



News & Case Notes

BOARD NEWS

Board Meeting - August 18, 2020 - Proposed Rules/ Amendments (Attorney Fees - OAR 438 Division 015) - "Contingent Hourly Rate"/ "Voluntary Bifurcation of Attorney Fee Award for Certain Cases on Board Review" (OAR 438-015-0010; OAR 438-015-0125) 1

Annual Adjustments to "Out-of-Comp" Attorney Fees/Hourly Rate for "Interview/Deposition" Fee Under "262(14)" - Effective July 1, 2020 2

Adoption of Permanent Rules/Amendments (Attorney Fees - OAR 438 Division 015) - Effective June 1, 2020 2

CASE NOTES

Claim Processing: Carrier Obligated to Pay "Final" Order on Recon's TTD Award - Carrier's "Worker" Challenge Precluded Via Finality of Recon Order 3

Course & Scope: Fall in Lobby of Office Building While Walking to Employer's Office to Begin Work Day - "Course Of" Employment - Employer's Lease Concerning "Common Areas" Established "Right of Passage" Through Lobby of Building; "Arising Out Of" Employment - No Facially Nonspeculative Explanation for Claimant's Fall - "Unexplained Fall" 5

Extent: Impairment Findings - Not Related to Accepted Condition/Medical Sequelae - No "Combined Condition" - Caren Distinguished 6

Extent: "Redetermination" for "Worsened Condition" - Accepted Worsened Condition Compared to Extent of Disability at Last Award/Arrangement of Compensation - "035-0016" 8

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Board Meeting - August 18, 2020 - Proposed Rules/ Amendments (Attorney Fees - OAR 438 Division 015) - "Contingent Hourly Rate"/"Voluntary Bifurcation of Attorney Fee Award for Certain Cases on Board Review" (OAR 438-015-0010; OAR 438-015-0125)

The Board has scheduled a public meeting for the Members to discuss written/oral comments presented at its July 31, 2020, rulemaking hearing, which concerned proposed rules/amendments relating to attorney fees (OAR 438 Division 015). Specifically, those proposed rules include:

- Allowing the submission and consideration of information regarding a claimant's attorney's "contingent hourly rate," including the calculation of such a rate. (OAR 438-015-0010).
- Establishing a procedure regarding the voluntary bifurcation of an attorney fee award from the merits concerning certain cases on Board Review. OAR 438-015-0125.

The meeting has been scheduled for August 18, 2020, at the Board's Salem office (2601 25th St. SE, Ste. 150) at 10:00 a.m. 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.

In addition, due to the logistical challenge of distributing written comments on the day of the meeting, the Members encourage parties/practitioners to submit any additional written comments regarding these rule amendments well in advance of the meeting. Any such 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.

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

Hearing Request: "Rebuttable Presumption" of Untimely Filing - Not "Rebutted" by Date of Cover Letter, Claimant's Attorney's Unsworn Representations, & Carrier's Receipt of Its Copy - No "Certification/Affidavit" of Mailing or Standard Office Procedures - "319(1)(a)," "005-0046(1)(c)" 9

Hearing Request: Reference to "Denial" Encompassed Carrier's Denials of Both "Aggravation" & "New/Omitted Medical Condition" Claims - Same "Injury Date," "Claim Number," Date of Denials - Checking of "Aggravation" Box Did Not Narrow Scope of Hearing Request 11

Interest: Based on Withheld TTD Benefits - Interest Due from Recon Order Until TTD Benefits Paid - "313(1)(b)" 3

"Third Party" Dispute: "NCE" Statutory Claim Agent for "WCD" - Initial Claim Acceptance Revoked via "DCS" - No "Paying Agency" Because No "Compensable Injury" - Claimant's Settlement Not Subject to "Third Party" Lien 12

APPELLATE DECISIONS

Supreme Court

Attorney Fee: "382(2)" - Dismissal of Carrier's Hearing Request Regarding "Recon Order" - Claimant's Attorney Entitled to Carrier-Paid Fee - Claimant's Successful Defense of Appealed Compensation Award May Be Procedural or Substantive in Nature 14

Court of Appeals

Occupational Disease: "802(2)(a)" - Claimant Must Prove Employment Conditions Were Major Cause of Claimed Disease - Burden of Proof Does Not Shift to Carrier to Prove That "Non-Work" Causes Outweighed "Work-Related" Causes 15

Annual Adjustments to "Out-of-Comp" Attorney Fees/Hourly Rate for "Interview/Deposition" Fee Under "262(14)" - Effective July 1, 2020

The maximum attorney fee awarded under ORS 656.262(11)(a), ORS 656.262(14)(a) and ORS 656.382(2)(d), which is tied to the increase in the state's average weekly wage (SAWW), rose by 4.693 percent on July 1, 2020. On June 15, 2020, the Board published Bulletin No. 1 (Revised), which sets forth the new maximum attorney fees. The Bulletin can be found on the Board's website at: <https://www.oregon.gov/wcb/legal/Pages/bulletins.aspx>

An attorney fee awarded under ORS 656.262(11) shall not exceed **\$4,797**, absent a showing of extraordinary circumstances. OAR 438-015-0110(3).

An attorney fee awarded under ORS 656.262(14)(a) shall be **\$366** per hour. OAR 438-015-0033. This rule, which was amended with an effective date of June 1, 2020, concerns the reasonable hourly rate for an attorney's time spent during a personal or telephonic interview conducted under ORS 656.262(14).

An attorney fee awarded under ORS 656.308(2)(d) shall not exceed **\$3,459**, absent a showing of extraordinary circumstances. OAR 438-015-0038; OAR 438-015-0055(5).

These adjusted maximum fees apply to attorney fees awarded under ORS 656.262(11)(a) and ORS 656.308(2)(d) by orders issued on July 1, 2020 through June 30, 2021, and to a claimant's attorney's time spent during a personal or telephonic interview or deposition under ORS 656.262(14)(a) between July 1, 2020 and June 30, 2021.

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, rulemaking 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-insured 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/legal/Pages/laws-and-rules.aspx> In addition, copies of the Order of Adoption have been distributed to all parties/practitioners on WCB’s mailing list.

CASE NOTES

Claim Processing: Carrier Obligated to Pay “Final” Order on Recon’s TTD Award - Carrier’s “Worker” Challenge Precluded Via Finality of Recon Order

Interest: Based on Withheld TTD Benefits - Interest Due from “Recon Order” Until TTD Benefits Paid - “313(1)(b)”

Calvin L. Wood, 72 Van Natta 638 (July 20, 2020). The Board held that a carrier was obligated to pay temporary disability (TTD) benefits granted by an Order on Reconsideration, as well as statutory interest pursuant to ORS 656.313(1)(b) because the reconsideration order had become final and, therefore, the carrier was precluded from contending that claimant had withdrawn from the work force during the period in which the order had awarded TTD benefits. During the reconsideration proceeding concerning a Notice of Closure (which had not awarded TTD benefits), claimant submitted an affidavit stating that he would have continued to work, but for his attending physician’s work restrictions. After an Order on Reconsideration found that claimant was a worker and awarded TTD benefits based on the attending physician’s time loss authorization, the carrier requested a hearing and stayed the payment of the TTD benefits. However, before the scheduled hearing, the carrier withdrew its hearing request. Following an ALJ’s dismissal of the hearing request, the carrier refused to pay the TTD benefits, arguing that claimant had left the work force. Thereafter, claimant requested a hearing, seeking the TTD benefits, as well as statutory interest on those withheld benefits, penalties and attorney fees.

The Board granted claimant’s requests. Citing *Drews v. EBI Cos.*, 310 Or 134, 139 (1990), the Board stated that under the doctrine of issue preclusion, a former adjudication precludes future litigation on a subject issue if the issue was actually litigated and determined in a setting where its determination was essential to the final decision reached. Referring to *Terry E. Mason*, 70 Van Natta 362 (2018), *Sharyle J. Burtch*, 59 Van Natta 233 (2007), and *Michele S. Thomas-Finney*, 47 Van Natta 174 (1995), the Board explained that issue preclusion applies to uncontested Orders on Reconsideration.

Carrier withdrew hearing request challenging “recon order” award of TTD benefits.

Carrier refused to pay TTD award contending claimant had left the workforce.

Claimant had submitted “workforce” affidavit during recon proceeding and “recon order” referred to “the worker” in awarding TTD benefits.

Because carrier had not pursued opportunity to contest “recon order” (but withdrew its hearing request), it was precluded from collaterally attacking final TTD award.

Statutory interest accrues from the date of the order granting benefits until the benefits are paid.

Failure to pay benefits and failure to pay interest were separate acts of unreasonable claim processing, justifying separate penalties/fees.

Turning to the case at hand, the Board acknowledged the carrier’s contentions that claimant’s “worker” status had not been finally determined in the reconsideration order and that the order’s reference to an “authorization” period did not represent a final computation of his TTD benefits. Nevertheless, the Board noted that the reconsideration order referred to claimant as “the worker” for the period in which TTD benefits were authorized. Moreover, the Board observed that, during the reconsideration proceeding, claimant had submitted an affidavit concerning his “workforce” status, which the carrier had not contested. Finally, the Board reiterated that, despite initially requesting a hearing from the reconsideration order, the carrier had withdrawn its request before the scheduled hearing.

Under such circumstances, the Board concluded that the carrier had previously been provided an opportunity to contest claimant’s status as “worker” under ORS 656.005(30) for the period in which he had been granted TTD benefits by the Order on Reconsideration. Because the carrier had not pursued that opportunity, the Board reasoned that the carrier’s challenge to the final reconsideration order’s TTD award amounted to an impermissible collateral attack on a final order. Consequently, the Board held that the carrier was precluded from contesting claimant’s entitlement to the reconsideration order’s TTD award.

Addressing ORS 656.313(1)(b), the Board stated that the statute requires the payment of statutory interest on withheld benefits from the date of the order granting such benefits until payment of the withheld benefits. *See Harley J. Gordineer*, 50 Van Natta 1615, 1616 (1998). Accordingly, the Board awarded statutory interest accruing from the date of the reconsideration order and continuing until the withheld benefits were paid.

Finally, the Board awarded separate penalties and attorney fee awards under ORS 656.262(11)(a), finding that the carrier had engaged in separate acts of unreasonable claim processing; *i.e.*, failing to pay the TTD award granted by the final reconsideration order and failing to pay statutory interest based on those withheld TTD benefits. *See Eliseo Sales-Parra*, DCD, 68 Van Natta 679, 682 (2016). Regarding the “statutory interest-based” penalty, the Board reiterated that statutory interest is considered part of a compensation award because it is meant to preserve the real value of an award during the pendency of a carrier’s appeal. *See James A. Bradley*, 56 Van Natta 3287 (2004), and *Markus M. Tipler*, 45 Van Natta 216, 217 (1993). Based on that proposition, the Board considered the unpaid statutory interest award to be “compensation,” which constituted another “amount then due” under ORS 656.262(11)(a) for purposes of the assessment of a second penalty for unreasonable claim processing, in addition to the carrier’s failure to pay the withheld TTD benefits.

Course & Scope: Fall in Lobby of Office Building While Walking to Employer's Office to Begin Work Day - "Course Of" Employment - Employer's Lease Concerning "Common Areas" Established "Right of Passage" Through Lobby of Building; "Arising Out Of" Employment - No Facially Nonspeculative Explanation for Claimant's Fall - "Unexplained Fall"

Catherine A. Sheldon, 72 Van Natta 580 (July 1, 2020), on recon, 72 Van Natta 712 (July 30, 2020). On remand from the Supreme Court, *Sheldon v. U.S. Bank*, 364 Or 831 (2019), the Board held that claimant's injury, which occurred when she fell while walking across the lobby of the office building where she worked to begin her work day, arose out of and in the course of her employment because her employer had a "right of passage" through the lobby area where she fell and because there was no "facially nonspeculative idiopathic explanation" for her injury, it constituted an "unexplained" injury.

Citing *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366 (1994), the Board stated that injuries sustained while an employee is going to, or coming from, the place of employment generally do not occur "in the course of" employment. However, again referring to *Gilmore*, the Board identified the "parking lot" exception to the "going and coming" rule, which occurs when the claimant is traveling to/from work and the injury is sustained "on or near" the employee's premises, provided that the employer exercises some control over the place where the injury occurs. Relying on *Sally Houk*, 72 Van Natta 372, 374 (2020), the Board reiterated that the requisite "control" over the place of a claimant's injury can be established by the terms of a lease under which the employer has a right of passage through the common areas of the office building in which the employer is a tenant.

"Control" over the place of an injury can be established by the terms of the employer's lease.

Lease gave employer a "right of passage" through public parts of office building.

Applying "parking lot" exception to the "going and coming" rule, Board found claimant's fall in lobby of building occurred "in the course of" employment.

Turning to the case at hand, the Board found that, under the terms of the employer's lease, it had a right of passage through the public parts of the building, including the lobby where claimant was injured. The Board further determined that the lease authorized the employer to obtain/require maintenance of the public parts of the building, as well as to use common areas of the building for purposes of ingress/egress (including the issuance of key cards).

Under such circumstances, the Board concluded that the employer had a property interest in the lobby where claimant was injured sufficient to establish the employer's "control" over the area. Consequently, applying the "parking lot" exception to the "going and coming" rule, the Board held that the injury occurred in the course of her employment.

Addressing the "arising out of" element, the Board stated that an unexplained injury is considered to have arisen out of employment provided that it occurred "in the course of" employment. See *Sheldon*, 564 Or at 843; *Phil A. Livesley Co. v. Russ*, 296 Or 25, 29-30 (1983). Citing *Sheldon* and *Elena Rodriguez*, 72 Van Natta 356 (2020), the Board reiterated that if there

is no facially nonspeculative explanation for a fall, an injury is unexplained and, if the record reveals facially nonspeculative idiopathic explanations for a fall, a claimant must eliminate those idiopathic causes to establish that the injury was unexplained.

Physician did not explain how any of the potential idiopathic causes contributed to claimant's fall - no facially nonspeculative explanation established; thus, "unexplained" injury that "arose out of" employment.

In conducting its review of the record, the Board acknowledged the carrier's contention that nonspeculative idiopathic factors explaining claimant's fall had been established by a physician's opinion (which had identified claimant's obesity and diabetes, as well as referred to claimant's ankle weakness and antihypertension medication as "potential" idiopathic causes of her fall). Nonetheless, reasoning that the physician had not explained how any of those "potential" idiopathic causes contributed to claimant's fall, the Board was not persuaded that the record established a facially nonspeculative explanation for the fall. Alternatively, noting that the treating physician had not found evidence that claimant was suffering from a peripheral neuropathy, loss of balance, ankle weakness, or lightheadedness due to medications and observing that claimant's testimony and the record did not support the existence of such problems before/after her fall, the Board determined that any idiopathic causes for claimant's fall had been eliminated.

Under such circumstances, the Board determined that the record did not support a facially nonspeculative explanation for claimant's fall. Accordingly, the Board held that claimant's injury was unexplained and, as such, arose out of her employment.

Extent: Impairment Findings - Not Related to Accepted Condition/Medical Sequelae - No "Combined Condition" - *Caren* Distinguished

Jesus Pena, 72 Van Natta 680 (2020). Applying ORS 656.268(15), OAR 436-035-0005(5), and OAR 436-035-0006(1), the Board held that claimant was not entitled to a permanent impairment award because his attending physician did not relate any impairment findings to his accepted cervical, thoracic, and lumbar sprains/strains or their direct medical sequelae. Citing *Caren v. Providence Health Sys. Or.*, 356 Or 466 (2019), claimant sought a permanent impairment award, asserting that a "combined condition" had not been accepted/denied before claim closure and, as such, all of his attending physician's "apportioned" impairment findings should be attributed to his accepted conditions.

The Board disagreed with claimant's contention. The Board recognized that *Caren* rationale does not allow for apportionment of impairment for preexisting conditions where a carrier has not processed the claim as a combined condition. Nonetheless, the Board distinguished *Caren*, explaining that the court did not address whether apportionment is appropriate for unaccepted conditions. Referring to ORS 656.268(15) and OAR 436-035-0006(1), as well as *Kevin B. VanBoeckel*, 69 Van Natta 1390 (2017), and *Stuart C. Yekel*, 67 Van Natta 1279 (2015), *aff'd per curiam*, *Yekel v. SAIF*, 286 Or App 837 (2017), the Board stated that permanent impairment is awarded based on the accepted conditions and the direct medical sequelae of the

In Caren, the court did not address whether apportionment of impairment is appropriate for unaccepted conditions.

accepted conditions. Citing OAR 436-035-0005(5), the Board observed that “direct medical sequela” is defined as “a condition that is clearly established medically and originates or stems *from an accepted condition.*” (Emphasis added).

Attending physician stated that impairment findings were the result of a work-related disc injury, rather than due to the accepted sprains/strains and their sequelae.

Turning to the case at hand, the Board acknowledged that the attending physician apportioned claimant’s permanent impairment findings between the work injury and preexisting conditions. However, the Board noted that the attending physician had consistently stated that, in addition to the accepted sprains/strains, claimant had also suffered intervertebral disc damage at the time of his initial injury, and had distinguished the disc condition from the accepted sprains/strains and their direct medical sequelae. The Board further observed that the attending physician had expressly opined that claimant’s permanent impairment findings that were related to the work injury were the result of the intervertebral disc injury, rather than the accepted sprains/strains and their medical sequelae.

Because impairment findings were not related to accepted conditions or their direct medical sequela, no permanent impairment was awarded.

Under such circumstances, the Board determined that the attending physician’s opinion/findings did not support a conclusion that the intervertebral disc damage originated or stemmed from the *accepted* cervical, thoracic, and lumbar sprains/strains, and, therefore, the disc condition did not satisfy the definition of a “direct medical sequela.” See OAR 436-035-0005(5); *Juan M. Orta-Carrizales*, 71 Van Natta 794 (2019). Thus, the Board concluded that claimant was not entitled to a permanent impairment award under his current claim because the attending physician did not attribute any impairment findings to the *accepted* conditions or their direct medical sequelae. *Id.*; ORS 656.268(15); OAR 436-035-0006(1); *VanBoeckel*, 69 Van Natta at 1396; *Yekel*, 67 Van Natta at 1286. In reaching its conclusion, the Board noted that a new/omitted medical condition claim may be filed at any time. See ORS 656.262(6)(d), (7)(a); ORS 656.267(1).

Dissent was persuaded that attending physician’s opinion supported impairment as a whole was caused in material part by the injury.

Member Lanning dissented, asserting that the attending physician had apportioned claimant’s impairment findings between the compensable injury and preexisting conditions, and that the carrier had not processed claimant’s claim as a “combined condition.” Further observing that the attending physician had considered the intervertebral disc injury to be “part and parcel of the initial injury and is the cause of [claimant’s] ongoing symptomatology[.]” Lanning was persuaded that the attending physician’s opinion supported a conclusion that claimant’s impairment as a whole was caused in material part by the compensable injury. Consequently, because the carrier did not process the claim as a “combined condition,” Member Lanning believed that claimant was entitled to a permanent impairment award. See *Caren*, 365 Or at 487; *Alicia Bermejo-Flores*, 71 Van Natta 1264 (2019).

Extent: “Redetermination” for “Worsened Condition” - Accepted Worsened Condition Compared to Extent of Disability at Last Award/Arrangement of Compensation - “035-0016”

Susan B. Raynor, 72 Van Natta 664 (July 24, 2020). Applying OAR 436-035-0016 (WCD Admin. Order 17-057, eff. October 8, 2017), the Board held that, in evaluating claimant’s permanent disability after closure of her aggravation claim for her accepted knee conditions, she was entitled to a “redetermination” of her permanent disability awards because a comparison of the extent of her permanent disability caused by the accepted worsened conditions with the extent of disability that existed at the time of her last award or arrangement of compensation showed greater permanent impairment. After the carrier requested reconsideration of its Notice of Closure (which had awarded additional permanent impairment/work disability on closure of claimant’s aggravation claim for knee conditions) and sought a medical arbiter examination, an Order on Reconsideration reduced claimant’s permanent impairment award to the amounts granted by her last awards of compensation. Thereafter, claimant requested a hearing, seeking increased permanent disability awards.

The Board granted claimant’s request. Citing OAR 436-035-0016(1) (2017), the Board stated that when an aggravation claim is closed, the extent of permanent disability caused by any worsened condition accepted under the aggravation claim is compared to the extent of disability that existed at the time of the last award or arrangement of compensation. Referring to section (2) of the rule, the Board noted that permanent disability caused by conditions not actually worsened continues to be the same as that established at the last arrangement of compensation. Finally, the Board observed that, pursuant to section (3) of the rule, when a redetermination under ORS 656.273 results in an award that is less than the total of the worker’s prior arrangements of compensation in the claim, the award is not reduced.

Turning to the case at hand, the Board compared the extent of claimant’s disability under the worsened condition claim to the extent of her disability at the time of the prior reconsideration order. OAR 436-035-0016(1), (3). After calculating claimant’s impairment (based on the arbiter’s findings) and recalculating claimant’s “social-vocational” factor values for her work disability award, the Board found that claimant’s current extent of permanent disability was greater than her extent of disability that existed at the last award or arrangement of compensation.

Under such circumstances, the Board concluded that claimant was entitled to a redetermination of her permanent disability awards on closure of her aggravation claim. Consequently, the Board held that claimant had established error in the reconsideration process and, as such, was entitled to increased permanent impairment/work disability awards. See ORS 656.266(1); OAR 436-035-0016(1); *Marvin Wood Prods. v. Callow*, 171 Or App 175 (2000).

For purposes of “redetermining” permanent impairment at closure of aggravation claim, Board compared extent of disability under the worsened condition claim to the disability at the time of the prior “recon” order.

Because permanent disability was greater, claimant was entitled to redetermination of permanent impairment.

Current version of WCD rule no longer requires an “actual worsening” be established for a “redetermination.”

In reaching its conclusion, the Board distinguished *Jeffrey Townsend*, 58 Van Natta 563 (2006), which had applied former OAR 436-035-0007(9) (2003) (since renumbered as OAR 436-035-0016 and amended). In contrast to the rule applied in *Townsend* (which required that an “actual worsening” be established by a physician’s opinion and authorized a redetermination of permanent disability only when an “actual worsening” occurred), the Board observed that the applicable version of OAR 436-035-0016 no longer requires that an “actual worsening” be established by a physician’s opinion for a redetermination of the extent of a claimant’s permanent disability. Instead, the Board reiterated that OAR 436-035-0016(1) provides that, “[w]hen an aggravation claim is closed, the extent of permanent disability caused by any worsened condition accepted under the aggravation claim is compared to the extent of disability that existed at the time of the last award or arrangement of compensation.”

In any event, to the extent that ORS 656.273(1) and OAR 436-035-0016 (2017) required an “actual worsening” for the redetermination of a claimant’s permanent disability at closure of an aggravation claim, the Board found that an “actual worsening” had been established by comparing the extent of her permanent disability caused by any worsened condition accepted under the aggravation claim to the extent of disability that existed at the time of her last award or arrangement of compensation. See OAR 436-035-0016(1); *Stepp v. SAIF*, 304 Or 375, 381 (1987).

Hearing Request: “Rebuttable Presumption” of Untimely Filing - Not “Rebutted” by Date of Cover Letter, Claimant’s Attorney’s Unsworn Representations, & Carrier’s Receipt of Its Copy - No “Certification/Affidavit” of Mailing or Standard Office Procedures - “319(1)(a),” “005-0046(1)(c)”

Eric C. Kopf, 72 Van Natta 647 (July 20, 2020). Applying ORS 656.319(1)(a), and OAR 438-005-0046(1)(c), the Board dismissed claimant’s hearing request from a carrier’s claim denial as untimely filed because the request (which was not mailed by certified mail) was received by the Hearings Division more than 60 days after the carrier’s denial, there was a rebuttable presumption that the request was untimely filed, and, because claimant’s counsel’s representations in a cover letter and the carrier’s confirmation that it had received a copy of the request did not establish when the request had been mailed to the Hearings Division, the presumption of untimeliness had not been rebutted. More than 60 days after the carrier’s denial, claimant’s counsel submitted a letter to the Hearings Division, which included copies of claimant’s hearing request and a cover letter (which was dated before expiration of the 60-day appeal period). Noting that the copy of the hearing request included the carrier’s date stamp (which was within the 60-day appeal period), claimant’s counsel represented that the original hearing request had been “simultaneously mailed to the Board.” In response, the carrier moved to dismiss the hearing request as untimely filed.

Hearing request concerning claim denial dismissed as untimely filed; presumption of untimeliness not rebutted.

Because hearing request was not sent by certified or registered mail, and was received by WCB after the date for timely filing, it was presumed to be untimely.

The Board affirmed an ALJ's order that granted the carrier's motion. Citing ORS 656.319(1)(a), the Board stated that a hearing request must be filed no later than 60 days after the denial was mailed to claimant. Relying on ORS 656.319(1)(b), and *Samuel Goodwin, II*, 72 Van Natta 508, 514-15 (2020), the Board noted that if a hearing request is filed after expiration of the 60-day period, but within 180 days of a denial, the Hearings Division has jurisdiction to address the denial if the claimant establishes "good cause" for the late filing. Referring to OAR 438-005-0046(1)(c), and *Teresa A. Sweeney*, 69 Van Natta 1062, 1063 (2017), the Board reiterated that, if a hearing request is not mailed by registered/certified mail and is received after the date for timely filing, it is presumed that the mailing was untimely unless the filing party establishes that the mailing was timely.

Turning to the case at hand, the Board found that, because claimant's hearing request (which was not mailed by registered/certified mail) was received by the Hearings Division after expiration of the 60-day appeal period, there was a rebuttable presumption that the mailing was untimely. In attempting to rebut this presumption of untimeliness, the Board noted that claimant referred to the following matters: (1) the date of his counsel's cover letter, which accompanied the hearing request; (2) the carrier's date stamp on its copy of the cover letter/hearing request; and (3) his counsel's representation on his letter (which submitted the aforementioned copies) that the original hearing request had been simultaneously mailed to the Hearings Division when the copies of the hearing request/cover letter had been mailed to the carrier.

"Untimely filing" presumption not rebutted by: (1) date of cover letter; (2) carrier's receipt of its copy of request; and (3) attorney's unsworn representation of mailing.

After considering claimant's contentions, the Board determined that the presumption of untimely filing had not been rebutted. Citing *Madewell v. Salvation Army*, 49 Or App 713, 715-16 (1980), the Board reiterated that the date on a letter does not establish that the letter was mailed/received in the regular course of the mail or that the letter was mailed on that date. Furthermore, the Board referred to *SAIF v. Cruz*, 120 Or App 65, 69 (1993), and *Scott V. Morelli*, 67 Van Natta 715, 719 (2015), for the proposition that an attorney's unsworn representations do not constitute evidence. Under such circumstances, the Board concluded that the record did not overcome the presumption that claimant's hearing request had been untimely mailed to the Hearings Division.

Record lacked a certificate of service/ mailing from claimant's counsel or an affidavit describing counsel's office procedures for mailing.

In reaching its conclusion, the Board distinguished *Sweeney*, where a claimant's counsel's cover letter/hearing request and a carrier's confirmation of its receipt of its copies of the letter/hearing request were found to have rebutted the presumption of untimely filing because the cover letter/request had also been accompanied by claimant's counsel's certificate of service attesting when the request had been mailed to the Hearings Division. In contrast to *Sweeney*, the Board reasoned that the record lacked a certificate of service from claimant's counsel (or an affidavit from any assistant describing the standard office procedures for mailing hearing requests to the Hearings Division and copies to carriers and their counsels). In the absence of such evidence, the Board determined that the record did not establish that claimant's hearing request was mailed to the Hearings Division before the expiration of the 60-day appeal period.

“Good cause” for untimely filing not established because record lacked corroboration for claimant’s allegation of “mistake” or “inadvertence” by the postal service.

Concurrence troubled by conclusion that attorney’s representation of mailing insufficient, but adhered to principles of stare decisis.

Carrier issued separate denials (aggravation and new/omitted medical condition) on the same day and claimant’s request for hearing listed that denial date.

Finally, the Board acknowledged claimant’s alternative argument that he demonstrated “good cause” for his untimely filed hearing request because the U.S. Postal Service had failed to deliver the hearing request before expiration of the 60-day appeal period. Relying on *Goodwin*, the Board recognized that a “good cause” determination under ORS 656.319(1)(b) must be liberally construed and viewed in the light most favorable to the party seeking relief when there is evidence of “mistakes” or “inadvertences.” Nonetheless, reasoning that, other than claimant’s assertion, the record lacked corroboration establishing any mistake or inadvertence by the U.S. Postal Service, the Board concluded that “good cause” for the untimely filed hearing request had not been established.

Member Ousey concurred. Although troubled by the conclusion that an attorney’s representation (that a request was timely mailed) is fundamentally different from a certificate of service/ mailing, Ousey recognized that the reasoning expressed in the aforementioned case precedent supported the proposition that an “untimely filed” presumption cannot be overcome by an attorney’s unsworn representation alone. Consequently, in accordance with the principles of *stare decisis*, Member Ousey concurred.

Hearing Request: Reference to “Denial” Encompassed Carrier’s Denials of Both “Aggravation” & “New/Omitted Medical Condition” Claims - Same “Injury Date,” “Claim Number,” Date of Denials - Checking of “Aggravation” Box Did Not Narrow Scope of Hearing Request

Christopher Karna, 72 Van Natta 688 (July 28, 2020). Analyzing ORS 656.283(2), and ORS 656.319(1)(a), the Board held that it was authorized to address the compensability of a denied new/omitted medical condition claim for a knee condition because, although claimant’s hearing request had checked the “aggravation” box, the hearing request had also referred to the “injury date” and “claim number” that coincided with the new/omitted medical condition denial, as well as the date of the new/omitted medical condition denial (which was the same date as the aggravation denial). On the same day, a carrier issued separate denials of claimant’s aggravation claim for a previously accepted knee bursitis condition, as well as a new/omitted medical condition claim for medial meniscal tear. Within 60 days of the denials, claimant filed a hearing request, which marked the “denial” box, listed a denial date that coincided with both denials, and marked the “aggravation” box. (The hearing request also referred to the “injury date” and “claim number” that coincided with both the aggravation and new/omitted medical condition claims.) Noting that claimant had marked the “aggravation” box on his hearing request, the carrier contended that the request pertained only to its “aggravation” denial and, because more than 60 days had elapsed since its denial of claimant’s new/omitted medical condition claim, his attempt to contest that denial was untimely.

The Board disagreed with the carrier’s contention. Citing ORS 656.283(2), ORS 656.319(1)(a), and *Naught v. Gamble, Inc.*, 87 Or App 145, 149 (1987), the Board stated that a claimant has an obligation to request a hearing in response to a denied claim to place the denial before the Hearings Division for resolution.

Although claimant checked the “aggravation” box on hearing request form, the record supported a conclusion that hearing request referred to both denials; e.g. “denial” box checked, request referred to date of new/ omitted medical condition denial, and listed correct claim number, and “injury date.”

Relying on *Goodwin v. NBC Universal Media*, 298 Or App 475, 484 (2019), and *Guerra v. SAIF*, 111 Or App 579, 584 (1992), the Board reiterated that a hearing request challenging a denial must be capable of being considered in relation to a particular denial by referencing the denial that is being challenged either directly or indirectly. Referring to *Goodwin*, and *Kevin C. O’Brien*, 44 Van Natta 2587, 2588 (1992), *on recon*, 45 Van Natta 97 (1993), the Board noted that, to determine whether a hearing request is referable to a denial, the request itself is considered, read as a whole and in the context in which it was submitted.

Turning to the case at hand, the Board acknowledged that the carrier had issued two denials and that claimant’s hearing request had checked the “aggravation” box. The Board further recognized that, had claimant checked the “partial denial after a claim acceptance” box on the hearing request, such clarification would have been helpful. Nonetheless, the Board noted that claimant’s hearing request had also checked the “denial” box and referred to a denial date that coincided with the new/omitted medical condition claim denial (as well as the aggravation claim denial). Moreover, the Board observed that the hearing request had identified the “injury date” and “claim number” that was consistent with both of the carrier’s denials.

Under such circumstances, when analyzed in context, the Board determined that the record supported a conclusion that claimant’s hearing request was referable to both of the carrier’s denials. In reaching its conclusion, the Board acknowledged that claimant’s checking the “aggravation” box helped clarify that the aggravation claim denial was disputed. Nevertheless, in light of the aforementioned additional information provided in the hearing request, the Board reasoned that such an action did not indicate that the new/omitted medical condition claim denial was not also at issue.

“Third Party” Dispute: “NCE” Statutory Claim Agent for “WCD” - Initial Claim Acceptance Revoked via “DCS” - No “Paying Agency” Because No “Compensable Injury” - Claimant’s Settlement Not Subject to “Third Party” Lien

Toni M. Dover, 72 Van Natta 623 (July 15, 2020). Analyzing ORS 656.005(8), ORS 656.054, ORS 656.576, and ORS 656.587, the Board held that because a statutory claim agent’s acceptance of claimant’s injury claim (on behalf of the Workers’ Compensation Division (WCD) concerning a “noncomplying employer (NCE)” claim under ORS 656.054) had been revoked pursuant to a Disputed Claim Settlement (DCS), neither the statutory claim agent nor WCD were “paying agencies” for purposes of the “third party recovery” statutes and, as such, they were not entitled to a share of claimant’s subsequent settlement with the negligent “third party.” Noting that claimant’s injury claim had been initially accepted and that it had had paid benefits to claimant, the statutory claim agent that it was a “paying agency” notwithstanding the subsequent DCS (which had resolved the compensability of the claim, but reserved its lien rights). Consequently, because it had not approved claimant’s settlement, the statutory claim agent argued that the settlement was void under ORS 656.587.

Statutory claim agent for WCD (concerning “NCE”) initially accepted claim, but DCS later found claim not compensable.

The Board disagreed, concluding that claimant's settlement with the negligent party was not subject to the third party statutes. Citing ORS 656.576, *SAIF v. Wright*, 113 Or App 267, 272 (1992), and *Jereme M. Beardall*, 66 Van Natta 1263, 1265 (2014), the Board reiterated that a "paying agency" means the self-insured employer or insurer "presently" paying benefits at the time of the "third party" settlement or distribution.

DCS revoked claim acceptance; claim agent essentially paid benefits on a "noncompensable" injury.

Turning to the case at hand, the Board acknowledged that the statutory claim agent had initially accepted claimant's injury claim and paid benefits. Nevertheless, referring to *Beardall*, the Board reasoned that the language of the subsequent DCS had, in effect, revoked the acceptance and, as such, the statutory claim agent had essentially paid benefits on a "noncompensable" injury. Furthermore, relying on *Wright*, the Board determined that no benefits were "presently" being paid at the time of claimant's settlement and, in light of the DCS, there was no certainty that there would be an entity paying benefits in the future. Under such circumstances, because claimant's settlement with the negligent party had occurred after the DCS's approval, the Board concluded that the statutory claim agent was not a "paying agency" when claimant's settlement was reached.

Because NCE's objection to the claim acceptance had resulted in a DCS, the payment of benefits did not constitute "compensation."

In reaching its conclusion, the Board acknowledged that the statutory claim agent's payment of benefits regarding an accepted claim would generally constitute "compensation." ORS 656.005(8). Likewise, the Board recognized that a claim for "compensation" made by a worker of an NCE shall be processed in the same manner as a claim made by a worker employed by a carrier-insured employer. ORS 656.054(1). Nevertheless, the Board noted that, pursuant to ORS 656.054(1), a NCE may, at any time within which a claim may be accepted/denied under ORS 656.262, request a hearing to object to the claim. Thus, in light of the NCE's express statutory right to contest the statutory claim agent's claim acceptance, the Board considered the statutory claim agent's payment of benefits to claimant to be contingent in nature. Moreover, because the NCE's objection to the statutory claim agent's claim acceptance had resulted in the DCS (which determined that the claim was not compensable), the Board determined that the statutory claim agent's previous payment of benefits did not satisfy the statutory definition of "compensation"; *i.e.*, all benefits, including medical services, provided for a *compensable injury*. ORS 656.005(8).

WCD was also not a "paying agency" under the third party recovery statute.

Finally, addressing WCD's status as a "paying agency," the Board acknowledged that ORS 656.593(4) recognizes WCD's entitlement to reimbursement from a "third party" recovery (on behalf of the Director) for "costs of another paying agency and to compensate or pay other costs of a worker's claim" due to an NCE. Reasoning that the statute was premised on the existence of "another paying agency," the Board concluded that, because the statutory claim agent did not qualify as a "paying agency," WCD was likewise not a "paying agency" for purposes of ORS 656.593(4).

APPELLATE DECISIONS SUPREME COURT

Attorney Fee: “382(2)” - Dismissal of Carrier’s Hearing Request Regarding “Recon Order” - Claimant’s Attorney Entitled to Carrier-Paid Fee - Claimant’s Successful Defense of Appealed Compensation Award May Be Procedural or Substantive in Nature

Arvidson v. Liberty Northwest Ins. Corp., 366 Or 693 (July 16, 2020).

Analyzing ORS 656.382(2), the Supreme Court reversed a Court of Appeals decision, 297 Or App 192 (2019), which had affirmed the Board’s order in *Danny E. Arvidson*, 69 Van Natta 1434 (2017) that had held that claimant’s counsel was not entitled to a carrier-paid attorney fee when a carrier’s hearing request from an Order on Reconsideration (which had granted permanent total disability benefits) was dismissed as untimely filed. Relying on *Agripac, Inc. v. Kitchel*, 73 Or App 132, 134 (1985), the Board had reasoned that an attorney fee award under ORS 656.382(2) was not warranted because the carrier’s hearing request was dismissed without a decision on the merits; *i.e.*, without a finding that claimant’s compensation award was not disallowed or reduced. On appeal, asserting that nothing in ORS 656.382(2) indicates that the reasons for a decision are pertinent, claimant contended that the Board had erred in requiring a finding “on the merits” to grant an attorney fee award under the statute.

The Supreme Court agreed. Citing *SAIF v. DeLeon*, 352 Or 130, 133-34 (2012), the Court reiterated that ORS 656.382(2) imposes three requirements for an attorney fee award: (1) a claimant’s benefit award; (2) a carrier’s initiation of a request for review of that award; and (3) the tribunal “finds” that the compensation award should not be disallowed or reduced. Reasoning that the term “finds” was inexact, the Court reviewed the Board’s interpretation for consistency with legislative intent. See *Springfield Educ. Ass’n v. School District*, 290 Or 217, 227 (1980). In doing so, the Court repeated that it does not interpret statutory inexact terms solely on the basis of dictionary definitions, but also examines word usage in context to determine which among competing definitions is the one the legislature more likely intended. See *DCBS v. Muliro*, 359 Or 736, 746 (2016).

After reviewing several possible usages of the term “to find/finds,” and considering the word “finds” in context of ORS 656.382(2), the Supreme Court reasoned that because the statute refers to carrier appeals to the Court of Appeals and Supreme Court, forums that do not render “findings of fact,” it was more likely that the legislature intended “finds” to encompass determinations beyond those of a factual nature; *i.e.*, “finds” was intended to have a more general ordinary meaning, such as the act of making a decision.

Referring to *Bracke v. Baza’r*, 294 Or 483, 487 (1983) (which had discussed the 1965 statutory amendments to ORS 656.382(2)), the Supreme Court further observed that the legislature was concerned about carriers pursuing harassing and frivolous appeals to wear down a claimant and that the “answer” to that concern was ORS 656.382(2). Although acknowledging that *Bracke* had not analyzed the word “find” in the statute, the Court noted that

Board had reasoned that an attorney fee was not warranted because request was dismissed without a decision on the merits.

“382(2)” provides that an attorney fee may be awarded if the tribunal “finds” that the compensation should not be disallowed or reduced.

“Finds” under “382(2)” intended to have a more generally ordinary meaning, such as making a decision.

“382(2)” concerns claimant’s successful defense of compensation award, whether defense was procedural or substantive in nature.

An ALJ's dismissal of a hearing request from an Order on Reconsideration constituted a situation where ALJ "finds" compensation award not disallowed or reduced.

Bracke had focused on a claimant who *successfully defended his award upon attack* by the carrier and that nothing in *Bracke* implied that it mattered whether this successful defense was procedural or substantive in nature.

Consequently, after reviewing the text, context, history, and purpose of ORS 656.382(2), the Supreme Court found that the legislature intended that an ALJ's dismissal of a carrier's hearing request as untimely would fall within the statute. In doing so, the Court recognized that the ALJ's dismissal order may not express an opinion that the appealed compensation award was properly made. Nevertheless, the Court reasoned that such a determination established (as definitively as any ruling on the substantive merits) that the compensation award should not be "disallowed or reduced."

In reaching its conclusion, the Supreme Court distinguished *SAIF v. Curry*, 297 Or 504, 507 (1984), which had declined to award an attorney fee under ORS 656.382(2) when a carrier's petition for review of a Court of Appeals decision had been denied. Reasoning that petitioning the Supreme Court to exercise its discretion to review a case does not establish that a carrier has "initiated" a "higher-level examination" of the compensation award itself, the Court explained that the only thing a denial of such a petition decides is that the Court will not make a decision about the case. In contrast to the "denied petition" in *Curry*, the Supreme Court considered the ALJ's dismissal of the carrier's hearing request in the present case was a decision about the case itself, bringing a close to the carrier's action and thereby establishing that claimant's compensation award would not be altered.

APPELLATE DECISIONS COURT OF APPEALS

Occupational Disease: "802(2)(a)" - Claimant Must Prove Employment Conditions Were Major Cause of Claimed Disease - Burden of Proof Does Not Shift to Carrier to Prove That "Non-Work" Causes Outweighed "Work-Related" Causes

Johnston v. Gordon Trucking - Heartland Express, 305 Or App 531 (July 15, 2020). Applying ORS 656.802(2)(a), and ORS 656.266(1), the court affirmed the Board's order in *Marc R. Johnston*, 69 Van Natta 164 (2017), that upheld an occupational disease denial for claimant's lumbar arthritis/degenerative disc disease. In reaching its conclusion, the Board had found that claimant's aging process (contributed to by his genetics) was an active, ongoing contributor to the development of his degenerative arthritic condition and that the medical evidence was not sufficiently persuasive to establish the existence of a compensable occupational disease. On appeal, claimant contended that: (1) once he presented evidence supporting his assertion that his work activities were the major contributing cause of his claimed conditions, the burden shifted to the carrier to establish that other causative factors outweighed the contribution from his work activities; (2) the Board had erroneously viewed aging as a nonwork-related factor; and (3) claimant's "genetics" should not have been weighed as a factor in analyzing the major contributing cause of the claimed conditions.

Claimant has “burden of proof” to establish that employment conditions were the major contributing cause of claimed occupational disease.

Court found no statutory support for shifting burden of persuasion to carrier.

Court rejected argument that contribution from “aging” must be viewed as related to years of work activities.

Court considered Board’s reference to “genetics” to reflect physicians’ opinions that aging process caused degenerative changes influenced by a person’s genetic make-up.

The court disagreed with claimant’s contentions. Citing ORS 656.266(1), and ORS 656.802(2)(a), the court stated that claimant had the burden of proving that employment conditions were the major contributing cause of his claimed occupational disease. Relying on *Lowells v. SAIF*, 285 Or App 161, 164 (2017), the court reiterated that the major contributing cause of a disease is the primary cause; *i.e.*, the cause that contributes more than all other causes combined.

Turning to the case at hand, the court found no support in ORS Chapter 656 for claimant’s argument that the burden of persuasion shifted to the carrier if the worker makes an initial showing of compensability. Referring to *SAIF v. Thompson*, 360 Or App 155, 161 (2016), the court further noted that the legislature had expressly enacted burden-shifting schemes in other workers’ compensation contexts, suggesting that it would have done so had it intended that for an ordinary occupational disease claim.

Based on those principles, the court determined that claimant had the burden of showing not only that employment conditions contributed to his claimed disease, but that those conditions were the *major* contributing cause of his disease. Although acknowledging that such a task was more challenging when evidence suggests the existence of nonwork-related contributions, the court reasoned that the burden of persuasion did not shift to a carrier merely because it offered evidence that nonwork-related factors contributed more to claimant’s disease than work conditions.

Addressing claimant’s second argument, the court noted that he did not dispute that aging was an active contributor to his disease, but rather was asserting that such “aging” contributions must be viewed as related to employment conditions because he continued (for 35 years) to perform his work activities as he aged. The court rejected claimant’s argument, determining that the record did not compel a finding that contributions from aging must be viewed as related to claimant’s employment. In doing so, the court referred to a physician’s opinion, which had cited studies (indicating that aging/genetic factors *themselves* predominate in causing degenerative disc conditions and physical mechanisms associated with work did not) and opined that claimant’s *life-long* work activities were not the major contributing cause of his claimed conditions. Given that evidence, the court determined that the Board could reach its conclusion that the claimed occupational disease was not compensable.

Finally, the court acknowledged claimant’s assertion that the Board could not properly take genetics into account because the record lacked evidence that genetic factors contributed to his claimed degenerative conditions. However, the court did not interpret the Board order to have found that claimant had some specific genetic characteristic that (independently of aging) had resulted in an active contribution to his claimed degenerative conditions, but instead read the Board order to reflect (based on the opinions of two examining physicians) that the way the aging process causes degenerative changes in a person’s spine is influenced by that person’s genetic make-up. Accordingly, the court found no error in the Board’s decision.