Workers' Compensation Board

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News & Case Notes

BOARD NEWS

Biennial Review/Attorney Fees/"388(4)"

As the Board begins its biennial review of its schedule of attorney fees under ORS 656.388(4), it is seeking written comments from parties, practitioners, and the general public. Those written comments should be directed to Katy Gunville, WCB's Executive Assistant at 2601 25th St. SE, Ste. 150, Salem, OR 97302, katy.e.gunville@wcb.oregon.gov, or via fax at (503)373-1684.

These written comments will then be posted on WCB's website. The comments will be compiled and presented for discussion at Board meetings, where the Members will also consider public testimony. In establishing its attorney fee schedules, the Members shall also consult with the Board of Governors of the Oregon State Bar, as well as consider the contingent nature of the practice of workers' compensation law, the necessity of allowing the broadest access to attorneys by injured workers and shall give consideration to fees earned by attorneys for insurers and self-insured employers. *See* ORS 656.388(4), (5).

Announcements regarding Board meetings will be electronically distributed to anyone who has registered for these notifications at https://service.govdelivery.com/accounts/ORDCBS/subscriber/new.

Own Motion Form Updated

The Board's "Carrier's Own Motion Recommendation" form has been revised, solely to reflect the changed name of the "Ombuds" office (see first section, for claimants). The new, revised form can be found on the Board's external website, https://www.oregon.gov/wcb/brdrev/Pages/brd-forms.aspx.

CASE NOTES

Extent: Claimant Entitled to Full Measure of Impairment Caused in Material Part by the Compensable Injury

Reina Cruz-Salazar, 74 Van Natta 683 (October 25, 2022). Applying ORS 656.214(1)(a) and OAR 436-035-0007(1), on remand, the Board held that claimant was entitled to the full measure of her permanent impairment award, without apportionment, because the medical arbiter's impairment findings were

due, in material part, to the accepted left elbow and left shoulder conditions and the carrier had not denied a combined condition pursuant to ORS 656.268(1)(b). Relying on *Caren v. Providence Health System Oregon*, 365 Or 466, 487 (2019), the Board reiterated that if a worker's total impairment is caused in material part by a compensable injury, the worker is entitled to the full measure of impairment unless the carrier has availed itself of the statutory process for denying a combined condition pursuant to ORS 656.268(1)(b). Citing *Robinette v. SAIF*, 369 Or 767 (2022), *Johnson v. SAIF*, 369 Or 579, and *Cruz-Salazar v. SAIF*, 317 Or App 342 (2022), the Board stated that the *Caren* rationale applies even where a combined condition does not exist.

If a worker's total impairment is caused in material part by a compensable injury, the worker is entitled to the full measure of impairment.

The Board noted that the medical arbiter had opined that claimant's significant limitation of the repetitive use of her left arm and shoulder, range of motion loss, strength loss, and sensation loss were 20 percent due to the accepted conditions and 80 percent due to "undiagnosed conditions." Because the medical arbiter's opinion established that the impairment findings were due in material part to the accepted conditions and SAIF had not denied the undiagnosed conditions as part of a combined condition, the Board concluded that claimant was entitled to the full measure of the impairment award without apportionment.

New/Omitted Medical Condition: Existence of CRPS Condition Not Established; Even Assuming Existence, Medical Causation Not Established

Karen Petrie, 74 Van Natta 687 (October 25, 2022). Applying ORS 656.005(7)(a), (7)(a)(A), and ORS 656.266(1), the Board relied on the opinion of Dr. Bell and upheld the carrier's denial of claimant's new/omitted medical condition claim for CRPS.

Based on a thorough explanation from Dr. Bell that proffered an alternative cause for claimant's symptoms and explained why those symptoms did not satisfy a CRPS diagnosis, the Board found that claimant did not establish the existence of the claimed CRPS condition. *See Darren S. Bollinger*, 70 Van Natta 1099, 1100 (2018) (physician's opinion on the non-existence of a claimed condition found persuasive when the physician explained why the claimant's symptoms did not meet the definition of the condition).

In contrast, the Board found that the opinion of Dr. Kim (on which Dr. Davis and claimant relied), did not explain how claimant's MRI and bone scan supported a CRPS diagnosis or how claimant met the CRPS criteria with a lack of allodynia. Accordingly, the Board reasoned that, without additional explanation, the opinions of Drs. Kim and Davis did not persuasively establish the existence of the claimed CRPS condition. *See Moe v. Ceiling Sys., Inc.*, 44 Or App 429, 433 (1980)

Even if CRPS existed, causation not established.

The Board also concluded that, even if claimant's CRPS condition was found to exist, the opinions of Drs. Kim and Davis did not persuasively establish

that the disability or need for treatment for that condition was compensably related to the work injury.

Own Motion: Additional Impairment and Work Disability Awarded for Left Knee Condition, but Not for a Surgery and Chronic Condition

Danny L. Sharer, 74 Van Natta 667 (October 12, 2022). Applying ORS 656.278(2)(d), and relying on the medical arbiter's findings, the Board modified a previous Own Motion Notice of Closure and awarded additional impairment for claimant's "post-aggravation rights" new/omitted medical condition claim for osteoarthritis of the left knee.

Separate value for a prior knee surgery not granted when awarding impairment for total knee arthroplasty.

The Board noted that claimant received a surgical impairment value for a total knee arthroplasty, but did not receive a separate value for a prior knee surgery. *See* OAR 436-035-0230(5)(d) ("no additional value is allowed for multiple, partial or total, replacements", (5)(e) ("[w]hen rating a prosthetic knee replacement, a separate value for meniscectomy(s) * * * for the same knee is not granted"). The Board also found that claimant was not entitled to a "chronic condition" award because the medical arbiter found that claimant was not significantly limited in the repetitive use of his left knee. *See* OAR 436-035-0019(1)(b); *Alton R. Granville*, 71 Van Natta 837, 841 (2019) (no entitlement to a "chronic condition" value when the medical arbiter panel unambiguously stated that the claimant was not significantly limited in the repetitive use of his left ankle).

The Board then applied the Director's standards to rate the "post-aggravation rights" new/omitted medical condition claim and, reasoning that the limitation in ORS 656.278(2)(d) applied, the Board modified the current Notice of Closure to award an additional 8 percent permanent impairment and an additional 11 percent work disability.

Own Motion Notice of Closure Set Aside as Premature - Attending Physician's "Medically Stationary" Opinion Addressed Condition at Time of Closure; Penalty and Fee Awarded for Failure to Timely Supply the Record to the Board and Opposing Party

Ryan Vinson, 74 Van Natta 645 (September 27, 2022). The Board set aside an Own Motion Notice of Closure as premature because, although the attending physician had initially concurred with a carrier's statement that the worker's accepted conditions were medically stationary, the physician subsequently explained that the worker was not medically stationary because further treatment (*e.g.*, nerve block procedures, surgery) were required. Reasoning that the attending physician's subsequent opinion was addressing the worker's condition when the claim was closed, the Board was persuaded that further material improvement in the worker's accepted conditions would reasonably be expected from medical treatment or the passage of

time. Under such circumstances, the Board concluded that the claim had been prematurely closed.

Addressing the worker's contention that the carrier's closure of the claim had been unreasonable, the Board determined that, based on the attending physician's "pre-closure" "medically stationary" opinion, the carrier had a legitimate doubt concerning the worker's "medically stationary" status when it closed the claim. Consequently, although the attending physician's "post-closure" opinion had persuasively established that the worker was not "medically stationary" at claim closure, the Board determined that the carrier's issuance of the closure notice had not been unreasonable.

Carrier had neither timely nor completely provided discovery of the record to the Board or claimant, the Board assessed a penalty and attorney fee award under ORS 656.262(11)(a) and OAR 438-012-0110(1).

However, noting that the carrier had neither timely nor completely provided discovery of the record to the Board or claimant, the Board assessed a penalty and attorney fee award under ORS 656.262(11)(a) and OAR 438-012-0110(1). Although acknowledging that the carrier's counsel had apparently been unaware of the Board's instructions to submit the record, the Board stressed that the responsibility to submit the record rests with the carrier, not its attorney. *See* OAR 438-012-0017(1). Under such circumstances, the Board concluded that a penalty and attorney fee were justified for the carrier's discovery violations.

Penalty – No Legitimate Doubt Regarding Obligation to Process New/Omitted Medical Condition Determined to be Compensable by ALJ Order, Carrier Presumed to Know Processing Obligations in Prior Case Law

Randy G. Simi, 74 Van Natta 675 (October 25, 2022). Analyzing ORS 656.262(7)(c) and ORS 656.262(11)(a), on remand from the Supreme Court, the Board held that claimant was entitled to a penalty for its processing inaction following a prior ALJ's order.

Citing *Simi v. LTI Inc. – Lynden Inc.*, 368 Or 330 (2021), the Board stated that the court had determined that the carrier had an obligation to reopen the claim for processing of new/omitted medical conditions because they were found compensable after claim closure pursuant to ORS 656.262(7)(c). Specifically, the Board explained that the court had focused on the prior ALJ's determination setting aside the employer's compensability denial, noting that the carrier had not subsequently altered the basis of that denial. The Board further noted the court's determination that the statute, as well as the prior ALJ's order, was unambiguous.

Turning to the penalty issue, the Board found the carrier's inaction after the prior ALJ's order to have been unreasonable. In analyzing this question, the Board relied on *Rebecca A. Munson*, 52 Van Natta 741 (2000), which applied *Fleetwood Homes v. VanWechel*, 164 Or App 637, 643 (1999). The Board noted that, in *Munson*, the carrier was required to reopen a claim for processing a new/omitted medical condition, even though the newly claimed condition (which was found by an ALJ to be a "more specific classification" of a previously

Because the new/omitted "encompassed" condition had been ordered accepted after claim closure, the carrier was required to reopen the claim for processing under ORS 656.262(7)(c).

accepted condition) had already been processed. In that case, the Board reasoned that the ALJ's compensability decision setting aside the carrier's denial (but declining to remand the claim for further processing) was "effectively ordering" the carrier to accept the previously denied condition. Consequently, because the new/omitted "encompassed" condition had been ordered accepted after claim closure, the carrier was required to reopen the claim for processing under ORS 656.262(7)(c). Because this case law existed at the time of the prior ALJ's order and the carrier did not comply with its statutory obligations, its conduct was found unreasonable. Under such circumstances, the Board awarded a penalty and related attorney fee.

APPELLATE DECISIONS UPDATE

Extent: Mental Impairment (Class 2) – "035-0400(3)" – "Permanent Changes" Not Limited to Current Symptoms at Claim Closure – Includes Effects if Worker Returns to "At-Injury" Job/Similar Duties

Deschutes County v. Leak, 322 Or App 396 (October 19, 2022). The court affirmed the Board's order in *Timothy Leak*, 71 Van Natta 1105 (2019), previously noted 38 NCN 10:7, that found that claimant was entitled to Class 2 permanent impairment for his accepted post-traumatic stress disorder (PTSD) condition because, although his attending physician had classified his current symptoms as Class 1 impairment, the physician had further opined that claimant's symptoms would likely return to Class 2 if he returned to his "job at injury" as a deputy sheriff patrol officer. On appeal, the carrier contended that the Board had misinterpreted OAR 436-035-0400 (which concerns mental impairment) and had erroneously failed to defer to the Appellate Review Unit's (ARU's) plausible interpretation of its administrative rule (which had found that claimant's mental impairment was Class 1, which was not entitled to a permanent disability award). *See Godinez v. SAIF*, 269 Or App 578, 582 (2015).

After analyzing ORS 656.214(1)(c) and OAR 436-035-0400(3), the court stated that a physician is required to evaluate "permanent changes" as a result of a worker's work-related mental illness, which does not merely address their symptoms at the time of claim closure. Consequently, the court reasoned that, even if a person is not working at the time of claim closure, the physician's evaluation would still encompass whether, if the worker were to be exposed to work or a work-like setting, the worker would experience deterioration or decompensation as described in the administrative rule for a Class 2 impairment rating.

Turning to the case at hand, the court understood ARU's decision to have disregarded the attending physician's opinion concerning the effects on claimant if he subsequently returned to his "at injury" job and to limit its evaluation to only his current symptoms. Based on its analysis of OAR 436-035-0400(3), the court considered ARU's construction of the rule to be inconsistent with the rule's

unambiguous text, which required an evaluation of a worker's permanent condition, not merely the worker's current symptoms.

The court concluded that the rule requiring a doctor's evaluation of the effects of permanent changes due to the worker's mental illness includes whether the worker would experience deterioration or decompensation in work or a work-like setting, even if the worker is not currently working.

Contrary to ARU's construction of the administrative rule, the court concluded that the rule requiring a doctor's evaluation of the effects of permanent changes due to the worker's mental illness includes whether the worker would experience deterioration or decompensation in work or a work-like setting, even if the worker is not currently working. Determining that ARU's interpretation of the rule was not a plausible one, the court rejected the carrier's contention that the Board had erred in not deferring to ARU's construction of the rule. Accordingly, the court concluded that the Board had correctly determined that the attending physician's opinion concerning the probability that claimant would experience deterioration or decompensation of his mental condition in a work, or a work-like, setting was relevant and supported a Class 2 level of permanent impairment.

Finally, the court declined to consider the carrier's second contention that the Board had erred in determining that claimant's "on-the-job" injury was "deputy sheriff" and, as such, had used an incorrect SVP value in determining his work disability. *See* ORS 656.214(1)(c)(B); ORS 656.214(1)(e); OAR 436-035-0012. Noting that the carrier had not challenged claimant's contention at the hearing level that his "job-at-injury" was a "deputy sheriff," the court determined that the carrier had not preserved the issue. *See Rushton v. Oregon Medical Board*, 313 Or App 574, 576-77 (2021). Alternatively, the court observed that substantial evidence supported the Board's "SVP" finding.