



# News & Case Notes

**BOARD NEWS**

- Van Natta Archiving Project Underway  
*By Greig Lowell* 1
- WCB Medford Office Moving 2

**CASE NOTES**

- Claim Preclusion: Disc "Protrusion" Condition Previously Litigated - Disc "Bulge" Condition Not Previously Litigated 2
- Penalty: "Amounts Then Due" - Based on Untimely Paid TTD Benefits, Less Recoverable Overpayment 4
- Recon Proceeding: ARU "Recon Denial/Evidentiary" Decision - "Abuse of Discretion" Review - No Authority to "Remand" to ARU, But Remedy May Be "Fashioned" For ARU to Reconsider Ruling 5
- TTD: "AP" Authorization - Chart Note Listed Accepted "Conjunctivitis" Condition (Among Other Conditions) - Sufficient to Trigger Carrier's "Time Loss" Obligation 8

**APPELLATE DECISIONS**

**Update**

- Consequential Condition: "005(7)(a)(A)" - Swelling From Compensable Foot Fracture - Major Cause of "Infection-Related" Conditions - "Preexisting Condition" ("005(24)(c)") No Bearing on "Consequential Condition" Analysis 9
- Responsibility: "Consequential Condition" Theory ("005(7)(a)(A)") - Compensable Injury Major Cause of Claimed Condition - "LIER" Not Applicable 10

**Court of Appeals**

- Consequential Condition: "005(7)(a)(A)" - "Compensable Injury" (Not "Accepted Condition") Must Be Major Cause of Claimed Condition 12

**BOARD NEWS**

## Van Natta Archiving Project Underway

*By Greig Lowell*

Those among us "of a certain age" remember thick green binders filled with Workers' Compensation Board (WCB) orders, carefully compiled and indexed by Robert Coe and Merrily McCabe – yes, those original Van Natta reporter volumes, from which case precedent and history were made.

To prevent that body of case law from being lost to fire, flood or pestilence, WCB has embarked on a project to digitally preserve all the Van Natta volumes. Working backwards from when the cases were first posted on the WCB website, the Board is scanning the old volumes and loading them as PDF files into a Van Natta Archive. Here is the link to the archive:

[http://www.wcb.oregon.gov/vn\\_archive/vn\\_archive.htm](http://www.wcb.oregon.gov/vn_archive/vn_archive.htm)

At this time, WCB staff is scanning the volumes from 1992, and steadily working backwards to the days before Grunge and before the Hair Metal bands. Not far away are skinny ties, A Flock of Seagulls, and the expanded 9-Member Board decisions. Board staff is feeding the old binders through Dr. Brown's "Flux Capacitor" to create the digital files.

The archives are in a searchable PDF format. By opening the PDF tool bar, you can use the search feature to look for cases by citations, names, and key words. The popular indexes from the bound volumes are also being scanned, to give you some additional research tools.

WCB took over publication of the Van Natta Reporter in 2002 and has provided it free to the public on its website. Legal research vendors, such as Westlaw and Lexis, plus the Oregon State Bar, also carry the Van Natta case reporter. However, not all of the prior years were available digitally.

"We believe it's important to both preserve and make available our entire case law reporter," said Board Chair Holly Somers. "Creating these digital files will allow practitioners to research old cases without having to go to a law library for the old volumes."

The first volume, originally published in 1969 by Fred and Robert Van Natta, begins with cases from August, 1967. In an introduction, the Van Nattas explain that they are picking up the task of compiling case decisions from the Oregon Workmen's Compensation Reporter, compiled by the Oregon Association of Defense Counsel.

**Court of Appeals (Cont.)**

Medical Services: "245(1)(a)" - Ankle Surgery Not Caused, in Material Part, by Compensable Injury - Medical Evidence Established Previously Accepted Condition "Resolved"	13
Medical Services: "245(1)(a)" - Femoral Bypass Surgery - Not "For" Condition Due "In Material Part" to Compensable Injury (Traumatic Occlusion of Popliteal Artery)	14
Preexisting Condition: "Susceptible" - "005(24)(a), (c)" - Recurrent Hernia Due to Weakening of Tissue in Abdominal Wall	16

The first volume was primarily a summary of the case decisions. However, by Volume 2 in October 1969, the Van Nattas report, "The Board opinions have become more informative and consequently, we have been able to quote from them extensively." By February 1970, decisions were printed in their entirety.

The Van Nattas published the volumes throughout the 1970s. In 1980, Merrily McCabe was listed as the editor, and by 1981 (volume 31), the Van Natta Reporter was "Edited and published by Robert Coe and Merrily McCabe."

## WCB Medford Office Moving

Effective July 13, the Medford Hearings Division will be located in the Lausmann Business Center in Suite 102. The new address is:

Workers' Compensation Board  
115 W Stewart Ave, Ste.102  
Medford, OR 97501

The new space offers easy access from I-5 and is centrally located for those who live in Medford or the surrounding area.

## CASE NOTES

### Claim Preclusion: Disc "Protrusion" Condition Previously Litigated - Disc "Bulge" Condition Not Previously Litigated

*Barbara J. DeBoard*, 67 Van Natta 909 (May 27, 2015). Analyzing ORS 656.267(1) and ORS 656.262(6)(d), the Board held that claimant's new/omitted medical condition claim for several thoracic disc "protrusions" was precluded because a prior litigation order had found that the disc "protrusions" did not exist, but because claimant's currently claimed thoracic disc "bulge" conditions had not been previously litigated, her new/omitted medical condition claim for those conditions was not precluded. In a prior proceeding regarding the carrier's denial of claimant's new/omitted medical condition claim for several thoracic disc "protrusions," the Board had affirmed an ALJ's decision that the claimed conditions did not exist. In an alternative finding, the Board had reasoned that even if physicians' references to "protrusion" and "bulge" should be considered interchangeably, the record established that the otherwise compensable injury was not the major contributing cause of the combined thoracic disc conditions. Thereafter, claimant again initiated new/omitted medical condition claims for thoracic disc "protrusions" and "bulges." The carrier denied the claims, asserting that, whether labeled "protrusions" or "bulges," claimant's current conditions had been previously litigated and, as such, were precluded.

The Board agreed with the carrier's contention regarding the disc "protrusion" claim, but not concerning the disc "bulge" claim. Citing *Drews v. EBI Cos.*, 310 Or 134, 139-40 (1990), the Board stated that "issue preclusion" means that, if a claim is litigated to a final judgment, a decision on a particular

*Claim preclusion does not apply merely because a claimant did not initiate a new/omitted medical condition claim at an earlier time.*

*Insofar as current claim pertained to “protrusions” at same disc level, prior litigation determination that conditions did not exist was preclusive.*

*Because alternative reasoning in prior litigation order regarding “bulge” claim was conditional and not essential to final decision, current “bulge” claim was not precluded.*

*Because claimant had previously been unsuccessful in establishing compensability of “protrusions” claim, dissent considered current claim precluded (whether labeled “protrusions” or “bulges”).*

issue of fact or law is conclusive in a later action between the same parties if the determination was essential to the final decision reached. Again relying on *Drews*, the Board added 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 had reached a final determination. Referring to *Evangelical Lutheran Good Samaritan Society v. Bonham*, 176 Or App 490, 497-98 (2001), the Board observed that, because a new/omitted medical condition claim may be initiated “at any time” under ORS 656.267(1), claim preclusion does not apply merely because a claimant did not initiate a claim for a new/omitted medical condition at an earlier time. Finally, the Board noted that claim preclusion may not bar a claim if the claimant’s condition has changed and the claim is supported by new facts that could not have been presented earlier. See *Stacy Frierson*, 59 Van Natta 399, 400 (2007).

Turning to the case at hand, the Board found that the prior litigation proceeding involved the compensability of several thoracic disc “protrusions” and that the previous litigation orders had determined that claimant had not established the existence of those “protrusions.” Reasoning that part of claimant’s current new/omitted medical condition claim pertained to thoracic disc “protrusions” at the same level, the Board concluded that the prior litigation determination that the conditions did not exist was preclusive. In reaching its conclusion, the Board also relied on a physician’s unrebutted opinion that claimant’s thoracic disc condition had not worsened since the prior proceeding.

The Board reached a different conclusion regarding the thoracic disc “bulges.” Although acknowledging that claimant had argued in the prior proceeding that the terms “bulge” and “protrusion” were interchangeable, the Board reasoned that the previous litigation order had specifically declined to find the two terms to be equivalent. The Board further recognized that, in alternative reasoning contained in its prior decision, it had addressed the medical “causation” issue if the two terms were interchangeable. Nonetheless, considering such an analysis to be conditional and not essential to its final decision that the claimed “protrusion” did not exist, the Board concluded that the disc “bulge” claim was not precluded.

Addressing the merits of the thoracic disc “bulge” conditions, the Board was persuaded by the medical record that claimant’s work injury was a material contributing cause of her need for treatment/disability for her bulges. Moreover, reasoning that a physician had not persuasively addressed whether claimant’s “otherwise compensable injury” (*i.e.*, the work-related injury incident) was not the major contributing cause of the disability/need for treatment for any combined condition, the Board determined that the carrier had not met its burden of proof under ORS 656.266(2)(a) and, as such, the “bulge” claim was compensable.

Member Johnson dissented from the majority’s decision regarding the thoracic disc “bulge” claim. Asserting that ORS 656.262(6)(d) and ORS 656.267(1) do not overrule the doctrine of “issue preclusion,” Johnson reasoned that, in the previous proceeding, claimant was required to prove that the claimed protrusion conditions existed and that her work injury was a material contributing cause of her disability/need for treatment, while the carrier had its statutory burden under ORS 656.266(2)(a) if claimant satisfied the aforementioned statutory requirements. Because claimant had previously been unsuccessful

in establishing the compensability of the claimed disc “protrusions,” Member Johnson contended that she was precluded from relitigating the compensability of the same thoracic disc conditions (whether labeled “protrusions” or “bulges”).

## Penalty: “Amounts Then Due” - Based on Untimely Paid TTD Benefits, Less Recoverable Overpayment

*Mauricio Gabino-Rivas*, 67 Van Natta 777 (May 6, 2015). Applying ORS 656.262(11)(a), the Board held that, when calculating a penalty for a carrier’s unreasonable failure to timely pay temporary disability (TTD) benefits, the “amount then due” was the untimely paid TTD benefits, less an offset for an overpayment that the carrier could have recovered from the payments. Following a previous litigation order regarding the calculation of claimant’s TTD benefits, the carrier overpaid such benefits. Thereafter, the carrier made two TTD payments in two-week intervals, but did not pay such benefits to within 7 days from the payment date as required by OAR 436-060-0150(6). (The carrier did not deduct 25 percent from either payment in partial recovery of its prior overpayment.) Claimant requested a hearing, seeking penalties and attorney fees for the carrier’s claim processing in violation of the aforementioned rule. In response, the carrier contended that, because its total overpayment exceeded the total of its two untimely paid TTD payments, there were no “amounts then due” on which to base a penalty under ORS 656.262(11)(a).

The Board held that a penalty was justified. Citing ORS 656.262(11)(a), the Board stated that, if a carrier unreasonably delays or refuses to pay compensation, a penalty is awardable based on the “amounts then due,” as well as an attorney fee. Relying on *Tricia A. Batchler*, 65 Van Natta 1059, 1062 (2013), *Julie A. Cleland*, 64 Van Natta 1828, 1843-44 (2012), and *Richard F. Sandusky, Jr.*, 58 Van Natta 379, 382 (2006), the Board reiterated that such a penalty is based on the “amounts then due” at the time of the carrier’s unreasonable conduct, *i.e.*, at the time of its untimely paid TTD payments.

Turning to the case at hand, the Board found that it was undisputed that the carrier’s two TTD payments were not paid within 7 days of the payment date, which was contrary to OAR 436-060-0150(6). The Board further noted that the carrier had also previously overpaid claimant’s compensation.

Referring to ORS 656.268(14)(a), and OAR 436-060-0170(1), and (2), the Board observed that a carrier may offset any compensation payable to a worker to recover an overpayment. Furthermore, citing ORS 656.268(14)(a), *David A. Fulcer*, 65 Van Natta 979, 981 (2013), and *Dan L. Prociw*, 62 Van Natta 1041, 1043 (2010), the Board stated that a recovery of an overpayment shall not exceed 25 percent of the payment and does not require prior authorization.

Under such circumstances, the Board concluded that the carrier was statutorily permitted to offset each of its untimely paid TTD payments by 25 percent to recover its overpayment. Consequently, in awarding a penalty for

*Because carrier was statutorily permitted to recover its overpayment (in 25 percent increments) from TTD payments without prior authorization, penalty was based on this amount “then due.”*

the carrier’s untimely payments, the Board found that the “amounts then due” were each untimely TTD payment, reduced by the 25 percent recovery of the undisputed overpayment that the carrier could have asserted. See *Johnson v. SAIF*, 219 Or App 82 (2008); *Troy J. Pachano*, 62 Van Natta 2777, 2784 (2010).

In reaching its conclusion, the Board acknowledged claimant’s contention that the carrier was not permitted to recover its overpayment because it had not provided a written explanation as required by OAR 436-060-0170(2). Nevertheless, the Board reasoned that the aforementioned rule does not premise a carrier’s authorization to recover an overpayment on its compliance with the notice requirement. Moreover, relying on ORS 656.268(14)(a), the Board determined that the carrier was statutorily permitted to recover its overpayment. See OAR 436-060-0170(1).

## Recon Proceeding: ARU “Recon Denial/Evidentiary” Decision - “Abuse of Discretion” Review - No Authority to “Remand” to ARU, But Remedy May Be “Fashioned” For ARU to Reconsider Ruling

*Joseph Federico, Jr.*, 67 Van Natta 799 (May 12, 2015). Analyzing OAR 436-030-0007(2), the Board held that, although the Appellate Review Unit’s (ARU’s) initial reason for denying a carrier’s request for further consideration of an Order on Reconsideration constituted an abuse of discretion, ARU’s subsequent order denying reconsideration was within its discretion, and as such, “post-reconsideration” information regarding claimant’s work disability that was submitted by the carrier for inclusion in the reconsideration record was not admissible at hearing. While claimant’s request for reconsideration of a Notice of Closure (NOC) (which had awarded permanent impairment, but no work disability) was pending before ARU and some three weeks before the expiration of the 60-day postponement under ORS 656.268(6)(b), her counsel faxed claimant’s affidavit and another report from her attending physician to ARU. In doing so, claimant’s counsel neglected to send the carrier’s counsel a copy. When this oversight was discovered, claimant’s counsel again faxed the copies to ARU and to the carrier’s counsel. This transmission was sent four days before the expiration of the statutory postponement period. The following day, the carrier’s counsel faxed to ARU an affidavit from claimant’s supervisor. On the final day of the statutory period, ARU issued an Order on Reconsideration, which affirmed the NOC’s permanent impairment award, but granted work disability. In doing so, ARU considered the documents submitted by both claimant and the carrier. Thereafter, the carrier requested reconsideration, submitting additional information (a job analysis, an affidavit from claimant’s head supervisor, and another report from claimant’s attending physician). ARU denied the request, reasoning that it was not authorized to perform a second reconsideration. After the carrier requested a hearing, an ALJ held that ARU had erred as a matter of law in that it had the discretion to abate and reconsider its decision. See *Boydston v. Liberty Northwest Ins. Corp.*, 166 Or App 336, 344 (2000). The ALJ then purported to “remand” the claim to ARU for further

action. Following a series of orders between ARU and the ALJ, ARU eventually acknowledged its authority to reconsider, but declined to exercise that discretion because it found that the carrier had an adequate opportunity to either timely respond to claimant's submission of the additional information or to request more time to do so. Continuing to consider ARU's decision to constitute an abuse of discretion, the ALJ allowed the parties to present additional evidence at hearing. Based on that record, the ALJ reversed claimant's work disability award.

On review of the ALJ's decision, the Board held that: (1) the ALJ was not authorized to "remand" the claim to ARU; (2) ARU was within its discretion in ultimately refusing to further consider its Order on Reconsideration; (3) the record was statutorily limited to that contained in the reconsideration record; and (4) claimant was entitled to a work disability award.

Referring to *Pacheco-Gonzalez v. SAIF*, 123 Or App 312, 316-17 (1993), and *Shanna C. MacPherson*, 63 Van Natta 763 (2011), the Board reiterated that it lacks authority to remand a claim to ARU. Nonetheless, based on the reasoning expressed in *Birrer v. Principal Fin. Group*, 172 Or App 654, 662 (2001), the Board observed that it has the authority to "fashion a remedy" to return a claim to the WCD for the scheduling of a medical arbiter exam and the issuance of an arbiter report.

Turning to the case at hand, the Board agreed with the ALJ's initial determination that ARU's first reasons to refuse to further consider its Order on Reconsideration was contrary to the *Boydston* holding. Citing OAR 436-030-0007(2), the Board stated that ARU (on behalf of the Director) may abate, withdraw, or amend the Order on Reconsideration during the 30-day appeal period for the order. Relying on *Boydston*, the Board further noted that the statutory time constraints for completion of the reconsideration process are unencumbered until a reconsideration order becomes final.

Under such circumstances, the Board found that further clarification of ARU's initial reasoning for denying reconsideration was warranted. However, rather than "remanding" the claim to ARU, the Board reasoned that the appropriate "remedy" would have been for the ALJ to direct the parties to notify ARU of the ALJ's decision, requesting that it consider supplementing its decision to further consider the reconsideration request in light of the ALJ's concerns. In any event, because ARU had eventually addressed the ALJ's concerns, the Board determined that its procedural concerns had been resolved.

Addressing ARU's ultimate refusal to further consider its reconsideration order and admit the "post-reconsideration" information, the Board concluded that its review was for an "abuse of discretion" because OAR 436-030-0007(2) uses the word "may." See *SAIF v. Kurcin*, 344 Or 399, 405 (2002); *Roberta L. Jones-Lapeyr*, 58 Van Natta 2202, 2207 (2006). After conducting that review, the Board found no abuse of discretion in ARU's decision, which had reasoned that the carrier had not requested more time to submit additional information before the issuance of the Order on Reconsideration. *Terry L. Cox*, 54 Van Natta 102, 103 (2002) (no abuse of ARU discretion in declining to abate/withdraw its reconsideration order to consider to a carrier's submission of a "post-reconsideration" report from a claimant's physician).

*Rather than "remanding" claim to ARU, the appropriate remedy when ARU's denial of reconsideration constitutes an abuse of discretion, appropriate remedy would be to direct parties to notify ARU of decision and request supplementation of earlier decision.*

*Because ARU not statutorily prohibited from abating its reconsideration order, Board found no abuse of discretion in ARU's denial of carrier's reconsideration request when carrier did not request additional time before issuance of reconsideration order.*

*Because "268(8)(b)" is focused on "medical arbiter" process, "283(6)" governs admissibility of "post-reconsideration" work disability evidence and limits such evidence to the presentation of "reconsideration record."*

In reaching its conclusion, the Board acknowledged that, in light of the strict statutory time limitations of ORS 656.268(6)(b), ARU may not have granted a further extension. Nonetheless, in light of the *Boydston* rationale, the Board noted that ARU would not have been statutorily prohibited from issuing an Order on Reconsideration and then abating its decision to await a further submission from the carrier. In any event, because the carrier had not sought additional time to submit further information before issuance of the Order on Reconsideration, the Board found no abuse of discretion or error of law in ARU's denial of the subsequent reconsideration request.

Consequently, the Board declined to consider any "post-reconsideration order" evidence submitted by the parties (including testimony). In doing so, the Board disagreed with the carrier's contention that the statutory prohibition against the admission of "post-reconsideration" evidence was limited to "medical evidence" of a worker's "impairment." See ORS 656.268(8)(h).

The Board acknowledged that ORS 656.268(8)(h) provides that, "[a]fter reconsideration, no subsequent *medical* evidence of the worker's *impairment* is admissible before the director, the Workers' Compensation Board or the courts for purposes of making findings of impairment on the claim closure." (Emphasis supplied). Nevertheless, after reviewing ORS 656.283(6), the Board noted that the statute provides that evidence on "an issue" regarding a notice of closure that was not submitted at the reconsideration "is not admissible" at hearing, but that a party is not prevented from presenting the "reconsideration record" at hearing to establish that the Director's disability standards under ORS 656.726 for the evaluation of a worker's "permanent disability" were incorrectly applied.

In light of such circumstances, the Board concluded that the focus of ORS 656.268(8)(h) is on the medical arbiter process, whereas ORS 656.283(6) governs the admissibility of "post-reconsideration" work disability evidence at hearing. Relying on ORS 656.283(6) as the controlling statute, the Board held that the "post-reconsideration" work disability evidence was inadmissible.

Finally, after reviewing the reconsideration record, the Board was persuaded that claimant was not released to and did not return to his "regular work" (which involved septic test pit inspections) and, as such, was entitled to a work disability award. See ORS 656.214(2)(a); ORS 656.726(4)(f)(E); OAR 436-035-0009(4). Citing *Thrifty Payless, Inc. v. Cole*, 247 Or App 232, 239 (2011), the Board stated 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. Finding that claimant's "regular job" involved climbing in and out of excavation holes and the regular use of a T-handled probe and auger, the Board determined that his physician's restrictions to modify such activities (as well as his supervisor's statement that claimant had not been assigned such duties since his injury) established that claimant had neither been released nor returned to his regular "at-injury" duties.

## TTD: “AP” Authorization - Chart Note Listed Accepted “Conjunctivitis” Condition (Among Other Conditions) - Sufficient to Trigger Carrier’s “Time Loss” Obligation

*Vincent O. Robison*, 67 Van Natta 938 (May 28, 2015). Citing ORS 656.262(4)(a), the Board held that claimant was entitled to temporary disability (TTD) benefits because, although his attending physician’s time loss authorization referred to unclaimed/unaccepted conditions, the authorization also mentioned an accepted condition. After the closure of claimant’s conjunctivitis/dermatitis eye claim was set aside, his attending physician reported that he had “work exposure limitations.” Although the attending physician diagnosed many conditions that had not been accepted, the physician’s report also referred to claimant’s conjunctivitis. When the carrier did not resume the payment of TTD benefits, claimant requested a hearing.

The Board awarded TTD benefits. Citing *Lederer v. Viking Freight, Inc.*, 193 Or App 226, 237, *recons*, 195 Or App 94 (2004), the Board stated that when an objectively reasonable carrier would understand contemporaneous medical reports to excuse an injured worker from work, a carrier is obligated to pay TTD benefits. Relying on *Ulutea Leiataua*, 65 Van Natta 1894 (2013), and *Corey J. McElldowney*, 62 Van Natta 1718, 1720 (2010), the Board noted that a time loss authorization is valid even if it concerns unclaimed or unaccepted conditions, provided that the authorization is due in part to an accepted condition.

Turning to the case at hand, the Board acknowledged that the attending physician’s chart note listed unaccepted bronchial reactivity or asthma as diagnosed conditions. Nevertheless, the Board noted that the attending physician’s chart note listed the accepted conjunctivitis condition that the Board was persuaded that the attending physician’s time loss authorization was due, in part, to the accepted conjunctivitis condition.

In reaching its conclusion, the Board recognized that the attending physician had submitted bills for medical treatment that used an “ICD-9-CM” code for conditions that did not coincide with the accepted conjunctivitis. Nonetheless, the Board reasoned that resolution of the TTD benefit issue should be based on the attending physician’s express statements, rather than billing codes for treatment purposes. See *Tony L. Clark*, 66 Van Natta 821, 827 (2014).

Member Curey dissented. Noting that the attending physician had not examined claimant for over a year when the time loss authorization had issued, Curey was not persuaded that the attending physician’s inclusion of “conjunctivitis” in the list of claimant’s conditions was sufficient to establish that he was unable to work due to, or had limitations due to, his accepted conjunctivitis condition. In addition, Member Curey observed that claimant’s attending physician’s chart notes had not related any “work exposure limitation” to any of the specifically diagnosed conditions. Finally, observing that the

*Because accepted condition was listed in attending physician’s chart note, time loss authorization was considered due, in part, to the accepted condition.*

*Because physician’s chart notes had not related any “work exposure limitation” to any specifically diagnosed conditions and physician’s billing codes did not refer to any accepted condition, dissent contended that physician had not authorized time loss.*

attending physician's billing codes for some two years before the more recent exam had not referred to the accepted conjunctivitis or dermatitis condition, Curey argued that the record did not establish that the physician had authorized time loss for an accepted condition and, as such, claimant had not met his burden of proving his entitlement to TTD benefits.

## APPELLATE DECISIONS UPDATE

### Consequential Condition: “005(7)(a)(A)” - Swelling From Compensable Foot Fracture - Major Cause of “Infection-Related” Conditions - “Preexisting Condition” (“005(24)(c)”) No Bearing on “Consequential Condition” Analysis

*SAIF v. DeMarco*, 271 Or App 226 (May 13, 2015). Applying ORS 656.005(7)(a)(A), the court affirmed the Board's order in *Daniel L. DeMarco*, 65 Van Natta 1862 (2013), previously noted 32 NCN 9, that set aside a carrier's denial of claimant's new/omitted medical condition claims for several left foot/lower leg cellulitis and infections, as well as a “below-the-knee” amputation. In reaching its conclusion, the Board had found that swelling from claimant's accepted left foot fracture was the major contributing cause of the claimed consequential conditions. On appeal, the carrier argued that: (1) the medical experts had improperly considered the contribution of claimant's foot swelling because it was a “predisposition” or “susceptibility” and, as such, must be legally excluded from the compensability analysis for a consequential condition; and (2) the medical opinions did not describe claimant's injury-related swelling as the “major contributing cause” of his infection and did not reflect the required weighing of injury-related factors and other causes.

The court disagreed with the carrier's contentions. Regarding the carrier's challenge to the sufficiency of the medical expert opinions, the court stated that it had repeatedly remarked that no “magic words” are required from experts. See e.g., *SAIF v. Durant*, 271 Or App 216 (2015); *SAIF v. Strubel*, 161 Or App 516, 521 (1999). Instead, the court reiterated that the Board was allowed to “draw reasonable inferences” about whether an expert was expressing a “major contributing cause” opinion and whether the expert had engaged in the required weighing process for that opinion. See *Durant*, 271 Or App at 216; *Benz v. SAIF*, 170 Or App 22, 26 (2000). After reviewing the Board's analysis of the expert opinions, the court determined that the evidence permitted the Board's inferences regarding the aforementioned “major contributing cause” and “weighing process” questions.

Next, the court addressed the carrier's argument that claimant's foot swelling was a mere “predisposition” or “susceptibility” and “legally excluded from consideration as a cause of his infection-related conditions.” In rejecting the carrier's argument, the court determined that the carrier's reliance on

*Board allowed to “draw reasonable inferences” about whether an expert was expressing a “major contributing cause” opinion and whether expert engaged in the required weighing process for opinion.*

*In analyzing occupational disease under “802(2)” “preexisting conditions” shall be deemed causes in determining major contributing cause.*

*“Preexisting condition” definition under “005(24)(c)” has no bearing on analysis of compensability of “consequential conditions” under “005(7)(a)(A).”*

*To determine whether infection-related conditions were compensable “consequential conditions,” contribution from “compensable injury” (including soft tissue swelling) must be considered.*

*Murdoch v. SAIF*, 223 Or App 144, 149-50 (2008), *rev den*, 346 Or 361 (2009), had no bearing on the analysis in the present case. In doing so, the court noted that *Murdoch* involved the compensability of an occupational disease under ORS 656.802(2), in which “preexisting conditions” shall be deemed causes in determining major contributing cause under the section. See ORS 656.802(2)(e).

Based on those principles, the court explained that, in *Murdoch*, it had reasoned that “if the major contributing cause is a preexisting condition *that is not related to employment*, the treatment is not compensable.” 223 Or App at 146 (emphasis added). In doing so, the court noted that, in *Murdoch*, it was focused on ORS 656.005(24), which supplies the definition of a “preexisting condition,” and specifically, paragraph (c), which provides that “[f]or the purposes of industrial injury claims, a condition does not contribute to disability or need for treatment if the condition merely renders the worker more susceptible to the injury.”

Turning to the case at hand, in contrast to *Murdoch*, the court stated that the “preexisting condition” definition has no bearing on the applicable analysis, which concerns the compensability of “consequential conditions” under ORS 656.005(7)(a)(A). In accordance with that statute, the court observed that “[n]o injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition.”

Consequently, in determining whether claimant’s infection-related conditions were a compensable “consequential condition,” the court reasoned that the Board was required to consider the contribution from claimant’s “compensable injury,” which (as found by the Board) included soft tissue swelling. In doing so, the court rejected the carrier’s suggestion that the Board could evaluate the contribution of claimant’s compensable injury without also considering the contribution of a part of that injury.

## Responsibility: “Consequential Condition” Theory (“005(7)(a)(A)”) - Compensable Injury Major Cause of Claimed Condition - “LIER” Not Applicable

*SAIF v. Durant*, 271 Or App 216 (May 13, 2015). Analyzing ORS 656.005(7)(a)(A), the court affirmed the Board’s order in *Jerry F. Durant*, 65 Van Natta 1182 (2013), previously noted 32 NCN 7, which held that an earlier carrier was responsible for the full tear of claimant’s rotator cuff because his compensable partial rotator cuff tear was the major contributing cause of his full tear. On appeal, the earlier carrier contended that the Board had erred in finding that the previous partial tear was the major contributing cause of claimant’s current full tear condition and the last injurious exposure rule (LIER) was not applicable because the earlier carrier was responsible for the “consequential condition” under ORS 656.005(7)(a)(A).

*Court rejected contention that physician's opinion "legally insufficient" because no confirmation that physician understood meaning of the phrase "major contributing cause."*

The court disagreed with the earlier carrier's contentions. Reviewing for substantial evidence, the court first addressed the earlier carrier's assertion that the medical opinions on which the Board had relied were "legally insufficient" because there was no confirmation that the physicians understood the meaning of the phrase "major contributing cause" as used in the workers' compensation law.

Citing *Freightliner Corp. v. Arnold*, 142 Or App 98, 104-05 (1996), the court reiterated that there are no "magic words" required for a medical expert to express a "major contributing cause" opinion. Moreover, relying on *Benz v. SAIF*, 170 Or App 22, 26 (2000), the court repeated that the Board is allowed to make reasonable inferences from the medical evidence. Finally, referring to *Allied Waste Industries, Inc. v. Crawford*, 203 Or App 512, 520 (2005), *rev den*, 341 Or 80 (2006), the court remarked that the Board may infer from the context of an expert opinion that the expert has engaged in weighing the relative contributions of the work incident and the other contributing causes.

Turning to the case at hand, the court noted that each medical opinion on which the Board had relied had taken into account the contribution of claimant's subsequent work to the worsening of his rotator cuff full tear and concluded that the original partial tear had never healed and was the major contributing cause. Finding nothing unreasonable regarding the Board's inference that the physicians had weighed the relative contributions of claimant's later work exposures against the contributions from the earlier partial tear injury, the court concluded that the Board's findings were supported by substantial evidence and reasoning. See ORS 656.298(7); ORS 183.482(8); *SAIF v. Martinez*, 219 Or App 182, 184 (2008).

*When a "consequential condition" is found, liability is assigned to that carrier, rather than referring to judicially created "LIER."*

The court also rejected the earlier carrier's contention that the LIER should have been applied to assign responsibility to a later employer. Citing *SAIF v. Webb*, 181 Or App 205, 211 (2002), the court reiterated that, when the Board finds a compensable "consequential condition" under ORS 656.005(7)(a)(A), liability is assigned to the carrier for that claim, rather than referring to a judicially created rule for assigning responsibility among multiple employers.

Referring to *Waste Management v. Pruitt*, 224 Or App 280, 285-86, *rev den*, 346 Or 66 (2009), the court acknowledged that it had affirmed the assignment of responsibility for an arthritic knee condition under the LIER to the last employer that could have contributed to the condition, despite the later employer's assertion that a prior compensable injury with an earlier employer was the major contributing cause of the claimed condition. However, the court explained that its *Pruitt* conclusion was based on a finding that the claimant's condition was most appropriately characterized as an occupational disease caused by "treatment of the [prior] injury and subsequent factors[.]" *Pruitt*, 224 Or App at 285-86. In contrast to *Pruitt* (where the Board had properly considered the claimant's condition as an occupational disease), the court reasoned that, in the present case, the Board had properly characterized the claimed condition as a "consequential condition."

*Consistent with '90 legislative history of "005(7)(a)(A)," intent is "to make it more difficult to shift responsibility to a subsequent employer."*

*General "LIER/responsibility" analysis did not apply when the disputed condition determined to be "consequential condition" caused in major part by a compensable injury.*

*Consistent with Brown, the "injury-incident based definition of 'compensable injury'" does not make the compensability question dependent on the acceptance of particular conditions.*

Under such circumstances, the court determined that the Board had correctly assigned liability according to the rules specified by the legislature. In doing so, the court referred to the 1990 legislative history regarding ORS 656.005(7)(a)(A), which expressed an intent "to make it more difficult to shift responsibility to a subsequent employer." *SAIF v. Drews*, 318 Or 1, 7 (1993).

Finally, the court acknowledged the earlier carrier's reliance on cases that applied LIER to shift responsibility in a way not contemplated by the legislature; *i.e.*, to shift responsibility to a later employer upon proof that the later employer actually contributed to a worsening of the underlying disease. See *SAIF v. Hoffman*, 193 Or App 750, 753 (2004); *Willamette Industries, Inc. v. Titus*, 151 Or App 76, 80 (1997). Nonetheless, the court noted the Board had correctly recognized that the general "LIER/responsibility" proposition recited in those cases did not apply when the disputed condition was determined to be a "consequential condition" caused in major part by a compensable injury. See *Webb*. Moreover, the court observed that neither "LIER" case had addressed a "consequential condition" or applied the judicially created rule of responsibility to override the strict rules of liability for "consequential conditions."

## APPELLATE DECISIONS COURT OF APPEALS

### Consequential Condition: "005(7)(a)(A)" - "Compensable Injury" (Not "Accepted Condition") Must Be Major Cause of Claimed Condition

*English v. Liberty Northwest Ins. Corp.*, 271 Or App 211 (May 13, 2015). Analyzing ORS 656.005(7)(a)(A), the court reversed the Board's order in *John M. English*, 64 Van Natta 2446 (2012), which had held that claimant's left knee condition was not a compensable consequential condition because his accepted left knee hamstring strain and/or lateral compartment contusion was not the major contributing cause of his currently claimed left knee conditions. Relying on *Brown v. SAIF*, 262 Or App 640, *rev allowed*, 356 Or 397 (2014), claimant argued that the correct inquiry was whether the claimed consequential condition was caused in major part by the "compensable injury" and was not limited to "accepted conditions" as reasoned by the Board.

The court agreed with claimant's contention. Citing ORS 656.005(7)(a)(A), the court stated that no injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition. Relying on *Brown*, the court reiterated that "compensable injury" as contained in ORS 656.005(7)(a) "requires a determination that there was injury incident that caused disability or required treatment – *i.e.*, an accidental injury – arising out of and in the course of the employment." 262 Or App at 646. Consistent with the *Brown* rationale, the court repeated 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.

*No basis to assign “compensable injury” under “005(7)(a)(A)” a different meaning than the same term in “005(7)(a)(B).”*

The court acknowledged that *Brown* addressed the compensability of a “combined condition” claim under ORS 656.005(7)(a)(B), whereas the current dispute concerned the compensability of a “consequential condition” pursuant to ORS 656.005(7)(a)(A). Nonetheless, reasoning that both statutes depended on the claimed condition’s relationship to the “compensable injury” (which must be its major contributing cause), the court found no basis to assign the “compensable injury” as used in ORS 656.005(7)(a)(A) a different meaning than the same term in ORS 656.005(7)(a)(B).

In reaching its conclusion, the court disagreed with the carrier’s argument that the reasoning expressed in *Albany General Hospital v. Gasperino*, 113 Or App 411, 414 (1992), suggested a different meaning for “compensable injury” as used in ORS 656.005(7)(a)(A) and introduced the terminology for distinguishing “industrial accident vs. accepted injury.” In doing so, the court clarified that the point of its discussion in *Gasperino* was to explain that the legislature’s adoption of the “consequential condition” language of ORS 656.005(7)(a)(A) did not supplant the material contributing cause standard for conditions directly related to the industrial accident. 113 Or App at 415. Moreover, the court reasoned that *Gasperino* simply describes a “consequential condition” as a condition caused in major part by the “compensable injury” rather than the “industrial accident.”

*Consequential condition is an injury or condition that does not arise directly from the industrial accident (work-related injury incident), but as a consequence of an injury or condition caused directly by the industrial accident.*

In conclusion, consistent with its *Brown* rationale, the court determined that a consequential condition is an injury or condition that does not arise directly from the industrial accident (*i.e.*, the work-related injury incident), but as a consequence of an injury or condition caused directly by the industrial accident. The court further reasoned that, although the compensability of a consequential condition does not depend upon what conditions the carrier has accepted, ORS 656.005(7)(a)(A) nonetheless requires that the “work-related injury incident” be the major contributing cause of the consequential condition. Consequently, the court remanded to the Board for it to reconsider claimant’s consequential condition claim under the above-described standard.

## Medical Services: “245(1)(a)” - Ankle Surgery Not Caused, in Material Part, by Compensable Injury - Medical Evidence Established Previously Accepted Condition “Resolved”

*Vukasin v. Liberty Northwest Ins. Corp.*, 271 Or App 142 (May 13, 2015). Applying ORS 656.245(1)(a), the court affirmed a Board order that upheld a carrier’s denial of claimant’s medical services claim for an ankle surgery. In reaching its conclusion, the Board had found that claimant’s surgery was not directed to any of her accepted foot and ankle conditions. Specifically, reasoning that claimant’s previously accepted conditions had “resolved” prior to her disputed surgery, the Board had concluded that the surgery was directed at her right ankle instability, which was a denied condition. On appeal, arguing that her surgery was for conditions that the carrier had previously accepted (some

nine years before the surgery), claimant argued that the surgery was compensable, notwithstanding the medical evidence establishing that the conditions treated by the surgery were not the ones caused by her earlier compensable injury.

The court disagreed with claimant's contention. Citing ORS 656.245(1)(a), the court stated that a carrier is responsible for services "for conditions caused in material part by" a compensable injury. Relying on *SAIF v. Sprague*, 346 Or 661, 674-75 (2009), the court noted that whether claimant's surgery was for a condition caused in "material part" by her workplace injury was a question of fact. Finally, emphasizing that claimant's theory of compensability was that her disputed surgery was for her previously "accepted conditions" in connection with her work injury, the court determined that she was not arguing that the Board was required to analyze the compensability of the disputed surgery under a different standard in light of *Brown v. SAIF*, 262 Or App 640, *rev allowed*, 356 Or 397 (2014), and *SAIF v. Carlos-Macias*, 262 Or App 629 (2014).

After conducting its review, the court found substantial evidence to support the Board's following findings: (1) the conditions treated by the surgery were not the same conditions that had been accepted as a result of claimant's work injury; (2) claimant's peroneal tendonitis that resulted from her work injury had resolved several years before the disputed surgery and was not the same peroneal tendonitis treated by the surgery; (3) claimant's synovitis that resulted from her work injury had been removed in a prior surgery and was not the same synovitis treated by the surgery; and (4) although the surgery involved treatment of claimant's right anterior talofibular ligament (ATFL), the evidence did not indicate that the procedure was directed at treating an ATFL *tear*, which was the particular *condition* accepted as a result of her work injury.

Finally, the court determined that there was no support for claimant's contention that, once conditions resulting from a work injury are accepted, any subsequent treatment for conditions of the same type is compensable, even when the medical evidence demonstrates (as a factual matter) that the conditions caused by the injury have been resolved or cured. To the contrary, the court reasoned that ORS 656.245(1)(a) only authorizes compensation for medical services for conditions that are, as a factual matter, causally related to a compensable work injury.

*Court found no support for the contention that, once a condition resulting from a work injury is accepted, any subsequent treatment for that condition of the same type is compensable, even when medical evidence establishes that the condition had resolved or cured.*

## Medical Services: "245(1)(a)" - Femoral Bypass Surgery - Not "For" Condition Due "In Material Part" to Compensable Injury (Traumatic Occlusion of Popliteal Artery)

*Weiker v. Douglas County School District No. 4*, 271 Or App 389 (May 28, 2015). Analyzing ORS 656.245(1)(a), the court affirmed the Board's order in *Dianne R. Weiker*, 64 Van Natta 2086 (2012), which had found that claimant's medical service claim for an aortobifemoral bypass surgery was not compensable. In reaching its conclusion, the Board was not persuaded that the proposed bypass surgery was for any condition caused in material part by

*“245(1)(a)” does not require that a particular medical service can only be “for” a single condition.*

*Even if the proposed surgery also treated a noncompensable condition, the carrier might still be responsible if the surgery was also treating a previous surgery, if the condition was caused in material part by the compensable injury.*

*Because proposed surgery would treat conditions that had no causal connection to compensable injury (and prior surgery had not required repair), Board had correctly determined that the proposed surgery was not “for conditions caused in material part by the injury.”*

claimant’s compensable injury (a traumatic blockage of the left popliteal artery). Instead, the Board had determined that the “condition” to which the bypass related was arterio/atherosclerosis (which was not caused by claimant’s compensable left leg injury). While acknowledging that there was evidence that the proposed surgery was necessary to improve and maintain the flow in the femoral-popliteal graft in the left leg, the Board had reasoned that no medical evidence established that the surgery was necessary to treat the compensable traumatic occlusion of the popliteal artery at the leg fracture site (in fact, the Board had noted that the popliteal graft had stayed open and was not occluded and that the occlusion in the popliteal artery had fully resolved after the initial surgeries).

On appeal, the court identified two issues: (1) whether the traumatic occlusion of the popliteal artery was the material cause of a condition; and (2) whether the proposed aortobifemoral bypass was “for” that condition. See *SAIF v. Swartz*, 247 Or App 515, 525 (2011). Relying on *Swartz*, the court reiterated that, under ORS 656.245(1)(a), the “conditions” referred to in the statute are the current conditions for which treatment is sought (which need not be the accepted condition). Furthermore, citing *SAIF v. Sprague*, 346 Or 661, 675 (2009), the court stated that ORS 656.245(1)(a) does not require that particular medical services can only be “for” a single condition.

Turning to the case at hand, the court noted that the record showed that the proposed bypass surgery would treat multiple conditions (not only the blockages/narrowing in claimant’s iliac arteries from a denied occlusive disease, but also to resolve a suboptimal flow to the popliteal graft in the left leg, which created a risk that the graft would occlude). Thus, even if the surgery treated the artery occlusive disease (which was not causally related to claimant’s compensable injury), the court reasoned that the carrier might still be responsible for medical services to treat the suboptimal flow to the left popliteal graft, provided that the condition was caused in material part by the compensable injury.

Addressing the aforementioned “causation” issue, the court found no evidence showing that the lack of inflow to the left popliteal graft and the associated risk of occlusion in the graft were caused, in material part, by the traumatic injury to the popliteal artery. Reasoning that the medical evidence established that the proposed surgery would treat conditions that had no causal connection to the compensable injury, the court concluded that the Board correctly determined that the proposed bypass surgery was not “for conditions caused in material part by the injury.”

Finally, the court acknowledged claimant’s assertion that the proposed bypass surgery was for the grafted popliteal artery (which would not have occurred but for the initial traumatic blockage). Nonetheless, the court observed that the left popliteal graft had not required repair and remained open and, as such, the surgery did not effect that graft itself. Consequently, the court concluded that there was substantial evidence supporting the Board’s determination that the surgery was not for the popliteal artery graft (even if it was considered a “condition”).

## Preexisting Condition: “Susceptible” - “005(24)(a), (c)” - Recurrent Hernia Due to Weakening of Tissue in Abdominal Wall

*Corkum v. Bi-Mart Corporation*, 271 Or App 411 (May 28, 2015).

The court reversed the Board’s order in *Dennis L. Corkum*, 64 Van Natta 2266 (2012), which had upheld a carrier’s injury denial for an inguinal hernia condition. In reaching its conclusion, the Board found that claimant’s current condition represented a recurrence of a previously repaired inguinal hernia (which constituted a legally cognizable preexisting condition) and that the work incident was not the major contributing cause of his need for treatment for the combined condition. Although acknowledging a physician’s opinion that claimant’s hernia had developed due to the weakening of tissue in his abdominal wall, the Board reasoned that such an explanation indicated that the abdominal wall weakness *caused* the hernia and was not *merely* a predisposition or susceptibility. On appeal, claimant contended that his abdominal wall weakness should not have been considered a preexisting condition, but rather constituted a “susceptibility” under ORS 656.005(24)(c).

The court agreed with claimant’s contention. Citing ORS 656.005(24)(c), the court stated that, for purposes of injury claims, a condition does not contribute to disability or need for treatment if the condition merely renders the worker more susceptible to the injury. Referring to the dictionary definition of “susceptible,” the court commented that the word means “of such a nature, character, or constitution as to admit or permit: capable of submitting successfully to an action, process or operation.” *Webster’s Third New Int’l Dictionary* 2303 (unabridged ed 2002). Furthermore, after reviewing the legislative history regarding the 2001 amendments to ORS 656.005(24)(c), the court noted that the intent of the term “susceptible” was to carve out of the definition of “preexisting condition” those conditions which do not actively contribute to the disability or need for treatment.

*A condition merely renders a worker more susceptible to injury if the condition increases the likelihood that the affected body part will be injured by some other action or process, but does not actively contribute to damaging the body part.*

Based on the text, context, and legislative history of the statute, the court reasoned that a condition merely renders a worker more susceptible to injury if the condition increases the likelihood that the affected body part will be injured by some other action or process, but does not actively contribute to damaging the body part. See *Murdoch v. SAIF*, 223 Or App 144, 149-50 (2008), *rev den*, 346 Or 361 (2009).

Applying its understanding of the term “susceptible” to the Board’s order, the court concluded that the record did not support the Board’s determination that a physician’s statement that claimant’s hernia had enlarged “due to the weakening of the tissue” indicated that the weakness had “caused” the hernia, rather than merely rendering him more susceptible to hernias. In arriving at its conclusion, the court found that, viewing the record as a whole, a reasonable person could find only that the physician meant that the abdominal wall weakness was a passive contributor that merely *allowed* the hernia to enlarge, while the “stresses and strains” of everyday life actively *caused* the hernia to enlarge. Reasoning that claimant’s abdominal wall weakness merely

*A reasonable person could find only that the physician meant that the abdominal wall weakness was a passive contributor that merely allowed the hernia to enlarge and, as such, merely rendered claimant more susceptible to injury, which did not constitute a “preexisting condition” under “005(24).”*

rendered claimant more susceptible to injury (without itself “contribut[ing] to disability or need for treatment,” the court determined that the abdominal wall weakness was not a preexisting condition within the meaning of ORS 656.005(24). Consequently, the court held that the Board had erred in finding otherwise.