

---

In the Matter of the Compensation of  
**JORGE ANDRADE, Claimant**  
WCB Case No. 15-01939  
ORDER ON REVIEW  
Schoenfeld & Schoenfeld, Claimant Attorneys  
MacColl Busch Sato PC, Defense Attorneys

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

Claimant requests review of Administrative Law Judge (ALJ) Mills's order that: (1) declined to find that the self-insured employer's acceptance of a right shoulder strain was a *de facto* denial of additional right shoulder conditions; and (2) declined to award penalties or attorney fees for allegedly unreasonable claim processing. On review, the issues are claim processing, penalties, and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

On review, claimant contends that the employer's acceptance of a shoulder strain was a "*de facto*" denial of other diagnosed right shoulder conditions. In essence, his argument is an objection to the employer's Notice of Acceptance (whether the initial and/or modified acceptance).

Yet, ORS 656.262(6)(d) and ORS 656.262(7)(a) provide that unless claimant objects to the omission of a condition under ORS 656.267, he "may not allege at any hearing or other proceeding on the claim a *de facto* denial based on information in the notice of acceptance."<sup>1</sup> Thus, claimant cannot establish a

---

<sup>1</sup>ORS 656.262 provides in pertinent part:

"(6)(d) An injured worker who believes that a condition has been incorrectly omitted from a notice of acceptance, or that the notice is otherwise deficient, first must communicate in writing to the insurer or self-insured employer the worker's objections to the notice pursuant to ORS 656.267. The insurer or self-insured employer has 60 days from receipt of the communication from the worker to revise the notice or to make other written clarification in response. A worker who fails to comply with the communication requirements of this paragraph or

*de facto* denial of a condition omitted from an initial Notice of Acceptance (or a Modified Notice of Acceptance) until after the carrier fails to respond to a claim under ORS 656.267 for the omitted medical condition. See *Mai K. Moua*, 66 Van Natta 848, 850-51 (2014); *Joyce A. Deitrich*, 63 Van Natta 2509 (2011); *Shannon E. Jenkins*, 48 Van Natta 1482 (1996), *aff'd without opinion*, 135 Or App 436 (1997).

Here, claimant challenges the employer's acceptance of a right shoulder strain, contending that: (1) such a condition does not exist; (2) he has other shoulder conditions; and (3) his claim should be processed as an occupational disease. However, the record establishes that the employer's April 6, 2015 acceptance was based on the February 6, 2015 801 form. (Exs. 3, 5). The 801 form listed "Strain Shoulder(s)" and described the cause of the injury as follows: "EE has a strained shoulder due to repetitious [sic] movement installing Batt Insulation." (Ex. 3). In response to the 801 form, the employer issued its acceptance of a nondisabling right shoulder strain. (Exs. 3, 5). The acceptance notice neither designated the claim as an injury, nor as an occupational disease.

Because the employer had already accepted the claim as a right shoulder strain, the statutory scheme prescribes a specific process for handling alleged deficiencies in the acceptance notice. Specifically, ORS 656.262(6)(d) mandates that an "injured worker who believes that a condition has been incorrectly omitted from a notice of acceptance, or that the notice is otherwise deficient, first must communicate in writing to the insurer or self-insured employer the worker's objections to the notice pursuant to ORS 656.267." In conjunction with that statutory mandate, ORS 656.262(7)(a) provides that a "worker who fails to comply

---

ORS 656.267 may not allege at any hearing or other proceeding on the claim a *de facto* denial of a condition based on information in the notice of acceptance from the insurer or self-insured employer. Notwithstanding any other provision of this chapter, the worker may initiate objection to the notice of acceptance at any time.

"(7)(a) After claim acceptance, written notice of acceptance or denial of claims for aggravation or new medical or omitted condition claims properly initiated pursuant to ORS 656.267 shall be furnished to the claimant by the insurer or self-insured employer within 60 days after the insurer or self-insured employer receives written notice of such claims. A worker who fails to comply with the communication requirements of subsection (6) of this section or ORS 656.267 may not allege at any hearing or other proceeding on the claim a *de facto* denial of a condition based on information in the notice of acceptance from the insurer or self-insured employer."

with the communication requirements of subsection (6) of this section or ORS 656.267 may not allege at any hearing or other proceeding on the claim a *de facto* denial of a condition based on information in the notice of acceptance[.]”

Similarly, ORS 656.267(1) mandates that: “To initiate omitted medical condition claims under ORS 656.262(6)(d) or new medical condition claims under this section, the worker must clearly request formal written acceptance of a new medical condition or an omitted medical condition from the insurer or self-insured employer.” It further provides that: “A claim for a new medical condition or an omitted condition is not made by the receipt of medical billings, nor by requests for authorization to provide medical services for the new or omitted condition, nor by actually providing such medical services.”

Here, it is undisputed that, before filing his hearing request, claimant did not communicate in writing to the employer about any objections to, or alleged deficiencies in, its Notice of Acceptance pursuant to ORS 656.262(6)(d) and ORS 656.267. As such, the statutory scheme prohibits him from alleging a *de facto* denial for such claimed conditions at a hearing.<sup>2</sup>

Accordingly, based on the aforementioned reasoning and for the reasons expressed in the ALJ’s order, we affirm.<sup>3</sup>

---

<sup>2</sup> Referring to ORS 656.262(1) (and its general directive to a carrier to process a worker’s claim), the dissent contends that claimant’s challenges to the employer’s acceptance notice must be considered. Yet, to do so would be to ignore the clear and specific requirements of ORS 656.262(6)(d) and ORS 656.267(1), which mandate that such challenges must first be communicated to the carrier in writing before a worker can file a hearing request and allege at hearing a *de facto* denial regarding the claimed conditions. *See Bradley R. Madrid*, 66 Van Natta 1080, 1084 (2014) (the issue of an unaccepted condition was premature and could not be considered where the claimant had not previously filed a “new/omitted” medical condition claim for that condition and the carrier raised a procedural challenge at hearing).

<sup>3</sup> Claimant also asserts that his claim should be analyzed as an “occupational disease.” Yet, in doing so, he challenges the employer’s acceptance of a “shoulder strain” and seeks the acceptance of other specified conditions. Thus, claimant is essentially objecting to the employer’s claim acceptance, and requesting acceptance of other conditions under an “occupational disease” theory. Such a position represents an “objection” based on information in the Notice of Acceptance, which, in accordance with the statutory scheme, must first be made in writing to the employer before requesting a hearing. *See Dietrich*, 63 Van Natta at 2510.

Finally, based on the aforementioned reasoning, the record does not establish that the employer’s claim processing was unreasonable. Consequently, penalties and attorney fees under ORS 656.262(11)(a) are not warranted.

---

ORDER

The ALJ's order dated August 17, 2015 is affirmed.

Entered at Salem, Oregon on March 24, 2016

Member Weddell dissenting.

Because I believe that the majority's reasoning ignores an employer's statutory responsibility to process claims in a prompt and reasonable manner, I respectfully dissent. For the following reasons, I conclude that the employer's claim processing was unreasonable.

Claimant is a 56-year-old Spanish speaking male, who cannot read English, and speaks only limited English. (Tr. 11, 14). His highest level of formal education is kindergarten. (Tr. 14). He has been working for the employer since 1997, installing insulation in the crawlspaces under houses. (Tr. 14-15).

Claimant carries 40 to 65 pound bags of insulation on his shoulders to where he is working, pulls them into the crawlspace, and opens them to pull out pieces of insulation. (*Id.*) He then has to work on his back, or on his knees, to install the insulation underneath the houses. (Tr. 15). A majority of the time, his arms are in an upward position, using an air stapler and a rope to secure the insulation. (Tr. 16).

Before seeking medical treatment, claimant had increasing shoulder pain for several months. (Tr. 17). On January 23, 2015, an MRI showed a full thickness tear of his right rotator cuff. (Ex. 1).

On February 5, 2015, claimant was examined by Dr. Bowman's physician's assistant, Ms. Bangs. Claimant gave a history of "pain beginning around September with no specific injury that he can recall." (Ex. 2-1). Ms. Bangs reported that: (1) claimant's "[p]ain has been worsening since he started to lose strength and range of motion"; (2) he experiences "sharp stabbing pain at work"; and (3) moving heavy bags at work "definitely produces pain for him." (*Id.*) Ms. Bangs assessed: "Complete Rupture Rotator Cuff (RIGHT), Rotator Cuff Tendonitis (RIGHT), Bicep Tendon Rupture, Long head (RIGHT), and SLAP LESION (RIGHT)." (Ex. 2-2). Claimant's treatment plan included "requesting a right shoulder arthroscopic labral repair, rotator cuff repair and subacromial decompression[,]" with a "follow-up with Dr. Bowman once this has been authorized." (*Id.*) Claimant was not released to work. (Ex. 2-3).

The next day, on February 6, 2015, the employer's branch manager completed an 801 form for claimant. (Ex. 3). The 801 form (which claimant did not sign) indicated that his injury was "strain shoulder(s)" and that he attributed his condition to "repetitious [sic] movement installing Batt installation." (*Id.*)

On March 10, 2015, Dr. Bowman examined claimant. (Ex. 4-1). Dr. Bowman repeated the assessment of "Complete Rupture Rotator Cuff [RIGHT], Bicep Tendon Rupture, Long head [RIGHT], SLAP LESION [RIGHT], Rotator Cuff Tendonitis [RIGHT]" and related those conditions to claimant's work. (Ex. 4-2).

On April 6, 2015, the employer accepted a nondisabling right shoulder strain. (Ex. 5). In response to Dr. Bowman's surgery request, the employer scheduled an examination with Dr. Teed. (Ex. 7).

On April 27, 2015, Dr. Teed, an orthopedic surgeon, examined claimant. (Ex. 8-1). Dr. Teed recorded a history of right shoulder pain that progressively worsened, noting that claimant was "unable to describe a specific injury." (Ex. 8-5). Dr. Teed concluded that claimant's condition was not an "occupational disease or on-the-job injury, but rather that of a chronic, degenerative process more related to genetics and aging than a job-related issue." (*Id.*)

On April 30, 2015, Dr. Bowman did not concur with Dr. Teed's opinion. Dr. Bowman considered claimant's rotator cuff tear to be a "manifestation of occupational disease[.]" noting that his insulation installation was very demanding. In Dr. Bowman's opinion, repetitive shoulder activity (rather than "metabolic factors, aging, etc.") would lead to a rotator cuff tear. (Ex. 9).

On April 30, 2015, claimant filed a hearing request, objecting to the employer's processing of his claim. In particular, he challenges the employer's acceptance of an undiagnosed "strain" condition and a failure to respond to his diagnosed shoulder conditions.

On May 14, 2015, the employer changed claimant's nondisabling classification to a disabling injury. (Ex. 10-1).

It is the employer's responsibility to process claims. ORS 656.262(1). This includes a duty to investigate a claim and, under ORS 656.262(6)(a), to issue an acceptance or denial within 60 days. In this case, the only claim presented to the employer was an occupational disease claim. There is absolutely no evidence that claimant suffered any accidental injury, nor that he experienced a "right shoulder strain."

Nonetheless, the majority concludes there was no *de facto* denial, that the employer's claim processing was reasonable, and that claimant must challenge the employer's inaccurate acceptance notice by filing a new/omitted medical condition claim.

The majority's reasoning raises the following questions regarding what actions it expects claimant to take in response to the employer's claim processing. Does the majority believe that the law requires claimant, having received the employer's inaccurate acceptance notice, to say to himself, "Hum, I notice that the acceptance shows my claim has been accepted as an injury claim, but my condition developed over a period of time and should be classified as an occupational disease." Likewise, does the majority expect claimant to then discern: "That could make a difference if, in the future, a combined condition is accepted and the employer issues a 'ceases' denial. Furthermore, the employer has accepted a 'right shoulder strain,' when my doctor has diagnosed and is treating me for 'Complete Rupture Rotator Cuff (RIGHT), Rotator Cuff Tendonitis (RIGHT), Bicep Tendon Rupture, Long Head (RIGHT), SLAP LESION (RIGHT).' Given the *Yekel* decision, that's going to make a difference when my claim is evaluated for permanent impairment and work disability. Perhaps, although my time loss has been paid, I need to file omitted medical condition claims pursuant to ORS 656.267. Given the different compensability standards for an accidental injury and occupational disease, I wonder what questions I should ask my doctor?"

Or, does the majority expect that in order for claimant to have the occupational disease claims for "Complete Rupture Rotator Cuff (RIGHT), Rotator Cuff Tendonitis (RIGHT), Bicep Tendon Rupture, Long Head (RIGHT), SLAP LESION (RIGHT)" considered, he must retain an attorney who then must write to the employer and object to the acceptance notice and demand acceptance of an occupational disease claim for "Complete Rupture Rotator Cuff (RIGHT), Rotator Cuff Tendonitis (RIGHT), Bicep Tendon Rupture, Long Head (RIGHT), SLAP LESION (RIGHT)?"

If the answer is yes to the former, I suggest the majority impermissibly transfers the employer's statutory obligation to process claims to claimant.<sup>4</sup> If the

---

<sup>4</sup> The legislative history of ORS 656.262(6)(d) and ORS 656.267 does not support any such intent. In *Brown v. SAIF*, 262 Or App 640, 650 (2014), in which the court determined that the phrase "otherwise compensable injury," as used in ORS 656.005(7)(a)(b), means the work-injury incident, it referred to the following legislative history:

answer is yes to the latter, I suggest that the contingent nature of claimant's attorney's practice should become a more important factor in determining a reasonable attorney fee should claimant finally prevail over a claim denial.

In either case, the majority's decision forces claimant to make an occupational disease claim, when in fact, that was done from the outset of this claim. In effect, the majority's decision forces claimant to challenge the acceptance of a "strain" when no doctor has diagnosed that condition.

---

"[Representative Mannix] said that the proposed amendment, now enacted as ORS 656.262(6)(d) and ORS 656.267, to require a worker to request a modification of acceptance for new or omitted medical conditions

"is really not aimed so much at the worker as the attorney. I never saw, in my experience, *a worker ever complain about the notice of acceptance*, unless a bill wasn't paid and then when the bill isn't paid, that is a legitimate issue and [insurers] are supposed to issue a denial if they are refusing to pay a bill.'

"[Tape Recording, House Committee on Labor, SB 369, Mar 6, 1995, Tape 46, Side A (statements of Rep Kevin Mannix)]. (emphasis added).

"When asked whether the new statutory language would encourage workers to secure an attorney or to seek out clarification from a doctor to ensure that they were not cut off from services to which they were entitled, Mannix responded:

"*The acceptance itself does not have any negative consequences for the worker. The negative consequences are if something isn't paid. If later on there is an issue about whether or not there is a new injury, it is important to go back and see what was accepted on the claim.*'

"*Id.* (emphasis added).

"Nothing in that legislative history suggests that, by enacting provisions relating to the listing of accepted conditions or to requesting acceptance of new or omitted conditions, the legislature intended to modify the incident-based definition of 'compensable injury.' To the contrary, the legislative history establishes that an insurer's or employer's obligation to specify the accepted conditions was not intended to have an adverse effect on a worker's right to benefits as a result of a compensable injury." *Brown*, 262 Or App at 650.

Here, the majority's decision has adverse effects on claimant's rights to benefits because, as in this case, the employer can avoid its obligation to determine the nature and extent of an alleged compensable injury by simply accepting the most benign condition (whether diagnosed or undiagnosed), thereby shifting the onus of claim processing to claimant to request (and prove) a new/omitted medical condition. Such a process would delay claimant's timely receipt of benefits, which would be contrary to the above legislative history acknowledged in *Brown*.

Furthermore, the majority declares the employer's claim processing to have been reasonable when it classified the claim as an injury when there was no evidence to support such a claim, and accepted a condition that no doctor diagnosed, and did not respond to any of the conditions which were diagnosed by the medical experts.<sup>5</sup> While I do not believe that claim processing must be perfect to be reasonable, I do think that the employer must do something right for claim processing to be reasonable. Moreover, the majority completely ignores the employer's obligation under ORS 656.262(6)(b)(F)<sup>6</sup> to modify the Notice of Acceptance as medical or other information changes a previously issued Notice of Acceptance. Indeed, here, the employer issued a Modified Notice of Acceptance in order to change the claim classification from nondisabling to disabling. (Ex. 10-1). The employer has not explained why its Modified Notice of Acceptance—which was issued May 14, 2015, more than two weeks after claimant's hearing request was filed—changed only the disabling classification.

In this case, the employer simply did not respond to the claim that was presented by claimant. That nonresponse to the presented claim constitutes a *de facto* denial, as well as unreasonable claim processing. Thus, I would reverse the ALJ's order, set aside the *de facto* denial, and award attorney fees under ORS 656.386(1), as well as a penalty and attorney fees pursuant to ORS 656.262(11)(a). Because the majority has concluded otherwise, I respectfully dissent.

---

<sup>5</sup> The employer appears to have been receiving Dr. Bowman's medical records. For instance, it responded to Dr. Bowman's request for surgery by scheduling a consultant exam with Dr. Teed. (Ex. 7). Moreover, the employer submitted its payment ledger into evidence, which shows payments to Dr. Bowman's medical clinic as early as March 23, 2015 for services provided, which was almost two weeks before the employer's initial acceptance notice was issued. (Exs. A-2, 5).

<sup>6</sup> ORS 656.262(6)(b)(F) provides that the notice of acceptance shall: "Be modified by the insurer or self-insured employer from time to time as medical or other information changes a previously issued notice of acceptance."