Workers' Compensation Board

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News & Case Notes

BOARD NEWS

Board Meeting on March 15 to Discuss Rule Change Concepts

The Workers' Compensation Board (WCB) members have scheduled a public meeting for March 15, 2022, at 10 a.m. The agenda includes discussion of administrative rule amendments to OAR 438 that would replace pronouns with gender-neutral and nonbinary language. A February 1, 2022, Memorandum describing and listing these proposed changes can be found here.

Because the Board's offices are currently closed to the public, arrangements have been made for participation by a phone conference link, found here.

Administrative Law Judge Survey Results Now Available

The results of the annual survey of attorneys regarding Administrative Law Judges of the Workers' Compensation (WCB) is now available on the Board's website. A summary of the report is also available here.

Recruitment for Administrative Law Judges

WCB intends to fill two (2) Administrative Law Judge positions in the Salem Hearings Division. The position involves conducting workers' compensation and OSHA contested case hearings, making evidentiary and other procedural rulings, conducting mediations, analyzing complex medical, legal, and factual issues, and issuing written decisions which include findings of fact and conclusions of law.

Applicants must be members in good standing of the Oregon State Bar or the Bar of the highest court of record in any other state or currently admitted to practice before the federal courts in the District of Columbia. The position requires periodic travel, including but not limited to Eugene, Roseburg, and Coos Bay, and working irregular hours. The successful candidate will have a valid driver's license and a satisfactory driving record. Employment will be contingent upon the passing of a fingerprint-based criminal background check.

The announcement (number REQ-90245), found on the Department of Consumer and Business Services (DCBS) website at http://www.oregon.gov/DCBS/jobs/Pages/jobs.aspx, contains additional information about compensation and benefits of the position and how to apply. Questions regarding the position should be directed to Ms. Kerry Anderson at

(503) 934-0104. The close date for receipt of application materials is April 28, 2022. DCBS is an equal opportunity, affirmative action employer committed to workforce diversity.

CASE NOTES

Extent: Medical Arbiter's Initial Statement Related Findings to Unaccepted Condition – Subsequent Clarification Attributed Impairment to Accepted Condition and Sequela

Michelle L. Showalter, 74 Van Natta 153 (February 15, 2022). Applying ORS 656.266(1), ORS 656.268(15), OAR 436-035-0006(1), and OAR 436-035-0007(1)(a) and (b)(A), the Board found that claimant established entitlement to permanent impairment benefits attributable to her accepted left wrist sprain and direct medical sequelae.

Arbiter's initial report related findings to unaccepted TFCC tear

The Board reasoned that, despite the medical arbiter panel's initial statements relating claimant's left wrist instability findings to an unaccepted TFCC tear and attributing the range of motion and instability findings to her "work injury," the arbiter panel's subsequent clarification opinion expressly and unambiguously attributed those impairment findings to claimant's "accepted condition or sequela of the accepted condition."

Thus, the Board concluded that the carrier had not established error in the reconsideration process that awarded such benefits. ORS 656.283(6); *Marvin Wood Prods. v. Callow*, 171 Or App 175 (2000).

Medical Opinion: Claimant's Testimony Credible – Physicians Opinions Were Based on an Accurate History – Aware of the Absence of Initial Complaints

James D. Miller, 74 Van Natta 119 (February 7, 2022). Applying *Coastal Farm Supply v. Hultberg,* 84 Or App 282 (1987), the Board held that claimant's testimony was credible, despite the employer's contention that the testimony was unreliable. The Board further held that the claimant provided timely notice of a work accident and that claimed new medical conditions from a previous injury were compensable.

Carrier contended medical opinions were based on testimony that was not credible

In reaching these conclusions, the Board disagreed with the carrier's contentions that because claimant's testimony was not credible, the physicians' opinions supporting compensability were based on an inaccurate history. Specifically, the Board noted that a lack of complaints in initial medical records did not diminish the claimant's credibility where the record as a whole supported his testimony. In addition, the Board observed that the physicians supporting compensability were aware of the absence of initial complaints. Accordingly, the Board set aside the carrier's denials.

Own Motion: Penalties/Attorney Fees – Untimely "Voluntary Reopening" – "Discovery" Rule Violations – "262(11)(a)" / "012-0110(1)"

Elena B. Castaneda, 74 Van Natta 109 (February 1, 2022). Applying ORS 656.262(11)(a), OAR 438-012-0001(4), and OAR 438-012-0030(1)(a), and(b), the Board held that claimant was entitled to penalties and attorney fees because the carrier's "voluntary reopening" of her Own Motion claim for a new/omitted medical condition had untimely issued more than 30 days after an ALJ's order had found the claimed condition to be compensable.

Thirty days after an ALJ's order set aside a carrier's denial of claimant's "post-aggravation rights" new/omitted medical condition claim for a "post-laminectomy" L4-5 syndrome, the carrier modified its Notice of Acceptance to include the compensable condition. Notwithstanding this "compensability determination," the carrier neither submitted an Own Motion Recommendation (for or against claim reopening) to the Board nor issued a Notice of Voluntary Claim Reopening with 30 days of the ALJ's decision. Instead, nearly five months after the ALJ's order (and nearly four months following its acceptance), the carrier voluntarily reopened claimant's Own Motion claim for the "post-aggravation rights" new/omitted medical condition. Contending that the carrier's claim processing had been unreasonable, claimant sought penalties and attorney fees.

Carrier must submit Own Motion recommendation or voluntarily reopen a claim within 30 days of a compensability determination

The Board granted claimant's request. Citing OAR 438-012-0001(3), the Board stated that, within 30 days after a "post-aggravation rights" new/omitted medical condition has been "determined to be compensable," a carrier must either voluntarily reopen the Own Motion claim or submit a recommendation to the Board for or against claim reopening. Relying on OAR 438-012-0001(4), the Board noted that a "post-aggravation rights" new/omitted medical condition claim is "determined to be compensable" if a carrier's denial has been set aside by an ALJ/Board order or the carrier issues a notice of acceptance of the claimed condition.

Turning to the case at hand, the Board acknowledged that, within 30 days of the ALJ's order (which set aside the carrier's denial of claimant's "post-aggravation rights" new/omitted medical condition claim), the carrier had issued an acceptance of the claimed condition. Nonetheless, the Board noted that the carrier's Notice of Voluntary Reopening of claimant's Own Motion for the new/omitted medical condition had not been issued until some five months after the ALJ's order (and some four months after the carrier's claim acceptance). Observing that the carrier had offered no explanation for its delay in processing claimant's Own Motion claim, the Board found the carrier's claim processing to have been unreasonable. Consequently, the Board awarded penalties (based on the compensation "then due" as of the date of the carrier's untimely voluntary reopening), as well as attorney fees under ORS 656.262(11)(a). *See Martin V. Turner*, 67 Van Natta 1237, 1242 (2015); *Troy J. Pachano*, 62 Van Natta 509 (2010).

Finally, the Board added that, contrary to its acknowledgment letter (which had requested that the carrier submit relevant documents marked as exhibits and accompanied by an exhibit list), the carrier had filed copies of its

Carrier did not submit exhibits properly marked nor an exhibit list

voluntary reopening and acceptance notice (which were neither marked as exhibits nor accompanied by an exhibit list). Referring to OAR 438-012-0017(1), OAR 438-012-0110(1), *Rigoberto Gonzalez-Hernandez*, 71 Van Natta 596 (2019), and *Doug R. Cooley*, 70 Van Natta 1072, 1079-80 (2018), the Board reiterated that carriers are obligated to comply with Board requests and that a carrier's failure to do so my result in the imposition of penalties and attorney fees under ORS 656.262(11)(a).

Applying those principles to the present case, the Board noted that the carrier had offered no explanation for its violation of the Board's rule. Under such circumstances, the Board found the carrier's actions to have been unreasonable. Accordingly, the Board assessed a second penalty (based on the compensation "then due" between the date of the carrier's voluntary reopening and the date of the Board's order), as well as another carrier-paid attorney fee. *See James F. Beyl*, 73 Van Natta 910, 921 (2021); *Sandra L. Sanders*, 70 Van Natta 218 (2018).

Preclusion: Prior ALJ's Final Order Determined That Time-loss Authorization Was Open-ended – Issue Preclusion Applies

Temporary Disability: "Open-ended" Authorization – Not Halted by Another Physician Who Treated a Different Body Part – No Legitimate Doubt – Penalty and Attorney Fee Awarded

Ryan Marchand, 74 Van Natta 179 (February 25, 2022). Applying ORS 656.262(4)(g), the Board held that claimant was entitled to additional temporary disability benefits because his attending physician had provided an "open-ended" time-loss authorization that had not yet ended.

Citing *North Clackamas School Dist. V.* White, 305 Or 48, 52, *modified on other grounds*, 305 Or 468 (1988) and *Drews v. EBI Cos.,* 310 Or 134, 139-40 (1990), the Board concluded that a prior ALJ's final order precluded the employer from "relitigating" the issue of whether the time-loss authorization was "open-ended."

Board applied the requisites of the issue preclusion doctrine

The Board determined that the requisites for the application of the issue preclusion doctrine had been met: (1) the two proceedings were the same; (2) the issue was actually litigated and essential to the final decision; (3) the party to be precluded was a party (or in privity with a party) in the prior proceeding, and; (4) the prior proceeding was the type of proceeding to which a court would give preclusive effect. The Board reasoned that, in the earlier proceeding, the employer could have offered the attending physician's declaration that his time-loss authorization was not meant to be open-ended, but did not do so. Accordingly, the Board awarded the temporary disability benefits.

The Board also concluded that Dr. Balkovich, who treated claimant for his left wrist conditions, was not claimant's new attending physician for the left shoulder conditions at issue. In his chart notes, Dr. Balkovich explained that "he

New physician explained that he was not treating claimant's shoulder condition

does not do shoulders." Thus, relying on *Dedera v. Raytheon Eng'rs & Constrs.*, 200 Or App 1, 7 (2005), the Board determined that claimant's "open-ended" time-loss authorization had not been "halted" by another attending physician. Accordingly, the Board ordered additional TTD benefits, an assessed attorney fee, and costs.

The Board also determined that the employer did not have a legitimate doubt as to its liability when it terminated claimant's TTD benefits, and awarded claimant a penalty of 25 percent of the "amounts then due" and a penalty-related attorney fee. ORS 656.262(11).

Third Party: Statutory Distribution is "Just and Proper" – Health Insurer Lien is Not Superior to WC Carrier's Lien – Public Policy to Reimburse Those Responsible for Payment of Compensation

Sarah J. Ramirez, 74 Van Natta 123 (February 7, 2022). Analyzing ORS 656.587 and ORS 656.593(1) and (3), the Board concluded that a distribution of claimant's third party settlement proceeds consistent with the statutory distribution scheme under ORS 656.593(1) was "just and proper."

Claimant was compensably injured in a motor vehicle accident involving a third party, and the carrier paid benefits related to the injuries. Claimant and the carrier later entered into a Claim Disposition Agreement (CDA) and Disputed Claim Settlement (DCS) which, among other things, settled claimant's "current condition" and provided that the denial of that condition would remain in full force and effect. The agreements also reserved the carrier's "third party" rights. After claimant settled her third party cause of action, the carrier sought partial reimbursement of its statutory lien in accordance with the statutory distribution scheme. Claimant objected, asserting that, because a private health insurer had a lien superior to the carrier's and she had remaining unpaid medical bills, a "just and proper" distribution of the settlement proceeds required a reduction of the lien.

Claimant asserted that the health insurer's lien was superior and that she had unpaid medical bills

Citing ORS 656.593(1) and *Donisha E. Cosby*, 63 Van Natta 235, 238 n 4 (2011), the Board stated that the statutory scheme envisions only three recipients of third party recoveries: claimant, claimant's attorney, and the paying agency. Thus, the Board concluded that the carrier's lien was preferable to the private health insurer lien. In any event, the Board did not consider there to be a conflict between the carrier's partial recovery of its lien (consistent with the statutory scheme) and the recovery of the private health insurer lien, because the private insurer's lien could be applied to claimant's one-third statutory share of the third party proceeds (which would exceed the amount of the private insurer lien).

Further, relying on *Garth L. Veeder*, 70 Van Natta 1869, 1874 (2018); *Rosie E. Reeves*, 63 Van Natta 1718, 1720 (2011); and *Santos King*, 47 Van Natta 2026, 2027 (1995), the Board reiterated that, where a paying agency's lien amount is otherwise unchallenged, the Board has consistently rejected arguments that the paying agency's statutory share of the settlement proceeds should be reduced because such a distribution would be more equitable. In

doing so, the Board noted that the public policy underlying the third party distribution statutes is to allocate third party recoveries between the claimant and the paying agency and to provide reimbursement to those responsible for statutory compensation for injured workers.

Claimant agreed in the DCS that she would be responsible for future medical bills

Turning to the case at hand, because claimant did not challenge the carrier's lien amount (other than to argue that a reduced partial recovery would be more equitable), the Board did not consider a distribution reducing the carrier's share of the third party proceeds to less than it would have recovered under the statutory scheme to be "just and proper." The Board emphasized that, although claimant asserted that she had additional unpaid medical bills, she had agreed in the DCS that her then "current condition" was not related to the compensable injury, and thus, that she would be responsible for any future medical bills related to that condition. Moreover, the Board noted that the carrier had specifically reserved its right to recover its "third party" lien in the CDA and DCS.

APPELLATE DECISIONS UPDATE

Attorney Fee: "Post-ALJ Order" Information – No ALJ "Abuse of Discretion" in Declining to Reopen Hearing Record – "007-0025"; Board Also Declines to Consider "Hearing-Related" Information Under "015-0029"

McGuire v. SAIF, 317 Or App 629 (February 16, 2022). The court affirmed the Board's order in *Marvin A. McGuire*, 71 Van Natta 762 (2019), previously noted 38 NCN 7:3, that: (1) found no abuse of discretion in an ALJ's refusal to reopen the hearing record pursuant to OAR 438-007-0025, following the ALJ's order finding a denied claim compensable and awarding a carrier-paid attorney fee, to consider claimant's counsel's "post-order" attorney fee information; and (2) declined to consider such information on Board review under OAR 438-015-0029 insofar as it concerned claimant's counsel's services at the hearing level. In reaching its conclusions, the Board reasoned that: (1) claimant had not established that the "post-order" information could not have been submitted with due diligence at the hearing; and (2) OAR 438-015-0029 concerns attorney fee requests for services before an ALJ and the Board when a claimant *first* prevails before the Board or succeeds in defending an ALJ's compensation award against a carrier's appeal.

The court found no error in the Board's decisions. Citing ORS 656.726(5)(a), the court stated that the Board has broad authority to make and declare all rules which are reasonably required in the performance of its duties, including but not limited to rules of practice and procedure in connection with hearing and review proceedings. Referring to *State v. Teixeira*, 259 Or App 184 (2013), the court reiterated that, in interpreting the Board's administrative rules, it applies the same analytical framework that it applies in the interpretation of statutes; *i.e.*, it considers the text and context of the rule, including other portions of the rule and related laws, and the rule's adoption history. Finally, relying on *DeLeon, Inc. v. DHS*, 220 Or App 542, 548 (2008), the court repeated that it

would defer to the Board's plausible interpretation of its own rule, including an interpretation made in the course of applying the rule, if it is not inconsistent with the text/context of the rule, or any other source of law.

Claimant sought to include information regarding services at the hearing after the ALJ's order awarding an attorney fee

Turning to the case at hand, the court acknowledged claimant's contention that his counsel's "post-ALJ's order" declaration and accompanying exhibits should not have been evaluated as "evidence" because they were materials that were simply provided to correct the ALJ's error in estimating claimant's attorney's time and effort in overturning the carrier's denial. Notwithstanding that description, the court reasoned that, in view of the Board's practice of requiring that attorney fees be awarded in the order on the merits and the Board's requirement that special requests for attorney fees be presented before closure of the hearing record, it could not say that the ALJ's/Board's characterization of claimant's "post-ALJ order" materials as "new evidence" for the ALJ to consider in determining an attorney fee award was implausible.

Court deferred to the Board's interpretation of its rule, in finding no abuse of discretion by the ALJ

Under such circumstances, the court deferred to the Board's interpretation of its administrative rule (OAR 438-007-0025). Consequently, the court concluded that the Board had neither erred in treating the "post-ALJ order" information as "new evidence" nor in finding no abuse of discretion in the ALJ's refusal to reopen the hearing record.

Board's rule adoption history explicitly described the Board's intention

Addressing the Board's refusal to consider the "post-ALJ order" information under OAR 438-015-0029 for purposes of determining claimant's attorney fee award for services at the hearing level, the court noted that the Board had referred to its Order of Adoption regarding the rule, which explained that the rule was intended to address the need for attorney fee information for purposes of determining, in the first instance, a reasonable attorney fee under ORS 656.386(1) (for services at both the hearings and Board level for finally prevailing on Board review) or ORS 656.382(2) (for services on Board review for successfully defending an ALJ's compensation order). Reasoning that the Board's interpretation of the rule's purpose was consistent with the rule's text, as well as with the rule's adoption history (which explicitly describes the Board's intention), the court concluded that the Board's understanding that OAR 438-015-0029 did not govern Board review of an ALJ's attorney fee award was plausible. Consequently, the court deferred to the Board's interpretation of its rule.

Finally, the court rejected claimant's assertion that OAR 438-015-0029 required that the Board must consider the "post-ALJ order" attorney fee-related materials because they were not part of the hearing record. In doing so, the court found that the Board's determination that, in reviewing an ALJ's attorney fee award it would only consider materials that were part of the hearing record was consistent with ORS 656.295 (which provides that Board review is based on the record) and under which the Board has long held that evidence not a part of the hearing record will not be considered on Board review. *See Haribu R. Steward*, 45 Van Natta 2086 (1993).

Extent: Permanent Impairment – "Undiagnosed Condition" Not Denied – All Impairment Rated - "Apportionment" Not Appropriate – *Caren* Applied

Cruz-Salazar v. SAIF, 317 Or App 342 (February 2, 2022). The court reversed the Board's order in *Reina Cruz-Salazar*, 71 Van Natta 525 (2019), previously noted 38 NCN 5:3, which had held that, in evaluating claimant's permanent impairment for a left arm/shoulder condition, she was not entitled to an impairment award for "undiagnosed conditions" identified by a medical arbiter. Relying on *Caren v. Providence Health System Oregon*, 365 Or 466, 487 (2019), claimant contended that she was entitled to a permanent disability award for the total impairment identified by the arbiter's findings because her work injury was a material contributing cause of her total impairment.

The court agreed with claimant's contention. After summarizing the *Caren* decision, the court understood the *Caren* opinion to mean that a worker's total impairment is compensable if it is caused in material part by a compensable injury, and that benefits for impairment may not be reduced for impairment caused by a preexisting condition, unless: (1) the preexisting condition is one that is "cognizable" under ORS 656.005(24); and (2) before claim closure, the carrier has formally denied a combined condition involving the preexisting condition. The court added, in accordance with the *Caren* rationale, if the aforementioned procedural steps do not occur before claim closure, the apportionment of a worker's permanent impairment is not permitted under ORS 656.214 or ORS 656.268(1)(b).

Turning to the case at hand, the court noted that the medical record showed that claimant's impairment was caused in material part by her work-related injury and, before claim closure, the carrier had not denied the undiagnosed conditions that the medical arbiter determined had contributed to her impairment. Under such circumstances, consistent with the *Caren* rationale, the court concluded that claimant was entitled to permanent disability benefits for the full measure of her impairment.

In reaching its conclusion, the court recognized that the present case was factually distinguishable from *Caren* in that it was unknown whether the "undiagnosed condition" was a cognizable preexisting condition or whether claimant's impairment was due to a combining of her otherwise compensable injury and the "undiagnosed condition." Nonetheless, reasoning that the *Caren* court's general rule relating to impairment benefits (*i.e.*, "the employer pays compensation for the full measure of the worker's permanent impairment if the impairment as a whole is caused in material part by the compensable injury," unless the carrier has, before claim closure, denied that portion of the impairment that is not attributable to the compensable injury) was not limited to claims involving combined conditions, the court assumed that, unless and until the Supreme Court qualifies or limits its statement of the general rule relating to a worker's right to compensation for impairment, the *Caren* court intended for its rule to be applied as written. Finally, the court noted that its conclusion was consistent with other cases addressing the *Caren* holding; *e.g.*, *Robinette v. SAIF*, 307 Or App 11 (2020), *rev allowed*, 367 Or 559 (2021); *Johnson v. SAIF*, 307 Or App 1 (2020), *rev allowed*, 367 Or 559 (2021).

General rule in Caren to pay full measure of compensation unless carrier has issued a denial is not limited to combined conditions

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