
In the Matter of the Compensation of
NANCY K. EDLUND, Claimant
Own Motion No. 04-0215M
INTERIM OWN MOTION ORDER
Cary et al, Claimant Attorneys
Hoffman Hart & Wagner, Defense Attorneys

Reviewing Panel: Members Langer and Biehl.

The insurer has submitted claimant's request for reopening her Own Motion claim for a "worsening" of her previously accepted cervical and lumbar conditions. *See* ORS 656.278(1)(a) (2001). Claimant's aggravation rights under her 1994 injury claim have expired. The insurer opposes reopening, contending that: (1) claimant's current condition is not causally related to the previously accepted condition; (2) it is not responsible for claimant's current condition; (3) the recommended treatment is not reasonable and necessary for claimant's compensable conditions; and (4) claimant is not in the work force. Based on the following reasoning, we direct the insurer to process the "worsened" condition claim in accordance with this order.

FINDINGS OF FACT¹

Claimant sustained a compensable injury on July 17, 1994. Numerous conditions were eventually accepted. As of May 29, 2001, the date of the last "Updated Notice of Acceptance at Closure," the accepted conditions included: combined condition of degenerative disc disease at C6-7, cervical strain resulting in cervical foraminotomy and discectomy C6-7, three level (L3-4, L4-5, L5-S1) laminectomy disc excision L3-S1 secondary to cervical/lumbar strain, rib contusion, and thoracic strain. (Ex. 50). Claimant's aggravation rights expired on April 4, 2002.

After her claim was closed in May 2001, claimant continued to seek treatment for neck and back pain from Dr. Carter, her treating physician. On May 2, 2003, Dr. Parvin, consulting orthopedist, examined claimant and recommended multilevel posterior decompression with fusion, instrumentation,

¹ Our findings are based on the parties' submissions regarding the worsened condition claim under ORS 656.278(1)(a) (2001) and the record created in WCB Case No. 03-08267.

and grafting and possible posterior lumbar interbody fusion at the L3-S1 levels. (Ex. 80-5). She noted that the L4-5 level procedure would be a revision procedure.

On May 8, 2003, Dr. Parvin reported an actual worsening of the underlying condition and indicated that claimant would be scheduled for surgery. (Ex. 84). She also released claimant from work. (*Id.*). On May 14, 2003, Dr. Parvin requested authorization for the aforementioned lumbar surgery, indicating that claimant would require three to four days of inpatient hospitalization. (Ex. 84A).

Claimant continued to treat with Dr. Carter for neck and back pain. On July 25, 2003, claimant returned to Dr. Parvin for neck pain and upper extremity radicular symptoms. (Ex. 86). Dr. Parvin recommended a three level anterior cervical revision decompression/discectomy with fusion, instrumentation, and bone grafting at C4-C7. (Ex. 86-3-4). On July 30, 2003, Dr. Parvin requested authorization for the cervical surgery, indicating that claimant would require three days of inpatient hospitalization. (Ex. 84A).

On August 5, 2003, Dr. Parvin reported an actual worsening of the underlying condition “per [patient],” indicating that claimant needed surgery and was released from work. (Ex. 88).

On November 18, 2003, claimant requested administrative review by the Medical Review Unit (MRU) regarding various unpaid medical bills, including bills from Drs. Carter and Parvin. (Ex. 89A-1). That same date, claimant requested a hearing before the Board’s Hearings Division, raising the issue of a *de facto* denial of an “aggravation claim” filed May 8, 2003. (WCB Case No. 03-08267).

On December 31, 2003, the MRU issued a Defer Order. (Ex. 92). This order noted that the insurer contended that the medical services were not causally related to the accepted conditions. Because this compensability issue was pending before the Board, administrative review was deferred pending resolution of that issue.

CONCLUSIONS OF LAW AND OPINION

On August 6, 2004, an Administrative Law Judge (ALJ) set aside the *de facto* denials of claimant’s medical services claims for services concerning Drs. Parvin’s and Carter’s medical bills and services. That order was not appealed and has become final by operation of law.

The hearing regarding the medical services claim was held on the written record. In its closing argument, the insurer agreed that claimant had submitted a “worsened” condition claim regarding the 1994 injury. On May 21, 2004, the insurer submitted its “Carrier’s Own Motion Recommendation.”

In its "Carrier's Own Motion Recommendation," the insurer referenced the closing arguments to indicate that, on March 24, 2004, claimant had submitted a claim for a "worsening" of her back conditions. The insurer did not agree that claimant's current condition was causally related to the accepted conditions or that it was responsible for the current condition. Notwithstanding these positions, the insurer did not issue a compensability or responsibility denial. *See* ORS 656.262; ORS 656.308(2).

In *Eva M. Tucker*, 55 Van Natta 2577 (2003), we explained that if a carrier contests the compensability of and/or its responsibility for a claimant's current condition in an Own Motion claim involving only a "worsened condition," the carrier's claim processing obligation includes issuance of a written denial of compensability and/or responsibility pursuant to ORS 656.262 and/or ORS 656.308(2), respectively. This requirement is described in the Board's "Carrier's Own Motion Recommendation" form. Compliance with ORS 656.262 and ORS 656.308(2) provides notice to the claimant of the carrier's position regarding compensability and responsibility. It also provides the claimant an opportunity to contest the carrier's position by requesting a hearing on the compensability and/or responsibility denials and/or by filing a "new injury" claim with any subsequent insurer.² A carrier does not have the option of "informally" disputing compensability of or responsibility for a current condition claim by failing to accept or deny the claim.

Here, the insurer contends that claimant has made a claim for a "worsened condition" under ORS 656.278(1)(a) (2001), but contests the compensability of,

² If a carrier issues a denial of the current condition claim, we defer review of the Own Motion matter to determine whether the claimant will request a hearing on that denial. If a hearing request is filed, we postpone action on the Own Motion matter to await resolution of the compensability/responsibility dispute. OAR 438-012-0050. If no hearing request is filed, we proceed with review of the Own Motion matter. Under such circumstances, the denial would become final by operation of law; therefore, causation would not be established and we would deny reopening the Own Motion claim on that basis. *Tucker*, 55 Van Natta at 2582. This normal processing sequence is interrupted where, as here, a carrier does not issue a denial of the current condition under ORS 656.262 and/or ORS 656.308(2), despite its contentions regarding compensability of and/or responsibility for such claims. *Id.*

and its responsibility for the current condition. Therefore, the insurer is required to issue compensability and responsibility denials pursuant to ORS 656.262 and ORS 656.308(2). *Sean Sullivan*, 56 Van Natta 3036 (2004); *Markus D. Perkins*, 55 Van Natta 4095 (2003), *Tucker*, 55 Van Natta at 2582.

Claimant argues that the ALJ's decision regarding the medical services claim determined that her current condition is compensable. However, the issue decided by the ALJ was "[w]hether the conditions for which medical services were sought were materially related to the accepted conditions; *i.e.*, those listed in the Defer Order of the Medical Review Unit that issued on December 31, 2003." In other words, the issue was whether a sufficient causal relationship existed between the specific medical services in question and the accepted claim. ORS 656.245; ORS 656.704(3)(b)(C). The ALJ determined that a sufficient causal relationship existed and set aside the insurer's *de facto* denials of claimant's medical services claim for services provided by Drs. Parvin and Carter.³

Finally, in its Carrier's Own Motion Recommendation, the insurer contended both that claimant had not submitted a "post-aggravation rights" new or omitted medical condition claim and that no acceptance or denial was required because the document received from claimant did not clearly request formal written acceptance of a new or omitted medical condition. Board staff wrote to the parties, requesting clarification of the status of any new or omitted medical condition claim. The insurer responded that, if claimant wishes to include any new or omitted medical conditions, she must "clearly request[] formal written acceptance" of such conditions. Claimant responded that the ALJ's order "establishes as a matter of law that [her] current condition *is* within the scope of the accepted claim and is not a 'new or omitted condition' for which a claim to expand is required." (Emphasis in original).

Considering the parties' responses, we find that claimant has not presented a "post-aggravation rights" new or omitted medical condition claim, although she

³ The ALJ upheld the insurer's *de facto* denial of medical services provided by Mr. Fisher, FNP. In a December 23, 2004 Administrative Order, the MRU noted that the issue presented to it was whether the insurer was liable for specific medical services provided by Drs. Parvin and Carter and Mr. Fisher. (Administrative Order MS 04-1076). The MRU found that, because the insurer paid Drs. Parvin and Carter for their medical services on November 30, 2004, the issue regarding those services was resolved. Furthermore, because the ALJ had found the services provided by Mr. Fisher not compensable, the MRU found the insurer not liable for those services.

may do so at any time.⁴ *See* ORS 656.267(1). Thus, claimant’s claim is for a “worsened condition” under ORS 656.278(1)(a) (2001). Furthermore, as explained above, the ALJ’s order was limited to medical service claims for previously accepted conditions. By its express terms, the ALJ’s order did not extend to any new or omitted medical conditions. Moreover, no claim for any new or omitted medical condition was presented to the ALJ.

Under the circumstances of this “worsened” condition claim, as explained above, the insurer is required to issue compensability and responsibility denials pursuant to ORS 656.262 and ORS 656.308(2). Because the insurer has not done so, we postpone further Own Motion action on the "worsened" condition claim to allow the insurer to fully process this claim. Considering its position as expressed in its recommendation, the insurer will likely choose to issue a compensability and/or responsibility denial. If so, the insurer is directed to issue such denials within 14 days from the date of this order. In the event that the insurer does not issue appropriate denials within that period, claimant is advised to submit her written position regarding whether she wishes to request a hearing. Pending clarification of the parties' positions, we shall defer further action regarding claimant's "worsened" condition claim.

IT IS SO ORDERED.

Entered at Salem, Oregon on March 22, 2005

⁴ If claimant wishes to pursue a “post-aggravation rights” new or omitted medical condition claim, she must clearly request formal written acceptance of the new or omitted medical condition from the carrier. ORS 656.267(1) (2001); OAR 438-012-0020(4).