

In the Matter of the Compensation of
RICHARD D. VANHOOK, Claimant

WCB Case No. 01-01515, 0101512

ORDER ON REVIEW

Mustafa T Kasubhai PC, Claimant Attorneys
Schwabe Williamson & Wyatt, Defense Attorneys

Reviewing Panel: Members Langer, Bock, and Phillips Polich. Member Phillips Polich dissents.

The insurer requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) found that claimant had established good cause for his untimely hearing request regarding its denial of an occupational disease claim for an L5-S1 disc herniation; (2) set aside the insurer's denial of claimant's occupational disease claim for an L5-S1 disc herniation; and (3) assessed a penalty against the insurer for an allegedly unreasonable denial. On review, the issues are good cause, compensability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has been performing the same job in the same location since 1989. Claimant has worked for two employers during that time span. Both employers were insured by the same insurer. Claimant has an accepted claim from 1996 for a disabling left hamstring strain. That claim was closed on May 12, 1997 with an award of temporary disability.

Claimant continued to perform his regular work with occasional low back and buttock pain. Around October 2000, he began to notice worsening back pain that radiated into his left thigh and foot. An MRI revealed a large herniated disc on the left at L5-S1. Claimant was treated by Dr. Amstutz.

Claimant filed a claim on November 21, 2000. On November 30, 2000, the insurer denied claimant's new injury/occupational disease claim. The November 30, 2000 denial stated, in part, that: "[The insurer] is re-opening and processing your claim from date of injury 12/27/96 and has 90 days to investigate the worsening/aggravation claim and for compensability issues." (Ex. 31). On the day prior to issuing the denial, the insurer's claims adjuster, Pam Schill, told

claimant that his 1996 claim was being “reopened” and that the denial was more of a “formality” because they were reopening the claim and did not need two claims. (Tr. 16).

Dr. Amstutz performed lumbar laminotomy and discectomy surgery at L5-S1 on December 5, 2000. (Ex. 32). Dr. Dietrich reviewed claimant’s records and issued a report at the insurer’s request on January 29, 2000. Dr. Dietrich opined that claimant’s condition was not a worsening or aggravation of his 1996 accepted injury. (Ex. 39). The insurer denied claimant’s aggravation claim under the 1996 injury claim on February 15, 2001. (Ex. 41).

Claimant filed a hearing request regarding the November 30, 2000 denial on February 23, 2000. The insurer sought dismissal of the hearing request, contending that it was untimely filed and that claimant had not established “good cause” for the late filing.

The ALJ concluded that based on the employer’s representation that it was “reopening” the old claim, continuing to pay benefits and indicating that the November 30, 2000 denial was a “formality,” claimant reasonably concluded that he need not take any action regarding the denial. The ALJ further concluded that claimant was reasonably misled by the combination of the use of the term “reopening” and the insurer’s express reliance on the opinion of Dr. Amstutz that the condition was a worsening of the 1996 injury. On this basis, the ALJ concluded that claimant had “good cause” for failing to request a hearing within 60 days of mailing of the November 30, 2000 denial and addressed the merits of the claim.

On review, the insurer argues that although the claims examiner’s use of the term “reopening” was confusing, claimant failed to establish good cause because: (1) he had made no claim of aggravation of the 1996 injury; (2) the text of the November 30, 2000 denial states that compensability issues were being investigated; and (3) the claims examiner did not tell claimant that the claim was being accepted or the denial was being withdrawn. Claimant responds that by telling claimant that it was going to “reopen” the 1996 claim, the insurer misled claimant into believing that his claim would be reopened and processed under the accepted 1996 claim. After reviewing this record, we find “good cause” for claimant’s untimely appeal of the insurer’s November 2000 denial.

There is no dispute that claimant's request for hearing was filed more than 60 days, but fewer than 180 days, following the insurer's denial. Therefore, under ORS 656.319(1)(b), claimant has the burden of proving "good cause" for the late

filing of his request for hearing. *See Cogswell v. SAIF*, 74 Or App 234 (1985). In this context, good cause means "mistake, inadvertence, surprise or excusable neglect," as defined under ORCP 71B(1). *Hempel v. SAIF*, 100 Or App 68, 70 (1990). Lack of diligence does not constitute good cause. *Cogswell*, 74 Or App at 237. However, good cause can be established through evidence that a claimant relied on the misleading statement of a carrier's representative. *See Voorhies v. Wood, Tatum, Moser*, 81 Or App 336, *rev den* 302 Or 342 (1986).¹ We have held previously that where the carrier's employee did not inform a claimant that the claim would be accepted, the claimant's reliance on the carrier's statements did not constitute good cause for an untimely filing. *See, e.g., Allan J. Schlegel*, 53 Van Natta 659 (2001).

Here, the insurer did not tell claimant the new injury/occupational disease claim would be accepted. However, it did suggest that the claim was being accepted as an aggravation of the prior injury. In this regard, we conclude that by informing claimant that the 1996 claim would be "reopened," the insurer's representative misled claimant into believing that the claim was being accepted as an aggravation of the 1996 injury. Although the term "reopen" is not statutorily defined, in the workers' compensation context, the term has a specific meaning. The term is used when an accepted claim is being reopened for processing and payment of benefits. *See, e.g., ORS 656.262(7)(c)* (if a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition). If a claim is "reopened" it necessarily must be re-closed and entitlement to temporary and permanent disability benefits determined. Thus, in the workers' compensation context, claims that are not accepted are not "reopened" for processing. Given that the claims examiner acknowledged verbally advising claimant that the 1996 claim was being "reopened," we conclude that claimant's belief that his claim was being accepted under the 1996 claim was understandable. We also note that claimant was receiving benefits and had received the impression from the claims examiner that the November 2000 denial was a mere formality and that two claims were unnecessary.

Based on his reasonable belief that his claim was being accepted as an aggravation of the 1996 injury claim, claimant did not appeal the November 30,

¹ In *Voorhies*, a claims supervisor erroneously advised a claimant that mailing a request for hearing on the 60th day after the denial would protect his rights to a hearing. The claimant relied on the claims supervisor's statement and the claimant's hearing request was dismissed by a referee and the Board as untimely. The court reversed, holding that the claimant's failure to file the hearing request on the 60th day was excused by good cause.

2000 new injury denial. Claimant testified that had he known the aggravation claim was going to be denied, he would have appealed the November 30, 2000 denial. By the time the insurer denied the aggravation claim on February 15, 2001, the appeal period regarding the November 30, 2000 denial had expired.

We acknowledge that the November 30, 2000 denial stated that the insurer was “re-opening and processing your claim from date of injury 12/27/96 and has 90 days to investigate the worsening/aggravation claim and for compensability issues.” However, given the insurer’s use of the term “reopening,” coupled with claimant’s discussions with the claims examiner before and after the denial issued, we are persuaded that claimant was reasonably led to believe that his claim was being accepted and processed under the 1996 claim.

Moreover, claimant testified that the claims examiner led him to believe that the November 30, 2000 denial was a “formality” because the insurer was reopening the claim and did not need two claims. Under the facts presented in this case, we conclude that claimant has established “good cause” that excused his late hearing request regarding the November 30, 2000 denial. Having determined that good cause existed, we turn to the merits.²

Compensability

We adopt the ALJ’s reasoning and conclusion regarding the compensability of claimant’s L5-S1 disc herniation as an occupational disease with the following supplementation.

Claimant’s occupational disease claim is based on the theory that he had a preexisting disc herniation at L5-S1 that was worsened by his work activities. Accordingly, because the occupational disease claim is based on the worsening

² We distinguish this case from *Debra A. Gould*, 47 Van Natta 1072 (1995). In *Gould*, the claimant was “confused” by the employer’s denial of her current condition as a new occupational disease and its reopening of her accepted claim. In concluding that good cause for her untimely appeal of the occupational disease denial had not been established, we noted that there was no evidence that the claimant exercised any diligence in attempting to resolve her confusion until after the employer closed the reopened claim several months after the denial issued. We find *Gould* distinguishable because it did not involve misleading statements by a representative of the insurer.

We also note that we have previously held that the receipt of interim compensation either before or at the same time as the receipt of a denial, and any confusion created by this action regarding the status of the claim, is not good cause. See e.g., *Mary M. Schultz*, 45 Van Natta 393 (1993). Here, however, we find that the receipt of benefits in conjunction with the other circumstances, including the misleading statements of the insurer’s representative, constitute good cause that excuses claimant’s untimely hearing request.

of a preexisting disease or condition pursuant to ORS 656.005(7), claimant must prove that his work activities were the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(b). To satisfy the major contributing cause standard, claimant must prove that his work activities contributed more to the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983).

The insurer argues that Dr. Amstutz' opinion supporting compensability is not persuasive because it does not address whether claimant had a combined condition. Based on our reading of Dr. Amstutz' opinion in Exhibit 45, we are persuaded that claimant had a "combined condition" and that claimant's work activities were the major contributing cause of the combined condition.

We note that no incantation of "magic words" or statutory language is required to establish the compensability of a claim, provided the opinion otherwise meets the appropriate legal standard. *Freightliner Corp. v. Arnold*, 142 Or App 98 (1996). Here, Dr. Amstutz opined that claimant's moderate preexisting degenerative changes played a minimal role in the development of the disc herniation and that claimant's ongoing work activities of lifting heavy boxes were more likely than not the major contributing cause of the reason that the 1996 disc insult pathologically worsened into a disk herniation requiring surgery. From this opinion, we are persuaded that claimant's preexisting degenerative disease combined with his work activities to cause claimant's need for treatment of the disc herniation. Thus, we are persuaded that the medical evidence establishes a "combined condition" and that claimant's work activities are the major contributing cause of the combined condition and a pathological worsening of the disc. Accordingly, we conclude that the requirements of ORS 656.802(2)(b) have been met.³

The insurer also argues that Dr. Amstutz' opinion is unpersuasive because it is based on an incorrect history. Specifically, the insurer contends that Dr. Amstutz assumed that the preexisting L5-S1 disc herniation was caused by the December 27, 1996 injury. We disagree.

The insurer cites Exhibit 45 in support of its contentions. Exhibit 45-1 clearly states that the November 1996 MRI showed what Dr. Amstutz believed was a disc herniation at L5-S1 of a slighter degree than what was identified in

³ By analogy, our conclusion that "magic words" are not necessary to establish the existence of a "combined condition" is supported by the court's conclusion in *Columbia Forest Products v. Woolner*, 177 Or App 639 (2001). There, the court concluded that magic words are not necessary to establish the acceptance of a combined condition.

November 2000. The same portion of Exhibit 45 notes that claimant's compensable injury occurred in December 1996. Thus, we are persuaded that Dr. Amstutz possessed an accurate history and understood that the disc herniation preexisted the December 1996 injury. Dr. Amstutz explained that claimant probably suffered an insult to his L5-S1 disc in 1996. Dr. Amstutz further explained that the ongoing work activities since that time caused the L5-S1 disc to pathologically worsen to the point that the disc sustained a large herniation that required surgery. (Ex. 45-2).

The insurer also argues that Dr. Amstutz' opinion is inconsistent because he initially opined that the L5-S1 condition was a worsening of the 1996 injury and then later opined that claimant's work activities caused a pathological worsening of the preexisting herniation. We are not persuaded that Dr. Amstutz' opinion is inconsistent. Dr. Amstutz has consistently opined that claimant's 1996 injury was a factor in the worsened disc condition.

In evaluating the medical evidence concerning causation, we rely on those opinions which are both well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). Based on this record, we are more persuaded by the opinion of Dr. Amstutz than that of Dr. Dietrich.⁴ Dr. Dietrich, who performed a records review on the insurer's behalf, only addressed the compensability of claimant's condition as an aggravation of the 1996 injury and did not address whether claimant's condition was compensable as an occupational disease. Accordingly, based on Dr. Amstutz' opinion, we are persuaded that claimant has established compensability of his occupational disease claim.

Penalty

The ALJ found that the November 30, 2000 denial was unreasonable and assessed a penalty against the insurer. For the following reasons, we are not persuaded that the denial was unreasonable.

ORS 656.262(11)(a) provides for a penalty if a carrier unreasonably delays or unreasonably refuses to pay compensation. The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. *International Paper Co. v. Huntley*, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered

⁴

We note that Dr. Amstutz' opinion also related claimant's disc herniation to his work activities.

in the light of all the evidence available. *Brown v. Argonaut Insurance Company*, 93 Or App 588 (1988).

Here, at the time it issued its denial, the insurer had obtained Dr. Amstutz' opinion that the condition was an aggravation of the 1996 accepted claim. Thus, the insurer had a legitimate doubt regarding its liability for a new injury or occupational disease claim. Accordingly, we do not find that the November 30, 2000 denial of claimant's new injury/occupational disease claim was unreasonable.⁵

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is \$2,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's attorney's uncontested fee request and claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. Claimant's counsel is not entitled to an attorney fee for services on review regarding the penalty issue. *Saxton v. SAIF*, 80 Or App 631 (1986).

ORDER

The ALJ's order dated December 10, 2001 is affirmed in part and reversed in part. That portion of the ALJ's order that assessed a penalty is reversed. The remainder of the order is affirmed. For services on Board review, claimant's attorney is awarded \$2,000, payable by the insurer.

Entered at Salem, Oregon on September 3, 2002

Board Member Phillips Polich dissenting

Unlike the majority, I conclude that the ALJ correctly assessed a penalty for unreasonably resisting the payment of compensation. Consequently, I respectfully dissent.

As the majority correctly notes, the standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. *International Paper*

⁵ Unlike the dissent, we do not conclude that the denial also denied compensability of an aggravation of the 1996 claim. Consistent with Dr. Amstutz' opinion, the denial states that the insurer was reopening and processing the claim to investigate the aggravation issue.

Co. v. Huntley, 106 Or App 107 (1991). Based on a finding of “no legitimate doubt as to liability,” we have previously assessed penalties for unreasonable compensability denials in the absence of evidence that non-work activities are possible causative factors. See *David C. Thompson*, 47 Van Natta 1614, 1616 (1995); *Michael P. Yauger*, 45 Van Natta 419 (1993); *Harold R. Borron*, 44 Van Natta 1579 (1992).

Here, the insurer’s initial denial ([of]“the claim in its entirety”) expressly stated that it was based on Dr. Amstutz’s report of November 28, 2000. (Ex. 31). Dr. Amstutz reported that claimant’s back condition (from a work injury of 4 years ago) had been stable until some recent work related lifting. (Ex. 27-1). Taking into account his examination findings, claimant’s history, and a review of imaging studies (from both November 1996 and November 2000), Dr. Amstutz opined that the major cause of claimant’s problem was “an exacerbation, with pathologic worsening” of the previous on-the-job injury. (Ex. 27-3).

Based on Dr. Amstutz’s report there are only two possible causes for claimant’s back condition: one is the 1996 work injury and the other is the recent work-related lifting activities. Thus, while Dr. Amstutz’s report may provide a legitimate doubt regarding responsibility, it does not provide a legitimate doubt regarding compensability. Nonetheless, the insurer denied both compensability and responsibility. Consequently, I conclude, as did the ALJ, that the compensability denial was unreasonable. Accordingly, consistent with *Thompson*, *Yauger*, and *Borron*, I would affirm the ALJ’s assessed penalty. Because the majority decides otherwise, I respectfully dissent.