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News & Case Notes

BOARD NEWS

Bulletin 1 (Revised) - Annual Adjustment to Attorney Fee Awards - Effective July 1, 2017

On June 1, 2017 “WCB Bulletin No. 1 (Revised)” published the annual adjustment to attorney fee awards under ORS 656.262(11)(a) and ORS 656.308(2)(d). See OAR 438-015-0038; OAR 438-015-0055(5); OAR 438-015-0110(3). In accordance with those statutes, the Board rules provide that the maximum attorney fee (in the absence of extraordinary circumstances) is subject to an annual adjustment on July 1, by the same percentage increase as made to the state’s average weekly wage (SAWW) defined in ORS 656.211, if any, as calculated by the Workers’ Compensation Division (WCD), on behalf of the Director.

WCD has reported that, effective July 1, 2017, the SAWW is $963.01, a decrease of 1.149 percent from the SAWW for the previous year (July 1, 2016 through June 30, 2017) of $974.20. See WCD’s Bulletin 111 (Revised) dated May 25, 2017; WCD’s Industry Notice dated May 18, 2017.

Consequently, there will be no adjustments to OAR 438-015-0110(3), OAR 438-015-0038, and OAR 438-015-0055(5). In other words, effective July 1, 2017 (regarding any order issued on and after that date), consistent with the current version of the rule, an attorney fee awarded under ORS 656.262(11)(a) may not exceed $4,225, absent a showing of extraordinary circumstances. OAR 438-015-0110(3). In addition, effective July 1, 2017 (regarding any order issued on and after that date), consistent with the current version of the rule, an attorney fee awarded under ORS 656.308(2)(d) shall not exceed $3,047, absent a showing of extraordinary circumstances. OAR 438-015-0038; OAR 438-015-0055(5).

The bulletin can be found on the Board’s website at: http://www.oregon.gov/wcb/Documents/wcbbulletin/bulletin1-rev2017.pdf

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George M. Morgan, 69 Van Natta 1056 (June 16, 2017). On reconsideration of its initial decision (which had reversed an ALJ’s “premature closure” decision and awarded temporary/permanent disability benefits based on the opinion/findings from a physician that the Appellate Review Unit (ARU) had found to be the “attending physician”) the Board declined to consider claimant’s contention that another physician was his “attending physician” because he had neither previously raised that argument at hearing nor on Board review of the ALJ’s order. At a hearing concerning an Order on Reconsideration (which had found a particular physician to be claimant’s “attending physician”), claimant contended that the claim was prematurely closed and sought additional temporary disability (TTD) benefits, as well as a work disability award based on the “attending physician’s” work release. In presenting his arguments, claimant did not contest ARU’s designation of the “attending physician.” After the ALJ’s “premature closure” decision, the carrier requested review, challenging the premature closure finding. Claimant did not file a respondent’s brief. In its initial decision, the Board reversed the ALJ’s premature closure finding and awarded temporary/permanent disability benefits based on the “attending physician’s” opinion/findings. Thereafter, claimant requested reconsideration, seeking (among other requests) an increased TTD award based on the opinion of another physician, who he asserted was his “attending physician.”

The Board adhered to its initial decision that because claimant’s accepted conditions were medically stationary before the date the claim was closed, the claim had not been prematurely closed. Furthermore, referring to Kevin W. McClellan, 65 Van Natta 560 (2013), and Jesus M. Zarzosa, 56 Van Natta 1683, recons, 56 Van Natta 1958 (2004), the Board reiterated that, when an ALJ’s premature closure determination is reversed and the record is sufficiently developed to resolve the remaining disputed issues raised at the hearing level, it is appropriate to proceed with review of the remaining issues.

Turning to the case at hand, the Board noted that, at hearing, claimant had raised the issues of premature closure, or, alternatively, his entitlement to additional temporary/permanent disability benefits beyond those awarded in the Order on Reconsideration. Reasoning that it had found that the claim was not prematurely closed and that the record was sufficiently developed to resolve the temporary/permanent disability issues raised by claimant at hearing (which were not addressed as a result of the ALJ’s premature closure determination), the Board explained that it was appropriate to proceed with its review of those remaining issues.
Finally, the Board acknowledged claimant’s contention (raised for the first time in his reconsideration motion) that a surgeon had been his “attending physician” for purposes of establishing his entitlement to additional TTD benefits. However, noting that claimant had neither previously contested ARU’s “attending physician” finding nor contended that the surgeon was his “attending physician,” the Board declined to consider his argument raised for the first time on reconsideration. In reaching its conclusion, the Board relied on Vogel v. Liberty NW Ins. Corp., 132 Or App 7 (1994), and William A. Hedger, 58 Van Natta 2382 (2006).


Jerald E. Atwood, 69 Van Natta 1002 (June 5, 2017). Applying OAR 436-035-0007(5)(b), the Board relied on the attending physician’s ratified impairment findings for claimant’s hearing loss because a medical arbiter’s findings (which found that claimant’s current audiogram was not valid for purposes of measuring impairment) did not mean that claimant did not have the permanent hearing loss documented by the audiogram findings ratified by his attending physician. Based on the attending physician concurrence with a physician’s audiogram for purposes of rating claimant’s hearing loss impairment, a Notice of Closure awarded 2 percent whole person impairment for hearing loss. An Order on Reconsideration reduced the permanent impairment award to zero based on a medical arbiter’s findings that a subsequent audiogram was not valid for measuring permanent impairment. Claimant requested a hearing, contending that the findings ratified by the attending physician were more accurate than the medical arbiter findings.

The Board agreed with claimant’s contention. Citing OAR 436-035-0007(5)(b) and SAIF v. Owens, 247 Or App 402, 414-15 (2011), recons, 248 Or App 746 (2012), the Board stated that impairment is established by the medical arbiter’s findings, except where a preponderance of the medical evidence demonstrates that different findings made or ratified by the attending physician are more accurate and should be used. Referring to Hicks v. SAIF, 194 Or App 655, recons, 196 Or App 146, 152 (2004), the Board acknowledged that, absent persuasive evidence to the contrary, it could not disregard the medical arbiter’s findings. However, referring to OAR 436-035-0007(5)(b), as well as SAIF v. Banderas, 252 Or App 136, 144-45 (2012), the Board observed that the attending physician’s ratified findings may be used where the preponderance of the medical evidence establishes that they are more accurate.

Turning to the case at hand, the Board noted that the medical arbiter considered the examination invalid for the purpose of measuring permanent impairment due, in part, to dramatic differences between his audiogram, which
Medical arbiter noted dramatic differences between “AP-ratified” and “arbiter” audiograms, but did not question “AP-ratified” findings.

Because arbiter did not opine that hearing loss had resolved, “AP-ratified” findings considered more accurate.

Remand is appropriate when Board is unable to review ALJ’s ruling due to lack of explanation.

showed severe hearing loss at all frequencies, and the earlier audiogram endorsed by the attending physician, which showed a precipitous drop-off at the higher frequencies of the left ear. Notwithstanding the arbiter’s statement, the Board did not interpret the medical arbiter’s opinion to mean that claimant did not have the permanent hearing loss that was documented by the earlier audiogram (in which the attending physician had ratified another physician’s opinion that claimant’s impairment findings were valid). Moreover, in the absence of a physician’s opinion that claimant’s hearing loss resolved after the earlier audiogram, the Board declined the carrier’s request to draw such an inference. See Benz v. SAIF, 170 Or App 22, 26 (2000); SAIF v. Calder, 157 Or App 224, 228 (1998).

Under such circumstances, the Board was persuaded that the findings endorsed by the attending physician were more accurate than the invalid findings of the medical arbiter. See OAR 436-035-0005(7)(5)(b); Banderas, 252 Or App at 144-45. Consequently, the Board reinstated and affirmed the Notice of Closure’s permanent impairment award.


Oscar Francisco, 69 Van Natta 1074 (June 16, 2017). Analyzing OAR 438-006-0031(2), the Board held that, when a claimant raised a “tinnitus” claim at a hearing regarding a denial of a “hearing loss” claim, an Administrative Law Judge (ALJ) was required to rule whether the “tinnitus” claim was encompassed within the denied “hearing loss” claim or whether claimant was allowed to amend the issues at the hearing and, if so, whether to grant a continuance of the hearing if the carrier wished to further develop the record. Rather than address a carrier’s procedural objection to claimant’s “tinnitus” claim at a hearing involving a denied “hearing loss” claim, the ALJ’s eventual order reasoned that the claimed “tinnitus” condition was not compensable. On Board review, claimant contended that his “tinnitus” was compensable, while the carrier asserted that the claimed condition was not properly before the ALJ.

The Board concluded that remand was warranted. Citing OAR 438-006-0031(2), the Board stated that, consistent with its policy described in OAR 438-005-0035, amendments to issues at a hearing may be allowed, subject to a motion by an adverse party for postponement/continuance of the hearing under OAR 438-006-0081 and OAR 438-006-0091. Relying on Dolores Catana-Cortez, 68 Van Natta 564, 566 (2016), the Board reiterated that it reviews an ALJ’s “issue amendment” ruling for an abuse of discretion. Referring to Catana-Cortez, the Board noted that remand is appropriate when an ALJ, in effect, amends the issues at hearing without explanation and the Board is unable to review the ALJ’s ruling for an abuse of discretion.
Turning to the case at hand, the Board determined that the ALJ had not made any finding or provided any reasoning concerning whether the “tinnitus” claim was encompassed within the carrier’s “hearing loss” denial or whether the issues had been amended at hearing. In the absence of such explanations, the Board was unable to review the ALJ’s procedural ruling for an abuse of discretion. Consequently, the Board remanded for further action. See ORS 656.295(5); Catana-Cortez, 68 Van Natta at 566.

In reaching its conclusion, the Board noted that, on remand, the parties may wish to present their respective positions regarding whether the carrier’s denial was sufficiently general to include a “tinnitus” claim or, considering that the initial claim only referred to “hearing loss” and was not altered until the hearing to include “tinnitus,” claimant had, in effect, sought to amend the issues for resolution. See OAR 438-006-0031; Sound Elevator v. Zwingraf, 181 Or App 150, 152, 154-55 (2002); Frank P. Courtell, 69 Van Natta 884, 887 (2016). Finally, referring to OAR 438-006-0031(2), OAR 438-006-0091(4), and Courtell, the Board observed that, if the ALJ allowed an amendment of issues, the carrier would have the opportunity to move for a continuance of the hearing (if it wished) to further develop the “tinnitus” issue.

Hearing Request: “005-0046(1)(c)” - “Rebuttable Presumption” of “Untimely Filing” Not Overcome by Only “Certificate of Service” Alone - Must Also Have Corroboration

Teresa A. Sweeney, 69 Van Natta 1062 (June 16, 2017). Applying ORS 656.319(1)(a) and OAR 438-005-0046(1)(c), the Board held that claimant had rebutted the presumption of untimely filing of her hearing request from a carrier’s claim denial because the record (which included her counsel’s certificate of service, as corroborated by her counsel’s cover letter and the absence of the other party’s contention that its copies of the hearing request had not been timely mailed) established that the hearing request had been mailed to the Hearings Division before the expiration of the statutory 60-day appeal period. After the Hearings Division received claimant’s request for hearing more than 60 days after the carrier’s denial, the carrier contended that the hearing request was untimely filed. See ORS 656.319(1)(a). In doing so, the carrier relied on the “rebuttable presumption” that the request was untimely filed because it was not mailed by certified mail and was received by the Hearings Division after the expiration of the 60-day appeal period from the denial. See OAR 438-005-0046(1)(c).

The Board disagreed with the carrier’s contention. Citing ORS 656.319(1)(a), the Board stated that a request must be filed within 60 days from the date of mailing of a denial. Referring to OAR 438-005-0046(1)(c), the Board noted that, if the filing of a hearing request is accomplished by mailing and the request is not mailed by registered or certified mail and is actually received by the Board after the date of filing, it shall be presumed that the mailing was
Without “certified mail” receipt, a certificate of mailing (alone) is insufficient to overcome “rebuttable presumption” of untimely filing.

Additional portion of record corroborated certificate of mailing, and together, overcame “rebuttable presumption” of untimely filing.

Purpose of statute is to obtain acceptance of a condition not included within carrier’s acceptance.

untimely unless the filing party establishes that the mailing was timely. Relying on Fernando R. Sanchez, 62 Van Natta 2977 (2010), and John R. Johanson, 46 Van Natta 946, 947 n 1 (1994), the Board explained that in the absence of a “certified mail” receipt, a certificate of mailing alone is insufficient to overcome the rebuttable presumption that the request was untimely filed. However, the Board clarified that the record as a whole may be considered when determining whether a request was timely mailed, which includes an attorney’s certificate of service. See, e.g., Lisa M. Kasel, 64 Van Natta 743 (2012); Brian L. Schmitt, 48 Van Natta 295 (1996); Douglas A. Anderson, 46 Van Natta 1456 (1994).

Turning to the case at hand, the Board concluded that, although claimant’s attorney’s certificate of service alone was not enough to rebut the presumption of timely filing of the request for hearing, the hearing request and the claimant’s attorney’s cover letter received by the Board’s Hearings Division three days after the certificate of service date corroborated that the request was mailed as claimant’s counsel certified. Moreover, the Board noted that neither the remainder of the hearing file nor the evidentiary record contradicted the claimant’s attorney’s certificate of service nor had the carrier disputed its counsel’s receipt of a copy of the hearing request that claimant’s counsel certified had been timely mailed.

Under those particular circumstances, the Board was persuaded that claimant’s counsel’s had mailed the hearing request to the Board before the expiration of the statutory 60-day period. Consequently, the Board concluded that the presumption of an untimely filed hearing request had been rebutted.

APPELLATE DECISIONS UPDATE

New/Omitted Medical Condition: “267” - Claimed Condition Previously Accepted as “Combined Condition”

Akins v. SAIF, 286 Or App 70 (June 7, 2017). Citing ORS 656.267, the court affirmed the Board’s order in Karlynn J. Akins, 66 Van Natta 1969 (2014), previously noted 33 NCN 12:3, which had upheld a “new/omitted medical condition” denial for a combined arthritic knee condition (i.e., a combination of the preexisting arthritis in the knee with claimant’s work injury event) because the record did not establish that the currently claimed condition existed separately from the arthritic knee condition that the carrier had previously accepted as the “preexisting condition” component of the combined knee condition. On appeal, claimant asserted that the carrier was required to accept the claimed new/omitted medical condition even if it was included within the previously accepted combined condition.

The court disagreed with claimant’s contention. Citing ORS 656.267, the court stated that the purpose of the statute is to permit a claimant to obtain acceptance of conditions that, as a factual matter, are not included within the scope of a carrier’s claim acceptance. Relying on Nacoste v. Halton Co., 275 Or App 600, 605-07 (2015), the court reiterated that the focus of the statute is on conditions that are “new” or “omitted” with respect to an existing Notice of Acceptance.

Purpose of statute is to obtain acceptance of a condition not included within carrier’s acceptance.
Carrier not required to reaccept and reprocess a condition already accepted.

Turning to the case at hand, the court reasoned that nothing in the text, context, or legislative history of the statute supported claimant’s argument that the legislature intended to require a carrier to reaccept (and reprocess) a condition that, as a factual matter, already has been accepted. Consequently, the court found no error in the Board’s upholding of claimant’s new/omitted medical condition claims.

The court also affirmed the Board’s decision to uphold the carrier’s “ceases” denial of claimant’s previously accepted combined knee condition. See ORS 656.262(6)(c). Reasoning that the Board could permissibly rely on physicians’ reports to determine that there had been a change in claimant’s combined knee condition between the effective date of the carrier’s acceptance of the condition and its subsequent denial (i.e., some physicians’ opinions that her accepted knee sprain/contusion had resolved by the effective date of the carrier’s denial), the court concluded that substantial evidence and reason supported the Board’s finding that claimant’s accepted work injury was no longer the major contributing cause of her combined knee condition. See Brown v. SAIF, 361 Or 241, 244 (2017); Rogue Advocates v. Jackson County, 282 Or App 381, 389 (2016); Oregon Drywall Systems, Inc. v. Bacon, 208 Or App 205, 210 (2006).

Subject Worker: “005(30)” - “Pre-Employment/Driver Test” Injury - “Engaged to Furnish Services For Remuneration”

Gadalean v. SAIF, 286 Or App 227 (June 14, 2017). Applying ORS 656.005(30), the court reversed the Board’s order in Cozmin I. Gadalean, 68 Van Natta 336 (2016), previously noted 35 CNN 3:15, which had held that claimant was not a “subject worker” when he sustained his hip injury because it occurred while he was participating in a pre-employment/driver’s test evaluation for a truck driving position and, as such, there was no agreement (express or implied) that he would receive remuneration for his services. On appeal, claimant contended that, in the course of his “pre-employment evaluation,” he was actually “put to work” and performed services for the employer (i.e., making a delivery for which the employer was compensated) and, as such, established that he was “engage[d] to furnish services for a remuneration” within the meaning of ORS 656.005(30).

The court agreed with claimant’s contention. Citing ORS 656.005(30), the court stated that a “worker” is defined as “any person * * * who engages to furnish services for a remuneration, subject to the direction and control of an employer * * *.” Relying on Rubalcaba v. Nagaki Farms, Inc., 333 Or 614, 619 (2002), the court noted that whether a claimant is a “worker” under the statute is a question of law that is reviewed for legal error under ORS 183.482(8)(a).

Turning to the case at hand, the court acknowledged the carrier’s assertion that, based on the Board’s express credibility findings regarding claimant and the alleged employer’s testimony, there had been no “agreement”
If claimant put to work, it did not matter that parties had not agreed to remuneration.

During “pre-employment” driving test, claimant performed an actual delivery for the employer and, as such, had been put to “work.”

for remuneration when claimant performed his driving test. Nonetheless, even accepting that assertion as true, the court reasoned that it was legally irrelevant because the law implied the existence of an agreement for the following reasons.

First, in the absence of a specific statutory exemption (which undisputedly did not apply in the present case), the court determined that, under the “minimum wage” statute, a person must be paid a wage for work. See ORS 653.025. Thus, the court explained that, if claimant was put to work for the employer (even if only for a brief time), it did not matter that the parties had not agreed concerning remuneration.

Second, noting that claimant performed an actual delivery for the employer for which he would have been paid had he been on the payroll, the court concluded that, as a matter of law, he had been put to “work,” which implied the existence of a contract. See Montez v. Roloff Farms, Inc., 175 Or App 532, 536 (2001). In reaching its conclusion, the court acknowledged that an employer may require a job applicant, without paying that person for his time, to take a test as part of the application process. See BBC Brown Boveri v. Lusk, 108 Or App 623 (1991), and Dykes v. SAIF, 47 Or App 187 (1980). Nonetheless, in contrast to Lusk and Dykes (where the claimants were also not performing services for the employers), the court reasoned that claimant’s “evaluation” involved being put to work.

Finally, the court rejected the carrier’s argument that the employer had received no “benefit” from claimant’s activity. Observing that the employer conceded that claimant performed the activities of a regularly employed driver, that the delivery was performed in the ordinary course of the employer’s business, and that the employer was probably compensated for the delivery, the court held that the record compelled a conclusion that the employer received a “benefit” from claimant’s services.

APPELLATE DECISIONS
COURT OF APPEALS

Extent: Impairment Findings - “Apportionment” Rule (“035-0013”) - Not Limited to “Accepted/Denied” Combined Condition Before Claim Closure

McDermott v. SAIF, 286 Or App 406 (June 28, 2017). Analyzing ORS 656.214(2), ORS 656.268(2), and OAR 436-035-0013 (2013), the court, en banc, affirmed the Board’s order in Maurice McDermott, 67 Van Natta 1250 (2015), that had held that, in evaluating claimant’s permanent impairment for his compensable knee injury, it was appropriate to apportion his impairment findings for his accepted knee strain/articular injury from an unaccepted/undenied preexisting arthritic condition. On appeal, claimant reiterated his previous contention that it was inappropriate to apply the “apportionment” rule in rating his permanent impairment because the carrier had not accepted/denied his combined knee condition. Specifically, claimant argued that the Workers’ Compensation Division’s (WCD’s) “apportionment” rule (OAR 436-035-0013
Apportionment rule not inconsistent with ORS 656.268(1).

Claimant’s legally cognizable preexisting condition (arthritis) was subject to “apportionment” rule, unless it was part of an accepted combined condition at claim closure.

Dissent argued that, except when carrier avails itself of “combined condition” apportionment process (by accepting/denying before claim closure), entire impairment must be rated without apportionment.

(2013) exceeded its statutory authority because it was: (1) inconsistent with ORS 656.268(1), which pertains to claim closure; (2) ORS 656.266(2)(a), which allocates the burden of proof to a carrier contesting the compensability of a combined condition; and (3) ORS 656.268(7)(b), which requires that a combined condition must be denied before claim closure.

The court disagreed with claimant’s assertions. Citing ORS 656.268(1)(b), the court acknowledged that a claim shall close and the extent of permanent disability determined when the accepted injury is no longer the major contributing cause of a combined condition and there is sufficient information to determine permanent disability due to the current accepted condition.

Nonetheless, the court did not consider OAR 436-035-0013 (2013) (the “apportionment” rule, which provides that, when a physician determines that a specific finding is partially attributable to the accepted condition, only that portion of those findings are due to the compensable condition and receives an impairment value) to be inconsistent with ORS 656.268(1)(b). The court reasoned that: (1) ORS 656.268(1) provides for “claim closure” policies and does not provide directives concerning disability rating standards otherwise within the Director’s authority; (2) ORS 656.268(1)(b) does not mean that the legislature intended to preclude other applicable “apportionment” rules; and (3) ORS 656.266 pertains to the burden of going forward to prove the compensability of a claim (during an earlier stage in the claim process), which has little relevance to the closure policies of ORS 656.268(1).

The court recognized that, in Schleiss v. SAIF, 354 Or 637 (2013), the “apportionment” rule could not be applied to the extent that it requires an apportionment of impairment due to noncognizable preexisting conditions in a permanent disability award. Nevertheless, the court observed that the Schleiss court reserved and did not decide the current issue; i.e., whether apportionment applies only to accepted and then denied combined condition claims. In addition, noting that, in the present case, it was undisputed that claimant’s arthritis was a legally cognizable preexisting condition within the meaning of ORS 656.005(24), the court determined that, under Schleiss, his arthritis was subject to apportionment, unless it was part of an accepted combined condition claim that remained compensable at claim closure.

Judge Flynn (joined by five other judges) dissented, asserting that, based on the Schleiss analysis and the Supreme Court’s historical construction of loss “due to” the compensable injury, the phrase “due to” refers to the entire impairment if it is caused in material part by the compensable injury (not just to the percentage of impairment that was caused entirely by the compensable injury). Consequently, the dissent’s position was that, except when the carrier avails itself of the “combined condition” apportionment process created by the legislature, compensation for permanent impairment continues to mean the entire impairment produced by symptoms that are caused in material part by the compensable injury. Thus, to the extent that OAR 435-035-0013 (2013) conflicted with this analysis, Judge Flynn considered the “apportionment” rule invalid.

In support of her position, Judge Flynn reasoned that: (1) Schleiss construed the rule of apportionment stated in ORS 656.268(1)(b) as implying a legislative intention to limit, at least somewhat, the Director’s ability to apportion...
improvement when the carrier would be unable to obtain apportionment through claim closure under ORS 656.268(1)(b); (2) Schleiss strongly suggested that whether permanent impairment was “due to” the compensable injury must be determined by considering the new impairment as a whole, unless the claim is closed under ORS 656.268(1)(b); and (3) in the absence of a carrier’s “pre-closure” denial of a previously accepted combined condition, there was no basis from departing from the rule announced by the Supreme Court in Barrett v. D & H Drywall, 73 Or App 184, rev’d, 300 Or 325 (1985), adh’d to on recons, 300 Or 553 (1986), and Nomeland v. City of Portland, 106 Or App 77, 81 (1991), that, when an injury causes new symptoms of a preexisting condition, the entire permanent impairment is “due to” the compensable injury.

Based on the aforementioned reasoning, Judge Flynn contended that, in contrast to the legislatively approved “apportionment” process, OAR 436-035-0013 (2013) allowed a carrier to limit its responsibility for impairment resulting from a claimant’s combined condition without proving that a qualifying preexisting condition is the major cause of his/her impairment pursuant to a “pre-closure” denial under ORS 656.262(7)(b), ORS 656.268(1)(b), and ORS 656.266(2)(a) and, as such, was invalid.