M E M O R A N D U M

December 11, 2020

To: Members of MLAC

From: Greig Lowell, Workers' Compensation Board

Subject: WCB Update

Cases of Interest

Kevin J. Siegrist, 72 Van Natta 491 (June 10, 2020). Applying ORS 656.386(2)(d), the Board held that a worker was not entitled to the reimbursement of his litigation costs exceeding the $1,500 statutory threshold because the record did not establish that his obtaining a specialist's report to prevail over a carrier's occupational disease denial of a bilateral carpal tunnel syndrome condition constituted "extraordinary circumstances." Reiterating that "extraordinary circumstances" means circumstances that are not usual, regular, common, or customary for workers' compensation matters and applying that standard to the present case, the Board found that the disputed claim had not been particularly complex. The Board further observed that the litigation of disputed occupational disease claims with multiple expert opinions (including the worker's obtaining of a specialist's opinion to rebut a carrier's specialist's opinion) was not uncommon. Although acknowledging the worker's policy arguments regarding the expense of medical experts and an inequity between workers and carriers in obtaining an expert's opinion, the Board reasoned that such arguments might be relevant for the legislature in support of increasing the $1,500 statutory threshold.

A concurring opinion noted that, because the $1,500 statutory threshold has not been reexamined since its 2007 adoption (at which time legislators had discussed the possibility of future adjustments), the legislature and the Management Labor Advisory Committee (MLAC) may wish to extend the threshold to a more reasonable figure that reflects the current realities of today's litigation process. In doing so, the concurrence further suggested that the legislature and MLAC consider the implementation of a "cost of living adjustment" similar to that contained in ORS 656.262(11)(a) (which concerns a threshold for a penalty-related attorney fee), as well as a possible expansion of a worker's

access to carrier-paid worker-requested medical examinations under ORS 656.325 to include all situations in which a carrier intended to rely on a medical opinion in support of its denial.

Herbert A. Williams, DCD, 72 Van Natta 517 (June 17, 2020). Applying ORS 656.226, and relying on court case precedent (*Allen* and *Thomas*), the Board held that the surviving cohabitant of a deceased worker was not entitled to survivor benefits because a child had not been born from her relationship with the worker. In reaching its conclusion, the Board disagreed with the cohabitant's contention that the prior case holdings were no longer controlling because ORS 656.226[1] had been subsequently amended. Noting that the statute had been amended in 2015 (after the court's decisions) to replace gender specific terms with gender neutral terms and emphasizing that the amendment had not altered the phrase previously interpreted by the court ("children are living as a result of that relation"), the Board determined that the statutory amendment had neither expressly declared nor necessarily implied a change to the meaning of the aforementioned phrase. Consequently, the Board concluded that the court's rationale remained controlling and, as such, the cohabitant was not entitled to survivor benefits.

The Board also declined to consider the cohabitant's argument that the court's interpretation of ORS 656.226 impermissibly discriminated against same sex couples in violation of the Oregon and U. S. Constitutions. Noting that the cohabitant and the deceased worker were not a same-sex couple and, thus, the cohabitant was asserting that the statute violated the rights of others, the Board concluded that she was not entitled to bring such a challenge in the present proceeding.

A concurring opinion expressed the Members' concern that ORS 656.226, as interpreted by the court, produced harsh results inconsistent with the purpose of the Workers' Compensation Act to provide benefits to the dependents of injured workers. Accordingly, these concurring Members encouraged the court to reexamine its prior decisions and suggested that ORS 656.226 be amended to account for modern family structures that were likely not considered when the statute was adopted.

Another concurring opinion wrote separately to clarify her position that, although she considered the result to be unfair, the Board's decision was legally correct in that

[1] **656.226 Cohabitants and children entitled to compensation**.

In case two unmarried individuals have cohabited in this state as spouses who are married to each other for over one year prior to the date of an accidental injury received by one or the other as a subject worker, and children are living as a result of that relation, the surviving cohabitant and the children are entitled to compensation under this chapter the same as if the individuals had been legally married.

the 2015 statutory amendments had not expressly declared or necessarily implied any legislative intent to substantively extend the benefits awardable under the statute.

A dissenting opinion noted that the 2015 statutory amendments had changed the gender specific terms to gender neutral terms (in response to a Federal Court of Appeals decision declaring Oregon's ban on same-sex marriage unconstitutional and permanently enjoining the state's executive branch from enforcing laws/rules denying benefits that accompany marriage). Given such circumstances, the dissent reasoned that the necessary implication of the amendment was to extend benefits under the statute to same-sex couples. The dissent contended that the court's case precedent (which limited benefits under the statute to couples who have children biologically related to both the surviving cohabitant and the deceased worker) conflicted with the amendment. Finally, the dissent emphasized that his interpretation was consistent with Oregon's domestic partnership law and the Governor's Executive Order ensuring equal treatment under the law for the LGBTQ+ community or, alternatively, the court's statutory interpretation violated the Oregon constitution because it subjected same-sex couples to disparate treatment.

Juan Lopez-Ciro, 72 Van Natta 166 (February 12, 2020). Applying ORS 656.268(5)(e), and OAR 436-030-0145(1), the Board held that a worker's request for reconsideration of a Notice of Closure (NOC), which was filed after the 60-day statutory appeal period had expired, was untimely and that there was no "good cause" exception for the untimely filing. Although acknowledging the worker's contention that the carrier's untimely response to his discovery request had delayed the filing of his reconsideration request and provided "good cause" for his untimely filing, the Board found that neither a statute nor an administrative rule provided a "good cause" exception to the 60-day statutory filing requirement for a request for reconsideration of a NOC under ORS 656.268(5)(e).

A concurring opinion expressed concern regarding the lack of a "good cause" exception to the 60-day filing requirements of ORS 656.268(5)(e), and OAR 436-030-0145(1). Noting that "good cause" exceptions are available in several statutory and regulatory contexts (*e.g.*, ORS 656.319(1)(b); ORS 656.265(4)(c); OAR 438-012-0060(2)), the concurrence urged the Management-Labor Advisory Committee to consider this apparent statutory "gap" and encouraged the legislature to address the matter.

Johanna L. Southard, 71 Van Natta 660 (June 25, 2019). In a dispute involving the correct medically stationary date, the Board relied on the attending physician's January, 2018 report that declared claimant medically stationary in Jun, 2017. A concurring

opinion noted that ORS 656.262(4)(g) limits retroactive authorization of TTD to 14 days, but there is no prohibition on a physician's ability to designate a medically stationary date retroactively.

Changes to WCB Administrative Rules in 2020

Effective June 1, 2020:

- Added a definition ("client paid fee") to describe fees paid by an insurer or self-insured employer to its attorney. OAR 438-015-0005.

- Added language based on ORS 656.388(5) to the "rule-based factors" in determination of an assessed fee: "The necessity of allowing the broadest access to attorneys by injured workers," and "Fees earned by attorneys representing the insurer/self-insured employer, as compiled in the Director's annual report pursuant to ORS 656.388(7) of attorney salaries and other costs of legal services incurred by insurers/self-insured employers under ORS Chapter 656." OAR 438-015-0010(4).

- Increased the hourly rate for an attorney's time spent during an interview or deposition under ORS 656.262(14)(a) from $275 to $350 (now $366), plus an annual adjustment commensurate with changes in the state average weekly wage. OAR 438-015-0033.

- Established a schedule of attorney fees for attorneys representing insurers and self-insured employers, requiring that such fees be reasonable and not exceed any applicable retainer agreement. OAR 438-015-0115.

Effective October 1, 2020

- Allowed the submission and consideration of information regarding a claimant's attorney's "contingent hourly rate," including the calculation of such a rate. (OAR 438-015-0010(4)(l)).

- Established procedures regarding the voluntary bifurcation of an attorney fee award from the merits concerning certain cases on Board Review. OAR 438-015-0125.

Additional cases of note

Supreme Court

Arvidson v. Liberty Northwest Ins. Corp., 366 Or 693 (July 16, 2020). Analyzing ORS 656.382(2), the Supreme Court held that a worker was entitled to a carrier-paid attorney fee when he successfully argued that a carrier's hearing request from an Order on Reconsideration had been untimely filed. Noting that the statute requires that the tribunal to which a carrier initiates a request for review must "find" that the compensation award should not be disallowed or reduced, the Court reasoned that a dismissal of a carrier's hearing request from an Order on Reconsideration (which granted permanent total disability benefits) established (as definitively as any ruling on the substantive merits) that the compensation award should not be "disallowed or reduced." Consequently, the Supreme Court concluded that, whether the worker's successful defense of the compensation award from which the carrier had appealed was procedural or substantive in nature, an attorney fee award under ORS 656.382(2) was justified.

Court of Appeals

Fleming v. SAIF, 302 Or App 543 (March 4, 2020). Interpreting ORS 656.289(4), the court held that, in analyzing a worker's occupational disease claim for a shoulder condition, he was not precluded from asserting that his employment exposure with an earlier employer was a contributing causal exposure in determining the compensability of his claim under the "last injurious exposure rule" (LIER), even though a Disputed Claim Settlement (DCS) between him and the earlier employer included a stipulation that his employment with the earlier employer had not contributed to his shoulder condition. Reasoning that the text of ORS 656.289(4) does not state or imply that the effect of a DCS goes beyond resolving a bona fide dispute over the compensability of a disputed claim between a worker and an employer, the court determined that the worker's DCS with his first employer did not preclude him from litigating the role his prior employment might have played in his current shoulder claim under LIER.

A dissenting opinion asserted that: (1) ORS 656.289(4) was silent regarding the impact of a DCS concerning a worker's claim with an earlier employer has in a proceeding involving a subsequent employer; (2) a disposition accomplished by a DCS is no less significant than that made by a Board award in a contested decision and represents a stipulated judgment; and (3) the worker's stipulated admissions in a DCS (which stated that his claimed shoulder condition was neither *medically* or legally attributable to his employment with the previous employer were preclusive against him in his current shoulder claim.

SAIF v. Ward, 307 Or App 337 (October 21, 2020). Analyzing ORS 656.027(15), the court affirmed the Board's order in 71 Van Natta 484 (2019), which held that claimant (a truck driver) was a "subject worker" when he sustained his work-related injury in a motor vehicle accident because he had not "furnished" his truck to a leasing company because he did not have a transferable interest in the truck (which he had leased from the trucking company). On appeal, the carrier contended that claimant was not a "subject worker" under ORS 656.027(15) because he had "an ownership or leasehold interest in equipment and * * * furnishes, maintains, and operates [it]."

The court disagreed with the carrier's contention. Citing ORS 656.027, the court stated that "all workers" are subject workers unless an exemption was applicable. Referring to ORS 656.027(15), the court identified two requirements for the aforementioned statutory exemption to "subject worker": (1) the worker must have "an ownership or leasehold interest in equipment;" and (2) the worker must "furnish[], maintain[], and operate[]" that equipment. Noting the statute's conjunctive stature, the court determined that the two requirements are separate and independent from each other; *i.e.*, the ownership/leasehold interest in the equipment must be in some way distinct from the furnishing, maintaining, and operating of that equipment.

After reviewing the statute's text, context, and legislative history, the court reasoned that a truck driver can "furnish" equipment to a trucking company by providing the equipment in the service of the trucking company; *i.e.*, by producing the equipment to haul loads for the company. Nonetheless, the court further concluded that ORS 656.027(15) requires a leasehold interest that exceeds the right to furnish the equipment to the company such that the driver has right to possess, use, and control the equipment for purposes other than providing it to the company.

Turning to the case at hand, the court acknowledged that the lease agreement concerning the truck provided that claimant had "exclusive possession, control, and use of the equipment" for the duration of the lease. Nonetheless, the court reasoned that the lease's statement was belied by the practical considerations regarding the many restrictions placed by the trucking company on claimant's use of the vehicle; *e.g.*, prescribed routes; availability for vehicle inspection; maintenance directives; company signage.

Given such circumstances, the court concluded that, despite being called a "lease," the agreement did not confer any interest in the leased vehicle to claimant beyond the authority to use it in service to the trucking company and its direction. As such, the court

reasoned that the only right of use and possession conferred by the lease was the right to furnish the equipment to the trucking company.

Reiterating that the leasehold interest described in ORS 656.027(15) must, at a minimum, allow the lessee sufficient authority over the equipment in some way other than furnishing, maintaining, and operating it in service of the lessor, the court determined that the lease agreement in the present case did not convey such an interest. Accordingly, the court held that the Board had not erred in finding claimant to be a subject worker.

Robinette v. SAIF, 307 Or App 11 (October 7, 2020). The court reversed the Board's order in *Theresa M. Robinette*, 71 Van Natta 269 (2019), that, in awarding permanent disability for an accepted knee condition (for a surgery and chronic condition), had not included permanent impairment for claimant's lost range of motion and instability because a medical arbiter had attributed those impairments to preexisting conditions (which had neither been claimed/accepted/denied either separately or as part of a combined condition). The court summarized *Caren v. Providence Health System Oregon*, 365 Or 466, 487 (2019), which had held that when a worker's impairment is caused by a combination of a work-related injury and a cognizable preexisting condition, and the work-related injury is a material contributing cause of the total impairment, a worker is entitled to be compensated for the "full measure" of impairment, unless the carrier has issued a "pre-closure" denial of the worker's combined condition that has contributed to the worker's total impairment.

Turning to the case at hand, the court found *Caren* distinguishable on its facts for two reasons. First, the court did not consider the present case to be about apportionment, *per se*, which related to a determination of impairment benefits when a type of impairment is caused in part by the work injury and in part by other, non-work-related causes. Rather, the court determined that no part of claimant's range of motion or instability impairment was attributable to the work injury. Second, the court stated that the present case was not about whether the carrier was required to deny a "combined condition." Specifically, the court emphasized that there was no contention that the impairment values for range of motion and instability represented a combining of claimant's work injury and her preexisting condition (which had not been identified until the claim was closed and the record did not address whether it was legally cognizable); *i.e.*, the two impairments were not related to the compensable injury. Nonetheless, the court reasoned that the *Caren* rationale is applicable even in the context of claims that do not involve some combining of the work injury and the preexisting condition. In doing so, the court explained that if the carrier intends to assert that a portion of the claimant's

impairment is not related to the work injury, the carrier is required to issue a "pre-closure" denial of the condition giving rise to the impairment and, only then is the carrier entitled to a reduction in impairment benefits for the portion of impairment attributable to a cognizable preexisting condition.

Applying such reasoning, the court found that claimant's impairment "as a whole" included her whole-person impairment, of which the work injury was a material contributing cause, as well as her impairment due to lost range of motion and instability. Because the carrier had not denied the condition to which claimant's lost range of motion/instability impairments were attributable, the court concluded that she was also entitled to be compensated for those impairments.

Alvarado-DePineda v. SAIF, 306 Or App 423 (September 10, 2020). Analyzing ORS 656.268(5)(a), the court held that a worker was entitled to a penalty based on the work disability award granted by an Order on Reconsideration because the award was based on information that the carrier could reasonably have known (*i.e.*, that the attending physician had not released the worker to her "at injury" job as a housekeeper) when it issued its Notice of Closure (which had not included a work disability award). The court reiterated that in assessing whether a carrier "could not reasonably have known" the extent of a worker's impairment when issuing its Notice of Closure, the following matters are taken into consideration: (1) the information in the carrier's hands at the time of claim closure, including the carrier's medical file concerning the worker; (2) the carrier's duty to gather the information necessary to issue its Notice of Closure; and (3) the carrier's related, legally recognized duty to seek clarification and gather additional information in the face of ambiguities.

Identifying multiple ambiguities regarding the attending physician's assessment of the worker's impairment at claim closure (*e.g.*, the attending physician had agreed with a work capacity evaluation that the worker could return to her "at injury" job, yet also reported that the worker had been released to "modified duty"), the court concluded that the carrier had an obligation to clarify any apparent ambiguities in the information necessary to determine the extent of the worker's impairment before closing the claim. Because the carrier had not sought such clarification and the attending physician's "post-closure" clarification (submitted by the worker's counsel) had resulted in the Order on Reconsideration's "work disability" award, the court held that a penalty under ORS 656.268(5)(g) (based on that work disability award) was warranted.

Board decisions

Lahna K. Lynn, 72 Van Natta 362 (April 30, 2020). The Board held that a dental hygienist's injury, which occurred when she slipped/fell on ice on a parking lot while walking to her employer's dentist office to begin her work day, occurred in the course of her employment because the employer's landlord (who had a leased parking lot where the dentist's patients could park) had also made arrangements (at the dentist's request) to have the dentist's employees park in an adjoining lot, which the landlord did not own. Although acknowledging that the dentist's lease with the landlord did not concern the adjoining parking lot, the Board noted that the landlord had leased the spaces in the adjoining parking lot specifically at the dentist's request for the dentist's employees. Moreover, consistent with testimony regarding the dentist's/landlord's past practices regarding the leased parking lot, the Board was persuaded that the landlord would have responded to any complaints from the dentist concerning the adjoining parking lot. Under such circumstances, the Board concluded that the dentist had sufficient control over the area where the worker had been injured (the adjoining parking lot) to satisfy the "parking lot" exception to the "going and coming" rule and, as such, the worker's injury had occurred in the course of her employment.

A dissenting opinion asserted that the dentist had neither owned/leased nor paid any maintenance costs for the adjoining parking lot where the worker had been injured. Under such circumstances, the dissent did not consider the dentist's exclusive use of nine spaces in an otherwise shared adjoining parking lot sufficient to establish that the dentist had control over the area where the worker was injured. Consequently, the dissent contended that the "parking lot" exception to the "going and coming" rule had not been satisfied and, as such, the worker's injury did not occur in the course of her employment.

Freiherr George Von-Bothmer Zuschwegerhoff, 72 Van Natta 442 (May 27, 2020). Analyzing ORS 656.262(4)(g), (4)(i), and ORS 656.005(12), the Board held that a carrier was not entitled to terminate a worker's temporary disability (TTD) benefits because, before he was enrolled in a Managed Care Organization (MCO), his "non-MCO" attending physician had issued an "open-ended" authorization of TTD benefits, he had not continued to seek care from the "non-MCO" physician after his MCO enrollment, and no "MCO-authorized" attending physician had terminated his TTD benefits for his compensable low back condition. Although acknowledging that the worker had been enrolled in an MCO after his "non-MCO" attending physician had "indefinitely" authorized TTD benefits, the Board determined that the worker had not "continued to seek care" from the "non-MCO" physician after he was notified that the physician was not "MCO-authorized." Under such circumstances, the Board concluded that the carrier

was not authorized to terminate the worker's TTD benefits under ORS 656.262(4)(i). Furthermore, noting that the "non-MCO" attending physician had taken the worker off work "indefinitely" and finding that no "MCO" attending physician had subsequently terminated the worker's TTD benefits for his compensable condition, the Board held that the worker was entitled to ongoing TTD benefits. *See* ORS 656.262(4)(i); ORS 656.005(12).

A dissenting opinion asserted that an "MCO" physician had subsequently become primarily responsible for the worker's compensable condition, opined that his condition had resolved, and concluded that he could perform his regular work. Reasoning that the "MCO" physician had taken affirmative steps to "halt" the worker's previous attending physician's TTD authorization, the dissent contended that the carrier was entitled to terminate the worker's TTD benefits.

Mohammad Abed-Rabuh, 72 Van Natta 478 (June 9, 2020). Applying OAR 436-060-0025 (WCD Admin Order 18-050 (eff. February 21, 2018)), the Board held that the rate of a worker's temporary disability (TTD) benefits were based on the average of his irregular weekly wages earned between the date of a new collective bargaining agreement (CBA) and the date of his compensable injury because the CBA constituted a "new wage earning agreement" that was not limited to only a change in the rate of his pay. Reiterating that WCD (on behalf of the Director) has broad authority to determine the methods for determining a worker's "at-injury" wage, the Board was persuaded by the employer's controller's testimony that the CBA made multiple changes beyond changing the rate of the worker's pay; *e.g.*, shift starting time, structure of overtime hours, vacation leave/eligibility, seniority, bonuses, IRA contributions. Under such circumstances, in accordance with the WCD rule, the Board concluded that the CBA constituted a "new wage earning agreement" and, as such, the worker's average weekly wage for his irregular job was based on weekly wages between the date of the CBA and the date of his injury (rather than his average weekly wage over the 52 weeks preceding his compensable injury).

In reaching its conclusion, the Board acknowledged that ORS 656.210(2)(d)(A) provides that TTD benefits are based on the "wage of the worker at the time of injury." Nonetheless, in accordance with court case law (*Poland*), the Board reiterated that WCD (on the Director's behalf) has broad authority to determine the methods in which a worker's wage at injury should be determined.

Catherine A. Sheldon, 72 Van Natta 580 (July 1, 2020), *on recon*, 72 Van Natta 712 (July 30, 2020). The Board held that an office worker's injury, which occurred when she fell while walking across the lobby of the office building where she worked to begin

her work day, arose out of and in the course of her employment because her employer's lease provided it with a "right of passage" through the lobby area and because her injury was unexplained because there was no "facially nonspeculative idiopathic explanation" for her fall. Noting that the employer's lease provided it with a right of passage through the common areas of the office building and further determining that the lease authorized the employer to obtain/require maintenance of the public parts of the building, the Board reasoned that the employer had a property interest in the lobby area where the worker's injury had occurred sufficient to establish its "control" over the area. Consequently, the Board concluded that the worker's injury was subject to the "parking lot" exception to the "going and coming" rule and, as such, her injury had occurred in the course of her employment.

Addressing the "arising out of" employment question, the Board acknowledged the carrier's contention that nonspeculative idiopathic factors explained the worker's fall; *e.g.*, obesity, diabetes, ankle weakness, and hypertension medication, which would contribute to problems with peripheral neuropathy, lightheadedness, balance and mobility. Nonetheless, reasoning that no physician had persuasively explained how any of these "potential" idiopathic causes had contributed to the worker's fall and noting that the record did not support the existence of any of these alleged problems either before or after her fall, the Board concluded that there was no facially nonspeculative idiopathic explanation for the fall. Accordingly, the Board determined that the worker's fall was "unexplained" and, because her injury had occurred in the course of her employment, it was deemed to also have arisen from her employment.

Julie A. Dellinger, 72 Van Natta 35 (January 8, 2020). Analyzing ORS 656.325(1)(e) and OAR 436-060-0147(1), the Board held that a worker was not entitled to a worker-requested medical examination (WRME) because, although the carrier conducted an "in person" insurer-arranged medical examination (IME) after its denial, at the time of the worker's WRME request, the carrier's denial had been based on an IME's "record review" report. The Board acknowledged the worker's assertion that the carrier's "post-denial" "in person" IME report supported her right to a WRME because the denial became based on that report. Nonetheless, reasoning that, when the worker requested the WRME, the carrier's denial had been based on a "record review" (rather than an "in person" examination) IME report, the Board concluded that the statutory prerequisite for a WRME (*i.e.*, an "in person" IME) had not been satisfied.