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**BOARD NEWS**

## Have a Question for Board Review? Who to Call

Rather than trying to figure out **who** will handle a transcript issue, a procedural motion, a briefing extension, or any other appellate matter, just remember **what number** to call – (503) 934-0103.

The Board has designated this phone number to handle all "Board Review-related" phone calls. It is constantly monitored during work hours (8 a.m. to 5 p.m.), which will avoid those situations when a staff member may be away from their desk, or absent. Multiple staff members access (503) 934-0103, so inquiries/messages are promptly addressed.

Some questions require legwork or research to answer. Therefore, please leave a complete message explaining your inquiry, and you will receive a response as soon as possible.

Other phone numbers to keep on hand:

- CDA inquiries (503) 934-0116
- Own Motion (503) 934-0113
- Board Review fax (503) 373-1684

## Board Meeting: August 2, 2016 - Consideration of Advisory Committee's Recommendations Regarding "Attorney Fee Concepts/Biennial Review"

The Members have scheduled a meeting to discuss its Advisory Committee's Recommendations concerning attorney fee concepts, as well as to assist the Board in conducting its biennial review of attorney fee schedules under ORS 656.388(4). The meeting will be held on August 2, 2016, at 9:30 a.m., at the Board's Salem office.

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## Rulemaking Hearing: July 29, 2016 - Proposed Amendments Regarding "E-Mail Filing" (OAR 438-005-0046(1)(f)(B)) and "Representation by Counsel" (OAR 438-006-0100)

At their May 17 meeting, the Members proposed amendments to the Board's Division 005 (Filing and Service) and Division 006 (Representation by Counsel) rules. The Members took this action after considering public comment regarding possible jurisdictional challenges to an "e-mail filing" under OAR 438-005-0046(1)(f)(B), and to conform OAR 438-006-0010(1) with statutory amendments to ORS 9.320.

The proposed change to OAR 438-005-0046(1)(f)(B) would state that strict compliance with the rule requiring a "Request for Hearing Form" (as an attachment to an "email" request) would not be a jurisdictional requirement. Furthermore, the Members propose to remove any reference to specific attachment formats, instead requiring that the format be readable by the Board.

The proposed change to OAR 438-006-0100(1) would replace the word "corporations" with the phrase "parties that are not natural persons" in referring to parties who must be represented by a member of the Oregon State Bar. This amendment is proposed to conform the rule to statutory amendments to ORS 9.320.

Notice of this rulemaking action has been filed with the Secretary of State's office. Electronic copies of these rulemaking materials are available on WCB's website at [www.wcb.oregon.gov](http://www.wcb.oregon.gov) (under the category "Laws and Rules"). Copies have also been distributed to parties and practitioners on WCB's mailing list.

A rulemaking hearing for these proposed rule amendments has been scheduled for July 29, 2016, at 10 a.m. at the Board's Salem office (2601 25th St. SE, Ste. 150, Salem, OR 97302-1280). Any written comments submitted in advance of the hearing may be directed to Debra Young, the rulemaking hearing officer. Those comments may be mailed to the above address, faxed to 503-373-1684, e-mailed to [rulecomments.wcb@oregon.gov](mailto:rulecomments.wcb@oregon.gov), or hand-delivered to a permanently staffed Board office (Salem, Portland, Eugene, Medford).

## Staff Attorney Recruitment

WCB is recruiting candidates for a staff attorney position. To be chosen, the applicant must have a law degree and extensive experience reviewing case records, performing legal research, and writing legal arguments or proposed orders. Excellent research, writing, and communication skills are essential. Preference may be given for legal experience in the area of workers' compensation.

Further details about the position and information on how to apply is available online at <http://www.oregon.gov/DCBS/jobs/Pages/jobs.aspx> or [www.oregonjobs.org](http://www.oregonjobs.org). The recruitment will run until July 29, 2016. WCB is an equal opportunity employer.

### **CASE NOTES**

**Attorney Fees: “386(1)(a)” - “Pre-Hearing” Rescission of Claim Denial - Record Did Not Establish Attorney Was “Instrumental” in Obtaining Rescission - Attorney Did Not File Hearing Request, Denial Withdrawn After Carrier Received “IME” Report**

**Penalty: “262(11)(a)” - Carrier’s Denial Not “Unreasonable” - “Legitimate Doubt” Based on Physician’s Chart Notes, “Arthritis” Diagnosis, No “Work Connection” Reference, Delay in Treatment/Claim Filing**

*Hobby L. Brooks*, 68 Van Natta 923 (June 16, 2016). Applying ORS 656.386(1)(a), the Board held that claimant’s counsel was not entitled to an attorney fee award when the carrier rescinded its claim denial before a scheduled hearing because the record (which included the filing of the hearing request before he retained the attorney and the carrier’s rescission of its denial shortly after it received a report from a physician who had conducted an examination at the carrier’s request before he obtained legal representation) did not establish that the attorney had been instrumental in obtaining rescission of the carrier’s denial. Claimant, *pro se*, filed a hearing request from the carrier’s denial of knee injury claim. In response, the carrier scheduled claimant for a medical examination with a physician of its choosing. Before that examination, claimant obtained legal counsel, who sent the carrier a letter announcing his representation, including a copy of his retainer agreement and a request for discovery. A few days later, claimant’s medical examination was conducted and the physician issued a report, supporting a work-related meniscus tear, combined with preexisting arthritis, for which the work injury had ceased to be the major contributing cause of claimant’s ongoing disability/need for medical treatment. Shortly after receiving the physician’s report, the carrier accepted the meniscus tear combined with the preexisting arthritic condition. The parties proceeded with the scheduled hearing, claimant seeking an attorney fee award for his counsel’s services in evoking the carrier’s “pre-hearing” rescission of its denial, as well as penalties/attorney fees for an unreasonable denial.

*IME supported work-related meniscus tear.*

The Board held that an attorney fee award concerning the rescinded denial was not warranted. Citing ORS 656.386(1)(a), the Board stated that a carrier-paid attorney fee shall be allowed when a claimant's attorney "is instrumental in obtaining rescission of the denial" prior to an ALJ decision. Relying on *Harris v. SAIF*, 292 Or 683, 690 (1982) (the burden of proof is on the proponent of a fact or position), the Board noted it was claimant's burden to prove that his attorney was "instrumental" in obtaining rescission of the denial. Referring to its dictionary definition, the Board remarked that "instrumental" means "being an instrument that functions in the promotion of some end or purpose."

Turning to the case at hand, the Board recognized that, in some cases, the submission of a retainer agreement and the notice that a claimant has obtained legal representation may be sufficient to justify an attorney fee award for a "pre-hearing" rescinded denial. However, based on the record in the particular case (when a carrier-arranged medical examination had been ordered before the carrier's receipt of claimant's retainer agreement, and the issuance of the carrier's acceptance coincided with the carrier's receipt of the physician's report supporting the compensability of the claim), the Board concluded that the record did not support claimant's assertion that his attorney had been "instrumental" in obtaining the "pre-hearing" rescission of the carrier's denial.

In reaching its conclusion, the Board distinguished several cases where the claimants' attorneys had been found "instrumental" in obtaining a "pre-hearing" rescinded denial. See e.g., *Richard A. Staley*, 66 Van Natta 1993 (2014); *Peggy L. Segur*, 62 Van Natta 1406 (2010); *Heriberto Valencia*, 44 Van Natta 1709 (1992); *Kimberly Wayne*, 44 Van Natta 328, 329 (1992). As examples, the Board noted that, in contrast to the situations described in those decisions, claimant's attorney in the present case had not filed a hearing request, the carrier had arranged the medical examination before claimant's attorney was retained, and the carrier rescinded its denial after receiving the physician's report (which it received a week after receiving notice of claimant's representation).

*Claimant's attorney had not filed the hearing request.*

Under such circumstances, the Board determined that, other than claimant's counsel's asserted presumption that his "appearance" had affected a rescission of the carrier's denial (an inference that the carrier had disputed), the record did not establish that claimant's counsel was instrumental in obtaining the "pre-hearing" rescission of the denial. Consequently, the Board concluded that an attorney fee award under ORS 656.386(1)(a) was not justified.

*Carrier disputed inference that attorney's appearance affected rescission of denial.*

Addressing the "unreasonable denial" issue, the Board found that the carrier's denial had been based on a "legitimate doubt" concerning its liability for the claim. See *Int'l Paper Co. v. Huntley*, 106 Or App 107 (1991); *Brown v. Argonaut Ins. Co.*, 93 Or App 588, 591 (1988). Although acknowledging that the carrier's denial had issued some five days after the claim was filed, the Board noted that the chart notes of the physician (to whom claimant had sought treatment some three weeks after the alleged work incident) had neither referred to a specific knee injury (work-related or otherwise), but rather had diagnosed bilateral knee osteoarthritis. Considering claimant's approximately three-week delay in seeking medical treatment (and some five-week delay in filing his claim), in conjunction with the aforementioned medical records (which did not mention a work-related cause for claimant's knee symptoms, but had referred to a bilateral

knee condition), the Board determined that the carrier had a legitimate doubt of its liability for the claim when it issued its denial and, as such, its denial was not unreasonable. See *Deborah A. Synkelma*, 67 Van Natta 1141, 1145 (2015).

Member Weddell dissented from both portions of the majority's decision. Concerning the "unreasonable denial" issue, Weddell argued that the carrier was obligated to conduct a "good faith effort to ascertain the facts of the claim" and, because it had not done so, its denial was unreasonable. See OAR 436-060-0140(1); *James Hurlocker*, 66 Van Natta 1930, 1937 (2014); *Kenneth A. Foster*, 44 Van Natta 148 (1992), *aff'd without opinion*, 117 Or App 543 (1993). Because of the relatively mundane nature of the mechanism of claimant's work injury (*i.e.*, striking a table with his foot and twisting his knee), Member Weddell did not consider claimant's decision to wait several weeks before seeking medical treatment and filing a claim to be out of the ordinary or to provide a basis for the carrier to doubt the validity of the claim before conducting a reasonable investigation.

Furthermore, Member Weddell contended that the carrier's conduct had substantially delayed claimant's receipt of benefits under a compensable claim and resulted in wholly unnecessary litigation, both of which conflicted with statutory policy objectives expressed in ORS 656.012(2)(a), and (b). Likewise, noting that the carrier had a statutory 60-day period within which to conduct its investigation before issuing an acceptance or denial (ORS 656.262(6)(a)) and an incentive to perform an adequate claim investigation or face penalties/ attorney fees (ORS 656.262(11)(a)), Weddell argued that the majority's decision appeared to disregard the requirement of an investigation and the availability of penalties for neglecting to do so, regardless of whether any questions regarding a delay in claim filing or initial treatment records would be clarified by an investigation.

Regarding claimant's counsel's entitlement to a carrier-paid attorney fee award under ORS 656.386(1)(a), Member Weddell noted that claimant's counsel's notice of representation to the carrier had also responded to the carrier's previous "discovery" request to claimant. Under such circumstances, Weddell reasoned that such a response was a step in maintaining claimant's previously filed hearing request (avoiding the potential that the hearing request could be dismissed under OAR 438-007-0015(8) for not complying with the carrier's discovery request) and ensured that the case could be convened on the scheduled hearing date.

Considering claimant's attorney's action as the functional equivalent of the filing of a hearing request because it effectively preserved claimant's right to continue the prosecution of the denial at the scheduled hearing, Member Weddell asserted that the attorney had been instrumental in obtaining the "pre-hearing" rescission of its denial and, as such, a carrier-paid attorney fee award under ORS 656.386(1)(a) was statutorily authorized. Furthermore, reasoning that statements in the physician's report gave the carrier a plausible basis on which to continue the defense of its denial at the hearing, Weddell contended that the record supported a conclusion that the presence of claimant's counsel in the litigation (including the potential raising of an "unreasonable denial" issue at the hearing if the carrier did not rescind its denial) contributed to the carrier's "pre-hearing" rescission.

*Dissent noted that attorney responded to discovery request, which maintained the hearing.*

Finally, Member Weddell believed that the majority's interpretation of the "instrumental" requirement in ORS 656.386(1)(a) discouraged representation of claimants with denied claims that undergo the carrier's initial claim investigation during the litigation process. Asserting that such a practice conflicts with the stated policy of the workers' compensation system as expressed in HB 2764, Section 1 (2015) ("[P]roviding for access to adequate representation for injured workers"), Weddell concluded that claimant's attorney was saddled with representation for which he could not be compensated (according to the majority's reasoning) because the carrier had chosen to conflate its investigation and litigation processes and, as such, claimant and his counsel had borne the cost of such actions in the form of delayed benefits and uncompensated representation, which was inconsistent with policy, statute, and rule.

## Consequential Condition: "005(7)(a)(A)" - Compensable Injury ("Work-Related Injury Incident") Not "Major Cause" of Claimed Knee Conditions

*John M. English*, 68 Van Natta 852 (June 2, 2016). Applying ORS 656.005(7)(a)(A), on remand from the Court of Appeals, *English v. Liberty Northwest Ins. Corp.*, 271 Or App 211 (2015), and analyzing the compensability of new/omitted medical conditions as "consequential conditions" under the "work-related injury incident" standard for a "compensable injury" as articulated in *Brown v. SAIF*, 262 Or App 640, *rev allowed*, 356 Or 397 (2014), the Board upheld the carrier's denial of the claimed conditions. After the carrier's acceptance of claimant's injury claim for a left knee medial hamstring strain and/or lateral compartment contusion, claimant initiated a new/omitted medical condition claim for several other left knee conditions; e.g., left knee instability. In doing so, claimant relied on a physician's opinion that the work injury had subsequently caused his knee to buckle, which resulted in his fall down some steps that caused his left knee instability and other claimed conditions. Asserting that the physician had previously not supported a causal relationship between the work injury and the currently claimed left knee conditions and had couched his opinion in terms of "possibility," the carrier contended that the claim was not compensable.

The Board agreed with the carrier's position. Citing ORS 656.005(7)(a)(A), *English*, and *Brown*, the Board stated that to establish compensability of the claimed consequential conditions, claimant had to prove that his compensable injury (*i.e.*, the "work-related injury incident") was the major contributing cause of the claimed conditions.

Turning to the case at hand, the Board acknowledged that the physician had initially attributed claimant's currently claimed knee conditions to his work injury because the injury had caused his knee to subsequently buckle, which had resulted in his fall down some steps, which had culminated in the claimed conditions. Nonetheless, the Board further noted that the physician had expressly clarified that claimant's accepted hamstring and buckling weakness

*Brown applied to consequential condition.*

*“Possibility” opinion insufficient, and no explanation for change of opinion.*

“may have been the etiology of his secondary event when he fell going down some steps.” Finally, the Board observed that the physician had earlier stated that the claimed left knee conditions should not be accepted as part of his injury claim.

Under such circumstances, the Board questioned whether the physician’s opinion had encompassed the “work-related injury incident” standard of *English-Brown*. In any event, even if the opinion was interpreted as encompassing the *English-Brown* standard, the Board reasoned that the physician’s opinion was couched in terms of “possibility” (e.g., “may have been”) rather than probability and, as such, was insufficient to persuasively meet the “major contributing cause” standard for a “consequential condition.” See *Gormley v. SAIF*, 52 Or App 1055 (1981); *Kyle G. Anderson*, 61 Van Natta 2117, 2117-18 (2009).

In reaching its conclusion, the Board acknowledged that “magic words” are not required to establish the compensability of a claim, where the record as a whole would satisfy a claimant’s burden of proof. See *McClendon v. Nabisco Brands, Inc.*, 77 Or App 412 (1986). Nevertheless, considering the complexity of the medical causation issue in the present case and the statutorily required “major contributing cause” standard, the Board did not consider the physician’s “possibility” opinion sufficient to persuasively establish the compensability of the claimed knee conditions.

Finally, even if the physician’s latest opinion was interpreted in terms of probability and as satisfying the “work-related injury incident” standard, the Board noted that the physician had not provided an explanation for the apparent change of his earlier opinion, which had not supported a relationship between the original injury and the claimed conditions. In the absence of such an explanation, the Board did not find the physician’s opinion persuasive. See *Moe v. Ceiling Systems*, 44 Or App 429, 433 (1980); *Francisco R. Mejia*, 61 Van Natta 1265, 1268, *recons*, 61 Van Natta 2005 (2009).

Member Lanning dissented. Noting that the physician had not discussed any other conditions that would constitute a “compensable injury,” Lanning reasoned that the physician had referred to the “hamstring strain” and the “[work] injury” in a synonymous manner and, as such, had adequately addressed the full effects of the “work-related injury incident” as required by the *English-Brown* standard. Further observing that the physician had also agreed that the work injury was “what caused” claimant’s fall, Member Lanning interpreted the physician’s opinion as extending beyond “possibility” to the requisite “medical probability.” Finally, because “magic words” were not required to establish the compensability of the claimed conditions, Lanning considered the physician’s opinion sufficient to meet the “major contributing cause” standard for the claimed consequential conditions.

## Course & Scope: “MVA” Injury - Riding in Co-worker’s Truck Between Job Sites - “Special Errand” Exception to “Going & Coming” Rule

*After working at a different vineyard for employer, claimant was directed back to his original work site.*

*Jose Vargas*, 68 Van Natta 859 (June 2, 2016). Applying the “special errand” exception to the “going and coming” rule, the Board held that claimant’s injury, which occurred while he was traveling in a co-worker’s truck between his employer’s work sites, arose out of and in the course of employment. Claimant, a farm worker, worked for his employer at various local vineyards. His employer did not provide transportation to its employees or reimburse travel expenses or pay for travel time. Claimant, who did not drive, relied on his supervisors and co-workers for transportation to his work sites. On the date of his injury, the starting time for claimant’s work assignment at one work site was delayed, prompting him and some co-workers to accept the employer’s offer to work at a different vineyard. Later that day, the employer directed claimant and two co-workers to travel to and work at the originally assigned vineyard. While in route to that work site, claimant was injured when he fell out of his co-worker’s pickup truck. After the carrier denied claimant’s injury claim (relying on the “going and coming” rule), claimant requested a hearing.

The Board set aside the carrier’s denial. Citing *Krushwitz v. McDonald’s Restaurants*, 323 Or 520, 526-27 (1996), the Board acknowledged that an injury suffered when a worker is traveling to or from work generally is not compensable because, during that time, the worker is rendering no service for the employer. However, relying on *JAK Pizza, Inc.-Domino’s v. Gibson*, 211 Or App 203, 207 (2007), the Board stated that a “special errand” exception applies when the employee is acting in furtherance of the employer’s business at the time of the injury or the employer had the right to control the employee’s travel in some respect.

Turning to the case at hand, the Board acknowledged that claimant’s employer did not have the right to control his route to the original work site and had not furnished transportation to that site (nor provided reimbursement for travel time or expenses). Nonetheless, finding that the employer directed claimant and his co-workers to travel from one work site to the originally assigned work site, the Board reasoned that his injury had occurred while he was acting in furtherance of the employer’s business.

Under such circumstances, the Board concluded that the “special errand” exception to the “going and coming” rule applied. See *Ryan K. Gibson*, 60 Van Natta 6 (2008); *Bethany Davidson*, 52 Van Natta 1351, 1352-53 (2000). Consequently, the Board determined that claimant’s injury occurred “in the course of” his employment.

Addressing the “arising out of” employment question, the Board stated that a worker’s injury is deemed to “arise out of” employment if the risk of the injury results from the nature of the worker’s work or when it originates from some risk to which the work environment exposes the worker. *Fred Meyer*,

*Inc. v. Hayes*, 325 Or 592, 601 (1997). Applying that analysis to the present case, the Board reasoned that, because claimant was injured while traveling between work assignments at the employer's direction, his injury resulted from a risk to which he was exposed by his work environment. Accordingly, the Board concluded that claimant's injury "arose out of" his employment.

Member Curey dissented. Emphasizing that claimant's employment agreement specifically provided that his work activities did not include travel and that he was not compensated for the time or expense for his transportation between work sites, Curey asserted that claimant's injury did not occur "in the course of" employment under the "going and coming" rule. Furthermore, reasoning that claimant was not acting in furtherance of the employer's business during his commute between work sites any more than any other employee who would drive to work and noting that claimant was free to accept or reject either work assignment at the two work sites, Member Curey was not persuaded that there was anything special or out of the ordinary about claimant's assignments.

Consequently, disagreeing with the majority's application of the "special errand" exception to the "going and coming" rule, Curey did not consider claimant's injury to have occurred "in the course of" his employment. In addition, reasoning that claimant's injury (while being transported on his personal time and without reimbursement from his employer) was not due to a risk connected with the nature of his work as a farmworker or to a risk arising out of the work environment, Member Curey further concluded that the injury did not "arise out of" his employment.

### Evidence: "006-0091(2)" - ALJ's "Continuance/Cross-Examination" Ruling - Claimant's "Sponsorship" of "Withdrawn" Report at Hearing - No Abuse of Discretion in ALJ's "Due Diligence" Ruling

*Carmen M. Francisco*, 68 Van Natta 897 (June 10, 2016). Applying OAR 438-006-0091(2), the Board found no abuse of discretion in an ALJ's ruling that granted a carrier's motion for continuance of a hearing for cross-examination of physicians who had authored reports offered by claimant at the hearing after the carrier had announced that it was not sponsoring the reports. Prior to a hearing regarding claimant's appeal of a carrier's injury denial, in providing discovery to claimant and submitting copies of the record to the ALJ, the carrier included physician reports (one from claimant's attending physician and one from a carrier's medical examiner) that could be interpreted as supporting the compensability of the denied claim. At hearing, the carrier announced that it was not sponsoring the aforementioned reports. In response, claimant offered the reports for admission into the record, which prompted the carrier's request for cross-examination of the physicians. Claimant objected, contending that the carrier had not met the "due diligence" requirement of the "continuance" rule. See OAR 438-006-0091(2). Referring to claimant's "at-hearing" offering of the reports and the carrier's immediate request for cross-examination, the ALJ

*After claimant offered the reports, carrier sought cross-examination.*

granted a continuance for the requested cross-examination. After the physicians' depositions (which were not supportive of the claim's compensability), the ALJ closed the record and upheld the carrier's denial. On review, claimant asserted that the continuance should not have been allowed and the physicians' depositions should not have been considered.

The Board found no abuse of discretion in the ALJ's ruling. *SAIF v. Kurcin*, 334 Or 399 (2002); *Brown v. SAIF*, 51 Or App 389, 394 (1981). Citing ORS 656.310(2), the Board stated that a party has the right to cross-examine a physician who has authored a medical report presented by the opposing party. Relying on OAR 438-006-0091(2), the Board noted that a continuance may be granted "upon a showing of due diligence, as described in OAR 438-006-0081(2), if necessary to afford reasonable opportunity to cross-examine on documentary \* \* \* evidence."

*Filing of documents did not establish sponsorship.*

Turning to the case at hand, the Board observed that the carrier was required to provide claimant with copies of all documents that were relevant and material to the matters in dispute at the hearing. See OAR 438-007-0018(1). Nonetheless, referring to OAR 438-007-0018(4), the Board emphasized that the so-called "filing" of these documents with the ALJ did not establish that the carrier was "sponsoring" the documents for purposes of their admission into evidence or for cross-examination purposes.

*ALJ's due diligence ruling affirmed.*

Given such circumstances, when the carrier clarified that it was not "sponsoring" the physicians' reports, claimant then "sponsored" the reports for admission into the record, and the carrier immediately sought cross-examination of the physicians, the Board found no abuse of discretion in the ALJ's "continuance/cross-examination" ruling, which was based on a determination that the carrier had acted with due diligence.

In reaching its conclusion, the Board distinguished *Cathy A. Inman*, 47 Van Natta 1316 (1995), *aff'd without opinion*, 144 Or App 192 (1995), where a carrier's cross-examination request (made some 17 days after the submission of exhibits in question and without an explanation for the delay) was considered to be untimely. In contrast to *Inman*, the Board reasoned that the carrier's cross-examination request had been made immediately after claimant sponsored the reports for admission into the record. Moreover, the Board noted that, unlike *Inman*, the present case concerned the effect of the "sponsorship" rule (OAR 438-007-0018(4)), which had not previously been interpreted.

Member Weddell dissented. Although acknowledging a party's statutory "cross-examination" rights, Weddell reasoned that such a right is subject to the procedural limitations in ORS 656.283(3)(a), OAR 438-006-0091, and OAR 438-006-0081(2) concerning the expeditious scheduling and convening of hearings. Further recognizing that the "continuance/cross-examination" rule contains "discretionary" language (*i.e.*, a continuance "may" be granted), Member Weddell noted that the "7-day rule" (OAR 438-006-0081(2), which is a component of the "continuance/cross-examination" rule) is not framed in discretionary terms and, as such, either applies, or does not apply, as a matter of law.

Addressing the present case, Weddell observed that the ALJ had specifically referred to, and paraphrased, the “7-day rule” before granting the carrier’s continuance/cross-examination request. Because the carrier had the reports in question in its possession before the hearing and had not received them from claimant when she offered them as evidence at the hearing (after the carrier had announced that it was not “sponsoring” them), Member Weddell reasoned that the situation did not meet the “due diligence” requirements of the “7-day rule.” Asserting that the ALJ’s continuance/cross-examination ruling was partially (if not completely) premised on the carrier’s satisfaction of the “7-day rule,” Weddell considered the ruling to represent an error of law and, as such, an abuse of discretion.

Furthermore, irrespective of the “7-day rule,” Member Weddell believed that the ALJ’s ruling constituted an abuse of discretion. Observing that the “sponsorship” rule (OAR 438-007-0018(4)) simply provides that the carrier’s “filing” of all “relevant and material” documents does not establish its “sponsorship” of such documents for purposes of admission into the record or the claimant’s “cross-examination” rights, Weddell contended that the rule does not address a carrier’s entitlement to cross-examine the authors of carrier-submitted documents or require a carrier to withdraw (or the claimant to reoffer) those documents to trigger a carrier’s entitlement to cross-examination.

Finally, noting that the carrier had the physicians’ reports in its possession some three weeks before the hearing and took no action even though it either knew or reasonably should have known that the reports would be offered into evidence at the hearing, Weddell found no support for the ALJ’s continuance/cross-examination ruling based on a “due diligence” determination and, as such, considered the ruling to represent an abuse of discretion.

## New/Omitted Medical Condition: “MVA” (“Work-Related Injury Incident”) Material Cause of Disability/Treatment for Claimed Labral Tear - Carrier Did Not Meet “266(2)(a)”/“Major Cause” Standard

## Attorney Fee: Attorneys Encouraged to Submit Statements/Information

*Cindy R. Johnson*, 68 Van Natta 832 (June 1, 2016). Applying ORS 656.005(7)(a)(B) and ORS 656.266(2)(a), the Board held that claimant’s new/omitted medical condition claim for a left shoulder labral tear was compensable because she established that her work-related injury (which occurred when her vehicle was “T-boned” on the passenger side by a truck) was a material contributing cause of her need for treatment/disability for her claimed condition and because the carrier had not proven that the work-related injury incident was not the major contributing cause of a combined shoulder condition.

Following claimant's motor vehicle accident (MVA) (from which the carrier accepted a cervical and left shoulder strain, as well as subacromial bursitis), she subsequently sought treatment for further left shoulder complaints, which included a diagnosis of a labrum tear. After the carrier denied her new/omitted medical condition claim, claimant requested a hearing.

The Board found that the claim was compensable. Citing ORS 656.005(7)(a), and *Betty J. King*, 58 Van Natta 977 (2006), the Board stated that claimant had the burden of establishing that her claimed condition existed and that the work injury was a material contributing cause of disability/need for treatment of that condition. Relying on ORS 656.266(2)(a), *Brown v. SAIF*, 262 Or App 640, 652 (2014), and *Jean M. Janvier*, 66 Van Natta 1827, 1832-33 (2014), the Board noted if an "otherwise compensable injury" and a "combined condition" were established, the carrier had the burden of proving that the "work-related injury incident" was not the major contributing cause of the disability/need for treatment for the combined condition.

*Pathological worsening of tear established material cause.*

Applying those points and authorities to the case at hand, the Board found the opinion of the physician supporting the compensability of claimant's labral tear condition to be persuasive. In doing so, the Board acknowledged that it could not be determined that the MVA "actually caused" the labral tearing and that the tear could be "degenerative" and could be "traumatic." Nonetheless, reasoning that the relevant inquiry was whether the work injury was a material contributing cause of the disability/treatment for the claimed labral tear condition (not necessarily the condition itself) and noting that the physician had also opined that the MVA pathologically worsened the degenerative labral tearing and was the major contributing cause of her need for treatment for a combined condition, the Board considered the physician's opinion to satisfy claimant's burden of proving an "otherwise compensable injury."

Furthermore, comparing the first physician's opinion with other physicians' opinions, the Board considered the first physician's analysis of claimant's mechanism of injury and causation opinion to be more consistent with the record. In addition, the Board found no explanation for another physician's apparent change of opinion (from initially identifying a degenerative tear and then, without further information, describing a congenital flap), as well as concluded that this other physician's opinion was based on an inaccurate history of claimant's pain complaints.

Under such circumstances, the Board found that the carrier had not established that claimant's work-related injury incident was not the major contributing cause of her need for treatment/disability for her combined left labral tear condition. Consequently, the Board set aside the carrier's denial.

Member Weddell specially concurred with the Board's \$12,000 attorney fee award under ORS 656.386(1). Referring to the 2015 amendments to ORS 656.012(2)(b), and ORS 656.388(5), Weddell observed that the Legislature clearly tied adequate representation for injured workers with adequate compensation for claimants' attorneys.

Considering that adequate representation of claimants is a matter of public concern and is in keeping with the best interests of all stakeholders in the workers' compensation system, Weddell believed that it was incumbent on

*Special concurrence encouraged claimants' attorneys to submit information on fee requests.*

claimants' attorneys to pursue fees that accurately reflected the value of their representation. Reasoning that without specific input from claimants' attorneys the Board is left to assess the attorneys' efforts and the benefits accruing to their clients based on a record developed to resolve the disputed claim and accompanying issues, Member Weddell encouraged claimants' attorneys to consider submitting a statement including the approximate amount of time spent, describing the attorney's efforts, and requesting an amount that the attorney deems reasonable and, if the carrier's attorney considered the requested amount to be too high, to consider submitting a proposed reasonable amount. See also OAR 438-015-0029.

Addressing the present record, Member Weddell observed that nearly all of the factors prescribed in OAR 438-015-0010(4) for the determination of a reasonable attorney fee weighed in favor of a substantial award. Nevertheless, noting that claimant's counsel had not offered an attorney fee submission (including a request for an assessed fee under OAR 438-015-0029) or information other than the record that was developed for the compensability issue, Weddell concurred with the \$12,000 attorney fee award.

Member Curey dissented from the majority's compensability decision. Asserting that the physician on whose opinion the majority had relied had not persuasively addressed or rebutted the contrary opinions that found claimant's complaints more consistent with a shoulder strain (rather than a labral tear) and did not believe that the biomechanics of the MVA would have caused a labral tear, Curey did not consider the first physician's opinion sufficient to establish the compensability of the claimed condition.

## “Non-Cooperation” Denial: “262(15)” - Denial Procedurally Invalid - Claimant Contacted Carrier W/I 30 Days of WCD Suspension Notice

*Basil D. Yauger*, 68 Van Natta 1000 (June 30, 2016). Applying ORS 656.262(15), the Board held that a carrier's “non-cooperation” denial was procedurally invalid because, within 30 days of the Workers' Compensation Division's (WCD's) notice concerning the suspension of claimant's compensation for a failure to cooperate in the carrier's investigation of his claim, he had contacted the carrier and, thereby, had not failed to cooperate for an additional 30 days following the suspension notice. Following the filing of claimant's injury claim, the carrier eventually sought a WCD order to suspend his compensation, asserting that he had failed to cooperate in its investigation of the claim. When no response was received from claimant to WCD's notice of the carrier's “suspension” request, WCD issued an order suspending his compensation until he cooperated with the claim investigation by contacting the carrier to arrange and submit to an interview. WCD's suspension order further provided that, if claimant did not cooperate for an additional 30 days from the date of its previous “suspension” notice, the carrier could deny the claim because of a failure to cooperate for an additional 30 days. Some two days after WCD's suspension order (and approximately two weeks after WCD's “suspension notice”), claimant

*Claimant e-mailed carrier twice during 30-day period.*

e-mailed the carrier, asserting that he had no knowledge of the previously scheduled deposition (which had been the basis for the carrier's "suspension" request) and was willing to cooperate. Approximately two weeks later (some 27 days after WCD's "suspension notice"), claimant signed a medical release (which had previously been mailed to him at an address where he did not reside) and sent another e-mail to the carrier asking what else could be done regarding his claim. The carrier did not directly respond to claimant's e-mail submissions. Instead, 32 days after the "suspension notice," the carrier issued a "non-cooperation" denial. Claimant requested a hearing, contending that the denial should be set aside.

The Board agreed with claimant's contention. Citing ORS 656.262(14), the Board stated that a worker has a duty to cooperate and assist the carrier in the investigation of a claim, which includes submitting to fully cooperating with personal and telephonic interviews and other formal or informal information gathering techniques. Relying on ORS 656.262(15), the Board noted that a carrier may deny a claim because of a worker's failure to cooperate with a claim investigation, if the worker does not cooperate for an additional 30 days after WCD's "suspension" notice. Referring to OAR 436-060-0135(9), the Board observed that, if the worker "makes no effort" to reinstate compensation within 30 days of the date of the "suspension" notice, the carrier may deny the claim pursuant to ORS 656.262(15).

Turning to the case at hand, the Board found that, in accordance with the aforementioned administrative rule, WCD's suspension order had provided that, if claimant did not cooperate for an additional 30 days after its previous "suspension" notice, the carrier could deny the claim because of his failure to cooperate. The Board further determined that, before the expiration of that 30-day period, claimant had e-mailed the carrier, stating that he had completed the required documentation and seeking advice on what further actions were needed.

*Requirements of claimant not applicable if denial is procedurally invalid.*

Under such circumstances, the Board concluded that claimant had not failed to cooperate in the carrier's claim investigation for an additional 30 days since WCD's "suspension" notice. Reasoning that the prerequisites for the issuance of "non-cooperation" denial had not been satisfied, the Board held that the carrier's denial was procedurally invalid.

In reaching its conclusion, the Board acknowledged that, in accordance with ORS 656.262(15) and *SAIF v. Hopper*, 265 Or App 465, 469 (2014), to prevail over a "non-cooperation" denial, claimant must meet one of the following requirements: (1) he "fully and completely cooperated with the investigation"; (2) he "failed to cooperate for reasons beyond [his] control"; or (3) the carrier's "investigative demands were unreasonable." Nonetheless, because the carrier's "non-cooperation" denial was procedurally invalid, the Board determined that the substantive requirements set forth in the *Hopper* analysis were not applicable.

## Own Motion: “Interim” Claim Reopening (“New/Omitted Medical Condition”) - Pending Carrier Appeal of ALJ’s “Compensability” Decision

*En Banc, Board agreed it is authorized to provisionally reopen Own Motion claim.*

*Patrick M. Shippy*, 68 Van Natta 885 (June 8, 2016). Applying ORS 656.278(1)(b), and OAR 438-012-0001(4), in an *en banc* decision, the Board held that it was authorized to provisionally reopen claimant’s Own Motion claim for a “post-aggravation rights” new/omitted medical condition pending a carrier’s appeal of an ALJ’s compensability decision regarding the claimed condition. After an ALJ found claimant’s new/omitted medical condition compensable, the carrier requested Board review of the ALJ’s order and submitted an Own Motion Recommendation against claim reopening.

The Board determined that the two requirements for the reopening of an Own Motion claim for a “post-aggravation rights” new/omitted medical condition claim had been met: (1) the new/omitted medical condition claim had been initiated after expiration of claimant’s aggravation rights under ORS 656.273; and (2) the new/omitted medical condition had been “determined to be compensable” by the ALJ’s order. See *Troy J. Pachano*, 62 Van Natta 509, 510 (2010); *James W. Jordan*, 58 Van Natta 34, 37 (2006). Under such circumstances, the Board considered it appropriate to issue an interim Own Motion order that provisionally reopened claimant’s Own Motion claim for the “post-aggravation rights” new/omitted medical condition.

*TTD benefits accruing from ALJ’s decision are payable.*

Consistent with ORS 656.313(1)(a)(A) and its Own Motion authority under ORS 656.278, the Board acknowledged that the carrier’s filing of a request for Board review of the ALJ’s order stayed payment of compensation flowing from that decision, except for temporary disability benefits that accrued from the date the order was appealed from until claim closure or until the ALJ’s order was reversed, whichever event first occurred. Furthermore, citing *SAIF v. VanLanen*, 127 Or App 346, *rev den*, 319 Or 211 (1994), *Diamond Fruit Growers v. Goss*, 120 Or App 390 (1993), and *Tricia A. Batchler*, 65 Van Natta 1460 (2013), the Board noted that the filing of such an appeal extended to such benefits subsequently awarded by a claim closure decision.

Finally, the Board explained that, if it eventually affirmed the ALJ’s compensability decision, it would replace its interim order with a final, appealable Own Motion Order reopening the Own Motion claim for the “post-aggravation rights” new/omitted medical condition. In that event, the Board commented that the carrier would continue to process the Own Motion claim, including the payment of any previously stayed “retroactive” temporary disability benefits (unless it chose to appeal the Board’s “compensability” decision and/or its final Own Motion Order). See ORS 656.313(1)(a)(A). Conversely, if it reversed the ALJ’s compensability decision, the Board clarified that it would issue a final, appealable Own Motion Order withdrawing its interim order and declining to reopen the Own Motion claim.

To the extent that any portion of its previous Own Motion case law (e.g., *Steven L. Traister*, 65 Van Natta 1295, *recons*, 65 Van Natta 1615 (2013), was inconsistent with the aforementioned practice, the Board disavowed such precedent.

## APPELLATE DECISIONS UPDATE

### Hearing Procedure: “Unperfected Claim” Defense Raised During Closing Arguments - Untimely - Defense Not Considered

### Attorney Fee Award: Board’s Order (Based on Attorney’s Request and “Rule” Factors) Met Substantial Reasoning

*Farmers Insurance Company v. Aranda*, 279 Or App 36 (June 22, 2016). The court affirmed the Board’s order in *Roberto S. Aranda*, 64 Or App 2340 (2012), previously noted 31 NCN 12:6, which held that a carrier’s “unperfected claim” defense to claimant’s new/omitted medical condition claim (which was not raised until the parties’ written closing arguments) was untimely raised and could not be considered. On appeal, the carrier contended that the Board had improperly reasoned that the carrier *waived* its right to procedurally challenge the claim as premature by not raising the issue at the hearing.

The court determined that the carrier’s argument did not fairly characterize the Board’s reasoning. Rather than relying on a finding that the carrier had *waived* its right to raise the “procedural” defense to the claim, the court interpreted the Board’s conclusion to be that, under OAR 438-006-0036, the time to raise “any additional issues” or “relief requested” was not at closing argument but rather before or during the hearing. The court further noted that a conclusion that an argument was not timely raised does not necessarily constitute a finding of waiver.

The court also rejected the carrier’s assertion that the Board’s determination had not addressed whether claimant had met his burden to prove a *de facto* denial; *i.e.*, he had not established when the carrier received his new/omitted medical condition claim. In doing so, the court observed that the carrier had overlooked the Board’s explanation that OAR 438-006-0036 required a party defending against a hearing request to “specif[y its] position on the issues raised by the party requesting the hearing” or, at the hearing, raise an issue not previously raised.

The court considered the carrier to be essentially asserting that its obligation to challenge the claimed *de facto* denial was excused because it was claimant’s burden to prove the elements necessary to establish such a claim. Yet, the court noted that the rule does not qualify the obligation to identify issues

*The time to raise issues is  
before or during the hearing.*

*Defending party must specify  
its position.*

*Carrier's "concedes nothing" statement not sufficient.*

as dependent on which party has the burden of production. Moreover, the court reasoned that the Board's determination that it would expect the carrier to *point out* at the outset of the hearing its "perfection" defense did not mean that the Board was requiring the carrier to *disprove* that claimant had made the claim.

The court acknowledged the carrier's statements at the hearing that it "concedes nothing" and "expects claimant to prove each element of the issues raised by [c]laimant." Nonetheless, after reviewing the Board's interpretation of those statements within the context of the hearing, as well as the parties' actions in continuing the hearing (for physicians' opinions regarding the existence of the claimed condition and its relationship to the work injury), the court understood the Board's finding to mean that the carrier's statements were not sufficiently particular to alert claimant or the ALJ that the carrier was challenging the existence of *de facto* denial.

Finally, the court affirmed the Board's attorney fee award for claimant's counsel's services at the hearing level and on Board review. See ORS 656.386(1). In doing so, the court rejected the carrier's argument that an attorney fee award was not authorized because claimant had not prevailed against a "denied claim" under ORS 656.386(1)(b)(A), which requires a carrier to refuse to pay on the express ground that the injury or condition for which compensation is claimed is not compensable. Reasoning that the Board had determined that claimant had prevailed over a *de facto* denial of a new/omitted medical condition claim, the court interpreted the Board to have granted an attorney fee award under subsection (b)(B) of the statute, which concerns the situation where a claimant files a new/omitted medical condition claim.

The court also disagreed with the carrier's contention that the Board's explanation for its attorney fee award was inadequate. In reaching its conclusion, the court distinguished *Schoch v. Leupold & Stevens*, 325 Or 112, 119 (1997), where the Supreme Court had held that a Board order (which had merely recited the "rule-based" factors of OAR 438-015-0010(4) and granted an attorney fee award in an amount less than half of the requested amount) was insufficient to determine how the Board had arrived at its award.

In contrast to *Schoch*, the court noted that, in the present case, claimant's counsel had requested a fee in an amount that was not, relatively speaking, a significant departure from the Board's award. Furthermore, the court observed that, in addition to identifying the "rule-based" factors, the Board order had considered "the time devoted to the [*de facto* denial] issue (as represented by the record, claimant's appellate briefs, his counsel's attorney fee submission, and the employer's objection)."

Considering that claimant's counsel had submitted an affidavit identifying his hourly rate and time spent on the matter and that the award was close to the requested amount, the court concluded that the Board's reliance on the circumstances of the proceeding concerning the amount of time spent by claimant's attorney and the other factors identified by the Board were adequate for its review. Cf. *Wal-Mart Associates, Inc. v. Lamb*, 278 Or App 622 (2016) (concluding that the record lacked any rationale for the attorney fee award and noting that a fee petition is unnecessary for judicial review). Regarding the reasonableness of the Board's attorney fee award, the court found no abuse of discretion. See *SAIF v. Wart*, 192 Or App 505, 507, *rev den*, 337 Or 248 (2004).

**APPELLATE DECISIONS**  
**SUPREME COURT**

TTD: “210(2)(b)(A)” - Supplemental Benefits - Carrier Must Receive Notice of “Secondary Job” W/I 30 Days of its Receipt of Claim - Notice to Employer Not “Imputed” to Carrier

*DCBS v. Muliro*, 359 Or 736 (June 16, 2016). Analyzing ORS 656.210(2)(b)(A), the Supreme Court affirmed the Court of Appeals opinion, 267 Or App 526 (2014), which had reversed a Board order that had awarded supplemental disability benefits based on a finding that claimant’s “at-injury” employer’s knowledge that she was also working for another employer at the time of her injury was imputed to its insurer for purposes of establishing that notice of this “secondary employment” had been received by the insurer within the statutorily required 30-day period from the insurer’s receipt of the initial claim. Reasoning that claimant had the burden of satisfying the “notice” requirements of ORS 656.210(2)(b) and that the entity (insurer, self-insured employer, or statutory administrator) responsible for processing the claim is not obligated to independently seek the “secondary employment” out, the Court of Appeals rejected claimant’s contention that the employer’s knowledge of her secondary employment should be imputed to the insurer. On appeal, claimant challenged the Court of Appeals’ conclusion that ORS 656.210(2)(b)(A) required her to provide, and the insurer to receive, actual notice of her secondary employment.

The Supreme Court rejected claimant’s contention. Citing ORS 656.210(b), the Court stated that, among other requirements, an injured worker is not entitled to supplemental disability benefits (based on earnings from an additional job at the time of the compensable injury) unless the insurer, self-insured employer or assigned claims agent for a noncomplying employer receives, within 30 days of receipt of the initial claim, notice that the worker was employed in more than one job at the time of injury. Furthermore, relying on OAR 436-060-0035(6)(b), the Supreme Court noted that an injured worker is eligible for supplemental disability benefits if “[t]he worker provides notification of a secondary job to the insurer within 30 days of the insurer’s receipt of the initial claim.”

After considering the text and context of ORS 656.210(2)(b)(A), the Court disagreed with claimant’s position that an insured employer’s knowledge of an injured worker’s secondary employment at the time of injury (regardless of how or when that knowledge was acquired) is imputed to the employer’s insurer for purposes of the statute. Reasoning that the statute plainly established a “30-day” time frame during which the “secondary employment” information must be received by a designated entity (which did not include an employer, other than a “self-insured” employer) for a claimant’s eligibility for supplemental disability benefits, the Supreme Court found no support in the text or context of the statute for claimant’s contention that her supervisors’ knowledge of her

*Employer’s knowledge is not imputed to insurer in supplemental TTD statute.*

*Claimant bears the burden to provide notice to insurer.*

secondary employment (at some unknown point that preceded her compensable injury) should be imputed to the insurer to satisfy the “notice” requirements of ORS 656.210(2)(b)(A).

Consequently, the Court determined that the text of the statute and its context indicated that the legislature intended an injured worker seeking supplemental disability benefits to bear the burden of providing notice of secondary employment to the employer’s insurer. In doing so, the Supreme Court observed that such a “notice” obligation could be met in multiple ways; e.g., the worker providing the information (such as delivering a completed claim form) directly to the insurer or to the employer, who was statutorily obligated to transmit such information to its insurer. The Court remarked that, in either scenario, such notice would not be imputed to the insurer, but rather the insurer would have received actual notice of the “secondary employment.”

Finally, addressing the 2001 legislative history (from two nonlegislator witnesses) concerning ORS 656.210(2)(b)(A), the Court considered the witnesses’ testimony consistent with its reading of the statute, which generally requires the injured worker to direct “secondary employment” information to the insurer but to also allow the worker to give such requisite information to the employer in connection with the worker’s initial claim (from which the employer would be obliged to transmit such information to the insurer).

In conclusion, because claimant did not communicate to her employer that she had “secondary employment” within 30 days of the insurer’s receipt of her initial claim (which could have been accomplished by checking the “secondary employment” box on either of two claims she had filled out) and because the insurer did not otherwise receive actual notice of her secondary employment within the aforementioned 30-day period, the Supreme Court held that the Board had erred in awarding supplemental disability benefits. Accordingly, the Court affirmed the Court of Appeals decision, which had remanded the case to the Board for further proceedings.

## **APPELLATE DECISIONS** **COURT OF APPEALS**

Consequential Condition: “005(7)(a)(A)” -  
Claimed Condition Arose From Compensable  
Injury, Not From Workplace Accident -  
Intervening/Intermediate Condition Between  
Compensable Injury/Claimed Condition Not  
Required

*Allen v. SAIF*, 279 Or App 135 (June 22, 2016). The court affirmed the Board’s order in *Donald L. Allen*, 67 Van Natta 185 (2015), which, in upholding the carrier’s denial of claimant’s left rotator cuff tear condition, found that the claim was subject to the “major contributing cause” standard for a “consequential condition.” Contesting the Board’s determination that the claimed rotator cuff

tear was a “consequential condition,” claimant contended that: (1) the Board was required to identify an intervening event between claimant’s original AC separation and his rotator cuff tear injury; and (2) because ORS 656.005(7)(a) establishes the “material contributing cause” standard as the “default” standard of proof, unless the carrier establishes that the “major contributing cause” standard for a “consequential condition” is applicable, the Board erred in applying the “major cause” standard.

The court disagreed with claimant’s contentions. Citing ORS 656.005(7)(a)(A), and *Albany General Hospital v. Gasperino*, 113 Or App 411, 415 (1992), the court reiterated that to recover benefits for a direct injury (which arises directly from the workplace accident), a claimant must establish that the accident was a “material contributing cause” of that injury. Relying on those same points and authorities, the court added that to recover benefits for a “consequential condition” (which arises from the initial, direct injury, rather than from the workplace accident), a claimant must show that the initial injury was the major contributing cause of the claimed condition.

Turning to the case at hand, the court rejected claimant’s argument that the submission of his rotator cuff tear claim should have established a presumption that his claimed condition arose directly from his workplace accident and thus was subject to the “default” standard of “material contributing cause.” Citing ORS 656.266(1), the court noted that the initial burden of proving the compensability of his claim rested with claimant. Thus, because claimant did not persuasively establish that his claimed rotator cuff tear arose directly from his workplace injury, the court reasoned that the Board was not required to apply the “material contributing cause” standard by default.

Addressing claimant’s contention that the “consequential condition” analysis required a finding of an intervening condition or event separating the initial compensable injury from the subsequent consequential condition, the court acknowledged that examples cited in *Gasperino* and other cases involved some identified intermediate conditions. Nevertheless, citing *English v. Liberty Northwest Ins. Corp.*, 271 Or App 211, 215 (2015), and *Vasquez v. SAIF*, 237 Or App 59, 61, *rev den*, 349 Or 370 (2010), the court reiterated that a consequential condition is an injury or condition that does not arise directly from the industrial accident, but rather as a *consequence* of an injury or condition caused by the industrial accident. Thus, the court reasoned that, so long as the claimed condition arose from a compensable injury rather than an underlying workplace accident, it was immaterial that there was no separately identifiable intervening condition between the compensable injury and the claimed condition.

Finally, in accordance with ORS 183.482(8)(c), the court considered whether substantial evidence supported the Board’s factual finding that the rotator cuff tear was a consequential condition that resulted, at least in part, from claimant’s compensable AC separation, and not directly from his underlying work-related logging incident. Citing *English*, the court acknowledged that the question of whether an injury is a consequential condition is not solely a function of timing.

Applying that rationale, the court noted that a physician’s opinion on which the Board had relied had indicated that the timing of claimant’s rotator cuff tear was a factor in determining its likely cause. However, when viewed in

*Board not required to apply material cause by default.*

*No intervening condition or event necessary for applying consequential condition standard.*

context, the court determined that the timing of the rotator cuff tear was one of several factors considered by the physician in determining the likely cause of the tear, and, as such, the “timing” factor had not been dispositive.

Consequently, based on the analysis of the physician’s opinion (as well as another physician’s opinion that attributed the rotator cuff tear entirely to a natural degenerative process), the court found that the record contained substantial evidence to support the Board’s conclusion that the compensable AC separation had been a cause (but not the major contributing cause) of claimant’s rotator cuff tear and that the claimed condition, as such, had not arisen directly out of the workplace accident.

## Substantial Evidence/Reasoning: Attorney Fee Award Lacked Substantial Reason

*Wal-Mart Associates, Inc. v. Lamb*, 278 Or App 622 (June 2, 2016). The court reversed that portion of a Board order, which affirmed an ALJ’s attorney fee award under ORS 656.386(1) and granted an attorney fee award pursuant to ORS 656.382(2) for claimant’s counsel’s services on Board review. Citing *Schoch v. Leupold & Stevens*, 325 Or 112, 119 (1997), the court determined that the Board had not adequately explained the basis for claimant’s attorney fee award. Because the Board’s award was without substantial reason, the court remanded for reconsideration.

In reaching its conclusion, the court disagreed with the carrier’s assertion that the record lacked any evidentiary basis for the amount of the Board’s attorney fee award because claimant’s counsel had not submitted a fee petition with evidence concerning the time spent on the matter and an hourly rate. Relying on *SAIF v. Wart*, 192 Or App 505, 522-23, *rev den*, 337 Or 248 (2004), and *SAIF v. May*, 193 Or App 515, 526 (2004), the court reiterated that, the Board’s rule (OAR 438-015-0010) does not expressly require the Board to make a finding about the time an attorney devoted to a case and, if the Board provides a sufficient explanation to allow judicial review, such evidence is unnecessary.

*Board not required to make a finding of time devoted if there is sufficient explanation for award.*