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In the Matter of the Compensation of  
**THOMAS JARRELL, Claimant**  
WCB Case No. 14-06278  
ORDER ON REVIEW  
Jodie Phillips Polich, Claimant Attorneys  
Reinisch Wilson Weier, Defense Attorneys

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

Claimant requests review of Administrative Law Judge (ALJ) Riechers's order that: (1) upheld the self-insured employer's denial of claimant's aggravation and new/omitted medical condition claims for a tooth condition; (2) declined to find a *de facto* denial of a medical services claim for the aforementioned condition; and (3) declined to award penalties and attorney fees for an alleged discovery violation and allegedly unreasonable claim processing. On review, the issues are aggravation, compensability, medical services, claim processing, penalties, and attorney fees. We vacate in part and affirm in part.

FINDINGS OF FACT

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

Claimant's January 17, 2006 work injury damaged preexisting dental implants. (Tr. 8). The employer's May 23, 2006 Initial Notice of Acceptance classified the claim as nondisabling and listed several conditions related to implants at teeth 8 and 9. (Ex. 5).

A February 11, 2010 Notice of Closure awarded no permanent disability benefits and awarded temporary disability benefits for various dates between February 20, 2008 and December 12, 2008. (Ex. 7). The closure notice stated that claimant's aggravation rights would end January 17, 2011. (*Id.*) An April 28, 2010 Order on Reconsideration rescinded the February 11, 2010 Notice of Closure as premature. (Ex. 8).

On June 16, 2010, Dr. Kaip, a dentist who performed an examination at the employer's request, noted that claimant had a "full upper denture" that was "not tolerable," and an "interim denture" that needed to be "relined" to improve his functioning. (Ex. 9-4).

An April 5, 2012 Notice of Closure awarded no permanent disability benefits and awarded temporary disability benefits for various dates between February 20, 2008 and December 12, 2008. (Ex. 12). The closure notice stated that claimant's aggravation rights would end April 5, 2017. (*Id.*)

On March 27, 2014, Dr. Geelan, a dentist, noted that claimant presented with an ill-fitting upper denture. (Ex. 13). He recommended treatment with interim overdentures. (*Id.*)

On April 10, 2014, Dr. Geelan stated that he would request pre-authorization with two different treatment plans. (Ex. 14). One option was a new upper denture with no additional implants, and the other option was a new upper denture with sinus lifts and two to four more implants. (*Id.*) He planned to call claimant "when we hear back from ins." (*Id.*)

On April 28, 2014, Dr. Geelan noted that he was waiting for claimant's paperwork to submit the treatment plan to the "insurance company." (Ex. 15). Dr. Geelan's chart notes bear date stamps indicating receipt by the employer on June 27, 2014. (Exs. 13, 14, 15).

On May 10, 2014, claimant signed a Form 827 asserting an aggravation claim and a new/omitted medical condition claim. (Ex. 16). The new/omitted medical condition claim was described as "The injury to teeth was never corrected properly." (*Id.*) Dr. Geelan signed the Form 827 on May 12, 2014. (*Id.*) That same date, Dr. Geelan wrote a letter "To Whom It May Concern," requesting that the claim be reopened so he could treat claimant. (Ex. 17). The copies of these documents bear a "banner" indicating they were faxed to the employer's claim administrator on September 3, 2014. (Exs. 16, 17).

In a letter dated September 17, 2014, claimant's counsel requested discovery from the employer. (Ex. 18).

In an October 31, 2014 denial letter, the employer stated that it received the Form 827 on September 3, 2014. (Ex. 19). The letter stated that the aggravation claim was denied because "it does not appear your accepted conditions resulting from the January 17, 2006 injury have worsened since the last award or arrangement of compensation." (*Id.*) The letter also stated, "[W]e hereby deny your September 3, 2014 request for acceptance of the new or omitted medical condition described as 'the injury to teeth was never corrected properly' as it is not

a valid/perfected condition.” (*Id.*) Finally, the letter stated, “This denial does not affect your entitlement to ongoing medical services related to the originally accepted conditions.” (*Id.*)

On November 4, 2014, in response to an e-mail inquiry from claimant’s attorney, the employer produced discovery. (Ex. 21).

In a December 29, 2014 hearing request regarding the employer’s denial, claimant also raised medical services, penalty, and attorney fee issues. The employer did not file a response to claimant’s request for hearing. When the hearing was convened on March 16, 2015, no representative for the employer appeared.

### CONCLUSIONS OF LAW AND OPINION

#### Aggravation

The ALJ upheld the aggravation denial, reasoning that claimant had not established an “actual worsening” of a compensable condition. Although neither party has raised the issue of jurisdiction, we conclude that the Hearings Division and the Board lack jurisdiction regarding an “aggravation” issue. We reason as follows.

Subject matter jurisdiction is a threshold question and cannot be waived by either the parties or the Board. *Tony L. Clark*, 66 Van Natta 91 (2014); *Evalyn V. Stevens*, 59 Van Natta 1925 (2007). Even if the issue is not raised by the parties, when presented by the record, we are obligated to consider whether we have subject matter jurisdiction. *See Southwest Forest Indus. v. Anders*, 299 Or 205, 207 (1985).

If a claim has been classified as nondisabling for at least one year after the date of acceptance, an aggravation claim must be filed within five years after the date of injury. ORS 656.273(4)(b). For a disabling claim, however, an aggravation claim must be filed within five years after the first Notice of Closure. ORS 656.273(4)(a). An aggravation claim filed after the expiration of aggravation rights cannot be perfected, and a denial of such a claim is a nullity. *See Mark D. Stapleton*, 51 Van Natta 1779, 1780 (1999); *David L. Dylan*, 50 Van Natta 276 (1998) (timely filing of aggravation claim a requirement for perfection of claim).

The requirement that an aggravation claim be timely filed under ORS 656.273 is jurisdictional. *SM Mather Co. v. Mather*, 117 Or App 176, 180 (1992). Claims for which aggravation rights have expired are processed under the provisions of ORS 656.278, the statute addressing our Own Motion jurisdiction, and our Own Motion rules. ORS 656.278(1)(a); OAR 438-012-0001 *et seq.*; *Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988).

Here, the employer initially accepted the claim as nondisabling on May 23, 2006. (Ex. 5). Claimant did not receive temporary disability benefits until February 20, 2008. (Exs. 7, 12). Thus, the record establishes that the claim was classified as nondisabling for at least one year after the date of acceptance (May 23, 2006). ORS 656.005(7)(c), (d) (defining “disabling” and “nondisabling” compensable injuries). Consistent with the statutory scheme, the initial Notice of Closure (which was later rescinded as premature) stated that claimant’s aggravation rights would end January 17, 2011, five years after the January 17, 2006 date of the nondisabling injury. (Ex. 7-1).

Furthermore, the expiration of claimant’s aggravation rights was not affected by the April 4, 2012 Notice of Closure, which erroneously stated that claimant’s aggravation rights would end April 5, 2017. *Miltenberger*, 93 Or App at 480 (Determination Order’s inaccurate statement that the claimant had five years to file an aggravation claim was not controlling); *see also Bill D. Coleman*, 48 Van Natta 2154 (1996) (expiration of aggravation rights was not affected by a carrier’s subsequent Notice of Acceptance for an “aggravation” claim).

Accordingly, the Hearings Division lacked jurisdiction over the aggravation dispute, as do we on review of the ALJ’s order.<sup>1</sup> Accordingly, we vacate that portion of the ALJ’s order that addressed the employer’s denial of claimant’s so-called aggravation claim and dismiss claimant’s hearing request regarding that denial.

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<sup>1</sup> Compensability/responsibility issues regarding “post-aggravation rights” new/omitted medical condition claims and “worsened condition” claims are in the Hearings Division’s jurisdiction in the first instance, with review to the Board in its “regular jurisdiction” and the courts. ORS 656.267; ORS 656.278; *Jimmie L. Taylor*, 58 Van Natta 75 (2006); *James W. Jordan*, 58 Van Natta 34 (2006). However, “claim reopening” issues regarding such claims are subject to the Board’s Own Motion jurisdiction. ORS 656.267(3); ORS 656.278(1)(a), (b); *Dorothy H. Latta*, 58 Van Natta 1645, 1646 n 2 (2006). Consequently, claimant’s purported “aggravation” claim was, in effect, an Own Motion claim for a worsening of claimant’s previously accepted tooth conditions. If such a claim is “determined to be compensable,” the employer would then have 30 days to process the Own Motion claim for that condition by either voluntarily reopening the claim or submitting a “Carrier’s Own Motion Recommendation” either for or against reopening. *See* OAR 438-012-0030(1); *Karen L. Young*, 64 Van Natta, 477, 478 (2012); *Taylor*, 58 Van Natta at 76-77.

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### New/Omitted Medical Condition

The ALJ concluded that the new/omitted medical condition claim was not for a “condition” that was “new” or “omitted.” Accordingly, the ALJ upheld the new/omitted medical condition claim denial.

On review, claimant contends that the claimed “injury to teeth was never corrected properly” was a “condition.” He further argues that he need not establish that the condition was “new” or “omitted” because the employer is limited by the terms of its denial, which disputed only whether the claim was for a “condition.” As explained below, we disagree with claimant’s assertion.

A new/omitted medical condition claim must be for a “condition” that is either “new” or “omitted.” *See* ORS 656.267(1). A “condition” is “the physical status of the body as a whole \* \* \* or of one of its parts.” *Young v. Hermiston Good Samaritan*, 223 Or App 99, 105 (2008). Whether a claim is for a medical “condition” is a question of fact to be decided based on the medical evidence in a particular case. *Id.* at 107. A condition is “new” if it arose after acceptance of an initial claim, was related to an initial claim, and involved a condition other than the condition initially accepted. *Johansen v. SAIF*, 158 Or App 672, 679 (1999). A condition is “omitted” if it was in existence at the time of the Notice of Acceptance, but was not mentioned in the notice or was left out. *Mark A. Baker*, 50 Van Natta 2333, 2336 (1998). A new/omitted medical condition claim may be denied, even if the claimed condition is compensable, if the claimed condition is neither “new” nor “omitted.” *Michael L. Long*, 63 Van Natta 2134, 2135, *recons*, 63 Van Natta 2330 (2011).

A carrier is bound by the express language of its denial. *Tattoo v. Barrett Bus. Serv.*, 118 Or App 348, 351 (1993). In *Milton D. Restoule*, 66 Van Natta 1731 (2014), for example, the carrier denied a new/omitted medical condition claim on the basis that the claim was not for a “condition,” but was instead for “a symptom, body part, mechanism/description of injury or medical procedure.” Because of the limited language of the denial, we declined to entertain the carrier’s alternative argument on review that there was no objective evidence that the condition required any treatment. 66 Van Natta at 1735-36.

Here, in contrast to *Restoule*, the employer denied claimant’s new/omitted medical condition claim on the ground that “it is not a valid/perfected condition.” (Ex. 19-1). The employer did not limit the basis for the denial to whether the claim was for a “physical status of the body as a whole \* \* \* or of one of its parts” (*i.e.*, a

“condition”). Instead, it broadly disputed the “validity” or “perfection” of the claimed condition. Considering the requirement, under ORS 656.267, that a new/omitted medical condition claim be for a “condition” that is “new” or “omitted,” we do not interpret the denial’s language as excluding a dispute regarding whether the claimed condition was “new” or “omitted.”

Turning to the record, the employer accepted several conditions involving two of claimant’s teeth as a result of his work injury. (Ex. 5). Dr. Geelan’s Form 827 did not identify any conditions other than those specifically identified by that acceptance. Rather, the description of the injury as “never corrected properly” indicates that the claimed “injury” was composed of the same conditions for which treatment had previously been provided pursuant to the initial acceptance. Moreover, Dr. Geelan did not opine that claimant suffered from a condition other than those previously accepted. (Exs. 13, 14, 15, 17). Thus, the record does not support the existence of an “omitted” medical condition.

Additionally, the assertion that the injury “was never corrected properly” indicates that the claimed condition did not arise after the initial claim acceptance. Thus, such a description does not support the existence of a “new” medical condition. *See Johansen*, 158 Or App at 680; *Gustavo B. Barjas*, 51 Van Natta 613 (1999) (condition that arose before acceptance of the initial claim was not a “new medical condition”).

Under such circumstances, we do not conclude that the new/omitted medical condition claim was for a condition that was “new” or “omitted.” Accordingly, we affirm the ALJ’s upholding the denial of claimant’s new/omitted medical condition claim.

### Medical Services

The ALJ declined to find a *de facto* medical services denial. In doing so, the ALJ reasoned that, although the employer had not agreed to pay for the proposed medical services, it had also not stated that it would not pay for the services, and its denial had reiterated claimant’s entitlement to ongoing medical services for his accepted conditions.

On review, claimant contends that the employer’s failure to respond to his request for medical services constituted a *de facto* denial. For the following reasons, we conclude that the medical services dispute does not raise an issue that is within our jurisdiction.

The Board, and the Hearings Division, have 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); *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 the Workers’ Compensation Division’s (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. Again, jurisdiction is a threshold issue that must be considered even if it is not raised by the parties. *See Anders*, 299 Or at 207.

Here, the medical services dispute is based on the fact that the employer did not approve medical services after receiving Dr. Geelan’s chart notes. After reviewing the record, we conclude that a “causation” dispute was not raised at any time.

After receiving Dr. Geelan’s chart notes, the employer did not affirmatively dispute that there would be a sufficient causal relationship between the accepted claim and any proposed medical services. The only statement by the employer pertaining to medical services was the statement, in the October 31, 2014 denial letter, that claimant’s “entitlement to ongoing medical services related to the originally accepted conditions” would not be affected by the denial. (Ex. 19-1).

Further, the employer did not file a response to claimant’s hearing request and did not appear at the hearing. It took no action, after claimant filed his hearing request, to dispute the causal relationship between medical services and the accepted claim. Moreover, claimant did not present evidence at the hearing establishing that the employer disputed the causal relationship between the proposed medical services and his compensable injury.

On this record, we are unable to conclude that a dispute regarding the causal relationship between medical services and the accepted claim has been raised.<sup>2</sup> Under such circumstances, the Hearings Division did not have jurisdiction over the

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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. *Anders*, 299 Or at 208; *Steven C. Johnson*, 67 Van Natta 1289, 1290-91 (2015).

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medical services issue. Accordingly, we vacate that portion of the ALJ's order that addressed the medical services dispute and dismiss claimant's hearing request regarding that issue for want of jurisdiction.

### Penalties/Attorney Fees

The ALJ did not award a penalty or related attorney fee, reasoning that the employer had not issued its denial without conducting a reasonable investigation and that claimant had not established the dates the employer had received various documents.

On review, claimant contends that the employer's denial was untimely because it received the claim shortly after May 12, 2014, the date on the Form 827. Similarly, he asserts that the employer's discovery was untimely and that it violated ORS 656.331 by failing to provide his attorney a copy of the denial because the employer received his discovery request and his attorney's retainer agreement shortly after September 17, 2014. Claimant also argues that the employer did not conduct a reasonable investigation of the aggravation and new/omitted medical condition claims before issuing its denial. For the following reasons, we disagree with claimant's contentions.

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). However, there is no presumption that a letter was mailed on the day it was written or the day it was dated. *Madewell v. Salvation Army*, 49 Or App 713, 716 (1998); *Anna Rembert*, 61 Van Natta 727, 730 (2009).

Here, the record does not establish that the Form 827 was mailed to the employer before September 3, 2014, the date the claim was faxed to the employer. Likewise, the record does not establish the mailing date, or the employer's receipt, of the discovery request and retainer agreement.<sup>3</sup> Under such circumstances, penalties and attorney fees based on the employer's alleged failure to act on those

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We do not 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. Instead, our conclusion is based on the observation that the record does not establish the existence of a "causation" dispute.

<sup>3</sup> Claimant's attorney's representations on this matter do not constitute probative evidence. See *SAIF v. Cruz*, 120 Or App 65, 69 (1993); *Gary D. Smith*, 67 Van Natta 292, 295 n 3 (2015).

documents are not warranted.<sup>4</sup> See *Bonnie L. Garber*, 61 Van Natta 2305 (2009) (record did not establish when the Appellate Review Unit received a request for reconsideration because the record did not establish when the request was mailed or delivered); *Mike Reman*, 60 Van Natta 1298 (2008) (date of a discovery request did not establish when the carrier received the request); cf. *David J. Lampa*, 66 Van Natta 1052 (2014) (testimony from the claimant's attorney's assistant regarding mailing procedures led to presumption that carrier received duly-mailed claim closure request).

Finally, we turn to claimant's contention that the employer denied the aggravation and new/omitted medical condition claims without conducting a reasonable investigation. Based on the following reasoning, we conclude that penalties and attorney fees are not justified.

If a carrier "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim," it shall be liable for a penalty of up to 25 percent of the amounts then due, plus an attorney fee. ORS 656.262(11)(a). Whether a denial was an unreasonable resistance to the payment compensation depends on whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. *Int'l Paper Co. v. Huntley*, 106 Or App 107 (1991). "Unreasonableness" and "legitimate doubt" are to be considered in light of all of the evidence available at the time of the denial. *Brown v. Argonaut Ins. Co.*, 93 Or App 588, 591 (1988). Legitimate doubt does not exist where the carrier precipitously denies a claim without conducting a reasonable investigation. See *Kenneth A. Foster*, 44 Van Natta 148, *aff'd mem*, *SAIF v. Foster*, 117 Or App 543 (1993).

At the time of its denial, the employer had received claimant's Form 827, which stated, "The injury to teeth was never corrected properly." (Ex. 16). The employer also had received Dr. Geelan's March and April 2014 chart notes and May 2014 request for claim reopening. (Exs. 13, 14, 15, 17).

As discussed above, these documents did not indicate that claimant's condition was either "new" or "omitted." Instead, they supported a conclusion that he continued to suffer from the same conditions that had initially been accepted. As such, these documents supported the conclusion that the new/omitted medical

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<sup>4</sup> Additionally, the typical consequence for a violation of ORS 656.331 is the assessment of a civil penalty by WCD. See ORS 656.331(2); OAR 436-060-0015(2); *Patti Hall*, 51 Van Natta 620 (1999).

condition *claim* was not compensable. Therefore, the employer had a legitimate doubt regarding the compensability of the new/omitted medical condition claim when it issued its denial.

Regarding the “aggravation” claim, we have previously concluded that such a claim was statutorily invalid. Under such circumstances, we do not consider the employer’s denial of such a claim to have been unreasonable.

Accordingly, based on the aforementioned reasoning, penalties and attorney fees for unreasonable denials are not appropriate.

### ORDER

The ALJ’s order dated March 27, 2015 is vacated in part and affirmed in part. Those portions of the ALJ’s order that purported to uphold the employer’s aggravation denial and that addressed the alleged *de facto* denial of medical services are vacated. Claimant’s hearing request (insofar as it pertained to the aggravation and medical service claims) is dismissed. The remainder of the ALJ’s order is affirmed.

Entered at Salem, Oregon on April 22, 2016

Member Weddell dissenting in part.

I agree with those portions of the majority opinion that dismiss claimant’s hearing request regarding the aggravation denial and decline to award a penalty or attorney fee for the allegedly untimely denial and alleged failure to comply with ORS 656.331. However, I would address the merits of the medical services issue and conclude that there was a sufficient causal relationship between the *de facto* denied medical services and claimant’s compensable injury. Further, I would set aside the employer’s denial of claimant’s new/omitted medical condition claim and award penalties and attorney fees for the employer’s issuance of a denial without a reasonable investigation and its untimely production of discovery. Accordingly, I respectfully offer this partial dissent.

### Medical Services

Contrary to the employer’s assertions, I conclude that claimant made a medical services claim, and the employer *de facto* denied that claim by failing to respond to that claim as required by statute. Further, the *de facto* denial presents

a causation dispute that is within our jurisdiction. Finally, I conclude that the medical evidence establishes a sufficient causal relationship between the *de facto* denied medical services and claimant's compensable injury.

I begin with the employer's argument that there was no *de facto* denial of a medical services claim. The employer does not dispute that claimant requested medical treatment, or that it failed to respond to his request. Instead, the employer argues that the record lacks documentation of any "unpaid bills." The employer reasons that claimant is "free to pursue the treatment recommended by Dr. Geelan and then have the doctor submit his bill for services rendered." The employer essentially contends, in other words, that a claim may only be made for past medical services, for which a claimant has already incurred liability. In this interpretation, a carrier could only be required to decide whether to pay for a medical service after the service has already been performed.

The statutory framework is inconsistent with such a limited description 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>5</sup>

A *de facto* denial occurs if a carrier fails to timely accept or deny a claim. *SAIF v. Allen*, 320 Or 192, 215-16 (1994). If a claimant, or someone on the claimant's behalf, makes a "written request for compensation," including "medical services provided for a compensable injury," that request is a "claim." ORS 656.005(6), (8). Therefore, if a physician requests medical services on a claimant's behalf, including future medical services, that request is a "claim." *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).

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<sup>5</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."

Here, Dr. Geelan's March 27, 2014 chart note described claimant's dental condition and recommended treatment in some detail. (Ex. 13-1). His April 10, 2014 chart note identified two alternative treatment plans. (Ex. 14). On April 28, 2014, Dr. Geelan noted that he was "waiting \* \* \* to submit t[reatment] plan to insurance company." (Ex. 15). However, the employer received all of these documents, including the March 27, 2014 and April 10, 2014 chart notes with treatment recommendations, on September 27, 2014. (Exs. 13, 14, 15). Additionally, by September 3, 2014, the employer received Dr. Geelan's report describing claimant's dental problems and recommending "more dental work and replacement of his current dentures." (Ex. 17). These documents constitute a "written request for compensation," and establish the existence of a medical services claim.<sup>6</sup>

The employer concedes that it did not respond to claimant's request, but argues that there is no legal authority "that requires [a carrier] to respond to a specific treatment recommendation for the type of treatment contemplated here." However, ORS 656.262(6)(a) requires a carrier to accept or deny a claim within 60 days. The employer's failure to respond to Dr. Geelan's treatment recommendation was a *de facto* denial of claimant's medical services claim. *Smith*, 117 Or App at 228; *Flanary*, 47 Van Natta at 989.

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 carrier *de facto* denied claimant's medical services claim, and did not specify the grounds for the denial.

The majority notes the October 31, 2014 denial letter's statement that claimant's entitlement to medical services "related to the originally accepted conditions" was not affected. (Ex. 19-1). Insofar as this statement can be interpreted to pertain to any request for medical services, the most reasonable interpretation would be that the employer would pay for medical services "related to the originally accepted condition," and that, conversely, any medical services not paid for are not "related to the originally accepted condition." In any event, the

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<sup>6</sup> The employer contends that claimant conceded, at hearing, that no medical services claim had been made. Specifically, the employer notes claimant's attorney's acknowledgment that there were no unpaid medical bills and that no medical services claim had been made that was not related to the aggravation claim. (Tr. 4-5). However, claimant's attorney also explained that the *de facto* denial was based on the employer's lack of response to Dr. Geelan's treatment recommendation, which included a report that was submitted with the aggravation claim. (Tr. 4, 33-34).

employer does not assert that this statement approved the medical services request or conceded the “causation” aspect of the medical services dispute, and I would not interpret it as such.

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.<sup>7</sup> 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.

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<sup>7</sup> 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 “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 the Workers’ Compensation Division’s (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.

Accordingly, I conclude that the record raises a “causation” dispute within the Board’s jurisdiction.<sup>8</sup> Turning to that dispute, I conclude that claimant should prevail in that dispute.

A carrier must generally cause to be provided medical services for conditions “caused in material part” by a compensable injury.<sup>9</sup> ORS 656.245(1)(a). The “compensable injury” is the “work-related injury incident,” not the accepted condition. *See Brown v. SAIF*, 262 Or App 640, 652 (2014); *SAIF v. Carlos-Macias*, 262 Or App 629, 637 (2014).

Dr. Kaip explained how claimant’s dentures were for his compensable injury. (Ex. 9-4). Additionally, Dr. Geelan explained that the proposed treatment related to the dentures, and he attributed claimant’s need for treatment to the workers’ compensation claim. (Exs. 13, 14, 15, 17). There is no contrary persuasive evidence. On this record, I conclude that the proposed medical services are for conditions caused in material part by the compensable injury.

#### New/Omitted Medical Condition Claim

The majority declines to find a compensable new/omitted medical condition because it concludes that claimant has not established that the condition was different from the condition already accepted, and therefore has not established

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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.

<sup>9</sup> It is not disputed that the requested medical services fall within the categories enumerated in ORS 656.245(1)(c), which describes medical services that are compensable after the worker’s condition is medically stationary. Further, there is no contention that the condition to which the proposed medical services are directed is a combined or consequential condition. *See* ORS 656.245(1)(a) (for combined or consequential conditions, the carrier is responsible only for “those medical services directed to medical conditions caused in major part by the injury”).

that the condition was “new” or “omitted.” See *Michael L. Long*, 63 Van Natta 2134, 2135, *recons*, 63 Van Natta 2330 (2011) (a new/omitted medical condition claim may be denied, even if the claimed condition is compensable, if the claimed condition is neither “new” nor “omitted”). However, the employer’s denial was based on the limited assertion that the claim regarding “the injury to teeth was never corrected properly” was not for “a valid/perfected condition.” (Ex. 19-1).

A carrier is bound by the express language of its denial. *Tattoo v. Barrett Bus. Serv.*, 118 Or App 348, 351 (1993). A denial based on the assertion that a new/omitted medical condition claim is not for a “condition” does not raise other defenses. See *Milton D. Restoule*, 66 Van Natta 1731 (2014) (where the carrier’s denial disputed only that the new/omitted medical condition claim was for a “condition,” the Board declined to address whether the carrier’s alternative argument on review that there was no objective evidence that the condition required any treatment).

The majority reasons that the denial’s assertion that the claim was not for “a valid/perfected condition” was not limited to whether the claim was for a “condition,” but encompassed the assertion that the “condition” was not “new” or “omitted.” I disagree with the majority’s interpretation of the denial’s language.

A condition is “new” if it arose after acceptance of an initial claim, was related to an initial claim, and involved a condition other than the condition initially accepted. *Johansen v. SAIF*, 158 Or App 672, 679 (1999). A condition is “omitted” if it was in existence at the time of the acceptance notice, but was not mentioned in the notice or was left out. *Mark A. Baker*, 50 Van Natta 2333, 2336 (1998). However, the employer did not explicitly dispute whether the claimed condition was “new” or “omitted,” nor did it otherwise assert that the claimed condition was the same as an accepted condition.

The employer’s choice of the terms “valid/perfected” to modify “condition” was vague in this context. Neither statutes nor case law use the terms “valid condition” or “perfected condition” in the context of a new/omitted medical condition claim. The denial did not further explain relevance of those terms.

Nevertheless, it is most reasonable to interpret the denial as disputing whether the claim was for a “medical condition.” See *Young v. Hermiston Good Samaritan*, 223 Or App 99, 107 (2008) (a new/omitted medical condition claim for a symptom of a previously accepted condition may be denied because the “symptom” is not a “medical condition”). A “condition” is “the physical status of

the body as a whole \* \* \* or of one of its parts.” *Id.* at 105. The contention that the claimed *condition* was not “valid” or “perfected” indicates that the employer did not consider the claim to be for a “condition” that could be accepted.

The defense that the claimed condition was neither “new” nor “omitted,” by contrast, would require an underlying premise that the claimed condition had actually been accepted by, mentioned in, or included in a Notice of Acceptance. Such a defense, in light of the denial’s assertion that the claimed condition was not “valid/perfected,” would only be possible if the accepted conditions themselves were not “valid/perfected.” However, the employer does not suggest, and I would not find, that the accepted conditions were not “valid/perfected.” Therefore, I conclude that the denial’s specific language is incompatible with the defense that the claimed condition was not “new” or “omitted.”

The employer concedes this point on review. The employer does not assert that it has already accepted “the injury to teeth [that] was never corrected properly.” Instead, the employer explains, its “valid/perfected condition” defense is based on the following reasoning:

“The reason this is not a valid/perfected claim is because of the unorthodox and non-existent ‘condition’ claimed. Common sense says this is obviously not a medical condition. This is not a claim for the ‘physical status of the body as a whole \* \* \* or of one of its parts.’ *Young, supra*. It does not describe an actual medical diagnosis or condition. It simply describes claimant’s opinion as to why he continues to have dental difficulties. There is no medical evidence in this record that addresses whether ‘the injury to teeth was never corrected properly’ is a medical ‘condition.’” (Resp. Br. at 9).

Thus, even on review, the employer does not suggest that the denial raised any defense other than the limited defense that the new/omitted medical condition claim was not for a “condition” (*i.e.*, “the physical status of the body as a whole \* \* \* or of one of its parts”). To the contrary, the employer’s position is wholly incompatible with a contention that it had already accepted the claimed new/omitted medical condition. Instead, the new/omitted medical condition claim was denied solely because the employer’s “[c]ommon sense says this is obviously not a medical condition”<sup>10</sup>

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<sup>10</sup> I note that the employer cites no medical evidence to support its “common sense” conclusion that “this is obviously not a medical condition.”

Accordingly, I do not interpret the denial to raise the contention that the claimed condition was the same as the accepted conditions and was, therefore, not “new” or “omitted.” Further, the employer did not amend the denial to raise such a defense. Accordingly, I evaluate the limited dispute regarding whether claimant’s new/omitted medical condition claim was for a “condition.”

The claim for an “injury to teeth” that “was never corrected properly” describes the physical status of claimant’s teeth. Likewise, Dr. Geelan’s chart notes and reopening request described symptoms and objective findings regarding the physical status of claimant’s mouth and teeth. (Exs. 13, 14, 15, 17). Such evidence establishes that claimant’s new/omitted medical condition claim was for “the physical status of the body as a whole \* \* \* or of one of its parts” (*i.e.*, a “condition”).

Therefore, I conclude that the new/omitted medical condition claim was for a “condition.” Accordingly, I would set aside the employer’s new/omitted medical condition claim denial.

#### Penalties/Attorney Fees

For the reasons explained below, I conclude that the employer issued its denial without a reasonable investigation regarding the compensability of the new/omitted medical condition and that its production of discovery was untimely. Consequently, I would award penalties and attorney fees.

Whether a denial was an unreasonable resistance to the payment compensation depends on whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. *Int’l Paper Co. v. Huntley*, 106 Or App 107 (1991). “Unreasonableness” and “legitimate doubt” are to be considered in light of all of the evidence available at the time of the denial. *Brown v. Argonaut Ins. Co.*, 93 Or App 588, 591 (1988). Legitimate doubt does not exist where the carrier precipitously denies a claim without conducting a reasonable investigation. See *Kenneth A. Foster*, 44 Van Natta 148, *aff’d without opinion*, 117 Or App 543 (1993).

At the time of its denial, the employer had the Form 827 and Dr. Geelan’s chart notes and request for reopening. The employer does not assert that it conducted any investigation at all, much less a reasonable one. Instead, it contends, “A claim for ‘the injury to teeth was never corrected properly’ is invalid on its face. Any reasonable adjuster would have looked at that ‘claim’ and immediately denied it.” (Resp. Br. at 13).

Yet, as discussed above, all of the documents in the employer's possession indicated that the claimed condition referred to the "physical status of the body as a whole \* \* \* or of one of its parts," *i.e.*, a "condition." Nevertheless, the employer denied the new/omitted medical condition claim solely on the basis that the claim was not for a "condition," without investigation and in the face of unanimous evidence to the contrary.

Additionally, I note that the employer did not deny the new/omitted medical condition claim on the grounds that the condition was not "new" or "omitted," or that the condition was not compensable, and does not suggest that it evaluated its liability in light of such issues. It did not attempt to gather evidence addressing those issues, and offers no interpretation of the evidence suggesting that the claim would not be compensable on those grounds.

Under such circumstances, I conclude that the employer did not perform a reasonable investigation, and did not have legitimate doubt as to its liability at the time the denial was issued. *See James S. Hurlocker*, 66 Van Natta 1930 (2014). Therefore, I would find the denial unreasonable, and would award a penalty and attorney fee for the employer's unreasonable new/omitted medical condition claim denial.

I turn to the discovery issue. Failure to comply with discovery responsibilities may result in the imposition of penalties and attorney fees under ORS 656.262(11)(a). *See OAR 438-007-0015(8); Sue J. Brock*, 67 Van Natta 2066, 2067 (2015).

Before the filing of claimant's December 29, 2014 hearing request, the WCD's rules regarding a carrier's discovery responsibilities apply. OAR 438-005-0011; *O'Leary v. Valley View Cutting*, 107 Or App 103, 106 (1991); *Mike Reman*, 60 Van Natta 1298, 1299 (2008). Under the WCD's discovery rule, claimant may request that the carrier furnish "legible copies of documents in its possession relating to a claim." OAR 436-060-0017(4). If the carrier has such documents in its possession, which are not archived, it must mail them within 14 days of its receipt of claimant's request. OAR 436-060-0017(7)(a).

Claimant's discovery request was dated September 17, 2014. (Ex. 18). However, the employer did not produce discovery until November 4, 2014, 48 days after the date of claimant's discovery request. (Ex. 21).

As the majority notes, there is no presumption that a document is mailed on the day it is dated. *Madewell v. Salvation Army*, 49 Or App 713, 716 (1998). Nevertheless, the date of the discovery request supports the inference that it was mailed on or shortly after that date. Further, the employer does not contest claimant's attorney's representation that the discovery request was mailed September 17, 2014 or that it received the discovery request within several days after that date.

Under such circumstances, I conclude that the employer received claimant's discovery request within several days of September 17, 2014. *See* ORS 40.135(1)(p)(q) (it is presumed that a letter duly directed and mailed was received in the regular course of the mail); *David J. Lampa*, 66 Van Natta 1052 (2014). Therefore, I conclude that the employer's November 4, 2014 production of discovery was untimely.

Because the majority concludes otherwise, I respectfully offer this partial dissent.