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BOARD NEWS

Rulemaking Hearing: December 4, 2015 - Proposed Amendments Addressing HB 2764 (Mostly Division 015 Attorney Fee Rules)

At its September 29 meeting, the Members proposed amendments to its Division 015 (Attorney Fee) rules and OAR 438-005-0035(1) (Board Policy) to apply statutory amendments arising from HB 2764 (2015). The Members took this action after considering a report from its Advisory Committee, which was appointed to consider the statutory amendments and to recommend rule amendments. (The committee members were Nelson Hall, Kathryn Olney, Bill Repogle, and Betsy Wosko. Presiding ALJ Joy Dougherty served as the facilitator for the committee. The Members wish to extend their grateful appreciation to the committee for their valuable assistance in this important matter.)

Notice of this rulemaking action has been filed with the Secretary of State's office. Electronic copies of these rulemaking materials are available on WCB's website at www.wcb.oregon.gov (under the category "Laws & 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 December 4, 2015, 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).

Board Meeting: December 10, 2015 - Consideration of Public Comments to Proposed Rule Amendments

A Board meeting has been scheduled for December 10, 2015, at 9 a.m., at its Salem office (2601 25th St. SE, Ste. 150, Salem, OR 97302-1280). At that time, the Members will consider the written/oral comments that were submitted in response to the December 4, 2015 rulemaking hearing regarding proposed rule amendments addressing HB 2764 (primarily Division 015 Attorney Fee Rules) and discuss the adoption of permanent rules to become effective January 1, 2016.

CASE NOTES

Attorney Fee: “262(11)(a)” - “Penalty-Related” - Claimant Appeal - Board Found “Unreasonable” Claim Processing - Award Granted for Both Hearing/Review Levels

Stanley T. Castle, 67 Van Natta 2055 (November 13, 2015). Applying ORS 656.262(11)(a), the Board held that claimant’s counsel was entitled to a carrier-paid attorney fee for services rendered at both the hearing and review levels when claimant successfully established on appeal of an ALJ’s order that a carrier’s termination of temporary disability (TTD) benefits had been unreasonable. After a carrier terminated TTD benefits when claimant did not accept a modified job offer, he requested a hearing, seeking reinstatement of his TTD benefits, penalties, and attorney fees. After an ALJ reinstated his TTD benefits (but did not find the carrier’s unilateral termination to have been unreasonable), claimant requested Board review. Asserting that the statute and rule in question (ORS 656.268(4)(c)(B) and OAR 436-060-0030(5)(c)(F)(i)) unambiguously focus on the “employment pattern” between the worker and the employer before the injury to establish the intent of the parties regarding whether the worker could be assigned to multiple or mobile work sites beyond the statutory “50-mile” limit, claimant contended that the carrier’s unilateral termination of his TTD benefits (based on the employer’s general practice of multiple/mobile work site assignments to its employees) was unreasonable.

The Board agreed with claimant’s contention. After reviewing the statute and rule in question, the Board stated that, if the modified job offer is for a work site beyond the “50-mile” statutory limit, TTD benefits can be terminated if the offer’s work site assignment was consistent with the intent of the parties that the job involved multiple or mobile work sites and the worker could be assigned to any such site. Relying on *Donald E. Fermanian*, 67 Van Natta 1834, 1840 (2015), the Board further noted that the “intent of the parties” is determined either: (1) at the time of hire; or (2) as established by the employment pattern prior to the injury. Finally, because the “employment pattern” is based on the intent of the *parties*, the Board reasoned that the phrase referred to the pattern of employment between *claimant and the employer* before the injury.

Turning to the case at hand, the Board acknowledged that the administrative rule expressly listed “construction workers” (claimant’s profession) among examples of “multiple or mobile work sites.” Nonetheless, the Board did not consider the rule to represent a regulatory mandate that *all* “construction workers” are deemed employed with the *intent* that the “worker could be assigned to any such site.” Instead, the Board determined that the “intent of the parties” is analyzed on a “case-by-case” basis by examining the relationship between the particular injured worker and the “at-injury” employer. Applying that analysis to the present case, the Board concluded that the carrier’s termination of TTD benefits based on the employer’s general practice with its “construction workers” (rather than on the employment pattern between claimant and the employer) was unreasonable.

“Intent of parties” determined at time of hire or by employment pattern between employer/worker before the injury.

“Intent of parties” is analyzed on “case-by-case” basis by examining employment relationship between employer/injured worker.

Consequently, the Board awarded penalties and attorney fees for the carrier's unreasonable action. In doing so, the Board granted the attorney fee award for claimant's counsel's services at both the hearing level and on its successful appeal of the ALJ's order.

In reaching its conclusion, the Board relied on *SAIF v. Traner*, 273 Or App 310 (2015), where a claimant's counsel was awarded an attorney fee under ORS 656.262(11)(a) for services rendered before the court for successfully defending against a carrier's appeal of a Board order finding its claim processing to have been unreasonable. The Board noted that, in *Traner*, the court had reasoned that, due to its affirmance of the Board's unreasonable claim processing determination, an attorney fee award under ORS 656.262(11)(a) for the claimant's counsel's services at the court level was justified.

Analyzing the *Traner* rationale, the Board recognized that the current case concerned claimant's successful appeal to secure an "unreasonable claim processing" determination, whereas *Traner* involved a claimant's successful defense of a previous "unreasonable claim processing" determination. Nonetheless, reasoning that both situations involved a determination that the carrier's claim processing had been unreasonable, the Board concluded that the *Traner* rationale was equally applicable to the present case. Consequently, the Board awarded carrier-paid attorney fees for claimant's counsel's services at both the hearing and review levels.

Based on finding of unreasonable claim processing, Board was authorized to award attorney fee for services rendered at both hearing/ review levels.

Attorney Fee: "307(5)" (Responsibility) Not Applicable - No "307" Order Had Issued - Fee Subject to "308(2)(d)"

Chris E. Pardue, 67 Van Natta 1960 (November 3, 2015). Analyzing ORS 656.307(5), and ORS 656.308(2)(d), the Board held that a claimant's counsel was entitled to an attorney fee for finally prevailing over a carrier's responsibility denial under ORS 656.308(2)(d), but no attorney fee was awardable under ORS 656.307(5) because the Workers' Compensation Division (WCD) had not issued an order designating a paying agent under ORS 656.307. Claimant had requested hearings regarding responsibility denials issued by two carriers (one carrier had denied his medical service claim for right carpal tunnel syndrome (CTS)). Before the hearing, WCD had declined to issue a ".307" order designating a paying agent because the claimed conditions were not for the exact body part. At the hearing, the parties stipulated that the dispute concerned responsibility for claimant's right CTS condition. After a ".307(5)" attorney fee award was granted for claimant's counsel's services in prevailing over the responsible first carrier's denial, that carrier appealed, contending that the attorney fee was payable under ORS 656.308(2)(d).

The Board agreed. Citing ORS 656.307(5), the Board stated that a claimant's counsel is entitled to an attorney fee for active and meaningful participation at a proceeding concerning a WCD order designating a paying agent under ORS 656.307. Relying on *Kevin D. Cierniak*, 58 Van Natta 2991, 2996 (2006), and *David W. Denton*, 43 Van Natta 1033, 1035, *on recon*, 43 Van Natta 1221 (1991), the Board noted that, in the absence of a WCD ".307" order, the attorney fee provision of ORS 656.307(5) does not apply.

In the absence of a WCD "307" order, an attorney fee under "307(5)" is not awardable.

Because WCD had declined to issue a “307” order, the hearing regarding the carrier’s denials was not subject to “307” and the attorney fee was subject to “308(2)(d).”

Turning to the case at hand, the Board found that WCD had declined to issue a “.307” order. Consequently, the Board determined that the hearing regarding the carriers’ denials (although limited to responsibility) was not convened subject to ORS 656.307. Under such circumstances, the Board concluded that the attorney fee provisions subject to ORS 656.307(5) were not applicable.

Instead, the Board found that an attorney fee award under ORS 656.308(2)(d) was warranted because the worker’s counsel had actively and meaningfully participated in finally prevailing over a carrier’s responsibility denial. Furthermore, because the record neither established, nor did the worker’s counsel contend, that the proceeding involved extraordinary circumstances, the Board awarded an attorney fee consistent with the “soft cap” of ORS 656.308(2)(d); *i.e.*, \$2,885.

Own Motion: NOC Invalid - Claim Closed W/O “AP” Impairment Findings

Charles D. Leffler, 67 Van Natta 1997 (November 6, 2015). In an Own Motion Order under ORS 656.278(6) and OAR 438-012-0055, the Board held that a Notice of Closure (NOC) was invalid because the carrier closed the claim without seeking impairment findings from claimant’s attending physician. After accepting and voluntarily reopening claimant’s Own Motion claim for several new/omitted medical conditions (including right tibia osteomyelitis), the carrier closed the claim when a non-attending physician reported that his condition was medically stationary. Before closing the claim, the carrier did not seek claimant’s attending physician’s opinion regarding his “medically stationary” status or permanent impairment findings. Claimant requested Board review, contending that the NOC was invalid.

The Board agreed with claimant’s contention. Citing ORS 656.278(1)(b), and *Edward A. Miranda, Sr.*, 55 Van Natta 784 (2003), the Board stated that the Director’s standards are applied in determining a permanent disability award for an Own Motion claim for a new/omitted medical condition. Relying on OAR 436-035-0007(5), (6), and *Miranda*, the Board reiterated that to conduct such an evaluation, the claimant’s attending physician must either make impairment findings or concur with the findings from another physician. Finally, referring to ORS 656.278(1)(b), (5), (6), and OAR 438-012-0055, the Board interpreted these statutory and regulatory provisions to require a carrier to close an Own Motion claim for a new/omitted medical condition based on impairment findings from, or ratified by, the attending physician.

Because the carrier had not attempted to obtain attending physician-related impairment findings before issuing its NOC, the claim closure was considered invalid.

Turning to the case at hand, the Board found that the carrier had not attempted to obtain impairment findings from claimant’s attending physician (either directly or through his concurrence with the other physician’s findings). Because claimant’s counsel had explicitly challenged the validity of the NOC seeking its rescission, the Board concluded that the closure was invalid. Consequently, the Board set aside the NOC and remanded the claim to the carrier for further processing.

In reaching its conclusion, the Board acknowledged that it had previously rejected arguments that Own Motion claims were prematurely closed due to insufficient information to determine permanent disability or to close the claim when the claimants had also requested and received medical arbiter examinations and findings. See *Steven J. Tekander*, 59 Van Natta 261, 266 (2007). Nonetheless, after further consideration of this claim processing matter, the Board determined that a NOC for a new/omitted medical condition claim may be found invalidly issued due to a failure to obtain impairment findings from, or ratified by, the attending physician. Consequently, to the extent that its rationale expressed in the present case conflicted with the *Tekander* holding, *Tekander* and its progeny were disavowed.

Own Motion: NOC - Issued W/O “AP” Findings - Not Invalid - Carrier Attempted to Obtain “AP” Findings

Dwayne L. Minner, 67 Van Natta 2006 (November 6, 2015). In an Own Motion Order under ORS 656.278(6) and OAR 438-012-0055, the Board held that a Notice of Closure (NOC) was not invalid because, although the carrier had closed the claim without obtaining impairment findings from claimant’s attending physician, the carrier had made two unsuccessful attempts to obtain the attending physician’s concurrence with impairment findings from another physician. Before closing claimant’s Own Motion claim for new/omitted medical conditions, the carrier made two attempts to obtain the attending physician’s concurrence with impairment findings issued by another physician. When the carrier received no response to its requests, it closed the claim. Claimant requested Board review, contending that the NOC was premature because his attending physician had not provided impairment findings.

The Board disagreed with claimant’s contention. Citing *Charles D. Leffler*, 67 Van Natta 1997 (November 6, 2015) (summarized above), the Board stated that a claim closure may be invalid when a carrier does not obtain impairment findings from the attending physician (either directly or through ratification of another physician’s findings).

Turning to the case at hand, the Board acknowledged that the claim had been closed without obtaining impairment findings from the attending physician. Nonetheless, the Board noted that, during a three-month period preceding the NOC, the carrier had made two unsuccessful attempts to obtain the attending physician’s ratification of impairment findings from another physician.

Under such circumstances, the Board concluded that the present case was distinguishable from the *Leffler* holding. Consequently, the Board declined to consider the NOC invalid. Instead, consistent with claimant’s alternative request, the Board referred the claim to the Appellate Review Unit for the appointment of a medical arbiter.

Because the carrier made two unsuccessful attempts to obtain the AP’s ratification of impairment findings during the 3-month preceding the NOC, the claim closure was not considered invalid.

APPELLATE DECISIONS UPDATE

Attorney Fee: “386(1)(a)” - “Pre-Hearing” Rescission of Medical Service Denial - Based on “Post-Denial” Acceptance of New/ Omitted Medical Condition - “Denied Claim”

SAIF v. Bales, 274 Or App 700 (November 4, 2015). Applying ORS 656.386(1)(a), the court affirmed the Board’s order in *Guy E. Bales*, 65 Van Natta 1376 (2013), previously noted 32 NCN 7:3, that awarded a carrier-paid attorney fee when a carrier paid for previously disputed medical services before a hearing regarding that claim was convened. In reaching its conclusion, the Board reasoned that claimant had prevailed over a rescission of a denied claim, even though the carrier continued its contention that the medical service (injections) was not causally related to his previously accepted meniscus tear condition (but rather related to an arthritic condition that was claimed/accepted after the injections were proposed). On appeal, the court clarified that claimant’s right to recover an attorney fee turned on two elements: (1) whether the case involved a denied claim; and (2) whether the carrier’s decision to pay for the disputed medical services amounted to a “rescission of the denial.”

Carrier’s refusal to pay for proposed injections constituted a “denied claim” under “386(1)(a).”

Concerning the first element, the court disagreed with the carrier’s argument that its refusal to pay for the injections did not constitute a “denied claim” under ORS 656.386(1). Relying on ORS 656.386(1)(a)(A), the court noted that “denied claim” is defined as a “claim for compensation which a carrier refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation.” Citing ORS 656.005(8), the court stated that the statutory definition was met because a claim for medical services is a “claim for compensation.”

Carrier’s position that injections were treatment for unclaimed/unaccepted condition amounted to denial on express grounds that request did “not give rise to an entitlement to any compensation.”

Addressing the second element, the court concluded that the carrier had refused to pay for the requested medical services on the “express ground” that “the condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation.” Noting that the carrier had denied the claimed compensation (payment for the injections) on the ground that that they were treatment for an unclaimed/unaccepted arthritic condition, the court determined that the carrier’s position amounted to a denial on the express grounds that claimant’s request for compensation for a condition did “not give rise to an entitlement to any compensation” (even if the carrier did not expressly deny the arthritic condition). See *SAIF v. Wart*, 192 Or App 505, 512, *rev den*, 337 Or 248 (2004); *Safeway Stores, Inc. v. Cornell*, 148 Or App 107, 112 (1997).

The court also rejected the carrier’s alternative position that it had not rescinded its denial because it had not conceded the theory for the denial (*i.e.*, that it did not pay for medical services related to a nonaccepted condition). Citing *SAIF v. Batey*, 153 Or App 634, 641, *adh’d to on recon*, 155 Or App 21 (1998), *rev den*, 328 Or 330 (1999), the court explained that a “rescission” for

A denial is considered rescinded regardless of whether the carrier concedes the theory for its denial, but withdraws it for a different reason.

purposes of ORS 656.386(1) is “simply the act of doing away with, taking away, or removing.” Noting that there was only one disputed medical service claim and that the carrier eventually paid for that claim, the court reasoned that the carrier had rescinded its denial of the claim.

In reaching its conclusion, the court found that nothing in the language of ORS 656.386(1) nor its case law suggested any reason to define “rescission” of a denied claim for compensation as meaning more than obtaining the carrier’s agreement to pay the requested, but previously denied, compensation. See *Batey, Stephenson v. Meyer*, 150 Or App 300, 304 (1997). Relying on *Batey*, the court reiterated that a denial is considered rescinded regardless of the fact that a carrier did not concede the theory for its denial, but withdrew it for a different reason.

APPELLATE DECISIONS COURT OF APPEALS

Combined Condition: “Ceases” Denial - “262(6)(c)” - “Otherwise Compensable Injury” - “Work-Related Injury Incident”

Goodman v. SAIF, 274 Or App 316 (October 14, 2015). The court reversed the Board’s order in *Cobey Goodman*, 65 Van Natta 1598 (2013) that had upheld a carrier’s “ceases” denial of claimant’s combined condition under ORS 656.262(6)(c), based on a finding that his “accepted” wrist contusion and strain no longer remained the major contributing cause of his disability/need for treatment of his combined wrist condition. Citing *Brown v. SAIF*, 262 Or App 640, 656, *rev allowed*, 356 Or 397 (2014), the court reiterated that, in evaluating a combined condition denial, the “question is whether claimant’s work-related injury incident is the major contributing cause of the combined condition.”

Under “262(6)(c),” the question is whether the otherwise compensable injury (work-related injury incident) ceased to be the major contributing cause of the disability/ need for treatment for the accepted combined condition.

Applying the *Brown* rationale, the court identified the Board’s task as determining whether the otherwise compensable injury (as distinguished from the accepted conditions) had ceased to be the major contributing cause of the worker’s disability or need for treatment for an accepted combined condition. Reasoning that the Board had considered only whether claimant’s accepted conditions remained the major contributing cause of his combined condition (which was not the correct legal test), the court remanded for the Board to consider whether “claimant’s work-related injury incident” continued to be the major contributing cause of the combined condition.