



News & Case Notes

BOARD NEWS

Board Meeting: Biennial Review/Attorney Fees/"388(4)" 1

Board Meeting: "Translation of Written Documents"/"Notice of Important Document" - Consideration of Advisory Committee Report 2

Own Motion: Practice Tips 2

CASE NOTES

Aggravation: Requires "Actual Worsening" of Previously Accepted Condition - "273(1)" 3

Consequential Condition: Depression - Emotional Reaction to Claim Processing Cannot Be Considered - Concerns About Inability to Work/Return to Work Can Be Considered 5

Responsibility: "O.D./"LIER - "Impossibility" Defense - "Presumptively Responsible" Carrier Did Not Prove "Impossible" for Its Coverage to Have Caused Decedent's Disease 6

APPELLATE DECISIONS

Update

Claim Filing: "Good Cause" for Untimely Filed Claim - Not Established by Claimant's Uncorroborated Explanation Regarding Effects of "MVA" Injury - "265(4)(c)" 7

Third Party Dispute: "Approved" Settlement Did Not Include "Workers' Compensation" Damages - Paying Agency Not Entitled to a Share of Settlement Proceeds 7

Court of Appeals

Combined Condition: "Ceases" Denial - Accepted Condition Not Major Cause of "Combined Condition" - "262(6)(c)" 8

BOARD NEWS

Board Meeting: Biennial Review/Attorney Fees/"388(4)"

The Board has scheduled a public meeting for the Members to review and discuss written responses received in reply to the Board's request for comments regarding its biennial review of its schedule of attorney fees under ORS 656.388(4). These comments have been posted on WCB's website since the Board began requesting them in earlier August 2018. The Members appreciate the time and effort expended by those who responded to the Board's August - October 2018 invitation for comments.

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). Consistent with this statutory directive, the Members welcome submissions (both written and oral) for their consideration from parties, practitioners, organizations, governmental bodies, and the general public, which address these mandated considerations.

The initial Board meeting has been scheduled for December 11, 2018, at the Board's Salem office (2601 25th St. SE), at 10 a.m. In addition to reviewing the previously-submitted written comments, the Members will consider other written comments presented at, or in advance of, that December 11 meeting, as well as public testimony presented at that time.

Additional written comments should be directed to Kayleen Atkins, WCB's Executive Assistant at 2601 25th St. SE, Ste. 150, Salem, OR 97302, kayleen.r.atkins@oregon.gov, or via fax at (503)373-1684. Any written comments received by the Board on or before December 11 will be considered by the Members.

Arrangements are also being made at each permanently staffed Board office (Durham, Eugene, and Medford) to allow attendees at those offices to participate remotely in the Board's Salem meeting.

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

Board Meeting: “Translation of Written Documents”/“Notice of Important Document” - Consideration of Advisory Committee Report

The Board has scheduled a public meeting for the Members to review and discuss an advisory committee’s report regarding rule concepts presented by the Oregon State Bar’s Workers’ Compensation Section’s Access to Justice Committee. Those concepts concerned the following subjects: (1) procedures for addressing the translation of “non-English” written evidence at hearing; and (2) requiring that certain documents sent to injured workers be accompanied by a separate notice in multiple languages (Spanish, Russian, Vietnamese, and Chinese) advising the workers of the importance of the document and possible avenues of assistance.

The meeting has been scheduled for November 27, 2018 at the Board’s Salem office (2601 25th St. SE, Ste. 150), at 10 a.m.

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

Own Motion: Practice Tips

To assist practitioners and carriers in processing/addressing Own Motion-related claims/issues, the Own Motion Unit has compiled the following practice tips.

1. To begin, if the dispute concerns a denial (express or *de facto*) regarding the compensability of, or responsibility for, a claim, it is premature to seek Own Motion relief from a carrier or the Board’s Own Motion Unit. Instead, a request for hearing may be filed with the Hearings Division.
2. When a claimant is seeking compensation (other than medical services) on an Own Motion claim and there is no compensability/responsibility dispute, a request for Own Motion relief may be directed to the Own Motion Unit. No hearing request with the Hearings Division should be filed. The request for Own Motion relief can be made in a letter to the Board’s Own Motion Unit.
3. When a claimant requests reopening of an Own Motion claim, the carrier is required to either voluntarily reopen the claim using <https://wcd.oregon.gov/forms/Pages/forms.aspx> or provide a recommendation to the Board using <https://www.oregon.gov/wcb/Documents/wcbform/omrecommedation2006b.pdf>. See OAR 438-012-0030. When submitting a reopening recommendation to the Board, the carrier is required to provide the following relevant documentation:
 - All acceptance notices.

- All prior claim closure documents (Determination Orders, Notices of Closure, Reconsideration Orders).
 - Current medical reports addressing the reopening request.
 - Any information regarding claimant's status in the workforce.
4. When a claimant requests review of an Own Motion Notice of Closure, the carrier is required to provide the Board all documents regarding the closure and prior PPD awards. These include (but are not limited to):
- All acceptance notices, and reopening documents (voluntary and by the Board).
 - The current Own Motion Notice of Closure.
 - Prior Determination Orders, Notices of Closure, and Reconsideration orders.
 - All prior evaluator's worksheets regarding calculation of PPD.
 - Prior litigation orders and settlement documents.
 - All physician reports and chart notes addressing the current claim closure and permanent impairment.
5. Other types of requests regarding an Own Motion claim should be addressed to the Board's Own Motion Unit. Examples include:
- A carrier's refusal to voluntarily reopen an Own Motion claim or submit an Own Motion Recommendation following a compensability determination.
 - A carrier's refusal to pay temporary disability benefits on a reopened claim, or a dispute regarding the temporary disability rate calculation.
 - A carrier's refusal to close an Own Motion claim.
6. A carrier is obligated to fully and timely comply with all Board rules/ letters and submit all relevant information regarding its processing of an Own Motion claim. See OAR 438-012-0017(1); OAR 438-012-0110(1). A carrier's failure to timely comply with these obligations, if found unreasonable or unjustified, may result in the imposition of penalties and attorney fees under ORS 656.262(11)(a). See OAR 438-012-0110(1); OAR 438-015-0110; *Doug R. Cooley*, 70 Van Natta 1072, 1079-80 (2018).

If you have any questions regarding Own Motion claim processing matters, you may contact the Own Motion Unit at 503-934-0113.

CASE NOTES

Aggravation: Requires "Actual Worsening" of Previously Accepted Condition - "273(1)"

Kimberly A. Samard, 70 Van Natta 1139 (October 4, 2018). Applying ORS 656.273(1), the Board upheld a carrier's aggravation denial because an unaccepted ligament tear of claimant's finger/hand did not establish that her accepted fracture condition had pathologically worsened. Contending that her ulnar collateral ligament tear was the same condition as her accepted finger fracture, claimant argued that she had sustained a compensable aggravation.

Aggravation claim is based on “actual worsening” of accepted condition.

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, there must be an “actual worsening” of an accepted condition since the last award or arrangement of compensation. Relying on *Ligatich v. Liberty Northwest Ins. Corp.*, 185 Or App 555, 561 (2003) and *Kim D. Wood*, 48 Van Natta 482, 484 (1996), *aff’d without opinion*, 144 Or App 496 (1996), the Board reiterated that the scope of an acceptance is a question of fact and, when a carrier accepts a specific condition, it is not necessary to resort to contemporaneous medical records to determine what condition was accepted.

Physicians described accepted fracture and ligament tear as separate conditions.

Turning to the case at hand, the Board found that the carrier’s acceptance of claimant’s finger fracture (as well as other conditions) was not ambiguous. Consequently, the Board considered it unnecessary to review the contemporaneous record to determine whether the carrier’s acceptance had included an ulnar ligament tear. Nonetheless, after conducting its review, the Board noted that physicians’ opinions had addressed claimant’s finger fracture and ulnar ligament tear as separate and distinct conditions.

Unaccepted ligament tear condition could not be considered for purposes of aggravation claim.

Under such circumstances, the Board was not persuaded that claimant’s ligament tear was the same condition as the accepted fracture condition. Therefore, the Board concluded that the ligament tear could not be considered for purposes of claimant’s aggravation claim. Instead, the Board noted that she could initiate a new/omitted medical condition claim at any time. See ORS 656.267(1).

Finally, the Board addressed whether claimant’s accepted finger fracture had actually worsened. 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).

Pathological worsening of accepted condition not established.

Following its review of the record, the Board acknowledged a previous attending physician’s opinion that claimant had sustained a “worsened condition” and an “aggravation of her original injury.” Nonetheless, the Board reasoned that the physician had neither explained which conditions had worsened nor how any documented findings related to those conditions. Moreover, the Board noted that the current attending physician had reported that claimant’s fracture had healed and had not worsened. Based on such evidence, the Board determined that a pathological worsening of claimant’s accepted fracture had not been established.

Consequential Condition: Depression - Emotional Reaction to Claim Processing Cannot Be Considered - Concerns About Inability to Work/Return to Work Can Be Considered

Timothy J. Poppleton, 70 Van Natta 1197 (October 26, 2018). Applying ORS 656.005(7)(a)(A), the Board held that claimant's new/omitted medical condition claim for depression was compensable because, despite his emotional reaction to the processing of his claim (which could not be considered), his physician had not focused on that matter, but, rather, had relied on claimant's pain symptoms and concerns regarding his inability to work and ability to return to work as a result of his accepted head and neck conditions, which were the major contributing cause of his claimed depression. Following the closure of his accepted head/neck claim, claimant initiated a new/omitted medical condition claim for depression. Asserting that his physician had attributed claimant's depression to "uncertainty associated with the progression" of his claim and "the extent to which he will ever be able to return to work," the carrier contended that such factors could not be considered for purposes of establishing his claimed consequential condition.

Physician attributed depression condition to "uncertainty associated" with processing of claim and ability to return to work.

"Uncertainty" regarding processing of claim could not be considered for purposes of "consequential condition" analysis, but claimant's reaction to inability to work and pain from accepted conditions could be considered.

Citing *Roseburg Forest Prods. v. Zimbelman*, 136 Or App 75, 79 n 2 (1995), the Board acknowledged that a claimant's reaction to claim processing cannot be considered to be caused by a compensable injury for purposes of analyzing a consequential condition under ORS 656.005(7)(a)(A). Consequently, to the extent that the physician considered claimant's "uncertainty" regarding the processing of his claim, the Board discounted that portion of the physician's opinion. Nonetheless, insofar as the physician had referred to claimant's reaction to his inability to work and attendant concerns about being able to return to work, the Board reasoned that such factors could be considered in analyzing the compensability of his consequential condition claim. See *Zimbelman*, 136 Or App at 79.

Turning to the case at hand, the Board found that the physician's opinion had focused on claimant's painful symptoms from his accepted concussion and cervical strain, as well as his inability to work, as opposed to the processing of his claim. Under such circumstances, despite discounting the portion of the physician's opinion that had referred to claimant's "uncertainty" concerning the processing of his claim, the Board reasoned that the physician's opinion, when considered in context of the medical record as a whole, persuasively established that claimant's accepted head/neck conditions were the major contributing cause of his depression. See *SAIF v. Strubel*, 161 Or App 516, 521-22 (1999) (medical opinions are evaluated in context and based on the record as a whole to determine sufficiency).

Finally, the Board acknowledged the carrier's argument that claimant's depression claim was precluded because an Order on Reconsideration had previously apportioned his permanent impairment for his cervical condition

Because carrier's "claim preclusion" argument not raised at hearing level, not considered on appeal.

based on preexisting arthritis. Nevertheless, noting that this "claim preclusion" argument had not been raised at the hearing level, the Board declined to consider it for the first time on review. See *Neftali Soto*, 69 Van Natta 577, 583 (2017). In any event, the Board reasoned that, because claimant's depression claim was not based on the same factual transaction as that addressed in the earlier Order on Reconsideration nor was the compensability of the currently claimed depression actually litigated during the reconsideration proceeding, claimant's new/omitted medical condition would not be precluded. See, e.g., *Virginia L. Gould*, 61 Van Natta 2206, 2209 (2009).

Responsibility: "O.D."/LIER - "Impossibility" Defense - "Presumptively Responsible" Carrier Did Not Prove "Impossible" for Its Coverage to Have Caused Decedent's Disease

Henry G. Miller, DCD, 70 Van Natta 1121 (October 2, 2018), *recons*, 70 Van Natta 1157 (October 10, 2018). Applying the last injurious exposure rule (LIER) in determining responsibility for a deceased worker's occupational disease claim for mesothelioma, the Board held that the last carrier was responsible because it had not established that it was impossible for conditions at its workplace to have caused the disease, or that the disease was caused solely by conditions at one or more previous employments. Asserting that the record established that the decedent's work during its coverage had involved new construction and not the removal/replacement of ceiling tiles, the last carrier contended that it was impossible for him to have been exposed to asbestos during this employment.

The Board disagreed with the last carrier's contention. Citing *Agricom Ins. v. Tapp*, 169 Or App 208, 213, *rev den*, 331 Or 244 (2004), the Board stated that the LIER assigns presumptive responsibility to the most recent potentially causal employer for whom the decedent worked or was working at the time he first sought or received treatment (whichever came first). Relying on *Roseburg Forest Prods. v. Long*, 325 Or 305, 313 (1997), the Board reiterated that a presumptively responsible carrier may shift responsibility to a prior carrier by establishing that: (1) it was impossible for conditions at its workplace to have caused the disease; or (2) the disease was caused solely by conditions at one or more previous employments. Referring to *Darrell Alcorn*, 69 Van Natta 1068, 1069 (2017), the Board stated that the impossibility standard is met where the medical evidence establishes, to a reasonable medical probability, that it was impossible for its exposure to have caused the decedent's condition.

Last carrier (presumptively responsible for claim) contended claimant was not exposed to asbestos during that employment.

Turning to the case at hand, the Board acknowledged an expert's opinion that, if the decedent was not exposed to asbestos with a particular employer, it would be impossible for that exposure to have contributed to the condition. Nevertheless, the Board noted that the expert had also stated that the decedent's work had exposed him to asbestos until his retirement and that a physician had opined that a single asbestos exposure could have led to the

Expert evidence established that single asbestos exposure could have contributed to decedent's disease, and witnesses did not establish that he had not been exposed.

development of the decedent's mesothelioma. Moreover, after considering testimony from the decedent's son and stepson regarding his work duties while employed by the last carrier, the Board determined that, because they had not worked alongside the decedent and their recollections conflicted regarding his work exposures, their testimonies did not establish that he had not been exposed to asbestos during the last carrier's coverage.

Finally, the Board reasoned that, even if the expert's opinions were discounted because they lacked specific information concerning the exact materials to which the decedent had been exposed during his employments, the last carrier would remain responsible because, as the "presumptively responsible" carrier (*i.e.*, the carrier for whom the decedent last worked before he sought or received treatment), it had not proven that it was impossible for its exposure to have caused the decedent's disease. See *Alcorn*, 69 Van Natta at 1069.

Based on the aforementioned reasoning, the Board concluded that the last carrier had not met its burden of proof under the "impossibility" defense of the LIER. Consequently, the Board held that the last carrier was responsible for the decedent's claim, which included reimbursing other carriers who had paid claim costs pursuant to a WCD order designating a paying agent under ORS 656.307, as well as an ALJ's responsibility determination.

Last ("presumptively responsible") carrier could not establish that it was "impossible" for its coverage to have contributed to claimed disease.

APPELLATE DECISIONS UPDATE

Claim Filing: "Good Cause" for Untimely Filed Claim - Not Established by Claimant's Uncorroborated Explanation Regarding Effects of "MVA" Injury - "265(4)(c)"

Lopez v. SAIF, 294 Or App 513 (October 17, 2018). The court affirmed without opinion the Board's order in *Dalia R. Lopez*, 69 Van Natta 941 (2017), previously noted 34 NCN 5:3, which had held that claimant had not established "good cause" for her untimely filed injury claim because her explanation that her delay in reporting her motor vehicle accident injury as work-related was attributable to memory deficits from the accident was not persuasively corroborated by the remainder of the record.

Third Party Dispute: "Approved" Settlement Did Not Include "Workers' Compensation" Damages - Paying Agency Not Entitled to a Share of Settlement Proceeds

SAIF v. Ramirez, 294 Or App 511 (October 10, 2018). The court affirmed without opinion the Board's order in *Joel B. Ramirez*, 69 Van Natta 1382 (2017), previously noted 36 NCN 9:12, which had held that a paying agency was not

entitled to a share of proceeds from a settlement between claimant and a third party (which the carrier had approved) because the settlement expressly provided that no portion of the proceeds pertained to workers' compensation damages. The Board order had applied *Robertson v. Davcol*, 99 Or App 542 (1989).

APPELLATE DECISIONS
COURT OF APPEALS

Combined Condition: “Ceases” Denial -
Accepted Condition Not Major Cause of
“Combined Condition” - “262(6)(c)”

Goodman v. SAIF, 294 Or App 297 (October 3, 2018). On remand from the Supreme Court, 362 Or 38 (2017), the court, per curiam, affirmed a Board order that had upheld a carrier's “combined condition” denial. The court cited *Brown v. SAIF*, 361 Or 241 (2017).