Workers' Compensation Board

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News & Case Notes

BOARD NEWS

WCB Offices Reopening to the Public

Workers' Compensation Board Chair Constance L. Wold announced (*here*) on April 26, 2022, the Board's plans for a gradual and phased return to in-person hearings and mediations.

The plans include continuation of telephonic and videoconference events during the transition, physical changes to WCB facilities, and new hearing notices to specify when a hearing will be conducted by telephone or by videoconference. For more details, see Presiding ALJ Dougherty's announcement (*here*).

May 27 Rulemaking Hearing to Consider Change in Board's Email Address and Update "Ombuds" Name

The Workers' Compensation Board will hold a public hearing on Friday, May 27, 2022, at 10:00 a.m. by teleconference to receive comments on a proposed amendment of the mandatory language in the Notice of Claim Denial and Hearing Rights.

The proposed amendments update the Board's email address for filing requests for hearing and Board review and the "email request" address included in the mandatory language for notices of acceptance and denial. Additionally, the office of the Ombudsman for Injured Workers has changed its name to the Ombuds Office for Oregon Workers. In response, the Board proposes amending its permanent rules to replace references to the Ombudsman for Injured Workers with the Ombuds Office for Oregon Workers. These proposed amendments will also affect the mandatory language for notices of acceptance and denial, as well as the mandatory language for subpoenas for individually identifiable health information, Disputed Claim Settlements, and Claim Disposition Agreements.

Further information regarding the proposed amendments and the public hearing are found in the Statement of Need and Fiscal Impact found *here*, and the Notice of Proposed Rulemaking Hearing found *here*. Instructions on how to join the hearing via telephone are available *here*.

Managing Attorney: Recruitment

The Workers' Compensation Board will be recruiting candidates for the Managing Attorney position in the Board Review Division. This is an Executive Service position, which serves at the pleasure of the Board Chair. The position is located in Salem. The salary range is $8,009.00 - $12,389.00 per month. Applicants must be members in good standing of the Oregon State Bar or the

Bar of the highest court of record in any other state or currently admitted to practice before the federal courts in the District of Columbia. This position manages the Board Review Division, including its staff attorneys and administrative staff, as well as assists the Board Chair and Members, providing analysis and consultation regarding workers' compensation and administrative law issues. The Managing Attorney also coordinates the drafting of orders/memos by the legal staff, which are prepared in accordance with the Members' instructions concerning the disposition of appealed ALJ orders, procedural motions, petitions for third party relief, crime victim cases, court remands, petitions for Own Motion relief, requests for reconsideration of Board decisions, and the processing of proposed agreements submitted for Member approval. The deadline for applications is June 13, 2022. Further details about the position and information on how to apply will be available online *here* WCB is an equal opportunity employer.

Mediation Evaluation Project

The Workers' Compensation Board will begin conducting a mediation evaluation project from April 1, 2022, through June 30, 2022. WCB will be sending evaluations to attendees of all held mediations. The purpose of the project is to increase feedback to WCB from mediation participants about their mediation experience. Evaluations will be mailed out and will include a postage-paid return envelope for your convenience. We would appreciate your participation in providing us with feedback during the three-month project period.

CASE NOTES

Claim Preclusion: Prior Litigation on Occupational Disease Claim Did Not Preclude New/Omitted Medical Condition – *Drews* Cited

New/omitted conditions can be claimed at any time.

Heidi Larson, 74 Van Natta 284 (April 13, 2022). Applying *Drews v. EBI Cos.*, 310 Or 134 (1990) and *Donald J. Dugas II,* 71 Van Natta 512 (2019), the Board held that the claimant's new/omitted medical condition claim was not barred by the doctrine of claim preclusion because new/omitted medical condition claims can be initiated at any time. Prior litigation pertaining to the compensability of claimant's occupational disease claim for a shoulder condition did not preclude the new/omitted condition claim.

Turning to the merits, the Board concluded that the record persuasively established that the new/omitted medical condition claim was compensable under an occupational disease theory. In reaching that conclusion, the Board found a treating physician's opinion in support of compensability more persuasive than the contrary opinions of two examining physicians. Accordingly, the Board set aside the carrier's denial.

Extent: No Impairment Awarded – Medical Arbiter Panel Findings Not Attributed to the Accepted Conditions – *Caren* Distinguished – None of the

Impairment Caused in Material Part by the Accepted Conditions

Maryann M. Edmonds, 74 Van Natta 256 (April 6, 2022). Applying OAR 436-035-0006(1) and OAR 436-035-0007(1)(a) and (b) in rating claimant's permanent impairment for accepted right shoulder and bilateral knee conditions, the Board held that, although a medical arbiter panel found decreased ranges of motion (ROM) in those body parts, claimant was not entitled to a permanent disability award because the panel did not attribute any of the ROM loss, nor her permanent impairment as a whole, to the accepted conditions. OAR 436-035-0007(1)(b)(C); *Svetlana Artunyan*, 74 Van Natta 162 (2022); *Viorica Gramada*, 73 Van Natta 969 (2021).

Arbiter attributed all impairment to denied and preexisting conditions.

In reaching its conclusion, the Board distinguished *Caren v. Providence Health Sys. Or*., 365 Or 466 (2019), *Johnson v. SAIF*, 307 Or App 1 (2020), and *Robinette v. SAIF*, 307 Or App 11 (2020). Unlike in *Caren*, the medical arbiter panel did not attribute any impairment to claimant's accepted conditions (or direct medical sequelae of those conditions) or a "combined condition." Similarly, unlike in *Robinette*, claimant had not received an impairment value for a surgery, chronic condition, or for any other reason. The Board noted that, instead of indicating that any of the loss of use or function of claimant's right shoulder and bilateral knees was partly caused by the compensable injury, the arbiter panel attributed all of the loss of use or function of those body parts/systems to a denied right shoulder condition and preexisting bilateral knee conditions. Thus, the Board found that the record did not support a conclusion that any of claimant's permanent impairment was caused in material part by the compensable injury.

Jurisdiction: Claimant Had "Good Cause" for Untimely Appeal of Denial – Confusion and Difficulty in Contesting Denial – Unable to Read English Language – Difficulty Securing Counsel During COVID-19 Pandemic

Roberto C. Ruiz-Gongora, 74 Van Natta 324 (April 29, 2022). Analyzing ORS 656.319(1)(b), the Board held that the claimant established "good cause" for his untimely filing of a hearing request in response to the carrier's denial.

The claimant contended that a combination of factors, including his difficulty understanding his right to request a hearing, difficulty obtaining counsel, and disruption from the COVID-19 pandemic, established that he had "good cause" for the untimeliness of his hearing request. The Board agreed with the claimant's contentions.

Good cause is liberally construed to avoid depriving a party of a hearing on the merits.

Record viewed in the light most favorable to the claimant.

Citing *Goodwin v. NBC Universal Media-NBC Universal*, 298 Or App 475, 486 (2019) the Board noted that "good cause" should be liberally construed to avoid depriving a party of a hearing on the merits, and that the record should be viewed in the light most favorable to the party seeking relief. With that standard in mind, the Board concluded that claimant was significantly reliant on the

assistance of others in navigating the workers' compensation claims process.

The Board observed that the claimant had previous experience with an accepted claim, but that he was unable to read the English-language denial of his claim, and that he experienced confusion and difficulty in contesting the denial. Thus, the Board concluded that the claimant's difficulty in understanding how to contest the denial constituted "excusable neglect."

The Board also found that claimant's intention to secure legal representation was complicated by the onset of the COVID-19 pandemic. The claimant testified that he contacted several attorneys by phone, but he was unable to secure representation. Thus, viewing the record in the light most favorable to the claimant, the Board considered claimant's difficulties in securing counsel before requesting a hearing to be another instance of mistake and excusable neglect. Consequently, the Board reinstated the claimant's hearing request, and determined that the claim was compensable.

Member Curey dissented. She observed that the carrier's denial contained instructions for requesting a hearing, as well as a "Multilingual Help Page" that explained the importance of the denial. Additionally, Member Curey noted that the claimant spoke on the phone with the adjuster after receiving the denial, and the adjuster explained the process for requesting a hearing. Member Curey noted that the claimant's spouse read the instructions contained in the denial to him, and claimant was able to contact several attorneys by phone. Thus, she was not persuaded by claimant's arguments that he believed he needed legal representation to contest the denial, and that his delay in obtaining legal representation was not explained by the COVID-19 pandemic. Consequently, Member Curey would have dismissed the claimant's hearing request as untimely.

Medical Opinion: Physician Did Not Persuasively Address MRIs and CT Myelogram Showing Degenerative Disc Disease – *Dube* Distinguished

Cameron M. Ingersoll, 74 Van Natta 280 (April 13, 2022). Applying ORS 656.802(2)(a) and ORS 656.266(1), the Board held that the record did not persuasively establish that the claimant's occupational disease claim was compensable. In reaching that conclusion, the Board found an examining physician's opinion more persuasive than the opinion of a physician who evaluated the claimant at the claimant's request.

Examining physician opined that claimant had a degenerative disc bulge, not a herniation.

In addition, the Board distinguished *David A. Dube*, 62 Van Natta 2923 (2010). Unlike in *Dube* (where the physician supporting compensability sufficiently addressed a radiologist's contrary interpretation of an MRI), the evaluating physician in the instant case did not adequately address the examining physician's opinion that two MRIs and a CT myelogram showed a disc bulge caused by degenerative disc disease, not a herniated disc. Finally, the Board disagreed with the claimant's contention that the examining physician's opinion was internally inconsistent. Accordingly, the Board upheld the carrier's denial.

Penalties: Carrier Unreasonably Failed to Process Injury During IME as an "Initial Injury" Claim – *Robinson* Cited

Claimant had right hip injury during examination of earlier left hip claim.

Lindsey Medina, 74 Van Natta 266 (April 11, 2022). Applying ORS 656.262(11)(a) and *Robinson v. Nabisco*, *Inc.*, 331 Or 178 (2000), the Board held that the carrier was liable for penalties and attorney fees for its unreasonable processing of claimant's claim for a right hip injury that occurred during an independent medical examination (IME), which was arranged by the carrier to determine the compensability of claimant's earlier claim for a left hip injury.

After attending the IME, claimant informed the carrier that her right hip was injured during the examination, and she and her treating physician signed 827 forms describing the injury. Although the carrier denied claimant's right hip conditions as new/omitted medical conditions under her left hip injury claim, it did not deny claimant's right hip condition as an initial injury until more than one year later. After the right hip condition was found to be compensable as an initial injury, claimant argued that she was entitled to interim temporary disability compensation, and sought penalties and attorney fees for the carrier's allegedly unreasonable denial and failure to pay interim compensation.

Signed 827 forms constitute a claim to be processed.

Citing ORS 656.262(6)(a), the Board stated that a carrier must furnish written notice of acceptance or denial of a claim within 60 days after the employer has knowledge of the claim. Referring to OAR 436-060-0010(1)(b), the Board explained that, for initial claims, a signed 827 form and a physician's report can constitute a "claim" when received by the carrier and shall start the claim process. *Dan M. Morgan*, 68 Van Natta 1196 (2016). Relying on *Robinson*, the Board noted that when a claimant sustains a work-related injury and, during a carrier-arranged IME conducted to evaluate that injury, suffers a second injury, the compensability of the second injury is analyzed as an initial injury that independently "arose out of" and occurred "in the course of" employment, and not a "consequential condition."

Case precedent requires carrier to process IME-related injury as a separate initial injury.

Turning to the case at hand, the Board acknowledged that the carrier had received signed 827 forms, chart notes, and emails that referred to claimant's right hip conditions as a part of her left hip injury claim. Considering the well-established case precedent that compensability of an IME-related injury is analyzed as an initial claim (and not a new or omitted "consequential condition" claim), the Board found that the carrier had no legitimate doubt as to its obligation to issue a written acceptance or denial of claimant's right hip condition as a separate initial injury claim related to the carrier-arranged IME. *Robinson*, 331 Or at 187; *see McAleny v. SAIF*, 191 Or App 105 (2003); *see also Getz v. Wonder Bur*, 183 Or App 494 (2002); *Sheryl L. Lane*, 62 Van Natta 2014, *recons*, 62 Van Natta 2621 (2010). Thus, the Board assessed a penalty and penalty-related attorney fee for the carrier's unreasonable and untimely denial. ORS 656.262(11)(a).

Own Motion: Impairment Rating for "Post-Aggravation Rights" New/Omitted Condition – PPD "Redetermined" Without Apportionment – *Johnson* Cited – Total Unscheduled PPD Exceeds 100 Percent – Precludes Additional Award

Jack L. Edwards, 74 Van Natta 307 (April 26, 2022). Applying ORS 656.278(2)(d), the Board concluded that claimant was not entitled an additional unscheduled permanent partial disability (PPD) award for his "post-aggravation rights" new/omitted medical condition (L3-4 disc protrusion with right L4 nerve root impingement and lateral recess stenosis). In reaching this conclusion, the Board redetermined claimant's unscheduled PPD for his low back condition.

Impairment due in material part to the compensable injury and no combined condition denial.

Although the Board acknowledged that the medical arbiter panel's impairment findings on which the parties relied had been apportioned, the Board declined to apportion the PPD award because the impairment was due in material part to the compensable injury and there was no "combined condition" denial. *See Johnson v. SAIF*, 369 Or 577, 601 (2022); *Caren v. Providence Heath Sys. Or.*, 365 Or 466, 487 (2019); *Robinette v. SAIF*, 307 Or App 11 (2020), *review allowed*, 367 Or 559 (2021).

After combining claimant's prior unscheduled right hip impairment with his redetermined unscheduled low back impairment, as well as adding the "social-vocational" factors to that value, the Board found that claimant had a total unscheduled PPD award of 111 percent for the low back and right hip. Nevertheless, the statutory maximum for an unscheduled permanent disability award is 100 percent. ORS 656.214(5); OAR 436-035-0011(1). Because claimant had previously been awarded 102 percent unscheduled PPD (as a result of the prior closure's lack of "combining" the unscheduled PPD of the right hip and low back), the Board concluded that the limitation precluded an award of additional unscheduled disability benefits. *See* ORS 656.278(2)(d); *Cory L. Nielsen*, 55 Van Natta 3199, 3208 (2003).

Despite surgery, no time loss authorization from attending physician.

In addition, applying ORS 656.278(1)(b), the Board determined that claimant was not entitled to additional temporary disability benefits. Specifically, the Board found that, despite undergoing low back surgery, claimant did not have an authorization from his attending physician "for the hospitalization, surgery, or other curative treatment."

Third Party: Distribution in Accordance With Statute "Just and Proper" – Carrier Does Not Meet Burden to Prove Future Expenditures - Asserted Future Expenditures Not Reduced to Present Value

Ryan J. Yancey, DCD, 74 Van Natta 303 (April 25, 2022). Applying ORS 656.593(1), the Board held that a distribution of proceeds from a third party settlement in accordance with ORS 656.593(1) was "just and proper." In reaching that conclusion, the Board found that the carrier was entitled to

recover its actual claim costs as of the date of the third party settlement. *See Edgar M. Woodbury*, II, 61 Van Natta 216, 219 (2009).

Actual costs determined as of the date of the third party recovery.

However, the Board also held that the carrier had not met its burden to establish the present value of reasonably expected future expenditures. Although the carrier asserted claims costs after the settlement constituted "actual" costs, the Board noted that "actual" costs are determined as of the date of the third party recovery.

Furthermore, the Board stated that the record lacked any evidence that asserted future cost expenditures were reduced to actuarial present value (*i.e.*, the amount of money which, if invested now at available interest rates, would yield the total amount of money required for future expenditures). ORS 656.593(1)(c).

APPELLATE DECISIONS
COURT OF APPEALS

Appellate Review: Substantial Evidence/Reason - Board Order Discounted Treating Physician's Opinion – Lacked Substantial Reasoning

Sullivan v. SAIF, 319 Or App 14 (April 13, 2022). Reviewing for substantial evidence/reasoning under ORS 656.298(7), and ORS 183.482(8)(c), the court reversed the Board's order in *Robert J. Culley, DCD*, 72 Van Natta 721 (2020), which in upholding a carrier's new/omitted medical condition denial of the deceased worker's L5-S1 radiculopathy found that the treating physician's opinion was unpersuasive because it was based on an incomplete/inaccurate medical history and had not sufficiently responded to a contrary opinion from an examining physician. On appeal, claimant argued, among other contentions that the Board's reasoning was based on a misreading of the medical record.

The court agreed with claimant's contentions. Citing *Dillon v. Whirlpool Corp.*, 172 Or App 484, 489 (2001), and *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206 (1988), the court reiterated that to be supported by substantial evidence, the Board's order must indicate what findings it makes *and how* those findings led to its ultimate conclusion; *i.e.*, the Board's order must be supported by substantial reason. Relying on *Minor v. SAIF*, 290 Or App 537, 545 (2018), the court emphasized that, to satisfy that requirement, the Board's order must "provide a rational explanation of how its factual findings led to the legal conclusions on which its order was based. Referring to *Guild v. SAIF*, 291 Or App 793, 796 (2018), the court clarified that, although it does not "reweigh the evidence or substitute its judgment for that of the Board as to any issue of fact supported by substantial evidence," if the Board makes a finding and conclusion based on one doctor's opinion, the finding/conclusion must be based on an analysis of the entirety of the information provided by that doctor and, if it is not, the Board's order lacks substantial evidence and substantial reason.

Board must explain how factual findings led to the legal conclusions.

Turning to the case at hand, the court determined that: (1) the record required a finding that the attending physician's opinion was based on accurate information that the worker had complained of foot pain to an examining physician two weeks after his work injury and, as such, the attending physician's

Record required a finding that the attending physician was aware of claimant's history.

opinion was not based on inaccurate information as the Board had found; (2) the record required a finding that the attending physician had for his review all of the worker's medical records and was aware of his history and, thus, the Board had erred in determining that the attending physician's opinion was based on an incomplete record as the Board had found; and (3) contrary to the Board's finding, the attending physician had adequately explained his reasoning that, despite the absence of back symptoms immediately following the worker's injury, his symptoms and diagnostic testing were indicative of L5-S1 radiculopathy.

Under such circumstances, the court concluded that the evidence did not support the Board's several rationales for discounting the attending physician's opinion. Because the Board's findings (including its rejection of the attending physician's opinion) were not supported by substantial evidence or substantial reason, the court remanded to the Board for reconsideration under the correct standard relating to consideration of the attending physician's opinion.

APPELLATE DECISIONS
SUPREME COURT

Extent: Permanent Impairment – Due In "Material Part" to Compensable Injury & Denied Condition (No "Combined Condition") – Claimant Entitled to "Full Measure" of Impairment (W/O Apportionment) – *Barrett* Rationale Remains, Except for "Combined Condition" Statutory Process under "268(1)(b)"

Johnson v. SAIF, 369 Or 577 (April 21, 2022). Analyzing ORS 656.214, the Supreme Court affirmed the Court of Appeals' opinion, 307 Or App 1 (2020), which had reversed the Board's order in *Marisela Johnson*, 67 Van Natta 1458, *recons*, 67 Van Natta 1666 (2015), which had affirmed an Order on Reconsideration's apportionment of claimant's permanent impairment for lost grip strength between her accepted left hand condition and her denied shoulder condition. Relying on *Caren v. Providence Health System Oregon*, 356 Or 466, 468 (2019), the Court of Appeals reasoned that, because claimant's impairment was not the result of a "combined condition" and because her impairment was due in material part to her compensable injury, she was entitled to the full measure of her impairment, without regard to the carrier's denial of her shoulder condition. On review, asserting that the statutory scheme supports the proposition that permanent disability benefits are not intended to flow from specifically denied conditions, the carrier argued that claimant was not entitled to an award for impairment attributable to her shoulder condition because she had never established that the denied condition was compensable.

Carrier contended that permanent disability benefits should not flow from specifically denied conditions.

The Supreme Court disagreed with the carrier's contention. Confronted with an issue of statutory construction (*i.e.*, the meaning of the word "impairment" under ORS 656.214(1)(a)), the court reviewed the text and context of the statutory scheme, as well as its prior case law addressing the term (*Barrett v. D & H Drywall*, 300 Or 325 (1985), *adh'd to on recons*, 300 Or 553 (1986); *Schleiss v. SAIF*, 354 Or 637 (2013); and *Caren*). After conducting that review, the Court summarized the *Barrett* holding as a determination that the claimant's

permanent partial disability was the full amount of his new impairment, without reduction for the portion of that loss attributable to his preexisting condition.

Notwithstanding its *Barrett* rationale, the Supreme Court acknowledged that, in its *Schleiss* decision, it had recognized that, subsequent to *Barrett*, the legislature had significantly revised the statutory scheme to address a "combined condition" (*i.e.*, an otherwise compensable injury combined with a preexisting condition). After examining its reasoning concerning the "combined condition" framework, the Court believed that its holding in *Schleiss* reflected the principle that, even after the legislature's creation of the "combined condition" framework, apportionment of a worker's impairment was only appropriate in claims that fell under the ambit of the "combined condition" process; *i.e.*, when an otherwise compensable condition combines with a legally cognizable preexisting condition. Stated another way, the Supreme Court understood *Schleiss* as confirming (consistent with *Barrett*) that when no legally cognizable preexisting condition exists, the general rule remains that, when an accepted, compensable injury is a *material contributing cause* of the claimant's impairment, the claimant is entitled to the full measure of compensation for that impairment, not just the percentage of impairment caused solely by the compensable injury.

Apportionment only available under the ambit of the combined condition process.

Turning to its *Caren* decision, the Court understood that the legislative amendments creating the "combined condition" process in ORS 656.268(1)(b) were intended to limit a carrier's liability for preexisting conditions, but only where the carrier follows the specific process laid out in the statute for reducing a worker's permanent partial disability award. In short, the Supreme Court reiterated that the legislature intended apportionment in "combined condition" claims to be a limited exception to the general rule that a worker is entitled to compensation for the full measure of the worker's impairment where the impairment is caused in material part by the compensable injury.

Applying its insights from the *Barrett*, *Schleiss*, and *Caren* decisions, the Supreme Court identified two primary propositions. First, the Court explained that *Barrett* and *Schleiss* stand for the basic, underlying rule that, when an accepted, compensable injury is a material contributing cause of the claimant's impairment, the claimant is entitled to a full measure of compensation for that impairment. Second, consistent with *Caren*, the Court emphasized that apportionment of impairment may only be used by a carrier to reduce benefits for impairment where the legislature has identified an exception to, or limitation on, the material contributing cause standard; *e.g.*, when the impairment is caused by a legally cognizable preexisting condition that the carrier formally denied as a "combined condition" prior to claim closure.

Court addressed two questions left unanswered by previous decisions.

Finally, the Supreme Court acknowledged two questions raised by the present case that had been left unanswered by its previous decisions: (1) whether the full measure of impairment is calculated as the percentage of the impairment that is directly caused by the compensable injury or as a whole; and (2) whether there is a limited exception to the general rule that allows for apportionment when there is a specific, previously denied condition.

Concerning the first question, the Court noted that, in *Barrett*, it had acknowledged the longstanding guideline that an employer takes the worker as he finds him. Although recognizing that the legislature had significantly overhauled the workers' compensation statutes following its *Barrett* decision,

If the accepted condition is a material cause, the full value of impairment would be due.

the Supreme Court did not understand those changes to have altered the aforementioned tenet. Rather, the Court believed that those statutory changes identified circumstances in which a carrier's liability for impairment can be limited because of a legally cognizable preexisting condition that combined with a compensable condition. In the absence of those circumstances, the Court reasoned that an injured worker is entitled to compensation for the full measure of their impairment that is caused in material part by the compensable injury.

Regarding the second question, the Supreme Court agreed with the carrier's contention that benefits are not intended to flow directly from denied conditions. *See* ORS 656.262(2). Nonetheless, unlike the "combined condition" process, the Court did not read that statute, nor any other statute, to create another limited exception that authorized apportionment of impairment even when the accepted compensable condition is a material contributing cause of the impairment.

If a denied condition is the sole cause of impairment, or if the accepted condition is not even a material cause, no compensation for impairment is due.

If a denied condition is the *sole* cause of a claimant's impairment, or if the accepted condition is not even a material cause of the impairment, the Supreme Court clarified that a denied condition would operate to cut off compensation. However, if the material contributing cause standard is met as to the accepted condition, the Court stressed that the full value of impairment would be due.

Applying its reasoning to the case at hand, the Supreme Court concluded that because claimant's overall loss of grip strength was caused in material part by her accepted, compensable injury, she was entitled to the full measure of impairment for her lost grip strength and her permanent disability award should not have been reduced due to apportionment.