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BOARD NEWS

Bulletin 1 (Revised) - Annual Adjustment to Attorney Fee Awards - Effective July 1, 2018

On June 1, 2016 “WCB Bulletin No. 1 (Revised)” published the annual adjustment to attorney fee awards under ORS 656.262(11)(a) and ORS 656.308(2)(d). See OAR 438-015-0038; OAR 438-015-0055(5); OAR 438-015-0110(3).

Effective July 1, 2018, an attorney fee awarded under ORS 656.262(11)(a) may not exceed \$4,418, absent a showing of extraordinary circumstances. OAR 438-015-0110(3). Also effective July 1, 2018, an attorney fee awarded under ORS 656.308(2)(d) shall not exceed \$3,186, absent a showing of extraordinary circumstances. OAR 438-015-0038; OAR 438-015-0055(5).

These adjustments apply to all attorney fee awards under these statutes granted by orders beginning July 1, 2018. The bulletin can be found on the Board’s website at: <https://www.oregon.gov/wcb/legal/Pages/bulletins.aspx>

Staff Attorney Recruitment

WCB is recruiting candidates for a staff attorney position. To be chosen, the applicant must have a law degree and extensive experience reviewing case records, performing legal research, and writing legal arguments or proposed orders. Excellent research, writing, and communication skills are essential. Preference may be given for legal experience in the area of workers’ compensation.

Further details about the position and information on how to apply is available online at <http://www.oregon.gov/DCBS/jobs/Pages/jobs.aspx> or www.oregonjobs.org. The recruitment will run until July 20, 2018. WCB is an equal opportunity employer.

Record Retention at WCB – What does the Board keep?

By Greig Lowell

A former client returns to your office, or an old case file comes back to life through an Own Motion request for reopening. You realize that the old paper file has been shredded, or otherwise destroyed. Is there any chance the Board has a copy of the prior litigation record?

Unfortunately, it is unlikely that the Board will have that record. The Board routinely purges files after the litigation has finally concluded at the Hearings Division, Board or Court level. The exhibits, briefs and correspondence are all securely destroyed about 90 days after the case becomes final.

From time to time, the Board will get inquiries from attorney firms, insurers and third party administrators seeking old case files, or information about them, such as final litigation orders and claim closure awards. Often, these inquiries arise in the context of an Own Motion claim.

While the Board does not retain the litigation file (exhibits, medical records, *etc.*), it does retain scanned copies of final litigation orders in the WCB Portal, from about 2012 and continuing forward. These include written orders from the Hearings Division and Board Review, plus settlement documents and orders of approval and dismissal. They can be accessed in the “Orders and Documents” tab from the WCB Case Status screen. The orders and documents may be of some assistance in determining the result of prior litigation, but are not a complete record of all activity concerning the claim or the litigation file.

The responsibility for insurers and service companies to retain claim records is governed by the Workers’ Compensation Division, see OAR 436-050-0120, and Bulletin 329:

https://wcd.oregon.gov/Rules/div_050/50-18056ub.pdf

https://wcd.oregon.gov/bulletins/bul_329.pdf

Insurers, service companies and attorneys are reminded that in processing Own Motion claims, the Board may require submission of old (and current) claim documents and medical records for purposes of:

- Reopening - OAR 438-012-0030(1)(b) and OAR 438-012-0061(2)
- Action by the Board - OAR 438-012-0040(2)
- Review of Claim Closure/Referral for Medical Arbitrator - OAR 438-012-0060(3)

Furthermore, the failure to comply with the Board’s Own Motion rules, including its request for records, if found unreasonable or unjustified, may result in the imposition of penalties and attorney fees, exclusion of evidence, referral for a fact-finding hearing, and/or a dismissal. See OAR 438-012-0110.

CASE NOTES

Course & Scope: “Rest Break / Walking” Injury - “Personal Comfort” Doctrine Applied - Met “Course Of” Prong, But “Arising Out Of” Not Satisfied - Fall on Public Sidewalk From Tree Root, No “Employer-Related” Risk

Claimant participated in wellness program offered by employer's benefits administrator.

Lori C. Watt, 70 Van Natta 755 (June 26, 2018). The Board held that, although claimant's injury, which was caused by her tripping on a tree root extending from a public sidewalk while she was walking during a paid rest break, occurred “in the course of” her employment under the “personal comfort” doctrine, her injury did not “arise out of” her employment because there was no “employer-related” risk to her injury. During her morning rest break, claimant put on her pedometer and went outside of her office on a public sidewalk, which was a route she, her coworkers, and supervisor often used. Claimant used the pedometer to participate in an online wellness program offered through the employer's benefits administrator. Participation in the program was affiliated with the administrator's “health employee maintenance program,” which provided a monetary incentive for participation. While on a public sidewalk a few blocks from the office, claimant caught her toe on an area where a tree root had broken the concrete, and tripped and fell, injuring her left hand. The carrier denied the claim, asserting that the injury did not arise out of or in the course of her employment. Claimant requested a hearing, contending that her injury had occurred within the “course and scope” of employment under the “personal comfort” doctrine.

The Board held that claimant's injury had occurred within the “course of” her employment, but determined that the injury did not “arise out of” her employment. Relying on *Fred Meyer, Inc. v. Hayes*, 325 Or 592 (1997), the Board stated that whether an injury “arises out of” and occurs “in the course of” employment concerns two prongs of a unitary “work-connection” inquiry that asks whether the relationship between the injury and the employment has a sufficient nexus such that the injury should be compensable. Referring to *Krushwitz v. McDonald's Restaurants*, 323 Or 520 (1996), and *Robinson v. Nabisco, Inc.*, 331 Or 178 (2000), the Board observed that the requirement that an injury “arise out of” employment depends on the causal link between the injury and the employment, whereas the requirement that an injury occur “in the course of” employment depends on the “time, place, and circumstances” of the injury. The Board explained that, under *Krushwitz* and *Redman Indus., Inc. v. Lang*, 326 Or 32 (1997), a sufficient work connection may exist where the factors supporting one prong are weak, if those supporting the other are strong, but that both prongs must be satisfied to some degree and neither is dispositive.

Sufficient work connection may exist where one prong is weak, if other is strong.

Citing *U.S. Bank v. Pohrman*, 272 Or App 31, rev den, 358 Or 70 (2015), the Board stated that the “in the course of” analysis begins with an inquiry into the nature of claimant's activity when injured to determine whether it bears a

Although injury did not occur on employer's premises, claimant was acting within course of employment, walking during paid break, acquiesced/encouraged by employer, wearing employer-provided pedometer.

sufficient connection to employment so that she cannot be considered to have left the course of employment, making the "personal comfort" doctrine applicable and the "going and coming" rule inapplicable. Based on *Pohrman*, the Board further noted that, if it is determined that claimant had not engaged in a personal comfort activity, but was injured while on a personal mission, or that the personal comfort activity did not bear a sufficient connection to the employment, then it may consider whether the "going and coming" rule, or any exceptions to that rule, would properly apply. Finally, in accordance with the *Pohrman* rationale, the Board observed that the seven factors from *Jordan v. Western Electric*, 1 Or App 441, 443 (1970), are used to determine whether the "personal comfort" doctrine applies, with a general focus on whether the activity was contemplated, directed by, or acquiesced in by the employer, where the activity occurred, and whether the employer benefits from the activity.

Turning to the case at hand, the Board found that claimant was still acting within the course of her employment when injured. In doing so, the Board reasoned that she was injured during her regular work hours, while on a paid break, and her walking activity during her break was acquiesced in by the employer. The Board further noted that claimant's un rebutted testimony established that, although walking on breaks was not mandatory and the employer did not designate walking routes, she was encouraged to take walks on her break in furtherance of the employer's wellness program, and she received a monthly monetary incentive for participation in the program. Finally, the Board observed that claimant had put on her pedometer to record her activity for that program, and went for a walk during her break.

Under such circumstances, the Board concluded that claimant's activity at the time of injury was not a departure from the employment relationship, even though it did not occur on the employer's premises, because she was engaged in an activity incidental to her employment, and had not "left work." Consequently, the Board determined that her injury was not subject to the "going and coming" rule and, as such, occurred in the course of her employment.

Injury occurred when claimant tripped on crack in public sidewalk more than a block from employer's premises.

However, concerning the "arising out of" prong of the "work connection" analysis, the Board determined that the risk of claimant's injury did not result from the nature of her work or originate from a risk to which the work environment exposed her. The Board found no suggestion that any defect or risk associated with the public sidewalk where claimant fell was an employment-created hazard or condition that contributed to her injury. Rather, the Board noted that claimant's injury had occurred on a public sidewalk, more than a block away from the employer's premises, as a result of a crack in the pavement caused by a tree root.

Injury did not "arise out of" employment.

Moreover, the Board acknowledged that the employer acquiesced in employees walking during their breaks. Nevertheless, the Board reasoned that there was no indication that on the day claimant was injured she was required to take that particular route by her employer or was precluded from walking a different route or taking her break elsewhere, such as on the employer's premises.

Under such circumstances, the Board concluded that the record did not establish a sufficient causal connection between claimant's risk of injury while walking on a public sidewalk during her rest break and her employment. Consequently, the Board upheld the carrier's denial.

In reaching its conclusion, the Board distinguished *Angelina Cox*, 68 Van Natta 792 (2016), and *Laura Brown*, 68 Van Natta 774 (2016). The Board noted that, in *Cox*, it had held that the claimant's injury "arose out of" a risk of employment because it occurred as she slipped and fell entering the building where her employer was a tenant. Similarly, the Board observed that, in *Brown*, it had held that the claimant's injury "arose out of" a risk of employment because the employer had designated a walking route that took the claimant into a more congested area. In the present case, in contrast to *Cox* and *Brown*, the Board reasoned that claimant's injury occurred far removed from the employer's premises, she was not walking on a route designated by her employer, and her injury was attributable to a non-employment-related hazard (a crack in a public sidewalk from a tree root).

Work Disability: "BFC" - Combination of DOT Codes for "At Injury" Job - Based on Job Descriptions, Job Analysis, Affidavits; "RFC" - "AP" Release, Based on Overall Lifting Capability - "035-0012(8)(g), (9)(a)(A), (10)

Claimant limited to under 50 lbs. lift/carry based on PCE (approved by AP).

Scott T. Richardson, 70 Van Natta 734, (June 5, 2018). Analyzing OAR 436-035-0012(8)(g), (9)(a)(A), and (10), in rating claimant's work disability award for a shoulder condition, the Board held that: (1) his Base Functional Capacity (BFC) was "heavy" based on a combination of Dictionary of Occupational Titles (DOTs) codes that most accurately described his "at-injury" job as a stock/inventory clerk (as detailed in a job description, job analysis, and affidavits from claimant and an employer representative); and (2) his Residual Functional Capacity (RFC) was "medium/light" because he was physically unable to perform the full range of "medium" activities. Before claim closure, claimant's attending physician concurred with a physical capacity evaluation (PCE), which limited all of claimant's lift/carry restrictions to under 50 pounds and determined that he was capable of "medium" work, with the exception that the physician disagreed with the PCE's assessment that he was limited to "light-medium" duties when working at shoulder height and above. Thereafter, claimant submitted an affidavit and his own job description disagreeing with the employer's regular job analysis, and the carrier submitted an employer representative's affidavit describing claimant's "regular job."

After an ALJ eventually awarded work disability, the carrier appealed, challenging the ALJ's finding that claimant's BFC was "heavy" and that claimant's RFC was "medium/light." Referring to the employer's job analysis and its representative's affidavit, the carrier asserted that a "light" BFC should be substituted for a specific DOT code or, alternatively, that a specific DOT

Claimant's affidavit may be used to corroborate a DOT description or a specific job analysis.

Combination of DOT codes provided most accurate description of "at injury" job. BFC of "heavy."

RFC was medium-light based on overall maximum lifting capacity.

Calculation of work disability award (monetary amount) is a claim processing matter.

code (for an "inventory clerk") established a BFC of "medium." Furthermore, based on the attending physician's concurrence with the PCE's "medium" assessment of claimant's capabilities, the carrier argued that his RFC should also be "medium."

The Board disagreed with the carrier's contentions. Citing *Debra J. Walker*, 67 Van Natta 2153 (2015), *Charles L. Chase*, 67 Van Natta 1205 (2015), and *Lavonne L. Hauser*, 52 Van Natta 883 (2000), the Board reiterated that OAR 436-035-0012(9)(a) requires that the strength category for the at-injury job be determined by either the category assigned in the DOT, a specific job analysis, or a job description agreed upon by the parties. Referring to *Walker* and *Chase*, the Board further noted that a claimant's affidavit may be corroborative of either a DOT description or a specific job analysis, relevant for determining what DOT description applies, or whether a DOT description or job analysis is more accurate.

Turning to the case at hand, the Board noted that claimant's description of his work and the weight lifted when he was injured was more than the lifting requirements described by the employer. Moreover, the Board observed that the medical records corroborated claimant's descriptions of his job duties as being greater than those listed in the employer's job analysis.

Under such circumstances, the Board concluded that the record did not support the carrier's assertion that claimant's BFC should be "medium" based on the DOT code for an "Inventory Clerk (clerical)" because the record indicated that the physical demands of his "at injury" job exceeded those of such a job description. Instead, based on both the employer's and claimant's job descriptions, as well as their affidavits, the Board found that the combination of the specific DOT descriptions ("Inventory Clerk (clerical)" and "Stock Clerk (retail trade)") most accurately described claimant's job-at-injury and established a BFC of "heavy" because the "Stock Clerk" DOT code had a strength category of "heavy." OAR 436-035-0012(9)(a)(A).

Addressing claimant's RFC, the Board noted that a worker's RFC is established by the attending physician's release, unless a preponderance of medical opinion describes a different RFC. OAR 436-035-0012(10)(a). Furthermore, relying on OAR 436-035-0012(10)(f), the Board stated that, for purposes of a RFC determination, a worker's lifting capacity is based on the whole person, not an individual body part.

Applying those principles to the present case, the Board acknowledged that the attending physician had concurred with the PCE that claimant was capable of "medium" work, except that the physician considered him capable of lifting above shoulder height at a weight greater than the "medium/light" duties listed in the PCE. Nevertheless, reasoning that the attending physician-approved PCE had limited claimant's overall maximum lifting capacity to less than 50 pounds, which was less than "medium" strength, the Board determined claimant's RFC to be "medium/light." OAR 436-035-0012(8)(g),(h).

Finally, in calculating claimant's work disability award, the Board declined to include the specific "dollar value" for the award. Relying on *Debra A. Dutkiewicz*, 63 Van Natta 1248, *recons*, 63 Van Natta 2211 (2011), the Board reiterated that such a calculation was a claim processing matter resulting from a determination of a claimant's work disability award.

APPELLATE DECISIONS UPDATE

Extent: Impairment Findings - “Significant Limitation”/“Repetitive Use” - “Meaningful”/“Important” Limitation - “035-0019(1)(i)”

Spurger v. SAIF, 292 Or App 227 (June 6, 2018). Analyzing OAR 436-035-0019(1)(i), the court reversed the Board’s order in *Angelica M. Spurger*, 67 Van Natta 1798 (2015), previously noted 34 NCN 10:2, that did not award a “chronic condition” impairment value for claimant’s hip condition. In reaching its conclusion, the Board had determined that claimant’s “attending physician” concurred with findings that she would have “difficulty” with “repetitive squatting, walking long distances, and static standing for long periods of time” did not establish that she was significantly limited in the repetitive use of her hip because it was not “meaningful” or “important.” On appeal, claimant asserted that the Board order did not explain why a “difficulty” performing repetitive squatting, walking long distances, and static standing was not a “meaningful” and “important” limitation on claimant’s use of her hip. See *Godínez v. SAIF*, 269 Or App 578, 583 (2015); *Webster’s Third New Int’l Dictionary*, 2116 (unabridged ed 2002).

Claimant asserted that physician’s finding of “difficulty” with repetitive squatting, walking, and standing is sufficient for chronic condition award.

The court agreed with claimant’s contention. The court considered it possible that the Board had concluded that claimant’s limitations were not sufficient because they are not general or comprehensive, but rather were limited to just one motion. Nonetheless, based on its review of the record, the court reasoned that such an interpretation of the Board’s conclusion did not seem likely.

The court also acknowledged that it was possible that the Board had simply found that claimant’s “difficulty” with repetitive use of her hip was not of a sufficient magnitude to be “meaningful” or “important.” However, the court considered such a finding would belie the physician’s recommendation of a change in claimant’s work schedule, which presumably was to accommodate her limitations related to the repetitive use of her hip.

Given such circumstances, the court concluded that the Board had not adequately explained why a difficulty performing repetitive movement was not a significant limitation. Consequently, the court held that the Board order was not supported by substantial reason, and, as such, remanded for reconsideration.

Court remanded to Board for reconsideration of whether claimant’s “difficulty” with repetitive use constituted “meaningful” or “important.”

Medical Services: “245(1)” / “225” - Proposed C6-7 Disc Surgery, Relationship to Preexisting Degenerative C6-7 Disc Condition

Arms v. SAIF, 292 Or App 217 (June 6, 2018). Applying ORS 656.245 (1) and ORS 656.225, the court reversed the Board’s order in *Tommy S. Arms*, 68 Van Natta 1230 (2016), previously noted 35 NCN 8:10, that upheld a carrier’s denial of claimant’s medical services claim for a worsened C6-7 disc herniation condition. Analyzing claimant’s worsened C6-7 disc condition as a consequential condition under ORS 656.245(1) and ORS 656.005(7)(a)(A), the Board had reasoned that medical evidence showed that claimant’s entire C6-7 disc degeneration was not caused in major part by his work injury and that the proposed surgery was directed not merely to treatment of the worsened portion of his condition but to the entire condition.

On appeal, claimant challenged the Board’s characterization of the worsened C6-7 condition as a consequential condition. Referring to *Fred Meyer, Inc. v. Evans*, 171 Or App 569, 573 (2000), the court acknowledged its holding that a preexisting condition made worse by a compensable injury is not a separate condition that constitutes a consequential condition. Nonetheless, the court observed that *SAIF v. Walker*, 260 Or App 327, 336 (2013), (which had upheld the compensability of a worsening of a preexisting disc herniation condition as a consequential condition) cast doubt on the continued viability of its statement in *Evans*.

Comparing the present case with *Walker*, the court reasoned that the record would support the Board’s determination that claimant’s worsened C6-7 disc degeneration was a consequential condition because it arose as a consequence of treatment for his accepted C5-6 condition. Relying on *Barrett Business Services v. Hanes*, 130 Or App 190, 193, *rev den*, 320 Or 492 (1994), the court determined that, in light of the Board’s finding that claimant’s worsened C6-7 degenerative disc condition was a consequential condition, it agreed with the Board that the compensability of the requested medical services depended on whether the compensable C5-6 disc injury (or its treatment) was the major contributing cause of his worsened C6-7 degenerative disc condition.

Nonetheless, the court concluded that the Board had not resolved the aforementioned issue. The court explained that, if, as the Board found, claimant’s worsened C6-7 condition was a consequential condition, and if claimant’s compensable C5-6 disc injury was its major contributing cause, then surgery directed to the treatment of that worsened compensable condition would be compensable, whether or not the surgery also incidentally treated that portion of the C6-7 disc degeneration that preexisted the C5-6 disc injury. See *SAIF v. Sprague*, 346 Or 661, 675 (2009). But, the court further questioned that, if, as the Board also had found, “the record did not establish that the worsening of the C6-7 disc degeneration was a distinct condition to be discretely addressed

If the worsened C6-7 was a consequential condition, and if the compensable C5-6 was its major contributing cause, surgery directed to the worsened compensable condition would be compensable even if it also treated the pre-existing condition.

If the worsened C6-7 disc was not analyzed as a consequential condition, Board should address compensability of medical service claim under “245” and limitation of “225.”

by the proposed surgery, as opposed to the overall C6-7 degeneration,” whether the worsened C6-7 degenerative disc condition was properly considered to be a separate consequential condition, rather than simply as a worsened preexisting condition. See *Fred Meyer, Inc. v. Crompton*, 150 Or App 531, 536 (1997).

Under such circumstances, the court reasoned that the Board should resolve the above-described question. If the Board subsequently concluded that the condition was not properly analyzed as a consequential condition, the court directed the Board to address whether the surgery was a compensable medical expense related to the original injury under ORS 656.245 and the limitations of ORS 656.225.

APPELLATE DECISIONS COURT OF APPEALS

Extent: Permanent Impairment -
“Apportionment” not Limited to
“Combined/Consequential Conditions”
Under “268(1)(b)”- Impairment Findings
Must be “Due To” Compensable Injury/O.D.

Netherton v. Aerotek, Inc., 292 Or App 550 (June 27, 2018). Analyzing ORS 656.214, and ORS 656.268(1)(a), (b), the court affirmed the Board’s order in *Jason D. Netherton*, 68 Van Natta 270, *corr*, 68 Van Natta 290 (2016), that did not award “range of motion” (ROM) permanent impairment for claimant’s accepted occupational disease claim for bilateral carpal tunnel syndrome because a medical arbiter panel had apportioned/attributed his reduced ROM finger findings to his body habitus, rather than to his accepted condition and subsequent surgery. On appeal, claimant contended that: (1) apportionment of his impairment findings between his body habitus and his accepted bilateral CTS was inappropriate because the claim closure did not concern an accepted combined or consequential condition under ORS 656.268(1)(b); and (2) the Appellate Review Unit (ARU) had erroneously reduced his permanent impairment award based on his “body habitus” (*i.e.*, his normal ROM in his fingers), rather than his impairment as determined under the Director’s uniform disability standard pursuant to ORS 656.726(4)(f).

The court disagreed with claimant’s contentions. Relying on *McDermott v. SAIF*, 286 Or App 406, 416 (2017), the court reiterated that the Board’s authority to apportion permanent impairment is not limited to claim closures under ORS 656.268(1)(b), but rather ORS 656.214 implicitly requires apportionment in the context of any claim when the impairment is not “due to” or the result of the compensable injury under the applicable standard of proof.

Turning to the case at hand, the court acknowledged that the *McDermott* decision involved an accepted injury, whereas the present case concerned an occupational disease. Nevertheless, noting that ORS 656.214 defines both impairment and permanent disability in reference to the “compensable industrial injury or occupational disease” and observing that OAR 436-035-0013(2)(a), (d)

Medical arbiter attributed ROM loss to body habitus, rather than accepted CTS.

“214” implicitly requires apportionment in any claim when impairment is not “due to” or result of the compensable injury.

Apportionment appropriate for occupational disease or injury.

Court emphasized finding that accepted condition had not caused abnormal ROM.

describes the procedures for determining impairment substantially identical for an injury or an occupational disease claim, the court concluded that apportionment for impairment for claims closed under ORS 656.268(1)(a) is appropriate whether for an injury, or an occupational disease.

The court also rejected claimant's second argument that, because ARU found that the ROM measurement in his fingers were "below the standard 'norms' outlined in the Oregon Disability Rating Standards," he was entitled to the full impairment rating under OAR 436-035-0060 for his specific ROM. Contrary to claimant's contention, the court emphasized that the ARU had found that claimant's accepted condition had not caused his abnormal ROM measurements.

Based on ARU's finding, the court reasoned that nothing more was required for ARU's determination to be "in accordance with the standards provided under ORS 656.726." See ORS 656.214(1)(a). As further support for its decision, the court noted that, in *Magana-Marquez v. SAIF*, 276 Or App 32, 36 (2016), it had affirmed a Board order that had not awarded permanent impairment for sensory loss and a reduced ROM as related to a claimant's accepted lumbar strain because a medical arbiter had attributed such impairment to body habitus, spondylosis, diabetes, or thyroid disorder, none of which had been claimed as compensable preexisting conditions.

APPELLATE DECISIONS SUPREME COURT

Attorney Fee: "386(1)(a)" - "Finally Prevail" - Supreme Court's Denial of Carrier's Petition for Review - Includes Attorney's Time in "Considering" Response to Carrier's Petition, Even Though No Response Filed

Shearer's Foods v. Hoffnagle, 363 Or 147 (June 21, 2018). Applying ORS 656.386(1)(a), the Supreme Court awarded claimant's counsel a carrier-paid attorney fee for time spent in considering whether to file a response to the carrier's unsuccessful petition for review of the Court of Appeals decision (284 Or App 859, *rev den*, 361 Or 866 (2017)), as well as claimant's counsel's time expended in responding to the carrier's objection to counsel's attorney fee petition. Citing *SAIF v. DeLeon*, 352 Or 130, 139 (2012), the court reiterated that ORS 656.386(1)(a) "applies in all instances in which a worker's claim for benefits has been denied." In making this pronouncement, the court acknowledged that in its older decisions (e.g., *Shoulders v. SAIF*, 300 Or 606, 611 (1986)), which had construed earlier versions of ORS 656.386, it had held that a claimant must "initiate" the appeal *from* an order or decision denying the claim for compensation. However, noting that the legislature had subsequently amended the pertinent text to its present form (i.e., in all cases where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation), the court reasoned that the phrasing relied on in *Shoulders* had been removed.

"386(1)" applies in all instances in which a worker's claim has been denied.

Thus, the court identified two pertinent inquiries when a claimant seeks an attorney fee award from the Supreme Court: (1) whether the case involves a denied claim; and (2) whether the claimant has “finally prevail[ed] against the denial in [a] * * * petition for review to the Supreme Court. Because it was undisputed that the case involved a denied claim, the court focused its attention on whether claimant had finally prevailed against the carrier’s denial when it denied the carrier’s petition for review of the Court of Appeals decision that had affirmed a Board order that had set aside the carrier’s claim denial.

Claimant “finally prevailed” when Supreme Court denied carrier’s petition for review.

After considering the text and context of the phrase “finally prevailed” in ORS 656.386(1)(a), the court disagreed with the carrier’s argument that, in order to prevail against its denial in a petition for review to the Supreme Court, the court must *allow* the petition and then enter a decision favorable to claimant on the merits. Looking to the ordinary meaning of the term “finally prevailed” for guidance in determining the legislature’s intention, the court consulted *Webster’s Third New Int’l Dictionary*, 1797 (unabridged ed 2002) and *Black’s Law Dictionary*, 1380 (10th ed 2014) and reasoned that “finally prevails” signifies the last stage in the process or the stage at which “prevailing” becomes permanent.

Timely petition for Supreme Court review made it possible that Court of Appeals decision might change until petition resolved.

Referring to ORS 2.520 and ORAP 14.05(2)(b), the Supreme Court observed that, because of the carrier’s timely petition for review, the Court of Appeals decision may still be changed until it resolved the petition. Thus, the Supreme Court concluded that the legislature intended “finally prevails” to include its denial of review of a Court of Appeals decision. In support of its conclusion, the court cited *Schoch v. Leupold & Stevens*, 325 Or 112, 117 (1997), which had described a “broad statement of a legislative policy” reflected in ORS 656.386 “that prevailing claimants’ attorneys shall receive reasonable compensation for their representation.”

The Supreme Court also rejected the carrier’s assertion that claimant did not “prevail” when it denied the carrier’s petition for review. Although acknowledging that its denial of the carrier’s petition expressed no comment on the merits of the Court of Appeals decision, the Supreme Court explained that it did not necessarily follow that no party “prevails” when a petition for review is denied. Likening the present case to situations where an appeal is dismissed on mootness grounds or for lack of jurisdiction, the court reasoned that the responding party has finally prevailed, even though no comment has been expressed whether the challenged decision was correct. See *DeYoung/Thomas v. Board of Parole*, 332 Or 266, 276 (2001).

Attorney’s discretion to refrain from filing an unnecessary response was reasonable representation.

Turning to the determination of a reasonable attorney fee under ORS 656.386(1)(a), the court disagreed with the carrier’s contention that it would be unreasonable to award attorney fees for claimant’s counsel’s time spent *considering* whether to file a response to the petition for review when no such response was ultimately filed. Although acknowledging that the lack of a written filing may be a significant factor when assessing the amount that represents “a reasonable attorney fee” for work performed in the case, the court concluded that an attorney’s exercise of considered discretion to refrain from filing an unnecessary response to the petition for review was quintessentially reasonable representation.

Applying ORS 20.075(2)(a), the Supreme Court stated that the factors it considered to be most significant in determining an attorney fee were “[t]he time and labor required in the proceeding, the novelty and difficulty of the questions involved in the proceeding and the skill needed to properly perform the legal services.” Given the similarities between the arguments presented by the carrier to the Court of Appeals and the issues raised in its petition for review, the Supreme Court considered three hours of attorney time to be a reasonable fee for work related to the petition for review. Furthermore, referring to *TriMet v. Aizawa*, 362 Or 1, 3 (2017), the court concluded that an additional 2.5 hours of time was reasonable for claimant’s counsel’s time spent litigating the attorney fee award, considering the extent to which counsel’s written arguments assisted the court in determining the award.

Under such circumstances, the court awarded a \$2,200 attorney fee for claimant’s counsel’s services. In doing so, the court accepted claimant’s counsel’s reduction of her customary hourly rate (\$425) to \$400 (presumably to accommodate the carrier’s objection) as reasonable given the experience of claimant’s attorney and her customary rate.

Court considered attorney’s time and hourly rate (\$400) to be reasonable given attorney’s experience and customary fee.