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BOARD NEWS

Portal Passages

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Settlement Documents Project

The Board is at work creating a process for users to file settlement documents electronically by uploading them through the WCB Portal. Portal participants will be able to submit Disputed Claim Settlements, Stipulations, and Claim Disposition Agreements on existing cases and new cases. Upon approval, parties will be notified through the portal, also.

This will save users time and expense, and allow settlement proceeds to be distributed more rapidly. We are in the process of developing screen prototypes, and will be reaching out to the stakeholder community for ideas and feedback. If you are interested in spending some time with us during the design and testing, please contact us at portal.wcb@oregon.gov or call Greig Lowell at (503) 934-0151.

Electronic Hearing Notices

You can now receive your Hearing Notice by email through the WCB Portal. The notice will arrive in your email inbox a few days before the regular mail and allow you to get the date on your calendar quickly. To activate this notification, go to your "contact detail" tab and click on the box for "Hearing Notice: Receive Hearing Notices by email."

If anyone in your firm activates this notification, we will no longer mail hard copies to your firm. Therefore, you should carefully consider this change in process before activating the notification. Having at least two people in your firm receive the notification is also a good idea.

In addition to the email notification, the Hearing Notice document will always reside in your "contact history." Utilize the "contact history" to view all of your prior notifications. You can also see the hearing date, time and location by accessing the case on the "events" tab in your "WCB Case Status" page. Both of these tabs have a search box in which you can look up cases by name, WCB number, claim number and other identifying data.

CASE NOTES

Hearing Request: “319(1)” - Timely Hearing Request From Carrier Denial - Request And Cover Letter Referred to “Injury Date”/ “Any Outstanding Denial”

Mauricio Cabrera-Vargas, 67 Van Natta 397 (March 3, 2015).

Applying ORS 656.319(1), the Board held that claimant’s hearing request and accompanying cover letter represented a timely appeal of the carrier’s “ceases” denial because, although the request and letter did not refer to the date of the denial, the request mentioned “any outstanding denial” and the letter listed the injury date for the claim on which the “ceases” denial was based. Claimant filed a hearing request contesting the carrier’s occupational disease denial and “any outstanding denials, orders, or decisions.” Claimant’s letter accompanying the request referred to the date of the occupational disease denial, the occupational disease claim number, and the injury date of the claim on which the carrier’s “ceases” denial was based which had issued some two weeks after the carrier’s occupational disease denial (but within 60 days of the hearing request). Claimant’s letter also mentioned that he was appealing any outstanding denials from the carrier. After the 60-day “appeal” period from the “ceases” denial had expired, the carrier contended that claimant had not timely requested a hearing from its “ceases” denial. In response, claimant asserted that his hearing request and accompanying cover letter (which were filed within 60 days of the carrier’s “ceases” denial) constituted a timely appeal from the denial.

The Board agreed with claimant’s assertion. Citing ORS 656.319(1)(a), the Board stated that, to object to a claim denial, a claimant must request a hearing within 60 days of the mailing of the denial. Relying on *Graves v. SAIF*, 111 Or App 579, 584 (1992), and *Naught v. Gamble, Inc.*, 87 Or App 145 (1987), the Board noted that a claimant has an obligation to request a hearing in response to particular denials. Referring to *Kevin C. O’Brien*, 44 Van Natta 2587, 2588 (1992), *recons*, 45 Van Natta 97 (1993), the Board reiterated that to determine whether a hearing request refers to a particular denial, the request itself, read as a whole and in the context in which it has been submitted, is considered.

Turning to the case at hand, the Board acknowledged that claimant’s hearing request and cover letter had not specifically identified the “ceases” denial. Nevertheless, the Board noted that the letter referred to the date of injury coinciding with the claim on which the carrier’s “ceases” denial was based and the letter/hearing request also mentioned that claimant was appealing “any outstanding denials.” Reasoning that the carrier’s “ceases” denial was in existence when claimant filed his hearing request within 60 days of that denial, the Board concluded that he had timely appealed the “ceases” denial. See *Alice A. Detrick*, 58 Van Natta 1070 (2006); *cf. Peggy Zamora*, 51 Van Natta 353 (1999).

Hearing request/ cover letter’s reference to “injury date” and “outstanding denials” found sufficient to encompass appeal of “ceases” denial.

Medical Services: “245(1)(a)” - Diagnostic Procedure (Discogram) - Proposed to Determine Cause/Extent of Work-Related Injury/Incident

Barbara A. Easton, 67 Van Natta 526 (March 27, 2015). On remand from the Court of Appeals, *Easton v. SAIF*, 264 Or App 147 (2014), applying ORS 656.245(1)(a), the Board held that a carrier was responsible for claimant’s proposed diagnostic medical service (discogram) because the procedure was due in material part to her compensable low back injury and was necessary to determine the cause or extent of that injury, even if the testing revealed that a condition was unrelated to the injury. After claimant’s work injury, the carrier accepted a lumbar strain. When claimant’s low back symptoms continued, her attending physician proposed a discogram (followed by a CT scan) to determine whether she was suffering from a disc condition that required surgery. The carrier disapproved the proposed medical services, contending that the procedures were not related to the work injury.

The Board disagreed with the carrier’s contention. Citing ORS 656.245 (1)(a), the Board stated that for every compensable injury, the carrier shall cause to be provided medical services for conditions caused in material part by the injury. Relying on *SAIF v. Carlos-Macias*, 262 Or App 629 (2014), and *Mize v. Comcast Corporation - AT&T Broadband*, 208 Or App 563, 569-71 (2006), the Board reiterated that “in material part” refers to a “fact of consequence” and that “compensable injury” is not limited to the accepted condition, but is defined by the work-related injury incident. Finally, referring to *Carlos-Macias* and *Counts v. Int’l Paper Company*, 146 Or App 768, 770-71 (1997), the Board observed that if diagnostic services are necessary to determine the cause or extent of a compensable injury, those services are compensable whether or not the condition that is discovered as a result of them is compensable.

Turning to the case at hand, the Board acknowledged claimant’s attending physician’s comments that the compensable injury might have only involved a lumbar sprain. Nonetheless, the Board further noted that the attending physician had explained that the discogram was a “diagnostic” test that would confirm whether a particular disc was painful and that, such information, in combination with the mechanism of the work injury and the nature of claimant’s symptoms, would help determine whether the compensable injury had involved a disc injury.

Finding that the attending physician’s opinion was not persuasively rebutted by the other physician’s opinion (which attributed claimant’s complaints to a preexisting degenerative condition), the Board concluded that the discogram was proposed to determine whether claimant’s work injury had caused a disc problem and, as such, was to determine the extent of conditions caused in material part by the compensable injury. Under such circumstances, the Board held that the discogram was due in material part to the compensable injury regardless of whether claimant was ultimately determined to have a compensable disc injury.

Discogram was due in material part to the compensable low back injury to determine the cause/extent of the injury, regardless of whether a disc condition was ultimately found compensable.

Dissent contended that any disc condition (whatever its extent) was not caused in material part by the compensable injury and, as such, discogram was not compensable.

Member Johnson dissented. Based on an attending physician's concurrence with an examining physician's opinion that claimant's symptoms were "highly inconsistent" with a disc injury and that MRI findings did not correlate with claimant's clinical findings (with no evidence of nerve root encroachment), Johnson considered claimant's work injury to be limited to the accepted strain and that any disc condition (whatever its extent) was not caused in material part by the work injury. Consequently, Member Johnson was not persuaded that further evaluation of claimant's disc would determine the cause or extent of the compensable injury, regardless of the result of the diagnostic testing.

Own Motion: TTD - Issue Preclusion- "Pre-Closure" Decision (Same Claim)

Tony L. Clark, 67 Van Natta 424 (March 6, 2015). In an Own Motion order regarding a Notice of Closure, the Board held that, based on a prior Own Motion order regarding claimant's entitlement to "pre-closure" temporary disability benefits concerning his reopened claim for a chronic cervical myofascial pain disorder, claimant was precluded from receiving additional TTD benefits once that same claim was closed, but the prior order had no preclusive effects on his entitlement to TTD benefits under another portion of the Own Motion claim that was reopened for another new/omitted medical condition (drug rebound headaches) after the earlier order. After claimant's Own Motion claim for a new/omitted medical condition (chronic cervical myofascial pain disorder) was reopened, claimant had requested Board relief, seeking TTD benefits. In a prior order, the Board had found that claimant's attending physician's time loss authorizations were not "ongoing" or "open-ended." Nonetheless, based on those authorizations, the Board had awarded some 3 months of TTD benefits under the reopened Own Motion claim for the aforementioned condition. Shortly thereafter, the carrier reopened the Own Motion claim for another new/omitted medical condition (drug rebound headaches) and then eventually closed the Own Motion claim for both the chronic myofascial pain disorder and headaches. The Notice of Closure did not award TTD benefits beyond that granted by the earlier Board order. Claimant requested Board review, seeking additional TTD benefits. In response, the carrier contended that claimant was precluded from receiving TTD benefits beyond that granted by the previous Board order.

The Board held that its prior order was preclusive insofar as claimant's request for TTD benefits under the "chronic cervical myofascial pain disorder" claim was concerned, but that there was no preclusive effect concerning the "drug rebound headache" portion of the claim. Citing *Drews v. E.B.I. Cos.*, 310 Or 134, 139 (1990), the Board stated that, under the doctrine of issue preclusion, a former adjudication precludes future litigation on a subject issue only if the issue was actually litigated and determined in a setting where its determination was essential to the final decision reached.

Turning to the case at hand, the Board found that the "TTD" issue in the prior and current proceeding was identical regarding claimant's entitlement to TTD benefits under the Own Motion claim for his "chronic cervical myofascial pain disorder" as of the date of its prior order. Reasoning that the issue had been actually litigated, was essential to a final decision on the merits of the prior

Because TTD issue in prior/ current proceeding regarding same Own Motion claim was identical/ actually litigated, the issue was precluded from further consideration.

Because Own Motion claim for another condition had not been reopened at time of prior proceeding, TTD issue regarding the claim for that condition was not precluded.

proceeding, and that claimant had a full and fair opportunity to be heard in the proceeding, the Board concluded that claimant was precluded from re-arguing his entitlement to TTD benefits for the “chronic cervical myofascial pain disorder.”

Conversely, the Board noted that claimant’s Own Motion claim had not been reopened for his drug rebound headache condition at the time of its prior order. Under such circumstances, the Board determined that its previous order had no preclusive effect on claimant’s entitlement to TTD benefits insofar as the “drug rebound headache” claim was concerned.

Addressing the attending physician’s reports, the Board awarded additional TTD benefits under the “drug rebound headache” portion of the claim to the extent the physician had contemporaneously authorized such benefits for that condition. The Board further acknowledged that the physician had subsequently stated that his previous time loss authorizations were also intended to extend for the previous two years. Nevertheless, noting that the attending physician had determined (after his initial contemporaneous authorization) that claimant did not have “drug rebound headaches,” the Board reasoned that the physician’s subsequent authorization could only have pertained to the “chronic myofascial” condition (which was precluded by its prior order). Moreover, the Board did not consider the attending physician’s authorization to constitute a “contemporaneous” authorization and, as such, was subject to the 14-day “retroactive” limitations under ORS 656.262(4)(g). Finally, because claimant’s conditions had become medically stationary several weeks before the attempted “retroactive” authorization, the Board held that it was not authorized to award “post-medically stationary date” TTD benefits. See ORS 656.278(1)(a), (b); *Judy L. Frazier*, 56 Van Natta 3270, *recons*, 56 Van Natta 3430, 3432 (2004).

Penalty: “268(5)(d)” - NOC “Permanent Impairment” Award for “Class 1” Respiratory Condition - Not Unreasonable

Christina Song, 67 Van Natta 445 (March 6, 2015). Applying ORS 656.268(5)(d), the Board held that a Notice of Closure (NOC) (which awarded Class 1 “immune system” permanent impairment for claimant’s asthma condition) was not unreasonable because “pre-closure” “attending physician-ratified” impairment findings indicated that claimant’s reaction to “wood dust” at the work place was a nuisance, but did not prevent her from performing most of her work activities. Claimant, who worked for a sunglass manufacturer, was exposed to various types of wood dust. After she developed an asthmatic reaction to some of the wood dust, she filed a claim, which was accepted for “occupationally induced asthma due to acute exposure.” Thereafter, claimant voluntarily left her “at injury” job. Subsequently, the attending physician concurred with another physician’s findings that claimant had suffered no permanent impairment, but if she returned to her employment, she would need to use a respirator, which might not be 100 percent successful. After a NOC awarded 3 percent permanent impairment (based on Class 1 “immune system” impairment under OAR 436-035-0450(1)(a) and 5 percent work disability,

claimant requested reconsideration, accompanied by “attending physician-ratified” findings that supported Class 2 “immune system” impairment. Following an Order on Reconsideration (which increased claimant’s awards commensurate with Class 2 “immune system” impairment), claimant requested a hearing, seeking a penalty under ORS 656.268(5)(d) and an attorney fee pursuant to ORS 656.382(1). In doing so, claimant contended that the NOC’s permanent impairment award was unreasonable.

The Board disagreed with claimant’s contention. Citing *Cayton v. Safelite Glass Corp.*, 232 Or App 454, 460 (2009), the Board stated that ORS 656.268(5)(d) provides for a penalty if: (1) there was a closure of a claim or refusal to close a claim; (2) the “correctness” of that closure was at issue in a hearing on the claim; and (3) there was a finding that the NOC or refusal to close was not reasonable. Referring to *Kerry K. Hagen*, 64 Van Natta 316, 319 (2012), the Board noted that the pivotal question was whether the NOC was reasonable.

Based on OAR 436-035-0450(1)(a), the Board observed that Class 1 “immune system” impairment is awarded “when the reaction is a nuisance but does not prevent most regular work activities.” The Board further noted that, under subsection (1)(b) of the rule, Class 2 “immune system” impairment is awarded “when the reaction prevents some regular work-related activities.”

Turning to the case at hand, the Board found that, when the carrier issued its NOC, the attending physician had ratified a physician’s findings that claimant was medically stationary, recommended that she not be exposed to dust from several “exotic” woods, and suggested the use of a respirator (although acknowledging that the device might not be 100 percent effective). The Board recognized that the attending physician had subsequently ratified a physician’s “post-closure” impairment findings supporting a rating of claimant’s “immune system” permanent impairment as Class 2. Nonetheless, the Board emphasized that the attending physician ratified the physician’s “pre-closure” findings, which indicated that claimant had been able to return to her work activities, most of which did not involve exposure to “exotic” wood dust that would trigger her asthma, with some modifications.

Under such circumstances, the Board considered the carrier’s reliance on the “attending physician-ratified” impairment findings in rating claimant’s permanent impairment in its NOC (without seeking further clarification) to have been reasonable. Consequently, the Board held that a penalty under ORS 656.268(5)(d) was not warranted.

Member Johnson specially concurred. Expressing serious reservations regarding the *Hagen* rationale (which extended the penalty under ORS 656.268(5)(d) to an unreasonable NOC award), Johnson considered it unnecessary to resolve that question because the carrier’s calculation of claimant’s permanent impairment in the NOC had not been unreasonable.

Member Weddell dissented. Referring to the “attending physician-ratified” statements that it would “not be prudent [for claimant] to work in the areas of exotic woods” and that even use of a full-time respirator might not be sufficient for her to continue her “at injury” work, Weddell considered the implementation of such measures supportive of a Class 2 “immune system”

Based on “AP-ratified” impairment findings (which indicated that claimant had been able to return to work with some modifications), the carrier’s issuance of a NOC with Class 1 “nuisance” impairment was not unreasonable.

Because “pre-closure” findings suggested that claimant was “prevented” from returning to work, dissent argued that carrier should have sought clarification from “AP” before closing the claim.

impairment (i.e., preventing some regular work-related activities) rather than a Class 1 impairment (which represented a nuisance, but did not prevent most regular work-related activities). Furthermore, referring to *Walker v. Providence Health System Oregon*, 267 Or App 87 (2014), Member Weddell reasoned that, at the very least, the carrier should have sought clarification of the “attending physician-ratified” findings before claim closure and, because the carrier neglected to do so, the NOC award was unreasonable.

Reconsideration Proceeding: “268(6)(f)” - “Clarifying” Report From Arbiter - ARU Forwarded Carrier’s “Clarification” Request to Arbiter - Report Admissible at Hearing

Gabriel Gallegos, 67 Van Natta 458 (March 10, 2015). Applying ORS 656.268(6)(f), the Board held that a medical arbiter’s clarifying report was admissible at a hearing regarding an Order on Reconsideration because the report was generated by a request from the Appellate Review Unit (ARU), even though ARU’s request originated from a carrier’s request. Following an Order on Reconsideration (which was based on an arbiter’s impairment findings), a carrier submitted a request for clarification of the arbiter’s findings to ARU, who then asked the arbiter for clarification of claimant’s impairment findings. After the arbiter provided such clarification, ARU modified its reconsideration order to award no permanent disability. Claimant requested a hearing, contending that the arbiter’s clarifying report should not be considered because it was generated at the carrier’s request.

The Board disagreed with claimant’s contention. Citing ORS 656.268(6)(f), the Board stated that any medical arbiter report may be received at a hearing even if the report is not prepared in time for use in the reconsideration proceeding. Relying on *Tinh Xuan Pham Auto v. Bourgo*, 143 Or App 73, 78 (1996), the Board noted that a supplemental or clarifying arbiter report prepared directly for a party is not admissible. Finally, referring to *Kerry K. Hagen*, 61 Van Natta 370, 373 (2009), and *Marine D. Miller*, 52 Van Natta 2069, 2070 (2000), the Board observed that supplemental arbiter reports prepared for ARU are admissible.

Turning to the case at hand, the Board acknowledged that the carrier had submitted a request for clarification of the medical arbiter’s impairment findings to ARU. Nevertheless, the Board noted that ARU had chosen to forward that request to the arbiter for a response. Based on ARU’s decision, the Board concluded that the arbiter’s report was generated in response to ARU’s clarification request and, as such, the report was admissible at hearing under ORS 656.268(6)(f).

Because ARU referred carrier’s request for clarification of impairment findings to arbiter, subsequent report from arbiter was admissible at hearing.

APPELLATE DECISIONS UPDATE

New/Omitted Medical Condition Claim: Even if For “Symptom,” Claim Must be Timely Accepted/Denied; Unreasonable Claim Processing: Untimely Denial - No “Amounts Then Due” For Penalty - “Ochs” Attorney Fee Awardable

SAIF v. Traner, 270 Or App 67 (March 25, 2015). The court affirmed the Board’s order in *Emma R. Traner*, 64 Van Natta 1207 (2012), previously noted 31 NCN 6, which had held that a carrier was obligated to either timely accept or deny claimant’s new/omitted medical condition claim, even when the claim was eventually determined to be for a “symptom” (rather than for a “condition”) and, despite the absence of “amounts then due” on which to base a penalty, awarded an attorney fee award under ORS 656.262(11)(a) for unreasonable claim processing. On appeal, the carrier raised three issues: (1) because the claimed “condition” (shoulder “arthralgia”) was ultimately determined to be a “symptom,” claimant had not initiated a new/omitted medical condition claim under ORS 656.267(1); (2) in the absence of such a claim, the carrier was not obligated to either formally accept or deny the claim within the statutory 60-day period; and (3) the carrier had not unreasonably failed to timely accept or deny the purported claim.

The court rejected each of the carrier’s contentions. Concerning the first issue, the court summarized *SAIF v. Stephens*, 247 Or App 107, 109 (2011), *Crawford v. SAIF*, 241 Or App 470, 480-81 (2011), and *Francisco G. Rodriguez*, 59 Van Natta 2422, 2425 (2007). Based on its review of that precedent, the court reiterated that a claimant initiates a claim for a new/omitted medical condition claim under ORS 656.267(1) when clearly requesting formal written acceptance of that condition, even if the requested condition is later determined to be a symptom. Furthermore, referring to *Rodriguez*, the court noted that a carrier’s “no perfected claim” letter in response to such a new/omitted medical condition claim does not suffice as the requisite acceptance or denial.

Having dispensed with the carrier’s argument that no new/omitted medical condition claim had been initiated, the court proceeded to the second issue; *i.e.*, whether, under ORS 656.262(11)(a), a penalty must first be assessed before an attorney fee award can be granted. After considering the plain and ordinary meaning of the word “plus” (as used in the statute’s phrase “shall be liable for an additional amount up to 25 percent of the amounts then due *plus* any attorney fees assessed under this section”), the court was not persuaded that the word “plus” required that benefits or a penalty be assessed as a precondition to an attorney fee award.

Carrier must accept/deny a new/omitted medical condition claim, even if claim is based on symptoms.

Penalty assessment is not a precondition to an attorney fee award under “262(11)(a).”

Noting that one of the dictionary definitions for “plus” was “with the addition * * * of,” the court reasoned that the “additional amount” or penalty under ORS 656.262(11)(a) might be zero *with the addition of* any attorney fees assessed under that statute. The court further observed that the carrier’s interpretation of the statutory provision would introduce additional criteria for an attorney fee award; *i.e.*, an incorrect denial, which gave rise to compensation. Reiterating that the statute provides for a penalty and an attorney fee for an unreasonable delay in accepting or denying a claim, the court concluded that the legislature had expressly contemplated the basis for a penalty or attorney fees in the present case, from which the court was forbidden from adding any additional requirement. See ORS 174.010.

In reaching its conclusion, the court reasoned that the carrier’s interpretation of the statute would assume that the legislature intended that there would be no mechanism by which to encourage timely responses to claims that ultimately prove to be unsuccessful. Emphasizing that ORS 656.262(7)(a) mandates a 60-day deadline for a claim denial, the court stated the issuance of a denial at least triggers procedural rights, the opportunity for a hearing, and potential remedies. Consequently, the court determined that such a statutory mandate did not suggest indifference to unreasonable delays, nor that delays should be ignored when claims prove unsuccessful.

The court further acknowledged the requirement in ORS 656.262(11)(a) that an attorney fee be proportionate to “the benefit to the injured worker.” Noting that the aforementioned statutory terms follow the reference in the statute to procedural delays and that the resulting standard refers to “*the* benefit to the injured worker” (without referring to the “compensation”), the court interpreted the statute’s intention to be that the attorney fee award should not be disproportionate to the general result achieved. Had the legislature intended attorney fees to be based on financial compensation alone, the court reasoned that it could simply have said so. Consequently, the court concluded that the Board had sufficient evidence to find that claimant’s counsel’s efforts had provided a benefit to claimant; *i.e.*, obtaining a hearing and soliciting an express position from the carrier regarding her claim.

Turning to the carrier’s third argument, the court disagreed with the carrier’s assertion that its response to the claim should not have been considered unreasonable because of the “confused state” of the law when it had taken the actions in question. To begin, the court noted that the carrier did not dispute that it had failed to issue an acceptance or denial of the claim. The court further determined that the carrier’s letter was an unreasonable form of a response to claimant’s new/omitted medical condition claim.

Finally, the court acknowledged that the carrier’s letter had issued several months before the *Stephens* decision. Nevertheless, the court stated that the *Stephens* rationale was consistent with that expressed in *Crawford*, which had issued about a month before the issuance of the carrier’s letter. Moreover, referring to the *Rodriguez* decision (which had issued over four years before the carrier’s letter), the court noted that the Board had already ruled on a carrier’s statutory obligation to issue a timely acceptance/denial of such a new/omitted medical condition claim. Under such circumstances, the court held that the Board had not erred in finding the carrier’s response to the claim to have been unreasonable.

Claimant’s counsel’s efforts provided a “benefit to the worker” in requesting a hearing from a carrier’s failure to timely accept/deny a claim and soliciting the carrier’s express position regarding the claim.

Carrier’s “no perfected claim” letter was an unreasonable form to response to a new/omitted medical condition claim.

TTD: Supplemental Disability - Includes “Secondary Job” Wages on “Injury Date”

Williams v. SAIF, 269 Or App 598 (March 4, 2015). The court affirmed without opinion the Board’s order in *James L. Williams*, 65 Van Natta 1240 (2013), previously noted 32 NCN 7, which held that claimant was entitled to supplemental disability benefits based on his wages at both his “at-injury” and “secondary” job because he was working at both jobs at the time of his injury, even though he was not working at the “secondary” job when he became temporarily disabled. (The Board order had also declined to award penalties and attorney fees for allegedly unreasonable claim processing.)

APPELLATE DECISIONS COURT OF APPEALS

Extent: “035-0019(1)” - “Chronic Condition” Permanent Impairment - “Significant Limitation/Repetitive Use” - Must Include Overall Conditions/Motions - “Lifting Above Shoulder” Limitation Only One Motion Insufficient for “Chronic Condition” Award

Godinez v. SAIF, 269 Or App 578 (March 11, 2015). Analyzing OAR 436-035-0019(1), the court affirmed the Board’s order in *Juan L. Godinez*, 64 Van Natta 1990 (2012), which had held that claimant was not entitled to a “chronic condition” impairment value for his left shoulder condition because the record had not established he was significantly limited in the repetitive use of his shoulder. In reaching its conclusion, the Board reasoned that, because claimant’s attending physician had specifically qualified claimant’s repetitive use limitation to lifting no more than 20 pounds above shoulder level, such a limitation was insufficient to establish entitlement to a “chronic condition” impairment value. Asserting that the plain and ordinary meaning of the rule’s terms should be applied, claimant contended that a “chronic condition” impairment value should be awarded because there was “a noticeable limit on using a ‘body part’ over and over again.” In response, the carrier argued that deference should be given to the Appellate Review Unit’s (ARU’s) interpretation of the “chronic condition” rule (*i.e.*, in declining to award a “chronic condition” value, ARU had reasoned that “chronic condition” impairment must include the worker’s overall conditions/motions and not just one motion).

The court agreed with the carrier’s position. Citing *DeLeon, Inc. v. DHS*, 220 Or App 542, 548 (2008), the court stated that agencies are permitted to “determine whether the standard established in a rule has been met in a particular instance by interpreting the rule in the course of applying it.” Again referring to *DeLeon*, the court reiterated that, when an agency does so, deference is given to the agency’s plausible interpretation, “including an interpretation made in the course of applying the rule[.]”

Deference is given to an agency’s plausible interpretation of its rule.

ARU's interpretation of "chronic condition" rule to require impairment of "overall condition/motions and not just one motion" was plausible.

Rulemaking history indicated that "significant limitation" inserted to require a higher threshold for receiving an impairment award than prior rule (which simply required a partial loss of ability to repetitively use body part).

Turning to the case at hand, the court noted that ARU had been asked to determine whether claimant had met the standard for a "chronic condition" impairment award under OAR 436-035-0019(1), which requires that the "worker is significantly limited in the repetitive use of [a listed body part]." Reasoning that ARU had explicitly interpreted the rule to require impairment of the worker's "overall conditions/motions and not just one motion," the court concluded that, as the delegate of the Director (who had adopted the administrative rule) deference should be accorded to ARU if its interpretation of the rule was plausible.

Reviewing the "chronic condition" rule, the court determined that ARU's interpretation of the rule was plausible. Furthermore, after considering the dictionary definitions of "significant" (e.g., "important," "weighty," and "notable") and "repetitive" (e.g., "containing repetition"), the court reasoned that the plain meaning of those terms did not demonstrate that ARU's interpretation of its rule was *not* plausible or inconsistent with the text of its rule, its context, or any other source of law.

Finally, referring to rulemaking history regarding the adoption of the rule containing the phrase "significant limitation," the court noted that the history indicated that the phrase was inserted to require a higher threshold for receiving an impairment award than the prior rule (which simply required a partial loss of ability to repetitively use the body part). The court determined that such history of the rule strengthened the plausibility of ARU's interpretation.

Addressing the merits of the Board's impairment decision, the court concluded that, based on the attending physician's opinion (which only referred to a limitation of use over claimant's shoulder), there was substantial evidence to support the Board's finding that he did not have a "limitation on his overall motions/conditions."