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BOARD NEWS

New ALJ - Trish Fleischman

WCB is pleased to announce the appointment of a new Salem Administrative Law Judge - Trish Fleischman. Trish grew up in Ketchikan, a small island town in Southeast Alaska. She completed her undergraduate work, with honors, at Arizona State University. Following college, she attended Lewis & Clark Law School, where she received her J.D. While in law school, she was the articles editor for The Journal of Small & Emerging Business Law. She began her career in workers' compensation law as a Certified Law Clerk for Mitchell & Guinn, P.C., in 2001. In 2002, she joined WCB as a Staff Attorney and was promoted to Senior Staff Attorney in 2010. Please join WCB in welcoming Trish Fleischman to the Hearings Division.

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 the week of May 13-17 and will run for two 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.

Permanent Rule/Amendments: "Translation of Written Documents" (OAR 438-007-0045); Amendments Concerning "Notices" of Denials/Acceptances (OAR 438-005-0050, -0053, -0055, - 0060) - Effective June 1, 2019

At their March 28, 2019 public meeting, the Members adopted OAR 438-007-0045 ("Translation of Written Documents") and permanent amendments to OAR 438-005-0050, -0053, -0055, -0060 ("Notices" concerning Acceptances/Denials). The Members took these actions after considering a report from their Advisory Committee, as well as written/verbal comments received at the Board's February 1, 2019 rulemaking hearing.

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OAR 438-007-0045 is designed to prescribe the procedures concerning the admission of documents at hearing that contain language other than English. Specifically, the proposed rule requires that any non-English language document must be translated. In addition, the proposed rule prescribes the manner in which such translations may be accomplished, as well as procedures for assigning costs for obtaining the translations or resolving any disputes regarding the translations. The proposed rule further provides that translation costs incurred by a claimant are subject to reimbursement under ORS 656.386(2).

OAR 438-005-0050, -0053, -0055, and -0060 are designed to require that all acceptance/denial notices comply with OAR 436-001-0600 (Bulletin 379), in which the Workers' Compensation Division (WCD) mandates that important claim processing documents such as these notices (as well as others) include a "multi-language help-page" informational insert that notifies non-English speaking workers of the importance of such documents, including access to the Ombudsman for Injured Workers.

The effective date for these rules is June 1, 2019. OAR 438-007-0045 is applicable to all cases pending before the Hearings Division in which the initial hearing is convened on and after June 1, 2019. The amendments to OAR 438-005-0050, -0053, -0055, and -0060 are applicable to all notices of acceptance/denial issued on and after June 1, 2019. (Consistent with WCD's adoption of its rules, the Members encourage carriers to begin complying with these OAR 438 Division 005 rules as soon as possible.)

The Board's Order of Adoption can be found here: <https://www.oregon.gov/wcb/Documents/wcbrule/rule-filings/1-2019/ooa1-2019.pdf> A copy of the order has also been posted on the Board's website. In addition, copies of the adoption order are being distributed to all parties/practitioners on WCB's mailing list.

CASE NOTES

Attorney Fee: Determination of Reasonable Attorney Fee Award - ALJ's Award Increased - "Out-of-Town" Travel to Hearing, Substantial Benefit Considered - Board Encourages Submission of "Rule-Based Factor" Information to ALJ Before "Attorney Fee" Determination - "015-0010(4)"

Brian E. Nodurft, 71 Van Natta 429 (April 23, 2019). Analyzing ORS 656.386(1), and OAR 438-015-0010(4), the Board modified an ALJ's attorney fee award for claimant's counsel's services at the hearing level in prevailing over a carrier's denial of claimant's low back injury claim. Claimant sought review of the ALJ's \$7,500 award, particularly referring to his counsel's travel (from the attorney's Portland office to the Pendleton hearing) and the significant benefits secured (surgery, suggesting the possibility of temporary/permanent disability benefits) in support of his request for a \$12,500 award.

The Board increased the ALJ's award to \$11,500. Relying on *Schoch v. Leopold & Stevens*, 325 Or 112, 118-19 (1997), the Board reiterated that in determining a reasonable assessed attorney fee, the following factors set forth in OAR 438-015-0010(4) are applied to the circumstances of each case: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated and the contingent nature of the practice of law; and (8) the assertion of frivolous issues or defenses. Citing *Robert L. Lininger*, 67 Van Natta 1712, 1718 (2015), the Board noted that application of the "rule-based" factors does not involve a strict mathematical calculation.

Attorney traveled from Portland to hearing in Pendleton.

Turning to the case at hand, the Board noted that the hearing took place in Pendleton, which was several hours from claimant's counsel's Portland office. See *Carmen O. Macias*, 53 Van Natta 689 (2001). The Board also considered the length of the hearing (46 minutes) and telephonic closing arguments (32 minutes), which totaled 52 pages of transcript, as well as 28 exhibits (including two concurrence reports submitted by claimant's counsel which were instrumental in prevailing over the carrier's denial). These latter reports further confirmed to the Board that claimant's counsel's services extended beyond the time spent at the hearing. See *Bowman v. SAIF*, 278 Or App 417 (2016).

Value and benefit (surgery, temporary/permanent disability) considered to be substantial.

Based on the range of disputed claims generally submitted for resolution before the Hearings Division, the Board evaluated the legal/medical complexity of the issues as average. In light of the physicians' disagreement regarding the compensability of the claim, the Board also took into account the risk that claimant's counsel's efforts might go uncompensated, as well as the contingent nature of a workers' compensation practice. Reasoning that the record suggested the possibility of surgery for claimant's compensable low back injury (which would include additional temporary/permanent disability benefits), the Board considered the value of the interest involved and the benefit secured to be substantial. Finally, the Board observed that counsels for both parties were experienced practitioners and presented their respective positions in a skillful and professional manner.

Statement of services, estimate of time spent, evaluation of "rule-based" factors encouraged.

Under such circumstances, the Board found that a \$11,500 attorney fee for claimant's counsel's services at the hearing level was reasonable. In reaching its conclusion, the Board noted that, prior to the ALJ's order, claimant's counsel had not filed a statement of services at the hearing level, an estimate of time spent, or provided any evaluation of the "rule-based" factors for the determination of a reasonable attorney fee under OAR 438-015-0010(4). The Board commented that such information would have been relevant to the ALJ in reaching a determination of a reasonable attorney fee.

Combined Condition: “Ceases” Denial - Requisite “Change” Since Acceptance Not Proven - Physicians Supported “Change” During “Acceptance” Period - “262(6)(c)”

Clara A. Zehrt-Shay, DCD, 71 Van Natta 477 (April 30, 2019). Applying ORS 656.262(6)(c) and ORS 656.266(2)(a), the Board set aside a carrier’s “ceases” denial of claimant’s combined right knee condition because the opinions on which the carrier relied to establish the requisite “change” in claimant’s combined condition since its acceptance supported a “change” during a period that an aggravation claim (based on the combined condition) had been accepted. Following the initial closure of claimant’s injury claim for medial, meniscal, and ACL tears of her knee, the carrier accepted a combined knee condition consisting of the knee tears combined with chondromalacia and reopened the claim for an aggravation. Some two years later, the carrier issued a “ceases” denial, contending that the knee tears were no longer the major contributing cause of claimant’s combined knee condition. In doing so, the carrier relied on physicians’ opinions that supported a “change” in claimant’s combined condition during the period that the claim had been reopened for the aggravation of the accepted combined knee condition.

The Board set aside the carrier’s “ceases” denial. Relying on *Brown v. SAIF*, 361 Or 241, 282 (2017), the Board stated that, under ORS 656.262(6)(c), a carrier may deny the accepted combined condition if the medical condition that the carrier previously accepted ceased to be the major contributing cause of the combined condition. Referring to *Oregon Drywall Sys. v. Bacon*, 208 Or App 205, 210 (2006), the Board observed that the effective date of the combined condition acceptance provides the baseline for determining whether there has been a “change” in claimant’s condition or circumstances.

Turning to the case at hand, the Board found that the “effective date” for the carrier’s acceptance of the combined condition was the date of claimant’s initial injury. Noting that the carrier’s “ceases” denial did not specify a particular date, the Board determined that the “effective date” for the denial was its issuance date. Thus, the Board clarified that the carrier must establish a change in claimant’s condition or circumstances between her original injury and the date of its “ceases” denial.

Addressing the physicians’ opinions on whom the carrier relied, the Board noted that the physicians supported a “change” in claimant’s combined knee condition during a period in which the combined condition was in accepted status. Reasoning that the physicians’ opinions supported a “change” in claimant’s combined condition that preceded the carrier’s acceptance of her aggravation claim for the combined right knee condition, the Board concluded that the carrier had not established the requisite “change” in claimant’s combined condition to support its “ceases” denial.

Carrier had reopened the claim for an aggravation of previously accepted condition.

Carrier relied on physicians’ opinions for a “change” in combined condition that preceded its acceptance of the aggravation for the accepted combined condition.

Hearing Request: “Good Cause” For Untimely Filed Request Not Established - Denial Not Confusing About “60-Day Period” to Timely File Request, No Evidence That Claimant Misled by Carrier - “319(1)(b)”

Daron J. Havlik, recons, 71 Van Natta 427 (April 22, 2019). Applying ORS 656.319(1)(b), the Board found that claimant’s confusion regarding when to request a hearing from a carrier’s denial did not constitute “good cause” for his untimely filed hearing request because the record did not establish that he had been misled by the denial or the carrier regarding when to file a hearing request. After claimant filed his hearing request regarding a carrier’s claim denial more than 60 days after the denial issued, the carrier moved for dismissal of the request as untimely filed. In response, claimant contended that he had “good cause” for the untimely filing because he believed he had to wait 60 days from the denial to file his hearing request.

The Board was not persuaded that claimant’s explanation established “good cause” for his untimely filed hearing request. Citing *Brown v. EBI Cos*, 289 Or 455, 460 n 3 (1980) and *Shawn L. Rhoades*, 50 Van Natta 2258, 2261 (1996), the Board reiterated that “good cause” under ORS 656.319(1)(b) is not a matter of “discretion,” but of agency judgment. Relying on *David R. McKenzie*, 63 Van Natta 89 (2011) (among other decisions), the Board determined that claimant’s mistaken belief that he had to wait 60 days before he could file a hearing request from the carrier’s denial did not constitute “good cause” for purposes of ORS 656.319(1)(b).

In reaching its conclusion, the Board was not persuaded that claimant used reasonable diligence to inquire about instructions in the denial that may have been confusing to him. Further finding that there was no indication that claimant had been misled by the carrier regarding the 60-day filing period, the Board reasoned that his confusion regarding the contents of the denial did not, without reasonable diligence, constitute “good cause” for his untimely filed hearing request.

Mental Disorder: Stress From “Emergency Dispatcher” Duties, Major Cause (By “Clear & Convincing Evidence”) of “PTSD” Claim - “Non-Excluded” “Work-Related” Stressors Must Be Weighed Against Statutorily Excluded “Work-Related” Stressors & “Nonwork-Related” Factors - “802(3)”

Sheila L. Minor, 71 Van Natta 354 (April 5, 2019). On remand, *Minor v. SAIF*, 290 Or App 537 (2018), applying ORS 656.802(3), the Board set aside a carrier’s denial of claimant’s mental disorder claim, determining that, by clear and convincing evidence, the major contributing cause of claimant’s Post-Traumatic Stress Disorder (PTSD) were her work activities as an emergency dispatcher because her treating physician’s opinion had persuasively weighed claimant’s stress from such activities against stress from statutorily

Claimant believed he had to wait 60 days to file hearing request.

“Good cause” is a matter of agency judgement.

Claimant’s mistaken belief about when to file hearing request did not constitute “good cause.”

Claimant did not use reasonable diligence to inquire about denial and was not misled by carrier.

Treating physician persuasively weighed excluded work and nonwork factors, with work-related stressors.

excluded work-related factors and nonwork factors. After the court reversed the Board's prior order (which had upheld the carrier's denial) and remanded for reconsideration, the carrier contended that the examining physician's opinion persuasively established that the claimed PTSD condition did not exist, and that the treating physician's opinion was not based on a sufficiently accurate history of claimant's traumatic incidents.

The Board disagreed with the carrier's contention. Citing *Liberty Northwest Ins. Co. v. Shothafer*, 169 Or App 556, 565-66 (2000), the Board stated that, in the context of a mental disorder claim, both those factors excluded by ORS 656.802(3)(b) and nonwork-related factors must be weighed against nonexcluded work-related factors. Relying on *Kienow's Food Stores v. Lyster*, 79 Or App 416, 421 (1986) and *Diana G. Hults*, 61 Van Natta 1886, 1888 (2009) the Board reasoned that a physician's greater opportunity to observe a claimant's condition over time, and to provide treatment before the occurrence of a pivotal event can place such a physician in an advantageous position.

Physician had treated claimant before occurrence of excludable work events.

Turning to the case at hand, the Board noted that the treating physician had regularly treated claimant for over a year, and evaluated her before the occurrence of statutorily excludable work-related events such as a reprimand concerning her job performance. Under such circumstances, the Board was persuaded that the treating physician provided a well-reasoned opinion that adequately weighed claimant's exposure to traumatic experiences at work and had weighed those stressors against claimant's excludable work-related and off-work stressors (e.g., a supervisor's reprimand and a previous shooting incident that had been the subject of a Disputed Claim Settlement).

Examining physician did not address PTSD symptoms documented by the treating physician.

In contrast, the Board was not persuaded by the examining physician's opinion because it did not consider or discuss PTSD symptoms which had been contained in the treating physician's chart notes. Reasoning that the examining physician's opinion was based on inadequate information, the Board discounted the physician's opinion.

Responsibility: "LIER" - "Impossibility/Sole Cause" Defense Not Established by Last Carrier - "Actual Causation" Not Applicable Because Compensability Conceded/Claimant Did Not Assert "Actual Causation" Against Any Employer

Last employer responsible for hearing loss claim under "LIER."

John M. Burlington, 71 Van Natta 408 (April 17, 2019). Applying the "last injurious exposure rule" (LIER), in determining responsibility for claimant's occupational disease claim for bilateral hearing loss, the Board held that the last employer was responsible for the claim because it had neither established that it was impossible for its employment to have caused claimant's hearing loss nor that his hearing loss was solely caused by his employment with a prior employer. In reaching its conclusion, the Board rejected the last employer's contention that it was not responsible for claimant's occupational disease claim because an earlier employer was the "actual cause" of his hearing loss condition.

“Actual causation” applies if claimant raises the argument; then carrier may use LIER to attempt to shift burden from that “actual causation” employer to another.

Because compensability was conceded, “actual causation” was irrelevant in assigning responsibility.

Because claimant did not attempt to prove “actual causation” against an employer, last employer had to prove it was “impossible” for its exposure to have caused/worsened the claimed condition or that a prior employer was the sole cause.

Despite “independent contractor” agreement, employer designated claimant’s routes, stops, and whether passengers were permitted; therefore trucker was a “worker.”

Citing *SAIF v. Hoffman*, 193 Or App 750, 753 (2004), and *Spurlock v. Int’l Paper Co.*, 89 Or App 461, 464-65 (1988), the Board stated that “actual causation” is a concept that arises when a *claimant* chooses to prove that a particular employer actually caused the claimed condition. If a claimant successfully proves that a particular employment was the major contributing cause of the claimed condition, the Board noted that the carrier can then use the LIER to attempt to shift responsibility to a subsequent carrier by proving that such employment independently contributed to a worsening of the disease. See *Willamette Indus., Inc. v. Titus*, 151 Or App 76, 80 (1997).

Turning to the case at hand, the Board likened the circumstances similar to those in *Roseburg Forest Prods. v. Long*, 325 Or 305, 308 (1997), where the compensability of a hearing loss condition had been conceded by all carriers. Under such circumstances, the Board noted that the *Long* court had applied the LIER, citing *Fossum v. SAIF*, 293 Or 252, 255-57 (1982), for the proposition that “actual contribution” to a claimant’s occupational disease was irrelevant in assigning responsibility under the LIER. *Id.* at 310.

Applying the aforementioned rationale, the Board observed that claimant had not attempted to prove “actual causation” against any particular employer/ carrier, but instead had asserted that LIER applied when the parties had conceded the compensability of his claim. Consequently, the Board applied LIER to determine the presumptively responsible employer. Finding that claimant had not treated for his hearing loss until after his retirement, the Board concluded that the last employer was presumptively responsible. Because the last employer had not proven it was either impossible for it to have caused/worsened claimant’s hearing loss or that a prior employer had solely caused the claimed condition, the Board determined that the last employer was responsible for claimant’s hearing loss claim.

Subject Worker: “Nonsubject Worker” Exception (“027(15)(c)”) - Claimant Did Not “Furnish” Truck to Motor Carrier - Had No “Transferable Interest” in Truck Leased to Carrier

Carl S. Ward, 71 Van Natta 484 (April 30, 2019). Applying ORS 656.027(15)(c), the Board held that claimant, a truck driver, was not a “nonsubject” worker because he had no “transferable interest” in the truck he leased to a motor carrier and, as such, he had not “furnished” the vehicle to the motor carrier as required by the statute to be excluded from coverage as a “subject worker.” Claimant had leased a tractor truck from the employer and signed an “independent contractor” agreement. Notwithstanding this agreement, the employer designated claimant’s routes, when he could make stops, and whether he was permitted to have passengers in the vehicle. Following his injury, claimant filed a claim, contending that he was a subject worker and was not a “nonsubject worker” because he had no right to “furnish” the vehicle to the employer within the meaning of ORS 656.027(15)(c).

The Board agreed with claimant's contention. Citing *S-W Floor Cover Shop v. Nat'l Council on Comp. Ins.*, 318 Or 614, 630 (1994), the Board explained that it must first determine whether an individual is a "worker" under ORS 656.005(30) before determining whether that individual is a "nonsubject" worker under ORS 656.027. The Board noted that the determination of whether an individual is a worker involves the application of the "right to control" test and the "nature of the work" test. The Board then addressed ORS 656.027(15)(c), which excludes from coverage "a person who has an ownership or leasehold interest in equipment and who furnishes, maintains and operates the equipment." Applying *May Trucking Co. v. Employment Dep't*, 279 Or App 530 (2016), and *3P Delivery, Inc. v. Employment Dep't Tax Section*, 254 Or App 180 (2012), in which the court interpreted similar language in other statutes involving motor carriers, the Board reasoned that in order to "furnish" equipment within the definition of ORS 656.027(15)(c), the person furnishing the vehicle must have a transferable interest in the vehicle.

Employer exercised significant control over claimant's job performance and was also free to terminate employment without contractual liability.

Turning to the case at hand, the Board reasoned that the employer's exercise of significant control over the manner of claimant's job performance, including which routes to take to his destinations, when he could make stops, and whether he could have passengers in his vehicle, the "right to control" weighed in favor of an employment relationship. The Board also analyzed the employer's right to terminate employment, finding that the employer was free to fire claimant without contractual liability, which also favored the existence of an employment relationship. The Board further determined that because claimant's work was a fundamental and continuous part of the employer's business, the "nature of the work" test also favored "worker" status.

Claimant had no equity or ownership rights in the vehicle.

Addressing the question of whether claimant "furnished" his vehicle within the meaning of ORS 656.027(15)(c), the Board noted that, pursuant to the parties' agreement, claimant would not acquire "any proprietary right, security interests or equity in the lease vehicle," nor could he "sell, rent, lend, mortgage or illegally transfer the vehicle to any other party other than [employer]." The Board further emphasized that claimant had "absolutely no right to purchase and no equity or any other ownership rights in the lease vehicle."

Because claimant had no "transferable interest" in vehicle, he could not "furnish" the vehicle to the motor carrier. Therefore, "nonsubject worker" exception did not apply.

Under such circumstances, the Board found that claimant had no transferable interest in the leased and leased-back vehicle. Consequently, the Board concluded that claimant could not "furnish" the vehicle and, thus, was not a "nonsubject" worker under ORS 656.027(15)(c). Accordingly, the Board set aside the carrier's claim denial.

Interim Compensation: No “AP-Authorized” TTD Benefits Established - “262(4)(a),” “005(12)(b)”

Penalty/Attorney Fee: Unreasonable Failure to Timely Accept/Deny “New Occupational Disease” Claim Unreasonable - Prior “Injury” Denial Did Not Encompass Later “New O.D.” Claim - No “Amounts Then” to Base Penalty, But “Attorney Fee” Awarded - “262(11)(a)”

Ted B. Minton, 71 Van Natta 362 (April 5, 2019). Applying ORS 656.262(4)(a) and ORS 656.262(11)(a), the Board held that claimant was not entitled to interim compensation pending a carrier’s acceptance/denial of a claim that was eventually found compensable because an attending physician had not authorized temporary disability benefits during that period, but because the carrier had not timely responded to claimant’s “new occupational disease” claim, an attorney fee award was warranted. After the carrier issued a denial of claimant’s bilateral knee injury claim, his attorney filed “new occupational disease” claim for assorted bilateral knee conditions (including osteoarthritis). When the carrier did not respond to the claim within 60 days, claimant requested a hearing, contending that the claims were compensable and that he was entitled to penalties and attorney fees for the carrier’s unreasonable claim processing.

Concluding that claimant’s occupational disease claim for bilateral knee osteoarthritis was compensable, the Board found that claimant was not entitled to interim compensation or penalties, but that an attorney fee award under ORS 656.262(11)(a) was justified because the carrier had not timely responded to claimant’s “new occupational disease” claim.

Citing ORS 656.262(4)(a), the Board stated that temporary disability benefits are due 14 days after the carrier has notice or knowledge of the claim, and of the worker’s disability if the attending physician (or nurse practitioner) authorizes the payment of such compensation. Relying on ORS 656.005(12)(b), the Board noted that an attending physician is primarily responsible for the worker’s treatment.

Turning to the case at hand, the Board acknowledged that, in his claim for interim compensation (temporary disability) benefits, claimant referred to various references to light duty work restrictions mentioned by a number of examining, consulting, and primary care physicians. However, noting that a physician provided brief consultation, the Board did not consider the physician to be an attending physician. See *Darlene L. Sparling*, 63 Van Natta 281, 285 (2011). Furthermore, the Board reasoned that, even if another physician’s comments were considered physical limitations from an attending physician, the record did not establish that such restrictions prevented claimant from performing his regular work and, as such, temporary disability benefits had not been authorized. See *Ralph T. Nisbet*, 69 Van Natta 521, 524 (2017).

After denial of injury claim, claimant filed “new occupational disease” claim.

Light duty restrictions did not come from an attending physician.

Record did not establish that claimant was prevented from regular work due to restrictions. Therefore,

no entitlement to interim compensation (TTD benefits).

Prior “injury” denial did not encompass “new occupational disease.”

Attorney fee awarded for unreasonable claim processing, but no penalty award granted because no “amounts then due.”

\$1,500 statutory cap on “claim costs” reimbursement, absent extraordinary circumstances.

Carrier asserted Board conflated “extraordinary” and “reasonable.”

Addressing the carrier’s claim processing, the Board acknowledged the carrier’s assertion that its previous denial encompassed his subsequent claim. Nonetheless, reasoning that the carrier’s earlier denial specifically described a bilateral knee injury claim, whereas claimant’s subsequent claim concerned a “new occupational disease” for assorted bilateral knee conditions (including osteoarthritis), the Board determined that the prior denial did not encompass claimant’s later claim. See *Tattoo v. Barrett Bus. Serv.*, 119 Or App 348, 351 (1993).

Because the carrier did not accept or deny the “new occupational disease” claim within 60 days, and did not provide a persuasive explanation for failing to do so, the Board concluded that the carrier’s claim processing was unreasonable. See ORS 656.262(11)(a); *Carol L. Williams*, 70 Van Natta 821, 822 (2018). Reiterating that there were no “amounts then due,” the Board declined to award a penalty. Nevertheless, the Board awarded a carrier-paid attorney fee under ORS 656.262(11)(a) for the carrier’s unreasonable conduct. See *SAIF v. Traner*, 270 Or App 67, 75-76 (2015).

APPELLATE DECISIONS UPDATE

Costs: “386(2)(d)” - “Extraordinary Circumstances”

SAIF v. Siegrist, 297 Or App 284 (April 24, 2019). The court reversed the Board’s order in *Kevin J. Siegrist*, 68 Van Natta 1283 (2016), *on recon*, 69 Van Natta 92 (2017), previously noted 36 NCN 1:6, which found that claimant had established “extraordinary circumstances” justifying reimbursement of his claim costs for overturning a carrier’s claim denial beyond the \$1,500 statutory cap. Identifying the issue as whether the circumstances regarding the litigation concerning the carrier’s denial of claimant’s bilateral carpal tunnel syndrome (CTS) claim were beyond those that were “usual, regular, common, or customary in this forum,” the Board had concluded that, in light of the opposing opinion of a highly credentialed expert supporting the carrier’s position, claimant would not have been able to prove his claim without obtaining, at significant cost, the specialist’s opinion that established the compensability of his claim and extended his costs beyond the \$1,500 cap (to \$1,550).

On appeal, the carrier presented three arguments: (1) because claimant did not demonstrate extraordinary circumstances *in his cost bill*, the Board should not have considered his request for reimbursement of his costs exceeding \$1,500; (2) the Board had conflated “extraordinary” and “reasonable” in concluding that claimant’s need for a specialist’s opinion to establish the compensability of his claim was alone sufficient to demonstrate extraordinary circumstances; and (3) the Board order was not supported by substantial evidence/reason.

Regarding the carrier’s first argument, the court noted that the Board had declined to address it as it had not been raised at the hearing level. Citing *Fred Meyer, Inc. v. Hofstetter*, 151 Or App 21, 26 (1997), the court reiterated that it is generally recognized that the Board has discretion on whether to reach issues not raised at the hearing level before an ALJ. Furthermore, relying on *Stevenson v. Blue Cross of Oregon*, 108 Or App 247, 252 (1991), the court stated that it will not review the merits of an issue when

Board has discretion whether to reach issues not raised at hearing level.

Board did not adequately explain why “circumstances” were “extraordinary” beyond “reasonably incurred” costs.

Court addressed “extraordinary” circumstances discussed in legislative history: (1) “extraordinarily complex”; (2) “out-of-region” expert.

Not apparent to court why obtaining “well-qualified” specialists’ opinions constituted “extraordinary circumstances.”

the Board did not decide it. Finally, even assuming that the “plain-error review” doctrine applied in this procedural posture, the court observed that the correct interpretation of the “cost bill” rule (OAR 438-015-0019) was not something that was “obvious” and “not reasonably in dispute,” as required by the “plain-error review” doctrine. See *Ailes v. Portland Meadows, Inc.*, 312 Or 376, 381 (1991).

Turning to the carrier’s additional arguments (which the court discussed together as a single assignment of error), the court concluded that the Board’s order failed to adequately explain why the circumstances were extraordinary, beyond the undisputed fact that it was reasonable for claimant to incur such costs. In reaching its conclusion, the court emphasized that the distinction between “reasonable” and “extraordinary” was important in that, under ORS 656.386(2)(a), the Board may only order a carrier to pay *reasonable* expenses and costs for records, expert opinions and witness fees. As such, the court reasoned that the legislature assumed that any costs that the Board ordered to be paid by the carrier would be reasonable, but it *nonetheless* imposed a \$1,500 cap in all but “extraordinary circumstances.”

After reviewing the legislative history concerning ORS 656.386(2)(a), the court considered the \$1,500 cap to have been carefully negotiated. In light of that history, the court determined that the cap would be meaningless if all that was required to overcome it was for a claimant to show that his/her reasonably incurred costs exceeded \$1,500. Noting that (2)(a) already limits ordered payments to reasonable costs, the court reasoned that the legislature could not have meant by “extraordinary circumstances” that carriers may be ordered to pay more than \$1,500 any time that a claimant reasonably needs to spend more than the \$1,500 statutory cap. The court concluded that to construe (2)(d) in such a manner would render the cap superfluous and deprive (2)(d) of all practical effect. See ORS 174.010.

As for what types of circumstances might qualify as extraordinary, the court found only two specific circumstances discussed in committee hearings: (1) an “extraordinarily complex” case; and (2) a case in which the claimant had to retain a more expensive out-of-region expert because no regional expert was available. Stating that there appeared to be no disagreement that claimant’s bilateral CTS was of average complexity and the specialist that claimant retained was an Oregon physician, the court focused its analysis on the reason given for the Board’s “extraordinary circumstances” finding; *i.e.*, claimant’s need for the specialist’s opinion in order to prevail over the carrier’s claim denial.

Noting that the Board had not disagreed with the ALJ’s statement that specialists’ opinions are “fairly common in this forum,” the court did not consider it apparent how “well-qualified” specialists’ opinions from both claimant and the carrier constituted an “extraordinary circumstance.” Similarly, it was unclear to the court how a physician’s change of opinion (who had previously supported the compensability of claimant’s claim) *after* claimant obtained the specialist’s opinion supporting his claim contributed to the Board’s “extraordinary circumstances” finding. Finally, reasoning that it will often presumably be the case when a claimant prevails over a denied claim that his/her expert proved more persuasive and “tipped the scale” in favor of compensability, the court commented that the extraordinariness of that circumstance was also not obvious.

Costs determined to be “warranted and necessary” provided little assistance to court in determining “extraordinary circumstances.”

Finally, the court acknowledged the Board’s statements that part of its evaluation of “extraordinary circumstances” was to determine whether the costs over \$1,500 were “warranted and necessary.” Nonetheless, the court reasoned that, although costs must be reasonable (which would seem to encompass being warranted and necessary), such a determination was of little assistance in determining when “extraordinary circumstances” exist within the meaning of ORS 656.386(2)(d).

Accordingly, concluding that the Board’s order lacked substantial reason regarding its explanation for why the circumstances of the present case were extraordinary (beyond the mere fact that claimant reasonably incurred more than \$1,500 in costs), the court remanded for reconsideration of whether extraordinary circumstances supported claimant’s request for reimbursement of costs exceeding the \$1,500 cap.

Occupational Disease: “Mere Susceptibility”/ “Predisposition” Exception to “Preexisting Condition” - “Active Contribution” Requirement - Applies to “O.D.” Claims

Congenital foot condition not considered a “preexisting condition” because it did not “actively contribute” to the claimed occupational disease.

SAIF v. Dunn, 297 Or App 206 (April 24, 2019). Analyzing ORS 656.005(24)(a), (c), and ORS 656.802(1)(a), and (2)(a), (e), the court reversed the Board’s order in *David Dunn*, 68 Van Natta 14 (2017), previously noted 36 NCN 1:8, that, in analyzing the compensability of an occupational disease claim for “apophysitis,” found that claimant’s congenital foot condition (“unfused apophysis”) was not a “preexisting condition” because the “apophysis” did not actively contribute to his claimed “apophysitis.” In reaching its conclusion, the Board had rejected the carrier’s contention that ORS 656.005(24)(c) (which provides that for purposes of industrial injury claims, a condition does not contribute to disability or need for treatment if the condition merely renders the worker more susceptible to the injury) does not apply in an occupational disease context.

“Susceptibility” or “predisposition” that does not actively contribute is not a “preexisting condition” in an “occupational disease” context.

Referring to *Multnomah County v. Obie*, 207 Or App 482, 487 (2006), and *Murdoch v. SAIF*, 223 Or App 144, 150 (2008), the court acknowledged that it should not have cited ORS 656.005(24)(c) as a source for its conclusions that, in analyzing the compensability of occupational disease claims, a susceptibility or predisposition that does not contribute to the cause of the occupational disease is not a preexisting condition. Instead, the court clarified that, in those cases, it should have separately addressed the question under the statutory context of occupational disease claims. In any event, after conducting such an analysis, the court adhered to its *Obie* holding that a mere susceptibility or predisposition that does not contribute to the cause of symptoms or need for treatment is not a preexisting condition in the occupational disease context.

Citing ORS 656.802(2)(e), the court stated that “preexisting conditions shall be deemed causes in determining major contributing cause” of an occupational disease. Referring to ORS 656.005(24)(b), the court noted that a preexisting condition in the occupational disease context is a condition that

Court rejected the contention that “susceptibilities” are treated as “preexisting conditions” for occupational diseases.

Legislature intended to exclude “predispositions” from consideration as “preexisting condition” in an occupational disease context.

Consistent with legislative history, a condition that renders worker more “susceptible” to injury/O.D. increases likelihood that body part will be injured by some other action/process, but does not “actively contribute” to damaging the body part.

Conclusion that condition merely made claimant “susceptible” was inconsistent with physician’s description

“contributes to disability or need for treatment.” Furthermore, relying on ORS 656.003 (which provides that the definitions given in ORS Chapter 656 govern unless context requires otherwise), the court determined that the definition of preexisting condition in ORS 656.005(24)(b) is applicable to ORS 656.802(2)(e).

As it had in *Obie*, the court rejected the carrier’s contention that, in light of ORS 656.005(24)(c), the legislature’s failure to similarly exclude susceptibilities from preexisting conditions in the occupational disease context reflected an intention that susceptibilities are to be treated as preexisting conditions. Instead, based on the definition of “preexisting condition” in ORS 656.005(24)(b) (which explicitly requires that a preexisting condition contribute to the disability or need for treatment) and the legislative history of that statute (which shows a clear intention that, with respect to both injury and occupational disease claims, susceptibilities that do not actively contribute to the cause of a condition are not to be weighed in determining major contributing cause), the court reasoned that the legislature intended to exclude predispositions from consideration as preexisting conditions in the occupational disease context.

In reaching its conclusion, the court did not consider other statutory provisions to be inconsistent with the aforementioned legislative intention. Referring to ORS 656.802(2)(e), and ORS 656.804, the court noted that both statutes require application of the definition of “preexisting condition” in ORS 656.005(24)(b), which requires that the preexisting condition “contributes to disability or need for treatment.”

Furthermore, relying on *Corkum v. Bi-Mart Corp.*, 271 Or App 411, 422 (2015), the court reiterated that, consistent with legislative history, a condition only renders a worker more susceptible to injury for purposes of ORS 656.005(24)(c) if the condition “increases the likelihood that the affected body part will be injured by some other action or process but does not actively contribute to damaging the body part.” Although acknowledging that *Corkum* involved an injury case and addressed the meaning of the term “susceptible” as used in ORS 656.005(24)(c), the court reasoned that *Corkum* had relied on the same legislative history on which it was relying in the present case, which was equally persuasive in the occupational disease context.

Consequently, the court held that, in the occupational disease context, a predisposition or susceptibility may be considered in the causation analysis only if it actively contributes to the disability or need for treatment. Applying that principle to the case at hand, the court identified the medical question as whether claimant’s apophysis constituted a mere susceptibility or predisposition, because it only increased the likelihood of claimant developing apophysitis and did not actively contribute to the cause of the inflammation.

After reviewing the physician’s opinion on which the Board had based its finding that claimant’s apophysis had merely made him susceptible to apophysitis, the court noted that the physician had also explained that claimant’s unfused apophysis and the tugging of tendon on the fibrous tissue around the unfused bone had caused inflammation and pain, which resulted in his apophysitis. Reasoning that the conclusion that the apophysis merely made claimant susceptible to apophysitis appeared to be inconsistent with the physician’s description of the apophysis (combined with the micromotion of claimant’s tendon pulling on the fibrous tissue when claimant walked) as a

of the cause of inflammation; therefore, court remanded for resolution of apparent inconsistency.

Court of Appeals relied on entitlement to payment under minimum wage laws in determining claimant's status as a worker.

Parties' "worker" dispute centered on what legislature meant in saying services must be furnished "for" remuneration.

Pivotal question was whether claimant reasonably expected remuneration for services rendered, not whether remuneration was required.

Entitlement to remuneration under "implied-in-law" contract theory ("minimum wage" law) did not qualify claimant as "worker" under statute.

mechanical cause of the inflammation, the court considered the Board's finding that claimant's apophysis did not itself actively contribute to claimant's disability or need for treatment to be supported by substantial reason. Accordingly, the court remanded for resolution of the apparent inconsistency and apply the correct legal standard in evaluating the cause of claimant's apophysitis.

APPELLATE DECISIONS SUPREME COURT

Subject Worker: "005(30)" - "Pre-Employment/Driver Test" Injury - No Reasonable Expectation "To Furnish Services For Remuneration"

Gadalean v. SAIF, 364 Or 707 (April 18, 2019). The Supreme Court reversed a Court of Appeals decision, 286 Or App 227 (2017), which in reversing the Board's order in *Cozmin I. Gadalean*, 68 Van Natta 336, on recon, 68 Van Natta 420 (2016), previously noted 35 CNN 3:15, had held that claimant was a "worker" within the meaning of ORS 656.005(30) because Oregon's minimum wage laws would have entitled him to be paid for the supervised delivery he was performing as a "pre-employment" commercial truck driving test when he was injured. The Supreme Court identified the determinative issue as whether the legislature intended that, if an employer had a claimant perform an activity for which minimum wage law required a wage, would the claimant have "engage[d] to furnish services for a remuneration" as required by ORS 656.005(30).

Framing the parties' disagreement as centering around what the legislature meant when it said that the services are furnished "for" a remuneration, the Supreme Court reasoned that "for" means "that the subject acted with an expected result." See *Webster's Third New Int'l Dictionary* 751 (unabridged ed 2002). Thus, the Court determined that the most plausible reading of ORS 656.005(30) was that a "worker" is one who satisfies both components of the statutory definition by demonstrating that: (1) he/she undertook an obligation to furnish services; and (2) he/she did so *for* - with the expected result of - remuneration. Because the expectation of remuneration arises out of the circumstances of a claimant's relationship with an alleged employer, the Court further concluded that the claimant's expectation of remuneration must be reasonable in light of the circumstances.

Addressing the Court of Appeals' opinion, the Supreme Court noted that the opinion had considered the minimum wage law dispositive of claimant's status as a "worker" under ORS 656.005(30); *i.e.*, he qualified as a "worker" because he was entitled to remuneration under an "implied-in-law" contracts theory. However, the Supreme Court disagreed with that approach, reasoning that, by requiring an "engagement to furnish services for a remuneration," ORS 656.005(30) necessarily required a claimant to have acted *expecting* remuneration and, as such, a contract implied in law was insufficient, standing alone, to fulfill the statutory requirement that a claimant engaged to furnish services "for a remuneration."

Phrased another way, the Supreme Court clarified that the pivotal question under ORS 656.005(30) is not whether the agreement *required* remuneration, but whether, in engaging to furnish services, a claimant reasonably *expected* remuneration. Thus, the Court concluded that the proposed application of the minimum wage statute would improperly substitute the definition of “employ” under the minimum wage law (*see generally* ORS 653.025, ORS 653.010(2)) for the legislature’s chosen definition of “worker” in the workers’ compensation statutory scheme.

After reviewing the text and context of ORS 656.005(30), the Supreme Court noted the legislature’s use of “contracts” to define “employer” under ORS 656.005(13), but not to define “worker” pursuant to ORS 656.005(30). Considering that difference, the Court reasoned that the legislature intended the definition of “worker” to require something different from a contract.

Although acknowledging that the definition of “worker” in ORS 656.005(30) includes all the requisite elements of a contract (and has long been construed as requiring a contract), the Supreme Court determined that the legislature had chosen to define “worker” with emphasis on the claimant’s engagement; *i.e.*, the claimant’s taking on of an obligation that meets the statutory requirements. Thus, the Court considered it consistent with that claimant-focused inquiry to interpret the definition of “worker” as requiring a determination of the claimant’s reasonable expectations.

Addressing the development of the statute, the Supreme Court observed that an employee has only workers’ compensation insurance benefits, which are statutorily capped. *See Smothers v. Gresham Transfer, Inc.*, 332 Or 83, 125 (2001), *overruled on other grounds*, *Horton v. OHSU*, 359 Or 168 (2016). In light of that consequence, and because it is the worker who is affected, the Court considered it likely that the legislature intended that the applicability of the workers’ compensation law depend, in part, on the worker’s agreement and expectations.

Finally, turning to the case at hand, the Supreme Court stated that the Board had found that the employer had told claimant that he would not be paid for the “pre-employment” drive test and discredited his assertion that he would receive a portion of the employer’s gross profit for the delivery. Because the Board had found that claimant had been told by the employer that he was to perform the test and to do so without remuneration, the Court held that claimant did not qualify as a “worker” under ORS 656.005(30).

Definition of “worker” interpreted as requiring determination of claimant’s reasonable expectations.

Board had discredited claimant’s assertion that he would receive a portion of the employer’s gross profit for his services.