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BOARD NEWS

"Housekeeping" Changes to OAR Chapter 438 Rules

At its June 30 meeting, the Members adopted "housekeeping" rule changes which pertain to references to the Board's email address and certain OAR 438 Divisions.

These changes have been filed with the Secretary of State's office. An electronic copy of these "housekeeping" rule changes are posted on WCB's website (under the category "Laws & Rules") at www.wcb.oregon.gov.

Two WCB Offices Relocating

- *By Greig Lowell*

One office move is under way this month and the other will likely happen later this year.

The Workers' Compensation Board (WCB) is moving its Medford operations to a new location. Beginning July 13, 2015, hearings will be held in the new office at 115 W Stewart Ave., Suite 102, Medford, Oregon 97501. The office phone and fax numbers remain the same.

The new office, located 1.4 miles south of the current location on E. Main Street, can be accessed from I-5 by taking the exit at milepost 27.

WCB's office is on the first floor of a modern building, with improved climate control. It features ample free parking, and bathrooms inside the suite of offices. The floor plan features two hearing rooms, two counsel rooms, a lobby, and offices for the WCB staff. Wi-Fi will be available throughout the office.

"We think this new office will better serve our Southern Oregon stakeholders," said WCB Chair Holly Somers. "It has easy first floor access and a more comfortable environment for employees and the public we serve."

Somers credits Administrative Services Manager Terry Bello for her leadership in executing the office relocation.

Board staff will be moving furniture and equipment out of the old office and setting up the new office during the week of July 6-10, with the hope of having as little disruption as possible for hearings and mediations.

APPELLATE DECISIONS**Update**

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Meanwhile, the Board also announced plans to move its Portland Hearings Division office from the Portland State Office Building to Durham Plaza at 16760 SW Upper Boones Ferry Rd., Portland, Oregon 97224.

A specific timetable has not been determined, but WCB expects to complete the move in the fall or early winter of 2015. Free public parking for WCB customers will be available at the new Durham Plaza location.

Many factors were analyzed in determining whether the Hearings Division office should be moved to a new location. Those included the need for more hearings and counsel rooms, increasingly limited parking near the Portland State Office Building, plus a planned renovation of the Portland State Office Building which would have temporarily displaced WCB operations.

Over the last few months, WCB sought out stakeholder input, studied transportation methods, and hosted an open house at the new facility.

"We appreciate all of the public input over the last few months," WCB Chair Holly Somers said in a June 18, 2015 statement. "It helped us to hone in on some of the factors we needed to consider in making this decision. I also want to take this opportunity to thank all of those who put in many hours helping us make the best, most informed decision possible."

WCB will provide updates on the schedule for the Portland office move in the coming months.

CASE NOTES

Course & Scope: Idiopathic Fall - Not Truly Unexplained - Personal/Idiopathic Causes Not Eliminated

Frances S. Lange, 67 Van Natta 974 (June 2, 2015). The Board held that claimant's injury, which occurred when she fell while performing her work activities as a hair stylist, did not arise out of her employment because her fall was not truly unexplained due to personal idiopathic causes. Before claimant's fall at work, she had received treatment for carotid artery stenosis and had a history of intermittent episodes of a loss of balance. Approximately 18 months before her work injury, she had fallen at home, fracturing her hip, when her leg "gave out." Following surgery for her leg fracture, claimant walked with a limp, wore an insert in her shoe, and worked in the back of the hair salon where there was less congestion. After her fall at work, claimant did not recall slipping, feeling dizzy, or being unstable. The carrier denied claimant's injury claim, contending that the injury did not arise out of her employment because personal factors had not been eliminated as the cause of her fall.

The Board upheld the carrier's denial. Citing *Redman Indus., Inc. v. Lang*, 326 Or 32, 36 (1997), the Board stated that, to establish whether an injury "arose out of" claimant's employment, the "causal connection must be linked to a risk connected with the nature of the work or a risk to which the work

A fall will be deemed “truly unexplained” only if the claimant “persuasively eliminates all idiopathic factors of causation.”

Because claimant’s personal idiopathic causes for her work fall had not been eliminated, the fall was not “truly unexplained” and, thus, her injury did not arise out of her employment.

environment exposes [the] claimant.” Relying on *Phil A. Livesley Co. v. Russ*, 296 Or 25, 29-30 (1983), the Board noted that a “truly unexplained” fall is considered to arise out of employment as a matter of law and is compensable, provided that it occurs in the course of employment. Referring to *Russ* and *Blank v. U.S. Bank of Oregon*, 252 Or App 553, 557-58 (2012), the Board reasoned that a fall will be deemed “truly unexplained” only if the claimant “persuasively eliminates all idiopathic factors of causation.”

Turning to the case at hand, the Board noted that a physician (who addressed claimant’s vascular/arterial condition) had opined that claimant’s fall at work was “essentially identical” to her earlier “at-home” fall. The Board further observed that another physician did not consider claimant’s fall at home to appear to be “related to TIA or stroke,” whereas a third physician was unable to rule out the personal causes for claimant’s work fall.

Under such circumstances, the Board determined that neither of the other physicians’ opinions rebutted the first physician’s opinion that claimant’s vascular/arterial condition would have caused her to fall. Reasoning that claimant’s personal idiopathic causes for her workplace fall had not been eliminated, the Board concluded that her work fall was not “truly unexplained” and, as such, her injury did not arise out of her employment.

Course & Scope: Injury During “Off-Day” While Checking on File at Work - “Arose Out of/In The Course of” Employment, Even Though Injury Occurred While Delivering “Secret Santa” Gift

Laina Haefer, 67 Van Natta 1076 (June 11, 2015). The Board held that claimant’s injury, which occurred when she fell on a staircase in her employer’s office while delivering a “Secret Santa” gift to a coworker during her “off-day,” arose out of and in the course of her employment because she had also come to her employer’s office to check on a work assignment. While taking her “floating holiday” leave during the Christmas season, claimant decided to go into the employer’s office to check on the status of a pending file that she was processing. She also intended to deliver some personal gifts, as well as a “Secret Santa” gift for another coworker. (Her employer did not object to the gift exchange, but also did not require employee participation in the exchange.) After checking on the file, claimant began delivering the presents and, while descending some stairs to deliver the “Secret Santa” gift, tripped and fell, injuring her ankle and leg. The carrier denied the claim, asserting that it did not arise out and in the course of her employment. The carrier did not contend (either in its denial or at hearing) that claimant was injured while engaged in a social/recreational activity primarily for her personal pleasure. See ORS 656.005(7)(b)(B).

The Board set aside the carrier's denial. To begin, the Board declined to consider the "affirmative defense" of whether claimant's injury had occurred while she was engaged in or performing a recreational or social activity primarily for her personal pleasure. See ORS 656.005(7)(b)(B). Citing *Oregonians for Sound Economic Policy, Inc. v. SAIF*, 218 Or App 31 (2008), the Board stated that an affirmative defense must be pleaded and proved, and can be waived if not timely raised. Furthermore, relying on *Cynthia A. Watson*, 48 Van Natta 609 (1996), the Board reiterated that, when a carrier used a "course and scope" defense at hearing, its argument on appeal for the first time that the claim was not compensable under ORS 656.005(7)(b)(B) was not timely raised.

Because "social/recreational" affirmative defense had not been raised at the hearing, Board declined to address the defense.

Turning to the case at hand, the Board found that the carrier had issued a standard "arising out of/in the course of" denial. In addition, the Board observed that there was no indication that the "social/recreational" affirmative defense had been raised at hearing. Under such circumstances, the Board declined to address the affirmative defense for the first time on review.

The Board next addressed the "in the course of/arising out of" prongs of the work-connection inquiry. Citing *Robinson v. Nabisco, Inc.*, 331 Or 178, 186 (2000), the Board stated that whether an injury occurs "in the course of" employment depends on the "time, place, and circumstances" of the injury. Relying on *Fred Meyer, Inc. v. Hayes*, 325 Or 592, 596 (1997), the Board noted that an injury is deemed to "arise out of employment" if the risk of the injury results from the nature of the claimant's work or when it originates from some risk to which the work environment exposes her.

Applying those standards, the Board determined that claimant was authorized to work during her "off days" without prior approval and it was not unusual for her to do so. In addition, the Board observed that her injury had occurred on the employer's premises, in a place where she would reasonably be expected; *i.e.*, on the stairs between her employer's office levels.

Because claimant was permitted to check on a file in her employer's office on her off day, her fall while walking down steps in the office to deliver a "Secret Santa" gift to a coworker did not constitute a personal departure that severed the relationship between her work and her injury.

The Board acknowledged that claimant was injured while delivering her "Secret Santa" gift to a coworker. Nonetheless, reasoning that her purpose for being in the employer's office was to check on a pending file (something she was permitted to do by her employer), the Board did not consider her walking down the stairs to deliver the gift (which was also permitted by the employer) constituted a personal departure that severed the employment relationship. Consequently, the Board concluded that claimant's injury arose out of and in the course of her employment.

Extent: Impairment Findings - Legally Cognizable “Preexisting Condition” - “Apportionment” Rule Applied to “Unclaimed/Unaccepted” Combined Condition

Claudia S. Stryker, 67 Van Natta 1003 (June 4, 2015). Applying former OAR 436-035-0013, the Board apportioned claimant’s permanent impairment between her compensable shoulder and low back conditions and “superimposed and unrelated conditions,” even though those latter conditions were legally cognizable “preexisting conditions” that had not been accepted or denied before claim closure. Relying on *Schleiss v. SAIF*, 354 Or 637 (2013), claimant argued that all of her “attending physician-ratified” impairment findings should be attributed to her compensable injury (without apportionment for her preexisting arthritic conditions) because the carrier had neither accepted nor denied a combined condition before claim closure.

The Board disagreed with claimant’s contention. After summarizing the *Schleiss* decision, the Board stated that the court had held that “to qualify for the apportionment of impairment, a cause must be legally cognizable.” 354 Or at 655. The Board further noted that, because there was no evidence in the record in *Schleiss* that either of the noncompensable causes for the claimant’s permanent impairment was a legally cognizable preexisting condition, the court had concluded that the “apportionment” rule’s requirement had not been satisfied. Finally, because of the absence of a legally cognizable preexisting condition in *Schleiss*, the Board observed that it was unnecessary for the court to resolve the disagreement presented in the present case; *i.e.*, whether claimant’s permanent impairment is “apportioned” when there is a legally cognizable “preexisting condition,” which has not been accepted or denied before claim closure.

After considering the statutory scheme and the *Schleiss* rationale, the Board concluded that apportionment under OAR 436-035-0013(1) was justified. Based on its review of the definition of “preexisting condition” under ORS 656.005(24)(a)(A) and (B)(i), the Board stated that the statutory scheme does not premise the existence of a legally cognizable “preexisting condition” on its acceptance. Consistent with that observation, the Board further noted that, in analyzing whether the purported “preexisting conditions” in *Schleiss* were legally cognizable, the court had not based its decision on whether the conditions had or had not been accepted.

Citing ORS 656.262(7)(b), and *SAIF v. Belden*, 155 Or App 568, 576-77 (1998), *rev den*, 328 Or 330 (1999), the Board acknowledged that, if a carrier accepts a “combined condition” before claim closure, it must issue a “pre-closure” denial of that condition or the entire “combined condition” is rated. Furthermore, referring to *Jonathan E. Ayers*, 56 Van Natta 1103, 1104 (2004), *recons*, 56 Van Natta 1470 (2004), the Board reiterated that, when a “pre-closure” combined condition has issued, the evaluation of permanent impairment

The statutory scheme does not premise the existence of a legally cognizable “preexisting condition” on its acceptance and, as such, apportionment of claimant’s permanent impairment between her compensable conditions and “preexisting conditions” was justified.

Because ARU had implicitly interpreted its “apportionment” rule as not dependent on a “pre-closure” acceptance/denial of a “preexisting condition” component of a combined condition, the Board deferred to this plausible interpretation.

Reasoning that a combined condition had been established in the reconsideration record, dissent argued that apportionment of claimant’s permanent impairment was not appropriate because the combined condition had neither been claimed, accepted, nor denied before claim closure.

would not extend to the denied legally cognizable “preexisting condition” and, as such, the “apportionment” rule would apply. Nonetheless, drawing on the *Schleiss* court’s rationale (which was not premised on the acceptance/denial of a “combined condition”), the Board reasoned that “apportionment” was also appropriate when the record supports the existence of a legally cognizable “preexisting condition.” 354 Or at 649-650.

Finally, in applying the “apportionment” rule in evaluating claimant’s permanent impairment, the Board determined that the Appellate Review Unit (ARU) had implicitly interpreted its rule as not dependent on a “pre-closure” acceptance/denial of a “preexisting condition” component of a combined condition. Finding that such an interpretation was plausible and not inconsistent with the wording of the rule or any other source of law, the Board further concluded that such an interpretation was entitled to deference. See *Godinez v. SAIF*, 269 Or App 578, 582 (2015).

Members Lanning and Weddell dissented. Regarding the shoulder condition, the dissent noted that an attending physician had agreed with an examining physician’s opinion that claimant’s work injury continued to be the major contributing cause of her right shoulder disability at claim closure. Relying on ORS 656.268(1)(a), and *Schleiss*, the dissenting members asserted that all of claimant’s shoulder impairment findings, without apportionment, should be rated.

Addressing claimant’s low back condition, Members Lanning and Weddell referred to the *Schleiss* court’s statement that impairment attributable to a legally cognizable preexisting condition must be apportioned in a permanent disability award *where a combined condition has been established*, and the compensable injury is no longer the major contributing cause of the impairment or the need for medical treatment. Based on that statement, the dissent reasoned that, under the statutory analysis delineated in *Schleiss*, apportionment only becomes applicable when a combined condition has been “established.” Because a “combined condition” had neither been claimed, accepted, nor denied before claim closure, the dissenting members asserted that claimant’s permanent impairment should not be apportioned.

Extent: Impairment Findings - Prior “Injury Denial” Litigation (Finding That Carrier Did Not Meet “BOP” Under “266(2)(a)” For Unspecified “Combined Condition”) - Did Not Establish Compensability of “Preexisting Condition” For Subsequent “Rating” Purposes

Jason C. Griffin, 67 Van Natta 978 (June 3, 2015). [Editor’s Note: The Board abated its order on July 2, 2015.] The Board held that, in rating claimant’s permanent impairment for a compensable low back injury, his impairment was

based on his accepted lumbar strain (rather than a combined low back degenerative/instability condition), because a prior litigation order regarding the carrier's injury denial had not found a specific combined condition compensable. In a previous litigation involving an injury denial, a prior ALJ's order had found that the carrier had not met its burden of proof under ORS 656.266(2)(a) of establishing that the "preexisting condition" was not the major contributing cause of the "combined condition." In doing so, the prior ALJ's order set aside the carrier's denial of a "low back" injury, without specifically identifying the condition to be accepted or the "preexisting condition" component of the "combined condition." Thereafter, the carrier accepted a lumbar strain and, eventually, closed the claim, without awarding permanent impairment. After an Order on Reconsideration affirmed that decision, claimant requested a hearing, contending that he was entitled to an "unapportioned" permanent impairment award based on the entire impairment "range of motion" findings reported by the medical arbiter (which had attributed the findings to degenerative disc disease and the residuals of a "pre-injury" lumbar surgery).

The Board disagreed with claimant's contention. Citing *Nelson v. Emerald People's Utility Dist.*, 318 Or 99, 104 (1993), the Board stated that the doctrine of "issue preclusion" bars future litigation of an issue that was "actually litigated" in an earlier proceeding and was "essential to a final decision on the merits" in that proceeding. Relying on *Boeing Aircraft Co. v. Roy*, 112 Or App 10, 15 (1992), the Board noted that a specific diagnosis need not be proven in the litigation of an injury claim. Finally, referring to *Mannie Burkman*, 58 Van Natta 2406, 2407 n 1 (2006), the Board further reiterated that the specific identity of the accepted condition following litigation regarding a compensability denial is a claim processing matter in the first instance pursuant to ORS 656.262.

Turning to the case at hand, the Board found that the issue "actually litigated" in the prior proceeding was the compensability of claimant's initial injury claim. Furthermore, although that proceeding involved a "combined condition," the Board reasoned that the parties did not litigate and the prior ALJ's order (which set aside the carrier's back injury denial and remanded "the claim" for acceptance) did not expressly identify the specific condition or "combined condition" components that should be accepted. Under such circumstances, the Board concluded that the specific identity of the "preexisting condition" component of the combined condition was not "essential to a final decision on the merits" in that prior proceeding. Consequently, the Board determined that the prior litigation order had no preclusive effect insofar as a specific compensable condition ("combined condition" or otherwise) was concerned.

In reaching its conclusion, the Board distinguished *Roseburg Forest Products v. Lund*, 245 Or App 65 (2011), where the court had held that a claimant was entitled to a permanent disability award for a combined condition because a prior final litigation order had concluded that a new/omitted medical condition claim for a specific combined condition was compensable. The Board noted that the *Lund* court had determined that, in light of the previous compensability litigation, the carrier's acceptance of specific conditions (but not a combined condition) was "properly understood" as accepting a combined condition.

The specific identity of an accepted condition following litigation regarding a compensability denial is a claim processing matter in the first instance under "262."

Because the specific identity of the "preexisting condition" component of the combined condition was not "essential to a final decision on the merits" in the prior proceeding regarding the initial compensability denial, the prior litigation order had no preclusive effect concerning a specific "combined condition."

Because claimant was authorized to challenge the carrier's acceptance or initiate a new/omitted medical condition claim at any time, he was not precluded from filing a claim for any unaccepted condition.

Because the arbiter had attributed no impairment to claimant's accepted strain combined with a preexisting disc pathology and the attending physician had found no impairment associated with the strain or preexisting "pathologies," no permanent impairment award was warranted.

Noting that prior ALJ's order had applied a "combined condition" analysis in setting aside carrier's compensability denial, dissent contended that carrier's strain acceptance encompassed a "combined condition" and, because the carrier had not issued a "pre-closure" combined condition denial, claimant was entitled to a permanent disability award based on that total combined condition.

In contrast to *Lund* (where the compensability issue concerned the compensability of a new/omitted medical condition claim, which requires the existence of the claimed condition to be established), the Board reasoned that the prior litigation in the present case involved the initial compensability of an injury claim (which did not require the existence of a specified condition). Accordingly, the Board concluded that the *Lund* rationale was not controlling in the present situation.

In addition, referring to ORS 656.262(6)(d), (7)(a), and ORS 656.267(1), the Board noted that claimant was authorized to challenge the carrier's acceptance notice or to initiate a new/omitted medical condition claim at any time. In light of those statutes, the Board stated that he was not precluded from filing a claim for any unaccepted condition that may be accepted or determined to be compensable and subsequently evaluated for permanent disability benefits.

Turning to the merits of the permanent impairment issue, the Board observed that the arbiter had attributed no impairment to claimant's accepted lumbar strain combined with preexisting L4-5 instability. Based on its finding that no compensable combined condition existed, the Board found persuasive reasons to reject the arbiter's impairment findings (which, in any event, did not support a permanent impairment award for claimant's compensable injury). Nonetheless, noting that his attending physician had found no permanent impairment associated with claimant's compensable strain or preexisting low back "pathologies," the Board determined that no permanent impairment award was warranted. In reaching this conclusion, the Board cited *Paula Magana-Marquez*, 66 Van Natta 1300, 1301-02 (2014), for the proposition that when a claimant's impairment is solely due to causes unrelated to the compensable injury, a permanent impairment award is not appropriate.

Member Weddell dissented. Based on the physicians' opinions presented in the prior proceeding, Weddell asserted that claimant's work incident had combined with significant preexisting L4-5 pathology to cause his need for treatment and disability. Consistent with this observation, Member Weddell further noted that the prior ALJ's order had applied a "combined condition" analysis and, following that order, the carrier had generated an opinion from an examining physician stating that claimant's lumbar strain had initially combined with his preexisting lumbar pathologies, but had subsequently ceased to be the major contributing cause of his need for treatment/disability for the "combined condition."

Under such circumstances, Member Weddell reasoned that the carrier's acceptance of a lumbar strain constituted an acceptance of a "combined condition." In addition, stressing that the carrier had a statutory obligation to process claims and to comply with litigation orders, Weddell considered it fundamentally unfair to require claimant to re-claim (and potentially re-litigate) the compensability of previously claimed conditions for which he had previously established. Finally, because the carrier had not denied the combined condition before the claim was closed, Member Weddell contended that claimant was entitled to a permanent disability award based on his total accepted combined condition.

Own Motion: Arbiter Request May be Filed Between Request for Review/Decision on Merits - “012-0060(1)(b)(C), (6)(a)”

Daniel S. Bishop, 67 Van Natta 955 (June 1, 2015). In an Own Motion order, the Board held that claimant’s request for an arbiter examination could be considered because, although the request was not initially filed along with his request for review, the arbiter request was filed before the Board had made any decision on the merits of the permanent disability issue. Following a Notice of Closure (which did not award additional permanent disability for claimant’s “new/omitted medical condition” Own Motion claim), claimant requested Board review. In doing so, he did not request the appointment of a medical arbiter. After the expiration of a briefing schedule, but before issuance of the Board’s decision on the merits of the appeal, claimant requested a medical arbiter examination. The carrier opposed claimant’s arbiter request, contending that it was untimely submitted.

The Board granted claimant’s arbiter request. Citing OAR 438-012-0060(1)(b)(C), the Board stated that claimant’s request for review of an Own Motion Notice of Closure should include, but is not limited to, a statement that provides the reasons for the request. The Board further noted that, as part of that statement, a claimant may request appointment of a medical arbiter, if he/she disagrees with the impairment used in the rating of permanent disability for a new/omitted medical condition claim. Finally, relying on OAR 438-012-0060(6)(a), the Board stated that, after a claimant requests review of an Own Motion Notice of Closure of a new/omitted medical condition claim, it may refer the claim to the Director for appointment of a medical arbiter.

Based on these rules, the Board determined that a claimant was not mandated to include an arbiter request in the initial request for review. Instead, the Board reasoned that a claimant may make an arbiter request between the filing of an appeal of the closure notice and the issuance of its decision on the merits of the appeal. See *Arthur W. Poland*, 57 Van Natta 2390 (2005) (arbiter request denied because it was made on reconsideration of Board decision on the merits of the claimant’s appeal of a Notice of Closure regarding entitlement to TTD benefits).

Because claimant’s arbiter request was made before any decision had issued on the merits of the permanent disability issue raised by claimant’s appeal, the Board rejected the carrier’s assertion that the arbiter request was untimely filed. Consequently, the Board referred the claim to the ARU for the appointment of a medical arbiter. See *Karl E. Mitchell*, 59 Van Natta 27 (2007). In reaching its conclusion, the Board emphasized that, to ensure expeditious case processing, it would be preferable if an arbiter request was filed early in the process.

Claimant may make an “Own Motion” arbiter request between the filing of an appeal of a closure notice and the issuance of its decision on the merits of the appeal.

To ensure expeditious case processing, it would be preferable if an arbiter request was filed early in the process.

Prospective Denial: Denial Pertained to “New Injury” Claim - Not Interpreted as Invalid Prospective/“Back-Up” Denial of Existing Claim

Jude S. Hardesty, 67 Van Natta 991 (June 2, 2015). Analyzing ORS 656.262(6)(a), the Board held that a carrier’s denial of claimant’s bilateral knee condition was not an invalid prospective/“back-up” denial of his previously accepted claim for the condition because, although the denial referred to the same “date of injury” as the prior claim, the denial listed a different claim number. Some two years after the carrier’s acceptance of claimant’s injury claim for a bilateral knee condition, he returned to his physician with knee complaints. Thereafter, his physician submitted an 827 form, referring to a “first report of injury or disease” for claimant’s knee condition from 30 years of performing his welding work. In response, the carrier issued a claim denial, asserting that there was insufficient information to establish that claimant had sustained a compensable injury or occupational disease. The denial referred to the same “date of loss” as the previously accepted injury claim, but included a different claim number. Claimant requested a hearing, contending that the carrier’s denial constituted an invalid prospective or “back-up” denial of his previously accepted claim.

The Board disagreed with claimant’s contention. Citing ORS 656.262(6)(a), and *Bauman v. SAIF*, 295 Or 788, 794 (1983), the Board stated that when a carrier attempts to deny a previously accepted condition, such a denial constitutes an impermissible “back-up” denial of that condition. Furthermore, relying on *Evanite Fiber Corp. v. Striplin*, 99 Or App 353, 357 (1989), and *Barbara J. Ferguson*, 63 Van Natta 2253, 2258-59 (2011), the Board noted that a carrier may not prospectively deny its future responsibility for benefits relating to a previously accepted claim.

Turning to the case at hand, the Board concluded that the carrier’s denial was neither an invalid “back-up” denial nor prospective denial of the previously accepted claim. In reaching its conclusion, the Board acknowledged that the carrier’s denial had referenced the same “date of loss” as the prior accepted claim. Nevertheless, the Board noted that the denial had expressly stated that it “constitute[d] a denial of the above referenced claim * * * [for which the carrier was] unable to provide any workers’ compensation benefits under *this claim*.” (Emphasis supplied). Moreover, the Board emphasized that the carrier’s denial referred to a new claim number, which was different from the claim number regarding the previously accepted claim.

Under such circumstances, the Board determined that the carrier’s denial pertained to a new claim for benefits, rather than an impermissible prospective denial of future benefits or “back-up” denial of claimant’s previously accepted claim. Consequently, the Board held that the carrier’s denial of the new claim was warranted. However, the Board stressed that claimant retained his ongoing rights to benefits related to his previously accepted claim for his bilateral knee conditions.

Although carrier’s denial referred to the same “date of loss” as a previous accepted claim, the denial contained a new claim number and, as such, the denial’s reference to “this claim” was interpreted as pertaining to a new claim for benefits, rather than constituting an impermissible “back-up” or prospective denial of benefits under the previously accepted claim.

TTD: “Physician Assistant” Time Loss Authorization - Limited to 30 Days From First Visit - “245(2)(b)(B)”

Ana Galvan, 67 Van Natta 1055 (June 8, 2015). Applying ORS 656.245(2)(b)(B), and ORS 656.262(4)(h), the Board held that, notwithstanding a physician’s assistant’s (PA’s) time loss authorization for an indefinite period, claimant was entitled to temporary disability (TTD) benefits for only 30 days from the date of the first visit. Shortly after her compensable injury, claimant began treating with a PA, who released her to light duty work. The carrier began paying TTD benefits, but notified claimant that such benefits would cease 30 days from the first visit, unless she changed physicians. Although the PA scheduled claimant for an examination with a physician, she did not attend that appointment. Instead, on the 30th day from her first visit with the PA, claimant returned to the PA, who provided another light duty work release for an indefinite period. When the carrier stopped paying TTD benefits as of the aforementioned 30th day, claimant requested a hearing. Asserting that the PA qualified as an “attending physician” when issuing the “open-ended” time loss authorization, claimant contended that she was entitled to ongoing TTD benefits.

The Board disagreed with claimant’s contention. Citing ORS 656.245(2)(b)(B), the Board stated that a medical service provider may qualify to serve as an attending physician and authorize the payment of TTD compensation for a period not exceeding 30 days from a claimant’s first visit on the initial claim. Relying on ORS 656.262(4)(h), the Board noted that a claimant’s disability may be authorized only by a person described in ORS 656.005(12)(b)(B) or ORS 656.245 for the period of time permitted by those sections. Finally, again referring to ORS 656.262(4)(h), the Board remarked that a carrier may unilaterally suspend the payment of TTD benefits “at the expiration of the period” until such benefits are reauthorized by an attending physician or nurse practitioner.

Turning to the case at hand, the Board found that, as claimant’s attending physician, the PA could authorize TTD benefits for a period of 30 days from the date of claimant’s first visit on the initial claim. Because that 30-day period had expired, the Board determined that the PA’s time loss authorization was no longer statutorily valid and, as such, the carrier was not obligated to continue paying TTD benefits based on that authorization.

In reaching its conclusion, the Board distinguished *Dedera v. Raytheon Engineers & Construction*, 200 Or App 1, 7, *rev den*, 339 Or 406 (2005), where an “open-ended” time loss authorization from a claimant’s attending physician was deemed effective beyond the period that the physician was no longer the “attending physician.” Noting that *Dedera* interpreted ORS 656.262(4)(g) (which does not specifically limit the duration of time loss authorization provided by an attending physician), the Board reasoned that the present case involved ORS 656.262(4)(h), which expressly limits a PA’s authorization of TTD benefits to 30 days from the first visit. Under such circumstances, the Board concluded that the PA’s “open-ended” time loss authorization could not extend beyond the aforementioned 30-day period.

As claimant’s attending physician, a “physician’s assistant” (PA) could authorize TTD benefits for a 30-day period from the date of claimant’s first visit on the initial claim.

PA’s “open-ended” TTD authorization could not extend beyond the statutory “30-day from first visit” period.

APPELLATE DECISIONS UPDATE

Course & Scope: “005(7)(b)(B)” - Fall
During “Coffee Break” - Lobby of Office
Building Where Claimant Worked - Not
“Social/Recreational” Activity Primarily
for Personal Pleasure

Course & Scope: “Personal Comfort”
Doctrine Considered Before Possible
Application of “Going & Coming” Rule

U.S. Bank v. Pohrman, 272 Or App 31 (June 24, 2015). Citing ORS 656.005(7)(b)(B), the court reversed the Board’s order in *Diane Pohrman*, 64 Van Natta 752 (2012), previously noted 31 NCN 4:6, which had held that claimant’s injury, which occurred when she slipped and fell while walking to a coffee shop in the lobby of an office building where she worked to meet a friend during her coffee break, was not excluded from compensability because she was not performing a social/recreational activity primarily for her personal pleasure and arose out of and in the course of her employment. On appeal, the carrier contended that claimant’s injury was *per se* noncompensable under ORS 656.005(7)(b)(B) because she was injured while engaging in a social activity primarily for her personal pleasure or, alternatively, that her injury did not arise out and in the course of her employment because the meeting with her friend during her coffee break served no employment purpose.

Regarding the carrier’s first contention, the court found substantial evidence to support the Board’s finding that the personal nature of claimant’s meeting with her friend was incidental or secondary to the work-related reason for her break and, as such, her injury did not occur during a recreational or social activity.

Citing *Roberts v. SAIF*, 341 Or 48, 52 (2006), the court stated that, pursuant to ORS 656.005(7)(b)(B), three questions must be answered in analyzing claimant’s injury: (1) was claimant engaged in or performing a recreational or social activity? (2) was she injured while engaging in or performing, or as the result of engaging in or performing, that recreational or social activity? (3) was she engaged in or performing the activity primarily for her personal pleasure? Relying on *Washington Group International v. Barela*, 218 Or App 541, 546-47 (2008), the court noted that “social activity” means an occupation or pursuit that is “marked by or passed in pleasant companionship with one’s friends or associates * * * taken, enjoyed, or engaged in with friends or for the sake of companionship.” Referring to *Liberty Northwest Ins. Corp. v.*

*“Social activity” means an occupation or pursuit that is “marked by or passed in pleasant companionship with one’s friends or associates * * * taken, enjoyed, or engaged in with friends or for the sake of companionship.”*

Noting that claimant had taken a mandatory, paid break at her employer's direction when she sustained her slip/fall injury while walking to a coffee shop in the lobby of the building where her employer's office was located to meet a friend, there was substantial evidence to support a finding that she was neither engaged in a recreational or social activity primarily for her personal pleasure.

Nichols, 186 Or App 664, 670 n 4 (2003), the court reiterated that the primary focus regarding a "social/recreational" activity is "primarily" for personal pleasure is not on the fact that the activity is pleasurable but rather on whether the activity is work-related. In other words, the court clarified that the injury is compensable if it occurred during a recreational/social activity that is *incidental to an employment activity*. *Nichols*, 186 Or App at 666-71.

Applying the aforementioned analysis to the case at hand, the court observed that claimant was neither engaged in a recreational activity nor was her activity purely social (taken for the sake of companionship). Moreover, the court emphasized that a work-related reason for her break activity existed; *i.e.*, she had taken a mandatory, paid break at her employer's direction. Given such circumstances, the court held that substantial evidence supported the Board's finding that the "social/recreational" defense under ORS 656.005(7)(b)(B) had not been established.

Turning to the "arising out of/course of" employment question, the court noted that the Board had determined that the "going and coming" rule did not apply to claimant's injury, which had occurred during her brief departure for personal comfort (*i.e.*, a coffee break). However, the court observed that the Board had relied on a prior decision, which the court had subsequently reversed. *See Enterprise Rent-A-Car Co. of Oregon v. Frazer*, 252 Or App 726, 730 (2012). Under such circumstances, the court determined that it must reverse and remand. *See Norris v. Board of Parole*, 152 Or App 57, 61-62 (1998).

Nevertheless, to assist the Board in its application of the "going and coming" rule and the "personal comfort" doctrine, the court further addressed the parties' arguments regarding those matters. Specifically, the court rejected the carrier's contention that the *Frazer* decision mandated that the application of the "going and coming" rule precluded the compensability of claimant's injury.

After reviewing its *Frazer* decision, the court noted that the carrier had neither raised any arguments regarding the "personal comfort" doctrine nor was the Board's *Frazer* decision based on a determination on the "personal comfort" doctrine. Furthermore, the court emphasized that its *Frazer* decision had not relied on the "personal comfort" doctrine. Consequently, the court clarified that its analysis in *Frazer* stands for the proposition that a proper understanding of the "going and coming" rule involves a level of inquiry into employer control, in addition to factors such as duration and proximity.

The "going and coming" rule is not implicated (never triggered) when a worker has not left work (e.g., is "still 'on duty' and otherwise subject to the employer's direction and control."

Addressing the "going and coming" rule, the court explained that the rule is not implicated at all (*i.e.*, is never triggered) when a worker has not left work. In other words, the court reasoned that the "going and coming" rule generally does not apply when the worker, although not engaging in an appointed work activity at a specific moment in time, still remains in the course of employment and, therefore, has not left work; *e.g.*, when a worker is "still 'on duty' and otherwise subject to the employer's direction or control." *Frazer*, 252 Or App at 731. Consequently, the court clarified that the "personal comfort" doctrine may apply in such a situation, depending on the nature of the activity in which the worker is involved; *e.g.*, while engaged in an activity that is not an appointed work task, but which is a "personal comfort" activity that bears a sufficient connection to his/her employment.

Citing *Mellis v. McEwen, Hanna, Grisvold*, 74 Or App 571, rev den, 300 Or 249 (1985), *Halfman v. SAIF*, 49 Or App 23 (1980), and *Jordan v. Western Electric*, 1 Or App 441, 443 (1970), the court reiterated that seven factors are examined to determine whether such a sufficient employment connection exists: was the activity for the benefit of the employer; contemplated by the employer (at the time of hiring or later); an ordinary risk of, and incidental to, the employment; was the worker paid for the activity; was the activity on the employer's premises; was the activity directed by or acquiesced in by the employer; and was the worker on a personal mission. In referring to the *Jordan* factors, the court acknowledged that the factors were no longer the independent and dispositive test of work-connection, but stressed that "depending on the circumstances, some or all of those factors will remain helpful inquiries" under the unitary work-connection test." See *First Interstate Bank v. Clark*, 133 Or App 712, 717 (1995).

Consistent with such reasoning, the court noted that the Supreme Court has focused on whether a worker's injury-producing activity was "expressly or impliedly authorized" by the employer and that the conduct or activity that the employer expressly authorizes "should be compensated whether it occurs in a directly related work activity or in conduct *incidental to the employment*." See *Clark v. U.S. Plywood*, 288 Or 255, 264 & 267 (1980) (emphasis supplied).

In sum, the court explained that, when a worker is injured, an inquiry must first be made into the nature of his/her activity to determine whether the activity bears a sufficient connection to the employment so that the worker cannot be considered to have left the course and scope of employment. Under such an analysis, the court reasoned that the "personal comfort" doctrine would be applicable and the "going and coming" rule would not be applicable. However, the court further clarified that, if after such an inquiry was made, the determination was that the worker had not engaged in a "personal comfort" activity, but rather was injured while on a "personal mission of his own," or a determination was made that the "personal comfort" activity did not bear a sufficient connection to the employment, then the "going and coming" rule (as well as any of the exceptions to that rule) would become applicable.

Because the Board's order had not analyzed claimant's injury claim in a manner consistent with the aforementioned reasoning, the court remanded so that the Board could explicitly address whether claimant was engaged in a "personal comfort" activity of a type that meant she still was acting in the course of her employment when she was injured under the *Jordan, Halfman, Clark, and Mellis* rationale.

Issue Preclusion: ARU's "Recon Order" "Premature Closure" Finding - Not Preclusive on Later Claim Closure

Kiltow v. SAIF, 271 Or App 471 (June 3, 2015). The court affirmed the Board's order in *Gaylen J. Kiltow*, 64 Van Natta 1136 (2012), previously noted 31 NCN 6:2, which held that a prior Order on Reconsideration's "premature closure" finding had no preclusive effect on determining whether a subsequent

An inquiry must first be made into the nature of the worker's activity to determine whether the activity bears a sufficient connection to the employment so that the worker cannot be considered to have left the course/scope of employment; thus, if it is determined that the "personal comfort" doctrine is applicable, the "going and coming" rule would not apply.

claim closure was also premature. Citing ORS 656.268(1), the Board had reasoned that the statutory scheme allowed the carrier to issue successive notices of closure, notwithstanding an earlier and final reconsideration order, which had determined that a previous claim closure was premature. On appeal, claimant contended that the prior reconsideration order (which had found the claim prematurely closed because his diabetes condition was part of the claim and the record did establish that his diabetes was medically stationary) precluded further consideration of whether claimant's diabetes was a part of the claim.

The court disagreed with claimant's contention. Citing *Nelson v. Emerald People's Utility Dist. v. White*, 318 Or 99, 103 (1993), the court stated that issue preclusion arises in a subsequent proceeding when an issue of ultimate fact has been determined by a valid and final determination in a prior proceeding. However, relying on *Drews v. EBI Cos.*, 310 Or 134, 141 (1990), the court clarified that, even a final determination is not conclusive when, by provision of a statute or valid rule of the body making the final determination, that determination does not bar another action or proceeding on the same transactional claim.

Turning to the case at hand, the court noted that both Appellate Review Unit (ARU) reconsideration orders had set aside the carrier's notices of closure as premature. Consistent with the statutory scheme (ORS 656.268(6)(a)), the court observed that a premature closure notice necessarily requires a new claim closure.

Under such circumstances, the court reasoned that an order setting aside a notice of closure as premature "does not bar another action or proceeding on the same transactional claim." *Drews*, 310 Or at 141. Consequently, the court concluded that the doctrine of issue preclusion did not apply to such an order and, as such, the Board was not precluded by the prior reconsideration order's finding (which had found claimant's diabetes to be part of the compensable injury claim).

The court next disagreed with claimant's argument that the carrier was not authorized to modify its notice of acceptance prior to claim closure by removing his diabetes as a "preexisting condition" component of a combined condition. Noting that an earlier ALJ's order (which had become final) had found that claimant's diabetes was not a "preexisting condition," the court determined that the carrier's claim processing (which removed the diabetes as part of claimant's foot injury claim) had been consistent with that final order.

In reaching its conclusion, the court rejected claimant's assertion that the carrier's action constituted a revocation of its prior claim acceptance. See ORS 656.262(6)(a). To the contrary, the court reasoned that the carrier's claim processing in issuing the "pre-closure" modified acceptance had complied with the earlier ALJ's order (which had ruled that the diabetes was not a "preexisting condition" component of claimant's compensable foot injury claim) and, if claimant wished to challenge the carrier's modified acceptance, he could do so pursuant to ORS 656.262(6)(d) and ORS 656.267.

Because an order setting aside a closure notice as premature necessarily requires a new claim closure, the doctrine of "issue preclusion" did not apply to such an order because the premature closure decision did not bar another action or proceeding on the same transactional claim.