Workers' Compensation Board

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News & Case Notes

BOARD NEWS

Permanent Rule/Amendments: "Translation of Written Documents" (OAR 438-007-0045); Amendments Concerning "Notices" of Denials/Acceptances (OAR 438-005-0050, -0053, -0055, -0060) - Effective June 1, 2019

At their March 28, 2019 public meeting, the Members adopted OAR 438-007-0045 ("Translation of Written Documents") and permanent amendments to OAR 438-005-0050, -0053, -0055, -0060 ("Notices" concerning Acceptances/Denials). The Members took these actions after considering a report from their Advisory Committee, as well as written/verbal comments received at the Board's February 1, 2019 rule making hearing.

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 rule requires that any non-English language document must be translated. In addition, the 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 rule further provides that translation costs incurred by a claimant are subject to reimbursement under ORS 656.386(2).

OAR 438-005-0050, -0053, -0055, and -0060 are designed to require that all acceptance/denial notices comply with OAR 436-001-0600 (Bulletin 379), in which the Workers' Compensation Division (WCD) mandates 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.

The effective date for these rules is June 1, 2019. OAR 438-007-0045 is applicable to all cases pending before the Hearings Division in which the initial hearing is convened on and after June 1, 2019. The amendments to OAR 438-005-0050, - 0053, -0055, and -0060 are applicable to all notices of acceptance/denial issued on and after June 1, 2019. (Consistent with WCD's adoption of its rules, the Members encourage carriers to begin complying with these OAR 438 Division 005 rules as soon as possible.)

The Board's Order of Adoption can be found here: https://www.oregon.gov/wcb/legal/Pages/laws-and-rules.aspx. A copy of the order has also been posted on the Board's website. In addition, copies of the adoption order are being distributed to all parties/practitioners on WCB's mailing list.

Managing Attorney: Recruitment

The Workers' Compensation Board is recruiting candidates for the Managing Attorney position in the Board Review Division. This is an Executive Service position, which serves at the pleasure of the Board Chair, and is a member of WCB's Executive Management team. The position is located in Salem. The salary range is $7,426- $10,936 per month. 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. This position manages the Board Review Division including its staff attorneys and administrative staff, as well as assists the Board Chair and Members, providing analysis and consultation regarding workers' compensation and administrative law issues. The Managing Attorney also coordinates the drafting of orders/memos by the legal staff, which are prepared in accordance with the Members' instructions concerning the disposition of appealed ALJ orders, procedural motions, petitions for third party relief, crime victim cases, court remands, petitions for Own Motion relief, requests for reconsideration of Board decisions, and the processing of proposed agreements submitted for Member approval. The deadline for applications is May 7, 2019. Further details about the position and information on how to apply is available online at https://oregon.wd5.myworkdayjobs.com/SOR_External_Career_Site. WCB is an equal opportunity employer.

"Five-Year" Review Report: OAR 438-011-0055 - "Third Party Election Letter" - Report Filed With Secretary of State

At their March 28, 2019 public meeting, the Board Members considered responses submitted in reply to their invitation for comments as they conducted their "five-year" review of OAR 438-011-0055 ("Third Party Election Letter"). *See* ORS 183.405. After reviewing comments received from the original advisory committee members concerning the rule and from other interested parties/practitioners who submitted written/oral comments at the original rulemaking hearing, as well as comments from the general public, the Members determined that the rule is achieving its intended effect (*i.e.*, the implementation of required procedures for a paying agency to follow when sending a worker/beneficiary a notice of election under ORS 656.583). The members further concluded that there was a continuing need for the rule and that there was no adverse fiscal impact on stakeholders or small business.

Consistent with the Members' direction, their "5-Year Rule Review" report has been finalized, signed, and filed with the Secretary of State. Copies of the report have been mailed to all members of the rule's original Advisory Committee. In addition, a copy of the report has been posted on the Board's website. https://www.oregon.gov/wcb/Documents/five-yr-review/2018/5-yr-rule-rev-rpt.pdf

CASE NOTES

CDA: Board Approval Withdrawn - CDA Lacked "Attorney Fee Lien" Provision - CDA "Void" - "10-Day Recon" Rule Not Applicable - "009-0035"/"015-0022"

Richardo Rojena-Fornaris, 71 Van Natta 340 (March 29, 2019). Analyzing ORS 656.236, OAR 438-009-0035(1), and OAR 438-015-0022, the Board held that a previously approved Claim Disposition Agreement (CDA) was void because, even though a motion for reconsideration of the CDA had not been filed within 10 days of its approval, the agreement had not contained a provision resolving a dispute regarding claimant's former counsel's attorney fee lien. More than 10 days after its approval of a CDA (which did not include a provision addressing the resolution of an attorney fee lien concerning claimant's former counsel), the carrier filed a motion for reconsideration, acknowledging that it had received the lien before negotiation/approval of the CDA involving claimant's current counsel. In submitting its motion, the carrier contended that claimant's former counsel had not been instrumental in settling the claim. In response, claimant's former attorney asserted that the CDA was void because the agreement had lacked a provision regarding the resolution of the attorney fee lien.

Carrier had received the lien before negotiation/approval of the CDA.

The Board held that the CDA was void. Citing OAR 438-015-0022(3), the Board stated that, if a carrier has received notice of a potential attorney fee lien, any proposed CDA shall include a provision resolving the lien. Furthermore, in accordance with the aforementioned rule, the Board noted that any approval of an agreement that does not include such a provision shall be void. Finally, referring to *Korey S. Eubanks*, 68 Van Natta 2031 (2016), the Board reiterated that if its previous approval of a CDA was invalid, it is authorized to invalidate the agreement even if a motion for reconsideration under OAR 438-009-0035(1) has not been filed within 10 days of its approval.

If prior CDA approval invalid, 10-day "recon" limit is not applicable.

Turning to the case at hand, the Board found that it was undisputed that there was a potential attorney fee lien in existence and in the carrier's possession before the negotiation/approval of the CDA. Because the CDA had not included a provision addressing the resolution of the lien, the Board determined that the agreement was contrary to OAR 438-009-0022(3) and, as such, was void. Consequently, notwithstanding the untimely filing of the carrier's reconsideration motion, the Board concluded that it was authorized to withdraw its invalid approval of the void CDA.

Without a provision addressing the lien, the agreement was void.

Finally, the Board reasoned that, once the parties had resolved the attorney fee lien dispute, they could resubmit a proposed CDA, which included a provision addressing the lien. In the event that the parties could not reach such a resolution, the Board noted that they could submit their dispute to the Hearings Division. *See* OAR 438-015-0022(4); *Sharon M. Kidd*, 62 Van Natta 413 (2010).

Claim Preclusion: Currently Claimed Condition Was "Same Condition" as Previously Claimed/ Denied Condition - Claim Limited to "Post-Claim" "Worsening"

Andrey V. Antonyuk, 71 Van Natta 321 (March 21, 2019). The Board held that, because a new/omitted medical condition claim was for the same condition that had been previously denied (which had become final by operation of law), the claim for that condition was precluded and, because the record did not establish a worsening of the denied condition, the denial was upheld. Some six months after a carrier's denial of a new/omitted medical condition claim for an L4-5 disc extrusion, claimant initiated another new/omitted medical condition claim for his L4-5 disc herniation. When the carrier denied the claim (based on claim preclusion), claimant requested a hearing, arguing that his claimed condition had worsened since the prior denial.

After a denial of L4-5 disc "extrusion," claimant initiated claim for an L4-5 herniation."

The Board upheld the carrier's denial. Citing *Drews v. EBI Cos.*, 310 Or 134, 142-43 (1990), and *Ahlberg v. SAIF*, 199 Or App 271 (2005), the Board stated that a claimant is barred from claiming compensation for the same denied condition, unless the condition has changed and the claim is supported by new facts that could not have been presented earlier, and that a worsening of a denied condition is a "change" that will support the relitigation of a previously denied claim.

Currently claimed condition was same condition as previously claimed/denied condition. Thus, new claim must be based on "post-denial" worsening of condition.

Physician did not distinguish any change in disc condition between prior denial and current claim.

Turning to the case at hand, the Board was persuaded that the currently claimed L4-5 disc "herniation" was the same condition that had been previously claimed and denied as an L4-5 disc "extrusion." Consequently, the Board determined that claimant was barred from claiming compensation for the L4-5 disc herniation unless that condition had changed since the prior denial. Addressing that question, the Board acknowledged that the attending physician had indicated that claimant's condition had worsened and "changed over time." However, reasoning that the physician had not distinguished between claimant's condition when the carrier's prior denial issued and when his current claim was made, the Board was not persuaded that claimant's condition had worsened since the prior final denial. Consequently, concluding that claimant's new/omitted medical condition claim for his current L4-5 disc herniation was precluded.

Course & Scope: "Rest Break/Walking" Injury - "Personal Comfort" Doctrine - But, Did Not "Arise Out of" Employment - No "Employment" Risk - Tripped on Public Sidewalk

Katherine Mandes, 71 Van Natta 240 (March 1, 2019). On remand, *Mandes v. Liberty Mut. Holdings-Liberty Mut. Ins.*, 289 Or App 268 (2017), the Board held that, while claimant was engaged in a "personal comfort" activity when injured while she was returning to the employer's premises after taking a paid "walking break," her injury (which occurred when she tripped on an uneven public sidewalk) did not "arise out of" her employment. Citing *U.S. Bank v.*

Pohrman, 272 Or App 31, 43, *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 sufficient connection to employment so that she cannot be considered to have left the course of employment, making the "personal comfort" doctrine (rather than the "going and coming" rule) applicable.

Walking break was subject to "personal comfort" doctrine; "course of employment" satisfied.

Turning to the case at hand, the Board found that claimant was injured during her regular work hours, while on a paid break, and her walking activity was acquiesced in by the employer. Under such circumstances, the Board concluded that claimant's activity at the time of injury was not a departure from her employment, 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 claimant's occurred in the course of her employment.

Employer had no control of, or duty to maintain, the public sidewalk where claimant fell on uneven pavement. Injury did not "arise out of" employment.

Addressing the "arising out of" prong of the unitary "work connection" analysis, the Board identified the issue as whether the risk of claimant's injury resulted from the nature of her work or originated from a risk to which the work environment exposed her. *See Fred Meyer, Inc. v. Hayes*, 325 Or 592, 601 (1997). Noting that claimant was injured when she tripped on an uneven part of a "public" sidewalk as she was returning to her employer's leased office space, the Board found no evidence that the uneven sidewalk where claimant fell was an employment-created hazard, or that the employer had any right of control, or duty to maintain, the area in which she fell. In addition, the Board reasoned that claimant had chosen when and where to walk during her break; *i.e.*, her employment did not require her to take any particular route, nor did her employer preclude her from walking a different route or taking her break elsewhere, such as on its 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 concluded that her injury did not arise out of her employment and, as such, was not compensable.

Concurrence considered "walking break" to be excluded "recreational" activity.

Member Lanning submitted a concurring opinion to explain that he would find claimant's walking activity to be the type of "recreational" activity that the legislature intended to be excluded from compensability under ORS 656.005(7)(b)(B) because she was engaged in that activity primarily for personal pleasure. Although recognizing that this statutory defense had not been preserved on appeal, Lanning considered it important to address its potential applicability given the evolving case law surrounding "rest break/walking" injuries.

Concurrence commented on tendency in case law to follow mechanistic approach in assessing "risk" of injury for "arising out of employment" prong.

Member Ousey and Chair Wold specially concurred. Specifically, they expressed frustration with what they believed to be a tendency from the case law to follow a mechanistic approach in determining what activities are deemed to "arise out of" employment. *See Phil A. Livesley Co. v. Russ*, 246 Or 25, 29-30 (1983). Reasoning that in assessing whether a "risk" resulting in an injury "arises out of" employment is divided into three categories (employment, personal, and neutral), the concurring Members questioned how there could ever be "minimal" factors sufficient to support the "arising out of" prong to satisfy

the unitary work-connection test. *See Hayes*, 325 Or at 596-97. Accordingly, agreeing that claimant's injury from falling on an uneven sidewalk was a "neutral" risk to which she was not exposed by her employment, Member Ousey and Chair Wold concluded that they were constrained to follow the limited confines of determining what risks are sufficiently related to work to satisfy the "arising out of" prong of the work-connection test and, based on that analysis, they concurred with the majority's determination that claimant's injury was not compensable.

Medical Services: Gastric Bypass Surgery - Directed Solely to Unrelated Obesity, Not Accepted Low Back Condition - Not Compensable - "245(1)(a)"

Richard D. Verkist, 71 Van Natta 312 (March 19, 2019) Applying ORS 656.245(1)(a), the Board found that claimant's proposed gastric bypass surgery was not compensable because the medical service was directed solely at his obesity, rather than directed, in material part, to his accepted low back condition. Claimant had several accepted low back conditions. In response to claimant's attending physician's request for authorization for gastric bypass surgery, the carrier denied the medical service claim, asserting that the surgery was not due in material part to claimant's accepted low back condition. Claimant requested a hearing, contending that the proposed surgery was compensably related to his accepted low back condition and that any benefit the surgery would provide concerning his obesity was incidental.

Claimant contended gastric bypass surgery was related to accepted back condition.

The Board disagreed with claimant's contention. Citing *SAIF v. Sprague*, 346 Or 661, the Board explained that medical services for "ordinary" conditions are compensable under ORS 656.245(1)(a) when the claimed medical service is for a condition caused in material part by the work injury. The Board further noted that *Sprague* rejected the consideration of incidental benefits to an unrelated condition when assessing the compensability of medical services for a compensable injury under ORS 656.245(1).

Persuasive opinion found no relationship to back injury; solely directed at unrelated obesity.

Turning to the case at hand, based on the persuasive opinion expressed by a physician who examined claimant on behalf of the carrier, the Board found that the gastric bypass surgery was solely directed to claimant's obesity. Under such circumstances, the Board determined that the surgery had no relationship to his accepted low back condition and, as such, the surgery did not provide an "incidental benefit" to claimant's obesity. Consequently, the Board concluded that the proposed gastric bypass surgery was not for a condition caused in material part by the accepted low back condition.

New/Omitted Medical Condition - Claimed Traumatic Brain Injury (TBI) Encompassed In Previously Accepted Concussion Condition - Carrier's "Compensability" Denial Set Aside

Kelli Phillips, 71 Van Natta 297 (March 18, 2019). The Board set aside a carrier's denial of claimant's new/omitted medical condition claim for a traumatic brain injury (TBI) because the carrier had denied that claimant's

work injury caused her claimed TBI and the record established that the TBI was "encompassed" within her previously accepted concussion condition. After the carrier accepted and processed claimant's injury claim for a concussion condition, claimant initiated a new/omitted medical condition claim for a TBI condition. After the carrier denied claimant's work injury had caused the TBI, claimant requested a hearing, asserting that the TBI condition was encompassed within the previously accepted concussion condition and, as such, the carrier's compensability denial must be set aside.

Carrier denied that work injury caused the TBI.

The Board agreed with claimant's assertion. Citing *Tattoo v. Barrett Bus. Serv.*, 118 Or App 348, 351 (1993), the Board stated that the language of a carrier's denial controls. Relying on *Sandy K. Koehn*, 69 Van Natta 421, 424 (2017), the Board reiterated that a denial of an "encompassed" condition is set aside when a condition is denied on compensability grounds. Finally, referring to *Karlynn J. Akins*, 66 Van Natta 1969, 1070 n 1 (2014), ***aff'd, Akins v. SAIF***, 286 Or App 70, 74 (2017), the Board clarified that, when an alleged "new/omitted" medical condition claim was denied as "not perfected," rather than denied based on "compensability," such a denial had been upheld.

Turning to the case at hand, the Board was persuaded that the TBI and concussion were the same conditions; *i.e.*, the TBI condition was "encompassed" within the previously accepted concussion. Under such circumstances, the Board concluded that the claimed TBI condition existed, and that the work injury was a material contributing cause of the need for treatment/disability for the TBI condition. *See* ORS 656.005(7)(a); ORS 656.266(1). Because the carrier had denied that claimant's work injury had caused the claimed TBI, the Board set aside the carrier's compensability denial.

Board was persuaded that accepted concussion and TBI were the same condition. However, because carrier denied compensability of TBI, denial was set aside.

Own Motion: "Worsened Condition" Claim - Reopening Denied - Claimant Not In "Work Force" On "Disability Date" (When Surgery Recommended)

Collin D. Stringer, 71 Van Natta 342 (March 29, 2019). Applying ORS 656.278(1)(a), the Board held that it was not authorized to reopen claimant's Own Motion claim for a worsened condition because he was not in the work force when his attending physician recommended surgery for his condition. Referring to his applications that he had submitted to prospective employers after his surgery was performed, as well as his affidavit that asserted he was willing to work, claimant contended that he remained in the work force and, as such, his Own Motion should be reopened for the payment of temporary disability benefits.

The Board declined claimant's request. Citing *David L. Hernandez*, 55 Van Natta 30 (2003), and *Thurman M. Mitchell*, 54 Van Natta 2607 (2002), the Board stated that the "date of disability" for the purpose of determining "work force" status for a "worsened condition" Own Motion claim under ORS 656.278(1)(a) is the date claimant's condition worsened: (1) resulting in a partial or total inability to work; and (2) requiring (including a physician's recommendation for) hospitalization, or inpatient or outpatient surgery, or

Claimant must be in the work force on "date of disability" - in this case, when surgery was recommended.

other curative treatment prescribed in lieu of hospitalization that is necessary to enable the injured worker to return to work. Referring to *Robert J. Simpson*, 55 Van Natta 3801, 3803 (2003), the Board reiterated that the "date of disability" is the date on which both of these factors are satisfied.

Turning to the case at hand, the Board found that, before the attending physician had recommended surgery for claimant's worsened compensable toe condition (which claimant had elected to proceed with), the physician had also agreed with a work capacity evaluator's light duty restrictions. Under such circumstances, the Board determined that the "date of disability" was when claimant's physician had recommended the surgery.

Affidavit and employment applications addressed claimant's status after the "disability date."

Addressing claimant's affidavit and employment applications, the Board noted that such materials documented his "work search" efforts several months after his "disability date." Furthermore, the Board referred to other portions of the record, which indicated that claimant (age 66 and receiving social security benefits) had last worked some two to five years before his "disability date."

Therefore, "work force" status not established for reopening of "worsened condition" claim.

Consequently, the Board concluded that claimant was not in the "work force" before his "disability date." Accordingly, the Board held that the requirements for reopening of claimant's Own Motion claim for his worsened condition had not been satisfied. *See* ORS 656.278(1)(a).

Preexisting Condition: Prior "Arm/Shoulder Blade" Treatment - Not For Currently Claimed Rotator Cuff Tear/Biceps Tendinitis - Not "Arthritic Conditions" - "005(24)"

Roger A. Miller, 71 Van Natta 314 (March 19, 2019). Applying ORS 656.266(2)(a) and ORS 656.005(24), the Board set aside a carrier's denial of a new/omitted medical condition claim for rotator cuff tear and biceps tendinitis conditions, holding that a carrier had not proven the existence of a "preexisting condition/combined condition" because, although some of claimant's "pre-injury" treatments referred to arm and shoulder blade complaints, the record did not persuasively attribute those treatments to his currently claimed conditions. Before his work injury, claimant had received treatment for thoracic and cervical conditions that affected his right arm and shoulder blade. When the carrier denied claimant's new/omitted medical condition claim for a rotator cuff tear and biceps tendinitis, claimant requested a hearing, contending that his need for treatment for the claimed conditions was materially caused by his work injury and that the carrier had not proven the existence of a "legally cognizable" preexisting condition and, thus, had not met its burden of proving a "combined condition" under ORS 656.266(2)(a).

Claimant's prior treatment was for right arm/shoulder blade complaints attributable to thoracic/cervical conditions.

The Board agreed with claimant's contention. Citing ORS 656.005(24), ORS 656.266(2)(a), and *SAIF v. Kollias*, 233 Or App 499, 505 (2010), the Board stated that, once a claimant establishes an "otherwise compensable injury," the carrier must prove that claimant had a "preexisting condition," which combined with the "otherwise compensable injury" and that the injury was not the major contributing cause of the need for treatment/disability for the combined condition.

Referring to ORS 656.005(24)(a)(A), the Board stated that, except for arthritis or arthritic conditions, a "preexisting condition" means that the worker was either diagnosed with the condition, or obtained medical services for the symptoms of the condition, before the work injury.

Prior arm and shoulder blade symptoms were not for claimed rotator cuff/tendinitis, rather for thoracic/cervical conditions.

Therefore, not "preexisting conditions."

Turning to the case at hand, the Board acknowledged physician opinions that attributed claimant's prior treatment to rotator cuff and bicep conditions. Nonetheless, after reviewing claimant's "pre-work injury" chart notes, the Board was persuaded that claimant's arm and shoulder blade complaints were attributable to his thoracic/cervical conditions, rather than to his claimed rotator cuff tear and biceps tendinitis conditions. Under such circumstances, the Board concluded that the record did not establish a "preexisting condition" under the "pre-injury treatment" component of ORS 656.005(24)(a)(A).

Also, physician's "arthritic condition" opinion was not persuasive.

Analyzing the "arthritis/arthritic condition" component of a preexisting condition under ORS 656.005(24)(a)(A), the Board acknowledged a physician's opinion supporting the presence of "arthritic conditions;" *i.e.*, AC joint arthritis and rotator cuff tendinosis. Nonetheless, reasoning that the physician had neither explained which joint(s) were involved concerning the rotator cuff tendinosis condition nor how the AC joint related to the rotator cuff tear and biceps conditions, the Board was more persuaded by another physician's opinion that did not consider claimant's condition to be arthritic. *See Schleiss v. SAIF*, 354 Or 637, 653 (2013); *Hopkins v. SAIF*, 349 Or 348, 363 (2010).

Consequently, determining that the carrier had not established the existence of a "legally cognizable" preexisting condition, the Board concluded that the carrier had not met its burden of proving a "combined condition" defense under ORS 656.266(2)(a). Therefore, the Board set aside the carrier's denial.

APPELLATE DECISIONS UPDATE

Attorney Fee: "383(2)"/"382(3)" - Application of '16 Statutory Amendments - Fees "Incurred" When "Post-January 1, 2016" Board Order Affirmed ALJ's TTD Award in Response to Carrier's Appeal

Travelers Ins. Co. v. Arevalo, 296 Or App 514 (March 13, 2019).

The court affirmed the Board's order in *Rodolfo Arevalo*, 68 Van Natta 1142 (2016), previously noted 35 NCN 7:7, that awarded carrier-paid attorney fees under ORS 656.383(2) and ORS 656.382(3) (when, in response to a carrier's appeal, it affirmed an ALJ's temporary disability (TTD) award and finding that a carrier's calculation of claimant's TTD rate had been unreasonable). In reaching its conclusion, the Board had determined that, because the carrier did not become liable for the attorney fees until claimant had finally prevailed (*i.e.*, when the Board issued its "post-January 1, 2016" order), the fees were not "incurred" until after the January 1, 2016 "effective date" of the aforementioned statutes and, as such, those statutes applied.

Carrier contended all legal services were performed before effective date of statutory amendments.

On appeal, the carrier contended that: (1) the Board had erroneously applied the statutory amendments because neither party had raised them as issues; (2) because all briefing and legal services had been performed before the effective date of the statutory amendments, the attorney fees were "incurred" before the statutes became effective; and (3) it had a legitimate doubt regarding its calculation of claimant's TTD rate and, as such, the Board's assessment of penalties and attorney fees under ORS 656.262(11)(a) was not warranted.

The court rejected each of the carrier's contentions. Concerning the carrier's first argument, the court stated that, pursuant to ORS 656.295(6), the Board is authorized to reverse or modify an ALJ's order, as well as to make such disposition of the case that it deems appropriate. Citing *Braden v. SAIF*, 187 Or App 494, 498 (2003), the court acknowledged that there are limits on the Board's *de novo* review authority; *e.g.*, it cannot "sidestep[] the statutory requirements for claim processing. However, relying on *Farmers Ins. Group v. Huff*, 149 Or App 298, 307 (1997), the court concluded that the Board had authority on its *de novo* review to address claimant's entitlement to attorney fees *sua sponte*.

Attorney fees "incurred" when party becomes obligated/responsible for payment, i.e., when Board order issues.

Turning to the Board's application of the statutory amendments, the court stated that, under Section 11 of Or Laws 2015, Chapter 521, the amendments applied to "orders issued and attorney fees incurred on and after the effective date of [the] Act * * *." Referring to *Menasha Forest Products Corp. v. Curry County Title*, 350 Or 81, 89 (2011), the court noted that attorney fees are incurred when "the party has become obligated in law or equity, or otherwise is subject to, responsible, or answerable for the payment of the reasonable value of an attorney's service." Reasoning that a claimant is not entitled to an attorney fee under the statutes in question until he/she prevails on the disputed issue, the court concluded that the fees are contingent on a favorable result and cannot be "incurred" until a final order is issued. Finally, the court observed that the legislative history (a letter from the Worker's Compensation Management-Labor Advisory Committee and a chart from the Oregon Trial Lawyers Association) supported its interpretation of the term "incurred."

Claimant was not entitled to attorney fees until issuance of Board's order, (which was after effective date of statutory amendments).

Applying its reasoning to the case at hand, the court acknowledged that claimant's attorney's briefing and other services were completed before the January 1, 2016 effective date of the statutory amendments. Nevertheless, because claimant was not entitled to, and the carrier was not liable for, the attorney fees in question until issuance of the Board's order (which issued after the effective date of the statutes), the court held that the Board did not err in applying those statutes.

Finally, addressing the Board's determination that the carrier's TTD rate calculation had been unreasonable, the court recognized that there was evidence from which the carrier could have understood that claimant had an ongoing employment relationship with the employer (rather than a temporary and "as needed" relationship as the Board had found). *See Tye v. McFetridge*, 342 Or 61, 74 (2006). Nonetheless, concluding that the Board's finding was supported by substantial evidence, the court affirmed the Board's determination that the carrier should have known that claimant's employment was not ongoing and, thus, it had no legitimate doubt regarding the proper method for calculating

his wages and TTD rate. *See Hamilton v. Pacific Skyline, Inc.*, 266 Or App 676, 680-81 (2014); *Cayton v. Safelite Glass Corp.*, 257 Or App 188, 192 (2013). Consequently, the court affirmed the Board's determination of penalties/attorney fees under ORS 656.262(11)(a) for the carrier's unreasonable claim processing.

APPELLATE DECISIONS
COURT OF APPEALS

Attorney Fee: Board Discretion to Award "Reasonable" Fee - Irrespective of Request or Objection - Order Must Articulate Application of "Rule-Based" Factors - "015-0010(4)", "015-0029"

Cascade In Home Care, LLC v. Hooks, 296 Or App 695 (March 20, 2019). Analyzing ORS 656.382(2), OAR 438-015-0010(4), and OAR 438-015-0029, the court reversed that portion of the Board's order in *Julie Hooks* (2017), that awarded a carrier-paid attorney fee for claimant's counsel's services on Board review in successfully defending an ALJ's compensability decision that was less than the requested amount. On appeal, claimant contended that: (1) because the carrier had not objected to claimant's counsel's request for a specific fee under OAR 438-015-0029(3); (2) substantial evidence did not support the Board's decision because her attorney's statement of services supported the requested fee and there was no contrary evidence; and (3) the Board abused its discretion by awarding less than the full amount requested by claimant's counsel.

The court rejected claimant's first two contentions. Addressing claimant's first argument, the court stated that an attorney fee award under the circumstances described in ORS 656.382(2) (*i.e.*, a carrier's request for review of an ALJ's decision and a Board finding that all or part of the compensation awarded has not been disallowed or reduced) is mandatory. In contrast, referring to OAR 438-015-0029, the court noted that the filing of a specific fee request is optional, with the consequence that the Board will award an attorney fee that it considers reasonable even in the absence of a specific request. *See, e.g., SAIF v. Wart*, 192 Or App 505, 520-22 (2004).

Relying on sections (2) and (3) of the administrative rule, the court further reasoned that, if a specific request *is* filed, the Board is required to *consider* the provided information that may well affect how it exercises its discretion in choosing a fee amount among the "range of choices available to it." *See Schoch v. Leupold & Stevens*, 325 Or 112, 118 (1997). On the other hand, when no specific request is filed, the court observed that the Board essentially infers the amount of time reasonably expended by the claimant's attorney and the reasonable value of services from the extent of the proceedings and the nature of the issues litigated. *See Wart*, 192 Or App at 522; *SAIF v. Bacon*, 160 Or App 596, 600 (1999).

Regardless of presence/absence of a specific request/objection, Board has discretion to determine a reasonable attorney fee.

Applying such reasoning to the case at hand, the court concluded that, regardless of the presence or absence of a specific request or objections, the Board has discretion in determining the amount of a reasonable attorney fee under ORS 656.382.

Concerning claimant's second contention, the court reasoned that several factors that the Board must consider in determining a reasonable carrier-paid attorney fee under OAR 438-015-0010(4) (*e.g.*, complexity of the issues, skills of the attorneys, risk in the particular case that an attorney's efforts may go uncompensated, and the assertion of frivolous issues or defenses) are essentially suited to the Board's own assessment and do no necessarily depend on submitted evidence. In addition, the court observed that other factors (*e.g.*, the nature of the proceedings, the value of the interest involved, and the benefit secured for the represented party) should be determinable from the record. Finally, the court noted that the contingent nature of the practice of workers' compensation law can be elaborated upon in an attorney fee request, but is already recognized by statute (ORS 656.388(5)), and that the time devoted to the case for legal services is particularly well suited to the submission of an attorney fee request, but as previously explained, an attorney fee will be awarded even in the absence of such a request.

Neither statute/rule limit Board's discretion in awarding attorney fee to submissions from claimant and carrier.

Under such circumstances, considering the nature of the factors that the Board must consider in determining a reasonable carrier-paid attorney fee, as well as the need to award a reasonable fee even absent a specific fee or objections, the court rejected claimant's assertion that the Board must award an amount dictated only by the "evidence" submitted by claimant and any "contrary evidence" submitted by the carrier. In reaching its conclusion, the court emphasized that neither the statute nor the administrative rules limited the Board's discretion in such a manner.

Finally, regarding claimant's third argument, the court disagreed that the Board had abused its discretion by awarding less than the amount requested by claimant's counsel. Nonetheless, the court determined that more information from the Board was necessary for review of its attorney fee award.

Board must articulate how application of the factors support the fee award.

Citing *Schoch*, and *Taylor v. SAIF*, 295 Or App 199, 203 (2018) (among other cases), as examples, the court stated that Board orders which have not contained a sufficient explanation regarding an attorney fee award have been remanded for reconsideration, particularly when they have involved a significant discrepancy between the amount requested and the amount awarded. Referring to its reasoning in *Taylor*, the court reiterated that 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 the fees awarded.

Consistent with its holding in *Taylor*, the court determined that the Board's order lacked an explanation for its reasoning regarding its attorney fee award to allow appellate review and, as such, was not supported by substantial reason. Consequently, the court reversed and remanded for reconsideration of the Board's attorney fee award.

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