Workers' Compensation Board

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News & Case Notes

BOARD NEWS

Managing Attorney: Recruitment

For personal reasons, Tom Sheridan has chosen not to accept the Managing Attorney position. The Board extends to Tom its best wishes. In the meantime, Roger Pearson has agreed to postpone his retirement plans.

The Board has begun its recruitment for candidates for the Managing Attorney position. This is an Executive Service position, which serves at the pleasure of the Board Chair, and is a member of WCB's Executive Management team. The position is located in Salem. The salary range is $7,586 - $11,171 per month.

Applicants must be members in good standing of the Oregon State Bar or the Bar of the highest court of record in any other state or currently admitted to practice before the federal courts in the District of Columbia. This position manages the Board Review Division including its staff attorneys and administrative staff, as well as assists the Board Chair and Members, providing analysis and consultation regarding workers' compensation and administrative law issues. The Managing Attorney also coordinates the drafting of orders/ memos by the legal staff, which are prepared in accordance with the Members' instructions concerning the disposition of appealed ALJ orders, procedural motions, petitions for third party relief, crime victim cases, court remands, petitions for Own Motion relief, requests for reconsideration of Board decisions, and the processing of proposed agreements submitted for Member approval.

The deadline for applications is November 4, 2019. Further details about the position and information on how to apply is available online at https://oregon.wd5.myworkdayjobs.com/en-US/SOR_External_Career_Site/job/Salem---WCB/WCB-Managing-Attorney--Principal-Executive-Manager-G-_REQ-23058. WCB is an equal opportunity employer.

Adoption of Permanent Amendments to "Subpoena" Rule ("007-0020(6)(b)") - Effective January 1, 2020

At their September 19, 2019 public meeting, the Members adopted permanent amendments to OAR 438-007-0020(6)(B), which concerns "subpoena duces tecum" for individually identifiable health information. The Members took these actions after considering a report from their Advisory Committee, as well as written/verbal comments received at the Board's August 23, 2019 rulemaking hearing.

OAR 438-007-0020(6)(b) is designed to prescribe the procedures to follow when serving such a subpoena, as well as for medical providers to follow after receiving a subpoena for a worker's individually identifiable health information.

Under the amended rule, the time period in which a party may object to the subpoena has been extended to 10 days (from 7 days under the prior version of the rule). In addition, the rule amendment also requires that: (1) a subpoena explain a recipient's obligations if a timely objection is received; and (2) require a subpoena to include language describing the manner in which to comply with the subpoena (*i.e.*, provide the record no sooner than 14 days after the issuance of the subpoena, but not later than 21 days after issuance of the subpoena).

The effective date for the rule amendment is January 1, 2020, and applies to all subpoenas issued on and after January 1, 2020.

The Board's Order of Adoption can be found here: https://www.oregon.gov/wcb/Documents/wcbrule/rule-filings/2-2019/ooa2-2019a.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.

Requests for Hearing - File Once, Not Twice

There are five ways a party can request a hearing before the Hearings Division of the Workers' Compensation Board:

- Regular mail
- Fax
- Email
- WCB Portal
- Hand delivery

https://www.oregon.gov/wcb/hearings/Pages/filing-instructions-hrg.aspx

However, if you file your request multiple times using several of these methods, processing errors can occur. For example, duplicate requests can lead to creation of a second WCB case number. Sometimes a second hearing is set, with another ALJ on a different date and time. Once created, tracking the extra case number becomes the responsibility of the parties and the Hearings Division. If the parties request to dismiss an unnecessary case number, while leaving the correct case number open, such processing requires extra care and attention on behalf of all the parties.

We understand that verification of receipt is important when deadlines are near. When filing a hearing request through the WCB Portal, the submitter will receive an immediate confirmation email showing the date and time of filing, along with a copy of the request. If you file in such manner, there is no need to file an extra copy by another method. If you did not get an email acknowledgment, you can contact us for assistance at portal.wcb@oregon.gov.

For email filings, a submission to request.wcb@oregon.gov will also generate an automated email confirming the submission was received.

For regular mail, fax, and hand delivery submissions, you can verify the WCB case number within a few days of the Board's receipt by checking WCB Case Status in the Portal. A hearing notice will also be generated.

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 and to consider proposals to amend its administrative rules (Division 015). 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.

CASE NOTES

Aggravation Claim: Filed W/I 5 Years of First Notice of Closure (Which Awarded TTD As of Initial Injury) - Carrier's "Nondisabling" Classification Was Improper - "273(4)"

First NOC awarded TTD benefits beginning day after injury.

Stuart A. MacDonald, 71 Van Natta 1052 (September 20, 2019). Applying ORS 656.273(4), the Board held that, although a carrier had reclassified claimant's injury as disabling more than one year after its "nondisabling" acceptance, claimant's 5-year "aggravation rights" ran from the date of the claim's first closure because that Notice of Closure (NOC) had awarded temporary disability benefits beginning the day after claimant's compensable injury. Claimant filed an aggravation claim more than five years after his compensable shoulder injury, but less than five years from the initial NOC. The carrier denied the claim, asserting that, because claimant's aggravation rights had expired five years from the date of his compensable injury, the Hearings Division/Board lacked jurisdiction to address the merits of the claim.

If a claim is properly classified as nondisabling, "aggravation rights" expire 5 years after injury.

The Board disagreed with the carrier's contention. Citing *SM Mather Co. v. Mather*, 117 Or App 176, 180 (1992), the Board stated that the requirement that an aggravation claim be timely filed under ORS 656.273 is jurisdictional. Referring to ORS 656.273(4)(a) and (b), the Board reiterated that, if a claim has been properly classified as nondisabling for at least one year after the date of acceptance, an aggravation claim must be filed within five years after the injury, whereas, for a disabling claim, an aggravation claim must be filed within five years after the first NOC. Relying on *Thomas Jarrell*, 68 Van Natta 615 (2016), and *Darrell K. Falline*, 42 Van Natta 919, 920 (1990), the Board explained that a determination of whether a claim has been properly classified as nondisabling for purposes of ORS 656.273(4)(a) is based on an examination of the record in each case.

Although claim not reclassified to disabling until more than one year after "nondisabling" classification, NOC awarded TTD back to injury date; claim improperly classified - "aggravation rights" ran from first NOC, not date of injury.

Turning to the case at hand, the Board acknowledged that the carrier had initially accepted the claim as nondisabling and had not reclassified the claim as disabling until more than a year later. Nonetheless, the Board noted that the first NOC had awarded permanent disability benefits, as well as temporary disability benefits beginning on the day after the compensable injury. Furthermore, the Board observed that the NOC had stated that claimant's aggravation rights expired five years from the NOC.

Under such circumstances, the Board concluded that the claim was improperly classified as nondisabling. Thus, relying on ORS 656.273(4)(b), the Board determined that claimant's aggravation rights ran five years from the NOC. Consequently, the Board held that it had jurisdiction to address the merits of claimant's aggravation claim, as well as his request for penalties/ attorney fees for unreasonable claim processing.

Concerning the merits of the aggravation claim, the Board found that the attending physician's undisputed opinion persuasively established that claimant's shoulder condition had actually worsened since the last award/arrangement of compensation. *See* ORS 656.273(1); *SAIF v. Walker*, 330 Or 102, 118-19 (2009). Accordingly, the Board set aside the carrier's denial.

Carrier's assertion that "aggravation rights" had expired conflicted with its first NOC; claim processing unreasonable.

Finally, regarding the penalty/attorney fee issue, the Board stated that the attending physician's "pre-denial" opinion was insufficient to satisfy the "actual worsening" requirement of ORS 656.273(1). As such, the Board did not consider the carrier's denial to have been unreasonable when it was issued. Nonetheless, the Board noted that the attending physician had subsequently unequivocally opined that claimant's condition had worsened, which was also based on decreased function supported by objective findings. Moreover, the Board reasoned that the carrier's assertion that claimant's 5-year "aggravation rights" had expired conflicted with the date it had included in its first NOC and also was not consistent with the TTD benefits awarded in that NOC. Under such circumstances, the Board concluded that the carrier had no legitimate doubt regarding its liability for claimant's aggravation claim and, as such, a penalty/attorney fee were warranted for an unreasonable denial (based on the amounts then due as of the date of hearing). *See* ORS 656.262(11)(a); *Int'l Paper Co. v. Huntley*, 106 Or App 107 (1991); *Brown v. Argonaut Ins. Co.*, 93 Or App 588, 591 (1988).

Claim Filing: Notice to Employer - Oral Report W/I One Year of Work Accident - Sufficient Notice - "265(1)(a), (4)"

Azam Ansarinezhad, 71 Van Natta 1003 (September 9, 2019). Applying ORS 656.265(1)(a) and (4), the Board held that claimant had provided the employer with adequate notice of a work injury where she orally reported the injury within one week, but did not file a formal written claim within one year of the accident. After orally reporting her work injury, claimant told the employer that she needed assistance performing her job duties. When she filed her written claim more than one year after the work accident, the carrier denied her claim as untimely under ORS 656.265(4). In response to claimant's hearing request, the carrier acknowledged that its contention was inconsistent with the Board's decision in *Jose Amador*, 59 Van Natta 2115, 2116 (2007), but asserted that *Amador* was wrongly decided. In the alternative, the carrier contended that claimant's oral notice under ORS 656.265(1)(a) was ineffective because she had "refused" to file a claim.

Carrier asserted Amador decision was wrongly decided.

The Board disagreed with the carrier's contentions. Citing ORS 656.265(1)(a), the Board stated that notice of the accident resulting in injury or death must be given by the worker to the employer within 90 days after the accident. The Board further noted that, under ORS 656.265(4), the failure to give notice "as required by this section" bars a claim unless the notice is given within one year of the accident and the employer had knowledge of the injury or death.

Subsection (4) not applicable when claimant satisfied "notice of accident" requirements of subsection (1).

After summarizing its *Amador* decision, the Board reiterated that, because the only "notice" described in subsection (1) is "notice of an accident resulting in an injury or death," the "notice as required by this section" to which subsection (4) refers, must be that same notice (*i.e.*, notice of the accident). Thus, the Board reasoned that, as it had in *Amador*, subsection (4) is not applicable where a claimant has satisfied the notice requirements of subsection (1).

1995 legislation did not amend "notice as required by this section" in subsection (4); 1995 legislative history of little assistance.

In reaching its conclusion, the Board acknowledged that the legislative history concerning the 1995 amendments to ORS 656.265(4) included references to filing a "written claim" within one year of the accident. However, citing *Tektronix, Inc. v. Dep't of Rev.*, 354 Or 531 (2014), the Board reasoned that, because the 1995 amendments did not alter the phrase at issue (*i.e.*, "notice as required by this section"), the legislative history of those amendments was of little assistance in determining a prior legislature's intended meaning of that phrase. Further, relying on *Suchi v. SAIF*, 238 Or App 48 (2010), the Board observed that, to the extent such legislative history was relevant, it did not overcome the plain wording of the statute.

Oral statement/report from worker to employer (within 30 days of accident) sufficient notice under "265(1)."

The Board next addressed the question of whether claimant satisfied the notice requirements of ORS 656.265(1). Citing *Godfrey v. Fred Meyer Stores*, 202 Or app 673 (2005), *rev den*, 340 Or 672 (2006), the Board reiterated that an oral statement or report from a worker is sufficient to establish notice of an accident resulting in injury or death under ORS 656.265(1) if it is provided to the employer within 90 days of the accident and it includes enough facts to indicate some likelihood that the accident involved a compensable injury.

Turning to the case at hand, the Board noted that claimant had reported the accident and her shoulder injury to the employer about one week after it occurred. The Board further found that claimant told her employer that she needed help completing her work because of the injury and the employer assigned another worker to assist her.

Under such circumstances, despite claimant's decision not to file a written claim, the Board concluded that she had provided a report to the employer indicating some degree of likelihood that the accident involved a compensable injury. Thus, the Board concluded that claimant had satisfied the notice requirements of ORS 656.265(1).

Claim Filing: Untimely Notice of Work Injury - "Good Cause" Not Established by Worker's Belief That Injury Not Significant - "Reasonable Worker" Standard Applied - "265(4)(c)"

Raymond A. Johnson-Chandler, 71 Van Natta 1072 (September 24, 2019). Applying ORS 656.265(4)(c), the Board held that claimant did not establish "good cause" for his untimely notice of his thumb injury because he was aware that he had sustained an injury at work which caused symptoms, the symptoms changed and did not resolve, and he did not relate his symptoms to anything other than the work injury. After claimant injured his right thumb at work, he did not report the injury to his employer for more than 90 days. Thereafter, when claimant's self-treatment (*e.g.*, ice, heat, wrapping, bracing) did not relieve his symptoms, he eventually sought medical treatment and filed an injury claim. When the carrier denied the injury claim as untimely, claimant contended that he had "good cause" for the untimely filing because he initially thought that the injury was just a sprain and that it would resolve without medical care.

Symptoms from injury did not resolve with self-treatment.

The Board disagreed with claimant's contention. Citing ORS 656.265(4), the Board stated that a failure to give timely notice (*i.e.*, notice of an accident resulting in injury or death within 90 days of the accident under ORS 656.265(1)(a)) did not bar a claim if the notice was given within one year of the accident and the worker had "good cause" for the failure to give notice within 90 days after the accident. Relying on *Estrada v. Federal Express Corp.*, 298 Or App 111 (2019), and *Juan Estrada*, 298 Or App 111 (2019), the Board noted that, in evaluating whether a worker knew of "an accident resulting in an injury or death," it considers whether the worker knew of enough facts to lead a reasonable worker to conclude that workers' compensation liability was a reasonable possibility and that notice to the employer was appropriate.

"Reasonable worker" standard under Estrada applied; claimant should have known that workers' compensation liability was a "reasonable possibility" and notice to employer was appropriate.

Referring to *John S. Smith*, 64 Van Natta 340 (2012), and *Corey A. Otterson*, 63 Van Natta 156 (2011), the Board reiterated that it had previously found "good cause" where the worker did not know of an "accident resulting in injury or death" to report. Nonetheless, citing *Michael D. Chilcote*, 64 Van Natta 766 (2012), the Board explained that if the worker had sufficient knowledge to lead a reasonable worker to conclude that workers' compensation

liability was a reasonable possibility and that notice to the employer was appropriate, the worker's choice to "work through" symptoms or to avoid professional medical care would not necessarily establish that the worker was unaware of an "injury" for purposes of ORS 656.265(1)(a).

Claimant's symptoms did not resolve, caused him to alter work duties, and regularly self-treat.

Turning to the case at hand, the Board found that claimant was aware that an injury/accident involving his right thumb occurred at work and caused immediate pain. The Board further noted that, within 90 days after the injury, claimant experienced new/worsened symptoms that did not resolve and that he had associated with the work injury. Finally, the Board observed that claimant's thumb symptoms caused him to alter his work duties and were significant enough that he regularly self-treated them.

Untimely notice not excused by worker's belief injury was not significant.

The Board acknowledged claimant's explanation that he delayed reporting the injury because he thought it was only a sprain, similar to injuries he had in the past, and that it would resolve without professional medical treatment. Nonetheless, referring to *Estrada* and *Chilcote*, the Board reiterated that untimely notice is not excused by a worker's belief that an accident or injury was or was not significant. Consequently, notwithstanding claimant's explanation, the Board reasoned that claimant's decision to self-treat and work through the injury did not establish that he was "unaware" of an "injury" within the meaning of ORS 656.265(1)(a).

Under such circumstances, the Board found that claimant knew of sufficient facts to lead a reasonable worker to conclude that workers' compensation liability was reasonably possible and that it was appropriate to report the accident within the 90-day period. Accordingly, the Board concluded that the record did not establish "good cause" for claimant's untimely notice.

Extent: Impairment Findings - Arbiter Findings (Invalid/Unrelated to Accepted Condition) Not "Ambiguous" - "AP-Ratified" Findings Not More Accurate - "Only "AP," "AP-Ratified," & "Arbiter" Findings Can Be Considered

Adam A. Arevalo, Jr., 71 Van Natta 1021 (September 16, 2019). Applying OAR 436-035-0007(5), the Board relied on a medical arbiter's findings of no permanent impairment for claimant's accepted lumbar, thoracic, and trapezius conditions, rejecting his contention that the arbiter had not sufficiently explained why claimant's findings were considered invalid and not attributable to his accepted conditions. An Order on Reconsideration had awarded no permanent impairment based on a medical arbiter's conclusion that claimant's impairment findings were not valid for rating purposes and unrelated to his accepted conditions. Claimant requested a hearing, contending that the arbiter had neither sufficiently explained why claimant's findings were invalid (when claimant has passed most of the validity tests) nor why such findings were

Claimant contended arbiter had not sufficiently explained "invalid" findings.

not due to the accepted conditions (when other "non-attending" physicians had reached different conclusions). Consequently, claimant argued that the attending physician-ratified impairment findings were more accurate than the arbiter's findings.

The Board disagreed with claimant's contention. Citing OAR 436-035-0007(5) and *SAIF v. Owens*, 247 Or App 402, 414-15 (2011), *recons*, 248 Or App 746 (2012), the Board reiterated that impairment is based on the medical arbiter's findings, except where a preponderance of the medical evidence demonstrates that different findings by the attending physician, or impairment findings with which the attending physician has concurred, are more accurate and should be used. Referring to OAR 436-035-0006(1), (2), OAR 436-035-0007(1), OAR 436-035-0013(1), (2), and *Khrul v. Foremans Cleaners*, 194 Or App 125, 130 (1994), the Board stated that only findings of impairment that are permanent and caused by the accepted condition and its direct medical sequelae may be used to rate impairment.

Arbiter findings were based on tests and non-physiological findings; not ambiguous.

Turning to the case at hand, the Board found no ambiguity in the arbiter's conclusion that claimant's impairment findings were not valid. Citing *Stephen M. Shaw*, 67 Van Natta 1603, 1610 (2015), the Board stated that no explanation is necessary for a finding of invalidity under OAR 436-035-0007(11). Nevertheless, the Board noted that the arbiter's findings were based on claimant's failed straight leg raising validity test and positive Waddell's signs, which were described as non-physiological findings.

Findings from non-arbiter physicians (not ratified by "AP") not considered.

In addition, the Board acknowledged that other physicians had related claimant's limitations to his accepted conditions. Nonetheless, relying on ORS 656.245(2)(b)(C), and *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 669-70 (1994), the Board emphasized that such opinions/findings (unless ratified by the attending physician) could not be considered.

Attending physician did not expressly relate findings to accepted conditions - findings not considered "more accurate."

Finally, addressing the impairment findings ratified by claimant's attending physician, the Board did not consider them to be more accurate than the arbiter's unambiguous findings. In reaching its conclusion, the Board observed that neither the attending physician nor the physician who rated claimant's impairment expressly related the impairment findings to his accepted conditions.

Under such circumstances, the Board concluded that claimant had not established that the Order on Reconsideration's award of no permanent impairment was in error. Consequently, the Board affirmed the reconsideration order.

Extent: Impairment Findings - "Brain Impairment" - Arbiter's "Invalid" Findings "Ambiguous" In Light of Claimant's Documented Symptoms - "AP" Opinion Constituted "More Accurate Evidence" (Addressed "035-0390" Criterion)

Brandy C. Aguirre, 71 Van Natta 1073 (September 25, 2019). Applying OAR 436-035-0390, the Board held that claimant was entitled to a permanent

disability award for her accepted concussion condition based on her attending physician's opinion that addressed (and supported) the criterion for Class 2 brain impairment, whereas a medical arbiter opinion (which had been unable to describe impairment findings) had not indicated whether the "brain impairment" criterion under the administrative rule had been considered. Following claimant's compensable injury at a psychiatric facility (when she was struck by a patient), the carrier accepted several conditions, including a concussion. Based on her attending physician's opinion (which supported Class 2 "brain impairment" under OAR 436-035-0390), a Notice of Closure awarded permanent impairment/work disability. After an Order on Reconsideration reduced these awards (based on a medical arbiter panel opinion that included a neuropsychological evaluation stating that claimant's testing was likely invalid), she requested a hearing. In doing so, claimant contended that the attending physician's finding were more accurate than the arbiter's findings.

Attending physician supported Class 2 brain impairment - addressed "035-0390" criterion.

The Board agreed with claimant's contention. Citing OAR 436-035-0007(5) and *SAIF v. Owens*, 247 Or App 402, 414-15 (2011), *recons*, 248 Or App 746 (2012), the Board stated that impairment is based on the medical arbiter's findings, except where a preponderance of the medical evidence demonstrates that different findings by the attending physician, or impairment findings with which the attending physician has concurred, are more accurate and should be used. Referring to *Kruhl v. Foreman Cleaners*, 194 Or App 125, 130-32 (2004) and *Mary M. Harvey*, 70 Van Natta 839, 842-43 (2018), the Board reiterated that it does not rely on a medical arbiter's impairment findings when the arbiter's report is ambiguous.

Turning to the case at hand, the Board acknowledged that the medical arbiter panel had concurred with a neuropsychologist's opinion that claimant's evaluation was likely invalid. Nonetheless, noting that the arbiter had acknowledged numerous documented symptoms indicative of brain impairment (*e.g.*, persistent headaches, dizziness, memory problems, difficulty focusing, and cognitive dysfunction), the Board reasoned that the arbiter panel had not explained why such documented symptoms did not constitute permanent impairment. Furthermore, the Board observed that the arbiter panel had not indicated that it had considered the "brain impairment" class criterion in OAR 436-035-0390. In contrast to the arbiter panel report, the Board reasoned that claimant's' attending physician's report had addressed the Class 2 "brain impairment" criterion and explained that claimant's persistent migraines, dizziness, irritability, and fatigue met that criterion.

Arbiter panel concurred that evaluation was likely invalid, but did not explain why documented symptoms did not constitute impairment and did not address criterion from "035-0390."

Under such circumstances, the Board concluded that the medical arbiter panel's opinion was ambiguous and that claimant's attending physician's opinion was more accurate. Consequently, the Board increased claimant's permanent impairment/work disability awards based on Class 2 "brain impairment."

Arbiter's opinion found ambiguous; "AP" opinion "more accurate."

Issue Preclusion: "Alternative" Findings in Prior Litigation Order Not "Preclusive" on Current Litigation - Two Proceedings (Concerning Separate Claim Closures for Different Conditions) Did Not Involve Same "Operative Facts"

Johanna L. Southard, 71 Van Natta 1033 (September 20, 2019). On reconsideration of its earlier opinion, 71 Van Natta 948 (2019) (*Southard II*), applying ORS 656.005(17), the Board continued to find claimant's accepted eye condition "medically stationary" date as of a date later than that found by an Order on Reconsideration. In seeking reconsideration, the carrier had contended that, in an earlier proceeding (*Johanna L. Southard*, 71 Van Natta 660 (2019) (*Southard I*)) involving a prior claim closure (which concerned the "medically stationary" status of other accepted conditions), the Board had also found claimant's then-unaccepted eye condition "medically stationary" as of a date that preceded the date had found in this current proceeding. Consequently, the carrier argued that the earlier "medically stationary" date finding was preclusive in the present case.

Carrier contended prior litigation order found unaccepted eye condition was medically stationary.

The Board disagreed with the carrier's contention. Citing *Drews v. EBI Companies*, 310 Or 134 (1990), the Board stated that issue preclusion precludes future litigation on an issue only if the issue was "actually litigated and determined" in a setting where its determination was essential to the final decision reached. Furthermore, relying on *Fred Meyer Stores, Inc. v. DeBoard*, 291 Or App 742 (2018), the Board noted that alternative reasoning applied in a prior proceeding is not preclusive on a subsequent proceeding.

Issue preclusion pertains to actual litigation/ determination that was essential to final decision reached.

Turning to the case at hand, the Board acknowledged that it had provided "alternative reasoning" in *Southard I* concerning the "medically stationary" date regarding claimant's eye condition (*i.e.*, it had reasoned that, assuming that the then-unaccepted eye condition was a direct medical sequelae of the accepted conditions, the record supported a conclusion that the eye condition was "medically stationary" as of a date earlier than the Board had found in the present case). Nonetheless, the Board emphasized that its primary reasoning in the prior proceeding was that claimant's eye condition was not at issue in that particular claim closure. Consequently, the Board concluded that its previous "medically stationary" determination did not pertain to the eye condition and, as such, had not been actually litigated or essential to a final decision on the merits in the prior proceeding; *i.e., Southard I*. *See DeBoard*, 291 Or App at 748.

Eye condition was not at issue in the prior proceeding; prior alternative finding of "medically stationary" not preclusive on subsequent proceeding.

The Board further noted that the two proceedings had separate exhibits and evidence that were relevant to their respective issues; *i.e*., the record in *Southard I* primarily focused on the claim closure pertaining to claimant's accepted right knee contusion, cervical strain, and concussion conditions, while the present case contained additional evidence concerning the claim closure of the subsequently accepted eye condition. Thus, while some of the "same" evidence was present in both records, the Board reasoned that additional evidence was contained in the current record, including some

Operative facts were also not the same in the records regarding the two proceedings - therefore, first litigation order not preclusive.

generated subsequent to that in *Southard I*. Under such circumstances, the Board concluded that the "operative facts" involved in the two records were not the "same." *See Messmer v. Deluxe Cabinet Works*, 130 Or App 254, 257 (1994), *rev den*, 320 Or 507 (1995).

APPELLATE DECISIONS

There were no "Board-related" textual decisions from the appellate courts this month.

Workers' Compensation Board
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