



News & Case Notes

BOARD NEWS

New Web Page Launched - Attorney Fee Statistical Information - For Use in Future Biennial Review of Attorney Fee Schedules - Effects of 2020 Rule Changes Still to be Evaluated 1

Practice Tip for WCB Portal Users – Selecting the Insurer or TPA 1

Update to Portal Hearing Request Form 2

WCB'S 2020 ALJ Anonymous Survey 3

CASE NOTES

Combined Condition: "Ceases" Denial - "Change of Condition/Circumstances" Not Established - "262(6)(c)" 4

Consequential Condition: Compensable Knee Surgery Major Cause of Claimed Knee Infection - "005(7)(a)(A)" 5

Jurisdiction: Hearing Request Limited to Solely Penalties/ Attorney Fees - Did Not Seek "Enforcement Action" - WCB Lacked Authority 6

Medical Opinion: "Attending Surgeon" Deference - Based on "Surgical Observations" (As Subsequently Clarified) 7

Medical Services: Surgery Directed at Accepted "Combined Condition" - "245(1)(a)" 4

Own Motion: "Notice of Closure" - Invalid - Copy Not Mailed to Claimant's Attorney - "012-0055" Permanent Impairment - Arbiter's Findings Ambiguous - "AP" Findings More Accurate - "035-0007(5)" 9

Own Motion: "Worsened Condition" Claim - "Reopening" Denied - "Epidural Injection" Did Not Satisfy "Surgery," "Hospitalization," "Other Curative Treatment" Requirements - "278(1)(a)" 10

BOARD NEWS

New Web Page Launched - Attorney Fee Statistical Information - For Use in Future Biennial Review of Attorney Fee Schedules - Effects of 2020 Rule Changes Still to be Evaluated

At their December 15, 2020, public meeting, the Members completed their biennial review of the Board's attorney fee schedules under ORS 656.388(4) and announced that information regarding attorney fee awards would be reviewed on an ongoing basis. The Members further emphasized that statistical information regarding attorney fees would be shared with the public.

The Board has created a web page devoted to statistical reports, including attorney fees. The web page can be found here: <https://www.oregon.gov/wcb/legal/Pages/statistical-reports.aspx>

In completing their biennial review, the Members noted that the effect of the rule changes adopted on October 1, 2020, had yet to be evaluated. Accordingly, the Board will continue to compile information regarding attorney fee awards in preparation for the next biennial review in 2022.

The Members wish to thank all stakeholders for their thoughtful participation in the biennial rule review.

Practice Tip for WCB Portal Users - Selecting the Insurer or TPA

The WCB Portal enables parties to file a Request for Hearing with the Board, and to also serve a copy to other parties through the Portal's email notification service, if the other party is a Portal user. OAR 438-005-0046(1)(e)(A), (2)(a). To help ensure service is accomplished through the Portal, the submitter should utilize the Portal's auto-select feature, which will help you select the Insurer/TPA's portal account.

The Insurers and TPAs are in separate lists on the Portal. To access one or the other, utilize the drop-down arrow in the Insurer/TPA tab to generate the proper auto-selection list. (See screen shots below). It may not be obvious whether a party is an Insurer or a TPA, but you should find the company in one of those lists.

You have the ability to hand-type an entry into that field, but a hand-typed entry will not serve a copy to that party through the Portal email system. In other words, for example, our computer system will consider a hand-typed entry as a

different SAIF Corp, or a *different* Corvel. The Portal’s email acknowledgment notification would then inform you that this hand-entered party has not been served a copy by email through the Portal.

We encourage you to use the auto-selection feature. If you can’t find a company in either list, feel free to contact us at portal.wcb@oregon.gov or call Greig Lowell at (503) 934-0151). We can help you find that company in the lists. If it’s a new company, we may need to add it to our database.

The screenshot shows the 'Insurer / TPA' dropdown menu open, with 'Insurer' selected. The form fields are: Name (SAIF CORPORATION), Claims Adjuster Name (Claims Adjuster Name), Address (400 HIGH ST SE), Address line 2, SALEM, OR, 97312.

The screenshot shows the 'Insurer / TPA' dropdown menu open, with 'TPA' selected. The form fields are: Name (CANNON COCHRAN MGMT SVCS INC), Claims Adjuster Name (Claims Adjuster Name), Address (PO BOX 13189), Address line 2, SALEM, OR, 97309.

Update to Portal Hearing Request Form

The WCB Portal request for hearing form has been updated with a checkbox for “ongoing” temporary disability. Submitters can now choose between an “end date” for the temporary disability request, or select the option for “ongoing” temporary disability. Below are views of the new Issues tab, and the printable version of the form.

If you have any questions or need assistance on the portal, please contact WCB at portal.wcb@oregon.gov.

List Requests New Hearing Request

Request Claimant information Insurer / TPA Employer Issues Accommodations Attachments

A hearing is requested for the reason(s) checked below

DENIAL (date) Defacto _____

Compensability - complete claim denial
 Partial Denial after a Claim Acceptance
 Challenge to Notice of Claim Acceptance
 Worker Noncooperation
 Aggravation
 Responsibility
 Medical Services

NONCOMPLYING EMPLOYER ORDER

TEMPORARY DISABILITY

Procedural Temporary Disability

Period sought: 11/09/2020 to _____ Ongoing

Temporary Disability Rate
 Supplemental Disability

Order on Reconsideration

Classification (disabling/nondisabling)
 Premature Closure
 Substantive Temporary Disability

Period sought: _____ to _____

Permanent Partial Disability
 Permanent Total Disability

OTHER (Explain and cite ORS)

Director's Order

PENALTY (Cite ORS)

ATTORNEY FEE (Cite ORS)

COSTS
 TEMPORARY DISABILITY OFFSET

A hearing is requested for the reason(s) check below:

A DENIAL (date) _____ Defacto _____

B Compensability - complete claim denial
 X Partial Denial after a Claim Acceptance
 Z Challenge to Notice of Acceptance
 V Worker Noncooperation
 K Aggravation
 L Responsibility
 C Medical Services (OS 656-245)

M NONCOMPLYING EMPLOYER ORDER

O TEMPORARY DISABILITY

D Period sought _____ 11/9/2020 Ongoing
 R Rate _____

F SUPPLEMENTAL DISABILITY

N ORDER ON RECONSIDERATION

Y Classification (disabling/nondisabling)
 I Premature Closure
 E Temporary Disability

Period Sought _____

H Permanent Partial Disability
 G Permanent Total Disability

Q OTHER (Explain and cite ORS)

P DIRECTOR'S ORDER

S PENALTY (Cite ORS) _____
 T ATTORNEY FEE (Cite ORS) _____
 W COSTS

WCB'S 2020 ALJ Anonymous Survey

Consistent with ORS 656.724(3)(b), attorneys regularly participating in workers' compensation cases will be sent a link, via email, to participate in the annual anonymous survey. So, please watch for your invitation to participate in this important survey tool. Please take a few minutes to complete the survey, which can be completed from your computer, smart phone, or tablet.

Responses will be accepted until February 11, 2021, and results will be posted on WCB's website by March 3, 2021.

Your participation is greatly appreciated.

CASE NOTES

Combined Condition: “Ceases” Denial - “Change of Condition/Circumstances” Not Established - “262(6)(c)”

Medical Services: Surgery Directed at Accepted “Combined Condition” - “245(1)(a)”

Paul A. Harvey, 73 Van Natta 34 (January 15, 2021). Analyzing ORS 656.262(6)(c) and ORS 656.245(1)(a), the Board set aside the carrier’s “ceases” denial of claimant’s combined lumbar strain condition and held that his medical services claim for a low back surgery was compensable. After the carrier had initially accepted a lumbar strain condition and subsequently a combined lumbar strain condition, it issued a “ceases” denial of the combined lumbar strain condition, contending that “the otherwise compensable injury” (*i.e.*, the accepted lumbar strain condition) ceased to be the major contributing cause of the combined condition. The carrier also contested its liability for a proposed low back surgery, asserting that it was not directed to a medical condition that was caused in major part by the work event. After claimant requested review by the Workers’ Compensation Division (WCD), the dispute was transferred to the Board’s Hearings Division for consolidation of the surgery’s causation dispute with a pending hearing regarding the carrier’s “ceases” denial.

The Board set aside the carrier’s denial and found claimant’s surgery causally related to the compensable combined condition. Citing ORS 656.262(6)(c), the Board stated that a carrier is authorized to deny an accepted combined condition if the “otherwise compensable injury” ceases to be the major contributing cause of the combined condition. Referencing *Wal-Mart Stores, Inc. v. Young*, 219 Or App 410, 419 (2008), *Oregon Drywall Sys. v. Bacon*, 208 Or App 205, 210 (2006), and *State Farm Ins. Co. v. Lyda*, 150 Or App 554, 559 (1997), the Board reiterated that the carrier bears the burden to establish a change in claimant’s condition or circumstances from the effective date of the combined condition acceptance, such that the “otherwise compensable injury” is no longer the major contributing cause of the combined condition. Relying on *Brown v. SAIF*, 361 Or 241, 282 (2017), and *Barbara J. DeBoard*, 71 Van Natta 550, 553-55 (2019), the Board observed that the “otherwise compensable injury” is the previously accepted condition, rather than the work incident.

Turning to the case at hand, the Board acknowledged that the physicians relied on by the carrier in support of its “ceases” denial had opined that the accepted lumbar strain condition had resolved. Nevertheless, the Board reasoned that one physician had not adequately explained why the condition had resolved and the other physician had not identified any clinical findings or a change in claimant’s symptoms that correlated with his condition resolving. Under such circumstances, the Board found that the physicians’ opinions had not persuasively established the requisite change in claimant’s condition/circumstances (between the effective date of the carrier’s acceptance of the combined condition, the date of its initial acceptance) and the effective date of its “ceases” denial) to support its “ceases” denial.

Carrier accepted a combined lumbar strain condition, then issued “ceases” denial.

Carrier also contested liability for a proposed low back surgery as unrelated to compensable condition.

Physicians’ “resolution” opinions were inadequately explained and did not identify findings in support of the requisite “change in condition/circumstances.”

Claimed medical service for combined condition is compensable if directed to a medical condition caused in major part by the work event.

Surgery was directed to accepted combined lumbar strain condition; because “ceases” denial overturned, surgery was causally related to accepted condition.

Treating physician opined that post-operative infection was present and asymptomatic for several months.

To prove new/omitted medical condition under “consequential condition” theory, claimant must prove that the compensable injury, or its treatment, was the major contributing cause of the claimed condition.

Addressing the medical services issue, citing *Garcia-Solis v. Farmers Ins. Co.*, 365 Or 26, 43 (2019), *SAIF v. Sprague*, 346 Or 661, 664 (2009), and *Slater v. SAIF*, 287 Or App 84, 95 (2017), the Board stated that a claimed medical service for a combined or consequential condition is compensable if it is directed to a medical condition caused in major part by the work event.

Applying the aforementioned principle to the present case, the Board found that the record persuasively established that the claimed surgery was directed to the accepted combined lumbar strain condition. Specifically, the Board noted that claimant’s surgeon had recommended the surgery to address low back pain and opined that the treatment was for a combination of claimant’s lumbar strain and his preexisting back changes. In addition, the Board observed that the other physicians had not addressed to what condition the surgery was directed.

Finally, in light of its overturning of the carrier’s “ceases” denial, the Board reiterated that claimant’s combined lumbar strain condition remained accepted. Given such circumstances, the Board was persuaded that the surgery was directed to a medical condition (*i.e.*, the accepted combined lumbar strain condition), which, due to its accepted status, was caused in major part by the work event.

Consequential Condition: Compensable Knee Surgery Major Cause of Claimed Knee Infection - “005(7)(a)(A)”

Ted W. Stallsworth, 73 Van Natta 80 (January 29, 2021). Analyzing ORS 656.005(7)(a)(A), the Board held that claimant’s new/omitted medical condition claim for a knee infection was compensable because a previous surgery for his accepted meniscus tear was the major contributing cause of the claimed knee infection. Relying on an examining physician’s opinion (who believed that the infection was not related to the surgery because the infection developed some nine months after the surgery and that the infection was more likely related to claimant’s scaly skin), the carrier denied the claimed knee infection. Claimant filed a hearing request, contending that his treating physician’s opinion (who explained that claimant’s post-operative infection was likely present for several months, then subsequently flared to cause his need for treatment) persuasively established the compensability of the claimed knee infection.

The Board agreed with claimant’s contention. Citing ORS 656.005(7)(a)(A), ORS 656.266(1), *Barrett Bus. Servs. v. Hames*, 130 Or App 190, 193, *rev den*, 320 Or 492 (1994), and *Robert D. Harrington*, 68 Van Natta 496, 498 (2016), the Board stated that to establish the compensability of his new/omitted medical condition under a “consequential condition” theory, claimant must prove that the condition existed and that his compensable injury, or its reasonable and necessary treatment, was the major contributing cause of the claimed condition.

Turning to the case at hand, the Board acknowledged that the treating physician had conceded that postoperative infections usually manifest several days after surgery. Nevertheless, the Board reasoned that the treating physician had personally explained that claimant’s particular bacteria species was slow growing, had settled in his damaged meniscal tissue caused by the surgery,

Treating physician persuasively opined that the bacteria which caused the infection was slow growing and settled in the surgically-damaged tissue.

Examining physician's opinion not based on a sufficiently accurate history and was speculative.

Dissent found treating physician's opinion inadequately explained and examining physician's opinion (which attributed infection to scaly skin and chronic dermatitis) to be more persuasive.

Claimant sought penalties/attorney fees for carrier's "provisional" acceptance pending "compensability" appeal.

Claimant contended that request also sought "enforcement" to require carrier to remove "provisional" from its acceptance.

and had subsequently flared to cause his need for treatment. Determining that the treating physician's opinion was well reasoned and based on complete information, the Board was persuaded that claimant's compensable surgery was the major contributing cause of his knee infection (the existence of which was undisputed).

In reaching its conclusion, the Board discounted the opinion of the examining physician. Noting that claimant's medical records did not document a "long history" of dry/scaly skin (as the physician had believed), the Board reasoned that the examining physician's "suspicion" that claimant's infection was related to chronic skin changes or a different portal of entry, was not based on a sufficiently accurate history and speculative.

Member Curey dissented. Asserting that the treating physician's opinion was predominantly couched in terms of possibility (not probability), Curey considered the opinion to be unpersuasive. In further support of her conclusion, Member Curey observed that the treating physician's reference to a "slow growing" infection had not adequately explained why the infection was not diagnosed until nine months after the surgery or why it had subsequently "flared."

In contrast to the treating physician's opinion, Member Curey noted that the examining physician had specifically considered the timing of claimant's surgery and the onset of his symptoms. Further reasoning that the examining physician had personally observed claimant's dry/scaly skin during his examination and recorded a history of chronic skin dermatitis, Curey found the examining physician's opinion (that claimant's knee infection was not related to his knee surgery) to be more persuasive.

Jurisdiction: Hearing Request Limited to Solely Penalties/Attorney Fees - Did Not Seek "Enforcement Action" - WCB Lacked Authority

Craig M. Selbee, 73 Van Natta 76 (January 29, 2021). Analyzing ORS 656.262(11)(a), the Board held that the Hearings Division was not authorized to address claimant's hearing request, which sought penalties/attorney fees for a carrier's "provisional" acceptance of claimant's toe claim pending its appeal of a prior ALJ's compensability decision. In filing its hearing request, claimant checked boxes listing "penalty," "attorney fee," "costs," and "other" as issues. Under "other" on the request, the words "unreasonable delay in payment of compensation" were included, along with the following statement in a blank area near the checked boxes: "Failure to properly accept claim after February 6, 2019 Opinion and Order → Provisional Notice of Claim Acceptance ≠ Initial Notice of Claim Acceptance." After an ALJ's order dismissed claimant's hearing request for a lack of jurisdiction under ORS 656.262(11)(a) and referring the matter to the Workers' Compensation Division (WCD) pursuant to ORS 656.704(5), claimant requested Board review. In doing so, he contended that the Hearings Division and the Board had jurisdiction, arguing that he was also seeking "enforcement" to require the carrier to remove the word "provisional" in its acceptance notice.

The determination of whether a request extends beyond penalties/ attorney fees occurs upon filing of the request.

Board interpreted the request as alleging processing misconduct that formed the basis of the penalty/fee request, rather than a request for an “enforcement action.”

Board transferred “penalty/fee” matter to WCD, along with reference to “Eggert” decision.

Although surgical report did not mention disc material, surgeon subsequently explained why disc material not addressed and how the disc compressed claimant’s nerves.

The Board disagreed with claimant’s contention. Relying on ORS 656.262(11)(a) and *Harry L. Rumer*, 69 Van Natta 536, 538 (2017), the Board stated that WCD has exclusive jurisdiction over proceedings regarding solely the assessment and payment of penalties and attorney fees. Referring to *Icenhower v. SAIF*, 180 Or App 297, 305 (2002), and *Rumer*, the Board observed that the determination of whether issues raised before the Hearings Division extend beyond penalties/attorney fees under ORS 656.262(11)(a) occurs upon the filing of the hearing request.

Turning to the case at hand, the Board acknowledged that, in addition to penalties/attorney fees, claimant’s hearing request also referenced a “failure to properly process a claim” and a “provisional” claim acceptance. Nonetheless, consistent with its reasoning in *Rumer*, the Board interpreted those references as an alleged act of misconduct that formed the basis of claimant’s penalties/attorney fee request (rather than as an additional issue). Reasoning that claimant’s hearing request had not sought an “enforcement action” to require the carrier to remove the word “provisional” from its acceptance notice, the Board determined that the request for relief only related to the assessment of penalties and attorney fees.

In reaching its conclusion, the Board distinguished *Leonard Kirklin*, 48 Van Natta 1571, 1572 (1996), which had held that the Hearings Division had jurisdiction over the claimant’s hearing request because, in addition to seeking penalties/attorney fees, he had requested enforcement of a Board order that allegedly had not been satisfied by the carrier. In contrast to *Kirklin*, the Board reiterated that claimant’s hearing request had not included a request for an “enforcement action.”

Accordingly, consistent with ORS 656.704(5), the Board transferred the matter to the WCD for the resolution of claimant’s request for penalties/attorney fees. In doing so, the Board commented that the parties might wish to address the effect, if any, *Eggert v. SAIF*, 301 Or App 177, 183-84 (2019), had on claimant’s contention that the carrier’s “provisional” acceptance notice was deficient.

Medical Opinion: “Attending Surgeon” Deference - Based on “Surgical Observations” (As Subsequently Clarified)

Scott J. Hanson, 73 Van Natta 1 (January 5, 2021). In setting aside a carrier’s denial of a new/omitted medical condition claim for a cervical disc herniation, the Board found persuasive the attending surgeon’s opinion because, even though the surgical report had not described disc material, the surgeon had subsequently explained why such material was not mentioned and described how claimant’s disc process compressed his nerves (as a result of his work incident) and was responsible for his symptoms. Relying on the opinions of several examining physicians (who asserted that there was no objective evidence of a disc herniation and believed that preexisting arthritic changes were the major cause of claimant’s need for treatment/disability), the carrier contended that the claimed disc herniation did not exist and was not compensable.

First-hand surgical observations may be accorded special deference if surgeon's opinion is based on those observations.

Surgeon explained that his practice in preparing surgical reports was to only dictate the surgical process, rather than describe the herniation.

Based on surgeon's clarification/explanation, Board was persuaded that work incident was a material cause of need for treatment of disc herniation.

Opposing expert opinions were directly contradicted by the attending surgeon's first-hand observations and inadequately explained/conclusory.

Dissent noted unremarkable MRIs and opposing expert opinion that seeing disc pathology during surgery would be "extremely difficult"; declined to give special deference to surgeon's opinion and found it insufficient to establish that disc herniation existed.

The Board disagreed with the carrier's contentions. Citing ORS 656.005(7)(a), ORS 656.266(1)(a), *Francisco Ramirez*, 72 Van Natta 211, 212 (2020), and *Maureen Y. Graves*, 57 Van Natta 2380, 2381 (2005), the Board stated that to establish the compensability of a claimed new/omitted medical condition, a claimant must prove that the claimed condition exists and that the work incident was a material contributing cause of the disability/need for treatment of the condition. Furthermore, the Board reiterated that, when a surgeon's opinion is based on first-hand surgical observation, such an opinion may be accorded special deference. See *Argonaut Ins. Co. v. Mageske*, 93 Or App 698, 702 (1988); *Catherine E. Cutler*, 71 Van Natta 472, 435 (2019); *c.f. Aaron M. Arakaki*, 70 Van Natta 439, 440 (2018) (no persuasive reason to conclude the surgeon's status provided a particular advantage).

Turning to the case at hand, the Board acknowledged that the surgical report had not described disc material. Nonetheless, the Board noted that the surgeon had subsequently recalled encountering "only soft tissue and not osteophytes" during the surgery. Moreover, the Board emphasized that the surgeon had explained that it was his practice to only dictate the surgical process (rather than to describe the disc herniation) in his surgery reports.

After considering the surgeon's aforementioned clarifications, explanation that an MRI was consistent with a disc protrusion/herniation (as opposed to an osteophyte), and rebuttal of the contrary opinions, the Board was persuaded by his opinion that claimant's work incident had caused the disc process in his cervical spine to compress his nerves, which had resulted in his disc herniation, rapid onset of symptoms, and need for treatment. See *Somers v. SAIF*, 77 Or App 259, 263 (1986); *Janet Benedict*, 59 Van Natta 2406, 2409 (2007), *aff'd without opinion*, 227 Or App 289 (2009). Consequently, the Board determined that the disc herniation existed and that claimant's work incident was a material contributing cause of his need for treatment for his disc herniation.

In reaching its conclusion, the Board discounted the opposing physicians' opinions. Reasoning that these contrary opinions (which contested the existence of a herniated disc) were directly contradicted by the attending surgeon's first hand observations during claimant's surgery and were inadequately explained/conclusory and based on an inaccurate history of claimant's symptoms, the Board considered these opposing opinions to be unpersuasive. See *Moe v. Ceiling Systems, Inc.*, 44 Or App 429, 433 (1980); *Miller v. Granite Construction Co.*, 28 Or App 473, 478 (1977); *Walter H. Loyd*, 70 Van Natta 1190, 1193 (2018). Accordingly, the Board concluded that the carrier had not met its burden of proving a "combined condition" defense under ORS 656.266(2)(a). See *Michael C. Corkill*, 70 Van Natta 983, 984-86 (2018) (because the physicians' opinions on which the carrier relied were not persuasive, the carrier did not meet its burden of proof under ORS 656.266(2)(a)).

Member Curey dissented. Emphasizing that neither interpreter of claimant's two cervical MRIs had found a disc herniation (but rather had noted "spurring," "bulging," "osteophyte complex," and "stenosis"), Curey believed that the MRIs did not support the existence of the claimed disc herniation. Moreover, in light of the contrary opinions (which concluded that the disc herniation did not exist), Member Curey did not consider the surgeon's opinion (that disc protrusion, herniation, and osteophyte complex were "the same thing") was sufficient to establish the existence of a disc herniation. Finally, referring to

another physician's opinion (that it would be "extremely difficult" to see disc pathology before it was removed in the type of surgery claimant had undergone), Curey declined to give special deference to the surgeon's opinion.

Consequently, in light of the countervailing medical opinions, Member Curey found claimant's attending surgeon's opinion insufficient to persuasively establish the existence of the claimed disc herniation. Therefore, Curey respectfully dissented.

Own Motion: "Notice of Closure" - Invalid -
Copy Not Mailed to Claimant's Attorney - "012-0055"
Permanent Impairment - Arbiter's Findings Ambiguous
- "AP" Findings More Accurate - "035-0007(5)"

Monika M. Gage, 73 Van Natta 55 (January 27, 2021). Citing OAR 438-012-0055, the Board held that an earlier unappealed Own Motion Notice of Closure was invalid because the carrier had not mailed a copy of the closure notice to claimant's attorney. After receiving claimant's request for review of an Own Motion Notice of Closure (NOC) that did not award additional permanent impairment for a new/omitted medical condition (L4-5 facet cyst), the Board noted that a previous unappealed NOC notice had also purported to close the claim without a permanent disability award. Nonetheless, reasoning that the parties agreed that the carrier had not mailed claimant's counsel a copy of the prior closure notice, the Board concluded that the earlier notice was invalid. See OAR 438-012-0055; *Long v. Argonaut Ins. Co.*, 169 Or App 625 (2000); *Barbara J. Johnson*, 55 Van Natta 1757 (2003).

Proceeding with its review of the record regarding the subsequent NOC, the Board stated that when other medical evidence concerning permanent impairment has been rejected and it is left only with the medical arbiter's opinion that unambiguously attributes the claimant's permanent impairment to the compensable condition, "the medical arbiter's report provides the default determination of a claimant's impairment." See *Hicks v. SAIF*, 194 Or App 655, *adh'd to as modified on recon*, 196 Or App 146, 152 (2004). However, the Board reiterated that, when the attending physician has provided an opinion of impairment that has not been rejected, it is permissible to prefer the attending physician's impairment findings, if the preponderance of the medical evidence establishes that they are more accurate. See OAR 436-035-0007(5); *SAIF v. Banderas*, 252 Or App 136, 144-45 (2012); *William E. Hannah*, 68 Van Natta 55 (2016).

Turning to the case at hand, the Board acknowledged that the medical arbiter had opined that claimant had a "walking/standing" restriction, which the arbiter attributed to her newly accepted L4-5 facet cyst. The Board further noted that the arbiter's assessment was based on claimant's statements that she required a walker since her most recent surgery. Notwithstanding the arbiter's opinion, the Board reasoned that claimant's most recent surgery had been performed for a denied L4-5 stenosis condition that the arbiter had not addressed. To the contrary, the Board noted that the arbiter had reported that there were no denied conditions.

Parties agreed that carrier had not mailed a copy of Notice of Closure to claimant's counsel. Therefore, earlier unappealed "NOC" was invalid.

Medical arbiter attributed limitations to newly accepted condition, but assessment was based on claimant's statements about most recent surgery for a denied condition.

Arbiter's opinion considered ambiguous. Board found attending physician's findings (that did not support additional impairment) more accurate.

Under such circumstances, the Board considered the arbiter's opinion to be ambiguous. In contrast, the Board observed that the attending physician had opined that claimant's L4-5 facet cyst had not resulted in any additional permanent impairment or work restrictions. Considering the attending physician's familiarity with claimant's low back conditions, the Board concluded that the attending physician's findings were more accurate than the ambiguous findings from the medical arbiter. Accordingly, the Board determined that claimant was not entitled to an additional permanent disability award.

Own Motion: "Worsened Condition" Claim - "Reopening" Denied - "Epidural Injection" Did Not Satisfy "Surgery," "Hospitalization," "Other Curative Treatment" Requirements - "278(1)(a)"

Carrier paid for epidural steroid injection, but recommended against reopening Own Motion claim.

Thomas J. McMackin, 73 Van Natta 53 (January 26, 2021). Analyzing ORS 656.278(1)(a), the Board held that it was not authorized to reopen an Own Motion claim for a "worsened condition" because, although claimant had undergone an epidural steroid injection for his accepted low back condition, the record did not establish that the injection constituted a "surgery," "hospitalization," or "other curative treatment" that was prescribed in lieu of hospitalization that was necessary to enable the worker to return to work." After paying for an epidural steroid injection that was administered for claimant's low back symptoms, the carrier submitted a recommendation opposing the reopening of claimant's Own Motion claim for a worsening of his previously accepted low back condition. Among other contentions, the carrier asserted that the claim had not satisfied the statutory "claim reopening" requirements of surgery, hospitalization, or other curative treatment in lieu of hospitalization that was necessary to enable claimant to return to work.

Epidural injection does not constitute "surgery" or "hospitalization" for purposes of claim reopening for a "worsened condition" claim; depending on the particular record, an injection may/ may not constitute "curative treatment."

The Board agreed with the carrier's contention. Citing *Larry D. Little*, 54 Van Natta 2536, 2542-48 (2002), the Board stated that "surgery" is an invasive procedure undertaken for a curative purpose that is likely to temporarily disable the worker; "hospitalization" is a nondiagnostic procedure that requires an overnight stay in a hospital or similar facility; and "curative treatment" is treatment that relates to or is used in the cure of diseases, tends to heal, restore health, or to bring about recovery. Relying on *Little*, as well as *Oscar Cano-Sanchez*, 67 Van Natta 1159, *recons*, 67 Van Natta 2115 (2015), *recons*, 68 Van Natta 303, 306 (2016), *Todd R. Ferguson*, 62 Van Natta 933 (2010), *Danny L. Johnson*, 56 Van Natta 129 (2004), and *Peter B. Waller*, 55 Van Natta 1905, n 3 (2003), the Board reiterated that an epidural injection does not constitute "surgery" or "hospitalization," but, depending on the particular record, such an injection may or may not constitute "curative treatment" in lieu of hospitalization that is necessary to enable a worker to return to work."

Record did not establish that claimant's injection met "curative treatment" requirement.

Turning to the case at hand, the Board determined that claimant's epidural steroid injection did not satisfy the "surgery" or "hospitalization" requirements for "claim reopening" under ORS 656.278(1). See *Michel J. Spurlock*, 69 Van Natta 219, 223 (2017). Furthermore, the Board found that the record did not establish that claimant's injection constituted curative treatment in lieu of hospitalization that was necessary to enable him to return to work. See *Johnson*, 57 Van Natta at 130-31; *Little*, 54 Van Natta at 2546.

Under such circumstances, the Board concluded that it was not authorized to grant claimant's request for reopening of his Own Motion claim for a worsening of his accepted low back condition. Accordingly, the request for "claim reopening" was denied.

**APPELLATE DECISIONS
UPDATE**

There were no textual "Board-related" decisions from the appellate courts this month.