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**BOARD NEWS**

## ALJ Recruitment Extended to August 31, 2021

The Workers' Compensation Board intends to fill an Administrative Law Judge position in the Salem Hearings Division. The position involves conducting workers' compensation and OSHA contested case hearings, making evidentiary and other procedural rulings, conducting mediations, analyzing complex medical, legal, and factual issues, and issuing written decisions which include findings of fact and conclusions of law.

Applicants must be members in good standing of the Oregon State Bar or the Bar of the highest court of record in any other state or currently admitted to practice before the federal courts in the District of Columbia. The position requires periodic travel, including but not limited to Eugene, Roseburg, and Coos Bay, and working irregular hours. The successful candidate will have a valid driver's license and a satisfactory driving record. Employment will be contingent upon the passing of a fingerprint-based criminal background check. The announcement is posted on the Department of Consumer and Business Services (DCBS) website at <https://www.oregon.gov/dcbs/jobs/Pages/jobs.aspx> and contains additional information about compensation and benefits of the position and how to apply.

Questions regarding the position should be directed to Ms. Kerry Garrett at (503) 934-0104. The close date for receipt of application materials for this recruitment has been extended to August 31, 2021. If you have previously submitted an application, you do not need to reapply in order to continue to be considered for the position. DCBS is an Equal Opportunity, Affirmative Action Employer Committed to Workforce Diversity.

## Annual Adjustment to Maximum Attorney Fee and Hourly Rate for Statement Fee Effective July 1, 2021

The maximum attorney fees awarded under ORS 656.262(11)(a), ORS 656.262(14)(a), and ORS 656.382(2)(d), which are tied to the increase in the state's average weekly wage (SAWW), will rise by 14.059 percent on July 1, 2021. On May 27, 2021, 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 **\$5,471**, absent a showing of extraordinary circumstances. OAR 438-015-0110(3).

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An attorney fee awarded under ORS 656.262(14)(a) shall be **\$418** per hour. OAR 438-015-0033. This rule 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 **\$3,946**, 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, 2021 through June 30, 2022, 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, 2021 and June 30, 2022.

**WCB Managing Attorney - ALJ Robert Pardington**

ALJ Robert Pardington has accepted the position of WCB's Managing Attorney on an interim basis, for a minimum of one year. ALJ Ian Brown will return to the Hearings Division's Portland office in September.

**CASE NOTES**

**Premature Closure: Concurrence with MCO Letter Was Not Supported by the Medical Record - Not a Qualifying Statement of No Permanent Disability**

**Attorney Fee: No Assessed Fee Where Dispute Did Not Encompass Temporary Disability Benefits**

*David L. Kelly*, 73 Van Natta 539 (July 7, 2021). Applying OAR 436-030-0020(1)(a) and (b), the Board held that claimant's injury claim, accepted for patellar tendinitis, was prematurely closed due to insufficient information to close the claim, but declined to award an attorney fee because the premature closure issue did not yet encompass a "dispute concerning temporary disability benefits."

The carrier closed the claim after claimant's attending physician signed a concurrence letter from the Managed Care Organization (MCO) agreeing that claimant was medically stationary without impairment and without work restrictions. Claimant asserted that the carrier had prematurely closed the claim. The Board agreed.

Citing ORS 656.268(1)(a) and OAR 436-030-0020(1)(a), the Board stated that a carrier may close a claim when the worker is medically stationary and there is sufficient information to determine permanent disability. Relying on OAR 436-030-0020(2), the Board noted that sufficient information requires either a qualifying statement of no permanent disability or a qualifying closing report. Additionally, the Board stated that OAR 436-030-0020(2)(a)(B) requires the qualifying statement of no permanent disability to be supported by the medical record; if the record reveals otherwise, a closing examination and report is required.

*Qualifying statement of no permanent disability must be supported by the medical record.*

*Attending physician noted permanent restrictions attributed to chronic tendinitis.*

Turning to the case at hand, the Board observed that there was no qualified closing report and the carrier relied on the attending physician's concurrence as a qualifying statement of no permanent disability. The Board also noted that the MCO had requested that the attending physician "focus the limitation" on claimant's accepted condition and release claimant to full duty work without any restrictions or impairment. The Board further observed that, subsequent to the concurrence, the attending physician had noted permanent restrictions and attributed claimant's pain to "acute on chronic patellar tendinitis."

The Board explained that although claimant's attending physician had concurred with a statement that claimant had no restrictions or impairments related to the accepted condition, the record, including the attending physician's subsequent report, revealed otherwise. Thus, the Board found that the attending physician's concurrence was not supported by the record and was not a "qualifying statement" of no permanent disability for the purposes of OAR 436-030-0020(2). Consequently the Board found insufficient information to close the claim.

*If claimant subsequently obtains temporary disability, counsel can seek an attorney fee.*

Citing *Bledsoe v. City of Lincoln City*, 301 Or App 11 (2019), the Board noted that the premature closure issue did not encompass the issue of entitlement to temporary disability benefits. Therefore, a carrier-paid attorney fee was not warranted. However, the Board reiterated if, following the Board's decision, claimant subsequently obtained temporary disability compensation, claimant's counsel could seek an attorney fee under ORS 656.383(1) if they were instrumental in obtaining such benefits prior to filing a hearing request.

### Settlement: Board Declined to Set Aside Approved Disputed Claim Settlement (DCS) or Remand for Further Development of the Record

*Daniel C. Carroll*, 73 Van Natta 545 (July 9, 2021). Applying ORS 656.283(5), ORS 656.289(4), and ORS 656.295, the Board declined to set aside an approved Disputed Claim Settlement (DCS) agreement or remand the matter to the Hearings Division. The Board reasoned that the record was sufficiently developed and did not establish "extreme" circumstances to warrant such an extraordinary remedy.

*ALJ held a recorded conference call to discuss the settlement and claimant's concerns.*

After claimant, who was unrepresented, requested a hearing, the parties executed a DCS. The ALJ received the DCS (resolving claimant's denied claims) and, on the same day, also received a letter from claimant stating that he felt he was "being taken advantage of" and did not "completely understand all of the terms" of the DCS. The ALJ held a recorded conference call to discuss the DCS and claimant's letter.

Claimant explained that, by agreeing to the DCS, he hoped the ALJ would approve the settlement and "it would be a closed case." Claimant stated that, although he had been pressured from the claim adjuster to return the DCS documents in a timely manner, he signed the DCS voluntarily. Although he did not understand all of the terms of the DCS, claimant explained that the Ombudsman's office was able to answer some of his questions and he

*Setting aside a settlement is an extraordinary remedy to be granted sparingly.*

*Record was sufficiently developed to evaluate the circumstances of the DCS.*

understood the agreement to his satisfaction. He understood that, as a result of his acceptance of the carrier's offer of payment, his case would be dismissed. The ALJ approved the DCS and dismissed the case with prejudice, and claimant subsequently requested review.

Citing *Dorothy J. Carnes*, 57 Van Natta 2003 (2005), the Board observed that setting aside an approved settlement is an extraordinary remedy to be granted sparingly. Relying on *Floyd D. Gatchell*, 48 Van Natta 467 (1993), the Board explained that the grounds for setting aside an approved DCS include mistake, inadvertence, surprise, excusable neglect, fraud, misrepresentation, or other misconduct of an adverse party. Referring to ORS 656.295(5) and *Jack A. Strubel*, 68 Van Natta 408 (2016), the Board stated that, where the record regarding objections to an approved settlement has not been developed, the appropriate remedy is remand to the ALJ for the development of such a record.

Turning to the case at hand, the Board noted that, because claimant requested review of the ALJ's approval order, the recorded prehearing telephonic proceedings (which included the telephonic proceeding pertaining to claimant's understanding and willingness to sign the DCS) were transcribed for the purpose of review. Further observing that claimant did not assert concerns regarding DCS other than those discussed on the record, the Board concluded that remand was not necessary because the record was sufficiently developed to evaluate the circumstances surrounding the parties' DCS agreement.

The Board acknowledged that claimant had several significant health issues and may have felt pressure from the claim adjuster to timely return the DCS documents. However, the Board noted that settlement negotiations normally include offers and counteroffers (often under stressful circumstances and impending deadlines) and that claimant discussed his health concerns with the ALJ and decided to accept the settlement. Thus, the Board did not find extraordinary or extreme circumstances to warrant setting aside the previously-approved DCS.

### Survivor's Benefits: Decedent and Claimant Had Not Cohabited in Oregon for More Than One Year - Claimant was Legally Married to Another at Time of Work Accident - Not "Unmarried" for Purposes of the Statute

*Antonio A. Mendoza*, DCD, 73 Van Natta 578 (July 21, 2021). Applying ORS 656.226, the Board held that claimant, the surviving cohabitant of the deceased worker, was not entitled to survivor benefits because she and the decedent had not cohabited in Oregon for more than one year and she was not "unmarried." Claimant, the decedent, and their two children had lived together in California for many years, and she had visited the decedent several times when he traveled to work in Oregon. During a brief separation from claimant

*Claimant and their children lived with the decedent in California for many years.*

in 2015, claimant married another man and that marriage remained legally valid through the date of the hearing. Claimant contended that she met the requirements for survivor benefits under ORS 656.226. Alternatively, she contended that the statute's cohabitation requirement was unconstitutional.

The Board disagreed that claimant met the statutory requirements for survivor benefits. Citing ORS 656.226, the Board noted that survivor benefits are awardable if two "unmarried individuals" cohabited in Oregon as spouses for over one year prior to the work accident and children are living as a result of that relation. Citing *Ruben Benito-Morales, DCD*, 69 Van Natta 251 (2017), the Board reiterated that, under ORS 656.226, a surviving cohabitant and the decedent must have cohabited in Oregon for more than a year prior to the date of injury. Further, relying on *Mell v. W.C. Ranch, Inc.*, 108 Or App 105, *rev den*, 312 Or 234 (1991), the Board concluded that ORS 656.226 applies only where neither party is legally married in the year preceding the work accident.

Turning to the case at hand, the Board concluded that because claimant and the decedent had not cohabited in Oregon for more than a year, she had not met the statute's cohabitation requirement despite any brief cohabitation when claimant visited the decedent at his job sites in Oregon. Additionally, the Board reasoned that claimant was not "unmarried" because she was legally married in the year preceding and at the time of the work accident. Under such circumstances, the Board determined that claimant was not entitled to survivor benefits under ORS 656.226. Because claimant's marital status disqualified her from meeting the requirements of ORS 656.226, the Board declined to address claimant's contention that the statute's cohabitation requirement is unconstitutional.

Member Ousey joined the majority but concurred to express his concern that ORS 656.226 produces arbitrary and harsh results inconsistent with the underlying purpose of the statute. Specifically, he expressed concern with the requirement that a surviving cohabitant and the decedent cohabit in a particular state, noting that he saw no sound policy basis for such a requirement. He encouraged the Management Labor Advisory Committee and the legislature to consider amending the statute to better serve the policy objective underlying the statute (*i.e.*, to protect the family unit from financial hardship on the death of an Oregon subject worker).

*Because claimant's marital status disqualified her from benefits under the statute, the Board declined to address contention that the cohabitation requirement is unconstitutional.*

## Worker Requested Medical Exam: Denial Issued Prior to IME Was Not “Based On” an IME Report - Worker Not Entitled to WRME

### Evidence: No Abuse of Discretion in Admitting IME Report

*Thomas S. Cardoza*, 73 Van Natta 561 (July 16, 2021). Analyzing ORS 656.325(1)(e) and OAR 436-060-0147(1), the Board held that claimant was not entitled to a worker-requested medical examination (WRME) because, at the time of his WRME request before the Workers’ Compensation Division (WCD), the carrier’s claim denial was not based on an independent medical examination (IME) report.

The carrier denied the claim on compensability grounds before an IME had occurred. Claimant requested a hearing, While the hearing was pending, the carrier obtained an IME and submitted it as a hearing exhibit, but did not amend its denial. Claimant’s attending physician did not concur with the IME report. Claimant requested a WRME, which the WCD denied because the carrier’s denial was not based on an IME.

The Board upheld the WCD’s determination. Citing OAR 436-060-0140(8)(b) and *Julie A. Dellinger*, 72 Van Natta 35 (2020), the Board noted that a claimant’s WRME entitlement depends on whether a denial “is based on one or more independent medical examination reports” at the time of the WRME request.

Turning to the case at hand, the Board reasoned that, because no IME had occurred at the time of the carrier’s denial, the denial was not “based on” an IME at the time of claimant’s WRME request. Therefore, citing *Dellinger*, the Board concluded that the claimant had not established his entitlement to a WRME. The Board also found that the ALJ did not abuse his discretion by admitting the IME into evidence. Further, the Board found no error in the ALJ’s decision not to require the carrier to amend its denial.

Based on *stare decisis*, Member Ousey concurred with the lead opinion’s application of *Dellinger* to the particular facts of the case. He commented that, if not for the holding of *Dellinger*, he would give broader meaning to the concept of whether a denial is “based on” an IME. Noting that the WRME is an important tool to address the financial disparity between injured workers and carriers by providing access to a medical expert that can author a thorough medical report in response to an IME, Member Ousey proposed that the legislature consider revisions to ORS 656.325(1)(e) and OAR 436-060-0147(1) to expand access to WRMEs to include post-denial IMEs.

*While hearing was pending, carrier obtained an IME and attending physician did not concur.*

*Board found no error in the ALJ’s decision not to require carrier to amend its denial.*

*Member Ousey concurred, proposed revisions to statute and rule to expand WRME access.*

## APPELLATE DECISIONS UPDATE

### Course & Scope: “MVA” While “Off Duty,” but Performing “Employer Errand” - Within Reasonable Bounds of Employment

*SAIF v. Sumner*, 313 Or App 434 (July 21, 2021). The court affirmed the Board’s order in *Cassandra Sumner*, 71 Van Natta 624 (2019), previously noted 38 NCN 6:4, that held that claimant’s injury arose out of and in the course of employment. Claimant’s motor vehicle accident (MVA) had occurred on her day off while she was driving her car to meet her supervisor to give him cash to pay for pizza for the employer’s holiday party. On appeal, the carrier contended that the Board had erred in overturning its denial because claimant was on a personal errand and not working at a place where she was expected to be when the MVA occurred.

The court disagreed with the carrier’s contention. Citing *Robinson v. Nabisco, Inc.*, 331 Or 178 (2000), the court stated that whether an injury occurs “in the course of” employment depends on whether the time, place, and circumstances of the injury justify connecting the injury to the employment. Referring to *Fred Meyer, Inc. v. Hayes*, 325 Or 592 (1997), the court reiterated that an injury takes place in the course of employment if it occurs while the worker is reasonably fulfilling the duties of the employment or is doing something reasonably incidental to it. Finally, the court observed that the fact that an employee’s task had not been requested (or may even have been prohibited) did not necessarily take it outside the course of employment if it was the type of activity that could be understood to be connected to the employment.

Turning to the case at hand, the court acknowledged that claimant’s supervisor had not asked her to bring him cash (and likely would not have authorized her to use her own money) at the time of the MVA. Nevertheless, noting that claimant had earlier responded to the supervisor’s request to come to the office to wrap holiday gifts, the court concluded that the record supported the Board’s finding that she was on a work-related errand.

The court also noted that an injury arises out of employment if it originates from a risk to which the work exposed the claimant. See *Legacy Health Systems v. Noble*, 250 Or App 596, 600-01 (2012). Recognizing the carrier’s assertion that claimant had not yet altered her route to drive to meet her supervisor when the MVA occurred, the court concluded that substantial evidence and reasoning supported the Board’s finding that she had interrupted her personal errand for her employer’s errand and was within the reasonable bounds of her employment as a project manager. Thus, the court concluded that the risk of injury during that task was a risk of her employment.

*MVA occurred while driving to meet supervisor to provide cash for employer’s holiday party.*

*Claimant had responded to supervisor’s request to wrap gifts at the office on the same day.*

## Survivor Benefits: “Cohabitant’s” Entitlement to “Survivor” Benefits - Must Have “Children Living as a Result of Relationship”

*Williams v. SAIF*, 313 Or App 739 (July 28, 2021). The court affirmed without opinion the Board’s order in *Herbert Williams, DCD*, 72 Van Natta 517 (2020), previously noted 39 NCN 6:6, which, in applying ORS 656.226, held that, although the deceased worker had lived with his surviving cohabitant for eight years before his death and he had acted as a father to her three children, she was not entitled to survivor benefits because a child had not been born of her relationship with the decedent, as required by the statute.

## APPELLATE DECISIONS COURT OF APPEALS

## Appeal/Review: “Substantial Evidence/Reasoning” - Board Accepted ALJ’s “Demeanor-Based” Finding Concerning Claimant’s Testimony, but Relied on Physician’s Opinion That Claimed Condition Predated Work Injury

*Deyo-Bundy v. SAIF*, 313 Or App 393 (July 14, 2021). Reviewing for “substantial reasoning” under ORS 183.482(8)(c), the court affirmed, *per curiam*, the Board’s order in *Brittany Deyo-Bundy*, 72 Van Natta 427 (2020), that upheld a carrier’s denial of claimant’s new/omitted medical condition claim for an opioid use disorder. In reaching its decision, the Board had reasoned that, despite an ALJ’s “demeanor-based” finding that claimant’s testimony (which stated that she did not have an opioid use disorder before her work injury) was credible, an examining physician had persuasively opined that the claimed opioid use disorder predated claimant’s compensable injury/treatment. On appeal, claimant contended that, based on the Board’s acceptance of the ALJ’s “demeanor-based” credibility finding and her testimony that she did not have the opioid use disorder before her work injury, the Board’s reliance on the physician’s opinion to the contrary was not supported by substantial reason.

The court disagreed with claimant’s contention. Citing ORS 183.482(8)(c), and *Walker v. Providence Health System Oregon*, 254 Or App 676, *rev den*, 353 Or 714 (2013), the court stated that whether a Board order is supported by substantial reason depends on whether the order articulates the reasoning that leads from the facts found to the conclusions drawn. Furthermore, relying on *McCoy and McCoy*, 28 Or App 919, 924, *clarified by* 29 Or App 287 (1977), the court reiterated that it had long recognized that demeanor-based credibility findings often will not be a basis for resolving an issue that turns on expert opinion.

*Court reiterated that demeanor-based credibility findings are often not a basis for resolving an issue that turns on expert opinion.*

Turning to the case at hand, the court concluded that the Board's finding was supported by substantial evidence and reasoning because the Board had considered the physician's opinion in the context of the record as a whole. Consequently, the court could not say that it had not been unreasonable for the Board to rely on the physician's opinion.

### Combined Condition: Physician Did Not Explain How Claimed "Disc Protrusion" Combined with Preexisting Arthritis or Which Condition Played Greater Role - Denial Set Aside

*Pedro v. SAIF*, 313 Or App 34 (July 8, 2021). Analyzing ORS 656.005(7)(a)(B) and ORS 656.266(2)(a), the court reversed the Board's order in *Maria I. Pedro*, 71 Van Natta 335 (2019), that, in upholding compensability denial, found that the carrier had established that her claimed condition had combined with a preexisting arthritis and the arthritis was the major contributing cause of her disability/need for treatment for the combined condition.

The court held that the Board's finding that the claimed L4-5 disc protrusion was part of a "combined condition," along with preexisting arthritis, lacked substantial evidence. Citing *Brown v. SAIF*, 361 Or 241 (2017), the court stated that the "injury" component of the phrase "otherwise compensable injury" in ORS 656.005(7)(a)(B) refers to a medical condition, not an accident. Furthermore, relying on *Carillo v. SAIF*, 310 Or App 8 (2021), the court reiterated that the term "combined condition" suggests two separate conditions that combine. Finally, referring to *Hammond v. Liberty Northwest Ins. Corp.*, 296 Or App 241 (2019), the court identified a narrow proposition that an initial claim can itself be a combined condition when a work accident, together with a preexisting condition, causes a separate injury.

Turning to the case at hand, the court reasoned that the present case involved an omitted medical condition claim for an L4-5 disc protrusion that was undisputedly caused in material part by claimant's work injury. The court clarified that the carrier was required to introduce evidence showing: (1) how claimant's L4-5 disc protrusion combined with his preexisting arthritis to result in a disability/need for treatment; and (2) that the L4-5 disc protrusion was not the major cause of claimant's disability/need for treatment resulting from that combined condition.

The court noted that the physician's opinion on which the Board had relied had not analyzed how the L4-5 disc protrusion interacted with her preexisting arthritis to result in a combined condition. The court concluded that the Board's determination that claimant's L4-5 disc protrusion was part of a "combined condition" with the preexisting arthritis was not supported by substantial evidence. Consequently, the court reversed and remanded.

## “Firefighter’s Presumption”: “Cardiovascular Disease” - Physical Impairment of Blood Vessels/Gradual in Onset

*Claimant asserted “firefighter’s presumption” applied because stroke condition was “cardiovascular” in nature.*

*Kalenius v. City of Corvallis*, 313 Or App 447 (July 21, 2021). Analyzing ORS 656.802(4), the court affirmed the Board’s order in *William G. Kalenius*, 71 Van Natta 1465 (2019), that, in upholding a carrier’s denial of claimant’s stroke claim, held that claimant was not entitled to rely on the “firefighter’s presumption” because the medical record did not establish that his stroke was a “cardiovascular-renal disease” as required by the statute. On appeal, claimant contended that his stroke was a cardiovascular disease because it was a “physical impairment of the blood vessels” that was gradual in onset. Asserting that the pathology of his stroke (a blood clot travelling through his vascular system from his lower extremities to his brain, where it impaired the function of blood vessels by blocking the passage of blood to his brain) was fundamentally inconsistent with a conclusion that the stroke was “sudden” or did not constitute cardiovascular disease, claimant argued that the Board’s reliance on the opinions of physicians who reached such conclusions lacked substantial reasoning.

The court disagreed with claimant’s assertion. The court stated that “cardiovascular-renal disease,” to which (among other conditions) the “firefighter’s presumption” applies, is defined as “a physical impairment of the heart or blood vessels, gradual in onset, that interrupts or modifies the performance of the body’s vital functions.” Relying on *City of Eugene v. McCann*, 248 Or App 527 (2012), the court clarified that a “disease” must cause an impairment of the physical structure of the blood vessels and must be gradual in onset.

*Court determined that substantial medical evidence did not establish the cause of the stroke was cardiovascular disease with gradual onset. Therefore, “802(4)” was not applicable.*

Turning to the case at hand, the court reasoned that, contrary to claimant’s contention, the theorized mechanism or pathology of claimant’s stroke (*i.e.*, a blood clot that travelled to claimant’s brain from his lower body) did not establish that the source of the clot itself was cardiovascular disease that was gradual in onset. The court noted that the medical experts did not know where, when, or why claimant’s clot had formed. Finally, the court determined that the only evidence connecting claimant’s clot or the stroke to cardiovascular disease was a physician’s opinion that the Board had rejected as conclusory. Consequently, reasoning that substantial evidence supported the Board’s finding that claimant did not have cardiovascular disease, the court held that the Board had correctly found that the “firefighter’s presumption” was not applicable.

## APPELLATE DECISIONS SUPREME COURT

### Claim Processing: “New/Omitted Medical Condition” Denial (Based on “Compensability”) Set Aside - Carrier Must “Reopen/Process” Claim (Even Though Denial Set Aside on “Encompassed” Basis)

*Simi v. LTI Inc. – Lynden Inc.*, 368 Or 330 (July 1, 2021). Analyzing ORS 656.262(7)(c), the Supreme Court reversed the Court of Appeals decision, 301 Or App 535 (2019), that had affirmed the Board’s order in *Randy G. Simi*, 70 Van

*Supreme Court reversed Board and Court of Appeal's orders that carrier was not required to reopen claim for condition found to be previously "encompassed."*

*Claimed conditions "found compensable after claim closure"; necessitated reopening.*

Natta 929 (2018), previously noted 37 NCN 8:3, which held that a carrier was not required to reopen a closed rotator cuff tear claim after its denial of claimant's new/omitted medical condition claim for supraspinatus and infraspinatus tears was set aside by an earlier litigation order because the claimed conditions were "encompassed" with the originally accepted rotator cuff tear.

The Supreme Court noted that the carrier's denial (which had expressly disputed the compensability of the claimed conditions) had previously been set aside by an earlier litigation order based on the carrier's concession that the claimed new/omitted medical conditions were encompassed within the previously accepted rotator cuff tear condition. Consequently, the Supreme Court determined that the claimed conditions had been "found compensable after claim closure."

Relying on *Arvidson v. Liberty Northwest Ins. Corp.*, 366 Or 693, 699 (2020), the Supreme Court reasoned that the legislature intended the verb "finds" to convey its ordinary meaning, encompassing a reviewing body's conclusion or determination. The Supreme Court also found nothing about the text or context of ORS 656.262(7)(c) suggesting that the legislature intended a different meaning for the verb "found" when requiring that a condition must be "found compensable after claim closure."

Moreover, after analyzing ORS 656.262(7)(c) in a broader statutory context, the Supreme Court identified a legislative intent to create a "procedural trade-off"; *i.e.*, rather than delay claim closure until the full scope of the compensable conditions had been resolved, claims will simply be reopened if a denied condition is later found compensable. In light of that procedural choice, the Court considered it most plausible that the legislature intended for claim reopening to be triggered by the event of a condition being "found compensable."

Accordingly, the Supreme Court determined that, because the claimed conditions had been found compensable after claim closure, the carrier must reopen the claim for further processing. However, because its decision did not resolve the question of whether the carrier should be assessed a penalty under ORS 656.262(11)(a) for unreasonable claim processing, the Court left resolution of that dispute for the Board on remand.