



# News & Case Notes

**BOARD NEWS**

Biennial Review/Attorney Fees/"388(4)" - December 11 Board Meeting – Referral to Advisory Committee 1

Rulemaking Hearing: February 1, 2019 – Proposed Rule Regarding "Translation of Written Documents" (OAR 438-007-0045); Proposed Amendments Concerning "Notices" of Denials/Acceptances (OAR 438-005-0050, -0053, -0055, - 0060) 2

"Five-Year" Review: OAR 438-011-0055 - "Third Party Election Letter" - Public Comment 3

ALJ Recruitment 3

ALJ Anonymous Survey - Coming Soon! 4

**CASE NOTES**

Combined Condition: Consists of "Two Medical Problems Simultaneously" - Carrier Met "Burden of Proof" Under "266(2)(a)" - Work Injury Not Major Cause of Disability/Treatment for "Combined" Shoulder Condition (Exacerbation of Symptoms From Preexisting Arthritic Condition) 4

Evidence: Exclusion of Expert Witness Testimony for Untimely "Notice" Under "007-0016" - ALJ Did Not Abuse Discretion - "Material Prejudice" to Opposing Party, Lack of "Good Cause" for Rule Violation 6

Extent: Impairment - "Chronic Condition" - "Significant Limitation/Repetitive Use" - "Pre-WCD Industry Notice" - "Important/Notable" Limitation/Difficulty 8

Offset: Carrier's Payment of TTD Benefits Granted by Final Order on Reconsideration - Subject to "25 Percent Offset Limitation" Under "268(14)" 9

**BOARD NEWS**

## Biennial Review/Attorney Fees/"388(4)" - December 11 Board Meeting - Referral to Advisory Committee

At its December 11 meeting, the Board Members discussed written/oral responses received in reply to their invitation for comments regarding their biennial review of the Board's schedule of attorney fees under ORS 656.388(4). Those responses concerned a number of subjects, such as the amount of ALJ/Board attorney fee awards and the total attorney fees/legal costs secured by attorneys representing insurers/employers and those representing workers. In addition, a number of rule concepts concerned methods for determining a reasonable carrier-paid attorney fee (including obtaining information regarding the attorney fees earned by carriers' attorneys, establishing a reasonable hourly rate for a worker's attorney's services, and calculating a "contingency multiplier" to account for the contingent nature of a workers' compensation practice).

After considering the testimony and written comments, the Members decided to refer the rule concepts to an advisory committee. Once the committee completes its review of the concepts and issues an advisory report, the Members will schedule another Board meeting, where they will discuss the report, as well as consider further comments from the public.

In the meantime, the Members encourage parties, practitioners, and the general public to continue to participate in the Board's biennial review process. To that end, additional written comments received in response to the Members' invitation will continue to be posted on WCB's website. Those written comments should be directed to Kayleen Atkins, WCB's Executive Assistant, at 2601 25th 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.

In addition, the Members have requested further statistical data from the Department of Consumer & Business Services (DCBS) regarding the amount/type of issues litigated before the Hearings Division and on Board review, as well as the amount/type of attorney fees awarded by orders issued and settlements approved by ALJs/Board and the amount of attorney fees/legal expenses incurred by insurers/employers. This data will also be considered by the Members when they discuss the advisory committee's eventual report.

After the Members complete their deliberations regarding the committee's report and the data from DCBS, they will decide whether to propose amendments to the Board's attorney fee rules.

**CASE NOTES (CONT.)**

Own Motion: "Worsened Condition" Claim - Claimant's Affidavit/Documents Established Presence in "Work Force" Before "Disability Date" - Carrier's Recommendation Against Reopening Not Unreasonable 12

TTD Rate: Calculation of "AWW" for Workers With "Irregular Wages" - "Averaging" Method Under Former Version of "060-0025(4)" - W/I Director's (WCD's) Discretion/Complied With "210(2)(d)(A)" - Subsequent Rule Amendment Did Not Mean Acknowledgment of Former Rule's Invalidity 12

**APPELLATE DECISIONS****Update**

Claim Processing: "Non-Cooperation" Denial - "Post-Suspension Order" Cooperation Must Be Reasonable - "262(15)" 13

**Court of Appeals**

Attorney Fee: "Pre-Hearing" Rescinded Denial - Board's "386(1)" Carrier-Paid Fee Award - Lacked Substantial Reason 14

Standards: Work Disability - Claimant's Use of Hearing Aids - Did Not Establish That Claimant Had Not Been Released, or Returned, to "Regular Work" - "214(1)(d),(e), (2)(b)" 15

## Rulemaking Hearing: February 1, 2019 - Proposed Rule Regarding "Translation of Written Documents" (OAR 438-007-0045); Proposed Amendments Concerning "Notices" of Denials/Acceptances (OAR 438-005-0050, -0053, -0055, -0060)

At their November 27 meeting, the Members proposed an administrative rule regarding the "Translation of Written Documents" (OAR 438-007-0045) and amendments to its existing rules concerning "Notices" of Acceptances/Denials (OAR 438-005-0050, -0053, -0055, -0060). The Members took these actions after considering a report from their Advisory Committee. The committee had been appointed to consider concepts submitted by the Oregon State Bar's Access to Justice Committee. The Members wish to extend their grateful appreciation to the Advisory Committee (Jennifer Flood, ombudsman for injured workers, Krishna Balasubramani, attorney at law, Bin Chen, attorney at law, Katherine Krametbauer, attorney at law, Matthew U'Ren, attorney at law, Ana Maria Meneses-Henry, interpreter, and ALJ Bruce Smith (facilitator)).

Proposed OAR 438-007-0045 is designed to prescribe the procedures concerning the admission of documents at hearing that contain language other than English. Specifically, the proposed rule requires that any non-English language document must be translated. In addition, the proposed rule prescribes the manner in which such translations may be accomplished, as well as procedures for assigning costs for obtaining the translations or resolving any disputes regarding the translations. The proposed rule further provides that translation costs incurred by a claimant are subject to reimbursement under ORS 656.386(2).

The proposed amendments to OAR 438-005-0050, -0053, -0055, and -0060 are designed to require that all acceptance/denial notices comply with proposed OAR 436-001-0600 (Bulletin 379), which the Workers' Compensation Division will be proposing to mandate that important claim processing documents such as these notices (as well as others) include a "multi-language help-page" informational insert that notifies non-English speaking workers of the importance of such documents, including access to the Ombudsman for Injured Workers.

Notice of this rulemaking action has been filed with the Secretary of State's office. Electronic copies of these rulemaking materials are available on WCB's website at [www.wcb.oregon.gov](http://www.wcb.oregon.gov) (under the category "Laws and rules"). Copies will also be distributed to parties and practitioners on WCB's mailing list.

A rulemaking hearing for these proposed rule amendments has been scheduled for February 1, 2019, at 10 a.m. at the Board's Salem office (2601 25th St. SE, Ste. 150, Salem, OR 97302-1280). Any written comments submitted in advance of the hearing may be directed to Trish Fleischman, the

rulemaking hearing officer. Those comments may be mailed to the above address, faxed to (503)373-1684, e-mailed to [rulecomments.wcb@oregon.gov](mailto:rulecomments.wcb@oregon.gov) or hand-delivered to a permanently staffed Board office (Salem, Portland, Eugene, Medford).

## “Five-Year” Review: OAR 438-011-0055 - “Third Party Election Letter” - Public Comment

In accordance with ORS 183.405, the Board is conducting its “five-year” review of OAR 438-011-0055, which prescribes the procedures to be followed by a “paying agency” in issuing a “third party election” letter. The Board has already requested/received written comments from members of the advisory committee regarding this rule, as well as parties/practitioners who offered comments during the initial rulemaking process. (Copies of those responses will be posted on the Board’s website.)

To further assist the Members in conducting their review of this rule, they are seeking written comment from the public. (Notice of this request for public comment will also be electronically distributed to those who have registered for “rule-related” notifications at <https://service.govdelivery.com/accounts/ORDCBS/subscriber/new>.) Any such comments should be directed to Kayleen Atkins, WCB’s Executive Assistant, at 2601 25th 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 written comments is February 28, 2019.

Those written comments, which will also be posted on the Board’s website, should address the following questions:

1. Did the rule achieve its intended effect?
2. Was the anticipated fiscal impact of the rule underestimated or overestimated? (See Board’s “Statement of Need and Fiscal Impact” dated June 28, 2013.)
3. Have any subsequent changes in the law required that the rule be repealed or amended?
4. Is there a continued need for the rule?
5. What impacts has the rule had on small business?

## ALJ Recruitment

WCB intends to fill an Administrative Law Judge position in the Salem Hearings Division. The position involves conducting workers’ compensation and OSHA contested case hearings, making evidentiary and other procedural rulings, conducting mediations, analyzing complex medical, legal, and factual issues, and issuing written decisions which include findings of fact and conclusions of law. Applicants must be members in good standing of the Oregon

State Bar or the Bar of the highest court of record in any other state or currently admitted to practice before the federal courts in the District of Columbia. The position requires periodic travel, including but not limited to Eugene, Roseburg, and Coos Bay, and working irregular hours. The successful candidate will have a valid driver's license and a satisfactory driving record. Employment will be contingent upon the passing of a fingerprint-based criminal background check. The announcement (number 18-0239), found on the Department of Consumer and Business Services (DCBS) website at <http://www.oregon.gov/DCBS/jobs/Pages/jobs.aspx> contains additional information about compensation and benefits of the position and how to apply. Questions regarding the position should be directed to Ms. Kerry Garrett at (503) 934-0104. The close date for receipt of application materials is January 9, 2019. DCBS is an equal opportunity, affirmative action employer committed to workforce diversity.

## ALJ Anonymous Survey - Coming Soon!

WCB's 2018 ALJ Anonymous Survey will soon be sent electronically to practitioners. Your participation in WCB's annual ALJ survey is greatly appreciated.

### CASE NOTES

Combined Condition: Consists of “Two Medical Problems Simultaneously” - Carrier Met “Burden of Proof” Under “266(2)(a)” - Work Injury Not Major Cause of Disability/Treatment for “Combined” Shoulder Condition (Exacerbation of Symptoms from Preexisting Arthritic Condition)

*Mario Carrillo*, 70 Van Natta 1815 (December 6, 2018): On remand from the court (*Carillo v. SAIF*, 291 Or App 589 (2018)), applying ORS 656.266(2)(a) and ORS 656.005(7)(a)(B), the Board upheld a carrier's denial of claimant's injury claim for a shoulder condition, finding that a carrier had established that claimant's work injury had combined with preexisting degenerative arthritic shoulder conditions (*i.e.*, there were two medical problems simultaneously; an exacerbation of his shoulder symptoms from his preexisting conditions as a result of his work) and that the work injury was not the major contributing cause of disability/need for treatment of the “combined condition.” While working, claimant experienced shoulder pain after moving and stacking heavy boxes of paper. An MRI showed preexisting rotator cuff tears and cranioclavicular joint arthritis. Physicians opined that claimant had a combined condition, consisting of his preexisting arthritic shoulder and the exacerbation of symptoms

from that condition resulting from his work activity. Thereafter, the carrier denied claimant's injury claim, asserting that his work injury was not the major contributing cause of his disability/need for treatment for his combined shoulder condition.

Following the court's decision to remand for reconsideration in light of *Brown v. SAIF*, 361 Or 241 (2017), claimant characterized his condition as a worsened preexisting condition, rather than as a "combined condition." Furthermore, relying on *Arms v. SAIF*, 268 Or App 761 (2015), claimant argued that the record did not support the existence of two separate medical conditions necessary to constitute a "combined condition." Finally, claimant asserted that his injury claim could not be analyzed as a "combined condition" because the carrier had not accepted a "combined condition" before issuing its denial.

The Board disagreed with claimant's contentions. Relying on *SAIF v. Kollias*, 233 Or App 499, 505 (2010), the Board stated that, under ORS 656.266(2)(a), the carrier had the burden of proving that: (1) claimant suffered from a statutory "preexisting condition"; (2) claimant's "otherwise compensable injury" under ORS 656.005(7)(a)(B) had combined with that "preexisting condition"; and (3) the "otherwise compensable injury" was not the major contributing cause of the disability/need for treatment of the combined condition. Referring to *Brown v. SAIF*, 361 Or 241, 272 (2017), the Board observed that the "injury" component of the phrase "otherwise compensable injury" refers to a medical condition, not an accident. In addition, citing *Amanda Cooper*, 69 Van Natta 1742, 1745 (2017), the Board reiterated that the denial of an injury claim based on a "combined condition" analysis can be upheld in the absence of an accepted "combined condition."

Furthermore, citing *Multifoods Specialty Distrib. v. McAtee*, 333 Or 629, 636 (2002), the Board stated that a "combined condition" can consist of "two medical problems simultaneously." In doing so, the Board distinguished *Arms*, reasoning that the *Arms* decision had concerned the compensability of medical services (rather than an injury claim, which was in dispute in the present case), and, in any event, *Arms* had not addressed the Supreme Court's description of a "combined condition" in *McAtee*. Finally, the Board compared the present case to *Maria J. Cordova*, 69 Van Natta 932, 935 (2017), where it had determined that a "symptomatic flare-up" of a claimant's preexisting condition constituted a "combined condition" under the *McAtee* rationale.

Turning to the case at hand, the Board found that the medical evidence established that claimant's lifting activities at work caused an exacerbation of symptoms of his preexisting condition. Relying on the *McAtee* and *Cordova* holdings, the Board concluded that the record supported the existence of a "combined condition." Furthermore, persuaded that the physicians' opinions established that the work injury was not the major contributing cause of claimant's need for treatment/disability for his combined shoulder condition, the Board upheld the carrier's denial of his injury claim.

*"Injury" in "otherwise compensable injury" refers to a medical condition, not an accident.*

*"Combined condition" can consist of "two medical problems simultaneously."*

*"Symptomatic flare-up" of preexisting condition can constitute a "combined condition."*

*Lifting activities exacerbated symptoms of preexisting condition; supported existence of "combined condition."*

## Evidence: Exclusion of Expert Witness Testimony for Untimely “Notice” Under “007-0016” - ALJ Did Not Abuse Discretion - “Material Prejudice” to Opposing Party, Lack of “Good Cause” for Rule Violation

*Claimant’s counsel’s unfamiliarity with “notice of expert witness” rule did not constitute “good cause.”*

*John Kramer*, 70 Van Natta 1856 (December 26, 2018). Analyzing OAR 438-007-0016, the Board found that it was not an abuse of discretion for an ALJ to have granted a carrier’s motion to exclude the testimony of a physician called by claimant to testify at a hearing regarding a denied new/omitted medical condition claim for post-traumatic stress disorder (PTSD). In doing so, the Board reasoned that claimant’s attorney had not timely notified the carrier of his intention to call the physician as an expert witness and the record supported the ALJ’s determination that the carrier was materially prejudiced by the lack of timely notice and claimant’s attorney’s unfamiliarity with the Board’s “expert witness” rule did not constitute “good cause” for the failure to provide timely notice.

Before the carrier had accepted a condition arising from claimant’s injury claim, claimant initiated a new/omitted medical condition claim for PTSD. After the denied PTSD claim, claimant requested a hearing. Before the hearing, claimant’s attorney did not provide timely notice of an intention to call a physician to testify at the hearing. When claimant called the physician as a witness at the hearing, the carrier objected to the physician’s testimony, asserting that claimant had not provided timely notice of his intention to call the physician as an expert witness. See OAR 438-007-0016 (*i.e.*, not less than 14 days before the hearing, or within seven days of claimant’s receipt of the insurer’s document index and documents (whichever was later). Following remand from the Board (*John Kramer*, 69 Van Natta 1379 (2017)), the ALJ found that the carrier was materially prejudiced by claimant’s lack of timely notice of the expert witness and did not consider claimant’s explanation for the untimely notice (*i.e.*, his attorney’s unfamiliarity with the Board rule) to constitute “good cause” for the attorney’s violation of the rule.

On review, claimant contended that the carrier’s failure to depose the physician or to obtain a rebuttal report from another physician represented a waiver of its initial objection to the physician’s testimony. Alternatively, claimant asserted that the ALJ’s exclusion of the physician’s testimony constituted an abuse of discretion. Finally, claimant argued that, because the carrier’s new/omitted medical condition denial had issued before any acceptance of a condition arising from the initial injury claim, the ALJ lacked jurisdiction to consider the merits of the PTSD claim and to have upheld the carrier’s denial.

The Board disagreed with claimant’s contentions. Citing OAR 438-007-0016 and OAR 438-007-0018(2), the Board stated that a party is required to provide timely notice (*i.e.*, in this particular case, not less than

14 days before the hearing) of an intention to call an expert witness to testify at a hearing and, if a party does not comply with this requirement, an ALJ has the discretion to allow the expert's testimony provided that the ALJ determines whether material prejudice results from the untimely disclosure and, if so, whether there is good cause for the untimely disclosure that outweighs the prejudice to the other party.

*Record supported ALJ's determination that carrier had been materially prejudiced by untimely notice of expert witness.*

Turning to the case at hand, the Board acknowledged claimant's admission that his former attorney had not provided timely notice of an intent to call the physician as a witness at the hearing because the attorney was unaware of the "notification" requirements of the rules in question. Nonetheless, after conducting its review, the Board concluded that the record supported the ALJ's determinations that the carrier had been materially prejudiced by claimant's failure to provide timely notice of the intent to call the physician as an expert witness and that claimant's attorney's explanation did not constitute "good cause" for a violation of the Board's "expert witness" rule that outweighed the material prejudice to the carrier. Accordingly, the Board found no abuse of discretion in the ALJ's exclusion of the physician's testimony. See *SAIF v. Kurcin*, 334 Or 399, 406 (2002); *Brown v. EBI Cos.*, 289 Or 455, 458 (1980); *Cogswell v. SAIF*, 74 Or App 234, 237 (1985); *Michelle D. Johnson*, 69 Van Natta 1607, 1608 (2017).

*Carrier did not waive initial objection to physician's testimony by declining to depose/rebut testimony.*

In reaching its conclusion, the Board disagreed with claimant's assertion that the carrier had waived its initial objection to the physician's testimony because it had chosen not to depose the physician or to obtain a rebuttal report from another physician. Reasoning that the carrier had objected to the physician's testimony at the initial hearing and continued to raise the evidentiary issue throughout the appellate/remand process, the Board determined that the carrier had not intentionally relinquished a known right (*i.e.*, its objection to the physician's testimony). See *Drews v. EBI Cos.*, 310 Or 134, 150 (1990); *Wright Schubart Harbor v. Johnson*, 133 Or App 680, 685 (1995).

*Validity of new/omitted medical condition denial, which issued before any claim acceptance, was not "jurisdictional." Procedural validity of denial not raised at initial hearing, not considered on appeal.*

Finally, addressing claimant's "jurisdictional" argument regarding the PTSD claim, the Board acknowledged that a carrier is not required to process a "new/omitted medical condition" claim that has been initiated before any condition has been accepted arising from the initial claim. See *Ernest R. Lyons*, 69 Van Natta 668, 692-93 (2017). Nevertheless, analogizing this situation to those addressed in *Robyn E. Stein*, 62 Van Natta 290 (2010), and *William C. Becker*, 47 Van Natta 1933 (1995), the Board considered such an issue to be a procedural challenge to the validity of a claim denial, rather than an issue regarding the ALJ/Board's "jurisdiction" to consider the merits of a denied claim. Furthermore, noting that claimant had not challenged the procedural validity of the carrier's PTSD denial at the initial hearing, on Board review, or at the subsequent "remand" hearing, the Board declined to consider claimant's "non-jurisdictional" procedural challenge to the denial. See *Thomas v. SAIF*, 64 Or App 193 (1983); *Stevenson v. Blue Cross*, 108 Or App 247 (1991); *Monika M. Gage*, 70 Van Natta 469 n 1 (2018); *Brian M. Eggman*, 49 Van Natta 835 (1997).

Extent: Impairment - “Chronic Condition” -  
 “Significant Limitation/Repetitive Use” -  
 “Pre-WCD Industry Notice” -  
 “Important/Notable” Limitation/Difficulty

*Angelica M. Spurger*, 70 Van Natta 1861 (December 26, 2018). On remand from the Court of Appeals, *Spurger v. SAIF*, 292 Or App 227 (2018), and evaluating whether claimant had sustained a “significant limitation” under OAR 436-035-0019 without considering the Workers’ Compensation Division’s (WCD’s) “Industry Notice” (because the claim was closed before the December 22, 2014 effective date of the “Notice”), the Board held that claimant was entitled to a “chronic condition” impairment value for her hip condition because findings ratified by her attending physician described physical limitations and difficulties pertaining to the repetitive use of her hip that were important, weighty, notable in influence, scope, or effect. Although acknowledging that the “attending physician ratified” findings had described claimant’s limitation as “some” and had not expressly addressed “repetitive use” limitations for her hip, the Board noted that the examiner had reported that claimant would have difficulty with repetitive squatting, walking long distances, and with static standing for long periods. The Board further observed that claimant had been released to a modified work schedule, with sedentary/light duties, which addressed her hip condition.

*Claimant experienced difficulty on repetitive squatting, walking long distances, and static standing.*

Citing *Godinez v. SAIF*, 269 Or App 578 (2015), as well as the court’s *Spurger* decision, the Board stated that the term “significant” in OAR 436-035-0019 refers to a limitation that is “meaningful” or “important.” Referring to *Spurger*, the Board observed that, for purposes of “chronic condition” impairment, the “limitation” must be important, weighty, notable in influence, scope, or effect. 266 Or App at 192. Finally, relying on *Russell W. Wayne*, 68 Van Natta 148, 153 n 2 (2016), the Board reiterated that, because the claim had been closed before December 22, 2014, when WCD issued its “Industry Notice” (which interpreted the relevant inquiry under OAR 436-035-0019(1) as whether the worker is “unable to repetitively use the body party for more than two-thirds of a period of time”), the “Notice” was inapplicable to a determination of whether claimant had experienced a significant limitation in the repetitive use of her hip.

*In context, physician’s descriptions of limitations were “important,” “weighty,” or “notable in influence, scope and effect.” Established “significant limitation” under “pre-WCD industry notice” standard.*

Turning to the case at hand, the Board concluded that claimant was entitled to a “chronic condition” impairment value for her hip condition. In doing so, the Board reasoned that, when the physician’s findings were read in context of the record, the physician’s descriptions of claimant’s limitations and difficulties pertained to the repetitive use of her hip as a result of her accepted hip condition and that such limitations in the repetitive use of her hip were important, weighty, or notable in influence, scope, and effect. Consequently, the Board held that claimant had established an error in the Appellate Review Unit’s decision that she had not satisfied the “significant limitation” requirement for a “chronic condition” impairment value for her condition. See *Marvin Wood Products v. Callow*, 171 Or App 175, 183 (2000).

## Offset: Carrier's Payment of TTD Benefits Granted by Final Order on Reconsideration - Subject to "25 Percent Offset Limitation" Under "268(14)"

*Jose Segovia-Funes*, 70 Van Natta 1823 (December 6, 2018). Applying ORS 656.268(14)(a), the Board held that a carrier was not entitled to fully offset an overpayment against claimant's underpaid temporary disability (TTD) benefits because those benefits had been awarded by a final Order on Reconsideration and, as such, were subject to the 25 percent statutory offset limitation. A Notice of Closure awarded temporary and permanent disability benefits, but a subsequent Order on Reconsideration reduced the closure's permanent disability award, creating an overpayment. In addition, the reconsideration order increased the period for claimant's TTD benefits. Thereafter, the carrier notified claimant that it was increasing his average weekly wage (AWW). As the result of the reconsideration order's increased TTD benefits and the increase in claimant's AWW, the carrier acknowledged that it had underpaid his TTD benefits. However, the carrier applied, in its entirety, its overpaid permanent disability benefits against claimant's TTD benefits. In response to the carrier's offset, claimant requested a hearing, seeking payment of the unpaid TTD benefits in full, subject to the 25 percent offset limitation of ORS 656.268(14)(a).

*Reconsideration order increased TTD period, and carrier increased AWW. Carrier tried to apply PPD overpayment to TTD award, beyond "268(14)(a)" offset limitation.*

The Board granted claimant's request. The Board noted that "substantive" temporary disability benefits are payable pursuant to ORS 656.210 and 656.212, and are determined at the time of claim closure. See *Tina M. Nattell*, 60 Van Natta 1050, 1051 n 1 (2008); see also *Atchley v. GTE Metal Erectors*, 149 Or App 581, rev den, 326 Or 133 (1997). The Board also cited *Lebanon Plywood v. Seiber*, 113 Or App 651, 654 (1992), for the proposition that it may not impose an "administrative" overpayment of temporary disability benefits when a claimant is not substantively entitled to such benefits. Finally, the Board observed that, pursuant to ORS 656.268(14)(a), "when overpayments are recovered from temporary disability \* \* \* benefits, the amount recovered from each payment shall not exceed 25 percent of the payment, without prior authorization from the worker."

*Underpaid TTD benefits were substantive because order granting them became final.*

Turning to the case at hand, the Board found that the Order on Reconsideration had determined claimant's entitlement to substantive TTD benefits, and because that order had become final, claimant's substantive entitlement to those benefits had been finally determined. Further, the Board noted that it was undisputed that the carrier had paid the TTD benefits (which were granted in the Order on Reconsideration) based on an incorrect AWW.

Under such circumstances, the Board reasoned that the underpaid benefits represented substantive TTD benefits that were awarded by a final order. Consequently, the Board concluded that directing the carrier to pay such benefits did not conflict with the *Seiber* rationale against creating an "administrative overpayment."

*Carrier limited to 25% offset limitation under “268(14)(a).”*

In reaching its conclusion, the Board disagreed with the carrier’s contention that ORS 656.268(14)(a) was not applicable, reasoning that the plain language of the statute unequivocally applied to temporary disability benefits and made no distinction between procedural and substantive benefits. Accordingly, the Board held that the carrier was obligated to fully pay the underpaid TTD benefits, subject to the 25 percent offset limitation under ORS 656.268(14)(a).

## Own Motion: “Worsened Condition” Claim - Claimant’s Affidavit/Documents Established Presence in “Work Force” Before “Disability Date” - Carrier’s Recommendation Against Reopening Not Unreasonable

*Stuart A. MacDonald*, 70 Van Natta 1837 (December 12, 2018). Applying ORS 656.278(1)(a), the Board reopened claimant’s Own Motion claim for a “worsening” of his previously accepted shoulder condition, finding that his affidavits and income/employment/tax documents established his presence in the “work force” before the “date of disability” (which for purposes of this claim was the date he underwent surgery for his shoulder condition). In response to the carrier’s recommendation against the reopening of claimant’s Own Motion claim for a worsening of his previously accepted shoulder condition (because he was not in the “work force” at the time of his shoulder surgery), claimant submitted documents regarding his income/employment/taxes during the year/months preceding his surgery. He also included an affidavit that described his self-employment as a general contractor, services that he had provided for a number of parties, and his declaration that he had stopped working on the date of his shoulder surgery. In reply, contending that claimant’s submissions did not establish that he had engaged in regular gainful employment before his surgery, the carrier argued that his Own Motion claim for a worsened condition should not be reopened.

*Claimant’s second affidavit described self-employment as a contractor, until surgery (“disability date”).*

The Board disagreed with the carrier’s contention. Relying on *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989), the Board stated that a worker is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and making reasonable efforts to obtain employment; or (3) not employed, but willing to work, but not making reasonable efforts to obtain employment because a work-related injury has made such efforts futile. Citing *Robert J. Simpson*, 55 Van Natta 3801 (2003), and *David L. Hernandez*, 55 Van Natta 30 (2003), the Board reiterated that, the “date of disability” is the date on which both of the following factors are satisfied: (1) the claimant’s condition resulted in a partial or total inability to work; and (2) required (including a physician’s recommendation for) hospitalization, inpatient or outpatient surgery, or other curative treatment. Finally, referring to *Mike J. Perkins*, 62 Van Natta 2005 (2010), and *Stuart T. Valley*, 55 Van Natta 475 (2003), the Board clarified that the relevant time period for which claimant must establish that he was in the work force is the time prior to the “date of disability.”

Turning to the case at hand, based on the physician's statement that claimant was unable to work following his shoulder surgery, the Board determined that the "date of disability" was the date of the surgery. Consequently, the Board identified the issue as whether claimant was in the "work force" in the period preceding his shoulder surgery.

The Board acknowledged that where claimants have not engaged in a "work search" for six or eight week periods preceding their "date of disability," they have been determined to have left the "work force." See *Cherry L. Donaldson*, 65 Van Natta 1558, 1560 (2013); *Joanne M. Abshire*, 63 Van Natta 549 (2011); compare *Perkins*, 62 Van Natta at 2005 (approximately four-week "gap" between last employment and "date of disability" found insufficient to establish that the claimant had withdrawn from the "work force"). After reviewing the record in the present case, the Board noted that, although claimant's first affidavit had discussed income he had received from several customers in the year preceding his surgery, he had not specifically addressed his activities in the months before his surgery. Lacking such specificity, the Board did not consider the information included in claimant's first affidavit to be sufficient to establish his presence in the work force before his surgery. However, noting that claimant had expressly sworn in his second affidavit that he had stopped working (*i.e.*, doing general contractor work for a number of employers) on the date of his surgery, the Board found (in the absence of persuasive rebuttal evidence) claimant's sworn statements sufficient to establish his presence in the "work force" before his "disability date." Accordingly, the Board reopened claimant's Own Motion claim. See ORS 656.278(1)(a).

In reaching its conclusion, the Board declined to grant claimant's requests for penalties and attorney fees. To begin, citing *Ford A. Cheney*, 68 Van Natta 1899, 1902 n 4 (2016), the Board reiterated that it was not authorized to award a carrier-paid attorney fee under ORS 656.383 concerning an Own Motion claim. Concerning claimant's penalty/attorney fee request pursuant to ORS 656.262(11)(a) for unreasonable claim processing, the Board noted that a carrier is not statutorily required to voluntarily reopen an Own Motion claim and that an Own Motion Recommendation (even if unreasonable) does not constitute an unreasonable denied claim. See ORS 656.278(5)(a); OAR 438-012-0030(1); *Noel G. Brown*, 62 Van Natta 2203, 2311 (2010).

Consequently, the Board reasoned that a carrier's submission of an Own Motion Recommendation in opposition to claim reopening would not represent an unreasonable resistance to the payment of compensation. In any event, if a penalty/attorney fee were available for such conduct, the Board noted that claimant's initial affidavit had not provided sufficient information to confirm his presence in the "work force" before his surgery. In light of such circumstances, the Board determined that it would not consider the carrier's position regarding claimant's "work force" status to have been unreasonable.

*Claimant's initial affidavit describing income in the year preceding surgery insufficient to establish presence in "work force" before "disability date."*

*Claimant's second sworn statement that he stopped working on "date of disability" (surgery date), in absence of persuasive rebuttal, established presence in work force.*

*Carrier's opposition to Own Motion claim reopening did not constitute unreasonable resistance to compensation.*

## TTD Rate: Calculation of “AWW” for Workers With “Irregular Wages” - “Averaging” Method Under *Former* Version of “060-0025(4)” - W/I Director’s (WCD’s) Discretion/Complied With “210(2)(d)(A)” - Subsequent Rule Amendment Did Not Mean Acknowledgment of Former Rule’s Invalidity

*Angela Simmons*, 70 Van Natta 1850 (December 18, 2018). Analyzing *former* OAR 436-060-0025, the Board found that a carrier had properly calculated the rate of claimant’s temporary disability (TTD) benefits for her irregular wages based on her average weekly average of total earnings for the 52 weeks preceding her injury because the rule was within the range of discretion granted the Director under ORS 656.210(2)(d)(A) and that a subsequent amendment of the rule did not establish that the former version of the rule had been invalid. When the carrier calculated the rate of her TTD benefits based on the *former* version of OAR 436-060-0025 (which was applicable at the time of her August 2017 injury), claimant requested a hearing, contending that her average weekly wage (AWW) should be calculated under the method prescribed in the amended version of the administrative rule. Referring to the Workers’ Compensation Division’s (WCD’s) statements in its temporary amendments to the rule (which stated that the wage averaging method in the former version of the rule had caused unintended harm to workers whose wages had increased in the year before their injuries), claimant contended that WCD (on behalf of the Director) had essentially acknowledged the invalidity of the *former* version of the rule and, as such, the current version of the rule should be applied to the calculation of her AWW/TTD benefits.

The Board disagreed with claimant’s contention. Citing *Richard Poland*, 70 Van Natta 172 (2018), the Board reiterated that the *former* version of OAR 436-060-0025 did not exceed the Director’s discretion. Furthermore, relying on *Hadley v. Cody*, 144 Or App 157, 160-61 (1996), and *Dennis W. Erickson*, 61 Van Natta 523, 525-26 (2009), the Board stated that to determine whether the *former* version of the rule was invalid it must analyze whether the rule was within the range of discretion allowed by the general policy of the statute.

Turning to the case at hand, the Board acknowledged that the amended version of OAR 436-060-0025(4) would prescribe a different method for calculating claimant’s AWW and TTD rate. Furthermore, the Board recognized that, in amending the *former* version of the rule, WCD (on behalf of the Director) had stated that the wage averaging method in the former rule had caused unintended harm to workers whose wages had increased in the year preceding their injuries.

*Claimant contended that WCD had essentially acknowledged former “TTD rate/irregular wage” rule was invalid based on statements accompanying temporary rule amendments.*

*WCD statements in temporary rule amendment did not mean that former version of rule was outside broad range of discretion delegated to Director.*

Nonetheless, the Board did not interpret such statements to mean that the former version of the rule was either contrary to legislative intent or outside the broad range of discretion delegated to the Director. Under such circumstances, the Board did not consider the Director's subsequent determination that it was reasonable to amend the rule to lead to the conclusion that the former version of the rule was invalid.

In addition, as explained in the *Hadley* decision, the Board noted that the "wage \* \* \* at the time of injury" is an "inexact term." *Hadley*, 144 Or App at 161. Moreover, the Board further observed that ORS 656.210(2)(d)(A) refers to a worker's wages over time, and not at the "precise moment of injury." See *Rivers v. SAIF*, 256 Or App 838 (2013).

Accordingly, consistent with the aforementioned reasoning, the Board determined that the former version of the rule (which calculated the AWW for a claimant with an "irregular wage" based on the 52 weeks preceding the date of injury) was based on a period that was reasonably germane to the calculation of the "wage at injury." Consequently, the Board concluded that the former version of the rule was within the Director's discretion and complied with the general policy contained in ORS 656.210(2)(d)(A).

## **APPELLATE DECISIONS UPDATE**

### Claim Processing: "Non-Cooperation" Denial - "Post-Suspension Order" Cooperation Must Be Reasonable - "262(15)"

*Hilton Hotels Corp. v. Yauger*, 295 Or App 330 (December 12, 2018). Analyzing ORS 656.262(15), the court reversed the Board's order in *Basil D. Yauger*, 68 Van Natta 1000 (2016), previously noted 35 NCN 6:13, that had set aside a carrier's "non-cooperation" denial. Finding that, within 30 days of a Workers' Compensation Division's (WCD's) "suspension" order under ORS 656.262(14)(a), claimant had e-mailed the carrier, the Board had reasoned that such a contact was sufficient to advise the carrier that he was willing to cooperate in the carrier's claim investigation and, as such, the carrier's denial had been invalid.

On appeal, the court identified the issue as what type of cooperation by a claimant is sufficient to prevent the issuance of a claim denial after the suspension of the benefits. After reviewing ORS 656.262(15), the court noted that there were three procedural stages: (1) the first sentence of ORS 656.262(15) provides for the suspension of benefits based on a failure to reasonably cooperate; (2) a denial of the claim based on noncooperation if the worker continues for 30 days to fail to reasonably cooperate; and (3) the worker's challenge to the noncooperation denial requiring him/her to establish "full[] and complete[]" cooperation with the investigation, or that the worker failed to cooperate for reasons beyond his/her control, or that the carrier's investigative demands were unreasonable. Notwithstanding these requirements, the court

*Board had reasoned that claimant's email to carrier was sufficient to advise carrier he was willing to cooperate and, thus, carrier's "post-suspension order" denial was procedurally invalid.*

reasoned that, as a preliminary matter, if the carrier's "non-cooperation" denial was procedurally invalid because the worker reasonably cooperated during the 30-day period after WCD's "suspension" order, the worker's duty to "fully and completely" cooperate under ORS 656.262(15) never arises.

Turning to the case at hand, the court stated that, based on its citation to OAR 436-060-0135(9), the Board had understood that "any effort" by a claimant to reinstate benefits was sufficient to express a willingness to cooperate. Nonetheless, the court determined that a standard of "any" effort did not necessarily comport with the standard of "reasonable cooperation" that was necessary to avoid a "non-cooperation" denial. Reasoning that the determination whether claimant reasonably cooperated is one that the Board should make in the first instance, the court remanded for a determination whether his conduct after WCD's "suspension" order reflected reasonable cooperation.

*A standard of "any effort" did not necessarily comport with "reasonable cooperation" standard, which was the statutory requirement.*

## APPELLATE DECISIONS COURT OF APPEALS

### Attorney Fee: "Pre-Hearing" Rescinded Denial - Board's "386(1)" Carrier-Paid Fee Award - Lacked Substantial Reason

*Taylor v. SAIF*, 295 Or App 199 (December 5, 2018). The court reversed the Board's order in *Christopher Taylor*, 68 Van Natta 1109 (2016), that awarded claimant's counsel an attorney fee for services rendered in obtaining a carrier's "pre-hearing" rescission of a compensability denial that was less than the amount requested by claimant's counsel because the Board's decision had lacked substantial reason. Applying the factors prescribed in OAR 438-015-0010(4), the Board had awarded \$8,000 which was more than the ALJ's \$5,000 award, but less than the \$12,000 requested by claimant's counsel.

*Board's award increased ALJ's award, but was less than requested amount.*

On appeal, claimant contended that the Board order had not adequately considered the contingent nature of his counsel's representation in calculating a reasonable attorney fee award because the Board's award equated to \$267 per hour (based on claimant's counsel's statement of services), which was less than claimant's counsel's normal hourly fee in non-contingent cases (\$300). In addition, claimant argued that the Board's award was contrary to OAR 438-015-0010(4)(g) (which requires consideration of "[t]he risk in a particular case that an attorney's efforts may go uncompensated"), as well as 2015 amendments to ORS 656.012(2)(b) and ORS 656.388(5), which require consideration of the contingent-fee nature of workers' compensation law and injured workers' access to adequate representation.

*To permit meaningful review, Board must articulate "how" application of "rule-based" factors supported fee award.*

Citing *Schoch v. Leupold & Stevens*, 325 Or 112, 119 (1997), the court stated that, in order to permit meaningful appellate review, the Board cannot simply recite certain factors and then state a conclusion, but rather must articulate *how* the application of those factors support the amount of fees awarded.

*Board order had not articulated connection between “rule-based” factors and conclusion to allow court to understand Board’s reasoning.*

Turning to the case at hand, the court determined that, although the Board order identified the applicable factors and stated that those factors had been considered, the order had not articulated a connection between those factors in its conclusion that were sufficient to allow the court to understand the Board’s reasoning. For example, the court noted that it was possible that the Board’s conclusion reflected a view that an excessive amount of time had been spent on the case or that a reasonable hourly rate was less than that which claimant’s counsel would have charged in a non-contingency fee representation (which might also implicate whether the contingent nature of such representation must factor into the Board’s reasons).

Because it could not determine why the Board made the award that it did, the court concluded that the order lacked substantial reason. Consequently, the court remanded for reconsideration.

## Standards: Work Disability - Claimant’s Use of Hearing Aids - Did Not Establish That Claimant Had Not Been Released, or Returned, to “Regular Work” - “214(1)(d),(e), (2)(b)”

*Wright v. SAIF*, 295 Or App 151 (December 5, 2018). Applying ORS 656.214(1)(d), (e), and (2)(b), the court affirmed the Board’s order in *Robin B. Wright*, 68 Van Natta 437 (2016), that did not award work disability for claimant’s hearing loss condition because the record did not establish that his inability to use hearing protection with hearing aids did not mean that he was not released to, or had not returned to, his regular work. On appeal, claimant contended that his ability to communicate was part of his “regular work” as a paver and that, because hearing aids and hearing protection affected that ability, he was entitled to work disability because he could not use both devices simultaneously at work.

The court held that substantial evidence supported the Board’s determination that a work disability award was not justified. Citing ORS 656.214(1)(d) and (2)(b), the Board stated that a worker receives a work disability award if the worker has not been referred to regular work by the attending physician or has not returned to regular work at the job held at the time of injury. Relying on *Thrifty Payless, Inc. v. Cole*, 242 Or App 232, 237 (2011), the court reiterated that regular work consists of the paid labor, task, duty, role, or function that the worker performs for an employer on a recurring or customary basis. Again, referring to *Cole*, the court added that this definition of “regular work” is not limited to what is expressly required by the employer, such as what is contained in the worker’s job description.

Turning to the case at hand, the court observed that nothing in the record established to what degree communication was part of claimant’s “regular work” or whether and how the inability to communicate created a hazard. Rather, the court identified the determinative question before the Board to concern whether

*Claimant contended that hearing aids and protection affected ability to communicate at work.*

*“Regular work” consists of paid labor, task, duty, role, or function worker performs on recurring/customary basis.*

*Record did not establish wearing both hearing aids/protection necessary to perform "regular work."*

wearing both hearing protection and hearing aids was necessary for claimant to perform his "regular work," under circumstances where he had previously performed that work without either device.

After conducting its review, the court acknowledged that the attending physician had subsequently changed his opinion that released claimant to regular work with "no restrictions." However, the court reasoned that the attending physician's opinion did not rely on medical or other evidence that wearing both hearing protection and hearing aids was necessary to the performance of claimant's "regular work." Under such circumstances, the court concluded that substantial evidence supported the Board's determination that claimant was not entitled to a work disability award.