Workers' Compensation Board

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News & Case Notes

BOARD NEWS

Rulemaking Hearing: November 21, 2014 - "Acknowledgment of Hearing Request" (OAR 438-006-0020)/"Expedited Claim Service - Notice of Hearing Date" (OAR 438-013-0025) - Amending "Mail"/"Mailing" to "Distribute"/"Distribution"

At its September 16 meeting, the Members proposed amendments to OAR 438-006-0020 (Acknowledgment of Hearing Request) and OAR 438-013-0025 (Expedited Claim Service - Notice of Hearing Date). Specifically, their proposal is to replace the terms "mail" and "mailing" in those rules with the terms "distribute" and "distribution." Such a rule change (in conjunction with further development of WCB's website portal, would eventually allow the Board to electronically distribute Notices of Hearing to portal users.

Notice of this rulemaking action has been filed with the Secretary of State's office. Electronic copies of these rulemaking materials are available on WCB's website (under the category "Laws & Rules"): www.wcb.oregon.gov. Copies will also be distributed to parties and practitioners on WCB's mailing list.

A rulemaking hearing for these proposed rule amendments has been scheduled for November 21, 2014, at 10 a.m. at the Board's Salem office (2601 25th St. SE, Ste. 150, Salem, OR 97302-1280). Any written comments submitted in advance of the hearing may be directed to Debra Young, the rulemaking hearing officer. Those comments may be mailed to the above address, faxed to 503-373-1684, e-mailed to rulecomments.wcb@state.or.us or hand-delivered to a permanently staffed Board office (Salem, Portland, Eugene, Medford).

"Housekeeping" Rule Change: OAR 438-019-0000(3) (Mediation Rules - Definition of "Party")

At its September 16 meeting, the Members adopted a "housekeeping" rule change to OAR 438-019-0000(3), which defines "party" in the "mediation" rules by referring to the definition of "party" in OAR 438-005-0040. Because

the current version of OAR 438-019-000(3) refers to section (11) of OAR 438-005-0040 and the definition of "party" is actually contained in section (10), the Members approved a change in the rule to update the reference. In support of this action, the Members relied on ORS 183.335(7).

The Members directed their staff to file the necessary notice with the Secretary of State's office. An electronic copy of this "housekeeping" rule change notice will be posted on WCB's website (under the category "Laws & Rules"): www.wcb.oregon.gov.

CASE NOTES

Attorney Fee: "386(1)" - "Void" Denial

Christopher L. Rowles, 66 Van Natta 1579 (September 16, 2014). Applying ORS 656.386(1), on reconsideration of its earlier decision, 66 Van Natta 1445 (August 21, 2014), the Board held that claimant's counsel was entitled to a carrier-paid attorney fee for finally prevailing over a carrier's denial of an omitted medical condition, even though the denial was void because it had not issued in response to a valid claim. After the carrier issued a denial of an omitted medical condition claim for a "bilateral hip degenerative disc disease" condition, claimant requested a hearing, contending that the denial was premature and invalid because no such claim had been initiated. Although acknowledging that the denial was invalid (because it purported to deny an anatomical impossibility), the carrier opposed an attorney fee award, arguing that the attorney's efforts had not resulted in the acceptance of a condition.

Terms of "386(1)" for an attorney fee award encompass circumstances where a denial is eventually determined to be void.

The Board held that a carrier-paid attorney fee award was warranted. Citing ORS 656.386(1)(a), and (b), the Board stated that an attorney fee is awardable where a claimant finally prevails against a carrier's denied claim for compensation for which the carrier refuses to pay on the express ground that the claimed injury/condition is not compensable or otherwise does not give rise to an entitlement to compensation. Relying on *Cervantes v. Liberty Northwest Ins. Corp.*, 205 Or App 316, 323 (2006), the Board noted that the terms of the statute encompass circumstances where a denial is eventually determined to be void.

Turning to the case at hand, the Board acknowledged the carrier's assertion that its denial (although void) was narrowly tailored, did not purport to deny a current or previously accepted claim, and that claimant's counsel's efforts had not resulted in the acceptance of the denied condition. Notwithstanding the carrier's characterization of its denial, the Board found that the denial had purported to deny a degenerative hip condition. Moreover, the Board noted that the parties had interpreted the denial as disputing the compensability of claimant's hip arthritis (even though a left hip post-traumatic arthritis condition was found compensable).

Despite no outstanding claim and no immediate financial benefit when denial set aside, an attorney fee award under "386(1)" was justified.

Under such circumstances, the Board considered the carrier's denial to be confusing and appearing to deny an ultimately compensable condition. In any event, the Board reasoned that it was sufficient that the carrier's void denial purported to deny a claim for compensation. *See Cervantes*, 205 Or App at 323; *Robyn E. Stein*, 62 Van Natta 290, 294 (2010). Consequently, even if there was

no outstanding claim and claimant received no immediate financial benefit when the claim denial was set aside, the Board determined that an attorney fee award under ORS 656.386(1) was justified. *Stein*, 62 Van Natta at 297.

Combined Condition: Acceptance Permissible W/O Claim - "262(6)(b)(F)" - "Ceases" Denial - Change in Circumstances/ Condition - "*Brown*" Standard Met

Samuel D. Allen, 66 Van Natta 1589 (September 17, 2014). Analyzing ORS 656.262(6)(b)(F), and (c), the Board held that a carrier's acceptance of claimant's combined low back condition (following its initial acceptance of a lumbar strain) was procedurally valid and its subsequent combined condition denial was legally supportable because the record established that claimant's work injury had initially combined with his arthritis and the injury had ceased to be the major contributing cause of the combined condition. Following the carrier's acceptance of claimant's low back strain, it accepted a combined condition of the strain and L4-5 and L5-S1 spondylosis. When the carrier also denied the combined condition, claimant requested a hearing, contending that the combined condition acceptance was procedurally improper (because he had never initiated such a claim, there was no preexisting/combined condition, and that the carrier's denial was not supportable (because it had not established that claimant's otherwise compensable injury was not the major contributing cause of the combined condition).

The Board disagreed with claimant's contentions. Citing ORS 656.262(6)(b)(F), the Board stated that a carrier is authorized to modify its acceptance as medical or other information changes a previously issued acceptance notice. Relying on *Schleiss v. SAIF*, 354 Or 637, 652-53 (2013), and *Hopkins v. SAIF*, 349 Or 348, 364 (2010), the Board noted that, to determine a preexisting condition under ORS 656.005(24)(a)(A), the term "arthritis" means the "inflammation of one or more joints, due to infectious, metabolic, or constitutional causes, and resulting in breakdown" and that a carrier must adduce expert evidence that the claimant suffers from "inflammation of whatever joint or joints it contends are affected by the arthritic condition."

Even without the initiation of a "combined condition" claim, a carrier was statutorily authorized to accept such a condition.

Turning to the case at hand, the Board found that an examining physician's opinion supported the existence of a preexisting/combined condition; *i.e.*, the preexisting spondylosis was "arthritis" that involved inflammation of the L4-5 joint and was due to infectious, metabolic, or constitutional causes, and resulted in breakdown, degeneration or structural change. Consequently, the Board determined that, even in the absence of a claim initiated by claimant, the carrier's combined condition acceptance was procedurally permissible.

Addressing the "ceases" denial, the Board observed 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. *See* ORS 656.262(6)(c). Relying on *Wal-Mart Stores, Inc. v. Young*, 219 Or App 41 (2008), the Board noted that the carrier has the burden to show

a change in circumstances or a change in condition such that the "otherwise compensable injury" ceases to be the major contributing cause of the disability/treatment for the combined condition. Referring to *Brown v. SAIF*, 262 Or App 640, 651 (2014), the Board stated that the "otherwise compensable injury" means "the work injury resulting from the work accident that caused the disability or need for treatment."

Because physician had referred to "work exposure," "acute event," and "injury" (as well as "accepted strain") as ceasing to be the major cause of combined condition, Board held that physician's opinion met "Brown" requirements.

Applying those principles to the medical record, the Board was persuaded by an examining physician's opinion that claimant's work injury had ceased to be the major contributing cause of his need for treatment. In reaching this conclusion, the Board acknowledged that the physician had referred at times to the accepted "strain." Nonetheless, reasoning that the physician had also mentioned "work exposure," "acute event," and the "injury" as ceasing to be the major cause of the combined condition, the Board concluded that the physician's opinion satisfied the *Brown* requirements.

Medical Services: "245(1)(a)" - "Diagnostic" Injections - Performed Before "Effective Date" of Combined Condition Denial

Robert Salazar, 66 Van Natta 1533 (September 3, 2014). Applying ORS 656.245(1)(a), the Board held that claimant's diagnostic cervical spine injections were compensable because they were proposed for his accepted combined cervical condition before the effective date of the carrier's combined condition denial. Following claimant's compensable cervical and lumbar spine injury, the carrier accepted a cervical strain combined with preexisting degenerative disc disease. Eventually, the carrier issued a denial of the combined condition, asserting that the work injury had ceased to be the major contributing cause of the combined cervical condition. However, before the effective date of that denial, claimant's attending physician had recommended and performed diagnostic cervical spine injections for claimant's radicular complaints, which the physician attributed to the combined cervical condition. After the carrier's combined condition denial had been upheld by a litigation order, the carrier refused to pay for the diagnostic injections.

The Board held that the medical service claim was related to a compensable condition. Citing ORS 656.245(1)(a), the Board stated that, for every compensable injury, the carrier shall provide medical services for conditions caused in material part by the injury. The Board further noted that, pursuant to the statute, for combined conditions, the carrier shall provide medical services directed to medical conditions caused in major part by the injury. Finally, relying on *SAIF v. Carlos-Macias*, 262 Or App 629, 637 (2014), the Board observed that disputed medical services must be related to the work injury, rather than to an accepted condition.

Turning to the case at hand, the Board acknowledged that the carrier's combined condition denial (which had been upheld in a previous litigation) had asserted that claimant's work injury had ceased to be the major contributing cause of his combined cervical condition after a specified date. Nevertheless, the Board noted that claimant's attending physician had administered the

Because physician had administered cervical injection before effective date of combined condition denial and physician attributed complaints to that condition, Board held that carrier was responsible for diagnostic service.

Because physician related all of low back treatments (as of a certain date) to the work injury, Board found that carrier was responsible for disputed medical treatments until that date.

diagnostic cervical spine injections before the effective date of the combined condition denial. Moreover, the Board was persuaded by the attending physician's opinion that the injections were performed to address claimant's radicular complaints, which the physician attributed to his combined cervical condition. Under such circumstances, the Board concluded that the disputed diagnostic medical service was directed to a medical condition caused in major part by the work injury.

Finally, the Board further determined that claimant's disputed diagnostic low back injections were related to his work injury. Reasoning that the previous litigation had not involved claimant's lumbar spine conditions, the Board disagreed with the carrier's argument that the prior litigation order resolved the current medical service dispute. Noting that claimant's attending physician had attributed all of claimant's low back treatment (as of a certain date) to his work injury, the Board concluded that the disputed medical services (which were performed that specific date) were materially related to claimant's work injury. *See* ORS 656.245(1)(a); *Mize v. Comcast Corp.-AT&T Broadband*, 208 Or App 563, 569-70 (2006).

Scope of Acceptance: Carrier's "Acceptance/ Denial" Constituted "Acceptance" - Lack of "Statutory Requirements" Not Determinative

William W. Hoffnagle, 66 Van Natta 1471 (August 26, 2014).

Applying ORS 656.262(6)(a), the Board held that a carrier's denial of claimant's new/omitted medical condition claim for several low back conditions was impermissible as a "back-up" denial because the carrier had previously accepted those conditions when in issuing a denial of his "new injury" claim stated that his "current condition/lower back injury" was related to his previously accepted work injury and that "all benefits would be paid on your prior claim." Following claimant's slip and fall while performing his work activities, the carrier accepted a left hip strain. Some three months later, while again working, he experienced lower back pain and sought further treatment, resulting in diagnoses of L4-5 and L5-S1 protruding discs, radiculopathy, and low back muscle pain. Thereafter, the carrier issued a letter, explaining that claimant's "current condition" appeared to be related to his prior accepted injury and that "all benefits would be paid on your prior claim." The carrier's letter further stated that it was denying claimant's new injury and included a "notice of hearing" appeal rights paragraph. Several months later, claimant initiated a new/omitted medical condition claim for the aforementioned low back conditions. When the carrier denied that claim, claimant requested a hearing, contending that, because the carrier had previously accepted the claimed low back conditions, its denial constituted an impermissible "back-up" denial.

The Board agreed with claimant's contention. Citing ORS 656.262(6)(a), the Board stated that once a claim is accepted, the carrier shall not revoke its acceptance, except for fraud, misrepresentation, or other illegal activity or in certain circumstances involving later obtained evidence. Relying on *Stockdale v. SAIF*, 192 Or App 289 (2004), the Board noted that a single

document may function as both an acceptance and a denial. The Board also referred to *Columbia Forest Products v. Woolner*, 177 Or App 639, 643 (2001), for the proposition that the scope of an acceptance is a question of fact.

Because the carrier's letter represented that "all benefits would be paid" on prior claim, Board found that letter constituted an acceptance.

Turning to the case at hand, the Board observed that the carrier's letter stated that it had denied claimant's "new injury" on the basis that his "current condition" was related to his prior accepted work injury. The Board further noted that the carrier had expressly represented that "all benefits would be paid on [claimant's] prior claim." Under such circumstances, the Board determined that the carrier's previous letter constituted an acceptance of claimant's then-current low back condition.

An acceptance of a claimed condition is not dependent on the inclusion of statutory "acceptance" information.

In reaching its conclusion, the Board disagreed with the carrier's assertion that because its prior letter lacked the "acceptance" information prescribed by ORS 656.262(6)(b)(B)-(E) it could not constitute an acceptance. In doing so, the Board distinguished *Tri-Met v. Wilkerson*, 257 Or App 80 (2013), where the court had held that there was substantial evidence to support a finding that a carrier's denial of a combined condition did not also simultaneously include an acceptance of the combined condition. Reasoning that the *Wilkerson* court had not held that a Notice of Acceptance cannot accept a claim if it fails to include all statutorily required "acceptance" information, the Board interpreted the court's holding to be that a combined condition had not been accepted by a document that lacked "any language" indicating acceptance. In contrast to *Wilkerson*, the Board reasoned that the carrier's letter in the present case had included its express representation that claimant's then current condition (a lower back injury) was attributable to his previously accepted work injury and that all benefits would be paid based on that prior claim.

Finally, the Board determined that, when the carrier had accepted claimant's "lower back injury" and "current condition," he had filed a lower back strain and the medical record identified L4-5 and L5-S1 disc conditions with radiating left leg symptoms. Based on its review of the contemporaneous record, the Board concluded that the carrier's acceptance had encompassed claimant's presently claimed low back conditions. *See Gilbert v. Cavenham Forest Industrial Division*, 179 Or App 341, 344 (2002) (if an acceptance is ambiguous or vague, the contemporaneous medical evidence was examined to determine what was accepted).

APPELLATE DECISIONS UPDATE

Claim Processing: "262(15)" - "Noncooperation" Denial - Failure to Cooperate in Investigation for Reasons Not Beyond Claimant's Control

Hopper v. SAIF, ___ Or App ___ (September 10, 2014). Applying ORS 656.262(15), the court affirmed the Board's order in *Naomi R. Hopper*, 64 Van Natta 1899 (2012), previously noted 31 NCN 10, that had upheld a carrier's "noncooperation" denial based on its finding that claimant had not

established that her failure to cooperate in the carrier's investigation was "for reasons beyond [her] control. In reaching its conclusion, the Board was not persuaded that claimant's failure to respond to the carrier's investigator's attempts to contact her was for reasons beyond her control; *i.e.*, her brother's death and an off-work motor vehicle accident. On appeal, claimant contended that: (1) she had fully and completely cooperated with the carrier's investigation; (2) the carrier's investigative demands were unreasonable; and (3) any failure to cooperate was due to reasons beyond her control.

The court disagreed with claimant's contentions. Citing ORS 656.262(15), the court stated that, to prevail over the carrier's "noncooperation" denial, claimant must prove one of three things: (1) she, in fact, "fully and completely cooperated with the investigation"; (2) she "failed to cooperate for reasons beyond [her] control"; or (3) the carrier's "investigative demands were unreasonable."

Because claimant had not previously contended that carrier's investigative demands were unreasonable, court declined to consider such contentions.

Turning to the case at hand, the court noted that claimant had not challenged on Board review the ALJ's finding that she had failed to cooperate with the carrier's investigative demands and that she had not previously contended that the carrier's demands had been unreasonable. Reasoning that claimant had not exhausted her administrative remedies before seeking further review of those issues, the court declined to consider them.

"262(15)" requires a worker to prove that any failure to cooperate was causally connected to reasons beyond the worker's control.

Addressing the issue of whether the Board had erred in determining that claimant had not proven that her failure to cooperate was "for reasons beyond [her] control," the court disagreed with claimant's argument that the Board had misinterpreted the statute. Reasoning that the ordinary dictionary meaning of "for" means "because of" or "on account of," (***Webster's Third New Int'l Dictionary*** 886 (unabridged ed 2002)), the court concluded that the statute requires a worker to prove that any failure to cooperate was *because of* (*i.e.*, causally connected to) reasons beyond the worker's control.

As evidenced by the Board's factual inquiry into whether claimant's failure to cooperate in the carrier's investigation was due to either her brother's death and her motor vehicle accident or her lack of diligence, the court determined that the Board had properly interpreted the statutory provision. Furthermore, after reviewing the record in light of the Board's factual finding that claimant's failure to cooperate was because of her lack of diligence, the court concluded that a reasonable fact finder could make such an inference and, as such, the Board's finding was supported by substantial evidence. *See* 183.482(7).

Course & Scope: "Home Health Care Worker" - "039(5)"

SAIF v. Tono, ___ Or App ___ (September 17, 2014). Analyzing ORS 656.039(5), the court affirmed the Board's order in *Alicia G. Tono*, 64 Van Natta 2424 (2012), previously noted 31 NCN 12, that had held that a home health care worker's injury, which occurred when she was involved in a motor vehicle accident while she was driving her client to breakfast at her client's request, arose out of and in the course of her employment even though the

specific task she was performing at the time of her injury was not expressly included on her "Task List" with the State of Oregon Department of Human Services (DHS) (the program administrator for the program that paid for the worker's services provided to the client). In reaching its conclusion, the Board had reasoned that the worker's injury was compensable because it occurred during her employment hours, while she was performing a service for her employer and at the employer's direction. On appeal, the carrier argued that the Board had misinterpreted ORS 656.039(5), asserting that the worker was not entitled to compensation because her injury had been incurred in an employer-directed activity that was not funded by the state; *i.e.*, an activity not listed on the worker's "Task List" with DHS.

The court disagreed with the carrier's assertion. Citing ORS 656.039(5), the court stated that the statute authorizes the state's Home Care Commission to elect coverage on behalf of clients of DHS who employ home care workers to make such workers "subject workers if the home care worker is funded by the state on behalf of the client."

When interpreted in context, "039(5)" provides that home care workers who receive state funding are "subject workers."

After considering the text and context of the statute, the court found nothing in the plain terms of the statute that imposed any limitation on the scope of workers' compensation coverage available to state-funded home care workers. In particular, the court noted that the statute did not state that coverage was limited to injuries incurred by the home care workers during state-funded *activities*. Rather, the court concluded that, when read in conjunction with the definition of "home care worker" in ORS 410.600(8), the statute made clear that home care workers who receive state funding are "subject workers" for purposes of the workers' compensation law.

In addition, the court reasoned that to read ORS 656.039(5) to provide for coverage for home care workers only for state-funded *activities* would require it to insert terms into the statute that the legislature did not include. Relying on ORS 174.010, the court noted that it was not authorized to rewrite the statute.

If legislature had intended to limit coverage for home care workers to particular activities, it would have expressly said so.

Finally, the court observed that other provisions of ORS Chapter 656 provided for workers' compensation coverage for certain unique categories of workers, but all also explicitly limited coverage to specific activities by these workers; *e.g.* ORS 656.031 (municipal volunteers); ORS 656.033 (worker experience trainees); and ORS 656.041 (city and county inmate workers). Thus, based on the contextual context of ORS 656.039(5), the court reasoned that, if the legislature had intended to limit coverage for home care workers to particular activities, it would have expressly said so.

In reaching its conclusion, the court emphasized that it was possible that there was some other limitation on the scope of workers' compensation coverage for home care workers, but the carrier had not identified one. For that reason, the court expressed no opinion on whether other limitations restrict workers' compensation coverage for home care workers to state-funded activities.

Firefighter's Presumption: "802(4)" - "Cardiovascular-Renal Disease" - Neurological Condition Causing Reduced Heart Rate - "Presumption" Not Applicable

McCann v. City of Eugene, (September 10, 2014). The court affirmed without opinion the Board's order in *Carolyn McCann*, 64 Van Natta 1759 (2012), previously noted 31 NCN 9, that held that claimant's occupational disease claim for an abnormal heart rate/autonomic dysfunction was not subject to the "firefighter's presumption" under ORS 656.802(4) because her abnormal heart rate was attributable to impairment of her nervous system that modified the functioning of her heart/vascular system, but did not impair the "normal state of the heart and blood vessels."

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