



News & Case Notes

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BOARD NEWS

ALJ Appointment - Ray Smitke

WCB is pleased to announce the appointment of a new Portland Administrative Law Judge - Ray Smitke. Ray comes with over 30 years experience in Oregon Workers' Compensation. Formerly, he was a trial attorney with Liberty Mutual Insurance Company and the SAIF Corporation. Before that, he was a partner at Erickson, Wilson, Wolf and Smitke. Please join us in welcoming Ray to WCB.

Rulemaking Hearing: May 30, 2014 - "Filing/Service" Rule (OAR 438-005-0046) - "Filing/Service" Via WCB Portal

At its March 20 meeting, the Members proposed amendments to OAR 438-005-0046(1) and (2) to provide for website portal filing/service of "any other thing" that is made available for filing by website portal. Noting that this action was consistent with WCB's "Technology" Advisory Committee's recommendation to provide for future electronic filing of settlement documents, the Members reasoned that the proposed amendments would permit website portal filing/service of additional things as WCB's website portal system is expanded in the future, without the need to amend OAR 438-005-0046(1), and (2) to explicitly list each new thing in the "filing/service" rule as it is added to the website portal.

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

A rulemaking hearing for these proposed rule amendments has been scheduled for May 30, 2014, at 10 a.m. at the Board's Salem office (2601 25th St. SE, Ste. 150, Salem, OR 97302-1280). Any written comments submitted in advance of the hearing may be directed to Debra Young, the rulemaking hearing officer. Those comments may be mailed to the above address, faxed to 503-373-1684, e-mailed to rulecomments.wcb@state.or.us or hand-delivered to a permanently staffed Board office (Salem, Portland, Eugene, Medford).

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APPELLATE DECISIONS

Public Board Meeting Dates

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

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

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

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

Parties/practitioners who wish to receive notice of Board meetings may subscribe to WCB's email notification system on its website. Questions may be directed to Karen Burton, WCB's Executive Secretary at: karen.burton@state.or.us.

"On-the-Record" Cases: Evidentiary/ Procedural Issues - Request for Public Comments Concerning Possible Solutions

At their March 20 meeting, the Members discussed the "evidentiary/procedural" issues that arise in "on-the-record" cases (where the parties have waived an in-person hearing) when the admitted exhibits have not been identified or the specific issues for resolution have not been clarified before the commencement of the "written argument" phase of the proceeding. At that meeting, the Members considered comments from Theodore Heus, Attorney at Law, Julie Masters, SAIF Corporation, and Presiding ALJ Joy Dougherty concerning such issues.

In addition, referring to cases such as *Cindy M. Penturf*, 50 Van Natta 1718 (1998), and *Lynda S. Sinnott*, 66 Van Natta 346 (February 24, 2014), the Members noted that such issues have periodically arisen over the past

14 years. The Members further observed that several of its case decisions have encouraged ALJs and parties to clarify what exhibits are submitted and/or admitted or what issues have been raised for resolution, before implementation of the written arguments. See e.g., *Kerry K. Hagen*, 61 Van Natta 370, 371 n 2 (2009).

To gather further information on the subject, the Members have asked Presiding ALJ Dougherty to discuss the matter with the ALJs during their quarterly meetings. In addition, the Members are seeking input from parties and practitioners. To be considered, those written comments may be submitted to Karen Burton, WCB Executive Secretary, at: karen.burton@state.or.us. The Members welcome your responses to the following questions:

1. Do you feel that the issues presented by the *Penturf* and *Sinnott* decisions constitute a problem?
2. If you think this situation represents a problem, what following action(s), if any, should the Board take?
 - a. Should the Board explore rulemaking for OTR cases?
 - b. Do you feel these problems can be addressed through “contested case” decisions?
3. Other comments?

Responses received by May 9, 2014 will be considered. Thereafter, the Members will schedule another Board meeting to continue their deliberations on this subject.

Important Information in Scheduling a Mediation

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

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

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

CASE NOTES

Attorney Fee: “308(2)(d)” - Responsibility Denial - “Extraordinary Circumstances” - Not Raised at Hearing/Review, Board Declined to Consider Request on Reconsideration

Rodney P. Cook, 66 Van Natta 427 (March 6, 2014). On reconsideration of its initial order (which set aside a carrier’s responsibility denial of claimant’s occupational disease claim for an elbow condition and awarded an attorney fee under ORS 656.308(2)(d) consistent with the statutory limitation of \$2,697), *Rodney P. Cook*, 66 Van Natta 305 (February 14, 2014), the Board declined to consider claimant’s counsel’s request for an “extraordinary” attorney fee because no such request had been raised at either the hearing level nor on Board review. After an ALJ upheld the carrier’s responsibility denial, claimant requested review, contending that the carrier was responsible for his elbow condition. In doing so, claimant’s counsel sought an attorney fee award that exceeded the statutory limitation of ORS 656.308(2)(d), but did not argue that the case presented “extraordinary circumstances.” When the Board reversed the ALJ’s order and awarded an attorney fee commensurate with the statutory limitation, claimant sought reconsideration and an increased award. Noting that the case was unusual (in that there was only the one carrier in the proceeding), claimant contended that there was a risk that he would not receive benefits and that his counsel had performed an extensive amount of services that would not have normally been necessary in typical responsibility disputes involving multiple potentially responsible carriers.

On reconsideration, the Board adhered to its previous attorney fee award. Citing ORS 656.308(2)(d), the Board stated that, absent extraordinary circumstances, the attorney fee award regarding litigation concerning a responsibility denial is currently limited to \$2,697. Furthermore, referring to *Anthony D. Cayton*, 65 Van Natta 1784, 1788 (2013), the Board noted that it had previously held that there was no entitlement to an “extraordinary” attorney fee beyond the statutory maximum prescribed in ORS 656.262(11)(a) when the claimant had not contended at the hearing level that “extraordinary circumstances” supported an increased award.

Turning to the case at hand, the Board found no indication from the hearing record that claimant’s counsel had either made a specific request for an attorney fee or sought an “extraordinary” attorney fee under ORS 656.308(2)(d). Moreover, the Board noted that, although claimant had submitted an attorney fee request on review that exceeded the statutory limitation, he had not asserted that “extraordinary circumstances” existed to award an attorney fee beyond the statutory limitation.

When claimant had not expressly argued, at hearing or on review, that “extraordinary circumstances” existed justifying an “extraordinary” attorney fee under “308(2)(d),” the Board declined his request for such an attorney fee award on reconsideration.

Because of claimant’s inconsistent histories regarding his work incident and its review of a DVD recording concerning the incident, the Board found him to be unreliable and, as such, concluded that the carrier had overcome the rebuttable presumption under “310(1)(b)” that an injury is not self-inflicted and had established that: (1) claimant’s condition resulted from his own volitional act; and (2) he had knowledge of the consequence of the act.

Under such circumstances, the Board concluded that claimant had not expressly argued at the hearing level or on review that “extraordinary circumstances” existed justifying an attorney fee award in excess of the statutory limitation prescribed in ORS 656.308(2)(d). Accordingly, the Board declined to grant claimant’s request for an “extraordinary” attorney fee.

Compensable Injury: “Intentional Injury” - “156(1)” - Hand “Thrust” Into Rollers of Press Machine - Carrier Rebutted Presumption Against “Self-Inflicted” Injury Under “310(1)(b)”

Trenton Wilson, 66 Van Natta 521 (March 21, 2014). Applying ORS 656.156(1), and ORS 656.310(1)(b), the Board held that claimant’s hand injury, which occurred when his hand was crushed between moving rollers of a metallic press machine, was not compensable because the carrier had established that the injury resulted from his deliberate intention to produce such an injury. During its investigation of claimant’s injury claim, the carrier reviewed a DVD recording of the incident, which showed him looking to either side, before thrusting his hand into the rollers of the press machine. Based on that recording, the carrier denied claimant’s injury claim, contending that he intentionally caused his injury. Claimant requested a hearing, asserting that the carrier could not persuasively rebut the presumption under ORS 656.156(1) that his injury was not occasioned by the willful intention to commit self-injury.

The Board disagreed with claimant’s assertion. Citing ORS 656.156(1), the Board stated that a worker’s injury claim is barred if it results from the deliberate intention of the worker to produce such an injury. Relying on Nathaniel D. Hardy, 63 Van Natta 1977 (2011), the Board noted that the test for determining whether an injury is intentional is: (1) whether claimant’s condition was the result of his/her own conscious volitional act; and (2) whether claimant had knowledge of the consequences of the act. Finally, referring to ORS 656.310(1)(b), the Board remarked that the carrier has the burden of rebutting the presumption that a claimant’s injury was not occasioned by the willful intention to commit self-injury.

Turning to the case at hand, the Board acknowledged that, before his injury, claimant had not expressed any dissatisfaction with his job or that he was angry with his employer. Nonetheless, the Board did not consider claimant’s “motive” for his action to be an essential component in resolving the “conscious, volitional act” question prescribed in the “intentional injury” statute (ORS 656.156(1)).

Noting that the explanations for claimant’s injury contained in his medical histories and the safety investigator’s report (e.g., his sleeve caught in the feeder; his coat stuck in the press machine, he was preparing the work area when the machine caught his shirt sleeve) were inconsistent with its evaluation of the DVD recording (which saw him look to both sides before thrusting his

hand into the rollers), the Board considered him to be an unreliable witness and historian. Furthermore, based on its review of the record (particularly its thorough evaluation of the DVD recording), the Board concluded that the carrier had overcome the rebuttable presumption contained in ORS 656.310(1)(b) and established that: (1) claimant's condition resulted from his own volitional act; and (2) he had knowledge of the consequences of the act. See ORS 656.156(1); Frankie J. Voth, 42 Van Natta 1970 (1990). Consequently, the Board upheld the carrier's denial.

Member Lanning dissented. Referring to testimony from claimant, as well as several relatives and coworkers, indicating that he enjoyed his job, hoped to be hired on a permanent basis, and was not effected by a "chewing out" by his foreman shortly before the work incident, Lanning asserted that claimant had no motivation for intentionally injuring himself. In the absence of such a motive, Member Lanning disagreed with the majority's conclusion that the carrier had met its burden of overcoming the statutory presumption in ORS 656.156(1) that claimant did not have an intent to self-injure.

Furthermore, based on his review of the DVD recording, Lanning considered claimant's action to be more likely the act of an untrained worker who was careless and had unfortunately paid the price for getting too close to an unguarded, dangerous piece of machinery. Citing Jean R. Louis, 50 Van Natta 2044, 2047 (1998), Member Lanning reasoned that ORS 656.156(1) does not apply where a claimant's injury results from negligence, carelessness, or recklessness.

Course & Scope: "Going & Coming" Rule - "Employer Conveyance" Exception Not Applied - Claimant "MVA" Injury While Traveling to Work - Employer Did Not Provide Transportation/Had No Direction/Control Concerning Co-Worker's Vehicle

Marcelina Quiroz-Garcia, 66 Van Natta 474 (March 11, 2014). The Board held that claimant's injury, which occurred as a result of a motor vehicle accident (MVA) while riding to work in a car driven by a coworker, did not arise out of and in the course of her employment because her employer neither owned nor controlled the car in which she was riding and her employment agreement expressly provided that her employer did not provide transportation to and from the job site. Alleging that the vehicle was owned by a co-owner of her employer and asserting that a coworker had arranged the transportation to the job site, claimant contended that there was a sufficient employer involvement to constitute an exception to the "going and coming" rule.

The Board disagreed with claimant's contention. Citing *Krushwitz v. McDonald's Restaurants*, 323 Or 520, 526 (1996), the Board stated that injuries sustained while a worker is going to or coming from the place of employment generally do not occur "in the course of" employment. However, referring to

Because claimant's employer did not provide transportation to the work site and because the vehicle she was riding to work in was operated by a coworker (who was not directed by the employer), the Board concluded that the "employer conveyance" exception to the "going and coming" rule had not been established.

Juan A. Renteria, 60 Van Natta 866 (2008), the Board acknowledged the "employer conveyance" exception to the "going and coming" rule, which generally focuses on whether the employer was directing where the vehicle should go, or requiring the use of the vehicle.

Turning to the case at hand, the Board recognized that the "employer conveyance" rule does not require that the employer own the vehicle in question. Instead, the Board explained that the pivotal issue was whether the employer had direction or control over the transportation of its employees.

After reviewing the record, the Board was not persuaded that the driver of the car involved in the MVA was the employer. Rather, the Board determined that the car's driver was a coworker, who was not directed by the employer to arrange transportation to the job site for other employees. Moreover, referring to claimant's employment contract, the Board noted that there was an express provision stating that the employer did *not* provide transportation to the job site.

Under such circumstances, the Board concluded that the "employer conveyance" exception to the "going and coming" rule had not been established. Consequently, the Board found that claimant's "MVA" injury had not arose out of and in the course of her employment.

Extent: Impairment Findings - "Apportionment" Rule - "035-0013(1)" - No "Preexisting Condition" - Apportionment Not Justified

Joseph Wagner, 66 Van Natta 485 (March 14, 2014). Analyzing OAR 436-035-0013(1), the Board held that claimant was entitled to a low back permanent impairment award based on his entire reduced range of motion (ROM) findings because, although a medical arbiter had attributed 50 percent of those findings to preexisting lumbar spondylosis, the record did not establish that the spondylosis constituted a legally cognizable "preexisting condition" under ORS 656.005(24)(a). After a medical arbiter determined that 50 percent of claimant's ROM impairment findings were due to preexisting lumbar spondylosis, an Order on Reconsideration applied the Director's "apportionment" rule (OAR 436-035-0013(1)) and attributed half of claimant's impairment findings to his accepted low back condition. Claimant requested a hearing, contending that all of his ROM impairment findings should be considered in rating his permanent impairment due to his compensable low back injury.

The Board agreed with claimant's contention. Citing *Schleiss v. SAIF*, 354 Or 637 (2013), the Board stated that only the contributions of the component parts of a combined condition (*i.e.*, the otherwise compensable injury and the preexisting condition) should be compared in identifying the major cause of any disability (including impairment) of a combined condition. Furthermore, relying on the *Schleiss* rationale, the Board observed that the Director's "apportionment" rule was inconsistent with the statutory scheme to the extent that it excluded

Because the record did not establish existence of a “preexisting condition,” the Board concluded that claimant’s “range of motion” findings were not subject to WCD’s “apportionment” rule and, as such, his entire findings should be included in the rating of his permanent disability.

non-legally cognizable conditions (*i.e.*, conditions that were not “preexisting conditions” under ORS 656.005(24)) from being rated for permanent disability purposes.

Applying the *Schleiss* holding, the Board found that the record did not establish that claimant’s lumbar spondylosis constituted a “preexisting condition.” Specifically, the Board noted that the record lacked either a diagnosis or previous treatment for symptoms of lumbar spondylosis. Moreover, the Board determined that the record lacked evidence establishing the presence of arthritis or an arthritic condition.

Accordingly, in the absence of a legally cognizable “preexisting condition,” the Board concluded that claimant’s ROM impairment findings were not subject to “apportionment.” Consequently, the Board included all of those impairment findings in rating claimant’s permanent disability.

In reaching its conclusion, the Board denied the carrier’s motion to remand to the Hearings Division for further evidence taking. Citing *Troy Shoopman*, 46 Van Natta 21 (1994), and *Betty S. Tee*, 45 Van Natta 289 (1993), the Board acknowledged that it had previously found a compelling reason where the record was devoid of evidence regarding a legal standard that had changed while Board review was pending. Nonetheless, relying on ORS 656.283(6), (7)(h), and *Sandi Jones*, 59 Van Natta 44 (2007), the Board reasoned that it was not authorized to consider evidence beyond the reconsideration record.

Extent: Impairment Findings - “Chronic Condition” - Limitation on Lifting At/Above Shoulder Level - Insufficient for “Significant Limitation” Finding

Edwardo Gonzales, 66 Van Natta 409 (March 4, 2014). Applying OAR 436-035-0019(1)(g), the Board held that claimant was not entitled to a “chronic condition” impairment value for a shoulder condition because his significant restriction regarding the repetitive use of his shoulder *at or above* his shoulder level was insufficient to establish a significant limitation of his ability to repetitively use his shoulder. Following claimant’s request for reconsideration concerning his right shoulder condition, a medical arbiter opined that he was significantly restricted in his ability to repetitively use his right shoulder *at or above* his shoulder level. When an Order on Reconsideration included a 5 percent impairment value to a “chronic condition” impairment value under OAR 436-035-0019(1), the carrier requested a hearing. Asserting that the arbiter’s findings did not support a conclusion that claimant was significantly limited in the repetitive use of his shoulder, the carrier argued that he was not entitled to a “chronic condition” impairment value.

The Board agreed with the carrier’s position. Citing OAR 436-035-0019(1)(g), the Board stated that a claimant is entitled to a “chronic condition” impairment value if a preponderance of medical opinion establishes that, due to a chronic and permanent medical condition, he was significantly

Medical arbiter's opinion that claimant was significantly and repetitively restricted "at or above" shoulder level was insufficient to establish a significant limitation to the repetitive use of the shoulder as a whole and, as such, he was not entitled to a "chronic condition" impairment value.

limited in the repetitive use of his shoulder. Relying on *Gonzalez v. SAIF*, 183 Or App 183, 190 (2002), the Board identified the issue as whether the loss of function to claimant's shoulder created a significant limitation to his ability to use his shoulder repetitively. Finally, referring to *Johnathan M. Myers*, 65 Van Natta 1174, 1178 (2013), the Board reiterated that a physician's limitation on repetitive use of a shoulder to only activities performed *at or above* shoulder level, is insufficient to establish entitlement to a "chronic condition" impairment value of the shoulder as a whole.

Turning to the case at hand, the Board found that the medical arbiter had opined that claimant was significantly restricted in his ability to repetitively use his right shoulder *at or above* shoulder level. Reasoning that such a limitation was insufficient to establish a significant limitation to the repetitive use of his shoulder as a whole, the Board concluded that he was not entitled to a "chronic condition" impairment value.

Reconsideration Proceeding: Carrier Authorized to Rescind/Correct NOC Once "Recon" Request Dismissed

Claim Processing: Unapproved "Lump Sum" Request - Did Not Preclude Carrier From Rescinding/Correcting "NOC" Under "030-0023"

Robert G. Green, 66 Van Natta 414 (March 5, 2014). Analyzing OAR 436-030-0023, the Board held that a carrier was authorized to rescind/correct a prior Notice of Closure (NOC) (which had awarded work disability) because the Appellate Review Unit (ARU) had dismissed claimant's request for reconsideration of that NOC before the reconsideration proceeding had been corrected, the 60-day appeal period from the NOC had not expired, and the carrier issued the rescinded/corrected NOC within 14 days of claimant's request for a lump sum payment of the permanent disability awarded by the prior NOC. After a NOC awarded permanent impairment and work disability for claimant's accepted low back condition, he requested reconsideration, contending (among other assertions) that he had been released to regular work (post-closure) and did not want work restrictions. That same day, his attending physician also released him to full duty without limitations. A few days later, claimant submitted to the carrier a request for a lump sum payment of the NOC permanent disability award, stating that he waived the adequacy of the award. That same day, he also withdrew his request for reconsideration. Thereafter, the ARU dismissed his request for reconsideration (without stating that it was "with prejudice"). Within 14 days of claimant's lump sum payment request, the carrier issued a corrected NOC, which withdrew the first NOC, reinstated the permanent impairment award that had initially been granted, but did not award work disability (noting that he had returned to regular work). Claimant requested

reconsideration, contending that the carrier was not authorized to issue the corrected NOC and that the prior NOC's work disability award should be reinstated. When the Order on Reconsideration affirmed the corrected NOC, claimant requested a hearing, arguing that the carrier was not authorized to issue the corrected NOC.

The Board disagreed with claimant's contention. Citing OAR 436-030-0023(1), the Board stated that a carrier may rescind or correct its NOC before the expiration of the appeal period for the NOC and before or on the same day that the Director receives a request for reconsideration of the NOC. Relying on ORS 656.268(5)(c), the Board observed that a claimant may request reconsideration of a NOC within 60 days.

Turning to the case at hand, the Board acknowledged that claimant had filed a request for reconsideration of the first NOC within 60 days of its issuance. Nevertheless, when the carrier subsequently issued its corrected NOC, the Board noted that claimant's request for reconsideration had been dismissed without prejudice (and before the reconsideration proceeding had been conducted).

Relying on *Rick Loucks*, 65 Van Natta 628 (2013), the Board reasoned that, once claimant's request for reconsideration was dismissed without prejudice, he could have again requested reconsideration, provided that the 60-day appeal period had not expired. Therefore, because the carrier had rescinded the first NOC and issued its corrected NOC before that 60-day period had expired, the Board concluded that the carrier's action was authorized.

The Board also disagreed with claimant's assertion that the remainder of the 60-day appeal period expired once he filed his lump-sum payment request and the carrier failed to respond to it. The Board recognized that claimant's lump-sum payment request included a waiver of the adequacy of the award granted by the first NOC. Nonetheless, reasoning that the appeal period from the first NOC had not expired when claimant made his lump-sum payment request and the carrier issued its corrected NOC within 14 days of the request (which was within the 14-day "response" period prescribed by OAR 436-060-0060(5)), the Board determined that the carrier was not required to pay the lump sum concerning the rescinded NOC work disability award. In doing so, the Board further noted the corrected NOC provided a new 60-day appeal period within which claimant could seek reconsideration.

Finally, the Board acknowledged that the elimination of a work disability award is not specifically listed as a ground for rescission of a NOC under OAR 436-030-0023. Nonetheless, noting that subsection (5) expressly states that the appropriate uses of a rescinded NOC "are not limited" to the examples provided in the rule, the Board did not interpret subsection (5) as a prohibition against the issuance of a rescinded NOC eliminating a work disability award to which a worker was not entitled.

Because claimant's request for reconsideration of a NOC had been dismissed before the reconsideration proceeding had been conducted and because the carrier rescinded/corrected its NOC before the expiration of the 60-day period from the previous NOC, the carrier's claim processing action was authorized.

Because the carrier issued its corrected NOC within 14 days of claimant's "lump-sum payment" request regarding the "rescinded" NOC's permanent disability award, the carrier was not required to comply with the "lump-sum payment" request.

Responsibility: “LIER” Defense Applicable in “307” Proceeding - “Joined” Carrier Able to Prove “Actual Contribution” to Worsening of Claimant’s Condition From Later “Un-joined” Carrier

Emory M. Schaffer, 66 Van Natta 441 (March 7, 2014). In a “responsibility” proceeding arising from a Workers’ Compensation Division (WCD) order designating a paying agent under ORS 656.307, the Board held that a carrier was entitled to apply the “last injurious exposure rule” (LIER) to shift responsibility for claimant’s hearing loss claim to a subsequent carrier by proving that claimant’s employment exposure with a later employer actually contributed to a worsening of his hearing loss condition, even though that subsequent carrier had not been joined as a party in the “307” proceeding. After claimant filed a hearing loss claim with several carriers, they sought a WCD order designating a paying agent under ORS 656.307. After the WCD’s order, but before the hearing regarding that order, a subsequent carrier issued a compensability/responsibility denial of the hearing loss claim. However, claimant declined to join that carrier as a party to the “307” proceeding. At the hearing, the “presumptively responsible” carrier asserted that claimant’s employment exposure with the subsequent “un-joined” carrier had independently contributed to a worsening of his hearing loss condition and, as such, responsibility shifted to that carrier. In response, claimant contended that the carrier was not entitled to rely on the LIER in a “307” proceeding because one of the joined carriers should be found responsible for the claim.

The Board disagreed with claimant’s contention. Citing *Reynolds Metals v. Rogers*, 157 Or App 147, 153 (1998), *rev den*, 328 Or 365 (1999), the Board stated that to transfer responsibility for a claimed condition to a later carrier, the presumptively responsible carrier must establish that claimant’s subsequent employment actually contributed to a worsening of his hearing loss condition (not just symptoms). Relying on *JH Kelly, LLC v. Smith*, 244 Or App 123, 128 (2011), the Board noted that a minor slight contribution to the underlying condition is sufficient to shift responsibility to a subsequent employer under the LIER. Furthermore, referring to ORS 656.308(2)(b), and *Frank Dolan*, 56 Van Natta 2501 (2004), the Board observed that a carrier may contend that responsibility rests with another carrier, regardless of whether claimant has filed a claim against that carrier.

Because claimant’s subsequent employment exposure with an “un-joined” carrier actually contributed to a worsening (albeit minimally) to a worsening of his claimed condition, responsibility shifted away from any of the “joined” carriers to the “307” proceeding under the “LIER.”

Turning to the case at hand, the Board found that, based on a persuasive medical opinion, claimant’s subsequent employment actually contributed (albeit minimally) to a worsening of his hearing loss condition. Furthermore, based on that persuasive medical opinion, the Board determined that claimant’s employment exposure with the un-joined carrier had actually contributed (albeit minimally) to a worsening of his condition. Under such circumstances, the Board concluded that responsibility for claimant’s hearing loss condition had shifted from any of the “joined” carriers.

“Joined” carriers to a “307” proceeding were allowed to use the LIER defensively to contend that responsibility for a claimed condition rested with a subsequent “un-joined” carrier.

In reaching its conclusion, the Board disagreed with claimant’s contention that the carriers were precluded from asserting that the “un-joined” carrier was responsible for the claim because they had entered into a “307” proceeding. Citing OAR 436-060-0180(6), and *Dolan*, the Board considered the agreement to designate a paying agent under “307” was not an admission that a claimed condition is compensably related to a particular carrier’s claim, but rather was solely an assertion that the condition is compensable against a subject Oregon employer. Moreover, because the carriers had invoked the LIER defensively, the Board reasoned that responsibility for the claimed condition was imposed on the last carrier that actually contributed to claimant’s disease. See *Roseburg Forest Products v. Long*, 325 Or 305, 310 (1997); *James A. Bradley*, 55 Van Natta 1373, 1375 (2003). Finally, noting that it was ultimately claimant’s decision not to join the carrier who had issued the compensability/responsibility denial for the claimed condition, the Board determined that the presumptively responsible carrier (as well as the other “joined” carriers) were allowed to use the LIER defensively to contend that responsibility for the condition rested with the “un-joined” carrier. See ORS 656.308(2)(b); *Rodney P. Cook*, 66 Van Natta 305, 309, n 6 (2014).

Scope of Acceptance: Acceptance of “Pain in Lower Back” Claim - Encompassed Underlying Low Back Fusion

Rodney L. Gaither, 66 Van Natta 509 (March 18, 2014). The Board held that, because a carrier had accepted claimant’s “pain in lower back” claim and the record lacked contemporaneous reports concerning his work injury, the acceptance encompassed a prior low back fusion and its sequelae and, as such, the carrier was responsible for his medical services claim for his current low back condition because that treatment was due in either material or major part to the fusion surgery and its residuals. Before his work injury, claimant had undergone low back fusion surgery. Following his work injury, claimant filed a claim for “pain in lower back.” The carrier marked the “acceptance” box on the claim form, without issuing a notice of acceptance. Shortly thereafter, the carrier denied claimant’s “low back condition,” from which claimant requested a hearing. However, before that hearing, the parties entered into a stipulation, in which the carrier withdrew its denial, acknowledging his preexisting lumbar fusion and its causal effect on his low back condition. In addition, several years later, the carrier sent a letter to a medical service provider, which described the accepted condition as a “low back strain requiring an L5-S1 fusion.” Some twenty years later, the carrier denied claimant’s medical services claim, contending that his current low back condition was not attributable to his compensable injury. Claimant requested a hearing, asserting that the carrier’s acceptance had encompassed his lumbar fusion and that his disputed medical treatment was due in both material and major part to that fusion.

The Board agreed with claimant’s assertion. Citing *SAIF v. Dobbs*, 172 Or App 446, 451, *recons*, 173 Or App 599 (2001), the Board stated that the scope of an acceptance is a question of fact. Relying on *Klutsenbeker v. Jackson County*, 185 Or App 96, 101 (2002), the Board noted that a carrier’s signature on a 801 form constitutes a written acceptance. Referring to *Gilbert v.*

When there are no contemporaneous records concerning an accepted claim, the acceptance of a non-specific condition must be read as constituting an acceptance of the claim as filed.

Noting that a carrier had acknowledged (in a stipulation withdrawing its claim denial) the causal effect of a preexisting lumbar fusion on claimant's low back condition, the Board concluded that the scope of the carrier's acceptance of claimant's "pain in lower back" claim included the preexisting fusion.

Cavenham Forest Industrial Division, 179 Or App 341, 344 (2002), the Board observed that, where there is no written acceptance, "determining the scope of acceptance requires examination of the medical records contemporaneous with the injury to determine what the parties contemplated." Finally, the Board commented that, when there are no contemporaneous records concerning an accepted injury claim, the acceptance of a non-specific condition must be read as constituting an acceptance of the claim as filed. See *Emmert v. City of Klamath Falls*, 135 Or App 209, 212 (1995).

Turning to the case at hand, the Board found that, because the earliest medical records began some four years after claimant's injury and the carrier's acceptance, the carrier had accepted a claim for "pain in lower back." Furthermore, applying the rationale expressed in *Georgia-Pacific Corp. v. Piwowar*, 305 Or 494 (1988), and *Cloud v. Klamath County School District*, 191 Or App 610 (2004), the Board determined that the carrier's acceptance included claimant's preexisting lumbar fusion and its sequelae.

In reaching its conclusion, the Board noted that, in withdrawing its previous claim denial pursuant to a stipulation, the carrier had acknowledged the preexisting lumbar fusion and its causal effect on claimant's low back condition. Moreover, the Board reasoned that the carrier's "post-stipulation" letter to a medical service provider (although factually inaccurate because it stated that the fusion occurred after the strain) supported the proposition that the carrier considered claimant's accepted condition to exceed a low back strain and include a low back fusion.

Under such circumstances, the Board concluded that the scope of the carrier's claim acceptance had included low back pain related to claimant's preexisting low back fusion. Because the physician's opinions related claimant's current medical treatment in major part to his previous low back fusion and its residuals, the Board concluded that the carrier was responsible for the requested medical services (regardless of whether the standard was "material" or "major"). See *SAIF v. Sprague*, 346 Or 661, 672-73 (2009).

Standards: Work Disability - "AP" Release Based on Inaccurate Understanding of Claimant's "At-Injury" Work Duties - Not Released to "Regular Work"/No Return to "Regular Work"; "BFC" Value - Based on "Job Description, Not "DOT" Code

Christine A. Schabeck, 66 Van Natta 430 (March 6, 2014). The Board held that claimant was entitled to a work disability award because his "at injury" regular work required "frequent" crouching, but his attending physician had released him to regular work based on a job description involving "occasional" crouching. Following claimant's compensable knee injury, her attending surgeon released her to regular work. Claimant requested reconsideration of a Notice of Closure (which did not award work disability), asserting that her attending

physician's work release was based on an understanding that she would be required to crouch on an "occasional" basis, whereas the employer's job description indicated that "frequent" crouching was required. When an Order on Reconsideration declined to award work disability, claimant requested a hearing, contending that she had neither been released, nor returned, to her regular work and, as such, she was entitled to a work disability award.

The Board agreed with claimant's contention. Citing ORS 656.726(4)(f)(E), and *Joshua A. Dorr*, 64 Van Natta 1934, 1937 (2012), the Board stated that impairment is the only factor to be considered in the evaluation of a worker's disability under ORS 656.214 if the worker has been released to regular work by the attending physician (or authorized nurse practitioner) or has returned to regular work at the job held at the time of injury. Relying on ORS 656.214(1)(d), and OAR 436-035-0005(15), the Board noted that "regular work" means "the job the worker held at injury."

Turning to the case at hand, the Board acknowledged that claimant's attending physician had released her to return to her work without restrictions. Nevertheless, the Board noted that the attending physician's release was based on an understanding that her "at injury" job required only "occasional" crouching. Based on the employer's detailed job description (which described claimant's position as requiring "frequent" crouching), the Board concluded that claimant's attending physician had an inaccurate understanding of her "regular work" (at-injury job) and, as such, had not released her to regular work.

Addressing the question of whether claimant had returned to her "at injury" job, the Board recognized that a medical arbiter had reported that she had returned to regular work. However, noting that claimant had difficulty crouching and should avoid squatting due to her knee condition, the Board reasoned that the arbiter's comments were inconsistent with her job description that described "frequent" crouching.

Under such circumstances, the Board concluded that claimant had not returned to regular work. Consequently, the Board held that she was entitled to a work disability award.

Calculating claimant's work disability award, the carrier challenged her contention that her Base Functional Capacity (BFC) value was "heavy" based on her employer's job description. Noting that no specific job analysis was present in the record, the carrier argued that the strength category for her relevant "Dictionary of Occupational Titles" (DOT) codes (all of which were rated as "sedentary") should be used.

The Board disagreed with the carrier's contention. Citing OAR 436-035-0012(9)(a), the Board stated that a claimant's BFC is determined by the highest "strength" category of the job(s) successfully performed during the five years before the date of injury. Again referring to the aforementioned administrative rule, the Board stated that, although strength categories are found in the DOT codes, when a preponderance of evidence established that the requirements of a specific job differ from the DOT description, a specific job analysis that includes the strength requirements may be substituted for the DOT description(s) if it most accurately describes the job.

Because the attending physician's release to regular work was based on a misunderstanding that claimant's "at injury" job required only "occasional" crouching (when the job description described "frequent" crouching), the Board found that the physician had not released claimant to regular work.

Under "035-0012(9)(a)," when a preponderance of evidence establishes that the requirements of a specific job differ from a DOT description, a specific job analysis that includes the strength requirements may be substituted for the DOT description if it most accurately describes the job.

Notwithstanding the DOT codes (which referred to “sedentary” strength categories), the Board based claimant’s BFC value (medium/ heavy) on the detailed job description for her “at-injury” job.

After reviewing the record, the Board acknowledged that the DOT codes for claimant’s jobs within 5 years of the NOC referred to “sedentary” strength categories. Nonetheless, based on the detailed job description for claimant’s “at-injury” job (which required occasionally lifting up to 59 pounds and frequently lifting less than 10 pounds for a total of 1.5 hours per day), the Board found that the job description established her BFC value. See *Chantal M. Thomas*, 65 Van Natta 1306, 1307 (2013); *Jeffery L. Frost*, 63 Van Natta 1641, 1645, *recons*, 63 Van Natta 1890 (2011).

Finally, the Board determined that the job description placed her BFC at more than “medium” strength, but less than “heavy.” Relying on OAR 436-035-0012(9)(a), and *Thomas*, the Board used the higher strength category (“heavy”) in calculating claimant’s BFC value.

Third Party Dispute: \$1 Million Settlement - “593(6)” - Board Authorized to Approve Settlement That Fully Released *All* of Claimant’s Future Rights to Benefits - Pending Dispute Before Court (“298(9))”

William Coultas, 66 Van Natta 560 (March 28, 2014). Applying ORS 656.298(9) and ORS 656.593(6), the Board approved a proposed stipulation, which resolved the parties’ pending “third party” dispute before the Court of Appeals regarding the carrier’s “just and proper” share of claimant’s third party settlements (exceeding \$1 million) and released his rights to *all* future benefits in return for the carrier’s receipt of settlement proceeds in reimbursement of its incurred claim expenses. Citing *Rebecca E. Seelye*, 60 Van Natta 332 (2008), the Board stated that it was authorized to consider proposed settlements resolving issues pending judicial review before the Court of Appeals, without the issuance of a court order remanding the case. Furthermore, relying on ORS 656.593(6), the Board noted that a carrier’s further liability regarding a claim may be released when a claimant is entitled to receive payment pursuant to a third party settlement/recovery in the amount of \$1 million or more.

The Board observed that, in most “\$1 million third party” stipulations under ORS 656.593(6), there is no pending dispute requiring resolution. Thus, in accordance with ORS 656.593(6), the Board explained that it simply acknowledges its receipt of the stipulation and release from the parties.

However, in the case at hand, the Board noted that the stipulation was also designed to resolve the parties’ “just and proper distribution” dispute pending before the court. Relying on ORS 656.593(6)(d), the Board determined that its approval of the stipulation was required. Finally, because the stipulation resolved the pending court matter, the Board concluded that it was also authorized to consider and approve the stipulation without awaiting a court order. See ORS 656.298(9)(a).

Because a proposed stipulation (in which claimant also fully released his rights to all future benefits) also resolved a pending dispute regarding a carrier’s share of a third party settlement (which exceeded \$1 million), the Board held that it was authorized to consider the proposed agreement pursuant to ORS 656.593(6) and ORS 656.298(9)(a).

APPELLATE DECISIONS

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