M E M O R A N D U M

July 14, 2025

To: Bob Livingston, Governor's Office; Kelly Brooks, Governor's Office; Sarah Foster, Governor's Office; and Members of the Management Labor Advisory Committee

From: Joy Dougherty, Workers' Compensation Board Chair

Subject: WCB Update

SIGNIFICANT/NOTEWORTHY CASES
(APRIL 2025 – JUNE 2025)

Court of Appeals

Barnes v. Cache Valley Elec. (April 2, 2025). Reviewing the Board's order for substantial evidence and errors of law, the Court of Appeals affirmed the Board's order in *Brian Barnes*, 75 Van Natta 282 (2023), that upheld the carrier's denial of the claimant's cervical spondylosis (a preexisting arthritic condition), upheld a "ceases" denial, and declined to award attorney fees.

The court disagreed with the claimant that, because the cervical sprain/strain injury made his preexisting spondylosis symptomatic and that those symptoms required treatment, the spondylosis was compensable, independent of its status as the preexisting component of the accepted combined condition. The court explained that the spondylosis could only be independently compensable if the work injury was the major contributing cause of its pathological worsening. ORS 656.225; *Schleiss v. SAIF*, 354 Or 637, 644 n 2 (2013). The court cited a lack of medical evidence that the workplace injury caused or was the major contributing cause of the preexisting spondylosis.

The claimant also alleged that the medical experts incorrectly compared the work accident, rather than the otherwise compensable cervical strain/sprain, and the preexisting spondylosis. As such, the claimant argued that it was legally insufficient for the Board to rely on their opinions when upholding the "ceases" denial. The court disagreed, stating

that a reasonable reading of the medical evidence established that the accepted cervical strain/sprain ceased to be the major contributing cause of the claimant's need for treatment.

Finally, the court agreed with the Board that an attorney fee under ORS 656.386(1) was not due, concluding that the carrier's acceptance of the spondylosis as the preexisting component of the combined condition was not an outright acceptance of that condition (but rather limited to the combined condition) and did not constitute a rescission of its denial of the same condition. *See Multifoods Specialty Distribution v. McAtee*, 164 Or App 654 (1999), *aff'd*, 333 Or 629 (2002). The court, therefore, affirmed the Board's order.

Geoghegan v. SAIF (April 16, 2025). In a nonprecedential memorandum opinion under ORAP 10.30, the court affirmed a Board order that upheld the carrier's denial of the claimant's new or omitted medical condition claim for a compression fracture. On appeal, the claimant argued that the Board erred in concluding that equitable estoppel did not apply. The court explained that, in order to establish equitable estoppel, the claimant was required to prove that the employer representative accepted his claim "with knowledge of the facts," among other requirements. *Brockway v. Allstate Property and Casualty Ins. Co.*, 284 Or App 83, 90 (2017). However, in reviewing the record, the court determined that there was insufficient evidence that the employer representative had such knowledge and, therefore, equitable estoppel did not apply.

Hibbs v. Sedgwick CMS (May 14, 2025). The court affirmed a Board order that transferred the claimant's penalty request under ORS 656.262(11)(a) to the director. The court analyzed the director's authority to impose penalties for a medical services dispute when the parties had a separate, unrelated matter pending before the Board's Hearings Division.

Citing ORS 656.704(3) and *Mantle v. SAIF*, 330 Or App 8 (2024), the court reiterated that the underlying medical services dispute was not a "matter concerning a claim" and, therefore, appropriately before the director. Applying *Icenhower v. SAIF*, 180 Or App 297 (2002), the court concluded that jurisdiction of the ORS 656.262(11)(a) penalty request lay with the director where, at the outset, jurisdiction over the medical services dispute properly lay with the director and the subsequent narrowing of issues did not relieve the director of jurisdiction once established. The court explained that this result was consistent with the legislative history of ORS 656.262(11)(a), as reviewed in *Icenhower*, which reflect a legislative intent to prevent the hearings process from becoming "clogged up with 'penalty only' issues."

Accordingly, the court affirmed the Board's order that the jurisdiction of a penalty request under ORS 656.262(11)(a) properly lay with the originating jurisdiction in the underlying matter.

Hibbs v. Sedgwick CMS (May 14, 2025). The court affirmed a Board order that transferred the claimant's hearing request to the director regarding an allegedly improperly requested independent medical examination by the carrier under ORS 656.325(1)(a) and related penalties and attorney fees. Analyzing ORS 656.325(6), the court determined whether disputes arising under ORS 656.325 that do not involve "matters concerning a claim" are under the authority of the director or the Board. Applying the principles of statutory construction, the court concluded that the text and context of ORS 656.325(6) directs "matters concerning a claim" to the Board and "matters not concerning a claim" to the director, as dictated by ORS 656.283(1) and ORS 656.704.

Because the dispute did not involve a matter concerning a claim, the court affirmed the Board's order.

Workers' Compensation Board

Laura Ayala (April 21, 2025). Citing ORS 656.005(12)(b) and ORS 656.262(4)(g), the Board held that the claimant was entitled to additional temporary disability benefits based on its determination that a physician who treated the claimant's compensable injury was the attending physician and authorized temporary disability benefits for that period. In reaching that conclusion, the Board found that issue preclusion did not apply to the attending physician/temporary disability issue. Referencing *Kiltow v. SAIF*, 271 Or App 471 (2015), the Board explained that, although a prior Order on Reconsideration had found that a different physician was the claimant's attending physician for a certain period, the issue preclusion doctrine did not apply to the reconsideration order because the order had rescinded the closure notice as premature and, thus, did not bar another action or proceeding on the same transactional claim.

Finally, the Board concluded that, although the claimant was entitled to additional temporary disability benefits, the carrier had a legitimate doubt as to its obligation to pay those benefits because the record included evidence of a different physician treating the claimant's compensable injury. Therefore, the Board found that the carrier's actions were not unreasonable and declined to award penalties.

Hipolito Coria (June 30, 2025). On remand from the Oregon Supreme Court, the Board held that a penalty and attorney fee were warranted under ORS 656.262(11)(a) for the carrier's unreasonable cessation of the claimant's temporary disability (TTD) benefits.

The Board explained that the claimant had the burden to prove that he is entitled to a penalty under ORS 656.262(11)(a). The Board stated that the carrier's decision to unilaterally terminate the claimant's TTD benefits for violation of a work rule or other disciplinary reasons was unreasonable because the only basis for its assertion at the time was its own letter notifying the claimant that the employer had informed it that his employment had been terminated for violation of a work rule or other disciplinary reason. Therefore, the Board concluded that the carrier did not have a legitimate doubt regarding its obligation to pay benefits and that the claimant met his burden of proof under ORS 656.262(11)(a).

The Board awarded an attorney fee under ORS 656.382(3) for services regarding the penalty issue at the Court of Appeals because the carrier raised the claimant's entitlement to a penalty at that level. However, because the carrier did not raise the penalty issue before the Supreme Court or on remand, the claimant's attorney was not entitled to an attorney fee under ORS 656.382(3) at those levels, but instead, under ORS 656.262(11)(a).

Member Ousey specially concurred, stating that he did not believe that the claimant also has the burden to establish that the carrier did not have a legitimate doubt as to its liability in unreasonably refusing to pay compensation. He stated that "legitimate doubt" does not appear in ORS 656.262(11)(a), and there are no cases in which it was the worker's burden to prove that the insurer lacked legitimate doubt. He stated that it was the claimant's burden to prove that the carrier unreasonably delayed or unreasonably refused to pay compensation, but not to prove the absence of legitimate doubt.

Cheri L. Goss (April 9, 2025). Analyzing ORS 656.325(1)(e), the Board reversed an Administrative Law Judge's (ALJ) order that denied a worker-requested medical exam (WRME). The Board determined that whether the claimant's hearing request on a medical services denial constitutes a hearing request on "a denial of compensability as required by ORS 656.319(1)(a)" entitling the claimant to a WRME, was a matter of statutory construction of ORS 656.325(1)(e).

First, the Board explained that ORS 656.319(1)(a) described a timely request for hearing as an "objection by a claimant to [a] denial of a claim for compensation under ORS 656.262" that was filed within 60 days of the denial. It noted that ORS 656.262(9)

stated that the carrier must provide written notice of the denial if it "denies a claim for compensation." Moreover, the Board indicated that ORS 656.005(6) defines a "claim" as 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," and that ORS 656.005(8) provides the definition of compensation, which includes "medical services."

Applying this information, the Board concluded that, for purposes of ORS 656.325(1)(e), "a denial of compensability" included denials of medical services. Under such circumstances, the Board determined that the claimant was entitled to a WRME based on the medical services denial.

A dissenting opinion agreed with the ALJ that there is no entitlement to a WRME for medical services disputes because ORS 656.325(1)(e) makes no reference to ORS 656.245(1)(a), the statute governing medical services claims. Moreover, the dissent disagreed with the majority that "compensability" and "compensation" are synonymous. Reasoning that claimant's request for administrative review of the disapproval of the proposed surgery was not a denial of compensability, the dissent would have found that the WRME eligibility criteria were not met.

Rodolofo Martinez (April 16, 2025). Citing ORS 656.265(5), *John Murray*, 70 Van Natta 667 (2018), and *Jackie S. Jacobson*, 63 Van Natta 865 (2011), the Board determined that it was unnecessary to address whether the claimant provided timely notice of his work injury because the issue was not jurisdictional and the record did not establish compensability. In reaching its compensability determination, the Board noted that the only physician who offered a causation opinion opined that the conditions and treatment were unrelated to the work event. *See* ORS 656.005(7)(a); ORS 656.266(1).

Kristian A. McLain (May 23, 2025). Analyzing OAR 436-060-0030(1)(b), the Board held that the claimant was not entitled to additional temporary disability benefits because the record did not establish that the employer incorrectly calculated his temporary partial disability (TPD) rate at zero. The Board explained that the record did not establish that the claimant's post-injury wages as the sole proprietor of his own business were less than his wages with the employer at the time of injury. *See* ORS 656.212 (TPD payments are based on "that proportion of the payments provided for [TTD] which the loss of wages bears to the wage used to calculate [TTD]").

In reaching that conclusion, the Board distinguished *Mir Iliaifar*, 57 Van Natta 1915 (2005), *aff'd* 217 Or App 104 (2007), in which the worker's post-injury wages as an independent contractor working for someone else's company did not include expenses

paid to the company for the use of the company's vehicles. The Board explained that, unlike in *Iliaifar*, the claimant owned his own company, was the sole proprietor, and made payments for vehicles that he owned. Accordingly, the Board concluded that the claimant's gross business income was "actual wages earned" under OAR 436-060-0030(1)(b).

David B. Miller (June 30, 2025). Applying ORS 656.265(1) and ORS 656.310(1)(a), the Board found that the claimant gave timely notice of a work injury and that the claim was timely filed. The Board deferred to the ALJ's demeanor-based credibility finding in determining that, despite the employer not recollecting or having a record of the injury, the claimant persuasively testified that he had immediately notified the employer of his right shoulder injury. Citing ORS 656.310(1)(a), the Board was not persuaded that the employer had overcome the presumption that the claimant provided timely notice of the work injury.

Turning to compensability, the Board relied on the only physician opinion in the record, which supported that the work event was a material contributing cause of the claimant's disability or need for treatment. As there was no persuasive medical evidence contradicting the physician's opinion, the Board determined that the injury claim was compensable.

Member Ogawa dissented. She disagreed that timely "claim filing" was at issue because the claimant filed his claim within one year of the date of injury. Because the claim was filed timely, ORS 656.265(4) and ORS 656.310(1)(a), in turn, would not apply. She stated that, instead, timely notice of the injury was at issue. Because she found that the claimant's testimony was inconsistent with the record, she would have concluded that the claimant did not provide timely notice of the work event. Additionally, she would have found that the claimant's testimony regarding the work event was not supported by the record and that the physician's opinion was insufficient to support compensability.

Amelia Negrini (June 11, 2025). The Board held that: (1) the claimant's new or omitted medical condition claim for right wrist osteoarthritis was not de facto denied; (2) the claimant was not entitled to a penalty or related attorney fee; and (3) the claimant was not entitled to interim temporary disability benefits.

Analyzing the carrier's claim processing obligation under ORS 656.262(6)(a), the Board found that the carrier had complied with its statutory obligation to accept or deny the claim within 60 days when it accepted the claimed right wrist osteoarthritis as the preexisting component of a combined condition. The Board acknowledged that the combined condition acceptance was not an outright acceptance of the claimed condition.

Nevertheless, the fact remained that the carrier had processed the claimed condition when it accepted a combined condition. *See Juan A. Arenas-Raya*, 65 Van Natta 1639 (2013). The Board noted that its conclusion was further supported by ORS 656.267(1), which did not require the carrier to accept each and every medical condition with particularity, as long as the acceptance reasonably apprised the claimant and the medical providers of the nature of the compensable conditions. In this case, the claimant's claimed condition was accepted as the preexisting component of a compensable combined condition and, as a result, rendered medical services for that condition compensable until the carrier issued a combined condition denial.

Moreover, the Board reiterated that, regardless of how a condition is claimed, it was the Board's obligation to determine the appropriate legal standard. *Dibrito v. SAIF*, 319 Or 344, 348 (1994). Here, the carrier's obligation to process the request as a combined condition was supported by ORS 656.005(7)(a)(B) because the parties did not contest that the claim was for a statutory preexisting condition and the persuasive medical evidence established the existence of a combined condition. Finally, citing to *Barnes v. Cache Valley Elec.*, 339 Or App 371(2025), the Board noted that the court's discussion regarding the appropriate legal standards for legally cognizable preexisting conditions – whether independently compensable under ORS 656.225 or as a combined condition – was instructive. Under such circumstances, the Board concluded that the carrier properly processed the claim as a combined condition and that it was not de facto denied. Therefore, the Board declined to award a penalty and related attorney fee.

Finally, citing ORS 656.262(2), (4), and *Stanley Smith Sec. v. Pace*, 118 Or App 602 (1993), the Board found that, because the carrier properly processed and accepted the claim within 14 days, the claimant was not entitled to interim temporary disability benefits.

Member Ousey dissented. He disagreed with the majority's reliance on *Arenas-Raya*, finding it distinguishable because, in this case, the claimant made a specific request that the right wrist osteoarthritis be processed as an independently compensable condition. He would have applied *Crawford v. SAIF*, 241 Or App 470 (2011), and *Rose v. SAIF*, 200 Or App 654 (2005), finding that the carrier did not process the claim as requested and that their actions were unreasonable. Thereafter, analyzing the compensability of an independent claim for right wrist osteoarthritis claim, he would find that the claimant established compensability of the previously asymptomatic right wrist osteoarthritis, award a penalty and related attorney fee, and interim temporary disability benefits.