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**BOARD NEWS**

## Bulletin 1 (Revised) - Annual Adjustment to Attorney Fee Awards - Effective July 1, 2017

On June 1, 2017 "WCB Bulletin No. 1 (Revised)" published the annual adjustment to attorney fee awards under ORS 656.262(11)(a) and ORS 656.308(2)(d). See OAR 438-015-0038; OAR 438-015-0055(5); OAR 438-015-0110(3). In accordance with those statutes, the Board rules provide that the maximum attorney fee (in the absence of extraordinary circumstances) is subject to an annual adjustment on July 1, by the same percentage increase as made to the state's average weekly wage (SAWW) defined in ORS 656.211, if any, as calculated by the Workers' Compensation Division (WCD), on behalf of the Director.

WCD has reported that, effective July 1, 2017, the SAWW is \$963.01, a decrease of 1.149 percent from the SAWW for the previous year (July 1, 2016 through June 30, 2017) of \$974.20. See WCD's Bulletin 111 (Revised) dated May 25, 2017; WCD's Industry Notice dated May 18, 2017.

Consequently, there will be no adjustments to OAR 438-015-0110(3), OAR 438-015-0038, and OAR 438-015-0055(5). In other words, effective July 1, 2017 (regarding any order issued on and after that date), consistent with the current version of the rule, an attorney fee awarded under ORS 656.262(11)(a) may not exceed \$4,225, absent a showing of extraordinary circumstances. OAR 438-015-0110(3). In addition, effective July 1, 2017 (regarding any order issued on and after that date), consistent with the current version of the rule, an attorney fee awarded under ORS 656.308(2)(d) shall not exceed \$3,047, absent a showing of extraordinary circumstances. OAR 438-015-0038; OAR 438-015-0055(5).

The bulletin can be found on the Board's website at: <http://www.oregon.gov/wcb/Documents/wcbbulletin/bulletin1-rev2017.pdf>

**CASE NOTES**

## Extent: Impairment Findings - "035-0007(5)" - Arbitrator's "Class 2" "Unambiguous" Findings for PTSD Applied - "AP-Deferred" Findings Not More Accurate

*Dale E. Boekhoff*, 69 Van Natta 972 (May 26, 2017). Applying OAR 436-035-0007(5), in determining the extent of claimant's permanent impairment for an accepted post-traumatic stress disorder (PTSD), the Board relied on

## APPELLATE DECISIONS

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O.D.: All Causes Considered - Medical Evidence Established "Personal Factors" (Weight/Deconditioning) Were "Causes" (Not "Susceptibility/Predisposition")

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*Claimant contended Class 3 applied based on anxiety driving a truck.*

*Arbiter discussed claimant's recent ATV incident, whereas "AP-deferred" findings did not.*

a medical arbiter's unambiguous and well-reasoned opinion (which rated claimant's impairment as Class 2), rather than an "attending physician-deferred" opinion (which had found Class 3 impairment). As a result of claimant's work-related motor vehicle accident, the carrier accepted a PTSD condition. After an attending physician concurred with a psychologist's impairment assessment of Class 1, the carrier issued a Notice of Closure that did not award permanent disability. Thereafter, while claimant's request for reconsideration with the Appellate Review Unit (ARU) was pending, his attending physician "deferred" to the psychologist's "post-closure" opinion that the Class 1 impairment had pertained to claimant's daily functioning since he was no longer a commercial truck driver, but considering his severe anxiety if he returned to his truck driving work, his impairment was Class 3. Following a medical arbiter report (which rated claimant's impairment at Class 2), an Order on Reconsideration awarded permanent disability based on the arbiter's impairment rating. Claimant requested a hearing, contending that the "attending physician-deferred" rating of Class 3 impairment should be used in rating his permanent disability.

The Board affirmed the Order on Reconsideration award based on the arbiter's Class 2 impairment rating. Citing OAR 436-035-0007(5), and *SAIF v. Owens*, 247 Or App 402, 414-15 (2011), *recons*, 248 Or App 746 (2012), the Board stated that impairment is established by the medical arbiter's findings, except where a preponderance of the medical evidence demonstrates that different findings made or ratified by the attending physician are more accurate and should be used. Relying on *Hicks v. SAIF*, 194 Or App 655, *recons*, 196 Or App 146, 152 (2004), the Board noted that, absent persuasive evidence to the contrary, it was not free to disregard the medical arbiter's impairment findings. Finally, again referring to OAR 436-035-0007(5), as well as *SAIF v. Banderas*, 252 Or App 136, 144-45 (2012), the Board observed that the attending physician's impairment findings may be used only if the preponderance of the medical evidence establishes that those findings are more accurate than the arbiter's findings.

Turning to the case at hand, the Board concluded that the medical arbiter sufficiently described claimant's permanent changes in mental function in terms of their effect on his activities of daily living, social functioning, and deterioration/decompensation in work or work-like settings to determine permanent impairment and loss of function attributable to permanent symptoms of affective, anxiety, and adjustment disorders. See OAR 436-035-0400(3), (5). The Board further noted that, in contrast to the attending physician and psychologist's opinions, the arbiter had also discussed claimant's recent ATV incident, which was of importance to the arbiter's opinion regarding claimant's stress reaction to driving. See *Miller v. Granite Constr. Co.*, 28 Or App 473, 476 (1977); *Jerry L. Parker*, 54 Van Natta 2688 (2002). Finally, the Board observed that the psychologist's examination was some seven months before the Order on Reconsideration, whereas the arbiter's examination was conducted one month before the reconsideration order. See *Nelida Cabellero*, 59 Van Natta 1728, 1731 (2007).

Under such circumstances, the Board was not persuaded that the "attending physician-deferred" impairment findings were more accurate than the medical arbiter's unambiguous findings. See OAR 436-035-0007(5); *Hicks*, 194 Or App at 659. Consequently, the Board affirmed the Order on Reconsideration's permanent disability award, which was based on the arbiter's Class 2 impairment rating.

In light of its conclusion, the Board considered it unnecessary to address the question of whether the attending physician's "deferring" to the psychologist's impairment findings constituted "concurring" with those findings.

## Filing: Untimely Claim Filing - "265(4)(c)" - Claimant's Uncorroborated Explanation Regarding Effects of "MVA" Injury Insufficient to Establish "Good Cause"

*Dalia R. Lopez*, 69 Van Natta 941 (May 16, 2017). Applying ORS 656.265(4)(c), on remand from the court (*Lopez v. SAIF*, 281 Or App 679 (2016)), the Board held that claimant had not established "good cause" for her untimely filed injury claim because her explanation that her delay in reporting her motor vehicle accident (MVA) injury as work-related was attributable to memory deficits from the MVA was not persuasively corroborated by the remainder of the record. Claimant was injured in a MVA after leaving her office for the day. The day after her MVA, at the hospital, she told her supervisor that she had been on her way home and was not on work time when the MVA occurred. Some six months later, claimant reported that the MVA occurred while she was on her way to a client's home to return some records before heading home. The carrier denied the claim, contending that the claim was untimely filed and that claimant had not established "good cause" for her untimely claim.

*Claimant first told supervisor that she was "off work" when MVA occurred.*

The Board agreed with the carrier's contention. Citing ORS 656.265(1)(a) and (4)(c), the Board stated that claimant was required to provide notice of an "accident resulting in an injury or death" not more than 90 days after the accident, but that untimely notice would not bar a claim if the notice was given within one year of the accident and claimant had "good cause" for the untimely notice. Referring to ORS 656.310(1)(a), which creates a rebuttable presumption that "[s]ufficient notice of injury was given and timely filed," the Board stated that where claimant relies on "good cause" to excuse notice given more than 90 days after the date of the accident, she bears the burden of showing "good cause." *Wilson v. SAIF*, 3 Or App 573 (1970); *Andrew Kuralt*, 67 Van Natta 589 (2015). Finally, relying on *Lopez*, the Board reiterated that medical evidence is not required for a claimant to establish "good cause," but rather the Board must decide whether it is persuaded by the evidence in the record, and whether or not that record includes medical evidence.

*Medical and lay evidence found insufficient to corroborate claimant's "loss of memory/impaired mental capacity" explanation for "good cause."*

Turning to the case at hand, the Board acknowledged claimant's testimony that she was unable to recall the work-related purpose of her travel at the time of the MVA as a result of her serious injuries and heavy medication. Nevertheless, the Board determined that the medical record did not suggest that she sustained any memory loss regarding the nature of her travel at the time of the MVA, noting that less than one month after the MVA, she was not taking any pain medication and she was driving. The Board further observed that an examining physician had reported that claimant's "immediate and remote history is intact" and that she had been released to work on a part-time basis with work limitations that did not pertain to any mental or memory-related matters.

Under such circumstances, based on its review of all lay and medical evidence, the Board considered claimant's uncorroborated explanation regarding the effects of her MVA injury and treatment insufficient to establish that her untimely filed claim was due to any impaired mental capacity or loss of memory. Consequently, the Board concluded that claimant had not proven "good cause" for her untimely filed claim.

## Hearing Procedure: "005-0035(5)," "006-0031(2)," "006-0091(5)" - ALJ's Continuance Ruling - "Injury" Theory Raised at Hearing for Denied "O.D." Claim - No Abuse of ALJ Discretion in Granting Continuance

*Frank P. Courtell*, 69 Van Natta 884 (May 9, 2017). Applying OAR 438-005-0035(5), OAR 438-006-0031(2), OAR 438-006-0081(1), and OAR 438-006-0091(5), the Board found no abuse of discretion in an ALJ's ruling that granted the carrier's motion for continuance of a hearing for further development when the issues at hearing were amended to include an "injury" theory advanced by claimant for his denied claim. Claimant's 801 forms described "repetitive stress \* \* \* over weeks of extra shifts." Subsequently, the carrier denied an "occupational disease" claim, asserting that claimant's "work [was] not the major contributing cause of [his] disease." Thereafter, he filed a hearing request, which referenced the carrier's denial. At hearing, claimant announced that he was proceeding on an injury theory of compensability, which prompted the carrier to seek a continuance to develop the record based on such a theory. Reasoning that the record indicated that the claim had been focused on an "occupational disease" theory until claimant's announcement at the hearing, the ALJ granted the carrier's continuance request. After the ALJ upheld the carrier's denial, claimant appealed, challenging (among other issues) the ALJ's continuance ruling.

The Board found no abuse of discretion in the ALJ's ruling. *SAIF v. Kurcin*, 334 Or 399, 406 (2002); *Scarlet M. Allen*, 58 Van Natta 3049, 3050-51 (2006). Citing OAR 438-005-0035(5) and OAR 438-006-0031(2), the Board stated that the ALJ was authorized to allow the amendment of "theories" concerning the compensability issue. The Board further noted that such amendments are subject to a request for a postponement or continuance. Relying on OAR 438-006-0091(5) and OAR 438-006-0081(1), the Board indicated that a continuance may be granted for any reason that would justify a postponement, which included consideration of whether "extraordinary circumstances" existed.

Turning to the case at hand, the Board considered the procedural background that prompted the continuance motion, which supported a conclusion that, until the hearing, the theory of claimant's claim was confined to an occupational disease. The Board emphasized that, consistent with its

*801 form described repetitive stress.*

*Until hearing, "OD" theory for denied claim had not been raised.*

*ALJ authorized to consider new theories and grant a continuance.*

stated policy, the ALJ was authorized to allow consideration of new theories and to grant a continuance for further development of the record. See OAR 438-005-0035(5); OAR 438-006-0031(2); OAR 438-006-0081(1); OAR 438-006-0091(5). Under such circumstances, the Board found no abuse of discretion in the ALJ's exercise of authority to grant the carrier's continuance motion.

## New/Omitted Medical Condition: "262(6)(d)," "(7)(a)," & "267(1)" - No "Pre-Acceptance" "New/Omitted Medical Condition" Claim - Claimant Must File Written Objection to Notice of Acceptance Before Requesting Hearing

*Before acceptance, an 827 form referred to a medical chondral defect.*

*Robert M. Coleman*, 69 Van Natta 850 (May 3, 2017). Analyzing ORS 656.262(6)(d), (7)(a), and ORS 656.267(1), the Board held that claimant's "pre-acceptance" 827 form (which referred to a knee medial femoral chondral defect) did not constitute a "new/omitted medical condition" claim, but instead, when the carrier subsequently accepted a knee strain/contusion (in response to a previously filed 801 form), claimant was required to file an omitted medical condition claim objecting to the carrier's acceptance notice before he could file a hearing request seeking acceptance of the omitted medical condition. After receiving an 801 form (claiming a knee strain/contusion) and an 827 form (referring to a medial chondral defect), the carrier accepted the strain/contusion. Thereafter, claimant filed a hearing request, asserting that the carrier had *de facto* denied his new/omitted medical condition claim for the medial chondral defect condition and that penalties and attorney fees for unreasonable claim processing were warranted.

*"Pre-acceptance" request for acceptance of additional condition is not "new/omitted medical condition" claim.*

The Board disagreed with claimant's contentions. Citing ORS 656.262(6)(a), the Board stated that a carrier has 60 days to accept or deny a claim after having notice or knowledge of the claim. Referring to ORS 656.262(6)(d), (7)(a), ORS 656.267(1), *Jorge Andrade*, 68 Van Natta 439, 440 (2016), and *Shannon E. Jenkins*, 48 Van Natta 1482, 1486, *aff'd without opinion*, 135 Or App 436 (1997), the Board noted that, if a worker is dissatisfied with the scope of a carrier's acceptance, or believes that additional conditions should be accepted, the statutory scheme requires the worker to clearly request formal written acceptance of new/omitted medical conditions. Relying on *Ernest R. Lyons*, 69 Van Natta 688, 693 (2017), the Board observed that: (1) a "pre-acceptance" request for acceptance of a condition does not constitute a "new/omitted medical condition" claim when the carrier subsequently accepts another condition; (2) a worker who fails to comply with the communication requirements in ORS 656.262(6)(d) and ORS 656.262(7)(a) may not allege a *de facto* denial of a condition based on information in the acceptance notice.

Turning to the case at hand, the Board acknowledged that claimant's physician had filed an 827 form (referring to the medial chondral defect condition) shortly after the filing of claimant's 801 form (pertaining to the knee injury claim) and that both claim forms had preceded the carrier's acceptance of his knee strain/contusion condition. Nonetheless, determining that the carrier's acceptance had issued within 60 days from the filing of claimant's 801 form, the Board concluded that the carrier had satisfied its initial claim processing obligations under ORS 656.262(6)(a).

*Claimant required to file written objection to acceptance notice before filing hearing request.*

Furthermore, relying on the *Lyons* rationale, the Board reasoned that claimant's "pre-acceptance" 827 form (submitted by his attending physician) did not constitute a new/omitted medical condition claim. See also *Andria D. Costello*, 55 Van Natta 498, 504 (2003), *aff'd without opinion*, 193 Or App 484 (2004) (no legislative intent in ORS 656.267(1) to allow a physician to file a new/omitted medical condition claim). Instead, in accordance with the *Lyons* holding, the Board found that claimant was required to file a written objection with the carrier concerning the acceptance notice communicating that he was clearly requesting formal written acceptance of the omitted medical condition (the medial chondral defect) before he could file a hearing request alleging a *de facto* denial of the condition.

Member Lanning specially concurred. Referring to the dissenting opinions in *Ernest R. Lyons* 69 Van Natta 688 (2016) and *Jorge Andrade*, 68 Van Natta 439 (2016), Lanning believed that the majority decisions ignored a carrier's statutory responsibility to process claims in a prompt and reasonable manner and impermissibly transferred that responsibility to the claimant. Nevertheless, acknowledging the principles of *stare decisis*, Lanning submitted a special concurring opinion.

## Standards: Work Disability - "AP" Release Not to "Regular At-Injury" Work - Claimant's Affidavit of Work Duties Outweighed "Job Analysis"

*After signing job analysis, claimant submitted affidavit concerning "at-injury" job duties.*

*Kevin S. Tucker*, 69 Van Natta 968 (May 26, 2017). Applying ORS 656.214(2)(b) and ORS 656.726(4)(f)(E), the Board held that claimant was entitled to a work disability award for a knee condition because his affidavits describing his work duties established that he had not been released to his "regular work" by his attending physician. After the carrier accepted claimant's knee condition, his attending physician imposed permanent restrictions regarding his return to his "at-injury" forklift operator job of no lifting or pushing/pulling more than forty pounds. Based on a job analysis (signed by claimant and his employer) indicating that claimant's regular work did not require lifting or pushing/pulling more than 20 pounds on a regular basis, his attending physician signed a form releasing him to "regular work." Thereafter, claimant submitted affidavits stating that his regular work required lifting and pushing/pulling more than 40 pounds on a regular basis. Based on the job analysis, an Order on Reconsideration did not award work disability. Claimant

requested a hearing, contending that his affidavits persuasively established that he had not been released to his regular, at-injury work and, as such, he was entitled to a work disability award.

The Board agreed with claimant's contention. Citing ORS 656.214(2)(a), and ORS 656.726(4)(f)(E), the Board stated that if a claimant returns to, or is released by an attending physician to return to, regular work, a work disability award is not warranted. Relying on ORS 656.214(1)(d), and OAR 436-035-0005(15), the Board noted that "regular work" means the claimant's "at-injury" job. Referring to *Joseph Federico*, 62 Van Natta 799 (2010), the Board reiterated that it determines whether claimant was released to "regular work" based on all evidence in the record, including his own description of his work history, the employer's job description, the vocational job analysis, and any evidence about his "post-injury" physical capacity. In concluding that claimant's affidavits were persuasive evidence of his regular work, the Board noted that claimant explained the inconsistencies between the job analysis and his affidavits.

Turning to the case at hand, the Board acknowledged that claimant's attending physician had signed the form releasing claimant to his "regular work" based on the employer's job analysis. Nevertheless, after considering claimant's affidavits regarding the physical requirements of his "at-injury" job, the Board was persuaded that the job analysis contained an inaccurate description of claimant's work and, as such, he was not released to "regular work" by his attending physician. See *Martha Navarro*, 53 Van Natta 1620 (2001). In making this determination, the Board reasoned that the attending physician had continued to impose restrictions (e.g., no lifting or pushing/pulling of more than 40 pounds) that prevented claimant from performing his "regular work" as described in his affidavits. See *Steven F. Knight*, 57 Van Natta 2603 (2005).

In reaching its conclusion, the Board distinguished *Lawrence W. Clement*, 62 Van Natta 578, 584 (2010), which had held that, in the absence of an explanation regarding the differences between a job analysis and a claimant's affidavit, the job analysis had been considered the most persuasive evidence of the claimant's "regular work." In contrast to *Clement*, the Board reasoned that claimant had explained the inconsistencies between the job analysis and his affidavits, noting further that some of his statements had been corroborated by a vocational counselor. Under such circumstances, the Board found claimant's affidavits to be persuasive evidence regarding his regular work.

## APPELLATE DECISIONS COURT OF APPEALS

Combined Condition: "262(6)(c)" - "Ceases"  
Denial - Accepted Lumbar Strain No Longer  
Major Cause of "Combined" Low Back  
Condition

*Evans v. SAIF*, 285 Or App 402 (May 10, 2017). Applying ORS 656.262(6)(c), the court affirmed the Board's order in *Robert C. Evans*, 67 Van Natta 866 (2015), that upheld a carrier's "ceases" denial of claimant's combined

*Affidavit established that job analysis of physical requirements for "at-injury" job were inaccurate.*

low back condition. In reaching its conclusion, the Board had applied *Brown v. SAIF*, 262 Or App 640 (2014), and found that the carrier established that claimant's work injury was no longer the major contributing cause of his disability/need for treatment of his combined low back condition. On appeal, claimant argued that: (1) the medical evidence showed only that claimant's accepted lumbar strain (rather than the work-related injury incident) was no longer the major contributing cause of claimant's combined condition; and (2) the record lacked substantial evidence that his condition had changed between the effective date his combined condition had been accepted and the effective date of the carrier's denial. See *Brown*, 262 Or App at 656; *Washington County v. Jansen*, 248 Or App 335, 345 (2012); *Wal-Mart Stores, Inc. v. Young*, 219 Or App 410, 418 (2008).

*Undisputed that accepted strain was no longer the major cause of combined condition.*

The court determined that claimant's first argument was foreclosed by the Supreme Court's recent decision in *Brown v. SAIF*, 361 Or 241, 283 (2017), which held that a carrier is entitled to issue a "ceases" denial of a combined condition "when the accepted injury is no longer the major contributing cause of that combined condition." Noting that it was undisputed that claimant's accepted lumbar strain was no longer the major contributing cause of his combined low back condition, the court rejected his first argument.

*Physician's opinion indicated that expected improvement in fact occurred, which supported a "change" in condition.*

Addressing claimant's second argument, the court concluded that substantial evidence supported the Board's finding that his accepted lumbar strain had improved by the effective date of the carrier's "ceases" denial. In doing so, the court acknowledged that an examining physician had expected claimant's condition to improve in another 30 days, which was not substantial evidence that the condition in fact *did change*. Nonetheless, referring to the attending physician's subsequent report (on which the carrier's "ceases" denial was based and which referred to the examining physician's anticipation that claimant's condition would persist for another 30 days), the court determined that the attending physician's opinion (which indicated that the "expected" improvement in fact occurred) could allow a reasonable factfinder to find that claimant's combined condition had changed between the effective date of its acceptance and denial.

## New/Omitted Medical Condition: "262(7)(a)" / "267" - Claimed Disc "Protrusion" - No "Diagnosis" Required, But Claimed Condition Must Exist

*DeBoard v. Fred Meyer*, 285 Or App 732 (May 24, 2017). Applying ORS 656.262(7)(a), and ORS 656.267, the court affirmed the Board's order in *Barbara J. DeBoard*, 66 Van Natta 978 (2014), that upheld a carrier's denial of claimant's new/omitted medical condition claim for thoracic disc "protrusions." In reaching its conclusion, the Board was persuaded by a physician's opinion that claimant had thoracic disc "bulges," which were not the equivalent to "protrusions" and, as such, the claimed "protrusions" conditions did not exist. On appeal, claimant contended that she established that she suffered from a

thoracic disc condition that was not part of her accepted thoracic strain and that she was not required to prove a specific name/diagnosis for that condition to prove a new/omitted medical condition claim.

*New condition must exist. Existence of symptoms not enough.*

The court disagreed with claimant's contention. Citing *Labor Ready v. Mogensen*, 275 Or App 491, 498 (2015), *rev den*, 360 Or 235 (2016), the court stated that, under ORS 656.262(7)(a) and ORS 656.267, a new/omitted medical condition claim requires a claimant to give notice of conditions for which compensation is sought, but "do not require notice of *diagnoses*." Again referring to *Mogensen*, the court reiterated that whether a condition is encompassed within the scope of a new/omitted medical condition claim is a question of fact. *Id.* at 497. Finally, relying on *DeLos-Santos v. Si Pac Enterprises, Inc.*, 278 Or App 254, 258, *rev den*, 360 Or 422 (2016), the court noted that, whatever the diagnosis, a claimant must prove that a claimed new/omitted medical condition exists and that proving the existence of new symptoms is not enough.

*Record established that disc "bulges" were beyond the scope of claim for "protrusions."*

Turning to the case at hand, the court stated that the Board's conclusion turned on its finding that claimant suffered from the condition of "disc bulges," which was a degenerative condition and not "equivalent" to the condition of "disc protrusions." Considering the Board's express finding that the referenced disc conditions were not "equivalent," the court rejected claimant's contention that that the Board had improperly focused on magic words or required her to prove a specific diagnosis for her disc pathology. *Cf. Freightliner Corp. v. Arnold*, 142 Or App 98, 105 (1996). Instead, the court understood the Board to have held as a factual matter that claimant had failed to prove the existence of the claimed new/omitted medical condition and that the disc "bulges" that existed were beyond the scope of claimant's new/omitted medical condition claim for disc "protrusions."

Reviewing for substantial evidence, the court observed that the Board had reasoned that the physician's opinion on which it had relied gave the most detailed explanation of claimant's spinal pathology and had discussed a more complete history of her symptoms. Consistent with the *DeLos-Santos* and *Mogensen* rationales, the court concluded that the Board could reasonably find that claimant had not proven the existence of the claimed "protrusions" condition. *See SAIF v. Williams*, 281 Or App 542, 543 (2016) ("substantial evidence" means that "the record, viewed as a whole, permits a reasonable person to find as the board did, in the light of supporting and contrary evidence").

**O.D.: All Causes Considered - Medical Evidence Established "Personal Factors" (Weight/Deconditioning) Were "Causes" (Not "Susceptibility/Predisposition")**

*Lowells v. SAIF*, 285 Or App 161 (May 3, 2017). The court affirmed the Board's order in *Doris L. Lowells*, 65 Van Natta 2032 (2013), that upheld an occupational disease denial for a chronic low back pain disorder. Referring to medical evidence that claimant's personal factors (e.g., her age, weight, and

*Claimant contended her personal factors were not causes, as a matter of law.*

*Whether a condition “actively contributes” is a medical question.*

*Physicians’ opinions supported Board’s finding that weight/deconditioning were causes of claimant’s symptoms.*

overall deconditioning) were the major contributors to her low back pain, the Board had concluded her work was not the major contributing cause of her chronic pain (assuming that her pain complaints constituted a “condition”). On appeal, claimant contended that her personal factors were susceptibilities or predispositions and, as such, as a matter of law, could not be *causes* of her back pain.

The court disagreed with claimant’s contention. *Citing Liberty Northwest Ins. Corp. v. Spurgeon*, 109 Or App 566, 569 (1991), *rev den*, 313 Or 210 (1992), the court reiterated that the major contributing cause of a disease must be determined by a weighing of all causes (as distinct from susceptibilities and predispositions). In doing so, the court stated that a worker’s personal factors are part of the equation, if, and only if, they are causes. *Id.*, *Multnomah County v. Obie*, 207 Or App 482, 486-88 (2006).

Relying on *Corkum v. Bi-Mart Corp.*, 271 Or App 411, 419 (2015), the court noted that “a condition merely renders a worker more susceptible to injury if the condition increases the likelihood that the affected body part will be injured by some other action or process but does not actively contribute to damage of the body part.” Finally, referring to *Portland Adventist Medical Center v. Buckallew*, 124 Or App 141, 144-45 (1993), the court observed that whether a condition only increases the likelihood of injury or disease, but does not actively contribute to the damage, is a medical question.

Turning to the case at hand, the court characterized claimant’s argument as a contention that, as a matter of law, her personal factors could not be considered contributing causes of her claimed condition. Nonetheless, the court determined that such an argument failed in light of its decisions in *Spurgeon* and *Obie*.

Alternatively, to the extent that claimant might also be asserting that the record did not support the Board’s finding of a causal link between her personal factors and her back pain, the court disagreed. Referring to the opinions of two physicians (who attributed the major contributing cause of claimant’s symptoms to her weight and deconditioning), the court reasoned that those opinions constituted medical evidence on which the Board could rely for its finding that claimant’s weight and deconditioning were causes, not just susceptibilities or predispositions, of claimant’s symptoms, and also supported the Board’s conclusion that factors other than claimant’s work were the major contributing cause of her symptoms.