Workers' Compensation Board

Volume XXXVIII, Issue 5

May 2019

News & Case Notes

BOARD NEWS

Annual Adjustment to Maximum Attorney Fee Effective July 1, 2019

The maximum attorney fee awarded under ORS 656.262(11)(a) and ORS 656.382(2)(d), which is tied to the increase in the state's average weekly wage (SAWW), will rise by 3.709 percent on July 1, 2019. On June 1, 2018, the Board published Bulletin No. 1 (Revised), which sets forth the new maximum attorney fees. The Bulletin can be found on the Board's website at: https://www.oregon.gov/wcb/legal/Pages/bulletins.aspx

An attorney fee awarded under ORS 656.262(11) shall not exceed $4,582, absent a showing of extraordinary circumstances. OAR 438-015-0110(3).

An attorney fee awarded under ORS 656.308(2)(d) shall not exceed $3,304, absent a showing of extraordinary circumstances. OAR 438-015-0038; OAR 438-015-0055(5).

These adjusted maximum fees apply to all attorney fee awards under statutes granted by orders issued on July 1, 2019 through June 30, 2020.

Board Meeting (June 18): Consideration of "Advisory Committee" Report/Discussion of Rulemaking - Possible Proposed Amendment to "Subpoena" Rule ("007-0020(6)(b)")

The Board has scheduled a public meeting for the Members to review and discuss an advisory committee's report regarding a rule concept (submitted by Marcia Alvey, Attorney at Law) concerning OAR 438-007-0020(6)(b), which will include whether to propose rule amendments consistent with the committee's recommendation. The rule concerns obtaining "individually identifiable health information" through a subpoena duces tecum, the information/notice to be included in such a subpoena, and where/when to send the information in case of an objection to the subpoena.

Members of the advisory committee are: Marcia Alvey, Stan Fields, Jennifer Flood, Georgia Green, Vincci Lam, Jenny Ogawa, Steve Schoenfeld, Larry Schucht, and Joy Dougherty (facilitator). The members gratefully appreciate the advisory committee's services. The advisory committee report and meeting agenda can be found here: https://www.oregon.gov/wcb/Pages/meetings-minutes.aspx

APPELLATE DECISIONS

Update

Court of Appeals

Supreme Court

The Board meeting has been scheduled for June 18, 2019, at the Board's Salem office (2601 25th St. SE, Ste. 150), at 10 a.m.

A formal announcement regarding this Board meeting has been electronically distributed to those individuals, entities, and organizations who have registered for these notifications at https://service.govdelivery.com/accounts/ORDCBS/subscriber/new.

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.

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

Extent: Impairment Findings - Apportionment - Impairment Related to "Undiagnosed" Condition Not Ratable - Superimposed/Unrelated Condition - "035-0007(1)(b)(B)"

Medical arbiter attributed 80% impairment to "as yet undiagnosed conditions."

Reina Cruz-Salazar, 71 Van Natta 525 (May 9, 2019). Applying OAR 436-035-0007(1)(b)(B), in rating claimant's permanent impairment between her accepted elbow/shoulder conditions, the Board apportioned her impairment findings between impairment attributable to her accepted conditions and those related to "as yet undiagnosed conditions." After a medical arbiter attributed 80 percent of claimant's permanent impairment findings to "as yet undiagnosed conditions," an Order on Reconsideration rated all of the findings as due to her accepted conditions, reasoning that the undiagnosed conditions were not "preexisting conditions." The carrier requested a hearing, contending that claimant's impairment findings must be apportioned between her accepted conditions and her undiagnosed conditions (which were not related to her accepted conditions or their direct medical sequelae).

When worker has "superimposed condition," only disability due to compensable condition is rated.

The Board agreed with the carrier's contention. Citing ORS 656.214(1)(a), ORS 656.268(15), and OAR 436-035-0007(1), the Board stated that a worker is entitled to an impairment value for findings that are permanent and caused by the accepted condition and direct medical sequelae. Referring to OAR 436-035-0007(1)(b) and OAR 436-035-0013, the Board noted that when a worker has a superimposed condition, only disability due to the compensable condition is rated under the "apportionment" rule. Finally, relying on *Kevin B. Van Boekel*, 69 Van Natta 1390, 1394 (2017), the Board reiterated that permanent impairment is based on the accepted conditions and their direct medical sequelae, rather than on conditions that were not accepted at the time of the claim closure.

Disability standards do not provide for impairment award for "undiagnosed condition" not related to accepted conditions.

Turning to the case at hand, the Board found that the record did not establish that claimant's impairment attributable to the undiagnosed conditions was caused by her compensable injury or a condition that existed before the initial injury or an accepted new medical condition. *See* OAR 436-035-0007(1)(b)(B)(i). Reasoning that the aforementioned rule does not provide for an impairment award for an "undiagnosed" condition, the Board concluded that, if such a condition was described at all in the Director's "disability" standards, it would be as a "superimposed condition."

Relying on OAR 436-035-0007(1)(b)(B)(ii), the Board determined that a "superimposed condition" is not entitled to a permanent impairment award. Consequently, apportioning claimant's permanent impairment findings, the Board awarded permanent disability based on that portion of her findings that were attributable to her accepted conditions.

In reaching its conclusion, the Board remarked that claimant might ultimately be entitled to a permanent disability award for the "as yet undiagnosed conditions." However, the Board reasoned that such an evaluation must await claimant's new/omitted medical condition claim for such conditions, as well as the carrier's acceptance, closure, and evaluation of such a claim. *See* OAR 436-035-0007(3); *Griffin v. Dish Network Svcs.*, 296 Or App 233, 239-40 (2019).

Interim Compensation: Awardable For Noncompensable Claim - Would Not Constitute "Administrative Overpayment" - Awardable From "AP" Verification of Inability to Work Until Denial (Or Date of Hearing, if No Denial)

Donald J. Dugas II, 71 Van Natta 512 (May 8, 2019). Applying ORS 656.262(4)(a), the Board awarded interim compensation based on claimant's attending physician's medical verification of an inability to work due to his claimed new/omitted medical condition, even though the claimed condition was determined to be not compensable. In response to claimant's new/omitted medical condition claim for a rotator cuff tear, the carrier neither accepted nor denied the claim, contending that the claim was precluded by an earlier litigation order that had upheld a denial for a shoulder contusion/strain. Claimant requested a hearing, alleging a *de facto* denial of the claim, as well as seeking interim compensation, penalties, and attorney fees. On appeal of the ALJ's order that found the claim not compensable, the carrier challenged the ALJ's interim compensation, penalties, and attorney fee awards for unreasonable claim processing. Specifically, the carrier contended that the Board was prohibited from awarding interim compensation because such an award would create an "administrative overpayment." *See Lebanon Plywood v. Seiber*, 113 Or App 651, 654 (1992).

Carrier neither accepted nor denied new/omitted condition claim.

The Board disagreed with the carrier's contention. The Board acknowledged that the *Seiber* holding prohibited an award of procedural temporary disability when such an award would conflict with a substantive determination of such benefits. Nonetheless, referring to *Ilene M. Hergert*, 47 Van Natta 2285, 2286 (1995), the Board reiterated that an award of interim compensation does not result in a procedural overpayment of temporary disability benefits because the carrier bears a statutory obligation to pay such benefits that are not dependent on whether the underlying claim is ultimately determined to be compensable.

Statutory obligation to pay interim compensation is not dependent on whether claim is ultimately compensable.

Turning to the case at hand, the Board reasoned that, unlike *Seiber*, there was no substantive award of temporary disability benefits for the new/omitted medical condition claim which would conflict with an award of interim compensation in order to create a procedural administrative overpayment. Furthermore, the Board determined that the carrier had a statutory obligation to pay interim compensation, which could have been limited by the carrier's issuance of a claim denial. In the absence of such a denial (in conjunction with claimant's attending physician's medical verification of an inability to work due to the claimed condition), the Board concluded that interim compensation, penalties, and attorney fees were justified.

Carrier could have limited its obligation for interim compensation by issuing a denial.

Finally, noting that the carrier had not issued a claim denial, the Board assessed the penalty on the unpaid interim compensation benefits, which were due from the carrier's notice of the claim (based on claimant's attending physician's ongoing verification of an inability to work) until the date of the hearing (because claimant had not returned to work). *See Daniel R. Caldwell*, 60 Van Natta 625, 629 (2008); *Karen A. Huffman*, 56 Van Natta 3641, 3643 (2004).

Penalty based on interim compensation due from carrier's notice of claim until hearing date.

Medical Services: "Prosthetic-Related" Dispute (Monitor, Replace, Repair) - Jurisdiction Rests With WCD - "704(3)(b)(B)", "245(1)(c)(E)"

Claimant's accepted hip fracture resulted in hip prosthesis.

Jack L. Edwards, 71 Van Natta 506 (May 7, 2019). Analyzing ORS 656.245(1)(a), ORS 656.245(1)(c)(E), and ORS 656.704(3)(b)(B), the Board held that it was not authorized to resolve a dispute regarding a medical service claim insofar as that dispute concerned whether services were necessary to monitor the status, replacement or repair of the prosthetic device that resulted from claimant's accepted hip fracture. Following claimant's accepted hip fracture, he eventually required a hip prosthesis. Several decades later, he initiated a new/omitted medical condition claim for a hip infection (involving both his prosthesis and other areas of his body), as well as a medical service claim. An ALJ upheld the carrier's new/omitted medical condition denial, but found it responsible for the medical services as related to the accepted hip fracture. On Board review, the carrier contended that the medical services were related to the denied hip infection (that claimant was no longer contesting) and, to the extent the services were necessary to monitor the status, replacement or repair of the prosthetic device, such a dispute was subject to the jurisdiction of the Workers' Compensation Division (WCD).

The Board agreed with the carrier's contentions. Citing ORS 656.245(1)(a), the Board stated that the medical service must be for, or directed to, conditions caused in material part, or major part, by the work injury. Relying on *SAIF v. Sprague*, 346 Or 661 (2009), the Board noted that the compensability of the medical service is governed by the causation standard that applies to the condition that it was "for" or "directed to."

Disputed medical services not due to accepted fracture.

Turning to the case at hand, the Board found that the disputed medical services were directed to claimant's denied hip infection. Because the condition for which the medical services claim was directed was not compensable, the Board determined that, insofar as the medical services were directed to that denied condition, such services were not compensable. *See* ORS 656.245(1)(a).

Insofar as disputed medical services concerned prosthesis, jurisdiction rested with WCD.

Nonetheless, to the extent that the medical services concerned claimant's prosthesis, the Board concluded that jurisdiction over that portion of the disputed claim rested with WCD. Relying on *Hazel M. Hand*, 59 Van Natta 1028, 1033 (2007) (citing *AIG Claim Servs. v. Cole*, 205 Or App 170, 173-74, *rev den*, 341 Or 244 (2006)), the Board reiterated that, under ORS 656.704(3)(b)(B), a dispute concerning whether medical services are excessive, inappropriate, ineffectual or in violation of the rules regarding the performance of medical services, or whether medical services for an accepted condition qualify as compensable medical services among those listed in ORS 656.245(1)(c), is not a matter concerning a claim, and falls within the jurisdiction of the Director.

Furthermore, referring to ORS 656.245(1)(c)(E), the Board noted that the authority to resolve disputes as to whether medical services were necessary to monitor the status, replacement or repair of prosthetic devices rested with WCD (on behalf of the Director). Consequently, insofar as the disputed medical services pertained to claimant's hip prosthesis, the Board referred that dispute to WCD for resolution.

Own Motion: PPD - No "Work Disability" Award - Released to "Regular Work" ("At-Injury" Job - "726(4)(f)(E)", "214(1)(d)", "035-0005(14)," "035-0009(4)")

Job at injury was press operator; claimant released to "at injury" job.

Patrick M. Shannon, 71 Van Natta 577 (May 30, 2019). Applying ORS 656.278(1)(b), ORS 656.214(1)(d), and ORS 656.726(4)(f)(E), the Board held that, on closure of claimant's Own Motion claim for a "post-aggravation rights" new/omitted medical condition (T8-9 disc displacement), he was not entitled to a work disability award because his former attending physician had previously released him to his regular work (his "at-injury" job as a press operator) and his current attending physician had not imposed any physical restrictions that would prevent him from performing his "at-injury" job. Following his initial compensable thoracic strain injury, claimant was released to return to his "at-injury" job as a pressman. Some seven years later (after his 5-year "aggravation rights" expired), claimant filed a new/omitted medical condition claim for a T8-9 disc displacement, which the carrier accepted and voluntarily reopened an Own Motion claim for the condition. Thereafter, claimant's former attending physician continued to release claimant to his regular work. When another attending physician assumed responsibility for claimant's treatment, that physician reported that claimant had received "excellent benefit" from an ongoing schedule of epidural steroid injections. This attending physician noted that claimant had been promoted to a managerial position, which was less physical labor. After the attending physician concurred with another physician's determination that claimant's condition was medically stationary, the carrier issued a Notice of Closure, which did not award work disability. Claimant requested review, arguing (among other issues) that he was entitled to a work disability award because his reassignment to a light duty job resulted from his accepted condition.

Several years later, claimant promoted to managerial position.

The Board declined claimant's request for a work disability award. Citing ORS 656.726(4)(f)(E), the Board stated that impairment is the only factor considered in evaluating a worker's permanent disability under ORS 656.214 if the worker has been released to regular work by the attending physician or has returned to regular work at the job held at the time of injury. Referring to OAR 436-035-0009(6), the Board noted that, if a claimant has not returned, or been released to return, to regular work, he/she is entitled to a work disability award. Finally, relying on ORS 656.214(1)(d), and OAR 436-035-0005(14), the Board observed that "regular work" means "the job the worker held at injury."

Although claimant no longer performed "at-injury" job, attending physician did not restrict claimant from "at-injury" work activities; therefore, no entitlement to "work disability" award.

Turning to the case at hand, the Board acknowledged that claimant was no longer performing his "at-injury" job as a pressman, but rather was performing a lighter duty job as a manager. Nonetheless, the Board noted that the record indicated that claimant had been promoted to the managerial position and that his previous attending physicians had released him to his "at-injury" job. Moreover, although claimant's current attending physician had recognized that his managerial position was less physical work, the Board reasoned that the physician had neither restricted claimant from performing his "at-injury" job nor imposed any permanent physical restrictions that would have prevent him from performing his "at-injury" work activities.

Under such circumstances, the Board was persuaded that claimant had been released to his regular work (his "at-injury" job). *See Cyril J. Allen*, 68 Van Natta 1367, 1373 (2016). Consequently, the Board concluded that a work disability award was not justified. *See Loyd E. Franks*, 66 Van Natta 892 (2014); *cf. Mark Legget*, 65 Van Natta 1232 (2013).

Penalties: Unreasonable Denial - Employer's Investigative Report/Physician's "Causal Relationship" Opinion - Eliminated "Legitimate Doubt" for Carrier's Liability for Injury Claim

Employer 's investigation report verified claimant's work incident and physicians' reports supported causal relationship between incident and claimed condition.

Reasonableness of denial is based on legitimate doubt regarding carrier's liability for claimed condition.

Nayef Salem, 71 Van Natta 571 (May 29, 2019). Applying ORS 656.262(11)(a), the Board held that a carrier's denial of claimant's low back injury claim was unreasonable because, when the carrier issued the denial, the employer's investigation had verified the work incident and an independent medical examiner's report (as concurred in by claimant's attending physician) had supported a causal relationship between claimant's work injury and his low back condition. Asserting that claimant (who reported the incident, which occurred while he was crawling under some equipment to dislodge a piece of wood, within two days of the event) had indicated that it was a workers' compensation matter and arguing that claimant had only filed the claim after surgery was proposed one week later, the carrier contended that it had a legitimate doubt regarding its liability for the claim.

The Board disagreed with the carrier's contention. Citing ORS 656.262(11)(a), the Board stated that, if a carrier unreasonably delays or refuses to pay compensation, it shall be liable for a penalty of up to 25 percent of any amounts due, plus an assessed attorney fee. Relying on *Int'l Paper Col v. Huntley*, 106 Or App 107 (1991), the Board noted that whether a denial constitutes an unreasonable resistance to the payment of compensation depends on whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability.

Referring to *Julie Altman*, 62 Van Natta 2409 (2010), the Board acknowledged that, where there is conflicting information at the time of a carrier's denial, it was not unreasonable for a carrier to deny the claim to allow for an ALJ's evaluation regarding the credibility/reliability of the claimant's and other witnesses' versions of events. However, summarizing *Robert L. Leming*, 44 Van Natta 2120 (1992), the Board observed that a carrier had lacked a legitimate doubt when a supervisor's statements, although contrary on other points, supported the claimant's version of events that established the existence of a compensable injury. Moreover, the Board noted that, in *Leming*, an owner's statement that he was not "really aware of an injury *per se*" had been found insufficient to provide the carrier with a legitimate doubt concerning its liability.

Turning to the case at hand, the Board considered the circumstances consistent with *Leming*. Specifically, the Board noted that: (1) claimant reported that he had picked up a piece of wood at work in connection with his back pain; (2) claimant subsequently described the work incident to the investigating supervisor; and (3) claimant's coworker had verified that the

Although claimant was unsure how he was injured, physicians opined that mechanism of injury was consistent with condition.

described incident had occurred. Moreover, the Board reasoned that, although claimant had told the investigator that he was unsure how he was injured, the carrier's physician (as concurred in by claimant's attending physician) had opined that the mechanism of injury was consistent with claimant's condition.

Under such circumstances, the Board determined that, once the carrier had verified the existence of claimant's work injury and possessed the examining physician's unrebutted opinion supporting a causal relationship between claimant's work injury and his low back condition, it did not have a legitimate doubt as to its liability. Accordingly, the Board concluded that the carrier's denial was unreasonable and, as such, a penalty and related attorney fee were warranted. *See* ORS 656.262(11)(a).

APPELLATE DECISIONS UPDATE

TTD: Rate - "060-0025(5)(a)(A)" - "AWW" Calculation - Based on "Portion" of Week That Claimant "Actually" Worked, Not "Entire" Week

Hearing Procedure: "Waiver" of Issues at Hearing - Must Actually Intend to Waive a Known Right

New/Omitted Medical Condition: Claimed "Condition" Must "Exist" - Mere "Symptoms" Insufficient

Marsh v. SAIF, 297 Or App 486 (2019). Analyzing ORS 656.210(1), (2)(a)(A), and OAR 436-060-0025(5)(a)(A), the court reversed that portion of the Board's order in *Robert J. Marsh*, 69 Van Natta 408 (2017) previously noted 36 NCN 3:20, which had held that claimant's rate for temporary disability (TTD) benefits (as an hourly wage earner) should be calculated based on the entirety of his first week of employment (and last week of employment before his compensable injury) even though he had not worked an entire work week during either week. On appeal, claimant contended that the calculation of his "average weekly wage" ("AWW") for purposes of determining the rate of his TTD benefits should treat his first week of employment and the week of his injury as partial (rather than entire) weeks.

The court agreed with claimant's contention. Citing ORS 656.210(1), the court stated that a worker is entitled to receive "total disability compensation equal to 66-2/3 percent of wages," but with limitations, including that the worker not receive "more than 133 percent of the average weekly wage." Moreover, referring to ORS 656.210(2)(a)(A), the court noted that, generally speaking, the weekly wage of a worker is calculated "by multiplying the daily wage the worker was receiving by the number of days per week that the worker was regularly employed."

Legislative intent to base TTD benefits on "wages" actually earned.

Based on those statutory provisions, the court identified a broad mandate that a worker receive an amount equal to two-thirds "of wages" that reflected a legislative intention that the worker's disability benefits be based on the "wage" that the worker had *actually* earned. Consistent with this interpretation, the court observed that it had held that "benefits for temporary total disability exist for the purpose of compensating a worker for wages lost because of an inability to work." *Bostick v. Ron Rust Drywall*, 138 Or App 552, 559 (1996).

Turning to the case at hand, the court commented that the Board's interpretation of OAR 436-060-0025(5)(a)(A) could result in a calculation of an "AWW" that did *not* reflect the worker's actual average wage at the time of injury. To the contrary, the court reasoned that the Board's inclusion of claimant's entire first/last week of employment before his injury (when he did not work his usual number of days during those weeks) reflected a calculation of his "AWW" that was less than what he actually earned, on average, each week during the period he was employed. The court considered such an interpretation of the administrative rule to be contrary to the legislature's intention to base disability benefits on what the worker *actually* earned.

Calculation of AWW includes whole and partial weeks during first and last "actual weeks of employment."

Consequently, the court concluded that OAR 436-060-0025(5)(a)(A) requires that the "AWW" to be calculated using the "actual weeks of employment," *i.e.*, the actual number of whole and partial weeks that claimant worked. Because claimant had worked only partial weeks during the first and last weeks of his employment preceding his injury, the court determined that the calculation of his "AWW" should reflect the portion of his five-day work week that he actually worked during each of those weeks. Accordingly, the court remanded for a redetermination of claimant's "AWW" based on its interpretation of the aforementioned administrative rule.

Whether an issue has been "waived" is based on actual intention of party considering totality of circumstances.

On another matter, the court also remanded to the Board for clarification of its decision that claimant had waived his right to seek additional TTD benefits for a specified period because his counsel had agreed with an ALJ's statement at hearing that the issue was "time loss rate." Citing *Wright Schuchart Harbor v. Johnson*, 133 Or App 680, 686 (1994), the court identified the issue as whether claimant "actually intended to waive a known right to assert a claim" based on the totality of circumstances.

After conducting its review of the record, the court noted that claimant had checked boxes on his hearing request form stating that reasons for the hearing were "temporary disability rate" and "procedural disability issue" for a specified period. The court further observed that, at the start of the hearing, claimant's counsel had agreed with the ALJ's statement that the temporary disability issue was "time loss rate." The court also remarked that, in closing arguments claimant had sought additional temporary disability benefits for the specified period and beyond, but the ALJ's order did not address the issues. Finally, the court recounted that, on review of the ALJ's decision, the Board declined to consider either issue, reasoning that the temporary disability issue for the specified period had been waived and the "post-specified period" TTD issue had not been raised until closing arguments.

The court found no error in the Board's declining to address claimant's entitlement to temporary disability benefits beyond the specified period based on his failure to raise the issue until closing argument. However, regarding the

Board's determination that claimant's request for temporary disability benefits during the specified period had been waived, the court considered the Board's analysis incomplete as to whether claimant had relinquished (waived) the "procedural disability issue" previously identified in the hearing request.

Court remanded for determination of whether claimant actually intended to waive issue of entitlement to TTD benefits during a specified period when agreeing with ALJ's statement that issue was "time loss rate."

Given the close relationship between the two issues of entitlement to "procedural" time loss (*i.e.*, procedural temporary disability) and the rate at which that entitlement would be calculated, the court did not consider claimant's attorney's agreement with the ALJ's description of the issue to necessarily constitute a waiver of the entitlement question. Therefore, the court remanded for the Board to address the question of waiver; *i.e.*, whether claimant actually intended to waive a known right to assert a claim (his entitlement to temporary disability benefits during the specified period) in the first instance.

Finally, the court disagreed with claimant's contention that, in upholding the carrier's denial of claimant's new/omitted medical condition claim for an L4-5 annular tear/disc protrusion, the Board had erroneously required him to establish the *existence* of the claimed condition. Relying on *DeBoard v. Meyer*, 285 Or App 732, 737-38, *rev den* 361 Or 885 (2017), and *De Los-Santos v. Si Pac Enterprises, Inc.*, 278 Or App 254, 257, *rev den* 360 Or 422 (2016), the court reiterated that "to prevail on a new or omitted condition claim under ORS 656.267, a claimant must establish-with medical evidence-that the claimant, in fact, has a *condition*" and that proof of "mere symptoms" is insufficient.

APPELLATE DECISIONS
COURT OF APPEALS

Attorney Fee: Determination of "Reasonable" Attorney Fee - Award Lacked Substantial Reasoning - "386(1)", "015-0010(4)"

Peabody v. SAIF, 297 Or App 704 (May 22, 2019). The court, *per curiam*, reversed that portion of the Board's order in *Karista D. Peabody*, 69 Van Natta 1579, *on recon*, 69 Van Natta 1698 (2017), that awarded a carrier-paid attorney fee under ORS 656.386(1) for claimant's counsel's services at the hearing level and on Board review for finally prevailing over the carrier's claim denial in an amount that was beneath that requested by claimant's counsel. Noting that her counsel requested $31,000 for services at the hearing level and on Board review, claimant contended that the Board's conclusion that a reasonable attorney fee award of $12,500 lacked substantial reasoning.

Board's fee award did not articulate a connection between "rule-based" factors and award sufficient for appellate review.

The court agreed with claimant's contention. Citing *Taylor v. SAIF*, 295 Or App 199, 203 (2018), the court stated that Board orders must be supported by substantial reason and that simply reciting certain "rule-based" factors from OAR 438-015-0010(4) and stating a conclusion does not articulate *how* the application of those factors supports the amount of an attorney fee award.

Turning to the case at hand, the court acknowledged that the Board order identified the specific "rule-based" factors that had been considered. Nonetheless, the court reasoned that the Board order did not "articulate a connection between those factors" and its attorney fee award "sufficiently to allow [the court] to understand the board's reasoning." *Taylor*, 295 Or App at 203.

Because the Board order simply gave a conclusion and did not explain how the "rule-based" factors as considered resulted in its decision, the court concluded that the Board order lacked substantial reason. Determining that more information was necessary for it to review the attorney fee award, the court remanded for reconsideration.

APPELLATE DECISIONS
SUPREME COURT

Course & Scope: "Unexplained Fall" - Claimant Must Eliminate Facially Nonspeculative Idiopathic Explanations for Fall to Establish "Arising Out Of" Prong

Claimant fell while walking through lobby of office building.

Sheldon v. US Bank, 364 Or 831 (May 23, 2019). The Supreme Court affirmed a Court of Appeals opinion, 281 Or App 560 (2016), which vacated the Board's order in *Catherine A. Sheldon*, 66 Van Natta 275 (2014), previously noted 33 NCN 2:7, that had held that claimant's fall while walking through the lobby of the office building where she worked before starting her workday was not unexplained because she had not eliminated idiopathic factors related to her personal medical conditions and, as such, her injury did not arise out of her employment. In reaching its conclusion, the Court of Appeals held that the Board had applied the wrong standard, which appeared to require claimant to persuasively eliminate the possible idiopathic reasons for her fall. Instead, the Court of Appeals had reasoned that a claimant must establish that idiopathic factors are less than equally likely as work-related factors to have caused the injury.

Although disagreeing with the standard expressed by the Court of Appeals, the Supreme Court agreed that the case must be remanded to the Board for reconsideration. After analyzing *Phil A. Livesley Co. v. Russ*, 296 Or 25, 32 (1983), the Supreme Court clarified that the question addressed in *Livesley* was, assuming that a claimant's injury was unexplained and that he/she had eliminated idiopathic causes of his/her fall, what else must a claimant prove for such an injury to be compensable. The Court reiterated that, because an unexplained fall only minimally satisfies the "arising out of employment" prong of the unitary work-connectedness test, a claimant attempting to establish the compensability of an unexplained fall must more substantially satisfy the "course of employment" prong.

The Supreme Court further explained that, as confirmed by subsequent decisions (*e.g.*, *Panpat v. Owens-Brockway Glass Container, Inc.*, 334 Or 342, 350 (2002); *Redman Industries, Inc. v. Lang*, 326 Or 32, 36 (1997)), the *Livesley* decision endorses the positional-risk doctrine, which states that an

Court endorses "positional-risk" doctrine to prove that an unexplained fall arises out of employment.

injury resulting from a neutral risk is deemed to arise out of employment "if the conditions of employment put claimant in a position to be injured." *Livesley*, 296 Or at 30 (quoting Arthur Larson, 1A Workmen's Compensation Law Section 7.00, 3-11 (1978)).

Consistent with the aforementioned line of cases, the Supreme Court stated that the positional-risk doctrine is applicable to determine whether injuries resulting from neutral risks may be deemed to arise out of employment. Specifically, the Court commented that the doctrine establishes the standard of proof that a claimant must satisfy to prove that injuries resulting from an unexplained fall arose out of employment; *e.g.*, by proving that a fall is unexplained and that it occurred in the course of employment. Conversely, the Court reasoned that a finding that a fall resulted solely from a personal risk is a finding that claimant has not proven that an injury arose out of employment.

Finding that a fall resulted solely from a personal risk is a finding that injury did not arise out of employment.

Turning to the case at hand, the Supreme Court identified the parties' disagreement to be a threshold question that was not disputed in *Livesley*; *i.e.*, whether claimant's fall was unexplained and whether she had eliminated the idiopathic causes of her fall. Specifically, for the purpose of assessing standards, the Court listed two separate issues: (1) which idiopathic causes does a claimant need to eliminate; and (2) what does it mean to eliminate those idiopathic causes.

Claimant need not eliminate all theoretically possible idiopathic causes.

Addressing those issues, the Supreme Court agreed with the Court of Appeals that a claimant need not eliminate all theoretically possible idiopathic causes. Nonetheless, the Court considered it appropriate to construct a broader framework within which to understand both which idiopathic causes need to be eliminated and what it means to eliminate those idiopathic causes.

If there is a nonspeculative explanation for a fall, such an explanation would prevent claimant from establishing that the fall is unexplained.

Reasoning that the determination of whether a fall is explained or unexplained is a matter of determining whether there are any nonspeculative explanations for the fall, the Supreme Court remarked that if there is a nonspeculative explanation for the fall, such an explanation would prevent the claimant from establishing that the fall is unexplained. Conversely, the Court observed that, if there is no nonspeculative explanation for the fall available, the fall is unexplained.

Claimant must prove there is no nonspeculative explanation for fall to establish an unexplained fall.

If there are some facially nonspeculative idiopathic causes for explaining a fall, claimant must offer countering evidence to establish that proposed idiopathic cause was speculative.

Consequently, the Supreme Court clarified that to prove that a fall is unexplained, the claimant must prove that there is no nonspeculative explanation for the fall. Consistent with such reasoning, the Court stated that eliminating idiopathic causes is an intermediate step that arises only when the record reveals facially nonspeculative idiopathic explanations for a fall. Phrased another way, the Court explained that, if there are some facially nonspeculative idiopathic causes for explaining a fall, the claimant must offer countering evidence sufficient to convince the Board that the proposed idiopathic cause is, in fact, speculative.

Accordingly, the Supreme Court concluded that, to determine that a fall is unexplained, the Board must find that there is no nonspeculative explanation for the fall. Applying its reasoning to the present case, the Court noted that it appeared that the Board had not applied that legal standard, which was needed

To determine that a fall is unexplained, Board must find that there is no nonspeculative explanation for the fall.

to determine whether claimant's injury arose out of her employment. Under such circumstances, the Supreme Court vacated the Board's decision for reconsideration as to whether claimant's injury both arose out of, and occurred in the course of, her employment.

Medical Services: "Injury" Means "Work Accident" - "245(1)(a)"

Garcia-Solis v. Farmers Insurance Company, 365 Or 26 (May 31, 2019). Analyzing ORS 656.245(1)(a), the Supreme Court reversed the Court of Appeals opinion, 288 Or App 1 (2017), which had affirmed a Board order, *Elvia Garcia-Solis*, 66 Van Natta 538 (2014), that had upheld a carrier's denial of claimant's medical service claim for a psychological referral. In reaching its conclusion, the Court of Appeals had relied on *Brown v. SAIF*, 361 Or 241, 283 (2017), for the proposition that "compensable injury" referred only to already accepted conditions and did not include any condition that had not been accepted. Consequently, the Court of Appeals had rejected claimant's contention that, to be compensable under ORS 656.245(1)(a), her medical services need not be related to any accepted condition, but can extend more generally to the workplace accident that created the need for medical treatment.

Supreme Court analyzed "245(1)" to determine whether "[compensable] injury" referred only to accepted conditions or to workplace accident.

The Supreme Court framed the issue as a legal question regarding the meaning of "compensable injury" in ORS 656.245(1)(a), which provides that "[f]or every compensable injury, the insurer * * * shall cause to be provided medical services for conditions caused in material part by the injury * * *." After extensively analyzing its *Brown* decision, the Court acknowledged that *Brown* leaves little doubt that it interpreted the statutory definition of "compensable injury" to mean medical conditions and not the work accident generally. 361 Or at 255-72.

Supreme Court examined "245(1)" independently to see how term "[compensable] injury" was used.

Nonetheless, the Court remarked that the *Brown* opinion was less clear as to whether "compensable injury" refers only to *accepted* medical conditions - a question that was not before it. Furthermore, the Court noted that *Brown* had specifically reserved any decision regarding whether it had determined the meaning of "[compensable] injury" as that phrased is used in ORS 656.245. 361 Or at 282. Thus, even if *Brown* was definitive on the question of what "compensable injury" means generally, the Supreme Court reasoned that it must examine ORS 656.245(1) independently to see how it uses the term "[compensable] injury."

The term "injury" has different meanings within "245(1)(a)"; i.e., workplace accident and medical condition that resulted from the accident.

After examining the statute, the Court determined that ORS 656.245(1)(a) presented a situation where the same term - "injury" - is used in different ways, with apparently different meanings, within the same statutory provision; *e.g.*, "medical services for conditions * * * by the injury" uses "injury" to mean a workplace accident, while the phrase "for such period as the nature of the injury * * * requires" uses "injury" to mean the medical condition that resulted from the accident. Consequently, rather than do violence to the statutory text by artificially imposing the same meaning on all uses of the term "injury," the Supreme Court sought to give effect to what the legislature actually intended.

*For purposes of statutory phrase, "medical services for conditions * * * caused by the injury," Supreme Court concluded that "injury" refers to the work accident.*

Clarifying that it was concerned with what "injury" means in the phrase "medical services for conditions * * * caused by the injury," the Court reasoned that use of "injury" refers to the work accident. As such, the Court concluded that the text of the statute supported claimant's position.

Turning to the statutory context, the Court examined the statute's history (dating from its 1965 enactment), as well as amendments in 1990 and 1995, which also included the adoption of other statutory amendments (*e.g.*, ORS 656.262(6)(a)). The Court acknowledged that, in 1990, the legislature adopted a requirement that a carrier issue a notice of acceptance and specify what conditions are compensable. While recognizing that such an amendment might be relevant to the question of what "compensable injury" means generally, the Court reasoned that it did not change how the word "injury" is used in the phrase "medical services for conditions caused * * * by the injury" in ORS 656.245(1)(a).

In summation, the Supreme Court concluded as follows. When ORS 656.245(1)(a) states that "[F]or every compensable injury, the insurer * * * shall cause to be provided medical services for conditions caused in material part by the injury," the "injury" is the work accident that caused the medical condition and resulted in the need for medical services. The "injury" does not mean medical conditions, and it is not limited to conditions that the insurer has accepted at the time that medical services are sought. The conclusion that "injury" means work accident is context-specific to exactly two uses in the first and second sentences of ORS 656.245(1)(a). It does not apply to the second use in the first sentence of ORS 656.245(1)(a). Finally, the Supreme Court emphasized that it did not decide or suggest that its conclusion regarding the meaning of "injury" in ORS 656.245(1)(a) applied to any other statute in the workers' compensation system.

For first (first use) and second sentences of "245(1)(a)," "injury" means work accident, not medical conditions and is not limited to accepted conditions.

Supreme Court did not decide/suggest that its "injury" conclusion regarding "245(1)(a)" applied to any other statute.

Because the Court of Appeals and Board decisions were based on a conclusion that "compensable injury" in ORS 656.245(1)(a) meant only "accepted conditions," the Supreme Court reversed those decisions. Accordingly, the Court remanded to the Board for further proceedings.

Workers' Compensation Board
2601 25th St., Ste. 150
Salem, OR 97302
503.378.3308
www.wcb.oregon.gov