Workers' Compensation Board

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News & Case Notes

BOARD NEWS

WCB Computer Systems - Unavailable Thursday, October 19 at 6 p.m. Through Monday, October 23

As part of scheduled maintenance, the Workers' Compensation Board computer databases, including the WCB Portal, will be off-line beginning Thursday, October 19, 2017 at 6 p.m. through the end of Monday, October 23, 2017. Systems are expected to be back up and working normally on Tuesday, October 24, 2017.

For stakeholders, please note the following:

- The WCB Portal will be unavailable for all activities.
- Hearing Notices will not be issued on Friday, October 20, and Monday, October 23.
- WCB staff will be unable to look up case information in our computer system during working hours on Friday, October 20, and may have only limited access on Monday, October 23.
- Email, phones and fax machines will be available during that time, and staff will have access to the paper files. However, WCB staff may not be able to answer all inquiries immediately.
- WCB's website will be available. Filing of requests for hearing and Board review can be done electronically by email, or by fax, during this time.

  Hearings: http://www.oregon.gov/wcb/hearings/Pages/filing-instructions-hrg.aspx

  Board Review: http://www.oregon.gov/wcb/brdrev/Pages/filing-instructions-brdrev.aspx

A reminder for those who work into the evening: The outage begins on Thursday, October 19 at 6 p.m.

If you have questions or need more information, please contact Greig Lowell at (503) 934-0151 or greig.lowell@oregon.gov.

ALJ Appointment - Ian Brown

WCB is pleased to announce the appointment of a new Salem Administrative Law Judge – Ian Brown. Ian grew up in Portland and attended Northwestern School of Law of Lewis and Clark College. Before entering into

Record not sufficiently developed to discern basis for ALJ's ruling – Board unable to conduct "abuse of discretion" review.

workers' compensation law, Ian worked as a contract attorney with Ashcroft & Wiles in Portland and as an associate at the Vandermay Law Firm in Salem. Ian joined WCB as a staff attorney in 2003 and has served as a staff attorney for 14 years, assuming a Senior Staff Attorney position in 2015. Please join us in welcoming Ian to the Hearings Division.

CASE NOTES

Evidence: "Expert Witness Testimony" Rule ("007-0016") - "Material Prejudice/Good Cause" Requirements Must Be Addressed Before "Un-Disclosed" Expert Testimony Allowed

John Kramer, 69 Van Natta 1379 (September 19, 2017). Applying OAR 438-007-0016, the Board held that before the testimony of an "un-disclosed" medical expert was allowable, the ALJ was required to address whether "material prejudice" had resulted from the eventual notice of the expert's testimony, and if so, whether there was "good cause" for allowing the testimony that outweighed the prejudice to the other party. At the hearing regarding a denied claim, claimant offered testimony from his treating psychologist. After noting the carrier's objection to the testimony based on untimely disclosure under OAR 438-007-0016, the ALJ allowed the testimony. Although the ALJ offered to continue the hearing, the carrier declined. After the ALJ's order set aside the carrier's compensability denial, the carrier requested Board review, challenging (among other issues) the ALJ's evidentiary ruling.

The Board vacated the ALJ's order. Citing OAR 438-007-0016, the Board stated that an ALJ has discretion to allow testimony of an expert witness not disclosed within the time parameters prescribed under OAR 438-007-0018. However, under OAR 438-007-0016, the Board noted that, in exercising that discretion, the ALJ must determine whether "material prejudice" had resulted from the timing of the disclosure and, if so, whether there was "good cause" for the failure to timely disclose that outweighed the prejudice to the other party. Relying on *Delores Catana-Cortez*, 68 Van Natta 564 (2016), and *Rick Sandeno*, 59 Van Natta 2779 (2007), the Board reiterated that, because it reviews an ALJ's evidentiary ruling for an "abuse of discretion," the record must be sufficiently developed to discern the basis for the ALJ's ruling.

Turning to the case at hand, the Board stated that it was undisputed that notice of the expert's testimony was not disclosed within the time parameters prescribed in OAR 438-007-0016 and OAR 438-007-0018. However, the Board observed that the ALJ had not addressed whether "material prejudice" had resulted from the timing of the disclosure and, if so, whether there was "good cause" for the failure to timely disclose that testimony that outweighed the prejudice to the other party. *See* OAR 438-007-0016. In the absence of such findings, the Board determined that it was unable to conduct its "abuse of discretion" review regarding the ALJ's evidentiary ruling and, therefore, concluded that remand for further development of the record was warranted.

CDA: "Medicare Set-Aside" Provision - Approval Limited to "Chapter 656" Matters

Karen E. Murray, 69 Van Natta 1330 (September 13, 2017). Applying ORS 656.236(1), the Board approved a Claim Disposition Agreement (CDA) that incorporated a "Workers' Compensation Medicare Set-Aside Arrangement" (WCMSA) in which claimant agreed to set aside a portion of her CDA proceeds to be offset against future medical services that would be otherwise reimbursable by Medicare.

Relying on the principles set forth in *David J. Willardson*, 58 Van Natta 522 (2006), the Board approved the CDA. As in *Willardson*, the Board construed the WCMSA as a description of how claimant's future Medicare reimbursements would be processed. In doing so, the Board did not interpret the CDA to limit or eliminate claimant's right to medical services for her compensable conditions under ORS 656.245, noting that the CDA expressly provided that claimant retained such rights.

Board's "656" approval authority did not extend to "Medicare set-aside."

In reaching its conclusion, the Board emphasized that its CDA approval only extended to those matters that were subject to ORS Chapter 656. Moreover, the Board stressed that it had no objection to "WCMSA" provisions, as long as the disposition itself satisfied the terms and conditions prescribed by the Board and was not unreasonable as a matter of law.

CDA: Second CDA for "Same Claim" Approvable - First CDA "Partially" Released PPD Benefits, Whereas Second CDA "Fully" Released Such Benefits for "Separate" Consideration

Vincent Rhea, 69 Van Natta 1333 (September 13, 2017). Analyzing ORS 656.236(1), the Board approved a second CDA for the same claim because it included new consideration for the release of additional benefits which had not been released in the first CDA. The Board had previously approved a CDA in consideration for claimant's release of "non-medical services-related" benefits. The "summary page" of the first CDA provided that claimant fully released all "non-medical services-related" benefits; however, the body of the first CDA provided that the carrier remained obligated to separately continue to pay, in monthly installments the current unpaid balance of claimant's permanent disability benefits. The first CDA also did not include "Social Security" language regarding a "pro rata monthly amount" calculation based on claimant's life expectancy.

Second CDA included Social Security language, and a larger lump-sum payment for "full" release of previously retained PPD benefits.

Some two months later, the parties submitted a second CDA, which included "Social Security" language and provided for the carrier's payment of a larger lump sum in return for the "full" release of all claimant's benefits. The second CDA also stated that the carrier would "receive credit" for payments made pursuant to the first CDA.

Citing *Lucille Boyer*, 47 Van Natta 2060, *recons*, 47 Van Natta 2190 (1995), the Board noted that "Social Security" language is permissible in CDAs, although the Board's authority is limited to matters under ORS chapter 656 and its approval of a CDA containing such language merely recognizes its inclusion in the CDA. However, the Board observed that, under OAR 438-009-0035(1), a motion for reconsideration of a final order approving a CDA must be filed within 10 days of the mailing of the order. Therefore, citing *Danusia Brandstetter*, 69 Van Natta 1102 (2017), and *Carl E. Worley*, 47 Van Natta 1636 (1995), the Board reasoned that a CDA cannot be amended to merely include "Social Security" language after the expiration of the 10-day reconsideration period.

Second CDA included separate consideration for "full" release of "partially" released PPD benefits.

Turning to the case at hand, the Board concluded that the first CDA had not fully released claimant's "non-medical services-related" rights. Relying on *Penny R. Doty*, 61 Van Natta 2704 (2009) and *Julie A. King*, 60 Van Natta 1312 (2008), the Board reasoned that the first CDA had "partially" released claimant's rights to permanent disability benefits because it had preserved claimant's right to the payment of his unpaid permanent disability benefits. Noting that the second CDA did not preserve such rights (but rather provided for the full release of all "non-medical service-related" benefits), the Board determined that the second CDA was a new agreement supported by separate consideration, rather than merely an attempt to amend the first CDA to include "Social Security" language. Under such circumstances, the Board concluded that the second CDA was not unreasonable as a matter of law and, therefore, was approvable.

DCS: "Post-Settlement Date" Medical Bills - Carrier Not Responsible - Hearing Request Untimely Filed - "313(4)(c), 319(6)" Applied

Shawna R. Neil, 69 Van Natta 1295 (September 6, 2017). Applying ORS 656.319(6), the Board held that claimant's hearing request regarding disputed medical bills was untimely filed because it was filed more than two years after a Disputed Claim Settlement (DCS), which provided that the carrier was responsible for all medical bills in its possession as of a specified date (when the settlement terms were agreed on). More than two years after the approval of a DCS, claimant requested a hearing seeking payment of medical bills that the carrier had received one day after the date on which the terms of the DCS were agreed upon.

Claimant sought payment of bills received by carrier one day after "settlement date" specified in DCS.

The Board declined to grant claimant's request. To begin, to the extent that claimant was seeking payment of medical bills outside of the DCS terms, the Board determined that her hearing request was untimely filed. Citing ORS 656.319(6), the Board determined that claimant's hearing request had been filed more than two years after the carrier's failure to pay the medical bills, and, as such, her contentions could not be considered.

Secondly, citing *Howard v. Liberty Northwest Ins.*, 94 Or App 283 (1988), the Board stated that, because it has jurisdiction to approve or disapprove a DCS, it retains authority to supervise the enforcement of a DCS. Relying on *Floyd D. Gatchell*, 48 Van Natta 467 (1996), and *Mary M. Mitchell*, 47 Van Natta 300 (1995), the Board explained that its authority over a previously-approved DCS was two-fold: First, it may set aside a DCS as

Board's DCS authority concerns: (1) set aside as invalid; or (2) enforce.

invalid, but only as an extraordinary remedy to be granted sparingly in the most extreme circumstances. Second, it may "enforce" a DCS and direct a carrier to fully comply with the terms of the settlement provisions.

Turning to the case at hand, the Board noted that claimant did not seek rescission of the previously-approved DCS. Consequently, under its "enforcement" authority, the Board considered whether the carrier was required to pay the disputed medical bills it had received between the "date of the settlement" and the approval of the DCS.

Under DCS, carrier obligated to pay billings received on and before date settlement terms agreed upon.

After reviewing the DCS, Board noted that the settlement provided that: (1) the carrier had received medical billings on and before the specified "date of the settlement," (2) claimant authorized the carrier to pay each provider pursuant to ORS 656.313, and (3) claimant had no further entitlement to compensation benefits (including medical treatment) for the denied claim. Reasoning that the DCS unambiguously provided that the carrier was obligated to pay for only such medical billings that it received on and before the specified "date of the settlement" and finding nothing in the agreement obligated the carrier to take any action regarding any "post-settlement" medical bills, the Board concluded that the carrier was not responsible for the payment of the disputed medical bills. *See* ORS 656.313(4)(c); OAR 436-009-0030(13) (2013).

Finally, to the extent that claimant's argument could be interpreted as a contention that the carrier had untimely paid the proceeds from, or had failed to make payments consist with, the approved DCS, the Board observed that such a dispute would be subject to the authority of the Workers' Compensation Division (on behalf of the Director). *See* ORS 656.262(12)(a); *Elvin Rodriguez*, 68 Van Natta 1618, 1620 n 3 (2016).

Hearing Request: "Good Cause" for Untimely Filed Hearing Request ("319(1)(b)") - Claimant Delegated Responsibility for Responding to Denial to Attorney - Record Did Not Establish That Copy of Denial Was Mailed to Claimant's Attorney

Carrier's description of general practice of mailing outweighed by claimant's counsel's assistant's description of office procedures.

Dan W. Fielder, 69 Van Natta 1299 (September 7, 2017). Applying ORS 656.319(1)(b), the Board found "good cause" for claimant's untimely hearing request from the carrier's claim denial because he had delegated responsibility for responding to denials to his attorney and the carrier's claim examiner's description of its general practice for mailing copies of its denials to attorneys was outweighed by claimant's counsel's assistant's description of their office procedures and determination that they had not received a copy of the denial within 60 days of its issuance. Although claimant received the carrier's claim denial, he believed that his attorney was responsible for handling such matters. When claimant's counsel did not file a hearing request until more than 60 days after the denial, the carrier moved for dismissal of the request as untimely.

Claimant contended that he had "good cause" for the untimely hearing request, relying on his counsel's legal assistant's description of their office's process for receiving mail and electronically scanning received denials. Based on the office's electronic records (which included the review/re-review from three staff members), the assistant testified that a copy of the carrier's denial had not been received until after the expiration of the 60-day appeal period (when they received an exhibit packet from the carrier concerning another case). In response, the carrier's claim examiner submitted an affidavit that described the adjuster's normal practice of sending an additional copy of any denial to a claimant's attorney by regular mail (which was confirmed by including a "cc" at the bottom of the denial letter).

Claimant delegated responsibility to respond to denial to his attorney.

The Board found that claimant had established "good cause" for the untimely filed hearing request. Citing *Freres Lumber Co. v. Jegglie*, 106 Or App 27, 30 (1991) and *Cowart v. SAIF*, 94 Or App 288 (1988) the Board noted that, if the record established that the claimant mistakenly believed that his counsel was sent a copy of the denial, the failure to timely request a hearing may constitute excusable neglect for purposes of establishing "good cause" pursuant to ORS 656.319(1)(b). In addition, relying on *James E. Dolan*, 63 Van Natta 2534, 2538 (2011), the Board observed that, if claimant assumed that his counsel would receive and handle the denial, but the carrier did not send a copy of the denial to his counsel, claimant's reliance on his counsel would constitute "good cause" under ORS 656.319(1)(b).

Three staff members of claimant's counsel would have had to miss recording the denial had a copy been received.

Turning to the case at hand, based on claimant's assumption that his attorney would contact him regarding the denial if it were important, the Board stated that it would consider his inaction to be excusable neglect if the record also established that his counsel was not mailed a copy of the denial when it issued. After reviewing the record, the Board was persuaded by claimant's counsel's legal assistant's testimony concerning their office procedures that their office did not timely receive a copy of the denial. In reaching this determination, the Board found that, based on claimant's counsel's office's procedures, three staff members would have had to miss recording the denial had a copy been timely received. Finally, considering the legal assistant's testimony, the Board did not find the claim examiner's affidavit regarding the carrier's normal practice concerning copies of denials to claimant's attorney (which did not specifically pertain to the carrier's denial in this particular claim) was not sufficient to establish that the denial had been mailed to claimant's attorney.

Under such circumstances, the Board determined that "good cause" for claimant's untimely filed hearing request had been established. *See* ORS 656.319(1)(b). Turning to merits of the claim, the Board found that the disputed new/omitted medical condition was compensable.

Interest: Attorney Fees and Costs Award - 2016 Board Order Affirmed ALJ's 2015 Order - Amended "313(1)(b)" Applied

Jorge A. Rodriguez, 69 Van Natta 1354 (September 15, 2017). Applying ORS 656.313(1)(b), the Board held that claimant was entitled to interest accrued on an attorney fee and cost award affirmed by the Board's

final August 12, 2016 order (which had affirmed an ALJ's 2015 compensability decision). After the Board's August 2016 order became final, the carrier timely paid the ALJ's/Board's attorney fee and cost awards. Claimant requested a hearing, seeking interest on the attorney fee and cost awards under ORS 656.313(1)(b). Noting that the ALJ's order had issued before the January 1, 2016 "effective date" for the statutory amendments, the carrier argued that claimant was not entitled to interest.

The Board disagreed with the carrier's contention. The Board stated that, effective January 1, 2016, ORS 656.313(1)(b) was amended to allow accrued interest on attorney fees and costs withheld pending appeal. Citing Or Laws 2015, ch 521, § 11 and *Rodolfo Arevalo*, 68 Van Natta 1142 (2016), the Board noted that the amended version of ORS 656.313(1)(b) applies to "orders issued and attorney fees incurred" on or after January 1, 2016. Relying on *Arevalo*, the Board reiterated that an attorney fee is incurred for purposes of section 11, when the claimant is entitled to the attorney fee award and the carrier consequently becomes liable for it.

Attorney fee award was not finalized/ "incurred" until Board's "post-January 1, 2016" order.

Turning to the case at hand, the Board explained that payment of the attorney fee award was automatically stayed pursuant to ORS 656.313(1)(a) when the carrier requested Board review of the ALJ's order. Reasoning that the attorney fee award was not finalized until the Board's August 2016 order, the Board concluded that the attorney fee was "incurred" after January 1, 2016. Under such circumstances, the Board held that claimant was entitled to accrued interest on the attorney fee and cost awards.

Dissent contended that fee award was "incurred" by 2015 ALJ order (affirmed by Board 2016 order).

Member Johnson dissented from the majority's conclusion that claimant was entitled to interest. Citing *Arevalo*, 68 Van Natta at 1149, Member Johnson contended that an attorney fee awarded for the first time on review was "incurred" for purposes of section 11 on the effective date of the Board's order. Because the Board order had affirmed the ALJ's 2015 order (which had granted the attorney fee/cost awards), Member Johnson reasoned that those awards had been "incurred" when the ALJ issued the 2015 decision. Inasmuch as the ALJ's 2015 order had preceded the January 1, 2016 effective date of amended ORS 656.313(1)(b), Member Johnson asserted that claimant was not entitled to interest.

Interest: Attorney Fees/Cost Awards - 2015 Order Became "Final" After January 1, 2016 - No Interest Payable - Amended "313(1)(b)" Not Applicable

Brian K. Mansfield, 69 Van Natta 1350 (September 15, 2017). Analyzing ORS 656.313(1)(b), the Board held that claimant was not entitled to accrued interest on attorney fees and costs awarded arising from a December 2015 final order, even though the order did not become final after January 1, 2016. After the Board's December 8, 2015 order (which affirmed an ALJ's compensability decision that awarded attorney fees and costs) became final, claimant requested a hearing, seeking accrued interest on the attorney fee and cost awards under the January 1, 2016 amendment to ORS 656.313(1)(b).

The Board declined to grant claimant's request. The Board stated that, effective January 1, 2016, ORS 656.313(1)(b) was amended to allow accrued interest on attorney fees and costs withheld pending appeal. Citing Or Laws 2015, ch 521, § 11 and *Rodolfo Arevalo*, 68 Van Natta 1142 (2016), the Board noted that the amended version of ORS 656.313(1)(b) applied to "orders issued and attorney fees incurred" on or after January 1, 2016. Relying on *Arevalo*, the Board reiterated that an attorney fee awarded or affirmed by a final order is "incurred" for purposes of section 11 on the "effective date" of that order.

Attorney fees incurred on date of Board's December 2015 order, not when order became final in January 2016.

Turning to the case at hand, the Board acknowledged that the Board's December 8, 2015 order did not become final until after the January 1, 2016 effective date of the statutory amendments to ORS 656.313(1)(b). Nevertheless, because the attorney fee and cost awards from the Board's December 2015 final order were "incurred" on the "effective date" of that order (*i.e.*, December 8, 2015), the Board concluded that the amended version of ORS 656.313(1)(b) did not apply. Consequently, the Board held that claimant was not entitled to interest.

In reaching its conclusion, the Board distinguished *Jorge A. Rodriguez*, 69 Van Natta 1354 (2017). In doing so, the Board explained that in *Rodriguez*, the order granting attorney fee/costs had issued *after* January 1, 2016 (the effective date of the statutory amendments), whereas the order in the present case had issued *before* January 1, 2016.

Own Motion: Claim Processing - Voluntary Claim Reopening Must Be Filed With WCD Within 30 Days of Claim Acceptance - "012-0030(4)"

Juan J. Martinez-Velazquez, 69 Van Natta 1317 (September 11, 2017). Applying ORS 656.262(11)(a) and OAR 438-012-0030, the Board held that, because a carrier had neither voluntarily reopened claimant's Own Motion claim for new/omitted medical conditions or submitted an Own Motion Recommendation within 30 days of its acceptance of the conditions, he was entitled to penalties/attorney fees for the carrier's unreasonable claim processing. After accepting claimant's new/omitted medical condition, a carrier began paying temporary disability benefits, but did not file a 3501 Form with the Workers' Compensation Division or submit an Own Motion Recommendation to the Board. *See* OAR 438-012-0030(1)(a), (b), (4). When the attending physician released claimant to modified duty, claimant returned to "modified" work with his employer in a job at his "at-injury" wage that had not been approved by his physician. Thereafter, the carrier converted claimant's temporary total disability (TTD) benefits to temporary partial disability (TPD) benefits. When claimant eventually stopped working at his modified job for reasons unrelated to his compensable injury (*i.e.*, he was angry about an anticipated work assignment), the carrier did not reinstate his TTD benefits. Claimant then sought Own Motion relief, seeking his disputed TTD benefits, as well as penalties and attorney fees.

Carrier accepted new/omitted condition and paid TTD, but did not file a voluntary reopening or Own Motion Recommendation.

The Board concluded that claimant was not entitled to TTD benefits. Citing ORS 656.268(4), *SAIF v. Vivanco*, 216 Or App 210 (2007), and *Jason D. Brown*, 61 Van Natta 1412, *recons*, 61 Van Natta 1875 (2009), the Board stated that the carrier was authorized to convert TTD to TPD benefits when claimant returned to modified work and was not obligated to reinstate TTD benefits when he left the modified job for non-injury related reasons.

To voluntarily reopen Own Motion claim, carrier must file a 3501 Form with WCD.

Turning to the penalty and attorney fee issue, the Board acknowledged the carrier's assertion that it had voluntarily reopened claimant's Own Motion claim when it began paying temporary disability benefits (shortly after its initial acceptance of the new/omitted medical condition). Nevertheless, the Board noted that the carrier had not filed a 3501 Form (a Notice of Voluntary Own Motion Claim Reopening) with the Workers' Compensation Division until some five months after its acceptance. Reasoning that the carrier was required to take such an action within 30 days of its claim acceptance, the Board concluded that its claim processing had been unreasonable and, as such, penalties and attorney fees under ORS 656.262(11)(a) were justified.

Penalties: "Discovery" - Hearing Request Did Not Seek Order to Compel Discovery - Matter Transferred to WCD

David C. Sellers, 69 Van Natta 1336 (September 14, 2017). Applying ORS 656.262(11)(a) and ORS 656.704, the Board determined that the Workers' Compensation Division (WCD) had exclusive jurisdiction over claimant's hearing requests, which alleged a failure to provide discovery and sought penalties and attorney fees. After claim acceptance, claimant's counsel initiated three discovery-related hearing requests. The first request, which followed a discovery request from claimant's counsel, alleged a failure to provide discovery and requested penalties, attorney fees, and costs. The second hearing request concerned an issue regarding the timing of the carrier's disclosure of a signed lump-sum request and alleged a failure to provide discovery, seeking penalties and attorney fees. Finally, claimant's third hearing request also asserted a discovery violation and raised penalties and attorney fees as issues.

Hearing requests sought only penalties and attorney fees.

The Board held that it lacked jurisdiction to address claimant's hearing requests. Relying on ORS 656.704(1) and (3)(a), the Board noted that the Hearings Division and the Board generally have jurisdiction over "matters concerning a claim," which are "matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue." However, the Board further observed that WCD (on behalf of the Director) has exclusive jurisdiction over proceedings regarding solely the assessment and payment of penalties and attorney fees under ORS 656.262(11)(a). Finally, referring to *Icenhower v. SAIF*, 180 Or App 297 (2002), the Board acknowledged that, if a dispute is properly before the Hearings Division, the subsequent narrowing of the issues to penalties and attorney fees does not divest the Hearings Division of jurisdiction.

Turning to the case at hand, the Board determined that the only relief sought by claimant's hearing requests was penalties and attorney fees. In reaching its determination, the Board acknowledged that it had previously held

in *James L. Williams*, 65 Van Natta 874 (2013), that the Hearings Division had jurisdiction over a hearing request that raised as issues the carrier's "failure to provide discovery," penalties and attorney fees. Upon further reflection, however, the Board concluded that the *Williams* reasoning was based on a false premise because it equated the mere reference to a "failure to provide discovery" in a hearing request as a motion for an ALJ's order compelling such discovery, yet nothing in that decision indicated that the claimant's hearing request sought such an order.

In absence of denial/ compensation issue, jurisdiction concerning a "discovery" request is dependent on a request to compel production of records.

After further considering the matter, the Board concluded that jurisdiction over a "discovery" hearing request (in the absence of a denial and when no compensation is at issue) is dependent on a request for an order to compel the production of records. Because the present record did not establish that any of claimant's hearing requests sought such an order, the Board held that the Hearings Division did not have jurisdiction over those matters. Reasoning that the Director had exclusive jurisdiction over the disputes, the Board dismissed the hearing requests and, consistent with ORS 656.704(5), transferred the matter to WCD.

Dissent argued that jurisdiction over "pre-denial" hearing request concerning "discovery" violation rests with WCD.

Member Curey specially concurred. Although agreeing that the Hearings Division did not have jurisdiction over the disputed issues, Curey stated that she would disavow *Williams* in its entirety and conclude that merely requesting an order to compel, on its own or in conjunction with a penalty/fee issue, was not sufficient to constitute a "matter concerning a claim" vesting jurisdiction with the Hearings Division. Noting that WCD has rules designated to address discovery issues, Member Curey asserted that the appropriate avenue for redress of the alleged violations rested with WCD.

Penalty: "268(5)(f)" - Lack of "Chronic Condition" Award in NOC - Based on "AP's" "Pre-Closure" Opinion, Which Changed "Post-Closure"

Keith J. Wiggins, 69 Van Natta 1310 (September 7, 2017). Applying ORS 656.268(5)(f), the Board held that a Notice of Closure (NOC) (which did not include a "chronic condition" permanent disability award) was not unreasonable because, at claim closure, claimant's attending physician had indicated that claimant had "some" limitation in the repetitive use of his injured knee, even though the physician subsequently rated claimant's limitation as "significant" during the reconsideration proceeding. At hearing regarding the Order on Reconsideration (which included a "chronic condition" award based on the attending physician's "post-closure" opinion), claimant sought a penalty under ORS 656.268(5)(f). Contending that the carrier's "pre-closure" request for information from the attending physician (which included a "gradation scale" asking whether claimant had "No limitation," "Some limitation," or "Significant limitation (more than 2/3 of the time)" in the repetitive use of the right knee), claimant argued that the carrier's NOC (lacking a "chronic condition" award) was unreasonable.

Board has previously questioned use of gradation scale, but carrier's "pre-closure" questionnaire was consistent with WCD's definition of "chronic condition."

The Board declined to grant claimant's penalty request. Citing *Ryan D. Grassman*, 62 Van Natta 270, 271 (2010), the Board acknowledged that it had previously questioned the utility of the carrier's "three-part" "significant limitation" questionnaire, which implies a "gradation" scale, rather than a "two-part" "either/or" analysis. Nevertheless, relying on *Scot T. Campbell*, 61 Van Natta 1818, 1832 (2009) the Board reiterated that a penalty under ORS 656.268(5)(f) was not justified when the increased compensation in the reconsideration proceeding was based on findings from a "post-closure" medical report that was not available to the carrier at the time of claim closure.

Turning to the case at hand, the Board noted that the carrier's questionnaire had included a carrier's definition of "significant limitation" as being "more than 2/3 of the time," which was consistent with the WCD's definition. The Board further reasoned that the attending physician's "reconsideration" report had included additional descriptions of claimant's limitations that were provided after issuance of the NOC. Under such circumstances, the Board concluded that the absence of a "chronic condition" award in the NOC was not unreasonable and, as such, a penalty under ORS 656.268(5)(f) was not warranted.

Premature Closure: "Accepted Conditions" and "Direct Medical Sequelae" Must Be "Medically Stationary" at Closure - Other "Work Injury/Incident-Related" Conditions Not Considered

Kevin B. VanBoeckel, 69 Van Natta 1390 (September 21, 2017). Applying ORS 656.268(1)(a), the Board held that, in determining whether a claim was prematurely closed, only medical information addressing the status of accepted conditions and their direct medical sequelae were required. The carrier accepted a right knee contusion and a lumbar strain combined with preexisting spondylosis. Although agreeing that these accepted conditions had resolved and were medically stationary, the attending physician also concurred with a medical opinion that claimant had a hip condition that resulted from the work accident. When an Order on Reconsideration found the claim prematurely closed because medical information had not addressed the medically stationary status of the hip condition, the carrier requested a hearing, contending that only the accepted conditions and their direct medical sequelae could be considered.

The Board agreed with the carrier's contention. Citing ORS 656.268(1)(a), the Board stated that claim closure was appropriate if the worker was "medically stationary" and there was "sufficient information to determine permanent disability." The Board noted that under the applicable Division 030 rules (WCD Admin. Order 15-059, eff. May 21, 2015) at the time the claim was closed, the "sufficient information" and "medically stationary" inquiries depended on medical evidence addressing conditions "directly resulting from the work injury," as well as accepted conditions and their direct medical sequelae. However, citing *Schultz v. Springfield Forest Prods*., 151 Or App 727 (1997), the Board reasoned that a rule promulgated by the Director will be given no effect if it is contrary to statutory authority.

Based on Brown decision, "accepted conditions/direct medical sequelae" must be "medically stationary" at claim closure.

Relying on *Manley v. SAIF*, 181 Or App 431 (2002), the Board reasoned that the statutory scheme limits the rating of permanent disability to accepted conditions and their direct medical sequelae, and that the legislature had necessarily implied that the propriety of claim closure depends on the medically stationary status of the conditions that must be rated. In addition, the Board referred to *Stuart C. Yekel*, 67 Van Natta 1279 (2015), ***aff'd per curiam***, *Yekel v. SAIF*, 286 Or App 837 (2017), for the proposition that the rating of permanent disability is limited to the accepted conditions and their medical sequelae, and *Katherine A. Lapraim*, 68 Van Natta 39 (2016), which had held that consideration of the "medically stationary" status of conditions other than the accepted conditions and their medical sequelae is contrary to the overall statutory scheme involving claim closure. Finally, the Board reasoned that, based on the analysis expressed in *Brown v. SAIF*, 361 Or 241 (2017), the "compensable injury" that must be "medically stationary" to support claim closure under ORS 656.268(1)(a) is defined by the carrier's Notice of Acceptance.

Turning to the case at hand, the Board observed that the Division 030 rule language regarding conditions "directly resulting from the work injury" had been promulgated in light of the Court of Appeals decision in *Brown v. SAIF*, 262 Or App 640 (2014), which was subsequently reversed by the Supreme Court's *Brown* decision. The Board also noted that the "directly resulting from the work injury" language had been removed from the Division 030 rules by WCD Admin. Order 07-053 (eff. April 11, 2017).

Board applied statutory scheme (as per Brown), rather than former WCD rule.

Insofar as the Court of Appeals *Brown* decision could be interpreted to support the consideration of conditions other than the accepted conditions and their direct medical sequelae, the Board reasoned that such case law had been reversed by the Supreme Court *Brown* decision. Because it would be contrary to statutory authority to apply the applicable Division 030 rules to require consideration of conditions other than the accepted conditions and their direct medical sequelae, the Board gave such an interpretation no effect.

Finally, finding that the record established that claimant's accepted conditions and direct medical sequelae were medically stationary, the Board concluded that the claim had been validly closed. Consequently, the Board reinstated the Notice of Closure.

Third Party Dispute: "Approved" Settlement Did Not Include "Workers' Comp" Recovery - Paying Agency Not Entitled to Share

Joel B. Ramirez, 69 Van Natta 1382 (September 19, 2017). Applying *Robertson v. Davcol*, 99 Or App 542 (1989), the Board held that the paying agency was not entitled to a share of proceeds from an approved settlement which expressly stated that no portion pertained to workers' compensation-related damages. Following his compensable injury, claimant filed a third party cause of action, asserting various employment-related causes of action, assault, battery, negligence and intentional infliction of emotional distress. Subsequently,

claimant and the third party carrier entered into a proposed settlement, which provided that the sole basis for the settlement arose from the employment law, emotional distress, and property claims, rather than the workers' compensation claim.

Paying agency approved settlement but did not agree to allocation terms.

The paying agency responded that it would approve the settlement under the statutory distribution provided for in ORS 656.593, but that it did not agree to the allocation terms. Claimant then filed a petition for resolution of the dispute with the Board.

Citing *Robertson*, the Board noted that where a third party settlement had expressly provided that no part of the agreement was attributable to claimant's negligence claim, and there was nothing in the record to show otherwise, the court had concluded that the paying agency was not entitled to a share of the settlement proceeds.

Because approved settlement allotted no portion to "workers' compensation" damages, paying agency not entitled to a share.

Turning to the case at hand, the Board determined that, as in *Robertson*, by not allocating any portion of the settlement to claimant's negligence claim, the settlement agreement had clearly apportioned the proceeds between the third party claim (no portion) and the other claims. In addition, consistent with *Robertson*, the Board interpreted the paying agency's response to the settlement as approval of the agreement, but a dispute concerning the allocation of proceeds. The Board explained that, by agreeing with the amount but disapproving the allocation terms, the paying agency was in effect taking issue with the apportionment of the settlement. In accordance with *Robertson*, the Board determined that the paying agency's remedy would be to reject the settlement outright, which would prompt the Board's review under ORS 656.587.

Had carrier not approved settlement, Board would likely not have granted approval.

Finally, the Board noted that, had the carrier not approved the settlement and the dispute had been submitted to it for resolution, it would likely not have granted its approval. Reasoning that the fundamental premise of the statutory scheme is that the tortfeasor is ultimately responsible for the costs of the workers' compensation claim, the Board observed that it likely would have considered a settlement in which no portion of the proceeds were allocated to the workers' compensation claim (when thousands of dollars of claim costs had been expended) to have been grossly unreasonable. *See Weems v. American Int'l Adjustment Co.*, 319 Or 140 (1994).

APPELLATE DECISIONS UPDATE

Extent: Impairment Findings - "Apportionment" Rule ("035-0013") - Not Limited to "Accepted/Denied" Combined Condition

Stryker v. SAIF, ___ Or App ___ (September 13, 2017). The court, *per curiam*, affirmed the Board's order in *Claudia S. Stryker*, 67 Van Natta 1003 (2015), previously noted 34 NCN 6:5, which, in rating claimant's permanent

impairment for compensable shoulder and low back conditions under *former* OAR 436-035-0013, apportioned her impairment between the accepted conditions and legally recognizable "preexisting conditions" that had not been accepted or denied before claim closure. The court cited *McDermott v. SAIF*, 286 Or App 406 (2017).

APPELLATE DECISIONS
COURT OF APPEALS

Medical Services: "245(1)(a)" - Diagnostic Services Necessary to Determine Cause/ Extent of Accepted Compensable Injury

Garcia-Solis v. Farmers Insurance Company, 288 Or App 1 (September 27, 2017). Applying ORS 656.245(1)(a), the court affirmed the Board's order in *Elvia Garcia-Solis*, 66 Van Natta 538 (2014), that upheld the carrier's denial of claimant's diagnostic medical service claim for a psychological referral to address "post-traumatic stress disorder (PTSD) like symptoms" related to her work injury (when she was struck by a tent pole during a wind storm). In reaching its conclusion, the Board had determined that, because the psychological evaluation was not caused in material part by her accepted conditions (a closed head injury, chronic headache syndrome, facial scarring, and right supraorbital nerve injury), the carrier was not required to authorize the requested diagnostic medical services. On appeal, claimant contended that diagnostic medical services need only relate to the work injury, not the accepted condition.

The court disagreed with claimant's contention. Citing *Easton v. SAIF*, 264 Or App 147 (2014), and *SAIF v. Carlos-Macias*, 262 Or App 629 (2014), the court acknowledged that it had previously ruled that diagnostic services are compensable if they are related to the work injury incident. The court noted that those holdings relied on the Court of Appeals opinion in *Brown v. SAIF*, 262 Or App 640 (2014) (*Brown I*). However, referring to *Brown v. SAIF*, 361 Or 241, 283 (2017) (*Brown II*), the court stated that the "injury incident" definition of "compensable injury" expressed in *Brown I* (which had held that the analysis of the compensability of a combined condition claim depended on its relationship to a previously accepted condition) had been reversed by the Supreme Court (*Brown II*).

Consequently, the court identified the question as whether *Brown II's* decision implicitly reversed the *Carlos-Macias* and *Easton* rationales. After analyzing *Brown II*, the court reasoned the Supreme Court had addressed the meaning of the term "compensable injury" as defined in ORS 656.005(7)(a), concluding that the term refers to a particular medical condition and not to a work injury incident.

Effect of Supreme Court's decision in Brown v. SAIF is to return to previous holdings that "compensable injury" refers to a medical condition, not an injury incident.

Accordingly, the court determined that the effect of *Brown II* was to overturn the *Carlos-Macias* and *Easton* holdings and to reinvigorate its previous holdings that diagnostic services are compensable only if they are necessary to determine the cause or extent of an accepted compensable injury. *Counts v. International Paper Co.*, 146 Or App 768, 771 (1997); *Roseburg Forest*

Products v. Langley, 156 Or App 454, 463 (1998). Under such circumstances, the court held that the Board had not erred in upholding the carrier's refusal to authorize the requested diagnostic services.

Judge Eagan dissented. Asserting that the *Brown II*'s "accepted condition" analysis concerned the interpretation of ORS 656.005(7)(a)(B) and combined conditions, Egan reasoned that the Supreme Court reserved judgment on implementing its "accepted condition" analysis in cases involving medical diagnoses such as *Carlos-Macias*.

Dissent argued that majority applied Brown too rigidly; previous case law makes clear that diagnostic services related to discovery of complaints (even if not due to accepted condition) may be compensable.

Pointing out that the Supreme Court had acknowledged that it may be necessary for the same words to be afforded different meanings within the Workers' Compensation Act to effectuate legislative intent, Judge Egan believed that the majority opinion had simply applied the "rule" of consistency too rigidly. Referring to several prior Court of Appeals' decisions, Eagan observed that the court had previously made it clear that diagnostic services related to the *discovery* of the cause of pain complaints (such as claimant's psychological reaction) can be reasonable and necessary expenses borne by the carrier, even if the results of the tests reveal that the condition was unrelated to the compensable condition. *See Counts*, 146 Or App at 768; *Faught v. SAIF*, 70 Or App 388 (1984); *Brooks v. D & R Timber*, 55 Or App 688 (1982).

Concerned that the majority decision leaves an injured worker completely without a remedy at the discretion of the carrier (rather than as required for the treatment of work-related conditions), Judge Egan contended that workers must have access to diagnostic procedures arising out of injuries rather than accepted conditions because all undiagnosed conditions arise out of injuries but not all undiagnosed conditions are related to accepted conditions.