Workers' Compensation Board

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News & Case Notes

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BOARD NEWS

New Managing Attorney - Jim Moller

Jim Moller has been selected for the position of WCB's Managing Attorney. Jim is a graduate of Stanford University, as well as Vanderbilt University School of Law. For the past six months, he has been a WCB staff attorney. Before assuming those duties, Jim was in private practice for twenty years as an appellate lawyer, specializing in workers' compensation (representing injured workers, employers, and insurers) and social security disability appeals at the federal court level. Prior to that, Jim was an appellate lawyer for the SAIF Corporation, a WCB Board Member, and a WCB staff attorney (review and senior). Jim will begin his duties February 3, 2020.

Rulemaking Hearing - January 31, 2020 - Proposed Rules/Amendments (Attorney Fees - OAR 438 Division 015)

The Board has scheduled a public rulemaking hearing on Friday, January 31, 2020 at 10 a.m. at its Salem office to receive public comments on proposed rules/amendments relating to attorney fees (OAR 438 Division 015). The proposed rules follow a series of public meetings, as well as an advisory committee report, regarding attorney fee concepts. The proposed rules include:

- Adding a definition ("client paid fee") to describe fees paid by an insurer or self-insured employer to its attorney. OAR 438-015-0005.
- Adding ORS 656.262(11) to the list of statutes in which attorney fees are not paid out of the claimant's compensation award. OAR 438-015-0010.
- Adding language from ORS 656.388(5) to the "rule-based factors" in determination of an assessed fee: "The necessity of allowing the broadest access to attorneys by injured workers," and "The fees earned by attorneys representing the insurer/self-insured employer." OAR 438-015-0100(4).
- Increasing the hourly rate for an attorney's time spent during an interview or deposition under ORS 656.262(14)(a) from $275 to $350, plus an annual adjustment commensurate with changes in the state average weekly wage. OAR 438-015-0033.
- Establishing a schedule of attorney fees for attorneys representing insurers and self-insured employers, requiring that such fees be reasonable and not exceed any applicable retainer agreement. OAR 438-015-0115.

- Establishing a voluntary process for bifurcation of the attorney fee award from the merits of the case when a claimant's attorney requests such bifurcation on Board Review. OAR 438-015-0125.

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 https://www.oregon.gov/wcb/legal/Pages/laws-and-rules.aspx. Copies will also be distributed to parties/practitioners on WCB's mailing list.

Any written comments to the proposed rules/amendments can be submitted for admission into the record by mail (2601 25th St. SE, Ste 150, Salem, OR 97302-1280), FAX (503-373-1684), by hand delivery at any permanently staffed Board office, or by email to rulecomments.wcb@oregon.gov. Please address your comments to Jim Moller, Rulemaking Hearing Officer, Workers' Compensation Board.

Following the hearing, a Board meeting will be scheduled, at which time the Members will consider those written/oral comments admitted at the hearing and discuss whether to adopt permanent rules/amendments.

Board Meeting: December 17, 2019 - Discussion of Language for Proposed Rules/Amendments (Attorney Fees - OAR 438 Division 015) - "Contingent Hourly Rate"

At their December 17, 2019, public meeting, the Members discussed language for several proposed rules/amendments regarding OAR 438, Division 015 (Attorney Fees). Several proposed rules/amendments were moved forward to a rulemaking hearing that has been scheduled at the Board's Salem office for January 31, 2020, at 10 a.m. As described in the previous article, notice of this rulemaking hearing has been posted on WCB's website and copies of rulemaking materials will be distributed to parties/practitioners on WCB's mailing list.

The Members also decided to continue their discussions regarding language for a proposed rule amendment that would concern a "contingent hourly rate" for use in determining a reasonable assessed attorney fee under OAR 438-015-0010(4). The Members directed staff to prepare possible language for such an amendment to be discussed at a future public meeting.

Should the Members decide at that public meeting to initiate rulemaking concerning a "contingent hourly rate" rule amendment, a public hearing will be scheduled, which will allow interested parties, practitioners, and the general public an opportunity to present written/oral comments regarding the proposed rule amendment. Following that public hearing, a future Board meeting will be scheduled for the Members to consider those written/oral comments and discuss whether to adopt the proposed amendment as a permanent rule.

A formal announcement regarding this future Board meeting (as well as copies of the possible rule language) will be electronically distributed to those individuals, entities, and organizations who have registered for these notifications at https://service.govdelivery.com/accounts/ORDCBS/subscriber/new.

WCB'S 2019 ALJ Anonymous Survey

Consistent with ORS 656.724(3)(b), attorneys regularly participating in workers' compensation cases will be sent a link, via email, to participate in the annual anonymous survey. So, please watch for your invitation to participate in this important survey tool. Please take a few minutes to complete the survey, which can be completed from your computer, smart phone, or tablet.

Responses will be accepted until February 10, 2020, and results will be posted on WCB's website by March 2, 2020.

Your participation is greatly appreciated.

In Camera Review - Relevant Medical Records to Be Provided to Parties Electronically

In September 2019, the Board promulgated rule changes regarding subpoenas. For more information regarding these changes, please see the September 24, 2019, Order of Adoption. As part of this process, the Advisory Committee considered whether the Hearings Division should adopt, as an option, sending medical records via disc. This was in response to the growing number of medical providers submitting voluminous medical records to the Hearings Division via disc when there is an objection to a subpoena. The committee recommended an option of utilizing discs be adopted.

Accordingly, beginning January 2020, in cases where there is an objection to a subpoena, and records are received on disc from a medical provider, or the medical records to be reviewed are voluminous, the Hearings Division will transmit the relevant medical records via disc.

Consistent with other procedures where discs are provided by WCB, a service charge of $5.00 will be billed to the party receiving the disc from the Hearings Division.

Mediation Evaluation Pilot Project

The Workers' Compensation Board will begin conducting a mediation evaluation pilot project from January 1, 2020, through March 31, 2020. WCB will be sending evaluations to attendees of all held mediations conducted during that period. The purpose of the project is to increase feedback to WCB from mediation participants about their mediation experience. Evaluations will be mailed out and will include a postage-paid return envelope for your convenience. We would appreciate your participation in providing us with feedback during the 3-month project period.

Adoption of Permanent Amendments to "Subpoena" Rule ("007-0020(6)(b)") - Effective January 1, 2020

At their September 19, 2019 public meeting, the Members adopted permanent amendments to OAR 438-007-0020(6)(B), which concerns "subpoena duces tecum" for individually identifiable health information. The Members took these actions after considering a report from their Advisory Committee, as well as written/verbal comments received at the Board's August 23, 2019, rulemaking hearing.

OAR 438-007-0020(6)(b) is designed to prescribe the procedures to follow when serving such a subpoena, as well as for medical providers to follow after receiving a subpoena for a worker's individually identifiable health information. Under the amended rule, the time period in which a party may object to the subpoena has been extended to 10 days (from 7 days under the prior version of the rule). In addition, the rule amendment also requires that: (1) a subpoena explain a recipient's obligations if a timely objection is received; and (2) require a subpoena to include language describing the manner in which to comply with the subpoena (*i.e.*, provide the record no sooner than 14 days after the issuance of the subpoena, but not later than 21 days after issuance of the subpoena).

The effective date for the rule amendment is January 1, 2020, and applies to all subpoenas issued on and after January 1, 2020.

The Board's Order of Adoption can be found here: https://www.oregon.gov/wcb/Documents/wcbrule/rule-filings/2-2019/ooa2-2019a.pdf. 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.

CASE NOTES

Course & Scope: "Unexplained Fall" - Claimant's Fall/Injury at Work (Due to Syncopal Episode) - "Facially Nonspeculative Idiopathic Explanation" - Not "Unexplained," Did Not "Arise Out of" Employment

Claimant told medical providers she felt faint and passed out.

Suzanne M. Brockie, 71 Van Natta 1456 (December 23, 2019). The Board held that claimant's injury, which occurred when she fell while walking during her rest break, did not "arise out of" her employment as an "unexplained fall/injury" because the record established that her fall was caused by a syncopal episode. Following her fall/injury, claimant had reported to numerous medical providers that she passed out, lost consciousness, felt faint, and saw black before the incident. Those providers described claimant's fall as being the result of a syncopal episode. In response to the carrier's denial, claimant asserted that the claim was compensable as an "unexplained injury."

Injury is not "unexplained" if record establishes a "facially nonspeculative idiopathic explanation" for the injury

The Board disagreed. Citing *Phil A. Livesly Co. v. Russ*, 296 Or 25, 29-30 (1983), the Board noted that an injury that is unexplained is considered to "arise out of" employment, if it occurred "in the course of" employment. Relying on *Sheldon v. U.S. Bank*, 364 Or 831, the Board explained that an injury is not unexplained if the record establishes a "nonspeculative idiopathic explanation"

that a claimant does not eliminate as a cause.

for the injury and that a claimant must eliminate idiopathic causes if the record supports a "facially nonspeculative idiopathic explanation" for the claimed injury. Referring to *Jeffrey E. Miller*, 66 Van Natta 1855 (2014), and *Billie J. Owens*, 58 Van Natta 392 (2006), ***aff'd without opinion***, 213 Or App 587 (2007), the Board reiterated that a fall caused by a syncopal episode is not unexplained.

Turning to the case at hand, the Board acknowledged claimant's subsequent testimony that she did not remember how she fell, as well as a physician's opinion that her injury was "unexplained." Nonetheless, the Board noted that claimant had consistently reported "passing out," "feeling faint," "losing consciousness," and "seeing black" before falling and that the contemporaneous medical providers had described her fall as being caused by a "syncopal episode." Furthermore, the Board reasoned that the physician who had authored the "unexplained" injury opinion had done so based on an inaccurate history.

Facially nonspeculative idiopathic explanation for fall established; i.e., syncopal episode.

Under such circumstances, the Board found that the record supported a nonspeculative idiopathic explanation for claimant's fall; *i.e.*, she had experienced a syncopal episode. Consequently, because claimant had not eliminated this nonspeculative idiopathic explanation for her fall, the Board determined that claimant's injury did not "arise out of" her employment.

Course & Scope: "Unexplained" Injury - "Loss of Consciousness" While Driving Employer's Truck - No "Facially Nonspeculative Idiopathic Explanation" - "Arose Out of" Employment; Also, "Increased Danger" Rule Applicable

MVA due to loss of consciousness for unknown reason while driving employer's truck.

Maxim Glodyanu, 71 Van Natta 1381 (December 4, 2019). The Board held that claimant's injury, which resulted from a motor vehicle accident, arose out of his employment as a truck driver because while driving his truck he had lost consciousness for an unknown reason. After colliding with another vehicle, claimant injured a leg, ribs, and his head. When the carrier denied his claim, contending that his injury did not arise out of his employment, claimant requested a hearing.

The Board found that claimant's injury arose out of his employment. Citing *Sheldon v. U.S. Bank*, 364 Or 831, 847 (2019), the Board stated that an injury that is unexplained is considered a neutral risk that "arose out of" employment provided that it occurred "in the course of" employment. Referring to *Sheldon*, the Board also noted that an injury is "unexplained" if the record does not establish a facially nonspeculative idiopathic explanation for the injury.

Turning to the case at hand, the Board observed that claimant did not remember what happened before the collision and the medical records supported a conclusion that the cause of the accident was unknown. Under such circumstances, the Board found that claimant's injury was unexplained

Injury "unexplained"; no facially nonspeculative idiopathic explanation.

because the record did not persuasively support a facially nonspeculative idiopathic explanation for his accident. Consequently, the Board concluded that, because claimant's unexplained accident occurred in the course of his employment, it also arose out of his employment.

Alternatively, under the "increased danger" rule, MVA-related injury arose out of employment because loss of consciousness while driving greatly increased risk of serious injury.

Alternatively, relying on *Marshall v. Bob Kimmel Trucking*, 109 Or App 101 (1991), the Board noted that, under the "increased danger" rule, an idiopathic accident is compensable if there is a substantial employment contribution to the risk or extent of harm. Referring to the *Marshall* rationale, the Board reiterated that losing consciousness for employees who are obligated to drive as part of their employment is markedly more dangerous than if they had not been so employed. Consistent with the *Marshall* holding, the Board concluded that the risk of serious injury from claimant's loss of consciousness was greatly increased because he was driving a truck for the employer's benefit and, as such, applied the "increased danger" rule in determining that his injury arose out of his employment.

Course & Scope: "Off Duty" Altercation With Business Patron on Public Sidewalk (After Removal From Work Premises) - Did Not "Arise Out of"/ "In Course of" Employment

Claimant injured as a result of altercation on public sidewalk after escorting patron from employer's pool hall.

Charles E. Davis, 71 Van Natta 1391 (December 5, 2019). The Board held that a pool hall manager's injury, which resulted from his physical altercation with a patron, did not arise out of and in the course of his employment because the incident occurred while the manager was off-duty and after the patron had been escorted from the premises. When the incident occurred, claimant was on the employer's premises, but was not on-duty. At the request of the "on-duty" manager, claimant escorted a patron from the premises. After the patron had exited the building, claimant "flicked" a cigarette out of the patron's hand, prompting the altercation, which resulted in claimant's injuries. The carrier denied the claim, contending that claimant's injuries did not arise out of and in the course of his employment.

Compensability of injury depends on whether the activity was within the ultimate boundary of the claimant's work.

The Board upheld the carrier's denial. Citing *Robinson v. Nabisco, Inc.*, 331 Or 178, 186 (2000) the Board noted that whether an injury occurred "in the course of" employment depends on the "time, place, and circumstances" of the injury. Relying on *Fred Meyer, Inc. v. Hayes*, 325 Or 592, 601 (1997), the Board explained that the worker's injury is deemed to "arise out of" employment if the risk of injury results from the nature of his or her work or it originates from some risk to which the work environment exposes the worker. Finally, the Board referred to *Andrews v. Tektronix, Inc*., 323 Or 154, 166 (1996), for the proposition that the compensability of an injury claim is dependent on whether the work-related activity was within the ultimate boundary of a claimant's work.

Claimant's duties did not authorize the use of force nor extend to interactions on a public sidewalk after escorting patron from premises; injury did not occur "in the course of" employment.

Turning to the case at hand, the Board acknowledged that claimant was a manager of the pool hall and that he had been requested to escort the patron from the premises. Nonetheless, the Board found that, on the night in question, claimant was off-duty and was at the employer's premises to meet friends to play pool. Furthermore, the Board reasoned that, when claimant was injured, he had finished ejecting the patron from the premises, he was not authorized to use

force, and the injury had occurred on a public sidewalk (rather than inside the employer's premises). *See Abderrahim Najjar*, 53 Van Natta 1544 (2001). Under such circumstances, the Board concluded that claimant's injury had not occurred "in the course of" his employment.

Claimant not performing any part of job by provoking altercation with ejected patron on public sidewalk; injury did not "arise out of" employment.

Addressing whether claimant's injury "arose out of" his employment, the Board recognized that claimant's interaction with the patron had begun on the employer's premises and that removing the patron from the premises was within the range of his regular work duties. However, the Board determined that claimant's duties did not extend to interacting with the patron on a public sidewalk. Moreover, based on the testimony of one of the responding police officers, the Board noted claimant had been the "aggressor" in the altercation. Under such circumstances, the Board concluded that claimant was not performing any part of his job by provoking an altercation with the ejected patron and, as such, his injury had not arisen out of his employment.

Hearing Request: Untimely Filed From Carrier's Claim Denial - Filed More Than 60 Days After Claimant's Receipt of Denial - Specific Mailing Date of Denial Not Established, But Record Established Denial Had Been Mailed to Correct Address (And Received by Claimant) - "319(1)"

Regardless of when denial was mailed, it was undisputed that request for hearing was filed more than 60 days after claimant's receipt of denial.

Christy L. Bolta, 71 Van Natta 1399 (December 10, 2019). Applying ORS 656.319(1), in finding that claimant's hearing request from a carrier's claim denial was untimely filed, the Board held that, although the record did not establish precisely when the denial had been mailed, it was undisputed that claimant had received the denial (at her correct address) and that her request for hearing had been filed more than 60 days after her receipt of the denial. Claimant filed a hearing request more than 60 days after she received the carrier's claim denial. In response to the carrier's motion to dismiss the hearing request as untimely filed, claimant contended that the carrier had not established when the denial was mailed and, thus, the 60-day time period under ORS 656.319(1) had not been triggered.

Although unclear precisely when the denial was mailed, record included a certified mail delivery receipt (with same tracking number as denial); also, it was undisputed that denial was mailed to claimant's correct address and she received it.

The Board disagreed with claimant's contention. Citing *Madewell v. Salvation Army*, 49 Or App 713, 715-16 (1980), and *Teresa A. Sweeney*, 69 Van Natta 1062, 1064 n 2 (2017), the Board stated that there is no presumption that a letter was mailed on the day it was dated or on the day it was written. Furthermore, relying on *Anna Rembert*, 61 Van Natta 727, 729-30, *on recons*, 61 Van Natta 1245 (2009), the Board reiterated that, when a record did not establish the date of mailing of a denial because there was no certified mail receipt indicating that it was actually mailed or returned as undeliverable, the 60-day time period for filing a hearing request under ORS 656.319(1) was not triggered.

Turning to the case at hand, the Board acknowledged that the record did not establish precisely when the carrier had mailed its claim denial. Nevertheless, the Board noted that the record included a "certified mail delivery receipt" (with the same tracking number as referenced in the denial), which

indicated that claimant had received the denial more than 60 days before she had filed her hearing request. Moreover, the Board observed that it was undisputed that the carrier had mailed its denial by regular and certified mail to claimant's correct address, which she had received.

Under such circumstances, the Board was persuaded that the carrier had mailed its denial to claimant's correct address, which claimant had received. Because claimant had not filed her hearing request regarding the carrier's denial within 60 days of her actual notice of the denial, the Board concluded that her hearing request had been untimely filed. *See* ORS 656.319(1); *Snyder v. Interstate Distributor Co.,* 246 Or App 130, 134 (2011). Consequently, the Board dismissed claimant's hearing request.

Penalties: Refusal to Close Claim Not Unreasonable - Carrier Scheduled "WCE" W/I a Week of Receiving "AP" Closing Exam Report (Which Had Not Specified "RFC") - "268(5)(f)"

Carrier scheduled "work capacity exam" within a week of receiving "AP's" closing report.

David W. Kerrigan, 71 Van Natta 1460 (December 23, 2019). Applying ORS 656.268(5)(f), the Board held that a penalty for a carrier's refusal to close claimant's low back claim was not appropriate because the carrier had scheduled a work capacity evaluation (WCE) within a week after receiving the attending physician's closing examination report (which had not specified how claimant's lifting restrictions would apply to his residual functional capacity (RFC)) and had also allowed sufficient time for the completion of a job analysis from a vocational consultant (for review at the WCE). After receiving the WCE report (which had evaluated claimant's work restrictions in the "medium/light" range), the carrier issued a Notice of Closure (NOC), which included a 25 percent work disability award for claimant's low back condition that was based in part on an RFC of "light." At an eventual hearing, claimant sought a penalty under ORS 656.262(11)(a) and an attorney fee pursuant to ORS 656.382(1), contending that the carrier's refusal to close the claim had been unreasonable.

In evaluating whether a carrier's refusal to close a claim was unreasonable, conduct before/after "closure" request can be considered.

The Board disagreed with claimant's contention. Citing ORS 656.268(5)(d), the Board stated that, if the requirements for a NOC have not been met, a carrier must issue a Notice of Refusal to Close within 10 days of a claimant's request. Relying on *Red Robin Int'l v. Dombrosky*, 207 Or App 476, 481 (2006), and *Oath Boun*, 60 Van Natta 411, 415 (2008), the Board reiterated that whether a refusal to close a claim is unreasonable is determined on a case-by-case basis that must necessarily depend on the particular facts and circumstances of each case. Referring to *Scott A. Burns*, 63 Van Natta 1118, 1121 (2011), the Board noted that in evaluating whether a carrier's refusal to close a claim was unreasonable, it may consider all conduct that preceded a claimant's closure request, as well as subsequent conduct. After summarizing OAR 436-030-0020(1)(a), the Board observed that a carrier is required to close a claim and determine the extent of a worker's disability within 14 days when medical information establishes there is sufficient information to determine the extent of permanent disability and indicates the worker is medically stationary. Finally, based on OAR 436-035-0012(10)(b), the Board remarked that, in making such an assessment, a carrier may use a WCE to establish RFC.

"AP's" lifting restrictions did not specify how they applied to "RFC" standards;

therefore, refusal to close claim for scheduling of "WCE" not unreasonable.

Turning to the case at hand, the Board acknowledged that claimant's attending physician had provided lifting restrictions for claimant. Nonetheless, noting that the attending physician had not specified how those lifting restrictions applied to "occasional" and "frequent" lifting (the "RFC" standards under OAR 436-035-012(8)), the Board did not consider it unreasonable for the carrier to schedule a WCE for assistance in determining claimant's RFC. The Board further observed that the carrier had scheduled the WCE within a week of receiving the attending physician's closing examination report and had allowed sufficient time for the completion of claimant's job analysis by a vocational consultant for WCE to review.

Under such circumstances, the Board determined that the carrier's refusal to close the claim had not been unreasonable. Accordingly, the Board held that a penalty under ORS 656.268(5)(f) and an attorney fee pursuant to ORS 656.382(1) were not warranted.

Standards: Work Disability Award Not Warranted - "AP" Released Claimant to "At-Injury" Job - "AP" Restrictions Affected *Manner* of Performing "At-Injury" Job Duties, But Did Not Affect Ability to Perform Customary/Recurring Duties – "214(2)"/"726(4)(f)(E)"

Work restrictions to elevate ankle as needed and limit lifting to 40 lbs. did not establish preschool teacher could not perform regular work.

Pamela K. Ruis, 71 Van Natta 1410 (December 10, 2019). Applying ORS 656.214(2) and ORS 656.726(4)(f)(E), the Board held that claimant was not entitled to a work disability award because the record did not establish that her work restrictions (to elevate her ankle as needed and a 40-pound lifting restriction) had affected her ability to perform the required duties of her at-injury job as a preschool teacher. After an Order on Reconsideration affirmed a Notice of Closure that had not awarded work disability, claimant requested a hearing, asserting that her work restrictions established that she could not perform her regular duties of her at-injury job.

"Regular work" consists of tasks/duties performed on recurring/customary basis.

"AP" released and claimant returned to "at-injury" job; record did not establish that "AP" restrictions affected claimant's ability to perform work duties on recurring/customary basis.

The Board disagreed with claimant's contention. The Board stated that, if a worker has been released, or has returned, to regular work, permanent disability is awarded only for "impairment." See ORS 656.214(d), (2)(a); ORS 656.726(4)(f)(E); OAR 436-035-0005(14); OAR 436-035-0009(4). Citing *Thrifty Payless, Inc. v. Cole*, 247 Or App 232, 237 (2011), the Board noted that "regular work" for the purposes of a work disability award consists of "paid labor, task, duty, role, or function that the worker performed on a recurring or customary basis." Relying on *Tyrel Albert*, 66 Van Natta 1212, 1216 (2014), the Board reiterated that whether claimant was released, or returned, to "regular work" is determined based on evidence in the record, including medical records describing the work that she was performing when she was injured, her own description of her work history, the employer's regular job description, and the evidence about her post-injury physical capacity.

Turning to the case at hand, the Board acknowledged that the attending physician had stated that claimant needed the ability to elevate her ankle when she was experiencing pain/swelling and had limited her lifting capacity to 40 pounds. Nonetheless, noting that the attending physician had also released

Injury-related modification of manner of performing duties does not support work disability award, if claimant able to perform "at-injury" job duties.

claimant to her "at-injury" job (to which she had returned) and finding nothing in the record to establish that her ability to perform her customary or recurring work duties had been affected by the attending physician's restrictions, the Board concluded that a work disability award was not warranted.

In reaching its conclusion, the Board reiterated that, when a claimant is able to perform his/her "at-injury" job duties, an injury related modification of the manner of performing those duties does not support a work disability award. *See Mark A. James*, 69 Van Natta 355, 361 (2017); *Geraldine Carter*, 62 Van Natta 1706, 1706 (2010); *Jessica A. Phares*, 60 Van Natta 3082, 3083 (2008); *c.f.*, *Amanda Armato*, 70 Van Natta 1022, 1024 (2018); *Teri A. Campbell*, 62 Van Natta 648, 651 (2010) (work disability awarded where the claimant was restricted from performing a required task of the "at-injury" job).

Worker-Requested Medical Examination ("WRME"): WCD Authorized to Rescind/Reconsider Initial "Approval" Order W/I 60-Day "Appeal Period" - "AP" Concurrence With IME Report - No Entitlement to "WRME" - "325(1)(e)"/"060-0147"

Michael R. Greco, Sr., 71 Van Natta 1405 (December 10, 2019). Analyzing ORS 656.325(1)(e) and OAR 436-060-0147, the Board held that claimant was not entitled to a Worker-Requested Medical Examination (WRME) because, although the Workers' Compensation Division (WCD) had initially granted claimant's request for a WRME (based on a record that did not include an attending physician's response to an insurer-arranged medical examination (IME) report), WCD had subsequently withdrawn its approval order within the 60-day appeal period and denied claimant's WRME request because the attending physician had concurred with the IME report. After the carrier denied claimant's aggravation claim (based on an IME report), claimant filed a hearing request with the Hearings Division, as well as a WRME request with the WCD. More than 30 days after claimant's request for hearing (and with no indication that the attending physician had concurred with the IME report), WCD granted claimant's WRME request. *See* OAR 436-060-0147(2)(b)(B). However, within the 60-day appeal period from WCD's order (and before the WRME was conducted), the carrier provided WCD with the attending physician's concurrence with the IME report. Thereafter, before the WRME was performed, WCD rescinded its previous order based on the attending physician's concurrence with the IME report. Claimant requested a hearing concerning WCD's order, asserting that all WRME requirements had been met at the time of WCD's initial approval order. Moreover, claimant argued that the subsequent submission of the attending physician's concurrence with the IME report was irrelevant because WCD's initial approval order had issued at least 30 days after claimant's hearing request from the carrier's denial as required by OAR 436-060-0147(2)(b)(B).

Within the 60-day appeal period from its WRME approval order, WCD was notified that the "AP" concurred with IME report and withdrew its initial approval order.

The Board affirmed WCD's decision to deny claimant's WRME request. Citing OAR 436-060-0147(1), the Board stated that a WRME is appropriate when a claimant has made a timely request for hearing on a compensability denial, the denial was based on a carrier-requested medical examination report,

and the attending physician did not concur with the report. Referring to OAR 436-060-0147(2)(b)(B), the Board noted that a claimant is eligible for an exam if WCD has not received documents that demonstrate the attending physician did or did not concur with the report, and at least 30 days after the worker's request for hearing has passed.

Administrative rule did not prohibit WCD's reconsideration of initial order granting WRME.

Turning to the case at hand, the Board acknowledged that, as of WCD's initial order, claimant was entitled to the WRME because all of the requirements under OAR 436-060-0147(2)(b)(B) had been satisfied. Nonetheless, noting that WCD's order had a 60-day appeal period, the Board found that, while WCD retained authority to reconsider its decision, the carrier had submitted the attending physician's concurrence with the carrier-arranged examination report.

Under such circumstances, the Board concluded that WCD was authorized to withdraw and reconsider its initial decision. Furthermore, based on the attending physician's concurrence with the IME report, the Board determined that WCD's decision to deny claimant's WRME request was justified because one of the eligibility requirements under OAR 436-060-0147(1) was no longer satisfied.

WCD had plenary authority to reconsider, withdraw, rescind its previous WRME approval order (which had not been appealed) within the 60-day appeal period.

In reaching its conclusion, the Board observed that OAR 436-060-0147(2)(b)(B) did not prohibit WCD's rescission/reconsideration of its initial order. *See Godinez v. SAIF*, 296 Or App 578, 582 (2015) (deference is given to an agency's plausible interpretation of its own rule, including an interpretation made in the course of applying the rule, if that interpretation is not inconsistent with the wording of the rule, its context, or any other source of law). Moreover, noting that WCD's initial order had not been appealed, the Board reasoned that WCD had plenary authority to reconsider, withdraw, and rescind its previous WRME order within the 60-day appeal period. *See Boydston v. Liberty Northwest Ins. Corp*., 166 Or App 336, 341, *rev den*, 331 Or 191 (2000); *Liberty Northwest Ins. Corp v. Allenby*, 166 Or App 331, 334 (2000); *SAIF v. Fisher*, 100 Or App 288, 291 (1990); *Joshua D. Kirchem*, 57 Van Natta 2657, 2662 (2004); *compare Fernando R. Figerora*, 60 Van Natta 1759, 1762-63 (2008).

Claimant's attorney fee request (based on carrier's payment of WRME bill) was subject to WCD authority.

Finally, the Board addressed claimant's request for an attorney fee award under ORS 656.386(1) because the carrier had eventually paid for the WRME bill. (The WRME had been conducted notwithstanding WCD's ultimate denial of claimant's request.) Reasoning that the "attorney fee" dispute concerned the carrier's liability for the WRME fee under ORS 656.325(1)(e) (which was a matter within the WCD's jurisdiction), the Board determined that an attorney fee award under ORS 656.386(1) (which concerns a "denied claim") was not available. Instead, the Board observed that, if any attorney fee was warranted, the authorized forum to address the matter was WCD. *See* ORS 656.248(12); ORS 656.325(1)(e); ORS 656.385; ORS 656.704(2)(a), (3)(a). Accordingly, the Board transferred claimant's attorney fee request to WCD. ORS 656.708(5).

APPELLATE DECISIONS UPDATE

Claim Processing: "Clarification" Request For "Notice of Acceptance" - Not "New/Omitted Medical Condition" Claim - No Requirement to "Accept/Deny"

Eggert v. SAIF, 301 Or App 177 (December 11, 2019). Analyzing ORS 656.262(6)(a), (6)(d), (7)(a), and (c), the court affirmed the Board's order in *Nancy E. Eggert*, 69 Van Natta 791 (2017), previously noted 36 NCN 4:3, that held that a carrier was not required to modify its "contingent" Notice of Acceptance after its appeal of a compensability decision was dismissed. In reaching its conclusion, the Board had determined that, although the carrier was required to respond to claimant's request for *clarification* of its "contingent" acceptance (as opposed to a request for acceptance of a new/omitted medical condition), there was no statutory obligation for the carrier to issue a new Notice of Acceptance. *See Crawford v. SAIF*, 241 Or App 470, 480 (2011). On appeal, claimant argued that, because there is no statutory authority for a "contingent" acceptance of a claim, the carrier was required to issue a statutorily recognized Notice of Acceptance in response to her request or, alternatively, if the carrier's "contingent" acceptance was valid, it was still obligated to issue a new Notice of Acceptance to remove the contingency.

Carrier required to process a claim as accepted, even pending compensability appeal, by reopening and processing claim through closure.

The court disagreed with claimant's arguments. Citing OAR 436-030-0015(1)(c)(A)(ii), the court stated that a carrier is required to include in its Notice of Acceptance at claim closure conditions that have been ordered accepted through litigation that are under appeal. Referring to *Albert D. Avery*, 51 Van Natta 814 n 1, *on recons*, 51 Van Natta 927 (1999), the court observed that, to avoid the outcome of *SAIF v. Mize*, 129 Or App 636, 639 (1994) (where a carrier's court appeal of a Board's compensability decision was dismissed based on the carrier's unequivocal acceptance of the claim) and to ensure that claims are fully processed despite pending compensability appeals, a claim may be accepted contingently pending the appeal. Relying on *Providence Health System v. Walker*, 252 Or App 489, 500, 507 (2012), *rev den*, 353 Or 867 (2013), the court noted that it had also ruled that a carrier is required to process a claim as accepted, even pending appeal, by reopening the claim and processing it through closure.

Carrier may include statement in Notice of Acceptance that it is contingent on final outcome of compensability appeal.

After reviewing its *Mize* decision, the court reiterated that it explicitly had not addressed whether a contingent acceptance was permissible. Nonetheless, based on *Walker* and *Mize*, along with OAR 436-030-0015(1)(c)(A)(ii), the court reasoned that, when a carrier challenges a litigation order requiring acceptance of a condition, the Notice of Acceptance at claim closure may include a statement that the acceptance is contingent on the final outcome of the challenged order.

Because contingency of acceptance was removed by operation of law when compensability appeal final,

Finally, the court rejected claimant's assertion that, based on ORS 656.262(6)(b)(F), the carrier was required to modify its Notice of Acceptance to reflect new information; *i.e.*, that its acceptance was no longer contingent. Noting that claimant's clarification request to the carrier had acknowledged

carrier not required to issue new acceptance.

that the carrier had accepted the claim and emphasized that the dismissal of the carrier's compensability appeal had caused its Notice of Acceptance to become final as a matter of law, the court concluded that the contingency had been removed by operation of law.

Consequently, the court agreed with the Board's decision that, although the carrier was required to respond to claimant's clarification request, it was not obligated to issue a new Notice of Acceptance by removing the "contingency" because the dismissal of the compensability had that effect as a matter of law.

Claim Processing: Prior Litigation Order Found Claimed Conditions "Encompassed" W/I Previously Accepted/Processed Condition - No "Reopening/ Re-Closing" Requirement Under "262(7)(c)"

Carrier's obligation to reopen a claim for processing under "262(7)(c)" occurs when conditions are in fact determined to be compensable after claim closure (rather than found to be encompassed within previously accepted condition).

Simi v. LTI, Inc. - Lynden, Inc., 301 Or App 535 (December 26, 2019). Analyzing ORS 656.262(7)(c), the court affirmed the Board's order in *Randy G. Simi*, 70 Van Natta 929 (2018), previously noted 37 NCN 8:3, that held that a carrier was not required to reopen claimant's rotator cuff tear claim because, in setting aside a carrier's new/omitted medical condition denial, a prior litigation order had found that the claimed infraspinatus/supraspinatus conditions were encompassed within the previously accepted rotator cuff condition. Relying on *Akins v. SAIF*, 286 Or App 70, 74, *rev den*, 362 Or 94 (2017), the Board had reasoned that, when a condition is determined to have been encompassed within a prior acceptance, there is no obligation for the carrier to "reaccept (and reprocess) a condition that, as a factual matter, already has been accepted." On appeal, claimant contended that, because the carrier's compensability denial of new/omitted medical conditions had been set aside by the prior litigation order, the claimed conditions had been found compensable after claim closure and, as such, the carrier was obligated to reopen/process the claim to closure under ORS 656.262(7)(c).

"262(7)(c)" concerns conditions that have not previously been processed, not conditions that have been determined to have been encompassed in original acceptance and processed.

The court disagreed with claimant's contention. After reviewing the statutory text and context for the processing of new/omitted medical condition claims (ORS 656.262(6) and (7)), the court understood the last sentence of ORS 656.262(7)(c) ("If a condition is found compensable after claim closure, [the carrier] shall reopen the claim for processing regarding that condition.") to impose an obligation to reopen a claim for processing only for conditions that *are in fact* determined to be compensable new/omitted medical conditions (or aggravations or combined conditions) after claim closure; *i.e.*, conditions that have not previously been processed; not for conditions that are only *alleged* to be new/omitted medical conditions, but have been determined to have been encompassed in an original acceptance and previously processed. *See Providence Health Systems v. Walker*, 252 Or App 489, 502, *rev den*, 353 Or 867 (2013).

Turning to the case at hand, the court acknowledged that the prior litigation order had set aside the carrier's compensability denial of the claimed new/ omitted medical conditions. Nonetheless, rather than overturning the denial on the basis that the medical conditions were new/omitted, the court emphasized

Prior litigation order expressly determined conditions were not "new/omitted"; rather, they were found to be reasonably encompassed within original acceptance; thus, no obligation to reopen/process claim.

that the prior litigation order had expressly determined that the conditions were not new/omitted, but rather (in light of the carrier's concession in that proceeding) were encompassed within the original acceptance.

Reasoning that a condition that is encompassed within an earlier acceptance is not "new/omitted" and has already been accepted and processed, the court reiterated that nothing in the text, context, and legislative history of ORS 656.267 supported the proposition that the legislature intended to require a carrier to reaccept (and reprocess) a condition that, as a factual matter, already had been accepted. *See Akins*, 286 Or App at 74. Under such circumstances, the court concluded that the Board had not erred in rejecting claimant's arguments that his claim should be reopened and that penalties/ attorney fees under ORS 656.262(11)(a) were warranted.

Dissenting opinion emphasized that carrier initially denied that claimed conditions were compensable; thus, considered conditions to have been "found compensable after claim closure," requiring claim reopening under "262(7)(c)."

Presiding Judge Lagesen dissented from the majority's decision that the carrier was not required to reopen the claim. Emphasizing that the carrier had initially denied claimant's new/omitted medical condition claim on the express basis that the claimed conditions were not compensable, Lagesen considered it hard to contend that the claimed supraspinatus and infraspinatus tears were not "found compensable after claim closure." Consequently under the plain terms of ORS 656.262(7)(c), and the court's construction of the statute in *Walker*, Judge Lagesen asserted that such a finding triggered the carrier's obligation to reopen the claim for processing of those conditions. Likewise, reasoning that ORS 656.262(7)(c) simply requires a post-closure finding of compensability to trigger a carrier's reopening and processing obligation, Judge Lagesen found no support for the majority's conclusion that a carrier's "reopening/processing" obligation is dependent on whether a condition ultimately is determined to be a new/omitted medical condition (or aggravation or combined condition).

Reconsideration Proceeding: Raising "Medically Stationary Date" Issue Did Not Encompass "TTD" - "TTD" Issue Did Not "Arise Out of" Recon Order "Medically Stationary Date" Modification

Offset: Carrier Did Not Establish an Overpayment - Record Did Not Establish "268(4)" Grounds for Terminating TTD Before "Med. Stat." Date (Even Though Unappealed "NOC" Had Awarded TTD for a Shorter Period)

Claimant did not dispute TTD award during reconsideration of NOC; only contested "med stat" date.

Bledsoe v. City of Lincoln City, 301 Or App 11 (December 4, 2019). The court reversed the Board's order in *Jared L. Bledsoe*, 70 Van Natta 608 (2018), previously noted 37 NCN 5:8, that held that a carrier was entitled to offset an overpayment of temporary disability (TTD) benefits (*i.e.*, TTD paid beyond that granted in an uncontested Notice of Closure (NOC)) from a worker's permanent disability award granted by an Order on Reconsideration. In reaching its conclusion, the Board determined that, because claimant had not disputed the TTD award granted by the NOC during the reconsideration proceeding

before the Appellate Review Unit (ARU) and because the reconsideration order's medically stationary determination beyond that found in the NOC did not encompass a TTD issue, the carrier was entitled to recover the overpaid TTD benefits that exceeded claimant's TTD award as granted by the NOC. On appeal, claimant contended that, by raising his "medically stationary date" as an issue during the reconsideration proceeding, he had implicitly encompassed a TTD issue or, in light of the Order on Reconsideration's extension of his "medically stationary" date, a TTD issue arose out of the reconsideration order and, as such, could be considered at the hearing.

Because claimant only raised "med stat" date during "recon" proceeding, TTD was not encompassed in "med stat" date and did not arise out of "recon" order "med stat" determination.

Citing *Scott v. Liberty Northwest Ins. Corp.*, 268 Or App 325, 331 (2014), the court stated that a worker's entitlement to TTD benefits often coincides with the worker's medically stationary date. However, referring to ORS 656.268(4), the court noted that TTD benefits are required to continue until: (1) the worker returns to regular or modified employment; (2) the physician who has authorized TTD benefits advises the worker that he/she is released to return to regular employment; or (3) any other event that causes TTD benefits to be lawfully suspended. *See also* OAR 436-060-0020.

Although claimant could not seek additional TTD, could defend against carrier's offset request (which depended on whether TTD under "268(4)" had been overpaid).

Consequently, the court concluded that there are many reasons why TTD benefits may end or be suspended before a worker becomes medically stationary. Therefore, the court agreed with the Board's determinations that: (1) the TTD issue was not encompassed in the "medically stationary date" issue; (2) the TTD issue did not arise out of the reconsideration order; and (3) because claimant had not raised TTD as an issue during the reconsideration proceeding, he could not assert entitlement to an *additional* TTD award.

Nonetheless, the court reasoned that claimant did not seek additional TTD benefits, but rather sought only to defend against the carrier's offset request (which necessarily depended on whether there was an overpayment, which, in turn, depended on whether claimant had received TTD payments in excess to which he was entitled). Relying on ORS 656.268(14)(a) and *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 248 (1988), the court noted that a carrier's statutory entitlement to an offset is dependent on it establishing an overpayment of compensation. Referring to *SAIF v. Coburn*, 159 Or App 413, 419, *rev den*, 329 Or 527 (1999), the court reiterated that an overpayment occurs when benefits are paid in excess of those to which the worker is entitled.

Because record did not establish a reason why TTD should have been terminated before "med stat" date, overpayment not proven.

Turning to the case at hand, the court observed that there was no contention that, during the period for which claimant received TTD benefits, he was not totally disabled or that such benefits were not authorized. Noting that ORS 656.268(4) provides that TTD benefits "shall continue" until one of the aforementioned reasons for terminating such benefits arises, the court determined that there was no evidence in the record from which the Board could find a reason why claimant's TTD benefits should have been terminated before his "medically stationary" date. Accordingly, because the record did not support the existence of an overpayment, the court concluded that the Board's authorization of an offset was erroneous.