



News & Case Notes

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BOARD NEWS

Portal "Open House" Meetings

The Workers' Compensation Board has scheduled "open house" meetings to preview future enhancements to WCB's Portal. We encourage you and your staff to drop in for 30-60 minutes to see the new case information, and provide feedback to us as we undergo development. For those not yet using the portal, staff will be on hand to explain all of its functions, answer your questions, and even activate your account.

Meetings will be held at WCB's offices on the following dates:

Medford (131 E Main St., Ste. 200)	Thursday, Jan. 22, 2015 (10 a.m. - 3 p.m.)
Salem (2601 25 th St. SE, Ste. 150)	Wednesday, Jan. 28, 2015 (10 a.m. - 3 p.m.)
Portland (800 NE Oregon St., Ste. 340)	Thursday, Jan. 29, 2015 (10 a.m. - 3 p.m.)
Eugene (1140 Willagillespie Rd., Ste. 38)	Friday, Jan. 30, 2015 (10 a.m. - 3 p.m.)

The meetings are free and reservations are not required. Come at your convenience. For more information, contact Greig Lowell at 503-934-0151 or e-mail at portal.wcb@state.or.us

Staff Attorney Recruitment

Since WCB's December staff attorney recruitment, an additional staff attorney position has become available. As a result, to augment its existing list of applicants, WCB is giving any additional candidates an opportunity to apply. (*Any candidate who applied during the most recent recruitment, need not reapply. Those applications will be considered.*) Applicants must have a law degree and extensive experience reviewing case records, performing legal research, and writing legal arguments or proposed orders. Excellent research, writing, and communication skills are essential. Preference may be given for bar membership and legal experience in the area of workers' compensation. The salary range is between \$5,028 and \$7,363 per month, with the beginning salary between \$5,028 and \$5,802 depending on the successful applicant's level of knowledge and experience. Further details about the position and information on how to apply are available online at www.oregonjobs.org. The recruitment will close on January 20, 2015. WCB is an equal opportunity employer.

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Board Review Inquiries - New Phone No. (503-934-0103)

Effective immediately, questions pertaining to "Board Review-related" matters should be directed to 503-934-0103. This centralized method will allow the staff to screen the call, analyze the question (whether it concerns a request for review, a hearing transcript, a procedural motion, a briefing question, or other appellate-related matter), and direct the inquiry to the appropriate staff member, who will promptly return the call.

There are no changes regarding "Own Motion" and "CDA-related" inquiries. Such questions should continue to be directed to 503-934-0113 for Own Motion, and 503-934-0116 for CDAs. The Board Review fax number is 503-373-1684.

CASE NOTES

Attorney Fee: "386(1)(a)" - "Pre-Hearing" Rescinded Denial - Attorney "Instrumental in Obtaining Rescission," Although Claimant (*Pro Se*) Filed Claim and Requested Hearing

Richard A. Staley, 66 Van Natta 1993 (December 5, 2014). Applying ORS 656.386(1)(a), the Board held that claimant's counsel was entitled to a carrier-paid attorney fee because, although claimant had filed his new/omitted medical condition claim and a hearing request from the carrier's claim denial without an attorney, the carrier had accepted the claim (thereby rescinding its denial) before the scheduled hearing and after claimant's attorney had been retained and the carrier had obtained a medical report supporting the compensability of the denied claim. Noting that it had accepted the claim within 60 days of claimant's counsel's claim for the same new/omitted medical condition claim (for right knee cellulitis), the carrier contended that claimant's attorney had not been instrumental in obtaining the "pre-hearing" rescission of the carrier's denial and, as such, no attorney fee award under ORS 656.386(1)(a) was warranted.

The Board disagreed with the carrier's contention. Citing ORS 656.386(1)(a), the Board stated that in cases involving denied claims where an attorney is instrumental in obtaining the rescission of a denial before an ALJ's decision, a reasonable attorney fee shall be allowed.

Turning to the case at hand, the Board noted that it was undisputed that the carrier had previously denied claimant's new/omitted medical condition claim for left knee cellulitis. Moreover, the Board found that claimant's counsel continued to prepare for the scheduled hearing, which was based on claimant's hearing request from the carrier's previous denial of his claim. Finally, the Board observed that, following claimant's counsel's representation, the carrier had sought a medical opinion and, once the medical report was obtained, accepted the claim, thereby effectively rescinding its denial.

Under such circumstances, the Board determined that claimant's counsel had contributed to the eventual withdrawal of the carrier's claim denial. Consequently, the Board concluded that claimant's counsel was instrumental in obtaining a rescission of the carrier's denial before an ALJ decision and, as such, was entitled to a carrier-paid attorney fee award under ORS 656.386(1)(a). See *Peggy L. Segur*, 62 Van Natta 1406, 1407 (2010).

Combined Condition: "Ceases" Denial - Carrier Proved That "Work-Related Injury/ Incident" Not Major Cause of Combined Condition; New/Omitted Medical Condition - Claimed "Combined Condition/Arthritis" Already Accepted/Processed as "Preexisting Condition" Component of Prior Combined Condition

Karlynn J. Akins, 66 Van Natta 1969 (December 4, 2014). Applying ORS 656.267(1), ORS 656.262(6)(c), and ORS 656.266(2)(a), the Board upheld a carrier's denial of claimant's new/omitted medical condition claim for a combined arthritic knee condition because the record did not establish that the claimed condition existed separately from the arthritic knee condition that the carrier had previously accepted as the "preexisting condition" component of a combined condition. Following claimant's work-related injury, the carrier had accepted a strain/contusion. When claimant sought a new/omitted medical condition claim for an arthritic condition in the knee, the carrier issued a "combined condition" acceptance and a "ceases" denial. Thereafter, claimant filed another new/omitted medical condition claim for a "combined condition," consisting of her work injury event and her preexisting arthritic condition. When the carrier denied that claim, claimant requested a hearing, contesting each of the carrier's denials.

The Board upheld the carrier's denials. Citing ORS 656.262(6)(c), the Board stated that a carrier may deny an accepted combined condition if the "otherwise compensable injury" ceases to be the major contributing cause of the combined condition. Relying on *Brown v. SAIF*, 262 Or App 640, 656 (2014), the Board noted that, under ORS 656.262(6)(c), the question is whether claimant's "work-related injury/incident" remained the major contributing cause of the disability/need for treatment of the combined condition. Furthermore, referring to *Wal-Mart Stores, Inc. v. Young*, 219 Or App 410, 419 (2008), and *Oregon Drywall System v. Bacon*, 208 Or App 205, 210 (2006), the Board observed that the carrier must prove a change in claimant's condition or circumstances since the "effective date" of its acceptance to establish its "ceases" denial under ORS 656.262(6)(c).

Turning to the case at hand, the Board was persuaded by the opinion of a physician, who had explained that, considering the severity of claimant's preexisting arthritic knee, the work injury had resulted in a temporary exacerbation of her symptoms, but, as of the "effective date" set forth in the carrier's denial, the injury was no longer the major contributing cause of her disability/need for treatment for the combined condition. In contrast, the Board found the contrary opinion from another physician (who concluded that the injury had pathologically worsened claimant's arthritic knee) to be unpersuasive because it had not adequately addressed the other physician's analysis of her x-ray and had apparently changed his opinion without an explanation.

Acceptance of arthritis as "preexisting condition" component of "combined condition" did not constitute acceptance of preexisting arthritis as independent claim.

Determining that the carrier had met its requisite burden of proof, the Board upheld the carrier's "ceases" denial under ORS 656.262(6)(c). Proceeding to an analysis of claimant's new/omitted medical condition claims, the Board stated that such claims must be for a "condition" that is either "new" or "omitted." See ORS 656.267(1); *Warren D. Duffour*, 64 Van Natta 619, 622-23, *recons*, 64 Van Natta 795 (2012); *Michael L. Long*, 63 Van Natta 2134, 2135, *recons*, 63 Van Natta 2330 (2011). The Board further noted that the carrier's acceptance of the claimed arthritis as a "preexisting condition" component of a "combined condition" did not constitute an outright acceptance of the preexisting arthritis and that claimant was authorized to initiate an independent claim for her knee arthritis. See *Fimbres v. SAIF*, 197 Or App 613, 618 (2005); *Kenneth Anderson*, 60 Van Natta 2534, 2543 (2008), *aff'd without opinion*, 233 Or App 227 (2010).

Because record did not establish that knee arthritis existed separately from its status as "preexisting condition" component of the previously accepted, denied, litigated "combined condition," a "new/omitted" medical condition did not exist.

Based on its analysis of the aforementioned medical evidence, the Board was persuaded that claimant's work injury had made her preexisting arthritic knee condition symptomatic and that those symptoms had required treatment for a period of time (until the injury had ceased to be the major contributing cause of claimant's need for treatment). Under such circumstances, the Board concluded that the record did not establish that claimant's knee arthritis (whether viewed as an "independent" new/omitted medical condition claim or as a "preexisting condition" component of a separately claimed "combined condition" involving the work event) existed separately from its status as the "preexisting condition" component of the combined condition that had been accepted and litigated pursuant to the "ceases" denial. Consequently, finding no separate "new" or "omitted" medical conditions, the Board upheld the carrier's denials.

Course & Scope: "Social/Recreational Activity Primarily for Personal Pleasure" - "005(7)(b)(B)" - "MVA-Related" Injury After Personal/Social Activity Following "Employer-Sponsored" Event

Harry Cruz, 66 Van Natta 2064 (December 19, 2014). Applying ORS 656.005(7)(b)(B), the Board held that claimant's injury, which occurred while riding as a passenger in a vehicle driven by an intoxicated coworker after they

When analyzing the “social/recreational activity” exclusion, the “activity” is not the particular action that causes the injury, but rather the activity within which that action occurs.

Because employer had not paid for employees going to a drinking establishment after “employer-sponsored” event, the “drinking establishment” activity was the focus of the “social/recreational activity” exclusion.

had gone to a drinking establishment following an “employer-sponsored” event, was excluded from compensation because he was engaged in a social activity primarily for his personal pleasure. Asserting that he felt pressured to ride along because of the coworker’s “position of authority,” claimant contended that the activity he was engaged in when he was injured was not a social/recreational activity primarily for his personal pleasure.

The Board disagreed with claimant’s contention. Citing ORS 656.005(7)(b)(B), the Board stated that a “compensable injury” does not include an injury incurred while engaging in or performing, or as a result of engaging in or performing, any recreational or social activities primarily for the worker’s personal pleasure. Relying on *Liberty Northwest Ins. Corp. v. Nichols*, 186 Or App 664, 670, n 4 (2003), the Board noted that, when analyzing whether an injury is excluded from coverage under the statute, the “activity” is not the particular action that causes the injury, but rather the activity within which that action occurs (working or not working).

Turning to the case at hand, the Board was persuaded that, after the work-sponsored event (a laser tag game) had ended, claimant had accompanied several employees to a drinking establishment to socialize. Finding that the employer did not pay for that latter activity and noting that no employer managers were present, the Board concluded that it was the activity of going to the drinking establishment that was the focus of the statutory exclusion.

Reasoning that claimant’s “drinking establishment” activity was a social/recreational activity that he had engaged in primarily for his personal pleasure, the Board concluded that his subsequent injury (which resulted from a motor vehicle accident after he left the drinking establishment) occurred because he had engaged in that social/recreational activity. Consequently, the Board held that claimant’s injury was statutorily excluded from compensation.

Course & Scope: “Traveling Employee” - Left Employer’s Truck in Highway to Go to Convenience Store - Reasonably Related to “Travel” Status

Jackson Hicks, 66 Van Natta 2024 (December 16, 2014). The Board held that claimant’s injury, which occurred when he was struck by a motor vehicle after he had exited his employer’s truck (at the driver’s suggestion) to cross a highway to walk to a convenience store to get a beverage and cigarettes while the truck would be getting gas, arose out of and in the course of his employment because he was a traveling employee, he was not engaged in a distinct departure on a personal errand, and he was not aware of his employer’s policy against such behavior (even assuming that such a policy existed). Claimant’s job entailed daily travel, as a passenger in his employer’s truck, from the employer’s premises to a job site. The truck routinely stopped at one of two gas stations for refueling, at which time claimant and his coworkers would frequently purchase food and drinks at nearby convenience stores. (One of the gas stations included a convenience store, while the other station had a

convenience store located near an adjoining intersection.) One the day of claimant's injury, the truck was headed toward the latter gas station for refueling. In response to claimant's inquiry about whether the truck would be stopping at the convenience store, the driver pulled into the turn lane of the highway in the intersection and stated that if claimant and his coworkers wanted to get out, "now's the time." Thereafter, claimant and a coworker disembarked the truck while it was still in the intersection, at which time he was struck by another vehicle, while trying to cross the highway to get to the convenience store. The carrier denied his claim, contending that he was injured while engaging in a purely personal activity that was unrelated to his employment.

The Board disagreed with the carrier's contention. Citing *Savin Corp. v. McBride*, 134 Or App 321 (1995), the Board stated that, when an employee's work entails travel away from an employer's premises, the employee becomes a traveling employee, even if the travel is local and of limited duration. Relying on *SAIF v. Scardi*, 218 Or App 403, 408 (2008), and *Sosnoski v. SAIF*, 184 Or App 88, 93, *rev den*, 335 Or 114 (2002), the Board noted that a traveling employee is considered to be continuously acting in the course of employment unless the employee has engaged in a distinct departure on a personal errand.

Turning to the case at hand, the Board determined that it was undisputed that claimant's job entailed daily travel in his employer's truck to and from its job sites. Thus, the Board identified the relevant question as whether he was engaged in a distinct departure on a personal errand when he disembarked the truck while in the middle of the highway to attempt to cross the intersection to reach the convenience store.

Referring to *Scardi* and *Sosnoski*, the Board stated that an activity is a "distinct departure" if it is not reasonably related to the employee's travel status and that an injury does not occur "in the course of" employment if the activity resulting in the injury was "inconsistent with the business trip's purpose or the employer's directives." However, based on the *Sosnoski* rationale, the Board remarked that an activity is reasonably related to a worker's travel status if it is an activity that an employer might reasonably contemplate that a traveling employee would engage in. Moreover, relying on reasoning expressed in *McBride* (in which the court had stated that "getting cigarettes during a trip to or from work in the employer's conveyance" was a "deviation[] for personal reasons [that] are so minor as to be insignificant"), the Board considered claimant's crossing the street to purchase cigarettes and a drink to be an activity reasonably related to his travel's status and, as such, not a "distinct departure."

In reaching its conclusion, the Board emphasized that it was not essential to the "course of" employment analysis to determine whether claimant's method of crossing the street in the middle of a highway without a crosswalk to be reasonable. Instead, citing *Slaughter v. SAIF*, 60 Or App 610, 616 (1982), the Board explained that the relevant question was whether the activity was "reasonably related to the claimant's travel status," as opposed to whether he undertook the activity in a reasonable manner.

Based on such principles, the Board reasoned that however unsafe or unreasonable it might consider claimant's *method* of crossing the highway to buy cigarettes and a drink had been, it was the *type* of activity that an employer might reasonably contemplate that a traveling employee would be engaged in.

An activity is reasonably related to a worker's travel status if it is an activity that an employer might reasonably contemplate that a traveling employee might be engaged.

Relevant question was whether the activity was "reasonably related" to the worker's travel status; not whether the activity was undertaken in a reasonable manner.

However unsafe/unreasonable claimant's method of crossing highway to buy cigarettes/drinks, it was the type of activity an employer would reasonably contemplate that a traveling employee would be engaged.

Because claimant's activity (crossing highway to buy cigarettes/drinks in preparation for work day) was a common work practice, consistent with employer's truck's "re-fueling" stops, and suggested by the lead worker, injury from being struck by a vehicle was an employment-related travel risk.

Furthermore, the Board noted that the driver of the employer's truck (who was in a leadership capacity) had approved claimant's activity (not only the day of the injury, but on previous occasions).

The Board acknowledged the carrier's assertion that claimant's activity was prohibited by the employer's policy. See *Hackney v. Tillamook Growers*, 39 Van Natta 655 (1979). Nonetheless, based on claimant's testimony that lead workers (including the driver of the truck on the day in question) had permitted he and his coworkers to exit the truck in the middle of the highway on previous occasions to purchase cigarettes and drinks and that they had never been told that such conduct was prohibited, the Board determined that claimant's activity was not inconsistent with an employer directive.

Finally, the Board concluded that claimant's injury "arose out of" his employment. Citing *Legacy Health Systems v. Noble*, 250 Or 596, 602-03 (2012), the Board stated that the "arising out of" prong of the work-connection test is satisfied if the worker's injury is the product of either: (1) a risk connected with the nature of the work; or (2) a risk to which the work environment exposed the worker. Relying on *Scardi*, the Board noted that, for a traveling employee, an injury arises out of employment if the risk of the injury results from the nature of the travel or originates from some other risk to which the travel exposes the worker.

Addressing the present case, the Board found that claimant's activity (crossing the highway to buy cigarettes and drinks in preparation for his work day at the job site) was a common practice in the work place, was consistent with allowing the truck to proceed to the gas station for re-fueling, and was specifically suggested by the driver of the truck (the lead worker). Consequently, the Board determined that claimant's injury did not result from a personal risk, but rather was from a risk to which his travel had exposed him.

Own Motion: Reconsideration - Claimant Entitled to Submit Chart Note That Carrier Had Not Previously Filed - Carrier Obligated to Submit All "Pertinent" Evidence - "012-0060(3)"

Michael K. Scheidt, 66 Van Natta 1989 (December 5, 2014). On reconsideration of its initial Own Motion Order (which had affirmed a Notice of Closure's permanent disability award for claimant's new/omitted medical left knee condition), the Board considered claimant's submission of his attending physician's chart note because the carrier had neglected to include the document with the initial record it had provided to the Board before its initial decision. In its initial decision, the Board discounted claimant's attending physician's most recent opinion (which supported increased permanent impairment findings) because it was inconsistent with the physician's earlier opinion (which had expressly concluded that claimant did not have a "chronic condition" limitation or strength loss). In reaching its earlier determination, the

In response to a request for review of an Own Motion Notice of Closure, a carrier is obligated to file all evidence pertaining to the compensable condition at the time of closure.

Board further noted that there was no indication that the attending physician had examined claimant during the interim period between the physician's two opinions. Thereafter, claimant requested reconsideration, submitting a chart note from the attending physician, documenting an examination of claimant's left knee condition, which had occurred between the two opinions. In response, the carrier objected to the Board's consideration of the chart note, asserting that a copy of the chart note had previously been disclosed to claimant's counsel and that it was claimant's responsibility to submit the document for inclusion in the record before the Board's initial decision.

The Board rejected the carrier's objection and considered the submitted chart note. Citing OAR 438-012-0060(3), the Board stated that, in response to a claimant's request for review of an Own Motion Notice of Closure, a carrier is obligated to submit to the Board (and to claimant's counsel) "all evidence that pertains to the claimant's compensable condition at the time of closure, including any evidence relating to permanent disability." Furthermore, relying on OAR 438-012-0017, the Board noted that the parties are obligated to fully and timely comply with all Board letters.

Turning to the case at hand, the Board reasoned that, because the chart note in question concerned claimant's compensable left knee condition, the carrier was required to submit a copy of the chart note to the Board (with a copy to claimant's counsel) in response to the request for review of the Notice of Closure. Moreover, the Board noted that two "pre-review" Board letters had reminded the carrier of its obligation to provide a record of all documents pertaining to the closed claim in response to claimant's request for review. Finally, even if the carrier had previously provided claimant's counsel with a copy of the chart note, the Board determined that the carrier was still obligated under OAR 438-012-0060(3) to also file a copy with the Board for its review.

Under such circumstances, the Board considered the submitted chart note from the attending physician. After conducting its reconsideration, the Board acknowledged that the attending physician had examined claimant between the physician's earlier and most recent opinions. Nevertheless, reasoning that the submitted chart note did not provide an explanation for the discrepancy between the attending physician's earlier and most recent opinions (the earlier one which gave claimant a "full work release without limitations," while the most recent one reported significant limitations and strength loss), the Board concluded that, in the absence of a reasonable explanation for the physician's differing opinions, the record did not persuasively establish that claimant was entitled to an additional permanent disability award. Consequently, the Board adhered to its previous decision to affirm the Notice of Closure permanent disability award.

Penalty: “268(5)(d)” - Carrier’s Claim Closure Not Unreasonable - “Sufficient Information” to Close Claim Based on Both “Aggravation” and “New/Omitted Medical Condition”

David J. Morley, 66 Van Natta 2052 (December 18, 2014). Applying ORS 656.268(5)(d), the Board held that a carrier’s issuance of a Notice of Closure was not unreasonable because, even though a previous Order on Reconsideration had set aside an earlier Notice of Closure as premature (based on insufficient information concerning only claimant’s worsened right carpal tunnel syndrome (CTS) condition, which was the condition for the which the claim had been reopened), it was not unreasonable for the carrier to determine that there was sufficient information to subsequently close the claim based on impairment findings regarding not only the worsened CTS condition, but also a degenerative right wrist condition, which had been accepted after the earlier reconsideration order. Following a prior Notice of Closure (which closed claimant’s aggravation claim for a previously accepted right CTS condition), an Order on Reconsideration had set aside the closure, determining that the available impairment findings did not solely address the CTS condition (which was the only condition for which the claim had been reopened). Following the reconsideration order (which was not appealed), the carrier accepted a degenerative right wrist condition. After receiving the attending physician’s report that claimant’s right wrist conditions (which included the CTS and degenerative conditions, as well as other previously accepted conditions) were medically stationary and that a previous surgery was due to the degenerative condition, the carrier issued another Notice of Closure, which awarded permanent disability based on the surgery and other impairment findings. Claimant requested reconsideration, contending that the carrier had not obtained sufficient information to close the claim because the attending physician’s findings had included previously accepted conditions. Claimant also sought a penalty under ORS 656.268(5)(d). An Order on Reconsideration set aside the closure as premature, reasoning that the impairment findings had not addressed only the conditions subject to claim closure. Claimant requested a hearing, seeking a penalty under ORS 656.268(5)(d) for an unreasonable claim closure.

The Board held that the closure notice was not unreasonable. Citing ORS 656.268(5)(d) and *Cayton v. Safelite Glass Corp.*, 232 Or App 454, 460 (2009), the Board stated that a penalty is warranted if: (1) there was a closure of a claim or refusal to close a claim; (2) the “correctness” of that closure or refusal to close was at issue in a hearing on the claim; and (3) there is a finding that the closure notice or refusal to close was not reasonable. Relying on *Warren D. Duffour*, 65 Van Natta 1744, 1745 (2013), the Board reiterated that, when a reconsideration order sets aside a closure notice, a claimant seeking a penalty for an unreasonable claim closure under ORS 656.268(5)(d) must request a hearing from the reconsideration order to put the “correctness” of the claim closure at issue in the hearing. Finally, referring to *Kerry K. Hagen*, 64 Van Natta 316, 321 (2012), and *Cindy A. Schrader*, 46 Van Natta 175, 179 (1994), the Board noted that the assessment of a penalty under ORS 656.268(5)(d)

Because information at claim closure related no impairment to “aggravation/worsened condition” claim and all impairment to “new/omitted medical condition” (which were the conditions for which the claim had been reopened), there was “sufficient information” on which to determine permanent disability and close the claim.

Because earlier reconsideration order had set aside the closure of only the aggravation claim, it had no preclusive effect on carrier’s subsequent decision to close the claim (which was also based on a “post-closure” accepted new/omitted medical condition).

depends on whether the Notice of Closure was reasonable and must be evaluated based on the information available to the carrier at the time of the closure.

Turning to the case at hand, the Board found that the attending physician had concurred with another physician’s opinion, that: (1) attributed claimant’s wrist surgery to his degenerative condition; (2) related his resulting reduced range of motion impairment to the surgery; and (3) concluded that claimant’s worsened CTS condition had resolved without physical signs. Reasoning that the information at claim closure attributed none of claimant’s impairment to his aggravation claim (*i.e.*, his worsened CTS condition) and all of his impairment to the omitted degenerative wrist condition, the Board concluded that there was “sufficient information” to determine claimant’s permanent impairment due to the conditions for which the claim had been reopened. See OAR 436-030-0020(2)(b). Under such circumstances, the Board did not consider the carrier’s issuance of the Notice of Closure to have been unreasonable.

In reaching its conclusion, the Board disagreed with claimant’s contention that the earlier reconsideration order’s directive to obtain additional information specific to the worsened CTS condition was preclusive because that order had not been appealed. Noting that the previous reconsideration order had found that the prior claim closure required information addressing impairment solely due to the worsened CTS condition (because the claim had only been reopened for an aggravation of that condition) and that the impairment findings were not limited to that worsened condition, the Board emphasized that, after that reconsideration order, the carrier had sought additional information from the attending physician (which had resulted in its acceptance of the degenerative wrist condition that was the basis for claimant’s surgery and impairment findings). Consequently, the Board neither considered the prior reconsideration order to have precluded the carrier’s subsequent claim processing actions nor found the carrier’s issuance of a closure notice (based on the attending physician’s impairment findings) to have been unreasonable.

Penalty: “268(5)(e)” - Increased PPD Award Granted by Recon Order - “Info” Carrier Could Reasonably Have Known at Claim Closure - “AP” Chart Notes Referred to “Heavy” Lifting in “At-Injury” Job

Liliya Khodakovskiy, 66 Van Natta 2126 (December 30, 2014). Applying ORS 656.268(5)(e), the Board held that claimant was entitled to a penalty based on the increased permanent disability granted by an Order on Reconsideration (*i.e.*, a “work disability” award) because the award was based on information that the carrier reasonably could have known at claim closure (*i.e.*, that despite claimant’s attending physician’s “regular work” release, which was based on a job description of light lifting duties, claimant’s “at-injury” job duties actually required heavy lifting that exceeded her attending physician’s

limitations). Following claimant's compensable wrist injury, her attending physician restricted her to light lifting in her "at-injury" position as a cook/kitchen helper. However, based on a job description provided by the carrier (which indicated that her "at-injury" job duties required only light lifting, the attending physician released claimant to her regular work. Thereafter, the carrier issued a Notice of Closure that awarded permanent impairment, but no work disability. Claimant requested reconsideration, including an affidavit, which explained that her lifting requirements at her "at-injury" job were heavy, rather than light. Thereafter, an Order on Reconsideration awarded work disability, as well as a penalty under ORS 656.268(5)(e). The carrier requested a hearing, contesting the penalty assessment. In doing so, the carrier argued that it had no reason to question the job description that it had provided to the attending physician until after claimant had provided her affidavit during the reconsideration proceeding.

The Board disagreed with the carrier's contention. Citing ORS 656.268(5)(e), the Board stated that if an increased permanent disability award is sufficient to satisfy the requirements for a penalty under that statute, such a penalty is not assessable if the carrier demonstrates that the increased permanent disability compensation results from information that it could not reasonably have known at the time of claim closure. Relying on *Walker v. Providence Health Sys. Oregon*, 267 Or App 87 (2014), the Board noted that the court had held that a penalty under ORS 656.268(5)(e) was justified based on an Order on Reconsideration's increased permanent disability award, reasoning that if a carrier was uncertain at the time of claim closure whether an attending physician had attributed all of a claimant's impairment to a compensable condition, the carrier could simply have requested clarification from the physician, as the ARU had subsequently done during the reconsideration proceeding.

Turning to the case at hand, the Board found that, at the time of claim closure, there were two chart notes from examining physicians discussing claimant's "heavy" lifting requirements at her "at-injury" job and restricting her to "light" lifting. Although recognizing that the employer's job description referred to "light" lifting, the Board reasoned that the description conflicted with the aforementioned chart notes. Under such circumstances, the Board concluded that clarification of claimant's job duties was reasonably required before the issuance of the Notice of Closure. See *Walker*, 267 Or App at 114.

In reaching its conclusion, the Board acknowledged that, despite the references to "heavy" lifting duties in the examining physicians' chart notes, the attending physician had released claimant to her regular work based on the job description (which referred to "light" lifting duties). Yet, the Board determined that the issue was not whether the carrier had a reasonable basis for finding that the attending physician had released claimant to regular work, but rather the issue was whether the reconsideration order's increased permanent disability award resulted from information that the carrier demonstrated that it "could not reasonably have known at the time of claim closure." See ORS 656.268(5)(e). Based on that applicable statutory standard, the Board concluded that a penalty was warranted.

Because employer's "light lifting" job description conflicted with "heavy lifting" references in physician's chart notes, clarification of job duties was reasonably required before claim closure.

"268(5)(e)" penalty was warranted because carrier did not establish that the reconsideration order's increased permanent disability award resulted from information that it "could not reasonably have known at the time of claim closure."

Sole Proprietor: “128” - Untimely Claim Filing - “Employer Knowledge” Exception Under “265(4)(a)” Satisfied - Proprietor Constitutes Both “Worker” and “Employer”

Eric M. Schwartz, 66 Van Natta 2099 (December 24, 2014). Analyzing ORS 656.128 and ORS 656.265(4)(a), the Board held that a sole proprietor’s injury claim was not untimely because the proprietor’s knowledge of his injury satisfied the “employer knowledge” exception to his otherwise untimely filed claim. More than 90 days after incurring a finger injury while performing his work activities, claimant (a sole proprietor) filed his claim. The carrier denied the claim, contending that it was untimely filed and, asserting that his knowledge of the injury did not satisfy the “employer knowledge” exception for an untimely filed claim. Claimant requested a hearing, asserting that, because of his dual capacity as “worker” and “employer,” his knowledge of his injury within 90 days of the work incident met the “employer knowledge” exception for his untimely filing of the claim.

The Board agreed with claimant’s assertion. Citing ORS 656.128(1), and (3), the Board stated that, upon a carrier’s acceptance of a sole proprietor’s application for coverage, the proprietor becomes subject to the provisions and is entitled to the benefits under ORS Chapter 656. Referring to ORS 656.265(1), the Board noted that a claim must be filed within 90 days of the worker’s injurious event. Nonetheless, relying on ORS 656.265(4)(a), the Board observed that the failure to provide such notice does not invalidate the claim if the notice is given within one year after the date of the accident and the employer had knowledge of the injury.

Turning to the case at hand, the Board reiterated that, because the carrier had accepted the sole proprietor’s application for coverage, he became subject to the provisions and was entitled to benefits under ORS Chapter 656. See ORS 656.128. Consequently, consistent with that provision, the Board reasoned that the proprietor must satisfy the notice requirements prescribed in ORS 656.265(1) or one of the available exceptions.

The Board acknowledged the carrier’s reliance on case precedent for the proposition that a supervisor’s knowledge of his/her own injury may not be imputed to the employer for purposes of ORS 656.265(4)(a). See *J. Bradley Ross*, 58 Van Natta 1714 (2006). Nonetheless, because a sole proprietor is in essence *both* the “worker” and the “employer” for purposes of ORS 656.265(4)(a), the Board considered the case precedent advanced by the carrier to be inapposite.

The Board further recognized the carrier’s assertion that it would be substantially prejudiced if a “sole proprietor” claim was not required to provide written notice of an injury within the 90-day period. Yet, relying on *Marshall v. SAIF*, 328 Or 49, 57-59 (1998), the Board stated that if there is the potential for such “prejudice,” the legislature has apparently addressed that issue by requiring “corroborative evidence” for establishing the *compensability* of the claim when a sole proprietor is also the claimant. See ORS 656.128(3).

Because a sole proprietor is both “worker” and “employer,” proprietor’s “knowledge” of his injury satisfies “265(4)(a)” exception to untimely filing of claim notice.

Any prejudice from carrier resulting from proprietor’s “employer knowledge” of his injury is addressed by “corroborative evidence” requirement for establishing the compensability of the claim under “128(3).”

Finally, addressing the “employer knowledge” exception of ORS 656.265(4)(a), the Board determined that, considering the proprietor’s “dual capacity” as both “worker” and “employer,” his knowledge of his injury within 90 days of the work incident satisfied the exception to his untimely filed injury claim. Because the carrier based its denial on the claim’s untimely filing, the Board set aside the denial and remanded the claim to the carrier for further processing.

Standards: “Special Determination” - “726(4)(f)(D)” - “Carotid Artery” Disability Not Addressed By Standards - Remand to ARU For Further Consideration

Valerie D. Stafford, 66 Van Natta 2014 (December 11, 2014). Applying ORS 656.726(4)(f)(D), the Board held that it was appropriate to remand claimant’s carotid injury claim to the Appellate Review Unit (ARU) for a “special determination” as to whether claimant’s disability was addressed in the Director’s disability standards because, although the Order on Reconsideration had included a statement that claimant’s disability was addressed by the standards, the Workers’ Compensation Division (WCD, on behalf of the Director) had subsequently asked that the claim be remanded to ARU for further consideration of the “special determination” question. Claimant, a counselor at a youth psychiatric care facility, had been injured when a resident grabbed and hung on her neck. After the carrier accepted a carotid artery dissection, claimant’s attending physician agreed with her surgeon’s opinion that claimant could return to her work, but with a warning that additional trauma to her artery could result in a recurrent dissection, stroke and death. After a Notice of Closure awarded no permanent impairment/work disability, claimant requested reconsideration. In doing so, she sought the appointment of a medical arbiter, as well as a special determination pursuant to ORS 656.726(4)(f)(D) based on her physicians’ warnings about returning to her work. Noting the warning from claimant’s treating physicians, the arbiter concluded that the restriction resulted in a loss of use or function with regard to her professional and recreational activities. Thereafter, an Order on Reconsideration awarded no permanent impairment/work disability, stating that claimant’s disability was addressed by the current standards. Claimant requested a hearing, reiterating her request for a “special determination.” After an ALJ denied the request and claimant appealed to the Board, WCD/ARU (on behalf of the Director) chose to participate pursuant to ORS 656.726(4)(h). In doing so, WCD asked that the claim be remanded to ARU for further consideration of the “special determination” request.

When a worker’s disability is not addressed by the standards, the Director shall, in a reconsideration order, determine the extent of permanent disability that addresses the worker’s impairment.

The Board granted WCD’s request. Citing ORS 656.726(4)(f)(D), the Board stated that when it is found that the worker’s disability is not addressed by the standards, the Director shall, in the Order on Reconsideration, determine the extent of permanent disability that addresses the worker’s impairment. Relying on *Gallino v. Courtesy Pontiac-Buick-GMC*, 124 Or App 538, 541 (1993), the Board stated that, under a prior version of the statute, it had the authority to remand a claim to the Director for promulgation of a temporary rule when a disability was not addressed by the existing standards.

If ARU's reasoning regarding a "special determination" is unclear, absent, or not legally supportable, remand to ARU is appropriate.

Because WCD/ARU had participated on review and asked that claim be returned for a "special determination," its request effectively rescinded a statement in the reconsideration order that claimant's disability was addressed in the standards.

Turning to the case at hand, the Board acknowledged that the previous version of the statute referred to the promulgation of a "temporary rule," whereas the current version describes a "special determination." Nonetheless, reasoning that the essential principle of each version of the statute was the same, the Board concluded that ARU (on behalf of WCD and the Director) is required to consider whether claimant's disability is addressed in the standards and, if it finds that the disability is not so addressed, include a "special determination" of that disability in its Order on Reconsideration. Likewise, consistent with the *Gallino* analysis of ORS 656.726(4)(f)(D), the Board found that, if ARU's reasoning regarding a "special determination" is unclear, absent, or not legally supportable, remand to ARU is an appropriate remedy.

Applying the aforementioned analysis to the present case, the Board acknowledged that the Order on Reconsideration had stated that claimant's disability was addressed by the standards. Citing *Terry J. Hockett*, 48 Van Natta 1297 (1996), the Board further recognized that the inclusion of such a statement in a reconsideration order had been one of the reasons that a remand request for a temporary rule under the former version of ORS 656.726(4)(f)(D) had been denied.

Nevertheless, in contrast to *Hockett* and its progeny, the Board noted that WCD/ARU (on behalf of the Director) had chosen to participate in the proceeding pursuant to ORS 656.726(4)(h). Moreover, the Board emphasized that WCD/ARU had specifically asked that the claim be returned to ARU for further consideration of the "special determination" request.

Under such circumstances, the Board concluded that, in effect, ARU had rescinded the statement in its reconsideration order stating that claimant's disability was addressed by the standards. In the absence of such a statement and considering the arbiter's and attending physician's comments concerning claimant's limitations, the Board held that it was appropriate to remand the claim to ARU for further consideration of claimant's "special determination" request.

Standards: Work Disability - Claimant Not Released/Returned to "At-Injury" Job - Heavier Duties (Not Mentioned in "Job Analysis") Were Customary Part of "At-Injury" Job

Stuart A. MacDonald, 66 Van Natta 2046 (December 18, 2014). Applying ORS 656.214(2)(a) and ORS 656.726(4)(f)(E), the Board held that claimant was entitled to a work disability award, finding that that he had not returned to his regular "at-injury" job because, even though his employer's job analysis did not describe heavier duties (which exceeded his "post-injury" physical limitations), affidavits from him and a coworker persuasively established that he had performed these heavier activities on a steady, customary basis. Following claimant's compensable shoulder injury, his attending physician restricted his lifting to no more than 50 pounds from the floor to waist, no more

than 10 pounds for above waist lifting, and no repetitive lifting. After a Notice of Closure did not award work disability, claimant requested reconsideration, including an affidavit and a report from his physician, noting that his “at-injury” job (as a field technician coordinator) required him to remove and install windows weighing up to “a couple hundred pounds.” Thereafter, an Order on Reconsideration rescinded the closure, finding that there was insufficient information to close the claim; *i.e.*, an accurate job analysis or description of the physical requirements of claimant’s “at-injury” regular work, agreed to and signed off by claimant, and approved by the attending physician. At the carrier’s request, a vocational consultant then prepared a job analysis, which described minimal lifting duties with limited “field” work. After claimant disagreed with the analysis (referring to his “at-injury” job duties of removing/installing heavy windows), the consultant declined to include these “carpentry” duties in the analysis, reasoning that if such activities had been performed, they were done so at claimant’s discretion and not as part of his job description. After another Notice of Closure did not award work disability, claimant again requested reconsideration, including affidavits from him and a coworker, which asserted that his “at-injury” job required carpentry duties occasionally involving lifting/carrying windows in excess of 50 pounds. Relying on the affidavits from claimant and his coworker, an Order on Reconsideration found that claimant had not been released or returned to his regular “at-injury” job and, consequently, granted work disability. In addition, finding that claimant’s permanent disability award met the criteria for a penalty under ORS 656.268(5)(e), the reconsideration order also assessed a penalty, finding that the carrier could reasonably have known that claimant’s “at-injury” job exceeded his “post-injury” work restrictions. The carrier requested a hearing, contending that, because claimant’s “at-injury” job did not require carpentry work, a work disability award was not justified.

The Board disagreed with the carrier’s contention. Citing ORS 656.214(2)(a), and ORS 656.726(4)(f)(E), the Board stated that whether claimant was entitled to work disability depended on whether he returned to, or was released by his attending physician to return to, regular work. Relying to ORS 656.214(1)(d), and OAR 436-035-0005(15), the Board noted that “regular work” means the job that claimant held at injury. Referring to *Thrifty Payless, Inc. v. Cole*, 247 Or App 232, 239 (2011), the Board observed that “regular work” tasks include tasks that are performed on a steady or customary basis, even if those tasks are not part of a worker’s job description or otherwise explicitly required.

Turning to the case at hand, the Board acknowledged that the analysis for claimant’s “at-injury” job did not describe work activities exceeding the physical restrictions imposed by his attending physician. Nonetheless, based on claimant’s affidavit, the Board was persuaded that his “regular work” occasionally included the removal and installation of windows, which involved lifting in excess of his physical limitations. The Board further noted that the vocational consultant had recognized that claimant may have performed such activities, but had not included them in the job analysis because the activities were performed at his own discretion.

Applying the *Cole* rationale, the Board determined that claimant’s “at-injury” job included the aforementioned lifting/carrying of windows, which were performed on a steady or customary basis. Because such activities

Based on claimant’s affidavit, Board found that “regular work” involved lifting in excess of his physical limitations (and beyond the limits set forth in a job description.

Because earlier reconsideration order had directed carrier to include a job analysis (agreed to by claimant), the increased permanent disability award granted by the later reconsideration order (which was based on claimant's affidavit disagreeing with the job analysis which he had not approved) had not been based on information that carrier could not reasonably have known at closure.

exceeded his "post-injury" physical limitations, the Board found that claimant was not released, and did not return, to his regular work and, as such, was entitled to a work disability award.

Finally, addressing the penalty issue under ORS 656.268(5)(e), the Board stated that such a penalty is not assessed if the increased permanent disability award granted by the Order on Reconsideration resulted from information that the carrier demonstrates it could not reasonably have known at the time of claim closure. OAR 436-035-0175(2).

Referring to the initial reconsideration order (which had set aside the previous closure notice), the Board reiterated that the carrier had been advised to include with its future claim closure a detailed job analysis, agreed to by claimant, and approved by his attending physician. Noting that claimant had disagreed with the subsequent analysis and reasoning that the vocational consultant's decision to exclude the heavier "carpentry" duties from the analysis was contrary to the *Cole* holding (which had issued well before the consultant's decision), the Board concluded that the Order on Reconsideration's increased permanent disability award had not been based on information that the carrier could not reasonably have known at claim closure. Consequently, the Board held that a penalty under ORS 656.268(5)(e) was warranted.

Third Party Dispute: "Just & Proper" Distribution - "593(3)" - Petition Not Precluded By Earlier Order - Claimant/Spouse "Combined" Settlement - Only Claimant's Share "Lienable" - Hearing Referral

David J. Hanson, 66 Van Natta 2131 (December 30, 2014). Applying ORS 656.593(3), the Board held that a paying agency's petition for determination of a "just and proper" distribution of proceeds from a claimant's share of a settlement from a third party (which also included his wife's "loss of consortium" claim) was not precluded by a prior Board order that had dismissed an earlier petition as premature. In reaching its earlier decision, the Board had reasoned that, because the parties had not quantified the portion of the combined settlement with the third party that was attributable to claimant's cause of action (which would be subject to the paying agency's "third party" lien) and his wife's "loss of consortium" claim (which would not be subject to the paying agency's lien), the record was insufficiently developed for a determination of a "just and proper" determination of the paying agency's portion of claimant's third party recovery. See ORS 656.593(3). Several years after the Board's dismissal order (which was not appealed), the paying agency filed another petition seeking resolution of a third party lien dispute. Acknowledging the Board's previous decision, the paying agency recounted that the parties' mediation efforts, as well as its civil court petition for a declaratory judgment (designed to quantify claimant's share of the combined settlement) had been unsuccessful. Submitting an affidavit from one of the third party's attorneys (which provided

Because earlier Board order had dismissed petition as “premature,” that order had no preclusive effect regarding the merits of current “just and proper distribution” dispute.

Because third party attorney’s affidavit was admissible, but claimant requested an opportunity to cross-examine the attorney, Board referred matter to a hearing for further development of the record.

For future “combined” settlements involving “lienable” third party recoveries and “unlienable” loss of consortium recoveries, Board recommended that a paying agency disapprove such a settlement until an apportionment of the two recoveries can be identified.

an estimation of claimant’s and his wife’s shares of the combined settlement), the paying agency again sought a Board determination of a “just and proper” distribution of claimant’s share of the settlement. In response to the paying agency’s petition, claimant argued that the Board’s previous dismissal order and the circuit court’s dismissal of the declaratory judgment petition (both of which were not appealed) precluded the current request for third party relief. Alternatively, claimant objected to the submission of the third party’s attorney’s affidavit, asserting that it could have been submitted during the first proceeding or that consideration of the affidavit (without his opportunity to cross-examine the attorney) constituted a violation of his constitutional rights to due process of law.

The Board held that it was authorized to resolve the parties’ dispute regarding a “just and proper” distribution of proceeds from a third party settlement. See ORS 656.593(3). Although acknowledging that considerable time had elapsed since its previous order, the Board found no statutory time limitation concerning its authority to resolve the parties’ “third party” dispute. Furthermore, noting that its earlier decision dismissed the paying agency’s petition as premature, the Board reasoned that its prior order had no preclusive effect regarding the merits of the parties’ “distribution” issue. Finally, observing that its prior order had not stated that the dismissal was “with prejudice,” the Board considered the dismissal to have been “without prejudice.” See *Michael R. Dunham*, 63 Van Natta 1627 (2011).

Addressing claimant’s objection to the paying agency’s submission of the third party’s attorney’s affidavit, the Board found no limitation regarding the presentation of evidence that may have been submitted during the earlier “dismissed” proceeding. Citing *Blackman v. SAIF*, 60 Or App 446, 448 (1992), the Board observed that its statutory obligation under ORS 656.298 was to ensure that the record was sufficiently developed to sustain judicial review. Considering this requirement, the Board determined that the parties may present whatever evidence they deem relevant to the development of the record regarding their current dispute regarding a “just and proper” distribution of claimant’s third party settlement proceeds.

Although it found the third party’s attorney’s affidavit admissible, the Board also determined that claimant was entitled to conduct a cross-examination of the attorney. Consequently, the Board referred the parties’ dispute to a hearing for further development of the record, which would include, but was not limited to, a cross-examination of the third party.

In reaching its decision, the Board emphasized that, based on the reasoning expressed in its earlier dismissal order, it would have preferred that the parties had reached a compromise regarding the portion of the combined settlement allocated to claimant and the portion attributable to his wife’s loss of consortium claim. Nonetheless, finding that the record persuasively established that such a compromise was unattainable in light of the unsuccessful mediation and declaratory judgment efforts, the Board considered it appropriate to address the parties’ “just and proper” dispute.

Finally, in the interests of avoiding future similar disputes, the Board offered the following suggestions for parties involved in combined settlements regarding a claimant’s claim and a spouse’s loss of consortium claim. First, a paying agency should consider disapproving such a settlement, until an

apportionment of the “lienable” and “nonlienable” shares of the combined settlement can be identified. In the absence of such an apportionment, the dispute could be submitted to the Board under ORS 656.587, which would likely refuse to approve the settlement until the requested apportionment of the settlement proceeds was specifically quantified.

Third Party Dispute: “Just & Proper” Distribution - Carrier Reimbursement for “Cohabitant” Death Benefits - Not Recoverable From Settlement Because “Cohabitant” Not Entitled to a Share

Brian A. Lacy, Dcd, 66 Van Natta 2070 (December 19, 2014). Applying ORS 656.593(3), the Board held that it was not “just and proper” for a paying agency to receive reimbursement for its claim costs attributable to the surviving “cohabitant” of a deceased worker from an “out-of-state” third party “wrongful death” settlement because the “cohabitant” was not entitled to a share of those settlement proceeds pursuant to the laws of that other state. Following the worker’s compensable death, the paying agency paid for his funeral expenses, as well as provided benefits to the cohabitant and the worker’s child. Thereafter, a wrongful death action was pursued in the state where the worker had died. Under the other state’s law, the cohabitant was not entitled to bring such an action. Eventually, the action was settled, with the proceeds allotted to the son and for burial/funeral expenses, as well as conscious pain and suffering to the worker. After the paying agency included its actual/future claim costs attributable to the cohabitant’s death benefits in its “third party” lien, she sought Board resolution of the “just and proper” dispute under ORS 656.593(3).

The Board held that the paying agency’s “just and proper” share of the third party settlement was limited to its claim costs attributable to the deceased worker’s surviving son and for funeral/burial expenses. Citing *Liberty Northwest Ins. Corp. v. Golden*, 116 Or App 64 (1992), *rev den*, 315 Or 442 (1993), the Board stated that allocation of damages among beneficiaries of a wrongful death action under ORS 30.030 is not the same as the distribution of the proceeds between the workers’ compensation paying agency and the decedent’s estate under ORS 656.593(3). In accordance with the *Golden* rationale, the Board explained that the issue for the probate court under ORS 30.030 was the amount that each beneficiary in the wrongful death action was to receive, according to that beneficiary’s loss, whereas, under ORS 656.593(3), the issue for the Board was what amount was “just and proper” for the paying agency to receive on its lien, which attaches after the litigation costs/attorney fees and statutory 1/3 shares are distributed.

Turning to the case at hand, the Board agreed with the paying agency’s assertion that its third party lien attached to the entire third party settlement. Nonetheless, consistent with the *Golden* holding, the Board clarified that the issue of “just and proper” distribution of the settlement proceeds remained within its discretion pursuant to ORS 656.593(3).

Because the worker's "cohabitant" was not entitled to a portion of an "out-of-state" wrongful death settlement, it was not "just and proper" for the paying agency to receive reimbursement from the settlement proceeds for any "cohabitant-related" claim costs.

In reaching its "just and proper" determination, the Board looked to its decision in *Theresa J. Lester*, 47 Van Natta 57 (1995), which had held that it was not "just and proper" for a paying agency to recover its claim costs for a surviving husband's death benefits because the third party settlement had been designed to compensate only the decedent's minor children (and not her estranged husband). Although acknowledging the "estranged" relationship in *Lester* (which distinguished it from the present case), the Board considered the two cases similar in that neither third party settlement was designed to include any recovery for a workers' compensation beneficiary for which the paying agency was attempting to seek reimbursement for its claim costs. Consequently, consistent with its *Lester* rationale, the Board did not consider it "just and proper" for the paying agency to receive reimbursement for its "cohabitant-related" claim costs from the third party settlement.

APPELLATE DECISIONS UPDATE

Firefighter Presumption: "802(4)" - "Clear & Convincing" Evidence - Standard Satisfied By Medical Opinion of "No Employment" Contribution to Claimed Condition, Even if Specific Cause Unknown

SAIF v. Thompson, 267 Or App 356 (December 3, 2014). Analyzing ORS 656.802(4), the court reversed the Board's order in *Roger J. Thompson*, 64 Van Natta 1713 (2012), previously noted 31 NCN 9, which held that a carrier had not overcome the "firefighter's presumption" by presenting clear and convincing medical evidence that the cause of claimant's claimed heart condition was unrelated to his employment. Noting that the cardiologist's opinion on which the carrier relied to overcome the "firefighter's presumption" had conceded that the cause of claimant's atherosclerosis (the condition which had caused the heart attack) was unknown, the Board reasoned that the cardiologist's conclusion that claimant's firefighter employment had not contributed to his heart condition was insufficient to overcome the presumption by "clear and convincing" evidence. On appeal, the carrier contended that the Board's decision went beyond the "clear and convincing" evidence standard by requiring the carrier to prove an alternative cause of the claimed occupational disease when medical science had not yet been able to pinpoint the ultimate cause.

Physician's opinions that firefighter's condition was not related to employment need not demonstrate an "alternative cause" for condition to overcome the "firefighter's presumption."

The court reversed the Board's decision. Citing *Long v. Tualatin Valley Fire*, 163 Or App 397, 401 (1999), the court noted that it had rejected a claimant's argument that physicians' opinions (which did not consider his condition related to his firefighter employment) were insufficient to overcome the "firefighter's presumption" because they did not demonstrate an "alternative cause" for the condition.

Turning to the case at hand, the court framed the question on review was whether, in contravention of *Long*, the Board's order had ultimately required the carrier to present evidence of an alternative cause for claimant's heart

condition in order to rebut the “firefighter’s presumption.” After reviewing the Board’s analysis of the cardiologist’s opinion, the court disagreed with claimant’s suggestion that the Board had simply found that the cardiologist had failed to sufficiently explain *how* he had concluded that claimant’s heart condition was unrelated to his firefighting work. Rather, the court determined that the Board had concluded that the cardiologist’s opinion could not be convincing because he had not identified what had caused claimant’s heart condition.

Reasoning that the only basis for the Board’s conclusion that the cardiologist’s opinion had not met the “clear and convincing” evidence standard was that it had failed to connect claimant’s atherosclerosis to a specific, non-work-related cause, the court found that the Board’s decision could not be harmonized with the *Long* decision. Concluding that the Board had misapplied the standard of proof under ORS 656.802(4), the court reversed the Board’s decision.

In reaching its conclusion, the court recognized that the firefighter’s presumption was “intended to give relief” to firefighters because statistical studies indicated that firefighters were much more likely to suffer from heart and lung diseases due to exposure to smoke and gases under strenuous conditions. *Wright v. SAIF*, 289 Or 323, 328 (1980). Nevertheless, the court emphasized that, in the present case, it was concerned with a *particular* condition’s connection to the activities associated with firefighting. In addition, when determining what “medical evidence” effectively rebuts the presumption, the court explained that, where such evidence established, as a general matter, that a particular condition was not caused by activities associated with firefighting, that evidence was sufficient to overcome the presumption (even when medical science could not identify a certain cause of the condition).

When medical evidence establishes, as a general matter, that a particular condition was not caused by firefighting activities, that evidence was sufficient to overcome the “firefighter’s presumption” (even when medical science could not identify a certain cause of the condition).

Supplemental Disability: “210(2)(b)(A)” - Notice of “Secondary Employment” - Not “Imputed” to Insurer/Compro From Employer

DCBS v. Muliro, 267 Or App 526 (December 10, 2014). Analyzing ORS 656.210(2)(b)(A), the court reversed the Board’s order in *Rebecca M. Muliro*, 64 Van Natta 1727 (2012), previously noted 31 NCN 9, that had awarded supplemental disability to claimant. In reaching its conclusion, the Board had reasoned that, although claimant had not timely notified the employer’s insurer that she had multiple employers (as required by ORS 656.210(2)(b)(A)), the insurer had “imputed notice” of her secondary employment because her employer was aware of such employment. Identifying the issue as one of statutory interpretation, the court framed the determinative question as whether an employer’s knowledge that a worker has secondary employment was sufficient to establish the notification required by ORS 656.210(2)(b)(A).

The court concluded that such “imputed notice” did not satisfy the statutory notification requirement. After analyzing the statute, the court stated that, as a prerequisite for supplemental disability benefits, the insurer (or self-

A prerequisite for “supplemental disability” benefits is that the carrier/assigned claim agent must receive, within 30 days of receipt of the initial claim, notice of the worker’s “secondary employment.”

insured employer or assigned claim agent) must *receive* “[w]ithin 30 days of receipt of the initial claim, notice that the worker was employed in more than one job with a subject employer at the time of injury[.]”

Turning to the case at hand, the court acknowledged claimant’s contention that, based on the “long and well-known common law surrounding imputed knowledge and notice,” the insurer had received timely “actual notice” of her secondary employment because her employer had such notice and that the insurer “had the means of informing itself, and ought to have done so.” The court further recognized that it had previously determined that an employer’s conduct or knowledge of the circumstances of a claim could affect the obligations of the insurer; *e.g.*, *SAIF v. Abbott*, 103 Or App 49, 53 (1990), *mod on recon*, 107 Or App 53 (1991); *Nix v. SAIF*, 80 Or App 656, 660, *rev den*, 302 Or 158 (1986); *Anfilofieff v. SAIF*, 52 Or App 127, 134-35 (1981).

Nonetheless, reasoning that each of the aforementioned decisions had found the employer’s conduct or knowledge relevant to assessing the quality of an insurer’s conduct or state of mind, the court found that none of those cases addressed the particular question in the present case; *i.e.*, whether an employer’s knowledge of a worker’s secondary employment was sufficient to establish the statutory notification that a worker is required to provide to an insurer under ORS 656.210(2)(b)(A). Consequently, the court did not consider the above-cited cases as helpful context for an interpretation of the statutory notice requirement pursuant to ORS 656.210(2)(b)(A).

Instead, the court found the reasoning expressed in *Valencia v. GEP BTL, LLC*, 247 Or App 115 (2011) instructive. After summarizing the *Valencia* decision (which held that it was not unreasonable for the statutory claim agent concerning supplemental disability not to have sought further information for calculating a worker’s “secondary employment” weekly wage), the court analyzed its holding to be that an injured worker seeking supplemental disability must satisfy the requirements of ORS 656.210(2)(b) and, as such, when the worker does not provide the necessary information required by the statute, the entity responsible for processing the claim is not obligated to independently seek that information.

Because the worker must provide the necessary information required by the statute, the employer’s knowledge of “secondary employment” is not sufficient to satisfy the statutory requirements for entitlement to supplemental disability benefits.

Consistent with the reasoning expressed in *Valencia*, the court rejected claimant’s argument that her employer’s knowledge of her “secondary employment” should be imputed to the insurer. Rather, the court determined that ORS 656.210(2)(b)(A) spelled out who must receive such notice and that the statute made no provision for any type of notice, other than actual notice. Consequently, because claimant had not provided notice of her “secondary employment” to the insurer within 30 days of its receipt of her initial claim, the court held that she was not entitled to supplemental disability.

TTD: “268(10)”/“340(12)” - “Actively Engaged” in ATP - “16-21 Month” Duration Per Program

Intel Corp. v. Batchler, ___ Or App ___ (December 24, 2014). Analyzing ORS 656.268(10), and ORS 656.340(12), the court affirmed the Board’s order in *Tricia A. Batchler*, 64 Van Natta 1436 (2012), previously noted 31 NCN 7, which held that claimant was entitled to temporary disability (TTD) benefits while participating in her second authorized training program (ATP), even though she had already received 16 months of TTD benefits during an earlier ATP. In reaching its conclusion, the Board had reasoned that the 16-month statutory maximum for TTD benefits during an ATP (subject to an extension to 21 months) under ORS 656.340(12) applied to each period that claimant was participating in an ATP. On appeal, the carrier contended that the aforementioned statutory maximum applied for the life of the claim and, because claimant had exhausted her TTD benefits during the first ATP, she was no longer entitled to such benefits during her second ATP.

The court disagreed with the carrier’s contention. Citing ORS 656.268(10), the court stated that a claimant who is “enrolled and actively engaged in” vocational training is entitled to receive “temporary disability compensation.” Relying on ORS 656.340(12), the court noted that a worker who is actively engaged in vocational training may receive temporary disability compensation for a maximum of 16 months (but that a carrier may voluntarily extend the payment of such benefits, but “in no event” not “for a period longer than 21 months”). Finally, observing that ORS 656.340(12) begins with the phrase “notwithstanding ORS 656.268(10), the court reasoned that ORS 656.340(12) controls over ORS 656.268(10), but only to the extent that ORS 656.340(12) carves out an exception to the general rule expressed in ORS 656.268(10).

After reviewing ORS 656.268(10), the court determined that the statute contains two substantive rules: (1) an explanation of the conditions that must exist for a claimant to be eligible for training-related TTD benefits (*i.e.*, a Notice of Closure must have been issued and the claimant must become enrolled and actively engaged in vocational training in accordance with the Director’s rules); and (2) an explanation of what the claimant must do to continue receiving such TTD benefits (*i.e.*, remain “enrolled and actively engaged in the training”). Based on its analysis of the statute, the court concluded that a claimant may receive training-related TTD benefits for an indefinite period of time as long as she remains enrolled and actively engaged in training.

After examining ORS 656.340(12), the court found that the statute provides for a cap on the duration of the aforementioned training-related TTD benefits, but does not address the conditions for a claimant’s eligibility. As such, the court reasoned that the two statutes are reconcilable in that ORS 656.268(10) establishes when a claimant becomes eligible for training-related TTD benefits and that ORS 656.340(12) addresses the duration of such benefits.

“268(10)” establishes when a claimant becomes eligible for training-related TTD benefits and “340(12)” addresses the duration of such benefits.

Harmonizing the two statutes, the court described the statutory scheme: (1) a claimant becomes eligible for training-related TTD benefits when her claim is closed and she begins an authorized ATP; (2) a claimant may receive TTD benefits for as long as she is “actively engaged” in her ATP; and (3) those benefits may not continue for more 16 months during such eligibility unless an extension is approved by the carrier and, in no event for more than 21 months.

Applying its statutory analysis to the case at hand, the court found that nothing precluded a claimant from becoming eligible to receive training-related TTD benefits more than once. Moreover, the court determined that the limits on the training-related TTD benefits applied only after a claimant becomes eligible for such benefits.

Consequently, the court reasoned that if a claimant becomes eligible to receive such benefits more than once, the limitations of ORS 656.340(12) likewise apply to each of those periods of eligibility separately. Because those circumstances had occurred in the present case, the court held that claimant was entitled to TTD benefits while she was “actively engaged” in her second ATP, provided that her training period did not exceed the statutory “maximum caps” prescribed in ORS 656.340(12).

If a claimant becomes eligible to receive “vocational training-related” TTD benefits more than once, the “340(12)” limitations regarding the duration of such benefits likewise apply to each of those periods separately.

TTD: “Open” Omitted Medical Condition Claim - “AP” Reference to “Permanent” (Rather Than “Temporary”) Disability & “Med Stat” Condition - Not Preclusive For “Pre-Closure” TTD

Scott v. Liberty Northwest Ins. Corp., ___ Or App ___ (December 31, 2014). Applying ORS 656.262(4), the court vacated the Board’s order in *Jackie A. Scott*, 63 Van Natta 2375 (2011), previously noted 30 NCN 11, that had held that claimant was not entitled to temporary disability (TTD) benefits while her low back claim had been reopened for an accepted “surgical scarring” condition. Reasoning that an attending physician’s comments had indicated that any disability attributable to the accepted “scarring condition” was permanent (rather than temporary) and that the condition was medically stationary, the Board had concluded that claimant was precluded from receiving TTD benefits (even assuming that her disability was due to the “surgical scarring”).

The court disagreed with the Board’s reasoning. Citing ORS 656.262(4)(a), and *Lederer v. Viking Freight, Inc.*, 193 Or App 226, 237, *adh’d to as modified on recons*, 195 Or App 94 (2004), the court stated that an attending physician’s authorization of TTD benefits is legally sufficient when an objectively reasonable carrier would understand contemporaneous medical reports to signify approval excusing the worker from work. Referring to several subsections in ORS 656.262 and ORS 656.268, the court summarized three distinct periods for the entitlement to TTD benefits: (1) at the outset of a claim during the period for which there is a time loss authorization, pending

Because claimant had been excused from work and the nature of her disability (permanent or temporary) had not been determined, the obligation to pay TTD benefits would have been triggered (if found due to the accepted omitted medical condition), which would continue until a basis for termination of such benefits had occurred.

The attending physician's reference to "permanent" (rather than "temporary") disability would not preclude claimant's entitlement to begin receiving TTD benefits on an open claim.

acceptance or denial (commonly referred to as interim time loss); (2) in the processing of an accepted claim (but before claim closure) during the period for which an attending physician continues to authorize time loss (commonly referred to as substantive time loss); and (3) for a period of disability on an accepted claim during which an attending physician considers the worker medically stationary, but before the carrier has determined that the worker is medically stationary and closes the claim (commonly described as procedural time loss).

Turning to the case at hand, the court noted that, before the carrier had accepted the omitted "surgical scarring" condition and reopened the claim, the attending physician had indicated that claimant would never return to work. The court further acknowledged that the attending physician had described claimant's disability as "permanent" and had considered the condition to be medically stationary.

Nevertheless, the court observed that the medical record established that claimant had been excused from working and that neither the nature of her disability due to the surgical scarring (permanent or temporary) nor its medically stationary date had been determined. Given such circumstances, the court reasoned that, if the medical record showed that claimant was disabled as a result of her surgical scarring (an issue that the Board had not decided), the carrier's obligation under ORS 656.262(4) to begin paying TTD benefits on the claim would have been triggered, which would continue until one of the bases for terminating such benefits had occurred; e.g., claim closure under ORS 656.268(1)(a) when the surgical scarring condition was medically stationary.

Because, as of the date of hearing, the claim remained open and none of the bases prescribed in ORS 656.268(4) for terminating TTD benefits had occurred, the court disagreed with the Board's reasoning that the attending physician's reference to "permanent" (rather than "temporary") disability from the surgical scarring precluded her entitlement to begin receiving TTD benefits. Accordingly, the court remanded for a determination as to whether the attending physician's opinion that claimant was disabled related to the surgical scarring claim and, if so, the duration of her entitlement to such benefits.