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BOARD NEWS

Staff Attorney Recruitment

WCB will soon be recruiting for a staff attorney position. 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 March and will run for two to three weeks. Further details about the position and information on how to apply will soon be available online at <https://oregon.wd5.myworkdayjobs.com/SOR> **External Career Site**. WCB is an equal opportunity employer.

Updated Report On Oregon Workers' Compensation Now Available Online

The Department of Consumer and Business Services (DCBS) has recently published its report on the Oregon workers' compensation system. This report, which had been commonly referred to as the "biennial report," is now available on the following web page: <https://www.oregon.gov/dcbs/reports/compensation/Pages/index.aspx>

The report is divided into several components, including the history of Oregon workers' compensation, safety and health, claims, medical care and benefits, disputes, insurance, and rate comparisons with other states.

The statistical tables within each section are prepared by the DCBS Information Technology and Research Section. This is the first year that the report and statistics have been made available online.

Readers can navigate to various reports from the web page, including information on workers' compensation disputes. This includes information about disputes at the Workers' Compensation Board (WCB), Workers' Compensation Division (WCD), and at the Oregon appellate courts. There is also a page devoted to attorney fees.

The statistical tables can be printed and downloaded into data files or PDF documents.

Jurisdiction: Hearings Division Authorized To Consider Decedent's Mother's Hearing Request Regarding "De Facto" Denial Of "Dependent" Claim - Filed W/I Two Years Of Claim - ARU's Order On Reconsideration (Concerning Decedent's "Fatality" Claim) Not Preclusive On "Beneficiary" Claim - "319(6)", "030-0015(1)(c)(B)"

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Wanna Get Away? Let WCB Know

Don't let the snow fool you. Summer is almost here. Taking a vacation this year? Want to do everything you can to try to avoid conflicts? Then, consider using the Board's "attorney availability" form. The Board has this form on its website at: <https://www.oregon.gov/wcb/hearings/Pages/atty-availability-form.aspx>

By submitting this form with your "unavailable" dates, the Board will do its best to avoid scheduling hearings while you are away. It is important that you provide us these dates as far in advance as possible. Keep in mind that the Hearings Division must schedule a hearing not more than 90 days after receipt of the request for hearing. ORS 656.283(3)(a). Because these hearing dates must be set timely throughout the state, it may not always be possible to accommodate all schedules, but every effort will be made to do so.

Notes And Tips For WCB Portal Users

The Board greatly appreciates all of the stakeholders who have used the Portal for filing of requests, settlements and other activities. Your ideas and suggestions have helped improve these processes. Below are some topics that come up regularly in phone calls and emails to the WCB Portal staff:

Keep your Users and Contacts lists current: As staff changes occur in your organization, please update your list of portal "Users" and "Contacts." Users are people who can log-in to the portal to file requests and documents, while Contacts are the people who receive email notifications. To ensure that you receive all of your email notifications, please keep your lists current as your staff changes. Your account administrator can make these changes, but if you need help, please don't hesitate to contact us.



Settlement addendums: If you need to submit additional documents, such as an addendum, to a settlement package, go to the Settlements tab to find the original submission. It will likely be in the section titled "In Process at the Board." If you are the original submitter, you can reopen that submission and "Add A Document." (Only the original submitter can add documents to an existing settlement package.) By adding to the original submission, WCB staff will be able to route the document more quickly to the ALJ or Board Members. If you attempt to submit an addendum on its own, you will not be able to do so. The box for a type of "settlement" (DCS, Stip, or CDA) must be checked for the submission to be submitted.

Settlement Documents
Uploaded: CDA DCS Stip Cover Letter Addendum

181203-Settlement Documents -
Stip signed by all parties.PDF X

Add A Document 

Supplemental or Amended Hearing Requests: If you have filed an original request for hearing through the Portal, you can avoid retyping all of the information on that form when you submit an additional hearing request (such as an amended or supplemental request. Go to the “Request a Hearing” tab, then “Click to Show Previous Requests.” From that list of requests, click on the + button, which will re-load your previous request on the screen. From there, you can make any changes to the issues or party information, and then hit “submit.” You won’t have to re-enter any information that is unchanged.



Original	Processed			  
Amended	Scheduled	PORTLAND	Thursday, May 23, 2019	  
Consolidated	Scheduled	PORTLAND	Thursday, May 23, 2019	  

Board Review Briefing Extensions: You can see the status of your request for an extension from the WCB Case Status Page. When the decision is made on an extension, it is quickly posted on the Portal page for that WCB number. This information will show if it was granted or denied. A letter with the new deadline (if any) will follow in the mail.

Events **Status** Orders and Documents Pleadings

Date	Status
11/15/2018	ORDER ON REVIEW
06/22/2018	APPELLANT EXTENSION GRANTED
06/06/2018	APPELLANT EXTENSION GRANTED
05/14/2018	CALL FOR BRIEFS
04/17/2018	CLAIMANT REQUESTED BOARD REVIEW
04/13/2018	ISSUED OPINION AND ORDER

If you have any questions or want assistance, contact Greig Lowell at (503) 934-0151 or write to portal.wcb@oregon.gov

CASE NOTES

Attorney Fee: Board Review - Carrier's Unsuccessful Appeal of ALJ's "Compensability" Decision - Claimant's Respondent's Brief Rejected as Untimely - Considered to Establish "Time Devoted" Factor for Determining Reasonable Attorney Fee Award

Craig Schommer, 71 Van Natta 123 (February 8, 2019). On remand from the court, *Schommer v. Liberty Northwest Ins. Corp.*, 294 Or App 147 (2018), in awarding claimant's counsel a carrier-paid attorney fee when the carrier's appeal of an ALJ's compensability decision was unsuccessful, the Board considered claimant's respondent's brief for purposes of establishing the "time devoted to the case" factor prescribed in OAR 438-015-0010(4), even though the brief had been stricken as untimely filed. In its initial review, the Board had declined to award a carrier-paid attorney fee, reasoning that claimant's respondent's brief had been rejected as untimely filed. On appeal, the court reversed, concluding that whether a claimant's counsel untimely filed a brief (or did not file a brief at all) was a factor for consideration in assessing the appropriate amount of an attorney fee award, but that claimant's counsel was statutorily entitled to a carrier-paid attorney fee. See *Schommer*, 294 Or App at 153.

In applying the factors prescribed in OAR 438-015-0010(4) to determine a reasonable carrier-paid attorney fee, the Board explained that, because claimant's respondent's brief had been rejected as untimely, the substance of the brief had not been considered. Nevertheless, the Board reasoned that the brief confirmed that claimant's counsel had expended time concerning the compensability issue on review. In addition, the Board found that the benefits secured and the value of the interest involved to claimant were significant, the claim presented average complexity, the attorneys were skilled practitioners, and there was a substantial risk that claimant's attorney's efforts might go uncompensated. Finally, taking into consideration the contingent nature of the practice of workers' compensation law, the Board determined that a reasonable carrier-paid attorney fee was \$3,500.

Filing of appellate brief not determinative regarding statutory entitlement to a carrier-paid attorney fee.

Although untimely filed brief not considered for substantive purposes, it did confirm that claimant's attorney expended time concerning compensability issue.

Attorney Fee: “386(1)” - Carrier’s Request For Review Dismissed Without Decision On Merits Of ALJ’s Compensability Decision - Claimant Did Not “Finally Prevail” Over Denial; “382(3)” - Carrier’s Request Did Not Raise ALJ’s “Attorney Fee” Award As Separate Issue

Penalties: Continuation of Denial After “Legitimate Doubt” Destroyed - Denial Unreasonable

Sanctions: “390” - Record Did Not Establish That “Withdrawn” Request For Review Was Frivolous, Without Reasonable Prospect of Prevailing

Devynne C. Krossman, 71 Van Natta 159 (February 13, 2019). (Editor’s note: On March 12, 2019, the Board’s initial order was abated in response to the carrier’s motion for reconsideration.) Applying ORS 656.262(11)(a), the Board held that the carrier’s continued denial of compensability of a new/omitted medical condition was unreasonable when, after physicians had changed their opinions to state that the currently claimed condition was synonymous with a previously accepted condition, the carrier had neither amended nor rescinded its denial (which contended that the claimed condition did not exist). In accepting a new/omitted medical condition (cold intolerance of the thumb), the carrier simultaneously denied a claim for Raynaud’s syndrome, stating that claimant did not have that condition. After several physicians changed their opinions and stated there was no distinction between cold intolerance and Raynaud’s syndrome, the carrier did not amend or rescind its denial. Instead, at hearing, the carrier asserted that its denial was reasonable because the claimed new/omitted medical condition was “encompassed” within the previously accepted condition or was a “symptom” rather than a “condition.”

The Board held that the carrier’s denial was unreasonable. Citing *Brown v. Argonaut Ins. Co.*, 93 Or App 588, 591 (1988), the Board noted that continuation of a denial in light of new medical evidence becomes unreasonable if the new evidence “destroys any legitimate doubt about liability.” Relying on *Tattoo v. Barrett Bus. Servs.*, 118 Or App 348, 351 (1993), the Board stated that carriers are bound by the express language of their denials.

Carrier denied existence of claimed new/ omitted medical condition, without asserting that it was encompassed within a previously accepted condition.

After physicians’ opinions changed, the carrier did not amend its compensability denial to assert that the claimed condition was neither “new” nor “omitted” - denial found unreasonable.

Turning to the case at hand, the Board found that the carrier's continued denial was unreasonable, because the record no longer supported the basis for its denial; *i.e.*, that the claimed condition did not exist. In reaching its conclusion, the Board acknowledged the carrier's argument that the record supported a conclusion that the claimed condition was "encompassed" within the accepted condition or was a "symptom" rather than a "condition." Nonetheless, because the carrier had not amended its denial to reflect those defenses, the Board determined that the carrier's denial was unreasonable.

Regarding a separate issue, the Board noted that, before the implementation of a briefing schedule, the carrier had withdrawn (and the Board had dismissed) its request for review of the ALJ's order, which had asserted had "erroneously set aside * * * the denial and awarded [an attorney fee and costs]." Based on such circumstances, claimant requested attorney fee awards under ORS 656.386(1) or ORS 656.382(3), as well as sanctions for a frivolous request for review pursuant to ORS 656.390.

The Board denied claimant's requests. Addressing the attorney fee issue, the Board stated that ORS 656.386(1) provides for an attorney fee "in cases involving denied claims where the claimant prevails finally * * * in a review by the Workers' Compensation Board." Furthermore, referring to ORS 656.382(3), the Board noted that the statute provides for an attorney fee when a carrier raises attorney fees as a *separate issue* in a request for review and the Board finds that the attorney fee award should not be disallowed or reduced.

Applying those principles to the present case, the Board found that claimant had not prevailed finally in a review by the Board under ORS 656.386(1) because the request for review had been withdrawn/dismissed before Board review had commenced. Moreover, based on the carrier's request, the Board reasoned that the carrier's request had raised the ALJ's attorney fee and costs award only as issues derivative of the "denial" issue. Determining that the carrier's request had not raised attorney fees as a *separate issue*, the Board declined to award attorney fees under ORS 656.382(3).

Finally, addressing the sanction issue, the Board stated that it may impose an appropriate sanction if a request for review was frivolous. See ORS 656.390. Noting that "frivolous" means the matter is not supported by substantial evidence or was initiated without a reasonable prospect of prevailing, the Board found that, because the request for review was withdrawn before the appellate briefs were filed concerning the compensability decision, the record was insufficient to support such a determination.

Because carrier withdrew its appeal before implementation of briefing schedule/ Board review, no "386(1)" attorney fee awardable because claimant did not finally prevail in a review by Board.

Because carrier's request for review did not raise ALJ's attorney fee award as a "separate issue," claimant's counsel not entitled to "382(3)" attorney fee.

Claim Filing: “Good Cause” For Untimely Filed Claim - Claimant’s Subjective Belief Of Firing For Filing Claim - “Objectively Reasonable” - “265(4)(c)”

Andrew Kuralt, 71 Van Natta 194 (February 22, 2019). Applying ORS 656.245(4)(c), on remand from the court, *Kuralt v. SAIF*, 290 Or App 479 (2018), the Board found that claimant had “good cause” for his untimely filed injury claim because the record established an objectively reasonable basis for his subjective belief that his job was in jeopardy if he filed another workers’ compensation claim. After injuring his shoulder at work, claimant did not immediately report the injury to his employer, but rather did so more than 90 days (but less than one year) after the injury. In doing so, he explained that he had not reported the injury sooner because of a conversation a month before the injury with the employer’s controller that led him to believe he would be laid off if he filed another workers’ compensation claim. When the carrier denied the claim as untimely filed, claimant requested a hearing, contending that he had “good cause” for his untimely claim.

Conversation with controller led claimant to believe he would be laid off if claim filed.

In its initial review, *Andrew Kuralt*, 67 Van Natta 589 (2015), the Board had found that claimant did not have “good cause” for his untimely filed claim. On appeal, analyzing *Riddel v. Sears, Roebuck & Co.*, 8 Or App 438 (1972), the court reasoned that, if the worker’s subjective belief that he will be laid off is based on an actual occurrence from which the worker would be laid off, the worker has established “good cause” under ORS 656.265(4)(c). Consequently, based on the Board’s finding that claimant had a subjective belief that he would be fired based on a conversation he had with the employer’s controller, the court concluded that the conversation was an “actual occurrence,” which could constitute “good cause” if the belief was “objectively reasonable.” *Kuralt*, 290 Or App at 483-84. Accordingly, the court remanded for a determination of that question.

Worker’s subjective belief that he would be fired for filing a claim must be “objectively reasonable;” it must be induced by some actual occurrence which is susceptible to such an interpretation by him.

On remand, referring to *Sarantis v. Sheraton Corp.*, 69 Or App 575 (1984), the Board noted that, in evaluating an “objective standard of reasonableness,” it applies the test of reasonableness to the situation as claimant knew it; rather than information of which claimant was unaware or was unable to appreciate. In addition, citing *Kuralt* and *Riddel*, the Board reiterated that a worker’s subjective belief must be objectively reasonable, *i.e.*, it “must be induced by some actual occurrence which is susceptible to such an interpretation by him.”

Turning to the case at hand, the Board noted claimant’s belief (based on his conversation with the controller) that his job was in jeopardy if he filed another workers’ compensation claim, his understanding of the controller’s role in hiring/firing decisions, and his knowledge that the controller had relayed to someone he believed was a supervisor that claimant had more accidents than anybody else and needed to be told. After considering that evidence, the Board

“Objectively reasonable” basis for claimant’s concern that his job would be in jeopardy if he filed another claim.

determined that claimant had an objectively reasonable basis for his concern that his job was in jeopardy if he filed another workers’ compensation claim. Accordingly, the Board concluded that claimant had established “good cause” for his untimely filed injury claim. See ORS 656.265(4)(c).

Member Lanning dissented. Contrary to the majority’s opinion, Lanning concluded that, based on what claimant knew at the time of his injury, his subjective belief that he would be fired if he filed a claim was not objectively reasonable. In reaching his conclusion, Member Lanning emphasized the following points: (1) claimant acknowledged that he had a good rapport with the company and was a valuable employee; (2) claimant had a senior union-represented position and was well-liked and respected; (3) claimant knew that the controller was concerned about safety; (4) the content of claimant’s conversation with the controller would not lead an objectively reasonable person to conclude that the controller’s comments about safety went beyond her normal “concerns”; and (5) claimant was aware that no other employees had ever been terminated for filing a workers’ compensation claim. Reasoning that such circumstances did not establish that claimant’s subjective belief that he would be fired if he filed an injury claim were objectively reasonable, Lanning was not persuaded that claimant “good cause” for his untimely filed claim.

Course & Scope: Slip/Fall On Employer’s Premises During Paid Rest Break - Met “Course Of” Prong Via “Personal Comfort” Doctrine - Met “Arising Out Of” Prong Because Returning From “Smoke Break” On Public Street Because Employer’s Premises “Tobacco Free”

Donna L. Combs, 71 Van Natta 169 (February 19, 2019). The Board held that claimant’s shoulder/hip injury, which occurred when she slipped and fell on an icy sidewalk on her employer’s premises, arose out of and in the course of her employment because she fell on the employer’s sidewalk while on her paid break and was returning from her initial destination (a public street) where employees congregated to smoke away from the employer’s premises due to its “tobacco free campus” policy. During her paid break, claimant exited the building where she worked to walk across her employer’s campus (where smoking was prohibited) to a public street outside the campus to smoke. Before she reached the public street and while she was still on her employer’s premises, due to the icy sidewalk, claimant turned around and started to return to her office. Thereafter, she slipped and fell, sustaining her shoulder and hip injuries. The carrier denied her claim, contending that her injury had not occurred while she was engaged in a “personal comfort” activity and did not arise out of her employment.

While on paid break, claimant slipped and fell on employer’s icy sidewalk - claimant initially headed for public street to smoke (because employer had “tobacco free” campus).

Employee remains in the course of employment if engages in activity that is not appointed work task, but is a “personal comfort” activity bearing sufficient connection to employment.

The Board disagreed with the carrier’s contentions. Citing *Robinson v. Nabisco, Inc.*, 331 Or 178, 186 (2000), the Board stated that the requirement that an injury occur “in the course of” employment depends on the “time, place, and circumstances” of the injury. Concerning the “arising out of” prong of the unitary “work-connection” inquiry, the Board noted that such a requirement depended on the causal link between the injury and the worker’s employment. See *Krushwitz v. McDonald’s Restaurants*, 323 Or 520, 525-26 (1996).

First addressing the “course of” prong, the Board reiterated that, under the “going and coming” rule, injuries sustained while an employee is traveling to and from work generally do not occur in the course of employment. *Krushwitz*, 323 Or at 526. Nonetheless, relying on *U.S. Bank v. Pohrman*, 272 Or App 31, 44, *rev den*, 358 Or 70 (2015), the Board remarked that an employee remains in the course of employment if he/she engages in an activity that is not his/her appointed work task, but which is a “personal comfort” activity that bears a sufficient connection to his/her employment. Again referring to *Pohrman*, as well as *Lori C. Watt*, 70 Van Natta 755 (2018), the Board identified “personal comfort” activities as those that are merely incidental to employment involving engaging in activity with a limited objective of achieving “personal comfort,” such as restroom breaks, getting something to drink, or other “typical kind of coffee break activity” that is contemplated by an employer and, therefore, do not remove the employee from the employment situation.

Manager aware claimant took breaks across employer’s campus to smoke on public street due to “tobacco free” policy.

Turning to the case at hand, the Board noted that claimant’s supervisors and manager knew that she (and other employees) smoked during her (their) rest breaks and walked across the employer’s campus to do so (because of the employer’s “tobacco free” policy). Under such circumstances, the Board determined that claimant was not on a personal mission when she sustained her injury, but rather was engaged in a typical kind of break activity while walking on her employer’s premises that was contemplated by her employer. Consequently, the Board concluded that claimant was injured in the course of her employment under the “personal comfort” doctrine.

Addressing the “arising out of” prong, the Board reiterated that an injury is deemed to “arise out of” employment “if the risk of injury results from the nature of the [employee’s] work or when it originates from risk to which the work environment exposes the worker.” *Fred Meyer, Inc. v. Hayes*, 325 Or 592, 601 (1997). Referring to *Legacy Health Systems v. Noble*, 250 Or App 596, 603 (2012), the Board stated that the “arising out of” prong is not satisfied unless the cause of the claimant’s injury was either “a risk connected with the nature of the work” (*i.e.*, an employment-related risk) or “a risk to which the work environment exposed claimant.”

After conducting its review, the Board did not consider the risk of claimant’s slipping and falling on an icy sidewalk to be a risk connected with the nature of her work as a patient access representative. Nonetheless, the Board noted that: (1) claimant had been injured while returning to her work station from her paid break; (2) she slipped/fell on her employer’s icy sidewalk; and (3) her employer contemplated that, because of its “tobacco free” policy, claimant and other employees would walk across the employer’s campus during their her/their paid break to reach a public street to smoke.

“Tobacco free” policy caused employees who wished to smoke during breaks to walk off campus; thus, work environment exposed claimant to risk of injury.

Unlike employer in Noble, this employer exercised some control over claimant’s break activity.

Claimant’s “injury-related” activity was walking on employer’s sidewalk, not smoking.

Under such circumstances, the Board determined that claimant’s work environment had exposed her to the risk of injury while walking on the employer’s premises during her paid break. Consequently, the Board concluded that claimant’s injury arose out of her employment.

In reaching its conclusion, the Board distinguished *Noble*, where the court held that the claimant’s injury, which occurred when she slipped/fell during her break while walking across her employer’s parking lot adjoining the employer’s separate facility to reach her credit union (located off the employer’s premises), did not arise out of her employment because the area where she slipped had no connection to her employment (*i.e.*, she did not work in the separate facility or park in the parking lot). In contrast to *Noble*, the Board noted that claimant had been injured while walking on her employer’s campus (directly across the street from the building where she worked) and, as a result of the employer’s “tobacco free” policy, was on the sidewalk regularly used to reach the area where employees smoked off-campus. Thus, unlike the employer in *Noble*, the Board reasoned that the employer had exercised some control over claimant’s break time activity.

Finally, the Board acknowledged that the carrier had focused on claimant’s smoking as the activity she was engaged in when she sustained her injury. Nevertheless, the Board emphasized that claimant’s injury had occurred when she slipped on the sidewalk while walking on the employer’s premises during her paid break.

Extent: Impairment Findings - “Apportionment” Rule Not Applicable - “Preexisting/Arthritic” Condition Not Established

Eric P. Svela, 71 Van Natta 91 (February 4, 2019). (*Editor’s note: On March 6, 2019 the Board abated its order in response to claimant’s motion for reconsideration.*) Applying ORS 656.214(1)(a), and OAR 436-035-0007(1), the Board held that apportionment of claimant’s permanent impairment findings was not appropriate because an arbiter’s attribution of a portion of the findings to “preexisting degenerative changes” neither established a legally cognizable “preexisting condition” nor that the findings were related to a “superimposed unrelated condition.” Following closure of claimant’s accepted L3-4 disc herniation claim, an arbiter attributed 50 percent of his reduced range of motion to the accepted condition and 50 percent to preexisting degenerative changes. When an Order on Reconsideration apportioned claimant’s permanent impairment findings by 50 percent, he requested a hearing.

The Board held that claimant was entitled to the entire impairment findings, without apportionment. Citing *Marvin Wood Products v. Callow*, 171 Or App 175, 183-84 (2000), the Board stated that claimant had the burden of establishing error in the reconsideration process. Referring to OAR 436-035-0013, the Board noted that, when a worker has a superimposed or unrelated condition, only disability due to the compensable condition is rated under the

Record did not establish that claimant's "degenerative changes" constituted a "preexisting condition" or "superimposed/unrelated condition." Therefore, apportionment of impairment findings not appropriate.

"apportionment" rule. Relying on *Schleiss v. SAIF*, 354 Or 637, 653 (2013), and *Hopkins v. SAIF*, 349 Or 348, 363 (2010), the Board reiterated that, to establish the existence of preexisting arthritis, the record must establish that the claimant suffers from "inflammation of whatever joint or joints * * * are affected by the arthritic condition." See also *Staffing Services, Inc. v. Kalaveras*, 241 Or App 130, 137-38, rev den, 350 Or 423 (2011).

Turning to the case at hand, the Board found that the record neither established that claimant was either diagnosed or treated for "degenerative changes" before the date of his work injury nor that such "degenerative changes" (as well as his history of "osteoarthritis") constituted joint inflammation. Consequently, the Board concluded that the record did not establish that claimant had a legally cognizable "preexisting condition." Likewise, the Board determined that the arbiter had not attributed claimant's impairment findings to a "superimposed or unrelated condition."

Under such circumstances, the Board reasoned that apportionment of claimant's permanent impairment was not appropriate. Therefore, the Board held that claimant had established that the Order on Reconsideration's impairment findings (which had apportioned his permanent impairment) was erroneous. Accordingly, the Board rated claimant's permanent impairment based on his entire impairment findings as reported by the arbiter.

Jurisdiction: Hearings Division Authorized To Consider Decedent's Mother's Hearing Request Regarding "De Facto" Denial Of "Dependent" Claim - Filed W/I Two Years Of Claim - ARU's Order On Reconsideration (Concerning Decedent's "Fatality" Claim) Not Preclusive On "Beneficiary" Claim - "319(6)", "030-0015(1)(c)(B)"

Death Benefits: "Dependent" - Decedent's Mother Dependent On Worker's Income (In Whole or Part) To Maintain Mode Of Living - "204(4)(a)", "005(10)(a)(A), (C)"

Bradley D. Yonker, 71 Van Natta 145 (February 13, 2019). Analyzing ORS 656.319(6), ORS 656.005(10)(a)(A), (C), ORS 656.204(4)(a), ORS 656.283, and ORS 656.726, the Board held that: (1) the Hearings Division was authorized to resolve a dispute regarding the deceased worker's mother's

Order on Reconsideration affirmed NOC that acknowledged acceptance of deceased worker's fatality claim.

(claimant's) dependent claim because, notwithstanding an unappealed Order on Reconsideration that affirmed a Notice of Closure concerning the carrier's acceptance of the worker's fatality claim, claimant's hearing request seeking survivorship benefits (on her behalf of herself, as well as the worker's disabled brother) was filed within two years of her claim; and (2) claimant established that she was dependent on the deceased worker's income to maintain her accustomed mode of living. The worker died in a work-related motor vehicle accident, which the carrier accepted. The carrier issued an "Updated Notice of Acceptance and Closure" (NOC) that was sent to the deceased worker's estate; *i.e.*, claimant's residence. The NOC indicated that "[t]he worker's beneficiaries are entitled to benefits for fatal injury pursuant to ORS 656.204."

Claimant requested reconsideration of the Notice, listing the issue as "[NOC] failed to award dependent benefits to deceased worker's mother." Responding that claimant had not provided supportive documentation, the carrier contended that it could not determine her entitlement to death benefits. An Order on Reconsideration affirmed the NOC, finding that it met OAR 436-030-0015(1)(c)(B), which requires the identification of all known beneficiaries and appraises them of their right to, and the extent of, fatal benefits due under ORS 656.204. Thereafter, claimant submitted an affidavit to the ARU describing the household finances and the worker's monthly contribution. The Appellate Review Unit (ARU) admitted the affidavit and republished its reconsideration order without substantive changes, on April 27, 2015. Neither party requested a hearing from the reconsideration order within the 30-day appeal period.

Some six months after claimant's submission of her affidavit to the carrier/ARU, she requested a hearing alleging a *de facto* denial of her death beneficiary claim. In response, the carrier contended that the Hearing Division lacked jurisdiction over the dispute, the unappealed reconsideration order resolved the dispute, or, alternatively, claimant was not a "dependent" of the deceased worker.

The Board disagreed with the carrier's contentions. Citing ORS 656.319(6), the Board noted that a hearing regarding a carrier's failure to process a claim or an allegation that the claim was processed incorrectly shall not be granted unless the request for hearing is filed within two years after the alleged action or inaction occurred. Referring to ORS 656.283(1) and ORS 656.726(2), the Board added that the ARU was not authorized to address a question of whether a claimant qualified as a beneficiary entitled to receive death benefits, as that question was a matter concerning a claim within the Board's authority. Finally, relying on ORS 656.204(4)(a) and ORS 656.005(10)(a)(A) and (C), the Board observed that a "dependent" is entitled to death benefits and includes a parent (and/or brother) of the decedent worker.

ARU not authorized to address "beneficiary" qualifications, which is a matter concerning a claim under "283(1)."

After discussing *Gallegos v. Amalgamated Sugar Co.*, 81 Or App 68, 72 (1986), the Board explained that, to establish dependency, claimant need not establish that the decedent contributed more than 50 percent of her average monthly income, but she must still establish "actual dependency," such that she was "in fact dependent on the contributions in whole or in part." The Board noted that, "[a] showing of actual dependency does not require proof that, without decedent's contributions, claimant would have lacked the necessities of life, but only that decedent's contributions were relied on by claimant to

To establish "dependency," claimant must establish that decedent's contributions maintained claimant's "accustomed mode of living" and "contributed more than own maintenance cost."

Hearing request filed within two years of carrier's alleged incorrect claim processing; thus, request not untimely filed under "319(6).

Resolution of "beneficiary" question within purview of Hearings Division, not precluded by unappealed Order on Reconsideration.

Because decedent contributed to household beyond maintenance costs, claimant found to be "dependent."

maintain claimant's accustomed mode of living" and "contributed more than his own maintenance cost." *Gallegos*, 81 Or App at 73 (citing *Paul v. Indus. Acci. Com.*, 127 Or 599 (1929)); *In re Meyers*, 25 Or App 303, 305-06 (1976).

Turning to the case at hand, the Board concluded that the Hearings Division had jurisdiction over the dispute. Reasoning that claimant had requested a hearing within two years of the carrier's allegedly incorrect claim processing (*i.e.*, a *de facto* denial of claimant's death benefit claim), the Board determined that her hearing request was timely filed. See ORS 656.319(6).

Addressing the carrier's "preclusion" argument, the Board acknowledged that the Order on Reconsideration had affirmed the NOC. Nonetheless, reasoning that the ARU was only authorized to address whether the NOC complied with OAR 436-030-0015(1)(c)(B) regarding the acceptance of the decedent's fatality claim and the identification of any current beneficiary, the Board concluded that the ARU did not address, and was not authorized to address, the question of whether claimant qualified as a beneficiary entitled to receive death benefits. Instead, because the "beneficiary" question constituted a "matter concerning a claim," the Board held that resolution of that question was within the purview of the Hearings Division and, as such, the unappealed Order on Reconsideration did not preclude claimant's hearing request concerning an alleged *de facto* denial of her death benefits claim. See ORS 656.283(1); ORS 656.726(2).

Finally, turning to the "dependent" issue, the Board found that, based on claimant's unchallenged affidavit and her credible testimony, as corroborated by the testimony of another witness, the record persuasively established that the decedent contributed monthly to the household, that his contribution exceeded his average maintenance costs, and that claimant was dependent, at least in part, on the deceased worker's contributions to maintain her accustomed mode of living. Under such circumstances, the Board held that claimant qualified as a "dependent" and was entitled to death benefits. ORS 656.005(10); ORS 656.204(4)(a).

Member Curey concurred in part and dissented in part. Although agreeing with the majority regarding the issues of jurisdiction and preclusion, Curey was not persuaded that claimant qualified as a "dependent" entitled to death benefits. Asserting that claimant's affidavit was inconsistent with her testimony and another witness, Member Curey did not consider the record sufficient to show that the decedent contributed any more than his own maintenance costs to the household. Alternatively, Curey reasoned that the record lacked information regarding claimant's accustomed mode of living and, as such, she was unable to determine that claimant was dependent, in whole or in part, on the worker's income.

“Non-Cooperation” Denial: Carrier’s Denial & “Suspension” Request Invalid - Based On Claimant’s Failure To Arrange Interview - Carrier’s Notice Did Not Include “Date, Time, Place” Of Interview Under “0060-0135(2)(a)” - Did Not “Strictly Comply” With Rule

Gustav A. Schenk, 71 Van Natta 178 (February 20, 2019). Analyzing ORS 656.262(15), and OAR 436-060-0135(2)(a), the Board, *en banc*, held that a carrier’s request for suspension of claimant’s compensation for failing to cooperate in its investigation of its claim was invalid because, although he had not responded to the carrier’s written attempt to schedule an interview, the carrier’s notice had not contained a date, time, and place for the interview as required by OAR 436-060-0135(2)(a). When claimant had not attempted to arrange an interview in response to its phone and written messages, the carrier filed a request for suspension of his compensation with the Workers’ Compensation Division (WCD). See ORS 656.262(15); OAR 436-060-0135(2)(a). WCD suspended claimant’s compensation and the carrier issued a noncooperation denial. Claimant requested a hearing, contending that the carrier had not strictly complied with OAR 436-060-0135(2)(a)(A)(i), which requires that a carrier must provide written notification to the worker of the date, time, and place of the interview.

The Board agreed with claimant’s contention. Citing *SAIF v. Robertson*, 120 Or App 1, 5 (1993), and *Eastman v. Georgia Pacific Corp.*, 79 Or App 610 (1986), the Board stated that, when a rule specifically directs a carrier to follow a certain procedure, strict compliance with the rule is required.

Turning to the case at hand, the Board quoted OAR 436-060-0135(2)(a), which provides that a carrier “*must* notify the worker in writing that an interview or deposition has been scheduled, or of other investigation requirements.” In addition, the Board emphasized that, under subsection (2)(a)(A) of the rule, the carrier’s notice must include the date, time, and place of an interview. Consequently, based on the text of the rule, the Board concluded that, in order to request suspension of compensation for failing to cooperate with an interview (rather than some other aspect of the carrier’s investigation), a carrier must send notice “that an interview has been scheduled,” including the date, time, and place of the interview.

After conducting its review, the Board found that the carrier’s suspension request was based on claimant’s failure “to submit to and fully cooperate with an interview.” Under such circumstances, the Board concluded that OAR 436-060-0135(2)(a) required the carrier to send claimant notice of the date, time, and place of a scheduled interview. Because the carrier had not done so, the Board held that the carrier had not strictly complied with the rule and, as such, WCD’s “suspension” order and the carrier’s denial must be set aside.

Claimant did not respond to phone and written messages to arrange an interview; carrier issued a “suspension” notice without including date, time, place of interview.

“060-0135(2)(a)” and “(2)(a)(A)” required that carrier’s notice “must” notify worker of date, time, place of interview before seeking WCD “suspension” of compensation.

Because carrier did not send “notice” of date, time, place of interview, carrier had not strictly complied with rule. Therefore, WCD’s “suspension” order and carrier’s denial set aside.

In effect, WCD rule requires that, when a carrier’s unable to arrange interview, it must provide claimant with date, time, place of interview, before seeking WCD “suspension” order.

In reaching its conclusion, the Board acknowledged that WCD had determined that the carrier had complied with OAR 436-060-0135(2)(a). However, noting that WCD's order had not provided an explanation or interpretation of the rule's requirements, the Board reasoned that it was not obligated to apply deference to WCD's decision. See *SAIF v. Miguez*, 249 Or App 388, 395 (2012).

The Board further recognized that the WCD rule contained some ambiguity regarding whether a carrier's notice must include the date, time, and place of a scheduled interview when its suspension request involves a failure to cooperate with "other investigation requirements", rather an interview. Nonetheless, because the carrier's suspension request in this particular case involved only the failure to cooperate with an interview, the Board reasoned that it was unnecessary to resolve the ambiguity concerning the "other investigation requirements" component of the rule.

Finally, the Board commented that, in effect, the WCD rule requires that when a carrier has been unable to arrange an interview, it must provide the claimant with the date, time, and place of an interview (and the claimant must fail to cooperate with that scheduled interview), before the carrier may seek suspension of the claimant's compensation.

Member Curey dissented. Based on her review of the rule's text, Curey reasoned that a carrier was required to notify a claimant of a scheduled interview before requesting WCD suspension only when an interview *has already been scheduled*. Thus, when, as in the present case, no interview has been scheduled, Curey asserted that the carrier was only obligated to notify claimant of "other investigation requirements" (*i.e.*, the need to contact the carrier to arrange an interview).

In reaching her conclusion, Member Curey acknowledged that subsection (2)(a)(A)(i) of the rule provides that a carrier "must" include the date, time, and place of the interview, which creates an ambiguity concerning whether such information must be placed in every notice. Nonetheless, reasoning that it would be absurd to require a carrier's notice of an "other investigation requirement" (which would necessarily not involve a scheduled interview) to include the date, time, and place of an interview, Curey declined to interpret the rule in such a manner. Moreover, noting that WCD had apparently applied its rule in this way in granting the carrier's suspension request, Member Curey believed WCD's decision constituted an interpretation of the rule and, as such, was entitled to deference.

Dissent argued that WCD rule did not require date, time, place for interview if carrier's "suspension" request was for not cooperating with "other investigation requirement;" i.e., not contacting the carrier to arrange an interview.

Own Motion: “Redetermination” - Evaluation of “Current” Permanent Impairment of Body Part - Impairment Values for Distal Body Parts (Thumb, Finger) Converted to Proximal Body Part (Hand)

Richard L. Zach, 71 Van Natta 98 (February 7, 2019). Applying ORS 656.278(2)(d), OAR 436-035-0011(5), and OAR 436-035-0070(1), in “redetermining” claimant’s permanent impairment for his “post-aggravation rights” new/omitted medical condition, the Board held that, because he had permanent impairment findings for two or more body parts (his hand, thumb, and fingers), the impairment findings in his distal body parts (thumb and fingers) must be converted to a value in the most proximal body part (hand) before combining with the other impairment values in the proximal body part (hand). Before the expiration of his five-year aggravation rights, claimant was awarded whole person permanent impairment and work disability for his right finger and right hand conditions. After the reopening of his Own Motion claim for “post-aggravation rights” new/omitted medical conditions involving the right hand and fingers, an Own Motion Notice of Closure did not award additional permanent disability. Following claimant’s request for Board review and the issuance of a medical arbiter report, claimant argued that, in rating his current permanent disability, the range of motion (ROM) impairment findings from the prior closure of his claim should be combined with the medical arbiter’s current impairment findings. Claimant further contended that, because converting the impairment values in his digits to his hand would not result in additional money, such a conversion pursuant to OAR 436-035-0070(1) was not appropriate.

The Board disagreed with claimant’s contentions. Citing *Cory L. Nielsen*, 55 Van Natta 3199 (2003), the Board explained that the limitation in ORS 656.278(2)(d) applies where there is (1) “additional impairment” to (2) “an injured body part” that has (3) “previously been the basis of a [permanent disability] award.” Referring to *James D. Miley*, 70 Van Natta 1268 (2018), *Kip G. Carty*, 63 Van Natta 473 (2011), and *Myrtle L. Alexander*, 57 Van Natta 2617, *recons*, 57 Van Natta 2970 (2005), *recons*, 58 Van Natta 82 (2006), the Board reiterated that, in redetermining a claimant’s permanent disability for “post-aggravation rights” new/omitted medical conditions, it was statutorily required to rate the current permanent impairment findings under the Director’s standards, and then apply the limitation in ORS 656.278(2)(d). Finally, relying on OAR 436-035-0011(5) (WCD Admin. Order 17-057, eff. October 8, 2017), the Board stated that the rule mandated that, if there are impairment findings in two or more body parts in an extremity, the total impairment findings in the distal body part are converted to a value in the most proximal body part before combining with the impairment values for the most proximal body part.

Turning to the case at hand, the Board determined that the limitation in ORS 656.278(2)(d) applied to claimant’s permanent disability award because he had received a prior disability award for the right hand and fingers. Thus, in rating claimant’s current permanent disability for his “post-aggravation” rights

When there are impairment findings in two or more body parts in an extremity, total impairment findings in distal body part are converted to most proximal body part before combining.

new/omitted medical conditions, the Board “redetermined” his permanent disability under the Director’s standards before the application of the statutory limitation.

Addressing claimant’s permanent impairment findings, the Board found that, because he had impairment findings in two or more body parts (*i.e.*, right hand, and right thumb/fingers) in an extremity (*i.e.*, right upper extremity), the impairment findings in the distal body parts (*i.e.*, thumb and fingers) must be converted to a value in the most proximal body part (*i.e.*, hand) before combining with the impairment values in the proximal body part (*i.e.*, hand). OAR 436-035-0011(5). The Board acknowledged claimant’s argument that his prior ROM impairment findings should be combined with his current impairment findings. Nonetheless, the Board disagreed with claimant’s contention, reasoning that, because his permanent disability was “redetermined,” claimant’s current permanent impairment findings must be rated under the Director’s standards, and the limitation in ORS 656.278(2)(d) must be applied. *Miley*, 70 Van Natta at 1270 n 2; *Carty*, 63 Van Natta at 478; *Alexander*, 58 Van Natta at 84-85.

After converting claimant’s thumb and finger impairments to a hand value, the Board calculated his hand impairment value at 82 percent. Converting that value to a whole person impairment value of 39 percent and reducing that amount by claimant’s prior award of 14 percent, the Board awarded an additional 25 percent whole person permanent impairment.

Third Party Settlement: No Portion Pertained To “Loss of Consortium” Claim - All Settlement Proceeds Subject To Carrier’s “Third Party” Lien - Claimant’s Litigation Costs Recoverable To Extent Reasonably/Necessarily Incurred In Third Party Action

Terry S. Powers, 71 Van Natta 136 (February 12, 2019). Applying ORS 656.593(1) and (3), the Board held that all proceeds from a settlement of claimant’s third party action were subject to a carrier’s lien because the record established that no portion of the settlement was attributable to his spouse’s loss of consortium claim and that claimant’s counsel was entitled to reimbursement of a portion of his litigation expenses to the extent that the record established that they were reasonably and necessarily incurred in his third party action. Following his compensable injury, claimant and his spouse retained a personal injury attorney and elected to pursue causes of action for damages and loss of consortium against the allegedly negligent third party. After the carrier approved a proposed settlement of claimant’s third party action, the parties presented

When “redetermination” required under Director’s standards, claimant’s current permanent impairment must be rated, then “278(2)(d)” limitation applied.

Carrier approved settlement, but parties disputed distribution of proceeds.

Because "loss of consortium" claim neither acknowledged/quantified in settlement offer, entire settlement subject to carrier's lien.

Claimant's counsel entitled to reimbursements for expenses reasonably and necessarily incurred during litigation of third party action.

the following disputes to the Board for resolution: (1) whether a portion of the settlement proceeds pertained to claimant's wife's loss of consortium claim and were not subject to the carrier's lien; (2) the amount of claimant's litigation expenses; and (3) the propriety of some of the carrier's asserted lien.

After considering the circumstances surrounding the third party settlement offer, claimant's acceptance of the offer, and the carrier's approval of the settlement, the Board concluded that the carrier's approval of the settlement concerned claimant's third party action only, and no portion of the settlement pertained to claimant's wife's loss of consortium claim. Under such circumstances, the Board declined to restructure the parties' settlement to recognize a consortium claim that was apparently neither acknowledged nor quantified in the settlement offer itself. See *SAIF v. Cowart*, 65 Or App 733 (1983).

The Board next addressed the "litigation expenses" issue. Citing ORS 656.593(1), OAR 438-015-0005(6), *Bennanico Rosales, III*, 68 Van Natta 1552 (2016), and *Thomas Lund*, 41 Van Natta 1352 (1989), the Board stated that a claimant is entitled to reimbursement from a third party recovery for previously unreimbursed costs that are reasonably and necessarily incurred during litigation of the third party action. Applying those points and authorities to the present case, the Board found that the costs payable to claimant's personal injury attorney were recoverable, as well as costs that were incurred for medical billing records, which were incurred while the third party litigation was pending. In doing so, the Board reasoned that, in the absence of any evidence to suggest otherwise, claimant's counsel had adequately explained why those costs were reasonably and necessarily incurred during litigation of the third party action. Conversely, noting that claimant's counsel had not explained the relationship of other disputed expenses to the third party action, the Board concluded that such costs were not recoverable.

Finally, the Board acknowledged claimant's contention that portions of the carrier's asserted lien were not recoverable. Nonetheless, noting that the undisputed portion of the carrier's lien exceeded the remaining balance of settlement proceeds that was statutorily reimbursable to the carrier under ORS 656.593(1) and (3), the Board determined that it was unnecessary to address claimant's contention.

APPELLATE DECISIONS UPDATE

Extent: Impairment Findings Related To Accepted “Lumbar Strain” Considered - Prior “Compensability” Decision Pertained To Injury Claim, Not A “Combined Condition” - “Lumbar Strain” Acceptance Did Not Encompass “Combined Condition”

Griffin v. Dish Network Services, 296 Or App 233 (February 27, 2019).

The court affirmed the Board’s order in *Jason C. Griffin*, 67 Van Natta 978 (2015), previously noted 34 NCN 6:6, which held that, in rating claimant’s permanent impairment for his low back injury, his impairment must be based on his accepted lumbar strain (rather than a combined low back degenerative/instability condition) because a prior litigation order regarding the carrier’s injury denial had not found a specific combined condition compensable. In reaching its decision, the Board rejected claimant’s arguments that its prior decision (which had set aside the carrier’s injury denial) had found a specific combined condition to be compensable and that the carrier’s subsequent acceptance of a “lumbar strain” constituted an acceptance of a combined condition. Finally, the Board noted that claimant could, at any time, object to the carrier’s acceptance of the “lumbar strain” and seek acceptance of a combined condition as a new/omitted medical condition. See ORS 656.262(6)(d); ORS 656.267(1).

On appeal, claimant contended that requiring him to file a new/omitted medical condition claim would force him to relitigate what has previously been determined (the compensability of his combined condition) and that he is entitled to permanent impairment/work disability awards based on a medical arbiter’s range of motion findings. In doing so, claimant asserted that, by virtue of the Board’s previous compensability decision and the carrier’s failure to subsequently deny his combined condition, he was entitled to permanent impairment/work disability awards based on the “preexisting condition” component of the combined condition.

The court rejected claimant’s arguments. Agreeing with the Board’s reasoning that the scope of acceptance is a question of fact, the court determined that the carrier’s acceptance of a “lumbar strain” was unambiguous and that the Board’s finding that such an acceptance did not encompass a combined condition was supported by substantial evidence. The court further concluded that the Board could reasonably interpret its previous compensability decision (which had rejected the carrier’s “combined condition” defense) as a determination that claimant’s low back strain was compensable, rather than a determination of the compensability of a particular combined condition or even that a combined condition was compensable. See *Nelson v. Emerald People’s Utility Dist.*, 318 Or 99, 104 (1993) (“issue preclusion” applies to an issue that was actually litigated and essential to a final decision on the merits).

Prior litigation order regarding denied low back injury claim did not find a specific “combined condition” compensable.

Order on Reconsideration only rated permanent impairment due to accepted lumbar strain.

Board reasonably interpreted its previous “compensability” decision as determination that lumbar strain was compensable (and not decision that a combined condition was compensable).

Finally, even assuming that the carrier's acceptance of a "lumbar strain" could be understood to encompass a "combined condition" (which would include L4-5 instability), the court concluded that there was substantial evidence to support the Board's determination that the medical arbiter had not attributed any permanent impairment to that condition.

Combined Condition: "Preexisting" Lung Cancer Spread To Femur Bone - "Injury" Claim For Fractured Femur Subject To "Combined Condition" Analysis - "005(7)(a)(B)" Applied

"Death" Benefits: "Combined Condition" Analysis Applied to "Death" Claim - "005(7)(a)(B)," "204"

Hammond v. Liberty Northwest Insurance Corporation, 296 Or App 241 (February 27, 2019). The court affirmed the Board's order in *Thomas J. Hammond, DCD*, 68 Van Natta 1243 (2016), previously noted 35 NCN 8:5, which had upheld the carrier's denial of the deceased worker's leg injury claim because the major contributing cause of his disability/need for treatment was his lung cancer. In reaching its conclusion, the Board had found that the worker's weight bearing on his leg while walking on his business trip was a material contributing cause of his disability/need for treatment, his "otherwise compensable injury" had combined with his preexisting lung cancer (for which he had previously received treatment for the diagnosed condition) and that the cancer was the major contributing cause of his combined leg fracture.

On appeal, claimant (the decedent's surviving spouse) contended that: (1) although the decedent's metastatic cancer and its spread to the bones had been previously diagnosed, the tumor in his femur had not been diagnosed, and, as such, the cancerous femur tumor did not constitute a "preexisting condition" under ORS 656.005(24); (2) the "combined condition" analysis under ORS 656.005(7)(a)(B) did not apply in the context of a death claim pursuant to ORS 656.204; and (3) based on the Supreme Court's decision in *Brown v. SAIF*, 361 Or 241 (2017), the case should be remanded to the Board for reconsideration of its "combined condition" analysis.

The court affirmed the Board's decision. Concerning claimant's first contention, the court acknowledged that the decedent's femur tumor had not been previously diagnosed. Nonetheless, reasoning that there was no dispute that the tumor was part of the decedent's cancer, the court found no error in the Board's determination that his cancer (and its spread to his bones) was a preexisting condition under ORS 656.005(24).

*Walking at work combined
with preexisting metastatic
cancer.*

No exclusion from “combined condition” limitation when injury results in death.

“Brown” concerned continued compensability of previously accepted combined condition and whether “OCI” was limited to an accepted strain under “262(7)(b)” and “268(1)(b).”

Under “005(7)(a)(B),” if a worker’s disability/ treatment is due to the combination of injury and a preexisting, noncompensable condition, injury is compensable if it is the major cause of disability/ treatment.

The court also rejected claimant’s second contention. Quoting ORS 656.204, the court stated that the statute describes the benefits due “[i]f death results from a compensable injury.” Analyzing the definition of “compensable injury” under ORS 656.005(7) and the “combined condition” limitation described in ORS 656.005(7)(a)(B), the court reasoned that benefits resulting from a combined condition are available only if the otherwise compensable injury is the major contributing cause of the disability/need for treatment of the combined condition and, furthermore, there is no exclusion when the injury results in the worker’s death.

Turning to the case at hand, the court noted that the Board had found that the fractured femur was a combined condition and it was undisputed the fracture caused/prolonged the decedent’s disability/need for treatment. Consequently, the court disagreed with claimant’s argument that the “combined condition” analysis does not apply when a claimed injury also contributes to a worker’s death.

Finally, addressing claimant’s third contention, the court observed that, unlike *Brown* (where the issue was the continued compensability of a previously accepted combined condition and whether the “otherwise compensable injury” was limited to an accepted lumbar strain under ORS 656.262(7)(b) and ORS 656.268(1)(b)), the dispute in the present case involved the applicability of ORS 656.005(7)(a)(B) to an initial claim for an injury that itself constituted the combined condition. Although the court rejected the Board’s characterization of the femur fracture as the “otherwise compensable injury” (but rather considered the fracture as the combined condition itself), the court nonetheless determined that the Board had reached the correct conclusion that the fracture was not compensable as an initial claim.

Citing *Tektronix, Inc. v. Nazari*, 117 Or App 409, *adh’d to as modified on recon*, 120 Or App 590, 594, *rev den*, 318 Or 27 (1993) and its interpretation of ORS 656.005(7)(a)(B), the court reiterated that, if in an initial claim, a worker’s disability/need for treatment is due to the combination of the injury and a preexisting, noncompensable condition, the injury is compensable only if it is the major contributing cause of the disability/need for treatment. Applying its *Nazari* analysis, the court reasoned that, although walking at work contributed to the decedent’s leg fracture, it was undisputed that the fracture was the result of a combination of the decedent’s leg bearing weight while walking and his preexisting cancer. Because the undisputed medical evidence attributed the major contributing cause of the fracture (and, therefore, its need for treatment) to the cancer, the court affirmed the Board’s holding that the claim was not compensable.