APPELLATE UPDATE
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APPELLATE UPDATE

COURT CASES

Attorney Fee: "383(2)"/"382(3)" - Application of '16 Statutory Amendments - Fees "Incurred" When "Post-January 1, 2016" Board Order Affirmed ALJ's TTD Award in Response to Carrier's Appeal

Travelers Ins. Co. v. Arevalo, 296 Or App 514 (March 13, 2019). The court held that the 2016 amendments to ORS 656.383(2) and ORS 656.382(3) (which provide for a carrier-paid attorney fee award for obtaining a temporary disability (TTD) award and for successfully defending an ALJ's penalty/attorney fee assessment in response to a carrier's request for Board review) applied to a "post-January 1, 2016" Board order because the carrier did not become liable for the attorney fee awards until the worker prevailed before the Board in its "post-January 1, 2016" order and that, therefore, the attorney fees in dispute were not "incurred" until after the January 1, 2016 "effective date" of the statutory amendments. Reasoning that attorney fees are "incurred" when a party has become obligated in law or equity and is responsible for the payment of the fee, the concluded that the attorney fees in question were contingent on a favorable result and could not be "incurred" until a final order had issued. Therefore, although the worker's attorney's briefing and other legal services were completed before the January 1, 2016 "effective date" of the statutory amendments, the court determined that the worker was not entitled to, and the carrier was not liable for, the attorney fees in question until issuance of the Board's "post-January 1, 2016" order.

Regarding a procedural issue, the court rejected the carrier's contention that the Board was not authorized to apply the "post-January 1, 2016" statutory amendments because neither party had raised such an issue. Noting that the Board is authorized under ORS 656.295(6) to reverse, modify, or make such disposition of the case that it deems appropriate (provided that it does not "sidestep" a statutory claim processing requirement), the court concluded that the Board had authority on its *de novo* review to address a worker's entitlement to attorney fees *sua sponte*.

Attorney Fee: Board Discretion to Award "Reasonable" Fee - Irrespective of Request or Objection - Order Must Articulate Application of "Rule-Based" Factors - "015-0010(4)," "015-0029"

Cascade In Home Care, LLC v. Hooks, 296 Or App 695 (March 20, 2019). Analyzing ORS 656.382(2), OAR 438-015-0010(4), and OAR 438-015-0029, the court held that, although the Board is statutorily required to award a carrier-paid attorney fee when a carrier appeals an ALJ's compensability decision and the Board finds that the worker's compensation award should not be disallowed or reduced, the

Board is not obligated to award the amount requested by the worker's attorney, even if the request is not objected to by the carrier. After reviewing OAR 438-015-0029 and its case precedent, the court reiterated that the Board is required to *consider* the information included in a worker's attorney's request for a fee (as well as a carrier's objections) and, when no specific request is filed, the Board essentially infers from the record the amount of time reasonably expended by the attorney and the reasonable value of services from the extent of the proceedings and the nature of the issues litigated. However, regardless of the presence or absence of a specific request or objections, the court reasoned that the Board has discretion in determining a reasonable carrier-paid attorney fee and that the amount awarded is not dictated only by the information submitted by the worker's and carrier's attorneys.

Finally, the court stated that there was a significant discrepancy between the amount requested by the worker's counsel and the Board's attorney fee award. Under such circumstances, to permit meaningful appellate review, the court reasoned that the Board order must articulate how the application of certain factors in OAR 438-015-0010(4) supported the amount of its attorney fee award. Consequently, the court remanded for reconsideration.

Attorney Fee: Board Review - Claimant's Respondent's/Cross-Appellant's Brief Stricken - Board Affirms ALJ's Compensability Decisions - Lack of Brief Relevant to *Amount* of, Not Entitlement to, Attorney Fee - "386(1)"/"382(2)"

Schommer v. Liberty Northwest Ins. Corp., 294 Or App 147 (September 19, 2018). Analyzing ORS 656.386(1) and ORS 656.382(2), the court held that, when a carrier unsuccessfully appeals an ALJ's compensability decision, a worker's counsel's entitlement to a carrier-paid attorney fee on Board review did not depend on whether the counsel had timely filed an appellate brief. Reasoning that the determinative question is whether the matter on Board review involved the sort of claim or issue identified in ORS 656.386(1) (finally prevailing against a denied claim) or ORS 656.382(2) (a determination by the final tribunal in response to a carrier's appeal of an award of compensation, penalties, or attorney fees that the appealed award should not be disallowed or reduced), and whether the worker ultimately prevailed, the court concluded that the worker's counsel was statutorily entitled to a carrier-paid attorney fee under such circumstances. In doing so, the court clarified that whether the worker's counsel had untimely filed an appellate brief (or did not file a brief at all) would be a factor in assessing the appropriate amount of an attorney fee award.

Attorney Fee: Determination of "Reasonable" Attorney Fee - Award Lacked Substantial Reasoning - "386(1)," "015-0010(4)"

Peabody v. SAIF, 297 Or App 704 (May 22, 2019). Reviewing for "substantial evidence/reason," the court held that a Board order (which had awarded $12,000 for a worker's counsel's services at the hearing level and on appeal, when the attorney had requested $31,000) did not articulate a connection between the "rule-based" factors for determining a reasonable attorney fee and the Board's award. Reasoning that the Board order had simply recited the "rule-based" factors without articulating *how* the application of those factors supported the amount of the attorney fee award, the court concluded that the Board order lacked substantial reason and that remand for reconsideration was warranted.

Attorney Fee: "Pre-Hearing" Rescinded Denial - Board's "386(1)" Carrier-Paid Fee Award - Lacked Substantial Reason

Taylor v. SAIF, 295 Or App 199 (December 5, 2018). The court held that a Board order, which awarded a worker's counsel an attorney fee award for services rendered in obtaining a carrier's "pre-hearing" rescinded denial in an amount less than the attorney's requested amount, lacked substantial reason and a further explanation. Noting that the Board's award equated to an hourly attorney fee that was less than the worker's counsel's hourly fee in "non-contingent fee" cases, the worker contended that the Board order had not adequately considered the contingent nature of the practice of workers' compensation law, the risk that the attorney may go uncompensated, and providing access to adequate representation for injured workers. *See* ORS 656.012(2)(b); ORS 656.388(5); OAR 438-015-0010(4)(g). The court reiterated that, to permit meaningful appellate review, a Board order must articulate how the application of the rule-based factors for a determination of a reasonable attorney fee support the amount of fees awarded. Reasoning that it was possible that the Board's conclusion reflected a view that an excessive amount of time had been spent on the case by the worker's counsel or that a reasonable hourly fee was less than the worker's counsel's "non-contingent fee" cases (which might also implicate whether the "contingent nature" of the practice of workers' compensation law had been considered in the Board's award), the court concluded that the Board order had not articulated a connection between those rule-based factors in its conclusion sufficient to allow the court to understand the Board's reasoning.

Claim Filing: "Good Cause" For Untimely Filed Claim - "265(4)(c)" - "Objective" Standard In Determining "Good Cause"

Estrada v. Federal Express Corp., 298 Or App 111 (June 12, 2019). Analyzing ORS 656.265(1) and (4), the court held that the Board had not erred in determining that a worker had not established "good cause" for not reporting a work accident to his

employer within 90 days because, although he initially believed that his "hernia" symptoms were just soreness, he had noted a particular lifting incident that had resulted in a "weird pull" and that his symptoms had continued to increase to the point that it was difficult for him to perform his work duties during the ensuing 90 days. In reaching its conclusion, the Board had reasoned that a "reasonable worker" would have concluded that workers' compensation liability was reasonably possible and that it was appropriate to report the accident to his employer within the 90-day period allowed by ORS 656.265(1)(a) and, because the worker had neglected to do so, he had not established "good cause" for untimely notifying his employer of the work accident.

In affirming the Board's decision, the court rejected the worker's contention that the Board's "reasonable worker" standard violated ORS 656.265(4)(c), which he argued imposed an individualized and purely subjective standard for determining whether a worker has established "good cause" for untimely reporting a work accident. Although acknowledging that the Board must make an individualized determination whether a worker had "good cause" to provide late notice of the work accident to the employer, the court reasoned that it did not follow that the Board could not apply an objective standard in determining whether the worker had established that requisite "good cause." Consequently, the court concluded that the Board could determine that the worker's failure to give timely notice of an accident, despite knowing facts from which a reasonable person would conclude that workers' compensation liability was a reasonable possibility and that notice to the employer was appropriate, did not constitute "good cause" under ORS 656.265(4)(c).

In reaching its conclusion, the court also rejected the worker's assertion that the Board had violated the "law of the case" doctrine by applying a different "good cause" legal standard than it had applied in its initial decision (which the court had previously reversed and remanded). Noting that its earlier decision had reversed the Board's initial order based on the lack of substantial reasoning, the court explained that it had not previously addressed the correct legal standard for "good cause," but rather had left that determination for the Board to address on remand.

<u>Claim Processing: "Non-Cooperation" Denial - "Post-Suspension Order" Cooperation Must Be Reasonable - "262(15)"</u>

Hilton Hotels Corp. v. Yauger, 295 Or App 330 (December 12, 2018). Analyzing ORS 656.262(15), the court held that, in determining the validity of a carrier's "noncooperation" denial of a worker's injury claim, the Board must decide whether his conduct (an e-mail to the carrier permitting access to his medical records and inquiring into what further information was needed regarding the investigation of his claim) within the 30-day period before the carrier's denial and after a Workers' Compensation Division's (WCD's) "suspension" order, constituted "reasonable cooperation" in the carrier's claim investigation. After reviewing ORS 656.262(15),

the court identified three procedural stages concerning a carrier's denial for a worker's failure to cooperate in a claim investigation: (1) a WCD decision to suspend benefits based on the worker's failure to reasonably cooperate; (2) a carrier's denial of the claim based on noncooperation if the worker continued for 30 days to fail to reasonably cooperate; and (3) the worker's challenge to the noncooperation denial requiring the worker to establish "full and complete" cooperation with the investigation, or that the worker failed to cooperate for reasons beyond the worker's control, or that the carrier's investigative demands were unreasonable.

Notwithstanding those requirements, the court clarified that, as a preliminary matter, if the carrier's "noncooperation" denial was procedurally invalid because the worker reasonably cooperated during the 30-day period after WCD's "suspension" order, the worker's duty to "fully and completely" cooperate under ORS 656.262(15) never arises. Turning to the present case, the court noted that the Board order (which set aside the carrier's "noncooperation" denial as procedurally invalid) had relied on a WCD rule (OAR 436-060-0135(9)) in finding that the worker's "post-suspension order" e-mail to the carrier was sufficient to express a willingness to cooperate in the carrier's claim investigation because the rule provides that a "noncooperation" denial can be issued only if the worker "makes no effort" to cooperate in the investigation following WCD's "suspension" order. Reasoning that the Board had apparently considered "any effort" by a worker to reinstate benefits after a WCD "suspension" order sufficient to express a willingness to cooperate in the claim investigation, the court remanded to the Board for a determination as to whether the worker's e-mail contact with the carrier reflected "reasonable cooperation" in the carrier's claim investigation.

<u>Combined Condition: "Preexisting" Lung Cancer Spread To Femur Bone - "Injury" Claim For Fractured Femur Subject To "Combined Condition" Analysis - "005(7)(a)(B)" Applied</u>

Hammond v. Liberty Northwest Insurance Corporation, 296 Or App 241 (February 27, 2019). Analyzing ORS 656.005(7)(a)(B) and ORS 656.204, the court held that, because a deceased worker's leg fracture injury combined with his preexisting lung cancer (which had spread to his bones), the worker's spouse's death claim was not compensable because the work injury was not the major contributing cause of his need for treatment/disability/death. The court disagreed with the surviving spouse's contention that, because the decedent's femur tumor had not been diagnosed before his injury, his bone cancer did not constitute a "preexisting condition" under ORS 656.005(24). Noting that there was no dispute that the worker's femur tumor was part of his cancer, the court found no error in the Board's determination that the cancer (which had spread to the decedent's bones) was a "preexisting condition" because the worker had received treatment for his cancer before his work injury.

The court also rejected the spouse's assertion that the "combined condition" analysis under ORS 656.005(7)(a)(B) did not apply in the context of a death claim pursuant to ORS 656.204. After analyzing the definitions of "compensable injury" and "combined condition," the court reasoned that benefits resulting from a combined condition are available only if the otherwise compensable injury is the major contributing cause of the disability/need for treatment of the combined condition and, furthermore, there is no exclusion when the injury results in the worker's death.

Finally, the court noted that, unlike the situation in *Brown v. SAIF* (where the Supreme Court had addressed the continued compensability of a combined condition and the "otherwise compensable injury" had been limited to an accepted lumbar strain), the present dispute involved the applicability of ORS 656.005(7)(a)(B) to an initial claim for an injury that itself constituted the combined condition. Nevertheless, reasoning that the undisputed medical evidence attributed the major contributing cause of the worker's leg fracture (and, therefore, its need for treatment) to the cancer, the court affirmed the Board's holding that the claim was not compensable.

Course & Scope: "Unexplained Fall" - Claimant Must Eliminate Facially Nonspeculative Idiopathic Explanations for Fall to Establish "Arising Out Of" Prong

Sheldon v. US Bank, 364 Or 831 (May 23, 2019). The Supreme Court held that, in determining whether a worker's injury (which occurred when she fell while walking through the lobby of the office building where she worked before starting her work day) arose out of her employment, if her fall was unexplained, she must prove that there was no "nonspeculative explanation" for the fall. Reiterating the "positional-risk" doctrine, the Court re-endorsed the proposition that an injury resulting from a "neutral risk" (*i.e.*, neither "personal" or "employment" related) is deemed to arise out of employment "if the conditions of employment put [the worker] in a position to be injured." Consistent with the "positional-risk" doctrine, the Court explained that, to establish that a fall arose out of employment, a worker must prove that the fall was unexplained (*i.e.*, did not result from a idiopathic/personal cause) and that it occurred in the course of employment

Reasoning that the determination of whether a fall is explained or unexplained is a matter of analyzing whether there are any nonspeculative explanations for the fall, the Supreme Court observed that, if there is a nonspeculative explanation for the fall, such an explanation would prevent the worker from establishing that the fall is unexplained (and, as such, the injury resulting from the fall would not be deemed to "arise out of" employment under the "positional-risk" doctrine). Conversely, the Court noted that, if there is no nonspeculative explanation for the fall available, the worker's fall would be unexplained (and, as such, the injury resulting from the fall would be deemed to "arise out of" employment under the "positional-risk" doctrine).

Finally, clarifying that, to prove that a fall is unexplained, a worker must establish that there is no nonspeculative explanation for the fall, the Supreme Court explained that if there is a facially nonspeculative idiopathic cause for explaining a fall, the worker must offer countering evidence sufficient to establish that the proposed idiopathic cause is, in fact, speculative. Concluding that, to determine that a fall is unexplained there must be a finding that there is no nonspeculative explanation for the fall, the Court remanded to the Board for reconsideration of the worker's injury claim in light of this legal standard.

Extent: Impairment Findings Related to Accepted "Lumbar Strain" Considered - Prior "Compensability" Decision Pertained to Injury Claim, Not a "Combined Condition" - "Lumbar Strain" Acceptance Did Not Encompass "Combined Condition"

Griffin v. Dish Network Services, 296 Or App 233 (February 27, 2019). Analyzing ORS 656.005(7)(a)(B), ORS 656.262(6)(d) and ORS 656.267(1), the court held that a Board order had not erred in limiting its evaluation of a worker's permanent disability to his accepted lumbar strain because, although a prior litigation order regarding the compensability of the worker's initial injury claim had found that the carrier had not established under ORS 656.266(2)(a) that the work injury was the major contributing cause of his need for treatment/disability for a combined condition, that previous order had not found a specific combined condition to be compensable. The court acknowledged the worker's contention that requiring him to file a new/ omitted medical condition claim for a combined low back condition (composed of the accepted lumbar strain combined with a preexisting degenerative condition) in response to the carrier's "post-litigation order" acceptance of a lumbar strain would force him to relitigate what had already been determined in the prior "compensability" litigation order and, as such, he was entitled to permanent disability awards based on a medical arbiter's range of motion findings which pertained to his low back degenerative condition.

However, reiterating that the scope of the carrier's acceptance was a question of fact, the court determined that substantial evidence supported the Board's finding that the carrier's acceptance of a lumbar strain was unambiguous and did not encompass a combined condition. Furthermore, the court concluded that the Board could reasonably interpret the prior compensability decision (which had rejected the carrier's "combined condition" defense) as a determination that the worker's low back strain compensable, rather than a finding that a combined condition (either specifically or in general) was compensable.

Hearing Request: Untimely Filed ("319(1)(a)") - "Request" Must Be Referable to Carrier's Denial; Board Has Discretion to Make "Good Cause" Determination Under "319(1)(b)" - Court Reviews for "Cognizable Basis for Relief" - Claimant Lacked Sophistication/Was Confused/Misunderstood 60-Day Deadline to File Hearing Request - Constituted "Mistake"/"Inadvertence"/"Misunderstanding" for Failing to Timely File Request

Goodwin v. NBC Universal Media, 298 Or App 475 (July10, 2019). Analyzing ORS 656.319, the court held that a worker's hearing request regarding a carrier's claim denial was untimely filed because his earlier requests (filed within 60 days of the denial) had not referenced the particular denial that was being challenged, but that the worker's explanations for why his request was untimely filed (*e.g.*, his lack of sophistication, confusion, misunderstanding) established a cognizable basis for the Board to determine whether such mistakes and inadvertence constituted "good cause" for his untimely filing. Reiterating that a hearing request that is intended as a challenge to a claim denial must be referable to a particular denial (*i.e.*, reference the particular denial that is being challenged either directly or indirectly), the court determined that the worker had not filed a hearing request referring to the carrier's claim denial within the statutory 60-day period of ORS 656.319(1).

Nonetheless, noting that a clarification from the Ombudsman's office (which accompanied the worker's hearing request that was filed two days after the expiration of the 60-day period) had indicated the worker's intention to "appeal the denial," the court concluded that such materials constituted a request for hearing from the carrier's claim denial. Turning to the question of whether the worker had established "good cause" for his untimely filed hearing request, the court characterized the worker's failure to explicitly state that he was seeking a hearing relating to a denial and his apparent misunderstanding that the hearing request had to be mailed on a specific date as "mistake[s]" or "inadvertence" (attributable to his lack of sophistication and confusion). Reasoning that the worker had a cognizable basis for relief because of mistake, inadvertence, surprise, or excusable neglect, the court remanded to the Board for a determination of whether his mistakes and inadvertence constituted "good cause" for the untimely filing of his hearing request.

Medical Services: "Injury" Means "Work Accident" - "245(1)(a)"

Garcia-Solis v. Farmers Insurance Company, 365 Or 26 (May 31, 2019). Analyzing ORS 656.245(1)(a), the Supreme Court held that, when determining the compensability of a worker's medical service claim, the term "[compensable] injury" refers to the work accident that caused the medical condition and resulted in the need for medical services. Although acknowledging that its *Brown* decision left little doubt

that it interpreted the statutory definition of "compensable injury" to mean medical conditions and not the work accident generally, the Court noted that in *Brown* it had specifically reserved any decision regarding the meaning of "[compensable] injury" as that phrase is used in ORS 656.245.

Seeking to give effect to what the legislature actually intended and, after reviewing the text and context of ORS 656.245(1)(a), the Supreme Court concluded that "injury" (insofar as it is first used in the first sentence of the statute, as well as the second sentence) means the work accident that caused the medical condition and resulted in the need for medical services. The Court further reasoned that the "injury" does not mean medical conditions, and it is not limited to conditions that the carrier had accepted at the time that medical services are sought.

In reaching its conclusion, the Supreme Court emphasized that it was not deciding or suggesting that its decision regarding the meaning of "injury" in ORS 656.245(1)(a) applied to any other statute in the workers' compensation system.

Medical Services: Injury During Medical Treatment for Compensable Injury

SAIF v. Rolen, 294 Or App 258 (September 26, 2018). Addressing the compensability of a worker's medical service claim for a gastroscopy, the court cited its previous case precedent (*Barrett Business Services v. Hames*), which had held that when a new injury is the direct result of reasonable and necessary treatment of a compensable injury, the compensable injury is the major contributing case of the new injury, which is compensable as a consequential condition.

Occupational Disease: "Mere Susceptibility"/"Predisposition" Exception to "Preexisting Condition" - "Active Contribution" Requirement - Applies to "O.D." Claims

SAIF v. Dunn, 297 Or App 206 (April 24, 2019). Analyzing ORS 656.005(24)(a), (c), and ORS 656.802(1)(a), and (e), the court held that, in determining the compensability of an occupational disease claim, the legislature intended to exclude a worker's predispositions from consideration as "preexisting conditions." Although acknowledging that ORS 656.005(24)(c) expressly provides that, for purposes of injury claims, a condition that does not contribute to disability/need for treatment if the condition merely renders the worker more susceptible to the injury, the court rejected the carrier's argument that the legislature failure to similarly exclude susceptibilities from preexisting conditions in the occupational disease context reflected an intention to treat susceptibilities as preexisting conditions in occupational disease claims.

Instead, the court referred to the definition of "preexisting condition" in ORS 656.005(24)(b) (which explicitly requires that a preexisting condition contribute to the disability/need for treatment) and the legislative history of that statute (which shows a

clear intention that, with respect to both injury and occupational disease claims, susceptibilities that do not actively contribute to the cause of a condition are not to be weighed in determining major contributing cause). Under such circumstances, the court reasoned that the legislature intended to exclude predispositions from consideration as preexisting conditions in the occupational disease context.

Finally, consistent with legislative history, the court reiterated that a condition only renders a worker more susceptible to injury for purposes of ORS 656.005(24)(c) if the condition "increases the likelihood that the affected body part will be injured by some other action or process but does not actively contribute to damaging the body part." Determining that the legislature intended to apply such an analysis to an occupational disease, the court reasoned that a predisposition or susceptibility may be considered in the "major contributing cause" analysis only if it actively contributes to the worker's disability/need for treatment.

Responsibility: "LIER" - "Sole Cause" Defense Proven by "Last" Carrier

Liberty Metal Fabricators v. Lynch Co., 295 Or App 809 (January 30, 2019). Analyzing the "last injurious exposure rule" (LIER) regarding a dispute concerning the responsibility for a worker's hearing loss claim, the court held that substantial evidence supported a Board decision that the last employer had proved that previous employers had solely caused the worker's claimed hearing loss. The court acknowledged that a physician had initially stated that it was possible for a hearing loss of one decibel to have occurred at the worker's last employer. Nevertheless, the court noted that the physician had further explained that a one decibel change was not measureable, would not be significant, and would be disregarded as falling within the range of "test-retest variability." Finally, the court observed that the physician had ultimately opined that, based on the worker's hearing tests before/after his last employment, the last employer had not contributed to his hearing loss.

Standards: Work Disability - Claimant's Use of Hearing Aids - Did Not Establish That Claimant Had Not Been Released, or Returned, to "Regular Work" - "214(1)(d), (e), (2)(b)"

Wright v. SAIF, 295 Or App 151 (December 5, 2018). Applying ORS 656.214(1)(d), (e), and (2)(b), the court held that a worker was not entitled to a work disability award for his hearing loss condition because the record did not establish that he had not been released to, or had not returned to, his regular work as a paver, even though he was unable to simultaneously use both hearing protection and hearing aids at work. The court acknowledged the worker's contention that his ability to communicate was part of his "regular work" as a paver and that, because hearing aids and hearing protection affected that ability, he was entitled to a "work disability" award because he could not simultaneously wear both devices. However, the court found that

nothing in the record established to what degree communication was part of the worker's "regular work" or whether and how the inability to communicate created a hazard. Identifying the dispositive question as whether wearing both hearing protection and hearing aids was necessary for the worker to perform his "regular work," under circumstances where he had previously performed that work without using either device, the court determined that the record did not establish that wearing both hearing devices was necessary to the performance of the worker's "regular work."

Statutory Construction: Statute of Limitations - Civil "Negligence" Action - "019(2)(a)" Limit (180 Days From Date of Order Affirming "Major Cause/Injury" Claim Not Compensable Becomes Final) Controls Over "30.275(9)" (Two Years From Alleged Loss/Injury)

Preble v. Centennial School District No. 287, 298 Or App 357 (June 26, 2019). Analyzing ORS 656.019(2)(a), the court held that a worker's personal injury/negligence cause of action against a public employer for a knee condition (that occurred when she was struck by a motor scooter at her school), which was filed within 180 days from a Board order upholding a carrier's denial of her workers' compensation injury claim (based on a determination that the work injury was not the major contributing cause of her combined knee condition), was timely filed, even though the cause of action had not been filed within two years after her injury as required by ORS 30.275(9). Based on its review of the two statutes (both of which contained "notwithstanding" clauses, purporting to give precedence over any other statutory provision), the court determined that the statutes were irreconcilably conflicting.

Applying standard rules of statutory construction, the court reasoned that ORS 656.019(2)(a) (which applies to a very specific type of workers' compensation claim; *i.e.*, one that was denied because of a worker's inability to satisfy the major contributing cause standard) was a more specific statute than ORS 30.275(9) (which applies to any claim asserted against any public body). Furthermore, the court observed that it was undisputed that ORS 656.019(2)(a) had been enacted some 20 years after ORS 30.275(9).

Under such circumstances, the court held that ORS 656.019(2)(a) controlled because it was the more specific statute and had been enacted after ORS 30.275(9). Accordingly, the court reversed a trial court decision, which had dismissed the worker's cause of action based on ORS 30.275(9).

Subject Worker: "Partner" - "Non-Subject Worker"

Pilling v. Travelers Insurance Company, 365 Or 236 (July 18, 2019). Analyzing ORS 656.128, the Supreme Court held that a satellite installer was a "subject worker," even though his business's application for workers' compensation coverage did not indicate that he was a partner of the satellite installation business, because the

application included the necessary information statutorily required to obtain coverage (*i.e.*, the application identified him as the person for which coverage was being sought, as well as information regarding his wages and duties). The Court acknowledged the carrier's assertion that the installer was a "non-subject worker" because he had neither applied for, nor made an election of, coverage as a "partner" as required by ORS 656.128(1). Nonetheless, the Court found nothing in the text of ORS 656.128 requiring that the application specify the applicant's legal status. Furthermore, noting that the statute indicates that the premium for workers' compensation coverage is based on the applicant's work classification and assumed wage, the Supreme Court reasoned that such information did not support the carrier's contention that the installer's legal status as a "partner" was necessary for premium calculation purposes.

Subject Worker: "005(30)" - "Pre-Employment/Driver Test" Injury - No Reasonable Expectation "To Furnish Services For Remuneration"

Gadalean v. SAIF, (April 18, 2019). Analyzing ORS 656.005(30), the Supreme Court held that because a trucker, who was injured while performing a "pre-employment" driving test (which involved making a delivery for the prospective employer), did not undertake to furnish such services with the expectation of receiving remuneration, he was not a "worker" and, as such, he had not sustained a compensable injury. Focusing on the phrase in ORS 656.005(30) ("engage[d] to furnish services for a remuneration"), the Court determined that the most plausible reading of the statute was that a "worker" is one that: (1) undertakes an obligation to furnish services; and (2) did so *for* - with the expected result of - remuneration. Furthermore, because the expectation of remuneration arises out of circumstances of a claimant's relationship with an alleged employer, the Supreme Court reasoned that the claimant's expectation of remuneration must be reasonable in light of the circumstances.

In reaching its conclusion, the Supreme Court rejected claimant's argument that he was a "worker" under ORS 656.005(30) because Oregon's "minimum wage" laws would have entitled him to be paid for the supervised delivery he was performing during his "pre-employment" test when he was injured. In doing so, the Court explained that the proposed application of the "minimum wage" statutes would improperly substitute the definition of "employ" under the "minimum wage" law (ORS 653.025; ORS 653.010(2)) for the legislature's chosen definition of "worker" in the workers' compensation statutory scheme.

Applying its reasoning to the present case, the Supreme Court noted that the Board had found that claimant had been told by the employer that he was to perform the test without remuneration. Given such circumstances, the Court concluded that claimant had no reasonable expectation of receiving remuneration for his services and, as such, did not qualify as a "worker" under ORS 656.005(30).

Substantial Evidence/Reasoning: Analyzing Persuasiveness of Physician's Opinion - No *Per Se* Rule Requiring Physician to Rebut Contrary Opinion from Another Physician

Carter v. Waste Management Disposal Services, 298 Or App 430 (July 3, 2019). The court held that substantial evidence supported a Board order's finding that an attending physician's opinion supporting a worker's aggravation claim was unpersuasive because the physician had not sufficiently responded to, or rebutted, another physician's opinion (who had found no clinical evidence of a pathological worsening of the worker's low back condition and had attributed the worker's condition to a degenerative disc condition). Emphasizing that there is no *per se* rule *requiring* a rebuttal report to satisfy the compensability standard for an aggravation claim, the court did not interpret the Board order as requiring such evidence. Instead, the court considered the Board's order's citation to its previous decisions regarding the absence of a rebuttal report to an opposing medical opinion to be merely illustrative of the Board's reasoning in the present case why a physician's opinion had been found unpersuasive.

Substantial Evidence/Reasoning: "Law of Case" Doctrine - Only Pertains to Prior Ruling/Decision From Appellate Court, Not Administrative Body

SAIF v. Maldonado, 294 Or App 252 (September 26, 2018). The court held that the "law of the case" doctrine only applies to an appellate court's rulings or decisions and, as such, has no application to a Board-approved stipulation. Noting that a Board order had discounted physicians' opinions regarding the compensability of the worker's low back spondylosis condition as being contrary to the "law of the case" (*i.e.*, a prior stipulation in which the carrier agreed to accept a low back strain and herniated discs), the court concluded that such reasoning was erroneous. Consequently, the court remanded for further consideration of the physicians' opinions.

Substantial Evidence/Reasoning: WCD's "Good Cause" Finding - Untimely Hearing Request From "Medical Bill" Dispute - Lacked Substantial Evidence That No "Responsible" Person For Medical Service Provider Received Timely Notice of "Administrative Decision" Before Expiration of Appeal Rights - "183.482(8)(c)"

Angel Medflight Worldwide Air Ambulance Service v. SAIF, 293 Or App 710 (September 6, 2018). Analyzing OAR 436-001-0019(7)(b), the court held that a Workers' Compensation Division (WCD) order (which had found that a medical service provider had established "good cause" for its untimely filed hearing request from a WCD administrative decision resolving a medical bill dispute between the provider and a carrier) was not supported by substantial evidence. Although acknowledging WCD's finding that two representatives of the medical service provider had not received a copy of WCD's administrative decision before the 30-day appeal period had expired, the court reasoned that such a finding had not resolved the dispositive

question; *i.e.*, whether some other "responsible" person employed by the medical service provider *had* received a copy of WCD's administrative decision within the 30-day appeal period. Noting that the record indicated that there were other officials for the medical service provider who may also have been "responsible" for deciding whether to file a hearing request from WCD's administrative decision, the court determined that no reasonable person could conclude that the medical service provider had established that WCD's administrative decision was misplaced by someone who "was not responsible for deciding whether a request for hearing should be filed." Consequently, the court concluded that substantial evidence did not support WCD's finding that the medical service provider had shown "good cause" for its untimely filed hearing request.

TTD: Rate - "060-0025(5)(a)(A)" - "AWW" Calculation - Based on "Portion" of Week That Claimant "Actually" Worked, Not "Entire" Week
Hearing Procedure: "Waiver" of Issues at Hearing - Must Actually Intend to Waive a Known Right
New/Omitted Medical Condition: Claimed "Condition" Must "Exist" - Mere "Symptoms" Insufficient

Marsh v. SAIF, 297 Or App 486 (May 15, 2019). Analyzing ORS 656.210(1), (2)(a)(A), and OAR 436-060-0025(5)(a)(A), the court held that, because a worker only worked parts of the first week of his employment in the 52 weeks preceding his compensable injury and the last week of his employment before his injury, the calculation of his "average weekly wage" (AWW) (for purposes of establishing his rate for temporary disability (TTD) benefits (as an hourly wage earner)) should reflect only those portions of the five-day work weeks (for his first and last week) that he actually worked during those weeks. Reasoning that the legislature intended that TTD benefits be based on what a worker *actually* earned, the court concluded that a worker's AWW should be calculated using the "actual weeks of employment;" *i.e.*, the actual number of whole and partial weeks that the worker worked.

BOARD CASES

Aggravation: Requires "Actual Worsening" of Previously Accepted Condition - "273(1)"

Kimberly A. Samard, 70 Van Natta 1139 (October 4, 2018). Applying ORS 656.273(1), the Board upheld a carrier's denial of a worker's aggravation claim, concluding that her unclaimed, unaccepted ligament tear of her finger did not establish an actual worsening of her accepted finger fracture. Finding that the examining physicians had addressed the worker's finger fracture and ligament tear as separate and distinct conditions, the Board reasoned that her unaccepted ligament

tear could not be considered in analyzing whether she had sustained a compensable aggravation. Confining its evaluation of the worker's aggravation claim to her accepted finger fracture, the Board determined that her accepted condition had not pathologically worsened since the last award or arrangement of compensation.

Finally, the Board noted that the worker could initiate a new/omitted medical condition claim for her ligament tear condition at any time. *See* ORS 656.267(1).

Attorney Fee: "386(1)" - Carrier's Request for Review Dismissed Without Decision on Merits of ALJ's Compensability Decision - Claimant Did Not "Finally Prevail" Over Denial; "382(3)" - Carrier's Request Did Not Raise ALJ's "Attorney Fee" Award As Separate Issue

Devynne C. Krossman, 71 Van Natta 159 (February 13, 2019). Analyzing ORS 656.386(1) and ORS 656.382(3), the Board held that, because a carrier's request for review of an ALJ's compensability decision had not raised attorney fees as a *separate* issue and because the carrier had withdrawn its request before the implementation of a briefing schedule and the Board's review of the compensability issue, the worker's counsel was not entitled to a carrier-paid attorney fee award. Noting that ORS 656.386(1) authorizes an attorney fee in cases involving denied claims where the worker "prevails finally * * * in a review by the [Board]," the Board reasoned that, because the carrier's request for review had been withdrawn/dismissed before Board review had commenced, the worker had not finally prevailed in a review by the Board and, as such, a carrier-paid attorney fee under that statute was not justified. Furthermore, addressing ORS 656.382(3), the Board found that the carrier's request for review had raised the ALJ's attorney fee and cost awards only as issues derivative of the "compensability denial" issue, the Board concluded that the carrier's request for review had not raised attorney fees as a *separate* issue and, as such, a carrier-paid attorney fee pursuant to the statute was not warranted.

Attorney Fee: "386(1)"/"382(2), (3)" - Services at Hearing Level/Board Review/ Reconsideration - Determining "Reasonable" Award - Applying "015-0010(4)" Factors

Daniel F. Judd, 71 Van Natta 898 (August 7, 2019). Citing ORS 656.386(1), and OAR 438-015-0010(4), in an Order on Reconsideration that adhered to its initial award of a reasonable carrier-paid attorney fee for a worker's counsel's services in finally prevailing over the carrier's denial of a bilateral hernia claim, the Board explained that it analyzed the factors prescribed in its administrative rule and applied them to the particular record. Observing that the reviewing Members drew upon their combined 63 years of workers' compensation experience as practitioners representing workers and carriers before the Hearings Division and on Board review, the Board made the following findings: (1) the nature of the proceedings and time spent at the hearing level supported a slightly higher than average fee because the worker's attorney had prepared for,

traveled to, and participated in an out-of-town deposition; (2) however, the Board considered the worker's appellate counsel's time spent on review (33 hours) unwarranted for a seasoned practitioner; (3) the worker's counsel's appellant's brief's focus on a medical study had not been of particular assistance in resolving the compensability dispute; (4) the case was of average complexity, which was a neutral factor in assessing a reasonable attorney fee; (5) the benefit to the worker (five medical visits and a single uncomplicated surgical repair) was relatively modest; (6) the risk of going uncompensated given the contingent nature of the practice of workers' compensation law was no greater than in other denied claims generally litigated on Board review; and (7) the worker's hearing and appellate counsels were experience practitioners and presented their positions in a skillful and professional manner, which supported a higher than average attorney fee award.

After considering these "rule-based" factors, the Board determined that a confluence of those factors as they related to the particular record resulted in a reasonable attorney fee of $15,000 ($10,000 for the hearing level and $5,000 for Board review).

Finally, applying ORS 656.382(3), the Board awarded an additional carrier-paid attorney fee for the worker's counsel's services on reconsideration insofar as those services concerned a response to the carrier's reconsideration motion. Although acknowledging that the carrier had not expressly contested the amount of the Board's initial attorney fee award, the Board reasoned that, by seeking an additional explanation for the Board's initial award, the carrier had necessarily placed the worker's counsel's entitlement to an attorney fee award at issue. Consequently, the Board awarded an additional $1,000 attorney fee for the worker's counsel's services regarding the carrier's reconsideration motion.

Attorney Fee: Board Review - Carrier's Unsuccessful Appeal of ALJ's "Compensability" Decision - Claimant's Respondent's Brief Rejected as Untimely - Considered to Establish "Time Devoted" Factor for Determining Reasonable Attorney Fee Award

Craig Schommer, 71 Van Natta 123 (February 8, 2019). The Board held that, because a worker's counsel was statutorily entitled to a carrier-paid attorney fee when a carrier's appeal of an ALJ's compensability decision had been unsuccessful, the worker's untimely filed respondent's brief (which was not considered for substantive purposes regarding the disputed compensability issue) was considered for purposes of establishing the "time devoted to the case" factor prescribed in OAR 438-015-0010(4) in determining the amount of a reasonable attorney fee award. Reasoning that the worker's counsel's brief confirmed that time had been extended concerning the compensability issue that the carrier had raised in its appeal, the Board considered the brief only for that purpose, along with the remaining "rule-based" factors prescribed in OAR 438-015-0010 in its determination of a reasonable carrier-paid attorney fee award.

Attorney Fee: "Post-ALJ Order" Information - ALJ Refusal to Reopen Record - No Abuse of Discretion ("007-0025"); Board Declined to Consider "Hearing-Related" Information Under "015-0029"

Marvin A. McGuire, 71 Van Natta 762 (July 11, 2019). Analyzing OAR 438-007-0025, the Board found no abuse of discretion in an ALJ's refusal to reopen the record for admission of a worker's counsel's "attorney fee" information because the submission had been filed after the issuance of the ALJ's order (which found the worker's claim compensable and awarded a carrier-paid attorney fee). Noting that there was no contention that the worker's counsel's "post-order" submission could not reasonably have been obtained/produced at the hearing, the Board concluded that the ALJ's refusal to reopen the record for consideration of such information was within the ALJ's discretion.

In addition, the Board declined to consider the worker's counsel's "declaration" of services rendered by the attorney at the hearing level. Reiterating that "attorney fee-related" information permitted on Board review under OAR 438-015-0029 does not extend to information concerning the review of an ALJ's attorney fee award for services provided at the hearing level, the Board declined to consider the worker's counsel's "declaration" that pertained to his counsel's "hearing" services.

CDA: Board Approval Withdrawn - CDA Lacked "Attorney Fee Lien" Provision - CDA "Void" - "10-Day Recon" Rule Not Applicable - "009-0035"/"015-0022"

Richardo Rojena-Fornaris, 71 Van Natta 340 (March 29, 2019). Analyzing ORS 656.236, OAR 438-009-0035, and OAR 438-015-0022, the Board held that a previously approved Claim Disposition Agreement (CDA) was void because, although a motion for reconsideration had not been filed within 10 days of its approval, the agreement had not contained a provision resolving a dispute regarding the worker's former counsel's attorney fee lien. Noting that it was undisputed that the lien had been in the carrier's possession when the CDA was negotiated and approved, the Board determined that, consistent with OAR 438-015-0022, the CDA was required to include a provision concerning the resolution of the lien.

Because the CDA lacked such a provision, the Board concluded that the agreement was void and its previous approval of the CDA was invalid, irrespective of an untimely motion for reconsideration.

CDA: Reconsideration - "10-Day" Period Expired on Saturday - Next Business Day, Monday, Final Day for Filing "Recon" Request/Addendum

Michael York, 70 Van Natta 1274 (November 26, 2018). Applying OAR 438-009-0035(1), and (2), the Board held that it was authorized to reconsider its approval of a Claim Disposition Agreement (CDA) to consider the parties' proposed addendum because the addendum was filed on the first business day (Monday) after the expiration of the 10-day "reconsideration" period had expired on the previous Saturday. Relying on statutory law and case precedent, the Board concluded that, when the last day of an appeal period falls on a weekend or legal holiday, the appeal period runs until the end of the next business day.

Claim Filing: "Good Cause" for Untimely Filed Claim - Claimant's Subjective Belief of Firing for Filing Claim - "Objectively Reasonable" - "265(4)(c)"

Andrew Kuralt, 71 Van Natta 194 (February 22, 2019). Applying ORS 656.245(4)(c), the Board found that a worker had "good cause" for his untimely filed injury claim because he had an "objectively reasonable" basis for his subjective belief that his job was in jeopardy if he filed another workers' compensation claim. Noting that, in evaluating an "objective standard of reasonableness," it analyzes the situation as the worker knew it (rather than information to which he was unaware or was unable to appreciate), the Board reiterated that a worker's subjective belief must be objectively reasonable; *i.e.*, it must be induced by some actual occurrence which is susceptible to such an interpretation by him.

Applying that standard to the present case, the Board found that, based on conversations with the controller where he worked, as well as his coworkers, and knowledge that the controller's concerns regarding his previous accidents had been relayed to his supervisor, the worker's subjective belief that his job would be in jeopardy if he filed another workers' compensation claim was objectively reasonable. Consequently, the Board concluded that the worker had established "good cause" for his untimely filed injury claim.

A dissenting opinion did not consider the worker's subjective belief that he would be fired if he filed another claim was objectively reasonable. In reaching this conclusion, the dissent noted that the worker acknowledged that he had a good rapport with the company, was a respected senior union-represented employee, and was aware that no other employee had ever been terminated for filing a workers' compensation claim.

Claim Preclusion: Currently Claimed Condition Was "Same Condition" as Previously Claimed/Denied Condition - Claim Limited to "Post-Claim" "Worsening"

Andrey V. Antonyuk, 71 Van Natta 321 (March 21, 2019). The Board held that, because a new/omitted medical condition claim was for the same condition that had been previously denied (which had become final by operation of law), the claim for that condition was precluded and, because the record did not establish a worsening of the previously denied condition, the currently claimed condition was not compensable. Finding that the medical evidence established that the worker's currently claimed L4-5 disc "herniation" condition was the same condition as his previously denied L4-5 disc "extrusion," the Board reasoned that the worker was barred from claiming compensation for his L4-5 disc herniation unless that condition had changed since the prior denial (which had become final by operation of law). Noting that a physician's opinion that the worker's condition had "changed over time" had not clarified that the change occurred after the previous denial, the Board was not persuaded that the worker had established a "post-denial" worsening of his claimed condition and, as such, his claim was precluded.

Claim Processing: Prior Litigation Order Did Not Find Specific Condition ("Wrist Infection") Compensable - But, "Infection" Was "Caused In Major Part" by "Compensable Injury" ("Work Accident") & Medical Services Were "Directed To" the "Infection" - "245(1)(a)"

Paul A. Mosely, 71 Van Natta 719 (July 8, 2019). Applying ORS 656.245(1)(a), the Board held that a worker's medical services claim for a wrist infection/compressed nerve condition was compensable, despite a carrier's "post-litigation order" acceptance of a wrist sprain. Noting that the prior litigation order had not found a particular condition compensable (but rather set aside the carrier's initial denial and remanded the claim to the carrier for further processing), the Board disagreed with the worker's contention that the carrier was required by the order to accept his wrist infection and to pay for the medical services for that condition. Nonetheless, persuaded by a physician's opinion that the work-related injury was the major contributing cause of the worker's wrist infection, the Board found that the disputed medical services were "directed to" a medical condition (*i.e.*, the wrist infection) caused in major part by the "work accident." Under such circumstances, the Board concluded that the carrier was responsible for the worker's medical service claim.

Combined Condition: "Ceases" Denial - Requisite "Change" Since Acceptance Not Proven - Physicians Supported "Change" During "Acceptance" Period - "262(6)(c)"

Clara A. Zehrt-Shay, Dcd, 71 Van Natta 477 (April 30, 2019). Applying ORS 656.262(6)(c) and ORS 656.266(2)(a), the Board set aside a carrier's "ceases" denial of a worker's combined knee condition because the opinions on which the carrier had relied

to establish a "change" in the combined condition since its acceptance of the combined condition referred to a period in which the worker's aggravation claim (based on that combined condition) was in accepted status. The Board reiterated that, to support its "ceases" denial of the worker's previously accepted combined knee condition, the carrier must establish a "change" in the combined condition since the effective date of its acceptance of the combined condition (which was the date of the worker's initial injury). Observing that the carrier had subsequently accepted an aggravation claim of the worker's knee condition (based on her accepted combined knee condition), the Board noted that the physicians' opinions on which the carrier relied to support a "change" in the worker's combined knee condition referred to a date during the period in which the combined condition was in accepted status. Under such circumstances, the Board concluded that the carrier had not established the requisite "change" in the worker's combined condition to support its "ceases" denial.

Combined Condition: Consists of "Two Medical Problems Simultaneously" - Carrier Met "Burden of Proof" Under "266(2)(a)" - Work Injury Not Major Cause of Disability/ Treatment for "Combined" Shoulder Condition (Exacerbation of Symptoms from Preexisting Arthritic Condition)

Mario Carrillo, 70 Van Natta 1815 (December 6, 2018). Applying ORS 656.005(7)(a)(B), and ORS 656.266(2)(a), the Board upheld a denial of a worker's injury claim for a shoulder condition, finding that the carrier had established the existence of a "combined condition" (*i.e.*, a "work-related" exacerbation of his shoulder symptoms from his preexisting degenerative arthritis) and that his work injury was not the major contributing cause of his need for treatment/disability for that combined shoulder condition. Relying on a Supreme Court decision (*McAtee*), the Board stated that a "combined condition" can consist of "two medical problems simultaneously" and, as such, disagreed with the worker's characterization of his claim as one for a worsened preexisting condition. Instead, reasoning that the "symptomatic flare-up" of the worker's preexisting arthritic condition constituted a "combined condition" under the *McAtee* rationale, the Board analyzed the claim under ORS 656.005(7)(a)(B) and ORS 656.266(2)(a). After conducting that analysis, the Board determined that the medical evidence persuasively established that the work injury was not the major contributing cause of the worker's need for treatment/disability for his combined shoulder condition.

Combined Condition: "Preexisting Condition" Includes Treatment/Disability for Previous "Out-of-State" Injury for Claimed Condition - "005(24)," "005(7)(a)(B)," "266(2)(a)"

Bruce H. Wooley, 70 Van Natta 1283 (November 30, 2018). The Board held that a carrier's denial of a worker's knee injury claim (which had been based on a contention that the work injury had combined with a preexisting arthritic condition and the injury was not the major contributing cause of the worker's need for treatment/disability for a

combined condition) was not invalid because it had not also disclaimed responsibility when a portion of the "preexisting condition" was allegedly attributable to a prior "out-of-state" work injury/treatment. The Board reiterated that "out-of-state" work injuries and resulting treatment constitute "preexisting conditions" under ORS 656.005(24) and that compensability is a threshold issue before resolving compensability/responsibility disputes. Consequently, because the carrier had chosen to deny the compensability of the worker's injury claim and had successfully met its burden of proving that the claim was not compensable under a "combined condition" defense pursuant to ORS 656.266(2)(a) and ORS 656.005(7)(a)(B), the Board concluded that it was unnecessary to address a "responsibility" issue because the claimed condition was not compensable.

Compensability: Claimant's "Hearsay" Statements in Physician's Reports (If Consistent) - *Prima Facie* Evidence for Purposes of "Diagnosis/Treatment" - "310(2)"

Juan F. Figueroa-Guzman, 71 Van Natta 1 (January 4, 2019). Applying ORS 656.310(2), the Board found that, despite a worker's non-appearance at a hearing regarding a carrier's denial of a worker's new/omitted medical condition claim for a hernia, his consistent statements from examining physicians' reports were given *prima facie* weight to establish medical causation of his claimed hernia and, because the carrier had previously accepted his initial leg injury claim stemming from the same work incident, legal causation of his claimed hernia had also been proven. Relying on court precedent (*Camacho v. SAIF*, *Zurita v. Canby Nursery*), the Board reiterated that a worker's hearsay statements in medical reports (to the extent they are consistent) concerning how an injury occurred, the nature of the pain resulting from the injury, and the medical history are considered to be "reasonably pertinent" to a physician's ability to diagnose and treat an injury and, as such, constitute *prima facie* evidence under ORS 656.310(2)

Consequently, based on the worker's uncontradicted statements in examining physicians' reports (*e.g.*, following his work incident, he experienced hernia pain, swelling, and bulging), the Board concluded that such statements were "reasonably pertinent" to his physicians' ability to diagnose and treat his injury and, as such, established that his claimed hernia was medically caused by his work incident. Moreover, because the carrier had already accepted conditions resulting from the work incident, the Board was persuaded that a potentially causal work event regarding the claimed hernia had occurred and, therefore, "legal causation" regarding his claimed hernia condition had been satisfied.

Consequential Condition: Depression - Emotional Reaction to Claim Processing Cannot Be Considered - Concerns About Inability to Work/Return to Work Can Be Considered

Timothy J. Poppleton, 70 Van Natta 1197 (October 26, 2018). Applying ORS 656.005(7)(a)(A), the Board held that, in analyzing the compensability of a worker's new/omitted medical condition claim for depression, his emotional reaction to the processing of his claim could not be considered, but his pain complaints and concerns regarding his inability to work and ability to return to work as a result of his previously accepted concussion/cervical conditions could be considered in determining whether those conditions were the major contributing cause of his claimed depression. Despite discounting a portion of a physician's opinion which had referred to the worker's "uncertainty" regarding the processing of his claim in analyzing the claimed depression condition, the Board determined that the remainder of the physician's opinion (which attributed the worker's depression to his pain symptoms and concerns about his ability to return to work resulting from his accepted concussion/cervical conditions) persuasively established that the accepted conditions were the major contributing cause of his depression.

Finally, the Board acknowledged the carrier's argument that the worker's depression claim was precluded because an earlier Order on Reconsideration had apportioned his permanent impairment for his cervical condition based on preexisting arthritis. However, because this "claim preclusion" argument had not been raised at the hearing level, the Board declined to consider it on appeal.

Course & Scope: "Mixed Risk" Doctrine - Fainting While Snow Shoveling at Work - "Personal/Work-Related" Reasons for Fainting - Injury "Arose Out Of" Employment

Torrey F. Wolbert, 71 Van Natta 645 (June 24, 2019). The Board held that a worker's injury, which occurred when he fainted and fell while shoveling snow at work, arose out of his employment under the "mixed risk" doctrine because, although there were some personal reasons for his fainting (*e.g.*, lack of sleep, lack of food, dehydration), the physical exertion of his work activities (*i.e.*, snow shoveling) had also contributed to his fainting episode. Under the "mixed risk" doctrine, the Board reiterated that an injury that results from a fall that is due to both personal and employment reasons arises out of employment because employment is a contributing factor to the fall.

Applying the "mixed risk" doctrine to the present case, the Board found that both of the examining physicians had attributed the worker's fainting episode, at least in part, to his physical exertion while snow shoveling. Consequently, because this work activity had contributed to the worker's fainting and fall, the Board concluded that his injury from that fall had arisen from his employment.

Course & Scope: "Parking Lot" Fall - No "Employer Control" Over Leased Lot - "Parking Lot" Exception to "Going/Coming" Rule N/A

Sherrie A. Miles, 71 Van Natta 40 (January 16, 2019). The Board held that a worker's injury, which occurred when she fell in a parking lot while coming to work at her employer's leased rental premises, did not occur in the course of her employment as a pharmacy technician because her employer had no right to control the parking lot. The Board acknowledged that the employer periodically removed trash and other hazards from the parking lot around its store. Nonetheless, reasoning that the maintenance of the parking lot was solely the responsibility of the landlord according to the employer's lease, the Board concluded that the employer had no right to exercise control over the parking lot. Accordingly, the Board determined that the "parking lot" exception to the "going and coming" rule did not apply and as such the worker's injury did not occur in the course of her employment.

Furthermore, concerning the "arising out of" prong of the "work connection" test, the Board found that the worker's risk of injury from falling in the parking lot did not result from the nature of her employment as a pharmacy technician nor did it originate from some risk to which her work environment exposed her. Under such circumstances, the Board also concluded that the worker's injury did not arise out of her employment.

Course &Scope: "Off-Day" MVA - Delivering Cash to Employer for Office Holiday Pizza Party - "Special Errand"/Within "Reasonable Bounds" of Employment/For Employer's Benefit - Injury Occurred W/I Course & Arose Out of Employment

Cassandra Sumner, 71 Van Natta 624 (June 14, 2019). The Board held that a worker's injury, which occurred during her off-day while she was driving to deliver cash to her supervisor at her coworker's request to pay for pizza for a holiday party, arose out of and in the course of her employment because she was acting within the reasonable bounds of her employment (as an administrator for a residential home for disabled individuals) and for the benefit of her employer. Although acknowledging that the worker was not scheduled to work on the day of her injury and recognizing that her supervisor had not directed her to deliver the cash to him, the Board reasoned that the worker was acting for the employer's benefit and was assisting a coworker, which was in accordance with her training to be a "team player." Further noting that the worker's duties were not limited to work hours (which included the performance of special tasks/errands for the employer), the Board concluded that her injury had occurred in the course of her employment.

Turning to the "arising out of employment" question, the Board determined that the risk of being injured while performing her special task/errand was a risk resulting from the nature of her employment. Consequently, the Board concluded that the worker's injury (which had been sustained while delivering cash to her supervisor to pay for pizza for the holiday party) "arose out of" her employment.

Course & Scope: "Rest Break/Walking" Injury - "Personal Comfort" Doctrine - But, Did Not "Arise Out of" Employment - No "Employment" Risk - Tripped on Public Sidewalk

Katherine Mandes, 71 Van Natta 240 (March 1, 2019). The Board held that a worker's injury, which occurred while she was returning to the office building where her employer leased office space as she was completing her "rest break" walk with coworkers, occurred "in the course of" her employment (under the "personal comfort" doctrine), her injury did not "arise out of" her employment because it was caused by her tripping on an uneven public sidewalk over which her employer had no right of control. Reasoning that the worker was injured during her regular work hours, while on a paid break, and her walking was acquiesced in by her employer, the Board determined that she had been engaged in a "personal comfort" activity and, as such, her injury had occurred in the course of her employment.

However, addressing the "arising out of" prong of the unitary work-connection test, the Board noted that the uneven public sidewalk where the worker had fallen was not an employment-created hazard and that her employer had no right of control, or duty to maintain, the area in which she had fallen. Furthermore, reasoning that the worker had chosen when and where to walk during her break (without any direction from her employer regarding any particular route), the Board concluded that the record lacked a sufficient causal connection between the worker's risk of injury while walking on a public sidewalk during her rest break and her employment. Consequently, because the worker's injury did not arise out of her employment, the Board held that her injury was not compensable.

A concurring opinion considered the worker's walking activity to be the type of "recreational" activity excluded from compensability under ORS 656.005(7)(b)(B). Although recognizing that this statutory affirmative defense to the worker's injury claim had not been preserved on appeal, the concurrence considered it important to address the statutory defense's applicability given the evolving case law surrounding "rest break/walking" injuries.

Another concurring opinion expressed frustration with a tendency from the court's case law to follow a mechanistic approach in analyzing whether an injury "arises out of" employment; *i.e.*, three categories for the risk of injury - employment, personal, and neutral. Questioning how there could ever be "minimal" factors sufficient to support the "arising out of" prong to satisfy the unitary work-connection test if the

risk of injury was "neutral" as in the present case, the concurrence felt constrained by the limited confines of the current case law to determine that the worker's injury did not "arise out of" her employment and, as such, was not compensable.

Course & Scope: Slip/Fall on Employer's Premises During Paid Rest Break - Met "Course Of" Prong Via "Personal Comfort" Doctrine - Met "Arising Out Of" Prong Because Returning from "Smoke Break" on Public Street Because Employer's Premises "Tobacco Free"

Donna L. Combs, 71 Van Natta 169 (February 19, 2019). The Board held that a worker's injury, which occurred when she slipped and fell on an icy sidewalk on her employer's premises arose out of and in the course of her employment because she fell on the employer's sidewalk while on her paid break and was returning from her initial destination (a public street) where employees congregated to smoke off the employer's premises due to its "tobacco free campus" policy. Concerning the "course of" employment prong of the work connection test, the Board stated that an employee remains in the course of employment if she/he engages in an activity that is not her/his appointed work task, but which is a "personal comfort" activity that bears a sufficient connection to her/his employment. Reasoning that the worker had been engaged in a typical kind of break activity while walking on her employer's premises that was contemplated by her employer (*i.e.*, walking to/from the public street to smoke due to the employer's "tobacco free campus" policy), the Board concluded that she was injured in the course of her employment under the "personal comfort" doctrine.

Addressing the "arising out of" prong, the Board did not consider the risk of the worker's slipping and falling on an icy sidewalk to be a risk connected with the nature of her work as a patient access representative. Nonetheless, reasoning that the worker had been injured while returning to her work station from her paid break on her employer's sidewalk, where her employer contemplated that she (and other employees) would walk due to its "tobacco free campus" policy, the Board determined that the worker's work environment had exposed her to the risk of injury while walking on the employer's premises during her paid break.

In reaching its conclusion, the Board acknowledged the carrier's focus on the worker's smoking as the activity she had engaged in when she sustained her injury. However, the Board emphasized that the worker's injury had occurred when she slipped on the sidewalk while walking on her employer's premises during her paid break.

Evidence: Exclusion of Expert Witness Testimony for Untimely "Notice" Under "007-0016" - ALJ Did Not Abuse Discretion - "Material Prejudice" to Opposing Party, Lack of "Good Cause" for Rule Violation

John Kramer, 70 Van Natta 1856 (December 26, 2018). Analyzing OAR 438-007-0016, the Board held that an ALJ's exclusion of a physician's testimony (based on a worker's attorney's failure to provide timely notice of an intent to call the physician as an expert witness) did not constitute an abuse of discretion because the record established that the carrier had been materially prejudiced by the "at-hearing" notice of the worker's intent to call the physician as a witness and that the worker's attorney's unfamiliarity with the "notice of expert witness" rule did not constitute "good cause" for the violation of the rule. In reaching its conclusion, the Board rejected the worker's argument that the carrier had waived its objection to the physician's testimony because it had subsequently chosen not to depose the physician or obtain a rebuttal report from another physician. Reasoning that the carrier had continued to raise the evidentiary issue throughout the litigation process, the Board determined that the carrier had not intentionally relinquished a known right (*i.e.*, its objection to the physician's testimony).

Finally, regarding the validity of the carrier's denial of a new/omitted medical condition claim, the Board acknowledged that a carrier is not required to process a new/omitted medical condition claim that has been initiated before the acceptance of any condition arising from the initial claim. Nevertheless, reasoning that such a challenge to the denial would be "procedural" (rather than "jurisdictional") in nature, the Board disagreed with the worker's assertion that it lacked "jurisdiction" to consider the merits of the denied new/omitted medical condition claim. Instead, noting that the worker had not raised his "procedural" challenge to the denial's validity at the initial hearing (nor at several other stages of the litigation process), the Board declined to consider the worker's "procedural" challenge on appeal.

Extent: Impairment Findings - Apportionment - Impairment Related to "Undiagnosed" Condition Not Ratable - Superimposed/Unrelated Condition - "035-0007(1)(b)(B)"

Reina Cruz-Salazar, 71 Van Natta 525 (May 9, 2019). Applying OAR 436-035-0007(1)(b)(B), in rating a worker's permanent impairment for her accepted elbow/shoulder conditions, the Board apportioned her impairment between that attributable to her accepted conditions and that related to "as yet undiagnosed conditions" as found by a medical arbiter. Stating that a worker is entitled to an impairment value for impairment findings that are permanent and caused by the accepted condition or its direct medical sequelae, the Board concluded that the Director's disability standards did not provide for an impairment award for an "undiagnosed" condition. Reasoning that the "undiagnosed" condition was most similar to a "superimposed condition," the Board determined that such a condition was not entitled to a permanent impairment award under the Director's disability standards.

In reaching its conclusion, the Board commented that the worker might ultimately be entitled to a permanent disability award for the "as yet undiagnosed condition," provided that the worker subsequently initiated a claim for a new/omitted medical condition claim that the carrier accepted, closed, and eventually evaluated for permanent impairment.

Hearing Request: "Good Cause" for Untimely Filed Request Not Established - Denial Not Confusing About "60-Day Period" to Timely File Request, No Evidence That Claimant Misled by Carrier - "319(1)(b)"

Daron J. Havlik, recons, 71 Van Natta 427 (April 22, 2019). Applying ORS 656.319(1)(b), the Board found that, in the absence of evidence that a carrier had misled a worker regarding when/how to contest a denial of his claim, his confusion regarding when to request a hearing from a carrier's denial did not constitute "good cause" for the untimely filing of a hearing request regarding the denial. Although acknowledging the worker's contention that he believed that he had to wait 60 days from the denial to file his hearing request, the Board found no indication in the record that either the carrier's claim denial or its claim examiner had misled him regarding the 60-day filing requirement.

Unpersuaded that the worker had used reasonable diligence to clarify any confusion he may have had about the instructions for appealing the carrier's denial, the Board concluded that he lacked "good cause" for his untimely filed hearing request. In reaching its conclusion, the Board reiterated that "good cause" under ORS 656.319(1)(b) is not a matter of "discretion," but rather is based on "agency judgment."

Interim Compensation: Awardable for Noncompensable Claim - Would Not Constitute "Administrative Overpayment" - Awardable from "AP" Verification of Inability to Work Until Denial (Or Date of Hearing, if No Denial)

Donald J. Dugas II, 71 Van Natta 512 (May 8, 2019). Applying ORS 656.262(4)(a), the Board held that a worker was entitled to interim compensation benefits because a carrier had received written notice of an attending physician's verification of a worker's inability to work due to his new/omitted medical condition and did not issue a denial of the claim, even though the new/omitted medical condition claim was not compensable. Reasoning that a carrier is statutorily obligated to provide interim compensation benefits pending its acceptance/denial of the claim, the Board reasoned that the carrier's responsibility to pay such benefits was not dependent on whether the underlying claim was ultimately determined to be compensable. Observing that the carrier could have reduced its liability for such interim compensation benefits by issuing a claim denial, the Board concluded that the worker was entitled to such benefits, beginning with the date of the carrier's written notice of the attending physician's medical verification and, because the worker had not returned to work, extending until the date of the hearing.

Jurisdiction: Hearings Division Authorized to Consider Decedent's Mother's Hearing Request Regarding "*De Facto*" Denial Of "Dependent" Claim - Filed W/I Two Years of Claim - ARU's Order on Reconsideration (Concerning Decedent's "Fatality" Claim) Not Preclusive on "Beneficiary" Claim - "319(6)," "030-0015(1)(c)(B)"

Bradley D. Yonker, Dcd, 71 Van Natta 145 (February 13, 2019). Analyzing ORS 656.319(6), ORS 656.005(10)(a)(A), (C), ORS 656.204(4)(a), ORS 656.283, and ORS 656.726, the Board held that the Hearings Division was authorized to resolve a dispute regarding a deceased worker's mother's dependent claim because, notwithstanding an unappealed Order on Reconsideration from the Appellate Review Unit (ARU) (which affirmed the carrier's Notice of Closure (NOC) concerning its acceptance of the decedent's fatality claim), the decedent's mother had filed her hearing request within two years of her benefits claim to the carrier. Although acknowledging that ARU was authorized to address whether the NOC had complied with a WCD rule regarding the acceptance of the decedent's fatality claim and the identification of any current beneficiary, the Board concluded that the question of whether the decedent's mother qualified as a "beneficiary" constituted a "matter concerning a claim," which was solely within the purview of the Hearings Division. Consequently, the Board reasoned that the unappealed Order on Reconsideration did not preclude the decedent's mother's hearing request concerning the carrier's alleged *de facto* denial of her death benefit claim and, because the request had been filed within two years of her claim for such benefits to the carrier (who had neither accepted nor denied the claim), her hearing request was not untimely under ORS 656.319(6).

Addressing the issue of whether decedent's mother qualified as a "dependent" entitled to death benefits under ORS 656.204(4)(a) and ORS 656.005(10)(a)(A), the Board stated that she must establish "actual dependency," which does not require proof that, without decedent's contributions, she would have lacked the necessities of life, but rather only that decedent's contributions were relied on by her to retain her accustomed mode of living and that he had contributed more than his own maintenance cost. Applying that standard to the present case, the Board found that, based on the decedent's mother's unchallenged affidavit and her credible testimony, as corroborated by another witness's testimony, the decedent contributed monthly to the household beyond his average maintenance costs. Consequently, the Board concluded that decedent's mother was dependent, at least in part, on the decedent's contributions to her accustomed mode of living and, as such, entitled to death benefits.

A dissenting opinion disagreed with the majority's "dependent" determination. Asserting that the decedent's mother's affidavit was inconsistent with her and another witness's testimony, the dissent did not consider the record sufficient to establish that the decedent had contributed any more than his maintenance costs to the household or that his mother was dependent, in whole or in part, on his income.

Medical Services: Denial of "Current" Medical Treatment - Not Invalid "Prospective" Denial

Randy W. Collins, 70 Van Natta 1224 (November 7, 2018). The Board held that a carrier's denial of a worker's "current need for treatment" did not constitute an invalid "prospective" denial of medical services because the carrier had neither denied the worker's "current *condition*" nor any potential future need for medical treatment. The Board reiterated that, in the absence of a claim, a carrier's denial of a worker's "current condition" is invalid as a prospective denial of a future need for medical treatment. However, reasoning that the carrier had expressly denied the worker's "current need for treatment" (rather than "current *condition*") and had not purported to deny any potential future need for medical treatment, the Board concluded that the denial was not invalid.

Medical Services: Gastric Bypass Surgery - Directed Solely to Unrelated Obesity, Not Accepted Low Back Condition - Not Compensable - "245(1)(a)"

Richard D. Verkist, 71 Van Natta 312 (March 19, 2019). Applying ORS 656.245(1)(a), the Board held that a worker's gastric bypass surgery was not compensable because the medical service was directed solely at his obesity, rather than directed, in material part, to his accepted low back condition. The Board acknowledged that, even if the worker would receive incidental benefit to his unrelated obesity from the surgery, the medical service would still be compensable if it was due, in material part, to his accepted low back condition.

Nonetheless, persuaded by a physician's opinion that the gastric bypass surgery was solely directed to the worker's unrelated obesity, the Board determined that the surgery had no relationship to his accepted low back condition and, as such, the benefit to his obesity was not "incidental." Consequently, the Board upheld the carrier's denial of the medical service claim.

Medical Services: "Hardware Removal" Surgery - Directed to "Combined Condition" - "Effective Date" of "Ceases" Denial Was After Surgery Requested - "245(1)(a)"

Fred D. Harris, 71 Van Natta 46 (January 16, 2019). Applying ORS 656.268(1)(b), and OAR 436-035-0014(4), the Board held that, in rating a worker's permanent impairment for an accepted wrist sprain and carpal tunnel syndrome (CTS), his surgery for a previously accepted combined arthritic wrist condition (as well as any impairment due to that surgery) could not be considered because, before claim closure, the carrier had denied the combined condition. Although acknowledging that the wrist surgery had been performed while the worker's combined wrist condition was accepted, the Board noted that the combined condition was denied before the claim was closed.

Furthermore, observing that the medical arbiter's findings had not attributed the worker's surgery-related impairment to his accepted wrist sprain/CTS, the Board concluded that no permanent disability was awardable for either the surgery or any impairment attributable to the surgery.

Medical Services: MRI Directed "In Material Part" to Accepted Knee Condition - Carrier Responsible for Medical Service Even if Partially Due to Noncompensable Degenerative Condition - "245(1)(a)"

Daniel B. Slater, 71 Van Natta 962 (August 28, 2019). Applying ORS 656.245(1)(a), the Board held that a carrier was responsible for a worker's MRI procedure for his knee condition because the record established that the medical service was directed, in material part, to his accepted knee strain/tear conditions, even though the MRI might also be attributable to a noncompensable degenerative condition. Reiterating that ORS 656.245(1)(a) does not limit the compensability of medical services simply because those services also provide incidental benefits that help or treat noncompensable conditions, the Board concluded that, even though the carrier's "ceases" denial of a combined knee condition had been upheld, the carrier remained responsible for the MRI procedure because the worker's physician had ultimately opined that the MRI was also materially related to his compensable injury and would be of assistance in determining the extent of that injury. Under such circumstances, the Board determined that the MRI was also "for" or "directed to" the worker's accepted knee condition and, as such, was a compensable medical service.

Medical Services: "Prosthetic-Related" Dispute (Monitor, Replace, Repair) - Jurisdiction Rests With WCD - "704(3)(b)(B)", "245(1)(c)(E)"

Jack L. Edwards, 71 Van Natta 506 (May 7, 2019). Analyzing ORS 656.245(1)(a), (c)(E), and ORS 656.704(3)(b)(B), the Board held that, insofar as a dispute regarding a medical service claim concerned whether such services were necessary to monitor the status, replacement or repair of a worker's hip prosthesis, jurisdiction to resolve such a dispute rested with the Workers' Compensation Division (WCD). Noting that a carrier's denial of the worker's new/omitted medical condition claim for a hip infection had been upheld as not causally related to his accepted hip fracture, the Board determined that, to the extent the worker's medical service claim concerned the hip infection, such a claim was not compensable. Nevertheless, insofar as the worker's medical service claim pertained to his hip prosthesis, the Board concluded that such a dispute was not a matter concerning a claim under ORS 656.704(3)(b)(B). Reasoning that jurisdiction over a medical service dispute regarding the prosthetic device fell within the jurisdiction of WCD, the Board referred that portion of the dispute to WCD for resolution.

Medical Services: Surgery "Due in Material Part" to "Work Accident" - Partial Relationship to "Off Work" Incident Not Determinative - WCB Retains "Causal Relationship" Jurisdiction Irrespective of "AP" Change of "Causation" Theory

Jose L. Cardona-Ornelas, 71 Van Natta 686 (July 2, 2019). Applying ORS 656.245(1)(a), the Board held that a carrier was responsible for a worker's medical service claim for ankle surgery because, even if the surgery was also directed at a "post-injury" unaccepted fracture, the surgery was also due in material part to his compensable injury (*i.e.*, his "work accident"). Reiterating that a medical service is compensable if it is for a condition due in material part to the "compensable injury" (which for purposes of the first part of the first sentence in ORS 656.245(1)(a) is the "work accident"), the Board reasoned that, even if the worker's subsequent "nonunion" in his ankle was considered a condition distinct from his accepted ankle fracture, his medical service claim was still compensable.

In reaching its conclusion, the Board rejected the carrier's contention that, because the attending physician's "nonunion" theory regarding the worker's ankle condition had arisen after a WCD order transferring the medical service "causation" dispute to the Hearings Division, it was premature for the Board to resolve the issue. Relying on ORS 656.704(3)(b)(C), the Board reasoned that it was authorized to determine whether a sufficient causal relationship existed between medical services and an accepted claim, regardless of a physician's change of opinion.

Medically Stationary: "030-0035(4)" Did Not Apply - No "Conflict" in "Med Stat" Date; Even if "Conflict," Conditions "Med Stat" on Earlier Exam Date

Johanna L. Southard, 71 Van Natta 660 (June 25, 2019). Analyzing ORS 656.005(17), and OAR 436-030-0035(1)(a), (4), the Board found that, because a worker's accepted conditions were medically stationary on a specific date based on her attending physician's opinion, it was unnecessary to apply OAR 436-030-0035(4) (which provides that, in the event of a conflict, a "medically stationary" date is the date of a worker's examination, rather than the date of the physician's report) because there was no "conflict" regarding the worker's "medically stationary" date. Noting that, after reviewing medical records, surveillance film, and concurring with the opinion of examining physicians, the attending physician had expressly declared the worker's conditions to be medically stationary as of a specific date, the Board disagreed with the worker's contention that the attending physician's subsequent concurrence with another physician's opinion (which noted some improvement in a condition that had been denied by the carrier) established a "medically stationary" date as of that later examination pursuant to OAR 436-030-0035(4). Reasoning that there was no "conflict" regarding

the worker's "medically stationary" date, the Board determined that the rule was not applicable. Alternatively, even assuming that a "conflict" existed and the rule did apply, the Board found that the earliest examination date on which the worker's condition was considered medically stationary was the same date that the attending physician had previously identified.

A concurring opinion expressed concern regarding a physician's ability to declare a worker's condition medically stationary several months after an examination. Noting that physicians are restricted from "retroactively" authorizing temporary disability benefits more than two weeks under ORS 656.262(4)(g), the concurrence considered it fair that physicians likewise be limited to "retroactively" authorizing "medical stationary" status for a similar two-week period.

New/Omitted Medical Condition: Claimed Traumatic Brain Injury (TBI) Encompassed in Previously Accepted Concussion Condition - Carrier's "Compensability" Denial Set Aside

Kelli Phillips, 71 Van Natta 297 (March 18, 2019). The Board set aside a carrier's denial of a worker's new/omitted medical condition claim for a traumatic brain injury (TBI) because the carrier had denied that the worker's injury had caused her claimed TBI, but the record established that the TBI was "encompassed" within her previously accepted concussion condition. The Board acknowledged that if a new/omitted medical condition claim is denied as being neither "new" nor "omitted" and the record supports such a conclusion, a carrier's claim denial on that basis is upheld. Nonetheless, emphasizing that the carrier had denied that the worker's TBI condition was caused by her work injury, the Board concluded that the denial must be set aside because the record established that his TBI was encompassed within his previously accepted concussion and, as such, was caused by her work injury.

New/Omitted Medical Conditions: Separate Psychological Conditions - Analyzed Under Different "Compensability" Standards - "PTSD" as a "Mental Disorder" Under "802(3)" - "Adjustment Disorder" as a "Consequential Condition" Under "005(7)(a)(A)"

Timothy L. Ogden, 70 Van Natta 1039 (September 5, 2018). Applying ORS 656.005(7)(a)(A) and ORS 656.802(3), the Board held that a worker's new/omitted medical condition claims for post-traumatic stress disorder (PTSD) and adjustment disorder should be analyzed under different compensability standards because the record established that the PTSD was a claimed "mental disorder" attributable to the work-related motor vehicle accident, while the claimed adjustment disorder was a "consequential condition" related to his accepted conditions (resulting from that MVA). Reiterating that accepted conditions must be the major contributing cause of a "consequential condition" under ORS 656.005(7)(a)(A) and that a "mental disorder"

must satisfy all of the statutory requirements for such a condition pursuant to ORS 656.802(3), the Board found that the opinion from the worker's psychologist had persuasively met each of these separate standards for establishing the compensability of the claimed conditions.

"Non-Cooperation" Denial: "262(15)" - Claimant "Reasonably Cooperated" with Carrier W/I 30 Days of WCD's "Suspension" Order - Denial Procedurally Invalid

Basil D. Yauger, 71 Van Natta 882 (August 6, 2019). Applying ORS 656.262(15), the Board held that a carrier's "noncooperation" denial was procedurally invalid because the worker's contact with the carrier within 30 days of the Workers' Compensation Division's (WCD's) "suspension" order constituted "reasonable cooperation" in the carrier's claim investigation. Although acknowledging that the worker had not specifically offered to arrange or submit to an interview/deposition, the Board reasoned that his responsibility was to contact the carrier and show a willingness to cooperate. Finding that the worker's contact with the carrier within 30 days of WCD's "suspension" order was consistent with WCD's directive, the Board determined that, rather than issuing its "noncooperation" denial, the carrier could have made arrangements for the worker's interview/deposition.

"Non-Cooperation" Denial: Carrier's Denial & "Suspension" Request Invalid - Based on Claimant's Failure to Arrange Interview - Carrier's Notice Did Not Include "Date, Time, Place" of Interview Under "0060-0135(2)(a)" - Did Not "Strictly Comply" with Rule

Gustav A. Schenk, 71 Or App 178 (February 20, 2019). Analyzing ORS 656.262(15), and OAR 436-060-0135(2)(a), the Board set aside a Workers' Compensation Division's (WCD) order suspending a worker's compensation and a carrier's "noncooperation" denial, holding that a carrier's notice to a worker to contact the carrier to schedule an interview was invalid because the notice did not also include a date, time, and place for an interview as required by the administrative rule. Emphasizing that the text of the WCD rule mandates that the worker must be notified in writing of the date, time, and place of an interview before the carrier may seek the suspension of his compensation for not cooperating with an interview (rather than some other aspect of the carrier's claim investigation), the Board concluded that the carrier had not strictly complied with the WCD rule and, as such, WCD's "suspension" order and the carrier's "noncooperation" denial must be set aside.

A dissenting opinion asserted that it would be absurd to require a carrier to include the date, time, and place of an interview when it was seeking to arrange such an interview. Consequently, the dissent declined to interpret the rule in such a manner, particularly when WCD itself had not done so in granting the carrier's request for suspension of the worker's compensation for his failure to cooperate in the claim investigation.

Offset: Carrier's Payment of TTD Benefits Granted by Final Order on Reconsideration - Subject to "25 Percent Offset Limitation" Under "268(14)"

Jose Segovia-Funes, 70 Van Natta 1823 (December 6, 2018). Applying ORS 656.268(14)(a), the Board held that a carrier was not entitled to fully offset its overpayment of permanent disability (PPD) benefits against a worker's underpaid temporary disability (TTD) benefits granted by a final Order on Reconsideration because its offset was subject to the 25 percent statutory offset limitation. Noting that it was undisputed that the carrier had paid the TTD benefits that had been granted by the Order on Reconsideration based on an incorrect TTD rate, the Board determined that the underpaid benefits that the carrier had attempted to fully offset by PPD overpayment represented substantive TTD benefits that were awarded by a final order. Reasoning that to direct the carrier to pay the withheld TTD benefits (to which the worker was substantively entitled) did not create an "administrative overpayment," the Board concluded that the carrier was obligated to fully pay the underpaid TTD benefits, subject to the 25 percent offset limitation under ORS 656.268(14)(a).

Own Motion: Attorney Fee - Voluntary Claim Reopening - Attorney's Services Did Not "Result In Increased TTD" - "015-0080(2)"; Penalties/Attorney Fees - Untimely Voluntary Reopening, Unreasonable Refusal to Close Claim, Untimely First Installment of PPD Award - "262(11)(a)," "012-0110(1)," "012-0036(3)(a)," "015-0110"

Rigoberto Gonzalez-Hernandez, 71 Van Natta 596 (June 6, 2019). Applying OAR 438-015-0080(2), in an Own Motion Order, the Board held that a worker's counsel was not entitled to an "out-of-compensation" attorney fee arising from a carrier's voluntary reopening of a worker's Own Motion claim for a new/omitted medical condition because the attorney's services had not resulted in additional temporary disability benefits to the worker. Noting that, when the carrier reopened the claim for the new/omitted medical condition, it had already paid the worker temporary disability benefits for the period in question pursuant to its earlier claim reopening (which had been based on a worsening of a previously accepted condition), the Board was not persuaded that the worker's counsel's services in prompting the subsequent voluntary reopening of the Own Motion claim for the new/omitted medical condition had resulted in any increased temporary disability benefits.

Although concluding that an attorney fee under OAR 438-015-0080(2) was warranted, the Board found that the carrier's voluntary reopening of the Own Motion claim for the new/omitted medical condition had issued a year after its acceptance of the condition. Because the carrier was required to either issue a voluntary reopening or file an Own Motion Recommendation within 30 days of its claim acceptance, the Board concluded that the carrier's claim processing had been unreasonable. Consequently, the Board awarded penalties and attorney fees under ORS 656.262(11)(a).

Own Motion: Deferral of Review of "NOC" - Carrier Must First Close Previous "Vocational Assistance" Claim Following "ATP" - "268(10)"

Adele H. Tom, 71 Van Natta 68 (January 29, 2019). Analyzing ORS 656.268(10), the Board deferred its review of Own Motion Notices of Closure (NOC), holding that, because the carrier had not previously closed a worker's "vocational assistance" claim when her authorized training program (ATP) had ended, it would be premature to address permanent disability, temporary disability, and overpayment issues arising from the worker's request for review of the Own Motion NOCs until the worker's "vocational assistance" claim was first closed under ORS 656.268(10). In accordance with ORS 656.268(10), the Board concluded that, once the worker ceased to be enrolled and actually engaged in the ATP, the carrier was obligated to close her claim pursuant to that statute. Because the carrier had not issued a NOC under ORS 656.268 (but rather had reopened/closed Own Motion claims for worsened and new/omitted medical conditions), the Board determined that it was premature to address the issues arising from the Own Motion NOCs. Consequently, the Board deferred its review to await the carrier's eventual NOC (and litigation orders) under ORS 656.268. Once determinations regarding temporary/permanent disability and overpayment issues arising that NOC were resolved, the Board explained that it would commence its review of the issues stemming from the Own Motion NOCs.

Own Motion: Hearing Referral - Carrier Did Not Provide Reviewable Record - ALJ Directed to Issue Recommendation, Consider Imposition of Penalties/Attorney Fees for Carrier Rule Violations - "012-0017(1)," "012-0110(1)"

Brian L. Dugger, 70 Van Natta 1275 (November 27, 2018). In an Own Motion order under ORS 656.278, the Board referred a worker's request for Own Motion relief to the Hearings Division because the carrier had not submitted a written record in response to the worker's request despite several requests/reminders from the Board. Reasoning that the carrier had neglected to comply with its Own Motion claim processing obligations to submit copies to the Board of all relevant materials regarding the worker's request, as well as to timely respond to Board inquiries, the Board concluded that the record was insufficiently developed to address his request for Own Motion relief. Consequently, the Board referred the Own Motion matter to an ALJ to conduct an evidentiary hearing to develop the record and submit a recommendation to the Board (including consideration of penalties/attorney fees for any violations by the carrier of Board discovery rules, OAR 438-012-0017(1), OAR 438-012-0110(1)).

Own Motion: Permanent Disability - "278(2)(d)" Limitation - "Redetermination" of Current Disability, Before Application of "Limitation" for Prior Award to Same Body Part

James D. Miley, 70 Van Natta 1268 (November 19, 2018). Applying ORS 656.278(2)(d), on review of the closure of an Own Motion claim for a "post-aggravation rights" new/omitted medical condition (left knee osteoarthritis), the Board held that, despite a prior litigation order (which, in granting the worker a permanent disability award for his knee, had stated that any anticipated future knee problems had not been considered), the statutory limitation under ORS 656.278(2)(d) applied to the redetermination of the worker's current permanent disability because his left knee osteoarthritis involved the same "injured body part" (left knee/leg) that had been the basis for his previous permanent disability award for his accepted leg fracture. The Board acknowledged that the prior litigation order had recognized the potential of traumatic arthritis in the future, but had not granted an award for such a possibility. Nonetheless, the Board emphasized that it was mandated to apply the statutory limitation under ORS 656.278(2)(d) whenever there was (1) additional impairment to (2) an injured body part that has (3) previously been the basis of a permanent disability award.

Reasoning that the worker's new/omitted medical condition (left knee osteoarthritis) involved the same "injured body part" (left leg/knee) that was the basis of his previous 40 percent scheduled permanent disability award, the Board concluded that the limitation under ORS 656.278(2)(d) applied. Therefore, after a redetermination of the worker's current permanent disability for his left knee (which resulted in 35 percent for the loss or function of the left leg (knee)), the Board applied the statutory limitation (*i.e.*, his prior 40 percent award). Because the worker's prior permanent disability award exceeded the worker's current redetermination of his permanent disability, the Board found that an additional award was not warranted.

Own Motion: "Post-Arbiter Report" Raising of "Premature Closure" Argument/ Untimely Raised - Carrier's TTD Argument Reviewable Based on Claimant's "NOC" Appeal - "Hearing Referral" on TTD Issue Unnecessary (Record Sufficiently Developed) - Unreasonable Failure to Pay TTD Award from NOC

Larry D. Higgins, 71 Van Natta 808 (July 16, 2019). In an Own Motion order, the Board declined to consider a worker's argument that his claim had been prematurely closed because he had not raised that argument until after he had requested a medical arbiter examination and received the arbiter's report. The Board explained that its practice is to defer a worker's medical arbiter request to determine whether the claim was properly closed, which avoids unnecessary delay and expense to the parties arising from a "post-arbiter" premature closure argument.

On another subject, the Board allowed consideration of a carrier's challenge to a temporary disability (TTD) award granted by the Own Motion Notice of Closure (NOC), even though the worker had only contested his permanent disability award in requesting review. Noting that the worker's request for review of the NOC remained pending, the Board adhered to its longstanding practice of considering arguments raised by responding parties, as long as the request for review had not been withdrawn.

Addressing the merits of the TTD issue, the Board denied the worker's request to refer the matter for a "fact-finding" hearing. Reiterating that such referrals are appropriate when the record is insufficient to determine a worker's entitlement to permanent total disability benefits and when a worker's credibility/veracity is contested, the Board reasoned that such matters were not disputed. Further noting that the parties had fully availed themselves of the opportunity to present documentary evidence on the disputed TTD issue, the Board concluded that the record was sufficiently developed to resolve the parties' dispute.

Finally, the Board held that the carrier had unreasonably failed to pay the TTD award granted by the NOC. Citing OAR 438-012-0035(4)(c), the Board stated that a carrier is obligated to make its first TTD payment within 14 days from the Own Motion NOC's award of such benefits. Finding it undisputed that the carrier had neglected to comply with the aforementioned rule and observing that the carrier had not offered an explanation for such conduct, the Board assessed penalties (based on the TTD benefits, which were "then due" at the time of its unreasonable conduct), as well as attorney fees. *See* ORS 656.262(11)(a).

Own Motion: PPD - "278(2)(d)" Limitation - Must Be Applied, Even if Carrier Untimely Submits "Prior PPD Award" Information - Penalty/Attorney Fee For "Rule Violations" Assessed - "012-0017(1)"/"012-0110(1)"

Doug R. Cooley, 70 Van Natta 1072 (September 18, 2018). In an Own Motion Order rating a worker's permanent disability for a new/omitted medical condition, applying ORS 656.278(1)(b), the Board held that, because it was statutorily required to evaluate a worker's permanent disability subject to a limitation for a worker's prior awards for the same body part, evidence of those previous awards must be considered, despite the carrier's untimely disclosure of such evidence. Nonetheless, finding that the carrier had untimely complied with its obligations to follow Board rules and letters, the Board assessed penalties and attorney fees for the carrier's rule violations.

Own Motion: PTD - Entitlement Based on "Pre-Injury" Disability, Last PPD Award Before Expiration of "Agg Rights," & Disability Due to "Post-Agg Rights" New/Omitted Medical Condition

Timothy C. Guild, 70 Van Natta 1207 (November 2, 2018). Applying ORS 656.206, the Board held that, on review of a closure of an Own Motion claim for a "post-aggravation rights" new/omitted medical condition (right shoulder posttraumatic arthritis), the worker was not entitled to a permanent total disability (PTD) award because the record did not establish that his disability was solely confined to his arthritic condition under his Own Motion claim (rather than to a subsequent right shoulder injury/surgeries under a different claim). The Board explained that, in determining a worker's entitlement to a PTD award on closure of an Own Motion claim regarding a "post-aggravation rights" new/omitted medical condition, the following factors are considered: (1) disability for a previously accepted condition as it existed at the last claim closure before expiration of the worker's 5-year "aggravation rights"; (2) any disability that pre-dated the worker's initial compensable injury; and (3) any disability from the "post-aggravation rights" new/omitted medical condition for which the Own Motion claim had been reopened/closed.

Applying those principles to the present case, the Board found that the worker did not have any disability preexisting his compensable injury and had not received any permanent disability award regarding his injury before the expiration of his 5-year "aggravation rights." Identifying the issue as whether the worker was permanently and totally disabled due to his "post-aggravation rights" new/omitted medical condition (right shoulder posttraumatic arthritis) for which his Own Motion claim had reopened/ closed, the Board acknowledged that his attending physician had opined that he was completely disabled. Nonetheless, reasoning that the physician had repeatedly referred to the worker's right shoulder condition on which the current Own Motion claim was closed, as well as a subsequent right shoulder injury/surgeries, the Board was not persuaded that the worker was totally disabled due solely to his "post-aggravation rights" new/omitted medical condition which was the only condition that could be considered in evaluating his entitlement to PTD benefits.

Own Motion: "Worsened Condition" Claim - Claimant's Affidavit/Documents Established Presence in "Work Force" Before "Disability Date" - Carrier's Recommendation Against Reopening Not Unreasonable

Stuart A. MacDonald, 70 Van Natta 1837 (December 12, 2018). In an Own Motion order under ORS 656.278(1)(a), the Board reopened an Own Motion claim for a worsening of a worker's previously accepted shoulder condition because the worker's second affidavit (along with income/employment/tax documents) established his presence in the "work force" before his surgery date (which was the date that he became disabled). Noting that the worker's first affidavit had only generally mentioned his work for several

customers in the year preceding his surgery, the Board did not consider such evidence sufficient to establish his presence in the work force during the three-four week period preceding his surgery. Nonetheless, reasoning that the worker had expressly sworn in a second affidavit that he had not stopped performing his general contract work until he underwent his shoulder surgery, the Board concluded that, in the absence of persuasive rebuttal evidence, his sworn statements established his presence in the "work force" before his "disability date." Consequently, the Board authorized the reopening of the worker's Own Motion claim.

Own Motion: "Worsened Condition" Claim - Reopening Denied - Claimant Not in "Work Force" On "Disability Date" (When Surgery Recommended)

Collin D. Stringer, 71 Van Natta 342 (March 29, 2019). Applying ORS 656.278(1)(a), the Board held that it was not authorized to reopen a worker's Own Motion claim for a worsening of his previously accepted toe condition because he was not in the work force when his attending physician recommended surgery for his condition. The Board acknowledged the worker's affidavit, accompanied by employment applications, asserting that he remained willing to work. Nevertheless, the Board reasoned that, when the physician concurred with an evaluator's physical limitations and recommended (and the worker elected to proceed with) the surgery, the worker (who was 66 years old and had been receiving social security benefits for the past year) had not worked for some two to five years. Moreover, the Board noted that the worker's employment applications documented his "work search" efforts several months *after* his physician's surgery recommendation. Under such circumstances, the Board determined that, before the worker's "disability date" (*i.e.*, the date his worsened condition resulted in a total/ partial inability to work and his physician recommended surgery), he was not in the work force. Consequently, the Board concluded that the requirements for reopening of claimant's Own Motion claim for a worsened condition had not been met.

Own Motion: "278(1)(a)" - Worsening - "Disability Date" - Surgery Recommendation/ Inability to Work Due to "Current Worsening"; "Work Force" - Established by "Work Search" Affidavits/Applications

Collin D. Stringer, 71 Van Natta 936 (August 21, 2019). Applying ORS 656.278(1)(a), in an Own Motion Order, the Board reopened a worker's "worsened condition" claim for a previously accepted toe condition, finding that the worker was in the "work force" on his "disability date" (*i.e.*, the date his physician's surgery recommendation coincided with the physician's verification of an inability to work due to his current worsened condition). Reasoning that an earlier "work capacity evaluation" (WCE) report (which had placed some physical limitations on the worker due to his toe condition) pertained to the worker's toe condition concerning the closure of a previously reopened claim, the Board determined that the WCE report did not pertain to his inability to work due to his current worsened condition, which had resulted in his current surgery

recommendation. Under such circumstances, the Board concluded that the worker's "disability date" did not occur until his physician had verified his inability to work due to his current worsened toe condition (some two days before his surgery, which was some six months after the WCE report). Because the worker's unrebutted affidavit (and employment applications) attesting to his "work search" efforts concerned his activities within three months of his toe surgery, the Board found that he was in the "work force" before his "disability date" and, as such, the reopening of his Own Motion claim for a worsened condition under ORS 656.278(1)(a) was warranted.

Penalty: Record Lacked "Amounts Then Due" - Penalty Not Assessable - "262(11)(a)"

Devynne C. Krossman, 71 Van Natta 775 (July 12, 2019). Analyzing ORS 656.262(11)(a), the Board held that a penalty for a carrier's unreasonable claim denial was not awardable because the record did not establish any "amounts then due" on which to base a penalty. Stating that ORS 656.262(11)(a) mandates that the penalty for a carrier's unreasonable refusal to pay compensation or unreasonable delay in the acceptance/denial of a claim must be based on the "amounts then due" at the time of the unreasonable conduct, the Board found that the record did not establish the existence of any "amounts then due" at the time of the issuance of the carrier's unreasonable claim denial. Under such circumstances, the Board concluded that a penalty under ORS 656.262(11)(a) was not justified. Nonetheless, reiterating that the award of an attorney fee pursuant to ORS 656.262(11)(a) was not dependent on "amounts then due," the Board determined that the worker's counsel was entitled to an attorney fee award for the carrier's unreasonable claim denial.

Penalty: Unreasonable Claim Closure - "268(5)(f)"

Juan M. Orta-Carrizales, 71 Van Natta 794 (July 16, 2019). Applying ORS 656.268(5)(f), the Board held that a carrier had unreasonably closed a claim because, before closing the claim, the carrier had not sought the attending physician's response to a physical capacity examiner's (PCE's) report (which had rated the worker's residual functional capacity (RFC) at a level beneath that reported in another physician's opinion to which the attending physician had concurred). Reiterating that a carrier is required to close a claim when the worker's condition is medically stationary and there is sufficient information to evaluate the worker's permanent disability, the Board concluded that, because the carrier had only submitted the physician's opinion with a lifting limitation above the "sedentary" level to the attending physician (when it also had the PCE's report indicating a "sedentary" limitation), the carrier had insufficient information on which to close the claim and, as such, its claim closure was unreasonable.

In reaching its conclusion, the Board acknowledged that the worker had not contended that his claim had been prematurely closed. Although recognizing that most penalty requests under ORS 656.268(5)(f) are accompanied by an argument that the claim was prematurely closed, the Board reasoned that the statute only requires that the "correctness" of the claim closure be challenged at hearing.

Finally, a concurring opinion noted that the worker had alternatively argued that a penalty under ORS 656.268(5)(f) was available based on the carrier's unreasonable calculation of his work disability benefits. Although acknowledging that it was unnecessary to address that argument, the concurrence reiterated a previous opinion that ORS 656.268(5)(f) is designed to address an unreasonable refusal to close or an unreasonable closure of a claim, while ORS 656.262(11)(a) applies to an unreasonable calculation of a worker's compensation award. The concurrence reasoned that such an approach would focus the penalty on the specific "unreasonable" action (under ORS 656.262(11)(a)), rather than all compensation awards granted by the Notice of Closure (under ORS 656.268(5)(f)).

Preexisting Condition: Prior "Arm/Shoulder Blade" Treatment - Not for Currently Claimed Rotator Cuff Tear/Biceps Tendinitis - Not "Arthritic Conditions" - "005(24)"

Roger A. Miller, 71 Van Natta 314 (March 19, 2019). Applying ORS 656.005(24) and ORS 656.266(2)(a), the Board set aside a carrier's denial of a new/omitted medical condition claim for a rotator cuff tear and bicep tendinitis, holding that the carrier had not proven the existence of a "preexisting condition/combined condition" because, although some of the worker's "pre-injury" treatments referred to arm and shoulder blade complaints, the record did not persuasively attribute those treatments to his currently claimed conditions. Finding that the worker's "pre-injury" complaints regarding his arm/shoulder blade were related to his treatment for cervical/thoracic conditions, the Board concluded that the worker was neither diagnosed with, nor received treatment for, his currently claimed rotator cuff tear and bicep tendinitis conditions before his work injury and, as such, the carrier had not established the existence of "preexisting conditions" under ORS 656.005(24)(a)(A) and ORS 656.266(2)(a). Furthermore, reasoning that a physician had neither explained which joint involved concerned a diagnosed rotator cuff tendinosis condition nor how the worker's allegedly arthritic AC joint was related to his rotator cuff tear and biceps condition, the Board was not persuaded that the carrier had established the existence of an "arthritic condition" and, as such, a "preexisting/combined condition" had not been proven. *Id.*

Penalties: Unreasonable Denial - Employer's Investigative Report/Physician's "Causal Relationship" Opinion - Eliminated "Legitimate Doubt" for Carrier's Liability for Injury Claim

Nayef Salem, 71 Van Natta 571 (May 29, 2019). Applying ORS 656.262(11)(a), the Board held that a carrier's denial of a worker's low back injury claim was unreasonable because, when the carrier issued its denial, the employer's investigation report had verified the work incident (from a supervisor and co-worker) and an independent medical examiner's report (as concurred in by the attending physician) had supported a causal relationship between the work incident and the claimed condition. Although acknowledging that the worker had told an investigator that he was unsure how he was injured, the Board reasoned that, based on the employer's investigative report (which contained verification from the supervisor and a co-worker of the work incident and the worker's low back complaints) and the physicians' reports (which considered the mechanism of the work incident consistent with the worker's claimed condition), the carrier did not have a legitimate doubt regarding its liability for the claim when it issued its denial.

Penalty/Attorney Fee: Unreasonable Failure to Timely Accept/Deny "New Occupational Disease" Claim Unreasonable - Prior "Injury" Denial Did Not Encompass Later "New O.D." Claim

Ted B. Minton, 71 Van Natta 362 (April 5, 2019). The Board held that a carrier's failure to accept/deny a worker's occupational disease claim for bilateral knee osteoarthritis was unreasonable because, although the carrier had previously denied a bilateral knee injury claim, the denial did not encompass his subsequent claim for additional conditions. Although acknowledging the carrier's previous injury denial, the Board noted that the denial specifically described a bilateral knee injury claim, whereas the worker's subsequent claim concerned a "new occupational disease" for assorted bilateral knee conditions (including osteoarthritis). Under such circumstances, the Board concluded that the carrier's prior denial did not encompass the worker's later claim and, as such, the carrier's claim processing was unreasonable.

Responsibility: "LIER" - "Impossibility/Sole Cause" Defense Not Established by Last Carrier - "Actual Causation" Not Applicable Because Compensability Conceded/ Claimant Did Not Assert "Actual Causation" Against Any Employer

John M. Burlington, 71 Van Natta 408 (April 17, 2019). Applying the "last injurious exposure rule" (LIER), in determining responsibility for a worker's occupational disease claim for bilateral hearing loss, the Board rejected the last employer's contention that it was not responsible for the claimed condition because an earlier employer was the "actual cause" of the condition. Noting that the worker had not asserted that a particular employer was responsible for his hearing loss

condition (but rather had relied on the LIER when the carriers had conceded the compensability of his claim), the Board concluded that, under the LIER, the last employer was required to prove that it was impossible for its employment to have caused/worsened the worker's hearing loss or that a prior employer had solely caused the claimed condition. Because the record did not support either determination, the Board held that the last employer was responsible for the worker's occupational disease claim.

Responsibility: "O.D."/LIER - "Impossibility" Defense - "Presumptively Responsible" Carrier Did Not Prove "Impossible" for Its Coverage to Have Caused Decedent's Disease

Henry G. Miller, Dcd, 70 Van Natta 1121 (October 2, 2018), *recons*, 70 Van Natta 1157 (October 10, 2018). Applying the "last injurious exposure rule" (LIER) in determining responsibility for a deceased worker's (a ceiling tile installer's) occupational disease claim for mesothelioma, the Board held that the presumptively responsible carrier remained responsible for the claim because it had not established that it was impossible for conditions at its workplace to have caused the disease or that the disease was caused solely by conditions at one or more of the worker's previous employments. The Board noted that: (1) an expert had stated that the decedent's work had exposed him to asbestos until his retirement; (2) a physician had opined that a single asbestos exposure could have led to the development of the worker's mesothelioma; and (3) the decedent's sons' testimony and had not established that he had not been exposed to asbestos during his last employment. Under such circumstances, the Board concluded that the presumptively responsible carrier (who had provided coverage during the decedent's final employment) had not met its burden of proving that it was impossible for his employment during its coverage to have caused his disease and, as such, it had not shifted responsibility for the claim to an earlier carrier.

Scope of Issues: "O.D." Claim Not Raised at Hearing (Which Concerned "New/Omitted Medical Condition" As Related to Accepted "Injury") - "O.D." Raised During Closing Arguments - Untimely

Socorro Martinez-Munoz, 71 Van Natta 665 (June 25, 2019). The Board declined to consider a worker's "occupational disease" theory on review of an ALJ's order (which had upheld a carrier's denial of a new/omitted medical condition claim based on an "injury" theory) because the "occupational disease" theory had not been raised until the parties' closing arguments after the hearing record was closed. Noting that the worker had not objected at hearing to the ALJ's characterization of the issue as concerning the carrier's denial of a claimed arm condition as unrelated to a work injury (for which the carrier had previously accepted the claim as nondisabling), the Board concluded that the ALJ was authorized to decline to consider the "occupational disease" theory because it had not been raised until after the hearing during closing arguments. Likewise, given such circumstances, the Board declined to consider the issue on review.

Subject Worker: "Nonsubject Worker" Exception ("027(15)(c)") - Claimant Did Not "Furnish" Truck to Motor Carrier - Had No "Transferable Interest" in Truck Leased to Carrier

Carl S. Ward, 71 Van Natta 484 (April 30, 2019). Applying ORS 656.027(15)(c), the Board held that a truck driver was a "worker" for a motor carrier company and not a "nonsubject" worker because he had no "transferable interest" in the truck he leased to the motor carrier and, as such, had not "furnished" the vehicle to the motor carrier. Applying court precedent involving language in other statutes involving motor carriers (regarding the "income tax" law) that was similar to that in ORS 656.027(15)(c), the Board reasoned that in order to "furnish" equipment to a motor carrier, the trucker furnishing the vehicle must have a transferable interest in the vehicle.

After reviewing the trucker's agreement with the motor carrier, the Board determined that the trucker had absolutely no right to purchase and no equity or any other ownership rights in the vehicle. Under such circumstances, the concluded that the trucker had no transferable interest in the leased vehicle and, as such, could not "furnish" the vehicle to the carrier. Accordingly, the Board held that the trucker was not a "nonsubject" worker under ORS 656.027(15)(c).

Subject Worker: "Non-Subject Worker" ("027(15)") - Trucker Had "Ownership Interest" in Truck Furnished, Maintained, Operated for a Motor-Carrier - Transfer of Title Not Determinative

Vladmir V. Ghelan, 70 Van Natta 1277 (November 27, 2018). Applying ORS 656.027(15), the Board held that a trucker was not a subject worker because, although the title of the truck he had operated for a motor carrier had not been transferred to him from the motor carrier and he had not fully paid for the truck when he was injured while operating the truck, he had an ownership interest in the truck which had been used in the transportation of property by a for-hire carrier, which he had furnished, maintained, and operated. Noting that the trucker had signed a bill of sale with the carrier for the truck (which provided for monthly installment payments), entered into an "independent contractor lease agreement" (which provided that he would furnish the truck and personnel at his own expense to drive, load, and unload property for the carrier), and that an insurance application identified him as the "owner-operator" of the truck, the Board concluded that the trucker had an "ownership interest" in the truck that he had furnished, maintained, and operated in the transportation of property for a for-hire carrier.

Under such circumstances, the Board determined that the trucker was a "non-subject worker" pursuant to ORS 656.027(15). In reaching its conclusion, the Board acknowledged that the title of the truck had not been transferred to the trucker and that

the monthly installments had not been completed. Nonetheless, the Board reasoned that, even if the worker did not have complete "ownership" of the truck, the record (based on the parties' course of conduct, agreements, and the worker's installment payments) was consistent with the establishment of the trucker's "ownership interest" in the truck.

Subject Worker: "Right to Control"/"Nature of Work" Tests - Intermittent Maintenance Work for Trucking Business - Not "Sole Proprietor"/"Independent Contractor" - "005(30)"/"027(7)(a)"/"670.600(2)"

Warren Nordland, 70 Van Natta 1028 (September 4, 2018). Applying ORS 656.005(30), ORS 656.027(7)(a), and ORS 670.600(2), the Board held that a maintenance worker for a trucking business was considered to be a "subject worker" because he performed several truck maintenance-related tasks for the business (*e.g.*, maintenance, repair, tarping), which were subject to the business's right to direct and control, as well as regular part of the business, even though he performed such duties on an intermittent basis for a specific payment. Although acknowledging that the worker's tasks were intermittent and involved only a few distinct tasks for which he was paid a specific sum, the Board reasoned that the business controlled the method of his performance, his work schedule, and furnished his equipment, which under the "right to control" test favored an employee-employer relationship. Furthermore, applying the "nature of the work" test, the Board determined that, because the worker's tasks concerned an essential and regular part of the trucking business, it considered it reasonable to expect that the business (not the worker) would carry the burden of accident insurance. Under such circumstances, the Board concluded that the worker was a "subject worker," rather than a "sole proprietor" / "independent contractor."

Third Party Dispute: Reimbursement for Litigation Expenses - Must Be "Reasonably/ Necessarily" Incurred in Third Party Litigation - "Filing Fees" in "Wrong" Jurisdiction Not Reimbursable - "Extraordinary" Attorney Fee Not Warranted - "593(1)(a)"

Robert Mackie, 71 Van Natta 677 (July 2, 2019). Applying ORS 656.593(1)(a), the Board held that a worker was entitled to recover from his third party judgment certain expenses incurred during the litigation of his third party cause of action to the extent that the record established that such costs were reasonably and necessarily incurred during that litigation. Persuaded by a detailed listing of litigation costs, as well as an affidavit from his third party attorney, the Board found that certain expenses (*e.g.*, expert/consultant fees, travel costs, and Oregon filing fees) were reasonably and necessarily incurred during his third party lawsuit. Under such circumstances, the Board determined that such costs were reimbursable from the worker's third party judgment. However, noting that the worker's "out-of-state" cause of action had been dismissed for lack of jurisdiction, the Board concluded that his filing fees in that state were not reasonably and necessarily incurred and, as such, were not reimbursable.

Finally, the Board denied the worker's counsel's request for an extraordinary attorney fee of 40 percent of the $75,000 third party judgment. Although acknowledging that numerous hours had been extended over a four year period that eventually resulted in an arbitration decision after a one-day proceeding, the Board did not consider such circumstances "extraordinary" warranting an attorney fee beyond the standard 1/3 share prescribed in OAR 438-015-0095. In reaching its conclusion, the Board compared the present situation to some previous decisions where an "extraordinary" attorney fee had been granted (*e.g.*, $3 million settlement, $100,000 in litigation expenses, 1,900 hours of attorney time; $300,000 settlement, several years of litigation, 5-day jury trial).

TTD: "Termination" of Employment - "325(5)(b)" - Record Did Not Support Termination for "Work Rule" Violation - Claimant Provided Written Notification of Work Release

Ronald D. McAllister, 71 Van Natta 590 (June 5, 2019). Applying ORS 656.325(5)(b), the Board held that a carrier was not entitled to convert a worker's temporary total disability (TTD) benefits to temporary partial disability (TPD) benefits because the record did not establish that his termination from employment had been for a violation of work rules or other disciplinary reasons. The Board reiterated that, although it was not authorized to resolve the propriety of a worker's termination from employment, it was required to examine the factual reasons for the termination to determine whether the worker was, in fact, terminated for a work rule violation or other disciplinary reason.

After conducting its review, the Board found that the worker had provided his attending physician assistant's release from work to his employer within 24 hours of his appointment (as required by the employer's policy). Under such circumstances, the Board was not persuaded that the worker had been terminated for a violation of a work rule or other disciplinary reason and, as such, reinstated his TTD benefits.

Finally, the Board determined that the carrier had converted the worker's TTD benefits to TPD benefits based on the attending physician's approval of a modified job that the physician assistant had subsequently retracted. Reasoning that the carrier lacked a legitimate doubt regarding its continuing liability to pay TTD benefits, the Board concluded that the carrier's claim processing had been unreasonable and, as such, penalties/attorney fees under ORS 656.262(11)(a) were warranted.

TTD: Termination of Employment ("325(5)(b)") - "Work Rule" Violation/"Disciplinary Reason" Not Established

Hipolito Coria, 71 Van Natta 742 (July 9, 2019). Applying ORS 656.325(5)(b), the Board held that a carrier was not entitled to terminate a worker's temporary disability (TTD) benefits because the record did not establish that his employment was terminated for violation of a work rule or for other disciplinary reasons. Although acknowledging that the worker had falsified some work logs several months before his dismissal from his employment, the Board found that the record lacked any document stating the basis for his termination and that no witness had neither explained who made the termination decision nor the basis for such a decision. Further noting the absence of an explanation for the employer's departure from its progressive disciplinary policy in terminating the worker (who had no previous disciplinary history) several months after it had learned of his falsification of the work logs, the Board was not persuaded that he had been discharged for a violation of a work rule or other disciplinary reason. Under such circumstances, the Board held that the carrier's termination of the worker's TTD benefits was unjustified and unreasonable. Consequently, the Board reinstated the worker's TTD benefits, as well as awarded penalties/attorney fees under ORS 656.262(11)(a) for unreasonable claim processing.