

Mythbusters in a legal world

**Presented by:
Larry Schucht
Elaine Schooler**

Coverage and subjectivity

Subjectivity—pre-employment activity. *Held: Truck driver who was injured while engaged in a pre-employment driving test was not a worker under the Workers' Compensation Law.* The Supreme Court ruled that a person who engages in an activity without a reasonable expectation of remuneration does not qualify as a "worker" under the definition in ORS 656.005(30), and that, under the facts found by the Workers' Compensation Board in this case, the driver had no such expectation. Accordingly, the court held that the driver was not a "worker" for purposes of the workers' compensation law, and reversed the Court of Appeals' decision to the contrary. The truck driver (claimant) applied for a job with a trucking company. Pursuant to DOT requirements, the company told the claimant that he would have to take a "safe driving test" as part of the application process. According to the board's findings of fact, the employer told claimant that this driving test would be "unpaid" and indicated that claimant had to successfully complete it to be hired. During the test, claimant drove one of the employer's trucks on an actual delivery, accompanied by an employee of the company as an observer. After driving about 30 miles, the worker was injured when he fell from the truck during a stop. Based on these facts, the board concluded the claimant was not a "worker" at the time of injury because the claimant understood that he was not going to receive "remuneration" for the driving test. The Court of Appeals reversed, concluding that, because the claimant had engaged in actual "work" for the employer, he was entitled to be paid for that work at the rate prescribed under the minimum wage law. The Court of Appeals concluded that a contract for "remuneration" in exchange for the claimant's truck-driving services had to be implied as a matter of law. On further review, the Supreme Court rejected the Court of Appeals' use of the minimum wage law in defining a "worker" under the Workers' Compensation Law. The Supreme Court concluded that the legislature had chosen specifically to define "worker" for workers' compensation purposes in ORS 656.005(30) and that importing the minimum wage law into that definition would constitute adding words to it. Under the definition in ORS 656.005(30), the court noted a person must be engaged to perform services "for" a remuneration. The court concluded that, in the context of the definition, the word "for" meant that a person "acted with an expected result," and also that the person's "expectation of remuneration must [be] reasonable in light of the circumstances." Given its interpretation of the definition in ORS 656.005(30), the Supreme Court concluded the board's findings of fact compelled the conclusion that claimant was not a "worker" under the Workers' Compensation Law during the driving test because the claimant did not have a reasonable expectation of "remuneration" for those services. Accordingly, claimant did not qualify for workers' compensation benefits. [Gadalean v. SAIF](#), 364 Or 707 (2019).

Subjectivity—election of coverage. *Held: Application for coverage was sufficient to cover applicant despite misidentification.* In this coverage election case, the Supreme Court concluded that the application for workers' compensation insurance coverage, although incorrectly identifying the claimant as an "employee" rather than a "partner" in the business, was still sufficient to satisfy the elements of an election of coverage under ORS 656.128. The court identified those elements as: (1) the application must be in writing; (2) the application must be for the coverage of a specific person; and (3) the application must provide sufficient information to allow the insurer to determine the rate for the requested coverage. The court held that the application submitted in this case satisfied all of those criteria. It ruled that nothing in the text of

the statute requires that the application specify the applicant's "legal status." Hence, the misidentification of the applicant as an employee rather than a partner was irrelevant, and the claimant's coverage was effective upon the insurer's acceptance of the application. [Pilling v. Travelers Ins. Co.](#), 365 Or 236 (2019).

Course and scope

Course and scope—mixed risk doctrine. *Held: Fainting while shoveling snow at work arose out of employment.* Claimant, a carpenter, finished a regularly scheduled work week on a Friday. He ate at 9 p.m. and then went to a bar to drink with friends until 2 a.m. At midnight that evening, claimant received a text from his supervisor instructing him to report to work in the morning at 7 a.m. After leaving the bar, claimant slept for a couple of hours and had a cup of coffee before leaving for work. He did not eat anything for breakfast that morning. After shoveling snow off the construction site for 3 hours, claimant was walking to start folding "snow blankets" when he lost consciousness and fell, sustaining a head injury. Following the carrier's denial, claimant requested a hearing, contending that the syncope episode was caused by his work activities. In response, the carrier asserted that a physician's opinion persuasively explained that personal factors specific to claimant (e.g., lack of sleep, lack of food, and dehydration) were the major contributing cause of the syncope. The ALJ agreed with the employer and upheld the denial, concluding the syncope was the result of hypoglycemia and idiopathic causes. The board reversed. The board found that claimant's injury arose out of his employment. Citing *Fred Meyer, Inc. v. Hayes*, 325 Or 592 (1997), the board noted an injury is deemed to "arise out of" employment when an injury results from the nature of the work or originates from some risk to which the work environment exposes the worker. Relying on *Phil A. Livesley Co. v. Russ*, 296 Or 25 (1983), the board reiterated that risks are generally categorized as either employment-related risks (which are compensable), personal risks (which are noncompensable), and neutral risks (which may or may not be compensable, depending on the situation). The board that, under the "mixed risk" doctrine, an injury that results from a fall that is due to both personal and employment reasons arises out of employment. The board further observed that, under the "mixed risk" doctrine, if employment is a contributing factor to the fall, the injury is considered to have arisen out of employment. The board reasoned that both physicians supported the proposition that claimant's snow shoveling work was at least one of several risks (including his personal risks) which contributed to his syncope event. Thus, based on the contribution of claimant's work-related snow shoveling activities, the board concluded that his injury arose out of his employment under the "mixed risk" doctrine and, as such, his injury claim was compensable. [Torrey F. Wolbert](#), 71 Van Natta 645 (2019).

Course and scope—special errand. *Held: Delivering cash to employer for office pizza party within reasonable bounds of employment.* Claimant, a program manager, worked a regular shift from 8 am to 4 pm, but was able to flex her schedule and was on call at times. On Thursday, December 21, 2017 claimant received a group text message asking program managers to come to the main office to wrap gifts for a holiday party. In response, claimant drove to the main office with one of her children. Claimant wrapped presents while her child played on the floor. After she was finished, she left the office and drove toward Salem to do some holiday shopping. Claimant then received a call to pick up some "petty cash" from the main office to pay for pizzas for the party. She then received another call to meet with her employer in Rickreall. While

driving to Rickreall, claimant was involved in a motor vehicle accident. SAIF denied claimant's injury claim, stating that the injury did not "arise out of" or occur "in the course" of her employment. Concluding that claimant's injury did not arise out of or occur in the course of her employment, the ALJ upheld the denial. The board reversed and reasoned that, because claimant's work duties involved performing special tasks/projects for the employer outside of her normal shifts, the risk of being injured while completing such a task was a risk resulting from the nature of her employment. Accordingly, the board held that claimant's injury (which occurred while delivering funds to her supervisor) "arose out of" her employment. [Cassandra Sumner](#), 71 Van Natta 624 (2019).

Course and scope—traveling employee. *Held: Board applied "social or recreational activities" exclusion to traveling employee.* Claimant attended an out-of-state conference and, after the end of a day of conference activities, claimant proceeded to barhop with co-workers. After returning to the hotel, claimant and a co-worker went to a nearby store to purchase cigarettes. Claimant was injured when she fell off a bark-dust island while smoking. The board applied the "social or recreational activities" exclusion, reasoning that the record did not establish that the employer endorsed, encouraged, or otherwise facilitated the outing to purchase cigarettes, and the record supported that the reason for leaving the hotel was to satisfy claimant's desire to smoke. [W. Leigh Castleton](#), 71 Van Natta 1261 (2019).

Course and scope—personal comfort doctrine. *Held: Injury caused by exploding energy drink arose out of and in the course and scope of employment.* The worker worked for a construction company and drove to a work site in a company pickup. He worked a couple of hours and then went on a paid 15-minute break. He went back to the truck he had driven to the site and was attempting to open a personal energy drink he had brought with him when it exploded and the cap of the bottle hit him in the eye, causing a detached retina. SAIF denied the claim for the injury on course and scope grounds. The ALJ upheld the denial on the theory that the exploding energy drink bottle was a personal risk, imported into the work environment. The board reversed, concluding that the circumstances under which the injury occurred (in a work truck, on the work site, while on a paid break, and while drinking a beverage that was acquiesced in by the employer) were sufficient to satisfy both the "arising out of" and "in the course of" elements of ORS 656.005(7)(a). [John Chavez-Cordova](#), 72 Van Natta 12 (2020).

Course and scope—personal comfort doctrine. *Held: Claimant's injury while on a smoke break was in the course and scope of employment.* Claimant worked as a patient access representative for a hospital. She had two paid 15-minute breaks and one paid 30-minute break per shift. She frequently used her 15-minute breaks to smoke. Two of claimant's supervisors and the department manager knew claimant smoked on her breaks. The employer has a strict "tobacco free" policy, and smoking was prohibited on the hospital's campus. Accordingly, to smoke on her breaks, claimant had to exit the building where she worked and walk one block to a street outside the campus. During a 15-minute break, claimant exited her building and attempted to walk off campus to smoke. However, the sidewalks on the hospital campus were icy, and before reaching her destination, she decided to turn around and return to her desk. While walking back, she slipped on the campus sidewalk directly across the street from the building where she worked. She fell, hitting her left shoulder and hip. The employer denied claimant's injury claim, asserting the injury did not arise out of, or occur within the course of, her employment. The ALJ set aside the denial, concluding the injury occurred in the course of claimant's employment as it occurred during a "personal

comfort" activity and the injury arose out of her employment. The board held claimant was still in the course of her employment because she was engaged in a "personal comfort" activity. The injury also arose out of work because it arose out of her work environment. [Donna L. Combs](#), 71 Van Natta 169 (2019).

Occupational disease

Occupational disease—cumulative effect. *Held: An occupational disease claim can be based solely on the cumulative effect of prior work-related injury events and need not also involve the worker's "general work activities."* In this compensability case, the worker had a series of work incidents over more than a decade of employment as a truck driver. Some of those events resulted in injuries that were accepted, others were the subjects of denials. Ultimately, the worker filed a new occupational disease claim based on the cumulative effects of the work incidents, which required surgery. The employer denied the claim because each of the work incidents the worker identified as contributing to his ultimate condition was a separate injury, and there was no evidence the worker's "general work activities" had also contributed to the condition. The board upheld the denial on that basis. The court reversed the board's order, concluding that the occupational disease statute only requires a worker's "employment conditions" contribute to the claimed disease and such conditions can include a series of prior traumatic injury events beyond just "microtrauma" events. However, the court also indicated the series of traumatic injury events must cumulatively result in a condition separate from the specific injuries associated with each event. The court held the evidence in the record could support a finding that such a separate condition existed, but sent the case back to the board for reconsideration, because the board had not addressed that issue. [Simi v. LTI Inc. – Lynden Inc.](#), 300 Or App 258 (2019).

Occupational disease—claim preclusion. *Held: Claim preclusion did not apply because the record did not support the the claim denials concerned the "same condition."* In July 2014, claimant submitted a claim for bilateral numbness of her hands and fingers. The employer denied claimant's "alleged occupational disease involving claimant's bilateral wrists/hands." Claimant did not file a hearing request contesting the denial. In April 2018, claimant filed a claim for "symptoms consistent with carpal tunnel syndrome (CTS). The employer issued a denial, stating claimant's condition did not arise out of and in the course of her employment, and was not worsened by her employment. Relying on the opinion of the attending physician, the ALJ determined claimant had established the compensability of her occupational disease claim for bilateral CTS. On review, the employer contended claimant's current claim is precluded by an unappealed September 2014 denial of her earlier occupational disease claim for bilateral hand and finger numbness. The board upheld the ALJ, finding claimant's current occupational disease claim was supported by new facts which could not have been presented in 2014. Namely, claimant's CTS diagnosis was established by nerve conduction studies, and she had performed an additional four years of work activities which contributed to the development of her CTS condition. *See Ahlberg*, 199 Or App at 275 (if the claimant's condition has changed and the claim is supported by new facts that could not have been presented earlier, then claim preclusion is not a bar); *Albert A. Ahlberg*, 57 Van Natta 2840 (2005). [Laurie A. Followell](#), 71 Van Natta 1186 (2019).

Attorney fees

Attorney fees—basis for amount. *Held: Board failed to adequately explain the basis for its attorney fee award.* The worker's attorney sought a fee of \$12,000 after SAIF rescinded a denial shortly before hearing. The request was based on a claim of 30.3 hours of work and an hourly rate of \$400. SAIF objected and contended that a fee of \$4,000 would be reasonable under the circumstances. The ALJ awarded \$5,000, which was increased by the board to \$8,000. On review by the court, the worker contended that the board had not adequately considered the "contingent nature" of the case. The court refused to address the amount of the fee award, concluding instead that the board had not adequately explained how it arrived at the fee it awarded. Thus, the court sent the case back to the board for further explanation. [Taylor v. SAIF](#), 295 Or App 199 (2018).

Evidence and discovery

Evidence—hearsay. *Held: Board sustains hearsay objection for compensability purposes.* The employer denied the worker's injury claim on the theory that the worker had "faked" the injury. In support of this theory, the employer submitted testimony by a manager that a co-worker of the worker had told him that the worker said that he was "going to do something" to "get moved to a different area, and if he had to get hurt, then I'll get moved." The worker objected to the testimony on hearsay grounds and the ALJ admitted it for purposes of a penalty issue, but not on the merits of the issue of whether the worker's claim was compensable. The employer sought board review, contending that the hearsay should have been admitted on the merits of the compensability issue, at least as impeachment, if not also as a business record, or simply as substantive evidence, since hearsay is generally admissible in workers' compensation proceedings. The board upheld the ALJ's ruling, holding that there was no abuse of discretion. In a footnote, the board commented that the record did not explain why the co-worker was "unavailable to testify" or why the manager could not have presented the evidence in some other form than hearsay testimony, presumably as some kind of written business record. [Tuan Tran](#), 70 Van Natta 1160 (2018).

Evidence—hearsay. *Held: Claimant's statements in medical records are prima facie evidence to establish a compensable new/omitted condition.* Claimant appealed the denial of a new condition claim but did not attend the hearing. The ALJ set aside the denial. On review, the insurer argued that because claimant did not testify, under *Zurita v. Canby Nursery*, 115 Or App 330 (1992), *rev den*, 315 Or 443 (1993), claimant's statements to his providers were unreliable hearsay and the medical opinions insufficient to carry claimant's burden. The board affirmed the ALJ's decision. In distinguishing this case from *Zurita*, the board explained that because the insurer accepted the initial injury, it conceded legal causation. The board then evaluated the reliability of claimant's statements to his providers in light of the existing record and explained that because claimant's statements were consistent, they were reliable, and constituted prima facie evidence of medical causation. [Juan F. Figueroa-Guzman](#), 71 Van Natta 1 (2019).

Evidence—post hearing evidence. *Held: The board ordered remand for admission of post-hearing CT scan.* The ALJ upheld the employer's denial relying upon doctors who opined that whatever injury occurred on October 2, 2016, when claimant was hit by a cart at work, had resolved without disability/need for treatment, and when he eventually sought medical treatment in January 2017, he did not present with findings of an acute left leg injury. On review, claimant submitted additional evidence pertaining to his claimed left leg condition. The proffered evidence consisted of a "post-hearing" April 22, 2019, chart note from an orthopedist; a "post-hearing" May 20, 2019, left knee CT scan report; and a "post-hearing" May 23, 2019, chart note from a doctor regarding a review of the CT scan report. Based on the CT scan report, which identified a meniscal tear, and a chart note, which related that tear to the October 2016 injury, claimant contended that remand is warranted because the proffered evidence concerns disability, was not obtainable with due diligence before the hearing, and is likely to affect the outcome of the case. The employer argued claimant could have obtained a CT scan of his left knee at any time before the February 7, 2019, hearing. Consequently, the CT scan report and chart notes regarding that report, were obtainable before the hearing. The board agreed with claimant and remanded the case to the ALJ, stating because none of the physicians who examined claimant before the hearing had ordered a CT scan, the proffered evidence was not obtainable with due diligence at the time of the hearing. [Marcos E. Miralrio-Guevara](#), 71 Van Natta 1111 (2019).

Penalties

Penalties—untimely denial. *Held: Penalty levied against insurer for late-reported claim resulting in late denial.* Employer had knowledge of a work-related incident that resulted in medical treatment, and thus had notice of a claim despite no written request for compensation. The employer did not report the claim to its insurer. The worker eventually filed a claim with the insurer and the insurer denied the claim within 60 days. The board found that the employer's notice of a claim triggered the insurer's responsibility to process, and because the insurer denied the claim beyond 60 days from the date of employer notice, the board awarded a 25 percent penalty to the worker under ORS 656.262(11)(a) for the insurer's untimely denial. [Bodean N. Holmes](#), 70 Van Natta 1172 (2018).

Claim filing and timeliness

Claim filing—good cause. *Held: Claimant's belief that he would be terminated if he filed a claim was "objectively reasonable."* On remand from the court, the board found claimant had "good cause" for his untimely filed claim. The board concluded that there was an objectively reasonable basis for claimant's subjective belief he would be terminated if he made another workers' compensation claim, based in part on a conversation he had with the controller. [Andrew Kuralt](#), 71 Van Natta 194 (2019).

Claim filing—timely notice. *Held: Claimant provided timely notice.* Claimant, a housekeeper, injured her left shoulder at work. She did not immediately report the injury. After a week, her shoulder continued to bother her, so she orally informed management of the injury, but no paperwork was completed. Over a year after the injury, claimant filed a written claim. The employer denied the claim on the bases it was

not timely filed and not compensable. The board held ORS 656.265(4), which requires a written claim within one year of the accident, is inapplicable when the notice requirements of making an oral report of injury in subsection (1) have been met. Consequently, because claimant gave notice of the accident within 90 days, she satisfied the notice requirements of the statute and did not need to provide a written claim within one year of the accident. The board rejected the employer's argument that claimant did not provide sufficient notice of the accident under subsection (1). Instead, the board concluded that, although claimant declined to file a claim when asked by her employer and a physician, claimant did not need to file a formal claim because she provided a report to the employer indicating some degree of likelihood the accident involved a compensable injury. [Azam Ansarinezhad](#), 71 Van Natta 1003 (2019).

Claim classification and suspension of benefits

Suspension of benefits—notice. *Held: Suspension request must be preceded by a notice to the worker stating the "date, time, and place of the interview.* The board reversed a suspension order and subsequent denial based on the insurer's failure to notify claimant of a date, time, and place of an interview. The board held that under the current version of OAR 436-060-0135(2), any suspension request must be preceded by a notice to the worker stating the "date, time, and place of the interview." Because SAIF's notice only requested that the worker call to set up an interview, the board held the suspension order was procedurally invalid. [Gustav A. Schenk](#), 71 Van Natta 178 (2019).

Denials

Denial—combined condition. *Held: Carrier did not prove "change" in combined knee condition since effective date of acceptance.* In this accepted combined condition knee claim, the board agreed with the ALJ that the IME opinion failed to persuasively explain how the injury ceased to be the major contributing cause of the need for treatment/disability for the combined left knee condition. Here, the IME doctor opined that claimant had a combined left knee condition, which involved her meniscal condition that was treated by a partial meniscectomy and preexisting degenerative joint disease. The IME doctor stated claimant's ongoing treatment, including a steroid injection, was due to preexisting osteoarthritis. In doing so, he reasoned that, as time passes, the degenerative disease progresses. He stated that claimant's meniscus tear was probably preexisting and, with such a minor injury, would never be the major contributing cause for her ongoing significant symptomatology and need for treatment. He also noted that claimant's meniscus tear had been surgically treated (on September 24, 2015), and that, within two or three months, the postoperative symptoms would resolve, and any ongoing symptomatology would relate to the preexisting disease. The board held that without more explanation concerning a "change in the worker's condition or circumstances", the IME doctor's opinion was conclusory and not well explained. [Peggy S. Shelton](#), 71 Van Natta 73 (2019).

Denial—noncooperation. *Held: Claimant "reasonably cooperated" with claim investigation prior to insurer issuing noncooperation denial.* Within 30 days of receiving WCD's suspension notice for non-cooperation, claimant sent two emails to the insurer's

general email address requesting claim updates and detailing his efforts to comply with the insurer's investigation requests. The board, on reconsideration, on remand from *Hilton Hotels Corp. v. Yauger*, 295 Or App 330 (2018), rejected the insurer's argument that "reasonable cooperation" - as identified by the court to overcome the WCD suspension notice - required claimant to email his adjuster directly, instead finding that claimant's emails to the general email address constituted "reasonable" cooperation. [Basil D. Yauger](#), 71 Van Natta 1255 (2019).

Medical benefits

Medical benefits—gastric bypass. *Held: Claimant's proposed gastric bypass surgery was not compensable because the medical service was directed solely at his obesity, rather than directed, in material part, to his accepted low back condition.* Claimant had several accepted low back conditions. In response to claimant's attending physician's request for authorization for gastric bypass surgery, the carrier denied the medical service claim, asserting the surgery was not due in material part to claimant's accepted low back condition. Claimant requested a hearing, contending the proposed surgery was compensably related to his accepted low back condition and any benefit the surgery would provide concerning his obesity was incidental. The board disagreed with claimant's contention. Citing *SAIF v. Sprague*, 346 Or 661, the board explained medical services for "ordinary" conditions are compensable under ORS 656.245(1)(a) when the claimed medical service is for a condition caused in material part by the work injury. The board further noted *Sprague* rejected the consideration of incidental benefits to an unrelated condition when assessing the compensability of medical services for a compensable injury under ORS 656.245(1). Turning to the case at hand, based on the persuasive opinion expressed by a physician who examined claimant on behalf of the carrier, the board found the gastric bypass surgery was solely directed to claimant's obesity. Under such circumstances, the board determined the surgery had no relationship to his accepted low back condition and, as such, the surgery did not provide an "incidental benefit" to claimant's obesity. Consequently, the board concluded the proposed gastric bypass surgery was not for a condition caused in material part by the accepted low back condition. [Richard D. Verkist](#), 71 Van Natta 312 (2019).

Medical benefits—diagnostic services. *Held: Diagnostic medical services materially related to a work-injury event are compensable under ORS 656.245(1).* The worker sustained multiple injuries at work when high winds caused a tent pole to strike her, throwing her against a wall. The insurer accepted the claim and designated various physical conditions as compensable, including a fractured clavicle, multiple rib fractures, multiple vertebral fractures, a full thickness scalp laceration, a concussion, and facial scarring. Later, the worker showed signs of psychological distress and her attending physician recommended a psychological evaluation to address "PTSD-like symptoms." The insurer refused to authorize the evaluation because it was not for an accepted medical condition. The Court of Appeals upheld the refusal, concluding the Supreme Court's decision in *Brown v. SAIF*, 361 Or 241 (2017), limited entitlement to medical services to the accepted medical conditions. In reversing the Court of Appeals' decision, the Supreme Court focused on the wording of the medical services statute, ORS 656.245(1). That statute begins, "For every compensable injury, the insurer or self-insured employer shall cause to be provided medical services for conditions caused in material part by the injury for such period as the nature of the injury or the process of recovery requires" The parties' arguments focused on whether the term "injury" in the statute referred to the accepted medical conditions, as suggested by *Brown*, or to

the work-injury event. The court concluded that the term "injury" is used inconsistently in the statute, referring sometimes to the work-injury event and sometimes to medical conditions. The court held that it meant the work-injury event in the requirement that the insurer provide medical services "for medical conditions caused in material part by the injury," and meant a medical condition in the subsequent phrase, "for such period as the nature of the injury or the process of recovery requires." Because the basic duty to provide medical services is defined in the first of the above phrases, the court held that an insurer must provide diagnostic medical services for medical conditions "caused in material part" by the work-injury event, even if those conditions have not been accepted. [Garcia-Solis v. Farmers Ins. Co.](#), 365 Or 26 (2019).

Medical benefits—nonaccepted condition. *Held: Medical services directed to a nonaccepted condition that developed as a consequence of a compensable condition are compensable.* The parties went to a hearing over initial compensability of a right wrist injury. An ALJ relied on the opinion of the treating doctor to set aside the insurer's denial. In addition to supporting compensability of multiple right wrist conditions, the treating doctor explained how claimant's injury, and not his diabetes, was the major contributing cause of the infection that was discovered during surgery for his right wrist. Following the order, the employer accepted a right wrist sprain. Thereafter, claimant requested reimbursement of his medical bills for his infection. At hearing and on board review, the employer asserted that the unpaid bills were for an unaccepted infection condition for which no new/omitted condition claim had been initiated. The board noted that the Supreme Court opined in [Garcia-Solis v. Farmers Ins. Co.](#), 365 Or 26 (2019), that "compensable injury" as referenced in ORS 656.245(1)(a) means "work accident" and not medical conditions. Additionally, it is not limited to conditions that the carrier has accepted at the time that medical services are sought. Turning to the medical evidence, the board concluded that the infection was a consequential condition and the medical services claim was subject to the second sentence of ORS 656.245(1)(a), which states that medical services directed to conditions that are caused in major part by the injury are compensable. Here, the board found the treating doctor's opinion to be the most persuasive evidence and the medical services were compensable even though the underlying condition was not accepted. [Paul A. Mosely](#), 71 Van Natta 719 (2019).

Permanent partial disability

Permanent partial disability—surveillance video. *Held: Board erred in upholding an Order on Reconsideration that was based in part on a medical arbiter opinion that had relied on certain surveillance video in violation of OAR 436-030-0155(4)(a).* That rule states that "surveillance video provided for arbiter review must have been reviewed prior to claim closure by a physician involved in the evaluation or treatment of the worker." The video at issue had not been reviewed as required by the rule. The board acknowledged the rule violation but concluded that it was not a basis for excluding the arbiter panel's opinion from consideration by the Appellate Review Unit. The court disagreed, concluding that the "only plausible interpretation" of the rule was that "it precludes the agency from relying upon findings in a medical arbiters' report that are based on consideration of surveillance video that never should have been part of the arbiter review." The court remanded the case to the board for reconsideration absent the medical arbiter opinion. [Pena v. Travelers Ins. Co.](#), 294 Or App 740 (2018).

Permanent partial disability—apportionment. *Held: An insurer may not apportion impairment without first issuing a combined condition acceptance and denial.* In this apportionment case, the Supreme Court ruled the workers' compensation statutes require the insurer or self-insured employer to fully compensate a worker for "new impairment" caused in material part by the work injury unless the insurer or employer accepts and then denies a "combined condition." With respect to "new impairment" the court acknowledged that a permanent impairment award should not compensate the worker "any disability that may have existed" before the compensable injury. However, relying on its pre-1990s decision in *Barret v. D & H Drywall*, 300 Or 325 (1985), on reconsideration, 300 Or 553 (1986), the court stated, if the work injury caused a preexisting disease to produce symptoms where none existed immediately prior to the accident, and those symptoms produced loss of earning capacity, then that loss of earning capacity is due to the compensable injury, and the statute requires an award of compensation therefor. The court ultimately determined the legislature intended the process of accepting and denying a "combined condition" to be an exception to prior law that otherwise would require insurers or employers to compensate the full measure of a worker's "new impairment" without apportionment; the worker has no responsibility to require acceptance of a "combined condition" in order to obtain impairment beyond that directly associated with the accepted medical conditions. The court found further support for the conclusion in the general requirement that employers and insurers must provide notice to workers when they are denying compensation, which it concluded would not always be given or apparent to a worker when impairment is apportioned in the absence of a combined condition denial. [Caren v. Providence Health System Oregon](#), 365 Or 466 (2019).

Temporary disability

Temporary disability—interim compensation. *Held: Interim compensation owed on new/omitted condition claim independent of closed initial claim.* The worker's initial claim was accepted for various right hip conditions. The worker later filed a new or omitted condition claim for a left shoulder strain allegedly resulting from falls due to the hip condition. That denial was upheld. Later, the worker filed another new/omitted condition claim for a left rotator cuff tear allegedly resulting from falls due to the hip condition. The claim was accompanied by a time loss authorization for the condition. The insurer sent the worker a letter stating that the claim was precluded by the prior litigation. More than 60 days after the worker's rotator cuff tear claim, the worker filed a request for hearing on a de facto denial basis. The ALJ found the rotator cuff tear claim not compensable but awarded interim compensation from the date of the insurer's receipt of the claim to the date of the ALJ's order. On board review, the insurer argued that the ALJ had erred in awarding interim compensation under *Lebanon Plywood v. Seiber*, 113 Or App 651 (1992), based on the closed initial claim. The board rejected this argument, concluding that interim compensation was owing on the rotator cuff new/omitted condition claim independent of the closed initial claim because there was no substantive determination of temporary disability benefits on the new claim. However, the board modified the ALJ's award to the date of hearing rather than that of the ALJ's order. [Donald J. Dugas](#), 71 Van Natta 512 (2019).