Workers' Compensation Board

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News & Case Notes

BOARD NEWS

Departing Board Members - Greig Lowell and Vera Langer

After completing their third consecutive terms of office, Greig Lowell and Vera Langer are departing as Board Members. WCB invites you to join us for a gathering to celebrate their service to the Board on Thursday, May 22, 2014, from 2 p.m. to 4 p.m. in the reception area of the Salem Hearings Division (2601 25th St. SE, Suite 150, Salem OR 97302-1280).

ALJ Anonymous Survey

Watch for your invitation to participate in WCB's 2013 ALJ Anonymous Survey. The survey is sent to OSB Workers' Compensation Section members via email for those members who have an email address, and by USPS mail for those members who do not have an email address. Responses will be accepted until May 28, 2014, and results will be posted to WCB's website by June 13, 2014.

Public Board Meeting Dates

At its March 20 meeting, the Members again discussed establishing a general pre-arranged schedule for public meetings. In doing so, they considered the responses that had been received concerning the questions it had posed in the October 2013 edition of the News & Case Notes regarding this subject.

The Members agreed that it was a worthwhile objective to identify particular days as potential "Board meeting" days, which could enable more interested parties and practitioners an opportunity to attend these meetings. At the same time, the Members recognized that they must retain the flexibility of scheduling meetings whenever necessary to address important issues that require their prompt attention.

To achieve both of these goals, the Members have decided to designate the following days in the coming calendar as potential "quarterly" Board meeting days (at 1:30 p.m. at the Board's Salem office): June 5, 2014, September 4, 2014, December 4, 2014. As the dates for these potential meetings approach, the Members plan to distribute notice to interested parties concerning whether the meeting will or will not be held. It is the Members' intention to distribute this notice at least two weeks before the potential meeting date.

Whenever it is necessary to convene a meeting that does not coincide with these potential "quarterly" meeting dates, notice of that meeting will be distributed as soon as practicable after the date is identified. Preferably, distribution of that notice will occur at least two weeks before the scheduled meeting date.

Parties/practitioners who wish to receive notice of Board meetings may register as an "interested party" on WCB's website. Questions may be directed to Karen Burton, WCB's Executive Secretary at: karen.burton@state.or.us.

Important Information in Scheduling a Mediation

When scheduling mediations, practitioners are asked to indicate the number of all necessary parties in attendance. Such information is essential to ensure that adequate space is available to accommodate the participants (and their respective representatives) at the mediation site. Absent this advance notice, the mediation may need to be canceled or rescheduled due to insufficient space.

In addition, should the number of participants in an already-scheduled mediation change (reduced or increased), practitioners are reminded to contact the ALJ-Mediator's judicial assistant. In this way, WCB will have as much time as possible to make the necessary arrangements to accommodate the change.

If practitioners have any questions regarding the mediation process, they may call Kerry Garrett at 503-934-0104 or access the "Mediation" page on WCB's website.

CASE NOTES

CDA: "236(1)" - "Lump Sum" Payment Provision for Prior PPD Award - Board Not Authorized to Approve "Request" - But, "Lump Sum" Payment May Be Included in CDA - "060-0060(6)"

Richard Duckett, 66 Van Natta 676 (April 17, 2014). Applying ORS 656.236(1), and OAR 436-060-0060(6), the Board approved a Claim Disposition Agreement (CDA), which included a provision stating that, in addition to the proceeds of the CDA, the carrier would pay a previously granted permanent disability award in a lump sum. Citing *Salvador Preciado*, 48 Van Natta 1559 (1996) and *Debbie K. Ziebert*, 44 Van Natta 51 (1992), the Board reiterated that the function of a CDA is not to accomplish claim processing functions.

Based on the aforementioned case precedent, the Board reiterated that it was not authorized to "approve" a lump sum payment request. Nevertheless, referring to OAR 436-060-0060(6), the Board noted that a lump sum payment which is part of a CDA does not require carrier approval.

Pursuant to OAR 436-060-0060(6), the carrier may agree in a CDA to the payment of a previously granted PPD award in a "lump sum" and, therefore, Board approval of such a "request" is not necessary.

Turning to the proposed CDA, the Board determined that the carrier was agreeing to pay claimant's permanent disability award in a lump sum, in addition to the proceeds from the CDA. Reasoning that the parties had agreed to such an arrangement, the Board concluded that its "approval" of the "lump sum payment" request was unnecessary. *See* OAR 436-060-0060(6). Based on such an interpretation of the parties' intentions, the Board concluded that the CDA was in accordance with all prescribed terms and conditions and, as such, approved the disposition.

Claim Processing: "Attending Physician" - "005(12)(b)(B)" - "60-Day" Period for "Chiropractor" - Runs From "First Visit"

Kenia M. Sandoval, 66 Van Natta 720 (April 29, 2014). In affirming an Order on Reconsideration that determined that a claim was properly closed, the Board found that a chiropractor was not claimant's "attending physician" at claim closure because the 60-day period pursuant to ORS 656.005(12)(b)(B) had expired before the claim was closed. Although acknowledging that claimant's first treatment with her chiropractor had occurred more than 60 days before the Notice of Closure (NOC), she noted that she had not formally designated the chiropractor as her "attending physician" until a later date, which was within 60 days of the NOC. Consequently, claimant contended that her chiropractor could be considered her "attending physician" at claim closure and, as such, her claim was improperly closed.

The Board disagreed with claimant's contention. Citing ORS 656.005(12)(b)(B), the Board stated that a chiropractor may treat a claimant for 60 days "from the *first visit on the initial claim* * * *." Furthermore, relying on *Brian A. Bundy*, 65 Van Natta 2479, 2482 (2013), the Board noted that it had previously held that a chiropractor's filing of an aggravation claim was invalid because the 60-day statutory "attending physician" period from the claimant's first visit with the chiropractor had expired before the aggravation claim was filed.

Because claimant first sought treatment with a chiropractor more than 60 days before the issuance of a Notice of Closure, the chiropractor was not the "attending physician" at claim closure.

Turning to the case at hand, the Board found that it was uncontested that claimant had first sought treatment with the chiropractor more than 60 days from the issuance of the NOC. Under such circumstances, the Board concluded that the chiropractor was not statutorily recognized as claimant's attending physician at claim closure and, as such, the NOC was not improperly issued.

Consequential Condition: "005(7)(a)(A)" - Conservative Medical Treatment For Accepted Low Back Condition - Major Cause of Claimed Myofascial Pain Syndrome

Juan A. Arenas-Raya, 66 Van Natta 590 (April 2, 2014). Applying ORS 656.005(7)(a)(A), the Board held that claimant's new/omitted medical condition claim for myofascial pain syndrome was compensable because conservative

treatment for his accepted lumbar strain and combined L5-S1 spondylosis was the major contributing cause of the claimed condition. After the carrier's initial acceptance of a lumbar strain (including a combined L5-S1 spondylosis condition), claimant's attending physician diagnosed myofascial pain syndrome, attributing the major contributing cause of the condition to his conservative treatment for his accepted conditions. The carrier denied claimant's new/omitted medical condition claim, contending that the condition did not exist and that the accepted conditions were not the major contributing cause of the claimed condition.

The Board disagreed with the carrier's contention. Citing *Maureen Y. Graves*, 57 Van Natta 2380, 2381 (2005), the Board stated that to prove a new/omitted medical condition, claimant must establish the existence of his claimed myofascial pain syndrome. Furthermore, to prove a compensable consequential condition under ORS 656.005(7)(a)(A), the Board noted that he must establish that an accepted condition (or treatment for such a condition) was the major contributing cause of the claimed condition. *See Barrett Business Services v. Hames*, 130 Or App 190, *rev den*, 320 Or 492 (1994).

Turning to the case at hand, the Board acknowledged that claimant's attending physician had initially reported that claimant's exam was "reminiscent" of some myofascial pain. The Board further recognized that the attending physician had occasionally remarked that claimant's "work injury" was the major contributing cause of his myofascial pain syndrome.

Nevertheless, the Board did not consider the attending physician's use of the term "reminiscent" to necessarily be inconsistent with the physician's later opinion diagnosing myofascial pain syndrome. Citing *Stephen E. Roseland*, 57 Van Natta 85, 87, n 1 (2005), the Board interpreted claimant's physician's ultimate opinion as an evolution of the physician's initial "reminiscent" diagnostic impressions (which had been contained in a chart note), rather than a change of the physician's opinion.

Reasoning that the physician's reference to "work injury," when viewed in context, encompassed nonsurgical conservative treatment for claimant's accepted conditions, the Board concluded that the physician's opinion was sufficient to establish that treatment for an accepted condition was the major contributing cause of the claimed consequential myofascial pain syndrome.

Furthermore, although the physician had occasionally stated that the "work injury" was the major contributing cause of claimant's myofascial pain syndrome, the Board reasoned that, when reviewed in context, the attending physician's reference to "work injury" encompassed treatment for the accepted conditions and, more particularly, the nonsurgical conservative treatment for those conditions. Based on such reasoning, the Board concluded that claimant's attending physician's opinion was sufficient to establish the compensability of the claimed consequential myofascial pain syndrome.

Member Langer dissented. Reasoning that claimant's attending physician's opinion was ambiguous and inadequately explained (using terms such as "possible," "might," and "suspected"), Langer did not consider the opinion sufficiently persuasive to establish that an accepted condition was the major contributing cause of the claimed myofascial pain syndrome. Accordingly, Member Langer disagreed with the majority's finding that the disputed consequential condition was compensable.

Course & Scope: Fall Not "Unexplained" - Personal, Not-Employment-Related, Reasons - "Mixed Risk" Doctrine Not Applicable

Rachel A. Romero, 66 Van Natta 636 (April 4, 2014). The Board held that claimant's injury, which occurred when she fell outside of the entrance to her employer's facility while coming to work, did not arise out of her employment because her fall was solely attributable to personal reasons and, as such, there was no "employment-related" contribution for her fall such that her injury would come within the "mixed risk" doctrine. For several months before the fall in question, claimant had previously fallen due to weakness in her extremities from her myopathy and medication. Although she indicated on her accident report that the reason for her fall was unknown, she also raised the possibility of possible breaks in the sidewalk, which caused her to stub her foot. After the carrier denied the claim, claimant requested a hearing, contending that her claim was compensable under the "mixed risk" doctrine.

The Board disagreed with claimant's contention. Citing *Theresa A. Graham*, 63 Van Natta 740, 744, *recons*, 63 Van Natta 970 (2011), the Board stated that, under the "mixed risk" doctrine, where both personal and employment factors are found to contribute to an injury, the concurrent contribution from a personal risk will not defeat the compensability of a claim. Nonetheless, relying on *Pamela M. Hamilton*, 63 Van Natta 736, 737 (2011), *aff'd Hamilton v. SAIF*, 256 Or App 256 (2013), the Board noted that the "mixed risk" doctrine does not apply where the sole cause of a fall or workplace event is a personal risk.

Because the medical record established that claimant's myopathy caused her difficulty lifting her foot and was the sole cause of her trip/fall, the Board concluded that there was no "employment-related" reason for her fall.

Turning to the case at hand, the Board acknowledged claimant's assertion that her fall was due to tripping on unevenness or irregularity in the employer's sidewalk. Nevertheless, noting that the medical record was replete with assessments that claimant's myopathy put her at risks for falls, the Board was persuaded that her myopathy caused her difficulty lifting her foot and was the sole cause of her tripping and falling.

Under such circumstances, the Board concluded that there was no "employment-related" reason for her fall. Consequently, the Board determined that claimant's injury from the fall did not arise out of her employment.

In reaching its conclusion, the Board acknowledged that, in *Cavalliere*, it had alternatively reasoned that, even if it had found that the claimant's fall from her employer-required shoe "gripping" on the floor was also partially caused by her idiopathic factors (*e.g.*, shuffling gait, history of stumbling and falling), the claimant's injury would have arisen out of her employment under the "mixed risk" doctrine because her fall was due to both personal and employment reasons. However, in contrast to *Cavalliere*, the Board emphasized that the record did not persuasively establish that an "employment risk" had contributed to claimant's fall and, as such, the "mixed risk" doctrine did not apply to the present case.

Own Motion: PPD - Impairment Findings - Accepted Foot/Ankle "Ankylosis" Condition - Retained "ROM" Findings - No "Ankylosis" Impairment Rating

Fred C. Parish, 66 Van Natta 606 (April 3, 2014). In an Own Motion Order regarding a Notice of Closure, the Board held that claimant was not entitled to an "ankylosis" permanent impairment value for his left foot/ankle condition because, although his accepted new/omitted medical condition was left ankle and foot ankylosis, the medical arbiter's findings had measured retained foot/ankle range of motion (ROM) findings. After reopening claimant's Own Motion claim for his accepted new/omitted medical conditions (left ankle and foot ankylosis), the carrier issued a Notice of Closure that did not include a permanent disability award for "ankylosis" impairment in his foot/ankle. Claimant requested Board review and a medical arbiter examination. The arbiter subsequently reported that claimant had a loss of motion in his left foot/ankle, but measured retained ROM findings in all planes of motion. Noting that the carrier had accepted "ankylosis" in his left foot/ankle, claimant contended that he was entitled to an ankylosis (fused) impairment value. *See* OAR 436-035-0190.

The Board disagreed with claimant's contention. Citing OAR 436-035-0005(2), the Board stated that "ankylosis" means a bony fusion, fibrous union, or arthrodesis of a joint. Relying on OAR 436-035-0190, the Board noted that sections (2), (4), (6), and (8) prescribe the rating of subtalar and ankle joint ROM impairment in all planes expressed in retained degrees of motion whereas sections (1), (3), (5), (7), and (9) prescribe those joints' impairment for "ankylosis" for each of these directions of movement. Finally, referring to *Stanley M. Shaw*, 50 Van Natta 1056, 1058-59 (1998), the Board observed that when the claimant's impairment findings support lost and retained ROM, an impairment value for "ankylosis" was not appropriate.

Turning to the case at hand, the Board acknowledged that the carrier had accepted a left ankle/foot ankylosis condition. Nonetheless, the Board reasoned that, in rating permanent impairment for claimant's foot/ankle, it must determine the "ROM" in that body part, which necessarily includes an evaluation as to whether there had been "ankylosis" in the foot/ankle.

Because impairment findings reported retained "ROM" findings for claimant's foot/ankle, she was not entitled to an "ankylosis" (fused joint) impairment value, even though the accepted condition was foot/ankle ankylosis.

Based on the arbiter's impairment findings, the Board concluded that claimant's foot/ankle had not been ankylosed (fused). Rather, noting that the arbiter had measured retained "ROM" findings in all planes of motion in the left foot/ankle, the Board determined that claimant had "loss of motion." Under such circumstances, the Board held that claimant was not entitled to an "ankylosis" impairment value. *See Robert K. Warren*, 47 Van Natta 1471, 1473 (1995).

Own Motion: Reconsideration - Additional "PTD-Related" Evidence Not Considered - Generated After Board's Initial Order

Richard L. Elsea, 66 Van Natta 727 (April 30, 2014). On reconsideration of its initial Own Motion (which had found that claimant was not entitled to grant permanent total disability (PTD) benefits for a "post-aggravation rights" new/omitted medical right knee condition), the Board declined to consider additional evidence concerning his "work search" efforts and vocational/medical evidence regarding his employment/physical limitations because that evidence had been generated after the Board's initial order and claimant had not previously challenged the sufficiency of the record before its earlier decision. In its initial order, the Board had held that claimant was not entitled to PTD benefits, finding that he had withdrawn from the work force and that the record (including his affidavit) did not persuasively establish that he had subsequently reentered the work force or was otherwise willing to work. The Board had further noted that a vocational expert's opinion had not focused his opinion regarding claimant's employability solely on his right knee condition. Following the Board's initial decision, claimant requested reconsideration, submitting his "supplemental" affidavit, letters from his last employer and a union representative, and additional reports from the vocational specialist and his attending physician, all of which addressed the findings reached in the Board's previous order.

The Board declined to consider the submitted additional evidence. Citing *Daren L. Johnson*, 65 Van Natta 2298 (2014), and *Rex A. Olson*, 55 Van Natta 3379 (2003), the Board noted that it had previously declined to consider "post-order" evidence from a represented party when the party had not earlier contended that the record was insufficiently developed. Relying on *Bobbie J. Blakely*, 51 Van Natta 1762 (1999), and *Donald P. Bond*, 40 Van Natta 361, *recons*, 40 Van Natta 480 (1988), the Board stated that to hold otherwise would potentially expose it to an endless string of reconsideration requests and submissions of additional evidence, all designed to "cure" a previously developed record and respond to conclusions reached by a previous order.

Because the represented claimant had presented multiple submissions of evidence in support of her PTD claim and had not indicated that the record was insufficiently developed before the initial Board determination that she was not entitled to PTD benefits, the Board declined to consider her submission of "post-order generated" PTD evidence.

Turning to the present case, the Board found that claimant (who was represented by legal counsel) had presented multiple submissions of additional evidence before its initial decision. The Board further noted that, before its prior order, claimant had not challenged the sufficiency of the record as developed and had relied on that record in support of his contention that he was entitled to a PTD award. Under such circumstances, the Board declined to consider the submission of the "post-order" evidence.

Finally, after further considering the previously developed record, the Board continued to find that he had withdrawn from the work force over three years before the Notice of Closure (when he retired) and, by the time of claim closure, and had not reentered the work force following his retirement. Consequently, the Board adhered to its earlier conclusion that claimant was not entitled to PTD benefits.

Preexisting Condition: "005(24)(c)" - Prior Disc Herniations/Surgery - More Than "Mere Susceptibility"

Shelby J. Vantassel, 66 Van Natta 599 (April 2 2014). Applying ORS 656.005(24)(c), the Board held that, because claimant's "pre-injury" L5-S1 disc herniations and surgery did not merely render him more susceptible to injury, but rather contributed to his disability or need for treatment for his claimed L5-S1 disc condition, his injury claim was not compensable. After exiting his truck at work, claimant experienced low back and radiating pain. Subsequent testing confirmed a recurrent L5-S1 disc herniation. (He had previously undergone two surgeries for a L5-S1 disc herniation and recurrent herniation.) The carrier denied claimant's injury claim, contending that his preexisting conditions were the major contributing cause of his disability/need for treatment for a combined L5-S1 disc condition. Claimant requested a hearing, asserting that his prior back conditions merely made him susceptible to another disc herniation and, as such, did not constitute "preexisting conditions" under ORS 656.005(24)(c).

The Board disagreed with claimant's contention. Citing ORS 656.005(24)(a), the Board stated that a "preexisting condition" is any injury, disease, congenital abnormality, personality disorder, or similar condition that contributes to disability or need for treatment. The Board also referred to ORS 656.005(24)(c), which provides that, for purposes of industrial injury claims, a condition does not contribute to disability or need for treatment if the condition merely renders a worker more susceptible to the injury.

Board was persuaded by medical opinion that "pre-injury" disc herniations/ surgeries weakened L5-S1 disc and were the major causes *of claimant's disability/need for treatment and, as such, did not render him merely more susceptible to injury.*

Turning to the case at hand, the Board acknowledged that two physicians (including his attending physician) opined that claimant's "pre-injury" disc herniations only made him "susceptible" to another disc herniation. Nevertheless, the Board was more persuaded by the opinion of another examining physician, who explained that the "pre-injury" disc herniations/ surgeries, by weakening the L5-S1 disc, were the major *causes* of his disability/need for treatment. Consequently, the Board determined that the carrier had persuasively established that claimant's work injury was not the major contributing cause of his need for treatment/disability for his combined L5-S1 disc condition.

In reaching its conclusion, the Board distinguished *Murdoch v. SAIF*, 223 Or App 144 (2008), *rev den*, 346 Or 361 (2009), where the court had reasoned that the record supported a conclusion that a claimant's diabetic condition merely rendered him more susceptible to his claimed foot infection and, as such, could not be considered a "cause" for purposes of determining the compensability of his claim for his foot infection and resulting toe amputation. In contrast to *Murdoch* (where the medical record established that the claimant's diabetes either masked the effects of a lesion on his foot or decreased his ability to mount a response to his infection), the Board determined that the medical record in the present case did not persuasively establish that his "pre-injury" disc herniation/surgeries either produced a masking effect or impaired his ability to respond to his disc herniation. Rather, based on the examining physician's

persuasive opinion, the Board concluded that claimant's "pre-injury" disc herniations/surgeries constituted contributing causes (instead of susceptibilities) for his disability/need for treatment for his current disc condition.

Settlement: Challenge to Approved "DCS/CDA" - Claimant Entitled to a Hearing (Unless Waived)

Karen D. Lester, 66 Van Natta 585 (April 2, 2014). Applying ORS 656.283(1), the Board held that claimant was entitled to hearing to develop the record regarding her objections to a previously approved Disputed Claim Settlement (DCS) and Claim Disposition Agreement (CDA), even though those agreements had been approved by final orders. More than 30 days after an ALJ's order approving a DCS and the Board's approval of a CDA, claimant requested a hearing, seeking to have the agreements overturned. Thereafter, the carrier moved to dismiss the hearing request, asserting that the Hearings Division lacked jurisdiction over the matter because both agreements were final. After an ALJ granted the motion, claimant appealed, contending that she was entitled to present evidence at a hearing in support of her request to have the agreements rescinded.

The Board agreed with claimant's contention. Citing ORS 656.283(1) and *Kevin A. Stanfield*, 60 Van Natta 3133 (2008), the Board stated that a party is entitled to request a hearing on any matter concerning a claim, which shall be conducted unless the hearing is waived. Furthermore, relying on *Mary Lou Claypool*, 34 Van Natta 943, 946 (1982), the Board noted that the proper remedy for a party seeking to have a DCS set aside is to request a hearing pursuant to ORS 656.283. Finally, the Board referred to *Larry DeWeese*, 60 Van Natta 3128, 3132 n 6, *recons*, 60 Van Natta 3325, *recons*, 60 Van Natta 3521 (2008), for the proposition that the passage of 30 days from the approval an agreement does not divest a claimant of the right to a hearing on the validity of such agreement.

Because claimant had requested a hearing seeking to rescind a DCS and CDA, and because she had not waived her right to a hearing to develop the record in support of her attempt, she was entitled to a hearing (regardless of the formidable procedural and substantive challenges in challenging such agreements).

Turning to the case at hand, the Board found no indication that claimant had waived her right to a hearing, but rather stressed that she had expressly requested an opportunity to present evidence seeking rescission of the DCS and CDA. Moreover, although 30 days had expired since the ALJ's order approving the DCS, the Board reasoned that, in accordance with *Claypool* and its progeny, claimant could attempt to have the DCS overturned. Finally, relying on *Dorothy J. Carnes*, 57 Van Natta 2003 (2005), the Board observed that claimant was also entitled to develop a record at hearing in support of her attempt to have approval of the CDA rescinded.

In reaching its conclusion, the Board acknowledged the formidable procedural and substantive burden that claimant faced in seeking the rescission of the DCS and CDA. In doing so, the Board cited *Carnes* for the proposition that to secure the rescission of a DCS, a claimant must establish extraordinary circumstances justifying the action, which is to be granted only in the most extreme situations. Similarly, the Board noted that a CDA is final and not subject to review once approved and the 10-day "motion for reconsideration" period

has expired. *See* ORS 656.236(2); OAR 438-009-0035; *Carnes*. Nonetheless, regardless of such obstacles, the Board determined that claimant was entitled to develop a record at hearing in support of her request for relief.

Finally, the Board recognized that, when a claimant had timely appealed an ALJ's order approving a DCS, it had remanded for a hearing. *See e.g.*, *Kimberly Coven*, 66 Van Natta 171 (2014). However, the Board explained that such case holdings did not overrule the *Claypool* rationale that a claimant could seek rescission of an approved DCS at any time. Instead, the Board reasoned that the *Coven* holding simply expedited the process for ALJ consideration of the DCS approval or the claimant's attempt to overturn that approval.

Member Langer concurred. Because the CDA was a final order and could not be set aside, Langer reasoned that claimant's attempt to challenge that agreement was futile. Nonetheless, because claimant's challenge to the CDA was intertwined with her objection to the DCS (from which she was entitled to a hearing to dispute its validity), Member Langer agreed that she could present her objections to both agreements at the hearing.

APPELLATE DECISIONS

There were no "written opinions" addressing Board decisions published this month.

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