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BOARD NEWS

Steve Lanning - Retirement

After eight years of service as a Member, Steve Lanning has retired from the Board. Steve's last day was September 9, 2020. WCB congratulates Steve for his years of public service and wishes him well in his retirement.

Adoption of Permanent Rules/Amendments (Attorney Fees - OAR 438 Division 015) - ("Contingent Hourly Rate" - "015-0010(4)(l)"); "Voluntary Bifurcation of Attorney Fee Award for Certain Cases on Board Review" - "015-0125") - Effective October 1, 2020

At their August 19, 2020, public meeting, the Members adopted rules/amendments relating to attorney fees (OAR 438 Division 015). The Members took these actions after considering comments presented at a July 31, 2020, rulemaking hearing, as well as discussing submissions from Members Ousey and Curey, and comments presented by attendees at the Board's August 19 meeting. The rule amendments are summarized as follows:

- 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(4)(l)).
- Establishing procedures regarding the voluntary bifurcation of an attorney fee award from the merits concerning certain cases on Board Review. OAR 438-015-0125.

The effective date for the permanent rules/amendments is October 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.

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

TTD: "AP" Retracted "Modified Job" Offer - Carrier Did Not Confirm That "AP" Continued to Approve "Modified Job" - Carrier Not Entitled to Terminate TTD - "268(4)(c)," "060-0030(3)(c)(E)" 8

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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

CDA: Attorney Fee - Based on Total CDA Proceeds - Despite "Overpayment Recovery" Provision - Fee Not Subject to "Offset" - "015-0085(2)"

Ernesto Capote-Escalona, 72 Van Natta 719 (August 3, 2020). Applying ORS 656.236(1), OAR 438-015-0052(1), and OAR 438-015-0085(2), in approving a Claim Disposition Agreement (CDA), the Board held that the carrier's recovery of an overpayment from the CDA proceeds did not affect claimant's counsel's entitlement to a proposed "out-of-compensation" attorney fee that was equal to 25 percent of the \$5,000 in total CDA proceeds. Citing OAR 438-015-0052(1), the Board stated that its rules provide for an attorney fee equal to 25 percent of the total CDA proceeds (which did not exceed \$50,000). Furthermore, relying on OAR 438-015-0085(2), the Board noted that attorney fee awards are not subject to offsets.

Turning to the case at hand, the Board acknowledged that the CDA included a provision that authorized the carrier to recover a portion of claimant's share of the CDA proceeds as reimbursement for an overpayment.

Carrier's recovery of an offset did not reduce the total CDA "proceeds" from which an attorney fee was calculated.

Recovery of an overpayment from a CDA did not constitute a “waiver” of overpayment.

Nonetheless, referring to *James E. Wood, III*, 66 Van Natta 685 (2014), the Board reiterated that a carrier’s recovery of an overpayment does not reduce the “proceeds” from which a permissible attorney fee may be calculated. Because the proposed attorney fee payable from the CDA proceeds was consistent with the aforementioned administrative rules and the *Wood* rationale, the Board concluded that the proposed fee was approvable.

In reaching its conclusion, the Board acknowledged that, in response to a staff letter, the parties had submitted another CDA, which had reduced the proposed attorney fee. However, the Board noted that the proposed reduction had been based on a false premise; *i.e.*, that the recovery of an overpayment from a CDA constituted a “waiver” of an offset. See *Stefan R. Cammann*, 64 Van Natta 2401, 2404-05 (2012). Consequently, because the initial CDA had been consistent with applicable terms and conditions, as well as case law, the Board approved that proposed disposition.

Combined Condition: Two Medical Problems Existing Simultaneously - Pain Resulting From Hyperextension of Knee at Work & Underlying Osteoarthritis

Preexisting arthritic condition combined with knee pain from work injury constituted a “combined condition.”

Terry D. Gibson, 72 Van Natta 793 (August 25, 2020). Analyzing ORS 656.005(7)(a)(B), and ORS 656.266(2)(a), the Board upheld a denial of claimant’s new/omitted medical condition claim for a tri-compartmental osteoarthritic knee condition because the carrier had established the existence of a combined condition (his preexisting osteoarthritic knee condition and his knee pain related to his work injury) for which the work injury was not the major contributing cause of his need for treatment/disability of his combined knee condition. In contesting the carrier’s denial, claimant contended that the record did not establish the existence of a “combined condition.”

The Board disagreed with claimant’s contention. Citing ORS 656.005(7)(a)(B), and ORS 656.266(2)(a), the Board stated that, if a claimant establishes that the work injury was a material contributing cause of the need for treatment/disability for a claimed condition, the carrier must establish that the otherwise compensable injury combined with a preexisting condition to cause/prolong disability/need for treatment and that work injury was not the major contributing cause of the need for treatment/disability for the combined condition. Relying on *Multifood Specialty Distrib. v. McAtee*, 333 Or 629, 636 (2002), and *Amy K. Metcalf*, 72 Van Natta 244, 247 (2020), the Board reiterated that a “combined condition” occurs when there are “two medical problems [existing] simultaneously.”

The existence of two medical problems established a “combined condition.”

Turning to the case at hand, the Board noted that a physician had explained that claimant’s work injury (which hyperextended his knee) had caused the rough surfaces of his underlying osteoarthritis to “pop over one another” resulting in knee pain. Based on that description, the Board determined that the record supported the existence of two medical problems; *i.e.*, the preexisting tri-compartmental osteoarthritis of the knee and the onset of knee pain due to the work injury. Consequently, the Board concluded that the carrier had established a “combined condition.” Furthermore, finding that the physician’s opinion that the underlying preexisting osteoarthritis was at all

times the major contributing cause of claimant's need for treatment was persuasive, the Board held that the carrier had met its burden of proof under ORS 656.266(2)(a). Accordingly, the Board upheld the carrier's denial of claimant's new/omitted medical condition claim.

Extent: Impairment Findings - Valid, Ratable Findings Attributable to Accepted Condition & Medical Sequelae - Arbiter's Reference to "Not Med Stat" Not Determinative

Melonie Cramer, 72 Van Natta 786 (August 17, 2020). Applying OAR 436-035-0007(5), the Board held that claimant was entitled to a permanent impairment award for a shoulder condition because, despite checking a box on a form indicating that claimant's condition was not medically stationary, a medical arbiter had considered claimant's impairment findings to be valid, permanent and attributable to her accepted condition and medical sequelae. The carrier contended that, because the arbiter had indicated that claimant's shoulder condition was not "medically stationary" at the time of the examination, the arbiter's findings were not permanent and should not be used to rate claimant's impairment.

The Board disagreed with the carrier's contention. Citing OAR 436-035-0007(5), the Board stated that when a medical arbiter panel is used, impairment is established based on objective findings of the arbiter panel, except where a preponderance of the medical evidence demonstrates that different findings by the attending physician, or impairment findings with which the attending physician has concurred, are more accurate and should be used. Relying on *Hicks v. SAIF*, 194 Or App 655, 659, *recons*, 196 Or App 146 (2004), the Board reiterated that, absent persuasive reasons to the contrary, they are not free to disregard a medical arbiter's findings. Finally, referring to *Ray L. Straws*, 61 Van Natta 2314, 2319 (2009), the Board noted that it had previously relied on an arbiter findings to rate permanent impairment when the arbiter commented that the claimant's condition was "not stationary," because the arbiter did not support a worsening of the condition and reported that the findings were valid and due solely to the accepted condition.

Turning to the case at hand, the Board acknowledged that the arbiter had responded "no," without further explanation, to an Appellate Review Unit inquiry on whether claimant's condition was medically stationary at the time of the arbiter examination. However, emphasizing that it was undisputed that claimant's shoulder condition was "medically stationary" at the time of claim closure, the Board further reasoned that the arbiter's report did not support a worsening of claimant's condition after claim closure. Compare *Timothy W. Trujillo*, 52 Van Natta 748 (2000) (arbiter findings not ratable because arbiter opined that the claimant's condition was no longer medically stationary *and* had worsened). Moreover, the Board observed that the arbiter had considered claimant's impairment findings to be "valid" for rating her impairment and had unequivocally attributed all of her findings to the accepted condition and medical sequelae. Compare *Jindriska Stavenikova*, 58 Van Natta 2444, 2446 (2006) (arbiter findings not ratable because arbiter stated it was undetermined whether findings were permanent).

Arbiter checked a box on a form indicating claimant was not medically stationary, but also noted that the findings were valid and permanent.

Undisputed that claimant's condition was medically stationary at the time of closure; arbiter's report did not support a worsening after closure; and arbiter reported "valid," permanent finding related to accepted condition/medical sequelae.

Under such circumstances, the Board did not find persuasive evidence that was sufficient to allow it to disregard the arbiter's unambiguous impairment findings. Accordingly, based on the arbiter's unequivocal findings, the Board awarded permanent impairment for claimant's accepted shoulder condition. See OAR 436-035-0007(5); *Straws*, 61 Van Natta at 2319.

Occupational Disease: Claimant Required to Prove Existence of "Condition" (Not Merely "Symptoms") - Not Required to Prove "Specific Diagnosis," Unless Expressly Claimed

Attorney Fee: Determination of "Reasonable" Attorney Fee - Includes Time Spent on Preparing Submission & Responding to Carrier's Objection

Yolanda S. Beverly, 72 Van Natta 799 (August 26, 2020). Analyzing ORS 656.802(2)(a), the Board held that, in attempting to establish the compensability of her occupational disease claim for bilateral upper extremity conditions, claimant was not required to prove the existence of a specific diagnosis because the carrier's denial had only generally referred to hand, wrist, and elbow conditions and because claimant had not narrowed her claim at hearing to a specific diagnosed condition. On the carrier's appeal of an ALJ's order that had found that claimant's use of a keyboard and mouse while performing her work activities were the major contributing cause of her bilateral upper extremity conditions, the carrier argued that claimant must prove the existence of several specific diagnoses because her counsel had referred to those diagnoses at the hearing.

The Board disagreed with the carrier's argument. Citing *Boeing Aircraft Co. v. Roy*, 112 Or App 10, 15 (1992), and *Jacquelyn Madarang*, 58 Van Natta 1237, 1240 (2006), the Board stated that, although a claimant must prove the presence of a condition (as opposed to merely symptoms) when claiming an occupational disease, she need not prove a specific diagnosis in order to prove a compensable claim. However, relying on *Scott A. Long*, 65 Van Natta 2348, 2351-52 (2013), the Board observed that, when the parties have agreed to litigate a denied claim based on a specific condition, a claimant must prove the compensability of that specific condition. Conversely, referring to *Emily C. Rogers*, 67 Van Natta 2204, 2207 (2015), the Board noted that a claimant's counsel's reference to a specific diagnosis at the hearing did not necessarily narrow the claimant's burden to prove the compensability of the specific diagnoses (rather than the claimed general condition). Finally, citing *Tattoo v. Barnett Bus. Servs.*, 118 Or App 348, 351 (1993), the Board reiterated that a carrier is bound by the express language of its denial.

Turning to the case at hand, the Board acknowledged that claimant's counsel had referenced specific diagnoses at the hearing. Nonetheless, the Board reasoned that claimant's counsel had explicitly stated that the issue was the compensability of claimant's bilateral wrist, forearm, and elbow *conditions*. In addition, the Board noted that this description of the claimed conditions

Carrier contended that claimant must prove the existence of diagnoses that her counsel referred to at hearing, rather than compensability of conditions generally referenced in denial.

Claimant explicitly stated at hearing that the issue was compensability of several "conditions," which was consistent with the description in carrier's denial; thus, claimant had not narrowed her occupational disease claim to specific diagnosed conditions.

was consistent with the carrier's denial. Under such circumstances, the Board determined that claimant had not narrowed her occupational disease claim to specific diagnosed conditions.

Addressing the merits, the Board was persuaded by the opinion of claimant's treating physician who had a more expansive opportunity to evaluate the effect of claimant's work activities, objective findings, and response to treatment, over an extended period of time. See *Allied Waste Industries, Inc. v. Crawford*, 203 Or App 512, 518 (2005); *Somers v. SAIF*, 77 Or App 259, 263 (1986); *Weiland v. SAIF*, 64 Or App 810 (1983). Consequently, the Board concluded that claimant's work activities were the major contributing cause of her claimed conditions. Accordingly, the Board held that claimant's occupational disease claim was compensable. See ORS 656.802(2)(a); *Bowen v. Fred Meyer Stores*, 202 Or App 558, 563-64 (2005).

Finally, in awarding claimant's counsel an attorney fee under ORS 656.382(2) for services on Board review in defense of the ALJ's compensability decision, the Board included in its determination of a reasonable attorney fee claimant's counsel's time devoted to preparing an attorney fee submission and in responding to the carrier's objection to that submission. Relying on *Shearer's Foods v. Hoffnagle*, 363 Or 147, 156 (2018), the Board reiterated that a reasonable attorney fee determination includes consideration of a claimant's counsel's time litigating an attorney fee.

In reaching its conclusion, the Board also rejected the carrier's assertion that a reasonable hourly rate for a claimant's counsel on Board review had been established in *Daniel F. Judd*, 71 Van Natta 898 (2019). Instead, the Board explained that, in *Judd*, it had found that the time spent on the case by the claimant's attorney had been excessive.

Addressing claimant's counsel's submission in the case at hand, the Board drew on the Members' combined 63 years of experience as practitioners representing carriers at the Hearings Division and Board review, as well as their collective nine years as Board Members. After doing so, the Board considered the amount of time spent by claimant's counsel on review as unwarranted, particularly for a seasoned practitioner. Consequently, when compared to similar disputed claims litigated before the forum, the Board found that the time reflected in claimant's counsel's submission was excessive. Accordingly, after considering the "rule-based" factors prescribed in OAR 438-015-0010(4), and applying them to the present record, the Board awarded a reasonable attorney fee of \$6,250 for claimant's counsel's services on review.

Scope of Denial: Disputed Issue Concerned Denial of Injury Claim for Knee Condition - Specifically Diagnosed Conditions Neither Expressly Denied Nor Raised at Hearing

Joseph E. Koubek, 72 Van Natta 775 (August 14, 2020). In setting aside a carrier's denial of claimant's injury claim of a knee condition, the Board held that he was not required to establish the compensability of specific diagnosed conditions because the carrier's denial had generally referred to a knee condition and claimant had not narrowed his claim at hearing to any particular condition.

Time devoted by claimant's counsel in responding to carrier's objection to a reasonable attorney fee can be considered in determining a fee award.

After applying "rule-based" factors, Board considered claimant's counsel's time on review represented to be excessive.

Parties agreed at hearing that the issue was compensability of the "work injury," specifically referring to carrier's denial of "knee condition."

Generally, a claimant does not have to prove a specific diagnosis for an initial injury claim, unless parties agree to litigate a specific condition.

Although claimant specified certain diagnoses after the carrier's denial, the carrier did not amend its denial and the parties had not agreed to litigate specific conditions.

After the carrier denied claimant's injury claim for a knee condition, claimant informed it that he was seeking acceptance of a left knee sprain/strain, superior tibiofibular joint and left knee ligament sprains, and a medial meniscal condition. The carrier did not further respond or amend its denial. At the hearing regarding the carrier's denial, the parties agreed that the issue concerned the compensability of claimant's "work injury," specifically referring to the carrier's denial, which identified a "knee condition."

After the ALJ found that the claim was not compensable, claimant appealed, contending that he had established that his work injury was a material cause of his need for treatment/disability for his knee condition. In response, the carrier argued that claimant must prove the compensability of the specifically diagnosed conditions (not merely a knee condition) because he had expressly identified these conditions after his initial injury claim.

The Board disagreed with the carrier's contention. Citing *Boeing Aircraft Co. v. Roy*, 112 Or App 10, 15 (1992), and *Sheryl L. Lane*, 62 Van Natta 2014, 2016 (2010), the Board stated that a claimant generally does not have to prove a specific diagnosis to establish the compensability of an initial injury claim. Conversely, referencing *Scott A. Long*, 65 Van Natta 2348, 2351-52 (2013), the Board noted that when the parties agree that an initial injury claim concerns a specific condition, the claimant must prove the compensability of that condition. Referring to *Coleman v. SAIF*, 304 Or App 122, 141-42 (2020), the Board further explained that a new/omitted medical condition claim arises only after a carrier's initial claim acceptance. Finally, citing *Tattoo v. Barrett Bus. Serv.*, 118 Or App 348, 351 (1993), the Board stated that in general, a carrier is bound by the express language of its denial.

Turning to the case at hand, the Board acknowledged that, following the carrier's denial, claimant had expressly identified diagnosed knee conditions. Nonetheless, the Board noted that claimant's injury claim and the carrier's denial were both for a knee condition. Furthermore, relying on *Coleman*, the Board reiterated that a new/omitted medical condition claim arises only after a carrier's initial *acceptance* of a claim. Thus, although following the carrier's denial of claimant's initial injury claim, claimant had subsequently specified certain diagnoses, the Board reasoned that the carrier had neither further responded nor amended its denial to account for those diagnoses. Moreover, the Board observed that the parties had not agreed to litigate the disputed claim regarding those specific conditions. Instead, the Board emphasized that the parties had agreed that the issue was the compensability of claimant's "work injury," specifically referencing the carrier's denial (which had identified a "knee condition," rather than a specifically diagnosed condition).

Under such circumstances, the Board determined that claimant had not narrowed his claim to any of the specific knee conditions. Addressing the merits of the denied claim, the Board found that the treating physician's opinion had persuasively established the compensability of claimant's injury claim and, therefore, set aside the carrier's denial.

TTD: “AP” Retracted “Modified Job” Offer - Carrier Did Not Confirm That “AP” Continued to Approve “Modified Job” - Carrier Not Entitled to Terminate TTD - “268(4)(c),” “060-0030(3)(c)(E)”

Ian M. Reoch, 72 Van Natta 743 (August 7, 2020). (Editor’s Note: Order abated September 2, 2020.) Applying ORS 656.268(4)(c), and OAR 436-060-0030(3)(c)(E), the Board held that a carrier was not authorized to convert claimant’s temporary total disability (TTD) benefits into temporary partial disability (TPD) benefits because, although his attending physician had initially approved a modified job offer, before that job began, his physician had modified claimant’s work restrictions and the carrier had not contacted the attending physician to confirm that the modified job remained within claimant’s work limitations. After claimant did not begin the modified job, the carrier stopped paying TTD benefits. Claimant requested a hearing, contending that he was entitled to TTD benefits, as well as penalties/attorney fees for allegedly unreasonable claim processing.

The Board agreed with claimant’s contention. Citing ORS 656.268(4)(c), the Board stated that an attending physician must agree that the worker is capable of performing the modified employment offered by the carrier. Referring to *Bobby D. Mitchell*, 61 Van Natta 786, 789 (2009), and *Richard C. Verrill*, 53 Van Natta 810, 811 (2001), the Board noted that this "modified job offer" requirement is not satisfied if the attending physician retracts a prior approval of a modified job. Relying on OAR 436-060-0030(3)(c)(E), the Board emphasized that a carrier is required to confirm with the attending physician that the modified job is within the worker’s capabilities. Finally, citing *Fairlawn Care Center v. Douglas*, 108 Or App 698, 701 (1991), and *Eastman v. Georgia Pacific Corp.*, 79 Or App 610, 613 (1986), the Board reiterated that a carrier must strictly comply with ORS 656.268(4) and its corresponding administrative rules to terminate TTD benefits.

Turning to the case at hand, the Board acknowledged that claimant’s attending physician had initially approved the carrier’s modified job offer. Nonetheless, the Board noted that, before the modified job had begun, the attending physician had modified claimant’s work restrictions. Under such circumstances, the Board determined that the attending physician had effectively retracted the modified job approval. Because the carrier had not confirmed with the attending physician whether the modified job offer was within claimant’s new work restrictions, the Board concluded that the carrier was not authorized to terminate his TTD benefits.

Furthermore, the Board found that the carrier had not contacted the attending physician as required by OAR 436-060-0030(3)(c)(E). Because the carrier had not complied with its obligation to confirm with the attending physician whether its modified job offer was within claimant’s new work restrictions, the Board determined that the carrier did not have a legitimate doubt concerning its responsibility to continue to pay claimant’s TTD benefits. Under such circumstances, the Board concluded that the carrier had

If “AP” retracts prior approval of “modified job,” carrier is required to confirm with attending physician that modified job remains within worker’s capabilities.

Because “AP” modified claimant’s work restrictions, carrier was obligated to confirm with “AP” that “modified job” remains within new restrictions before TTD benefits could be terminated.

Because carrier did not comply with its obligation to confirm with attending physician as required by WCD rule, termination of TTD benefits was unreasonable.

unreasonably terminated claimant's TTD benefits and, as such, a penalty/ attorney fee award was warranted. See ORS 656.262(11)(a); *Int'l Paper Co. v. Huntley*, 106 Or App 107, 110 (1991); *Brown v. Argonaut Ins.*, 93 Or App 588, 591 (1988).

APPELLATE DECISIONS UPDATE

Jurisdiction: “319(6)” - Hearing Request Challenging Carrier’s TTD Calculation - Must Be Filed W/I Two Years After Alleged Action/Inaction Occurred

Swint v. City of Springfield, 305 Or App 679 (August 5, 2020). Analyzing ORS 656.319(6), the court reversed the Board’s order in *Justin A. Swint*, 70 Van Natta 451 (2018), previously noted 37 NCN 4:10, which had dismissed, as untimely, a hearing request contesting a carrier’s calculation of claimant’s temporary disability (TTD) benefits because the request was filed more than two years after the carrier’s first payment of the TTD benefits based on its alleged miscalculation. In reaching its conclusion, the Board had rejected claimant’s contention that each separate payment of TTD benefits by the carrier involved a new alleged action (or inaction) regarding its alleged miscalculation of the benefits and, as such, his hearing request was not untimely under ORS 656.319(6) for any TTD payment made within two years of the request. On appeal, claimant renewed his argument that the “alleged action or inaction” concerned the carrier’s ongoing claim processing obligation that was breached within the two-year limitation period.

The court determined that the “timeliness” question was bound up, to a significant extent, in the merits of claimant’s allegations that ORS 656.262(4)(b) creates an ongoing or recurring obligation to pay TTD benefits based on “the same wage at the same pay interval that the worker received at the time of injury,” whereas the carrier contended that the statute contemplates only an initial wage calculation, which would constitute *when* the “alleged action or inaction occurs” for purposes of the two-year limitation under ORS 656.319(6) for that type of processing error.

Citing ORS 656.319(6), the court stated that “[a] hearing for failure to process or an allegation that the claim was processed incorrectly shall not be granted unless the request for hearing is filed within two years after the alleged action or inaction occurred.” Relying on *French-Davis v. Grand Central Bowl*, 186 Or App 280, 285 (2003), the court reiterated that “inaction” refers to “what might be called (oxymoronically) affirmative inaction” – “failure to perform a time-specific, discrete duty, request or obligation.”

After analyzing the statute, the court clarified that, in the case of challenges to computations required in the course of claim processing, the timeliness inquiry under ORS 656.319(6) depends on: (1) when the statutes and rules require that computations be made; and (2) what, if any, obligations are imposed to reevaluate those computations.

Timeliness of hearing request is tied to the merits of claimant’s allegation that carrier had an ongoing or recurring obligation under “262(4)(b)” to pay benefits correctly.

Hearing request under “319(6)” must be filed within two years of alleged “action/inaction.”

“262(4)(b)” addresses timing/nature of carrier’s wage calculation obligations under that statute.

Board order did not explain why carrier’s first TTD payment constituted claim processing action under “319(6),” but subsequent TTD payments did not.

Turning to the case at hand, the court stated that the Board had never addressed the question of what ORS 656.262(4)(b) specifically requires with regard to processing and, in particular, the timing and nature of a carrier’s wage calculation obligations under that statute. The court further noted that the Board had failed to account for claimant’s allegation that the carrier had a discrete processing obligation to review and correct any past errors in the wage rate, but had not taken such an action. Finally, the court considered this lack of reasoning in the Board order was especially pronounced because the carrier had relied on its notice of calculation to claimant (before its first TTD payment) as a claim processing action that required claimant’s response and had never argued that its first TTD payment constituted the claim processing action that triggered the two-year statutory period under ORS 656.319(6).

Under such circumstances, the court reasoned that the record supplied no basis for the Board to conclude that the carrier’s first check to claimant involved a processing action or inaction that each subsequent check did not also involve. Because the Board order did not adequately explain why the carrier’s first payment constituted a claim processing action under ORS 656.319(6) but each subsequent payment did not, the court concluded that the Board order failed to articulate the connection between the facts of the case and the result reached. *See Walker v. Providence Health System Oregon*, 254 Or App 676, 686, *rev den*, 353 Or 714 (2013). Consequently, the court reversed and remanded for reconsideration.

Subject Worker: Surrogate for Surrogacy Center - Center Did Not Provide Remuneration or Have Right to Control Surrogate

Lorenzen v. SAIF, 305 Or App 412 (July 8, 2020). The court affirmed without opinion the Board’s order in *Petra Lorenzen*, 70 Van Natta 936 (2018), previously noted 37 NCN 8:8, which held that a gestational carrier for a surrogacy center was not a “subject worker” under ORS 656.005(30) because the center neither provided remuneration for her services nor had the right to control her services.