Workers' Compensation Board

Volume XXXVIII, Issue 8

August 2019

News & Case Notes

BOARD NEWS

New Managing Attorney - Tom Sheridan

Tom Sheridan has been selected for the position of Managing Attorney, Board Review. Born and raised in Oregon, Tom is a graduate of Notre Dame University. He obtained his JD from Lewis & Clark Law School. Tom has practiced law since 1983 and brings to the Board 30 years of experience in workers' compensation law, representing insurance companies and self-insured employers, including Sedgwick as the claims processing agent for the State of Oregon in NCE cases; Tom also brings to the Board decades of management expertise. Tom has been a member of the Workers' Compensation Section Legislative Subcommittee and a presenter at Workers' Compensation Claims Association Meetings and other workers' compensation-related groups. Tom enjoys spending time with his two children, traveling and playing soccer. He will begin his duties on October 1, 2019.

Board Meeting: Consideration of Comments Concerning Proposed Amendments to "Subpoena" Rule ("007-0020(6)(b)") - September 19, 2019

The Board has scheduled a public meeting for the Members to discuss comments submitted at its August 23, 2019, rulemaking hearing, which concerned proposed amendments to OAR 438-007-0020(6)(b) and to consider the adoption of the proposed amended rule. The proposed amendments: (1) change the period for a timely objection to a subpoena from seven calendar days to 10 calendar days; (2) require that a subpoena explain a recipient's obligations if a timely objection is received; and (3) require a subpoena to contain language describing the manner in which the recipient timely complies with the subpoena (*i.e.*, provide the records no sooner than 14 days after issuance of the subpoena, but not later than 21 days after issuance of the subpoena).

The Board meeting has been scheduled for September 19, 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.

Board Meeting: Consideration of "Attorney Fee Advisory Committee" Report - October 29, 2019

The Board has scheduled a public meeting to discuss the report from its "Attorney Fee" Advisory Committee. The meeting has been scheduled for 10 a.m., Tuesday, October 29, 2019, in the Board's Salem office. Arrangements are also being made at each permanently staffed Board office (Durham, Eugene, and Medford) to allow attendees to view the Board's Salem meeting and participate remotely.

Copies of the Advisory Committee's report, as well as statistical data regarding attorney fee awards, have been posted on WCB's website. (Some of these materials are in addition to other "attorney fee-related" comments/ concepts, and data, which were considered by the committee.)

The members of the Advisory Committee are: Theodore Heus, Elaine Schooler, William Replogle, Art Stevens, Jennifer Flood, and ALJ Mark Mills (facilitator). The Board Members extend their grateful appreciation to the committee for participating in this important project.

In advance of their public meeting, the Members invite comments to the Advisory Committee report and these accompanying materials. Any written comments should be directed to Kayleen Atkins, WCB's Executive Assistant at 2601 25th St. SE, Ste. 150, Salem, OR 97302, kayleen.r.atkins@oregon.gov, or via fax at (503)373-1684. Any written comments submitted by October 29 will be considered by the Members at their meeting. These written comments will be posted on WCB's website. Public testimony will also be welcomed at the meeting, as the Members proceed with their deliberations.

Staff Attorney Recruitment

WCB is 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 begins September 10th and ends October 1st . Further details about the position and information on how to apply will be available online at https://oregon.wd5.myworkdayjobs.com/SOR_External_Career_Site. WCB is an equal opportunity employer.

Assignment of Counsel - Process Change Coming This Fall

The Board will be modifying its process for assigning counsel on litigated cases. Beginning this fall, the Board will require attorney firms to provide written notification when they are representing a party. An Appearance by a firm can be accomplished with a letter of representation, a hearing request, or an attorney retainer agreement. WCB Portal users can file their Appearance electronically using the "File an Appearance" tab. A Response to Issues can also be filed through the WCB Portal. In addition, formal letters can be filed by mail or fax.

The change is an effort to decrease errors in WCB's Notices of Hearing. Historically, the Board would identify an attorney firm as the party representative when that firm was copied or named on a Request for Hearing. However, the Board has seen a notable increase in communications from attorney firms announcing that they have not been retained on a case, despite receiving a copy of a hearing request and a Hearing Notice. Such written notice, whether by portal, email, mail or fax, will help ensure accurate notices for all cases.

WCB Website Update: "Printer-Friendly" Version of OAR 438 - "Van Natta Archives" Project Completed

The Board has created a "printer-friendly" .PDF version of its OAR 438 rules and posted it on the "Laws and Rules" page of its website: Here is a link to the full document: https://www.oregon.gov/wcb/Documents/wcbrule/438-rules.pdf

In addition, the Board continues to include a link to the OAR 438 rules pages of the Oregon Secretary of State.

Meanwhile, the scanning of the old green binders is now complete. The Board's "Van Natta Archive" project was finished in July. Going all the way back to Van Natta Volume 1 (August 1967), readers now have on-line access to all volumes of this publication in searchable .PDF format. https://www.oregon.gov/wcb/brdrev/Pages/vn-archive.aspx

Special thanks to all of the Board Review staff who assisted in maneuvering those brittle, old pages through the scanning equipment, as well as cataloguing and organizing them.

CASE NOTES

Attorney Fee: "386(1)"/"382(2), (3)" - Services at Hearing Level/Board Review/Reconsideration - Determining "Reasonable" Award - Applying "015-0010(4)" Factors

Carrier asserted Board's initial fee award was not adequately explained. Claimant asked for an increase in Board's initial award.

Daniel F. Judd, 71 Van Natta 898 (August 7, 2019). On reconsideration of its earlier decision, 71 Van Natta 441 (2019), applying ORS 656.386(1) and OAR 438-015-0010(4), the Board further explained its analysis in determining a reasonable carrier-paid attorney fee award for claimant's counsel's services at the hearing level and on review in prevailing over a carrier's denial of a bilateral hernia claim. After the Board's initial order had granted a $15,000 carrier-paid attorney fee when claimant successfully appealed an ALJ's order that had upheld the carrier's compensability denial, the carrier sought reconsideration, asserting that the Board did not adequately explain how the factors of OAR 438-015-0010(4) supported the attorney fee award. In doing so, the carrier did not challenge the amount of the Board's attorney fee award. In response, claimant asked that the Board's award be increased.

Although it considered its initial decision sufficient to withstand appellate review, the Board offered further supplementation to address the parties' arguments on reconsideration. Citing *Schoch v. Leopold & Stevens*, 325 Or 112, 118-119 (1997), the Board stated that in determining a reasonable attorney fee award, it applies the factors set forth in OAR 438-015-0010(4) to the circumstances of each case. Furthermore, relying on *Cascade In Home Care v. Hooks*, 296 Or App 695, 698 (2019), the Board noted that, regardless of the presence or absence of a specific fee request or objection, it has discretion in setting the amount of a reasonable carrier-paid attorney fee.

Board Members drew upon their collective 63 years of experience as practitioners.

Turning to the case at hand, the Board Members observed that, in assessing the reasonableness of an attorney fee, they drew upon their combined 63 years of workers' compensation experience as practitioners representing claimants and carriers before the Hearings Division and on Board review litigating thousands of denied claims. After conducting its review, the Board found that the nature of the proceedings and time spent at the hearing level supported a slightly higher than average attorney fee because claimant's counsel prepared for, traveled to, and participated in an out-of-town deposition. *See Peggy S. Shelton*, 70 Van Natta 73, 75 (2019); *Carmen O. Macias*, 53 Van Natta 689 (2001). At the Board review level, however, the Board considered the time spent by claimant's appellate counsel (some 33 hours) was unwarranted for a seasoned practitioner. The Board also noted that claimant's appellant's brief's focus on a medical study had not been of particular assistance in resolving the compensability dispute. *See SAIF v. Calder*, 157 Or App 224, 227-28 (1998) (because the Board is not an agency with specialized medical expertise, its findings must be based on medical evidence in the record).

"Out-of-town" deposition - slightly higher than average "nature of proceedings/time spent" factor.

Time spent by appellate counsel considered unwarranted for seasoned practitioner

Focus on medical study was not of particular assistance to the Board in resolving compensability dispute.

The Board viewed the case to be of an average complexity level, which was a neutral factor in its assessment of a reasonable fee. In addition, the Board found the benefit to claimant (five medical visits and a single uncomplicated surgical repair) was relatively modest. *See Sonny Roman*, 56 Van Natta 1706, 1711 (2004); *Melvin L. Martin*, 47 Van Natta 268 (1995). Furthermore, although the disagreement between the medical experts in the present case, coupled with claimant's not prevailing at the hearing level created a risk that his counsel's efforts might go uncompensated given the contingent nature of the practice of workers' compensation law, the Board considered such a risk no greater than in other denied claims generally litigated on review. The Board also commented that claimant's hearing and appellate counsel were both experienced and presented their positions in a skillful and professional manner, supporting a higher than average attorney award.

In conclusion, after considering the parties' arguments regarding the application of the "rule-based" factors prescribed in OAR 438-015-0010(4), the Board determined that a confluence of those factors as they related to the particular record resulted in reasonable attorney fee of $15,000 ($10,000 for claimant's counsel's services at the hearing level and $5,000 for his counsel's services on Board review).

Finally, applying ORS 656.382(3), the Board awarded an additional carrier-paid attorney fee for claimant's counsel's services on reconsideration insofar as those services concerned a response to the carrier's reconsideration motion. The Board acknowledged that, in requesting reconsideration, the carrier had not argued that the Board's initial attorney fee award was excessive. Nonetheless,

By seeking an explanation of Board's initial award, carrier's request placed the fee award at issue; thus, attorney fee award under "382(3)" justified.

considering its *de novo* review authority, the Board reasoned that, by seeking an additional explanation in support of the reasonableness of the Board's initial award, the carrier's reconsideration request had necessarily placed claimant's entitlement to the attorney fee award at issue. *See Wal-Mart Stores, Inc. v. Climer*, 173 Or App 282, 286 (2001); *Antonio L. Martinez*, 61 Van Natta 1892, 1896 (2009). Consequently, the Board awarded an additional $1,000 carrier-paid attorney fee for claimant's counsel's services on reconsideration regarding the carrier's reconsideration request.

Medical Service: MRI Directed "In Material Part" to Accepted Knee Condition - Carrier Responsible for Medical Service Even if Partially Due to Noncompensable Degenerative Condition - "245(1)(a)"

Daniel B. Slater, 71 Van Natta 962 (August 28, 2019). On remand from the Court of Appeals (*Slater v. SAIF*, 287 Or App 84 (2017)), applying ORS 656.245(1)(a), the Board held that a carrier was responsible for claimant's MRI for his knee condition because the record established that the medical service was directed, in material part, to his accepted knee strain/tear conditions, even though the MRI might also be attributable to a noncompensable degenerative condition. Noting that the court had affirmed the Board's previous decision that had upheld its "combined condition" denial, the carrier contended that it was not responsible for the MRI because that medical service was directed to claimant's noncompensable preexisting degenerative condition. Asserting that the MRI was related, at least in part, to his accepted strain/tear conditions, claimant argued that the medical service claim was compensable.

Accepted knee strain/tear combined with degenerative condition. "Combined condition" denial had been upheld.

Medical service dispute concerned MRI for knee.

The Board agreed with claimant's assertion. After summarizing the court's opinion, the Board stated that the court's mandate was to determine whether the disputed MRI was "directed to," in material part to the "compensable injury" or whether the medical service was "directed to" a combined or consequential condition. *See* ORS 656.245(1)(a). Relying on *SAIF v. Sprague*, 346 Or 661, 675 (2009), and *Brooks v. D&R Timber*, 55 Or App 688, 692 (1982), the Board reiterated that ORS 656.245(1)(a) does not limit the compensability of medical services simply because those services also provide incidental benefits that help or treat noncompensable conditions.

Compensable medical services can provide incidental benefits for noncompensable conditions.

Turning to the case at hand, the Board stated that the carrier had accepted a medial meniscus tear and a medial collateral strain. In addition, the Board noted that the carrier had initially accepted a combined knee condition (including a preexisting osteoarthritic condition), but had subsequently issued a "ceases" denial of that condition (which the Board had upheld and the court had affirmed the Board's decision).

Addressing the medical evidence, the Board acknowledged that claimant's physician had attributed the MRI recommendation in part to "accelerated degeneration" and to assess whether there had been a new injury. Nonetheless, the Board further observed that the physician had ultimately opined that the MRI was also materially related to claimant's compensable work injury and would be of assistance in determining the extent of his work injury.

Although physician had partially attributed need for MRI to degenerative knee condition, physician also materially related MRI to compensable work injury; physician's opinion was found sufficient to establish that MRI was "directed to" compensable meniscus tear.

Under such circumstances, the Board recognized that claimant's attending physician (as well as another physician) had offered comments that could be interpreted as support for the proposition that the MRI would provide evaluation for the noncompensable preexisting osteoarthritis. Nevertheless, despite the incidental benefits from the MRI to claimant's noncompensable condition, the Board was persuaded that the physicians' opinions persuasively established that the MRI was also "for" or "directed to" claimant's accepted knee meniscal tear. *See Sprague*, 346 Or at 665; *Brooks*, 55 Or App at 692. Under such circumstances, the Board concluded that the MRI was a compensable medical service. *See* ORS 656.245(1)(a).

"Non-Cooperation" Denial: "262(15)" - Claimant "Reasonably Cooperated" with Carrier W/I 30 Days of WCD's "Suspension" Order - Denial Procedurally Invalid

Basil D. Yauger, 71 Van Natta 882 (August 6, 2019). [Editor's note: On September 4, 2019, the Board abated its decision in response to the carrier's Motion for Reconsideration.] On remand from the Court of Appeals, *Hilton Hotels Corp. v. Yauger*, 295 Or App 330 (2018), applying ORS 656.262(15), the Board set aside a carrier's "noncooperation" denial as procedurally invalid, finding that claimant's contact with the carrier (within 30 days of the Workers' Compensation Division's (WCD's) "suspension" order) constituted "reasonable cooperation" in the carrier's claim investigation.

There are three procedural stages under "262(15)."

After summarizing the court's decision, the Board reiterated the three procedural stages under ORS 656.262(15): (1) the first stage "provides for the suspension of benefits based on a failure to reasonably cooperate"; (2) the "second stage permits the denial of the claim based on noncooperation if the worker continues for 30 days to fail to reasonably cooperate"; and (3) the "third procedural stage is the challenge to a noncooperation denial," at which point "the required level of cooperation increases." *Yauger*, 295 Or App at 337-38.

Because claimant contacted the carrier within 30 days of WCD "suspension" order, Board found "reasonable cooperation."

Turning to the case at hand, the Board found that, within 30 days of WCD's "suspension" order, claimant had contacted the carrier several times and asked for direction on how to move forward with his claim. The Board further noted that, although the carrier had received claimant's inquiry, it had not specifically responded, but rather had issued its "noncooperation" denial. Under such circumstances, the Board determined that claimant had reasonably cooperated in the carrier's claim investigation within 30 days of WCD's "suspension" order and, as such, the carrier's "noncooperation" denial was procedurally invalid.

Claimant's responsibility was to contact the carrier and show a willingness to cooperate. Once contact was made, carrier could make arrangement for interview/deposition.

In reaching its conclusion, the Board acknowledged that claimant had not specifically offered to arrange or submit to an interview/deposition. Nonetheless, the Board noted that, according to WCD's "suspension" order, claimant's responsibility was to contact the carrier and show a willingness to cooperate. Once such a contact was made, the Board reasoned that, consistent with WCD's order, the carrier could have made arrangements for claimant's interview/deposition, which it had not done.

Own Motion: "278(1)(a)" - Worsening - "Disability Date" - Surgery Recommendation/Inability to Work Due to "Current Worsening"; "Work Force" - Established by "Work Search" Affidavits/Applications

Collin D. Stringer, 71 Van Natta 936 (August 21, 2019). On reconsideration of its earlier opinion, 71 Van Natta 342 (2019), previously noted 38 NCN 3:7, applying ORS 656.278(1)(a), the Board reopened claimant's Own Motion claim for a "worsening" of his previously accepted toe condition, finding that his "disability date" (*i.e.*, the date his physician's surgery recommendation coincided with his physician's verification of an inability to work due to the current worsened condition) was some six months later than the Board had previously determined (because that prior finding had been based on a physician's assessment of claimant's physical limitations regarding an earlier closure of the claim) and, as of that "disability date," claimant was in the "work force" (based on his unrebutted affidavits and employment applications). In its earlier decision, the Board had found that a treating physician's concurrence with a Work Capacity Evaluation (WCE) report (which concerned claimant's accepted toe condition before the closure of his previously reopened Own Motion claim for new/omitted medical conditions that included his toe condition). Based on that concurrence and the attending physician's surgery recommendation, the Board identified that period as claimant's "disability date" for purposes of determining his "work force" status. Because claimants' affidavits and employment applications concerned his unsuccessful work searches some six months *after* this "disability date," the Board had initially concluded that he was not in the "work force" at the time of his current worsened toe condition and, as such, denied his request for reopening of his Own Motion claim. *See* ORS 656.278(1)(a).

On reconsideration, Board found that claimant's "disability date" was six months later than it had originally found.

For "worsened condition" Own Motion claim to be reopened, claimant must be in the workforce on "date of disability."

On reconsideration, the Board authorized reopening of claimant's Own Motion claim for his current worsened condition. Citing *Stuart A. MacDonald*, 70 Van Natta 1837 (2018), *Robert J. Simpson*, 55 Van Natta 3801 (2003), *Thurman M. Mitchell*, 54 Van Natta 2607 (2002), and *David L. Hernandez*, 55 Van Natta 30 (2003), the Board reiterated that, the "date of disability" for purposes of determining whether an Own Motion claim for a worsened condition under ORS 656.278(1)(a) should be reopened is the date on which both of the following factors are satisfied: (1) the claimant's condition resulted in a partial or total inability to work; and (2) required (including a physician's recommendation for) hospitalization, inpatient or outpatient surgery, or other curative treatment. Relying on *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989), the Board stated that a worker is in the "work force" at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and making reasonable efforts to obtain employment; or (3) not employed, but willing to work, but not making reasonable efforts to obtain employment because a work-related injury has made such efforts futile.

Claimant's "pre-closure" WCE report concerned his condition as of an earlier claim closure; WCE report not relevant to current "worsened condition" claim.

Turning to the case at hand, the Board acknowledged the treating physician's concurrence with the "pre-closure" WCE report, which had addressed claimant's partial inability to work. Nonetheless, the Board reasoned that the WCE report concerned claimant's physical limitations before the earlier

"Disability date" was when surgery was recommended, coupled with physician's verification of inability to work due to current "worsened condition"/ surgery recommendation.

closure of his claim, rather than an inability to work attributable to a subsequent worsening of his accepted toe condition, which had resulted in his current surgery recommendation. Under such circumstances, the Board concluded that the physician's concurrence with the WCE report did not support the establishment of a "disability date" regarding claimant's current "worsened condition."

Relying on the attending physician's subsequent "work status" report and chart note (which issued some six months after the physician's earlier concurrence with the WCE report), the Board determined that those documents established a total or partial inability to work. Consequently, based on claimant's physician's surgery recommendation, coupled with the physician's verified inability to work due to claimant's current worsened toe condition (some six months after the surgery recommendation and two days before the surgery), the Board determined that the "date of disability" (when those two factors were both present) was two days before claimant's surgery.

Addressing the question of whether claimant was in the "work force" as of his "date of disability," the Board noted that he had submitted employment applications, which had been filed within a three-month period preceding his current toe surgery. The Board further observed that the most recent application was within 30 days of claimant's "disability date." Finally, the Board acknowledged that claimant's affidavit attested that he was both willing to, and seeking, work.

Claimant's unrebutted affidavit of willingness to work and job applications preceding "disability date" was found sufficient to establish presence in "work force."

In the absence of persuasive evidence rebutting claimant's representations/ submissions, the Board found claimant's sworn statements and job applications sufficient to establish his presence in the "work force" before his "disability date." *See Ronald R. Funke*, 61 Van Natta 2823 (2003) (employment applications that had been submitted near the date of disability (*i.e.*, the last within 23 days) established that the claimant was actively seeking employment at the time of disability). Accordingly, the Board held that the reopening of claimant's Own Motion claim for a worsening of his current toe condition was warranted. *See* ORS 656.278(1)(a).

Responsibility: "308(1)" - Applied to Dispute Regarding "Same Condition" Between Multiple Employers/Insurers - *"Pilgrim"* Rationale Applicable to O.D. Claims with Same Employer/Insurer

Scope of Denial/Attorney Fee: Carrier's "Upper Extremity" Denial Included "Epicondylitis/Tendinitis" Condition - Carrier Subsequently Rescinded "Epicondylitis/Tendinitis" Portion of Denial at Hearing Level - "386(1)" Fee Award

Jurisdiction: "Aggravation" Claim Not Filed W/I Five Years of First Claim Closure - Hearings Division Lacked Authority to Consider - "273(4)(a)" - "Claim" Must Be Processed as "Own Motion" Claim (Assuming No "Compensability/Responsibility" Dispute) - "267(3)"/"278"/"012-0030(1)"

Subsequent work exposure did not pathologically worsen the condition accepted by prior carrier; thus, responsibility under "308(1)" did not shift to subsequent carrier.

Leisa K. Bulick, 71 Van Natta 858 (August 2, 2019). Applying ORS 656.308(1), the Board held that a later carrier was not responsible for claimant's occupational disease claim for a bilateral wrist condition because her subsequent work exposure with that carrier had not pathologically worsened her condition for which a prior carrier was responsible. In reaching its conclusion, the Board rejected claimant's contention that responsibility rested with the later carrier because her work activities with both carriers were the major contributing cause of her claimed wrist condition.

Specifically, the Board disagreed with claimant's assertion that the responsibility issue was governed by *Pilgrim v. Delta Airlines, Inc.*, 234 Or App 80 (2010) and *Karen X. Nguyen*, 62 Van Natta 2392 (2010). After summarizing the *Pilgrim* and *Nguyen* decisions, the Board noted that, in *Pilgrim*, the court had determined that where a preexisting condition and the worsening of that condition are both work-related, under ORS 656.802(2)(b), the claimant need not establish that the current employment conditions are the major contributing cause of the combined condition. The Board further observed that the *Pilgrim* court (as well as in the *Nguyen* decision) had applied such reasoning in finding the same employer/carrier responsible for the claimants' new occupational disease claims.

Successive occupational disease claims with different employers/carriers is governed by "308(1)."

"Pilgrim" holding applies to successive employment exposures with same employer/carrier.

In contrast to *Pilgrim* and *Nguyen* (which concerned successive occupational disease claims with the same employer/carrier), the Board reasoned that the present case involved successive occupational disease claims with different employers/carriers, which is governed by ORS 656.308(1). Citing *Tamara J. Bierman*, 65 Van Natta 1520 (2013), the Board explained that, pursuant to ORS 656.308(1), to shift responsibility for a new occupational disease involving the "same condition" to the later carrier, the claimant's work activities with the later carrier must be the major contributing cause of a combined condition and a pathological worsening of the disease.

After conducting its review, the Board determined that claimant's wrist condition for which the first carrier had previously accepted (bilateral medial epicondylitis/tendonitis) had not been pathologically worsened by her work activities performed during the later carrier's coverage. Under such circumstances, the Board upheld the later carrier's responsibility denial of the aforementioned condition.

However, applying ORS 656.386(1), the Board held that claimant's counsel was entitled to a carrier-paid attorney fee because the later carrier's compensability denial had also extended to other conditions for which the carrier had subsequently withdrawn (during closing arguments at the hearing level) its denial insofar as it concerned those conditions. The first carrier had

previously accepted bilateral medial epicondylitis/tendinitis. After the first carrier denied claimant's aggravation claim for those conditions and new/omitted medical conditions (bilateral carpal/cubital tunnel syndrome), claimant submitted an 827 claim form and the first carrier's denial to the subsequent carrier, asking the second carrier to treat the submission as "notice of a claim." In response, the subsequent carrier issued a compensability denial of claimant's right/left "upper extremity" conditions. Following the hearing regarding the carrier's denials, the subsequent carrier asserted that its denial was limited to claimant's carpal/cubital tunnel syndrome conditions. In reply, claimant contended that the subsequent carrier had, in essence withdrawn its denial of the compensability of the bilateral medial epicondylitis/tendinitis condition and, as such, her counsel was entitled to a carrier-paid attorney fee under ORS 656.386(1).

The Board agreed with claimant's contention. Citing *Tattoo v. Barrett Bus. Serv.*, 118 Or App 348, 351 (1993), the Board stated that a carrier is bound by the express language of its denial. Furthermore, relying on *Mills v. Boeing Co.*, 212 Or App 678, 682-83 (2007), the Board noted that a denial is interpreted in context, including the carrier's knowledge at the time. Finally, referring to *Paul M. Vanderzanden*, 62 Van Natta 1273, 1277 (2010), the Board reiterated that an attorney fee is awarded under ORS 656.386(1) when a carrier rescinds the compensability portion of its denial in the context of a responsibility dispute.

Because carrier's "compensability" denial extended to carpal/cubital syndrome conditions, when carrier limited its denial following the hearing to epicondylitis/tendonitis conditions, it essentially rescinded a portion of its "compensability" denial. Thus, "386(1)" attorney fee award justified.

Turning to the case at hand, the Board noted that claimant had submitted an 827 claim form and the first carrier's denial to the subsequent carrier, explaining that the documents should be construed as a claim. The Board further observed that, in response to that claim, the subsequent carrier had expressly denied claimant's "right upper extremity conditions and left upper extremity conditions." Under such circumstances, the Board determined that the denial was not limited to claimant's new claims for bilateral carpal/cubital tunnel syndrome, but also included her bilateral medial epicondylitis/tendonitis condition.

Consequently, the Board reasoned that when the subsequent carrier asserted in closing arguments that its denial was limited to carpal/cubital tunnel syndrome, the carrier had essentially rescinded its compensability denial of the epicondylitis/tendinitis conditions. Accordingly, the Board held that an attorney fee award under ORS 656.386(1), payable by the subsequent carrier, was justified.

"Aggravation" claim filed more than 5 years after first NOC; Hearings Division lacked authority to consider "aggravation" claim. Because "causation" not disputed, claim must be processed as Own Motion request.

Finally, the Board noted that claimant's "aggravation" claim with the first carrier had been filed more than five years from the first Notice of Closure. Relying on ORS 656.273(4)(a), *SM Mather Co. v. Mather*, 117 Or App 176, 180 (1992), and *Thomas Jarrell*, 68 Van Natta 615, 617 (2016), the Board reiterated that the denial of an untimely aggravation claim is a "nullity" and the Hearings Division lacks jurisdiction to consider such an "aggravation" claim. Accordingly, the Board dismissed claimant's hearing request insofar as it concerned the "aggravation" denial, reminding the parties that such a claim (because there did not appear to be a compensability dispute regarding the underlying medical service issue) was subject to the Board's Own Motion authority under ORS 656.278(1). *See* OAR 438-012-0030(1); *Karen L. Young*, 64 Van Natta 477, 478 (2012); *Dorothy H. Latta*, 58 Van Natta 1645, 1646 n 2 (2006); *Jimmie L. Taylor*, 58 Van Natta 75 (2006).

APPELLATE DECISIONS UPDATE

Cost Award: "Extraordinary Circumstances" - "386(2)(d)"

SAIF v. Siegrist, 299 Or App 93 (August 14, 2019). On reconsideration of its initial opinion, 297 Or App 284 (2019), in a *per curiam* opinion, the court adhered to its previous decision that reversed the Board's order in *Kevin J. Siegrist*, 68 Van Natta 1283 (2016), *modified on recons*, 69 Van Natta 92 (2017), previously noted 35 NCN 8:4 and 36 NCN 1:6, that had found extraordinary circumstances under ORS 656.386(2)(d) warranting a cost award to claimant beyond the $1,500 statutory threshold. The court modified its earlier opinion in response to claimant's assertion that, because it was reviewing the Board's order (rather than the ALJ's order) it was improper to refer to the ALJ's statements, unless it viewed them as factual findings adopted by the Board.

Court clarified its earlier reasoning regarding references to ALJ's "average complexity" and "fairly common" statements.

Specifically, the court explained that its only point in referencing the ALJ's statements (*i.e.*, that the case was one of "average complexity" and that expert opinions from medical specialists were "fairly common" in the forum) was that the Board never said that the case at hand was of *greater* than average complexity or that it was *uncommon* in the forum for parties to obtain expert opinions from medical specialists. Consequently, the court considered it irrelevant to its review of the Board's order whether the Board actually agreed with the ALJ's statements or merely did not consider those issues necessary to its analysis.

Nonetheless, to avoid any risk of its opinion being misread, the court modified footnote 10 in its initial opinion to reflect its aforementioned explanation.

APPELLATE DECISIONS SUPREME COURT

Extent: Impairment Findings - "Combined Condition" -Without "Pre-Closure" Denial, All Impairment "Due to the Compensable Injury" Ratable - "214", "262(7)(b)", "266(2)(a)", "268(1)(b)"

Caren v. Providence Health System Oregon, 365 Or 466 (August 8, 2019). The Supreme Court reversed the Court of Appeals opinion, 289 Or App 157 (2017), that had affirmed a Board order that had held that an Order on Reconsideration had correctly apportioned claimant's permanent low back impairment between her accepted strain/sprain and an unclaimed/unaccepted arthritic condition. On appeal, claimant contended that apportionment of her permanent impairment was not appropriate because the carrier had not accepted/denied a "combined condition" before claim closure. *See* ORS 656.268(1)(b); ORS 656.262(7)(b).

Legislature intended that "combined condition" denial is a limited exception to the general rule that PPD award is calculated based on full amount of permanent impairment, without reduction of impairment due to preexisting condition.

The Supreme Court agreed with claimant's contention. The Court identified the question as whether the legislature intended the combined condition statutory process to change the rule for calculating permanent partial disability

(PPD) whenever the carrier identifies a "preexisting condition," or whether the legislature intended only to create an exception when a combined condition is identified, denied, and closed under the process set out in ORS 656.268(1)(b).

After reviewing *Barrett v. D&H Drywall*, 300 Or 325 (1985), *adh'd to on recons*, 300 Or 553 (1986), as well as the text/context of the statutory scheme, the Court was persuaded by three aspects of the "combined condition" statutory framework that the legislature intended to create a limited exception to the general rule that *Barrett* described for calculating PPD under ORS 656.214 (*i.e.*, a worker's PPD was the full amount of his/her new impairment, without reduction for the portion of that loss attributable to a preexisting condition).

Legislature created a specific process for application of the "combined condition" exception to the evaluation of permanent impairment.

The Supreme Court described those three aspects as follows: (1) although the legislature has provided a process for addressing a carrier's liability for combined conditions (ORS 656.268(1)(b)), it has not changed the key phrase construed in *Barrett* that PPD under ORS 656.214 was measured by the loss "due to the compensable injury"; (2) the legislature set out the standard for compensability in cases of "preexisting condition(s)" as an exception to the general definition of "compensable injury," allowing carriers to limit their liability for an "otherwise compensable injury" (ORS 656.005(7)(a)(B)); and (3) the proof requirements for a combined condition suggest that the legislature intended that process to provide a limited exception (*e.g.*, only certain preexisting contributing causes qualify as a "preexisting condition" that can form a "combined condition," ORS 656.005(24)(a), and once a worker proves a compensable injury, the carrier has the burden to prove that the injury combined with a qualifying preexisting condition in a way that cuts off the carrier's liability for medical services/disability, ORS 656.266(2)(a)).

Legislature did not intend for carriers to obtain the benefit of "combined condition" exception without issuing a "pre-closure" denial.

Consequently, the Supreme Court concluded that the text of the "combined condition" statutes suggests that the legislature intended "combined conditions" to be a limited exception to the general rule that the carrier is obligated to pay compensation for the full measure of the worker's disability. In addition, the Court reasoned that the legislature created a specific statutory process by which employers will obtain the benefit of that exception. Thus, although not a foregone conclusion, the Court determined that, in combination, the aforementioned considerations suggested that the legislature did not intend for carriers to obtain the same benefit by following some unspecified process.

Referring to *Schleiss v. SAIF*, 354 Or 637, 651 (2013), the Supreme Court noted that, although *Schleiss* had not addressed the issue in the present case (*i.e.*, whether the legislature intended that carriers receive the benefit of an impairment deduction for a preexisting condition even when the carrier has not denied a combined condition), *Schleiss'* analysis of the combined condition statutes provided important guidance in two ways.

First, the Supreme Court explained that *Schleiss* confirmed that the impairment reduction for preexisting conditions is an exception to the general rule that all of a worker's impairment is "due to" the compensable injury if the impairment as a whole is caused in material part by the injury. Second, the Court observed that *Schleiss* had attributed significance to the legislature's creation of a specific process for carriers to follow to obtain the benefit of that "combined condition" exception.

Statutory process requires a written denial of combined condition before a carrier may reduce PPD due to preexisting condition.

Finally, after reviewing the context of the statutory scheme (*e.g.*, ORS 656.268(1)(b), (5)(c), ORS 656.262 (6)(d), (7)(b) and (c), (9)), the Supreme Court did not consider it plausible that the legislature intended that carriers to, in effect, deny compensation to which a worker would otherwise be entitled for his/her permanent impairment without providing a notice that would afford him/her a meaningful opportunity to challenge that denial of compensation at an evidentiary hearing. Instead, the Court reasoned that the legislature created a process that guarantees sufficient notice to a worker because the process requires a written denial of a "combined condition" before the carrier reduces the impairment to account for a preexisting condition. Consistent with such reasoning, the Court concluded that the legislature intended that carriers follow that process to obtain the benefit of that impairment reduction.

In the absence of a "pre-closure" denial of "combined condition," claimant's permanent impairment as a whole was "due to the compensable injury."

Accordingly, turning to the case at hand, the Supreme Court understood the Board decision to have found that claimant's new impairment was caused in material part by her accepted lumbar strain. Thus, in the absence of a "combined condition" denial, the Court determined that claimant's impairment as a whole was "due to the compensable injury" and should have been reflected in her PPD award.

APPELLATE DECISIONS
COURT OF APPEALS

"Substantial Evidence/Reasoning" Review: Board Order Provided Rational Explanation for Reliance on Physician's Opinion, Despite Inconsistent Descriptions of Injury

SAIF v. Harrison, 299 Or App 104 (August 21, 2019). The court affirmed the Board's order in *Michael Harrison*, 69 Van Natta 649 (2017), that set aside the carrier's denial of claimant's knee injury claim. In doing so, the Board had concluded that the carrier had not established that claimant's work injury was not the major contributing cause of his need for treatment/disability for his combined knee condition. *See* ORS 656.266(2)(a). In reaching its conclusion, the Board acknowledged that claimant's attending physician had either endorsed the description or described the mechanism of claimant's knee injury in three ways. Nonetheless, reasoning that the attending physician's initial description of claimant's injury ("stepped down off a load") and a description in a second concurrence letter from the attending physician ("jumped down off of his truck") were "materially consistent" with claimant's testimony ("pushed off" the load) and the description provided by an examining physician ("hopped back down"), the Board rejected the carrier's contention that the attending physician's endorsement of a description in an earlier concurrence report (claimant's falling "five and a half feet") meant that the attending physician's opinion (which supported the compensability of claimant's knee condition) was based on an inaccurate understanding of the mechanism of injury.

Board acknowledged claimant's injury was described three ways by attending physician.

On appeal, the court identified the issue as whether substantial evidence/ reason supports the Board's reliance on the attending physician's opinion that claimant's work injury was the major contributing cause of his need for treatment when the physician's description of the mechanism of the injury varies and were

Court described five precepts in conducting "substantial evidence/reason" review in "combined condition" cases.

in conflict. In conducting its "substantial evidence/reason" review under ORS 183.482(8)(a), (c) in a "combined condition" case, the court set forth the following precepts: (1) determining causation is a complex medical question to be resolved only by expert medical opinion; (2) to be persuasive, the opinion regarding the major contributing cause of a condition must evaluate the relative contribution of other potential causes to determine whether the compensable injury is primary; (3) when medical experts disagree, more emphasis should be placed on opinions that are well reasoned and based on the most complete and relevant information; (4) the court reviews the Board's finding that an expert opinion evaluates alternative potential causes and is based on sufficiently complete information for substantial evidence; and (5) if there are doctors on both sides of a medical issue, whichever way the Board finds the facts will probably have evidentiary support and the court will reverse "only" when the credible evidence apparently weighs overwhelmingly in favor of one finding and the Board finds the other without giving a persuasive explanation. *Jackson County v. Wehren*, 186 Or App 555, 559-60 (2003).

Court reiterated the framework for Board to use when it accepts a medical opinion containing inconsistencies.

Referring to *SAIF v. January*, 166 Or App 620 (2000), the court reiterated its framework for the Board to use when it accepts a medical opinion that contains inconsistencies: (1) acknowledge the inconsistencies; (2) reconcile those inconsistencies; and (3) explain why it found that opinion to be more persuasive than that of the other experts.

Although Board's explanation for relying on attending physician's opinion (despite claimant's inconsistent descriptions) was not lengthy or in-depth, court held that explanation was sufficient for "substantial evidence/reasoning" review.

Turning to the case at hand, the court noted that the physician's opinion on whom the Board had relied had not rendered inconsistent opinions, but instead had maintained one opinion based on inconsistent descriptions of claimant's work injury. Nevertheless, the court considered reference to the *January* precepts to be helpful in evaluating whether the Board had properly reconciled the inconsistent descriptions in assessing the attending physician's opinion.

Applying the *January* precepts, the court acknowledged that the Board's explanation of how it had reconciled the inconsistent descriptions was not lengthy or in-depth. Nonetheless, framing the question as whether the Board had provided a reasonable explanation for its decision to rely on the attending physician's opinion, the court determined that the Board's explanation was sufficient.