a new or omitted medical condition claim at any time.”

Finally, the Board acknowledged that claimant had attempted to raise an “L5-S1 disc protrusion” claim at the hearing. However, because the carrier objected to consideration of that claim as premature, the Board declined to consider the claim. See ORS 656.262(6)(d); *Diane S. Hill*, 48 Van Natta 2351, 2353 (1996), *aff’d without opinion*, 149 Or App 496 (1997).

Member Weddell concurred to express serious reservations regarding *Juan A. Arenas-Raya*, 65 Van Natta 1639 (2013), and its holding that a carrier’s “combined condition” acceptance in response to a claimant’s new/omitted medical condition claim for a specific condition is legally sufficient. However, because the lead opinion had distinguished *Arenas-Raya*, Member Weddell considered it unnecessary to revisit the *Arenas-Raya* reasoning in this particular case.

Scope of Acceptance: “Low Back Pain” Acceptance - Encompassed L4-5 Disc Herniation - Subsequent Stipulation, DCS, CDA Did Not Change That Acceptance

Alan W. Morley, 66 Van Natta 1061 (June 4, 2014). The Board held that a carrier’s acceptance of claimant’s “low back pain” constituted acceptance of his L4-5 disc herniation and because that condition and subsequent related surgeries/residuals were the major contributing cause of his arachnoiditis and other conditions, his new/omitted medical condition claims were compensable. Following claimant’s compensable injury, the carrier accepted “low back pain.” At that time, he had previously undergone surgery for a L4-5 disc herniation and shortly after the claim acceptance, underwent further surgery to remove scar tissue and a herniated disc. Over the next 25 years, additional surgeries involving the L4-5 disc and surrounding discs were performed, all but one of which were processed under his injury claim. Eventually, when claimant’s attending physician proposed a seventh surgery (concerning L2-3 and L3-4 discs) and diagnosed arachnoiditis (as well as other conditions as attributable to his L4-5 herniated disc and subsequent surgeries), the carrier denied the

surgery and the new/omitted medical condition claims. In doing so, the carrier contended that “post-acceptance” stipulations, a disputed claim settlement (DCS), and a Claim Disposition Agreement (CDA) referred to the accepted condition as “low back strain” and, because his claimed conditions (and proposed surgery) were not caused by the strain, his claims were not compensable.

The Board disagreed with the carrier’s contention. Citing *Georgia-Pacific v. Piwowar*, 305 Or 494, 501-02 (1988), the Board stated that, if a carrier accepts a *symptom* of an underlying condition, it is precluded from later denying the underlying condition, regardless of its cause. Relying on *Hill v. Qwest*, 178 Or App 137, 140 (2001), the Board noted that acceptance of a particular symptom automatically includes acceptance of the underlying condition causing that symptom.

Turning to the case at hand, the Board found that, before the carrier’s claim acceptance, a physician had diagnosed a lumbar disc condition, which had been confirmed by a later myelogram and operative findings during the L4-5 disc surgery. Under such circumstances, the Board concluded that the carrier’s acceptance of “low back pain” encompassed acceptance of the L4-5 disc herniation.

In reaching its conclusion, the Board did not consider the parties’ subsequent agreements (which referred to an accepted “low back strain”) to have modified the scope of the carrier’s initial claim acceptance. Concerning the stipulations, the Board noted that the agreements involved penalties regarding medical bills and temporary disability benefits. Reasoning that the stipulations neither referred to a dispute over the scope of the carrier’s acceptance nor purported to involve a “back-up” denial of the initially accepted claim, the Board did not consider the carrier’s previous acceptance of “low back pain” to be a “raised or raisable” issue resolved by the stipulations.

Because previous stipulations, DCS, and CDA neither resolved disputes regarding, nor had any effect on, the scope of carrier’s initial claim acceptance, the agreements did not alter the scope of the carrier’s previous unequivocal acceptance of “low back pain” and, as such, the acceptance encompassed the underlying L4-5 disc herniation which had caused the low back pain.

The Board reached similar conclusions concerning the DCS and CDA. Noting that the DCS resolved denied claims involving a “cervical strain” and “psychiatric condition,” the Board determined that the agreement had no effect on the carrier’s initial acceptance of claimant’s low back pain. Concerning the CDA, the Board reiterated that it is not the function of a CDA to resolve disputes arising from the processing of a claim. See *Felix R. Sanchez*, 59 Van Natta 524, 534 (2007). Consequently, the Board held that the CDA’s inclusion of “low back strain” as the accepted condition did not alter the scope of the carrier’s prior and unequivocal acceptance of “low back pain.”

Addressing the medical evidence, the Board noted that several physicians’ opinions had been based on the proposition that claimant’s accepted condition had been a low back strain. Because that assumption was inaccurate, the Board did not consider those opinions to be persuasive. Instead, the Board relied on other physicians’ opinions that attributed claimant’s currently claimed conditions (and surgery) to his L4-5 disc herniation and resulting surgeries. Based on those opinions, the Board set aside the carrier’s denials of claimant’s new/omitted medical condition and medical service claims.

TTD: Rate - “Commission” Earnings - None Earned as of “Injury Date” - Statutory Minimum of \$50 Per Week Applied - “210(1)”

Ashley A. Rehfeld, 66 Van Natta 1102 (June 5, 2014). Applying ORS 656.210(1), the Board held that the rate of claimant’s temporary total disability (TTD) benefits was based on \$50 per week because at the time of her compensable injury she was to be paid based on a commission basis for which she had not received earnings. After claimant was found to be a “subject worker” by an earlier litigation order, the carrier did not pay TTD benefits, asserting that she had not earned any wages. Claimant requested a hearing, seeking a TTD award.

The Board granted claimant’s request. Citing OAR 436-060-0025(5), the Board stated that the rate of compensation for workers employed with unscheduled, irregular or no earnings shall be computed on the wages determined by the rule. Referring to subsection (5)(j) of the rule, the Board noted that for workers without 52 weeks of earnings, a carrier must use the assumed wage on which a premium is based. Finally, relying on ORS 656.210(1), the Board observed that a worker’s TTD rate is equal to 66-2/3 of wages, but not more than 133 percent of the average weekly wage (AWW) nor less than the amount of 90 percent of wages a week or the amount of \$50 a week, whichever amount is less.

Turning to the case at hand, the Board found that, although claimant was to receive 30 percent as a commission for her sales at the time of her compensable injury, she had not received any earnings when she was injured. Determining that she did not have 52 weeks of earnings preceding her injury and that her employer (who was noncomplying) had not paid insurance premiums, the Board concluded that she did not have an average weekly wage.

Under such circumstances, the Board turned to ORS 656.210(1), which prescribes a calculation method for a TTD rate that sets a minimum of \$50 per week. Relying on this statutory prescription, the Board based claimant’s TTD rate on the statutory minimum of \$50 per week.

TTD: “Work Force” Determination - As of “Injury Date” - Grounds for “Termination” Not Satisfied - No “Modified Job” Offered - “325(5)(a)”/“268(4)(c)”

Teresa Hull, 66 Van Natta 1154 (June 24, 2014). Analyzing ORS 656.268(4)(c) and ORS 656.325(5)(a), the Board held that a carrier was not entitled to terminate claimant’s temporary total disability (TTD) benefits when her attending physician released her to a light duty job because the employer did not

Because claimant had not received “commission” earnings at the time of her compensable injury and because her “noncomplying” employer had not paid any insurance premiums, her TTD rate calculation was based on \$50 per week under “210(1).”

offer the job to her because she had resigned after her compensable injury to return to school. Asserting that claimant's actions constituted a withdrawal from the workforce and a refusal to continue her employment, the carrier contended that its termination of TTD benefits once the attending physician had approved the modified job was justified.

The Board disagreed with the carrier's contention. Citing *Weyerhaeuser Co. v. Kepford*, 100 Or App 410, 414 (1990), the Board stated that the critical time for determining whether a claimant has withdrawn from the workforce is at the time of disability. Relying on *Randy L. Meyer*, 64 Van Natta 1956 (2012), the Board noted that a claimant does not withdraw from the workforce, even if she is not working, while she is receiving TTD benefits resulting from an accepted claim that resulted in an inability to work.

Turning to the case at hand, the Board acknowledged that claimant resigned her position following her compensable injury, planning to work part-time as she returned to school. Nonetheless, despite her resignation, the Board determined that she was in the workforce when she sustained her compensable injury and TTD benefits were authorized by her attending physician. Under such circumstances, the Board concluded that claimant remained entitled to TTD benefits, notwithstanding her "post-injury" resignation.

In reaching its conclusion, the Board disagreed with the carrier's contention that ORS 656.325(5)(a) allowed it to terminate claimant's TTD benefits. After reviewing the statute, the Board identified three requirements for the termination of TTD benefits: (1) agreement of the attending physician that the worker is capable of performing the duties of a particular job; (2) an employment offer; and (3) the worker's refusal to accept the job offer. See *Arturo G. Vasquez*, 44 Van Natta 2443 (1992). Moreover, referring to OAR 436-060-0030(5)(c), the Board noted that a carrier must have "confirmed the offer of employment in writing to the worker" before termination of TTD benefits was authorized.

Applying the aforementioned principles to the present case, the Board found that the attending physician-approved light duty job had not been offered to claimant. Because claimant was never given the opportunity to accept or refuse the light duty job, the Board reasoned that the carrier was not entitled to terminate her TTD benefits. See ORS 656.325(5)(a); ORS 656.268(4)(c). In doing so, the Board commented that there was no support for the carrier's assertion that claimant was required to communicate with her former employer if she was interested in modified work. To the contrary, the Board noted that the controlling law require the employer to offer modified work (in writing) to claimant before a refusal of such an offer can be determined, which could then justify termination of TTD benefits.

Because claimant had not withdrawn from the work force following her compensable injury (but rather was willing to work part-time while she returned to school) and because she had never been offered (in writing) the attending physician-approved light duty job, the carrier was not statutorily authorized to terminate her TTD benefits.

APPELLATE DECISIONS UPDATE

Claim Processing: Invalid “Current Condition” Denial - No Medical Services Nor Unpaid Bill

Jeld-Wen v. Cooper, 263 Or App 715 (June 11, 2014). The court affirmed without opinion the Board’s order in *Penny I. Cooper*, 64 Van Natta 1644 (2012), previously noted 31 NCN 8, which held that a carrier’s medical services denial was invalid because the record did not establish that the carrier had either received a medical bill for treatment for claimant’s accepted condition or that claimant had required medical services.

Evidence: “310(2)” - “Prima Facie” Evidence in Medical Reports - Claimant Did Not Appear at Hearing

Camacho v. SAIF, 263 Or App 647 (June 18, 2014). Applying ORS 656.310(2), the court reversed the Board’s order in *Marcelino Camacho*, 64 Van Natta 1278 (2012), previously noted 31 NCN 7, which in upholding a carrier’s back injury denial, did not give probative weight to claimant’s statements to medical providers regarding the cause of his injury because he did not appear at the hearing to testify and the statements were inconsistent. In reaching its conclusion, the Board reasoned that claimant’s statements regarding the circumstances of his injury were not statements to which it was required to afford *prima facie* weight under ORS 656.310(2), but rather constituted hearsay statements that it was free to give whatever weight it deemed appropriate. In addition, noting that some statements referred to claimant’s *lifting* a pallet when he was injured at work, while others mentioned that he was *pulling* on a pallet jack, the Board determined that his account of his injury was inconsistent and insufficient to establish the compensability of his claim.

Statements in medical reports concerning how an injury occurred, the nature of the pain resulting from the injury, and medical history are considered statements “reasonably pertinent” to a physician’s ability to diagnose and treat an injury and, as such, constitute prima facie evidence under “310(2).”

The court concluded that the Board’s determination was erroneous. Citing ORS 656.310(2), the court stated that “[t]he contents of medical, surgical and hospital reports presented by claimants for compensation shall constitute prima facie evidence as to the matter contained therein.” Relying on *Zurita v. Canby Nursery*, 115 Or App 330, 334, *rev den*, 315 Or 443 (1993), the court reiterated that a claimant’s statements in medical reports constitute *prima facie* evidence under ORS 656.310(2) if those statements were for the purpose of medical diagnosis or treatment. Referring to *State v. Moen*, 309 Or 45, 54-59 (1990), the court explained that statements in medical reports concerning how an injury occurred, the nature of the pain resulting from the injury, and medical history are considered statements “reasonably pertinent” to a physician’s ability to diagnose and treat an injury.

Turning to the case at hand, the court concluded that claimant's statements in the medical reports (e.g., while he was moving pallets using a pallet jack, he experienced a "pop" in his back and immediate lower back and thigh pain) were all "reasonably pertinent" to his physician's ability to diagnose and treat his injury. Consequently, in accordance with ORS 656.310(2), the court determined that the Board was required to afford claimant's statements *prima facie* weight, at least to the extent that such statements were not contradictory. Therefore, the court considered it appropriate to remand to the Board for such an assessment of the evidence.

In addition, addressing the Board's "inconsistent statement" finding, the court acknowledged claimant's statements in the medical reports that described his work injury while "pulling" on a "pallet jack" and other statements referring to a work injury after "lifting" a "pallet." Although recognizing that one possible understanding of claimant's statements was that they were inconsistent, the court reasoned that another possible understanding was that claimant had been lifting the pallet *using the pallet jack* and, as such, the statements would be consistent (with the exception of "immaterial discrepancies" concerning the estimated weight of the pallet and whether claimant was loading or unloading a trailer).

Furthermore, the court noted that claimant's statement (written in Spanish) in his initial form completed by his physician had not been translated. Finding that claimant had timely requested an interpreter in advance of the hearing and observing that the claim form (including claimant's Spanish statement) had been admitted into the record without objection, the court reasoned that the Board had disregarded written evidence because such evidence was not in English. Discovering nothing in the Board's rules that would authorize it to disregard such evidence, the court determined that remand was also warranted to take into account claimant's description of the injury in the claim form. ORS 183.482(8)(a)(B), (b).

Penalty: "268(5)(d)" - Unreasonable Claim Closure - Based on "Amounts Then Due" When Closure Set Aside

Bales v. SAIF, ___ Or App ___ (June 25, 2012). The court affirmed without opinion the Board's order in *Guy E. Bales*, 64 Van Natta 231, *on recon*, 64 Van Natta 1599 (2012), previously noted 31 NCN 8, which held that the penalty under ORS 656.268(5)(d) for an unreasonable claim closure was based on all compensation "then due" as of the date the record was closed regarding the hearing that resulted in the rescission of the Notice of Closure.

Because claimant's statements (which were written in Spanish) had been admitted into the record without objection, the court reasoned that the Board was not authorized to disregard such admitted evidence (which had not been translated).

TTD: Rate - “Extended Gaps” - Understanding Between Claimant/Employer on Hiring Date

Tanner v. SAIF, ___ Or App ___ (June 25, 2014). The court affirmed without opinion the Board’s order in *Verna A. Tanner*, 64 Van Natta 2100 (2012), previously noted 31 NCN 11, which held that claimant’s 7-week gap during the 52 weeks preceding his compensable injury as a temporary service worker did not constitute an “extended gap” because the record established that such gaps were contemplated when he was hired.