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BOARD NEWS

Staff Attorney Recruitment

WCB is recruiting for a staff attorney position. Applicants must have a law degree and extensive experience reviewing case records, performing legal research, and writing legal arguments or proposed orders. Excellent research, writing, and communication skills are essential. Preference may be given for bar membership and legal experience in the area of workers' compensation. The salary range is between \$5,028 and \$7,363 per month, with the beginning salary between \$5,028 and \$5,802 depending on the successful applicant's level of knowledge and experience. Further details about the position and information on how to apply are available online at www.oregonjobs.org. The recruitment will close on December 19, 2014. WCB is an equal opportunity employer.

Board Review Inquiries - New Phone No. (503-934-0103)

Effective immediately, questions pertaining to "Board Review-related" matters should be directed to 503-934-0103. This centralized method will allow the staff to screen the call, analyze the question (whether it concerns a request for review, a hearing transcript, a procedural motion, a briefing question, or other appellate-related matter), and direct the inquiry to the appropriate staff member, who will promptly return the call.

There are no changes regarding "Own Motion" and "CDA-related" inquiries. Such questions should continue to be directed to 503-934-0113 for Own Motion, and 503-934-0116 for CDAs. The Board Review fax number is 503-373-1684.

CASE NOTES

Appellate Procedure: "Remand" Motion to Address "Brown" Standard - Denied - Not Accompanied by Proposed Evidence - Unable to Determine Reasonably Likely to Affect Outcome

Rebecca Littlefield, 66 Van Natta 1820 (November 3, 2014). On reconsideration of its initial decision, *Rebecca Littlefield*, 66 Van Natta 1048 (2014) (which had set aside a carrier's "ceases" denial of claimant's combined shoulder condition based on *Brown v. SAIF*, 262 Or App 640 (2014)), the Board,

APPELLATE DECISIONS

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en banc, denied the carrier’s motion to remand for further development of the record in light of the *Brown* standard because the motion was not accompanied by a physician’s report and, as such, the Board was unable to determine whether additional evidence was likely to affect the outcome of the case. In its initial opinion, the Board applied the rationale expressed in *Brown* (which had issued after the ALJ’s order that had upheld the carrier’s “ceases” denial of a combined shoulder condition under ORS 656.262(b)(c)) and concluded that the carrier had not met its burden of proving that the “otherwise compensable injury” (the work-related injury/incident, rather than the accepted shoulder strain) had ceased to be the major contributing cause of claimant’s combined should condition because the physician’s opinion (submitted by the carrier at hearing) had ultimately analyzed claimant’s combined condition in relationship to his accepted strain. After issuance of the Board’s order, the carrier sought remand to the Hearings Division to further develop the record in light of the *Brown* holding.

The Board denied the carrier’s remand motion. Citing ORS 656.295(5), *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986), and *SAIF v. Avery*, 167 Or App 327, 333-34 (2000), the Board stated that there must be a compelling reason to remand for the taking of additional evidence, which exists if the evidence: (1) concerns disability; (2) was not obtainable with due diligence at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. Relying on *Jose L. Hernandez*, 65 Van Natta 1763 (2013), among other decisions, the Board noted that, in determining whether remand is warranted in a particular case, it will evaluate proposed evidence submitted by the moving party.

Turning to the case at hand, the Board found that the existing record included claimant’s attending physician’s opinion that supported the compensability of claimant’s combined condition under the *Brown* standard. The Board further observed that the carrier had not submitted proposed evidence addressing claimant’s combined condition utilizing the *Brown* standard.

In the absence of such a submission, the Board concluded that it could not determine whether additional evidence was “reasonably likely” to affect the outcome of the case. Accordingly, the Board held that the carrier (the proponent of the remand motion) had not established a compelling reason for remand.

In reaching its conclusion, the Board acknowledged that, in *Betty S. Tee*, 45 Van Natta 289 (1993) it had not required a submission of proposed evidence before remanding a case for further development of the record to address claimant’s request for PTD benefits in light of the Supreme Court’s pronouncement that “gainful occupation” was defined as “profitable remuneration.” However, reasoning that the record in *Tee* (as well as similar cases) was devoid of evidence addressing the pertinent “post-hearing” legal standard that was not obtainable through the exercise of due diligence, the Board explained that the submission of proposed evidence by the proponent of the remand motion was not required.

In the present case, in contrast to *Tee*, the Board reiterated that claimant’s attending physician’s opinion had supported the compensability of claimant’s combined condition under the *Brown* standard. Thus, because the record was not devoid of evidence addressing the “post-hearing” change of

Without a submission of proposed evidence, Board could not determine whether such evidence was “reasonably likely” to affect the outcome of the case.

the law, the Board concluded that without a submission of proposed evidence from the carrier who was seeking remand, it could not determine whether such additional evidence would be “reasonably likely” to affect the outcome of the case.

Appellate Procedure: “Remand” Motion to Address “*Brown*” Standard Concerning “Ceases” Denial Denied - Physician’s Opinion Unpersuasive on Other Grounds

Mujo Brcaninovic, 66 Van Natta 1890 (November 21, 2014). In a case involving a carrier’s “ceases” denial of a combined condition under ORS 656.262(6)(c), the Board denied a carrier’s motion to remand for further development of the record in light of *Brown v. SAIF*, 262 Or App 640 (2014) because: (1) the medical record established that claimant’s accepted L4-5 disc herniation was the “otherwise compensable injury” (whether analyzed under either the *Brown* (“work-related injury/incident”) or “pre-*Brown*” standard); (2) the physician’s opinion supporting the carrier’s burden of proof under ORS 656.262(6)(c) was unpersuasive for reasons unrelated to the *Brown* standard; and (3) the carrier had not submitted the proposed additional evidence concerning the *Brown* standard for the Board’s consideration. On appeal of an ALJ’s order upholding its “ceases” denial of a combined L4-5 disc herniation condition, a carrier moved for remand to further develop the record to address the *Brown* rationale, which had issued after the ALJ’s order.

The Board held that remand was not warranted. Citing ORS 656.295(5), *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986), and *SAIF v. Avery*, 167 Or App 327, 333-34 (2000), the Board stated that a compelling reason to remand exists if additional proposed evidence: (1) concerns disability; (2) was not obtainable with due diligence at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. Relying on *Rebecca Littlefield*, 66 Van Natta 1820, 1823 (2014), the Board noted that it has previously declined to remand for further evidence addressing the *Brown* standard where the moving party had not presented proposed additional evidence that would demonstrate that such evidence was reasonably likely to affect the outcome of the case.

Turning to the case at hand, the Board determined that the medical evidence established that claimant’s L4-5 disc herniation (his previously accepted condition) was the injury that resulted from his work accident that caused his disability/need for treatment, which combined with his preexisting arthritic condition. The Board further found that there was no contention that claimant’s “work-related injury/incident” (as described in *Brown*) caused other conditions that would constitute an “otherwise compensable injury.” Under such circumstances, the Board concluded that claimant’s L4-5 disc herniation was the “otherwise compensable injury,” whether analyzed under the *Brown* standard or the “pre-*Brown*” standard. See *Samuel D. Allen*, 66 Van Natta 1589, 1592 (2014) (medical evidence satisfied the *Brown* standard when a physician referred to “work exposure,” “acute event,” and the “injury” as ceasing to be the major cause of the combined condition).

Based on the particular record, the accepted L4-5 disc herniation was the “otherwise compensable injury,” whether analyzed under the “Brown” or “pre-Brown” standard.

Because physician's opinion was deficient on grounds other than the "Brown" standard, remand was not warranted because the physician's opinion would still be discounted even if reframed to address the "Brown" standard.

The Board further noted that the physician's opinion on which the carrier had relied had not fully distinguished between claimant's statutory "preexisting condition" and other non-legally cognizable conditions. Reasoning that such a deficiency did not concern the *Brown* and "pre-*Brown*" standard, the Board concluded that it would continue to discount the physician's opinion even if his opinion was reframed to address the *Brown* standard.

Finally, the Board observed that the carrier had not submitted proposed medical evidence addressing the *Brown* standard for the Board's consideration. In the absence of such a submission, the Board was unable to determine whether additional evidence would be reasonably likely to affect the outcome of the case. See *Littlefield*, 66 Van Natta at 1823.

Based on the aforementioned reasoning, the Board held that the present record was sufficiently developed under the *Brown* standard and that there was no compelling reason to remand for further development. Accordingly, the Board denied the carrier's remand motion.

Addressing the merits of the "ceases" denial, the Board noted that the physician's opinion advanced by the carrier had included other conditions (such as L3-4 disc bulging and a congenitally narrow spinal canal) in analyzing whether claimant's L4-5 disc herniation "injury" had ceased to be the major contributing cause of his combined condition. Finding that claimant was neither diagnosed with, nor treated for, either of those "non-arthritis" conditions before his work injury, the Board concluded that they did not constitute "preexisting conditions" and could not be considered in the "major contributing cause" analysis. See ORS 656.005(24)(a); *Schleiss v. SAIF*, 354 Or 637, 652-53 (2013); *Karjalainen v. Curtis Johnston & Pennywise, Inc.*, 208 Or App 674, 676 (2006), and *Vigor Indus. LLC v. Ayres*, 257 Or App 795, 803 (2013).

Under such circumstances, the Board was not persuaded that the "otherwise compensable injury" had ceased to be the major contributing cause of claimant's need for treatment/disability for his combined condition. Accordingly, the Board set aside the carrier's "ceases" denial under ORS 656.262(6)(c).

CDA: Attorney Fee Lien - "015-0022(3)" - CDA Provision Must Confirm That "Lien" Has Been "Resolved"

Rafael A. Mejia, 66 Van Natta 1916 (November 24, 2014). Applying OAR 438-015-0022(3), the Board approved a Claim Disposition Agreement (CDA), which had been amended to confirm that claimant's former counsel's attorney lien had been "resolved." The initial CDA submitted for Board approval included a provision stating that claimant agreed that his former attorney should be paid a "reasonable fee," which was specified in the CDA from the settlement proceeds. In response, the Board requested that the parties submit an addendum to the CDA clarifying that claimant's former attorney agreed with claimant's statement regarding the attorney fee lien. In reply, the parties submitted claimant's former counsel's message confirming that the specified amount described in the CDA had resolved the attorney fee lien.

When a potential attorney fee lien has been filed, a proposed CDA must include a provision confirming that the lien “resolving” the lien.

The Board approved the proposed CDA. Citing OAR 438-015-0022(3), the Board stated that a proposed CDA “shall include a provision *resolving the potential attorney fee lien.*” Relying on that rule, the Board determined that the initial CDA (which merely stated that claimant agreed that a fee to his former attorney in a specific amount was reasonable) was insufficient to satisfy the requirement that the CDA provide that the potential attorney fee lien had been resolved.

Addressing the parties’ addendum, the Board concluded that the parties (as well as claimant’s former counsel) had confirmed that the attorney fee lien had been resolved. See OAR 438-015-0022(3). Accordingly, the Board approved the amended CDA.

CDA: Handwritten Interlineation of One Party - Ineffective When Not Approved By Other Party - “Specific” Provision Controlled Over “General” Provision

William L. Smith, 66 Van Natta 1888 (November 21, 2014). In approving a Claim Disposition Agreement (CDA), the Board declined to consider handwritten interlineations from one party and his attorney because neither the other party nor the party’s attorney had approved the interlineation. A proposed CDA included on its “summary page” a provision stating that all of claimant’s “non-ORS 656.245-related” rights were fully released. However, next to that statement, claimant and his attorney had initialed a handwritten interlineation, noting that claimant’s future attorney fees, costs, and penalties were retained as provided in a later section of the CDA. According to that later provision, claimant’s release of benefits did not include attorney fees, costs, or penalties associated with any “post-CDA filed” action/inaction.

Because a party’s handwritten interlineation had not been initialed by the other party (or its counsel), the interlineation was not considered by the Board.

Reasoning that the handwritten interlineation was not initialed by either the carrier or its counsel, the Board gave no effect to the interlineation. Nonetheless, citing *Penny R. Doty*, 61 Van Natta 2704 (2009), the Board relied on the specific provision (in which claimant retained his rights to penalties, costs, and attorney fees), rather than the general “summary page” provision (which indicated that all of his “non-medical service-related” benefits had been fully released. Based on that interpretation, the Board approved the CDA.

Course & Scope: Fall at Work Due to “Fainting” - Not “Unexplained” - No “Work Connection” Established

Jeffrey E. Miller, 66 Van Natta 1855 (November 7, 2014). The Board held that claimant’s injury, which occurred when he fell at work, did not arise out of his employment because his fall was not unexplained (he had fainted) and it was equally possible that his fainting was due to personal idiopathic factors as it was due to work-related factors. While performing his work duties, claimant

fell, suffering a laceration to his chin. After the carrier denied his injury claim, claimant requested a hearing, contending that his injury was either due to a truly unexplained fall or that his physician's opinion persuasively established that the fall was due to work-related factors (fatigue from his work schedule, high temperatures, and possible dehydration).

The Board disagreed with claimant's contention. Citing *Phil A. Livesley Co. v. Russ*, 296 Or 25, 30 (1983), the Board stated that an unexplained fall that occurs on an employer's premises during work hours while the claimant is performing required duties is compensable if the claimant can eliminate idiopathic (personal) causes. Relying on *McAdams v. SAIF*, 66 Or App 415 (1984), the Board noted that, where it was equally possible that the claimant's fainting spell was idiopathic as that it was work-related, the "arising out of employment" requirement for establishing a compensable injury had not been established. Finally, referring to *Billie J. Owens*, 58 Van Natta 392 (2006), *aff'd without opinion*, 213 Or App 587 (2007), the Board observed that a fall caused by fainting is not a truly unexplained fall, even if the cause of the fainting is unknown.

Because claimant's fall was not unexplained (he lost consciousness) and there were several potential idiopathic reasons for his losing consciousness, record did not establish that his injury from the fall had arisen from his employment.

Turning to the case at hand, the Board found that the medical evidence established that claimant had lost consciousness, which caused his fall. Consequently, the Board determined that claimant's fall was not unexplained. See *Owens*, 58 Van Natta at 393; *Magaly V. Villiers*, 56 Van Natta 510, 511 (2004).

Addressing the question of whether claimant's fainting had been caused by work-related factors, the Board acknowledged that he had not fainted or experienced a seizure episode before the work incident. Moreover, the Board noted that a physician had subsequently suggested that a "sleep deprived EEG" study would have been useful in diagnosing claimant's condition. Nonetheless, the Board observed that the physician had also identified several potential idiopathic factors for claimant's fall (including hypercholesterolemia and borderline "untreated" hypertension) and had ultimately opined that claimant had fallen for personal "yet to be defined" reasons, which included a possible seizure disorder or syncopal episode.

After considering such evidence, the Board determined that it was equally possible that claimant's loss of consciousness resulted from personal, idiopathic factors as from work-related factors. Consequently, the Board was not persuaded that claimant's injury had arisen from his employment.

Hearing Request: "Claim Processing/TTD" Issue - Untimely Filed Under "319(6)" - "Two-Year" Limitation - Raisable "*Sua Sponte*"

Jesse G. Ayala, Jr., 66 Van Natta 1845 (November 7, 2014). Applying ORS 656.319(6), the Board dismissed claimant's hearing request (that sought conversion of his previous temporary partial disability (TPD) award, which had been granted by a final Notice of Closure, to temporary total disability (TTD)) as untimely filed because the "two-year" limitation period from the alleged action or

inaction by the carrier had expired. Following his compensable injury, claimant was terminated from his employment, which resulted in a conversion of his TTD benefits to TPD benefits. See ORS 656.325(5)(b). Thereafter, a Notice of Closure awarded TPD benefits. The closure notice was not appealed. Claimant had also pursued a civil action contesting his employment termination, which eventually resulted in a judgment of unlawful termination. More than two years after the NOC, claimant requested conversion of his TPD award to TTD and, when the carrier refused, he filed a hearing request. After the ALJ granted claimant's request, the carrier appealed.

The Board held that claimant's hearing request was untimely filed. Citing ORS 656.319(6), the Board stated that a hearing for failure to process or an allegation that the claim was processed incorrectly shall not be granted unless the request for hearing is filed within two years after the alleged action or inaction occurred. Relying on *Sweeden v. City of Eugene*, 95 Or App 577, 578 (1989), and *Allen P. Croyle*, 49 Van Natta 1091, 1092 (1997), the Board noted that an untimely hearing request under subsection (1) of ORS 656.319 is a jurisdictional matter that cannot be waived and is raisable on its own motion. Finally, the Board observed that both section (1) and (6) of ORS 656.319 contained the phrase "hearing * * * shall not be granted" unless the requirements of the subsection are met.

The Board acknowledged that the provisions of ORS 656.319(6) had not been addressed at the hearing level. Nonetheless, relying on *Southwest Forest Indus. v. Anders*, 299 Or 205 (1985), and *Tony L. Clark*, 66 Van Natta 91 (2014), the Board stated that it was its duty to raise the lack of jurisdiction *sua sponte*. Under such circumstances, based on the statutory language that a "hearing * * * shall not be granted," the Board concluded that the time limitations prescribed in ORS 656.319(6) for the filing of a hearing request are jurisdictional and can be raised at any time *sua sponte*. (The Board further noted that the parties had been allowed to submit supplemental briefing on the jurisdictional/timeliness issue.)

Turning to the timeliness issue, pursuant to ORS 656.319(6), the Board observed that a claimant must request a hearing on a carrier's action/inaction in processing a claim within two years of the action/inaction. Based on the carrier's "pre-closure" conversion of claimant's TTD benefits to TPD benefits (as well as its subsequent TPD award granted by the Notice of Closure), the Board found that claimant's hearing request was challenging the carrier's claim processing "action" (whether the conversion or the award). See *Howard E. Benjamin*, 65 Van Natta 215 (2013); *Terrizino D. Williams*, 58 Van Natta 1487 (2006). Because claimant's hearing request had been filed more than two years after either "action," the Board determined that the request must be dismissed as untimely.

In reaching its conclusion, the Board recognized claimant's contention that he could not have obtained relief until obtaining the "unlawful termination" judgment because neither an ALJ nor the Board would have disturbed the employer's termination action. Nonetheless, citing *Roger D. Curtis*, 65 Van Natta 171 (2013), the Board responded that it was not a foregone conclusion that any such challenge raised by claimant before the "unlawful termination" determination would have been precluded. Moreover, the Board noted that claimant could have sought to hold such a hearing in abeyance pending the

The "two-year" time limitations for filing a hearing request under "319(6)" are jurisdictional and can be raised by the Board sua sponte.

Because claimant's challenge to the carrier's calculation of his temporary disability benefits was filed more than two years after the carrier's "action," the hearing request was dismissed as untimely filed.

Because the carrier had not raised the untimeliness of the hearing request to the ALJ, dissent contended that the issue had been waived.

“unlawful termination” action or, if unsuccessful in doing so, continued to appeal such decisions until the civil judgment was obtained. In any event, the Board ultimately considered such reasoning speculative because claimant had not timely filed a hearing request.

Member Weddell dissented. After reviewing legislative history, as well as *SAIF v. Roles*, 111 Or App 597, *rev den*, 314 Or 391 (1992), Member Weddell reasoned that the two-year procedural time limitation represented a procedural “statute of limitations,” but did not deprive the ALJ/Board of “subject matter” jurisdiction over the claim processing dispute. Noting that the carrier had not raised the untimeliness of claimant’s hearing request before the ALJ, Weddell considered the issue to have been waived. Furthermore, analyzing ORS 656.319(6) as an affirmative defense that must be presented, Member Weddell also believed that it was fundamentally unfair for the carrier to take advantage of such a defense by means of the majority’s raising of the issue *sua sponte*.

New/Omitted Medical Condition: “Combined Condition” - “Otherwise Compensable Injury” Combined with Preexisting Arthritic Condition - “*Brown*” Standard Applies to “266(2)(a)”

Jean M. Janvier, 66 Van Natta 1827 (November 4, 2014). Applying ORS 656.266(2)(a), the Board held that claimant’s new/omitted medical condition claim for a combined cervical disc condition was compensable because she had established the existence of a combined condition (otherwise compensable injury combined with a preexisting arthritic/fusion condition) for which the carrier had not proven that the “otherwise compensable injury” work-related injury/incident was not the major contributing cause of the combined condition. After claimant’s accepted cervical strain claim was closed, she initiated a new/omitted medical condition claim for combined condition disc conditions (which were composed of “the otherwise compensable injury” combined with preexisting cervical disc arthritic/fusion conditions). The carrier denied the claim, contending that the claimed combined condition did not exist or alternatively that it had established that the otherwise compensable injury was not the major contributing cause of the need for treatment/disability for the combined condition.

Because claimant initiated new/omitted medical condition claim for a “combined condition,” she had the burden of proving claimed condition’s existence.

The Board disagreed with the carrier’s contention. Citing ORS 656.266(1), ORS 656.005(7)(a)(B); *Ronald R. Kimble*, 65 Van Natta 720 (2013); and *Gail Moon*, 62 Van Natta 1238, 1239 (2010), the Board stated that because claimant had initiated the new/omitted medical condition claim for a “combined condition,” she had the burden of proving the existence of the claimed condition. If claimant met this burden of proof, the Board reiterated that the burden shifted to the carrier to prove that the otherwise compensable injury was not the major contributing cause of the need for treatment/disability for the combined condition. See ORS 656.266(2)(a); *SAIF v. Kollias*, 233 Or App 495, 505 (2010). Finally, relying on *Brown v. SAIF*, 262 Or App 640, 652 (2014), the Board determined that the court’s holding that “otherwise compensable injury” means “work-related

injury/incident” for purposes of a “ceases” denial under ORS 656.262(6)(c) is likewise applicable to the analysis of a new/omitted medical condition claim under ORS 656.266(2)(a).

Turning to the case at hand, the Board found that the opinions of several physicians persuasively supported the proposition that claimant’s work-related injury/incident had combined with a preexisting condition to cause/prolong her need for treatment/disability. Consequently, the Board determined that claimant had established the existence of the claimed combined condition. See *Armenta v. PCC Structures, Inc.*, 253 Or App 682, 692 n 7 (2012) (whether a claim is a medical “condition” is a question of fact to be based on medical evidence in individual cases); *Young v. Hermiston Good Samaritan*, 223 Or App 99, 105 (2008) (“condition” refers as physical status of the body).

In reaching its conclusion, the Board acknowledged that the Court of Appeals had previously referred to a combined condition as “two conditions that merge or exist harmoniously.” See *Luckhurst v. Bank of America*, 167 Or App 11 (2000) and *Multifoods Specialty Distribution v. McAtee*, 164 Or App 654 (1999). Nonetheless, the Board noted that the Supreme Court in *McAtee* (333 Or 629, 636 (2002)) had referred to a combined condition as “two medical problems simultaneously” and that the *Brown* court had considered the Supreme Court’s *McAtee* decision to be consistent with its combined condition analysis which refers to the accidental injury/incident. Under such circumstances, the Board concluded that the *Brown* court’s description of a combined condition as a “work-related injury/incident” combined with a preexisting condition was consistent with the Supreme Court’s reference to a combined condition as “two medical problems simultaneously.”

Addressing whether the carrier had met its burden of proof under ORS 656.266(2)(a), the Board determined that the medical evidence did not persuasively establish that the otherwise compensable injury (*i.e.*, the work-related injury/incident) was not the major contributing cause of claimant’s disability/need for treatment of the combined condition. In doing so, the Board noted that the opinions of the physicians advanced by the carrier either did not accept the proposition that a combined condition existed or had not addressed the cause of claimant’s “disability/need for treatment.” Considering such deficiencies, the Board did not find the physicians’ opinions to be persuasive. See *Roxie J. Bartell-Fudge*, 66 Van Natta 1009, 1016 (2014), *Lowell P. Hubbell*, 62 Van Natta 2446, 2449 (2010). Furthermore, noting that another physician had attributed to claimant’s initial need for treatment of her combined condition to the work injury, the Board found that the physician’s opinion supported a conclusion that the otherwise compensable injury was the major cause of the disability/need for treatment of the combined condition, at least initially. See *Braden v. SAIF*, 187 Or App 494 (2003).

Brown court’s description of a “work-related injury/incident” combined with a preexisting condition was consistent with the McAtee Supreme Court’s reference to “two medical problems simultaneously.”

APPELLATE DECISIONS UPDATE

Penalty: “268(5)(d)” - Carrier’s Refusal to Close Claim - Based on Claimant’s Failure to Attend “IME” – Not Unreasonable

Penalty: “262(11)(a)” - Unreasonable Failure to Accept New/Omitted Medical Condition - Amounts “Then Due” Based on Ultimate Award

Walker v. Providence Health System Oregon, ___ Or App ___ (November 19, 2014). The court affirmed those portions of the Board’s order in *Joy M. Walker*, 63 Van Natta 564 (2011), previously noted 30 NCN 3, that declined to award a penalty under ORS 656.268(5)(d) for the carrier’s refusal to close claimant’s claim because, considering claimant’s failure to attend the carrier’s requested independent medical exam (IME) under ORS 656.325(1)(a), the carrier’s refusal had not been unreasonable. On appeal, claimant asserted that the IME was not “reasonably requested,” as prescribed in OAR 436-060-0095(1), but rather had been pursued for an abusive and improper purpose because the carrier was aware that claimant’s attending physician would not concur with the IME’s eventual impairment rating.

The court affirmed the Board’s determination. Citing ORS 656.325(1), the court stated that a worker who is receiving compensation is required to submit up to three IMEs. Furthermore, relying on *Robinson v. Nabisco, Inc.*, 331 Or 178, 187 (2000), the court noted that the statute is self-explanatory and gives claimants no role in selecting the person who performs the examination, but, by implication, leaves that matter to the person or entity that requests the examination.

Turning to the case at hand, the court found that it was undisputed that the requested IME was claimant’s third. Consequently, notwithstanding claimant’s concern that the IME would support the carrier’s position regarding claimant’s permanent impairment and her belief that her attending physician would not concur in the IME’s findings, the court concluded that the carrier was statutorily entitled to the IME.

In reaching its conclusion, the court emphasized that, absent an order from the WCD’s Compliance Section that relieved claimant of her obligation to attend the IME, she was required to attend the IME. The court further observed that the record supported by the Board’s determination that claimant’s concerns regarding the carrier’s motive in requesting the IME was speculative.

Absent a WCD order, the court held that claimant was required to attend the carrier’s third requested IME (even if claimant did not believe that her attending physician would concur with the IME’s findings).

Addressing another portion of the Board's order, the court reversed the Board's decision to not award a penalty under ORS 656.262(11)(a) for the carrier's unreasonable refusal to accept a "major depression" new/omitted medical condition claim (as directed by a prior litigation order) because no compensation was "then due" at the time the carrier unreasonably delayed its acceptance of the aforementioned condition. On appeal, claimant contended that a penalty award under ORS 656.262(11)(a) for the carrier's failure to accept the claim should be properly based on the compensation ultimately awarded; *i.e.*, the 35 percent unscheduled permanent disability award that she was eventually granted once the claim was accepted, processed, closed, and evaluated.

The court agreed with claimant's contention. Citing *Walker v. Providence Health Systems*, 254 Or 676, 684, *rev den*, 353 Or 714 (2013), and *Johnson v. SAIF*, 219 Or App 82 (2008), the court stated that, for the purpose of a penalty assessment under ORS 656.268(5)(d), it is the amount of compensation that is ultimately determined to be due the claimant on the date of the carrier's *de facto* refusal to close the claim that determines the basis for the penalty.

For purposes of "262(11)(a)," the amount "then due" is the compensation that was ultimately determined to be owed claimant as of the date of the carrier's unreasonable delay in accepting the claim.

Applying the *Walker* rationale concerning the term "then due" in ORS 656.268(5)(d) to the case at hand, the court held that the amount "then due" claimant for the purposes of a penalty under ORS 656.262(11)(a) is the amount of compensation that was ultimately determined to be owed to claimant as of the date of the carrier's unreasonable delay in the acceptance of the claim. Consequently, the court remanded the case for a determination of the penalty.

The court next addressed the parties' challenges to the Board determination that a Director's order suspending claimant's compensation for failing to attend the IME was unreasonable, but that the suspension ended once the carrier issued a Notice of Closure. To begin, the court acknowledged claimant's assertion that the carrier's suspension request had not strictly complied with OAR 436-060-0095(8). Nonetheless, reasoning that the rule further provided that the failure to comply with one or more requirements "may" be grounds for the denial of a suspension request, the court found no abuse of discretion in the Director's decision to suspend claimant's compensation (even if the carrier had not strictly complied with the rule).

Director's suspension authority includes limiting the duration of the suspension to the date of a closure notice.

Finally, the court considered the carrier's argument that the Director was not authorized to terminate the suspension of claimant's compensation on issuance of a Notice of Closure (even when claimant had continued to refuse to agree to the IME). The court determined that the requirement in ORS 656.325(1) that the Director consent to the suspension of benefits means that the Director's authority to give consent implicitly encompasses the authority to limit the scope of that consent, and thereby the duration of the suspension.

Claim Processing: “325(1)(a)” - WCD Suspension Order - Suspension Terminated When “NOC” Issued

Penalty: “268(5)(e)” Penalty - Order on Reconsideration PPD Award Based on Information Carrier Could Reasonably Have Known at Closure

Walker v. Providence Health System Oregon, ___ Or App ___ (November 19, 2014). The court affirmed that portion of the Board’s order in *Joy M. Walker*, 63 Van Natta 1225 (2011), previously noted 30 NCN 6, that found that a carrier was required to pay a permanent disability award granted by an Order on Reconsideration because a prior Director’s order suspending claimant’s compensation had terminated when the carrier closed the claim. Referring to OAR 436-060-0095(1), the carrier contested that, once the Director suspended claimant’s compensation (based on her refusal to attend an IME), that suspension continued until such time as the IME was completed.

The court disagreed with the carrier’s position. After reviewing ORS 656.325(1), the court stated that the Director was statutorily authorized to determine whether to give consent to a carrier’s “suspension of compensation” request. Moreover, the court reasoned that the Director implicitly had authority to determine the duration of that consent.

Turning to the case at hand, the court found that in issuing that suspension order, the Director had expressly limited the consent to suspend compensation to the period during which the claim was open. Consequently, once the carrier closed the claim, the court concluded that the suspension of compensation terminated.

The court next addressed claimant’s appeal of those portions of the Board’s order that did not award a penalty under ORS 656.268(5)(e) and an attorney fee under ORS 656.382(1) for the carrier’s failure to award permanent disability in its Notice of Closure for claimant’s new/omitted depression condition. In reaching its conclusion, the Board had reasoned that the carrier could have reasonably interpreted claimant’s attending physician’s opinion to have attributed at least a portion of claimant’s symptoms to causes other than her compensable conditions. Because clarification of the attending physician’s findings were not received until the ARU conducted its reconsideration proceeding (which resulted in claimant’s permanent disability award), the Board had concluded that the carrier could not reasonably have known at the time of claim closure that claimant’s work-related permanent impairment would be at least 20 percent. See ORS 656.268(5)(e).

Because the carrier could have requested clarification of the attending physician's impairment findings before issuance of the closure notice, the court concluded that the carrier could reasonably have known the information that ultimately resulted in the Order on Reconsideration's permanent disability award.

The court rejected the Board's reasoning. Had the carrier been uncertain at the time of closure when the attending physician believed that all of claimant's permanent impairment was related to her compensable condition, the court reasoned that it could have simply requested clarification from the attending physician (as ARU eventually did). In the absence of such an inquiry, the court disagreed with the Board's conclusion that the carrier could not reasonably have known such work-related "impairment information" at the time of closure.

The court also rejected the Board's procedural analysis that ambiguity in the Director's suspension order (concerning when the suspension terminated) established that the employer could not have reasonably known at claim closure that the suspension order had terminated upon claim closure. Reiterating that the Director's order expressly stated that the order terminated upon closure of the claim, the court did not consider it to be a plausible interpretation of ORS 656.325 that a suspension of benefits could continue after the termination of the suspension order.

Premature Closure: "Post-ATP"/"268(10)" - "Med Stat"/"Closing Exam" Requirements

Penalty: "268(5)(d)" - Unreasonable Claim Closure - Based on "All" Amounts "Then Due" When "NOC" Issued

Liberty Northwest Insurance Corp. v. Olvera-Chavez, ___ Or App ___ (November 19, 2014). The court affirmed that portion of the Board's order in *Jose L. Olvera-Chavez*, 64 Van Natta 1745 (2012), previously noted 31 NCN 9, which found that the carrier had prematurely closed claimant's low back claim because, following the termination of an Authorized Training Program (ATP), the carrier had not obtained an attending physician's opinion that his condition was medically stationary and had not generated sufficient information to determine the extent of his permanent disability at the time of claim closure. In reaching its conclusion, the Board had acknowledged that a "pre-ATP" Order on Reconsideration had affirmed a previous Notice of Closure (NOC) finding that claimant's condition was medically stationary before the ATP and, in addition, had recognized that, following the ATP, (because there was no contention that claimant had experienced an aggravation), he was only entitled to a redetermination of his work disability award on closure of his "post-ATP" claim. Nonetheless, reasoning that such a redetermination required consideration of claimant's abilities in light of his impairment and further necessitated a closing medical examination, the Board had held that there was insufficient information to close the claim.

On appeal, the carrier argued that there was no statutory or administrative requirement for a redetermination of claimant's medically stationary status before claim closure after an ATP. Moreover, the carrier noted that, in issuing its Order on Reconsideration, the Appellate Review Unit (ARU)

Before closing a claim after an “ATP,” a carrier was required to have “sufficient information” to determine work disability which necessitated a closing exam, including a “post-ATP” medical opinion concerning “medically stationary” status.

Penalty for unreasonable closure under “268(5)(d)” is based on all compensation determined to be “then due” at the time of the unreasonable claim closure.

Attorney fees are neither awarded for prevailing on a penalty issue on appeal nor for defending an attorney fee award on appeal.

had affirmed the “post-ATP” NOC, which indicated that there was no need to a redetermination of claimant’s medically stationary status or a new closing examination to determine the extent of his work disability. See *Don’t Waste Oregon Com. v. Energy Facility Siting Council*, 320 Or 132, 142 (1994); *Coats-Sellers v. ODOT*, 209 Or App 281, 287 (2006) (when an agency interprets its own rules, the court defers to the agency’s interpretation if it is plausible and not inconsistent with the wording of the rule, its context, or any other source of law).

The court disagreed with the carrier’s contention. The court acknowledged that, under ORS 656.268(10), the redetermination of permanent disability after an ATP is limited to work disability. Nonetheless, reasoning that ORS 656.268(1) permits claim closure when the worker is medically stationary and there is sufficient information to determine permanent disability (without any exception for a “post-ATP” claim closure), the court agreed with the Board’s determination that the carrier was required to have “sufficient information” to determine work disability which necessitated a closing examination, as well as a “post-ATP” medical opinion concerning claimant’s “medically stationary” status.

To the extent that ARU had interpreted its administrative rule (OAR 436-030-0020(13)(c)) to support the proposition that a closing examination was not required where there had been no aggravation, the court held that such an interpretation conflicted with ORS 656.268 and was neither plausible nor entitled to deference.

Addressing the Board’s finding that the carrier’s claim closure had been unreasonable, the court agreed with the Board’s determination that the carrier had unreasonably failed to continue paying temporary disability (TTD) benefits after the ATP, until claim closure. Citing OAR 436-060-0040(4), and *Atchley v. GTE Metal Erectors*, 149 Or App 581, 586, *rev den*, 326 Or 133 (1997), the court reasoned that, because claimant was not entitled to the resumption of a permanent disability award following the ATP, and was not working, the carrier was obligated to continue paying “post-ATP” TTD benefits until claim closure.

Finally, the court agreed with claimant’s cross-petition that the penalty assessment should be based on all compensation determined to be “then due” when the unreasonable NOC had issued, rather than the amount then due as of the date the hearing record closed (as the Board had awarded). Citing *Walker v. Providence Health System Oregon*, 254 Or App 676, 684 (2013), the court reiterated that the “relevant point in time” for determining the amount “then due” is “the time at which the unreasonable notice of closure or refusal to close was issued.”

Regarding claimant’s attorney fee award under ORS 656.382(1), the court disagreed with his contention that the Board had erred in limiting his counsel’s award to services expended at the hearing level and not for services before the Board in establishing his right to penalties and attorney fees. Relying on *Cayton v. Safelite Glass Corp.*, 258 Or 522, 525 (2013), and *Dotson v. Bohemia, Inc.*, 80 Or App 233, 236, *rev den*, 302 Or 35 (1986), the court reiterated that penalties are not “compensation,” attorney fees are not awarded for prevailing on an issue of penalties and that the term “compensation” as used in ORS 656.382(2) does not include attorney fees.