Workers' Compensation Board

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News & Case Notes

BOARD NEWS

WCB Managing Attorney - ALJ Ian Brown/One-Year "Rotational" Opportunity

For personal reasons, Jim Moller has resigned his position as WCB's Managing Attorney. The Board extends to Jim its grateful appreciation for his service to the agency and wishes him well in this upcoming stage of his life. To assist the Board Review Division during this transition, Administrative Law Judge Ian Brown has accepted a "rotational" opportunity as the Managing Attorney. Ian is scheduled to serve in this capacity for one year.

Board Meeting: June 23, 2020 - Discussion of Language For Proposed Rules/Amendments (Attorney Fees - OAR 438 Division 015) - "Contingent Hourly Rate" - "Bifurcation of Board Attorney Fee Awards/ Voluntary Procedure"

"Public Participation" Via "Phone" Link - Written Comments Encouraged

At their February 27, 2019, public meeting, the Members decided to continue their discussions regarding language for proposed rule amendments that would concern: (1) a "contingent hourly rate" for use in determining a reasonable assessed attorney fee under OAR 438-015-0010; and (2) the bifurcation of a determination of a reasonable attorney fee from the merits of the claim for certain cases on Board review.

Members Lanning and Ousey have each offered language for proposed rule amendments that will address a "contingent hourly rate" under OAR 438-015-0010. Those proposals have been posted on WCB's website. https://www.oregon.gov/wcb/Pages/meetings-minutes.aspx. In addition, draft language for the "bifurcation" rule (from Jim Moller, the Board's former Managing Attorney, and Julene Quinn, Attorney at Law) have been posted on WCB's website. https://www.oregon.gov/wcb/Pages/meetings-minutes.aspx

A public meeting was initially scheduled for Tuesday, April 7, 2020, at the Board's Salem office. However, consistent with the Governor's executive order regarding the coronavirus pandemic, the April 7 meeting was cancelled.

APPELLATE DECISIONS

The Board's public meeting has now been rescheduled for Tuesday, June 23, 2020, at 1:30 p.m., at the Board's Salem office. Because of the Governor's "social distancing" requirements, arrangements have been made to allow the public to participate in the meeting by means of a "phone conference" link. This "phone conference" link will be available the week before the meeting. Any questions regarding this link may be directed to Greig Lowell, 2601 25th St SE, Suite 150, Salem, OR 97302, by phone (503)378-3308, email greig.lowell@oregon.gov or by fax at (503)373-1458.

At their June 23 public meeting, the Members will discuss the memos from Members Lanning and Ousey, as well as those from Mr. Moller and Ms. Quinn, and consider approval of proposed rule amendments regarding these concepts. In advance of this meeting, because of the "social distancing" limitations and because the distribution of written comments on the day of the Board meeting will create logistical challenges, parties/practitioners are encouraged to submit written comments regarding the proposed rule language offered by Members Lanning and Ousey, as well as their own suggestions regarding rule language. Any written comments should be directed to Kayleen Swift, WCB's Executive Assistant at 2601 25th St SE, Suite 150, Salem, OR 97302, kayleen.r.swift@oregon.gov, or via fax at (503)373-1684.

Following their meeting, should the Members decide to 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 any proposed rule amendments. Following that public hearing, another Board meeting will then be scheduled for the Members to consider those written/oral comments and discuss whether to adopt permanent rule amendments.

Adoption of Permanent Rules/Amendments (Attorney Fees - OAR 438 Division 015) - Effective June 1, 2020

At their February 27, 2020, public meeting, the Members adopted rules/ amendments relating to attorney fees (OAR 438 Division 015). The Members took these actions after considering written/oral comments presented at a January 31, 2020, rule-making hearing, as well as discussing submissions from Members Ousey, Curey, and Woodford and comments presented by attendees at their February 27 meeting. The rule adoptions include (among other rule amendments):

- Adding a definition ("client paid fee") to describe fees paid by an insurer or self-insured employer to its attorney. OAR 438-015-0005.
- Adding language based on ORS 656.388(5) to the "rule-based factors" in determination of an assessed fee: "The necessity of allowing the broadest access to attorneys by injured workers," and "Fees earned by attorneys representing the insurer/self-insured employer, as compiled in the Director's annual report pursuant to ORS 656.388(7) of attorney salaries and other costs of legal services incurred by insurers/self-insured employers under ORS Chapter 656." OAR 438-015-0010(4).

- Increasing the hourly rate for an attorney's time spent during an interview or deposition under ORS 656.262(14)(a) from $275 to $350, plus an annual adjustment commensurate with changes in the state average weekly wage. OAR 438-015-0033.
- Establishing a schedule of attorney fees for attorneys representing insurers and self-insure employers, requiring that such fees be reasonable and not exceed any applicable retainer agreement. OAR 438-015-0115.

The effective date for the permanent rules/amendments is June 1, 2020, to be applied in the manner prescribed in the Board's Order of Adoption. The Board's Order of Adoption can be found here: https://www.oregon.gov/wcb/Documents/wcbrule/rule-filings/1-2020/ooa1-2020.pdf. In addition, copies of the Order of Adoption have been distributed to all parties/practitioners on WCB's mailing list.

CASE NOTES

CDA: Attorney Fee Award (Multiple Attorneys) - Payable to "Attorney of Record" - Precise Distribution of Fees/Matter for Attorneys

Although CDA provided for separate amounts payable to multiple attorneys, Board approved fee payable to attorney-of-record.

Daniel Poole, 72 Van Natta 405 (May 11, 2020). In approving a Claim Disposition Agreement (CDA), the Board held that the entire attorney fee approved in the CDA was payable to claimant's current attorney-of-record, rather than awardable in separate amounts to multiple attorneys as provided in the agreement. Citing *Orlando M. Gongora*, 63 Van Natta 1127 (2011), and *Franklin E. Chase*, 61 Van Natta 2154, *on recon*, 61 Van Natta 2686, 2687 (2009), the Board reiterated that attorney fee awards are payable only to the attorney-of-record.

Precise method for apportioning the fee was a matter between the attorneys.

Turning to the case at hand, the Board noted that the proposed CDA provided for separate attorney fee awards to two attorneys. Consistent with the *Gongora/Chase* rationale, the Board interpreted the CDA as providing that the entire attorney fee approved in the CDA was payable to claimant's current attorney-of-record, with the precise manner in which the fee was apportioned to be a matter between the attorneys. *See Jenni L. McCoy*, 69 Van Natta 1550 (2017).

Hearing Procedure: Carrier's Appeal of Recon Order's "Premature Closure" Decision – Claimant's "Closing Argument" Raising of "Work Disability" Untimely

Carrier requested a hearing contesting reconsideration order's "premature closure" decision; claimant did not raise "work disability" until closing arguments.

Matthew Halbrook, 72 Van Natta 415 (May 19, 2020). The Board declined to consider claimant's request for a work disability award arising from a reinstated Notice of Closure because, after the parties had agreed at the hearing level (before closure of the record) that an Order on Reconsideration's "premature closure" decision should be reversed, he had not raised the "work disability" issue until the parties' written closing arguments. Noting that he had initially raised the "work disability" issue (along with a "premature closure"

contention) during the reconsideration proceeding concerning the closure notice, claimant contended that the "work disability" issue did not become ripe for adjudication until (in response to the carrier's hearing request from the reconsideration order's "premature closure" decision), the parties had agreed to the reversal of the reconsideration order. Under such circumstances, once the Notice of Closure was reinstated, claimant argued that the ALJ should have addressed his entitlement to a work disability award.

The Board disagreed with claimant's contention. Citing *Stevenson v. Blue Cross of Oregon*, 108 Or App 247, 252 (1991), and *Patricia Ferrer-Cruz*, 67 Van Natta 1001, 1001 n 1 (2015) (among other decisions), the Board reiterated that it has consistently declined to consider issues raised for the first time during closing argument.

Turning to the case at hand, the Board observed that the parties had been instructed to submit the disputed issues to the ALJ for resolution before the commencement of their written closing arguments. The Board further noted that claimant did not raise work disability as an issue before the submission of written arguments. Instead, the Board determined that claimant had agreed before the parties proceeded to written closing arguments that the sole issue was whether the reconsideration order had erroneously rescinded the Notice of Closure. Under such circumstances, the Board concluded that claimant did not timely preserve work disability as an issue for resolution and, as such, the issue would not be considered on review.

Sole issue identified before record closed was rescission of the Notice of Closure; because claimant did not timely preserve "work disability" issue, Board did not consider it.

Member Lanning dissented. Citing *Joshua D. Kirchem*, 56 Van Natta 2594, 2594-95 (2004), and *Katherine M. Tofell*, 51 Van Natta 1845, 1847 (1999), Lanning analogized this situation to cases where the ARU did not consider a claimant's "medical arbiter" request because it found the claim to have been prematurely closed, but at hearing (or after Board review) the "premature closure" determination was rescinded. Member Lanning reasoned that, consistent with the *Tofell/Kirchem* rationale (where the "medical arbiter" request was routinely considered upon the rescission of the Order on Reconsideration's "premature closure" decision and the reinstatement of the Notice of Closure), claimant's previous "reconsideration" challenge to the closure notice's lack of a "work disability" award automatically became ripe for resolution once the closure notice was reinstated.

Dissent contended that previous "work disability" challenge during "recon" proceeding automatically became ripe once the closure was reinstated.

Furthermore, Member Lanning noted that, after initially raising "work disability" as an issue during the reconsideration proceeding, claimant had not intentionally and expressly relinquished his entitlement to work disability benefits after the carrier had requested a hearing from the Order on Reconsideration (which in rescinding the closure notice as premature, had identified "work disability" as an issue). Asserting that claimant had not waived the "work disability" issue, Lanning contended that the merits of the issue should be considered. *Drews v. EBI Cos.*, 310 Or 134, 150 (1990); *Marsh v. SAIF*, 297 Or App 486, 492 (2019); *Wright Schuchart Harbor v. Johnson*, 133 Or App 680, 685-86 (1995).

Preexisting Condition: "Diabetes" (Diagnosed/Treated Before Work Injury) Was "Active Contributor" of Need for Treatment for "Combined" Foot Ulcer Condition - "Delay in Treatment" Not a "Causal" Factor, But One of Several "Components" of Diabetes (Diminished Sensation/Blood Flow, Elevated Blood Sugar, Compromised Healing) - "005(24)(a), (b), (c)"

Guillermo Torres, 72 Van Natta 382 (May 1, 2020), *on recons*, 72 Van Natta 452 (May 29, 2020). Analyzing ORS 656.005(24)(a), (b), and (c), and ORS 656.005(7)(a)(B), and ORS 656.266(2)(a), the Board held that claimant's injury claim for a foot ulcer condition was not compensable because his work injury (which arose from a blister while he was working as a firefighter) combined with his diabetes condition (for which he had received treatment for the diagnosed condition before his work injury) and that his diabetes had actively contributed to his need for treatment (due to diminished sensation/blood flow in his foot, which had resulted in a delay in him seeking treatment) and that his work injury was not the major contributing cause of his combined foot ulcer condition. On review, the Board determined that claimant's frequent walking in his boots while working as a firefighter had resulted in his foot blister and was a material contributing cause of his need for treatment. However, persuaded by a physician's opinion that claimant's preexisting diabetic condition (which had been diagnosed/treated before his work injury) had actively contributed to his need for treatment (in that it caused diminished sensation and diminished blood flow, which resulted in a delay in treatment), the Board found that the diabetes was a "preexisting condition" under ORS 656.005(24)(a). Again relying on the physician's opinion, the Board concluded that claimant's preexisting diabetes was the major contributing cause of claimant's need for treatment for his combined foot ulcer condition and, as such, the carrier had met its burden of proof under ORS 656.266(2)(a) and ORS 656.005(7)(a)(B).

Foot ulcer developed from a blister while claimant worked as a firefighter, which combined with a preexisting diabetes condition.

Record established that diabetes actively contributed to claimant's need for treatment and was the major contributing cause of treatment/combined condition.

In reaching its conclusion, the Board distinguished *Craig M. Selbee*, 71 Van Natta 1474 (2019), where it had held that a carrier had not met its burden of proving a "combined condition" defense under ORS 656.266(2)(a) because a physician's opinion had *equally* apportioned the major contributing cause of the claimant's need for treatment to the boots he wore at work and to complications associated with his preexisting diabetes. In the present case, in contrast to *Selbee*, the Board reasoned that the physician's opinion had persuasively established that ulcer complications from claimant's preexisting diabetes were the major contributing cause of his need for treatment for his combined condition.

Claimant contended that Board's reliance on physician's opinion that included "delay in treatment in "determining compensability illegally introduced fault" into the analysis.

On reconsideration, claimant contended that the Board had erroneously injected "fault" into its compensability analysis by including claimant's "delay in treatment" as a "causal" factor to his combined diabetic foot ulcer condition. In doing so, he asserted that the insertion of "fault" into the Board's analysis violated ORS 656.012(2)(a). In addition, claimant argued that the physician's reference to claimant's "elevated blood sugar" was not an "actual" cause of the combined foot ulcer condition, but rather was a "susceptibility" under ORS

656.005(24)(c) and, as such, could not included in the "preexisting condition" analysis for purposes of the carrier's "combined condition" defense under ORS 656.266(2)(a) and ORS 656.005(7)(a)(B).

The Board disagreed with claimant's contentions. The Board acknowledged that the physician whose opinion it had found persuasive had initially appeared to include claimant's "delay in treatment" as an independent causal contributor to his diabetic foot ulcer. However, the Board noted that the physician had ultimately explained that the diabetes condition was the active contributor to claimant's need for treatment because the diabetes had caused peripheral neuropathy and diminished sensation (which had resulted in a delay in treatment), as well as vascular disease with diminished blood flow resulted in compromised healing.

Board clarified that, according to medical expert, "delay in treatment" was a residual of diminished sensation from the diabetes.

Under such circumstances, the Board concluded that the physician's final opinion had not included "delay in treatment" as a contributory component of claimant's need for treatment for his combined condition, but rather had considered the "delay in treatment" as a residual of claimant's diabetes; *i.e.*, his diminished sensation from the diabetes. Consequently, rather than inserting "fault" into its compensability analysis, the Board determined that it had merely clarified its interpretation of the physician's ultimate opinion.

"Elevated blood sugar" considered to be a component of diabetes.

Finally, the Board recognized that the physician had described claimant's "elevated blood sugar" as rendering his tissues more "susceptible" to bacterial infection. Nevertheless, when analyzed in context, the Board interpreted the physician's opinion to have considered the elevated blood sugar as one of many components of claimant's preexisting diabetes. Moreover, because the physician had ultimately attributed the major contributing cause of claimant's need for treatment for his combined foot ulcer condition to his preexisting diabetes (because it had caused peripheral neuropathy and diminished sensation, as well as diminished blood flow resulting in compromised healing), the Board reasoned that the physician's opinion extended beyond mere "susceptibility" to explain how claimant's preexisting diabetes (of which his elevated blood sugar level was only one component) was an active contributor to his need for treatment for his combined condition. *See Vantassel v. SAIF*, 284 Or App 335 (2017).

TTD: Prior "Non-MCO" "AP's" Time Loss Authorization "Open Ended" - No "MCO/AP" Later Terminated Authorization - Claimant Did Not Continue to Seek Care After "MCO Notice" - "262(4)(i) "Termination" Authorization Not Applicable

Previous "non-MCO" attending physician issued an "open-ended" TTD authorization.

Freiherr George Von-Bothmer, Zuschwegerhoff, 72 Van Natta 442 (May 27, 2020). Analyzing ORS 656.262(4)(g), ORS 656.262(4)(i), and ORS 656.005(12), the Board held that a carrier was not entitled to terminate claimant's temporary disability (TTD) benefits because, before he was enrolled in a Managed Care Organization (MCO), his "non-MCO" attending physician issued an "open-ended" authorization of TTD benefits, claimant had not continued to seek care from the "non-MCO" physician after his MCO enrollment,

and an "MCO-authorized" attending physician had not terminated his TTD benefits for his compensable condition. Prior to claimant's enrollment in an MCO, his then-attending physician (who was not "MCO-authorized") took him off work "indefinitely" for his compensable low back condition. Following his MCO enrollment, claimant did not continue to seek care from his "non-MCO" physician, but rather received treatment from a number of physicians (one who was "MCO-authorized"). After claimant did not respond to the carrier's letter requesting that he choose a "MCO-authorized" attending physician, the carrier terminated his TTD benefits. Thereafter, claimant requested a hearing, contending that he was entitled to ongoing TTD benefits because his prior "non-MCO" physician had authorized "open-ended" TTD benefits for his compensable low back condition and no "MCO-authorized" attending physician had terminated such benefits.

TTD benefits may be unilaterally suspended when worker continues to seek care from "non-authorized" physician after "MCO enrollment" notice.

The Board agreed with claimant's contention. Citing ORS 656.262(4)(i), the Board stated that compensation may be unilaterally suspended when an MCO-enrolled worker continues to seek care from a "non-authorized MCO" physician more than seven days after the carrier's mailing of a notice that the physician is not "MCO authorized." Referring to ORS 656.262(4)(g), the Board noted that TTD benefits are not due and payable after a claimant's attending physician ceases to authorize such benefits. Relying on ORS 656.005(12)(b) and *Jason Greenslitt*, 58 Van Natta 716, 7187 (2006), the Board reiterated that an attending physician is primarily responsible for the worker's treatment, which is a question of fact. Finally, the Board cited *Dedera v. Raytheon Eng'rs & Constr.*, 200 Or App 1, 6-8 (2005), for the proposition that when a prior attending physician authorizes ongoing "open-ended" TTD benefits, the subsequent attending physician must take an affirmative step to "put a stop to" the previous authorization.

Turning to the case at hand, the Board acknowledged that claimant had been enrolled in an MCO. Nonetheless, the Board determined that claimant had not "continued to seek care" from a "non-MCO authorized" physician more than seven days after he was notified that his former attending physician was not "MCO-authorized." Under such circumstances, the Board concluded that the carrier was not authorized to terminate claimant's TTD benefits under ORS 656.262(4)(i). *See Jason Sellars*, 60 Van Natta 1569, 1570-71 (2008).

Claimant did not continue to seek care from a non-authorized physician after "MCO" notice, and no "MCO attending physician" halted TTD benefits.

Furthermore, because claimant's former attending physician had taken claimant off work "indefinitely," the Board found that the authorization for TTD benefits was "open-ended." *See Charlene Y. Pearce*, 55 Van Natta 728, 730 (2003). Reasoning that no "MCO-authorized" attending physician had "halted" the prior TTD authorization, the Board concluded that claimant was entitled to ongoing TTD benefits. *See Kevin E. Dedera*, 55 Van Natta 1885, 1889, *on recons*, 55 Van Natta 2048, 2049 (2003), *rev'd on other grounds, Dedera*, 200 Or App at 6-8.

Dissent contended that "MCO-authorized" "AP" took affirmative steps to "halt" TTD benefits for compensable condition.

Member Curey dissented. Although acknowledging that claimant's initial attending physician had provided an "open-ended" time loss authorization, Curey contended that a subsequent "MCO-authorized" physician had become primarily responsible for claimant's compensable condition and had provided opinions supporting the proposition that those conditions had resolved and that claimant

could perform regular work. Reasoning that the subsequent "MCO-authorized" physician had taken affirmative steps to "halt" the previous attending physician's TTD authorization, Member Curey asserted that claimant was not entitled to ongoing TTD benefits.

APPELLATE DECISIONS UPDATE

New/Omitted Medical Condition - "262(6)(d)," "(7)(a)," and "267(1)" - No New/Omitted Medical Condition Claim Perfected Before Acceptance Of Initial Claim - Must First File Written Objection to Notice of Acceptance Before Requesting Hearing

Coleman v. SAIF, 304 Or App 122 (May 13, 2020). The court affirmed the Board's order in *Robert M. Coleman*, 69 Van Natta 850 (2017), previously noted 36 NCN 5:5, which held that a carrier's acceptance of claimant's initial injury claim for a knee strain/contusion did not constitute a *de facto* denial of a medial femoral chondral defect, even though claimant had also filed an 827 form regarding the latter condition before the carrier's acceptance. On appeal, noting that ORS 656.267(1) provides that a new medical condition claim may be initiated "at any time," claimant contended that the carrier was required to independently process his medial femoral chondral defect claim, regardless of whether it had yet to accept his initial knee strain/contusion claim (all of which stemmed from the same work injury).

Claimant contended that carrier was required to process "new medical condition" claim, regardless of whether it had first accepted the initial injury claim.

The court disagreed with claimant's contention. Framing the issue as whether a new medical condition claim can precede the initial claim acceptance, the court determined that the answer hinged on statutory interpretation. After reviewing the text, context, and legislative history of ORS 656.267(1) (including language which was initially set forth in ORS 656.262(7)(a)), the court concluded that, although distinct from a worker's initial or "ongoing" claim, a "new medical condition" claim has always been understood to relate to an initial claim that the carrier has accepted; *i.e.*, a new condition that was not covered at the time of acceptance. Concerning the "notwithstanding any other provision" and "at any time" language of ORS 656.267(1), the court reasoned that the provision means there can be no time limitation on new medical condition claims *other* than that they can only be submitted after initial claim acceptance. *See Johansen v. SAIF*, 158 Or App 672, 679, *adh'd to on recons*, 160 Or App 579, *rev den*, 329 Or 527 (1999).

Court interpreted "267(1)" to mean that there is no time limitation on a "new medical condition" claim, other than it be submitted after initial acceptance.

Turning to the case at hand, the court noted that the 827 form concerning claimant's medial femoral chondral defect was filed before the carrier's acceptance of the initial injury claim for a knee strain/contusion. Under such circumstances, the court held that the Board had not erred in concluding that the carrier was not required to respond to the "pre-acceptance" submission of the 827 form. Nonetheless, in doing so, the court commented that a carrier was not precluded from voluntarily accepting an otherwise premature new medical condition claim.

Claimant's letter to the ALJ did not constitute a clear request for acceptance "from the insurer," as required by "267(1)."

The court also affirmed the Board's decisions that claimant's counsel's letter to the ALJ and his physician's chart note did not constitute an omitted medical condition claim for which the carrier was required to respond. Citing ORS 656.262(6)(d), the court stated that a worker who believes a condition has been incorrectly omitted from an acceptance notice must first communicate in writing *to the carrier* the worker's objections to the notice pursuant to ORS 656.267. Furthermore, relying on ORS 656.267(1), the court reiterated that the worker must "clearly request formal written acceptance of * * * [the] omitted medical condition *from the insurer*." (Emphasis supplied).

Applying those principles to the current record, the court observed that claimant's counsel's letter was directed to the ALJ, not the carrier. More importantly, the court reasoned that the letter did not ask *the carrier* to do anything, but rather raised a *de facto* denial issue concerning the medial femoral chondral defect. Under such circumstances, the court held that the Board had not erred in concluding that claimant's counsel's letter to the ALJ had not satisfied the communication requirements of ORS 656.262(6)(d) and ORS 656.267(1).

Omitted medical condition claim may be initiated by physician, but claim must clearly request formal written acceptance of condition from the carrier.

Finally, regarding claimant's physician's chart notes, the court disagreed with the Board's determination that an omitted medical condition claim could not be initiated by a physician, on a worker's behalf. *See Safeway Stores, Inc. v. Smith*, 117 Or App 224, 227 (1992). Nonetheless, reasoning that the physician's chart note had not clearly requested formal written acceptance of an omitted medical condition from the carrier, the court concluded that the chart note did not satisfy the communication requirement of ORS 656.267(1).

APPELLATE DECISIONS
COURT OF APPEALS

Appellate Procedure: "Compensability Standard for New/Omitted Medical Conditions" - Argument Not Preserved at "Board" Level - Not Considered on Appeal; Board's Reliance on Physician's Opinion on Remand - No Violation of "Law of the Case," Board Decision Supported by "Substantial Evidence/Reason"

SAIF v. Williams, 304 Or App 233 (May 13, 2020). The court affirmed the Board's order in *David M. Williams*, 70 Van Natta 242 (2018), that had found claimant's new/omitted medical condition claim for a thoracic spine Tarlov cyst compensable. On appeal, the carrier contended that the Board had erred in: (1) applying an incorrect legal compensability standard for new/omitted medical conditions; and (2) finding medical causation contrary to the law of the case and without substantial evidence/reason.

The court declined to address the carrier's argument that the Board had erred by requiring claimant to prove that his work injury was a material contributing cause of his need for treatment/disability, rather than proving that the injury contributed to the new/omitted medical condition itself. *See Brown v. SAIF*, 361 Or 241 (2017); *Schleiss v. SAIF*, 354 Or 637, 643-44 (2013). Noting

Carrier's "new/omitted medical condition/ compensability analysis" argument not preserved for appellate review.

that the carrier had not raised its different theory concerning the compensability of the claimed new/omitted medical condition until its reply brief to the Board on remand, the court concluded that claimant was deprived of a meaningful opportunity to respond to the carrier's argument. Under such circumstances, the court held that the carrier had not preserved this assignment of error. *Snyder v. SAIF*, 237 Or 361, 365 (2017).

Court's earlier remand order did not preclude the Board from relying on a particular physician's opinion.

Addressing the carrier's "law of the case" argument, the court reiterated that an appellate decision is binding and conclusive for purposes of future proceedings in the same case that are "necessary to the disposition of the appeal." *Estrada v. Federal Express Corp.*, 298 Or App 111, 118, *rev den*, 365 Or 769 (2019); *Hayes Oyster Co. v. Dulcich*, 199 Or App 43, 53, *rev den*, 339 Or 544 (2005). Applying that standard to the present case, the court disagreed with the carrier's argument that the court's first decision (*SAIF v. Williams*, 281 Or App 542 (2016), which had reversed and remanded an earlier Board decision for reconsideration in light of two misstatements of fact) precluded the Board from relying on a particular physician's opinion. Reasoning that it had previously expressly left open the possibility that the Board could still find the physician's opinion persuasive (provided that it did so without relying on factual inaccuracies) the court concluded that the Board's analysis did not violate the "law of the case."

Physician's opinion relied on by the Board was permitted to use the reports available, and physician's expertise, to formulate opinions that provided reasonable basis for Board's conclusion (notwithstanding numerous contrary physicians' opinions).

Concerning the carrier's "substantial evidence" argument, the court acknowledged that numerous physicians had opined that claimant's work injury was not a material contributing cause of his need for treatment of a T5 Tarlov cyst. Nonetheless, reasoning that the physician's opinion relied on by the Board and the medical evidence that the Board found persuasive had provided a reasonable basis to support the Board's conclusion (which had weighed the context of the opinions/testimony not by simply counting the number of expert witnesses presented by the parties), the court concluded that substantial evidence supported the Board's decision. *Garcia v. Boise Cascade Corp.*, 309 Or 292, 294 (1990); *Akins v. SAIF*, 286 Or App 70, 76, *rev den*, 362 Or 94 (2017); *Labor Ready v. Mogenson*, 275 Or App 491, 497 (2015).

In reaching its conclusion, the court explained that the physician supporting claimant's T5 Tarlov cyst claim was not required to independently verify everything that claimant told him about his symptoms, but rather was permitted to use the reports available to him and his expertise to formulate his conclusion about what caused claimant's need for treatment. *See SAIF v. Lewis*, 335 Or 92, 101 (2002).

Finally, regarding the carrier's "substantial reasoning" argument, the court determined that the Board had thoroughly considered claimant's surgeon's analysis and explained why it had found the surgeon's opinion persuasive (while also explaining why other physicians' opinions were less persuasive) in concluding that claimant's work injury was a material contributing cause of his need for treatment. Reasoning that the Board's conclusion logically followed its findings of fact and resolved the physicians' conflicting opinions/report, the court held that the Board's opinion was supported by substantial reason.

Board was not required to dispute each physician's contrary opinions (which were redundant/resolved by Board's findings regarding claimant's surgeon's opinion).

In reaching its conclusion, the court acknowledged the carrier's contention that the Board order had not explicitly addressed all of the physicians' reports. Nonetheless, the court stated that the Board was not required to dispute each physician's contrary observation about claimant's symptoms when those observations were redundant and resolved by the Board's findings regarding claimant's surgeon's opinion.

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