



News & Case Notes

BOARD NEWS

Biennial Review/Attorney Fees/"388(4)" 1

August 23 Board Meeting - "Subpoena" for Obtaining "Individual Identifiable Health Information" - Notice to Recipient/Timely Objection - "007-0020(6)(b)" 1

CASE NOTES

Attorney Fee: "Responsibility" Denial - "308(2)(d)" - "Statutory Maximum" Award Cumulative - For Services Provided at All Litigation Levels - "Extraordinary Circumstances" Must Be Raised at Hearing Level 2

Claim Processing: Prior Litigation Order Found Claimed Conditions "Encompassed" W/I Previously Accepted/Processed Condition - Carrier Not Required to Reopen/Re-Close Claim - "262(7)(c)" 3

Extent: Impairment Findings - Arbiter Findings Ambiguous (Appeared to Consider Denied Degenerative Condition) - "AP-Ratified" Findings "More Accurate" - "035-0007(1), (5)" 4

Penalty: "268(5)(g)" - Recon Order's "Work Disability" Award Based on "Info" Carrier Could Not Reasonably Have Know at Claim Closure - "AP" Had Provided "Pre-Closure" Release to "At Injury" Job, Which Changed "Post-Closure" 6

Standards: Work Disability - Claimant Unable to Perform All "Regular Work" Duties - One of the "Functions/Tasks" of Her Job - Performed on "Steady or Customary" Basis - "214(1)(d), (2)(a)", "035-0005(15)" 7

Subject Worker: Gestational Carrier For Surrogacy Center - Center Did Not Provide Remuneration for Services, Did Not Have Right to Control Carrier's Activities 8

TTD: "325(5)(a)" - Carrier's Conversion of TTD Benefits to TPD Benefits Unreasonable - AP "Modified Job" Approval Had Been Retracted 10

BOARD NEWS

Biennial Review/Attorney Fees/"388(4)"

As the Board begins its biennial review of its schedule of attorney fees under ORS 656.388(4), it is seeking written comments from parties, practitioners, and the general public. Those written comments should be directed to Kayleen Atkins, WCB's Executive Secretary at 2601 25th St. SE, Ste. 150, Salem, OR 97302, kayleen.r.atkins@oregon.gov, or via fax at (503)373-1684. The deadline for these comments is October 31, 2018.

These written comments will be posted on WCB's website. The comments will be compiled and presented for discussion at Board meetings, where the Members will also consider public testimony. In establishing its attorney fee schedules, the Members shall also consult with the Board of Governors of the Oregon State Bar, as well as consider the contingent nature of the practice of workers' compensation law, the necessity of allowing the broadest access to attorneys by injured workers and shall give consideration to fees earned by attorneys for insurers and self-insured employers. See ORS 656.388(4), (5).

Announcements regarding Board meetings will be electronically distributed to anyone who has registered for these notifications at <https://service.govdelivery.com/accounts/ORDCBS/subscriber/new>.

August 23 Board Meeting - "Subpoena" for Obtaining "Individual Identifiable Health Information" - Notice to Recipient/Timely Objection - "007-0020(6)(b)"

At its August 23 meeting, the Board Members discussed a proposed rule concept, which was presented by Marcia Alvey, Attorney at Law. The concept involves OAR 438-007-0020(6), which concerns obtaining "individual identifiable health information" through a subpoena. Specifically, the concept suggests including in OAR 438-007-0020(6)(b) the language prescribed in OAR 438-007-0020(6)(f) (which requires including in the subpoena a notice to the recipient that, if it receives a timely objection from the individual whose information is being subpoenaed, the information being sought shall be mailed to the Board's Salem office).

After discussing the concepts and considering comments from the public and its staff presented at the meeting, the Members decided to refer this matter to an advisory committee. After that committee completes its review of the concept and issues an advisory report, a Board meeting will be scheduled, at

APPELLATE DECISIONS**Court of Appeals**

Combined Condition: "Ceases" Denial ("262(6)(c)") - "Otherwise Compensable Injury" (Accepted Condition) 11

Medical Services: Medication Related to "DCS'd" Nerve Pain, Not Due to Accepted Disc Herniation - "245(1)(a)" 12

Responsibility: "308(1)" N/A - Claimed Condition Not "Same Condition" as Previously Accepted Condition - Claim Analyzed as "Initial" Occupational Disease ("802(2)(a)") 13

Carrier amended responsibility denial to state condition was encompassed within prior claim acceptance.

"308(2)(d) maximum attorney fee is cumulative; encompasses all litigation levels.

Claimant did not raise "extraordinary circumstances" at hearing level.

which time the Members will discuss this concept and report, along with any public comments. Thereafter, the Members will decide whether an amendment to the rule is appropriate.

CASE NOTES

Attorney Fee: "Responsibility" Denial - "308(2)(d)" - "Statutory Maximum" Award Cumulative - For Services Provided at All Litigation Levels - "Extraordinary Circumstances" Must Be Raised at Hearing Level

Melissa Hartvigsen, 70 Van Natta 904 (August 3, 2018). Applying ORS 656.308(2)(d), in awarding claimant's counsel a carrier-paid attorney fee for finally prevailing over a carrier's responsibility denial, the Board did not grant an "extraordinary" fee beyond the statutory maximum for services at all litigation levels because claimant had not raised the "extraordinary circumstances" issue at the hearing level. Before a hearing regarding a carrier's responsibility denial, the carrier amended its denial to state that the claimed condition was encompassed within its prior acceptance. When the Board did not award an assessed fee under ORS 656.308(2)(d), claimant petitioned for judicial review. Reasoning that the carrier had ultimately acknowledged its responsibility for the claimed condition (by amending its denial to concede that the claimed condition was encompassed within its original acceptance), the court concluded that claimant had "finally prevailed" against a responsibility denial and remanded for a determination of a reasonable attorney fee. *Hartvigsen v. SAIF*, 291 Or App 619 (2018).

Citing ORS 656.308(2)(d), OAR 438-015-0038, and Bulletin 1-2018, the Board stated that, absent a showing of extraordinary circumstances, a fee awarded for an attorney's appearance and active and meaningful participation in finally prevailing against a responsibility denial shall not exceed \$3,186. Relying on *Liberty Northwest Ins. Corp. v. Gordineer*, 150 Or App 136, 141-42 (1997), and *Tammy Locke*, 48 Van Natta 250 (1996), the Board reiterated that the maximum attorney fee under ORS 656.308(2)(d) is cumulative and encompasses all litigation levels. Finally, referring to *Jerry F. Durant*, 65 Van Natta 1182 (2013), *aff'd SAIF v. Durant*, 271 Or App 216 (2015), the Board noted that the "extraordinary circumstances" issue will not be considered unless it is raised at the hearing level.

Turning to the case at hand, the Board found that claimant had not contended at the hearing level that extraordinary circumstances existed to award an attorney fee in excess of the statutory maximum. In the absence of such a contention, the Board declined to consider an "extraordinary circumstances" issue. In any event, the Board did not consider the record sufficient to support a finding of "extraordinary circumstances" warranting an attorney fee in excess

of the statutory maximum fee. See *Jeff R. Lutz*, 69 Van Natta 1562 (2017). Accordingly, the Board awarded an attorney fee equal to the statutory maximum for claimant's counsel's services at all levels of litigation.

Claim Processing: Prior Litigation Order Found Claimed Conditions “Encompassed” W/I Previously Accepted/Processed Condition - Carrier Not Required to Reopen/Re-Close Claim - “262(7)(c)”

Randy G. Simi, 70 Van Natta 929 (August 7, 2018). Analyzing ORS 656.262(7)(c), the Board held that a carrier was not obligated to reopen claimant's injury claim following a prior litigation order because the order had determined that conditions (which claimant had initiated as “new/omitted”) were encompassed within a previously accepted condition (which had already been processed to claim closure) and the prior litigation order had not directed the carrier to further process the conditions. Several years after the carrier had accepted and processed the claim to closure for shoulder, rotator cuff tear, and wrist conditions, claimant initiated a new/omitted medical condition claim for supraspinatus and infraspinatus tendon tears. After the carrier denied the compensability of the conditions, claimant requested a hearing. At this previous hearing, the carrier contended that the conditions were encompassed within the already accepted rotator cuff tear condition. A prior ALJ agreed with the carrier's contention. However, the prior ALJ still set aside the carrier's denial, but, in doing so, expressly stated the claimed conditions “remain encompassed with[in] the accepted rotator cuff tear claim.” The prior ALJ's order also did not remand the claim to the carrier for further processing according to law. Thereafter, while the carrier's appeal of the prior ALJ's order was pending, claimant requested another hearing, asserting that it was required to process the new/omitted medical condition claim to closure under ORS 656.262(7)(c).

The Board disagreed with claimant's assertion. Citing ORS 656.262(7)(c), the Board stated that when a condition is found compensable after claim closure, the carrier must reopen the claim for processing regarding that condition. However, relying on *Akins v. SAIF*, 286 Or App 70, 74 (2017), the Board noted that a carrier is not required to “reaccept a condition that, as a factual matter, already has been accepted.” See ORS 656.267.

Turning to the case at hand, the Board acknowledged that the prior ALJ's order had set aside the carrier's compensability denial. Nevertheless, noting that the prior ALJ's order (as well as the Board order affirming the prior ALJ's decision) had expressly determined that the claimed conditions were encompassed within the already accepted condition, the Board reasoned that the claimed conditions were neither “new” nor “omitted.”

Prior ALJ set aside denial, but found claimed conditions encompassed within prior accepted claim and did not remand claim for further processing.

Because prior ALJ determined conditions were encompassed in acceptance, they were not new/omitted.

Claimed conditions were not “found compensable” after claim closure; carrier’s claim processing obligations under “262 (7)(c)” not triggered.

Under such circumstances, the Board concluded that the claimed conditions were not “found compensable” after claim closure, but rather were compensable as of the original claim acceptance. Consequently, the Board held that any claim processing obligations under ORS 656.267 and ORS 656.262(7)(c) had not been triggered.

In reaching its conclusion, the Board recognized claimant’s arguments that, under *Tattoo v. Barrett Bus. Serv.*, 118 Or App 348, 351 (1993), the language of the carrier’s initial compensability denial of the claimed conditions should control and that the *Akins* decision had not involved the compensability of a disputed claim. Nonetheless, the Board did not consider such assertions determinative, emphasizing that the prior litigation orders had set aside the carrier’s denial on the express finding that the claimed conditions were encompassed within the previously accepted condition and had not remanded the claim to the carrier for further processing.

Because carrier initially denied compensability of claimed conditions, dissent argued it must reopen/process condition when denial is set aside.

Member Lanning dissented. Noting that the carrier had also denied the claimed conditions on the explicit basis that they were not compensable (*i.e.*, that claimant’s work injury had not “materially cause[d]” the conditions or that they had not “otherwise arose out of and in the course of” his employment), Lanning considered the claimed conditions to have been “found compensable” after claim closure by virtue of the earlier ALJ/Board orders. Under such circumstances, even though the prior orders had not remanded the claim for further processing, Member Lanning contended that the carrier was not absolved from its statutory obligation to reopen the claim for further processing under ORS 656.262(7)(c).

Extent: Impairment Findings - Arbiter Findings Ambiguous (Appeared to Consider Denied Degenerative Condition) - “AP-Ratified” Findings “More Accurate” - “035-0007(1), (5)”

Before claim closure, carrier accepted/denied a combined condition.

Richard K. Moffat, 70 Van Natta 990 (August 28, 2018). Applying OAR 436-035-0007(5), the Board held that claimant was not entitled to a permanent impairment award for his accepted low back strain because the impairment findings of his attending physician (who had concurred with a physician’s findings that attributed claimant’s impairment to a preexisting degenerative condition, which had been denied prior to claim closure) to be more accurate than the findings from a medical arbiter (whose findings had been based on both the strain and preexisting degeneration as accepted conditions). Before closure of claimant’s accepted lumbar strain, the carrier accepted, and then denied, a combined condition of lumbar strain combined with preexisting lumbar spondylosis. After claimant’s attending physician ratified another physician’s findings (which attributed no permanent impairment to claimant’s lumbar strain), a Notice of Closure awarded no permanent disability award. Following claimant’s request for reconsideration, a medical arbiter found reduced range of motion in claimant’s lumbar spine due to his “accepted conditions” (“lumbar

strain with preexisting spondylosis”). After an Order on Reconsideration awarded permanent impairment based on the arbiter’s findings, the carrier requested a hearing, contending that the attending physician-ratified impairment findings were more accurate than the arbiter’s findings.

The Board agreed with the carrier’s contention. Citing OAR 436-035-0007(5), and *SAIF v. Owens*, 247 Or App 402, 414-15 (2011), *recons*, 248 Or App 746 (2012), the Board stated that impairment is based on objective findings of the medical arbiter, except where a preponderance of the medical evidence demonstrates that different findings by the attending physician, or findings with which the attending has concurred, are more accurate and should be used. Relying on OAR 436-035-0007(1), and *Khrul v. Foreman Cleaners*, 194 Or App 125, 130 (2004), the Board noted that only impairment findings that are permanent and caused by the accepted compensable condition may be used to rate impairment. Finally, referring to *Jonathan E. Ayers*, 56 Van Natta 1103, *recons*, 56 Van Natta 1470, 1471 (2004), the Board reiterated that when a combined condition has been accepted and denied before claim closure, only impairment findings related to the accepted condition and medical sequelae are considered. See also *Marisela Johnson*, 67 Van Natta 1458, *recons*, 67 Van Natta 1666, 1670 n 6 (2015) (consideration of impairment from a denied condition would “short-circuit” the evaluation process for a closed claim).

Turning to the case at hand, the Board found that the medical arbiter had erroneously described claimant’s accepted conditions as “lumbar strain with preexisting spondylosis.” Moreover, the Board noted that the arbiter had not explained what, if any, portion of claimant’s reduced range of motion findings were attributable to the accepted lumbar strain.

Under such circumstances, and in the absence of a clarification from the medical arbiter regarding the scope of claimant’s accepted condition, the Board considered the arbiter’s impairment findings to be ambiguous. Consequently, the Board declined to rely on the arbiter’s findings in rating claimant’s permanent impairment. See *Khrul*, 194 Or App at 130; *John C. Fowler*, 61 Van Natta 2218, 2221-22 (2009).

Instead, the Board found more accurate the impairment findings provided by another examining physician (as ratified by the attending physician), which had attributed claimant’s reduced range of motion in his lumbar spine to his preexisting degenerative condition. Accordingly, based on those impairment findings, the Board concluded that claimant was not entitled to a permanent disability award for his accepted low back strain.

Medical arbiter erroneously included denied preexisting condition in impairment rating; did not apportion “accepted condition-related” impairment.

“AP ratified” findings more accurate.

Penalty: “268(5)(g)” - Recon Order’s “Work Disability” Award Based on “Info” Carrier Could Not Reasonably Have Known at Claim Closure - “AP” Had Provided “Pre-Closure” Release to “At Injury” Job, Which Changed “Post-Closure”

Maria D. Alvarado-Depineda, 70 Van Natta 918 (August 3, 2018).

Analyzing ORS 656.268(5)(g), the Board held that a penalty award was not warranted because the increase in permanent disability benefits granted by an Order on Reconsideration (i.e., the work disability award) resulted from information in an attending physician’s “post-closure” medical reports that the carrier could not reasonably have known at the time of claim closure. Following a closing examination regarding claimant’s shoulder condition, her attending physician had released her to her “at injury” housekeeping job. Subsequently, the attending physician concurred with another physician’s recommendation that claimant not lift over 10 pounds with her right arm and avoid overhead lifting. Nonetheless, the attending physician also concurred with a work capacity evaluation (WCE), which stated that claimant demonstrated the ability to engage in repetitive movement activities and was capable of returning to her “at injury” housekeeping duties. After a Notice of Closure awarded permanent impairment (but no work disability), claimant requested reconsideration, along with “post-closure” report from her attending physician, which provided work restrictions that prevented claimant from performing her regular housekeeping duties. Based on those reports, an Order on Reconsideration awarded work disability benefits. Furthermore, finding that the carrier could reasonably have obtained the “post-closure” information from the attending physician, the reconsideration order also awarded a penalty under ORS 656.268(5)(g). The carrier requested a hearing, contending that the increase in compensation (i.e., the work disability award) was based on information that it could not reasonably have known prior to claim closure.

Before claim closure, “AP” released claimant to “at injury” job.

AP’s “post-closure” report provided work restrictions.

The Board agreed with the carrier’s position. Citing ORS 656.268(5)(g), the Board stated that, if a reconsideration order awards an increase of 25 percent or more from that granted by a Notice of Closure and the claimant is more than 20 percent permanently disabled, a 25 percent penalty shall be assessed. Relying on *Tyrel Albert*, 66 Van Natta 1212, 1219 (2014), and *Scot T. Campbell*, 61 Van Natta 1818, 1832 (2009), the Board reiterated that, under ORS 656.268(5)(g), a penalty award is not warranted when the increased compensation resulted from findings in a “post-closure” medical report that the carrier could not reasonably have known at the time of claim closure.

Because AP provided an accurate job description before claim closure and unambiguously confirmed release to “at injury” job, “post-closure” “AP” restriction was information that carrier could not have reasonably known.

Turning to the case at hand, the Board noted that, before claim closure, the attending physician had been provided an accurate job description, as well as a WCE report and had unambiguously confirmed claimant’s release to her “at injury” housekeeping job in response to the carrier’s “pre-closure” inquiries. Under such circumstances, the Board concluded that the Order on Reconsideration’s increase of permanent disability benefits had resulted from

information that the carrier could not reasonably have known at claim closure. Consequently, the Board held that a penalty under ORS 656.268(5)(g) was not warranted.

In reaching its conclusion, the Board distinguished *Anita Ferrer*, 67 Van Natta 5 (2015), where a penalty under ORS 656.268(5)(g) had been assessed because the carrier had not given a job description to the claimant's attending physician before it closed the claim and a "post-closure" report from the attending physician (based on an accurate job description) had resulted in an Order on Reconsideration's increased award. In contrast to Ferrer, the Board reasoned that, in the present case, before claim closure, claimant's attending physician had been provided an accurate job description, as well as a WCE report and had unambiguously confirmed claimant's release to her "at injury" job.

Standards: Work Disability - Claimant Unable to Perform All "Regular Work" Duties - One of the "Functions/Tasks" of Her Job - Performed on "Steady or Customary" Basis - "214(1)(d), (2)(a)", "035-0005(15)"

Amanda Armato, 70 Van Natta 1022 (August 31, 2018). Analyzing ORS 656.214(1)(d), and OAR 436-035-0005(15), the Board held that claimant was entitled to a work disability award because she had not been released by her attending physician to return to her "at injury" regular work because, although she rarely performed a particular activity at work, it was one of the tasks of her job and her physician's restrictions prevented her from performing it. Following claimant's accepted thumb laceration injury, her attending physician concurred with an examining physician's restrictions, which stated that claimant was unable to do fine, delicate tasks with her hand such as unscrewing small screws, grasping with the tip of her thumb, and twisting needed to break down certain equipment. Thereafter, claimant's manager signed an affidavit, stating that, while one of the "functions and tasks" of claimant's job consisted of breaking down and cleaning yogurt and smoothie machines, a different shift at work usually performed this task, and claimant had only broken down the machines once in the past year. Based on this affidavit, a Notice of Closure did not grant a work disability award and an Order on Reconsideration affirmed. Claimant requested a hearing, contending that she was entitled to a work disability award because her attending physician had restricted her from performing her regular work.

Claimant unable to perform fine, delicate tasks with injured hand.

"Regular work" means job held at injury.

The Board agreed with claimant's contention. Citing ORS 656.214(2)(a), ORS 656.726(4)(f)(E), and OAR 436-035-0009(4), the Board stated that whether claimant was entitled to work disability depended on whether she returned to, or was released by her attending physician to return to, regular work. Relying on ORS 656.214(1)(d), and OAR 436-035-0005(15), the Board noted that "regular work" means the job that held at injury. Referring to *Thrifty Payless, Inc. v. Cole*, 247 Or App 232, 239 (2011), and *Marco Ruiz, III*, 66 Van Natta 777, 780

“Regular work” includes tasks performed on steady or customary basis.

Although claimant rarely performed a duty, manager acknowledged that it was one of “functions/tasks” of her “at injury” job.

Following pregnancy, claimant contracted with intended parents, and was paid through account with third-party escrow agent.

Claimant developed a heart condition and filed claim.

(2014), the Board reiterated that “regular work” includes tasks that are performed on a steady or customary basis, even if those tasks are not part of a worker’s job description or otherwise explicitly required.

Turning to the case at hand, the Board acknowledged claimant’s manager’s statement that claimant rarely broke down the yogurt/smoothie machines because that task was usually performed by a different shift at work. Nevertheless, the Board further noted that the manager had admitted that such an activity was one of the “functions and tasks” of claimant’s job, which she had performed once within the past year.

Under such circumstances, the Board was persuaded that claimant’s inability to break down the machines represented a restriction preventing her from performing a task that was performed on a steady or customary basis. Consequently, the Board concluded that she was restricted from her “regular work” and, as such, entitled to a work disability award.

Subject Worker: Gestational Carrier For Surrogacy Center - Center Did Not Provide Remuneration for Services, Did Not Have Right to Control Carrier’s Activities

Petra Lorenzen, 70 Van Natta 936 (August 9, 2018). Applying ORS 656.005(30), the Board held that claimant, a gestational carrier for a surrogacy center, was not a “subject worker” when she developed a heart condition after giving birth as part of her surrogacy services because the center neither provided remuneration for her services nor had the right to control such services. After being selected as a gestational carrier by a surrogacy center, claimant entered into a contract with intended parents, who agreed to pay claimant’s compensation and expenses pursuant to specific terms, and to place the monies in a trust account administered by the center. Once claimant’s pregnancy was confirmed, she and the parents signed a separate agreement establishing a disbursement account with a third-party escrow agent to manage her base compensation according to the surrogacy contract. After giving birth, claimant was diagnosed with a heart condition and filed a claim. After the carrier denied her claim, claimant requested a hearing, contending that she was a subject worker for the center.

The Board disagreed with claimant’s contention. Citing ORS 656.005(30), the Board stated that a “worker” is a person who engages to furnish services for remuneration, subject to the direction and control of an employer. Relying on *Hopkins v. Kobos Co.*, 186 Or App 273, 277 (2003), the Board noted that the definition contains two elements: (1) the employer will provide remuneration for the claimant’s services; and (2) the employer has the right to direct and control the services that the claimant provides. Referring to *Rubalcaba v. Nagaki Farms, Inc.*, 333 Or 614, 627 (2002), the Board reiterated that the “right to control” test and the “nature of the work” test are used to determine whether a person is “subject to the direction and control of an employer.”

Based on *Stamp v. DCBS*, 169 Or App 354, 357 (2000), the Board identified the principal factors to be considered in determining an employment relationship under the “right to control” test: (1) direct evidence of the right to, or the exercise of, control over the method of performance; (2) method of payment; (3) furnishing of equipment; and (4) right to terminate employment. Citing *Woody v. Waibel*, 276 Or 189, 195 (1976), the Board stated that the “nature of the work” test involves consideration of: (1) the character of the claimant’s work or business; that is, how skilled it is, how much of a separate calling or enterprise it is, and to what extent it may be expected to carry its own accident burden; and (2) the relation of the claimant’s work to the alleged employer’s business; in other words, how much it is a part of the employer’s regular work, whether it is continuous or intermittent, and whether the duration is for the completion of a particular job.

Surrogacy center did not provide remuneration to claimant; parents did.

Turning to the case at hand, the Board concluded that the Center did not agree to provide, nor provide, remuneration for claimant’s services. Rather, the Board found that the parents had agreed to compensate claimant for her services.

Center’s “screening” activities did not establish right to control.

Concerning the “right to control” test, the Board did not consider the Center’s “pre-surrogacy” contract activities (*i.e.*, its “screening” activities, finding a parent match, directing her to apply for health insurance, arranging a home visit with the parents) to be evidence of the right to, or the exercise of, control over claimant’s performance. Instead, the Board considered such activities to be designed to gauge claimant’s qualifications or prepare her for undertaking a surrogacy. In any event, the Board noted that claimant was not injured while attempting to qualify for a surrogacy; rather, she was injured in the course of bearing children, after she had entered into the surrogacy contact with the parents.

Center not a “party” to claimant/parents’ contract.

Regarding the surrogacy contract, the Board acknowledged that claimant was required to perform detailed services and the center was obligated to monitor those services and to take specific actions. Nonetheless, reasoning that the center was not a party to the contract, the Board determined that, under the contract, the parents had sole discretion to stop the prescribed payments and pursue any legal/equitable remedies.

Considering the “method of payment” factor to be neutral and noting that the contract required the parents to pay for anything that could be considered “tools/equipment,” the Board addressed the “right to fire” factor. Reiterating that the parents had sole discretion to terminate payments and pursue legal/equitable remedies under the contract, the Board concluded that the center was not authorized to either terminate the agreement or “fire” claimant.

Claimant carried her own accident burden by means of contract with parents.

Although not persuaded that the center had the right to control, or exercised control over, claimant’s performance, the Board addressed the “nature of the work” test. Reasoning that claimant’s agreements anticipated one pregnancy (rather than ongoing services for an undefined period) and noting that, with the advice of legal counsel, she had voluntarily entered into an agreement with the parents for the completion of a particular assignment, the Board determined that claimant carried her own “accident burden” by means of the contract which was for the completion of a particular job.

Under such circumstances, after application of both the “right to control” and the “nature of the work” tests, the Board was not persuaded that claimant was a “worker” under ORS 656.005(30). Consequently, the Board upheld the carrier’s denial of the claim.

Dissent contended the center exercised control over the method and means of accomplishing the desired result.

Member Lanning dissented. Noting that the center set and advertised the amount of payment, and collected the amount from the parents and disbursed it under the terms of the contracts that it drafted for claimant and the parents, Lanning viewed the center as providing the remuneration for claimant’s services, likening it to a “worker leasing company” or a “temporary service provider.” Lanning further reasoned that, by requiring a psychological evaluation, choosing claimant’s health insurance provider, requiring a home visit, assisting a case worker for appointments/procedures, forbidding claimant from having any contact with the father of her eldest child, and requiring her to abstain from sexual intercourse for a certain period, the center exercised control over the method and means of accomplishing the desired result (*i.e.*, a healthy baby). Lanning also considered the “method of payment” (a monthly expense allowance and monthly “base compensation” installments) and “tools/equipment” (coordination of fertilizing of the eggs, implanting the embryos, and injecting medication) to be factors supportive of a “right to control” by the center over claimant’s performance.

Similarly, Member Lanning asserted that, under the “nature of the work” test, there was an employment relationship because: (1) claimant’s services were an integral part of the Center’s business, which was a for-profit entity for the sole purpose of operating a surrogacy business; (2) the Center advertised and recruited surrogates and intended parents and provided/coordinated nearly all of the services needed to accomplish its business purpose; (3) the Center worked with multiple gestational carriers simultaneously; and (4) the Center required claimant to sign a six-month noncompetition agreement.

TTD: “325(5)(a)” - Carrier’s Conversion of TTD Benefits to TPD Benefits Unreasonable - AP “Modified Job” Approval Had Been Retracted

Before claimant began modified job, carrier received a report that he should remain off work pending further examination.

Ronald D. McAllister, 70 Van Natta 912 (August 3, 2018). Citing ORS 656.325(5)(a), and OAR 436-060-0030(7)(a), the Board held that a carrier’s conversion of claimant’s temporary total disability (TTD) benefits to temporary partial disability (TPD) benefits was unreasonable because, before claimant began an attending physician-approved modified job, the carrier had received a report indicating that the prior approval had been retracted. On the day his “attending physician approved” modified job was scheduled to begin, claimant was examined by a physician’s assistant for the attending physician, who reported that claimant should remain off-work until an evaluation by another physician in a few days. Noting that another portion of the physician assistant’s report had indicated that claimant’s estimated “return to work” date was the date of assistant’s exam, the carrier terminated claimant’s TTD benefits. Claimant requested a hearing, seeking reinstatement of his TTD benefits, as well as

When “AP’s” prior “modified job” approval is retracted, carrier obligated to continue TTD benefits.

Although report listed an estimated “return-to-work” day, it also stated claimant was off work until seen by another physician.

Required change in a “ceases” denial is that otherwise compensable injury is no longer the major contributing cause of the combined condition.

penalties and attorney fees. Although eventually not contesting its responsibility for the TTD benefits, the carrier contended that its claim processing had not been unreasonable considering the physician assistant’s report.

The Board disagreed with the carrier’s contention. Citing ORS 656.325(5)(a), the Board stated that a carrier is authorized to cease TTD benefits and begin TPD benefits when a claimant refuses employment if the employer notified the attending physician of the specific duties to be performed and the attending physician approves the employment offer. Relying on OAR 436-060-0030(7)(a), the Board noted that temporary partial disability benefits under ORS 656.212 only continue until the attending physician verifies that the worker can no longer perform the modified job and is again temporarily totally disabled. Referring to *Bobby D. Mitchell*, 61 Van Natta 786, 789 (2009), the Board observed that, when an attending physician’s prior “modified job” approval had been retracted and the claimant had not returned to the modified job, the carrier was obligated to continuing paying TTD benefits.

Turning to the case at hand, the Board acknowledged that the physician assistant’s report had listed an estimated return-to-work day as of the date of the exam (which coincided with the day that claimant was scheduled to begin his modified job). Nonetheless, noting that the report also declared that claimant was not released to work and specifically stated (in a handwritten note) that he was to remain off work until seen by another physician several days later, the Board reasoned that the attending physician’s prior “modified job” approval had been effectively retracted and it was unreasonable for the carrier to have terminated claimant’s TTD benefits based on the physician assistant’s report. Consequently, the Board awarded penalties and attorney fees under ORS 656.262(11)(a). See *Int’l Paper Co. v. Huntley*, 106 Or App 107, 110 (1991).

APPELLATE DECISIONS COURT OF APPEALS

Combined Condition: “Ceases” Denial (“262(6)(c)”) - “Otherwise Compensable Injury” (Accepted Condition)

Zinser-Rankin v. SAIF, 293 Or App 601 (August 29, 2018). On reconsideration of its earlier opinion, 291 Or App 495 (2018), the court, *per curiam*, adhered to its previous decision that affirmed a Board order that had applied the rationale expressed in *Brown v. SAIF*, 361 Or 241 (2017), in upholding a carrier’s “ceases” denial under ORS 656.262(6)(c) of a claimant’s combined cervical spine condition. The court granted claimant’s petition for reconsideration to clarify its earlier opinion, which had cited *Fillinger v. The Boeing Co.*, 290 Or App 187 (2018).

On reconsideration, claimant first argued that *Fillinger* was consistent with his contention that the carrier was required to establish both a change in causation and a change in condition sufficient to support a “ceases” denial under ORS 656.262(6)(c) of a combined condition. The court disagreed with claimant’s argument, citing its statement in *Fillinger* that “to support the denial of a previously accepted combined condition claim, the required ‘change’ in the

worker's condition or circumstances is that "the otherwise compensable condition is no longer the major contributing cause of the combined condition." *Fillinger*, 290 Or App at 192-93.

Regarding claimant's second argument, the court acknowledged his point that *Fillinger* did not control the question of whether substantial evidence supported the Board's finding that the requisite change in claimant's combined condition had been established to support the carrier's "ceases" denial. Nonetheless, the court clarified that it had reviewed the record and rejected claimant's "substantial evidence" arguments.

Medical Services: Medication Related to "DCS'd" Nerve Pain, Not Due to Accepted Disc Herniation - "245(1)(a)"

Graham v. Liberty Northwest Ins. Corp., 293 Or App 529 (August 29, 2018). Analyzing ORS 656.245(1)(a), the court affirmed the Board's order in *Jason L. Graham*, 68 Van Natta 286 (2016), that upheld a carrier's medical service denial of claimant's prescription medication. In reaching its conclusion, the Board had relied on a physician's opinion that, although claimant's compensable L5-S1 disc herniation may have contributed materially (but no more than 20 percent) to his nerve pain, the disc herniation was not the major contributing cause of his nerve pain (for which the medication had been prescribed), but rather his nerve pain was caused in major part by his preexisting back condition. Because claimant's nerve pain was not compensable under the terms of a previously approved Disputed Claim Settlement, the Board had determined that the pain medication was not causally related to the work-related injury and, thus, was not compensable.

On appeal, noting the physician's opinion that the disc herniation may have made a 20 percent contribution to his nerve pain, claimant contended that the record established a compensable connection between the recurrent disc herniation and his need for medical treatment for the nerve pain. The court disagreed with claimant's contention.

Based on the physician's opinion, the court noted that the medication would not have been prescribed only for a disc herniation, but rather was directed to nerve pain. Referring to the DCS, the court observed that the DCS extinguished claimant's right to further benefits for his nerve pain conditions. Furthermore, the court determined that substantial evidence supported the Board's finding that the medication had been prescribed for a noncompensable radiculitis condition (*i.e.*, a nerve pain condition).

In light of the DCS, the court concluded that the fact that there was medical evidence that the compensable disc herniation contributed to claimant's nerve pain did not make treatment of the nerve pain compensable. Instead, because claimant was not entitled to compensation for nerve pain conditions and because substantial evidence supported the Board's finding that the medication was

Medication was directed to nerve pain condition that was noncompensable via DCS; medication not related to accepted disc condition.

prescribed for or directed to treatment of the nerve pain conditions (and not the recurrent disc herniation), the court affirmed the Board's decision that the medication was not compensable.

In reaching its conclusion, the court acknowledged that, in *SAIF v. Sprague*, 346 Or 661, 674 (2009), the Supreme Court had stated that “[t]here is no requirement that the need for medical services be directly ‘caused by’ the original compensable injury at all.” Based on such reasoning, the court observed that, in the absence of the DCS (in which claimant had stipulated that the nerve pain conditions were denied and not materially related to his work injury), he may have been entitled to the prescribed medication under ORS 656.245(1)(a) as a medical service for treatment of conditions caused in material part by the accepted recurrent disc herniation.

Responsibility: “308(1)” N/A - Claimed Condition Not “Same Condition” as Previously Accepted Condition - Claim Analyzed as “Initial” Occupational Disease (“802(2)(a)”)

SAIF v. Dunn, 293 Or App 242 (August 8, 2018). Analyzing ORS 656.802(2)(a) and ORS 656.308(1), the court affirmed the Board's order in *Jarrod S. Dunn*, 68 Van Natta 1977 (2016), that had found a carrier responsible for claimant's current L4-5 disc condition as a new occupational disease. Persuaded by a physician's opinion, the Board had found that claimant's prior work-related injuries and his physically demanding work activities were the major contributing cause of his current L4-5 disc herniation. In reaching its conclusion, the Board had rejected the carrier's contention that ORS 656.308(1) applied to the claim and that responsibility remained with a previous carrier who had accepted an injury claim for an earlier L4-5 disc herniation. On appeal, the carrier argued that the Board had erred in determining that ORS 656.308(1) was inapplicable and that the Board's findings were inconsistent.

The court disagreed with the carrier's assertions. Citing *Liberty Northwest Ins. Corp. v. Senters*, 119 Or App 314, 317 (1993), the court stated that responsibility under ORS 656.308(1) is assigned when a worker sustains a new occupational disease that involves the same condition as a previous injury. Referring to *SAIF v. Webb*, 181 Or App 205, 209, n 3 (2002), *Sanford v. Balteau Standard*, 140 Or App 177, 182 (1996), and *SAIF v. Yokum*, 132 Or App 18, 23 (1994), the court reiterated that, for ORS 656.308(1) to be triggered, there must be an accepted claim *for the condition* and that, where an occupational disease has not been previously accepted by the carrier, the statute was inapplicable to assign responsibility to that carrier.

Turning to the case at hand, the court rejected the carrier's contention that the Board had erred in determining that claimant's new occupational disease did not involve the same condition that the first carrier had previously accepted.

Medical evidence established that first L4-5 disc herniation had resolved, and current herniation was new; thus not “same condition” and “308(1)” not applicable.

Based on its review of the record, the court concluded that the medical evidence would support finding that, despite leaving claimant's L4-5 "abnormal" and less resilient, claimant's first herniation had resolved and his current herniation was new.

Moreover, reasoning that substantial evidence supported the Board's finding that claimant's currently claimed condition was not the same condition that had been accepted by the prior carrier, the court determined that the claim was an initial occupational disease claim. Under such circumstances, the court concluded that ORS 656.308(1) did not apply in the assignment of responsibility.