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**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 Kayleen Atkins, WCB's Executive Assistant at 2601 25<sup>th</sup> St. SE, Ste. 150, Salem, OR 97302, [kayleen.r.atkins@oregon.gov](mailto:kayleen.r.atkins@oregon.gov), or via fax at (503)373-1684. The deadline for these comments is October 31, 2018.

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>.

## Board Meeting - Discussion of Potential Rule Concept - "007-0020(6)(b)" - "Subpoena" for Obtaining "Individual Identifiable Health Information" - Notice to Recipient if Timely Objection

A Board meeting has been scheduled for August 23, 2018, at the Board's Salem office. The meeting, which will be held at 1:30 p.m., will concern consideration of the following matter:

Discussion of rule concept (submitted by Attorney Marcia Alvey) concerning OAR 438-007-0020(6), which concerns obtaining "individual identifiable health information" through a subpoena. Specifically, the concept suggests including in OAR 438-007-0020(6)(b) the language prescribed in OAR 438-007-0020(6)(f) (which requires including in the subpoena a notice to the recipient that, if it receives a timely objection from the individual whose information is being subpoenaed, the information being sought shall be mailed to the Board's Salem office).

**CASE NOTES (CONT.)**

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**APPELLATE DECISIONS****Court of Appeals**

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*While WCD "classification" review was pending, carrier reclassified claim as disabling based on a later accepted condition.*

*Board not authorized to make initial determination on "277(1)(b)" attorney fee. Parties directed to contact WCD.*

More information about the meeting can be found on the Board's website at <https://www.oregon.gov/wcb/Pages/meetings-minutes.aspx>.

**CASE NOTES**

## Classification: Reclassification Request - WCD Dismissed Review, Must First Address "277(1)(b)" Attorney Fee - Board "Fashions a Remedy"

*Donald L. Brant*, 70 Van Natta 824 (July 13, 2018). Analyzing ORS 656.277(1)(b), the Board held that, because the Workers' Compensation Division (WCD) had not addressed claimant's entitlement to an attorney fee when it dismissed his request for claim reclassification after a carrier had reclassified the claim to disabling, the Board was authorized to "fashion a remedy" to allow WCD an opportunity to address his attorney fee request. After the carrier denied his request to reclassify his "eye" claim to disabling, claimant requested WCD review. While that review remained pending, the carrier modified its acceptance to include a tinnitus/hearing loss condition, but also continued to classify the claim as nondisabling. When claimant requested that the carrier reclassify that claim to disabling, the carrier timely did so, based on information indicating that he had sustained permanent hearing loss. Thereafter, WCD dismissed claimant's pending reclassification request based on the carrier's action, but did not address whether claimant's counsel was entitled to an attorney fee under ORS 656.277(1)(b). Claimant requested a hearing, asserting that the matter should be returned to WCD to address the attorney fee issue.

Citing ORS 656.277(1)(b), the Board stated that, if a worker's attorney is instrumental in obtaining a Director's order that reclassifies a claim from nondisabling to disabling, the Director may award a reasonable attorney fee. Relying on *Birrer v. Principal Fin. Group*, 172 Or App 654, 662 (2001) and *Joseph Federico Jr.*, 67 Van Natta 1043, 1044 (2015), the Board reiterated that it is authorized to "fashion a remedy" by referring an issue to WCD in the first instance where the statute places initial authority over an issue with WCD for which it has not previously considered and also remanding the case to the Hearings Division to await WCD's decision.

Turning to the case at hand, the Board interpreted WCD's dismissal of claimant's reclassification request as a determination that the reclassification issue was "no longer viable." See *JRP Const. Enters. v. Dep't of Consumer Bus Servs.*, 269 Or App 372, 375 (2015); *Jaime Jimenez*, 68 Van Natta 1864 n 1 (2016) (an agency may dismiss a request for review based on a concept other than mootness in the course of carrying out its delegated statutory authority). Nonetheless, in the absence of a WCD decision regarding claimant's entitlement to an attorney fee under ORS 656.277(1)(b), the Board concluded that it was not statutorily authorized to make such an initial determination. Under such circumstances, the Board considered it appropriate to "fashion a remedy" by remanding the case to the Hearings Division and directing the parties to contact WCD to request a supplemental determination regarding claimant's counsel's entitlement to an attorney fee under ORS 656.277(1)(b).

In reaching its conclusion, the Board observed that the reclassification request pending before WCD appeared to pertain to the “eye” portion of claimant’s injury claim, whereas the carrier’s reclassification decision had appeared to be based on the subsequent “hearing loss” portion of the claim. Nonetheless, reasoning that a determination as to whether claimant’s counsel was instrumental in obtaining an order reclassifying the claim from the Director rested with WCD in the first instance, the Board expressed no further comments regarding claimant’s counsel’s entitlement to an attorney fee pursuant to ORS 656.277(1)(b).

## Course & Scope: “Going/Coming” Rule - “Traveling Employee” Exception - Flight Attendant’s “Airport Parking Lot” Injury - 18 Hours Before Work Shift Began - Not in “Travel” Status

*Rebecca J. Strachan*, 70 Van Natta 787 (July 9, 2018). The Board held that a flight attendant’s injury, which occurred when she fell exiting a shuttle bus in an airport parking lot, did not occur within the course of her employment because her work shift did not begin until some 18 hours after her fall and, as such, she was not a “traveling employee” when she sustained the injury. After taking a commuter flight from her home in anticipation of the beginning of her work shift at another airport, claimant was injured while exiting a shuttle bus in the airport’s parking lot. The carrier denied her injury claim, asserting that it did not occur within the “course and scope” of her employment. Relying on the “traveling employee” doctrine, claimant argued that her injury occurred while she was working, regardless of when the injury occurred.

The Board disagreed with claimant’s contention. Relying on *Robert M. Coleman, Jr.*, 65 Van Natta 1748 (2013), the Board stated that, where the claimant had worked at different locations and his job involved travel, the initial commute to work was not considered work-related travel and, as such, an injury suffered during that initial commute was excluded by the “going and coming” rule. In contrast, the Board noted that a claimant who was injured while traveling between work locations during a normal time for such travel (for which he was paid for his mileage) had been considered to be in the course of his employment as a “traveling employee.” See *Bruce Hohensee*, 56 Van Natta 1847 (2004).

Turning to the case at hand, the Board acknowledged that part of claimant’s job as a flight attendant involved work-related travel. Nonetheless, the Board reasoned that such an activity did not transform her commute in anticipation of her work shift (that began some 18 hours after her arrival at the airport) into work-related travel.

In reaching its conclusion, the Board further noted that claimant was not required to arrive at the airport until one hour before her scheduled “check-in” time, which was not until 90 minutes before her shift. Moreover, the Board observed that claimant was neither on a layover/other continuation of travel status nor performing any work-related services for her employer when her injury occurred.

*Where job involved travel, initial commute to work not considered work-related travel.*

*Because injury occurred 18 hours before check-in, did not occur “in course of” employment.*

Under such circumstances, the Board concluded that claimant's injury did not occur in the "course of" her employment. Consequently, the Board upheld the carrier's denial.

## Extent: Impairment Findings - "Newly Accepted Condition" - Findings Rated *All* Accepted Conditions, Including "New" Condition - "035-0007(3)(b)"

*Sandra Ocapan-Pantoja*, 70 Van Natta 817 (July 12, 2018). Analyzing OAR 436-035-0007(3)(b), the Board held that, when the medical arbiter's impairment findings following the closure of claimant's new/omitted medical condition (shoulder biceps tendinopathy) claim related the findings to all of her accepted shoulder conditions (including the biceps tendinopathy), the Appellate Review Unit (ARU) had not erred in awarding additional impairment based on the amount left after her prior permanent impairment award had been deducted from her current impairment rating. After claimant had been initially awarded 3 percent whole person impairment for a shoulder strain/capsulitis condition, the carrier reopened her claim for a new/omitted condition (left shoulder biceps tendinopathy). When an Order on Reconsideration awarded an additional 13 percent permanent impairment (based on a medical arbiter's findings of 16 percent for all of claimant's accepted shoulder conditions, including the biceps tendinopathy), the carrier requested a hearing. Relying on OAR 436-035-0007(3)(b), the carrier argued that claimant was not entitled to the increased permanent impairment award because the arbiter's impairment findings were not attributed *solely* to the newly accepted biceps tendinopathy condition.

The Board disagreed with the employer's contention. Citing OAR 436-035-0007(3), the Board stated that, when a new/omitted medical condition has been accepted since the last arrangement of compensation, the extent of permanent disability must be "redetermined." Referring to OAR 436-035-0007(3)(b), the Board noted only impairment related to the newly accepted condition is evaluated for "redetermination" purposes and that impairment for any previously accepted condition is not reevaluated, but is given the same impairment rating as established at the last arrangement of compensation. Relying on *Marvin Wood Products v. Callow*, 171 Or App 175, 183-84 (2000), the Board observed that, as the party requesting the hearing, the carrier bore the burden of establishing error in the reconsideration record.

Turning to the case at hand, the Board noted that the medical arbiter had related all of claimant's impairment findings to her accepted shoulder conditions, specifically including the newly accepted left shoulder biceps tendinopathy condition. The Board further observed that the arbiter's report had made no indication that any unaccepted, denied, preexisting, or superimposed condition had been included in the rating of claimant's permanent impairment. Under such circumstances, the Board reasoned that the medical arbiter had included claimant's 3 percent impairment for her previously accepted shoulder conditions in the current 16 impairment rating for all of her shoulder conditions (including her newly accepted biceps tendinopathy condition).

*Only impairment related to newly accepted condition is evaluated for "redetermination" purposes; impairment for previously accepted condition given same rating at last arrangement of compensation.*

*No unaccepted, denied, preexisting, or superimposed conditions noted in arbiter report.*

*Current 16-percent rating included prior 3-percent award; therefore, 13 percent for new condition.*

Based on the aforementioned reasoning, the Board concluded that the carrier had not established error in the reconsideration order's determination that claimant was entitled to an additional 13 percent permanent impairment award for her new biceps tendinopathy condition. Consequently, the Board affirmed the Order on Reconsideration award.

In reaching its conclusion, the Board distinguished *Randy D. Schollenberger*, 66 Van Natta 1792 (2014), *Manuel O. Rivera*, 61 Van Natta 928 (2009), and *Mark Holmes*, 57 Van Natta 1651 (2005). In doing so, the Board reasoned that, in contrast to the present case, in each of those cases, a medical arbiter had either expressly attributed the claimant's impairment findings to a condition other than the newly accepted condition or was unable to determine whether *any* impairment was attributable to the newly accepted condition.

## Extent: Impairment Findings - Fatigue/ Attention Deficit Due to Brain Condition - "AP" Findings More Accurate Than Arbiter Panel's Findings - "035-0390(10)"

*Mary M. Harvey*, 70 Van Natta 839 (July 18, 2018): On remand from the court (*Harvey v. SAIF*, 286 Or App 539 (2017)), analyzing OAR 436-035-0390(10), the Board held that claimant was entitled to a Class 2 brain impairment rating based on the impairment findings by her attending physician because (unlike the medical arbiters) the physician had specifically addressed claimant's fatigue as related to her cognitive defects from her accepted concussion and the impact on her activities of daily living (ADL) and employment capacity and, as such, the attending physician's findings were more accurate than the ambiguous arbiters' findings. Before claim closure, the attending physician noted that, based on two neuropsychological evaluations, claimant had cognitive deficits and persistent fatigue related to the increased energy she expended to overcome her attention/multi-tasking deficits at work. Restricting claimant from working more than 32 hours per week, the attending physician rated claimant's brain impairment as Class 2. After both parties requested reconsideration of a Notice of Closure, a medical arbiter panel rated claimant's permanent brain impairment as Class 1 for her accepted concussion. A physiatrist based the rating on "some minor abnormalities on the neuropsychological testing combined with [claimant's] general complaints," whereas a psychologist reached the Class 1 impairment conclusion based on the medical records, testing, and claimant's interview. After an Order on Reconsideration reduced claimant's permanent impairment/work disability awards based on the arbiters' findings, claimant requested a hearing, contending that her attending physician's findings were more accurate because those findings (as opposed to the arbiters') had considered her fatigue/limited work hours.

*Attending physician limited claimant to 32 hours of work per week, and rated Class 2 brain impairment.*

The Board agreed with claimant's contention. Citing OAR 436-035-0007(5) and *SAIF v. Owens*, 247 Or App 402 (2011), *recons*, 248 Or App 746 (2012), the Board stated that, where a medical arbiter is used, impairment is established based on objective findings of the medical arbiter, except where a preponderance of the medical evidence demonstrates that different findings by the attending physician are more accurate and should

*Medical arbiter had not discussed whether fatigue was a residual/sequela of accepted concussion in rating Class 1.*

be used. Referring to *SAIF v. Banderas*, 252 Or App 136 (2012), the Board also explained that, where the attending physician's opinion of impairment is not expressly rejected, OAR 436-035-0007(5) permits the preference of the attending physician's impairment findings, if the preponderance of the medical evidence establishes that they are more accurate.

Turning to the case at hand, the Board found that, despite acknowledging claimant's reports of fatigue, the medical arbiter psychologist had not otherwise discussed whether claimant's fatigue was a residual/sequela of her accepted concussion (and therefore included in his Class 1 rating). The Board also reasoned that the psychologist's Class 1 rating was inconsistent with claimant's uncontested representations regarding her fatigue and its residuals/impairments. Additionally, the Board noted that the psychologist had not explained how the results of claimant's various neuropsychological evaluations indicated a Class 1, rather than a Class 2, level of impairment. Finally, addressing the arbiter psychiatrist's opinion, the Board observed that the psychiatrist had neither described the "minor abnormalities" on claimant's neuropsychological testing, nor specifically addressed her fatigue/reduced work hours, in concluding that claimant had Class 1 brain impairment.

In contrast to the arbiter panel's ambiguous opinions and conclusions, the Board reasoned that the attending physician had specifically attributed claimant's fatigue as related to her cognitive deficits from the accepted concussion, and addressed the impact on her daily living and employment capacity as compared to her "preinjury" abilities. The Board was further persuaded that the attending physician understood that, pursuant to OAR 436-035-0390(10)(e), the highest class of impairment must be used when a worker's impairment falls between one or more categories.

*Arbiter panel's opinions ambiguous. Attending physician's unambiguous opinion (supporting Class 2 impairment) more persuasive.*

Consequently, based on the attending physician's unambiguous opinion, the Board found that the record persuasively supported claimant's entitlement to a Class 2 brain impairment rating. Therefore, the Board modified the Order on Reconsideration's impairment and work disability awards that had been based on the medical arbiters' impairment findings.

## Own Motion: "PTD" Request - "Fact Finding" Hearing Not Necessary (No Credibility/Veracity Dispute, Documentary Record Sufficiently Developed) - "Willingness to Work" Evaluation Based as of Date of Claim Closure

*Lloyd D. Irwin, Jr.*, 70 Van Natta 797 (July 10, 2018): Analyzing ORS 656.206(1)(d) and ORS 656.206(3), in reviewing a claimant's request for a permanent total disability (PTD) award arising from Own Motion Notices of Closure concerning new/omitted medical conditions, the Board held that: (1) a "fact finding" hearing was unnecessary to determine claimant's entitlement to PTD benefits because his credibility/veracity as expressed in affidavits and the documentary record were not contested and the record was sufficiently

*Claimant submitted affidavits concerning his physical limitations and willingness to work, as well as medical/vocational reports.*

developed to determine whether he was “permanently incapacitated” from gainful employment; and (2) he was not entitled to a PTD award because the record did not establish that he was in the “workforce” at the time of the closure of his Own Motion claims. In requesting review of Own Motion Notices of Closure, claimant sought PTD benefits and a “fact finding” hearing. In presenting their written arguments regarding claimant’s requests, the parties submitted evidence pertaining to claimant’s entitlement to PTD benefits (which included his affidavits concerning his physical limitations and willingness to work). In doing so, claimant alternatively argued that his affidavits established his willingness/efforts to seek work, and that the opinion of his vocational counselor (which was based on the truthfulness of his representations in his affidavits) established that it was “futile” for him to seek work.

*“Workforce” status for an Own Motion claim is made as of the date of claim closure.*

The Board held that a “fact finding” hearing was not necessary and that a PTD award was not justified. Referring to OAR 438-012-0060(7), *Koskela v. Willamette Indus. Inc.*, 331 Or 362 (2000), *Laura A. Heisler*, 55 Van Natta 3974 (2003), and *Stuart T. Valley*, 55 Van Natta 2521 (2003), the Board noted that due process entitles a worker seeking PTD benefits an opportunity for “at least some kind of an oral evidentiary hearing” where such a determination requires a resolution of factual disputes and judgments about a claimant’s credibility/veracity regarding willingness and efforts to seek/obtain gainful employment. Citing ORS 656.206(1)(d) and (3), *SAIF v. Stephen*, 308 Or 41 (1989), *Leonard L. Seeger*, 67 Van Natta 263, *recons*, 67 Van Natta 655 (2015), *aff’d without opinion*, 281 Or App 460 (2016), and *Richard L. Elsea*, 66 Van Natta 493, *recons*, 66 Van Natta 727 (2014), *aff’d*, *Elsea v. Liberty Mutual Ins.*, 277 Or App 475 (2016), the Board stated that, in addition to establishing that his physical condition (or his physical condition in combination with other social/vocational factors) left him permanently incapacitated from gainful employment, claimant must also demonstrate his presence “in the workforce.” Referring to *Elsea*, the Board reiterated that a determination of claimant’s “workforce” status is made as of the date of claim closure, when PTD benefits are evaluated.

*Because claimant’s veracity/credibility unchallenged and documentary record sufficiently developed, “fact-finding” hearing unnecessary.*

Applying the aforementioned principles to the case at hand, the Board acknowledged that portions of the record appeared to be inconsistent with claimant’s current affidavits regarding his willingness to work. Nonetheless, reasoning that claimant’s credibility/veracity was unchallenged, the Board explained that its decision regarding his entitlement to PTD benefits was not based on those alleged inconsistencies. In addition, noting that both parties had availed themselves of the opportunity to present documentary evidence on claimant’s PTD claim and that there was sufficient medical/vocational evidence to make such a determination, the Board concluded that a “fact finding” hearing was not necessary. See *John R. Taylor*, 68 Van Natta 1866 (2016); *Michelle A. Griffith*, 68 Van Natta 1505, *recons*, 68 Van Natta 1731 (2016); *Adolfo S. Lopez*, 57 Van Natta 1056 (2005).

*Claimant’s affidavit’s representations on future intentions/willingness to work did not address condition at claim closure.*

Turning to the merits of the PTD claim, the Board found that the representations in claimant’s affidavit concerning his future intentions/willingness to work (even if credible and uncontradicted) were insufficient to establish that, as of claim closure, he was willing to seek regular gainful employment and making reasonable efforts to obtain such employment. Moreover, even if the record otherwise supported the proposition that he was unable to perform any gainful employment (a conclusion that the Board considered inconsistent with

medical/vocational assessments that he was capable of performing “sedentary/light” work), the Board determined that the record did not establish that it would be “futile” for claimant to seek work.

Under such circumstances, the Board concluded that claimant was not entitled to PTD benefits. Consequently, the Board affirmed the closure notices.

## Penalty: Separate Unreasonable Acts - Discovery Violation/Unreasonable Denial - Separate Amounts “Then Due” - As of Date Violation “Cured” & Date of “Hearing Record” Closure

*Sherrie L. Brandaw*, 70 Van Natta 856 (July 18, 2018). Applying ORS 656.262(11)(a), the Board assessed penalties for both a carrier’s unreasonable discovery violation and its unreasonable denial because there were separate “amounts then due” on which to base the separate penalties. The carrier denied an injury claim, three days after its consultant’s report had stated that the claimed condition was work-related. In addition, the carrier untimely provided discovery before a scheduled hearing regarding the denial. Claimant sought separate penalties for these unreasonable acts based on the compensation then due resulting from a decision that the claim was compensable.

The Board granted claimant’s requests. Citing ORS 656.262(11)(a), the Board stated that a penalty of up to 25 percent of “amounts then due” plus an attorney fee may be awarded if a discovery violation or unreasonable denial results in an unreasonable delay or refusal to pay compensation. Referring to *Bradley P. Ballantyne*, 64 Van Natta 2280 (2012), and *James O. Robinson*, 61 Van Natta 2707 (2009), the Board explained that a penalty for an unreasonable discovery violation is based on the amounts then due when the discovery violation is cured. Relying on *Wacker Siltronic Corp. v. Satcher*, 91 Or App 654 (1988), the Board observed that a penalty for an unreasonable denial is based on the amounts then due as of the time of the hearing (or when the hearing record closed). Finally, citing *Eliseo Sales-Parra, Dcd*, 68 Van Natta 679 (2016), the Board clarified that multiple penalties under ORS 656.262(11)(a) cannot be assessed against the same amounts then due.

Turning to the case at hand, the Board concluded that claimant was entitled to a penalty and related attorney fee under ORS 656.262(11)(a) for the carrier’s unreasonable discovery violation (which resulted in a delay in compensation given that the claim had been determined to be compensable), based on the amounts then due when the discovery violation was cured before the scheduled hearing. Furthermore, finding that the carrier did not have a legitimate doubt about its liability when it issued its denial, the Board also determined that a penalty and related fee under ORS 656.262(11)(a) were warranted for that unreasonable conduct.

*Penalty for unreasonable discovery violation is based on amounts then due when violation is cured.*

*Multiple penalties cannot be assessed against the same amounts.*

*Because penalty for unreasonable denial based on compensation due as of hearing record closing, there was separate amount “then due” (between “cure of discovery violation” date and closure of hearing record).*

Because the penalty for the discovery violation was based on the amounts then due when the violation was cured (before the scheduled hearing), the Board reasoned that there were separate amounts then due on which to base a penalty for the unreasonable denial; *i.e.*, compensation then due after the discovery violation was cured through the date the hearing record closed. Accordingly, the Board awarded separate penalties/fees under ORS 656.262(11)(a) for both acts of unreasonable conduct.

### Third Party Dispute: “Extraordinary” Attorney Fee Not Granted - Complex, Time Consuming Investigation/Discovery - But No Trial/Mediation, Settlement Approximately 1/3 of Carrier’s Lien - Carrier’s “No Position” Not Determinative

*Jerry D. Smith, Dcd*, 70 Van Natta 791 (July 9, 2018). Applying ORS 656.593(1)(a) and OAR 438-015-0095, the Board held that claimant’s counsel was not entitled to an “extraordinary” attorney fee concerning a third party action settlement, because, although claimant had expended extensive time in investigating and preparing the case for litigation (and the carrier took no position regarding the request), no trial/mediation had been convened and the eventual settlement was less than one-third of the carrier’s actual lien. Following a worker’s work-related fatality, claimant (his beneficiary) filed a third party cause of action. According to his retainer agreement, his counsel would receive one-third of the total amount recovered prior to 30 days before the first mediation or trial date, or 40 percent of the total amount if the case was settled within 30 days of the first mediation or trial date. After the carrier approved the third party settlement offer, claimant petitioned the Board for approval of an extraordinary attorney fee award of 40 percent from the settlement proceeds. The carrier took no position regarding the request.

The Board declined to grant the request. Citing OAR 438-015-0095, the Board stated that, absent a finding of extraordinary circumstances, an attorney fee not to exceed 33-1/3 percent of the third party recovery is authorized.” Relying on *Gary D. Smith*, 67 Van Natta 292 (2015), *William Coultas*, 64 Van Natta 1375 (2012), *Manfred Schiller*, 59 Van Natta 2768 (2007), the Board reiterated that, in determining whether “extraordinary circumstances” exists, the following factors are considered: the attorney’s efforts and resources devoted to the case, the complexity and extent of the litigation, the stage of litigation at which the claimant prevailed, whether the results achieved were favorable, and the carrier’s position regarding the “extraordinary” attorney fee request.

After comparing the case with its past decisions regarding requests for “extraordinary” attorney fees, the Board did not consider that the present case warranted an “extraordinary” fee. In reaching its conclusion, the Board contrasted the present case with references to several cases discussed in the *Schiller* decision that had granted “extraordinary” attorney fees based on extensive trials and appeals. In addition, the Board considered the case

*Factors considered for “extraordinary” fee: efforts/resources devoted; stage of litigation when recovery achieved; favorable results.*

*Carrier's objection to fee request not determinative; considering no trial/mediation and recovery less than 1/3 of actual lien, "extraordinary" fee not warranted.*

*Physician's opinion that condition was caused by work activities over time, in combination with work event; analyzed as "O.D."*

*Claimant contended that it was also compensable as an injury.*

*Symptoms arose during discrete period, but condition developed gradually.*

similar to *Anthony L. St. Julien*, 62 Van Natta 43 (2010), where, in not granting an "extraordinary" attorney fee, it had reasoned that, although the claimant's counsel had expended significant efforts and resources, the case had not proceeded to trial/appellate litigation and the settlement (approximately 80 percent of the carrier's unopposed lien) was not exceptionally favorable.

The Board acknowledged that, in *St. Julien*, the carrier had opposed the request for an "extraordinary" attorney fee. Nonetheless, the Board reiterated that a carrier's objection to an "extraordinary" attorney fee request was not determinative. Finally, noting that the settlement in the present case had occurred without the commencement of a trial/mediation and was in an amount less than one-third of the carrier's actual lien, the Board did not find extraordinary circumstances warranting an attorney fee in excess of the standard one-third share prescribed in OAR 438-015-0095.

## APPELLATE DECISIONS COURT OF APPEALS

### Injury v. O.D.: Board Must Apply Appropriate "Standard" - *Symptoms* Arose During Discrete Period, But *Condition* Developed Gradually

*Miller v. SAIF*, 293 Or App 74 (July 25, 2018). Applying ORS 656.802(1)(a)(C) and ORS 656.005(7)(a), the court affirmed the Board's order in *Jeffery L. Miller*, 67 Van Natta 1497 (2015), that had set aside a carrier's occupational disease denial for a shoulder condition, but upheld the carrier's injury denial for his shoulder condition. Persuaded by a physician's opinion that claimant's shoulder condition was caused by his work activities over time in combination with a work incident, the Board analyzed his claim as an occupational disease and found it compensable because employment-related events or occurrences were the major contributing cause of his claimed condition. See *Hunter v. SAIF*, 246 Or App 755, 760 (2011). In reaching its conclusion, the Board emphasized that it was obligated to review the record to determine the appropriate legal standard between an occupational disease or injury theory. See *DiBrito v. SAIF*, 319 Or 244, 248 (1994). On appeal, claimant contended that the Board had erred in not also finding a compensable shoulder injury.

The court disagreed with claimant's contention. Citing *Smirnoff v. SAIF*, 188 Or App 438, 449 (2003), and *LP Company v. Disdero Structural*, 118 Or App 36, 40 (1993), the court reiterated that, when an "injury" is claimed to have resulted from "repetitive trauma," the medical evidence must establish it "develop[ed] within a discrete, identifiable period of time due to specific activity." Furthermore, relying on *Luton v. Willamette Valley Rehabilitation Center*, 272 Or App 487, 490-91 (2015), the court stated that the proper inquiry for determining the applicable standard(s) is whether the condition itself, not its symptoms, occurred gradually, rather than suddenly and, even where *symptoms* arise within a discrete period, the medical evidence may support a finding that the *condition* which caused those symptoms did not necessarily develop in that same period.

Turning to the case at hand, and reviewing for substantial evidence/reasoning, the court determined that the Board could infer that claimant's work incident was the discrete period in which his rotator cuff condition *became symptomatic*, but that his condition developed through occupational overuse over many years. Consequently the court held that the Board could conclude that the evidence did not support an accidental injury theory of compensability.