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. The Board requests that any comments be submitted by Friday, September 16, 2022.

These written comments will 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.

Annual Adjustment to Maximum Attorney Fee and Hourly Rate for Statement Fee Effective July 1, 2022

The maximum attorney fee awarded under ORS 656.262(11)(a), ORS 656.262(14)(a), and ORS 656.382(2)(d), which is tied to the increase in the state's average weekly wage (SAWW), rose by 6.263 percent on July 1, 2022. On July 1, 2022, the Board published Bulletin No. 1 (Revised), which sets forth the new maximum attorney fees. The Bulletin can be found on the Board's website at: http://www.oregon.gov/wcb/legal/Pages/bulletins.aspx

An attorney fee awarded under ORS 656.262(11)(a) shall not exceed **$5,813**, absent a showing of extraordinary circumstances. OAR 438-015-0110(3).

An attorney fee awarded under ORS 656.262(14)(a) shall be **$444** per hour. OAR 438-015-0033. This rule concerns the reasonable hourly rate for an attorney's time spent during a personal or telephonic interview conducted under ORS 656.262(14).

An attorney fee awarded under ORS 656.308(2)(d) shall not exceed **$4,193**, absent a showing of extraordinary circumstances. OAR 438-015-0038; OAR 438-015-0055(5).

These adjusted maximum fees apply to attorney fees awarded under ORS 656.262(11)(a) and ORS 656.308(2)(d) by orders issued on July 1, 2022 through June 30, 2023, and to a claimant's attorney's time spent during a personal or telephonic interview or deposition under ORS 656.262(14)(a) between July 1, 2022 and June 30, 2023.

Hearings Division Update for August 1, 2022

It is difficult to believe that we are halfway through summer. As announced last April, WCB Hearings Division operations will default back to in-person proceedings beginning August 1. If you have a pending case that has already been designated (via the assigned ALJ) as telephonic or videoconference, that proceeding will not change, even after August 1. NOTE: Cases that were defaulted to telephonic before August 1, will not automatically remain telephonic. There must be an affirmative request made to the assigned ALJ.

For events where the parties wish to change the manner in which a case proceeds, like changing from an in-person hearing to videoconference, the parties should direct such requests directly to the assigned ALJ. If the assigned ALJ has approved a hearing to be conducted by phone or videoconference, that status will be retained for that case. New hearing notices indicating that a hearing or mediation will be conducted telephonically or by videoconference are now being used for these "assigned ALJ-approved" hearing sets.

For hearings, we cannot currently accommodate requests for telephonic or videoconference hearings on the request for hearing form. Best practices are, once a case is docketed for hearing and the assigned ALJ is known, contact opposing counsel to confer on the manner which best suits the case. Thereafter, bring any change requests to the ALJ, noting the position of opposing counsel. Regarding mediation, determination of the manner in which a mediation will be conducted is determined by the ALJ Mediator.

Travel to unstaffed offices and leased locations is also starting August 1. If you wish to change the manner of conducting a case that is docketed for an unstaffed office or one of our leased facilities, best practice would be to start that process as early as possible. Given all aspects associated with travel away from one's home and office, early determination of a change in manner is of benefit to all parties involved.

Thank you for everyone's continued patience as we have navigated these last few months adjusting our processes for our slow return to in-person events. It has been greatly appreciated. Please do not hesitate to reach out to Board Chair Wold at connie.l.wold@wcb.oregon.gov or me at joy.m.dougherty@wcb.oregon.gov if there are questions or concerns.

CASE NOTES

Combined Condition: Evidence Did Not Support Existence of Combined Condition Claimed by Claimant

Ivan Zhiryada, 74 Van Natta 422 (June 10, 2022). Applying ORS 656.005(7)(a) and ORS 656.266(1), the Board held that the record did not persuasively establish that the claimant's new/omitted medical condition claim was compensable under a combined condition theory.

If claimant initiates a claim for a combined condition, it is claimant's burden to prove its existence

Citing *Helen D. Lewis*, 67 Van Natta 1856, *recons*, 67 Van Natta 2037 (2015), and *Rick L. Langton*, 67 Van Natta 704 (2015), the Board stated that to establish the compensability of a new/omitted medical condition claim under a combined condition theory, it is the claimant's burden to prove the existence of the combined condition. In addition, referencing *Lewis* and *Deborah R. Graff*, 60 Van Natta 1167 (2008), the Board noted that regardless of whether the claim is analyzed as an independent new/omitted medical condition claim or as part of a combined condition, the claimant must independently establish an "otherwise compensable injury" (*i.e.*, that the work event was a material contributing cause of the disability or need for treatment of the claimed conditions).

The Board found that the medical opinions did not support the existence of the combined condition asserted by the claimant. Further, the Board concluded that the claimant did not meet his burden to independently establish that the claimed conditions were otherwise compensable. In reaching that conclusion, the Board noted that for purposes of a new/omitted medical condition claim under a combined condition theory, the claimant could not rely on a previously accepted condition to establish an "otherwise compensable injury." *See Betty J. King*, 58 Van Natta 977, 977 (2006). Accordingly, the Board upheld the carrier's denial.

Medical Opinion: Treating Surgeon's Comments General In Nature and Not Supported by Explanation of How Operative Findings Supported Opinion

Craig Nelson, 74 Van Natta 440 (June 29, 2022). Applying ORS 656.005(7)(a) and ORS 656.266(1), the Board held that the record did not persuasively establish that the claimant's left shoulder injury claim was compensable. In reaching that conclusion, the Board found the opinion of the claimant's treating orthopedic surgeon to be unpersuasive because the physician's comments were general in nature and not based on the claimant's particular circumstances. *See Sherman v. Western Employer's Ins.*, 87 Or App 602, 606 (1987).

Moreover, the Board determined that the physician's position as the claimant's treating surgeon did not entitle his opinion to special deference because the physician did not explain how his surgical findings supported his opinion. *See Dillon v. Whirlpool*, 172 Or App 484, 489 (2001); *Aaron M. Arakaki*, 70 Van Natta 439, 440 (2018); *see also Moe v. Ceiling Sys., Inc.*, 44 Or App 429, 433 (1980). Accordingly, the Board upheld the carrier's denial of the claimant's left shoulder injury claim.

Medical Services: Right Shoulder Surgery Causally Related

Acceptance of a particular condition was an acknowledgement that the condition was compensable for medical services inquiry

Rebecca L. Marin, 74 Van Natta 415 (June 2, 2022). Applying 656.245(1)(a) and ORS 656.266(1), the Board held that the record persuasively established that the claimant's proposed right shoulder surgery was causally related to the work injury. In reaching that conclusion, the Board found the opinion of the claimant's treating orthopedic surgeon more persuasive than the opinion of an examining physician.

The Board also determined that the employer's acceptance of a right shoulder condition diagnosed by the treating physician was an acknowledgment that the condition was compensable. *See SAIF v. Sprague*, 346 Or 661, 674 (2009); *Bauman v. SAIF*, 295 Or 788, 794 (1983); *Daniel B. Slater*, 71 Van Natta 962, 967 (2019); *see also SAIF v. Dobbs*, 172 Or App 446, 451, *recons*, 173 Or App 599 (2001). Accordingly, the Board determined that the disputed medical services were causally related to the claimant's work injury.

Penalty: Regarding Allegedly Unreasonable "Duplicative Discovery" Not Raised Below

Carriers should be careful not to provide duplicative discovery

Serge Alexandre, 74 Van Natta 410 (June 1, 2022). Applying *Marsh v. SAIF*, 297 Or App 486 (2019), *Fister v. South Hills Health Care*, 149 Or App 214 (1997), *Stevenson v. Blue Cross*, 108 Or App 247 (1991), and *Terry L. Byers*, 69 Van Natta 1190 (2017), the Board held that the claimant had not raised a penalty issue at the hearing level regarding allegedly unreasonable claim processing for duplicative discovery. Instead, the Board stated that the penalty issue the parties agreed to litigate pertained to an allegedly unreasonable denial.

Turning to the merits, the Board concluded that a penalty was not warranted for an allegedly unreasonable denial. Specifically, the Board stated that the carrier had a legitimate doubt as to its liability at the time of the denial based on a physician's opinion that did not support compensability.

Finally, Member Ceja specially concurred to express his concerns regarding the manner in which the carrier provided discovery in this case. Noting that the carrier's discovery production was largely duplicative, Member Ceja stated that such a practice could delay the proper disposition and payment of claims for injured workers.

Temporary Disability: No Additional TTD Awardable Due To Termination For Work Rule or Other Disciplinary Reason; Attending Physician Approved Modified Job

Stephanie Stadjuhar, 74 Van Natta 427 (June 21, 2022). Applying ORS 656.325(5)(b) and OAR 436-060-0030(4), the Board held that the claimant was not entitled to additional temporary disability benefits because she was

terminated for a work rule violation or other disciplinary reason and her attending physician had approved employment in a modified job offer before the carrier stopped paying temporary total disability (TTD) benefits.

Citing *Morales v. SAIF*, 339 Or 574 (2005), *Richard Blackwell*, 62 Van Natta 768 (2010), and *Robert A. McHale*, 61 Van Natta 2426 (2009), the Board explained that, if a worker has been terminated for violation of work rules or for other disciplinary reasons, ORS 656.325(5)(b) obligates a carrier to stop paying TTD and start paying temporary partial disability (TPD) compensation when the attending physician approves employment in a modified job that would have been offered to the worker if the worker had remained employed. Referring to ORS 656.005(12)(b) and *Bobby D. Mitchell*, 61 Van Natta 786 (2009), the Board stated that an "attending physician" is a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury, and the determination of an "attending physician" is a factual evaluation based on the reviewable record.

Attending physician approved employment in a modified job that would have been offered to claimant

The Board determined that, because the claimant's attending physician approved the carrier's modified job offer as being within her capabilities on March 3, 2021, the carrier was obligated to stop paying TTD (and start paying TPD, which was "zero") on that date. Moreover, because the claimant's subsequent attending physician confirmed that the earlier attending physician's modified job approval and work restrictions were ongoing until he removed her from work for surgery, the Board found that the carrier's failure to pay temporary disability benefits during the disputed time period was not unreasonable.

APPELLATE DECISIONS UPDATE

Claim Filing: Untimely - "Good Cause" Not Established – "265(4)(c)"

Johnson-Chandler v. The Reed Institute, 320 Or App 15 (June 2, 2022). Analyzing ORS 656.265(4)(c), the court affirmed the Board's order in *Raymond A. Johnson-Chandler*, 71 Van Natta 1072 (2019), previously noted 38 NCN 9:6, which held that claimant had not established "good cause" for his untimely filed injury claim. Relying on the "reasonable worker" standard as discussed in *Estrada v. Federal Express Corp.*, 298 Or App 111, 122, *rev den*, 365 Or 769 (2019), the Board had concluded that, although claimant initially thought that his thumb injury was a sprain that would resolve without treatment, he had experienced excruciating pain when the injury occurred, had subsequently adjusted some of his work tasks, and had begun wearing a wrist brace, and, as such, acquired sufficient knowledge, within the 90-day period for filing his claim that his injury was possibly subject to workers' compensation liability and should be reported.

On appeal, claimant contended that the Board had misapplied the "reasonable worker" standard for determining whether "good cause" for an untimely filed claim has been established, asserting that the legislative history concerning ORS 656.265(4)(c) addresses a worker's decision to "work through" an injury and that "good cause" exists if the worker gives notice when the worker reasonably becomes aware of the need for medical treatment. The court

acknowledged that a witness's testimony before a legislative committee described circumstances where a worker thinks that an injury will heal on its own as satisfying "good cause" under the statute.

Court will not substitute its judgement for the Board on the meaning of "good cause"

Nonetheless, citing *Estrada*, the court reiterated that the legislature has delegated the responsibility for determining the meaning of "good cause" to the Board and the court will not substitute its own judgment of "good cause." In accordance with its *Estrada* rationale and the Board's "reasonable worker" standard, the court repeated that a worker does not have "good cause" for an untimely filed claim if the worker had "sufficient knowledge to lead a reasonable worker to conclude that workers' compensation liability was a reasonable possibility and that notice to the employer was appropriate."

Turning to the case at hand, the court acknowledged that claimant's decision to "work through" his symptoms and wait to see whether the injury healed on its own before seeking may have been among the circumstances considered by the Board in determining whether he had sufficient knowledge under the "reasonable worker" standard to conclude that notice of his injury to his employer was appropriate. Nevertheless, contrary to claimant's argument, the court concluded that, under the "reasonable worker" standard and its *Estrada* holding, the Board was not required to find that claimant lacked the aforementioned sufficient knowledge until he decided to go to a doctor.

Accordingly, noting that claimant did not challenge the Board's findings, the court held that the Board had not erred in determining that claimant had not established "good cause" for the untimely notice of his claim.

Claim Closure: No "AP" Impairment Findings – Unreasonable – Penalty Under "268(5)(f)"

Precision Castparts Corp – PCC Structurals v. Cramer, 320 Or App 324 (June 15, 2022). Analyzing ORS 656.268(5)(f), the court affirmed the Board's order in *Melonie Cramer*, 72 Van Natta 76, *on recon*, 72 Van Natta 183 (2020), previously noted 39 NCN 2:7, which found that a carrier's closure of a claim was unreasonable because it was not based on sufficient information. In reaching its conclusion, the Board had determined that the carrier had based its claim closure on impairment findings from a physician who was no longer claimant's "attending physician." *See* ORS 656.005(12(a); ORS 656.245(2)(b)(C). On appeal, the carrier contended that, regardless of whether claimant desired to have a different attending physician, the physician who had provided the impairment findings for purposes of closing the claim was primarily responsible for claimant's care at the time of claim closure and, thus, its closure of the claim had not been unreasonable.

The court disagreed with the carrier's contention. Citing ORS 656.245(2)(b)(C), the court stated that only the attending physician (or a physician to whom the attending physician has referred the worker) may provide "sufficient information" under ORS 656.268(1)(a) to close a claim, because only the attending physician may address impairment and release the worker to regular or modified work at claim closure. Referring to ORS 656.005(12)(b), and OAR 436-010-0210(1), the court noted that an "attending physician" is "a doctor

primarily responsible for the treatment of a worker's compensable injury" and "authorizes temporary disability, and prescribes and monitors ancillary and specialized care." Finally, the court agreed with the Board's conclusion that whether a medical service provider is an "attending physician" is a question of fact.

Turning to the case at hand, the court concurred with the Board's reasoning that claimant's choice of an attending physician was relevant to whether the physician whose findings the carrier had based its claim closure was "primarily responsible" for her treatment. In doing so, the court noted that, pursuant to ORS 656.245(2)(a), "[t]worker may choose an attending doctor."

Substantial evidence supported that the carrier based its claim closure on a physician who was not primarily responsible for the claimant's treatment

In any event, even if claimant's wishes had no bearing on the "attending physician" determination, the Board determined that substantial evidence supported the Board's finding that the physician in question was not claimant's "attending physician." In reaching its conclusion, the court noted the Board's findings that: (1) although claimant had initially consented to the physician to be her "attending physician," she had decided to treat with another physician; and (2) when that other physician was not willing to continue treating claimant, she returned to the previous physician only once and for the purpose of obtaining a physical therapy referral because she was required to do so by an MCO.

Under such circumstances, the court determined that the Board could find that the physician whose findings the carrier had based its claim closure upon was not "primarily responsible" for claimant's treatment and, thus, was not the "attending physician" at claim closure. Consequently, the court held that the Board had not erred in finding that there was insufficient information on which to close the claim.

Finally, the court rejected the carrier's assertion that the Board's assessment of a penalty under ORS 656.268(5)(f) for an unreasonable claim closure had been erroneous. Citing *Liberty Northwest Ins. Corp. v. Olvera-Chavez*, 267 Or App 55, 64 (2014), the court reiterated that the evaluation of whether a carrier's claim closure was reasonable depends on whether it had a legitimate doubt as to whether the claim could be closed. Relying on *Providence Health System v. Walker*, 252 Or App 489, 505 (2012), the court noted that it reviews a Board's penalty assessment under ORS 656.268(5)(f) for whether the Board applied the correct legal standard and for whether its finding has substantial evidentiary support in light of the evidence to the carrier at the time of claim closure.

Applying the aforementioned standard, the court disagreed with the carrier's argument that the Board had relied solely on claimant's personal beliefs that the physician in question was not her "attending physician." To the contrary, the court determined that the Board order had explained how claimant's actions, her history with doctors, and her medical records had made it unreasonable for the carrier to believe that the physician whose findings it used to close the claim was "primarily responsible" for her treatment. Accordingly, the court held that the Board had not erred in assessing a penalty under ORS 656.268(5)(f).

SUPREME COURT

Extent: Impairment Findings – "ROM" / "Instability" Findings Not "Due in Material Part" to Compensable Injury – Impairment Not Rated

Robinette v. SAIF, 369 Or 767 (June 3, 2022). Analyzing ORS 656.214, the Supreme Court reversed the Court of Appeals opinion, 307 Or App 11 (2020), which had reversed the Board's order in *Theresa M. Robinette*, 71 Van Natta 269 (2019), that had not included impairment findings for lost range of motion and instability in rating claimant's permanent disability for an accepted knee condition because a medical arbiter had entirely attributed those findings to causes other than his compensable injury. Citing *Caren v. Providence Health System Oregon*, 365 Or 466, 487 (2019), the Court of Appeals held that "claimant's impairment 'as a whole' includes her whole-person impairment, of which the work injury is a material contributing cause [*i.e.*, a surgical value and chronic condition], as well as impairment due to loss of range of motion and stability." Before the Supreme Court, the carrier contended that findings of loss due entirely to causes other than the compensable injury did not satisfy the statutory definition of "impairment" under ORS 656.214 and, accordingly, should be excluded from claimant's permanent disability award.

The Supreme Court agreed with the carrier's contention. Summarizing the evolution of the statutory scheme concerning permanent disability awards for "impairment" "due to the compensable injury" as framed in ORS 656.214, the Court stated that, prior to the 1990 statutory amendments, the general rule underlying all workers' compensation claims was that a worker is entitled to compensation for impairment that is caused in material part by the compensable injury, even if that impairment is heightened (or different) because of a worker's individual circumstances prior to the injury. Referring to its *Caren* decision, the Court reiterated that, following the 1990 statutory enactments (which included the creation of the "combined condition" framework), the legislature had carved out a process through which a carrier could apportion a claimant's permanent disability according to the percentage of the impairment caused by the compensable injury, provided that the carrier availed itself of the statutory requirements (*i.e.*, issued a "pre-closure" denial of a "combined condition" prior to claim closure). Nonetheless, when this "combined condition" statutory framework is not applicable, the Court clarified that the following "pre-1990" general rule remained: Where an accepted, compensable injury is a *material contributing cause* of the claimant's impairment, then the claimant is entitled to the full measure of compensation for that impairment. *Johnson v. SAIF*, 369 Or 579, 595 (2022).

Turning to the case at hand, the Supreme Court identified the specific issue to be whether a claimant who establishes that her compensable injury was a material cause of *some* new findings of loss is entitled to compensation for *all* new loss of use or function, even loss findings that are wholly unrelated to the compensable injury. Noting that it had addressed a parallel (though ultimately different question) in *Johnson*, the Court reiterated its holding in *Johnson* that the claimant was entitled to the full measure of her loss of grip strength (even though 50 percent of the impairment had been attributed to a previously denied condition) because that loss had been found to be caused in material part by the compensable injury and the claim did not qualify as a "combined condition."

No part of claimant's reduced range of motion or decreased stability finding could be attributed to her accepted condition

Comparing its reasoning in *Johnson* with the present case, the Supreme Court acknowledged that, in the absence of a "combined condition," claimant would be entitled to the full measure of her impairment due, in material part, to her compensable injury. Nonetheless, the Court reasoned that the current case did not present the same question implicated by its *Johnson* and *Barrett* decisions. Specifically, the Court explained that, in *Johnson*, the case involved a situation where the loss of use or function was caused in material part by the compensable injury, but also had other contributing causes. In contrast to *Johnson*, the Court emphasized that, in the present case, there were multiple distinct losses of use or function at issue and, based on the record and ALJ's findings, no part of claimant's reduced range of motion or decreased stability findings could be attributed to her accepted condition.

Under such circumstances, the Supreme Court concluded that claimant's reduced range of motion and decreased stability findings did not qualify as "impairment" because they were not "due to the compensable injury." *See* ORS 656.214. Consequently, the Court determined that such findings were not part of the calculation of claimant's permanent disability award. Accordingly, the Court affirmed the Board's decision, which had limited claimant's permanent disability award to impairment attributable to her surgery and chronic condition.