



News & Case Notes

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BOARD NEWS

Bulletin 1 (Revised) - Annual Adjustment to Attorney Fee Awards - Effective July 1, 2018

On June 1, 2016 "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).

Effective July 1, 2018, an attorney fee awarded under ORS 656.262(11)(a) may not exceed \$4,418, absent a showing of extraordinary circumstances. OAR 438-015-0110(3). Also effective July 1, 2018, an attorney fee awarded under ORS 656.308(2)(d) shall not exceed \$3,186, absent a showing of extraordinary circumstances. OAR 438-015-0038; OAR 438-015-0055(5).

These adjustments apply to all attorney fee awards under these statutes granted by orders beginning July 1, 2018. The bulletin can be found on the Board's website at <https://www.oregon.gov/wcb/Documents/wcbbulletin/bulletin1-rev2018.pdf>

Board Member - Barbara Woodford

Barbara Woodford was appointed and confirmed as a new Member on June 1, 2018. A graduate of Cornell University, Barbara obtained her JD from Lewis & Clark College of Law. She has practiced law since 1981, initially with a claimant's/plaintiff's firm, followed by 25 years with Liberty Northwest/Liberty Mutual, and, since 2013, as a staff attorney for the Workers' Compensation Board.

Staff Attorney Recruitment

WCB will soon be recruiting staff attorney candidates. The key criteria includes 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.

The recruitment is scheduled to begin in late June and will run for approximately three weeks. Further details about the position and information on how to apply will soon be available online at <http://www.oregon.gov/DCBS/jobs/Pages/jobs.aspx> or www.oregonjobs.org. WCB is an equal opportunity employer.

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WCB Portal Enhancements - Briefing Extensions and Case Status

The Board has added some new features to the "Status" tab in "WCB Case Status." Portal users can now check on-line to see if a Board Review briefing extension has been granted and can also see when the Board has initiated the briefing schedule ("Call for Briefs"). This status update is specific to cases on Board Review, not for cases at the Hearings level.

Below is an example of the new Status view. When the Board has made a decision on a request for an extension, that information ("Granted" or "Denied") will be displayed on the case in your WCB Case Status tab. In most cases, that status will be updated prior to the issuance of the letter announcing the new due date, so you can check the status of your extension request before you leave the office for the day. (You will have to click into a different tab and then go back to WCB Case Status for the page to "refresh").



Events		Status	Orders and Documents	Pleadings
Date	Status			
09/05/2014	CARRIER REQUESTED COURT OF APPEALS ACTION			
09/03/2014	ORDER ON RECONSIDERATION			
08/26/2014	ORDER ON REVIEW			
06/05/2014	REPLY EXTENSION GRANTED			
05/15/2014	REPLY EXTENSION GRANTED			
04/14/2014	RESPONDENT EXTENSION GRANTED			
03/14/2014	APPELLANT EXTENSION GRANTED			
02/14/2014	APPELLANT EXTENSION GRANTED			
01/23/2014	CALL FOR BRIEFS			

To optimize the WCB Case Status tab, the Board has also made a change to the default display. Now, the default will list your "open" cases only, which will speed up the time it takes to load that web page. If you want to look at closed cases, you can check the box to list those. The best way to find an individual case is to type the WCB number (including the dash) into the "Filter" box on the right. (See below). Typing in claimant's last name also works well, but may pull up similar names from the "Parties" list within the various case details. If you use the "Filter" box to search for a specific case, the results will show both Open and Closed cases.



Contact us at portal.wcb@oregon.gov if you have questions or need assistance.

CASE NOTES

Aggravation: “Actual Worsening” of Accepted Condition Required - Increased Symptoms/Reduced “ROM” Findings (Without Physician’s Supporting Opinion) Insufficient

Judy Munstenteiger, 70 Van Natta 637 (May 23, 2018). Applying ORS 656.273(1), the Board held that claimant’s aggravation claim for her accepted sacroiliac joint sprain was not compensable because the medical record did not establish that her previously accepted condition had pathologically worsened since the last award/arrangement of compensation. Referring to changes in her lumbar range of motion findings since the initial closure of her sacroiliac joint sprain claim (which did not result in a permanent impairment award) and noting that her attending physician’s “post-closure” report (which stated that her sprain had incompletely healed), claimant contended that her accepted condition had actually worsened and, as such, her aggravation claim was compensable.

The Board disagreed with claimant’s contention. Citing ORS 656.273(1) and *Nacoste v. Halton Co.*, 275 Or App 600 (2015), the Board stated that, to establish a compensable aggravation claim, claimant must prove an “actual worsening” of her accepted left sacroiliac joint sprain condition since the last award or arrangement of compensation. Relying on *SAIF v. Walker*, 330 Or 102, 118-19 (2000), the Board noted that an “actual worsening” can be established either by direct proof of a pathological worsening or through inference of such a worsening based on increased symptoms. Referring to *SAIF v. January*, 166 Or App 620, 624 (2000), the Board observed that, if a physician’s opinion establishes that a symptomatic worsening represents an actual worsening of the underlying condition, such evidence may satisfy the statutory requirement under ORS 656.273(1).

Turning to the case at hand, the Board had acknowledged that, after claim closure, the attending physician had agreed that claimant developed a “chronic condition” that limited the repetitive use of her sacroiliac joint. Nonetheless, the Board noted that the attending physician (as well as an examining physician) had expressly opined that claimant’s increased symptoms were not an aggravation of her accepted condition because there were no new objective findings. Moreover, the Board observed that the examining physician had suggested that claimant’s increased symptoms might be attributable to preexisting degenerative conditions. Under such circumstances, the Board concluded that the record did not establish that claimant’s accepted sacroiliac joint sprain had pathologically worsened since the last award/arrangement of compensation.

Finally, addressing claimant’s decreased lumbar range of motion (ROM) findings since claim closure, the Board reasoned that both the attending and examining physician had specifically opined that there were no new objective findings supporting an aggravation of claimant’s accepted condition. In the absence of a physician’s opinion supporting an inference that claimant’s

To establish a compensable aggravation, accepted condition must “actually worsen,” either by direct proof of pathological worsening or inference based on increased symptoms.

Notwithstanding reduced “ROM” findings, physicians did not support inference of actual worsening of accepted condition.

symptoms and decreased ROM findings established an actual worsening of her accepted condition, the Board determined that a compensable aggravation claim had not been proven. See *DeRoest v. Keystone RV. Co.*, 276 Or App 698 (2016); *Randall L. Childers*, 60 Van Natta 591, 592 (2008).

Attorney Fee: “383(1)” - Not Applicable For “Recon” Services Resulting in Rescission of NOC

Robert L. Stanley, 70 Van Natta 618 (May 15, 2018). Analyzing ORS 656.383(1), the Board, *en banc*, held that claimant’s counsel was not entitled to a carrier-paid attorney fee for services rendered during the reconsideration proceeding that resulted in a premature closure finding. After claimant requested reconsideration of a Notice of Closure, an Order on Reconsideration rescinded the claim closure as premature. Claimant requested a hearing, seeking a carrier-paid attorney fee under ORS 656.383(1), asserting that his attorney had been instrumental in obtaining increased temporary disability benefits before an ALJ decision.

The Board concluded that ORS 656.383(1) was not applicable to claimant’s counsel’s services during the reconsideration proceeding. Summarizing ORS 656.383(1), the Board stated that a carrier-paid attorney fee is allowable if the claimant’s counsel is instrumental in obtaining temporary disability compensation pursuant to ORS 656.210, 656.212, 656.268, or 656.325 prior to an ALJ decision. However, referring to its decision in *Mekayla N. Dancingbear*, 70 Van Natta 550 (April 27, 2018), the Board explained that an assessed attorney fee under ORS 656.383(1) is not available for services rendered during the reconsideration process.

Turning to the case at hand, consistent with the rationale expressed in *Dancingbear*, the Board reiterated that ORS 656.383(1) was not intended to apply to the reconsideration process. Consequently, the Board concluded that claimant’s counsel was not entitled to an assessed attorney fee under ORS 656.383(1) for services rendered during the reconsideration proceeding in support of the reconsideration order’s rescission of the Notice of Closure.

Members Lanning and Ousey specially concurred. Referring to their dissenting opinion in *Dancingbear*, the concurring members believed that ORS 656.383(1) was applicable to a claimant’s counsel’s services rendered during the reconsideration process. Nevertheless, acknowledging the principles of *stare decisis*, Lanning and Ousey followed the *Dancingbear* holding.

“383(1)” attorney fee not intended to apply to reconsideration proceeding when Order on Reconsideration rescinds NOC as premature.

Combined Condition: “Post-Injury” DVT Condition (Resulting From Injuries From Lower Extremities) Combined With “Pre-Injury” DVT Condition - Carrier’s Acceptance/Denial in Same Document - Procedurally Valid

Mitchell D. Clem, 70 Van Natta 694 (May 31, 2018). Applying ORS 656.262(6)(c) and ORS 656.266(2)(a), the Board upheld a carrier’s “ceases” denial of claimant’s combined deep vein thrombosis (DVT) condition, finding that the carrier’s acceptance of the combined condition was procedurally valid because, although the acceptance was included in the same letter in which the carrier denied the accepted combined DVT (*i.e.*, claimant’s “post-injury” DVT resulting from injuries to his lower extremities combined with preexisting DVT conditions), the combined condition had changed since the effective date of the acceptance and the otherwise compensable injury was no longer the major contributing cause of his need for treatment/disability for his combined DVT condition. Claimant sustained multiple lower extremity fractures as a result of a fall at work. The carrier accepted several bilateral leg/ankle fractures. Before the injury, claimant had taken an anticoagulant prescription concerning multiple episodes of deep vein thrombosis in his left leg. Following his work injury, he required bilateral ankle surgery, which required him to discontinue his anticoagulant medication. To protect him while no longer taking the medication, a “venacaval filter” was inserted until he resumed taking the medication. Thereafter, the carrier issued a letter accepting a combined condition consisting of the preexisting DVT condition and a “single episode” of DVT following the work injury. In the same letter, the carrier denied the combined condition after the venacaval filter was removed and he resumed his medication. Claimant requested a hearing, contending that the carrier’s denial was procedurally invalid and neither a preexisting nor combined condition existed.

The Board disagreed with claimant’s contentions. Citing ORS 656.005(24) and *Guadalupe Arias-Santos*, 69 Van Natta 667, 669 (2017), the Board stated that a “preexisting condition” is defined, in part, as an injury or disease that contributes to disability or need for medical treatment that was diagnosed or treated before the work injury. Referring to *Stockdale v. SAIF*, 192 Or App 289 (2004), the Board reiterated that a carrier may include an acceptance and a denial in a single document. Relying on *SAIF v. Kollias*, 233 Or App 499, 505 (2010), and *Dezi Meza*, 63 Van Natta 67, 70 (2011), the Board noted that a carrier must establish a “preexisting condition” and a “combined condition.”

Turning to the case at hand, the Board was persuaded by a physician’s opinion that claimant’s pre-injury DVT condition constituted a “preexisting condition” that had combined with his “post-injury DVT” resulting from injuries to his lower extremities. Moreover, based on the physician’s persuasive opinion, the Board found that, following the removal of the venacaval filter and the resumption

Carrier's acceptance/denial of a "combined condition" may be included in same document (if "effective date" of acceptance precedes "effective date" of denial).

of claimant's anticoagulant medications, the otherwise compensable injury was no longer the major contributing cause of his need for treatment/disability for his combined DVT condition.

Under such circumstances, the Board concluded that the carrier's acceptance/denial contained in the same letter was procedurally valid because the combined DVT condition had been accepted effective as of the date of the work injury and had changed as of the effective date of the carrier's denial of the combined DVT condition. Furthermore, the Board determined that the carrier had established that the otherwise compensable injury had ceased to be the major contributing cause of claimant's need for treatment/disability for his combined DVT condition. Consequently, the Board upheld the carrier's "ceases" denial of the combined condition.

Jurisdiction: "Vocational Services-Related" Attorney Fee Under "385(1)" - WCD Authority

Robert L. Montgomery, 70 Van Natta 663 (May 30, 2018). Analyzing ORS 656.340, ORS 656.385(1), and ORS 656.704, the Board held that the Hearings Division lacked authority to consider a dispute regarding claimant's entitlement to an attorney fee involving a "letter of agreement" concerning a vocational services matter. The Workers' Compensation Division (WCD) issued a "letter of agreement" that provided for an attorney fee. Thereafter, the parties' Claim Disposition Agreement (CDA) was approved, which released claimant's rights to all "non-medical service-related" benefits. When the carrier subsequently refused to pay the "vocational services-related" attorney fee, claimant requested a hearing.

The Board held that authority to consider the vocational services-related matter rested with WCD. Citing ORS 656.283(1), and ORS 656.704(1), the Board stated that the Hearings Division and Board generally have jurisdiction over "matters concerning a claim," which are defined as "matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue." Referring to ORS 656.704(3)(a), the Board noted that "matters concerning a claim" do not include any disputes arising under ORS 656.340. Relying on ORS 656.340(16)(b), the Board observed that a claimant must request Director review regarding any vocational assistance dispute. Finally, based on ORS 656.385(1) and OAR 436-120-0008(1), (9), the Board summarized that an attorney fee is authorized when a claimant's attorney has been instrumental in settling a vocational service dispute prior to a Director decision and that the Director may issue a "letter of agreement" that may include an agreement to pay an attorney fee.

"Matters concerning a claim," for purposes of requesting a hearing with WCB, do not include vocational services disputes under "340."

Turning to the case at hand, the Board acknowledged claimant's contention that, because of the need to interpret the CDA, jurisdiction rested with the Board, rather than WCD. Yet, referring to *Jordan v. Brazier Forest Prods.*, 152 Or App 15, 20 (1998), the Board explained that the nature of the necessary *determination* (i.e., interpreting the CDA) did not change the nature of the *proceeding* (i.e., a request for an attorney fee for a vocational service that is not a "matter concerning a claim" under ORS 656.283(1) and ORS 656.704(3)(a)).

Jurisdiction over dispute concerning attorney fee related to “vocational services” matter rested with WCD.

Furthermore, referring to *Ronald C. Faust*, 8 CCHR 196 (2013), the Board noted that WCD had previously interpreted the provisions of a CDA while resolving a vocational assistance dispute. Under such circumstances, the Board concluded that resolution over the “vocational service-related” attorney fee dispute rested with WCD. Consequently, the Board dismissed claimant’s hearing request and transferred the matter to WCD. See ORS 656.704(5); *Harry L. Rumer*, 69 Van Natta 536, 539 (2017).

Premature Closure: “NOC” Found Invalid - “Updated Notice of Acceptance” Violated “030-0015” - Included “Conditional” in Title

William Hoffnagle, 70 Van Natta 688 (May 31, 2018). Analyzing OAR 436-030-0015(1)(c)(A)(i), the Board found no error in an Order on Reconsideration’s rescission of a Notice of Closure (NOC), which had been based on the carrier’s updated acceptance notice that had been titled “conditional” because such a title had not strictly complied with the administrative rule. While seeking judicial review of a Board order setting aside its claim denial, the carrier issued an updated acceptance notice that was titled “conditional” and closed the claim. Following claimant’s request for reconsideration, the Appellate Review Unit (ARU) rescinded the NOC because the acceptance notice did not comply with OAR 436-030-0015(1)(c)(A)(i), which expressly requires the title of an acceptance notice to be titled “Updated Notice of Acceptance at Closure.” The carrier requested a hearing contesting ARU’s determination, while claimant sought penalties and attorney fees for unreasonable claim processing.

The Board affirmed ARU’s rescission of the NOC and granted claimant’s penalty/attorney fee request. Citing *Paniagua v. Liberty Northwest Ins. Corp.*, 122 Or App 288, 289 (1993), the Board stated that strict compliance with an administrative rule is required for claim closure. Relying on *SAIF v. Robertson*, 120 Or App 1, 5 (1993), the Board noted that, when an administrative rule requires the carrier to follow a certain procedure, substantial compliance with the requirement is not sufficient.

The Board further observed that OAR 436-030-0015(1)(c)(A)(i) specifically requires an Updated Notice of Acceptance at Closure to be titled “Updated Notice of Acceptance at Closure.” In addition, the Board commented that the administrative rule allows the carrier to list the accepted conditions and designate any conditions that are “under appeal.” See OAR 436-030-0015(1)(c)(A)(ii).

Turning to the case at hand, the Board determined that the carrier’s “Conditional Updated Notice of Acceptance at Closure” did not comply with OAR 436-030-0015(1)(c)(A)(i). Given such circumstances, the Board found no error in ARU’s rescission of the NOC as invalid.

In reaching its conclusion, the Board acknowledged the carrier’s need to protect its rights while processing the claim during its appeal of the underlying litigation decision. See *SAIF v. Mize*, 129 Or App 636 (1994); *Nancy E. Eggert*, 69 Van Natta 791, 794 (2017); *Valerie Barbeau*, 49 Van Natta 1189 (1997). Yet, the Board reasoned that OAR 436-030-0015(1)(c)(A)(ii) expressly allows a carrier

WCD rule allows acceptance notice to designate any conditions that are “under appeal,” but title of the notice cannot include “conditional.”

Because carrier's acceptance notice did not strictly comply with WCD rule, its claim processing was unreasonable.

to separately designate in its acceptance notice any conditions that remain under appeal (in the "information," rather than the "title," section of the acceptance notice).

Finally, based on the unambiguous requirements of the administrative rule, the Board concluded that the carrier's claim processing had been unreasonable. See *Gary W. Fallis, Jr.*, 69 Van Natta 1734, 1738 (2017). Consequently, relying on *Walker v. Providence Health Sys.*, 254 Or App 676, 684 rev den, 353 Or 714 (2013), and *Jose L. Olvera-Chavez*, 67 Van Natta 1455, 1456 (2015), the Board awarded a penalty under ORS 656.268(5)(f) based on the compensation ultimately determined by a subsequent Notice of Closure or final appellate decision from such a closure notice, as well as an attorney fee pursuant to ORS 656.382(1).

Reconsideration Proceeding: "Med Stat" Date in NOC Raised, But Not TTD Award - No ARU Error in Only Addressing "Med State" Date, But Affirming TTD Award - Carrier Entitled to Recover TTD "Overpayment," Despite "Med Stat" Date Modification

Jared L. Bledsoe, 70 Van Natta 608 (May 9, 2018). Analyzing OAR 436-030-0115(7), the Board held that, because claimant's request for reconsideration of a Notice of Closure (NOC) had only raised the "medically stationary date" determination in the NOC, the Appellate Review Unit (ARU) had not erred in affirming the NOC's temporary disability (TTD) award (which granted such benefits to the "medically stationary" date as found by the NOC). As such, the carrier was entitled to recover as an overpayment the TTD benefits paid after the NOC's "medically stationary" date (even though the reconsideration order had extended the NOC's "medically stationary" date forward for an additional 18 months). After issuing a NOC, the carrier notified claimant of its intent to recover an overpayment of TTD benefits paid beyond the "medically stationary" date determined by the NOC. In requesting reconsideration, claimant contended that the claim was prematurely closed, challenged the NOC's "medically stationary date" determination, and, alternatively, sought an increased permanent impairment award. The Order on Reconsideration did not rescind the NOC as premature, modified the "medically stationary date" to a date some 18 months after the date determined by the NOC, and affirmed the NOC's TTD and permanent impairment awards. Claimant requested a hearing, asserting that he was entitled to TTD benefits payable until the "medically stationary date" found by the Order on Reconsideration and, as such, the carrier was not entitled to an offset because there had not been an overpayment.

The Board disagreed with claimant's assertion. Citing ORS 656.268(14)(a), the Board stated that a carrier "may offset any compensation payable to the worker to recover an overpayment from a claim with the same insurer or self-insured employer." Relying on *SAIF v. Coburn*, 159 Or App 413, 419, rev den, 329 Or 527 (1999), the Board observed that an overpayment occurs

Because claimant's request for reconsideration of NOC raised only "medically stationary" date (and not TTD), ARU did not err in not modifying TTD award when it modified "med stat" date.

when an amount is paid in excess of the compensation to which the worker is entitled. Referring to *Chester J. Dzienies, Jr.*, 66 Van Natta 1090, 1092 (2014), the Board reiterated that, when a reconsideration order modified a medically stationary date, but did not alter a TTD award, there was no entitlement to additional TTD benefits when the reconsideration order became final. The Board added that, when a reconsideration order modifies the "medically stationary date" determined in a NOC, but neither reduces the TTD award nor authorizes an offset based on the modified "medically stationary date," the carrier is responsible for the TTD benefits granted in the NOC. See *Annette M. Lane*, 69 Van Natta 1537 (2017).

Turning to the case at hand, the Board acknowledged that the "medically stationary date" determination prescribed in the NOC had been modified by the Order on Reconsideration to a date beyond that granted in the NOC. Nonetheless, the Board reasoned that claimant had not raised and the reconsideration order had not addressed the TTD issue. Relying on OAR 436-030-0115(7), the Board noted that, during the reconsideration proceeding, ARU "will review those issues raised by the parties and the requirements under ORS 656.268(1)." Under such circumstances, the Board found no error in ARU's affirmance of the NOC TTD award. See ORS 656.268(9); ORS 656.283(6); *Marvin Wood Prods. v. Callow*, 171 Or App 175, 183 (2000).

Furthermore, the Board concluded that, because the reconsideration order did not modify the NOC's TTD award, and the TTD issue raised by claimant at hearing did not arise from the reconsideration order, he was not entitled to the additional TTD benefits he was requesting. Likewise, the Board determined that the carrier was authorized to offset the TTD benefits that were paid beyond the "medically stationary" date listed in the NOC. See *Steve Meadows*, 67 Van Natta 1598, 1598 n 1 (2015).

Standards: Work Disability - Claimant Was "Released to Regular Work" - Record Did Not Establish That "Job Description" Represented "Regular Work" That Claimant Performed

Ralph T. Nisbet, 70 Van Natta 576 (May 1, 2018). Applying ORS 656.214(1)(d) and OAR 436-035-0005(15), the Board held that claimant was not entitled to a work disability award because he had been released to his "regular work," which the record established was as a "flagger," rather than as a maintenance worker as detailed in a job description. Although injured while performing the duties of a flagger, claimant's job title was an operations maintenance worker (OMW), which included a wide range of duties including "heavy" manual labor. Following an evaluation of his work capacity, claimant was released to the "full range of medium activities," subject to small positional changes to reduce weight bearing through his lower extremity. His attending physician released him to medium/light range work, noting that there were no work restrictions needed for his flagger job. After an Order on Reconsideration

affirmed a Notice of Closure that declined to award work disability, claimant requested a hearing. Asserting that the attending physician's work release was not consistent with the OMW job description and arguing that his need to make small positional changes prevented him from returning to his flagger job, claimant contended that he was entitled to a work disability award.

The Board disagreed with claimant's contentions. Citing ORS 656.214(2)(a) and ORS 656.726(4)(f)(E), the Board stated that claimant's entitlement to a work disability award depended on whether he returned to, or was released by his attending physician to return to, regular work. Referring to ORS 656.214(1)(d) and OAR 436-035-0005(15), the Board noted that "regular work" means the job that claimant held at injury. Relying on *Tyrel Albert*, 66 Van Natta 1212 (2014) the Board noted that whether claimant was released to regular work was based on evidence in the record, including medical records describing the work that he was performing when he was injured, his own description of his work history, the employer's regular duty job description, and the evidence regarding his post-injury physical capacity.

Turning to the case at hand, the Board acknowledged that the OMW job description referred to a wide range of job duties, some of which required the ability to perform "heavy" tasks. The Board further recognized claimant's assertion that he held the job title of an OMW at the time of his injury. Nonetheless, after conducting its review, the Board determined that, although claimant's duties fell within the OMW job description, the record established that his actual work activities were more limited than the OMW job description (*i.e.*, the record did not support a conclusion that he regularly performed work duties other than those of a flagger). Under such circumstances, the Board concluded that claimant had not established error in the reconsideration order's determination that he was not entitled to a work disability award because he had been released to return to his regular work. See *Marvin Wood Prods. v. Callow*, 171 Or App 175, 183-84 (2000).

Although job description referred to wide range of duties, record established that actual work activities involved less physical duties.

No ARU error in determining claimant returned to regular work.

APPELLATE DECISIONS UPDATE

Claim Preclusion: Disc Claim for "Protrusion" Precluded By Prior Litigation - But Disc "Bulge" Not Previously Litigated, Not Precluded

Fred Meyer Stores, Inc. v. DeBoard, 291 Or App 742 (May 16, 2018). The court reversed the Board's order in *Barbara J. DeBoard*, 67 Van Natta 909 (2015), previously noted 34 NCN 5:2, which had held that claimant's new/omitted medical condition claim for disc "bulges" was compensable. In reaching its conclusion, the Board had determined that, although claimant was precluded by a prior litigation order from bringing her disc "protrusions" claim (which had found that the claimed "protrusions" did not exist), she was not precluded from bringing a "bulges" claim because its alternative reasoning in the previous decision that the "claimed conditions" (whether "protrusions" or "bulges") would not be compensable had not been essential to the outcome of the first litigation.

Conclusion that earlier litigation decision was limited to non-existence of claimed “protrusions” (and discussion of “compensability” issue was not “essential” to outcome) was reasonable--thus, current “protrusion” claim not precluded.

Furthermore, addressing the compensability of the claimed “bulges,” the Board had not explicitly decided whether claimant had suffered a “combined condition,” but had applied the Court of Appeals rationale expressed in *Brown v. SAIF*, 262 Or App 640 (2014).

On appeal, the court rejected the carrier’s contention that claimant’s new/omitted medical condition for the disc bulges was barred by issue preclusion. Referring to its earlier decision (*DeBoard v. Fred Meyer*, 285 Or App 732, 739, n 1, *rev den*, 361 Or 885 (2017)), the court noted that it had affirmed the Board’s finding in its earlier decision, which had determined that because the “claimed conditions” were for “protrusions” and the persuasive medical evidence established the existence of “bulges,” she had not proven the existence of the “claimed conditions” for “which she had sought compensation.” The court further observed that, in affirming the prior Board decision, it had not addressed claimant’s challenge to the Board’s additional determination that “[e]ven assuming that claimant established the existence of the claimed conditions,” she had not proven that they were compensable. *Id.* Under such circumstances, and assuming that the earlier litigation order would be given preclusive effect (see *Evangelical Lutheran Good Samaritan Soc. v. Bonham*, 176 Or App 490, 498 (2001), *rev den*, 334 Or 75 (2002)), the court considered the Board’s conclusion in the present case that the earlier litigation order was limited to the non-existence of the claimed “protrusions” (and that its prior alternative resolution of the compensability of the “claimed conditions” had not been “essential” to the outcome) to be a reasonable one.

However, turning to the Board’s compensability analysis of the “bulges” claim, the court noted that the Board had applied the rationale expressed in the Court of Appeals opinion in *Brown*, which had interpreted “otherwise compensable injury” in ORS 656.266(2)(a) as “work-related injury incident.” Noting that the Supreme Court had subsequently reversed the Court of Appeals opinion (*Brown v. SAIF*, 361 Or 241 (2017)), the court remanded to the Board for reconsideration under the standard described in the Supreme Court’s opinion.

APPELLATE DECISIONS COURT OF APPEALS

Attorney Fee: “308(2)(d)” - Subsequent “Encompassed” Amendment to Responsibility Denial - Rescission of Initial “Claim” Denial

Hartvigsen v. SAIF, 291 Or App 619 (May 9, 2018). Analyzing ORS 656.308(2)(d), the court reversed a Board order that held that claimant’s counsel was not entitled to an attorney fee when, after an initial carrier (with a previously accepted bilateral wrist sprain claim) issued a denial of claimant’s bilateral deQuervain’s tenosynovitis (on the basis that it was a new condition for which a subsequent carrier was responsible), the initial carrier ultimately acknowledged its responsibility for the condition by amending its denial to state that the claimed condition was encompassed within its previous wrist sprain acceptance. In reaching its conclusion, the Board had reasoned that: (1) because the claimed tenosynovitis was encompassed within the original wrist sprain acceptance, the responsibility issue was moot; and (2) because the

carrier's denial of the new/omitted medical condition claim was upheld (because the claimed tenosynovitis was neither "new" nor "omitted"), no attorney fee award under ORS 656.308(2)(d) was justified. On appeal, claimant argued that the carrier's subsequent acknowledgment that the claimed tenosynovitis was encompassed within its previous wrist sprain acceptance was, in effect, a rescission of its initial responsibility denial and, as such, entitled claimant to an attorney fee award under ORS 656.308(2)(d) for prevailing over that denial.

The court agreed with claimant's contention. Citing ORS 656.308(2)(d), the court noted that a reasonable attorney fee shall be awarded to the attorney for the injured worker for the attorney's appearance and active and meaningful participation in finally prevailing against a responsibility denial. Relying on *SAIF v. Stephens*, 247 Or App 107, 113 (2011), and *Crawford v. SAIF*, 241 Or App 470 (2011), the court stated that the compensability of a new/omitted medical condition claim may be denied on the basis that the claimed condition is neither "new" nor "omitted"; *i.e.*, it is encompassed in the original claim acceptance.

Turning to the case at hand, the court found no error in the Board's determination that the claimed tenosynovitis was neither a "new" nor "omitted" medical condition, but rather was "one in the same" with the previously accepted wrist sprain. However, the court disagreed with the Board's conclusion that claimant was not entitled to an attorney fee under ORS 656.308(2)(d).

Had the carrier's initial denial been based on the proposition that the claimed new/omitted medical condition was encompassed within the original acceptance, the court reasoned that claimant would have been assured that the carrier was responsible for the condition and that she would not need to pursue litigation. Under such circumstances, the court reiterated that, pursuant to *Stephens* and *Crawford*, there would have been no entitlement to an attorney fee award.

Nonetheless, unlike the *Stephens/Crawford* scenarios, the court determined that, in the present case, the carrier had not initially asserted that the claimed condition was encompassed within the original acceptance, but rather had asserted that the condition was the responsibility of another carrier. Because the carrier ultimately acknowledged its responsibility for the claimed condition (by amending its initial denial to assert that the claimed condition was neither "new" nor "omitted," but rather encompassed within its original acceptance), the court reasoned that the practical effect of the carrier's amended denial was to rescind its initial responsibility denial, thereby entitling claimant to benefits from the carrier for the claimed tenosynovitis condition.

Consequently, the court concluded that claimant had "finally prevail[ed] against a responsibility denial," entitling her counsel to an attorney fee under ORS 656.308(2)(d) for efforts expended in causing the carrier to acknowledge its responsibility for the claimed condition. Accordingly, the court remanded to the Board for an attorney fee award pursuant to ORS 656.308(2)(d).

Because carrier amended initial denial to assert that the claimed condition was encompassed within original acceptance, claimant entitled to "308(2)(d)" attorney fee for prevailing over initial denial (which had denied any responsibility for the claimed condition).

Combined Condition: “Otherwise Compensable Injury” Equates With “Accepted Condition”

Carrillo v. SAIF, 291 Or App 589 (May 2, 2018). The court, *per curiam*, vacated the Board’s order in *Mario Carrillo*, 67 Van Natta 1197 (2015), that upheld a carrier’s injury denial of claimant’s left shoulder condition, finding that claimant’s work-related injury incident had combined with a preexisting condition and that the injury incident was not the major contributing cause of his need for treatment/disability for the combined condition. In reaching its decision, the Board had relied on the reasoning expressed in *Brown v. SAIF*, 262 Or App 640 (2014) that the “work related injury/incident” constitutes an “otherwise compensable injury” under ORS 656.005(7)(a)(B).

Citing the Supreme Court’s decision in *Brown* (361 Or 241, 261 (2017)), the court stated that an “otherwise compensable injury” for purposes of ORS 656.005(7)(a)(B) equates with an “accepted condition.” Reasoning that the Court of Appeals’ opinion in *Brown* had been central to the Board’s analysis, the court remanded for reconsideration in light of the Supreme Court’s opinion.

Extent: Impairment Findings - “Apportionment”

Nunn v. LTI, Inc. - Lynden, Inc., 291 Or App 839 (May 16, 2018). The court, *per curiam*, affirmed the Board’s order in *Dustin L. Nunn*, 67 Van Natta 1693 (2015), that had affirmed Orders on Reconsideration, which in rating claimant’s permanent due to his compensable injury, had applied the “apportionment” rule under OAR 436-035-0013. The court cited *Brown v. SAIF*, 361 Or 241 (2017), and *McDermott v. SAIF*, 286 Or App 406 (2017).

Occupational Disease: Based on “Gradual Onset” of “Condition” - Claimed “Symptoms” Were Due to a “Condition”

Jewell v. SAIF, 291 Or App 703 (May 16, 2018). The court affirmed the Board’s order in *Liska I. Jewell*, 68 Van Natta 1746 (2016), that upheld a carrier’s denial of claimant’s elbow claim. In reaching its conclusion, the Board had determined that, based on medical evidence that claimant’s condition had developed over time, the claim should be analyzed as an occupational disease (rather than as an “injury” as advanced by claimant) and, because the evidence did not establish that her work activities were the major contributing cause of her elbow condition (or its worsening), the claim was not compensable. On appeal, claimant contended that, irrespective of the conditions underlying her symptoms, her work event constituted a compensable injury because her work incident (experiencing elbow symptoms while working as a sign language interpreter) was a material cause of her need for medical treatment.

The court disagreed with claimant's contention. Citing *DiBrito v. SAIF*, 319 Or 244, 248 (1994), the court stated that it is within the Board's authority to determine that a claim brought on an "injury" theory is properly characterized as an "occupational disease." Relying on *Luton v. Willamette Valley Rehabilitation Center*, 272 Or App 487, 490 (2015), and *Smirnoff v. SAIF*, 188 Or App 438, 449 (2003), the court reiterated that, when the medical evidence identifies a condition causing the claimant's symptoms and establishes that the condition developed gradually over time, the claimant has not experienced an injury, and the claim must be analyzed as an occupational disease.

Although claimant pursued "injury" theory, Board must determine whether claimed symptoms had their origin in an "injury" or "occupational disease."

Turning to the case at hand, the court acknowledged that claimant had not pursued an "occupational disease" theory in asserting her elbow claim. Nonetheless, the court reasoned that claimant's pursuit of the "injury" theory did not obviate the need for the Board to determine whether the symptoms for which she sought compensation had their origin in an "injury." After conducting its review, the court determined that the medical evidence supported the Board's finding that claimant's symptoms were caused by preexisting elbow/shoulder conditions.

When symptoms are caused by a condition that gradually develops, claim is subject to "occupational disease" analysis.

The court recognized that claimant need not establish a "condition" to obtain compensation. However, based on the *Luton* rationale, the court reasoned that, when symptoms are caused by a condition that has gradually developed, a claim is subject to an "occupational disease" analysis.

Finally, referring to *Million v. SAIF*, 45 Or App 1097, 1103, *rev den*, 289 Or 337 (1980), the court stated that a claimant does not need to elect a particular theory of a claim and can have both an occupational disease and an injury. Nevertheless, explaining that to prevail on such a claim there must be evidence in support of the claimant's chosen theory, the court held that the medical evidence in the present record required the conclusion that claimant's medical services were for "diseases" (medial epicondylitis and ulnar neuropathy), rather than an "injury."

Substantial Evidence/Reasoning: Board's Own Motion Order - Finding That "AP" Opinion (Which Referred to "Age/Education") Did Not Establish That Claimant Was "Completely Physically Disabled" for "PTD" Purposes - Not Supported by "Substantial Evidence/Reasoning"

Guild v. SAIF, 291 Or App 793 (May 16, 2018). Applying ORS 656.206(1)(d), the court reversed the Board's Own Motion order in *Timothy C. Guild*, 68 Van Natta 741 (2016), which had held that claimant was not entitled to a permanent total disability (PTD) award for his "post-aggravation

rights” new/omitted medical condition (right shoulder traumatic arthritis). In reaching its conclusion, the Board had reasoned that, because the attending physician took into account claimant’s age and education in opining that claimant was PTD, the record did not establish that he was completely *physically* disabled. Reviewing for substantial evidence/reasoning, the court determined that the Board’s finding was not supported by substantial evidence and that, because the Board did not adequately explain its reasons for rejecting the physician’s opinion, the Board’s order lacked substantial reasoning. See ORS 656.298; ORS 183.482(7), (8); *Elsea v. Liberty Mutual Ins.*, 273 Or App 475, 476 (2016).

Citing ORS 656.206(1)(d), the court stated that “permanent total disability” is defined as “the loss, including preexisting disability, of use or function of any portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation.” Relying on *Clark v. Boise Cascade Corp.*, 72 Or App 397, 399 (1985), the court reiterated that a claimant may establish PTD by proving that: (1) he is completely physically disabled and thus precluded from gainful and suitable employment; or (2) if he is capable of performing some work, he is nonetheless PTD due to a combination of his physical condition and certain non-medical factors, such as age, education, and mental capacity.

Turning to the case at hand, the court observed that, in concluding that claimant had not established his entitlement to PTD benefits, the Board order had exclusively focused on the physician’s concurrence with the statement that “[g]iven his age, educational background and his injury you do not believe there are any jobs out there he could do.” Yet, noting a number of other reasons for the physician’s PTD opinion (e.g., continuing deterioration of his shoulder condition; narcotics prescription preventing his concentration at work), the court reasoned that the physician’s references to claimant’s age and education were surplusage and immaterial to the physician’s PTD opinion.

In any event, at a minimum, the court determined that the Board should have considered the balance of the physician’s concurrence letter before interpreting the physician’s opinion as it had. Moreover, referring to the physician’s early chart notes (which repeatedly stated that claimant was “completely disabled” and that “distracting pain making other work impossible”), the court observed that such evidence could not be viewed as tying claimant’s inability to work to matters other than his physical condition.

Under such circumstances, the court concluded that, rather than viewing the record as a whole, the Board had focused on the physician’s isolated statement in a single exhibit. Furthermore, the court reasoned that the Board had not acknowledged other evidence (including the physician’s opinion that claimant was completely physically disabled) and, as such, had not adequately explained why such an opinion was rejected. Consequently, determining that the Board’s order was not supported by substantial reason, the court remanded.

“PTD” may be established by: (1) complete physical disability; or (2) “odd-lot” doctrine (combination of physical and non-medical factors).

Because Board order had focused on isolated statement in single exhibit (without acknowledging other evidence), remand warranted.