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In the Matter of the Compensation of  
**MICHAEL E. DEROEST, Claimant**  
WCB Case No. 13-04288  
ORDER ON REVIEW  
Doblie & Associates, Claimant Attorneys  
Sather Byerly & Holloway, Defense Attorneys

Reviewing Panel: Members Weddell, Johnson, and Somers. Member Weddell dissents in part.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Smitke's order that: (1) excluded claimant's "post-hearing" submission of information regarding the certified mailing of the self-insured employer's denial; (2) declined to award additional temporary disability; (3) dismissed claimant's request for hearing regarding medical services; (4) upheld the employer's denial of his new/omitted medical condition claim for a left foot bone fragment; and (5) declined to award penalties or attorney fees for the employer's allegedly untimely denial of the new/omitted medical condition claim. On review, the issues are evidence, temporary disability, jurisdiction, medical services, compensability, penalties, and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the following summary and supplementation.

After claimant's May 24, 2007 work injury, the employer accepted a "fractured cuboid left foot." (Ex. 5). An August 29, 2007 Notice of Closure did not award permanent disability benefits. (Ex. 8).

The employer paid temporary total disability (TTD) benefits from January 7, 2013 through February 17, 2013. (Exs. 41, 46). After the termination of his TTD benefits, claimant requested a hearing.

In a December 26, 2013 Order on Review, we reversed that portion of a prior ALJ's order that had set aside a *de facto* denial of an aggravation claim. *Michael Deroest*, 65 Van Natta 2542 (2013).<sup>1</sup>

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<sup>1</sup> The court has affirmed our decision. *DeRoest v. Keystone RV Co.*, 276 Or App 698 (2016).

On January 21, 2014, claimant filed a new/omitted medical condition claim for “bone fragment, left foot.” (Ex. 48A).

On January 27, 2014, claimant’s attorney informed the employer of claimant’s new address in La Grande, Oregon. (Ex. 50).

In a letter dated March 21, 2014, the employer denied claimant’s new/omitted medical condition claim for a left foot bone fragment. (Exs. 55, 56). One copy of the denial was addressed to claimant in La Grande. (Ex. 55-1). Another copy of the denial was addressed to claimant’s former address in Baker City, Oregon. (Ex. 56-1). Both copies of the denial stated that they were sent “CERTIFIED/RETURN RECEIPT.” (Exs. 55, 56).

On May 29, 2014, Dr. Gutierrez referred claimant to Dr. Weintraub, an orthopedist, for evaluation. (Ex. 59).

In an October 23, 2014 written statement, a scheduler for Dr. Weintraub’s office stated that in May 2014, she had called the claim specialist assigned to administer claimant’s workers’ compensation claim, to confirm that diagnostic testing was appropriate. (Ex. 62). The scheduler stated that the claim specialist had stated that the claim was closed, and that the appointment request was “declined as [the] claim was closed.” (*Id.*)

In an October 27, 2014 written statement, the claim specialist stated that she recalled the May 2014 conversation as a request to “authorize a referral exam,” not a request for approval of diagnostic testing. (Ex. 63). She recalled telling the caller that referrals did not need authorization. (*Id.*) She stated that she “would have” “advised of the litigation status,” but “did not advise that the status on this claim was closed.” (*Id.*)

A hearing was convened on October 28, 2014. The ALJ postponed admitting any of the submitted exhibits until they were renumbered. (I Tr. 17-18). The hearing was continued.

On November 14, 2014, the employer submitted a revised master exhibit list, which renumbered the previously-submitted exhibits.

On December 12, 2014, claimant’s attorney submitted additional exhibits (including Exhibit 58A, which included tracking information for the employer’s certified mailing of its denial). The hearing was reconvened on April 13, 2015 to address the employer’s objection to claimant’s submission.

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## CONCLUSIONS OF LAW AND OPINION

### Evidence

Reasoning that Exhibit 58A did not comport with the reason for which the record had been held open, the ALJ excluded it. (II Tr. 5). Claimant contends that the ALJ's exclusion of the submitted exhibit was an abuse of discretion.

As discussed below, even without considering the proposed exhibit, we conclude that the employer did not timely mail the denial of the new/omitted medical condition claim for a left foot bone fragment. Accordingly, we need not resolve the evidentiary question.

### Temporary Disability

We adopt the ALJ's reasoning regarding the temporary disability issue, except for the ALJ's references to ORS 656.325(5)(c).

### Medical Services

The ALJ concluded that the record did not establish the existence of a dispute regarding the causal relationship between proposed medical treatment and the compensable claim. Accordingly, the ALJ dismissed claimant's hearing request regarding the medical services issue for lack of jurisdiction. *See* ORS 656.704(3)(b) (describing division of authority over medical services disputes between the Board and the Director of the Workers' Compensation Division (WCD)).

On review, claimant contends that the employer denied his medical services claim for a future appointment with Dr. Weintraub. As explained below, we agree with the ALJ's reasoning.

Whether jurisdiction over a medical services dispute lies with the Board or with the Director depends on whether the dispute is a "matter concerning a claim." ORS 656.704(3)(a); *AIG Claim Servs. v. Cole*, 205 Or App 170, 174 (2006). The Board, and the Hearings Division, has jurisdiction over a medical services dispute to determine whether a sufficient causal relationship exists between medical services and an accepted claim, because such a dispute is a "matter concerning a claim." ORS 656.704(3)(b)(C); *Cole*, 205 Or App at 173-74. However, a dispute regarding whether medical services are excessive, inappropriate, ineffectual, or

in violation of the rules regarding the performance of medical services is in the WCD's jurisdiction because such a dispute is not a "matter concerning a claim." ORS 656.704(3)(b)(B); *Cole*, 205 Or App at 174.

To begin, a "claim" is "a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge." ORS 656.005(6). A *de facto* denial is based on a carrier's failure to meet its statutory obligation to timely accept or deny a claim. *SAIF v. Allen*, 320 Or 192, 215-16 (1994). If there is no claim, there can be no *de facto* denial. See *Praxedis Alvarez-Barrera*, 65 Van Natta 183 (2013).

Here, claimant alleges that there was a "claim" based on the recommendations for further evaluation by Drs. Rushton and Gutierrez, who treated him. (Exs. 43, 47, 53, 57, 58, 59, 60). However, although Drs. Rushton and Gutierrez recommended further evaluation, the record does not indicate that they made any request that the employer cause such services to be provided. To the contrary, Dr. Rushton specifically opined that he could not relate claimant's complaints to the compensable injury. (Exs. 53, 57-21-23). Further, although Dr. Gutierrez mentioned the referral in a chart note, the record does not establish that he, or anyone else, directed that recommendation to the employer. (Exs. 59, 60).

Therefore, we do not consider any of these documents to be written requests for compensation. Accordingly, there was no medical services claim.

Furthermore, even if there was a "claim" for medical services, the record does not establish the existence of a "causation" dispute. We reason as follows.

Claimant notes that Dr. Weintraub's office made a verbal inquiry to the employer regarding the referral, and that Dr. Weintraub did not evaluate claimant because of that conversation. (Exs. 62, 63). The content of that conversation is in some dispute, but does not establish the existence of a "causation" dispute regarding a medical services claim.<sup>2</sup>

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<sup>2</sup> The dissent reasons that a hearing request alleging a dispute regarding a *de facto* denial is, itself, sufficient to bring the dispute within the Board's jurisdiction because the hearing request alleges a denial that implicates both "propriety" and "causation" disputes. However, a medical services dispute

may involve matters concerning a claim, matters not concerning a claim, or both. If the medical services dispute does not involve a matter concerning a claim, it is not within our jurisdiction. ORS 656.704(3)(b)(C); *Cole*, 205 Or App at 173-74. Thus, although a claimant may request a hearing alleging a *de facto* denial, our threshold inquiry is whether the dispute concerns an issue within our jurisdiction. *Southwest Forest Indus. v. Anders*, 299 Or 205, 208 (1985); *Steven C. Johnson*, 67 Van Natta 1289, 1290-91 (2015).

Claimant's interpretation of the evidence, at most, supports only the conclusion that the employer refused to authorize the requested medical services because the "claim was closed." (Ex. 62). Such an interpretation does not establish the existence of a dispute regarding the causal relationship between the medical services and the accepted claim. If anything, it suggests only a "propriety" dispute, which would be within WCD's jurisdiction.<sup>3</sup> *Cf. Stephen H. Moore*, 66 Van Natta 812, 815, *recons*, 66 Van Natta 1003 (2014) (where a denial raises both "causation" and "propriety" disputes, the worker may request a hearing on a "matter concerning a claim" without first requesting administrative review by WCD).

Further, throughout this proceeding, there is no indication that the employer disputed the causal relationship between the medical services and the accepted claim. Instead, it has consistently asserted that there was no medical services denial, and that any medical services dispute was subject to WCD's jurisdiction, not the Board's authority. (I Tr. 16-17).

Under such circumstances, we conclude that the medical services issue is not within our jurisdiction. *See Thomas Jarrell*, 68 Van Natta (issued this date) (where a carrier did not affirmatively concede the causal relationship between proposed medical services and the accepted claim, but did not dispute such a relationship, the mere lack of such a concession did not raise a "causation" dispute). Consequently, we affirm that portion of the ALJ's order that dismissed claimant's hearing request regarding the medical services issue.

### Compensability

The ALJ concluded that claimant had not established the existence of the claimed "bone fragment" condition. We adopt the ALJ's reasoning regarding the compensability of this claim, with the following supplementation.

Claimant bears the burden to establish the existence of the claimed "bone fragment" condition and, if the condition arose directly from the work injury, to show that the work injury was a material contributing cause of his disability or need for treatment of the condition. ORS 656.005(7)(a); ORS 656.266(1); *Albany Gen. Hosp. v. Gasperino*, 113 Or App 411, 415 (1992); *Maureen Y. Graves*,

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<sup>3</sup> We do not conclusively determine whether there is a "propriety" dispute regarding medical services. No "propriety" dispute is before us, and the existence of a "causation" dispute does not depend on the existence or absence of a "propriety" dispute. Nevertheless, comments suggestive of a "propriety" dispute do not support the existence of a "causation" dispute.

57 Van Natta 2380, 2381 (2005). If the condition arose as a consequence of a compensable injury, claimant must prove that the compensable injury was the major contributing cause of the consequential condition. ORS 656.005(7)(a)(A); ORS 656.266(1); *English v. Liberty NW Ins. Corp.*, 271 Or App 211, 215 (2015); *Gasperino*, 113 Or App at 415.

In addition to the ALJ's reasoning, we note that Dr. Rushton, who excised the bone spur (which he had described as a "fragment," although it was attached to the cuboid bone) in 2011, did not opine that the spur resulted from the work injury or the accepted cuboid fracture. (Exs. 30-27, 53-1, 57-7). Under such circumstances, we conclude that claimant has not established that the claimed "bone fragment" is compensably related to the work injury under either the "material" or "major" contributing cause standards.

Additionally, we disagree with claimant's contention regarding the effect of our previous order, which referred to a bone "fragment." See *Deroest*, 65 Van Natta at 2542. Our order addressed the compensability of a denied aggravation claim and specifically addressed the question of whether there had been an actual worsening of the compensable cuboid fracture.<sup>4</sup> *Id.* at 2543. In that context, to the extent our discussion could be interpreted as implying a distinction between a bone "fragment" and a bone "spur," such an implication would be immaterial to the issue in the current proceeding. Thus, because the description of the spur as a "fragment" was not "actually litigated and essential to a final decision on the merits in the prior proceeding," that description was not preclusive. This conclusion is further supported by our order itself, which emphasized that our decision addressed the alleged aggravation of cuboid fracture, not the merits of any potential new/omitted medical condition claim. *Id.* at 2544 n 2.

Therefore, based on the aforementioned reasoning, as well as the reasoning expressed in the ALJ's order, we conclude that claimant has not established the compensability of his new/omitted medical condition claim for a bone fragment.

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<sup>4</sup> In *Nacoste v. Halton Co.*, 275 Or App 600 (2015), the court ratified this statutory analysis. The court held that an aggravation claim must be based on the worsening of an accepted condition, and not on the development of a new condition. 275 Or App at 607-08. The court further explained that *Brown v. SAIF*, 262 Or App 640, *rev allowed*, 356 Or 397 (2014), did not apply in the context of an aggravation claim because *Brown* addressed the definition of a "compensable injury" rather than "compensable condition," which is the phrase used in ORS 656.273 to define compensable aggravation claims. In affirming our earlier *DeRoest* decision, the court cited the *Nacoste* holding. 276 Or App at 699.

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Penalties/Attorney Fees

In declining to award a penalty or attorney fee for an untimely denial of claimant's new/omitted medical condition claim, the ALJ was not persuaded that the employer's denial had been untimely mailed to claimant. On review, claimant disputes the ALJ's conclusion. As explained below, we disagree with the ALJ's determination.

A carrier that unreasonably delays acceptance or denial of a claim shall be liable for a penalty of up to 25 percent of the amounts then due, plus an assessed attorney fee. ORS 656.262(11)(a). An assessed attorney fee may be awarded even if there are no amounts due on which to base a penalty. *SAIF v. Traner*, 270 Or App 67, 75 (2015).

Here, the claim was filed on January 21, 2014. (Ex. 48A). Claimant's attorney notified the employer's attorney of claimant's new address in La Grande on January 27, 2014. (Ex. 50). One copy of the employer's denial was addressed to claimant's former address in Baker City, while the other copy of the denial was addressed to claimant's La Grande address. (Exs. 55, 56). Both copies were dated March 21, 2014, and included statements that they were sent by certified mail with return receipt requested. (Exs. 55, 56).

Nevertheless, claimant testified that he did not receive a copy of the denial from the employer in the mail. (I Tr. 34). Instead, he first saw it when his attorney provided it to him. (*Id.*) No return receipt regarding either copy of the denial letter was admitted into the record.

ORS 656.262(7)(a) required the employer to respond to claimant's new/omitted medical condition claim with a written notice of acceptance or denial that "shall be furnished to the claimant by the insurer or self-insured employer within 60 days." ORS 656.262(7)(a). A written notice of denial must "be delivered by registered or certified mail with return receipt requested or by personal service meeting the requirements for service of a summons." OAR 438-005-0065.

In *Bishop v. OBEC Consulting Eng'rs*, 160 Or App 548 (1999), the court evaluated the effect of a claimant's actual receipt of a claim denial that was not mailed to him and held that his actual knowledge of a notice of denial did not vitiate noncompliance with the explicit requirements of ORS 656.262(6)(a) and OAR 438-005-0065. Consistent with the *Bishop* rationale, we have concluded that a denial

that is mailed to an incorrect address is not effective, regardless of a claimant's actual knowledge of the denial. *Michael S. Belgarde*, 66 Van Natta 1424, 1429 (2014) (hearing request was timely when it was filed more than 60 days after the carrier mailed its denial to the wrong address).

The employer contends that it timely provided notice of its denial to claimant's attorney.<sup>5</sup> However, ORS 656.262(7)(a) requires that the written notice of acceptance or denial be "furnished to the claimant," and does not permit the employer to satisfy its obligation by furnishing the notice to the claimant's attorney instead. Further, the employer identifies no legal authority allowing it to furnish the denial "to the claimant" by delivering it to his attorney.

Finally, while we can conceive of circumstances in which documents might be furnished to a claimant by delivery to the claimant's attorney, this particular claimant's attorney's retainer agreement does not authorize the attorney to receive documents on claimant's behalf, and neither claimant nor his attorney directed the employer to furnish documents to claimant by directing them to his attorney. Instead, claimant informed the employer of his mailing address in La Grande. (Ex. 50). Thus, we do not conclude, either as a general matter or in this particular case, that the employer may "furnish to the claimant" its denial, as required by ORS 656.262(7)(a), by mailing it to claimant's attorney.

Here, it is undisputed that the denial was issued after claimant informed the employer of his La Grande address. Consequently, based on *Bishop* and *Belgarde*, we conclude that any denial that was not directed to the correct address was ineffective, regardless of any mailing to claimant's attorney or of claimant's actual knowledge of the denial. Therefore, the denial was timely only if it was mailed to claimant's La Grande address by March 22, 2014, the sixtieth day after the January 21, 2014 claim was filed.

It is presumed that a writing is truly dated and that a letter duly directed and mailed was received in the regular course of the mail. ORS 40.135(1)(p), (q). Nevertheless, there is no presumption that a letter is mailed on the day it was written or on the day it is dated. *Madewell v. Salvation Army*, 49 Or App 713, 715-16 (1980); *Bonnie L. Garber*, 61 Van Natta 2305, 2306 (2009).

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<sup>5</sup> Neither *Bishop* nor *Belgrade* involved timely notice sent to the claimant's attorney. In *Bishop*, the carrier mailed its denial to an attorney who the carrier believed to be the claimant's attorney, but who did not represent the claimant. The claimant actually received the denial approximately two months later. 160 Or App at 522. In *Belgrade*, the carrier attempted to mail a denial to the claimant, but used the wrong address. The claimant actually received the denial approximately two months later. 66 Van Natta at 1425.

As noted above, claimant testified that he did not timely receive a mailing of the denial from the employer. Further, although the denial indicated that it was mailed by certified mail with a return receipt, the record does not include any corroborative documentary or testimonial evidence of when the denial was mailed or delivered.<sup>6</sup> Cf. *David J. Lampa*, 66 Van Natta 1052 (2014) (testimony of the claimant's counsel's legal assistant established when a claim closure request was mailed).

Under such circumstances, this record does not persuasively establish that the employer timely furnished written notice of its denial to claimant. Therefore, we conclude that the employer unreasonably delayed its denial of claimant's new/omitted medical condition claim.

The record does not establish that there were "amounts then due" on which to base a penalty. See ORS 656.262(11)(a) (providing for a penalty of up to 25 percent of "amounts then due" plus an attorney fee); *Joyce A. Dietrich*, 63 Van Natta 2507, 2513 (2011) (no entitlement to a penalty where there were no "amounts then due"). Nevertheless, claimant's counsel is entitled to an assessed fee under ORS 656.262(11)(a) for services at the hearing level and on review. See *SAIF v. Traner*, 273 Or App 310, 322 (2015) (awarding an assessed fee under ORS 656.262(11)(a) for defending an ORS 656.262(11)(a) fee on appeal, which had been awarded although there were no "amounts the due" on which to base a penalty); *Stanley T. Castle*, 67 Van Natta 2055, 2058 (2015).

After considering the factors set forth in OAR 438-015-0010(4) and OAR 438-015-0110, we find that a reasonable attorney fee for claimant's services at the hearing level and on review under ORS 656.262(11)(a) is \$2,000, payable by the employer. In reaching this conclusion, we have considered the proportionate benefit to claimant, giving primary consideration to the result achieved and to the time devoted to the issue (as represented by the record and claimant's appellate briefs).

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<sup>6</sup> Claimant's attorney offered to leave the record open for any documentation of timely mailing to claimant's La Grande address. (I Tr. 56). The employer declined to submit such evidence.

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ORDER

The ALJ's order dated May 20, 2015 is affirmed in part and reversed in part. That portion of the ALJ's order that declined to award an attorney fee under ORS 656.262(11)(a) is reversed. For services at hearing and review regarding the penalty issue, claimant's counsel is awarded an assessed fee of \$2,000, payable by the employer. The remainder of the ALJ's order is affirmed.

Entered at Salem, Oregon on April 22, 2016

Member Weddell dissenting in part.

Although I agree with those portions of the majority opinion that address the ALJ's evidentiary ruling, the temporary disability issue, the new/omitted medical condition denial, and the penalty and attorney fee issues, I disagree with the majority's conclusion that the medical services issue is not within our jurisdiction. Addressing the merits of the medical services issue, I would uphold the *de facto* denial. Accordingly, I offer the following analysis.

To begin, I disagree with the employer's contention that there was no medical services claim and no medical services *de facto* denial.

ORS 656.262(6)(a) requires a carrier to accept or deny a claim within 60 days. Failure to timely accept or deny a claim constitutes a *de facto* denial. *SAIF v. Allen*, 320 Or 192, 215-16 (1994). A "written request for compensation from a subject worker or someone on the worker's behalf" is a "claim." ORS 656.005(6). "Compensation" includes medical services. ORS 656.005(8). Therefore, if a physician requests future medical services on a claimant's behalf, that request is a "claim," and the failure to timely respond to the claim is a *de facto* denial. *Safeway Stores, Inc. v. Smith*, 117 Or App 224, 228 (1992) (physician's request for medical treatment constituted a "claim," and carrier's failure to timely respond to the claim constituted a *de facto* denial); *Marsha K. Flanary*, 47 Van Natta 988, 989 (1995) (finding a *de facto* denial where the carrier had failed to timely accept or deny a request for future treatment).

On November 20, 2013, Dr. Rushton recommended that claimant see an orthopedic surgeon in Portland, Oregon, to evaluate the possibility of a fusion to alleviate claimant's foot and ankle symptoms. (Ex. 47-2). He discussed this chart note, and his recommendation specifically, in a deposition with the employer's

attorney. (Ex. 57-10-12, -18-21). On February 18, 2014, Dr. Gutierrez explained, in a concurrence opinion drafted by the employer, his recommendation that claimant be seen by a specialist for consultation. (Ex. 52-3). In a May 29, 2014 chart note, he referred claimant to see orthopedist Dr. Weintraub for evaluation. (Ex. 59-3). He repeated that referral on June 3, 2014. (Ex. 60). I conclude that the record establishes that the evaluation by Dr. Weintraub was requested in writing.

Further, the employer does not dispute that it received a written request from Dr. Gutierrez, on claimant's behalf, that claimant be evaluated by Dr. Weintraub. Instead, it contends that such a "referral to a specialist does not require any advance action by a claims examiner." In particular, the employer argues that the Workers' Compensation Division's (WCD's) rules do not specifically require preauthorization of this type of service (as they would for diagnostic testing, for example), and that no bill for past service has been refused. In other words, the employer presumes that it has no obligation to respond to a claim for future medical services unless WCD's rules specifically create such an obligation.

The statutory framework is inconsistent with such a limited conception of a claimant's rights or a carrier's responsibilities. The carrier bears the responsibility to process claims and provide compensation to an injured worker. ORS 656.262(1). That responsibility is governed, in part, by ORS 656.245(1)(a), which requires a carrier to "cause to be provided medical services for conditions caused in material part by the injury" (for consequential and combined conditions, the medical services must be "directed to medical conditions caused in major part by the injury"). A carrier is not merely required to *reimburse* medical services for conditions that bear a sufficient causal relationship to the injury, but is required to *cause* those medical services to be provided.<sup>7</sup> Finally, as discussed above, a carrier's failure to timely accept or deny a request for future medical services is inconsistent with its claim processing responsibilities and constitutes a *de facto* denial.

Having concluded that there was a *de facto* denial of a medical services claim, I turn to the question of whether this *de facto* denial involves an issue within the Board's jurisdiction. The Board has jurisdiction over a medical services dispute to determine whether a sufficient causal relationship exists between medical services and an accepted claim, because such a dispute is a

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<sup>7</sup> The mandate of ORS 656.245 to "cause" medical services "to be provided" contrasts with, for example, the language of ORS 742.524(1), which mandates payments for reasonable and necessary medical expenses "incurred."

“matter concerning a claim.” ORS 656.704(3)(b)(C); *AIG Claim Servs., Inc. v. Cole*, 205 Or App 170, 173-74 (2006). However, a dispute regarding whether medical services are excessive, inappropriate, ineffectual, or in violation of the rules regarding the performance of medical services is in WCD’s jurisdiction because such a dispute is not a “matter concerning a claim.” ORS 656.704(3)(b)(B); *Cole*, 205 Or App at 174.

A medical services claim, by its nature, implicates the requirement of a sufficient causal relationship between the claimed medical services and the accepted claim. Here, the employer *de facto* denied claimant’s medical services claim, and did not specify the grounds for the denial.

The employer has not conceded “causation,” nor has it affirmatively disputed the claim on “propriety” grounds. The record presents no reason to conclude that the medical services dispute raises issues that are subject to WCD’s jurisdiction, but not issues that are subject to the Board’s jurisdiction. Under such circumstances, I would not presume to conclude that the denial was so limited. Instead, I conclude that the *de facto* denial implicates both “propriety” and “causation” disputes. Therefore, claimant could request a hearing on the “matter concerning a claim” (*i.e.*, the “causation” dispute) without first requesting administrative review by WCD, just as he had the right to request review by WCD without first requesting a hearing. *See Stephen H. Moore*, 66 Van Natta 812, 815, *recons*, 66 Van Natta 1003 (2014).

To conclude that the *de facto* denial did not raise a causation issue would essentially write the employer’s denial on the employer’s behalf, without knowing its reason for *de facto* denying the claim. A carrier might dispute medical services based on “causation” issues, or on “propriety” issues, or both. Presuming that “causation” is not at issue unless it is explicitly raised does not affect only those *de facto* denials in which the underlying dispute solely concerns “propriety,” but also those *de facto* denials in which the underlying dispute regards “causation,” or both “causation” and “propriety.” In such instances, the Board’s dismissal of the hearing request would require the claimant to seek review by the wrong body, WCD, which would then transfer the dispute back to the Board.

It is no more logical for the Board to take such an approach than it would be for WCD to transfer any medical service dispute to the Board if the carrier fails to specify a “propriety” dispute. The medical services *de facto* denial is now before the Board. The scope of that issue has not been narrowed to a “propriety” dispute.

I would resolve that portion of the medical services dispute that is within our jurisdiction, which is the causal relationship between the compensable injury and the disputed medical services.<sup>8</sup>

Accordingly, I conclude that the record raises a “causation” dispute within the Board’s jurisdiction. Turning to that dispute, I am not persuaded that claimant has established the requisite causal relationship between the work injury and the disputed medical service.

As noted, ORS 656.245(1)(a) requires the carrier to “cause to be provided medical services for conditions caused in material part by the injury.” Dr. Rushton explained that the referral was to evaluate the possibility of a fusion to alleviate claimant’s foot and ankle symptoms, but could not identify a condition causing those symptoms that was causally related to the work injury. (Exs. 53, 57-21-23). Dr. Gutierrez explained that he only related claimant’s complaints to the work injury because claimant, himself, did. (Ex. 58-22). He did not have a persuasive explanation of how the medical services would be for a condition caused in material part by the work injury. (Ex. 58-19-30). His conclusory opinion is insufficient to establish the requisite causal relationship between the work injury and the medical services. *Moe v. Ceiling Sys., Inc.*, 44 Or App 429, 433 (1980).

Accordingly, I would reinstate claimant’s hearing request regarding the medical services *de facto* denial and address the merits of that issue, insofar as it lies within the Board’s jurisdiction. By doing so, I would resolve the parties’ dispute by upholding the *de facto* denial. Because the majority does otherwise, I respectfully dissent in part.

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<sup>8</sup> I observe that a claimant’s hearing request alleging a dispute regarding a matter concerning a claim, based on a *de facto* denial, is sufficient to bring the dispute within the Board’s jurisdiction even if the record ultimately does not support the existence of a claim or *de facto* denial. See *Tamara R. Bain*, 66 Van Natta 577 (2014). If, after evaluating the matter, the Board concludes that there was not, in fact, a claim or a *de facto* denial, the proper resolution is to deny the claimant relief, not to dismiss the hearing request. *Id.*

The majority essentially reasons that a hearing request alleging a *de facto* denial of medical services does not automatically raise an issue within the Board’s jurisdiction because such a denial could involve a “propriety” dispute instead. Even if this conclusion is correct, a claimant should be able to raise a “matter concerning a claim” within the Board’s jurisdiction by specifying a causation dispute. Here, however, claimant generally alleged a *de facto* medical services denial, rather than specifying that he sought resolution of a causation dispute.