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In the Matter of the Compensation of  
**FRANCISCO M. CARLOS-MACIAS, Claimant**  
WCB Case Nos. 10-04555, 10-04446  
ORDER ON REVIEW  
Dale C Johnson, Claimant Attorneys  
Bruce A Bornholdt, SAIF Legal, Defense Attorneys

Reviewing Panel: Members Langer, Weddell, and Herman. Member Langer dissents in part and concurs in part.

Claimant requests review of Administrative Law Judge (ALJ) Donnelly's order that: (1) upheld the SAIF Corporation's denial of claimant's aggravation claim for a left shoulder condition; (2) upheld SAIF's denials of claimant's current left shoulder condition; (3) found that claimant's diagnostic medical services claim was not compensable; and (4) declined to award penalties and attorney fees. On review, the issues are aggravation, compensability, medical services, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," but not the "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

Aggravation Denial

The ALJ rejected claimant's argument that SAIF's aggravation denial was premature because no valid aggravation claim had been filed. The ALJ concluded that the requirements of ORS 656.273(3), pertaining to the filing of an aggravation claim, were satisfied and that SAIF appropriately processed the aggravation claim in a timely manner. Because it was undisputed that claimant did not sustain an actual worsening of his accepted conditions, the ALJ upheld SAIF's denial and declined to award penalties and attorney fees for allegedly unreasonable processing of the aggravation claim.

On review, claimant contends that, because no aggravation claim was perfected, SAIF's denial was premature. For the following reasons, we disagree.

ORS 656.273(3) provides:

“A claim for aggravation must be in writing in a form and format prescribed by the director and signed by the worker or the worker’s representative and the worker’s attending physician. When an insurer or self-insured employer receives a completed aggravation form, the insurer or self-insured employer shall process the claim.”

We begin our analysis with an examination of the text and context of the statute. *State v. Gaines*, 346 Or 160, 171 (2009); *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12 (1993). The first requirement of ORS 656.273(3) is a “claim for aggravation.”

In relevant part, ORS 656.005(6) states that a “claim” means a “written request for compensation from a subject worker \* \* \*.” Here, claimant checked a box on the form 827, reporting an aggravation of the original injury. (Ex. 71). This would constitute a written request for compensation for an aggravation of the compensable injury, *i. e.*, a claim for aggravation within the meaning of ORS 656.273(3).

There is no dispute that the aggravation claim was in a form and format prescribed by the director. The next requirement is that the form be signed by the worker or a worker’s representative and the attending physician. Here, claimant, the “worker,” signed the form 827 and the attending physician, Dr. Lin, did as well. There is no requirement that the attending physician endorse the aggravation claim by checking the box indicating an aggravation.<sup>1</sup> All the statute requires is that the physician sign the form. There is no question that the attending physician did so. While the lack of a checked aggravation box may be relevant to whether a compensable aggravation occurred on the merits, the absence of a checked box on the physician’s portion of the form 827 does not affect the issue of whether an aggravation claim was perfected.

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<sup>1</sup> Also, Dr. Lin did not check the box, which refers to a “palliative care request.” (Ex. 71). Thus, Dr. Lin registered no express disagreement with claimant’s “report of aggravation of original injury.” (Ex. 71). Moreover, Dr. Lin indicated that claimant’s condition was not medically stationary and that he was only released to modified work, which further supports our conclusion that there was an aggravation claim for SAIF to process.

The next sentence of the statute requires that when a carrier receives a “completed aggravation form,” it shall process the claim. As previously noted, the requirements of the first sentence of the statute were satisfied; thus SAIF received a completed aggravation form when the form 827 was submitted to it by Dr. Lin. Upon its receipt of the completed form, SAIF was statutorily required to “process the claim.” This is precisely what SAIF did when it asked Dr. Lin to clarify whether claimant sustained an aggravation. (Ex. 75). SAIF further processed the claim when it issued its aggravation denial after Dr. Lin indicated that he was requesting only palliative care and declined to check the box indicating an aggravation reopening.

Based on our review of the language of ORS 656.273(3), we conclude that an aggravation claim was “perfected” and that SAIF’s claim processing was in compliance with the statute. Moreover, the legislative history behind the enactment of the current version of ORS 656.273(3) supports our conclusion that SAIF was required to process an aggravation claim in response to the submission of the form 827.

In 1995, ORS 656.273(3) was amended by Senate Bill 369 to require that a claim for aggravation be accompanied by the attending physician’s report establishing by written objective findings that the claimant had suffered a worsened condition attributable to the compensable injury. The amendments to that version of ORS 656.273(3) were enacted in 2005 in House Bill (HB) 2405.

According to the testimony of Martin Alvey, a workers’ compensation practitioner who testified in support of passage of HB 2405, the purpose of the 2005 amendments was to uncouple the aggravation claim form and the report of the attending physician. (Exhibit D, Senate Commerce Committee, April 19, 2005). Alvey’s testimony indicates that the previous requirement that a physician’s report “accompany” an aggravation claim form was used by carriers to elevate form over substance. The history surrounding this legislation indicates that there was a proposal to return to the pre-1995 law that the carrier’s receipt of a doctor’s report would constitute an aggravation claim. Subsequently, however, the requirement that the aggravation claim form be signed by the worker or by a representative was restored. Alvey testified that, if HB 2405 passed, insurers would know that an aggravation claim was being presented upon submission of an aggravation claim form signed by the attending physician.

Thus, our review of the relevant legislative history indicates an intention to lessen the procedural hurdles that the previous version of ORS 656.273(3)

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had erected with regard to the filing of aggravation claims, and to simplify the circumstances under which a carrier should process an aggravation claim. Our interpretation of the current statute facilitates that intent.

Here, both claimant and his physician signed a form containing an aggravation claim. The form 827 was then submitted to SAIF for processing. That was all the statute requires for claim processing to be initiated. While the aggravation form was arguably incorrectly completed by the attending physician, it is clear that claimant intended to file an aggravation claim. Once SAIF was put on notice that he was seeking compensation for a worsened condition, only claimant could withdraw the claim. Because he did not do so, SAIF was not relieved of its duty to process the claim.

Under these circumstances, we find that SAIF's denial of an aggravation claim was not premature. Therefore, we affirm that portion of the ALJ's order that upheld SAIF's denial of claimant's aggravation claim.<sup>2</sup>

### Current Condition

In upholding SAIF's denials of claimant's current left shoulder condition, the ALJ determined that the most persuasive medical opinions established that the accepted conditions were no longer a material contributing cause of claimant's current left shoulder condition and need for treatment. On review, among other contentions, claimant asserts that SAIF's denial was procedurally invalid because it lacked the specificity required by OAR 438-005-0060, which provides that partial denials "shall set forth with particularity the injury, condition, benefit or service for which liability is denied and the factual and legal reasons therefore." Based on the following reasoning, we disagree with claimant's assertion.

The August 12, 2010 denial noted that claimant's injury had been accepted for left shoulder conditions, which were specifically identified in the denial letter, but that claimant's current condition and need for treatment of left shoulder strain, left shoulder sprain, left shoulder acromioclavicular sprain and left shoulder hypertrophic rotator cuff tendinosis were denied. (Ex. 85). SAIF later issued an amended denial that listed the accepted conditions and stated that those conditions were no longer a material contributing cause of claimant's left shoulder complaints and need for treatment. Thus, SAIF denied claimant's current left shoulder condition. (Ex. 87).

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<sup>2</sup> Given this conclusion, it follows that SAIF's claim processing was not unreasonable. Therefore, we affirm the ALJ's decision to not award a penalty or penalty-related attorney fee.

Having reviewed the aforementioned denials, we consider them sufficiently specific to satisfy the above administrative rule. Thus, they were procedurally valid.

Finally, because we agree with the ALJ's reasoning that the opinion from claimant's attending physician was contradictory, we concur with the ALJ's conclusion that claimant did not satisfy his burden of proving that his current left shoulder condition is compensable. Therefore, we affirm this portion of the ALJ's order.

### Diagnostic Medical Services

The ALJ determined that proposed diagnostic medical services, consisting of a triple phase bone scan and EMG/nerve conduction tests, were not causally related to the accepted conditions. In making this determination, the ALJ reasoned that Dr. Lin's opinion did not establish that the proposed medical services were necessitated in material part by the compensable injury, which the ALJ considered to be the previously accepted conditions.

On review, claimant contends that the proposed diagnostic tests are compensable. SAIF responds that the record does not establish that the proposed medical treatment was necessitated in material part by the accepted conditions. For the following reasons, we find the diagnostic medical treatment compensable.

ORS 656.245(1)(a) provides:

“For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions caused in material part by the injury for such period as the nature of the injury or the process of the recovery requires, subject to the limitations in ORS 656.225, including such medical services as may be required after a determination of permanent disability. In addition, for consequential and combined conditions described in ORS 656.005(7), the insurer or the self-insured employer shall cause to be provided only those medical services directed to medical conditions caused in major part by the injury.”

If diagnostic services are necessary to determine the cause or extent of a compensable injury, those services are compensable whether or not the condition that is discovered as a result of them is compensable. *Counts v. Int'l Paper Co.*, 146 Or App 768, 771 (1997); *see also Roseburg Forest Products v. Langley*, 156 Or App 454, 463 (1998) (tests were for determining extent of compensable injury and not for establishing the existence of a new or consequential condition).

Here, Dr. Lin, claimant's attending physician, opined that the recommended diagnostic testing was reasonable and necessary to determine the extent of the accepted injury. Claimant's attorney's letter to Dr. Lin listed the accepted conditions due to the accepted injury claim. Dr. Lin stated that the testing was particularly important when, as in this case, the patient presented in an exaggerated manner that may actually be a culturally related presentation. In addition, the recommended tests were important to determine diagnosis and treatment. (Ex. 91).

We equate Dr. Lin's reference to "accepted injury" with "accepted conditions." Accordingly, we conclude that Dr. Lin's opinion supports a conclusion that the accepted conditions were at least a material contributing cause of the proposed diagnostic testing. Moreover, Dr. Lin's opinion establishes that the requested testing was also necessary to determine the extent of claimant's compensable left shoulder injury; *i.e.*, his accepted left shoulder conditions.<sup>3</sup> Consequently, we conclude that the disputed diagnostic medical service claim is compensable.<sup>4</sup>

In reaching this conclusion, we acknowledge that Drs. Matteri, Straub and Ackerman reasoned that the proposed diagnostic testing was not necessary to determine the extent of the accepted conditions. (Exs. 88, 89, 90). However, in the absence of persuasive reasons to the contrary, we generally give greater weight to the opinion of an attending physician. *Weiland v. SAIF*, 63 Or App 810, 814

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<sup>3</sup> We acknowledge that Dr. Lin's opinion was contradictory concerning the causal relationship between the accepted conditions and the current left shoulder condition. However, that does not mean that his opinion regarding the compensability of the recommended diagnostic medical services is unpersuasive. The issue of whether the proposed diagnostic procedures are necessary to determine the extent of the compensable injury is different from the issue of whether the current left shoulder condition is compensable.

<sup>4</sup> Claimant contends that SAIF's specification of the disputed medical issues was unreasonable when it indicated the medical services were disapproved because they were for new/omitted medical conditions for which he had not requested acceptance. (Ex. 81). Thus, claimant requests penalties and attorney fees for unreasonable claim processing. We adopt the ALJ's reasoning that SAIF's conduct was not unreasonable.

(1983); *Shereena Oden*, 62 Van Natta 1754, 1756 (2010). Here, we do not find persuasive reasons to disregard the opinion of Dr. Lin, the current attending physician, with regard to compensability of the proposed diagnostic medical services. Accordingly, we reverse that portion of the ALJ's order that found the proposed diagnostic tests not compensable.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding the medical services issues.<sup>5</sup> ORS 656.386(1). 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 at hearing and on review is \$5,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record, and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Finally, claimant is awarded reasonable expenses and costs for records, expert opinions, and witness fees, if any, incurred in finally prevailing over the medical services denial, to be paid by SAIF. *See* ORS 656.386(2); OAR 438-015-0019; *Nina Schmidt*, 60 Van Natta 169 (2008); *Barbara Lee*, 60 Van Natta 1, *recons*, 60 Van Natta 139 (2008). The procedure for recovering this award, if any, is prescribed in OAR 438-015-0019(3).

### ORDER

The ALJ's order dated December 10, 2010 is reversed in part and affirmed in part. SAIF's denial of medical services is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of \$5,000, to be paid by SAIF. Claimant is awarded reasonable expenses and costs for records, expert opinions, and witness fees, if any, incurred in finally prevailing over the medical services denial, to be paid by SAIF. The remainder of the ALJ's order is affirmed.

Entered at Salem, Oregon on November 4, 2011

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<sup>5</sup> In the absence of either a denial contesting the medical services on both causation and propriety bases or a concurrently pending dispute regarding the propriety of the medical services before WCD, we conclude that claimant finally prevailed over a denied claim at the Hearings Division and, as such, his counsel is entitled to a "non-contingent," employer-paid attorney fee award under ORS 656.386(1). *See Todd R. Ferguson*, 62 Van Natta 304, 305 (2010) (in the absence of either a denial contesting the medical services on "propriety" grounds or a concurrently pending "propriety" dispute before WCD, the claimant had finally prevailed over a medical services denial).

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Member Langer dissenting in part and concurring in part.

The majority concludes that the disputed medical services are compensable. Because I disagree with that determination, I respectfully dissent.<sup>6</sup>

In setting aside the denial of medical services, the majority relies on Dr. Lin's opinion that the requested testing was necessary to determine the extent of claimant's compensable left shoulder injury. However, I disagree with the majority's reliance on Dr. Lin's opinion.

The majority adopted the ALJ's reasoning, with regard to the compensability of claimant's current left shoulder condition, that the opinions of Drs. Straub, Ackerman and Matteri were more persuasive than Dr. Lin's. The latter physicians concluded that the proposed diagnostic testing was not necessary to determine the extent of the accepted conditions. (Exs. 88, 89, 90). I see no reason for rejecting that part of their opinion while accepting the other. Under these circumstances, I agree with the ALJ's determination that the claimed diagnostic medical services are not compensable.

Moreover, diagnostic services for the purpose of establishing the existence of a new or consequential condition are not compensable. Only diagnostic services that are proposed for the purpose of determining a causal relationship, if any, between an accepted condition and the worker's condition are compensable. *See Roseburg Forest Products v. Langley*, 156 Or App 454, 462-63 (1998).

Here, Dr. Lin at first indicated that the disputed diagnostic services were intended to determine the cause or extent of the "accepted work injury." (Ex. 79-1). However he did not explain his understanding of the scope of that term. Moreover, elsewhere in the record, Dr. Lin stated that the proposed bone scan was designed to rule out complex regional pain syndrome (CRPS). (Ex. 87A). At another point, Dr. Lin indicated that the proposed medical services were intended to rule out new diagnoses. (Ex. 91). Thus, I would conclude that Dr. Lin recommended the disputed diagnostic services to rule out the existence of new medical conditions.

Consequently, I would conclude that claimant has not proven that the proposed medical services are compensable under *Langley*. Therefore, I respectfully dissent.

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<sup>6</sup> I agree with the majority's reasoning and conclusion that an aggravation claim was perfected and is not compensable on the merits. I further agree with the majority that claimant's current left shoulder condition is not compensable.