



# News & Case Notes

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### Portal Housekeeping

WCB's Portal is designed to be managed by the users. WCB does not have access to usernames/passwords or specific user settings. It is vital that Portal entities make sure to keep their users and contacts up to date. WCB recommends that you include Portal username/contact setups in your personnel checklists. This ensures that when an employee is hired/departs that the portal account stays secure. Below is a checklist designed to assist users in this process.

#### Adding New Users:

- Have your Administrator log into your portal account and click the "Users" tab.
- Click "Add User."
- Fill in the required and optional information.
- Choose the authorizations for this user.
- Click "Save."

The new user will receive an email with their username and a link to create their password.

#### Creating a Contact:

- Log into the Portal.
- Click the "Contacts" Tab.
- Click "Add Contact."
- Fill in the required/optional information.
- Choose the notifications that this email address will receive.
- Click "Save."

Please double check the email address is entered correctly to ensure notifications will be received.

#### Removing a User:

- Have your Administrator log into your portal account and click the "Users" tab.
- Select the user you want to remove.
- Click "Remove User."
- Click "Remove User" again at the bottom of the page.

Removing a Contact:

- Log into the Portal.
- Click the “Contacts” tab.
- Select the contact you want to remove.
- Click “Remove Contact.”
- Click “Remove Contact” again at the bottom of the page.

Contact Portal Support:

At any time, you may can contact WCB for assistance. The portal email address is [portal.wcb@state.or.us](mailto:portal.wcb@state.or.us) or call 503-378-3308 and ask for Portal Support. We also offer one-on-one training and are happy to come to your location and assist with setting this up.

**CASE NOTES**

## CDA: Deceased Worker - “Pre-Closure” - No “Statutory Beneficiaries” - “Personal Representative” Authorized to Execute CDA - “218(2), (5)”

*Blake T. Pokorny, Dcd.*, 66 Van Natta 1437 (August 20, 2014). Analyzing ORS 656.236 and ORS 656.218, in approving a Claim Disposition Agreement (CDA), the Board held that, because the deceased worker’s claim had not been closed and because any remaining balance of a permanent disability award would have been payable to his estate, the personal representative for the estate was authorized to execute the agreement. In submitting the CDA for Board consideration, the parties stipulated that the deceased worker’s claim had not been closed and that he was not survived by a statutory beneficiary under ORS Chapter 656. Nevertheless, the CDA further provided that the personal representative of the deceased worker’s estate was authorized to act as a beneficiary under ORS 656.218.

The Board concluded that the personal representative was entitled to proceed with the CDA. Citing ORS 656.218(2), the Board stated that, if a worker’s death occurs before a Notice of Closure, the carrier shall determine compensation for permanent disability, if any. Relying on ORS 656.218(5), the Board further noted that the payments provided in ORS 656.218 shall be made to the persons who would have been entitled to receive death benefits if the injury had been fatal. Finally, again referring to ORS 656.218(5), the Board observed that, in the absence of a person entitled to such benefits, the unpaid balance of the award shall be paid to the worker’s estate.

Turning to the case at hand, the Board determined that, because the worker died before the claim was closed, the carrier was obligated to close the claim for a determination of permanent disability compensation, if any. Moreover, if that evaluation resulted in a permanent disability award, the Board reasoned that such an award would be payable to the estate because there was no surviving statutory beneficiary.

*If a worker’s death occurs before claim closure, the carrier shall determine compensation for permanent disability, if any.*

*If the evaluation for a deceased worker results in a permanent disability award, the award would be payable to the worker’s estate if there were no surviving statutory beneficiaries.*

*Because there were no surviving statutory beneficiaries, the personal representative could execute the CDA.*

Considering the procedural posture of the particular claim, the Board held that the personal representative of the estate was authorized to execute the CDA. Furthermore, because the CDA had been amended to include the “age, education, vocational history” information required by OAR 438-009-0022(4)(e), and (f) for a worker’s “beneficiary” (i.e., the “personal representative”), the Board approved the amended CDA.

## Claim Processing: “015-0070(4)” - “Selection” of “AP” - No Objection to “Non-MCO” Physician

*Carmen M. Reyes*, 66 Van Natta 1492 (August 27, 2014). Analyzing ORS 656.005(12)(b) and OAR 436-015-0070, the Board held that a “non-Managed Care Organization (MCO)” physician constituted claimant’s attending physician for purposes of claim closure because, based on her course of treatments with the “non-MCO” physician (to which the carrier had not objected), she had “selected” the physician and, as such, the physician was authorized to evaluate her “medically stationary” status. Following claimant’s compensable injury, she began treating with a “non-MCO” physician. Without raising objections, the carrier processed claimant’s medical bills from this physician. When the physician determined that claimant’s condition was medically stationary, the carrier issued a Notice of Closure (NOC). Claimant requested reconsideration, which resulted in an Order on Reconsideration setting aside the NOC as premature because the physician was not an “attending physician” and, as such, was not qualified to provide impairment findings. The carrier requested a hearing, arguing that the “non-MCO” physician was authorized to be claimant’s “attending physician” and, as such, the NOC was valid.

The Board agreed with the carrier’s contention. Citing ORS 656.005(12)(b), and *Marina V. Nozdrin*, 58 Van Natta 2953 (2006), the Board stated that an “attending physician” means a physician who is primarily responsible for the treatment of a worker’s compensable injury. Relying on *Troy O. West*, 58 Van Natta 2699 (2006), the Board noted that whether a physician qualifies as an “attending physician” is a question of fact.

Turning to the case at hand, the Board found that the “non-MCO” physician had treated claimant beginning a few days after her compensable injury until the date the physician had determined that her condition was medically stationary. Further noting that claimant had not treated with any other physician during this period, the Board concluded that the “non-MCO” physician was primarily responsible for claimant’s care and, as such, was her “attending physician.”

In reaching its conclusion, the Board rejected claimant’s assertion that the “non-MCO” physician could not qualify as her “attending physician” because she had not “selected” the physician as required by OAR 436-015-0070(4). Noting that the rule did not describe a specific process for the selection of an “attending physician,” the Board reasoned that the carrier’s claim acceptance notice had identified the “non-MCO” physician as the “attending physician” and that neither the carrier nor claimant had objected to the physician’s “attending

*Because claimant had treated with a “non-MCO” physician from shortly after her compensable injury until the physician reported that she was medically stationary (without objection from the carrier), the physician constituted her “attending physician” for purposes of claim closure.*

*Based on claimant's course of treatment, she had "selected" the "non-MCO" physician as her "attending physician."*

physician" status. Consequently, based on claimant's course of treatment with the "non-MCO" physician, the Board determined that claimant had selected the physician as her "attending physician."

Finally, the Board observed that, because the Order on Reconsideration had set aside the NOC as premature, claimant's request for an arbiter examination had not been processed. Because the NOC was being reinstated, the Board remanded the claim to the Hearings Division to await the scheduling of the exam and the eventual receipt of an arbiter report. See *Karen L. Schueller-Susbauer*, 63 Van Natta 1526 (2011).

## Course & Scope: "Arising Out of" Employment - Syncopal Episode While Driving Employer's Vehicle - No "Work- Related" Reason for Episode - "Syncope" Claim Not Compensable

*Walter Guill*, 66 Van Natta 1322 (August 6, 2014). The Board held that claimant's injury for a syncopal episode, which occurred while he was performing his work activities as a truck driver, did not arise out of his employment because the cause of the episode was unexplained and, as such, not work-related. Claimant, a truck driver, suffered a syncopal episode while operating his employer's truck. Although the truck crashed, he sustained no injury from the accident. Instead, he sought diagnostic medical services to determine the reason for his syncopal episode. Those services did not ascertain the source of his episode. When claimant filed a claim for the syncopal episode, the carrier issued a denial, contending that the episode did not arise out of his employment. Noting that the reason for his episode was unexplained, claimant asserted that his claim was compensable because it occurred while he was in the course of his employment.

The Board disagreed with claimant's assertion. Citing *Fred Meyer, Inc. v. Hayes*, 325 Or 592, 596 (1997), the Board stated that the "arising out of" employment prong requires that a causal link exists between the worker's injury and his employment. Relying on *Phil A. Livesley Co. v. Russ*, 296 Or 25, 29-30 (1983), the Board noted that, when the cause of a fall is unknown, it is a "neutral" risk that is considered to arise out of employment as a matter of law provided that it occurs in the course of employment. Finally, referring to *Blank v. U.S. Bank of Oregon*, 252 Or App 553, 557-58 (2012), the Board observed that a fall will be deemed "truly unexplained" only if the claimant persuasively eliminates all idiopathic factors of causation.

*Because the cause of claimant's injury was not unexplained (he suffered a syncopal episode while driving a truck), the "unexplained fall" doctrine was not applicable and because there was no connection between his work and his episode, his claim was not compensable.*

Turning to the case at hand, the Board did not consider the "unexplained fall" doctrine to be applicable. In doing so, the Board reasoned that it was the cause of the syncopal episode that was unexplained, rather than the cause of the crash (which had not resulted in any injury). Because the record did not establish a connection between claimant's work activities and his syncopal episode, the Board concluded that the claim was not compensable.

*Because claimant received diagnostic medical services for his syncopal episode, dissenting opinion argued that the episode was the result of a neutral risk of his employment and, as such, “arose out of” his employment.*

See *Alfred L. Hillard*, 60 Van Natta 254, 259-60 (2008) (claim not compensable when the claimant suffered an idiopathic syncope episode, and the record did not establish that an employment-related risk contributed to his injury).

Member Lanning dissented. Noting that it was undisputed that claimant had received diagnostic medical services for his syncopal episode and that the “course of employment” requirement had been satisfied, Lanning argued that the claim was compensable because his “truly unexplained” syncope was the result of a neutral risk of employment and, as such, “arose out of” his employment as a matter of law. In doing so, Member Lanning referred to *K-Mart v. Evenson*, 167 Or App 46, 51-52 rev den, 331 Or 191 (2000), for the proposition that receiving diagnostic medical services satisfied the definition of compensable injury, as well as *McTaggart v. Time Warner Cable*, 170 Or App 491, 504 (2000), rev den, 331 Or 633 (2001), for the principle that a truly unexplained fall that occurred in the course of employment arose out of employment as a matter of law.

## Course & Scope: “Course of” Employment - Injury on Public Sidewalk - Awaiting “Employment Discharge” Hearing While on “Administrative Leave” - “Going & Coming” Rule

*Russell Young*, 66 Van Natta 1496 (August 27, 2014). The Board held that claimant’s injury, which occurred when he fell after his foot became pinned between the curb of a public sidewalk and the wheel of his vehicle while he was exiting his vehicle to reach a parking meter, did not occur in the course of his employment as a city electrical inspector because he was on paid administrative leave and waiting for a call from his union representative to attend his “employment discharge” hearing. Relying on the “going and coming” rule, the carrier denied claimant’s knee injury claim, asserting that the injury did not occur in the course of his employment. Arguing that his employer (a city) had some responsibility for the maintenance of public sidewalks under municipal ordinances, claimant contended that his injury was subject to the “parking lot” exception to the “going and coming” rule.

The Board disagreed with claimant’s contention. Citing *Legacy Health Systems v. Noble*, 232 Or App 93, 99 (2009), the Board stated that injuries sustained while a worker is going to or coming from the place of employment generally do not occur within the course of employment. Relying on *Enterprise Rent-A-Car of Oregon v. Frazer*, 252 Or App 726, 736 (2012), the Board noted that the “parking lot” exception to the “going and coming” rule provides that where an injury sustained on premises controlled by the employer while an employee is coming to or going from work occurred within the “course of employment.”

*Because claimant was on paid administrative leave and had parked near the location of his “employment discharge” hearing at the request of his union representative (not at his employer’s direction), his injury while “feeding” a parking meter was not subject to the “parking lot” exception to the “coming and coming” rule.*

*Because claimant had not fallen for any reason attributable to the sidewalk curb and his appearance at the “discharge” hearing was a matter totally outside the direction/control of his employer, concurring opinion asserted that his injury did not “arise out of” his employment.*

Turning to the case at hand, the Board found that, although claimant was on paid administrative leave and was required to call his employer each morning, there was no indication that he had been requested to work. The Board further noted that he had parked near the location of his “employment discharge” hearing at the request of his union representative, not his employer. Finally, the Board reasoned that claimant’s injury had occurred not while going to the “employment discharge” hearing, but rather while leaving his vehicle to “feed” a parking meter while waiting to receive a possible call from his union representative to attend the hearing. Under such circumstances, the Board concluded that the “parking lot” exception did not apply.

In reaching its conclusion, the Board acknowledged that the employer (a city) had a general duty related to the maintenance of public sidewalks. Nonetheless, the Board reasoned that the employer’s limited “control” over public sidewalks far from claimant’s work place did not demonstrate a sufficient temporal and spatial nexus between the injury and his employment for application of the “parking lot” exception.

Member Curey concurred, expressing her opinion that the injury also did not “arise out of” claimant’s employment. Noting that claimant had not been directed by his employer to appear at his “employment discharge” hearing, Curey reasoned that his appearance was a matter between him and his union representative and an action totally outside the direction/control of his employer. Furthermore, determining that claimant had not fallen for any reason attributable to the sidewalk curb, Member Curey asserted that his injury neither resulted from the nature of his work nor originated from some risk to which the work environment exposed him. See *Fred Meyer, Inc. v. Hayes*, 325 Or 592, 601 (1997); *Rebecca L. Nehring*, 66 Van Natta 734 (2014).

## Extent: Impairment Findings - Cognitive Brain Impairment - “Attending Physician” Findings Used - Arbiter Findings Were Based on “Inaccurate History” and “Internally Inconsistent”

*Gary Oldham*, 66 Van Natta 1386 (August 15, 2014). Applying OAR 436-035-0007(5), the Board held that, in rating claimant’s permanent impairment attributable to his accepted concussion, it was appropriate to rely on his attending physician’s “Class 2” impairment findings because the “Class 1” findings reached by a medical arbiter had been based on an inaccurate history and were internally inconsistent. Following its acceptance of claimant’s cervical, thoracic, and concussion conditions, the carrier issued a Notice of Closure, which rated his concussion as Class 2 cognitive impairment based on his attending physician’s opinion. Thereafter, the carrier requested reconsideration and a medical arbiter examination, which resulted in a Class 1 impairment rating. After an Order on Reconsideration reduced claimant’s cognitive impairment rating to Class 1, he requested a hearing, contending that the arbiter had incorrectly believed that his mental difficulties did not arise shortly after his work injury and, as such, the arbiter’s findings should not be used.

The Board agreed with claimant's contention. Citing OAR 438-035-0007(5) and *SAIF v. Owens*, 247 Or App 402, 414-15 (2011), *recons*, 248 Or App 746 (2012), the Board stated that a medical arbiter's impairment findings are used, except where a preponderance of the medical evidence demonstrated that different findings made (or concurred with) by the attending physician are more accurate and should be used. Relying on *Hicks v. SAIF*, 194 Or App 655, *recons*, 196 Or App 146, 152 (2004), the Board noted that when other medical evidence concerning impairment has been expressly rejected and it is left only to the arbiter's opinion that unambiguously attributes impairment to the compensable condition, the arbiter's report provides the default determination of impairment.

Turning to the case at hand, the Board found that the arbiter had an inaccurate understanding of the onset of claimant's cognitive complaints; e.g., the arbiter believed that claimant's first such complaints occurred six months "post-injury," whereas they arose some three months after his injury when he resumed driving and returned to his work activities. In addition, the Board noted that the arbiter had found that claimant's "overall course" supported a Class 1 rating, although his subjective deficits/limitations were of Class 2 severity. In the absence of a persuasive explanation from the arbiter, the Board considered the arbiter's findings to be inconsistent because the arbiter had conceded that claimant had sustained a severe blow in his work-related accident, had reported problems consistent with a profile of "executive dysfunction" due to a frontal lobe injury, and that claimant had no known history of shirking employment or somatization tendencies.

In contrast to the arbiter's finding/reasoning, the Board determined that the findings from the attending physician had been based on the physician's long-time familiarity with claimant. Moreover, the Board noted that the attending physician had reviewed the Director's disability standards and had explained why claimant's cognitive impairment satisfied the Class 2 criteria with "mild cognitive and memory deficits requiring compensatory strategies/devices."

Under such circumstances, the Board concluded that the attending physician's impairment findings were more accurate than the medical arbiter's. Consequently, the Board held that claimant was entitled to a Class 2 cognitive impairment based on the attending physician's findings.

Member Curey dissented. Reasoning that whether claimant's cognitive symptoms arose three to six months "post-injury" did not appear to be determinative to the arbiter's analysis, Curey considered the arbiter's opinion to be based on a materially accurate history. Furthermore, Member Curey found persuasive the arbiter's reasoning that, considering the severity of claimant's subjective deficits, there would have been noticeable complaints within the early weeks after his injury.

Finally, Curey observed that the arbiter had expressly analyzed previous tests, which had evaluated claimant's performance within normal limits. In contrast to the arbiter's findings, Member Curey believed that the attending physician had neither explained how claimant's subjective deficits exceeded the objective and normal test results nor why his condition would prevent him from returning to his "at injury" job. Unpersuaded that the attending physician's

*Because the arbiter's findings were inconsistent and the attending physician's findings were based on a long-time familiarity with claimant, the attending physician's findings were more accurate and were used in rating claimant's cognitive impairment.*

*Considering arbiter's opinion to be based on a materially accurate history, previous test findings, and more persuasive than unexplained opinion from the attending physician, dissenting opinion contended that the arbiter's findings should be applied.*

findings/opinion were more accurate than those provided by the arbiter, Curey disagreed with the majority's determination that claimant was entitled to Class 2 impairment.

## Hearing Request: Claim Denial - Mailed to Incorrect Address - "60-Day" Appeal Period Under "319(1)" Not Triggered

*Michael S. Belgarde*, 66 Van Natta 1424 (August 20, 2014).

Analyzing ORS 656.319(1), and OAR 438-005-0065, the Board held that claimant's hearing request concerning a carrier's claim denial was not untimely filed because, although the request was filed more than 60 days after the denial had been mailed to him, the carrier had not mailed the denial to the address that claimant had provided with his 801 claim form. In response to claimant's injury claim, the carrier mailed its denial to claimant at an address that was different than the one he had set forth on his claim form. The denial was returned to the carrier, along with notification of his correct address. Eventually, claimant received the denial about one week before the "60-day" period under ORS 656.319(1) would have expired. When he filed his hearing request about one week after the aforementioned "60-day" period would have run, the carrier moved for dismissal of the request as untimely.

The Board concluded that the 60-day period pursuant to ORS 656.319(1) had never been triggered. Citing ORS 656.319(1)(a), the Board stated that a request for hearing must be filed not later than the 60<sup>th</sup> day after the mailing of the denial to the claimant. Relying on OAR 438-005-0065, the Board noted that the notice of denial from which the statutory time runs against a claimant shall be in writing and shall be delivered by registered or certified mail or by personal service. Finally, referring to *Bishop v. OBEC Consulting Engineers*, 160 Or App 548 (1999), the Board observed that a claimant's actual notice of a carrier's denial did not "cure" a carrier's failure to furnish notice of its denial in accordance with OAR 438-005-0065.

Turning to the case at hand, the Board acknowledged that claimant eventually received the denial about one week before the 60-day period was set to expire. Nevertheless, the Board found that the carrier had mailed the denial to the wrong address, even though claimant had provided his correct address on his claim form.

Under such circumstances, the Board concluded that the carrier had not complied with OAR 438-005-0065 by mailing its denial to claimant at his correct address as had previously been provided to it. Further reasoning that claimant's eventual actual knowledge of the denial had not "cured" the carrier's noncompliance with the administrative rule, the Board determined that the 60-day period under ORS 656.319(1) had never been triggered and, thus, claimant's hearing request was not untimely filed.

In reaching its conclusion, the Board noted the court's holding in *Snyder v. Interstate Distributor Co.*, 246 Or App 130, 135 (2011) that, because the claimant had not responded to a denial within 60 days, despite having had

*Because the carrier had not mailed its denial to claimant's correct address (even though claimant had provided it on his claim form), the 60-day period for the filing of a hearing request under "319(1)" had never been triggered.*

actual notice of the denial within the 60-day period, his subsequent hearing request was untimely filed. However, the Board reasoned that the *Snyder* court had explained that the claimant had *not* contended that the 60-day period under ORS 656.319(1) had never been triggered when the carrier had mailed the denial to an incorrect address. Because claimant in the present case had made such a contention, the Board considered *Snyder* to be distinguishable.

## Mental Disorder: “802(3)” - “Stress-Related” Heart Condition - Physician’s Opinion Established “Existence” of Claimed Condition

*Karen A. Vermeulen*, 66 Van Natta 1456 (August 21, 2014). Applying ORS 656.802(1)(b) and (3), the Board held that claimant’s new/omitted medical condition claim for a “stress-related” heart condition (Takotsubo syndrome) was compensable because the record established that her claimed condition satisfied the requirements for a mental disorder under ORS 656.802(3)(a)-(d). After the carrier accepted an “adjustment disorder with mixed anxiety and depressed mood” stemming from a work-related encounter, claimant sought acceptance of two stress-related heart conditions (Takotsubo syndrome and coronary vasospasm). The carrier denied claimant’s new/omitted medical condition for both conditions, contending that her attending physician had been unable to say which condition was more likely and, as such, she had not established the existence of a diagnosed condition. Claimant requested a hearing, arguing that her attending physician’s opinion persuasively established the existence of the Takotsubo syndrome and satisfied the requirements for a compensable mental disorder under ORS 656.802(3).

*Because claimant was claiming a physical disorder (a heart condition) caused or worsened by mental stress, the “mental disorder” requirements of ORS 656.802(3)(a)-(d) must be satisfied.*

The Board agreed with claimant’s assertion. Citing *Maureen Y. Graves*, 57 Van Natta 2380 (2005), the Board stated that because claimant was initiating a new/omitted medical condition claim for Takotsubo syndrome, she was required to establish the condition’s existence. Furthermore, relying on *Estacada Rural Fire Dist. No. 69 v. Hull*, 256 Or App 729, 734, *rev den*, 354 Or 61 (2013), the Board noted that, because claimant was claiming a physical disorder (a heart condition) caused or worsened by mental stress, she must also satisfy the “mental disorder” requirements of ORS 656.802(3)(a)-(d).

Turning to the case at hand, the Board acknowledged that claimant’s physician had stated that there was a 50/50 likelihood that she had either Takotsubo syndrome or coronary vasospasm. Nevertheless, the Board reasoned that the physician had subsequently opined that claimant fulfilled the criteria for Takotsubo syndrome on several testing methods (although one test result had not been “classic”). Finally, the Board noted that the physician had previously doubted that claimant had coronary vasospasm.

Under such circumstances, evaluating the physician’s opinion in context and based on the record as a whole, the Board found that the physician had persuasively established the existence of the Takotsubo syndrome and was more persuasive than a contrary medical opinion that had incorrectly interpreted some test findings and had an incomplete or inaccurate understanding of claimant’s work-related stress.

*Noting that a physician had used terms of “possibility” in addressing the causal relationship between the claimed condition and claimant’s work-related stress, dissenting opinion did not consider claim compensable.*

Furthermore, the Board determined that claimant’s employment had produced the Takotsubo syndrome, which existed in a real and objective sense and that the employment conditions were other than conditions “generally inherent” in every working situation. Finally, finding that the diagnosed Takotsubo syndrome was generally recognized in the medical community and that there was clear and convincing evidence that the claimed condition arose out of and in the course of her employment, the Board concluded that the requirements for a compensable mental disorder had been met. See ORS 656.802(3); *Hull*.

Member Johnson dissented. Noting that claimant’s physician had eventually stated that the likelihood of claimant’s heart-related episode being attributable to Takotsubo syndrome or to coronary vasospasm was roughly equal, Johnson reasoned that the physician’s opinion was insufficient to establish the existence of the claimed Takotsubo syndrome. Moreover, referring to the physician’s statements that stress was “very likely a potential trigger” of claimant’s event and that it was “more likely than not” that her extreme stress at work “played a role” in her chest pain syndrome, Member Johnson considered such evidence insufficient to establish that her work activities were the major contributing cause of her claimed Takotsubo syndrome.

## Reconsideration Proceeding: Disagreement With “Permanent Disability Rating” - Encompassed “Work Disability” - Evaluation as of “Recon Order” Date

*Nisar Ahmed*, 66 Van Natta 1368 (August 15, 2014). Citing ORS 656.268(9), and OAR 436-030-0005(12), and (20), the Board held that claimant had raised work disability as an issue during the reconsideration proceeding because, in requesting reconsideration of a Notice of Closure (which had not awarded work disability), he had checked the box on the “reconsideration request” form indicating that he disagreed with the rating of his permanent disability. Asserting that claimant was obligated to specifically refer to “work disability” in requesting reconsideration of the closure notice, the carrier argued that he was not entitled to raise “work disability” as an issue at hearing.

The Board disagreed with the carrier’s contention. Citing ORS 656.268(9), the Board stated that no hearing shall be held on any issue that was not raised and preserved before the Director at reconsideration. Relying on OAR 436-030-0005(12) and (20), the Board noted that “work disability” means the separate factoring of impairment as modified by age, education, and adaptability to perform the “at injury” job. Finally, referring to *Pressing Matters v. Carr*, 248 Or App 41 (2012), the Board observed that the issue of “premature closure” had been considered to have been raised during the reconsideration proceeding despite the claimant’s failure to check the “improper closure/not medically stationary” box on the reconsideration request form because the claimant had submitted a report indicating that the claimant was not medically stationary.

*Because claimant checked a box on the “request for reconsideration” form indicating his disagreement with the rating of permanent disability and because “work disability” includes factoring impairment as modified by age, education, and adaptability to perform the “at injury” job, the request for reconsideration necessarily included “work disability.”*

*The determinative date to evaluate claimant’s disability was “as of the date of issuance of the reconsideration order pursuant to ORS 656.268.*

*Based on claimant’s “post-closure” affidavit and his attending physician’s “post-closure” report (both of which referred to his inability to lift heavier items in performing his work activities), claimant had not returned to his regular work, as of the date of the reconsideration order and, as such, he was entitled to a work disability award.*

Turning to the case at hand, the Board acknowledged that claimant had not expressly referred to “work disability” as an issue when requesting reconsideration of the Notice of Closure. Nevertheless, the Board reasoned that the Director’s reconsideration request form did not include a box specifically referring to such an issue, but rather contained a box (which claimant had checked) indicating that he “disagree[d] with the rating of permanent disability.” Finally, the Board noted that the Appellate Review Unit’s (ARU’s) Order on Reconsideration described the issues as disagreement with impairment findings and extent of whole person permanent partial disability (impairment and social factors). Reasoning that “work disability” means factoring impairment as modified by age, education, and adaptability to perform the “at injury” job, the Board concluded that claimant’s request for reconsideration necessarily included “work disability.”

The Board also found no abuse of discretion in the ALJ’s admission of several “post-claim closure” documents submitted to the ARU during the reconsideration proceeding. Reasoning that the documents concerned claimant’s condition and physical limitations at the time of the reconsideration order and noting that the documents were part of the reconsideration record, the Board determined that there was no abuse of discretion in the ALJ’s evidentiary ruling. See ORS 656.283(6); *Kenneth P. Anderson*, 63 Van Natta 1496 (2011).

Finally, the Board concluded that claimant was entitled to a work disability award for his accepted low back condition. The Board recognized that, when the claim was closed, claimant had been released, and in fact had returned, to his regular work. Nonetheless, citing *SAIF v. Hernandez*, 155 Or App 401, 406 (1998), *Jeffery L. Frost*, 63 Van Natta 1641, *recons*, 63 Van Natta 1890, 1892 n 1 (2011), and *Stephanie M. Parshall*, 63 Van Natta 1483, 1485, *recons*, 63 Van Natta 1818 (2011), the Board reasoned that the determinative time to evaluate claimant’s disability was “as of the date of issuance of the reconsideration order pursuant to ORS 656.268.”

Finding that claimant’s attending physician’s “post-closure” lifting restrictions (25-30 pounds) necessarily meant that he could not perform his regular work (which included lifting up to 100 pounds), the Board determined that, as of the date of the reconsideration order, he had not been released to his regular work. Furthermore, based on claimant’s “post-closure” affidavit and his attending physician’s “post-closure” report (both of which referred to his inability to lift heavier items in performing his work activities), the Board concluded that, as of the date of the reconsideration order, he had not returned to his regular work. Under such circumstances, the Board held that a work disability award was warranted. See ORS 656.214(2)(b); OAR 436-035-0009(6).

## APPELLATE DECISIONS

There were no “written opinions” addressing Board decisions published this month.