



# News & Case Notes

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## BOARD NEWS

### Adoption of Permanent Rules/Amendments (Attorney Fees - OAR 438 Division 015) - ("Contingent Hourly Rate" - "015-0010(4)(l)"); "Voluntary Bifurcation of Attorney Fee Award for Certain Cases on Board Review" - "015-0125" - Effective October 1, 2020

At their August 19, 2020, public meeting, the Members adopted rules/amendments relating to attorney fees (OAR 438 Division 015). The Members took these actions after considering comments presented at a July 31, 2020, rulemaking hearing, as well as discussing submissions from Members Ousey and Curey, and comments presented by attendees at the Board's August 19 meeting. The rule amendments are summarized as follows:

- Allowing the submission and consideration of information regarding a claimant's attorney's "contingent hourly rate," including the calculation of such a rate. OAR 438-015-0010(4)(l).
- Establishing procedures regarding the voluntary bifurcation of an attorney fee award from the merits concerning certain cases on Board Review. OAR 438-015-0125.

The effective date for the permanent rules/amendments is October 1, 2020, to be applied in the manner prescribed in the Board's Order of Adoption. The Board's Order of Adoption can be found here: <https://www.oregon.gov/wcb/legal/Pages/laws-and-rules.aspx>. In addition, copies of the Order of Adoption have been distributed to all parties/practitioners on WCB's mailing list.

### Adoption of Permanent Rules/Amendments (Attorney Fees - OAR 438 Division 015) - Effective June 1, 2020

At their February 27, 2020, public meeting, the Members adopted rules/amendments relating to attorney fees (OAR 438 Division 015). The Members took these actions after considering written/oral comments presented at a January 31, 2020, rulemaking hearing, as well as discussing submissions from Members Ousey, Curey, and Woodford, and comments presented by attendees at their February 27 meeting. The rule adoptions include (among other rule amendments):

- Adding a definition ("client paid fee") to describe fees paid by an insurer or self-insured employer to its attorney. OAR 438-015-0005.

**APPELLATE DECISIONS****Update**

Penalty: "268(5)(g)" - Recon  
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- Adding language based on 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 "Fees earned by attorneys representing the insurer/self-insured employer, as compiled in the Director's annual report pursuant to ORS 656.388(7) of attorney salaries and other costs of legal services incurred by insurers/self-insured employers under ORS Chapter 656." OAR 438-015-0010(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.

The effective date for the permanent rules/amendments is June 1, 2020, to be applied in the manner prescribed in the Board's Order of Adoption. The Board's Order of Adoption can be found here: <https://www.oregon.gov/wcb/legal/Pages/laws-and-rules.aspx>. In addition, copies of the Order of Adoption have been distributed to all parties/practitioners on WCB's mailing list.

## Reminder – Prohibition on Unofficial Recordings of Hearings

The Workers' Compensation Board Hearings Division will be using Zoom for Government to conduct proceedings by video conference. All WCB hearings are officially recorded, whether it be in-person, teleconference, or videoconference. Please remember that parties are prohibited from making separate recordings of the proceedings. [OAR 438-007-0030](https://www.oregon.gov/wcb/007-0030).

To obtain a copy of the recorded proceedings, please request a copy using this website form: <https://www.oregon.gov/wcb/hearings/Pages/req-recorded-proceedings-form.aspx>

For information about how to request a videoconference, please refer to the announcement from Presiding Administrative Law Judge (PALJ) Joy Dougherty: <https://www.oregon.gov/wcb/Documents/announcements/zoom-hrgs091420.pdf>

**CASE NOTES**

Aggravation: "Actual Worsening" - Surgery to Repair "Skin Flap" from Initial Surgery for Accepted Finger Condition - "273(1)"

*Alberto Rios-Garcia*, 72 Van Natta 813 (September 2, 2020), *on recons*, 72 Van Natta 907 (October 1, 2020). Applying ORS 656.273(1), the Board

held that claimant's aggravation claim for his accepted finger condition was compensable because his attending physician's opinion regarding his pain from improperly healed skin from his first surgery and the need for further surgery to repair his "skin flap," along with worsening pain following the "flap" surgery, constituted an "actual worsening" of his accepted finger condition. Asserting that the attending physician had initially opined that claimant's finger condition had not worsened, the carrier contended that its aggravation denial should be upheld.

*"Actual worsening" may be proven by pathological worsening or through physician's inference of such worsening by claimant's increased symptoms.*

The Board disagreed with the carrier's contention. Citing ORS 656.273(1), the Board stated that, to establish a compensable aggravation claim, a claimant must establish an "actual worsening" of an accepted condition since the last award/arrangement of compensation. See *Robin G. Guzman*, 67 Van Natta 1062, 1064 (2015). Relying on *SAIF v. Walker*, 330 Or 102, 118-19 (2000), and *SAIF v. January*, 166 Or App 620, 624 (2000), the Board reiterated that an actual worsening may be proven by a pathological worsening of the accepted condition or through inference of such a worsening from increased symptoms supported by a physician's opinion. Referring to *Jerry G. Bump*, 59 Van Natta 807, 809-10 (2007), the Board noted that it had previously found an attending physician's report of post-surgical scarring represented objective evidence of the claimant's worsened symptoms, even when the attending physician later stated that there had been no objective worsening of the accepted condition.

*"AP" explained that "skin flap" removal surgery addressed improperly healed "skin flap" from first surgery and worsened claimant's pain for several weeks during healing process.*

Turning to the case at hand, the Board acknowledged that claimant's attending physician had concurred with the carrier's statement that claimant's condition had not worsened. Nevertheless, the Board noted that the attending physician had subsequently explained that the second surgery was performed to address claimant's pain from an improperly healed "skin flap" from his initial finger surgery. Moreover, the Board observed that the attending physician had further opined that the "skin flap" removal worsened claimant's finger pain for several weeks during the healing process.

Under such circumstances, the Board found that the attending physician's opinion persuasively established, through objective findings and documented increased symptoms, an actual worsening of claimant's accepted finger condition since the last award of compensation. Consequently, the Board held that claimant's aggravation claim was compensable.

### CDA: "Recon" Denied - "Amended" CDA Filed More Than 10 Days After CDA Approval - "009-0035(1), (2)"

*Bruce W. McCoy*, 72 Van Natta 871 (September 17, 2020). Applying OAR 438-009-0035(1), and (2), the Board declined to consider the parties' submission of a proposed amendment to their previously approved Claim Disposition Agreement (CDA) because the submission had been filed more than 10 days after the CDA had been approved.

*Parties' addendum was filed 30 days after CDA approval.*

Citing ORS 656.236(2), the Board stated that an approved CDA is not subject to review. Referring to OAR 438-009-0035(1), and (2), the Board noted that it may reconsider an approved CDA provided that the motion for reconsideration was filed within 10 days of the CDA approval.

*Because addendum was filed more than 10 days after CDA approval, Board could not consider it.*

Turning to the case at hand, the Board found that the parties' addendum had been filed some 30 days after approval of the CDA. Reasoning that the submission constituted a motion for reconsideration that was filed more than 10 days after approval of the CDA, the Board concluded that the addendum/motion could not be considered. See *Mark J. Lackey*, 63 Van Natta 795 (2011); *Randy G. Shamblin*, 62 Van Natta 40 (2010).

Course & Scope: "Alcohol" Defense - Carrier Did Not Prove "Alcohol Consumption" Was Major Cause of Decedent's "MVA" - "005(7)(b)(C)"

Attorney Fee: Determination of "Reasonable" Attorney Fee Award - Prevailing Over Denied Claim at Hearings Level - Applying "015-0010(4)" Factors

*Christopher L. Garrett, DCD*, 72 Van Natta 880 (September 23, 2020). Analyzing ORS 656.005(7)(b)(C), the Board held that the deceased worker's injury, which occurred as a result of motor vehicle accident (MVA) while performing his work activities as a trucker, arose out of and in the course of his employment and that his beneficiary was entitled to compensation because the carrier had not established that the decedent's consumption of alcohol was the major contributing cause of his MVA. Relying on a physician's opinion (which was based on the absence of any other factor to explain why the decedent's truck had driven off the shoulder of the road and the decedent's blood alcohol concentration (BAC) of .048) that the decedent's alcohol-related impairment was the major contributing cause of the MVA, the carrier denied the decedent's claim. The decedent's beneficiary asserted that the physician had not adequately addressed the opinions from a motor vehicle collision reconstructionist and a forensic toxicologist. These experts had reasoned that, before the MVA, the decedent had successfully negotiated a left-hand curve and reacted in a more timely than average manner for an unimpaired driver and that, based on witnesses' testimony concerning the decedent's behavior immediately after the MVA and the accident scene, assessed that his BAC was closer to .02. Relying on these expert opinions (which did not consider the decedent's alcohol consumption to be the major contributing cause of the MVA), the decedent's beneficiary (his surviving spouse) contended that the carrier had not met its burden of disproving the compensability of the claim pursuant to ORS 656.005(7)(b)(C).

*Carrier relied on a physician's opinion that no other factor besides "BAC" explained the MVA.*

*Accident reconstructionist and forensic toxicologist did not consider decedent's alcohol consumption to be the major cause of MVA.*

The Board agreed with the surviving spouse's contention. Citing ORS 656.005(7)(b)(C), the Board stated that a compensable injury does not include an "[i]njury the major contributing cause of which is demonstrated to be by a preponderance of evidence the injured worker's consumption of alcoholic beverages[.]" Referring to *Raul Solano-Alcantar*, 54 Van Natta 42, 44 (2002), the Board reiterated that the carrier has the burden of proving under ORS 656.005(7)(b)(C) that the decedent's alcohol consumption was the major contributing cause of the MVA, which had resulted in his death.

*Because carrier's medical expert had not adequately addressed opinions from other experts, medical expert's opinion was discounted.*

*No additional weight given to the medical expert's opinion relative to the evaluation of other contributing factors noted by the other experts.*

*After applying "rule-based factors," Board modified ALJ's attorney fee award (\$42,000) to \$60,000.*

Turning to the case at hand, the Board acknowledged that the carrier had submitted a medical toxicologist's opinion that the decedent's alcohol consumption was the major contributing cause of the MVA. Nevertheless, reasoning that the carrier's physician had not adequately addressed the opinions from the accident reconstructionist and forensic toxicologist (which had not considered the decedent's alcohol consumption to be the major contributing cause of the MVA), the Board discounted the medical toxicologist's opinion. Consequently, the Board concluded that the carrier had not met its burden of disproving the claim under ORS 656.005(7)(b)(C).

In reaching its conclusion, the Board recognized that the surviving spouse had not presented a *medical* expert's opinion, but rather opinions from an accident reconstructionist and a forensic toxicologist. Nonetheless, the Board noted that the record did not indicate that the medical toxicologist had any education, skill, knowledge, or training in accident reconstruction. Under such circumstances, the Board did not accord any additional weight to the medical toxicologist's opinion relative to the evaluation of other potential contributing factors concerning the cause of the decedent's MVA when compared to the contrary opinions from the accident reconstructionist and forensic toxicologist (both of whom were former state troopers).

Finally, the Board modified the surviving spouse's counsel's attorney fee award under ORS 656.386(1) for services at the hearing level in prevailing over the carrier's denial from \$42,000 (as granted by the ALJ's order) to \$60,000. Citing *Schoch v. Leopold & Stevens*, 325 Or 112, 118-19 (1997), the Board applied the factors prescribed in OAR 438-015-0010(4) to the particular circumstances presented in the case. In doing so, the Board noted that it has discretion in setting the amount of a reasonable carrier-paid attorney fee, regardless of the presence or absence of a specific fee request or objection. *Cascade In Home Care v. Hooks*, 296 Or 695, 698 (2019). Finally, referring to *Peabody v. SAIF*, 297 Or App 704, 706 (2019), and *Daniel F. Judd*, 71 Van Natta 548, *on recons*, 71 Van Natta 898, 898-99 (2019), the Board recognized that its order must articulate how the application of the rule-based factors supports the amount of its attorney fee award in order to furnish the court with the information necessary to review its attorney fee award.

After conducting its review of the record, the Board acknowledged that, in support of his request for an attorney fee award totaling \$157,200, the surviving spouse's counsel had submitted an itemized statement of services documenting more than 131 hours expended at the hearing level. In light of the legal, medical, and factual challenges involved in the denied claim, the Board stated that it was understandable that the spouse's counsel would expend more hours in garnering evidence, hearing preparation, and otherwise pursuing the litigation of this particular denied claim than those generally incurred in compensability disputes typically presented to the Hearings Division. Nonetheless, given the surviving spouse's counsel's extensive experience (37 years), the Board considered 131 hours to be an excessive amount of hours of time devoted to the compensability issue at the hearing level (particularly some 60 hours after the hearing for written closing arguments).

Notwithstanding the aforementioned qualification, the Board determined that, based on the significant complexity of the compensability dispute (which included legal, factual, and medical issues), the significant risk that the

*Although time devoted by claimant's counsel was considered excessive, Board determined the case was significantly complex, the value of the benefits was substantial, and there was a significant risk of going uncompensated.*

*Orders on Reconsideration had set aside two previous claim closures based on insufficient information.*

*After concurring with "med stat" statement, "AP" subsequently opined that accepted condition and direct medical sequelae were not medically stationary.*

*The "med stat" status of accepted conditions and their direct medical sequelae must be considered.*

surviving spouse's counsel might go uncompensated, the substantial value of the spouse's death benefit claim, the experience/skill of the spouse's counsel, and the contingent nature of the practice of workers' compensation law, the confluence of the rule-based factors supported a reasonable carrier-paid attorney fee for the spouse's counsel's services at the hearing level in prevailing over the carrier's denial of \$60,000. In reaching its conclusion, the Board Members drew on their combined years of workers' compensation experience as practitioners representing claimants and carriers before the Hearings Division and Board review levels involving the litigation of thousands of denied claims.

Premature Closure: Accepted Condition (Including Direct Medical Sequelae) Must Be "Med Stat" at Claim Closure

Issue Preclusion: Final "Recon Order" Determination of "Non-Med Stat" Had Preclusive Effect on Subsequent Recon Order's "Med Stat" Finding

Attorney Fee: "383(2)" - Not Awarded for ALJ's "Premature Closure" Determination - Claimant Did Not Obtain Temporary Disability

*James A. Hoyt*, 72 Van Natta 848 (September 8, 2020). Analyzing ORS 656.268(1)(a), and ORS 656.005(17), the Board held that claimant's low back injury claim was prematurely closed because the record did not establish that his accepted L4-5 disc condition *and* its direct medical sequelae were medically stationary when the claim was closed. Following two Orders on Reconsideration, which had set aside two previous claim closures for insufficient information, the carrier issued another Notice of Closure. After an Order on Reconsideration found that the claim was not prematurely closed, claimant requested a hearing. Asserting that his attending physician's previous concurrence with a statement that claimant's L4-5 disc condition and fusion "remain[ed] medically stationary" did not establish that claimant's medical sequelae from the accepted L4-5 disc condition were also medically stationary, claimant contended that the claim was prematurely closed because the attending physician had subsequently opined that claimant's accepted L4-5 disc condition and direct medical sequelae were not medically stationary.

The Board agreed with claimant's contention. Citing ORS 656.268(1)(a), the Board stated that a carrier was authorized to close a claim when the worker has become medically stationary and there is sufficient information to determine permanent impairment. Relying on ORS 656.005(17), the Board noted that "medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. Finally, referring to *Manley v. SAIF*, 181 Or App 431, 438 (2002), and *Katherine A. Lapraim*, 68 Van Natta 39, 40 (2016), the Board reiterated that, in determining whether a claim is prematurely closed, it considers the medically stationary status of the accepted conditions and their direct medical sequelae.

*Examining physicians' "med stat" opinions were inconsistent with previous reconsideration orders' "non-med stat" determinations; "issue preclusion" applied in discounting opinions.*

*When "direct medical sequelae" of accepted L4-5 disc (leg pain) was considered, "AP" concluded that claimant was not "med stat."*

*Because ALJ's "premature closure" decision did not establish entitlement to TTD, no "383(2)" fee awardable; "383(1)" fee possible if claimant subsequently obtained TTD.*

Turning to the case at hand, the Board acknowledged that several examining physicians had considered claimant's low back condition to be medically stationary several years before the claim was closed. Nonetheless, noting that previous Orders on Reconsideration had set aside claim closures based on those physicians' previous "medically stationary" opinions, the Board considered those physicians' opinions to be inconsistent with the previous reconsideration order's "non-medically stationary" determinations. Consequently, consistent with the principles of "issue preclusion," the Board reasoned that the carrier's attempt to establish a "medically stationary" date before the previous reconsideration order's "non-medically stationary" determination was impermissible. See *Calvin L. Wood*, 72 Van Natta 638, 640 (2020); *Terry E. Mason*, 70 Van Natta 362, 366-67 (2018).

The Board further recognized that another examining physician had attributed claimant's leg and back pain to unaccepted stenosis/spondylolisthesis conditions at L1-4 and L3-4. Nevertheless, the Board observed that, before and after the examining physician's evaluation, claimant's attending physician had opined that claimant was not medically stationary. Moreover, the Board noted that the examining physician's opinion had not specifically addressed the medically stationary status of claimant's accepted L4-5 disc condition and its direct medical sequelae. In contrast, the Board emphasized that, when claimant's attending physician had been questioned about claimant's L4-5 disc condition (including its direct medical sequelae), the attending physician had opined that claimant was not medically stationary.

Finally, the Board acknowledged that the attending physician had previously stated that claimant's L4-5 disc condition and fusion "remain[ed]" medically stationary. Nonetheless, reasoning that the attending physician had not been asked to comment on the status of claimant's direct medical sequelae of the L4-5 disc condition, the Board concluded that the attending physician's previous opinion was not adequate support for a conclusion that claimant's accepted L4-5 disc condition *and* its direct medical sequelae were medically stationary when the claim was closed. Consequently, the Board held that the claim was prematurely closed.

Next, the Board addressed claimant's counsel's entitlement to an attorney fee award for establishing that the claim was prematurely closed. Relying on *Guadalupe Gonzalez-Ramirez*, 72 Van Natta 141, 145-46 (2020), the Board reiterated that, because a "premature closure" determination does not establish a claimant's entitlement to temporary disability benefits, a claimant's counsel is not entitled to an attorney fee award under ORS 656.383(2).

However, in reaching its conclusion, the Board noted that, if following the "premature closure" decision, claimant subsequently obtained temporary disability benefits, his counsel could seek an attorney fee pursuant to ORS 656.383(1). See *Gonzalez-Ramirez*, 72 Van Natta at 146, n 5.

Member Curey dissented from the majority's "premature closure" decision. Reasoning that the attending physician's opinion that claimant's condition (including left leg symptoms) were not medically stationary was predicated on his need for a neurological evaluation, Curey noted that the results of that subsequent evaluation attributed claimant's left leg symptoms to unaccepted conditions at other levels of his lumbar spine. Because the attending physician

*Because “AP” opinion had not addressed physician’s opinion (that leg symptoms were unrelated to accepted L4-5 disc), dissent considered “AP’s” “not med stat” opinion unpersuasive.*

did not subsequently address the neurosurgeon’s report (which had not attributed claimant’s leg symptoms to his accepted L4-5 disc condition), Member Curey considered the attending physician’s opinion (which concluded that claimant’s accepted condition and its direct medical sequelae were not medically stationary) to have been based on incomplete information. Consequently, Curey was not persuaded that the record established that the claim was prematurely closed.

## APPELLATE DECISIONS UPDATE

### Penalty: “268(5)(g)” - Recon Order’s “Work Disability” Award - Based on “Info” Carrier Could Reasonably Have Known - By Seeking Clarification of “AP” Opinion Before Claim Closure

*Alvarado-DePineda v. SAIF*, 306 Or App 423 (September 10, 2020). Analyzing ORS 656.268(5)(g), the court reversed the Board’s order in *Maria D. Alvarado-DePineda*, 70 Van Natta 918 (2018), previously noted 37 NCN 8:6, that had declined to award a penalty based on a work disability award granted by an Order on Reconsideration because it found that the award was based on “post-closure” information from claimant’s attending physician that the carrier could not reasonably have known at the time of the Notice of Closure (which had not granted work disability). Reasoning that, at the time of claim closure, the attending physician had released claimant to her “at-injury” job, the Board determined that the carrier could not have reasonably known that the physician would have changed his opinion and not released claimant to her “at-injury” job. On appeal, asserting that the attending physician’s information was ambiguous, claimant argued that the carrier had a duty to clarify the extent of claimant’s impairment before closing the claim and, because it had not done so, the Board had erred in not awarding a penalty under ORS 656.268(5)(g) based on the Order on Reconsideration’s work disability award (which was based on the attending physician’s “post-closure” report, which, in response to an inquiry from claimant’s counsel, clarified that claimant was not released to her “at-injury” job).

*Claimant argued that the carrier had a duty to clarify ambiguous information from “AP” before closing claim.*

The court agreed with claimant’s contention. Citing ORS 656.268(5)(g), and *Walker v. Providence Health Systems Oregon*, 267 Or App 87 (2014), *mod on recon*, 269 Or App 404 (2015), the court reiterated that when assessing whether a carrier “could not have known” at claim closure the extent of a claimant’s impairment, it takes into account the information in the carrier’s hands at the time of closure, including the carrier’s medical file on the claimant, the carrier’s “duty to gather the information necessary to issue its Notice of Closure,” and the carrier’s related legally recognized duty to seek clarification and gather additional information in the face of ambiguities.

*Carrier has duty to seek clarification of information in the face of ambiguities before closing a claim.*

Turning to the case at hand, the court identified multiple ambiguities regarding the attending physician’s assessment of claimant’s impairment at claim closure; e.g., the attending physician had agreed with a work capacity evaluation’s conclusion that claimant could return to her “at injury” job, yet had also reported that claimant had been released to “modified duty”; the attending physician had also concurred with two conflicting reports regarding claimant’s ability to use her arm above her shoulder and her lifting limitations.

*Because the carrier had not sought clarification regarding claimant's impairment/limitations before closing the claim, "268(5)(g)" penalty was due based on the "post-closure" information that resulted in Order on Reconsideration's "work disability" award.*

Under such circumstances, the court concluded that the carrier had an obligation to gather the information necessary to determine the extent of claimant's impairment and clarify any apparent ambiguities in that information. Because the carrier had not sought such clarification and the attending physician's "post-closure" clarification had resulted in the Order on Reconsideration's work disability award, the court agreed with claimant's contention that the Board had erred in not awarding a penalty under ORS 656.268(5)(g).