M E M O R A N D U M

October 14, 2025

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

From: Joy Dougherty, Workers' Compensation Board Chair

Subject: WCB Update

SIGNIFICANT/NOTEWORTHY CASES
(JULY 2025 – SEPTEMBER 2025)

Supreme Court

Teitelman v. SAIF (September 25, 2025). Analyzing ORS 656.325(1)(e) and OAR 436-060-0147 regarding a claimant's entitlement to a worker requested medical examination (WRME), the Supreme Court held that a carrier's denial may be "based on" an independent medical examination (IME) in cases where the IME occurs after the denial. The Workers' Compensation Division (WCD) and the Board on review, had determined that the carrier's denial could not be "based on" a post-denial IME under the statute because the IME had not taken place until after the carrier's issuance of the denial. The Court of Appeals in *Teitelman v. SAIF*, 332 Or App 72, had reversed WCD's and the Board's decisions.

The Supreme Court affirmed the Court of Appeals' decision, reversing WCD's and the Board's decisions, and remanded the case to the Board. Applying statutory interpretation principles to ORS 656.325(1)(e), the court determined that one must look at the grounds for the denial at the time the WRME request was decided, not when the hearing request was filed or when the compensability denial issued. The court explained that the statutory language "is based on" utilizes the present tense and, contrary to the carrier's position, could plausibly be understood to mean that the denial "is based on" an IME report whenever the carrier uses an IME report to defend its continued denial of compensability until the claim is resolved, not just when the carrier mails notice of its

decision. Reasoning that the carrier intended to rely on the IME report to defend its continued denial at the upcoming hearing, the court concluded that the claimant was entitled to a WRME, even though the IME was conducted after the initial denial notice.

In reaching this conclusion, the court explained that a carrier's "denial of compensability" is not just the initial written notice, but continued throughout the claim process. Moreover, it noted that the legislative history showed that ORS 656.325(1)(e) was intended to address perceived bias in the IME process by allowing workers to get a "second opinion" when a claim is "in litigation." Under such circumstances, the court found that limiting a worker's right to a WRME based solely on the timing of the insurer's IME request would be inconsistent with the policies of providing "a fair and just administrative system" and interpreting the Workers' Compensation Law "in an impartial and balanced manner."

Two justices dissented. Justice Garrett, joined by Justice DeHoog, reasoned that, in his view, the legislature intended the word "denial" in ORS 656.325(1)(e) to mean the decision to deny the claim, with the corresponding notice to the claimant stating the basis for that decision, rather than the status of that denial over time.

Court of Appeals

Employer Solutions Staffing Group, LLC v. SAIF (September 4, 2025). Reviewing *Jared R. Zeigler, DCD*, 75 Van Natta 275 (2023), for legal error and substantial evidence, the Court of Appeals affirmed the Board's order that assigned responsibility to Employer Solutions Staffing Group (ESSG), a national staffing agency, and not a staffing recruiting agent (Atlas) or the worksite client (BRF), in a deceased worker's claim and awarded an attorney fee under ORS 656.307(5).

First, ESSG argued that, because BRF asserted in an Employment Liability Law (ELL) action that it was the decedent's sole employer, it should be judicially estopped from denying responsibility in the present case and that the Board erred in declining to apply judicial estoppel. The court disagreed. Because there was no evidence in the record that a judicial tribunal made a final determination regarding the identity of the decedent's employer, the court agreed with the Board that BRF was not judicially estopped from asserting the position that it did in the workers' compensation proceeding. To the extent that ESSG contended that a settlement necessarily constituted a final determination because it is a benefit obtained through assertion of BRF's position, the court found that ESSG did not make that argument before the Board, and, accordingly, the court declined to address it.

The court also affirmed the Board's finding that ESSG had an implied-in-fact contract with BRF. In doing so, the court looked to the conduct of the parties, including that ESSG had accepted service fees and paid decedent's wages with knowledge that the decedent was working on a project of BRF. Moreover, through ESSG's agreement with Atlas, Atlas's knowledge that the claimant was working for BRF was imputed to ESSG. The court also found that there was no employer-employee relationship between the decedent and BRF because ESSG paid the decedent's wages and decedent submitted his IRS W-4 form to ESSG. Ultimately, the court determined that the Board's conclusion that ESSG was the responsible employer was supported by substantial evidence and reason.

Finally, the court found that the claimant's attorney was entitled to an attorney fee under ORS 656.307(5) for "actively and meaningfully" participating in the responsibility litigation. The director had issued a "307" order under ORS 656.307 designating ESSG's workers' compensation carrier as the paying agent. The claimant's attorney had taken a clear position that ESSG or Atlas was the responsible employer, took the case to hearing, responded to procedural matters and motions, and participated in the hearing. Therefore, the court affirmed the Board's attorney fee determination.

Marholin v. SAIF (August 27, 2025). In a nonprecedential memorandum opinion, the Court of Appeals affirmed a Board order that determined that the claimant was not eligible for an impairment award for his shoulder condition. The court found that the Board correctly applied OAR 436-035-0007(11) and that its interpretation of the medical arbiter's report was supported by substantial evidence. The court found that neither the arbiter panel nor the claimant's attending physician supported an award of permanent impairment. Additionally, the court reaffirmed that the claimant is not owed permanent partial disability based on findings of loss unrelated to the accepted condition. *See Robinette v. SAIF*, 369 Or 767 (2022).

Reed v. Helmsman Management Services, Inc. (July 2, 2025). In a nonprecedential memorandum opinion, the Court of Appeals affirmed the Board's order in *Robert Reed, Sr.*, 75 Van Natta 193 (2023) that found that the claimant's occupational disease claim for a right wrist condition was not compensable. Reviewing the Board's order for substantial evidence and errors of law, the court agreed with the Board that an IME physician's opinion constituted substantial evidence to support that the claimant's work conditions did not contribute to the claimed right wrist condition. Finally, the court held that the Board did not commit legal error in concluding that the last injurious exposure rule (LIER) did not apply because substantial evidence supported the Board's finding that the claimant had not met his burden to prove that employment conditions at more than one employment was the major contributing cause of his wrist condition.

Workers' Compensation Board

Andrew Burke (September 23, 2025). The Board affirmed an administrative law judge's (ALJ) order, which found that the claimant established good cause for his untimely filed hearing request and set aside the employer's denial. On review, the employer contended that the Board lacked jurisdiction because the hearing request that was filed by the claimant's former attorney was invalid. Analyzing ORS 656.283(2) and *Havi Group LP v. Fyock*, 204 Or App 558 (2006), the Board found that, although the attorney-client relationship ended before the claimant's former attorney filed the hearing request, it was signed in the interest of, for the benefit of, and on behalf of the claimant.

Finding the request for hearing valid, the Board distinguished *Sekermestrovich v. SAIF*, 280 Or App 723, 727 (1977), to conclude that the claimant had good cause for his untimely filed hearing request. Unlike in *Sekermestrovich*, the claimant's former attorney did not represent him at the time of filing and was not acting within the scope of authority as the claimant's attorney. Therefore, the Board concluded that the court's holding in that case did not preclude a finding of good cause.

Bill Cleary (September 17, 2025). Analyzing ORS 656.260(7) and OAR 436-010-0008(1)(e), the Board vacated an ALJ's order that determined that WCB had jurisdiction over a medical services dispute and set aside the carrier's alleged de facto denial of the claimant's surgery request for his accepted medical conditions. The Board found that the director had exclusive jurisdiction over managed care organization (MCO)-related disputes. In *Cleary*, the claims administrator did not send preauthorization for the claimant's surgery to the MCO, the claimant had not requested review through the MCO's internal process, and the director had not reviewed the dispute before the claimant filed a hearing request. Because the MCO and director had not yet reviewed the dispute, the Board dismissed the claimant's request for hearing for lack of jurisdiction.

Member Ousey dissented. He expressed concern that the Board's dismissal, in addition to the Medical Resolution Team's dismissal of the claimant's request for administrative review, would leave the claimant without a remedy for the claim administrator's and MCO's failure to process the claimant's surgery request.

Frank A. Fasciana (September 30, 2025). The Board found that the claimant's attorney was entitled to an attorney fee under ORS 656.383(1), but not under ORS 656.262(11)(a) or ORS 656.268(6)(c).

Citing *Loren L. Boll*, 58 Van Natta 3115, 3119 (2006), *recons*, 59 Van Natta 56 (2007), the Board found that, because the Order on Reconsideration did not award additional compensation, the claimant's attorney was not entitled to 10 percent out-of-compensation fees under ORS 656.286(6)(c). Finding that there was no additional compensation due, the Board found that the carrier did not unreasonably delay or refuse to pay compensation. Therefore, no fee under ORS 656.262(11)(a) was awardable.

The Board also found that, because the claimant's attorney was instrumental in overturning the Notice of Closure and additional temporary disability benefits were paid after the reconsideration order, but before the ALJ's order, an assessed fee under ORS 656.383(1) was awardable. In reaching that conclusion, the Board distinguished *Brandon E. Lamb*, 75 Van Natta 167 (2023), *John C. Cole*, 74 Van Natta 692 (2022), and *Robert L. Stanley*, 74 Van Natta 359 (2022), where temporary disability benefits were not due as a result of reconsideration proceedings.

Quintus L. Hall, Sr. (August 21, 2025). The Board affirmed an ALJ's order that found that the "going and coming" rule applied and that the claimant was not injured in the course of employment.

Claimant, a bus driver, would park his personal vehicle in a public parking lot and walk to a public bus stop where the employer's shuttle would provide transportation to the employer's garage. On the date of injury, he slipped on an icy sidewalk and fell on his back before he had clocked in for work. The Board found that the "going and coming" rule applied because the injury occurred before he had started his shift, and he was not required to take the shuttle by his employer.

The Board distinguished the case from *Tri-Met, Inc. v. Lamb*, 193 Or App 54 (2004), in which the claimant, also a bus driver, was injured while returning to the employer's garage after being relieved by another driver (an activity known as "road relief"). The Board explained that the court did not apply the "going and coming" rule because the claimant had not yet ended her work day and the road relief activity was part of the claimant's job description and collective bargaining agreement for which she received an allowance.

The Board stated that, unlike in *Lamb*, the claimant had not yet started his shift, was not receiving wages for his time, and the activity was not part of his job description or a collective bargaining agreement. Therefore, the Board found that the "going and coming" rule applied and that the claimant did not establish that the injury occurred in the course of employment.

Member Ceja dissented. Applying *Fred Meyer, Inc. v. Hayes*, 325 Or 592, 596 (1997), Member Ceja would have found that the claimant's injury was "in the course of" employment and that the "going and coming" rule did not apply because the claimant's injury was reasonably incidental to his employment, the injury occurred within a reasonable time before his shift, the employer's shuttle was for employees only, it was common for bus drivers to take the shuttle, and the claimant was in a place where the employer could reasonably expect him to be. Alternatively, he would have found that the "employer's conveyance" exception would overcome the "going and coming" rule because the worker was waiting for a vehicle under the employer's control to take him to work.

Member Ceja also would have found that the claimant's injury "arose out of" his employment because the slip and fall was a neutral risk, as agreed to by the parties, and was a risk to which the work environment exposed him.

Jeremy Orozco (July 23, 2025). The Board reversed those portions of an ALJ order that upheld the carrier's back-up, combined condition ceases, and new or omitted medical condition claim denials for right knee conditions, and declined to award a penalty for untimely payment of temporary disability benefits before the combined condition ceases denial. The Board affirmed those portions of the ALJ's order that declined to award penalties and penalty-related attorney fees for allegedly unreasonable back-up and combined condition ceases denials and failure to pay temporary disability benefits following the combined condition ceases denial. Additionally, the Board did not find an abuse of discretion when the ALJ admitted a post-hearing medical report without redaction.

Regarding the evidentiary issue, the claimant challenged portions of a post-hearing medical report that addressed the existence of a combined condition rather than the carrier's combined condition ceases denial. Citing *Brown v. SAIF*, 51 Or App 389, 394 (1981), the Board stated that ALJs have broad discretion concerning admissibility of evidence and that the existence of a combined condition was central to the ceases denial issue. Thus, the Board found no abuse of discretion.

Addressing the back-up denial, the Board applied ORS 656.262(6)(a) and *Greenbriar Ag. Mgmt. v. Lemus*, 156 Or App 499, 504 (1998), *rev den*, 328 Or 594 (1999), finding that the record did not establish a material misrepresentation supporting the carrier's denial. At the time of acceptance, the carrier did not have a 2015 chart note that referenced claimant's prior right knee symptoms. The claims adjuster testified that he would have processed the claim differently if he was in possession of the chart note. However, the chart note itself did not attribute right knee symptoms to a right knee

injury, condition, diagnosis, treatment, or surgery, but rather tight hamstrings. Additionally, at the time of acceptance, the carrier did not pursue additional information even though it had a right knee MRI showing degeneration and an interview summary with the claimant indicating "Yes, not related" concerning his relevant medical history/prior claims. Nevertheless, the Board found that the carrier did not act unreasonably in issuing the back-up denial because the carrier performed a reasonable investigation and the 2015 chart note raised a legitimate doubt.

Having set aside the back-up denial, the Board then analyzed the combined condition ceases denial. Under ORS 656.262(6)(c), it found that the record did not persuasively support the existence of the accepted combined condition such that a preexisting condition could cease to be the major contributing cause of the claimant's need for treatment or disability. Consequently, the Board set aside the carrier's combined condition acceptance and ceases denial. However, it did not find the ceases denial unreasonable because the carrier obtained an IME before issuing the denial. The Board reasoned that, even though that opinion was ultimately found unpersuasive, the carrier was entitled to pursue its denial for the Board's determination regarding the persuasiveness of that opinion.

The Board also set aside the carrier's denial of the claimant's new or omitted medical condition claims for right knee conditions relying on the persuasive medical opinions of the treating surgeon and a worker-requested medical exam that explained that the work event was a material and the major contributing cause of the claimant's need for treatment of the claimed right knee conditions.

As a result of setting aside the carrier's new or omitted medical condition claim, back-up, and combined condition ceases denial, as well as the record establishing ongoing temporary disability authorizations during the period in question, the Board awarded temporary disability benefits post-ceases denial. Nevertheless, the Board did not find the carrier's nonpayment of temporary disability benefits for this period unreasonable because it also found the ceases denial was not unreasonable.

Finally, the Board awarded a penalty and penalty-related attorney fee for unreasonable claim processing related to the untimely payment of temporary disability payments because the carrier did not have a legitimate doubt that it owed those benefits.

Luis Orozco (September 25, 2025). The Board reversed that portion of an ALJ's order that upheld the carrier's ceases denial of a combined condition on the basis of claim preclusion. Applying *Yi v. City of Portland*, 258 Or App 526, 530-31 (2013), the Board

reasoned that a previously set aside ceases denial was based on the same set of facts as the current ceases denial. The Board, therefore, set aside the employer's denial.

The Board also declined to award a penalty and penalty-related attorney fee. Although the Board did not find that the medical opinions relied on by the carrier established new operative facts on which to base its denial, the opinions provided legitimate doubt as to whether the accepted condition remained the major contributing cause of the claimant's disability and need for treatment.

Member Curey dissented, in part, regarding the claim preclusion issue. She agreed with the ALJ's determination that the issue in the previous litigation was not identical to the current issue and that issue preclusion did not apply. Moreover, she would have found that the carrier was not barred by claim preclusion because claimant was not yet diagnosed with or treated for the additional accepted condition at the time of the previous denial. Additionally, Member Curey would have found that the claimant's "otherwise compensable injury" was no longer the major contributing cause of the disability or need for treatment of the combined condition and would have upheld the denial.

Christopher J. Smith (September 8, 2025). The Board concluded that an ALJ did not abuse their discretion in admitting a physician's rebuttal report. In reaching this conclusion, the Board found that the rebuttal report addressed the carrier's combined condition "major contributing cause" defense. Because the record was left open for the carrier to obtain such a report addressing its burden to prove that the otherwise compensable injury was not the major contributing cause of the claimant's disability or need for treatment, the ALJ did not abuse their discretion.

The Board also upheld the carrier's denial of a new or omitted medical condition claim for a combined cervical myelopathy condition. First, the Board found that the claim was properly analyzed as a new or omitted medical condition claim for a combined condition based on persuasive medical opinion evidence. Moreover, the Board found that the preexisting degenerative conditions were the major contributing cause of the claimant's disability or need for treatment of the combined cervical myelopathy condition. Therefore, the Board affirmed the ALJ's order that upheld the carrier's denial.

Member Ceja dissented in part regarding the compensability determination, and would have found that the claim should have been analyzed as a standard new or omitted medical condition claim. He would have concluded that claimant had met his burden to prove that the cervical myelopathy condition existed and that the work event was a material contributing cause of the disability or need for treatment of the condition. Moreover, Member Ceja would have found that the record had not persuasively establish

the carrier's combined condition defense under ORS 656.266(2)(a) and, therefore, that the claim was compensable.

Johnny A. Stacey (August 22, 2025). The Board affirmed an ALJ's order that authorized the self-insured employer's offset for an alleged overpayment of temporary disability benefits and declined to award penalties and attorney fees for allegedly unreasonable claims processing. Applying *Metro Rigging v. Tallent*, 94 Or App 245, 248 (2008) and *Nyla J. Vanalstine*, 67 Van Natta 510, 510 (2015), the Board found that the employer had met its burden of proof in establishing sufficient evidence of the overpayment. The record included the employer's audit calculation, payment ledger, and testimony from the claims adjuster that the claimant continued to receive temporary total disability payments after he had returned to modified work. Additionally, the claimant did not provide rebuttal evidence.

The Board declined to award penalties and attorney fees for unreasonable claim processing because it found that the employer was authorized to recover the overpayment and there was no evidence that it had unreasonably delayed, refused to pay, or resisted payment of compensation. *See* ORS 656.262(11); ORS 656.382(1).

Member Ousey dissented in part. While he agreed that no penalties or attorney fees were awardable in this case, he disagreed that the self-insured employer had met its burden of proof in establishing the overpayment. He would have found that the employer's evidence did not explain how the amount of the overpayment was calculated and that the inclusion of a "TTD/TPD Calculator" was insufficient.