

**MLAC Significant Cases Subcommittee  
Compilation of Cases and Summaries  
Presented as of 4/11/2008  
Prepared by the Workers' Compensation Division**

*Clarke v. Oregon Health Sciences Univ.*

**343 Or 581 (2007)**

[www.publications.ojd.state.or.us/S053868.htm](http://www.publications.ojd.state.or.us/S053868.htm)

Issue: Whether statutory remedies are adequate under the remedy clause. Clarke is a medical malpractice case, and the concurring opinion observed that the workers' compensation system provides a substantial remedy for remedy clause purposes.

Suggested by: Sue Cline (City of Portland) and DCBS

Date presented: Jan. 15, 2008

NOTE: On hold pending the Legislature's Tort Claims Act Interim Task Force.

Summary:

In this medical malpractice case, the Oregon Supreme Court held that provisions of the Oregon Tort Claims Act, as applied, violate the remedy clause of the Oregon Constitution. The plaintiff alleged economic damages in excess of \$12 million and non-economic damages of \$5 million. Plaintiff initially sued OHSU and the individual providers who treated him. On OHSU's motion, it was substituted as the sole defendant. The trial court entered judgment in favor of plaintiff against OHSU in the amount of \$200,000, the maximum awarded under the Oregon Tort Claims Act.

The court held that the cap on damages as to OHSU does not violate the remedy clause because OHSU would have been entitled to immunity at common law. Because plaintiff would have had a claim at common law against the individual defendants, however, the court held that the elimination of a remedy against the individual providers and the substitution of a capped remedy against OHSU does not provide an adequate remedy and therefore violates the remedy clause.

In a concurring opinion, Justice Balmer stated that the majority opinion does not impact the workers' compensation system, which provides workers generally with a "substantial remedy" for remedy clause purposes.

Court of Appeals opinion:

*Clarke v. Oregon Health Sciences Univ.*, 206 Or App 610 (2006).

[www.publications.ojd.state.or.us/A124560.htm](http://www.publications.ojd.state.or.us/A124560.htm)

***Freightliner LLC v. Holman***

**195 Or App 716 (2004)**

[www.publications.ojd.state.or.us/A122945.htm](http://www.publications.ojd.state.or.us/A122945.htm)

Issue: Statute of limitations in occupational disease claims

Suggested by: Deborah Sather and Norman Cole

Date presented: March 14, 2008

Summary:

At issue in this case was whether the worker's hearing loss claim was timely filed. During his 29 years working for the employer, the worker was regularly exposed to loud noise. He knew he suffered from work-related hearing loss although he did not have medical confirmation, nor was his condition disabling. He filed a workers' compensation claim six years after leaving his employment. Shortly thereafter his physician verified that he had work-related hearing loss. The employer denied his claim as untimely. An ALJ set aside the denial and the board affirmed.

The Court of Appeals, again noting the "imperfect drafting" of the statute, examined the text and context of ORS 656.807(1), which provides that an occupational disease claim must be filed by the later of one year from the date the worker first discovered or should have discovered the occupational disease or one year from the date the worker becomes disabled or is informed by a physician that the worker has an occupational disease. The court concluded that the start of the one-year limitation period is suspended until the last of the four events occurs. The court stated, "[E]mployer argues that ORS 656.807(1) as interpreted by the board creates a potentially limitless statute of limitations \* \* \* . That argument, however, must give way to the statute's textual indicators and its legislative history."

***Godfrey v. Fred Meyer Stores***

**202 Or App 673 (2005)**

[www.publications.ojd.state.or.us/A124562.htm](http://www.publications.ojd.state.or.us/A124562.htm)

Issue: Statute of limitations in injury claims

Suggested by: Deborah Sather and Norman Cole

Date presented: March 14, 2008

Summary:

ORS 656.265 requires that a worker give the employer notice of an accident resulting in injury or death. The issue in this case was whether a worker's oral report of an injury to her employer was legally sufficient notice.

The worker orally advised her supervisor that she injured her wrist at work the day before. The supervisor then made an entry into the employer's computerized database under "Employee Incident Report." More than a year later, the worker filed a written claim, which the employer denied. The employer argued that the statute requires a worker to submit written notice within 90 days of an accident, or within one year if the employer knew of the injury. The worker argued that she was only required to provide notice within one year, and the notice does not need to be in writing. The board upheld the denial.

The Court of Appeals, noting that the drafting of ORS 656.265 is less than perfect, examined the text of the statute and discussed two possible interpretations. Under the first possibility, the worker's notice to the employer of an accident or injury must be in writing. Under the second possible interpretation, notice of an injury may be given in one of three ways: 1) written notice apprising the employer when, where, and how an injury has occurred; 2) a report or statement secured from the worker concerning an accident which may involve a compensable injury; and 3) use of a form prescribed by the director. The court concluded that under the second way of providing notice – a report or statement secured from the worker – the notice need not be in writing. Noting that the purpose of the notice is to ensure that employers obtain enough information to enable them to determine whether to investigate an accident, the court concluded that an oral report from a worker is sufficient, if it contains the required information. Accordingly, the worker's notice was timely.

On remand the board set aside the employer's denial of the claim. The board declined to consider the employer's argument that claimant failed to timely file her injury claim because it was not filed within one year of the injury, holding that employer failed to preserve the argument. The board noted the distinction between timely notice of an injury and timely filing of a claim.

Board Order on Remand:

*Karen M. Godfrey*, 58 Van Natta 2892 (2006).

[www.cbs.state.or.us/external/wcb/2006/remand/nov/0304253a.pdf](http://www.cbs.state.or.us/external/wcb/2006/remand/nov/0304253a.pdf)

The board's Order on Remand was appealed to the Court of Appeals, and the court released its opinion on March 19, 2008. The court affirmed, finding that the board acted within its discretion in finding that employer had not preserved the issue of whether claimant was required to bring her claim within one year of the date of injury.

*Fred Meyer Stores v. Godfrey*, \_\_\_ Or App \_\_\_ (2008).

<http://www.publications.ojd.state.or.us/A134247.htm>

Related case:

*Jose Amador*, 59 Van Natta 2115 (2007).

Board Order on Reconsideration: [www.cbs.state.or.us/external/wcb/2007/recon/aug/0601101.pdf](http://www.cbs.state.or.us/external/wcb/2007/recon/aug/0601101.pdf)

In this Order on Reconsideration the board, citing *Godfrey*, rejected the employer's argument that ORS 656.265(4) requires a claim to be filed within one year of the accident, stating that ORS 656.265(4) refers to notice of an accident, but does not impose a requirement regarding the timeliness of claim filing.

*Jose Amador*, 59 Van Natta 1538 (2007).

Board Order on Review: [www.cbs.state.or.us/external/wcb/2007/remand/jun/0601101a.pdf](http://www.cbs.state.or.us/external/wcb/2007/remand/jun/0601101a.pdf)

***Karjalainen v. Curtis Johnston & Pennywise, Inc.***

**208 Or App 674 (2006), rev denied 342 Or 473 (2007)**

[www.publications.ojd.state.or.us/A127490.htm](http://www.publications.ojd.state.or.us/A127490.htm)

Issue: Scope of definition of “arthritis or arthritic condition” for purposes of establishing a pre-existing condition.

Suggested by: Sommer Tolleson (Attorney) and DCBS

Date presented: Nov. 13, 2007

Summary:

Claimant was injured when he fell down a flight of stairs at work. Employer accepted a claim for a nondisabling thoracic strain. Medical tests revealed claimant had a herniated disc as well as moderate degenerative disc disease. Claimant asked that the scope of acceptance be expanded to include the herniated disc and a lumbar strain. Employer accepted the lumbar strain but denied the herniated disc. At issue was whether the claimant’s disc herniation was a result of his work injury and a pre-existing condition of degenerative disc disease (arthritis or arthritic condition) and therefore a “major contributing cause” standard applied, as the employer argued. Or, as the claimant argued, that his degenerative disc disease was not a pre-existing condition (arthritis or an arthritic condition) and a material contributing cause standard applied.

A preexisting condition must have been diagnosed or treated prior to the injury, unless it is arthritis or an arthritic condition. The court held that the definition of arthritis is a question of law, and the term should be given its ordinary (i.e. dictionary) meaning. The court defined arthritis as a matter of law as an “inflammation of one or more joints.” The court rejected the position that the term should be defined by medical experts on a case-by-case basis. Consequently, the court remanded the case to the board for reconsideration based on this definition.

On remand, the board reversed its prior position that claimant’s degenerative disc disease was an arthritic condition and found that the record did not persuasively establish that degenerative disc disease involved inflammation of a joint and concluded that it was not a pre-existing condition so a material contributing cause standard applied.

**Analysis:**

This case narrows the definition of arthritis, which may reduce the number of pre-existing conditions. As a result, the number of claims subject to the “major contributing cause” standard may decrease, which could increase the number of compensable claims. However, as a result of this position, parties in future similar claims may adjust the focus of their dispute to whether the medical opinions persuasively established “inflammation of one or more joints,” instead of whether the claimant has “arthritis or an arthritic condition.”

In addition, the definition of pre-existing conditions was revised under SB 485 as part of the legislative response to the Smothers decision. Smothers held that the exclusive remedy provisions of workers' compensation law were unconstitutional because a worker was precluded from obtaining a remedy for a work-related condition and, as such, the worker could sue the employer in circuit court for damages from a work-related condition. SB 485 intentionally funneled more workers into the workers' compensation system by requiring that work-related claims be initially directed into the system and a noncompensability determination be reached before a civil negligence action could be pursued against the employer. SB 485 also amended the statutory scheme in a manner that narrowed the number of claims that could be successfully defended based on the major contributing cause standard. The statutory requirements for a "pre-injury" diagnosis or treatment (subject to the arthritis exception) in order to qualify as a "pre-existing condition" were expected to increase the number of compensable "combined condition" claims by 10 percent.

Specifically, the during the discussions on SB 485 these definitions were proposed:

SB 485 Oct 13, 2000 Management proposed this language which labor did not agree with:

For the purposes of this section, "arthritis" or an "arthritic condition" means the process of post-traumatic, developmental, joint, vertebra, or proximate ligamentous, fibrous or cartilaginous structures, regardless of whether such changes are yet symptomatic.

October 19, 2000 definition from staff to MLAC:

"For the purposes of this subparagraph only, "arthritis" or an "arthritic condition" means inflammation of a joint, usually accompanied by pain, swelling and, frequently changes in structure."

The court in Karjalainen looked at the legislative history and found it inconclusive and gave examples of testimony. When the administrator of the Workers' Compensation Division was asked if the courts had interpreted arthritis, his response was that he did not know. An MLAC co-chair stated that there was sufficient legal precedent that determined what arthritis meant and it was defined in case law. Another witness said the definition would work out case by case. The same witness said ultimately the Court of Appeals and the Supreme Court will come up with language "we'll all start being comfortable with."

Board Order on Remand:

*Adam M. Karjalainen*, 59 Van Natta 3076 (2007).

[www.cbs.state.or.us/external/wcb/2007/remand/dec/0306069a.pdf](http://www.cbs.state.or.us/external/wcb/2007/remand/dec/0306069a.pdf)

***Roberts v. SAIF Corp.***

**341 Or 48 (2006)**

[www.publications.ojd.state.or.us/S52078.htm](http://www.publications.ojd.state.or.us/S52078.htm)

Issue: Tort law implications of excluding a class of work-related injuries from compensability and restricting the worker's remedy (recreational/social activity exclusion).

Suggested by: DCBS

Date presented: Nov. 13, 2007

Summary:

Claimant's claim arose out of and in the course of employment but was excluded from compensability because it was incurred while engaging in recreational activities primarily for the worker's personal pleasure. Justice Durham issued a concurring opinion addressing the potential tort law ramifications of excluding a class of work-related injuries from the scope of compensable injuries and restricting the worker's remedy for a work-related injury to the workers' compensation system whether or not the injury is compensable.

**Analysis:** The interesting issue in this case is the concurring opinion by Justice Durham. The question is whether an injury is considered work related and therefore covered under workers' compensation or, as in this case, work related but not covered. If a class of injuries is not covered it raises the issue of Smothers, that is, a class of injuries that are not compensable may mean the exclusive remedy provisions of workers compensation for that class are unconstitutional. In that event, the tort system would provide the remedy, if any, for the plaintiffs. The policy question is whether to provide workers the possibility of a remedy under the workers compensation system, or the tort system.

**59 Van Natta 2422, abated 59 Van Natta 2729 (2007)**

[www.cbs.state.or.us/external/wcb/2007/remand/oct/0507566b.pdf](http://www.cbs.state.or.us/external/wcb/2007/remand/oct/0507566b.pdf)

Issue: Denials for unperfected new and omitted condition claims.

Suggested by: SAIF

Date presented: DCBS summary presented April 11, 2008

Summary:

Claimant had an accepted injury claim for a disabling left chest wall contusion and left 8<sup>th</sup> rib fracture. Claimant requested acceptance of “chronic chest wall pain as a result of the 8<sup>th</sup> rib fracture condition” as a new or omitted medical condition. The insurer responded with a “No Perfected Claim” letter, which stated that claimant’s claim was not perfected because he requested acceptance of a symptom rather than a medical condition or diagnosis. Claimant appealed, arguing that the letter was a denial. The ALJ upheld the insurer’s *de facto* denial of chronic chest wall pain.

On review the board found that claimant had perfected his claim. The board reasoned that whether claimant’s request described a condition or merely a symptom was a question to be resolved when determining compensability. Because claimant had clearly requested acceptance of chronic chest wall pain, he had perfected his claim for a new medical condition under ORS 656.267(1). Because the insurer had neither accepted nor denied the claim within the required time period, the claim was *de facto* denied.

The board abated its order and the parties subsequently settled, so the case is not binding in future cases.

Order of Abatement:

*Francisco G. Rodriguez, 59 Van Natta 2729 (2007).*

[www.cbs.state.or.us/external/wcb/2007/miscellaneous/nov/0507566.pdf](http://www.cbs.state.or.us/external/wcb/2007/miscellaneous/nov/0507566.pdf)

**48 Van Natta 395 (1996)**

[www.cbs.state.or.us/wcd/sandoval.doc](http://www.cbs.state.or.us/wcd/sandoval.doc)

Issue: Backup denials and mistakenly accepted claims.

Suggested by: SAIF

Date presented: DCBS summary presented April 11, 2008

Summary:

SAIF provided coverage for the employer on Oct. 6, 1992, the date of claimant's injury. CNA assumed coverage for the employer effective Jan. 1, 1993. Claimant filed his claim in March 1993 using a CNA claim form. CNA accepted the claim. The employer subsequently realized the mistake and notified its parent corporation, which notified CNA. CNA issued a disclaimer of responsibility; advised claimant to file a claim with SAIF; rescinded its acceptance of claimant's claim; denied responsibility for claimant's injury; and requested designation of a paying agent. SAIF issued a compensability denial (which it later rescinded) and a responsibility disclaimer. The ALJ determined that CNA could rescind its acceptance, CNA was not prohibited from issuing a back-up denial on the merits, and SAIF was responsible for claimant's injury. The ALJ ordered SAIF to reimburse CNA for its claim costs.

The board reversed those portions of the ALJ's order, concluding that CNA's denial was not based on "later obtained evidence" sufficient to support a back-up denial under ORS 656.262(6). The board reasoned that at the time the claim was filed CNA, as a corporate entity, knew or should have known that it was not providing coverage, even if accurate coverage information was not available to the branch office.

Related case:

*Oregon Insurance Guaranty Assoc. v. Hall*, 200 Or App 128, rev den 339 Or 544 (2005).

[www.publications.ojd.state.or.us/A122994.htm](http://www.publications.ojd.state.or.us/A122994.htm)

Reliance provided workers' compensation coverage to employer until Aug. 1, 2000. AAIC began providing coverage to employer on Aug. 1, 2000. Claimant sustained an injury on Sept. 13, 2000 and filed a claim. Employer mistakenly sent the claim to Reliance, which in turn mistakenly accepted the claim. When Reliance became insolvent on Oct. 3, 2001, OIGA assumed Reliance's rights, duties, and obligations. OIGA notified claimant that his claim was not a covered claim and that it would not be assuming responsibility for it. Claimant asked AAIC to process the claim and AAIC denied responsibility, acknowledging that it would have been responsible had another insurer not accepted the claim. The ALJ and board found that OIGA was responsible.

The Court of Appeals reversed and remanded, finding that the claim was not a “covered claim” under the OIGA statutes because the policy with Reliance was not in force at the time of claimant’s injury. The court stated that OIGA steps into the shoes of an insolvent insurer only if the claim is a “covered claim.” The court noted that OIGA is intended to be the insurer of last resort and in this case OIGA was not claimant’s insurer of last resort because AAIC provided coverage on the date of injury and remained a solvent insurer.

On remand, the board held AAIC responsible for claimant’s claim.

Board Order on Remand:

*Mark S. Hall*, 58 Van Natta 1461 (2006).

<http://www.cbs.state.or.us/external/wcb/2006/remand/jun/0207574.pdf>

*Specialty Risk Services v. Royal Indemnity Co.*

**213 Or App 620 (2007)**

[www.publications.ojd.state.or.us/A130618.htm](http://www.publications.ojd.state.or.us/A130618.htm)

Issue: Proper forum for resolving workers' compensation-related disputes.

Suggested by: DCBS

Date presented: Nov. 13, 2007 and Jan. 15, 2008

Summary:

SRS mistakenly accepted a claim for which Royal was responsible. SRS was unable to issue a backup denial, and brought a claim against Royal in circuit court seeking restitution for unjust enrichment. The Court of Appeals held that the circuit court had jurisdiction over the action. The action was not a matter concerning a claim within the board's jurisdiction, and the legislature did not create a specific remedy in chapter 656 intended to resolve this kind of dispute and replace SRS' restitution claim.

**Analysis:** This is another exclusive remedy case. The policy issue is whether to include a process for addressing the issue of a mistakenly accepted claim that is not otherwise addressed under the "backup denial" statute inside the workers compensation system or keeping jurisdiction solely with the circuit court. Any change would need to be done through statute.