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BOARD NEWS

Permanent Rule Amendments: Division 015 (Attorney Fee) Rules - Effective November 1, 2016

At their October 11 meeting, the Members adopted permanent amendments to the Board's Division 015 (Attorney Fee) rules. This action is a culmination of a process that included consideration of an Advisory Committee report, which addressed several attorney fee-related concepts, as well as advised the Board concerning its biennial review of attorney fee schedules as prescribed in ORS 656.388(4). The Members wish to extend their grateful appreciation to the Advisory Committee (Martin L. Alvey, Matthew M. Fisher, Jennifer Flood, Philip H. Garrow, Julie Masters, Graham Trainor, Sheri Sundstrom, and ALJ Mark Mills (facilitator)).

Among the notable changes, these amendments: (1) increase the "thresholds/caps" for attorney fees payable from DCS and CDA proceeds from \$17,500 to \$50,000; (2) eliminate the "caps" for attorney fees payable from increased permanent partial disability awards; (3) increase the "caps" for attorney fees payable from permanent total disability awards from \$12,500 (hearing)/\$16,300 (Board review) to \$20,000 (hearing)/\$30,000 (Board review); (4) eliminate the "cap" for attorney fees payable from "Own Motion" temporary disability awards; (5) include the "contingent nature of the practice" of workers' compensation in the "risk of going uncompensated" factor for determining a reasonable attorney fee award; (6) include consideration of legal services performed by a claimant's attorney's legal staff in the determination of a reasonable attorney fee award; and (7) reduce the time for payment of an assessed attorney fee award from a final order from 30 days to 14 days.

These amendments are effective November 1, 2016 and apply in the manner described in the Board's Order of Adoption. Electronic copies of these amended rules, along with the Board's Order of Adoption, are available on WCB's website at www.wcb.oregon.gov (under the category "Laws and rules"). Copies have also been distributed to parties and practitioners on WCB's mailing list.

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Permanent Rule Amendments: Amendments Regarding "E-Mail Filing" (OAR 438-005-0046(1)(f)(B)) and "Representation by Counsel" (OAR 438-006-0100)

At their September 15 meeting, the Members adopted permanent amendments to the Board's Division 005 (Filing and Service) and Division 006 (Representation by Counsel) rules. The amendments are designed to address possible jurisdictional/procedural challenges to an "e-mail filing" under OAR 438-005-0046(1)(f)(B), and to conform OAR 438-006-0010(1) with statutory amendments to ORS 9.320.

The amendments to OAR 438-005-0046(1)(f)(B) state that strict compliance with the rule requiring a "Request for Hearing Form" (as an attachment to an "email" request) is not a jurisdictional requirement. In addition, a previous reference to specific attachment formats has been removed. Instead, the rule provides that the format of the attachment must be readable by the Board.

The amendments to OAR 438-006-0100(1) replace the word "corporations" with the phrase "parties that are not natural persons" in referring to parties who must be represented by a member of the Oregon State Bar. This amendment is consistent with the statutory amendments to ORS 9.320.

These amendments are effective November 1, 2016 and apply in the manner described in the Board's Order of Adoption. Electronic copies of these amended rules, along with the Board's Order of Adoption, are available on WCB's website at www.wcb.oregon.gov (under the category "Laws and rules"). Copies have also been distributed to parties and practitioners on WCB's mailing list.

CASE NOTES

Attorney Fee: Based on Carrier's "Pre-Hearing" Acceptance of Denied Condition - Acceptance Based on "Injury" Theory, Rather Than Initially Denied "OD" Theory, Did Not Preclude "386(1)" Fee For Prevailing Over "Denied Claim"

David J. Boswell, 68 Van Natta 1701 (October 24, 2016). Analyzing ORS 656.262(6)(a), and ORS 656.386(1)(a), the Board held that claimant's counsel was entitled to an attorney fee award when, after the carrier denied

his shoulder condition (based on an “occupational disease” theory), the carrier subsequently accepted the claim (based on an “injury” theory) before a postponed hearing on its denial (which had been rescheduled for further development on the “injury” theory). Claimant filed a claim for a shoulder condition related to lifting/pulling pipes at work, referring to a specific “date” of injury or disease. After the carrier issued a denial describing the claim as an “occupational disease,” claimant requested a hearing. The initial hearing was postponed to allow the parties an opportunity to further develop the “injury” theory. Thereafter, the carrier accepted an injury claim for the shoulder, but refused to pay an attorney fee, asserting that it had accepted the claim within 60 days of learning that claimant was pursuing an injury theory.

The Board disagreed with the carrier’s position. Applying ORS 656.262(6)(a) and ORS 656.386(1), the Board held that a carrier-paid attorney fee award was justified because the carrier’s express denial had either encompassed an “injury” theory of claimant’s claim, or constituted a *de facto* denial of the claimed condition under an “injury” theory, which had been subsequently rescinded when the carrier accepted the shoulder claim as an injury.

The Board acknowledged that the carrier had chosen to identify claimant’s claim as an “occupational disease.” Nevertheless, the Board reasoned that the carrier’s decision had not entitled it to an additional 60 days to respond to an “injury” theory for the same claimed condition. Because the carrier ultimately accepted claimant’s single claim for a shoulder condition, the Board concluded that the carrier’s denial (insofar as it had pertained to the claim under an injury theory) had been effectively rescinded before the hearing, and that a carrier-paid attorney fee under ORS 656.386(1) was warranted.

Carrier not entitled to additional 60 days to accept/deny new theory based on the same denied claim.

Claim Processing: “005(6)” - Electronically Filed 801 Form - Constituted “Claim” - Need Not Be Accompanied by Disability/Need for Treatment

Attorney Fee: “386(1)” - “Pre-Hearing” Rescission of *De Facto* Denial - Instrumental in Obtaining Rescission - Two Weeks “Post-Hearing Request” - *Brooks* Distinguished

Amalia C. Garcia-Cortes, 68 Van Natta 1585 (October 3, 2016). Applying ORS 656.005(6), the Board held that claimant’s unsigned 801 form constituted a “claim” because the record established that the employer electronically processed such claims in a manner that did not allow for signatures. Claimant submitted an unsigned 801 form to his employer, which included the printed words “Reported by Internet.” When the carrier did not

respond within 60 days of the employer's receipt of the form, claimant filed a hearing request, alleging a *de facto* denial. Some two weeks later, the carrier accepted the claim. At the subsequent hearing, claimant sought an attorney fee award under ORS 656.386(1). The carrier opposed the request, contending that claimant had not filed a "claim" because the form was unsigned and there was no evidence when the employer received the form that claimant was disabled or in need of treatment.

The Board disagreed with the carrier's contentions. Citing ORS 656.005(6), the Board stated that a claim is a "written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge." Relying on *David J. Rosenboom*, 43 Van Natta 950, 955 (1991), the Board noted that a written request for compensation need not be additionally supported by evidence of disability/need for treatment in order to constitute a "claim."

Turning to the case at hand, the Board acknowledged that claimant had not signed the 801 form and that instructions on the form advised a worker not to sign the form if he/she did not intend to file a workers' compensation claim. Nevertheless, noting that the employer had inserted the phrase "Reported by Internet" onto the form, the Board reasoned that the employer had accepted the form in a format that did not allow for a signature. Under such circumstances, the Board declined to find that the lack of claimant's signature on the form established an intention not to file a "claim."

Concerning the carrier's "lack of disability/need for treatment" argument, the Board recognized that, in the absence of a written request for compensation, a claim can consist of the employer's notice of a work-related injury combined with notice of resulting disability or need for medical treatment. See e.g., *Bryan V. Dechand*, 68 Van Natta 703, 706 (2016). However, when a written request for compensation has been filed, the Board reiterated that such a request need not be additionally supported by evidence of disability/need for treatment to constitute a "claim." See *Rosenboom*, 43 Van Natta at 955. Consequently, the Board concluded that claimant's electronically submitted 801 form was sufficient to constitute a "claim," which required the carrier to accept/deny within the statutory 60-day period of ORS 656.262(6)(a).

Addressing the attorney fee issue, the Board acknowledged that the carrier's "pre-hearing" acceptance of the claim had occurred some two months after receiving claimant's physician's treatment plan. Nonetheless, noting that the carrier's acceptance had issued about two weeks following claimant's counsel's request for hearing, the Board found that claimant's counsel was instrumental in obtaining the carrier's "pre-hearing" rescission of its *de facto* denial and, as such, was entitled to an attorney fee award under ORS 656.386(1).

In reaching its conclusion, the Board distinguished *Hobby Brooks*, 68 Van Natta 923, 927 (2016), where the record had established that a carrier's claim acceptance (which occurred before a hearing that had been requested by claimant before he retained an attorney) had been based on a medical report that the carrier had requested before the claimant's counsel's representation. As in *Brooks*, the Board acknowledged that the claim acceptance had been preceded by the carrier's receipt of a medical report. However, in contrast

Carrier's claim format permitted electronic processing; handwritten signature not required.

Acceptance issued two weeks after counsel's hearing request. Attorney instrumental in obtaining rescinded "de facto" denial.

to *Brooks*, the Board reasoned that, in the present case, the carrier's claim acceptance (which issued some two months after its receipt of the medical report) had been preceded by claimant's counsel's hearing request (which was filed some two weeks before the "pre-hearing" acceptance). Under such circumstances, the Board concluded that claimant's counsel was instrumental in obtaining the "pre-hearing" rescission of the carrier's *de facto* denial and, as such, an attorney fee award under ORS 656.386(1) was warranted.

Claim Processing: Notice of Claim to Carrier's Attorney Found Sufficient (Based on Attorney's Representations); Penalty - Untimely Claim Denial - Encompassed Later Amendments - Not Separate Acts of Misconduct

Michael Sherman, 68 Van Natta 1627 (October 11, 2016). The Board held that a carrier's denial of a new/omitted medical condition claim was untimely, finding that the filing of claimant's claim with the carrier's counsel constituted sufficient notice on the carrier to trigger its claim processing obligations. More than 60 days after claimant filed his new/omitted medical condition claim with the carrier's counsel, he filed a hearing request, alleging a *de facto* denial. In response, the carrier contended that, because the claim had not been directed to it, the claim was invalid. In reply, claimant argued that the carrier's counsel had previously represented himself as an employee of the carrier and had stated that all communication should be directed to him. Asserting that the carrier's claim denial had not issued until the expiration of the statutory 60-day period, claimant sought penalties and attorney fees for an untimely denial.

The Board granted claimant's request. Citing *Dep't of Consumer & Bus. Servs. v. Muliro*, 359 Or 736, 752 (2016), the Board stated that notice to an agent is notice to the principal.

Turning to the case at hand, the Board noted that, in an earlier proceeding involving the parties in the underlying claim, the carrier's counsel had directed claimant to submit all correspondence/communication to the carrier's counsel. The Board further observed that the carrier's counsel's letterhead referred to himself as the carrier's employee.

Under such circumstances, the Board concluded that claimant's new/omitted medical condition claim had been validly filed with the carrier. Because the carrier had not issued a denial within the statutory 60-day period, the Board determined that the denial was unreasonable and, as such, a penalty and attorney fee award was warranted.

Because carrier's counsel represented that communications should be directed to him, claim was validly filed.

Finally, the Board declined to award a separate penalty/attorney fee for an untimely responsibility denial. Citing *Eliseo Sales-Parra*, 68 Van Natta 679, 683-84 (2016), the Board reasoned that, because a penalty and attorney fee award had already been assessed for the carrier's untimely claim denial, the carrier's amendment of that denial (to also include responsibility) was encompassed within the already untimely denial and did not constitute a separate act of misconduct.

In reaching its conclusion, the Board noted that, if the responsibility denial was unreasonable (*i.e.*, issued without a legitimate basis for denying responsibility, as opposed to being issued untimely), a separate penalty/attorney fee for the separate unreasonable act might be justified. However, because the alleged unreasonable conduct was essentially the same conduct (*i.e.*, an untimely denial) the Board did not consider a separate penalty/attorney fee for that same unreasonable action to be warranted.

Own Motion: TTD - "Work Force" - Established By Employer's Report; "Disability Date" - Based on Physician's "Surgery" Recommendation

Ford A. Cheney, 68 Van Natta 1649 (October 14, 2016). Applying ORS 656.278(1)(b) on an Own Motion claim for a new/omitted medical condition, the Board awarded temporary disability (TTD) benefits, finding that claimant was in the "work force" before the "date of disability" and that the attending physician had excused him from work as of the date of surgery.

Under *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989), a worker is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and making reasonable efforts to obtain employment; or (3) not employed, but willing to work, but not making reasonable efforts to obtain employment because a work-related injury has made such efforts futile.

Citing ORS 656.278(1)(b) and *Butcher v. SAIF*, 247 Or App 684, 689-90 (2012), the Board held that, the "date of disability" is the date on which both of the following factors are satisfied: (1) the claimant's condition resulted in a partial or total inability to work; and (2) required (including a physician's recommendation for) hospitalization, inpatient or outpatient surgery, or other curative treatment. The Board further clarified that the relevant time period for which claimant must establish that he was in the work force is the time prior to the "date of disability."

Turning to the case at hand, the Board determined that, when the attending physician recommended surgery, he did not indicate that claimant's condition currently resulted in an inability to work. Instead, he discussed the length of the hospital stay and the recovery period in the context of the recommended future surgery. Based on the physician's opinion, the Board

Disability date was date of eventual surgery, not date it was recommended.

determined that the “date of disability” was the date of the eventual surgery. Based on a report from the manager of claimant’s employer, the Board further found that claimant was in the work force as of this “date of disability.”

Addressing claimant’s entitlement to TTD benefits under ORS 656.278(1)(b), citing *Butcher*, 247 Or App at 689, the Board stated that: (1) the claimant must require (including a physician’s recommendation for) hospitalization, inpatient or outpatient surgery, or other curative treatment; (2) TTD benefits are payable from the date the attending physician authorizes temporary disability for the hospitalization, surgery, or other curative treatment; and (3) TTD benefits are payable under ORS 656.210, ORS 656.212(2), and ORS 656.262(4).

Applying these factors to the case at hand, the Board found that the attending physician’s discussion of the length of hospitalization and recovery period for the recommended surgery established the physician’s contemporaneous approval excusing claimant from work as of the date of surgery, as well as his authorization of temporary disability “for the hospitalization, surgery or other curative treatment” under ORS 656.278(1)(b). Noting that the attending physician’s reports expressly included the length of hospitalization and recovery period, the Board distinguished cases holding that a recommendation for surgery or surgery in and of itself is not sufficient to satisfy the requirement for payment of temporary disability under ORS 656.278(1)(b). See e.g., *Robert Dubray*, 57 Van Natta 2035, *recons*, 57 Van Natta 2279 (2005).

Member Johnson dissented, reasoning that claimant was not in the work force at the date of disability and, as such, was not entitled to TTD benefits. Johnson noted that, in addition to the manager’s report, a later report from the employer’s assistant director had recorded that claimant had left his former position and was last paid as of a date that was approximately 10 months before his “date of disability.” Based on those reports, Member Johnson was persuaded that claimant was not in the work force when he underwent surgery; i.e., his “date of disability.” Further reasoning that the record did not establish that, in the time period before the date of disability, claimant was making reasonable efforts to obtain employment or that his compensable condition made it futile for him to work or look for work, Member Johnson asserted that he was not entitled to TTD benefits.

Penalty: “262(11)” - Unreasonable
Conversion of TTD to TPD - Record Did
Not Establish Termination for “Work Rule”
Violation - Employer Knowledge Imputed
to Insurer

Dustin E. Hall, 68 Van Natta 1615 (2016). On reconsideration of its initial decision, 68 Van Natta 1465 (2016), the Board continued to hold that an insurer had unreasonably converted claimant’s temporary total disability (TTD) benefits to temporary partial disability (TPD) benefits because the record did

Employer's knowledge imputed to insurer for purposes of analyzing "legitimate doubt."

not establish that claimant had been terminated from his employment for a violation of his employer's work rules or other disciplinary reasons. See ORS 656.325(5)(b); ORS 656.262(11)(a). In reaching its initial conclusion, the Board had imputed the employer's knowledge/conduct to its insurer. In seeking reconsideration, the insurer contended that such reasoning conflicted with prior Board decisions and that ORS 656.262(11)(a) only provides for a penalty against an insurer for its own conduct, not for the conduct of its insured employer.

The Board disagreed with the insurer's contentions. In doing so, the Board acknowledged that prior cases contained *dicta* suggesting that an employer's assertion that a worker's employment termination was for work rule violations or other disciplinary reasons would be sufficient to avoid a penalty assessment against its carrier. See e.g., *Keith J. Wiggins*, 65 Van Natta 1592 (2013). The Board noted, however, that the court has imputed the employer's knowledge/conduct to the insurer in assessing penalties and attorney fees for the insurer's unreasonable claim processing. See also *Nix v. SAIF*, 80 Or App 565, rev den, 302 Or 158 (1986) (penalties assessed against the carrier where compensation was unreasonably delayed due to the employer's failure to report the accident).

Turning to the case at hand, the Board found that, unlike in the cases cited by the insurer, the events leading to claimant's employment termination were not in dispute. Specifically, the Board noted that, although the reason identified by the employer for the termination was claimant's absenteeism, the employer had testified that claimant's absence resulting from staying home with his sick child was not a violation of its work rules. Moreover, the Board observed that the employer had previously initiated a disciplinary process in response to claimant's prior absenteeism, which it had not subsequently followed in terminating claimant's employment.

In the absence of any explanation for the aforementioned discrepancies (and imputing the employer's knowledge to the insurer), the Board reasoned that the record did not support the insurer's assertion that claimant's termination was for a violation of work rules or other disciplinary reasons. Because the statutory prerequisite for ceasing TTD benefits under ORS 656.325(5)(b) was not present, the Board concluded that the insurer's claim processing had been unreasonable and, as such, penalties and attorney fees were justified.

Penalty: "262(11)(a)" - Untimely
Acceptance - "Existence" Concerns
Regarding Claimed Condition - Not
Reasonable Explanation for Untimely
Acceptance/Denial

Nataliya Vaughan, 68 Van Natta 1678 (October 21, 2016). Applying ORS 656.262(7)(a), and ORS 656.262(11)(a), the Board held that a carrier's concerns regarding the existence of a claimed new/omitted medical condition did not provide a carrier with a legitimate doubt regarding its statutory responsibility

No legitimate doubt about carrier's obligation to timely accept/deny the claim, regardless of its questions concerning claim's merits.

to timely accept or deny the claim. When a carrier did not issue an acceptance or denial of her new/omitted medical condition claim within 60 days after the filing of her claim, claimant filed a hearing request, seeking penalties and attorney fees. Explaining that it initially had a legitimate doubt regarding the existence of the claimed condition, the carrier contended that its eventual acceptance of the claim (once the existence of the condition was confirmed) was not unreasonable.

The Board disagreed with the carrier's position. Citing *Brown v. Argonaut Ins. Co.*, 93 Or App 588 (1988), the Board noted that a penalty and attorney fee may be awarded if a carrier unreasonably delays acceptance or denial of a claim, and that the reasonableness of a carrier's actions depends on whether it had a legitimate doubt as to its liability, based on all evidence available to the carrier at the time of the allegedly unreasonable conduct. Referring to *SAIF v. Stephens*, 247 Or App 107 (2011), the Board noted that a delay in the issuance of an acceptance or denial required by ORS 656.262(7)(a) may be reasonable if the law is in a confused state regarding a carrier's statutory obligation to respond. However, relying on *SAIF v. Traner*, 270 Or App 67 (2015), the Board explained that where a carrier understands its statutory obligation to timely accept or deny a new/omitted medical condition claim, its failure to do so is considered unreasonable, regardless of the carrier's view of the merits of the claim.

Turning to the case at hand, the Board disagreed with the carrier's contention that its delay in issuing an acceptance was reasonable because it had a legitimate doubt as to the existence, and thus the compensability, of the claimed new/omitted medical condition. The Board explained that if the carrier had issued a denial, legitimate doubt as to compensability could be a defense against a contention that such a denial was unreasonable, even if the claim were subsequently determined to be compensable. However, the Board concluded that such doubt did not pertain to the carrier's statutory obligation to timely accept or deny the claim under ORS 656.262(7)(a). Under such circumstances, the Board found that a penalty and attorney fee were justified. See ORS 656.262(11)(a).

In reaching its conclusion, the Board distinguished *Red Robin Int'l v. Dombrosky*, 207 Or App 476 (2006), which the carrier had cited for the proposition that a failure to timely issue a required notice within a statutorily mandated timeframe is not *per se* unreasonable. The Board observed that *Dombrosky* addressed former ORS 656.268(5)(d) (2003), *renumbered* as ORS 656.268(5)(f) (2015), which provided for a penalty for a claim closure or refusal to close if found unreasonable. In contrast to *Dombrosky*, which involved a situation where a failure to properly respond to a request for claim closure would only support a penalty under ORS 656.268(5)(d) (now (f)) if the failure constituted an unreasonable refusal to close the claim, the Board reasoned that the present case concerned ORS 656.262(11)(a), which does not limit the grounds for a penalty to circumstances in which the *de facto* denial created by the delay would be unreasonable but rather provides for a penalty when the delay itself is unreasonable.

Responsibility: Occupational Disease - Later Employer's "Untimely Claim" Defense Under "807(1)" Rejected - Claim Against Initial Employer Timely Filed

Gary L. Jordan, 68 Van Natta 1642 (October 12, 2016). Analyzing ORS 656.807(1), the Board held that, because claimant's occupational disease claim for bilateral hearing loss against his first employer had been filed timely (*i.e.*, within one year from his physician informing him that he had an occupational disease), his claim against a later employer (which was filed more than one year after he was informed by his physician of his disease) was not untimely. Claimant, a carpenter who worked for multiple employers over a 30-year period, filed a hearing loss claim against his employer at the time his attending physician informed him that he was suffering from an occupational disease. When the employer denied the claim (asserting that a subsequent employer may be responsible for claimant's condition), claimant filed a claim against that employer. Although claimant's first claim had been filed within one year of his physician informing him of his occupational disease, his claim against the subsequent employer had been filed more than one year from his "physician-informed date." Asserting that claimant's second hearing loss claim was untimely filed under ORS 656.807(1), the subsequent employer denied the claim. Claimant requested a hearing concerning both employers' denials, arguing that, because his claim against the first employer had been timely filed, his claim (for the same hearing loss condition) against the subsequent employer was not untimely.

The Board agreed with claimant's position. In reaching its conclusion, the Board distinguished *Baker v. Liberty Northwest Ins. Corp.*, 257 Or App 205, *rev den*, 354 Or 597 (2013), where the claimant had not filed a claim (against either of two potential employers) within one year after he was informed by a physician that he had an occupational disease. The Board noted that the *Baker* court had rejected the claimant's contention that his claim against the second employer was not untimely under ORS 656.807(1) because he was entitled to a new one-year limitation period under ORS 656.807(1) for each subsequent period of employment. The Board observed that, in doing so, the *Baker* court had reasoned that ORS 656.807(1) "provides that *all* occupational disease claims 'shall be void' if not filed within that one-year period." *Baker*, 257 Or App at 214 (Emphasis in original).

In contrast to *Baker*, the Board noted that claimant had filed a claim against the first employer within one year of being informed that he had an occupational disease. Reasoning that this fact provided an important distinction to the *Baker* rationale, the Board declined to extend the *Baker* holding to a situation where claimant had timely filed his occupational disease claim against the first potentially responsible employer, but, as a result of the first employer's responsibility denial, and his continuing exposure with a subsequent employer, claimant's claim against the second employer was filed more than one year after his notice from a physician of an occupational disease.

Timely filing against first employer distinguishes "Baker" holding.

Turning to the responsibility issue, the Board stated that there was no dispute that the first employer was presumptively responsible for the claimed hearing loss condition. Citing *Reynolds Metals v. Rogers*, 157 Or App 147, 153 (1998), *rev den*, 328 Or 265 (1999), the Board concluded that the medical evidence did not allow the presumptively responsible employer to transfer liability for claimant's condition to the subsequent employer because the record did not persuasively establish that his subsequent employment had actually contributed to a worsening of his condition.

In reaching its conclusion, the Board distinguished *Dennis Hunter*, 65 Van Natta 1158, 1161 (2013), where a physician's opinion that "all of [the] claimant's work exposure contributed to the progress of his hearing loss" allowed the presumptively responsible carrier to shift responsibility to a subsequent period of employment. In contrast to *Hunter*, the Board noted that the physician in the case at hand opined that claimant's lifelong exposure to work-related noise contributed more than 50 percent to his hearing loss. Observing that claimant's audiograms, which were administered before and after he began working for the second employer, were fairly comparable, the Board was not persuaded that the physician's opinion established a worsening of claimant's hearing loss condition from his exposure while working for the second employer. Consequently, the Board concluded that responsibility for claimant's condition remained with the first employer.

Comparable audiograms did not establish worsening at second employer.

Finally, in addition to awarding an attorney fee under ORS 656.308(2)(d) for claimant's counsel's services regarding the responsibility issue (to be paid by the first employer), the Board also granted attorney fee awards payable by the second employer under ORS 656.386(1) and ORS 656.382(2). In doing so, the Board reasoned that, although the second employer had successfully appealed the ALJ's responsibility decision, the second employer was the only carrier that had placed claimant's right to compensation at risk at hearing or on review by challenging the timeliness of his occupational disease claim. See *Cigna Ins. Cos. v. Crawford & Co.*, 104 Or App 329 (1990); *Damon E. Smith*, 67 Van Natta 1910, 1913 (2015).

APPELLATE DECISIONS UPDATE

Claim Filing: "Good Cause" - Mental State - No "Medical Evidence" Requirement

Lopez v. SAIF, 281 Or App 679 (October 19, 2016). Applying ORS 656.265(4)(c), the court reversed the Board's order in *Dalia R. Lopez*, 65 Van Natta 2173 (2013), previously noted 32 NCN 11:4, which had held that claimant had not established good cause for her untimely filed injury claim resulting from a motor vehicle accident (MVA) because no medical evidence supported her contention that she had been overwhelmed and heavily medicated as a result of her injury which had caused her to forget that her MVA had occurred while she was performing a work-related activity (rather than driving home at the end of her work day as she had reported to her supervisor). Claimant, who traveled to student's homes in her job for a "Head Start" program, was injured in a MVA, which occurred some 30 minutes after leaving her office. Shortly after the MVA, she told her supervisor that, at the time of the MVA, she was headed home and

Claimant contended injuries and medication caused her to forget work connection to MVA.

was not on work time. However, within one year from the MVA, claimant found paperwork that reminded her that she had intended to go to a student's home when the MVA occurred and filed her injury claim. The carrier denied the claim, asserting that the claim was untimely filed. Claimant requested a hearing, contending that she had provided sufficient notice of a work-related injury to her employer within 90 days of the MVA or, alternatively, that she had good cause for the untimely filed claim because she was overwhelmed and heavily medicated as a result of her severe injuries which had caused her to forget her intended visit to the student's home. The Board had upheld the carrier's denial, finding that claimant's statements to her supervisor had given the employer no reason to conclude that workers' compensation liability was a possibility and that, because she had not provided medical evidence supporting her delay in reporting her work-related injury, she had not established "good cause" for her untimely filed claim. See ORS 656.265(4)(a), (c). On appeal, claimant argued that the Board's findings were not supported by substantial evidence and that it had relied on a misconception of "good cause."

The court concluded that substantial evidence supported the Board's finding that claimant's supervisor's knowledge was insufficient to lead a reasonable employer to conclude that workers' compensation liability was a possibility and that a claim investigation was appropriate. See ORS 656.265(4)(a); *Safeway Stores, Inc. v. Angus*, 200 Or 94, 98 (2005).

Board has authority to determine good cause. Medical evidence not required.

However, concerning the Board's determination that claimant had not established "good cause" for her untimely filed claim, the court noted that the Board had simply ruled that claimant could only prove her contention that the MVA and her medication had caused her delay in filing the claim by presenting medical evidence. Citing *Meza v. Bruce Packing Co., Inc.*, 186 Or App 452, 459 (2003), the court stated that the Board has authority to determine within statutory limits, whether a claimant had "good cause" for the failure to file a timely claim. Relying on ORS 183.482(8)(b), and *Ogden Aviation v. Lay*, 142 Or App 469, 476 (1996), the court noted that its inquiry of a Board's "good cause" determination is whether the Board's order falls within the range of the Board's discretion.

Reasoning that there is no requirement in ORS 656.265 that a claimant present medical evidence to support her contention that her mental state or confusion constituted "good cause" for her untimely filed claim, the court clarified that the Board must decide whether it was persuaded by the evidence in the record, whether or not that record included medical evidence. Because the Board's order seemed to imply, as a matter of law, claimant could satisfy the "good cause" requirement *only* by presenting medical evidence, the court concluded that the Board had relied on a misconception of law. Consequently, the court reversed and remanded.

Course & Scope: “Unexplained Fall” Doctrine - Idiopathic (Personal) Causes Must Be Proven “Less Likely” to Have Caused Fall - No Requirement to Conclusively Rule Out All Possible Idiopathic Causes (No Matter How Remote)

Sheldon v. U.S. Bank, 281 Or App 560 (October 12, 2016). The court vacated the Board’s order in *Catherine A. Sheldon*, 66 Van Natta 275 (2014), previously noted 33 NCN 2:7, which had found claimant’s injury, which occurred when she fell while walking through the lobby of a building where her employer leased an office to begin her workday, did not arise out of her employment because she had not persuasively eliminated idiopathic reasons for her fall. Based on two physicians’ opinions (which discussed diabetes, obesity, and their relationship to balance and mobility problems), the Board had reasoned that claimant’s fall was not “truly unexplained” and, as such, did not arise out of her employment. See *Blank v. U.S. Bank of Oregon*, 252 Or App 553, 557 (2012). On appeal, contending that the physicians’ opinions on which the Board had relied established, at most, that idiopathic factors *generally* associated with diabetes and obesity had the potential to cause problems with balance and mobility, claimant argued that neither opinion had proven that those idiopathic factors existed for her or were possible causes of her fall. Therefore, claimant asserted that the Board’s finding was not supported by substantial reasoning.

The court agreed with claimant’s contention. Citing *Phil A. Livesley v. Russ*, 296 Or 25, 30 (1983), the court stated that an injury that is unexplained and occurs in the course of employment is presumed, as a matter of law, to arise out of employment. Relying on *Russ*, the court noted that whether an injury is “truly unexplained” is a question of fact, and an injury “will be deemed truly unexplained only if the claimant persuasively eliminate[s] all idiopathic factors of causation.” Referring to *McTaggart v. Time Warner Cable*, 170 Or App 491, 503 (2000), *rev den*, 331 Or 633 (2001), the court declared that the legal question is whether claimant has adequately explained why idiopathic factors were not the cause of the injury, not whether claimant has disproved all possible explanations for an unexplained fall.

Turning to the case at hand, the court observed that the Board had concluded that because “the medical evidence raised the *possibility* that idiopathic factors * * * caused, or contributed to, claimant’s fall,” she had failed to persuasively eliminate idiopathic causes. Reasoning that such a standard effectively required claimant to conclusively rule out all possible idiopathic causes of her injury (no matter how remote) to prove her injury, the court determined that such a standard was inconsistent with claimant’s burden of persuasion, which only required her to prove that idiopathic factors were less likely to have caused her fall than some other, unexplained factors.

Injury will be deemed truly unexplained only if the claimant persuasively eliminates all idiopathic factors of causation.

Claimant is required to show it was less than equally likely that idiopathic factors caused her to fall, not that there was no possibility that such idiopathic factors could have contributed to the fall.

In reaching its conclusion, the court distinguished *Blank*, where it had affirmed a Board finding that a claimant's injury had not arisen out of employment because the claimant had not adequately eliminated all idiopathic causes for the fall. The court explained that, in *Blank*, the claimant actually had a diagnosed medical condition and associated symptoms that, in view of medical experts, likely caused her fall.

In other words, the court clarified that, in *Blank*, the evidence did not persuade the fact finder that the cause of the injury was more likely work-related than personal to the claimant. In the present case, in contrast to the *Blank* standard, the court reasoned that the Board had held claimant to a higher standard when it required her to disprove all possible idiopathic causes of her fall. Because that standard was inconsistent with the *Blank* decision (*i.e.*, which requires the claimant to show that it was less than equally likely that idiopathic factors caused her to fall, not that there was *no possibility* that such idiopathic factors could have contributed to the fall), the court remanded for reconsideration under the correct legal standard.

Judge Lageson concurred. Noting that claimant had presented direct evidence on the causation issue in support of her theory that a tripping hazard in the lobby (most likely an uneven floor tile) had caused her fall and that she had not sought to prove causation indirectly by invoking the "unexplained fall" doctrine, Lageson considered it appropriate to remand to the Board to address claimant's theory.

Judge Lageson acknowledged that the Board had found "no [] employment contribution" after it concluded that claimant was advocating that her work environment had caused her fall. Nevertheless, observing that the Board had not specifically discussed the role the floor tile may have played in claimant's fall, had not addressed the ALJ's finding concerning her "tile-related" explanation for her fall, and had applied the "unexplained fall" doctrine when claimant had not invoked the doctrine but rather presented direct evidence of causation, Lageson believed that the Board might have seen the case differently had it understood claimant's theory correctly. Because the majority was remanding (albeit for a different reason), Judge Lageson did not consider the Board foreclosed from taking his considerations into account on remand.

Penalty: No "Legitimate Doubt" For Carrier's Failure to Pay TTD Benefits

Scott v. Liberty Northwest Insurance Corporation, 281 Or App 516 (October 12, 2016). Applying ORS 656.262(4)(a), and (11)(a), the court reversed that portion of the Board's order in *Jackie A. Scott*, 67 Van Natta 1375 (2015), previously noted 34 NCN 8:10, which had found that the carrier's failure to pay temporary disability (TTD) benefits for an accepted new/omitted medical condition (surgical scarring in her low back) was not unreasonable because, although the attending physician attributed claimant's disability to claimant's surgical scarring low back condition, the physician had described the scarring as permanent (rather than temporary) and medically stationary. On appeal, claimant contended that the attending physician's statements that she was

disabled from the surgical scarring triggered the carrier's duty under ORS 656.262(4)(a) to pay TTD benefits until claim closure, regardless of whether the disability was temporary and, as such, the carrier's failure to pay such benefits was unreasonable.

The court agreed with claimant's contention. Citing *Providence Health System v. Walker*, 252 Or App 489, 505 (2012), *rev den*, 353 Or 867 (2013), the court stated that, in determining whether a refusal to pay compensation is unreasonable under ORS 656.262(11)(a), the question is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. Relying on *Walker*, the court reiterated that, in conducting its review, it considers whether substantial evidence supported the Board's finding that the carrier had a legitimate doubt regarding its obligation to pay TTD benefits when it accepted the surgical scarring low back condition.

The court noted that, in its previous decision (*Scott v. Liberty Northwest Ins. Corp.*, 268 Or App 325, 330-31 (2014)), it had ruled that, once the attending physician "has contemporaneously excused the injured worker from work, the payment of temporary disability benefits is authorized[.]" The court further declared that its prior statement was not a resolution of an unsettled question of statutory construction, but rather had been the state of the law since its opinion in *Lederer v. Viking Freight, Inc.*, 193 Or App 226, 237, *adh'd to as modified on recons*, 195 Or App 94 (2004), which had reasoned that a carrier's obligation to pay TTD benefits begins "when an objectively reasonable insurer * * * would understand contemporaneous medical reports to signify" approval excusing the claimant from work.

Turning to the case at hand, the court emphasized that the Board had found that an objectively reasonable carrier would have understood the attending physician had excused claimant from work due, at least in part, to pain from her surgical scarring condition. In light of the Board's finding, the court reasoned that the carrier could not have had a legitimate doubt from a legal standpoint as to its liability to begin paying TTD benefits when it accepted the surgical scarring condition. Consequently, the court reversed the Board's decision and remanded for penalty/attorney fee awards.

TTD: "245(2)(b)(B)" - "Emergency Room" Physician's TTD Authority - 14-Day Limitation

Osborne v. Travelers Insurance Co., 281 Or App 461 (October 5, 2016). The court affirmed without opinion the Board's order in *Jason Osborne*, 67 Van Natta 1410 (2015), previously noted 34 NCN 8:11, which applied ORS 656.245(2)(b)(B) and ORS 656.262(4)(h), and held that a carrier was not obligated to pay temporary disability benefits beyond 14 days because an "open-ended" authorization from an "emergency room" physician was limited to 14 days.

Because Board had found that objectively reasonable carrier would have understood "AP" had excused claimant from work due in part to compensable condition, carrier could not have legitimate doubt from a legal standpoint for not paying TTD benefits.

APPELLATE DECISIONS COURT OF APPEALS

Medical Service: “245(1)(c)(D), (J), & (L)” - Palliative Treatment/“Prosthetic Device”

Landis v. Liberty Northwest Insurance Corporation, 281 Or App 639 (October 19, 2016). Analyzing ORS 656.245(1)(c)(J), and (L), the court affirmed a Workers' Compensation Division (WCD) order that found that claimant's attending physician's prescribed physical therapy and transcutaneous electrical nerve stimulation (TENS) unit were palliative (rather than curative) treatment and were not compensable because the record did not establish that the services were necessary to allow him to continue employment and that the TENS unit did not constitute a “prosthetic device.” On appeal, claimant contended that: (1) the Director (through WCD) erred in determining that claimant's treatments were palliative, rather than curative; (2) if the treatments were palliative, they were compensable under ORS 656.245(1)(c)(J) because they were necessary to enable him “to continue current employment”; and (3) the Director (through WCD) erred in concluding that the TENS unit was not a prosthetic device for which claimant was entitled to compensation under ORS 656.245(1)(c)(D).

Concerning his first assignment of error, claimant asserted that his treatments were consistent with the dictionary definition of curative in that they were necessary to avoid a deterioration in his condition. The court considered it unnecessary to decide the meaning of “curative,” noting that, under ORS 656.245(1)(c)(L), after a claimant has become medically stationary, curative care is compensable only if it is provided “to stabilize a temporary and acute waxing and waning of symptoms.” Reasoning that the medical evidence was undisputed that claimant's condition was medically stationary (meaning that “no further material improvement would reasonably be expected from medical treatment, or the passage of time” under ORS 656.005(17)) and that his symptoms were of long duration and chronic, the court concluded that substantial evidence supported WCD's determination that claimant's treatments were not provided “to stabilize a temporary and acute waxing and waning of symptoms” and, therefore, were not compensable under ORS 656.245(1)(c)(L).

Regarding his second assignment of error, claimant argued that WCD had erroneously interpreted the term “employment” by, in particular, requiring that he demonstrate a level of income that is “self-sustaining.” The court found that it was unnecessary to address WCD's “self-sustaining” reasoning because, even if that determination was incorrect, the record supported WCD's finding that claimant's “taxidermy” activities were a hobby, not employment. In reaching its determination, the court noted that the medical records consistently reported claimant's history that he was not working. Under such circumstances, the court concluded that WCD had not erred in its determination that claimant was not entitled to compensation for his palliative care under ORS 656.245(1)(c)(J).

Addressing his third assignment of error, claimant contended that WCD had erred in concluding that the TENS unit was not a prosthetic device for which he was entitled to compensation under ORS 656.245(1)(c)(D). Although acknowledging that OAR 436-009-0080 (2010) categorizes the TENS unit as “durable medical equipment” rather than a “prosthetic device,” he asserted that

Palliative treatment not compensable, because not necessary to enable claimant to continue employment (record indicated it was a hobby, rather than employment).

WCD's interpretation of its rule on prosthetic device entitled to deference (i.e., "durable medical device," not "prosthetic device").

his attending physician had prescribed the TENS unit as a "prosthetic device" as defined in OAR 436-009-0080(2) (2010) and OAR 436-010-0230(12) (2010), aiding in the performance of natural functions, such as standing, walking, and sitting.

After conducting its review and analyzing WCD's administrative rules, the court considered a portion of WCD's interpretation of its "prosthetic device" rule (*i.e.*, that such a device must be "mechanical" or aid in mechanical functions) to be inconsistent with the text of the rule, which defines a prosthetic as a device that aids in "natural function." Nonetheless, noting that WCD had categorized a TENS unit as a "durable medical device" (under OAR 436-009-0080 (2010)), which is a device that is "primarily and customarily used to serve a medical purpose, can withstand repeated use, could normally be rented and used by successive patients," the court concluded that WCD's interpretation of the text of its rule and characterizing a TENS unit as a "durable medical device" not also as a "prosthetic device" was a plausible one entitled to deference.

Judge Egan dissented from the majority's conclusion that the Director (through WCD) had not erred in determining that the TENS unit was not a prosthetic as defined under OAR 436-009-0080 (2010) and in accordance with ORS 656.245(1)(c)(D). Noting that the "prosthetic device" rule (OAR 436-010-0230(12) (2010) defined a "prosthetic appliance" as "an artificial substitute for a missing body part or *any device by which performance of a natural function is aided * * **," Egan asserted that WCD's decision had ignored the reality that some appliances fall into the categories of both prosthetic and durable medical equipment based on the rules' definitions.

Specifically, in regards to claimant's TENS unit, Judge Egan reasoned that, although prescribed for the medical purpose of relieving pain, the device also had the incidental effect of aiding in the natural functions of the back. Under such circumstances, Egan contended that the majority's upholding of WCD's interpretation of its rule as establishing mutually exclusive categories and characterizing a TENS unit as durable medical equipment and, not also a prosthetic device, was not supportable.

Dissent reasoned that, because TENS unit assists neurologic function and, therefore, operates as a "prosthetic device," WCD's interpretation of its rule was not plausible.

Referring to court and WCD decisions which had found devices (such as modified vans and compression stockings) that were not "personal to the individual" to be "prosthetics," (*Sedgwick Claims Management Services v. Jones*, 214 Or App 446, 454 (2007), *Toni L. Anderson*, 16 CCHR 202 (2011)), Judge Egan did not consider the majority's distinction between "prosthetics" and "durable medical equipment" to stand up in light of those prior interpretations. Reasoning that a TENS unit that stimulates the nerves of the back so as to assist the neurologic function operates as a "prosthetic device," Egan asserted that any other conclusion had the effect of amending and restricting ORS 656.245(1)(c)(D) and, as such, WCD's interpretation of its administrative rule was not plausible.

Substantial Evidence: Erroneous Board Findings Regarding Physicians' Opinions - Court Unable to Determine Effect on Board's Ultimate Decision

SAIF v. Williams, 281 Or App 542 (October 12, 2016). Reviewing for substantial evidence, the court vacated the Board's order in *David M. Williams*, 65 Van Natta 2144 (2013), that had set aside a "new/omitted medical condition" denial for a thoracic spine Tarlov cyst because the Board's decision was predicated on two factual errors regarding the medical evidence and the court could not determine to what extent the errors affected the Board's decision. In reaching its compensability decision, the Board had found claimant's surgeon's opinion to be persuasive, reasoning that: (1) the surgeon had personally examined claimant a month before the surgery and had opined that he was experiencing "T5 Tarlov cyst" symptoms; and (2) another physician had made findings of "T5 dermatome" symptoms shortly after claimant's work injury. On appeal, the carrier asserted that both Board findings were erroneous.

The court agreed with the carrier's assertions. Citing *Luton v. Willamette Valley Rehabilitation Center*, 272 Or App 487, 490 (2015), the court stated that it reviews the Board's legal conclusions for legal error and factual determinations for substantial evidence. Relying on *State Farm Ins. Co. v. Lyda*, 150 Or App 554, 559, *rev den*, 327 Or 82 (1998), the court reiterated that substantial evidence exists when the record, viewed as a whole, permits a reasonable person to find, as the Board did, in the light of supporting and contrary evidence. Finally, referring to *SAIF v. Pepperling*, 237 Or App 79, 85 (2010), the court noted that it does not substitute its judgment for that of the Board, but rather determines whether the Board's evaluation of that evidence was reasonable.

Turning to the case at hand, the court observed that claimant had conceded that the Board's first contested factual finding was erroneous. Furthermore, after analyzing the Board's second contested factual finding, the court reasoned that the physician's reports did not support the Board's interpretation of those reports.

Having determined that the Board's findings were erroneous, the court next addressed claimant's argument that such errors were harmless because: (1) claimant's surgeon had eventually examined claimant before his surgery; and (2) substantial evidence in the record supported the Board's finding that claimant had experienced "T5 level" symptoms since his work injury.

Reasoning that the Board's decision was essentially reduced to a credibility contest between claimant's surgeon and the carrier's medical experts, the court considered it at least plausible that the Board's misstatements affected its decision to credit the surgeon's opinion over that of the carrier's experts. Because it was not possible to determine what extent the aforementioned errors had on the Board's decision, the court remanded for reconsideration.

Concluding that Board's order contained two misstatements of facts, court considered it at least plausible that such findings affected Board's analysis of physicians' opinions, warranting remand.