



# MEMORANDUM

September 8, 2014

**To:** Duke Shepard, Governor's Office  
MLAC

**From:** Holly Somers, Workers' Compensation Board Chair

**Subject:** WCB Update

## **SIGNIFICANT/NOTEWORTHY CASES (JUNE 2014 – AUGUST 2014)**

### Court of Appeals

*Camacho v. SAIF*, (June 18, 2014). Applying ORS 656.310(2), the court held that a worker's statements in medical reports that were "reasonably pertinent" to a physician's ability to diagnose and treat his injury constituted *prima facie* evidence under the statute and, as such, could be considered as substantive evidence in support of his injury claim, even though he did not appear as a witness at the hearing concerning the carrier's claim denial. Noting that ORS 656.310(2) provides that "[t]he contents of medical, surgical and hospital reports presented by claimants for compensation shall constitute *prima facie* evidence as to the matter contained therein," the court concluded that the worker's statements in the medical reports (such as that he felt a "pop" in his back and immediate lower back and thigh pain while moving pallets with a jack) were "reasonably pertinent" to his physician's ability to diagnose and treat his injury and, therefore, were entitled to *prima facie* weight, at least to the extent that such statements were not contradictory. Finally, because some of the worker's written statements on a claim form were in Spanish and had been admitted (without objection) but not translated, the court determined that the Board was not authorized to disregard such evidence.

*SAIF v. Camarena*, (July 23, 2014). Applying ORS 656.278(1)(b), the court held that a worker was entitled to temporary total disability (TTD) benefits based on a reopened Own Motion claim for a new/omitted medical condition because the record supported a conclusion that his attending physician had authorized such benefits for "curative treatment." Noting that the attending physician had opined that the worker's condition was not medically stationary, had prescribed pain medication, ice, and heat, directed him to continue to seek treatment, and had not made a "palliative care plan,"

the court concluded that the record supported an inference that the purpose of the physician's treatment was to heal the worker, and, as such, was curative treatment, rather than palliative or diagnostic care.

Furthermore, rejecting the carrier's assertion that the record in every particular case must contain a physician's explicit opinion that a course of treatment was curative and that the treatment was for the claimed condition, the court concluded that specific medical testimony that the prescribed treatment was designed to heal the worker's condition was not required to reach a finding that the treatment was curative in nature and for the claimed condition. Although envisioning instances when the record could not support a determination that a particular course of treatment was curative without specific medical evidence on that point, the court did not consider the present record (which concerned a back strain that was not medically stationary, treatment familiar to ordinary people which would significantly interfere with a person's ability to work, and no contrary evidence that the physician's TTD authorization was for a purpose other than the worker's claimed condition) to be such a case.

Finally, the court held that the worker's counsel was entitled to a carrier-paid attorney fee for services rendered before the Board in responding to the carrier's motion for reconsideration of the Board's initial order that had awarded TTD benefits. Relying on a Supreme Court decision interpreting ORS 656.382(2), the court determined that, as a result of its affirmance of the Board's TTD award in response to the carrier's appeal of the Board's decision, the worker's counsel was entitled to an attorney fee award for his legal representation "at and prior to" the court appeal.

### Workers' Compensation Board

*Vanetta Abdellatif*, (July 8, 2014). The Board held that a clinical service manager's injury, which occurred when she fell in a parking garage after attending a board meeting as a director for a health care system, arose out of and in the course of her employment because part of her duties as the clinical service manager was developing and maintaining relationships with health care systems. Although acknowledging that her supervisor had questioned whether accepting membership as a director of the particular organization exceeded the scope of her work and raised "time" concerns because her membership would total three such boards, the Board reasoned that the clinical service manager was not precluded from serving on the board, but rather was encouraged to resign from another board. Determining that 50 percent of the clinical service manager's work day was spent in locations away from her office and finding that a substantial portion of her job involved developing and maintaining "external

relationships” with health care-related organizations, the Board concluded that she was a “traveling employee” when she was injured and that it was reasonably expected that she would need to park her car to attend the board meeting. Consequently, the Board rejected the carrier’s contention that she was engaged in a distinct departure on a personal errand from her duties when she fell in the parking garage following the board meeting.

*Nisar Ahmed*, (August 15, 2014). Analyzing ORS 656.268(9), and OAR 436-030-0005(12), and (20), the Board held that a worker’s request for reconsideration of a Notice of Closure (NOC) (which checked a box indicating that he disagreed with the rating of his permanent disability) was sufficient to indicate that he was raising the issue of “work disability” during the reconsideration proceeding and, as such, he was entitled to raise the issue at hearing when the Order on Reconsideration had not granted such an award. Although acknowledging that the worker had not expressly referred to “work disability” as an issue when filing his request for reconsideration of the NOC, the Board noted that the Director’s “reconsideration request” form did not include a box specifically referring to “work disability,” but rather contained a box (which the worker had checked) stating that he “disagree[d] with the rating of permanent disability.” Reasoning that “work disability” means factoring impairment as modified by age, education, and adaptability to perform the “at-injury” job and observing that the Order on Reconsideration had listed the issues as disagreements with impairment findings and extent of whole person permanent partial disability (impairment and social factors), the Board concluded that the worker’s request for reconsideration of the NOC had necessarily included work disability.

Turning to the merits of the work disability issue, the Board recognized that, when the NOC issued, the worker had been released and had returned to his “at-injury” job. Nevertheless, finding that, by the time of the issuance of the Order on Reconsideration, he was no longer released nor had he returned to his “at-injury” job, the Board concluded that he was entitled to a work disability award. *See* ORS 656.283(6) (a worker’s disability is evaluated “as of the date of issuance of the reconsideration order pursuant to ORS 656.268”).

*Jereme M. Beardall*, (July 24, 2014). Analyzing ORS 656.576, ORS 656.578, and ORS 656.593, the Board held that the statutory claim agent for the Workers’ Compensation Division (WCD) assigned to process a worker’s injury claim regarding a “noncomplying employer (NCE)” pursuant to ORS 656.054 was not a “paying agency” under the “third party” statutes at the time of the NCE’s settlement with the worker concerning his injury because, although the statutory claim had initially accepted the claim and paid benefits, that acceptance had subsequently been nullified by a Disputed

Claim Settlement (DCS), which had been approved before the NCE's settlement with the worker. Reasoning that a "paying agency" must be paying benefits at the time of the "third party" settlement or distribution, the Board concluded that the DCS (which expressly provided that the claim agent's acceptance was "null and void *ab initio* without any effect") had nullified that acceptance. Because the NCE's settlement with the worker had occurred after the approval of the DCS, the Board determined that the statutory claim agent was not a "paying agency" when the settlement was reached and, as such, the settlement was not subject to the "third party" statutes and did not require the claim agent's approval. Finally, noting that the DCS had preserved the statutory claim agent's "first party" lien for its claim costs in processing the NCE claim under ORS 656.054, the Board observed that the claim agent could seek enforcement of the DCS/lien by requesting a hearing regarding this "matter concerning a claim."

*Michael S. Belgarde*, (August 20, 2014). Analyzing ORS 656.319(1), and OAR 438-005-0065, the Board held that a worker's hearing request concerning a carrier's claim denial was not untimely filed because the carrier had not mailed the denial to the address that the worker had provided on his injury claim form. The Board acknowledged that the worker had eventually received notice of the carrier's denial about one week before the 60-day period (to timely file a hearing request) under ORS 656.319(1) had expired and had not filed a hearing request until one week after the 60-day period ended. Nonetheless, reasoning that the carrier was required, pursuant to OAR 438-005-0065, to mail its denial to his correct address and noting that the worker had provided that correct address on his claim form, the Board concluded that the denial had not been properly mailed and, as such, the 60-day period under ORS 656.319(1) had not been triggered and, therefore, the worker's hearing request was not untimely filed. In reaching its conclusion, the Board reasoned that the worker's eventual actual knowledge of the denial's issuance had not "cured" the carrier's noncompliance with OAR 438-005-0065.

*Walter Guill*, (August 6, 2014). (*Appealed to Court of Appeals*). The Board held that a truck driver's injury claim for a syncope episode, which occurred while he was performing his driving duties, did not arise out of his employment because the cause of the episode was unexplained and, as such, had not been established to be work-related. Disagreeing with the worker's contention that the "unexplained fall" doctrine was applicable, the Board reasoned that the cause of the syncope episode (not the truck accident, which had not resulted in any injury) was unexplained. Because the medical opinions did not establish a connection between the worker's fainting episode and his work activities, the Board concluded that the claim was not compensable.

A dissenting opinion noted that it was undisputed that the worker had required diagnostic medical services to determine the cause of the syncope episode, which had occurred while he was in the course of his employment as a truck driver. The dissent contended that the episode occurring in the course of his employment should be found to have arisen out of his employment as a matter of law because the cause of his fainting episode was considered to be “truly unexplained.”

*Teresa Hull*, (June 24, 2014). Applying ORS 656.268(4)(c) and ORS 656.325(5)(a), the Board held that a carrier was not entitled to terminate a worker’s temporary disability (TTD) benefits when the attending physician released her to a light duty job because the employer did not offer her the job due to her resignation. Reasoning that she was in the work force when she sustained her compensable injury and her physician authorized TTD benefits (and had not withdrawn from the work force because she was willing to work part-time), the Board concluded that the carrier was statutorily required to offer the attending physician-approved modified job to the worker and, if she refused the offer, it could then terminate the payment of TTD benefits. Because the carrier had never given the worker an opportunity to accept or refuse the modified job, the Board determined that the payment of TTD benefits must continue.

*Jose Jimenez*, (June 3, 2014). The Board held that a worker’s new/omitted medical condition claim for post-traumatic stress disorder (“PTSD”) and anxiety was precluded by a previous Disputed Claim Settlement (DCS), which had resolved his earlier new/omitted medical condition claim for his “current psychological condition” because the medical evidence established that his PTSD and anxiety was a continuation of his previously settled condition. Although acknowledging that, at the time of the DCS, the worker had neither been treated for, nor diagnosed with, a specific psychological condition, the Board was persuaded by the worker’s physician’s opinion that the PTSD and anxiety had existed when the DCS resolved the worker’s “current psychological condition.” Reasoning that the worker’s presently claimed psychological conditions were a continuation of the same conditions that had been previously settled by the DCS, the Board concluded that the worker’s new/omitted medical condition claim was precluded.

*David J. Lampa*, (June 3, 2014). (*Appealed to Court of Appeals*). In determining whether a carrier had received a worker’s request for claim closure under ORS 656.268(5)(b), the Board found that the un rebutted testimony from the worker’s attorney’s legal assistant that the letter requesting claim closure was “sent” to the carrier was sufficient to establish that the request had been “mailed” to the carrier on the date set forth in the letter and, as such, evoked the presumption under ORS 40.135(1)(q) that the request was received by the carrier in regular course of mail. Reasoning that the carrier

had neither challenged the legal assistant's testimony nor presented any evidence indicating that the letter was not properly addressed, returned as undeliverable, or not received, the Board determined that the assistant's testimony that the letter had been "sent" adequately established that the claim closure request was mailed to the carrier on the date listed in the letter. Applying the statutory presumption that a letter duly mailed is received in the regular course of the mail, the Board concluded that the carrier had received the claim closure request and, because there had not been a timely response, refused the request.

A dissenting opinion noted that there were other methods for the worker to prove the carrier's receipt of the claim closure request; *e.g.*, certified mail, a "date stamp" copy of the request from the carrier, testimony from the carrier's claim examiner. Asserting that the worker's attorney's legal assistant was never asked when the letter was "duly directed and mailed" to the carrier, the dissent considered the testimony insufficient to establish that the request had been mailed to the carrier on the date set forth in the letter and, as such, the statutory presumption for receipt of the letter had not been evoked.

*Bradley R. Madrid*, (June 4, 2014). Applying ORS 656.267(1), the Board held that a carrier was obligated to specifically respond to a worker's new/omitted medical condition claim for "lumbar disc @ L5-S1," even though the medical evidence did not establish that the claim was for a "condition" (*i.e.*, the physical status of the body). Although acknowledging that the carrier had issued a "combined condition" acceptance which referred to an L5-S1 protruded disk and arthritis (as preexisting conditions), the Board reasoned that because the carrier had not specifically accepted or denied the claim for the purported "condition," the claim had been *de facto* denied. Addressing the merits of the claim, the Board determined that the medical evidence did not establish that "lumbar disc @ L5-S1" described "the physical status of the body as a whole \* \* \* or of one of its parts." Consequently, the Board was not persuaded that the claimed condition existed and, as such, upheld the carrier's *de facto* denial.

A concurring opinion expressed serious reservations regarding a previous Board decision that a carrier's "combined condition" acceptance in response to a worker's new/omitted medical condition claim for a specific condition could be legally sufficient. However, because that earlier decision had been distinguished in the present case, the concurrence considered it unnecessary to revisit the prior decision.

*Paula Magana-Marquez*, (July 25, 2014). (*Appealed to Court of Appeals*). Analyzing ORS 656.214, and OAR 436-035-0013(1), the Board held that a worker was not entitled to a permanent disability award for her accepted low back strain condition because she had not sustained any permanent impairment related to her compensable injury, but rather all of her impairment was attributable to conditions (body habitus and spondylosis) that were non-legally cognizable preexisting conditions. The Board recognized that the Supreme Court has held that all of a worker's permanent impairment should be considered due to the compensable injury when some of the impairment findings were attributable to non-legally cognizable preexisting conditions. Nonetheless, in contrast to the Supreme Court decision, the Board reasoned that the medical record in the present case did not relate any of the worker's permanent impairment to her compensable injury, but rather solely attributed her impairment to causes unrelated to her injury.

*Gerald W. Mogensen*, (June 4, 2014). (*Appealed to Court of Appeals*). The Board held that a worker's new/omitted medical condition claim for complex regional pain syndrome (CRPS) was in existence and was causally related to his accepted finger amputation, regardless of whether the CRPS was "Type 1" or "Type 2." Reasoning that the worker had claimed CRPS (rather than a particular "type") and finding that the record supported the existence and compensability of the claimed condition (whether described as Type 1 or 2), the Board concluded that the carrier was responsible for the claim. In reaching its conclusion, the Board noted that any dispute concerning which "type" of CRPS would be accepted was a claim processing matter that could be addressed when the carrier issued its modified acceptance.

A dissenting opinion argued that the carrier's refusal to rescind its denial was unreasonable. Relying on ORS 656.262(6)(b)(F), the dissent contended that the carrier had a continuing obligation to modify its acceptance based on medical information and changes in its knowledge of a compensable condition. Reasoning that any legitimate doubt regarding the carrier's statutory responsibility to modify its acceptance had been extinguished after the denial issued, the dissent asserted that the carrier's failure to rescind its denial was unreasonable.

*Alan W. Morley*, (June 4, 2014). (*Appealed to Court of Appeals*). The Board held that, because the record established that a worker was experiencing symptoms from his L4-5 disc herniation and surgery when the carrier issued an acceptance of "low back pain," the carrier's acceptance encompassed the disc herniation, and that subsequent agreements (which referred to the accepted condition as a low back strain) did not alter the carrier's initial acceptance. Reasoning that none of the later agreements (stipulations,

disputed claim settlement, or claim disposition agreement) purported to resolve disputes regarding the scope of the carrier's initial acceptance, the Board determined that the acceptance of the L4-5 disc herniation had not been modified. Furthermore, finding that the medical evidence established that the accepted disc herniation and subsequent surgeries for that condition were the major contributing cause of the worker's currently claimed conditions and need for further surgery, the Board concluded that the carrier was responsible for those conditions and medical services.

*Blake T. Pokorny, Dcd.*, (August 20, 2014). Analyzing ORS 656.236 and ORS 656.218(2), and (5), the Board held that a personal representative of a deceased worker's estate was authorized to execute a Claim Disposition Agreement (CDA) because the claim had not been closed. Reasoning that the carrier was obligated to close the claim and to determine compensation for permanent disability (if any) that would have been payable to the deceased worker and noting that any unpaid balance of such an award would be payable to the decedent's estate (because he was not survived by any statutory beneficiaries), the Board concluded that the estate's personal representative was entitled to proceed with the CDA.

*Ashley A. Rehfeld*, (June 5, 2014). (*Appealed to Court of Appeals*). Applying ORS 656.210(1), the Board held that the rate of a worker's temporary total disability (TTD) benefits was based on \$50 per week because at the time of her compensable injury she was to be paid on a commission basis, but had not received any earnings before her injury. Finding that the worker had not received earnings for the 52 weeks preceding her compensable injury and noting that her employer had not paid insurance premiums (because it was a noncomplying employer), the Board concluded that her average weekly wage under OAR 436-060-0025(5) was zero. Under such circumstances, the Board reasoned that the worker's TTD rate must be calculated in accordance with ORS 656.210(1), which provides for a rate based on a minimum of \$50 per week.

*Carmen M. Reyes*, (August 27, 2014). Analyzing ORS 656.005(12)(b), and OAR 436-015-0070, the Board held that a "non-Managed Care Organization (non-MCO)" physician constituted a worker's "attending physician" because the carrier had not objected to the worker's course of treatments with the "non-MCO" physician and, as such, the physician was authorized to evaluate the worker's "medically stationary" status for claim closure purposes. Noting that the applicable administrative rule did not describe a specific process for selecting an "attending physician," the Board found that, based on the worker's course of treatment (from shortly after her compensable injury until the physician reported that her condition was medically stationary) and in the absence of an objection to the physician's treatments (from either party), the "non-MCO"

physician was qualified to serve as the “attending physician.” Consequently, based on the “non-MCO” physician’s report, the Board concluded that the closure of the claim was valid.

*Ramiro Ruiz-Solis, Dcd.*, (July 11, 2014). (*Appealed to Court of Appeals*). Applying ORS 656.226, the Board held that an alleged “surviving spouse” was entitled to death benefits because, although she and the decedent were unmarried and had not lived together every day during the year preceding his death, based on the nature of their 15-year continuing relationship as a couple, they were considered to have “cohabitated” as husband and wife. Reasoning that the statute did not require the couple to have cohabitated “continuously” for the year before the worker’s death, the Board found that serious financial problems and transportation difficulties had caused temporary separations, but had not changed the nature of their continuing relationship. Persuaded that they had not terminated their relationship in the year preceding the worker’s death, the Board concluded that they had continued to cohabit as husband and wife and, as such, she was entitled to survivor benefits under ORS 656.226.

*Russell W. Wayne*, (July 1, 2014). Applying ORS 656.268(5)(d), the Board held that a carrier had not unreasonably refused to close a worker’s claim because it had been attempting to obtain further medical information from his physicians involving the “medically stationary/impairment” status of his accepted conditions, including a potential “direct medical sequelae.” Noting that claim closure would not be appropriate if a direct medical sequelae of an accepted condition was not medically stationary, the Board considered it reasonable for the carrier to seek further “closing examination” information regarding a potential “direct medical sequelae” of the worker’s accepted cervical disc condition (*i.e.*, a subcutaneous granuloma from his cervical surgery) and, as such, it was not unreasonable for the carrier to have refused to close the claim.

*Russell Young*, (August 27, 2014). The Board held that a city electrical inspector’s injury, which happened when he fell when his foot became wedged between a public sidewalk curb and the wheel of his parked vehicle after he had exited the vehicle to “feed” the parking meter, did not occur in the course of his employment because he was on paid administrative leave and was waiting to be notified by his union representative to attend his “employment discharge” hearing. Although acknowledging that the employer (a city) had a general duty related to the maintenance of public sidewalks, the Board reasoned that the employer’s limited “control” over such sidewalks far from the worker’s

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place of work did not demonstrate a sufficient temporal and spatial nexus between his injury and his employment for application of the “parking lot” exception to the “going and coming” rule.

A concurring opinion also determined that the worker’s injury did not arise out of his employment. Persuaded that the worker had not been directed by his employer to appear at his “employment discharge” hearing, the concurrence asserted that the worker’s injury neither resulted from the nature of his work nor originated from some risk to which the work environment had exposed him.