Workers' Compensation Board

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News & Case Notes

BOARD NEWS

Board Meeting: October 29, 2019 - Discussion of "Attorney Fee Advisory Committee" Report/ Consideration of Proposed Rule Concepts

At their October 29, 2019, public meeting, the Members discussed the "Attorney Fee Advisory Committee" report, as well as comments from parties and practitioners regarding concepts concerning possible amendments to the Board's administrative rules (Division 015). The meeting was also broadcast by video link to WCB offices in Portland, Eugene, and Medford.

After reviewing/discussing the committee's report, submitted documents, and public comment, the Members directed WCB staff to draft language regarding the following rule concepts.

- Increasing the attorney fee for time spent during an interview or deposition from $275 per hour to $400 per hour. OAR 438-015-0033(1).
- Establishment of a "schedule" of fees for attorneys representing insurers and self-insured employers. ORS 656.388(4).
- Implementation of a voluntary "bifurcation" process to allow a claimant's counsel to bifurcate the attorney fee award on cases that are on Board review of an ALJ's order. (The Members discussed a process similar to that followed for the processing of a "cost bill" under OAR 438-015-0019.)
- Require attorneys for insurers/self-insured employers to file a statement of services indicating their fees earned during the litigation of the claim. *See* ORS 656.388(5). Also, add "consideration of fees earned by attorneys for insurers and self-insured employers" to the "rule-based" factors for determining a reasonable assessed attorney fee under OAR 438-015-0010(4).
- Include a "contingency multiplier" (modeled on Ex. 24, previously submitted by Member Lanning) to the "rule-based" factors prescribed in OAR 438-015-0010(4) for the determination of a reasonable assessed attorney fee.

Board Meeting: December 17, 2019 - Discussion/ Consideration of Proposed Rule Amendments

The Board has scheduled a public meeting for the Members to further discuss concepts/proposed rule amendments arising from the "Attorney Fee Advisory Committee" report and public comments/Members' discussions at the October 29 Board meeting. The Members' next public meeting is scheduled for Tuesday, December 17, 2019, at 1 p.m. in the Board's Salem office. Public testimony will be welcomed at the meeting as the Members proceed with their deliberations. Arrangements are also being made at each permanently staffed Board office (Portland, Eugene, and Medford) to allow attendees to view the Board's Salem meeting and participate remotely.

At the December 17 meeting, the Members will consider the approval of proposed rule amendments. Should the Members take such an action and initiate rulemaking, a public hearing will be scheduled, which will allow interested parties, practitioners, and the general public an opportunity to present written/oral comments regarding the proposed rule amendments. Following that public hearing, a future Board meeting will be scheduled for the Members to consider those written/oral comments and discuss whether to adopt permanent rule amendments.

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

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.

CASE NOTES

Claim Preclusion: Current "CTS" Occupational Disease Claim Not Precluded by Prior Unappealed Denial of Hand/Finger Numbness - Not "Same Condition"

Laurie A. Followell, 71 Van Natta 1186 (October 16, 2019). The Board held that, in setting aside a carrier's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS), the claim was not precluded by the carrier's previous unappealed denial of bilateral hand/finger numbness because the record did not establish that the two conditions were the "same

condition." Some four years after the carrier's unappealed denial of bilateral hand/finger numbness, claimant filed an occupational disease claim for bilateral CTS. In response, the carrier contended that claimant's current claim for bilateral CTS was precluded by the prior unappealed denial of her bilateral hand/finger numbness claim.

Preclusion did not apply if previously denied condition is not "same condition" as currently claimed condition.

The Board disagreed with the carrier's contention. Citing *Barbara J. DeBoard*, 67 Van Natta 909, 913 (2015), ***aff'd***, *DeBoard v. Meyer*, 285 Or App 732 (2017), the Board reiterated that claim preclusion does not apply if a previously denied condition is not the "same condition" as the currently claimed condition. Referring to *Ahlberg v. SAIF*, 199 Or App 271, 275 (2005), the Board further noted that claim preclusion does not apply if the claimant's condition has changed since the prior claim, and the claim is supported by new facts that could not have been earlier presented.

Claimant continued to work for 4 more years after "finger/hand numbness" claim denial and had recent nerve conduction tests supporting CTS condition - record did not establish that the currently claimed condition was the "same condition" as previously denied.

Turning to the case at hand, the Board determined that the prior unappealed denial concerned a claim for bilateral numbness of the hands and fingers, while the current claim was for symptoms consistent with CTS. Moreover, the Board noted that claimant had continued to work for an additional four years after the unappealed denial and had recently obtained nerve conduction studies supporting a CTS condition, which had not been previously available. Finally, the Board observed that the record did not support a conclusion that the previous and current claims were for the "same condition."

Under such circumstances, the Board concluded that claimant's bilateral CTS claim was not precluded. Furthermore, based on the attending physician's persuasive opinion, the Board found that the claimed condition was compensable.

Course & Scope: "Arose Out Of" Employment - "Mixed Risk" Doctrine - Hip Prosthesis Failed While Waiting to Check Out for Rest Break

Timothy W. Blankenship, 71 Van Natta 1128 (October 4, 2019). The Board held that claimant's hip injury, which occurred when his prosthesis failed when he moved his foot while waiting to "check out" for a scheduled rest break, arose out of his employment under the "mixed risk" doctrine. Claimant, who had a preexisting left hip prosthesis which had degraded over time, moved his leg "to relax it" while he waited to use the employer's computer to check out for a scheduled rest break. His attending physician opined that this leg movement created "negative pressure," which caused components of the hip prosthesis to separate and misalign. The carrier denied claimant's injury claim, contending that it did not arise out of his employment.

Claimant's leg movement while waiting to check out for rest break caused hip prosthesis to separate/misalign.

The Board disagreed with the carrier's contention. Citing *Fred Meyer, Inc. v. Hayes*, 325 Or 592 (1997), the Board stated that a claimant's injury is deemed to "arise out of" employment if the risk of injury results from the nature of his/her work, or originates from some risk to which the work environment exposes the worker. Relying on *Phil A. Livesley Co. v. Russ*, 296 Or 25 (1983), the Board noted that such risks are generally categorized

as: employment-related risks, which are compensable; personal risks, which are noncompensable; or neutral risks, which may or may not be compensable, depending on the situation.

"Mixed risk" doctrine does not weigh the relative importance of two causes; it only considers whether work was a contributing factor.

Referring to *Janet G. Cavalliere*, 66 Van Natta 228, 234 (2014) and *Theresa A. Graham*, 63 Van Natta 740, 744, *recons*, 63 Van Natta 970 (2011), the Board reiterated that if a claimant's injury was due to both personal and employment reasons, it is compensable under the "mixed risk" doctrine, which, as explained in *Graham*, provides that "[t]he law does not weigh the relative importance of the two causes, nor does it look for primary and secondary causes; it merely inquires whether the employment was a contributing factor. If it was, the concurrence of the personal cause will not defeat compensability."

Turning to the case at hand, based on claimant's testimony regarding the occurrence of the injury, as well as his physician's explanation of how claimant's leg movement caused the left hip prosthesis to separate, the Board determined that there was a work-related cause for claimant's hip injury. Specifically, the Board considered claimant's work-related task to be his waiting to use the computer to record the beginning of his break period. Consequently, applying the "mixed risk" doctrine, the Board concluded that claimant's hip injury arose out of his employment.

"AP" persuasively explained that claimant's hip injury also included a "work-related" component; i.e., leg movement while waiting to check out for rest break.

In reaching its conclusion, the Board distinguished *Patches J. Brady*, 63 Van Natta 935 (2011), where the claimant had suffered a fall while leaving the employer's premises, and the medical evidence established that the fall resulted entirely from idiopathic causes. The Board acknowledged that claimant's injury included the personal risk of the preexisting left hip prosthesis and its degradation over time. Nonetheless, in contrast to *Brady* (where the claimant's fall was entirely due to idiopathic causes), the Board reasoned that, in the present case, the attending physician's opinion persuasively established that claimant's hip injury also included a work-related component consisting of his leg movement.

Course & Scope: "Rest Break" Fall/Parking Lot - No "Employer Control" - Area Where Claimant Performed Regular Work Duties

Courtesy clerk for grocery store tripped on pinecone in parking lot (not controlled by employer) during rest break.

Justin Walker, 71 Van Natta 1118 (October 3, 2019). The Board held that claimant's right ankle injury, which occurred during his rest break when he tripped over a pinecone in the parking lot of the employer's store, arose out of and in the course of his employment because, although the employer had no right to control the parking lot, claimant was in an area where he performed his work duties. While on a paid break from his duties as a courtesy clerk for a grocery store, claimant left the store to comply with the employer's smoking policy which required employees to smoke away from the store's entrance and out of its customers' view. While jogging across the parking lot (which the employer had no right to control), claimant tripped on a pinecone and injured his right ankle. The carrier denied claimant's injury claim, contending that the injury did not arise out of or in the course of his employment.

The Board disagreed with the carrier's contentions. First applying the "personal comfort" doctrine, the Board found that claimant's injury occurred "in the course of" his employment. *See Mandes v. Liberty Mut. Holdings - Liberty Mut. Ins.*, 289 Or App 268 (2017). Concerning the "arising out of" prong, the Board reiterated that an injury is deemed to "arise out of" employment if the risk of injury results from the nature of the [employee's] work or when it originates from a risk to which the work environment exposes the worker. *See Fred Meyer, Inc. v. Hayes*, 325 Or 592, 601 (1997). Citing *Legacy Health Systems v. Noble*, 250 Or App 596, 603 (2012), the Board stated that the "arising out of" prong is not satisfied unless the cause of the claimant's injury was either a risk connected with the nature of claimant's work" (*i.e.*, an employment-related risk) or "a risk to which the work environment exposed claimant."

Parking lot was used as part of employer's business; i.e., claimant retrieved shopping carts from the lot.

Employer required employees to leave the store to smoke.

Because employer acquiesced in claimant leaving the store and crossing the parking lot for smoke break, work environment exposed him to risk of tripping over pinecone.

Turning to the case at hand, the Board did not consider the risk of claimant's tripping on a pinecone to be a risk connected with the nature of his work as a courtesy clerk for a grocery store. The Board further acknowledged that the parking lot where claimant tripped was not owned or controlled by the employer. Nonetheless, finding that claimant was injured while on a paid break and had not left work, the Board reasoned that the parking lot was used as part of the employer's business (*i.e.*, customers left shopping carts in the lot) and claimant routinely walked through the parking lot to perform his work duties (*i.e.*, retrieving shopping carts left in the lot). Finally, the Board observed that, rather than maintaining a smoking area in the store, the employer had required employees to leave the store to smoke.

Under such circumstances, the Board determined that the employer had acquiesced in claimant leaving the store and crossing the parking lot to smoke on his break. Consequently, the Board found that claimant's work environment had exposed him to the risk of tripping over a pinecone in the parking lot. Accordingly, the Board concluded that claimant's injury arose out of his employment.

Dissent argued that mere fact claimant performed work duties in the parking lot (at another time) did not outweigh "personal risk" factors (i.e., jogging to a friend's car to retrieve personal items to smoke).

Member Curey dissented from the majority's opinion that claimant's injury "arose out of" his employment. Reiterating that the employer did not have any right to control or duty to maintain the parking lot area where claimant tripped, Curey did not consider the pinecone on which he had tripped to constitute an employer-created hazard or condition. Although acknowledging that the employer required its employees to leave the store to smoke, Member Curey noted that the employer maintained a designated smoking area, which claimant did not intend to use when he was injured. Finally, Curey reasoned that the mere fact that claimant was injured in the parking lot where he may have performed work duties (at another time) did not outweigh the "personal risk" factors (*e.g.*, jogging to a friend's car to retrieve personal items and smoke) which did not support a connection between the injury and the work environment.

Extent: Impairment Findings - "Class 2" (Mild) Brain Impairment - "AP's" Opinion (Concerning Effects on Condition if Claimant "Returned to Work") Not Considered Speculative - "035-0400(5)"

Attending physician restricted claimant from regular work without a monitored trial period, but claimant retired.

Timothy Leak, 71 Van Natta 1105 (October 1, 2019): Analyzing OAR 436-035-0400(5), the Board held that claimant was entitled to a Class 2 (mild) brain impairment rating because, although his attending physician had referred to his impairment as Class 1 for his accepted post-traumatic stress syndrome (PTSD) (because he would not be returning to his at-injury job in law enforcement because he had retired), his attending physician had ultimately rated his impairment as Class 2 if he did return to his at-injury job. Before claim closure, the attending physician described claimant's residual anxiety/depressive symptoms and work limitations connected to his accepted PTSD condition, restricting him from returning to his law enforcement job without a trial period to monitor his reactions while in active treatment. Claimant did not return to work in any position, but instead retired. After a Notice of Closure awarded zero percent whole person impairment for a Class 1 brain impairment, claimant requested reconsideration. During the reconsideration proceeding, the attending physician reported that claimant qualified for a Class 2 brain impairment because of his inability to return to his job at injury without suffering "deterioration or decompensation in maintaining ADLs, social relationships, persistence, pace, or adaptive behaviors."

Determining that the attending physician's Class 2 impairment findings were premised on claimant's symptoms if he attempted to return to his at-injury job (something which he had not done), an Order on Reconsideration rated his permanent impairment as Class 1 and did not grant a permanent impairment award. Claimant requested a hearing, contending that his attending physician's impairment findings supported a Class 2 brain impairment award.

The Board agreed with claimant's contentions. Citing the definitions of Class 1 and Class 2 impairment under OAR 436-035-0400(5), the Board noted the differences, in pertinent part, as follows: Class 1 impairment applies when anxiety/depressive symptoms are minimal and do not materially impair ADL, or the type of work the worker may perform (as compared with preinjury levels); and Class 2 impairment applies when, due to permanent residual anxiety/ depressive symptoms, the worker may need ongoing treatment, occasional therapy, and insomnia and those complaints/symptoms limit the worker's ability to return to his job at injury.

After initially giving a Class 1 brain impairment, AP later concurred with Class 2 rating.

Turning to the case at hand, the Board acknowledged that the attending physician had concurred with the carrier's statement that claimant's residual PTSD symptoms were appropriately classified as Class 1 impairment. Nonetheless, noting that the attending physician's findings were specifically based on claimant not returning to his "at-injury" job, the Board emphasized that the attending physician had further explained that, if claimant returned to his "at injury" job, he would most likely experience residual PTSD symptoms consistent with a Class 2 (mild or moderate) rating. Furthermore, the Board observed that, in a later opinion, the attending physician had concurred with claimant's counsel's statement that claimant's impairment was consistent with Class 2 brain impairment (moderate).

Record established that, if claimant returned to regular work, his PTSD complaints/ symptoms would deteriorate/ decompensate.

Under such circumstances, the Board was persuaded that claimant's complaints/symptoms were consistent with a Class 2 brain impairment rating; *e.g.*, insomnia, loss of interest in activities. Moreover, the Board concluded that the record supported a determination that, if claimant had returned to his regular work, he would have continued to have such complaints/symptoms, and that his PTSD symptoms would deteriorate or decompensate in work or work-like settings.

Board viewed AP's "PTSD" assessment as a permanent work restriction; similar to "lift/carry" weight restriction.

In reaching its conclusion, the Board rejected the carrier's contention that the attending physician's opinion should be discounted as a "prediction" and constituted speculation. In doing so, the Board considered the attending physician's opinion regarding the effect on claimant's condition if he returned to work to be analogous to a physician's physical limitation on an injured claimant; *e.g.*, a 20-pound lifting/carrying restriction. As such, the Board viewed the attending physician's assessment as essentially placing permanent restrictions on claimant regarding his potential return to his regular work activities.

Accordingly, the Board found that the attending physician's findings supported a Class 2 brain impairment rating. Furthermore, based on such findings, the Board determined that claimant's inability to return his "at injury" job without significant decompensation/deterioration of his condition and his need for ongoing treatment (medications, occupational therapy), equated with a "mild" Class 2 brain impairment. *See* OAR 436-035-0400(5)(b).

Medical Opinion: "Changed" Opinion Not Discounted - "Change" Explained, Physician Maintained Opinion That Initial Treatment Related to Work Incident

Angie M. Soto, 71 Van Natta 1155 (October 10, 2019). The Board held that claimant's injury claim for an arm condition was compensable, finding that her treating physician had persuasively explained that a "change" of opinion pertained to the relationship between claimant's work incident and her current condition, rather than the relationship between the work incident and her initial need for medical treatment. Claimant, an instructional assistant for a school district, was injured when a student pulled on her wrist with both hands. Her treating physician initially opined that the work event was a material contributing cause of claimant's need for treatment, but after treating claimant several more times, opined that her ongoing symptoms were not related to the work event. Another physician, who evaluated claimant at the carrier's request, initially opined that the work event was a material contributing cause of claimant's need for treatment, but later was unable to say that the work event was a material contributing cause. After the carrier denied the claim, claimant requested a hearing. In response, the carrier argued that the record did not support compensability of claimant's injury because both physicians had ultimately opined that the work event was not a material contributing cause of her need for treatment.

The Board disagreed with the carrier's contention. The Board determined that the carrier-requested physician's opinion had not persuasively explained the inconsistencies between the stated reasons for his initial report and the new opinion, which was also not based on additional information or further

"IME" physician changed opinion without sufficient explanation; opinion discounted.

examination. In the absence of a further explanation for this change of opinion, the Board discounted the carrier-requested physician's opinion. *See Pedro De La Rosa Hernandez*, 71 Van Natta 998 (2019); *Kathy K. Kincaid*, 59 Van Natta 925 (2007).

Addressing the treating physician's opinion, the Board acknowledged that the physician had adjusted his opinion regarding claimant's ongoing symptoms. Nonetheless, in contrast to the opinion from the carrier-requested physician, the Board considered the treating physician's explanation for his subsequent opinion to be reasonable because he had treated claimant several times between his initial and subsequent opinions. *See Kelso v. City of Salem*, 87 Or App 630 (1987); *Carolynn Simonds*, 59 Van Natta 960 (2007).

"AP" maintained opinion that initial need for treatment was due to work-related event. Found sufficient to establish compensability of injury claim.

Moreover, the Board further noted that the treating physician had continued to maintain his original opinion that claimant's initial need for treatment was due to the work event. Under such circumstances, the Board found the treating physician's opinion regarding claimant's initial treatment sufficient to establish the compensability of her injury claim. *See Braden v. SAIF*, 187 Or App 494 (2003); *Kristie L. Haas*, 59 Van Natta 2761 (2007).

Member Woodford dissented. Citing *Howard L. Allen*, 60 Van Natta 1423 (2008) and *Kathy K. Kincaid*, 59 Van Natta 925 (2007), Woodford asserted that both physicians' opinions were unpersuasive because they had changed without reasonable explanation. Further noting inconsistencies in the treating physician's opinion, Woodford observed that the physician had specifically agreed with the carrier-requested physician's subsequent opinion, which contradicted the treating physician's initial opinion. Contending that the record lacked a persuasive medical opinion to establish that the work event was a material contributing cause of claimant's disability/need for treatment for her claimed condition, Member Woodford believed that the compensability of the claim had not been proven.

Dissent argued that treating physician's opinion was inconsistent and, thus, unpersuasive.

Own Motion: Attorney Fee - Must Be "Instrumental" in Obtaining Voluntary Reopening/Resulting in TTD - "015-0080(2)"

Rafael Corona-Gambino, 71 Van Natta 1190 (October 18, 2019). Analyzing OAR 438-015-0080(2), the Board held that claimant's counsel was not entitled to an "out-of-compensation" attorney fee arising from a carrier's voluntary reopening of an Own Motion claim because the record did not establish that his counsel was instrumental in obtaining a voluntary reopening, or that the claim reopening resulted in increased temporary disability compensation. Following an ALJ's approval of the parties' stipulation in which the carrier agreed to accept a new/omitted medical condition claim, provide compensation according to law, and pay claimant's counsel an assessed attorney fee for prevailing over the carrier's *de facto* denial, the carrier timely reopened claimant's Own Motion claim for the new/omitted medical condition. Several months later, after claimant underwent surgery and the carrier began paying temporary disability (TTD) benefits, claimant sought an "out-of-compensation" attorney fee for his counsel's services in obtaining the carrier's voluntary reopening of his Own Motion claim.

After approval of a stipulation to accept a new/omitted medical condition (which also awarded an attorney fee), carrier timely reopened an Own Motion claim.

The Board declined claimant's request. Citing OAR 438-015-0080(2), the Board stated that, if an attorney is instrumental in obtaining a voluntary reopening of an Own Motion claim that results in increased temporary disability compensation, the attorney is entitled to an attorney fee to be paid out of the increased temporary disability compensation resulting from the voluntary reopening. Relying on *Rigoberto Gonzalez-Hernandez*, 71 Van Natta 596 (2019), the Board noted that it had declined to award such an attorney fee when a claimant's counsel's efforts had not resulted in increased TTD benefits.

Record did not establish that claimant's attorney was instrumental in prompting voluntary reopening of Own Motion claim or in obtaining TTD benefits.

Turning to the case at hand, the Board acknowledged that claimant's attorney was instrumental in obtaining the acceptance of claimant's new/omitted medical condition claim by virtue of the approved stipulation. However, the Board observed that the record did not establish that claimant's counsel took any particular action (other than prompting the stipulation) that was "instrumental in obtaining a voluntary reopening" of claimant's Own Motion claim. Furthermore, the Board found that, at the time of the voluntary reopening, claimant was not entitled to TTD benefits, but rather received such benefits several months later following his surgery.

Under such circumstances, the Board was not persuaded that claimant's counsel's was "instrumental in obtaining a voluntary reopening" of an Own Motion claim. Moreover, even if claimant's counsel's actions were considered "instrumental" in prompting the carrier's voluntary claim reopening, the Board found that the claim reopening did not "result[] in increased temporary disability compensation." Consequently, the Board concluded that the prerequisites for an attorney fee award had not been met. *See* OAR 438-015-0080(2).

Own Motion: "PTD" - "Work Force/Futility" Requirements Must Be Established As of "NOC"; "Work Disability" - "Education" Value - Claimant's Affidavit (Stating No "High School Diploma/No GED") Outweighed Form Indicating "College Courses"; Penalty - Discovery Violation - "012-0110(1)"

Sandra L. Sanders, 71 Van Natta 1092 (October 1, 2019). Analyzing ORS 656.206(1)(d) and ORS 656.206(3), on review of an Own Motion Notice of Closure, the Board held that claimant was not entitled to permanent total disability (PTD) benefits because the record did not establish that she was "in the work force" at the time of claim closure. In seeking a PTD award, claimant argued that, although she had last worked a year before the closure of her claim, she was willing to seek regular gainful employment because she continued to work after her initial injury despite undergoing numerous left shoulder surgeries, and that it was futile for her to seek work based on her attending physician's statement that she would be incapable of competitive employment in the restricted sedentary capacity to which she was released.

In seeking PTD benefits, claimant contended it was futile for her to seek work due to restricted/sedentary capacity.

Citing ORS 656.206(3), *SAIF v. Stephens*, 308 Or 41 (1989), and *Lloyd D. Irwin, Jr.*, 70 Van Natta 797, *recons*, 70 Van Natta 1093 (2018), and *Richard L. Elsea*, 66 Van Natta 493, *recons*, 66 Van Natta 727 (2014), *aff'd, Elsea v. Liberty Mutual Ins.*, 277 Or App 475 (2016), (among other decisions), the Board stated

that, in addition to establishing that a claimant is permanently incapacitated from regularly performing work at a gainful and suitable occupation under ORS 656.206(1)(d), he/she must also demonstrate his/her presence "in the workforce." Referring to *Stephens*, the Board explained that to satisfy the "work force" requirement under ORS 656.206(3), a claimant must prove that, but for the compensable injury, he/she (1) is or would be willing to seek gainful employment and (2) has or would have made reasonable efforts to obtain such employment unless seeking such work would have been futile.

"Futility" determined from the record as a whole including medical and vocational evidence.

Relying on *Irwin,* and *Seferino C. Hernandez*, 58 Van Natta 821 (2006), the Board also observed that the issue of whether it would be futile for claimant to seek work is an objective standard determined from the record as a whole, especially considering persuasive medical evidence regarding his/her ability to work and/or seek work. The Board reiterated that a worker must prove the "futility of seeking work if the worker has not made reasonable work search efforts by *competent written vocational testimony*." *See* OAR 436-030-0055(4)(c); *Anne M. Hayes*, 71 Van Natta 971 (2019); *Sherlee M. Samel*, 56 Van Natta 931 (2004).

In addition, the Board referred to ORS 656.206(1)(a) and *Gornick v.* SAIF, 160 Or App 338 (1999) for the proposition that the ability to work at least part-time, at a minimum wage job, constitutes "gainful employment." Finally, the Board emphasized that a determination of claimant's "work force" status is made as of the date of claim closure, when his/her entitlement to PTD benefits is evaluated.

Record lacked persuasive vocational evidence that claimant was precluded from "gainful employment," as of date of NOC.

Applying the aforementioned principles to the case at hand, the Board found that, although claimant had continued to work after her compensable injury despite undergoing numerous surgeries, it was undisputed that she had last worked more than one year before the closure of her Own Motion claim. The Board also acknowledged the attending physician's opinion that claimant could not perform competitive employment in the broad range of general occupations due to her work restrictions. Nonetheless, the Board found that the record lacked persuasive vocational evidence indicating that claimant was precluded from "gainful employment" such that it would be futile for her to seek work.

Under such circumstances, the Board concluded that claimant did not establish that she was willing to seek regular gainful employment and making reasonable efforts to obtain such employment *at the time of the Own Motion Notice of Closure*, when her entitlement to PTD benefits was evaluated. Accordingly, the Board declined to award PTD benefits.

Alternatively, based on the closure of her Own Motion claim for her new/omitted medical condition, claimant requested an increased work disability award. Specifically, she sought an "education" value of 1 because the record did not establish that she earned or acquired a high school diploma or general equivalency diploma (GED) certificate. *See* OAR 436-035-0012(4). In response, the carrier argued that the education value should be zero, noting that a work/educational history form signed by claimant indicated that she completed grade 12 of high school and had completed college certification programs.

The Board disagreed with the carrier's contention. After reviewing the record (including the work/educational history form), the Board acknowledged that claimant had circled grade "12" for high school, listed "1972," and indicated that she had two years of college with a major in mental health. Nonetheless, the Board noted that neither "Diploma or GED" had been circled on the form. Moreover, the Board observed that claimant's sworn affidavit stated that she had not obtained or acquired a high school diploma or GED.

Sworn affidavit stating claimant did not have a high school diploma outweighed a form indicating that she attended two years of college.

Under such circumstances, the Board was persuaded that claimant lacked a high school diploma or GED and, as such, was entitled to a formal education factor value of 1. OAR 436-035-0012(4)(b). In reaching its conclusion, the Board reasoned that while claimant's completion of college certification programs would suggest that she had earned or acquired a high school diploma or GED certificate, it declined to infer such a finding based on her sworn affidavit.

Carrier's claim processing found unreasonable for failing to submit all evidence as required by Board discovery rules.

Finally, applying ORS 656.262(11)(a) and OAR 438-012-0110(1), the Board awarded a penalty and attorney fee for the carrier's failure to comply with the Board's Own Motion rules in submitting all evidence pertaining to claimant's conditions at the time of claim closure, including any evidence relating to permanent disability pursuant to OAR 438-012-0017(1) and OAR 438-012-0060(3). The Board noted that, although granted an extension to provide all relevant materials, the carrier had not submitted several relevant materials (including prior closure notices, worksheets, and litigation orders). Reasoning that the carrier had no legitimate doubt regarding its discovery obligations, the Board found the carrier's failure to comply with the Board's Own Motion rules to be unreasonable and unjustified. *See Doug R. Cooley*, 70 Van Natta 1072 (2018); *Sandra L. Sanders*, 69 Van Natta 1426 (2017).

Premature Closure: "Insufficient Information" to Close Claim - Carrier Did Not Seek Clarification of "AP's" Inconsistent Opinions - Closure Unreasonable - "268(5)(f)" Penalty Awarded

Humzah Al-Rawas, 71 Van Natta 1133 (October 4, 2019). Analyzing ORS 656.005(17), ORS 656.283(6), and OAR 436-030-0035(5), the Board held that claimant's thoracic fracture injury claim was prematurely closed because the carrier had not sought clarification of an attending physician's inconsistent opinion before closing the claim. Following claimant's compensable injury, his attending physician reported that claimant's condition was not medically stationary and recommended referral to develop a return to work plan likely requiring a work hardening program. Some three months later, the carrier provided the attending physician with another physician's report (which found claimant medically stationary without permanent impairment), along with a surveillance video, and asked the attending physician whether he concurred with the "findings." Without further explanation, the attending physician indicated his concurrence with the "findings." Based on that concurrence, the carrier issued a Notice of Closure (NOC). After an Order on Reconsideration rejected claimant's contention that the claim had been prematurely closed and affirmed the NOC, he requested a hearing, arguing that the attending physician's concurrence with the other physician's "findings" conflicted with the attending physician's previous statements that claimant was not medically stationary

"AP's" concurrence with "findings" of an IME report (which found no permanent impairment) conflicted with AP's prior comments that claimant was not "medically stationary."

and that physical therapy/work hardening was recommended. In response, the carrier asserted that its closure of the claim was justified because the attending physician's concurrence with the examining physician's opinion extended to claimant's "medically stationary" status. *See* OAR 436-030-0035(5).

The Board disagreed with the carrier's assertion. Citing ORS 656.005(17), the Board stated that a condition is "medically stationary" if no further material improvement would reasonably be expected from medical treatment or the passage of time. Referring to *Maarefi v. SAIF*, 69 Or App 527, 531 (1984), the Board recognized that "medically stationary" did not mean that there is no longer a need for continuing medical care. Finally, the Board noted that whether a condition is medically stationary is primarily a medical question to be decided based on competent medical evidence, not limited to the opinion of the attending physician. *See Harmon v. SAIF*, 54 Or App 121, 125 (1981),

Carrier should have clarified claimant's "medically stationary" status before closing claim; without such clarification, there was "insufficient information" to close the claim.

Turning to the case at hand, the Board acknowledged that the examining physician had found claimant's condition to be "medically stationary." The Board further recognized that the attending physician had concurred with the "findings" in the examining physician's report. Nonetheless, based on the attending physician's repeated comments that clamant was not "medically stationary," along with further treatment recommendations, the Board determined that the carrier should have clarified that the attending physician's "concurrence" with the examining physician's "findings" extended to the examining physician's "medically stationary" determination.

Under such circumstances, the Board concluded that there was insufficient information for the carrier to close the claim. *See, e.g., Juan M. Orta-Carrizales*, 71 Van Natta 794, 803 (2019). Consequently, finding that claimant had established error in the reconsideration record, the Board set aside the Order on Reconsideration's closure of the claim. *See* ORS 656.283(6); *Marvin Wood Products v. Callow*, 171 Or App 175, 183 (2000); *Fred A. Harris*, 70 Van Natta 1105, 1106 (2018).

Carrier specifically limited its question to "AP" concerning concurrence to IME "findings," rather than the entire IME report (including "medically stationary" comments); "030-0035(5)" distinguished.

In reaching its conclusion, the Board acknowledged that, under OAR 436-030-0035(5), a physician's "concurrence" with another physician's "report" represents "agreement in every particular," including "the medically stationary impression and date." Nonetheless, the Board reasoned that, in the present case, the carrier had specifically limited its question to the attending physician to the examining physician's "findings," rather than to the entire "report," or claimant's "medically stationary" status. Considering the attending physician's previous comments that claimant was not medically stationary and recommendations for further treatment/programs, the Board found that it was incumbent on the carrier to seek "clarification" of the attending physician's opinion before the record would support sufficient information on which to close the claim.

Because carrier did not seek clarification of "AP's" "medically stationary" status before closing the claim, its conduct was found unreasonable.

Finally, in light of the attending physician's previous unambiguous opinions that consistently stated that claimant was not medically stationary and recommendation for further modes of treatment to prepare him for a return to work, the Board concluded that such observations supported a reasonable expectation of material improvement in claimant's condition. *See* ORS 656.005(17). Because the carrier had not sought clarification of the attending

physician's opinion before closing the claim, the Board determined that the NOC was unreasonable. Accordingly, the Board awarded penalties and attorney fees. *See* ORS 656.268(5)(f); ORS 656.382(1); *Orta-Carrizales*, 71 Van Natta at 803-04.

Remanding: "Post-Hearing" CT Scan/Physician's Chart Notes - Unobtainable at Hearing Level/ Reasonably Likely to Affect Outcome - "Compelling Reason" to Remand - "295(5)"

"Post-ALJ order" CT scan confirmed existence of meniscus tear, which had not been identified at hearing level.

Marcos E. Miralrio-Guevara, 71 Van Natta 1111 (October 2, 2019): Citing ORS 656.295(5), the Board held that it was appropriate to remand a case to the Hearings Division for consideration of a "post-hearing" CT scan (and accompanying chart notes) because the documents were not obtainable at the hearing level and they were reasonably likely to affect the outcome of claimant's denied knee injury claim. Following claimant's appeal of an ALJ's order upholding a carrier's injury denial of his knee condition, claimant underwent a CT scan, which confirmed the existence of a meniscus tear. While his appeal was pending, claimant submitted the CT scan report (along with a physician's chart notes, which reviewed the CT scan and supported a causal relationship between the findings and the work incident). In doing so, claimant sought remand to the ALJ, asserting that the proffered evidence concerned disability, was not obtainable with due diligence before the hearing, and was likely to affect the outcome of the case. In response, the carrier opposed remand, contending that the CT scan report and physician's chart notes were obtainable before the hearing with due diligence.

The Board granted claimant's remand request. Citing ORS 656.295(5), the Board stated that remand is appropriate when a case has been "improperly, incompletely, or otherwise insufficiently developed." Relying on *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986), and *SAIF v. Avery*, 167 Or App 327, 333 (2000), the Board reiterated that there must be a compelling reason to remand to an ALJ which exists when new evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case.

Claimant's health issues prevented an MRI at hearing level, and no physician had recommended a CT scan until after the ALJ's order, when claimant was examined by a new physician.

Turning to the case at hand, the Board determined that the proffered evidence concerned the disability of claimant's disputed knee injury claim and was not obtainable before the hearing with due diligence. In doing so, the Board noted that, before the hearing, no physician had recommended an MRI because claimant apparently had a "BB" in his chest, which had raised health concerns. Noting that a CT scan had not been recommended until claimant was examined by another physician after the hearing, the Board was persuaded that the submitted CT scan report and accompanying chart notes from the new physician were unobtainable at the hearing level. *See Linda J. Curtis,* 68 Van Natta 376, 377 (2016) ("post-hearing" operative report not obtainable with due diligence at the hearing because the surgery occurred after the hearing); *George P. Black*, 55 Van Natta 43, 46 (2003) (evidence derived from a "post-hearing" surgery not obtainable with due diligence at the hearing).

Furthermore, the Board concluded that consideration of the "post-hearing" CT scan report and accompanying chart notes (which supported the existence of a meniscal tear and its relationship to claimant's work incident) were reasonably likely to affect the outcome of the case. *See Parmer v. Plaid Pantry #54*, 76 Or App 405, 408-09 (1985) (remand warranted where physician's "post-hearing" operative report provided further findings in support of compensability of disputed claim); *Curtis*, 68 Van Natta at 377 (same). In reaching this conclusion, the Board noted that the record developed at the previous hearing had not supported the existence of acute knee findings following claimant's work incident.

"Post-ALJ order" CT scan/chart notes confirmed the existence of acute knee findings, which had been lacking at the hearing level; reasonably likely to affect outcome of compensability issue; "compelling reason" to remand.

Under such circumstances, the Board found a compelling reason to remand the case to the Hearings Division. Consequently, the Board remanded the case to the ALJ for consideration of claimant's submission, as well as any other documents from either party the ALJ deemed would achieve substantial justice. In reaching its conclusion, the Board emphasized that its decision to remand should not be interpreted as offering an opinion on the compensability issue, which was an issue for the ALJ's resolution on remand. *See Curtis*, 68 Van Natta at 378, n 3.

APPELLATE DECISIONS UPDATE

Attorney Fees: "Pre-Hearing" Rescission of Claim Denial - Record Did Not Establish Claimant's Counsel "Instrumental" in Obtaining Rescission - "386(1)(a)"

Penalty: Unreasonable Denial - "Legitimate Doubt" - Reasonable Investigation - "262(11)(a)," "060-0140(1)"

Brooks v. Tube Specialties - TSCO International, 300 Or App 361 (October 30, 2019). The court affirmed that portion of the Board's order in *Hobby L. Brooks*, 68 Van Natta 923 (2016), previously noted 35 NCN 6:3, which held that claimant's counsel was not entitled to a carrier-paid attorney fee award under ORS 656.386(1) when the carrier rescinded its claim denial before the hearing because the record did not establish that his counsel had been instrumental in obtaining rescission of the carrier's denial. In reaching its conclusion, the Board found that, with the exception of the filing of a hearing request and notice of representation, the record was devoid of any action by claimant's counsel that could have influenced the carrier's decision to rescind its denial before the hearing. On appeal, claimant contended that his counsel's agreement to represent him in the proceeding, coupled with entering an appearance and performing necessary work to further that litigation to its end was all that was necessary to be "instrumental" in obtaining the "pre-hearing" rescission of the carrier's denial and, thereby, warranting an attorney fee award under ORS 656.386(1)(a).

Claimant's attorney filed a hearing request/sought discovery, but took no other action before carrier rescinded its claim denial before the hearing.

The court disagreed with claimant's contention. Referring to *Webster's Third New Int'l Dictionary* 1172 (unabridged ed 1993), the court stated that "instrumental" is commonly defined as "serving as a means or intermediary determining or leading to a particular result" or "being an instrument that

functions in the promotion of some end or purpose." Furthermore, based on the legislative history regarding the 1991 amendments to ORS 656.386(1) (which adopted the language providing for a carrier-paid attorney fee when a worker's counsel is "instrumental" in obtaining a "pre-hearing" rescission of a claim denial), the court remarked that the legislature was primarily concerned with making attorney fees *available* for claims resolved before a hearing, rather than the specifics of who would qualify for a fee. In addition, given the text, context, and legislative history of ORS 656.386(1)(a), the court considered it an open question whether the 1991 legislature intended "instrumental" in the more directly causative sense of "serving as a means or intermediary determining or leading to a particular result" or in the less directly causative sense of "being an instrument that functions in the promotion of some end or purpose."

"Open question" regarding 1991 legislative intent regarding meaning of "instrumental" concerning amendments to "386(1)."

However, based on the Board's unchallenged factual findings (*i.e.*, that the only action taken by claimant's counsel before the carrier's rescission of its denial was to send a letter to the carrier announcing his representation and requesting discovery), the court concluded that regardless of what meaning was given to "instrumental," the Board had not erred in holding that an attorney fee award under ORS 656.386(1)(a) was not warranted. In reaching its conclusion, the court agreed with the Board's determination that the statute required *something* from claimant's counsel that affected the carrier's decision to rescind its claim denial. Likewise, the court rejected claimant's view that, when an attorney appears in a workers' compensation matter and the carrier subsequently rescinds its claim denial, the attorney is necessarily "instrumental" in obtaining the rescission and automatically is entitled to a fee.

Statute requires "something" from claimant's counsel that affected decision to rescind its denial.

Noting that ORS 656.386(1)(a) provided for a different standard for an attorney fee award after a hearing (*i.e.*, in all cases where a claimant finally prevails against the denial), the court reasoned that ignoring that distinction and treating the statute as creating a blanket entitlement to an attorney fee would be inconsistent with the statutory text and context, under either definition of "instrumental," and would effectively deprive "instrumental" of any meaning as a condition for an attorney fee award. Acknowledging that there may be a persuasive policy argument for an amendment to the statute to provide for an attorney fee in every case concerning pre-hearing rescissions of claim denials, the court observed that the legislature was free to do so.

"Instrumental" standard for a fee in "pre-hearing" denial rescission differs from that after a hearing (which provides for a fee in "all cases" where a claimant finally prevails against a denial).

In conclusion, the court determined that the legislative history concerning ORS 656.386(1)(a) provided some insight into what the legislature understood "instrumental" to mean; *i.e.*, several proponents of the legislation described situations in which a claimant's attorney was "instrumental" in obtaining the rescission of a claim denial. The court considered that limitation to be in stark contrast to the rest of the statutory provision, which expressly provides for an attorney fee in *every* case involving a denied claim where the claimant finally prevails in a hearing, on Board review, or on judicial review. Reasoning that it could not ignore the distinction between the two provisions in ORS 656.386(1), or the legislative intent reflected therein, the court affirmed the Board's decision that claimant's counsel was not entitled to an attorney fee award.

Court could not ignore the distinction between the two "386(1)" provisions or the legislative intent reflected therein.

On another issue, the court reversed that portion of the Board's order that declined to award a penalty for an unreasonable denial. In reaching its conclusion, the Board had reasoned that the carrier had a legitimate doubt

Carrier is required to conduct a "reasonable" investigation based on all available information in determining whether to deny a claim.

Because Board order had not addressed whether carrier conducted a reasonable claim investigation under "060-0140(1)" before issuing its denial, court remanded for determination of whether the carrier's denial (based on delays in treatment/claim and ambiguities regarding cause of injury) was unreasonable.

Dissent argued that Board's prior case law indicated that attorney need not demonstrate that his/her work directly caused a rescinded denial; rather, if denial was after attorney began work to challenge the denial, it was assumed attorney's presence impacted rescission.

Legislative intention was to provide workers with competent counsel at all stages of representation.

regarding its liability for the claim because claimant had delayed seeking medical treatment, delayed reporting his injury, and a physician's records had not mentioned the circumstances or cause of claimant's injury. Asserting that the Board had not addressed whether the carrier had conducted a reasonable investigation under OAR 436-060-0140(1) before issuing its denial, claimant argued that the Board had erred in not assessing a penalty.

The court noted that the Board order had cited OAR 436-060-0140(1) and two previous decisions (*James S. Hurlocker*, 66 Van Natta 1930, 1937 (2014), and *Kenneth A. Foster*, 44 Van Natta 148, 149, ***aff'd without opinion***, 117 Or App 543 (1992)) for the proposition that a carrier is required to conduct a "reasonable" investigation based on all available information in determining whether to deny a claim. Notwithstanding those citations, the court observed that the Board had not addressed whether or why the delays and ambiguities mentioned in its order made it unnecessary for the carrier to conduct even a minimal investigation to determine (for example) whether claimant's accident was work-related (if that was what the carrier doubted).

Because claimant had challenged the reasonableness of the carrier's claim investigation, the court reasoned that, based on the Board's interpretation of OAR 436-060-0140(1) as requiring a carrier to conduct a reasonable investigation before denying a claim, the Board was required in the first instance to determine whether the carrier's investigation was reasonable as part of deciding whether the claim denial was unreasonable. Consequently, the court remanded for the Board to make such a determination.

Chief Judge Egan dissented from the majority's decision that claimant was not entitled to an attorney fee award under ORS 656.386(1)(a). Although acknowledging that the legislative history regarding the 1991 amendments to the statute did not "directly" address the meaning of the term "instrumental," Judge Egan considered it was clear what the legislature understood the Board's case law to have been at the time of the amendments.

Summarizing two previous Board decisions (*Edward M. Anheluk*, 34 Van Natta 205 (1982), and *Clarence A. Hooper*, 1 Van Natta 160 (1968)), Egan reasoned that both decisions rested explicitly on an understanding that, to be "instrumental" for purposes of an attorney fee award under ORS 656.386(1), an attorney need not demonstrate that the attorney's work in representing a client directly *caused* a carrier to rescind a denial. Instead, Judge Egan considered the focus of both Board decisions to be on the timeline; *i.e.*, if the carrier's rescission of its denial was *after* the claimant's attorney began to do work to challenge the denial, it was assumed that the attorney's presence had some impact on the carrier's decision.

Referring to statements made in the 1991 legislative history concerning the need for "fairness" and to provide compensation to injured worker's attorneys for their work, Chief Judge Egan considered such intentions grounded on one of the stated objectives of ORS 656.012(2)(b); *i.e.*, providing access to adequate representation for injured workers. Reasoning that the legislative intention was to provide workers with access to competent counsel *at all stages of*

representation, Judge Egan believed that, by focusing on the attorney's "entitlement" to a fee, the majority had ignored the broader picture; *i.e.*, that the "entitlement" really belongs to the worker and that entitlement is access to counsel, not to a fee.

Fee always limited to a "reasonable" fee spent on "pertinent, litigation-related issues."

Finally, Judge Egan considered the majority's focus on a "causative" relationship between the attorney's work and the carrier's ultimate decision to be an extra step not required by the statute. Similarly, Egan believed that such an analysis was also superfluous because a claimant's counsel's fee would always be limited to a "reasonable" fee that was spent on "pertinent, litigation-related issues." *Bowman v. SAIF,* 278 Or App 417, 426 (2016).

Penalties: "Significant Limitation" Form Furnished to "AP" - Did Not Accurately Reflect WCD's "Industry Notice"

Wiggins v. SAIF, 300 Or App 319 (October 30, 2019). The court reversed the Board's order in *Keith J. Wiggins*, 69 Van Natta 1310 (2017), previously noted 36 NCN 9:10, that declined to award penalties/attorney fees under ORS 656.268(5)(f) or ORS 656.262(11)(a) because it did not find a Notice of Closure (which did award a "chronic condition" permanent impairment value) to have been unreasonable. In reaching its conclusion, the Board rejected claimant's contention that the carrier's "check-the-box" form to the attending physician regarding whether claimant had a "significant limitation" under OAR 436-035-0019(1) was unreasonable.

Carrier's "significant limitation" form letter to "AP" was not the same standard as used in WCD's "Industry Notice."

On appeal, claimant asserted that the Board had erred as a matter of law in finding that the carrier's form correctly stated the chronic condition impairment standard as interpreted by the Workers' Compensation Division (WCD) in its Industry Notice. In response, framing the question as whether its form had correctly captured the "chronic condition" standard articulated in WCD's Notice, the carrier argued that substantial evidence supported the Board's finding. *See* ORS 183.482(8)(c).

*A person is "significantly limited" in repetitive use of a body part if the person "is restricted * * * for one-third or more of a period of time."*

The court concluded that, whether treated as a question of law or one of fact, the Board had erred. *See* ORS 183.482(8)(a), (c). If treated as a question of fact, the court reasoned that a reasonable person could not have found that the carrier's form referred to WCD's interpretation of the "chronic condition" standard. In other words, the court explained that the carrier's form indicated that a worker who is limited two-thirds of the time or less (and thus can repetitively use a body part one-third of the time or more) does not have a "significant limitation," whereas the standard articulated by WCD a person is significantly limited in the repetitive use of a body part if the person "*can use* the body part repetitively for up to, but not more than, two-thirds of the time." *See Broeke v. SAIF*, 300 Or App 91, 99 (2019). Relying on its *Broeke* rationale, the court reiterated that a person is significantly limited in the repetitive use of a body part if the person "is restricted from repetitive use of a body part for one-third or more of a period of time."

The court reached the same result under a "question of law" standard. Specifically, the court determined that the "significant limitation" standard recited on the carrier's form was not the same as WCD's interpretation.

Accordingly, in view of its conclusion that the Board had erred when it determined that the carrier's form referred to WCD's interpretation of the "chronic condition" standard, the court remanded to the Board for reconsideration of claimant's requests for penalties and attorney fees.

APPELLATE DECISIONS
COURT OF APPEALS

Course and Scope: "Going and Coming" Rule - Fall in "Non-Employer" Parking Lot" After "Work Shift" Ended - Not "In Course Of" Employment

King v. SAIF, 300 Or App 267 (October 30, 2019). The court affirmed a Board order, which found that a substitute teacher's (claimant's) foot injury, which she sustained after falling on the ice in the parking lot of an elementary school, did not occur in the course of her employment because her principal had ended her regular shift early due to inclement weather and claimant was walking to her car in the parking lot when she sustained her injury. Applying the "going and coming" rule, the Board had concluded that because claimant was released from work and was no longer subject to her employer's direction and control, her injury did not occur in the course of her employment.

Claimant's shift had ended when she was walking to her car in the parking lot (not owned/controlled by employer); thus, injury was subject to "going/coming" rule.

On appeal, claimant acknowledged that the parking lot was not owned nor controlled by her employer (the school district) and, as such, did not challenge the Board's determination that the "parking lot exception" to the "going and coming" rule did not apply. Nonetheless, contending that the parking lot was part of her employment premises and had she encountered a child in the parking lot while she was still technically "on the clock," it would have been within her responsibility to assist the student and return to the school before her shift technically ended, claimant argued that her injury was sustained in the course of her employment.

The court disagreed with claimant's contention. Citing *Krushwitz v. McDonald's Restaurants*, 323 Or 520, 526-27, and *SAIF v. Massari*, 291 Or App 349 (2018), the court stated that, under the "going and coming" rule, injuries sustained while an employee is traveling to or from work do not occur in the course of employment.

Turning to the case at hand, the court acknowledged claimant's assertion that her situation was analogous to the situation in *Massari*, where a physician's slip and fall injury in a hospital parking lot on his way to work after his shift had begun was compensable. However, the court distinguished *Massari*, reasoning that in that case the claimant was on duty and under his employer's direction and control at the time of his injury, whereas in the present case, claimant had been released from work and was travelling "from work" when her injury occurred.

Although claimant may have been required to attend to students outside of school building, on the day of injury she had been released from work, and was not under employer control.

In reaching its conclusion, the court determined that the fact that claimant's job ordinarily required her to tend to students outside of the school building did not mean that on the particular day and time of her injury she was still working as she walked to her car (at a time when she was not attending to students). In addition, even though claimant was technically within the hours of her regular shift and could have assisted a student in the parking lot (had the opportunity arisen), the court held that substantial evidence supported the Board's finding that she had been released from work and was no longer under the employer's direction and control as she left the school.

Extent: Impairment Findings - "Standing" Limitation "Chronic Condition"/"Significant Limitation" - "035-0019," "035-0230"

Broeke v. SAIF, 300 Or App 91 (October 16, 2019). Analyzing OAR 436-035-0019 and OAR 436-035-0230, the court affirmed that portion of a Board order that determined that claimant was not entitled to a 15 percent permanent impairment value under OAR 436-035-0230 for his bilateral foot/ ankle condition because he could be on his feet for more than two hours in an eight hour period, but reversed that portion of the Board's order that did not award a "chronic condition" impairment value because he was not significantly limited in the repetitive use of his lower legs. On appeal, claimant contended that: (1) the Board's determination that he could not stand more than two hours in an eight-hour period was not supported by substantial evidence/reasoning; and (2) the Board's determination that claimant did not have a significant limitation concerning the repetitive use of his feet/ankles was based on an erroneous understanding of OAR 436-035-0019(1)(a) and not supported by substantial evidence/reason.

15 percent "standing/ walking" impairment value for leg is awardable when worker cannot be on feet for more than two hours in an 8-hour period.

The court disagreed with claimant's assertion regarding the "standing limitation" impairment value under OAR 436-035-0230(14). Citing the rule, the court stated that a 15 percent impairment value for the leg is awardable when the worker cannot be on his/her feet for more than two hours in an 8-hour period.

Turning to the case at hand, the court acknowledged that the Appellate Review Unit's Order on Reconsideration had declined to grant the "standing limitation" impairment value because claimant could be on his feet for exactly two hours, but not more than two hours. Nonetheless, the court understood that, in affirming the reconsideration order, the Board's subsequent explanation had been that claimant's attending physician had opined that claimant could be on his feet for more than two hours in an eight-hour period; *i.e.*, 20 minutes per hour, which equated to 160 minutes (two hours, 40 minutes) in an eight-hour period.

Board's finding that claimant could be on feet for over two hours in an 8-hour period was supported by substantial evidence/reasoning.

Under such circumstances, the court found that the Board's determination that claimant was not entitled to the 15 percent "standing limitation" permanent impairment was supported by substantial evidence/reasoning. *See Garcia v. Boise Cascade Corp.*, 309 Or 292, 294 (1990); *Akins v. SAIF*, 286 Or App 70, 76, *rev den* 362 Or 94 (2017).

Regarding the "chronic condition" issue, the court agreed with claimant's assertion that the Board's determination that no such value was awardable lacked substantial reasoning. Citing OAR 436-035-0019(1)(a), the court noted that a worker is entitled to a 5 percent chronic condition impairment value for a body part when a preponderance of medical opinion establishes that, due to a chronic and permanent medical condition, the worker is significantly limited in the repetitive use of that body part. Relying on *Spurger v. SAIF*, 266 Or App 183, 194-95 (2014) (*Spurger I*), the court observed that, in a previous holding, it had declined to supply a judicial interpretation of the term "significantly limited" under OAR 436-035-0019, considering that interpretation to be the province of the agency that promulgated the term."

WCD's interpretation of "significantly limited" entitled to deference.

Following *Spurger I*, the court remarked that the Workers' Compensation Division (WCD) had issued an Industry Notice explaining its interpretation of OAR 436-035-0019, which authorizes a chronic condition impairment value for a worker who can repetitively use the body part at issue for at most two-thirds of a period of time. Stated another way, the court observed that, under WCD's interpretation of "significant limitation," a worker who is restricted from repetitive use of a body part for one-third or more of a period of time is entitled to a chronic condition impairment value. Referring to *SAIF v. Eller*, 189 Or App 113, 119 (2003), the court considered WCD's interpretation of the rule to be a plausible one, given the rule's text and context, and, as such, was entitled to deference.

A worker who is restricted from repetitive use of a body part for one-third or more of a period of time is entitled to a "chronic condition" impairment value.

With that background in mind, the court acknowledged claimant's contention that the carrier's "significant limitation" questionnaire to his attending physician was misleading in that it suggested that a worker's limitation on repetitive use must extend to more than two-thirds of the time, which was contrary to WCD's interpretation of the rule, which provides for a chronic condition impairment value for a worker who can use the body part repetitively for up to, but no more than, two-thirds of the time. The court further recognized claimant's argument that the Board's determination that he did not have a "significant limitation" was not supported by substantial reason because his attending physician's most generous assessment of claimant's ability to use his feet for standing/walking allowed him to be on his feet at most one-third of the time.

Relying on *Spurger v. SAIF*, 292 Or App 227, 23 (2018) (*Spurger II*), the court noted that, when the medical evidence established that the claimant had difficulty performing "repetitive squatting, walking long distances, and static standing," it had previously held that a Board order had not explained why those limitations did not constitute a significant limitation. Given such circumstances, the court further observed that it had determined that such a Board order was not supported by substantial reason and, as such, had remanded for reconsideration of the Board's finding of no "significant limitation."

Board order did not explain why great difficulties using feet to stand/walk did not rise to "significant limitation" level under "035-0019" (as interpreted by WCD's "Industry Notice").

Applying *Spurger II* to the present case, the court stated that it was undisputed that claimant had great difficulties using his feet to stand and walk. Reasoning that the Board order did not explain why the aforementioned difficulties did not rise to the level of a "significant limitation" under OAR 436-035-0019 (as interpreted by WCD), the court reversed the Board's decision and remanded for reconsideration. In doing so, the court directed the Board to take into account that the carrier's "significant limitation" questionnaire appeared to

Board was directed to take into account that carrier's "significant limitation" questionnaire appeared to conflict with WCD "Industry Notice."

use the term "significant limitation" in a manner that conflicted with WCD's interpretation of OAR 436-035-0019 and, as such, created the risk that the attending physician did not understand "significant limitations" as interpreted by WCD.

Occupational Disease: "Series of Traumatic Events or Occurrences" - No "General Work Activities" Requirement - "802(1)(a)(C), (2)(a)"

Simi v. LTI Inc. - Lynden Inc., 300 Or App 258 (October 30, 2019). Analyzing ORS 656.802(1)(a)(C) and (2)(a), the court reversed the Board's order in *Randy G. Simi*, 69 Van Natta 364 (2017), that upheld the carrier's denial of claimant's occupational disease claim for a shoulder condition. In reaching its conclusion the Board had found that a physician's opinion that several discrete work-related injuries contributed to claimant's shoulder condition was insufficient to demonstrate that his "general work activities" had contributed to his condition. On appeal, claimant contended that the Board had erred in concluding that, for an occupational disease when the record shows that a claimant's condition was the result of a series of work injuries, the record must nonetheless also show that his/her "general work activities" contributed to the condition.

The court agreed with claimant's contention. Citing ORS 656.802(1)(a)(C) and (2), the court stated that an occupational disease includes "[a]ny series of traumatic events or occurrences which requires medical services or results in physical disability or death," provided that the worker prove that "employment conditions were the major contributing cause of the disease."

Turning to the case at hand, the court acknowledged the carrier's contention that a "series of traumatic events or occurrences" under ORS 656.802(1)(a)(E) is meant to address only occupational diseases that are brought on gradually by physical overuse or repetitive motion and not to encompass a series of injuries. Consistent with the carrier's position, the court noted that the legislative history of ORS 656.802 shows that subsection (1)(a)(C) was intended to clarify that conditions brought on by microtraumas or overuse are to be evaluated as occupational diseases.

No indication that "802(1)(a)(C)" was intended to encompass only claims arising out of microtraumas or overuse, but instead refers to "a series of traumatic events or occurrences," which was broad enough to encompass a series of injuries.

Nonetheless, the court observed that neither the statute nor its legislative history showed that subsection (1)(a)(C) was intended to encompass *only* claims arising out of microtraumas or overuse, but instead refers to "a series of traumatic events or occurrences," which was broad enough to encompass a series of injuries. Moreover, referring to *Kepford v. Weyerhaeuser Co.*, 77 Or App 363, *rev den,* 300 Or 722 (1986), the court reiterated that, although a series of injuries in and of itself is not an occupational disease, an occupational disease can be established by medical evidence that discrete work-related injuries have caused a separate condition.

"802(2)(a)" refers to "employment conditions," not "general work activities."

Furthermore, referring to ORS 656.802(2)(a), the court stated that "employment conditions" must be the major contributing cause of the occupational disease. In doing so, the court emphasized that the statute refers to "employment conditions," not to "general work activities" as used

in the Board's order. The court also reiterated that work-related injuries are themselves "employment conditions" under ORS 656.802(2)(a). *See Hunter v. SAIF*, 246 Or App 755, 760 (2011).

Under such circumstances, the court concluded that if the medical evidence persuades the Board that an occupational disease was caused by the cumulative effect of a series of work-related injuries, the disease itself is also work-related and compensable. In doing so, the court added that there was no need to show that the disease was caused by the worker's "general work-activities."

O.D. may be caused by cumulative effect of a series of work-related injuries; no need to show disease caused by "general work activities."

Applying its rationale to the present case, the court noted that it was undisputed that claimant experienced several work-related injuries, including multiple injuries with his employer, and that there was medical evidence from which a fact finder could find that claimant's cumulative injuries caused a separate medical condition requiring surgery. Because the Board had not made findings directed at determining whether claimant's condition requiring surgery was a condition separate from his discrete injuries (as well as a condition that developed gradually as the result of the cumulative effect of the work-related injuries), the court remanded for reconsideration.