Workers' Compensation Board

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News & Case Notes

BOARD NEWS

New Managing Attorney - Tom Sheridan

Tom Sheridan has been selected for the position of Managing Attorney, Board Review. Born and raised in Oregon, Tom is a graduate of Notre Dame University. He obtained his JD from Lewis & Clark Law School. Tom has practiced law since 1983 and brings to the Board 30 years of experience in workers' compensation law, representing insurance companies and self-insured employers, including Sedgwick as the claims processing agent for the State of Oregon in NCE cases; Tom also brings to the Board decades of management expertise. Tom has been a member of the Workers' Compensation Section Legislative Subcommittee and a presenter at Workers' Compensation Claims Association Meetings and other workers' compensation-related groups. Tom enjoys spending time with his two children, traveling and playing soccer. He will begin his duties on October 1, 2019.

Board Meeting: Consideration of "Attorney Fee Advisory Committee" Report - October 29, 2019

The Board has scheduled a public meeting to discuss the report from its "Attorney Fee" Advisory Committee. The meeting has been scheduled for 10 a.m., Tuesday, October 29, 2019, in the Board's Salem office. Arrangements are also being made at each permanently staffed Board office (Durham, Eugene, and Medford) to allow attendees to view the Board's Salem meeting and participate remotely.

Copies of the Advisory Committee's report, as well as statistical data regarding attorney fee awards, have been posted on WCB's website. (Some of these materials are in addition to other "attorney fee-related" comments/ concepts, and data, which were considered by the committee.)

The members of the Advisory Committee are: Theodore Heus, Elaine Schooler, William Replogle, Art Stevens, Jennifer Flood, and ALJ Mark Mills (facilitator). The Board Members extend their grateful appreciation to the committee for participating in this important project.

In advance of their public meeting, the Members invite comments to the Advisory Committee report and these accompanying materials. Any 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, or via fax at (503)373-1684. Any written comments submitted by October 29 will be considered by the Members at their meeting. These written comments will be posted on WCB's website. Public testimony will also be welcomed at the meeting, as the Members proceed with their deliberations.

Rulemaking Hearing - August 23, 2019 - Proposed Amendments/OAR 438-007-0020(6) - "Subpoena Rule"

The Board has scheduled a public rulemaking hearing for August 23, 2019 to receive public comments regarding proposed amendments to the "subpoena rule" (OAR 438-007-0020(6)). The proposed amendments concern the information/notice to be contained in a subpoena for "individually identifiable health information," as well as where/when to send the information, including when there has been an objection to the subpoena.

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 (under the category "Laws and rules"). Copies will also be distributed to parties and practitioners on WCB's mailing list.

A rulemaking hearing for this proposed amended rule has been scheduled for August 23, 2019, at 10 a.m., at the Board's Salem office (2601 25th St. SE, Ste. 150, Salem, OR 97302-1280). Any written comments can be submitted for admission into the record by mail, FAX (503-373-1684), email rulecomments.wcb@oregon.gov, or hand delivery to any permanently staffed Board office. Those written comments may be directed to Trish Fleischman, the rulemaking hearing officer. The last day for public comment is August 23, 2019 at 5 p.m.

Annual Adjustment to Maximum Attorney Fee Effective July 1, 2019

The maximum attorney fee awarded under ORS 656.262(11)(a) and ORS 656.382(2)(d), which is tied to the increase in the state's average weekly wage (SAWW), will rise by 3.709 percent on July 1, 2019. On June 3, 2019, the Board published Bulletin No. 1 (Revised), which sets forth the new maximum attorney fees. The Bulletin can be found on the Board's website at: https://www.oregon.gov/wcb/legal/Pages/bulletins.aspx

An attorney fee awarded under ORS 656.262(11) shall not exceed $4,582, absent a showing of extraordinary circumstances. OAR 438-015-0110(3).

An attorney fee awarded under ORS 656.308(2)(d) shall not exceed $3,304, absent a showing of extraordinary circumstances. OAR 438-015-0038; OAR 438-015-0055(5).

These adjusted maximum fees apply to all attorney fee awards under statutes granted by orders issued on July 1, 2019 through June 30, 2020.

Assignment of Counsel - Process Change Coming This Fall

The Board will be modifying its process for assigning counsel on litigated cases. Beginning this fall, the Board will require attorney firms to provide written notification when they are representing a party. An Appearance by a firm can

be accomplished with a letter of representation, a hearing request, or an attorney retainer agreement. WCB Portal users can file their Appearance electronically using the "File an Appearance" tab. A Response to Issues can also be filed through the WCB Portal. In addition, formal letters can be filed by mail or fax.

The change is an effort to decrease errors in WCB's Notices of Hearing. Historically, the Board would identify an attorney firm as the party representative when that firm was copied or named on a Request for Hearing. However, the Board has seen a notable increase in communications from attorney firms announcing that they have not been retained on a case, despite receiving a copy of a hearing request and a Hearing Notice. Such written notice, whether by portal, email, mail or fax, will help ensure accurate notices for all cases.

WCB Website Update: "Printer-Friendly" Version of OAR 438 - "Van Natta Archives" Project Completed

The Board has created a "printer-friendly" .PDF version of its OAR 438 rules and posted it on the "Laws and Rules" page of its website: Here is a link to the full document: https://www.oregon.gov/wcb/Documents/wcbrule/438-rules.pdf

In addition, the Board continues to include a link to the OAR 438 rules pages of the Oregon Secretary of State.

Meanwhile, the scanning of the old green binders is now complete. The Board's "Van Natta Archive" project was finished in July. Going all the way back to Van Natta Volume 1 (August 1967), readers now have on-line access to all volumes of this publication in searchable .PDF format. https://www.oregon.gov/wcb/brdrev/Pages/vn-archive.aspx

Special thanks to all of the Board Review staff who assisted in maneuvering those brittle, old pages through the scanning equipment, as well as cataloguing and organizing them.

CASE NOTES

Attorney Fee: "Post-ALJ Order" Information - ALJ Refusal to Reopen Record - No Abuse of Discretion ("007-0025"); Board Declined to Consider "Hearing-Related" Information Under "015-0029"

Marvin A. McGuire, 71 Van Natta 762 (July 11, 2019). Applying OAR 438-007-0025, the Board found no abuse of discretion in an ALJ's refusal to reopen the record for admission of a claimant's counsel's "post-order" attorney fee information. After an ALJ found a claimed condition compensable and awarded a carrier-paid attorney fee, claimant's counsel submitted a "declaration" describing his services rendered during the litigation and seeking an increased attorney fee award. After the ALJ declined to reopen the record and republished the attorney fee award, claimant requested review. In addition to challenging the ALJ's refusal to reopen the record, claimant's counsel submitted the "declaration" for consideration under OAR 438-015-0029.

Counsel submitted a declaration describing services in seeking an increased fee after ALJ's final order issued.

Citing OAR 438-007-0025 and *Jeffrey C. Bach*, 61 Van Natta 477, 481 (2009), the Board stated that an ALJ has discretion to reopen the record for consideration of new evidence when a motion states the nature of the evidence and explains why it could not have been reasonably discovered and produced at the hearing.

Submission could have been produced at hearing; therefore, ALJ did not abuse discretion in declining to reopen record.

Turning to the case at hand, the Board noted that there was no contention that claimant's counsel's "post-order" submission could not reasonably have been obtained and produced at the hearing. Under such circumstances, the Board found no abuse of discretion in the ALJ's refusal to reopen the record.

Attorney's "declaration" also not considered on review of ALJ's attorney fee award under "015-0029."

Addressing claimant's counsel's submission of the "declaration" on review, the Board noted that OAR 438-015-0029 provides that a claimant's attorney may file, on Board review, a request for a specific fee. However, relying on *Daniel L. Demarco*, 65 Van Natta 1837 (2013), the Board reiterated that information submitted for the first time on Board review pursuant to the rule is not considered in reviewing an ALJ's attorney fee award.

Applying those points and authorities to the present case, the Board found that claimant's counsel's "declaration" was submitted regarding the ALJ's attorney fee award. Accordingly, the Board concluded that the "declaration" could not be considered under OAR 438-015-0029.

Claim Processing: Prior Litigation Order Did Not Find Specific Condition ("Wrist Infection") Compensable - But, "Infection" Was "Caused In Major Part" by "Compensable Injury" ("Work Accident") & Medical Services Were "Directed To" the "Infection" - "245(1)(a)"

Paul A. Mosely, 71 Van Natta 719 (July 8, 2019). Applying ORS 656.245(1)(a), the Board held that claimant's medical services claim for a wrist infection/compressed nerve condition was compensable, despite a carrier's "post-litigation order" acceptance of a wrist sprain. After a prior litigation order set aside the carrier's denial of claimant's initial claim for a wrist condition and the carrier's acceptance of a wrist sprain, he requested reimbursement for medical bills concerning a wrist infection condition. When the carrier did not respond to claimant's request, he requested a hearing, contending that the carrier should have paid the bills pursuant to the prior litigation order. In response, the carrier argued that it was not responsible for the medical bills because they were not due to his accepted wrist sprain, but rather were attributable to an unaccepted wrist infection.

Carrier argued medical bills were not due to accepted strain.

The Board held that, because the prior litigation order did not find a particular condition compensable, but rather remanded the claim for processing, the carrier was not required to accept claimant's wrist infection. *See Nancy E. Eggert*, 69 Van Nata 681 (2017). Nevertheless, citing ORS 656.245(1)(a), the Board stated that, for consequential conditions, the carrier shall cause to be provided medical services directed to medical conditions caused in major part by the compensable injury. Finally, relying on *Garcia-Solis v. Farmers Ins. Co.*,

Under Garcia-Solis, medical services are not limited to accepted conditions, but extend to conditions caused by "work accident."

365 Or 26 (2019), the Board observed that compensable medical services under ORS 656.245(1)(a) are not limited to accepted conditions, but extend to those caused by the "work accident."

Disputed medical services were "directed to" a medical condition ("infection") caused in major part by "work accident."

Turning to the case at hand, the Board concluded that, despite the absence of a new/omitted medical condition claim for the unaccepted wrist infection condition, a persuasive physician's opinion established that claimant's work injury was the major contributing cause of his wrist infection. Furthermore, finding that the disputed medical services were "directed to" a medical condition caused in major part by the "work accident," the Board determined that the carrier was responsible for the medical services.

Medical Services: Surgery "Due in Material Part" to "Work Accident" - Partial Relationship to "Off Work" Incident Not Determinative - WCB Retains "Causal Relationship" Jurisdiction Irrespective of "AP" Change of "Causation" Theory

Jose L. Cardona-Ornelas, 71 Van Natta 686 (July 2, 2019). Applying ORS 656.245(1)(a), the Board held that claimant's medical service claim for ankle surgery was due in material part to his "compensable injury" (his work accident), even if the surgery was also directed at a subsequent unaccepted fracture. Following the acceptance of claimant's ankle fracture, his attending physician interpreted x-rays as showing a "well-healed" fracture. After claimant's subsequent "off work" incident, his attending physician interpreted new x-rays as showing a "re-fracture" and "aggravation" of the accepted fracture. Thereafter, after additional x-rays, a CT scan, and further clinical examinations, the attending physician ultimately concluded that claimant had separately sustained two fractures as a result of his two incidents (one work-related, which was considered a "nonunion" of his fracture and required surgery, and the other "off work," which had healed). Relying on the attending physician's opinion, claimant contended that the carrier was responsible for his ankle surgery. Asserting that the attending physician was not persuasive due to his changed opinions and arguing that the surgery was directed to an unaccepted "nonunion" condition, the carrier responded that the surgery was not causally related to the compensable injury.

Claimant sustained two fractures, one work related and the other off work.

Citing *Garcia-Solis v. Farmers Ins. Co.*, 365 Or 26, 42-43 (2019), the Board stated that, under ORS 656.245(1)(a), a medical service is compensable if it is for a condition due in material part to the compensable injury; *i.e.*, a "work accident." Furthermore, relying on *Kelso v. City of Salem*, 87 Or App 630 (1987), the Board noted that a changed medical opinion that is based on a reasonable explanation for the change may still be persuasive.

Original work-related fracture had not "clinically" healed; therefore, even if surgery was also directed at an unaccepted "non-union" condition, the medical service was due, in material part, to work accident.

Turning to the case at hand, the Board determined that the attending physician's change of opinion had been based on further diagnostic images that were obtained during the course of claimant's treatment, as well as clinical examinations, which indicated that claimant's original fracture had not healed.

Noting that another physician had acknowledged the attending physician's clinical findings, the Board was persuaded by the attending physician's explanation that claimant's original fracture appeared healed "radiographically," but not "clinically."

In reaching its conclusion, the Board recognized the carrier's contention that the surgery was directed at a non-accepted "nonunion" condition. Nonetheless, emphasizing that the disputed medical service must be due, in material part, to the work accident, the Board reasoned that, even if the "nonunion" was considered a distinct condition from the accepted ankle fracture, the medical service would still be compensable under the *Garcia-Solis* standard.

Board maintained jurisdiction under "704(3)(b)(C)" despite physician's "post-WCD transfer order" change of opinion regarding causation.

Finally, the Board addressed the carrier's procedural argument that, because the attending physician's "nonunion" theory had arisen after a WCD order had transferred the medical service dispute to the Hearings Division for resolution of the "causation" issue, it was premature to resolve the issue. Citing ORS 656.704(3)(b)(C), the Board stated that it was authorized to determine whether a sufficient causal relationship existed between medical services and an accepted claim. Under such circumstances, the Board reasoned that the attending physician's change of opinion did not divest the Board of jurisdiction to resolve the "causation" issue regarding the medical service dispute.

Own Motion: "Post-Arbiter Report" Raising of "Premature Closure" Argument/Untimely Raised - Carrier's TTD Argument Reviewable Based on Claimant's "NOC" Appeal - "Hearing Referral" on TTD Issue Unnecessary (Record Sufficiently Developed) - Unreasonable Failure to Pay TTD Award from NOC

Larry D. Higgins, 71 Van Natta 808 (July 16, 2019). In an Own Motion Order applying ORS 656.262(11)(a), OAR 438-012-0035(4)(c), and OAR 438-012-0110(1), the Board held that: (1) claimant's "premature closure" argument was untimely because it was raised after the issuance of a medical arbiter report; (2) it would consider a carrier's challenge to claimant's temporary total disability (TTD) award granted by a Notice of Closure (NOC) because claimant's request for review of the NOC remained pending; (3) it was unnecessary to refer the TTD dispute to a fact-finding hearing because the record was sufficiently developed; and (4) the carrier had unreasonably failed to pay the TTD benefits awarded by the NOC. After a NOC awarded TTD and scheduled permanent partial disability (PPD) benefits for a "post-aggravation rights" new/omitted medical condition, claimant sought the appointment of a medical arbiter, additional scheduled PPD benefits, and penalties/attorney fees for the carrier's failure to pay the TTD granted by the NOC. After the Board referred the arbiter request to the Appellate Review Unit and an arbiter report issued, claimant contended that his claim had been prematurely closed (his argument was not based on the arbiter's findings). In addition, the carrier challenged claimant's entitlement to the TTD benefits awarded in the NOC,

asserting that an attending physician had not authorized such benefits and that he continued to work during the disputed time period. Claimant objected to the carrier's challenge to the TTD award, arguing that he had not disputed the TTD award in his request for review. Alternatively, claimant requested that the dispute be referred to the Hearings Division for a fact-finding hearing.

"Premature closure" raised after arbiter report; Board declined to consider the issue on review of Own Motion NOC.

Board's Own Motion practice is to defer medical arbiter exam until claim closure is determined valid.

Referring to *Vogel v. Liberty Northwest Ins. Corp*., 132 Or App 7 (1994), *William A. Hedger*, 58 Van Natta 2382 (2006), and *Arthur W. Poland*, 57 Van Natta 2390 (2005), the Board declined to address claimant's "post-arbiter report" premature closure argument. Reasoning that claimant had not raised any concern regarding the validity of the NOC before issuance of the arbiter report (and noting that claimant's premature closure argument was not based on the arbiter's findings), the Board considered claimant's argument to have been untimely raised. In doing so, the Board explained that its practice was to defer a claimant's medical arbiter request unless/until it was determined that the claim closure was valid, which avoided unnecessary delay and expense to the parties arising from a "post-medical arbiter" premature closure argument. Parenthetically, the Board commented that, even if the premature closure issue was addressed, it would not have found the claim to have been prematurely closed.

Because claimant's appeal of Own Motion NOC remained pending, Board considered carrier's challenge to NOC's TTD award.

Addressing claimant's objection to the carrier's challenge to the TTD award granted in the NOC, the Board determined that it would consider the issue. Citing *Neely v. SAIF*, 43 Or App 319, *rev den*, 288 Or 493 (1980), and *Jimmie Parkerson*, 35 Van Natta 1247 (1983), the Board stated that, where a respondent's brief raises an issue that diverges from those raised in the appellant's brief, it has been its longstanding practice to consider the additional issue, provided that the request for review has not been withdrawn. Consistent with the *Neely/Parkerson* rationale, the Board reasoned that, because claimant's request for review of the NOC had not been withdrawn, it would consider the carrier's argument concerning his TTD award.

TTD issue did not turn on "credibility/veracity" questions and record was sufficiently developed; unnecessary to refer for fact-finding hearing.

Next, the Board found it unnecessary to refer the TTD issue for a "fact-finding hearing." *See* OAR 438-012-0060(7). Citing *Koskela v. Willamette Indus. Inc*., 331 Or 362 (2000), and *Noel G. Brown*, 61 Van Natta 2944 (2009), the Board reiterated that an evidentiary hearing is appropriate when the record is insufficient to determine a claimant's entitlement to permanent total disability (PTD) benefits, and when the claimant's credibility/veracity regarding willingness and efforts to seek/obtain gainful employment is at issue.

Applying that rationale to the present case, the Board clarified that the TTD issues concerned whether such benefits had been authorized by an attending physician and whether the carrier had paid the TTD benefits awarded in the NOC. Observing that the parties had fully availed themselves of the opportunity to present documentary evidence on the issues, the Board considered the record sufficiently developed to resolve the TTD-related issues. Consequently, the Board concluded that a "fact-finding hearing" was not warranted. *John R. Taylor*, 68 Van Natta 1866 (2016).

After reviewing the merits of the TTD issue, the Board found that claimant's attending physician (who had recommended surgery for the accepted condition) had restricted claimant to modified work. Under such circumstances, the Board

modified the NOC to award temporary partial disability (TPD) benefits, rather than TTD benefits. ORS 656.212(2); *Willard H. Holly,* 68 Van Natta 1716 (2016).

Carrier must pay TTD benefits awarded by NOC within 14 days.

Finally, the Board turned to claimant's request for a penalty/attorney fee for the carrier's nonpayment of the TTD benefits granted in the NOC. Citing OAR 438-012-0110(1), the Board stated that a penalty and attorney fee under ORS 656.262(11)(a) may be imposed for a carrier's unreasonable or unjustified failure to comply with the Board's Own Motion rules. Relying on OAR 438-012-0035(4)(c), the Board further noted that a carrier must make the first payment of temporary disability compensation within 14 days from the date of an Own Motion NOC that finds the worker entitled to temporary disability benefits.

Penalties awarded based on TTD award (which was due within 14 days of NOC), even though TTD later modified to TPD.

Applying those principles to the case at hand, the Board observed that the carrier neither disputed that the NOC had awarded TTD benefits nor offered any explanation for its nonpayment of such benefits. Reasoning that the carrier had no legitimate doubt concerning its obligations to timely pay the TTD award granted by the NOC, the Board found the carrier's conduct to be unreasonable. Consequently, the Board awarded a penalty (based on the TTD benefits, which were "then due" at the time of the carrier's unreasonable conduct) and attorney fee. *See* ORS 656.262(11)(a); *Michael Kehoe*, 60 Van Natta 3510 (2008).

Penalty: Record Lacked "Amounts Then Due" - Penalty Not Assessable - "262(11)(a)"

Devynne C. Krossman, 71 Van Natta 775 (July 12, 2019). On reconsideration of its earlier decision, 71 Van Natta 159 (2019), applying ORS 656.262(11)(a), the Board concluded that a penalty was not awardable based on the carrier's unreasonable denial of claimant's new/omitted medical condition because the record did not establish any "amount then due" on which to base a penalty. After the Board's initial order had assessed a penalty under ORS 656.262(11)(a) for an unreasonable denial, the carrier sought reconsideration, asserting that there were no "amounts then due" to support a penalty.

Carrier asserted there were no "amounts then due" on which to base a penalty.

The Board agreed with the carrier's contention. The Board stated that ORS 656.262(11)(a) provides for a penalty up to 25 percent of any "amounts then due" if the carrier unreasonably refuses to pay compensation or unreasonably delays the acceptance or denial of a claim. Relying on *Alma R. Aguilar*, 55 Van Natta 3690 (2003) and *Major G. Clough*, 55 Van Natta 2848 (2003), the Board reiterated that a penalty is not assessable under ORS 656.262(11)(a) when the record does not contain evidence of "amounts then due."

Penalty not assessable when record lacked evidence of "amounts then due."

Turning to the case at hand, the Board noted that it was undisputed that the record did not contain evidence of any "amounts then due" related to the claimed condition. Under such circumstances, the Board concluded that a penalty under ORS 656.262(11)(a) was not awardable. Nevertheless, the Board reasoned that claimant's counsel remained entitled to a penalty-related attorney fee for the carrier's unreasonable claim processing. *See Stanley T. Castle*, 67 Van Natta 2055, 2057 (2015).

Notwithstanding absence of "amounts then due" to base a penalty, attorney fee awardable.

In reaching its conclusion, the Board acknowledged that, in *Walker v. Providence Health Sys. Oregon*, 267 Or App 87 (2014), the court had stated that the "amount then due" for purposes of ORS 656.262(11)(a) was the amount ultimately determined to be owed to the claimant as of the date of the carrier's unreasonable action. Nonetheless, noting that the record in *Walker* contained evidence of the amount ultimately awarded on the claim (*i.e.*, the "amount then due"), the Board reasoned that *Walker* did not support the proposition that an ORS 656.262(11)(a) penalty is awardable in the absence of evidence in the record of any "amounts then due."

Penalty: Unreasonable Claim Closure - "268(5)(f)"

Carrier had not sought attending physician's response to a PCE before closing a claim.

Juan M. Orta-Carrizales, 71 Van Natta 794 (July 16, 2019). Applying ORS 656.268(5)(f), the Board held that a carrier had unreasonably closed a claim because, before closing the claim, it had not sought claimant's attending physician's response to a physical capacity examiner's (PCE's) report regarding claimant's residual functional capacity (RFC). Prior to closing claimant's injury claim (regarding numerous lumbar, ribs, coccygeal, and pubic fractures), the carrier referred claimant to another physician for an examination, as well as to a PCE. After the examining physician issued a report (which imposed a 50-pound lifting restriction), the carrier forwarded the report to claimant's attending physician, who concurred with the opinion. The carrier also received the PCE report, which placed claimant's RFC at "sedentary" (which was below the "lifting restriction" provided by the examining physician). Without seeking the attending physician's response to the PCE report, the carrier closed the claim and rated claimant's work disability based on the examining physician's RFC opinion. Following the claim closure, the attending physician was provided with the PCE report and concurred with its RFC opinion. Eventually, at a hearing regarding an Order on Reconsideration (which had increased claimant's permanent impairment/work disability awards granted by the Notice of Closure (NOC)), claimant sought a penalty under ORS 656.268(5)(f), contending that the carrier's claim closure had been unreasonable.

The Board agreed with claimant's contention. Citing ORS 656.268(5)(f), the Board stated that, if the "correctness" of a claim closure is at issue in a hearing, and a finding is made at the hearing that the NOC was not reasonable, a penalty of 25 percent of "all compensation determined to be then due the claimant" shall be assessed. *Cayton v. Safelite Glass Corp.*, 232 Or App 454, 460 (2009). Relying on *Williams v. SAIF*, 291 Or App 328, 330 (2018), the Board reiterated that such a penalty is based on the total amount of compensation due claimant at the time of the unreasonable NOC (which is determined to be ultimately due, including any final appellate decision from that closure. *See also Liberty Northwest Ins. Corp. v. Olvera-Chavez*, 267 Or App 55, 65 (2014). Finally, referring to ORS 656.268(1)(a), and *Robert E. Charbonneau*, 57 Van Natta 591, 602 (2005), the Board noted that a carrier must close a claim once the worker is medically stationary and there is sufficient information available to support a reasonable belief that the requirements for claim closure have been met.

Turning to the case at hand, the Board acknowledged that the attending physician had concurred with the examining physician's opinion, which included a lifting restriction that was above a "sedentary" level for RFC purposes. Nonetheless, the Board determined that, when the carrier closed the claim

Claim closure based on "AP" concurrence with an examining physician's report that had a different "RFC" level than another physician (whose report had not been provided to the AP); Board found insufficient information to close claim.

based on the attending physician's concurrence with the examining physician's opinion, it was aware that a PCE had considered claimant's RFC to be at a "sedentary" level and had not sought the attending physician's response to the PCE's "RFC" opinion.

Under these particular circumstances, the Board concluded that the carrier had insufficient information on which to close the claim and, as such, the claim closure was unreasonable. *See Silviu V. Moisescu*, 68 Van Natta 244, 247 (2016). Accordingly, the Board assessed a penalty based on all compensation that was ultimately due, including any final appellate decision from the claim closure. *Olvera-Chavez*, 267 Or App at 65.

"Correctness" of closure was at issue, satisfying statutory requirements for a penalty, even though claimant did not raise "premature closure."

In reaching its conclusion, the Board noted that claimant had neither contended at the hearing level or on review that the claim had been prematurely closed. Although recognizing that most penalty requests under ORS 656.268(5)(f) for unreasonable claim closure are accompanied by a contention that the claim was prematurely closed, the Board reasoned that the statute does not mandate that a "premature closure" argument be advanced at the hearing level. Consequently, because claimant had challenged the "correctness" of the NOC at the hearing level, the Board concluded that the statutory prerequisite for a seeking a penalty under ORS 656.268(5)(f) had been satisfied.

Concurrence suggests penalty for unreasonable calculation of a PPD award granted by NOC is "262(11)," not "268(5)(f)."

Member Curey specially concurred. Although agreeing with the determination that a penalty under ORS 656.268(5)(f) was justified, Curey noted that claimant had alternatively argued that such a penalty would have also been available for the carrier's allegedly unreasonable calculation of claimant's work disability. Referring to her dissenting opinion in *James L. Williams*, 67 Van Natta 664, *recons*, 67 Van Natta 1406 (2015), Member Curey reiterated her opinion that ORS 656.262(11)(a) (rather than ORS 656.268(5)(f)) is designed to address a carrier's unreasonable calculation of a claimant's permanent disability benefits at claim closure, which would focus the penalty on the specific "unreasonable" action, rather than on all compensation awards granted by the NOC (many or most of which would not have been the result of a carrier's unreasonable calculation of a claimant's compensation. Notwithstanding her "statutory construction" concerns, Curey concluded that an answer to these questions must await a future case.

TTD: Termination of Employment ("325(5)(b)") - "Work Rule" Violation/"Disciplinary Reason" Not Established

Hipolito Coria, 71 Van Natta 742 (July 9, 2019). Applying ORS 656.325(5)(b), the Board held that a carrier was not entitled to terminate claimant's temporary total disability (TTD) benefits because the record did not establish that his employment was terminated for violation of a work rule or for other disciplinary reasons. Claimant, a maintenance worker at a hotel, sustained a compensable injury when he fell from a ladder. Three days later he was terminated. The carrier initially paid TTD benefits, but terminated those benefits, asserting that modified work would have been made available if he had still been working for the employer. After claimant requested a hearing (seeking reinstatement of his TTD benefits, as well as penalties/attorney fees

Carrier terminated TTD benefits, asserting modified work would have been available but for claimant's termination for disciplinary reasons.

for unreasonable claim processing), the carrier responded that it was allowed to terminate claimant's TTD benefits because he had been terminated for disciplinary reasons.

The Board disagreed with the carrier's position. Citing *Robert P. Krise*, 54 Van Natta 911, (2002), *aff'd on other grounds, SAIF v. Krise*, 196 Or App 608 (2004), and *Dustin E. Hall*, 68 Van Natta 1465, 1473 (2016), the Board stated that termination of employment for violation of work rules or other disciplinary reasons is a condition precedent to the application of ORS 656.325(5)(b), which authorizes a carrier to cease TTD benefits pursuant to ORS 656.210. Referring to *Krise* and *Hall*, the Board reiterated that, although it was not authorized to resolve the propriety of a termination, it was required to examine the factual reasons for the termination to determine whether claimant was, in fact, terminated for a work-rule violation or other disciplinary reason.

Claimant denied receiving termination document and it was not produced at hearing, nor was testimony submitted explaining employer's termination decision.

Turning to the case at hand, the Board acknowledged that claimant had falsified swimming pool maintenance logs. Nonetheless, the Board noted that, although the carrier maintained that claimant was given a document stating that he was terminated for recording false pool logs and refusing to follow daily tasks, it had not submitted such a document as evidence and claimant had denied receiving such a document. In addition, the Board was not persuaded who had made the "termination" decision nor the basis for such a decision. The Board further found no explanation in the record for the employer's departure from its progressive disciplinary policy in terminating claimant (who had no previous disciplinary history). *See Hall*, 68 Van Natta at 1474 (declining to find that termination was for a disciplinary reason, in part, because there was no explanation why the employer chose termination in lieu of a warning). Finally, the Board reasoned that the timing of claimant's termination did not support the carrier's position because the employer had learned of claimant's falsification of pool logs some two months before the termination.

Board not persuaded claimant was discharged for violation of work rule/disciplinary reasons; thus, termination of TTD invalid, and carrier's claim processing found unreasonable.

Under such circumstances, the Board was not persuaded that claimant was discharged for violation of a work rule or for other disciplinary reasons. Consequently, because the condition precedent to the application of ORS 656.325(5)(b) was not satisfied, the Board held that the carrier was not authorized to terminate claimant's TTD benefits.

Addressing claimant's request for a penalty and attorney fee under ORS 656.262(11)(a), the Board determined that the statutory prerequisite for ceasing TTD benefits under ORS 656.325(5)(b) had not been established. Therefore, the Board concluded that the carrier had unreasonably resisted the payment of claimant's TTD benefits. *See Hall*, 68 Van Natta at 1474; *Morin*, 68 Van Natta at 1071 (a carrier's conversion of TTD to TPD benefits was unreasonable where the statutory prerequisite was not established). Accordingly, the Board assessed a penalty and attorney fee under ORS 656.262(11)(a).

Third Party Dispute: Reimbursement for Litigation Expenses - Must be "Reasonably/Necessarily" Incurred in Third Party Litigation - "Filing Fees" in "Wrong" Jurisdiction Not Reimbursable - "Extraordinary" Attorney Fee Not Warranted - "593(1)(a)"

Filing fees in another state not reimbursable because complaint in that state dismissed for lack of jurisdiction - expense not reasonably incurred in third party cause of action.

Robert Mackie, 71 Van Natta 677 (July 2, 2019). Applying ORS 656.593(1)(a), the Board held that claimant was entitled to recover certain litigation expenses incurred during his third party lawsuit (which had resulted in a judgment) because those costs were reasonably and necessarily incurred in the litigation, but that a "filing fee" was not reimbursable because it had been incurred in a jurisdiction that had resulted in the dismissal of his cause of action in that state. Following claimant's third party judgment, the carrier petitioned the Board to resolve a dispute concerning his request for reimbursement of certain litigation costs (*pro hac vice* admission fees, expert/consultant fees, travel costs, and Oregon/California filing fees). In response, claimant's third party counsel submitted a detailed listing of litigation costs, along with an affidavit swearing that such expenses had been reasonably and necessarily incurred during the third party lawsuit.

The Board concluded that, with the exception of the filing fees for the "out-of-state" jurisdiction (which had dismissed claimant's cause of action), the claimed litigation expenses were reimbursable. Citing *Thomas Lund*, 41 Van Natta 1352, 1356 (1989), the Board reiterated that a claimant is entitled to reimbursement from a third party recovery for previously unreimbursed costs that are reasonably and necessarily incurred during the litigation of the third party action.

Turning to the case at hand, the Board was persuaded by claimant's detailed listing of his litigation expenses, as supported by his third party attorney's affidavit, that (with the exception of the filing fees incurred in the wrong jurisdiction) the claimed costs were reasonably and necessarily incurred during the litigation of his third party cause of action. Consequently, the Board concluded that claimant was entitled to reimbursement for those litigation expenses from his third party judgment.

Addressing an additional issue, the Board denied claimant's request for an extraordinary attorney of 40 percent of the $75,000 third party judgment. Citing OAR 438-015-0095, the Board stated that, in the absence of a finding of "extraordinary circumstances," a claimant's attorney fee from a third party recovery is confined to one-third of the gross recovery. *See Gary D. Smith*, 67 Van Natta 292 (2015); *Anthony L. St. Julien*, 62 Van Natta 43, 50-51 (2010).

When compared to prior Board decisions, current case did not rise to "extraordinary cidcumestances" level.

After discussing several past decisions in which an "extraordinary" attorney fee was granted (*e.g.*, *Smith*, which involved a $3 million settlement, $100,000 of litigation expenses, and 1,900 hours of attorney-related time, or *Alva Anderson*, 57 Van Natta 1457 (2005), which concerned a $300,000 settlement following several years of litigation and a 5-day jury trial), the Board explained that, in addition to whether the carrier objects to the requested fee, it considers

factors such as the attorney's efforts and resources devoted to the case, the complexity of the litigation, the stage of the litigation at which the claimant prevailed, and whether the results achieved were favorable.

Turning to the present case, the Board acknowledged that claimant's counsel had expended numerous hours over four years in procuring claimant's judgment by means of a one-day arbitration decision. Nonetheless, after contrasting claimant's situation with those situations where an "extraordinary" attorney fee was granted, the Board considered claimant's situation comparable to that presented in *Anthony L. St. Julien*, 62 Van Natta 43, 50-51 (2010) (two years of litigation, two mediations, $500,000 settlement), in which an "extraordinary" fee had not been granted. Under such circumstances, 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.

Distribution of third-party judgment subject to Oregon law despite claimant's "out-of-state" attorney fee agreement.

In reaching its conclusion, the Board rejected claimant's contention that his attorney fee should be 40 percent of his recovery, which was consistent with his retainer agreement with his California counsel. Noting that claimant was receiving workers' compensation benefits pursuant to an Oregon claim, the Board reasoned that, notwithstanding his relationship with his "out-of-state" attorney, distribution of claimant's third party judgment was subject to Oregon workers' compensation law.

APPELLATE DECISIONS UPDATE

Hearing Request: Untimely Filed ("319(1)(a)") - "Request" Must Be Referable to Carrier's Denial; Board Has Discretion to Make "Good Cause" Determination Under "319(1)(b)" - Court Reviews for "Cognizable Basis for Relief" - Claimant Lacked Sophistication/Was Confused/Misunderstood 60-Day Deadline to File Hearing Request - Constituted "Mistake"/"Inadvertence"/"Misunderstanding" for Failing to Timely File Request

Goodwin v. NBC Universal Media, 298 Or App 475 (July10, 2019). Analyzing ORS 656.319, the court reversed the Board's order in *Samuel Goodwin, II*, 68 Van Natta 730 (2016), previously noted 35 NCN 5:9, that found that claimant's hearing request concerning a carrier's new/omitted medical condition denial was untimely filed and that he had not established "good cause" for not filing his hearing request within 60 days of the carrier's mailing of its denial. In reaching its conclusion, the Board had found that, because two letters from claimant did not refer to the carrier's denial, the letters were ineffective as requests for hearing. In addition, the Board determined that, if claimant's second letter (which was filed two days after the expiration of the 60-day filing deadline) was an effective hearing request, he had not established "good cause" for his untimely filed request. On appeal,

Claimant contended that the circumstances surrounding hearing request constituted "good cause."

claimant contended that: (1) his first letter (filed within the 60-day period), which requested "help resolving these issues," unequivocally constituted a request for hearing; or, alternatively, (2) the record did not establish support for the Board's determination that the circumstances surrounding the untimely filing of claimant's hearing request did not constitute "good cause."

Addressing claimant's first contention, the court concluded that claimant had not filed a hearing request referring to the carrier's denial within the 60-day period. Citing ORS 656.319(1), the court stated that a hearing request regarding an objection to a denial must be filed within 60 days of the mailing of the denial. Referring to ORS 656.283, the court noted that a claimant has the right to request a hearing "on any matter concerning a claim." Relying on *Guerra v. SAIF*, 111 Or App 579 (1992), the court reiterated that a request for hearing that is intended as a challenge to the denial of a claim must be referable to a particular denial; *viz.*, referencing the particular denial that is being challenged either directly or indirectly.

Hearing request under "319(1)" must be referable to a particular denial.

Turning to the case at hand, the court determined that claimant's' letters themselves did not refer to the carrier's denial. Nonetheless, noting that a clarification from the ombudsman (which accompanied claimant's second letter that was filed two days after the expiration of the 60-day period) had stated that claimant's intention was to "appeal the denial," the court concluded that claimant's letters, together with the ombudsman's letter, constituted a request for hearing. *See Kevin C. O'Brien*, 44 Van Natta 2587, 2288 (1992), *modified on recon*, 45 Van Natta 97 (1993) (in determining whether a hearing request is referable to a particular denial, the Board considers the request itself, "read as a whole and in the context in which [it was] submitted.").

Claimant's letter, together with ombudsman's letter, constituted a request for hearing from carrier's claim denial.

Because the ombudsman's letter was not filed until the expiration of the 60-day period, the court stated that claimant was entitled to have his hearing request considered only if he established "good cause" for not filing his request within 60 days. *See* ORS 656.319(1)(b). Citing *Sekermestrovich v. SAIF*, 288 Or 723 (1977), the court noted that the standard for determining "good cause" under ORS 656.319(1)(b) is analogous to the standard of "mistake, inadvertence, surprise or excusable neglect" set forth in ORCP 71B. Referring to *Union Lumber Co. v. Miller*, 360 Or 767, 778 (2017), the court observed that, although the ultimate determination on whether to grant relief from a judgment under ORCP 71B is discretionary and reviewed for an abuse of discretion, the question whether a party has offered a cognizable ground for relief on account of mistake, inadvertence, surprise, or excusable neglect, is a legal question to be decided "in accordance with established legal principles."

Whether claimant has cognizable ground for relief on account of mistake, inadvertence, surprise, or excusable neglect is a legal question.

Consequently the court identified the first step in the "good cause" determination was whether claimant had offered a reasonable excuse (due to neglect, surprise, inadvertence, or mistake) for failing to timely request a hearing, which is a determination of law that is reviewed for errors of law. Because the facts were undisputed and the question was a legal one, the court proceeded to conduct its review for errors of law.

Mindful that ORCP 71B(1)(a) is liberally construed in the light most favorable to the party seeking relief (*Terlyuk v. Krasnogorov*, 237 Or App 546, 553 (2010, *rev den* 349 Or 603 (2011)), the court reasoned that claimant's failure to explicitly request a hearing or refer to the claim denial in his first letter was

Failure to explicitly request a hearing in first letter was due to claimant's lack of sophistication and confusion, which was sufficient for "mistake" or "inadvertence."

due to his lack of sophistication and his confusion, due to the many procedures that were in process. Under such circumstances, the court determined that claimant's failure to explicitly state in his first letter that he was seeking a hearing related to his denial was a "mistake" or "inadvertence."

Court determined that claimant's misunderstanding about need to file request within 60 days was reasonable, also characterized as "mistake" or "inadvertence."

Referring to claimant's second letter (which was filed two days after the expiration of the 60-day period), the court acknowledged that the ombudsman had told him that he had 60 days from the date of mailing the denial to request a hearing. Nonetheless, the court reasoned that it appeared from the record that claimant did not understand that the request for hearing had to be mailed on a specific date (which was the 60th day since the denial's mailing) and believed he could comply by mailing the letter "as fast as [he] could." Under such circumstances, the court concluded that claimant's explanation of his misunderstanding was a reasonable one and was also characterized as a mistake or inadvertence.

Because claimant had cognizable basis for relief, Board must first address whether his mistake/ inadvertence constituted "good cause."

Having determined that claimant had a cognizable basis for relief because of mistake, inadvertence, surprise, or excusable neglect, the court explained that it was for the Board to decide in the first instance whether claimant's mistakes and inadvertence constitute "good cause" for the untimely filing of his hearing request. *See Brown v. EBI Companies*, 289 Or 455, 460 (1980); *Ogden Aviation v. Lay*, 142 Or App 469, 473 (1996). Because the Board's decision had not included its reasoning in support of its conclusion that the facts did not give rise to "good cause," the court determined that it could not review whether, in light of claimant's mistakes and inadvertence, the Board had properly exercised its delegated discretion under ORS 656.319(1)(b) to find that claimant did not have "good cause." Consequently, the court remanded to the Board for reconsideration of its previous decision.

APPELLATE DECISIONS
COURT OF APPEALS

Substantial Evidence/Reasoning: Analyzing Persuasiveness of Physician's Opinion - No *Per Se* Rule Requiring Physician to Rebut Contrary Opinion from Another Physician

Carter v. Waste Management Disposal Services, 298 Or App 430 (July 3, 2019). The court affirmed the Board's order in *Dana Carter*, 69 Van Natta 1595 (2017), that upheld a carrier's denial of claimant's aggravation claim for a lumbosacral sprain/strain. In reaching its conclusion, the Board had found the opinion of the attending physician (who supported a conclusion that claimant's lumbosacral strain had worsened) was insufficient to establish the compensability of claimant's aggravation claim because the attending physician had not sufficiently responded to, or rebutted, another physician's opinion (who had concluded that there was no clinical objective evidence of an actual, pathological worsening and that claimant's symptoms were solely due to degenerative disc disease). On appeal, claimant argued that: (1) the Board had erroneously increased his burden of proof by requiring him to obtain

Claimant argued that the Board had erroneously increased his burden of proof by requiring him to obtain rebuttal report.

a rebuttal report to overcome the opinion of the carrier's physician's opinion; and (2) the Board's finding that the attending physician did not respond or rebut the other physician's opinion lacked substantial evidence.

There is no "per se" rule requiring a rebuttal report.

As an initial matter, the court agreed with the principle that a *per se* rule *requiring* a rebuttal report would be inconsistent with the statutory standard for compensability of an aggravation. *See SAIF v. January*, 166 Or App 620, 624 (2000) ("If medical evidence - *i.e.*, a physician's expert opinion - establishes that the symptomatic worsening represents an actual worsening of the underlying condition, such evidence may carry the worker's burden.").

Board did not apply a "per se" rule of persuasiveness; citation to other decisions illustrative of Board's reasoning why evidence in particular case found unpersuasive.

Nevertheless, the court did not read the Board's order as stating a *per se* rule of persuasiveness. Instead, the court reasoned that the more plausible reading of the Board's decision (and its citation to its previous orders) was that it was merely illustrative of the Board's reasoning as to why the evidence in the particular case at hand was found unpersuasive. Consequently, the court rejected claimant's first argument.

Concerning claimant's second argument, the court determined that the competing medical opinions, viewed in light of the record as a whole, would permit a reasonable person to make the Board's finding that the attending physician had not sufficiently responded or rebutted the other physician's opinion. Accordingly, the court concluded that the Board's finding was supported by substantial evidence.

APPELLATE DECISIONS
SUPREME COURT

Subject Worker: "Partner" - "Non-Subject Worker"

Pilling v. Travelers Insurance Company, 365 Or 236 (July 18, 2019). The Supreme Court reversed the Court of Appeals opinion, 289 Or App 715 (2018), which had affirmed the Board's order in *Mark Pilling*, 68 Van Natta 129 (2016), previously noted 35 NCN 2:13, that held that claimant was a "non-subject worker" because he was a "partner" of a business at the time of his motor vehicle-related injury and had not applied for or made an election of coverage as required by ORS 656.128(1). On appeal, claimant contended that, even assuming that he was a partner of the business at the time of his injury, his application for workers' compensation coverage had met the requirements for an application for coverage for a non-subject worker under ORS 656.128 and, as such, he was eligible for workers' compensation benefits.

Claimant contended that even if he was a partner (and had not indicated that he was in his application for coverage), he had still met the requirements of an application for coverage.

The Supreme Court agreed with claimant's contention. After reviewing the statute, the Court stated that the text of ORS 656.128 indicates that an application for workers' compensation coverage under the statute must be a written application for coverage of a specific person and must contain information from which a prospective insurer can determine the person's work classification and wage for coverage purposes. Referring to *SAIF v. D'Lyn*, 74 Or App 64, 68 (1985), the Court observed that the Court of Appeals has held that no particular form is required for such an application.

Application satisfied requirements of "128" because it identified the specific individual, described his duties, and provided wage information

Turning to the case at hand, the Supreme Court noted that the application stated that: (1) claimant's wife (who was filing on behalf of the business) was requesting coverage for only claimant; (2) they were the only persons who worked for the business; (3) claimant was the sole employee, who "d[id] everything" (install, service, and repair satellite dishes); and (4) claimant's wages were a specified portion of the total payroll. Reasoning that the application was for coverage for a specific, identified individual, whose duties were described and whose wage information was provided, the Court concluded that the application satisfied the requirements of ORS 656.128.

Nothing in text of "128" required application to specify applicant's legal status as a "partner."

The Supreme Court acknowledged the carrier's assertion that the application did not specify that claimant was a partner of the business, which was necessary to accurately assess policy premiums. Nevertheless, the Court found nothing in the text of ORS 656.128 requiring that the application specify the applicant's legal status. Moreover, noting that the statute indicates that the premium is based on the applicant's work classification and assumed wage, the Court reasoned that such information did not support the carrier's assertion that claimant's legal status as a "partner" was necessary for premium calculation purposes.

Finally, the Supreme Court rejected the carrier's argument that, if applicants were not required to specify their legal status, all non-subject workers would automatically be allowed coverage. Observing that coverage under ORS 656.128 for a non-subject worker requires an application that specifically identifies the worker and must contain the information necessary to determine the worker's work classification and assumed wage, the Court explained that a general application for coverage for all employees of a business would not be sufficient to secure coverage for a non-subject worker.