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BOARD NEWS

Housekeeping” Rule Changes - OAR 438-015-0010, 438-015-0045, 438-015-0055

At its March 17, 2016 public meeting, pursuant to ORS 183.335(7), the Board approved minor (“housekeeping”) changes to OAR 438-015-0010(2) to renumber reference from “House Bill 2764 (2015) sections 9 and 10” to “ORS 656.383” and to supplement “history” sections (“statutes implemented”) accordingly regarding OAR 438-015-0010, 438-015-0045, and 438-015-0055.

Public Comment Requested - OAR 438-005-0046(1)(f) (Filing and Service of Documents; Correspondence)

At its March 17, 2016 meeting, the Board Members discussed OAR 438-005-0046(1)(f) (the filing by “e-mail” rule) and potential “jurisdictional” arguments that could arise if a party does not attach the appropriate completed form under paragraph (B) of that subsection with its “e-mail” filing. The Member’s discussion involved a March 16, 2016 staff memo that has been posted on WCB’s website at: <http://www.cbs.state.or.us/wcb/contents/1-2016rulememo.pdf>. After considering the matter (including comments from attendees at the meeting), the Members decided to seek further public comment regarding the following conceptual language:

**438-005-0046
 Filing and Service of Documents; Correspondence**

“(1) Filing:

“* * * * *

“(f) To electronically file the requests listed in subsection (e) of this section by e-mail, a party shall:

“(A) Send an e-mail to: request.wcb@oregon.gov; and

“(B) Attach an electronic copy of a completed Workers’ Compensation Board “Request for Hearing Form,” or a completed request for Board review, or a completed request for extension of the briefing schedule, or a completed request for waiver of the Board’s rules, or a completed Board “Response to Issues Form.” These attachments must be in a

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format of Microsoft Word 2000® (.doc, .txt, .rtf), Adobe Reader® (.pdf), or formats that can be viewed in Internet Explorer® (.tif, .jpg).

Strict compliance with paragraph (B) of this subsection is not jurisdictional. Also, consistent with the Board's policy in OAR 438-005-0035(3), an unrepresented party shall not be held strictly accountable for failure to comply with Board rules.

“(C) For purposes of this rule, the date of an electronic filing is determined by the date the Board receives the [appropriate completed electronic form which must be in a format of Microsoft Word 2000® (.doc, .txt, .rtf), Adobe Reader® (.pdf), or formats that can be viewed in Internet Explorer® (.tif, .jpg)] **e-mail described in paragraph (A) of this subsection.** An electronic filing under subsections (e) and (f) of this section received by the Board by 11:59 p.m. of a non-holiday, weekday is filed on that date.”

The Board has scheduled its next public meeting for May 17, 2016, at its Salem office. In anticipation of this meeting, the Members invite written comments from parties, practitioners, and the general public concerning this rule. The Members also welcome oral comments at their upcoming public meeting. Any written comments regarding this rule concept may be directed to the Board by mail, FAX (503-373-1684), e-mail (rulecomments.wcb@oregon.gov), or by means of hand-delivery to any permanently staffed Board office. The written comments should be addressed to the attention of Karen Burton, WCB Executive Secretary, and received by May 13, 2016.

CASE NOTES

Attorney Fees: “386(1)” - Denial Not “Void” - Issued in Response to “O.D.” Claim (Physician’s “827” Form)

Paris Jennings, 68 Van Natta 322 (March 4, 2016). Applying ORS 656.386(1), the Board declined to award a carrier-paid attorney fee for allegedly finally prevailing over a purported “void” denial of a new/omitted medical condition claim for a glaucoma condition because the denial pertained to a non-compensable occupational disease claim for the same condition. In response to claimant’s attending physician’s 827 form (which claimant did not sign and identified “traumatic glaucoma OD”), the carrier (which had previously accepted several right eye conditions, including “traumatic glaucoma”) denied an occupational disease claim, asserting that the condition had already been accepted as an injury. Contending that his attending physician was not authorized to initiate a new/omitted medical condition claim, claimant argued that the carrier’s denial was void and, as such, his counsel was entitled to an attorney fee award under ORS 656.386(1).

The Board disagreed. Citing *Cervantes v. Liberty Northwest Ins. Co.*, 205 Or App 316 (2006), the Board stated that, in the absence of a valid claim, a carrier’s denial is void. Furthermore, based on *Cervantes*, the Board noted that an attorney fee under ORS 656.386(1) was available where the claimant’s attorney was instrumental in securing a carrier’s clarification that its denial

“827” form (without claimant’s signature) does not constitute new/ omitted medical condition claim.

Physician’s report can constitute an initial claim, which obligates carrier to process claim.

Board without authority to award attorney fees when court remands for implementation of its decision, with no substantive matters to be decided.

ultimately had denied nothing. Finally, relying on *Andria D. Costello*, 55 Van Natta 498 (2003), *aff’d without opinion*, 193 Or App 484 (2004), the Board reiterated that ORS 656.267(1) does not authorize a physician to file a new/omitted medical condition claim.

Turning to the case at hand, the Board acknowledged that claimant had not signed the attending physician’s 827 form. Thus, based on the *Costello* rationale, the Board stated that a denial of a new/omitted medical condition claim would be considered “void.” Nonetheless, after reviewing the carrier’s denial in its entirety, the Board considered it apparent that the carrier had interpreted the 827 form as a claim for an occupational disease, not as a new/omitted medical condition claim (because the denial referred to the carrier’s previous acceptance of the “traumatic glaucoma” condition).

Under such circumstances, the Board found that claimant’s attorney was not instrumental in either obtaining a rescission of the carrier’s denial or clarification that its previously accepted glaucoma condition remained accepted. Accordingly, the Board concluded that an attorney fee award was not justified.

Finally, citing *Kachel v. Weyerhaeuser Co.*, 210 Or App 46, 51 (2006), the Board observed that a physician’s report may constitute an initial claim, which triggers a carrier’s claim processing obligations. Consequently, the Board determined that the carrier’s denial of an occupational claim was appropriate and, because such a claim was not compensable, an attorney fee award was not warranted.

Attorney Fees: “262(11)(a)” - On Remand For “Penalty” Determination - Board Not Authorized to Award Attorney Fee

Joy M. Walker, 68 Van Natta 371 (March 11, 2015). On remand from the court, *Walker v. Providence Health System Oregon*, 267 Or App 87 (2014), the Board held that it was not authorized to award an attorney fee under ORS 656.262(11)(a) for claimant’s counsel’s services before the court and on remand because the court had expressly remanded for the determination of a penalty under ORS 656.262(11)(a). After affirming that portion of a Board order awarding a carrier-paid attorney fee under ORS 656.262(11)(a), but reversing the Board’s decision that there were no amounts then due on which to award a penalty under the statute, the court remanded for a determination of that penalty. Following the Board’s penalty determination, claimant requested reconsideration, seeking attorney fees under ORS 656.262(11)(a) for her counsel’s services at all levels of review for ultimately securing the penalty. Claimant cited *SAIF v. Traner*, 273 Or App 310 (2015).

The Board disagreed with claimant’s contention. Relying on *Traner*, the Board stated that ORS 656.262(11)(a) independently authorizes an attorney fee award where there is a finding that the carrier unreasonably delayed payment, acceptance, or denial of a claim. Furthermore, referring to *Aguilar v. J.R. Simplot Co.*, 94 Or App 658 (1989), and *Charles M. Kepford*, 42 Van Natta 1994, 1995

(1990), the Board noted that, when the court remands for the implementation of its decision and no substantive matters remain to be decided, in the absence of further court instructions, it is without authority to award additional attorney fees.

Turning to the case at hand, the Board found that claimant had not appealed to the court the Board's previous attorney fee award under ORS 656.262(11)(a), but rather had only contested the Board's refusal to award a penalty. The Board further noted that, in holding that claimant was entitled to a penalty, the court had neither awarded an attorney fee under ORS 656.262(11)(a) nor made any reference to such an attorney fee award in expressly remanding this case to the Board for a penalty determination.

The Board acknowledged that the *Traner* decision had issued after the *Walker* court's decision. Nevertheless, the Board observed that the *Traner* decision had addressed amendments to ORS 656.262(11)(a) that had been in effect since 1990 and 2003. Under such circumstances, the Board reasoned that, although the court had not previously expressly addressed a claimant's counsel's entitlement to an attorney fee award for appellate services under the amended statute, the statute's authorization for such an attorney fee award was an available remedy to seek from the court before the issuance of its mandate remanding the case for a penalty determination under ORS 656.262(11)(a). Because claimant had not made an attorney fee request to the court before the court's issuance of its mandate for a penalty determination, the Board determined that it was not authorized to award an attorney fee under ORS 656.262(11)(a).

In reaching its conclusion, the Board rejected claimant's assertion that it would have been premature for the court to consider her attorney fee request before she finally prevailed regarding the penalty determination. Reasoning that claimant had prevailed when the court held that she was entitled to an ORS 656.262(11) penalty based on the amount of compensation ultimately awarded on the claim, the Board concluded that only the penalty amount remained to be determined when the court remanded for the implementation of its decision.

Member Weddell dissented. Asserting that the only condition for awarding an "ORS 656.262(11)(a)" attorney fee was met by the Board's previous order (which had found that the carrier unreasonably delayed its claim acceptance), Weddell believed that an attorney fee award was authorized for claimant's counsel's services at all review levels for the carrier's unreasonable conduct. Because the penalty assessment resulting from the carrier's unreasonable conduct had not been determined until the Board's remand decision, Member Weddell argued that the attorney fee determination could not be made until issuance of the Board's penalty decision. Finally, reasoning that the penalty dispute presented a novel legal issue that was ultimately resolved at the court and that claimant's counsel's persistent efforts had resulted in significant benefits, Weddell considered an extraordinary attorney fee award was justified.

Because attorney fee award was available remedy to seek from the court before issuance of its mandate, Board not authorized to award attorney fees on remand.

Because penalty assessment not determined until remand, dissent argued that attorney fee could not be made until Board's remand decision.

CDA: “Mooted” Hearing Request (WCD Suspension Order, Penalty, Fees) Dismissed

Timothy J. Lisac, 68 Van Natta 463 (March 29, 2016). Applying ORS 656.236(1)(a), the Board held that an approved Claim Disposition Agreement (CDA) rendered all issues raised by claimant’s hearing request (*i.e.*, an appeal of a Workers’ Compensation Division (WCD) order suspending compensation, as well as penalties and attorney fees) moot and, thus, justified the dismissal of the hearing request. Asserting that his motion for reconsideration of the ALJ’s initial dismissal order (which had issued in response to the approved CDA) constituted an objection to the CDA, claimant contended that his hearing request should not have been dismissed.

The Board disagreed with claimant’s contention. Citing ORS 656.236(1)(a), the Board stated that, unless otherwise specified, a CDA resolves *all matters* and all rights to compensation, attorney fees and penalties potentially arising out of claims, except medical services, regardless of the conditions stated in the agreement.

Turning to the case at hand, the Board noted that the approved CDA released all “non-medical service-related” benefits, without preserving any other rights. Reasoning that the CDA released all rights other than those related to medical services and had not preserved the carrier’s rights under WCD’s suspension order, the Board concluded that the CDA had rendered moot all issues raised by claimant’s hearing request.

In reaching its conclusion, the Board emphasized that claimant’s hearing request (which had been filed before the CDA) had not concerned a dispute regarding the approved CDA. Relying on *Karen D. Lester*, 66 Van Natta 585, 586 (2014), the Board commented that the finality of an approved agreement does not divest a party from requesting a hearing seeking rescission of the agreement. Thus, if claimant wished to have the CDA overturned, the Board observed that his remedy would be to file a request for hearing seeking such relief and to develop a record in support of such a request, despite the formidable burden accompanying such a request. *Id.* at 588.

Claim Processing: “262(6)(d)” - Objection to Notice of Acceptance - First Submit Written Communication to Carrier - Hearing Request Premature

Jorge Andrade, 68 Van Natta 439 (March 24, 2016). Applying ORS 656.262(6)(d), (7)(a), and ORS 656.267, the Board held that, because claimant had not first submitted a written communication to the carrier objecting to its Notice of Acceptance, he was prohibited from filing a hearing request alleging a *de facto* denial of other claimed conditions. After the filing of claimant’s 801 form (which referred to “strain shoulder(s),” the carrier accepted a nondisabling right shoulder strain. Thereafter, claimant filed a hearing request, alleging that:

Because approved CDA did not preserve any “non-medical service-related” benefits, issues concerning pending hearing request regarding WCD suspension order were rendered moot.

(1) the accepted condition did not exist; (2) he had other shoulder conditions; and (3) his claim should be processed as an occupational disease claim. Asserting that claimant had not submitted a written communication objecting to its acceptance notice before filing his hearing request, the carrier contended that his contentions could not be considered.

The Board held that claimant was currently prohibited from raising his contentions at a hearing. Citing ORS 656.262(6)(d) and (7)(a), the Board stated that, unless a claimant objects to the omission of a condition from an acceptance notice pursuant to ORS 656.267, the claimant may not allege a *de facto* denial at any hearing based on the acceptance notice. Relying on *Mai K. Moua*, 66 Van Natta 848, 850-51 (2014), *Joyce A. Deitrich*, 63 Van Natta 2509 (2011), and *Shannon E. Jenkins*, 48 Van Natta 1482 (1996), *aff'd without opinion*, 135 Or App 436 (1997), the Board noted that a claimant cannot establish such a *de facto* denial at a hearing until after the carrier fails to respond to a claim under ORS 656.267 for the omitted medical condition.

Because claimant had not communicated in writing to the carrier concerning his objections to acceptance notice before filing a hearing request, he was statutorily prohibited from alleging a de facto denial for other conditions at hearing.

Turning to the case at hand, the Board found that it was undisputed that, before filing his hearing request, claimant had not communicated in writing to the carrier any objections to, or alleged deficiencies in, its acceptance notice. Under such circumstances, the Board concluded that the statutory scheme prohibited claimant from alleging a *de facto* denial for such claimed conditions at a hearing.

In reaching its conclusion, the Board acknowledged claimant's assertion that his claim should be analyzed as an "occupational disease" and that the carrier was responsible for processing his claim. See ORS 656.262(1). Yet, reasoning that claimant's "occupational disease" challenge (which also objected to the carrier's acceptance and sought the acceptance of other specified conditions) was essentially an objection to the carrier's acceptance notice, the Board determined that it could not ignore the clear and express requirements of ORS 656.262(6)(d) and ORS 656.267, which mandate that claimant first communicate his objection to the carrier in writing before filing a hearing request. See *Bradley R. Madrid*, 66 Van Natta 1080, 1084 (2014).

Dissent argued that carrier has independent duty to initially determine what conditions are compensable and to modify its acceptance as it receives information regarding a compensable new/omitted medical condition.

Member Weddell dissented. Although acknowledging a claimant's right to pursue an omitted medical condition claim under ORS 656.262(6)(d) and (7)(a), Weddell reasoned that a carrier has an independent duty to initially determine what conditions are compensable and to modify its acceptance as it receives medical and other information regarding a compensable new/omitted medical condition. See ORS 656.262(1). Asserting that no evidence supported the carrier's subsequent classification of the claim as an injury nor had a physician diagnosed a shoulder strain, Member Weddell contended that the majority's decision had adverse effects on claimant's timely receipt of benefits for all of his compensable conditions. Furthermore, reasoning that the majority had completely ignored the carrier's obligations under ORS 656.262(6)(b)(F) to modify its acceptance notice as medical or other information changed a previously issued acceptance notice, Weddell considered the carrier's claim processing unreasonable, justifying the assessment of penalties and attorney fees under ORS 656.262(11)(a).

Extent: Impairment Findings - “Chronic Condition” - “Significant Limitation/ Repetitive Use” - Established Via “Lifting” Restrictions

Jennifer Kunzman, 68 Van Natta 384 (March 15, 2016). Analyzing OAR 436-035-0019(1)(g), the Board held that claimant was entitled to a “chronic condition” impairment value for her left shoulder condition because the attending physician’s “somewhat limited” description, in conjunction with the limitations described in an “attending physician-ratified” work capacity report, established that her ability to repetitively use her shoulder was “significantly limited.” After an Order on Reconsideration affirmed a Notice of Closure (which had not granted a “chronic condition” award for a left shoulder condition), claimant requested a hearing, asserting the repetitive use of her left shoulder was significantly limited, entitling her to a chronic condition impairment value.

The Board agreed with claimant’s contention. Citing *Angelica M. Spurger*, 67 Van Natta 1798, 1804 (2015), the Board stated that OAR 436-035-0019 denotes a limitation that is meaningful or important. Relying on *Godinez v. SAIF*, 269 Or App 578 (2015), *Edwardo Gonzales*, 66 Van Natta 409 (2014), *Ryan D. Grassman*, 62 Van Natta 270 (2010), and *Fidel Vivanco*, 59 Van Natta 1287 (2007), the Board acknowledged that “qualified” limitations and lifting restrictions, without more evidence, have been considered insufficient to meet a “significant limitation in the repetitive use” requirement. However, referring to *Julia L. Johnson*, 66 Van Natta 1304 (2014), the Board noted that it has found a “significant limitation in the repetitive use” of a body part when an arbiter had reported that the claimant was limited in the repetitive use of her shoulder and in any reaching activity at or above shoulder level as a result of the compensable injury.

Turning to the case at hand, the Board considered the record analogous to the *Johnson* holding. In doing so, the Board reiterated the *Johnson* reasoning that the additional information from an arbiter provided an example of the limited repetitive activities (rather than a “qualified” limitation) that were attributable to the injured body part and that the absence of the arbiter’s use of the term “significant” limitation was not determinative.

Consistent with the *Johnson* rationale, the Board determined that the attending physician’s statement that claimant was “somewhat limited” in the repetitive use of her shoulder, in conjunction with the physician’s ratification of a work capacity evaluation (which stated that she was unable to frequently perform overhead work and was limited to medium work at the floor to chest level) were more than a “qualified” limitation (or a “residual functional capacity”), was sufficient to establish a significant limitation regarding the repetitive use of her shoulder. In other words, the Board reasoned that, taken together, the “attending physician-ratified” restrictions (in the absence of countervailing evidence) established that claimant had a limitation pertaining to the overall use of her shoulder, which supported a “chronic condition” impairment value for a significant (*i.e.*, meaningful, important) limitation concerning the repetitive use of her shoulder.

“Significant Limit/Repetitive Use” has been found based on arbiter’s finding of limitation in repetitive use of shoulder and in any reaching activity at/above shoulder level.

Attending physician-ratified restrictions (“somewhat limited” in repetitive use, in conjunction with inability to frequently perform overhead work and limited to medium work at floor-chest level), in absence of countervailing evidence, established limitation pertaining to overall use of shoulder.

Considering qualified nature of work restrictions and attending physician's "somewhat limited" repetitive use statement, dissent contended that "chronic condition" impairment value for shoulder as a whole was warranted.

Member Curey dissented, disagreeing with the majority's conclusion that claimant was entitled to a "chronic condition" impairment value under OAR 436-035-0019(1)(g). Citing *Godinez, Spurger, and Vivanco* (among other cases), Curey did not find the qualified nature of the work capacity evaluation's restrictions (as ratified by the attending physician), or the attending physician's opinion that claimant was only "somewhat limited" in the repetitive use of her left shoulder, sufficient to meet the requirements for a "chronic condition" impairment value of the left shoulder as a whole. Reasoning that the work capacity evaluation was incomplete and claimant was capable of more repetitive work post-injury than her job at injury required, Member Curey considered the *Johnson* holding to be distinguishable.

Hearing Procedure: "Amendment of Issues" - "006-0031"/"006-0036" - "May Be Allowed" - Subject to ALJ's Discretion

Michael D. Leming, 68 Van Natta 298 (March 1, 2016). Applying ORS 656.295(5), OAR 438-006-0031(2) and OAR 438-006-0036(2), the Board held that it was appropriate to remand a case to the Hearings Division for further development because, in granting a carrier's motion to amend the contested issues to include an amended "ceases" denial for a combined condition, the ALJ had applied former versions of OAR 438-006-0031(2) and OAR 438-006-0036(2), which provided that amendment of issues "shall be freely allowed," whereas the current version of the rule provides that the ALJ "may allow" such amendments. At hearing regarding the carrier's "ceases" denial of his combined condition, claimant objected to the carrier's motion to amend the issues to include a modified acceptance and combined condition "ceases" denial, which had issued the day before the scheduled hearing. Those modifications included a new effective date for the carrier's acceptance of the combined condition. Asserting surprise from these amended issues, claimant requested an opportunity for supplemental argument, as well as potential evidence to respond to the amendment as necessary or a postponement. Reasoning that the amendment of issues "shall" be freely allowed, the ALJ allowed the additional issues and further argument, but declined to postpone/continue the hearing. After the ALJ upheld the carrier's amended denial, claimant requested Board review, contesting the ALJ's procedural and substantive rulings.

The Board vacated the ALJ's order and remanded for further proceedings. See ORS 656.295(5). Citing the former versions of 438-006-0031(2) and OAR 438-006-0036(2), the Board acknowledged that those versions provided that amendments to issues "shall" be freely allowed. However, the Board noted that the current version of those rules provide that such amendments "may be allowed," subject to the adverse party's motion for a postponement/continuance of the hearing.

Because current "amendment of issues" rule provides that amendments "may" be allowed, Board remanded to ALJ to provide explanation for prior ruling.

Turning to the case at hand, the Board determined that, considering the use of the term "shall" in allowing the amended issue, it appeared that the ALJ's ruling was based on the former version of the rules (which mandated such amendments). Reasoning that the current version of the rules is discretionary

When amendment of issues is permitted, to afford due process, responding party given an opportunity to respond to the newly raised issues.

("may" be allowed), the Board considered the difference between the two versions of the rules to be significant. Consequently, the Board remanded to the ALJ for further proceedings.

In reaching its conclusion, the Board noted that the consolidation of issues is within an ALJ's discretion when the parties are the same for both denials and the denials pertain to the same claim. See OAR 438-006-0065(5); *Ronald L. White*, 55 Van Natta 4203, 4204 (2003). The Board further observed that when amendment of the issues is permitted, to afford due process, a responding party must be given an opportunity to respond to the newly raised issues. See OAR 438-006-0091(4); *SAIF v. Ledin*, 149 Or App 94 (1997); *Neely v. SAIF*, 43 Or App 319, 323, *rev den*, 288 Or 493 (1979); *Sandra L. Shumaker*, 57 Van Natta 2986 (2005).

Medical Services: "245(1)" - Treatment Still Due "In Material Part" to Compensable Injury - Notwithstanding Intervening Off-Work Injury

Nathan N. Patrick, 68 Van Natta 410 (March 18, 2016). Applying ORS 656.245(1)(a), the Board held that claimant's medical services claim for a knee condition was compensable because, although the treatment resulted from an off-work ankle injury, his need for medical treatment was due in material part to his compensable knee injury. After closure of his compensable knee claim, claimant rolled his ankle, and he fell on his injured knee. Opining that tearing of scar tissue in the knee and underlying ankle instability had contributed to claimant's fall, his attending physician recommended treatment for both the knee and ankle conditions. The carrier did not pay for medical services related to claimant's knee condition, contending that the need for treatment was attributable to his unrelated ankle condition.

The Board disagreed with the carrier's contention. Citing ORS 656.245(1)(a), the Board stated that it must determine whether the disputed medical treatment was "for conditions caused in material part by the injury." Referring to *Mize v. Comcast Corp-AT & T Broadband*, 208 Or App 563 (2006), the Board noted that the phrase "in material part" means a "fact of consequence." Citing *SAIF v. Carlos-Macias*, 262 Or App 629 (2014), and *Fernando Javier-Flores*, 67 Van Natta 2245 (2015), the Board explained that the "compensable injury" is not limited to the accepted condition, but is defined by the work-related injury incident, and that the requisite causal relationship must be shown between the work-related injury incident and the condition that the disputed medical service is "for" or "directed to."

Although off-work ankle roll caused fall which resulted in medical treatment that included compensable knee condition, the knee treatment was compensable because the work-related injury incident remained a fact of consequence for claimant's need for knee treatment.

Turning to the case at hand, the Board acknowledged the carrier's argument that claimant's ankle roll had caused him to fall, which resulted in medical treatment that happened to address the compensable knee condition. However, citing *SAIF v. Sprague*, 346 Or 661 (2009), and *Donald E. Beck*, 46 Van Natta 1259 (1994) (on remand), the Board stated that ORS

656.245(1)(a) does not limit the compensability of medical services simply because those services also help to treat other medical conditions not caused by the compensable injury.

Based on the attending physician's reference to tearing of scar tissue in claimant's knee, the Board found that the medical service was "for" claimant's compensable knee condition (*i.e.*, the likely tearing of scar tissue from his previous surgery), as well as his underlying ankle instability. Furthermore, in the absence of contrary medical evidence, the Board determined that the work-related injury incident (which resulted in claimant's previous surgery) was a fact of consequence related to the likely tearing of the scar tissue. Under such circumstances, the Board concluded that the disputed medical treatment was for conditions caused in material part by the compensable knee injury.

In reaching its conclusion, the Board observed that ORS 656.245(1) does not provide for an "off work/major contributing cause" defense as in "aggravation" claims under ORS 656.273(1). *See Fernandez v. M&M Reforestation*, 124 Or App 38 (1993). Instead, referring to *Beck v. James River Corp.*, 124 Or App 484 (1993), the Board reasoned that, notwithstanding an intervening unrelated event, subsequent medical treatment is compensable if "the need for medical services bears a material relationship to the compensable injury."

"245(1)" does not include an "off work/major contributing cause" defense as is present in aggravation claims under "273(1)."

Own Motion: Worsened Condition - "Curative Treatment In Lieu of Hospitalization" - Physician's "Palliative" Statement Not Determinative

Oscar Cano-Sanchez, 68 Van Natta 303 (March 2, 2016). Applying ORS 656.278(1)(a) in reviewing an Own Motion claim for a worsened condition, the Board held that claimant's "epidural steroid injection" treatment satisfied the "other curative treatment prescribed in lieu of hospitalization that is necessary to enable the injured worker to return to work" requirement because, notwithstanding the attending physician's statement that such treatment was "palliative," the record established that his compensable leg condition had ultimately resolved and enabled him to return to work. Asserting that the epidural injections did not constitute a qualified "medical treatment" under ORS 656.278(1)(a) and that claimant's attending physician's opinion did not satisfy the "curative treatment" requirement, the carrier contended that the reopening of his "worsened condition" claim was not warranted.

The Board disagreed with the carrier's contention. Citing *Larry D. Little*, 54 Van Natta 2536, 2546 (2002), the Board stated that "qualifying treatment" under ORS 656.278(1)(a) requires the establishment of three elements: (1) curative treatment (treatment that relates to or is used in the cure of diseases, tends to heal, restore to health, or to bring about recovery); (2) prescribed (directed or ordered by a doctor) in lieu of (in the place of or instead of) hospitalization; and (3) is necessary (required or essential) to enable (render able or make possible) the injured worker to return to work. Referring to

SAIF v. Camarena, 264 Or App 400, 407 (2014), the Board noted that where conditions and treatments were not beyond the range of an ordinary person's understanding and experience, specific medical testimony regarding the "curative treatment" element was not necessarily required.

Turning to the case at hand, the Board acknowledged that, based on the record in *Little*, claimant's epidural steroid injections had not been found to meet the "hospitalization, surgery, curative treatment" requirement of ORS 656.278(1)(a). Nonetheless, relying on *Daren L. Johnson*, 59 Van Natta 1351 (2007), and *Peter B. Wallen*, 55 Van Natta 1905 (2003), the Board reiterated that the resolution of the aforementioned statutory requirement is determined on a "case-by-case" basis considering the particular record, rather than as a matter of law.

After conducting its review, the Board recognized that the attending physician had previously indicated that claimant's epidural steroid injections were "palliative" treatment. Nonetheless, the Board noted that subsequent medical evidence established that claimant's treatment was curative; e.g., following the injections, his leg pain had resolved, enabling him to return work. Furthermore, based on the attending physician's statement, the Board found that the injections had been prescribed in lieu of hospitalization. Under such circumstances, the Board concluded that the statutory requirements for the reopening of claimant's Own Motion claim for a "worsened condition" had been satisfied. See ORS 656.278(1)(a).

Member Johnson dissented. Noting that the attending physician had unequivocally described the epidural injections as "palliative" and that none of the subsequent medical reports had addressed this "palliative" opinion, Johnson asserted that the "curative treatment" requirement had not been met. Furthermore, considering the attending physician's un rebutted opinion that the injections were "palliative," Johnson reasoned that the Board was not free to substitute its opinion for that of a medical expert. Consequently, Member Johnson contended that claim reopening was not justified.

Penalties/Attorney Fees: "262(11)(a)" - Unreasonable "Causation" Denial of Medical Services - Awards "Contingent" on Eventual "Propriety" Decision of Denial by WCD

Michael L. Oakley, 68 Van Natta 360 (March 11, 2016). Applying ORS 656.262(11)(a), the Board held that, because a carrier's "causation" challenge to claimant's medical service claim for medications was unreasonable, a "contingent" penalty and attorney fee was justified, which would become payable if he finally prevailed over the remaining issues regarding the carrier's medical services denial that were pending before the Workers' Compensation Division (WCD). After claimant sought WCD review of a dispute regarding reimbursement for his medications, the carrier challenged the causal relationship

Notwithstanding physician's initial "palliative" treatment comment, subsequent medical evidence established that treatment was curative, thereby satisfying "claim reopening" requirements of "278(1)(a)" for a "worsened condition."

Asserting that no subsequent medical reports had addressed the attending physician's "palliative treatment" opinion, the dissent argued that the Board was not free to substitute its opinion for that of a medical expert.

between the medications and his compensable injury. WCD deferred its review and transferred the “causation” dispute to the Hearings Division. At the hearing, claimant also requested penalties and attorney fees, asserting that the carrier’s position was unreasonable because it was relying on a physician’s opinion that had not addressed whether the disputed medications were directed, in part, to the compensable cardiac condition.

Finding that the carrier’s denial was unreasonable, the Board awarded penalties and attorney fees under ORS 656.262(11)(a), but conditioned the awards on claimant finally prevailing on the medical service claim before WCD. Citing *AIG Claim Services, Inc. v. Cole*, 205 Or App 170, 178, *rev den*, 341 Or 244 (2006), the Board stated that, when a dispute involves a challenge regarding the causal relationship of medical services to the compensable claim and a question concerning the appropriateness of the medical services, both issues must be resolved favorably to the claimant for the medical services to be compensable. Relying on *Antonio L. Martinez*, 58 Van Natta 1814 (2006), *aff’d*, *SAIF v. Martinez*, 219 Or 182 (2008), the Board noted that, when a claimant prevails over the “causation” portion of a medical service denial (but the “propriety” aspect of the denial remains pending before WCD), it awards a “contingent” attorney fee under ORS 656.386(1) to become payable if the claimant finally prevails over the denial before WCD.

Finding the “causation” portion of a carrier’s medical service denial (which also denied the claim on “propriety” grounds) to be unreasonable, the Board awarded a “contingent” penalty/ attorney fee to become payable if claimant finally prevailed on the “propriety” portion of the denial before WCD.

Turning to the case at hand, the Board determined that the carrier’s denial of a causal relationship was unreasonable. Nonetheless, considering that issues concerning the medical service denial remained pending before WCD, the Board reasoned that it could not be finally determined whether the medical services denial itself was unreasonable. Under such circumstances, consistent with the *Martinez* “contingent attorney fee” rationale, the Board awarded a penalty and attorney fee under ORS 656.262(11)(a) contingent on claimant finally prevailing over the remaining aspects of the disputed medical service claim that were pending before WCD.

Dissent asserted that for “contingent” penalty/ attorney fee to become payable, WCD must also determine that “propriety” defenses were unreasonable.

Member Johnson dissented. Asserting that a physician had attributed claimant’s need for medication to preexisting coronary artery disease and hypertension, Johnson considered the carrier’s denial of the medical service claim to be based on a legitimate doubt regarding its liability for the claim and, as such, not unreasonable. Furthermore, Member Johnson believed that, in order for the “contingent” penalty and attorney fee awards to be assessable, WCD must also determine that the carrier’s remaining defenses to the medical service were unreasonable.

Reconsideration Proceeding: “268(5)(c)” - Carrier’s “Recon” Request Did Not Raise “PTD” Issue - Claimant’s “Cross-Request” Untimely Filed

Brian S. Patrick, 68 Van Natta 366 (March 11, 2016). Applying ORS 656.268(5)(c), the Board held that, because a carrier’s request for reconsideration of a Notice of Closure (which had not addressed a permanent

total disability (PTD) issue) was limited to contesting claimant's impairment findings, such a request did not include an issue as to whether he was entitled to PTD benefits and because claimant's "cross-request" for reconsideration was untimely filed, a PTD issue did not arise out of the Order on Reconsideration (which had not addressed a PTD issue). After a carrier timely requested reconsideration of a Notice of Closure (NOC) (which did not address PTD, but awarded permanent impairment and work disability) and the 60-day "appeal" period from the NOC had expired, claimant submitted a reconsideration request that checked the "issue" boxes for premature/improper claim closure, medically stationary date, temporary disability dates, and impairment findings. In response to the carrier's timely request, the Appellate Review Unit (ARU) scheduled a medical arbiter examination. Based on a medical arbiter panel's impairment findings, the Order on Reconsideration reduced claimant's permanent disability awards (impairment and work disability). In doing so, the reconsideration order also found that claimant's cross-request had been untimely filed. Thereafter, claimant requested a hearing, seeking a PTD award.

Carrier's request for reconsideration of a NOC is limited to impairment findings and medical arbiter exam.

The Board declined to consider claimant's PTD request. Citing ORS 656.268(5)(c), the Board stated that a request for reconsideration must be filed within 60 days from the date of issuance of a NOC. Furthermore, relying on ORS 656.268(5)(c), ORS 656.268(8)(a), OAR 436-030-0145(1)(b), and *David A. Fulcer*, 65 Van Natta 979, 981 (2013), the Board noted that a carrier's request for reconsideration of a NOC was limited to impairment findings and triggered a medical arbiter examination.

Because ARU had reduced impairment/ work disability awards granted by NOC (and found claimant's cross-request for reconsideration untimely filed), "PTD" issue did not arise out of reconsideration order and could not be considered at hearing level.

Turning to the case at hand, the Board found that claimant's request for reconsideration of the NOC, which was filed more than 60 days after the NOC, was untimely. Furthermore, reasoning that the carrier's reconsideration request was limited to a challenge to claimant's permanent impairment findings, the Board determined that the carrier's request did not raise a PTD issue. Finally, because the ARU had found claimant's reconsideration request untimely and reduced his permanent impairment and work disability awards, the Board concluded that a "PTD" issue had not arisen out of the reconsideration order. Under such circumstances, the Board held that a PTD issue could not be considered. See ORS 656.268(9); ORS 656.283(6).

Because "rating of permanent disability" box in reconsideration request form had not been checked and supplemental information had not requested PTD assessment, PTD not raised during reconsideration proceeding.

In reaching its conclusion, the Board observed that, even if claimant's reconsideration request had been timely filed, it did not consider the request to have raised a PTD issue. Citing *Darlene L. Sparling*, 67 Van Natta 85 (2015), the Board stated that, when a claimant's reconsideration request had checked the "issue" box indicating a disagreement with the "rating of permanent disability" and provided clarifying information assessing whether she was PTD, the issue of PTD was considered to have been raised during the reconsideration proceeding. Yet, in contrast to *Sparling*, the Board reasoned that the "rating of permanent disability" box had not been checked in claimant's reconsideration request and that his supplemental information had not requested a PTD assessment.

Standards: Work Disability - Calculation of Benefits - Based on “AWW” for “Job At Injury” - “Second Job” Wages Not Considered

Chris D Harder, 68 Van Natta 326 (March 7, 2016). Analyzing ORS 656.214(2)(b), ORS 656.210, and OAR 436-035-0009(6)(d)(A), the Board held that the calculation of claimant’s work disability award must be based on the weekly wage for the job at injury, without including his supplemental disability for a second job he had performed at the time of his compensable injury. At the time of his compensable injury while employed as a volunteer firefighter, claimant was also employed as a paramedic. He received temporary disability benefits based on wages from his “at injury” job, as well as supplemental disability based on his wages from his secondary job. See ORS 656.210(2)(a). After an Order on Reconsideration based claimant’s work disability award on his average weekly wage (AWW) at his “job at injury,” he requested a hearing, asserting that his “second job” wages should also be considered.

The Board disagreed with claimant’s contention. Citing ORS 656.214(2)(b), the Board stated that the determination of “work disability” benefits is premised on “the worker’s weekly wage for the *job at injury* as calculated under ORS 656.210(2).” (Emphasis supplied.) Consistent with the aforementioned statute and the Director’s rulemaking authority under ORS 656.726(4)(e), and (4)(f)(C), the Board noted that OAR 436-035-0009(6)(d)(A) provides that supplemental disability is not considered in determining the worker’s AWW when calculating the value of a work disability award. Furthermore, based on its review of the 2001 amendments to ORS 656.210 (SB 485), the Board observed that the statutory changes concerning supplemental disability were explicitly limited to *temporary* disability benefits.

Based on its analysis of the statutory scheme, the Board rejected claimant’s argument that the reference to “ORS 656.210(2)” in ORS 656.214(2)(b) constituted a legislative incorporation of supplemental disability benefits into a work disability award. Instead, the Board determined that, by its terms, this statutory phrase clearly referenced the weekly wage “for the job at injury,” which mentioned a single job. In doing so, the Board reasoned that, if the legislature had intended to include all of the worker’s employment at the time of injury in the work disability calculation, it would have been unnecessary to include the singular “for the job at injury” language in the statute.

Therefore, in accordance with the express terms of ORS 656.214(2)(b), the Board concluded that a work disability award must be based on the weekly wage *for the job at injury*, which would not include consideration of supplemental disability. Consequently, considering OAR 436-035-0009(6)(d)(A) to be consistent with the statutory scheme, the Board affirmed the Order on Reconsideration’s calculation of claimant’s work disability award.

Because “214(2)(b)” bases work disability award on weekly wage “for the job at injury,” legislature did not intend to include supplemental disability (i.e., wages from secondary job on date of injury) to be included in the calculation of work disability benefits.

Turning to the case at hand, the Board found that the second Order on Reconsideration properly applied OAR 436-035-0009(6)(d)(A) in determining claimant's AWW without considering his supplemental disability; *i.e.*, his earnings from jobs other than his job at injury.

Subject Worker: “Pre-Employment/Driver Test” Injury - No Agreement to Provide Services for Remuneration - “Worker” Confined to Chapter 656, Not Chapter 653 (Employment Law)

Cozmin I. Gadalean, 68 Van Natta 336 (March 8, 2016). Applying ORS 656.005(30), the Board held that claimant was not a “subject worker” when he incurred his hip injury while making a truck delivery because the injury occurred while he was participating in a pre-employment/driver’s test evaluation for a truck driving position, and there was no agreement (express or implied) that he would receive remuneration for such activities. After completing a drug screening and providing DMV/social security information, claimant drove one of the employer’s trucks, accompanied by an employee, to a designated delivery location. (It was the employer’s usual practice to have prospective employees perform an unpaid safe driving test as part of the pre-employment evaluation process.) While disconnecting hoses from the truck’s trailer at the designated location, claimant fell, injuring his left hip. Asserting that claimant was not a “subject worker” at the time of his injury, the carrier denied his claim. After an ALJ upheld the carrier’s denial, claimant appealed, contending that: (1) under employment law, he actually performed work, and was therefore entitled to at least a minimum wage under ORS 653.025; and (2) the employer’s “driving test” requirement did not exempt it from its obligation to pay a worker a minimum wage for work performed.

“Worker” is a person who engages to furnish services for remuneration subject to the direction and control of an employer.

The Board disagreed with claimant’s contentions. Citing ORS 656.005(30), the Board stated that a “worker” is a person who engages to furnish services for remuneration subject to the direction and control of an employer. Relying on *Oremus v. Oregonian Publ’g Co.*, 11 Or App 444, 446 (1972), the Board observed that an “engagement” or remuneration agreement may be based on an express or implied contract.

Because claimant’s employment was contingent on completing pre-employment driving test, he was not considered to be a subject worker when he was injured.

Turning to the case at hand, the Board found that claimant was injured while participating in a pre-employment activity to gauge his qualifications for the position. Furthermore, the Board was not persuaded that there was an implied or express agreement for remuneration, or that claimant had been hired at the time of injury. Instead, reasoning that his employment was contingent on his completion of the pre-employment driving test, the Board concluded that claimant was not a subject worker when his injury occurred. See *BBC Brown Boveri v. Lusk*, 108 Or App 623 (1991); *Dykes v. State Acc. Ins. Fund*, 47 Or App 187 (1980); *Mary K. Meyers*, 67 Van Natta 1725 (2015); *Stanley V. Burch*, 63 Van Natta 1732 (2011).

Board did not consider it appropriate to consider “minimum wage” laws (Chapter 653) to determine claimant’s workers’ compensation benefits, particularly when “worker” is defined under “005(30).”

Dissent contended that claimant’s actual provision of services benefited the employer and, as such, established an implied-in-law contract, which was further supported by the “minimum wage” law.

Finally, the Board acknowledged claimant’s argument that he should be considered a “worker” for remuneration because, under employment law (Chapter 653), a person who performed work must be paid at least a minimum wage for such work. See ORS 653.010(2), (3); ORS 653.025. Nevertheless, citing *Ashley A. Rehfeld*, 66 Van Natta 1198 (2014), *Alejandro Estolano*, 53 Van Natta 1585 (2001), and *Glenda Jensen*, 50 Van Natta 1074 (1998), the Board did not consider it appropriate to look beyond the confines of Chapter 656 to determine claimant’s workers’ compensation benefits. In reaching its conclusion, the Board reasoned that ORS Chapter 656 contained its own definition of “worker” under the workers’ compensation law. See ORS 656.005(30).

Member Weddell dissented. Considering the employer’s receipt of claimant’s services on the day of injury without providing remuneration to be unjust, and, on its face, contrary to Oregon law, Weddell inferred the presence of an implied-in-law contract establishing him as a subject worker. Referring to *Daniel Muchka*, 46 Van Natta 1090 (1994), Weddell reasoned that claimant’s actual provision of services by making the truck delivery was a benefit to the employer (whether classified as a “tryout,” “safety test,” or as regular employment), and further established an implied-in-law contract. Finally, Member Weddell believed that claimant’s rights under ORS 653.025 supported the existence of an implied-in-law contract.

APPELLATE DECISIONS COURT OF APPEALS

Aggravation: “273(1)” - Worsening of “Compensable Condition”

DeRoest v. Keystone RV Company, 276 Or App 698 (2016). The court, *per curiam*, affirmed the Board’s order in *Michael DeRoest*, 65 Van Natta 2542 (2013), which held that claimant’s aggravation claim must be based on a worsening of his previously accepted condition, rather than on a new/omitted medical condition. Citing *Nacoste v. Halton Co.*, 275 Or App 600, 607 (2015), the court reiterated that “an aggravation, under ORS 656.273, may only occur upon a condition identified in a notice of acceptance.”

Subject Worker: “Householder” Exemption - “027(2)”

Royer v. Touch of Grey Ranch, 276 Or App 909 (2016). Applying ORS 656.027(2), the court affirmed an ALJ’s order holding that claimant was not a subject worker because his work activities (repairing an apartment dwelling near his employer’s personal residence) had fallen within the “householder” exemption from workers’ compensation coverage. On appeal, claimant contended that his work at the time of his injury was not “about” his employer’s “private home,” and that the character of his work did not constitute “gardening, maintenance, repair, remodeling or similar work” for purposes of the “householder” exemption under ORS 656.027(2).

An apartment or guest house near an employer's home qualifies under the "householder" exemption provided that it is truly an extension of the home and share the private character of the home (i.e., exclusively private and noncommercial).

Barn apartment claimant was repairing was exclusively for private, noncommercial use to lodge visitors and workers.

Claimant's use of chainsaw and mini-sawmill was for felling trees and cutting boards for repair to the barn apartment and were activities within the "householder" exemption.

The court disagreed with claimant's contention. Citing *Fincham v. Wendt*, 59 Or App 416, 419, *rev den*, 294 Or 149 (1982), the court stated that the basis of the "householder" exemption is the character of the home as a private place, not as business premises. Relying on *Blevins v. Mitchell*, 138 Or App 29, 32 (1995), the court reiterated that the policy underlying the exemption is that workers' compensation insurance is intended to spread the cost of insurance to the price of goods and services to a business's consumers and that a homeowner who employs people to work "in or about the private home" in a noncommercial capacity cannot pass workers' compensation costs on to others. Finally, again referring to *Fincham* and *Blevins*, the court clarified that an apartment or guest house near an employer's home qualifies under the "householder" exemption only if it is truly an extension of the home and shares the private character as the home; *i.e.*, whether the apartment or guest house is a rental (which would be capable of producing income) or whether its purpose was exclusively private and noncommercial, such as to lodge visitors and workers.

Turning to the case at hand, the court found that the evidence showed that the barn apartment that claimant was repairing was exclusively for a private, noncommercial use to lodge visitors and workers (as demonstrated by claimant's extensive residence there). Considering the apartment's close proximity to the employer's home, the court determined that the ALJ's conclusion that claimant's work on the apartment was "about" the employer's "private" residence was consistent with the application of the "household" exemption.

Furthermore, the court rejected claimant's contention that his heavy skilled work on the employer's property (particularly tree felling and lumber milling) did not qualify as "gardening, maintenance, repair, remodeling or similar work" for purposes of the "householder" exemption. Reasoning that the aforementioned activities were necessary to the maintenance of rural households with acreage and outbuildings, the court considered claimant's use of a chainsaw and mini-sawmill for purposes of felling trees and cutting boards for repairs to the hay barn apartment were activities encompassed within the "householder" exemption.

Finally, even if converting a hay barn into apartments would be more akin to new construction (which would not be subject to the "householder" exemption) than to a remodel, the court noted that, when claimant was injured, the apartments had already been constructed and he had been residing in one of them for a number of years. Under such circumstances, the court determined that, at the time of his injury, claimant was repairing the floor of an existing structure, not constructing a new one. See *Caddy v. SAIF*, 110 Or App 353, 357 (1991).