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BOARD NEWS

Portal Troubleshooting Tips

The Workers' Compensation Board offers a number of notifications through the portal. Those notifications are listed under the "Contacts" tab in each user's portal account. Some portal users have experienced difficulties receiving some of their notifications. Set forth below are measures that users can take to address any "notification" problems.

SETTING UP YOUR CONTACTS

Verify Notification: Review your "contacts." In doing so, verify that the appropriate check box is marked.

Verify your Email: If your email address has been entered incorrectly you will not receive the notifications.

Check Contact History: Review whether a notification was sent to you in the "Contact History" link under the "Contacts" tab. This "history" lists all notifications sent to the user's designated contacts.

Firm Notifications vs. Person Notifications: Verify whether you are designated to receive a specific attorney's notifications. To edit this "designation notification," uncheck the box that states "Notify me of cases I am directly involved in." This will ensure that you will receive all notifications.

More than one Contact: If a registered user has more than one contact, confirm that all the above measures are reviewed for each individual contact.

Always Accept Email from the Portal: Add the Portal's email address to your "safe" email addresses. This action will ensure that spam filters or other email rules will not block the portal notifications.

CHECK YOUR FIREWALL/SPAM FILTER/EMAIL SETTINGS

Below is a list of articles regarding spam filters for various email providers. These articles vary in difficulty but are a first step for users who are having "email notification" issues. This list is a compilation of major email providers as well as some others.

Comcast - <http://customer.comcast.com/help-and-support/internet/spam-filters-and-email-blocking/>

Yahoo - <https://help.yahoo.com/kb/mail/check-filters-sln5075.html>

(Google) Gmail - <https://support.google.com/a/answer/2368132?hl=en>

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Hotmail - <http://onlinehelp.microsoft.com/en-us/msn/ff808716.aspx>

Outlook - [http://technet.microsoft.com/en-us/library/cc179183\(v=office.15\).aspx](http://technet.microsoft.com/en-us/library/cc179183(v=office.15).aspx)

CenturyLink (Qwest) - <http://www.centurylink.com/help/index.php?assetid=130>

AOL -

<http://help.aol.com/help/microsites/microsite.do?cmd=displayKC&docType=kc&externalid=217148>

Frontier - <http://www.frontierhelp.com/faq.cfm?qstid=995>

BendBroadBand -

http://help.bendbroadband.com/sp_kb_detail.asp?kb=100119&adct=3&pageID=bbbs&subID=hsi

Mac Mail - <http://support.apple.com/kb/PH4868>

FiOS (Verizon) -

<http://www.verizon.com/support/residential/internet/highspeed/email/messagecenter/questions/email+settings.htm#>

You can also contact your Internet Service Provider (ISP) to assist you further.

CONTACT PORTAL SUPPORT

You may also contact WCB for assistance. The portal email address is wcbportal@cbs.state.or.us or call 503-378-3308 and ask to be connected to Portal Support. In addition, "one-on-one training" at a user's office is available.

CASE NOTES

Attorney Fee: "386(1)" - Medical Services - Causation Dispute - Prior Unappealed, "Final" ALJ's Order Neglected to Award "Contingent" Award

John G. Adams, 66 Van Natta 819 (May 7, 2014). The Board held that the Hearings Division was not authorized to award a carrier-paid attorney fee under ORS 656.386(1) because an earlier ALJ order (which had found a causal relationship between a proposed medical service and his accepted condition, but neglected to award a "contingent" attorney fee) had not been appealed and had become final. Following an earlier proceeding before an ALJ, claimant established that a disputed medical service was causally related to his accepted left shoulder condition. However, noting that a "propriety" dispute remained pending before the Workers' Compensation Division (WCD), the earlier ALJ order did not award a "contingent" attorney fee. That order was not appealed and became final. Thereafter, a WCD order found that the medical services were appropriate treatment and awarded a carrier-paid attorney fee under ORS 656.385(1) for claimant's counsel's services rendered before WCD. Claimant

then filed a request for an attorney fee award under ORS 656.386(1) for his counsel's services expended during the previous hearing regarding the causation dispute. When the ALJ denied the request, claimant appealed, contending that the earlier ALJ's order was not final.

The Board disagreed with claimant's contention. Citing *Antonio L. Martinez*, 58 Van Natta 1814 (2006), *aff'd*, *SAIF v. Martinez*, 219 Or App 182 (2008), and *Nathaniel D. Erdkamp*, 63 Van Natta 2325, 2329 (2011), the Board stated that, when a claimant prevails over the "causation" portion of a medical service denial, but the "propriety" dispute remains pending before WCD, an ALJ is authorized to award a "contingent" attorney fee, which would be payable in the event the claimant prevails before WCD.

When earlier ALJ's order did not include a "contingent" attorney fee and became final by operation of law, current ALJ/Board lacked authority to alter that decision.

Turning to the case at hand, the Board acknowledged that the earlier ALJ's order (which finally determined the "causation" dispute concerning the medical service claim) had neglected to also include a "contingent" attorney fee award. Nevertheless, the Board reasoned that claimant's remedy to correct that omission was to either seek reconsideration or request review before the earlier ALJ's order became final. Because the earlier ALJ's order had not been appealed and had become final by operation of law, the Board concluded that the present ALJ had no authority to alter the earlier final decision, which had not granted a carrier-paid attorney fee award pursuant to ORS 656.386(1).

Claim Preclusion: New/Omitted Medical Condition Claim - "267(1)" - Prior Unappealed Denial - Precluded Claim For "Same Condition"

Dennis E. Reynolds, 66 Van Natta 966 (May 23, 2014). Analyzing ORS 656.267(1), the Board held that claimant's new/omitted medical condition claim for a L5-S1 disc herniation was precluded because the carrier's previous unappealed denial of that condition had severed the causal relationship between his work injury and the claimed L5-S1 disc condition. Following claimant's work injury, the carrier accepted a lumbar strain. Subsequently, claimant filed a new/omitted medical condition claim for a L5-S1 disc herniation. The carrier denied that claim, contending that the condition was unrelated to claimant's work injury. Claimant did not file a hearing request contesting that denial. Approximately one year later, claimant filed another new/omitted medical condition claim for his L5-S1 disc herniation. The carrier issued a denial, asserting that the claim was precluded by the previously unappealed denial. Claimant requested a hearing, arguing that his claimed condition had worsened since the prior denial and, as such, was not precluded.

The Board disagreed with claimant's contention. Citing *Drews v. EBI Cos.*, 310 Or 134, 142-43 (1990), the Board stated that claim preclusion bars the litigation of a claim based on the same factual transaction that was, or could have been, litigated between the parties in a prior proceeding that has reached a final determination. Relying on *Yi v. City of Portland*, 258 Or App 526, 530-31 (2013), the Board noted that new evidence, without new operative facts, does

When a previous denial of a new/omitted medical condition claim for the same condition as a subsequent claim had not been appealed, the subsequent claim was precluded because a compensable causal connection between the work injury and the condition had been severed.

not allow a party to escape claim preclusion. Finally, referring to *Stacy Frierson*, 59 Van Natta 399, 400 (2007), the Board reiterated that, notwithstanding ORS 656.267(1) (which provides that a new/omitted medical condition claim may be initiated “at any time,” see *Evangelical Lutheran Good Samaritan Society v. Bonham*, 176 Or App 490, 497-98 (2001)), an unappealed denial precludes a later claim for that denied condition.

Turning to the case at hand, the Board acknowledged that the treating surgeon opined that claimant’s L5-S1 disc herniation had arisen from his work injury and worsened over time. Yet, despite any change in claimant’s condition after the previous denial, the Board determined that the present new/omitted medical condition claim was based on the same operative facts that existed when the prior denial had issued (*i.e.*, the causal relationship between claimant’s L5-S1 disc herniation and his work injury). Under such circumstances, the Board concluded that claimant’s new/omitted medical condition claim for his current L5-S1 disc herniation was precluded.

In reaching its conclusion, the Board distinguished *Ahlberg v. SAIF*, 199 Or App 271, 275-76 (2005), which had held that a claimant’s occupational disease claim was not precluded by a previous occupational disease denial. Relying on its reasoning in *Frierson*, the Board explained that an occupational disease claim under ORS 656.802(2)(b) concerns “any or all working conditions” (which according to *Ahlberg* applies regardless of whether the employment exposure preceded or followed the earlier denial), whereas the present case concerned a new/omitted medical condition claim for the same condition that was based on the same facts that the previous, unappealed denial had addressed.

Finally, even assuming that the present new/omitted medical condition claim was not precluded, the Board was not persuaded by the treating surgeon’s “causation” opinion. Noting that the previous unappealed denial had asserted that claimant’s L5-S1 disc herniation did not result from his work injury, the Board reasoned that the surgeon’s opinion (which was based on a causal relationship between claimant’s condition and the work injury) was contrary to the “law of the case” and, as such, unpersuasive. See *SAIF v. Kuhns*, 73 Or App 768, 772 (1985).

Claim Processing: Objection to Initial Notice of Acceptance - “262(6)(d), (7)(a)” - Claimant Must First File New/Omitted Medical Condition Claim - No *De Facto* Denial From Carrier’s Initial Claim Acceptance

Mai K. Moua, 66 Van Natta 848 (May 13, 2014). The Board held that a carrier’s acceptance of a shoulder sprain in response to claimant’s injury claim for pain her shoulder, lower back, and left leg did not constitute a *de facto* denial of her lumbar conditions. After the carrier’s shoulder acceptance in response to claimant’s initial claim, claimant eventually filed a new/omitted medical condition

A de facto denial of an omitted condition from an initial Notice of Acceptance cannot be established until after a carrier fails to respond to an omitted medical condition claim initiated under “267.”

claim for lower back and leg “pain.” Within 60 days of the new/omitted medical condition claim, the carrier issued a denial, contending that “symptoms” did not constitute medical “conditions.” After claimant filed a hearing request regarding the denial, she also filed another new/omitted medical condition claim for lumbar strain, L4-5 disc herniation, and L5 nerve root impingement. When the carrier accepted the claim for those conditions, claimant requested an attorney fee award for securing the acceptance and penalties/attorney fees for unreasonable claim processing.

The Board denied claimant’s requests. Citing ORS 656.262(6)(d) and (7)(a), the Board stated that, unless a claimant objects to the omission of a condition from an initial Notice of Acceptance by claiming the omitted medical condition under ORS 656.267, the claimant may not allege a *de facto* denial at any hearing based on the acceptance notice. Relying on *Kenneth Hawes*, 54 Van Natta 1915 (2002), *Shannon E. Jenkins*, 48 Van Natta 1482 (1996), *aff’d without opinion*, 135 Or App 436 (1997), the Board stated that a claimant cannot establish a *de facto* denial of a condition omitted from an initial Notice of Acceptance until after the carrier fails to respond to a claim under ORS 656.267 for the omitted medical condition.

Turning to the case at hand, the Board found that the carrier had issued a timely acceptance of claimant’s initial injury claim. In addition, the Board noted that the carrier had timely responded to claimant’s new/omitted medical condition claim for lower back/leg pain by issuing a denial on the basis that “symptoms” were not “conditions.” See *SAIF v. Stephens*, 247 Or App 107 (2011); *Young v. Hermiston Good Samaritan*, 223 Or App 99, 107 (2008). Finally, the Board observed that, within 60 days of claimant’s eventual new/omitted medical condition claim for specific low back conditions, the carrier had accepted the properly claimed conditions.

Under such circumstances, the Board concluded that the carrier had timely responded to claimant’s claims, including accepting her eventual new/omitted medical condition claim within 60 days of its filing. Consequently, the Board determined that the carrier’s claim processing was not unreasonable and that penalties/attorney fee awards were not warranted.

Relying on “262(6)(b)(F),” the concurrence asserted that claimant’s right to pursue a new/omitted medical condition claim does not relieve a carrier of its independent duty to modify its claim acceptance based on changes in its knowledge of a compensable omitted medical condition.

Member Weddell concurred. Although agreeing that penalty and attorney fee awards were not justified in the present case, Weddell emphasized that a carrier has the duty to modify its acceptance as medical or other information changes a previously issued Notice of Acceptance. See ORS 656.262(6)(b)(F). Although acknowledging a claimant’s right to pursue an omitted medical condition claim under ORS 656.262(6)(d) and (7)(a), Member Weddell reasoned that a carrier was not relieved of its independent duty to initially determine what conditions are compensable and to modify its acceptance based on changes in its knowledge of a compensable omitted medical condition.

In those cases where a carrier neglects to process a claim in accordance with the aforementioned statutory requirements, Weddell observed that such inaction could result in penalties and attorney fees under ORS 656.262(11)(a) and ORS 656.382(1) for an unreasonable resistance to the payment of compensation. However, because there was evidence at the time of the carrier’s initial acceptance and subsequent new/omitted medical condition denial that claimant’s lumbar conditions were not compensable, Member Weddell did not consider the carrier’s conduct to have been unreasonable.

Claim Processing: “Recon Order” Rescinded “NOC” - No TTD Due/Payable - “Pre-Closure” “Ceases” Denial Remained Pending

John S. McKean, 66 Van Natta 805 (May 7, 2014). The Board held that a carrier was not obligated to reinstate claimant’s temporary disability (TTD) benefits after an Order on Reconsideration rescinded a Notice of Closure (NOC) as premature because the carrier’s “pre-closure” “ceases” denial of his combined condition remained pending. Following the closure of claimant’s lumbar strain claim, claimant requested acceptance of a combined spondylosis condition. Thereafter, the carrier accepted the combined condition, reopened the claim and, before claim closure, issued a “ceases” denial of the combined condition under ORS 656.262(6)(c) and (7)(b). Claimant then requested a hearing, contesting the carrier’s denial. After a reconsideration order rescinded the NOC, claimant filed another hearing request, contending that the carrier had unreasonably refused to reinstate his TTD benefits.

The Board disagreed with claimant’s contention. Citing ORS 656.262(4)(a), OAR 436-060-0020, and *Zachary Stegman*, 65 Van Natta 1002, 1005 (2013), the Board stated that, upon accepting claimant’s combined condition, the carrier was required to determine his entitlement to TTD benefits and, if claimant was so entitled, begin paying such benefits within 14 days of its acceptance.

Turning to the case at hand, the Board noted that, within 14 days of the carrier’s acceptance, it had issued its “ceases” denial of the combined condition. Thus, the Board concluded that the carrier was not obligated to begin paying TTD benefits after its combined condition acceptance.

Furthermore, the Board acknowledged that the Order on Reconsideration had rescinded the NOC, thereby reinstating the carrier’s responsibility to process the claim. Nonetheless, reasoning that the carrier’s “ceases” denial remained pending following the Order on Reconsideration, the Board determined that it was not unreasonable for the carrier to refrain from paying TTD benefits commencing after the effective date of its “ceases” denial.

Costs: “386(2)(a)” - “Reasonable” Witness Fee” - “44.415(1)” Rate - Even Though SAIF “Public Body” Under “44.415(2)”

Ronald Dean, 66 Van Natta 961 (May 22, 2014). Applying ORS 656.386(2)(a), the Board held that claimant’s counsel was entitled to full reimbursement of a claimed witness fee (which was based on \$30 per day and 25 cents per mile, as prescribed in ORS 44.415(1)), despite the SAIF Corporation’s status as a “public body” under ORS 44.415(2) (which provides that witness fees and mileage reimbursement for proceedings involving a “public

Because a carrier’s “ceases” denial remained pending after a reconsideration order rescinded a closure notice, it was not unreasonable for a carrier to refrain from reinstating claimant’s TTD benefits after the effective date of its denial.

body” are \$5 per day 8 cents per mile). After claimant prevailed over SAIF’s claim denial, his counsel submitted a cost bill to SAIF, seeking reimbursement (\$31.44) for a witness fee/mileage reimbursement for a witness who appeared at the prior hearing. SAIF reimbursed claimant’s counsel \$5.69, asserting that because it was a “public body” under ORS 44.415(3), a reasonable witness fee/mileage reimbursement was subject to ORS 44.415(2), rather than ORS 44.415(1), which claimant’s counsel had applied. Claimant requested a hearing, contending that the witness fee/mileage costs that his counsel had incurred at the previous hearing were reasonable and, as such, SAIF was obligated to provide full reimbursement of the claimed costs.

The Board agreed with claimant’s contention. Citing ORS 656.386(2)(a), the Board stated that a claimant who finally prevails over a denial may be awarded reimbursement of a claimant’s reasonable expenses and costs for records, expert opinions, and witness fees. Relying on subsection (2)(b), the Board noted that an ALJ, Board, or court is authorized to determine the reasonableness of such fees, expenses, and costs to be reimbursed. Referring to OAR 438-007-0020(5), the Board observed that witness fees and mileage costs shall be provided at the time the subpoena is served, in the amount provided for in civil actions. Finally, examining ORS 44.435(1) and (2), the Board acknowledged that, under section (1), a daily witness fee is \$30 and mileage reimbursement is 25 cents per mile, whereas under section (2) for proceedings involving a “public body” a daily witness fee is \$5 and mileage reimbursement is 8 cents per mile.

Turning to the case at hand, the Board stated that, pursuant to ORS 44.415(3), a public corporation is a “public body.” Furthermore, citing ORS 656.751(1), *Johnson v. SAIF*, 343 Or 139 (2007), and *Frohnmayr v. SAIF*, 294 Or 570, 577 n 3 (1983), the Board noted that SAIF is an “independent public corporation.”

Under such circumstances, the Board acknowledged that a witness in a proceeding to which SAIF is a party is “entitled” under ORS 44.415(2) to receive \$5 per day and 8 cents per mile. Nevertheless, the Board reasoned that such a determination did not end the inquiry regarding the reasonableness of claimant’s claimed witness fee.

After reviewing ORS 44.415, the Board considered the codification of the witness fee in section (1) as the generally applicable statutory witness fee, to which section (2) is merely an exception. As such, the Board interpreted section (1) as a reasonable fee to pay a witness. The Board further commented that section (2) neither prohibits parties to such proceedings from paying the witness fee under section (1) nor did it mean that claimant’s counsel’s payment of the witness fee pursuant to section (1) was unreasonable.

Finally, the Board observed that the legislative history (as presented by a claimant’s attorney) supported an intention to provide reimbursement to claimants for “out-of-pocket expenses” and the typical “witness fee” anticipated to be “thirty five or forty dollars.” The Board further noted the absence of testimony/comments in the legislative history indicating a contrary interpretation that SAIF would reimburse claimants’ witness fees at a lower rate.

Although SAIF is a “public body,” a claimant’s cost bill seeking reimbursement of a witness fee paid pursuant to ORS 44.415(1) (rather than subsection (2)) was reasonable.

Under such circumstances, the Board concluded that claimant's counsel's claimed witness fee was reasonable. Consequently, the Board directed SAIF to fully reimburse the claimed fee.

Course & Scope: Fall During Rest Break - Returning From "Smoking Hut" in Public Parking Lot - No "Employer" Right of Control - "Parking Lot" Exception to "Going & Coming" Rule Not Applicable

Appellate Procedure: Scope of Review on Remand Limited to "Parking Lot" Exception to "Going & Coming" Rule - Based on Court's "Mandate"

Kevinia L. Frazer, 66 Van Natta 761 (May 2, 2014). On remand from the Court of Appeals, *Enterprise Rent-A-Car Co. of Oregon v. Frazer*, 252 Or App 726 (2012), the Board held that claimant's injury, which occurred when she fell while returning to her employer's office from a "smoking hut" in the parking lot of the "strip mall" where her employer was a tenant, did not occur in the course of her employment because her employer did not have the right to exercise control over the parking lot or the area where she had fallen. Although her employer had two break rooms for its employees, they were also permitted to leave the office during breaks to get coffee or to run errands. The employer's office was located in a "strip mall" with other businesses. The mall also contained a public parking lot, which included some spaces for customers and employees. The employer neither owned nor exercised control over the parking lot, but leased some spaces. Those spaces were not in the same area as a "smoking hut," where some of the employer's workers would take their breaks. Claimant's employer did not own the "smoking hut." Although the employer had "shooed away" some homeless people from the "hut," its use was not limited to only claimant's coworkers. On the day of her injury, claimant took her break with some coworkers at the "smoking hut." As she returned to her employer's office through the parking lot, she tripped on a crack in the pavement, causing her to fall, twisting her knee and ankle. The carrier denied her claim, contending that her injury did not arise out of and in the course of her employment because it occurred while she was returning to work in an area where her employer did not exercise any control.

Consistent with the court's mandate, the Board identified the issue as whether the "parking lot" exception to the "going and coming" rule applied. Citing *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366 (1994), the Board stated that injuries sustained while an employee is going to or coming from the place of employment generally do not occur "in the course of" employment. However,

the Board noted that, under the “parking lot” exception to the “going and coming” rule, when an employee traveling to or from work sustains an injury “on or near” the employer’s premises, the “in the course of employment” portion of the work-connection test may be satisfied if the employer has the right to exercise some “control” over the place where the injury is sustained. *Gilmore*, 318 Or at 367; *Beverly M. Helmken*, 55 Van Natta 3174, 3175 (2003), *aff’d without opinion*, 196 Or App 787 (2004). The Board further observed that “control” may arise from the employer’s property rights to the area, as a result of an increased employer-created hazard, from the employer’s obligation to maintain the area where the injury occurred, or the employer’s obligation to pay for maintenance (together with the right to require maintenance). See *Cope v. West Amer. Ins. Co.*, 307 Or 232, 239 (1990); *Montgomery Ward v. Malinen*, 71 Or App 457 (1984); *Montgomery Ward v. Cutter*, 64 Or App 759 (1983).

Because the employer did not have sufficient control over the area where claimant was injured while on her paid break, the “parking lot” exception to the “going and coming” rule did not apply.

Turning to the case at hand, the Board found that claimant was injured in an area of the parking lot that was open to the public, rather than the fenced area, where her employer’s leased parking spaces were located. The Board further determined that the employer was not obligated, or had any right, to direct how the area where claimant was injured was maintained, handled, used, or operated.

Under such circumstances, the Board concluded that the employer did not have sufficient control over the area where claimant was injured. Consequently, the Board held that the “parking lot” exception to the “going and coming” rule did not apply. See *Christyne Belden*, 65 Van Natta 737 (2013).

In reaching its conclusion, the Board acknowledged that portions of the *Frazer* court’s opinion could be interpreted as expanding its scope of review on remand beyond the “parking lot” exception to other theories. Nonetheless, noting that the court’s mandate at the conclusion of its opinion expressly (and unequivocally) focused on the “exercise of control” issue under the “parking lot” exception, the Board reasoned that its scope of review was limited to that particular exception.

Even if “personal comfort” doctrine was considered, the controlling case precedent did not expressly recognize the doctrine as an exception to the “going and coming” rule.

In any event, even if it could consider other theories, the Board determined that such arguments were not adequately raised in the prior proceedings and, as such, declined to address them for the first time on remand. See *Karen M. Godfrey*, 58 Van Natta 2892 (2006), *aff’d*, 218 Or App 496 (2008); *William A. Hedger*, 58 Van Natta 2382 (2006). Finally, even if it could consider the “personal comfort” doctrine (a theory advanced by claimant on remand), the Board observed that the controlling case precedent did not expressly recognize the doctrine as an exception to the “going and coming” rule.

Member Weddell dissented. Reasoning that the court had remanded for the Board to consider whether “any exceptions to [the going and coming] rule applied” and observing that both parties had argued the merits of the “personal comfort” doctrine as an exception to the “going and coming” rule, Weddell contended that the doctrine should be addressed.

Applying that doctrine, Member Weddell stated that, had claimant’s injury occurred on the employer’s premises, it would have satisfied the “personal comfort” doctrine because the conduct she was engaged in was expressly or impliedly allowed by her employer. See *Clark v. U.S. Plywood*, 288 Or 255

(1980). However, observing that claimant's injury had occurred off the employer's premises, Weddell acknowledged that application of the "personal comfort" doctrine was less straightforward.

Nevertheless, as illustrated by *Mellis v. McEwen, Hanna, Gisvold*, 74 Or App 571, *rev den*, 300 Or 249 (1985), *Halfman v. State Acc. Ins. Fund*, 49 Or App 23 (1980), and *Jordan v. Western Electric Co.*, 1 Or App 441 (1970), Member Weddell reasoned that a worker traveling to or from work during a break does not take the worker out of the course of employment if the time, place, and circumstances of the injury establish a sufficient work relationship during a "personal comfort" activity. After comparing those decisions with the present record, Weddell was persuaded that there was a sufficient work relationship between claimant's "personal comfort" activity and her injury.

Because claimant was injured during "employer-contemplated" coffee break at a location customarily used by the employer's employees and her "off-premises" break provided some benefit to the employer, dissent considered the "personal comfort" doctrine to have been satisfied as an exception to the "going and coming" rule.

Specifically, Member Weddell contended that claimant was injured during her coffee break that was contemplated and acquiesced in by her employer, she was on a paid break at a location customarily used by the employer's employees during such breaks (and she was not permitted to take a break at her work space) and her "off-premises" break provided some benefit to her employer. Consistent with the *Jordan*, *Halfman*, and *Mellis* holdings (and noting that the connection between claimant's "personal comfort" activity and the course of employment was slightly stronger than that present in *Mellis*, where the claimant was permitted to remain in her work space during her breaks), Weddell considered the "personal comfort" doctrine to have been satisfied and, as such, operated as an exception to the "going and coming" rule.

Course & Scope: "Resident" Mobile Home Park Manager - Fell While Inspecting Park for "Storm Damage" - Sufficient Work Connection, Despite Also Taking Dog for "Potty Break" - "Bunkhouse Rule" Also Applicable

Rebecca L. Nehring, 66 Van Natta 734 (May 1, 2014). The Board held that an injury sustained by claimant (an on-site mobile home park manager), which occurred when she fell in her yard while looking for storm damage in the park, arose out of and in the course of her employment because her injury happened during her regular work hours in preparation for her meeting with her supervisor and the fact that she was also taking her dog for a "potty break" did not sever the connection between her injury and her employment. Following a wind storm the previous evening, claimant decided, in advance of a scheduled meeting with her supervisor, to go outside of her home to inspect damage to the park, as well as to take her dog out for a "potty break." While she was outside, claimant lost her balance due to a wind gust, striking her head on a railroad tie that had been installed by her employer as a border between her yard and the park's general parking area. The carrier denied the claim, contending that claimant's injury occurred while she was engaged in a purely personal activity with her dog.

The Board disagreed with the carrier's contention. To begin, the Board determined that the carrier had not established that claimant was injured while participating in a recreational or social activity engaged in primarily for her personal pleasure. See ORS 656.005(7)(b)(B). In doing so, the Board was not persuaded that claimant's "dog-related" activity was either "social" or "recreational." See *Roberts v. SAIF*, 196 Or App 414, 417 (2004), *aff'd*, 341 Or 48 (2006); *Legacy Health Systems v. Noble*, 232 Or App 93, 98 (2009).

The Board further concluded that claimant's injury arose out of and in the course of her employment. Citing *Robinson v. Nabisco, Inc.*, 331 Or 178, 186 (2000), the Board stated that to occur "in the course of" employment, the time, place, and circumstances of the injury must justify connecting the injury to the employment. Furthermore, relying on *Krushwitz v. McDonald's Restaurants*, 323 Or 520, 525-26 (1996), the Board noted that to meet "the arising out of" employment prong of the work connection test, there must be some causal relationship between the injury and the employment. Finally, referring to *Krushwitz*, the Board observed that the work connection test may be satisfied if the factors supporting one prong are minimal while the factors supporting the other prong are many. 323 Or at 531.

Turning to the case at hand, the Board found that "the course of" employment element had been strongly satisfied. In reaching this finding, the Board determined that claimant was injured within the period of her employment, at a place where she was reasonably expected to be (the yard of her home), while she was reasonably fulfilling the duties of her employment or doing something reasonably incidental to it (check, or at least intending to check, for storm damage).

The Board also found the "arising out of" employment element satisfied. In doing so, the Board reasoned that claimant's injury resulted from a risk of her work environment because she was outside during her regular work hours for the purpose of inspecting storm damage and in preparation for an upcoming meeting with her supervisor, which fulfilled her obligations as the mobile home park manager.

The Board recognized that claimant was also outside at the time of her injury to take her dog for a "potty break." Nonetheless, the Board noted that her employer was aware that she owned a dog and did not prohibit the dog from being on the premises. In any event, the Board reasoned that the additional personal reason for claimant's being outside was not sufficient to sever the connection between her injury and her employment.

Alternatively, the Board concluded that claimant's injury was compensable under the "bunkhouse rule," which is applicable when a worker is required to live on the employer's premises and is injured as a result of the condition in which the employer maintains those premises. See *Leo Polehm Orchards v. Hernandez*, 122 Or App 241, 246 (1993) *Margaret A. Jones*, 61 Van Natta 1867, 1872 (2009).

Because claimant was injured within the period of her employment (as an on-site manager for a mobile home park), at a place where she was reasonably expected to be (the yard of her home), while she was reasonably fulfilling her duties of employment (intending to check for storm damage), her injury occurred in "the course of" her employment.

Because claimant was required to live on the employer's premises and was injured when she fell on a railroad tie installed by the employer, her injury was also compensable under the "Bunkhouse Rule."

In reaching this alternative conclusion, the Board reasoned that both elements of the rule had been satisfied. First, the Board stated that it was undisputed that claimant was required to live on the employer's premises. Secondly, the Board found that she was injured when she fell on a railroad tie that her employer had installed between her yard and a parking area for residents and guests of the mobile home park.

Consequently, even if claimant's injury was not compensable under the conventional "arising out of and in the course of employment" analysis, the Board held that her injury would be compensable under the "bunkhouse rule."

Medical Services: "704(3)(b)(C)" - Unpaid Medical Bill - "Causation" Dispute - Jurisdiction - Board

Attorney Fee: "386(1)" - "Contingent" Award - 30 Days to Seek WCD Review Concerning "Propriety" Dispute

Stephen H. Moore, 66 Van Natta 812 (May 7, 2014). Applying ORS 656.704(3)(b)(C), the Board held that the Hearings Division was authorized to resolve a dispute regarding the causal relationship between claimant's accepted psychological condition and unpaid medical bills. In response to claimant's medical bill for his psychological condition, the carrier issued an "explanation of benefits," stating that the bill was disallowed because the service appeared to be unrelated to his compensable condition. After claimant requested a hearing concerning a *de facto* denial of his medical service claim, the carrier moved to dismiss the request, asserting that the matter should first be presented to the Workers' Compensation Division.

Because the carrier was contesting the causal relationship between unpaid medical bills and an accepted condition, the dispute was subject to the Hearings Division's jurisdiction.

The Board disagreed with the carrier's assertion. Citing ORS 656.704(3)(b)(C), and *AIG Claim Services, Inc. v. Cole*, 205 Or App 170, 173 (2006), the Board stated that a dispute regarding whether a sufficient causal relationship exists between medical services and an accepted claim is within its jurisdiction because it is a "matter concerning a claim" under ORS 656.283(1). Conversely, relying on ORS 656.704(3)(b)(B), and *Cole*, the Board noted that a dispute regarding whether medical services are excessive, inappropriate, ineffectual, or in violation of the rules regarding the performance of medical services rests with WCD because such a dispute is not a "matter concerning a claim."

Turning to the case at hand, the Board found that the carrier had asserted that the disputed medical services were unrelated to claimant's compensable condition. Reasoning that the carrier was contesting the causal relationship between the medical services and an accepted condition, the Board concluded that the dispute constituted a "matter concerning a claim" and, as such, was subject to its jurisdiction.

A potential “propriety” dispute concerning the medical services did not divest jurisdiction of the Hearings Division to resolve the “causation” dispute.

In reaching its conclusion, the Board rejected the carrier’s argument that claimant’s hearing request was inconsistent with OAR 436-009-0008(2)(b)(A), which requires a worker to request WCD review within 90 days after he knew, or should have known, there was a medical service dispute. In doing so, the Board reasoned that the administrative rule applied to requests for WCD review, not requests for hearing regarding “causation” disputes concerning medical service claims filed with the Board.

Furthermore, the Board acknowledged that the carrier was also contesting the propriety of the medical services. Nonetheless, the Board determined that such contention did not divest the Hearings Division of jurisdiction, but rather was a matter for WCD resolution, should such review be requested.

Finally, turning to the merits of the “causation” dispute, the Board found that the medical evidence established that the medical services were materially related to claimant’s accepted psychological condition. In addition, the Board awarded a “contingent” attorney fee award for claimant’s counsel’s services rendered at hearing and on review, which would become payable within 30 days of the Board order (if no request for WCD review was filed within that 30-day period) or until WCD resolved the “propriety” dispute in claimant’s favor.

Reconsideration Process: 30-Day Appeal Period From “Recon Order” - “268(6)(g)” / “319(4)” - Order Denying Recon - No Extension of Appeal Period

David L. McDermid, 66 Van Natta 857 (May 14, 2014). Applying ORS 656.268(6)(g), and ORS 656.319(4), the Board held that the Hearings Division lacked authority to address claimant’s hearing request from an Order on Reconsideration because, although the request was filed within 30 days from the Appellate Review Unit’s (ARU’s) order denying reconsideration, the request was not filed within 30 days of the reconsideration order itself. Approximately one week after an Order on Reconsideration affirmed a Notice of Closure that did not award work disability, claimant filed a request for reconsideration, including his attending physician’s report indicating that he could not return to his regular work. A few days before the statutory appeal period from the reconsideration order expired, ARU issued an order denying reconsideration. On the 30th day from the Order on Reconsideration, claimant filed another request for reconsideration with ARU, seeking its consideration of the attending physician’s report. After ARU again denied reconsideration (without extending the 30-day appeal period from the Order on Reconsideration), claimant filed a request for hearing, which was received some 47 days after the Order on Reconsideration. The carrier moved to dismiss claimant’s hearing request, contending that it was untimely filed because the Order on Reconsideration had become final. In response, claimant argued that, because he filed his hearing request within 30 days of ARU’s order denying reconsideration, his request was timely.

Because the 30-day appeal period from an ARU Order on Reconsideration had expired when claimant filed a hearing request from an ARU Order Denying Reconsideration, the Hearings Division lacked authority to consider the reconsideration order.

The Board disagreed with claimant's argument. Citing ORS 656.268(6)(g), and ORS 656.319(4), the Board stated that a hearing request from a reconsideration order must be filed within 30 days after the issuance of the order. Relying on *Boydston v. Liberty Northwest Ins. Corp.*, 166 Or App 336, 344 (2000), the Board noted that, if ARU abates and withdraws a reconsideration order and issues another reconsideration order, a hearing request is timely if filed within the 30-day appeal period from the later reconsideration order. Finally, referring to *Terry L. Cox*, 54 Van Natta 102, 103 (2002), the Board observed that ARU's decision to abate and withdraw a reconsideration order is reviewed for an abuse of discretion.

Turning to the case at hand, the Board found that the 30-day statutory appeal period began to run from the issuance of the reconsideration order. Furthermore, the Board noted that ARU had neither abated, withdrawn, nor republished its reconsideration order. Under such circumstances, the Board concluded that ARU's denials of reconsideration did not create a new 30-day appeal period. Consequently, because the 30-day appeal period from the reconsideration order had expired when claimant filed his hearing request, the Board held that the Hearings Division lacked authority to consider the reconsideration order.

In reaching its conclusion, the Board reasoned that claimant could have requested a hearing with the Hearings Division contesting ARU's first denial of his reconsideration request, rather than to request further reconsideration of ARU's decision. Moreover, the Board noted that claimant could have filed a hearing request while his request for further reconsideration was still pending before ARU. Relying on *Laurie L. Boyce*, 63 Van Natta 2551, 2553 (2011), *aff'd without opinion*, 255 Or App 294 (2013), the Board explained that if ARU had then abated its order before expiration of the 30-day appeal period, that action would have taken precedence over claimant's simultaneous filing of a hearing request.

Finally, the Board rejected claimant's assertion that his request for reconsideration with ARU constituted a request for hearing with the Hearings Division. See ORS 656.704(5) (if a request for hearing or administrative review is filed with either the Director or the Board and it is determined that the request should have been filed with the other, the dispute shall be transferred). Noting that claimant's request was expressly titled a request for reconsideration from a refusal to abate the reconsideration order, the Board reasoned that the request could not be considered a hearing request from the reconsideration order that should have been filed with the Hearings Division.

Standards: Work Disability - “Cold Intolerance” From Accepted Finger Amputation - Physician’s “Gloves” Recommendation, Not a Retraction of “Regular Work” Release - “Job Description” for “At-Injury” Job Referred to “Gloves”

Marco Ruiz, III, 66 Van Natta 777 (May 2, 2014). Applying ORS 656.726(4)(f)(E), the Board held that claimant was not entitled to a work disability award for his finger amputation because the record established that his attending physician’s recommendation that he wear gloves when working in cold temperatures did not constitute a retraction of the physician’s approval of his return to his “at-injury” job because the job description for that job referred to the use of gloves. Following claimant’s compensable injury in which he lost a portion of his left index finger, his attending physician released him to full duty, without restrictions. After a Notice of Closure awarded permanent impairment (but no work disability), claimant requested reconsideration, submitting the attending physician’s recommendation that he could try gloves or a hand heater for his “cold intolerance” and, if that did not work, he “should not work in those temperatures.” Claimant also included his affidavit, stating that sometimes the cold temperatures (below 50 degrees) at work made it unable for him to perform his duties. After an Order on Reconsideration increased his permanent impairment award (but continued to deny work disability because of the attending physician’s release to regular work), claimant requested a hearing, contending that the physician’s subsequent statements and his affidavit established that he was not released, and did not return to his regular work.

The Board disagreed with claimant’s contention. Citing ORS 656.726(4)(f)(E), the Board stated that impairment is the only factor to be considered in the evaluation of a worker’s disability under ORS 656.214 if the worker has been released to regular work by the attending physician or has returned to regular work at the job held at the time of injury. Relying on ORS 656.214(1)(d), and OAR 436-035-0005(15), the Board noted that “regular work” means “the job the worker held at injury.” Finally, referring to *Thrifty Payless, Inc. v. Cole*, 247 Or App 232, 239 (2011), the Board observed that “regular work” includes tasks that are performed on a steady or customary basis, even if those tasks are not part of a worker’s job description or otherwise explicitly required.

Turning to the case at hand, the Board acknowledged that the attending physician had eventually recommended that claimant wear gloves or a hand warmer and, if that did not work, he should not work in cold temperatures. Nevertheless, noting that the attending physician had previously reviewed and approved claimant’s “at-injury” job description (which reported that 5 percent of the job was conducted outdoors, which involved wearing gloves), and had subsequently reiterated that claimant had “no restrictions” despite the pain in his finger when exposed to cold weather, the Board was not persuaded that the physician’s eventual comments during the reconsideration proceeding constituted a retraction of the physician’s “regular work” release.

The physician’s “post-closure” recommendations and comments did not constitute a retraction of the physician’s “regular work” release.

Despite claimant's affidavit, the Board's decision must be based on the attending physician's work release, not claimant's personal assessment of his physical capabilities.

In reaching its conclusion, the Board emphasized that claimant had the burden of establishing error in the reconsideration process regarding the Order on Reconsideration's determination that he was not entitled to work disability. See ORS 656.283(7); *Marvin Wood Prods. v. Callow*, 171 Or App 175, 183-84 (2000). Reasoning that the attending physician's ultimate comments created ambiguity as to whether the physician believed that claimant had "cold intolerance" and was unable to work in temperatures below 50 degrees, the Board determined that any such ambiguity would be construed against him, as the party with the burden of proving error. See *James P. Hollis*, 60 Van Natta 826, 827-28 (2008).

Finally, the Board recognized that claimant's affidavit indicated that he could not work in cold temperatures. Nonetheless, relying on *Juan J. Ayala*, 64 Van Natta 1494, 1497 (2012), the Board determined that its decision must be based on the attending physician's work release, not claimant's personal assessment of his physical capabilities.

APPELLATE DECISIONS UPDATE

Combined Condition: "Ceases" Denial - "262(6)(c)" - "Otherwise Compensable Injury" is "Work Injury/Incident," Not "Accepted Condition"

Brown v. SAIF, 262 Or App 640 (May 7, 2014). Applying ORS 656.005(7)(a)(B), and ORS 656.262(6)(c), the court reversed the Board's order in *Royce L. Brown*, 64 Van Natta 1100 (2012) (Member Weddell concurring), previously noted 31 NCN 6, that, in upholding a carrier's "ceases" denial of claimant's combined low back condition, concluded that his previously accepted lumbar strain constituted the "otherwise compensable injury." In reaching its conclusion, the Board relied on *Reid v. SAIF*, 241 Or App 496, *rev den*, 351 Or 216 (2011), for the proposition that, in analyzing a "ceases" denial under ORS 656.262(6)(c), the focus is on claimant's accepted combined condition (*i.e.*, his lumbar strain combined with preexisting disc disease and spondylolisthesis). On appeal, contending that the Board had improperly conflated the statutory terms "otherwise compensable injury" and "accepted condition," claimant asserted that the carrier was required to prove that his "accidental injury" was no longer the major contributing cause of his combined condition.

The court agreed with claimant's contention. Citing ORS 656.005(7)(a), the court stated that a "compensable injury" is an "accidental injury * * * arising out of and in the course of employment requiring medical services or resulting in disability or death." Relying on ORS 656.005(7)(a)(B), the court noted that, if an "otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only, so long as and to the extent that the otherwise compensable injury is the major contributing cause" of the disability or need for treatment for the combined condition.

Based on its review of the statutory scheme, the court observed that the “injury-incident-based” definition of “compensable injury” does not make the compensability of an injury dependent on the carrier’s acceptance of particular conditions. Consequently, the court rejected the carrier’s “accepted condition-based” interpretation of the statutory scheme, reasoning that it would give a carrier the ability to define and limit the scope of a compensable injury by specifically articulating the “accepted condition.”

In support of its statutory analysis, the court referred to legislative history concerning 1990 and 1995 statutory amendments, which did not equate the “otherwise compensable injury” with the “accepted condition.” The court further noted that the legislative history described the phrase “otherwise compensable injury,” as used in ORS 656.005(7)(a)(B), as the “work injury,” the “industrial injury,” the “injury incident,” or the “work incident.” Finally, the court found no indication in the legislative history of an intention to change the incident-based focus of the definition of “compensable injury” in ORS 656.005(7)(a) and also determined that there was no legislative intention that a carrier’s obligation to specify the accepted conditions would have an adverse effect on a worker’s rights to benefits as a result of a compensable injury.

To satisfy its statutory burden concerning a combined condition denial, a carrier must establish that the “otherwise compensable injury” (the work-related injury/ incident) is no longer the major contributing cause of the disability or need for treatment of the combined condition

In reaching its conclusion, the court acknowledged that there was *dicta* in its *Reid* decision that suggested an interpretation that the accepted condition and the “otherwise compensable condition” are one and the same. Nonetheless, in light of its examination of its prior case law and the legislative history, the court concluded its understanding in *Reid* was incorrect. Thus, to satisfy its statutory burden of proof to deny a combined condition, the court reasoned that a carrier must establish that the “otherwise compensable injury” (the work-related injury/incident) is no longer the major contributing cause of the disability or need for treatment of the combined condition.

The court further recognized that its conclusion was potentially at odds with what it and the Supreme Court had said in *dicta* in the context of medical service disputes. See e.g., *SAIF v. Sprague*, 346 Or 661 (2009); *SAIF v. Swartz*, 247 Or App 515, 522-23 (2011). Yet, the court reasoned that those cases did not have the present issue precisely before them, nor had those cases examined the persuasive legislative history regarding the legislature’s intentions concerning the statutory amendments.

Finally, the court rejected the carrier’s argument that its decision in *Multifoods Specialty Distribution v. McAtee*, 164 Or App 654 (1999), *aff’d other grounds*, 333 Or 629 (2002), supported the proposition that a “combined condition” denial depends on the “accepted condition” no longer being the major contributing cause of the combined condition. In doing so, the court reasoned that *McAtee* was fact specific and involved the question of responsibility under ORS 656.308. Moreover, although the *McAtee* court had referred to the claimant’s previously accepted lumbar strain in determining whether the new compensable injury was the major contributing cause of the combined condition, the court considered from the context of the *McAtee* decision that the reference was to the “accidental injury incident” (which happened to be the lumbar strain that the carrier had accepted). Thus, the court explained that *McAtee* had concluded that the combined condition could be denied because the otherwise compensable injury (*i.e.*, the work incident) was no longer the major contributing cause of the claimant’s need for treatment.

In sum, the court noted that the Board had held that the carrier satisfied its statutory burden by proving that claimant's accepted lumbar strain was no longer the major contributing cause of his combined condition. Because the correct test was whether claimant's work-related injury incident was the major contributing cause of the combined condition, the court remanded for reconsideration.

Medical Services: "Diagnostic" Service - "245(1)(a)" - Necessary to Determine Cause/Extent of Disability of Compensable Injury

SAIF v. Carlos-Macias, 262 Or App 629 (May 7, 2014). Applying ORS 656.245(1)(a), the court affirmed the Board's order in *Francisco M. Carlos-Macias*, 63 Van Natta 2184 (2011), previously noted 30 NCN 11, which had found a causal relationship between claimant's diagnostic medical services and his left shoulder condition. In reaching its conclusion, the Board acknowledged that it had found the attending physician's opinion contradictory and insufficient to establish a causal relationship between claimant's accepted left shoulder conditions (shoulder strain, AC sprain, and rotator cuff tendinosis) and his current left shoulder condition. Nevertheless, the Board reasoned that the physician's opinion persuasively supported a conclusion that the proposed diagnostic procedures were necessary to determine the extent of his compensable injury (*i.e.*, his accepted left shoulder conditions). On appeal, the carrier contended that, in light of the Board's determination that claimant's current left shoulder condition was not compensable, it could not be responsible for the proposed diagnostic medical services.

The court disagreed with the carrier's contention. Citing *Counts v. International Paper Co.*, 146 Or App 768 (1997), *Faught v. SAIF*, 70 Or App 388 (1984), and *Brooks v. D&R Timber*, 55 Or App 688 (1982), the court stated that it had repeatedly held that diagnostic services related to the discovery of the cause of pain complaints can be reasonable and necessary expenses borne by the carrier even if the results of the testing reveal that the condition was unrelated to the compensable condition. Furthermore, relying on ORS 656.245(1)(a), and *Brown v. SAIF*, 262 Or App 640 (May 7, 2014), the court reiterated that the terms "compensable injury" and "accepted condition" are not interchangeable and that the term "compensable injury" is used in ORS 656.245(1)(a) to define compensable medical services, which includes diagnostic procedures for conditions not yet discovered. Finally, consistent with its reasoning in *Brown*, the court explained that when analyzing the compensability of diagnostic medical procedures for currently undiscovered conditions, the distinction between a compensable injury and an accepted condition can have no greater significance.

Applying such reasoning to the case at hand, the court rejected the carrier's assertion that, based on *SAIF v. Swartz*, 247 Or App 515, 525 (2011), to be compensable, diagnostic medical services must derive from the "accepted conditions." Referring to its reasoning expressed in *Brown*, the court explained that such a compensability analysis was not the scheme created by the legislature.

The terms "compensable injury" and "accepted conditions" are not interchangeable and the term "compensable injury" in "245(1)(a)" is used to define compensable medical services, which includes diagnostic procedures for conditions not yet discovered.

Based on such reasoning, the court concluded that the Board had correctly stated that the issue of whether the proposed diagnostic procedures were necessary to determine the extent of the compensable injury was different from the compensability issue regarding claimant's current left shoulder condition. The court further noted that the Board had distinguished the *Swartz* situation based on the necessity of determining the extent of claimant's disability.

Finally, the court acknowledged that the Board had unnecessarily conflated claimant's accepted conditions with the compensable injury. Nevertheless, the court concluded that the Board had fully articulated and accurately outlined the distinction between the evidence regarding the diagnostic services from that related to the current condition denial. Reasoning that the Board's explanation was cogent and supported by the medical evidence, the court affirmed.

APPELLATE DECISIONS COURT OF APPEALS

Appellate Procedure: "Estate" Not "Party/ Beneficiary" - No "Standing" to Continue Appeal of Compensability Decision

Sather v. SAIF, 262 Or App 597 (May 7, 2014). Applying ORS 656.281, the court held that a deceased worker's estate was not authorized to proceed with his appeal of a Board order upholding a "combined condition" denial under ORS 656.262(6)(c) because the worker was not survived by any statutory beneficiaries. While his petition for judicial review of the Board order was pending before the court, the worker died and was not survived by a statutory beneficiary. When the carrier moved to dismiss the petition, the personal representative of the deceased worker's estate (his adult son) sought to be substituted as the petitioner. In response, the carrier contended that an estate is not a "person" entitled to pursue a claim under ORS 656.218(3).

The court agreed with the carrier's contention. Citing ORS 656.218(4) and (5), the court stated that when a worker has requested a hearing and death occurs before final disposition of the request or when a worker dies before requesting a hearing, the persons entitled to pursue the claim are "the persons described in subsection (5)." Relying on the first sentence of subsection (5), the court noted that such "persons" are those who would have been entitled to receive death benefits if the injury causing the disability had been fatal; *i.e.*, under ORS 656.204 (the "death benefit" statute), the surviving spouse, minor children, and other dependents. Finally, referring to *Cato v. Alcoa-Reynolds Metals Co.*, 210 Or App 721, 730, *rev den*, 343 Or 115 (2007), and *SAIF v. Balcom*, 162 Or App 325, 329, *rev den*, 329 Or 650 (2000), the court observed that, under the former version of ORS 656.218, such "persons" do not include the worker's estate or personal representative.

Because worker had died (without statutory beneficiaries) before a final determination had been reached concerning his denied combined condition claim, his estate did not have statutory authority to pursue his claim to final resolution.

Turning to the case at hand, the court commented that it was undisputed that the deceased worker's combined condition claim had not been finally determined. Because his death occurred after he had filed a hearing request contesting the denial but before a final determination had been reached

regarding all issues presented by that request, the court concluded that ORS 656.218(3) was applicable. Thus, the court identified the issue as whether, under the current version of ORS 656.218, was claimant's estate a "person" described in subsection (5) entitled to pursue the matter to final determination.

After reviewing the statutory amendments, the court noted that subsection (5) now provides that "[i]n the absence of persons so entitled [to death benefits], the unpaid balance of the award shall be paid to the worker's estate." The court did not consider that change to demonstrate a legislative intention that, in the absence of statutory beneficiaries, the estate may pursue the deceased worker's undetermined claim.

In reaching its conclusion, the court noted that subsection (5) continues to provide that payments are to be made to "the persons who would have been entitled to receive death benefits," which, in the most straightforward reading of the text, would not include the estate or personal representative. The court further reasoned that the inclusion of the new sentence in subsection (5) revealed two factors, central to its application: (1) an estate is not among the "persons so entitled"; and (2) the existence of a previous award with an unpaid balance; *i.e.*, the worker's entitlement to benefits has been previously determined.

Based on such an analysis, the court was persuaded that the inclusion of the aforementioned sentence in subsection (5) did not provide independent authority for the estate to pursue an undetermined claim. Likewise, the court did not consider the statement in subsection (1) ("whether eligibility therefor or the amount thereof have been determined, payment *shall be made* for the period during which the worker, if survived, would have been entitled thereto") to create an absolute right to pursue undetermined benefits (either by statutory beneficiaries or the estate). Instead, the court reasoned that the subsection must be read in context with subsections (2) through (5), including the limitations it had previously described concerning who may pursue a claim.

Judge Egan dissented. Based on the amendment to ORS 656.218(5), Egan believed that the legislature had added a new class of beneficiary, one which was entitled to receive benefits if the worker died without statutory dependents.

Based on this statutory modification, Judge Egan reasoned that the legislature also intended to endow that new beneficiary class with the corresponding right to pursue a pending claim in order to obtain that award to which this beneficiary class is now entitled. Egan considered the majority's conclusion to effectively nullify a significant provision in ORS 656.218(1) that requires, in the absence of statutory beneficiaries, that payment "shall be made" to the estate "whether eligibility therefor or the amount thereof have been determined."

Dissent reasoned that legislature also intended to endow a new beneficiary class (the deceased worker's estate or personal representative) with the corresponding right to pursue a pending claim.