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BOARD NEWS

Rulemaking Hearing: September 30, 2016 - Proposed Rule Amendments Regarding Division 015 (“Attorney Fee”) Rules

At their August 2 meeting, the Members proposed amendments to the Board’s Division 015 (Attorney Fee”) rules. The Members took these actions after considering a report from their Advisory Committee. The committee had been appointed to consider attorney fee concepts, as well as to advise the Board as it conducted its biennial review of attorney fee schedules under ORS 656.388(4). The Members wish to extend their grateful appreciation to the Advisory Committee (Martin L. Alvey, Matthew M. Fisher, Jennifer Flood, Philip H. Garrow, Julie Masters, Graham Trainor, Sheri Sundstrom, and ALJ J. Mark Mills (facilitator)).

Notice of this rulemaking action has been filed with the Secretary of State’s office. Electronic copies of these rulemaking materials is available on WCB’s website at www.wcb.oregon.gov (under the category “Laws and rules”). Copies have also been distributed to parties and practitioners on WCB’s mailing list.

A rulemaking hearing for these proposed rule amendments has been scheduled for September 30, 2016, at 10 a.m. at the Board’s Salem office (2601 25th St. SE, Ste. 150, Salem, OR 97302-1280). Any written comments submitted in advance of the hearing may be directed to Debra Young, the rulemaking hearing officer. Those comments may be mailed to the above address, faxed to 503-373-1684, e-mailed to rulecomments.wcb@oregon.gov or hand-delivered to a permanently staffed Board office (Salem, Portland, Eugene, Medford).

CASE NOTES

Attorney Fee: “015-0010(4)” - No Statutory Requirement to Find a Requested Fee “Unreasonable”

Randell R. Ledbetter, 68 Van Natta 1316 (August 12, 2016). Applying ORS 656.386(1) and OAR 438-015-0010(4), the Board held that in determining a reasonable attorney fee award it was not obligated to first find a claimant’s counsel’s requested fee to be “unreasonable.” On review, claimant’s counsel sought the fee previously requested at the hearing before the ALJ, arguing that

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the ORS 656.386(1)(a) mandate (*i.e.*, the ALJ "shall" allow a reasonable attorney fee) requires that the requested fee be approved, absent a finding that the request is unreasonable.

The Board disagreed with claimant's contention. Citing *Schoch v. Leupold & Stevens*, 325 Or 112, 117-18 (1977), the Board stated that it (as well an ALJ) is authorized to determine a reasonable attorney fee award by applying the factors prescribed in OAR 438-015-0010(4) to the particular circumstances of a case. Consistent with the statutory directive of ORS 656.386(1) to "allow" a reasonable attorney fee, the Board noted that it has adopted OAR 438-015-0035 and OAR 438-015-0055(4), which authorize the Board (and an ALJ) to award a reasonable carrier-paid attorney fee in accordance with ORS 656.386(1), based on the factors prescribed in OAR 438-015-0010(4).

Turning to the case at hand, the Board observed that claimant's counsel's fee request at the hearing level had not provided information or argument applying the "rule-based" factors to the hearing record. Based on the limited information available on review to determine a reasonable attorney fee, the Board affirmed the ALJ's award.

Fee request did not provide information or arguments applying rule factors.

Member Weddell specially concurred. Although agreeing with the majority's conclusion that the ALJ's attorney fee award was reasonable, Member Weddell disagreed with its application of the *Schoch* holding. Based on the statutory mandate of ORS 656.386(1), Member Weddell reasoned that, where a claimant's counsel submits a specific fee request, the Board must first determine whether the request is reasonable and, if it is, "shall allow" the requested fee. Consequently, Member Weddell concluded that the Board should proceed to a determination of a reasonable attorney fee based on consideration of the OAR 438-015-0010(4) factors only after determining that a requested fee is not reasonable.

In the present case, Member Weddell observed that claimant's counsel's fee request was made in closing arguments and did not include a detailed discussion of the OAR 438-015-0010(4) factors or an estimate of time devoted to the case. Based on the record available on review, Member Weddell concluded that the requested fee at the hearing level was not a reasonable assessed fee for services rendered at that level. Therefore, agreeing with the majority's application of the "rule-based" factors, Member Weddell concurred with their affirmance of the ALJ's attorney fee award.

Claim Preclusion: Specific "CTS" Denial Did Not Preclude Subsequent Tendinitis Claim - Even When Carrier Aware of Tendinitis Diagnosis When "CTS" Denial Issued

Dan M. Morgan, 68 Van Natta 1196 (August 3, 2016). The Board held that a carrier's prior untimely appealed denial (which specifically denied a bilateral carpal tunnel syndrome (CTS) condition) did not preclude claimant's

subsequent claim for a bilateral wrist tendinitis condition. Asserting that its earlier untimely appealed denial was a "complete claim" denial, the carrier contended that claimant's subsequent bilateral wrist tendinitis claim was precluded. Citing *SAIF v. Allen*, 193 Or App 742, 749 (2004), the carrier argued that, where a carrier is aware of certain conditions at the time of its denial, the denial is properly construed as including all symptoms and conditions that had arisen or would arise from the work exposure.

The Board held that claimant's current bilateral wrist tendinitis claim was not precluded by the earlier untimely appealed denial of his bilateral CTS claim. Citing *Tattoo v. Barrett Bus. Serv.,* 118 Or App 348, 351-52 (1993), the Board stated that a carrier is bound by the express language of its denial. Relying on *Longview v. Snyder*, 182 Or App 530, 536 (2002), the Board noted that a limited and specific denial does not encompass all possible conditions. Finally, referring to *Allen*, the Board observed that, when a carrier was aware of medical evidence describing the claimed condition as a combined condition, the carrier's claim denial encompassed a "combined condition."

Limited and specific denial did not encompass all conditions.

Turning to the case at hand, the Board acknowledged that the carrier was aware of both the CTS and tendinitis conditions when it issued its denial. Nonetheless, in contrast to *Allen*, the Board noted that the present case did not concern the existence of a "combined condition" when the carrier had issued its denial. Likewise, the Board reasoned that the *Snyder* decision had analyzed the scope of a "combined condition" denial and determined that the denial did not extend to an unclaimed condition which the carrier was unaware of when it issued its denial.

Under such circumstances, the Board did not consider the *Snyder* and *Allen* rationales to be dispositive. In particular, the Board did not interpret the *Snyder* holding (which pertained to the scope of a combined condition denial to a new diagnosis that arose after the denial) to extend to an initial claim denial of a specific condition when the carrier was aware of additional diagnosed conditions when it issued its denial.

Instead, the Board framed the issue as determining the scope of the carrier's denial of a specific condition following an initial claim for multiple conditions. Relying on *Tattoo*, the Board reiterated that the carrier was bound by the express language of its denial. Because the carrier had specifically denied bilateral CTS, the Board determined that the denial did not encompass his bilateral wrist tendinitis condition. Consequently, the Board held that claimant's occupational disease claim for his bilateral wrist tendinitis condition was not precluded.

Specific denial of CTS did not extend to tendinitis claim.

In reaching its conclusion, the Board noted that a more general denial of claimant's initial bilateral hand and wrist condition might have been interpreted as encompassing both the CTS and tendinitis conditions such that an untimely appeal of that denial might have had a preclusive effect on a subsequent tendinitis claim. Nevertheless, because the carrier's denial was expressly limited to a CTS condition, the Board reasoned that the denial did not extend to the tendinitis condition.

A more general denial might have had preclusive effect on subsequent claim.

Costs: "386(2)(d)" - "Extraordinary Circumstances" - Specialist's Fee for Report that Persuasively Responded to IME's Report

Kevin J. Siegrist, 68 Van Natta 1283 (August 11, 2016). [Editor's note: Board decision was abated on August 31, 2016.] Applying ORS 656.386(2)(d), the Board required a carrier to reimburse claimant's litigation costs exceeding the $1,500 statutory threshold because his costs to obtain an additional physician's opinion (which was decisive in prevailing over the carrier's denial) constituted "extraordinary circumstances." Following an ALJ's order overturning the carrier's denial and awarding litigation costs, claimant's counsel submitted a cost bill that exceeded the $1,500 statutory threshold (because of an additional physician's opinion, which was found to have persuasively rebutted a carrier-generated physician's opinion). Asserting that there were no "extraordinary circumstances," the carrier declined to provide reimbursement beyond the $1,500 threshold.

"Extraordinary circumstances" beyond "usual, regular, common, customary."

The Board disagreed with the carrier's contention. Citing ORS 656.386(2)(d), the Board stated that reimbursement for a claimant's expenses and costs for records, expert opinions, and witness fees was limited to $1,500, unless the claimant demonstrated extraordinary circumstances justifying payment of a greater amount. Referring to *Ken L. Circle*, 67 Van Natta 61, 62 (2015), and *Webster's Third New Int'l Dictionary* 807 (unabridged ed 1993), the Board noted that "extraordinary circumstances" are evaluated by examining whether the circumstances went beyond what were "usual, regular, common, or customary."

Claimant required to procure additional report of specialist.

Turning to the case at hand, the Board recognized that costs associated with presenting claimants' cases vary. Nonetheless, considering that claimant had been required to procure the additional report of the consulting specialist to overcome the countervailing evidence regarding the denied claim, the Board concluded that such circumstances were not usual, regular, common, or customary. Accordingly, the Board found that the reimbursement of the cost bill exceeding $1,500 was justified by "extraordinary circumstances."

Course & Scope: Leg Injury While Walking "Arose Out of" Traveling Employment

Preexisting Condition: "005(24)" - Lung Cancer (Which Spread to Femur) Was a "Preexisting Condition" - Previously Diagnosed and Treated - "Active Cause," Not Mere "Susceptibility"

Thomas J. Hammond, Dcd, 68 Van Natta 1243 (August 5, 2016). Applying ORS 656.005(24)(a) and ORS 656.005(7)(a)(B), the Board held that a worker's leg injury, which occurred when he was walking while on a "work-related" travel assignment, arose out of his employment, but because his work-related leg injury had combined with a preexisting lung cancer condition (which had spread to his leg), the "otherwise compensable injury" was not the major contributing cause of the disability or need for treatment for the combined leg condition. The worker, who had been treating for lung cancer, was walking in his hotel during work-related travel when his leg fractured. After returning from his travel, claimant underwent and expired from sepsis. After the carrier denied the worker's injury claim and the beneficiaries' death claim, claimant requested a hearing. In response, the carrier asserted that the leg fracture did not "arise out of" employment because it resulted from an idiopathic risk or, alternatively, that there was a combined condition and the major contributing cause of the disability and need for treatment was the preexisting lung cancer (which had metastasized to the worker's leg).

The Board concluded that the worker's leg fracture "arose out of" employment, but determined the leg fracture was a "combined condition" and the otherwise compensable injury was not the major contributing cause of the disability or need for treatment. Citing *SAIF v. Scardi*, 218 Or App 403, 408 (2008), the Board stated that, because the worker was a traveling employee, an injury resulting from the nature of the travel, or originating from some other risk to which the travel exposed the worker, would be compensable. Referring to ORS 656.005(24)(a)(A) and (c), *Hopkins v. SAIF*, 349 Or 348, 352 (2010), and *Corkum v. Bi-Mart Corp.*, 271 Or App 411, 422-23 (2015), the Board noted that a legally cognizable "preexisting condition" must have been previously diagnosed or treated, or be an arthritic condition, and must actively contribute to damaging the body part, and not be a mere "susceptibility (*i.e.*, a condition that increases the likelihood that an affected body part will be injured by some other action or process).

Walking was a travel-related risk.

Turning to the case at hand, the Board reasoned that the weight bearing involved in walking was a travel-related risk. Furthermore, the Board found that the physicians' opinions persuasively established that such weight

bearing materially contributed to the worker's leg fracture and the related disability and need for treatment. Accordingly, the Board concluded that the worker had suffered an injury "arising out of" employment.

However, after reviewing the physicians' opinions, the Board was persuaded that the worker's preexisting lung cancer (for which he had previously received medical treatment) had metastasized to the worker's femur. Under such circumstances, the Board reasoned that the cancer in the worker's femur was part of the previously-diagnosed and treated lung cancer condition. Furthermore, the Board was persuaded by the physicians' opinions that the cancer had invaded the leg bone and destroyed the bone structure. Reasoning that the cancer had actively damaged the worker's leg and was, therefore, a "cause" of the fracture, the Board concluded that the cancer in the leg was a legally cognizable "preexisting condition." *See Corkum*, 271 Or App at 422-23.

Lung cancer actively damaged leg, thus, was a "cause" of the fracture.

Accordingly, the Board concluded that the worker's leg fracture was a "combined condition." Further determining that the cancer was the major contributing cause of the fracture and related disability and need for treatment, the Board held that the worker's leg injury claim was not compensable. *See* ORS 656.266(2)(a).

In reaching its conclusion, the Board disagreed with the beneficiaries' contention that the compensability analysis was not governed by the "major contributing cause" standard for "combined conditions" under ORS 656.005(7)(a)(B) because the worker's injury had resulted in his death. Although acknowledging that the statute did not mention a worker's death, the Board emphasized that the statute expressly applies the "major contributing cause" standard if an otherwise compensable injury combines with a preexisting condition "to cause or prolong disability or a need for treatment." Reasoning that the record established that the worker's cancer had combined with his otherwise compensable injury to cause his disability and need for treatment of his leg fracture (before his subsequent death), the Board concluded that the "major contributing cause" analysis of ORS 656.005(7)(a)(B) applied to the disputed injury claim. Furthermore, because the leg injury claim was not compensable, the Board considered it unnecessary to resolve the question of what causal relationship is required between a compensable injury and a subsequent death to support benefits under ORS 656.204.

Because "005(7)(a)(B)" applied to worker's "leg" claim (before death) which was not compensable, unnecessary to address "compensability" standard for "death benefits" based on "leg" claim.

Evidence: "006-0091(2)" - ALJ's "Continuance/Cross-Examination" Ruling - Claimant's "Sponsorship" of "Withdrawn" Report at Hearing - No Abuse of Discretion in ALJ's Denial of Motion for Continuance

Patrick Shippy, 68 Van Natta 1342 (August 17, 2016). Applying OAR 438-006-0091(2), the Board found no abuse of discretion in an ALJ's ruling that denied a carrier's motion for a continuance of a hearing for cross-examination of a physician who had authored an employer-generated report, but which had

been withdrawn by the employer shortly before the hearing and subsequently offered by claimant. Prior to hearing, the carrier had submitted copies of the record to the ALJ, including the physician's report and claimant's counsel's letter initiating the new/omitted medical condition claim (which referred to the physician's report as support for the compensability of the claimed condition). A week before the scheduled hearing, the carrier announced that it was not sponsoring the aforementioned report and requested cross-examination/submittal of rebuttal evidence if claimant intended to reply on the report.

At the hearing, claimant offered the report for admission into the record, but argued that the carrier did not have an "automatic" right to cross-examination and there was no "due diligence" to justify a continuance. Reasoning that the carrier had retained the physician, submitted his report for admission into the record, and made no showing of the physician's unavailability or other evidence of due diligence to justify a continuance, the ALJ denied the carrier's motion for a continuance for the requested cross-examination.

After the ALJ set aside its denial, the carrier requested Board review. Referring to the "7-day rule" (OAR 438-006-0081(2)), the carrier contended that it exercised due diligence by immediately requesting cross-examination upon claimant's submission of the physician's report for admission into the evidentiary record. Citing *Fister v. South Hills Health Care*, 149 Or App 214 (1997) and *Stevenson v. Blue Cross*, 108 Or App 247 (1991), the Board did not address the carrier's reliance on the "7-day rule" because the application of that rule had not been raised at the hearing or employed by the ALJ's evidentiary ruling.

"7-day rule" not raised at hearing.

Turning to the ALJ's ruling, the Board found no abuse of discretion. *See SAIF v. Kurcin*, 334 Or 399 (2002); *Brown v. SAIF*, 51 Or App 389, 394 (1981). The Board found that, during the 16 weeks between the carrier's receipt of the report in question and the hearing, the carrier had not made any attempt to clarify or supplement the physician's opinion. Under such circumstances, the Board found no abuse of discretion in the ALJ's ruling that a continuance of the hearing for the purpose of cross-examination was not justified because the carrier had not met the "due diligence" requirement of OAR 438-006-0091(2).

Because carrier had not attempted to clarify report for 16 weeks, ALJ's "no due diligence" finding within discretion.

In reaching its decision, the Board distinguished *Carmen Francisco*, 68 Van Natta 897 (2016), where the majority of the review panel in that case had found no abuse of discretion in an ALJ's ruling that allowed a continuance under similar circumstances. In distinguishing *Francisco*, the Board reasoned that its review (for an abuse of discretion) was limited to whether the particular record in the present case supported the ALJ's ruling regarding a continuance/cross-examination.

Member Curey specially concurred. Reasoning that the "7-day rule" applies to situations where "the requesting party received [a copy of the report] from another party," Curey observed that, in contrast to such a situation, the carrier in the present case had requested an independent medical examination, obtained the physician's report, and provided it to claimant as part of the exhibit packet it was required to file under OAR 438-007-0018(1). Member Curey concluded that the carrier's request for cross-examination of a report it generated and disclosed prior to the scheduled hearing, following its subsequent "withdrawal" of the report and claimant's "sponsorship" of the report for submission into the hearing record, did not satisfy the criteria for "due diligence"

Concurrence did not consider "7-day rule" to apply to situation where carrier generates/discloses physician's report in advance of hearing, then withdraws sponsorship, and seeks cross-examination when claimant offers report.

under the "7-day rule." Member Curey further commented that the "sponsorship" rule (OAR 438-007-0018(4)) simply provides that a carrier must file all relevant and material documents and does not mean that a party is automatically entitled to cross-examine the authors of any of those documents. Finally, noting that her analysis of the "7-day" and "sponsorship" rules did not, in general, preclude a party from seeking/obtaining a hearing continuance for purposes of cross-examining an admitted report's author, Member Curey reasoned that the party requesting a continuance for cross-examination must satisfy the "due diligence" requirement of OAR 438-006-0091(2), without reliance on the "7-day rule" or the "sponsorship" rule.

Extent: Impairment Findings - "Permanent" Despite Claimant's Decision to Forego Surgery

Juan A. Arenas-Raya, 68 Van Natta 1203 (August 3, 2016). The Board held that claimant was entitled to a permanent impairment award for his back condition, despite an arbiter's opinion that surgery would have resolved his impairment. Prior to claim closure, claimant decided to forego surgery based on his attending physician's opinion that surgery would not have significantly benefited his low back pain. After a Notice of Closure awarded permanent impairment, the carrier requested reconsideration and an arbiter's examination. When the arbiter reported that surgery would have resolved claimant's permanent impairment, an Order on Reconsideration reversed the Notice of Closure permanent impairment award. Claimant requested reconsideration, seeking a permanent impairment award. In response, the carrier asserted that no permanent impairment should be awarded because the impairment was not permanent and because the impairment resulted from claimant's unreasonable refusal to submit to recommended treatment.

The Board disagreed with the carrier's contentions. Citing *Hicks v. SAIF*, 194 Or App 655, *adh'd to as modified on recons*, 196 Or App 146 (2004), and *Khrul v. Foremans Cleaners*, 194 Or App 125 (2004), the Board stated that, if impairment is not permanent, it will not support an impairment award. Again, relying on *Hicks* and *Khrul*, the Board noted that an arbiter's opinion must be interpreted if the opinion is ambiguous as to whether impairment is permanent.

No dispute that claimant was medically stationary.

Turning to the case at hand, the Board found no dispute that claimant's condition was medically stationary. After analyzing the opinions of the arbiter and attending physician, the Board reasoned that the opinions supported the permanence of claimant's impairment in the absence of the surgery. *See Ray L. Straws*, 61 Van Natta 2314 (2009) and *Todd M. Resseguie*, 56 Van Natta 3489 (2004). Noting that claimant had chosen not to undergo the surgery, the Board determined that the impairment findings were deemed permanent.

Referring to ORS 656.325, *Nelson v. EBI Cos.*, 296 Or 246 (1983), *Sarantis v. Sheraton Corp.*, 69 Or App 575 (1984), and *Clemons v. Roseburg Lumber Co.*, 43 Or App 135 (1978), the Board stated that a claimant should not be compensated for the consequences of an unreasonable refusal of recommend treatment, but that a refusal is unreasonable only if a carrier can

establish that no reasonable person would refuse the treatment. Citing *Dale E. VanBibber*, Jr., 59 Van Natta 1962, *recons*, 59 Van Natta 2174 (2007), *aff'd SAIF v. VanBibber*, 234 Or App 68 (2010), the Board reiterated that ORS 656.325 and the *Nelson*/*Clemons* rationale are not applicable to reduce permanent impairment based on a claimant's noncompliance with treatment when the question on review is limited to whether the permanent disability resulted from the compensable injury (*i.e.*, the Board's review of the evaluation of a claimant's permanent disability, rather than the review of the Director's application of ORS 656.325).

Refusal of surgery not unreasonable.

Consistent with the *VanBibber* rationale, the Board reasoned that the question before it was the measurement of claimant's permanent disability due to the compensable injury under the Director's standards, rather than any Director decision concerning ORS 656.325 concerning a reduction in compensation. Furthermore, based on the attending physician's opinion that surgery would probably not help claimant's low back condition and that no further treatment was recommended, the Board did not consider claimant's refusal of the surgery to be unreasonable. Accordingly, the Board concluded that claimant was entitled to an impairment award for the impairment findings that were permanent and due to the compensable condition.

Firefighter Presumption: "802(5)" - Clear/Convincing Evidence "Cancer" Not "Caused/Contributed in Material Part" By Firefighting Activities

Carl D. Boulden, 68 Van Natta 1388 (2016). Applying ORS 656.802(5), the Board held that a carrier had not rebutted the "firefighter presumption" that claimant's follicular lymphoma resulted from his employment as a firefighter. Noting a physician's opinion that it was highly likely that claimant's firefighting was not a material cause of his development of the claimed lymphoma, the carrier contended that it had overcome the "firefighter presumption" under ORS 656.802(5).

The Board disagreed with the carrier's contention. Citing ORS 656.802(5)(b), the Board stated that certain described cancers (including claimant's lymphoma) are presumed to result from a qualifying firefighter's employment, subject to a carrier's right to rebut that presumption by clear and convincing evidence that the cancer was not caused or contributed in material part by firefighting. Referring to *Riley Hill General Contractor, Inc. v. Tandy Corp*, 303 Or 390, 407 (1987), the Board noted that "clear and convincing" means "that the truth of the facts asserted must be highly probable." Relying on *Mize v. Comcast Corp-AT&T Broadband*, 208 Or App 563, 571 (2006), the Board observed that the phrase "in material part" means a "fact of consequence." Finally, based on *SAIF v. Thompson*, 360 Or 155 (2016), the Board clarified that the carrier had the burden of both production and persuasion to overcome the statutory presumption.

Physician opinion did not indicate that reference to "development" encompassed "contributed to in material part."

Turning to the case at hand, the Board acknowledged that the physicians had opined that it was highly likely that claimant's firefighting activities were not a material cause of the "development" of his lymphoma. However, the Board reasoned that neither physician had defined "material cause" nor indicated that their use of the term "development" encompassed the legal standard of "contributed to in material part" in ORS 656.802(5)(b). Moreover, the Board noted that one physician was unable to rule out claimant's firefighting as a contributor to his cancer. Under such circumstances, the Board concluded that the carrier had not overcome the "firefighter presumption" under ORS 656.802(5) and, as such, set aside the carrier's denial.

Under "802(5)," carrier must prove, by clear and convincing evidence, that condition/impairment was not caused or contributed to in material part by firefighting.

In reaching its conclusion, the Board noted that, to overcome the "firefighter presumption" under ORS 656.802(4) (which pertains to lung, respiratory, hypertension or cardiovascular-renal disease), the carrier must establish, by clear and convincing evidence, that the *cause* of the condition or impairment is unrelated to the firefighter's employment. In contrast, the Board reiterated that to overcome the "firefighter presumption" under ORS 656.802(5) (which pertains to specified cancers), the carrier must establish by clear and convincing evidence that the condition or impairment was not caused or contributed to in material part by the firefighter's employment.

Medical Services: "245(1)(a)" - Proposed C6-7 Disc Surgery Directed To a Worsened Preexisting Condition - Analyzed as "Consequential Condition" - Compensable C5-6 Disc Injury/Surgery Not Major Cause of C6-7 Disc Condition

Tommy S. Arms, 68 Van Natta 1230 (August 5, 2016). On remand from the Court of Appeals, *Arms v. SAIF*, 268 Or App 761 (2015), the Board applied ORS 656.245(1)(a) in evaluating claimant's medical services claim for C6-7 discectomy and fusion surgery and concluded that because his compensable C5-6 fusion surgery was not the major contributing cause of his worsened C6-7 disc condition, the proposed surgery was not compensable. Claimant had a compensable C5-6 herniation, which was addressed by a C5-6 fusion. Thereafter, his preexisting C6-7 degeneration condition worsened, prompting a C6-7 disc surgery request. When the carrier denied the medical service claim, claimant requested a hearing. (Claimant also initially filed a new/omitted medical condition claim for his C6-7 disc condition, but subsequently did not contest that portion of an ALJ's order that upheld the carrier's denial of that claim.) On remand from the court, the Board addressed the question of whether a limitation identified in ORS 656.245(1)(a) (*i.e.*, the limitations set out in ORS 656.225 and the limitations for consequential or combined conditions) applied regarding the compensability of the disputed C6-7 surgery.

Referring to *SAIF v. Sprague*, 346 Or 661, 663 (2009), the Board stated that the requisite causal relationship between a compensable injury and a claimed medical service depends on whether the condition is an "ordinary condition," a "preexisting condition," a "consequential condition," or a "combined condition." Citing *Allen v. SAIF*, 279 Or App 135, 138 (2016) and *English v. Liberty Northwest Ins. Corp.*, 271 Or App 211, 215 (2015), the Board noted that the distinguishing feature of a "consequential condition" is that it is not directly caused by the compensable injury (*i.e.*, the "work-related injury incident") but is instead a separate condition that arises as a consequence of an injury or condition caused directly by the compensable injury. Finally, the Board observed that, under ORS 656.245(1)(a), a medical service directed to a "consequential condition" would only be compensable if the condition were "caused in major part" by he compensable injury.

Compensable injury contributed to worsening of C6-7 degeneration indirectly. "Consequential condition" standard applied.

Based on its review of the medical record, the Board found that the compensable injury did not directly cause a worsening of claimant's preexisting C6-7 degeneration, but rather contributed to the preexisting C6-7 degeneration indirectly, by causing a C5-6 herniation that required a C5-6 surgery that, in turn, worsened the C6-7 degeneration. Accordingly, relying on *SAIF v. Walker*, 260 Or App 327, 336 (2013) and *Clementita L. MacKenzie*, 60 Van Natta 1744 (2008), the Board concluded that the worsened C6-7 degeneration was only causally related to the compensable injury on a "consequential" basis, and, as such, "consequential condition" standards applied to the condition. Further, because the proposed C6-7 surgery was directed to the overall C6-7 degenerative condition, the Board concluded that the surgery could only be compensable if the overall C6-7 degeneration was caused in major part by the compensable injury.

After analyzing the medical evidence, the Board determined that the compensable injury was not the major contributing cause of claimant's overall C6-7 degeneration. Further noting claimant no longer challenged the carrier's denial of his "consequential" new/omitted medical condition claim for the C6-7 degeneration, the Board reasoned that it was the "law of the case" that the C6-7 degeneration was not "caused in major part" by the compensable injury. *See Americold Corp. v. Hoyt*, 209 Or App 243, 247 (2006); *Kenneth E. Horner*, 66 Van Natta 1631, 1633 (2014). Accordingly, the Board concluded that the proposed surgery was not compensable under ORS 656.245(1)(a).

Unnecessary to address limitations of 656.225.

Finally, the Board reiterated the court's explanation that ORS 656.225 does not direct carriers to provide benefits, but instead creates a limitation that, along with the limitations for consequential or combined conditions, may preclude compensation for medical services for conditions caused in material part by compensable injuries. Consistent with the court's reasoning, the Board disagreed with claimant's contention that the proposed surgery was compensable under ORS 656.225. Instead, because it had determined that the "consequential condition" limitation of ORS 656.245(1)(a) precluded claimant from receiving compensation for the proposed surgery, the Board concluded that it was unnecessary to address the additional limitations of ORS 656.225.

Member Weddell dissented. Referring to the *Sprague* court's categorization of conditions into four statutorily-defined categories, Weddell noted that it was the law of the case that claimant's C6-7 degeneration was a worsened "preexisting condition," and not a "combined condition." Further

Dissent argued that "consequential condition" standard did not apply because "degeneration" preexisted compensable injury.

citing *Fred Meyer, Inc. v. Evans*, 171 Or App 569, 273 (2000), and *Fred Meyer, Inc. v. Crompton*, 150 Or App 531, 536 (1997), Member Weddell noted that a "consequential condition" is, by definition, "a separate condition that arises from a compensable injury," and that a condition that preexisted a compensable injury did not arise from the compensable injury. Reasoning that claimant's C6-7 degeneration preexisted, and did not arise from, the compensable injury, Weddell concluded that the proposed surgery was directed to a worsened "preexisting condition," not a "consequential condition." Accordingly, Member Weddell asserted that the "consequential condition" standards did not apply to claimant's medical services claim.

Because compensable C5-6 fusion was the major cause of worsened preexisting C6-7 degeneration, "exceptions to "225" limitations satisfied.

Turning to ORS 656.225(1) (which provides that medical services solely directed to a preexisting condition are not compensable unless work conditions or events constitute the major contributing cause of a pathological worsening of the preexisting condition), Weddell was persuaded by a physician's opinion that the C5-6 fusion, which had treated the compensable C5-6 herniation, was the major contributing cause of the worsening of the preexisting C6-7 degeneration (although not the major contributing cause of the overall condition). Further reasoning that the proposed surgery was prescribed to treat the worsening, and "not merely as an incident to the treatment of a compensable injury or occupational disease," Member Weddell concluded that the requirements of ORS 656.225(1) and (3) had been satisfied. Accordingly, finding no statutory limitation to the proposed surgery, Weddell concluded that the medical services claim was compensable.

TTD: "245(4)(a)" - "MCO-Based" Termination of TTD Invalid - "MCO Enrollment" Notice - Not "Actual Notice" or Notice by "Regular Mail" - Strict Compliance With Statute/Rule Required

Misty R. Fox, 68 Van Natta 1184 (August 2, 2016). Analyzing ORS 656.245(4)(a), the Board held that a carrier was not authorized to terminate claimant's temporary disability (TTD) benefits for treating with a "non-MCO" physician because the record did not establish that she received actual notice of the carrier's "MCO enrollment" letter or that the carrier had mailed the letter to her correct address. Following its acceptance of claimant's injury claim, the carrier mailed an "MCO enrollment" letter to her at an incorrect address. Claimant did not receive the letter and was unaware that she was enrolled in an MCO. Subsequently, she began treating with a "non-MCO" physician, who restricted her to modified work duties. Sometime thereafter, the carrier sent claimant an "MCO enforcement" letter (addressed to her correct address), which notified her that her TTD benefits would be terminated if she continued to treat with a "non-MCO" physician. When claimant continued to treat with the "non-MCO" physician, the carrier terminated her TTD benefits. Thereafter, claimant requested a hearing, seeking reinstatement of her TTD benefits. In doing so,

she contended that the carrier was not authorized to terminate her TTD benefits because it had not provided the requisite written notice to her regarding her MCO enrollment under ORS 656.245(4)(a).

The Board agreed with claimant's contention. Citing ORS 656.245(4)(a), the Board stated that a "worker" becomes subject to an MCO contract upon receipt of actual notice of MCO enrollment, or upon the third day after the notice was sent by regular mail by the carrier, whichever event occurred first. Referring to OAR 436-010-0275(4), the Board noted that, in enrolling a worker in an MCO, a carrier "must simultaneously provide written notice *to the worker*, the worker's representative, all medical service providers, and the MCO of enrollment."

"MCO enrollment" letter mailed to incorrect address – "245(4)(a)" "notice" requirement not met.

Turning to the case at hand, the Board found that it was undisputed that the carrier's "MCO enrollment" letter had been mailed to an incorrect address and the record did not establish that she had either received the letter or was aware of its contents. Furthermore, concerning the language in ORS 656.245(4)(a) regarding a worker becoming subject to the MCO contract "upon the third day after the notice was sent by regular mail," the Board reasoned that such notice by "regular mail" must be accomplished by mailing to the worker at the proper address. Because it was undisputed that the "MCO enrollment" letter was mailed to claimant at an incorrect address, the Board concluded that the letter was not properly mailed and, thus, notice by "regular mail" had not been achieved.

"MCO enforcement" letter sent to correct address, but did not constitute "MCO enrollment" because not all required information included.

Finally, the Board acknowledged that the carrier's "MCO enforcement" letter had been mailed to claimant's correct address and that she had received the letter. Nonetheless, reasoning that the "MCO enforcement" letter did not include all of the required information for an "MCO enrollment" letter, the Board determined that the "MCO enforcement" letter did not constitute a "MCO enrollment" letter and, as such, the carrier was not authorized to terminate claimant's TTD benefits under ORS 656.245(4)(a). *See* OAR 436-010-0275(4)(a)-(h), (8) (WCD Admin. Order 14-053, eff. April 1, 2014). Relying on *SAIF v. Robertson*, 120 Or App 1 (1993), the Board reiterated that, when a rule specifically and unambiguously requires a carrier to follow a certain procedure, substantial compliance is not sufficient.

APPELLATE DECISIONS

SUPREME COURT

Firefighter's Presumption: "802(4)" - Presumption Not Met By "Clear and Convincing Evidence" - Physician's "Not Major Cause" Opinion Did Not Satisfy "Unrelated to Employment" Requirement

SAIF v. Thompson, 360 Or 155 (August 4, 2016). Analyzing the "firefighter's presumption" as prescribed in ORS 656.802(4), the Supreme Court reversed the Court of Appeals decision, 267 Or App 356 (2014), which had

reversed a Board order that had set aside a carrier's denial of the carrier's denial of claimant's occupational disease claim for a heart attack. The Court of Appeals had reasoned that because a physician's explanation was not met with contrary evidence or criticized by the Board, the Board must have viewed the physician's opinion inadequate to overcome the presumption because it lacked proof of the ultimate cause of claimant's atherosclerosis. 267 Or App at 364. Interpreting the Board's order as requiring proof of individual risk factors unrelated to claimant's firefighting work (such as diabetes, tobacco use, or high cholesterol) to rebut the "firefighter's" presumption, the Court of Appeals reversed the Board's decision as contrary to *Long v. Tualatin Valley Fire*, 163 Or App 397 (1999).

On review to the Supreme Court, claimant (among other arguments) contended that, even if the carrier may rely on the physician's testimony that atherosclerosis generally is unrelated to firefighting, the Board reasonably found that the physician's testimony did not meet the carrier's burden of persuasion to overcome the "firefighter's" presumption by clear and convincing evidence. *See* ORS 656.802(4). The Supreme Court agreed with claimant's contention.

After reviewing the Board order, the Supreme Court read the Board's decision differently from the Court of Appeals. In reaching that assessment, the Supreme Court made the following observations: (1) the Board asked whether the carrier had persuaded it by clear and convincing medical evidence that claimant's atherosclerosis was "unrelated" to his "firefighting" employment; and (2) the Board had neither said nor intimated that only evidence of individual risk factors unrelated to claimant's work could be considered in finding whether the carrier had met its burden of persuasion. Based on these points, the Supreme Court determined that the Board reasonably could (and did) find the physician's report and testimony were not persuasive, without resorting to the legal rule that the Court of Appeals had attributed to it.

Board could reasonably find medical evidence unpersuasive without requiring carrier to prove alternative cause.

Turning to the physician's report, the Supreme Court noted that the physician had opined that firefighting was not the major contributing cause of claimant's atherosclerosis. Yet, because claimant had already proved the predicate facts necessary to establish the "firefighter's presumption" under ORS 656.802(4), the Supreme Court reasoned that the statute presumed that his atherosclerosis "resulted from" his employment and was an occupational disease. Thus, in accordance with the "firefighter presumption" statute, the Supreme Court clarified that the question was whether claimant's condition was "unrelated to [his] employment." Because the physician's opinion that claimant's employment was not the major contributing cause of his condition did not mean that his condition was unrelated to his employment, the Supreme Court concluded that the Board reasonably could have discounted the persuasive value of the physician's report.

Addressing the physician's testimony, the Supreme Court identified three propositions from such testimony: (1) the causes of atherosclerosis are unknown; (2) claimant did not exhibit risk factors that are related to the development of atherosclerosis; and (3) atherosclerosis is unrelated to firefighting. Regarding the first and second propositions, the Supreme Court determined that the Board could reasonably find that the statements provided no persuasive evidence that claimant's condition was unrelated to his employment. Concerning the third proposition, the Supreme Court reasoned that the Board

could reasonably find that the physician's opinion that atherosclerosis was unrelated to firefighting was at odds with his testimony that the causes of atherosclerosis were unknown.

Opinion that condition was unrelated to work was at odds with testimony that causes of condition were unknown.

Under such circumstances, the Supreme Court held that the Board permissibly concluded that the carrier had not met its burden of persuasion of overcoming the "firefighter presumption" by clear and convincing evidence. In reaching its conclusion, the Supreme Court acknowledged the carrier's argument that the physician had offered a cogent and clear opinion, which "was legally sufficient to rebut the [firefighter's] presumption." Nonetheless, the Supreme Court reasoned that there is a difference between saying that there is sufficient evidence to permit the Board to find that the carrier met its burden of persuasion and saying that the Board was required to make that finding. Thus, even if the physician's testimony was sufficient to meet the carrier's burden of production, the Supreme Court concluded that the Board reasonably could find, for the reasons it had stated, that the physician's testimony did not meet the carrier's burden of persuasion under ORS 656.802(4).

APPELLATE DECISIONS UPDATE

Course & Scope: "Traveling Employee" Doctrine - "Distinct Departure" - MVA Returning From "Unauthorized" Activity

Swager v. SAIF, ___ Or App ___ (August 31, 2016). The court affirmed without opinion the Board's order in *Justen A. Swager*, 67 Van Natta 1259 (2015), previously noted 34 NCN 7:5, which held that claimant's injury, which resulted from a motor vehicle accident (MVA) while returning from an unauthorized activity after he had completed his work duties, did not occur "in the course of" his employment under the "traveling employee" doctrine because he had been engaged in a "distinct departure" on a personal errand when his injury was sustained.

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