BOA RD N EWS

Mediation Evaluation Project

WCB is conducting a mediation evaluation project from April 1, 2021, through June 30, 2021. Evaluations will be sent to all attendees of mediations. 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 the participant’s convenience. WCB appreciates this opportunity receive valuable feedback from participants during this three-month period.


As summarized in previous issues of the Board’s News & Case Notes, during their December 15, 2020, public meeting, the Members announced that information regarding ALJ and Board attorney fee awards would be shared with the public.

Consistent with that announcement, a web page has been created that concerns statistical reports, including attorney fees. The web page can be found at: https://www.oregon.gov/wcb/legal/Pages/statistical-reports.aspx

CASE NOTES

Attorney Fee: “386(1)” - Rule Factors Now Include Consideration of Necessity of Allowing Broadest Access to Attorneys, Defense Fees, Contingent Nature of Practice, and Contingent Hourly Rate

Attorney Fee: Fee Determined by Considering Hours and Contingent Rate in Light of Other Factors Because Claimant Asserted Hours and Contingent Rate and Submitted Information Regarding Those Factors - Overall "Time Devoted" Was Considered Excessive

“Classification: Carrier Reclassified Claim to Disabling, While Claimant's Hearing Request from WC&D's "Nondisabling Classification" Order Was Pending - Reclassification "Finally Determined" by Board Order - Entitlement to Attorney Fee Award

“De Facto Denial,” “Back-Up Denial”: Where Claim Initially Accepted as an "Injury" and Later Designated an "Occupational Disease," the Initial Acceptance Did Not "De Facto Deny" an "Occupational Disease" Claim, and the Later Designation Did Not "Back-Up Deny" the Accepted Injury Claim
Attorney Fee: "386(1)" Fee Not Awarded For Services on Reconsideration, Judicial Review, or Remand - Only Issue Was Claimant’s Attorney Fee Argument - Claimant Had "Finally Prevailed" on Compensability at Initial Board Review

Karista D. Peabody, 73 Van Natta 244 (April 8, 2021), recons, 73 Van Natta 322 (April 20, 2021). Applying ORS 656.386(1) and OAR 438-015-0010(4), on remand, the Board, en banc, determined that $21,280 represented a reasonable attorney fee award for claimant’s counsel’s services at the hearing level and on review based on a reasonable number of hours and a reasonable contingent hourly rate.

Citing OAR 438-015-0010(4), the Board reiterated that the determination of a reasonable attorney fee involves the consideration of the "rule-based" factors. The Board noted that, after the court’s remand, the rule had been amended to mandate consideration of “the necessity of allowing the broadest access to attorneys by injured workers,” “the fees earned by attorneys representing the insurer/self-insured employer as compiled by the Director’s annual report under ORS 656.388(7),” and, if asserted, “claimant’s attorney’s contingent hourly rate * * * together with any information used to establish the basis on which the rate was calculated.” The Board acknowledged its case law holding that the determination of a reasonable attorney fee did not involve a mathematical calculation. But, because the rule now allowed for the consideration of a contingent hourly rate, if submitted, and claimant’s counsel had submitted such information, along with the hours spent on the case, as a basis for the fee request, the Board found it appropriate to use such information as the starting point for determining a reasonable attorney fee award.

Turning to the case at hand, the Board stated that claimant’s counsel requested a $31,000 fee award based on 63 reported hours and the contingent hourly rate of $492. Analyzing the time reported for services at the hearing level, the Board found time spent on pre-litigation and litigation tasks to be reasonable, given the numerous physicians’ opinions involved in the case and claimant’s counsel’s experience. However, the Board found the 19.8 hours devoted to written closing argument to be excessive, given the relatively straightforward nature of the proceedings and legal arguments. The Board also noted that a portion of the written closing argument concerned an unsuccessful alternative theory. Based on their experience as Board Members and litigators, and fee submissions in similar cases, the Board determined that 10 hours devoted to written closing argument would have been reasonable. Further evaluating the 9.6 hours spent at the Board review level, the Board found that time to be reasonable.

Next, the Board considered claimant’s counsel’s proposed $492 contingent hourly rate. The Board accepted counsel’s assertion that $220 represented a reasonable non-contingent hourly rate and counsel’s calculation, based on dividing $220 by 55 percent to account for the contingent nature of the practice, that $400 was a reasonable contingent hourly rate. The Board noted that its recent attorney fee statistics revealed that an attorney fee is awarded in about 40 percent of all Administrative Law Judge Opinions and Orders. The
Board also noted that it expected attorney fee awards which better reflect the contingent nature of the practice to encourage attorneys to continue representing claimants, and to reduce the $17 million gap between the fees earned by attorneys representing claimants and carriers (as described by the Director’s Annual Report on Attorney Fees). However, the Board did not accept claimant’s contention that the complexity of the issue and value of the interest involved supported a contingent hourly rate beyond $400. Consequently, the Board awarded a $21,280 attorney fee, based on 53.2 hours and a $400 contingent hourly rate.

Member Curey dissented. Explaining that she found the majority’s mathematical calculation approach to a reasonable attorney fee award to be beyond the scope of the court’s instructions on remand, inconsistent with the Board’s conclusions in its 2018 biennial review of attorney fees, and otherwise problematic, Member Curey did not support such an analysis. Rather, she advocated an approach to attorney fee awards based on the Board’s recent statistical data reflecting attorney fees awarded in cases involving denied claims before the Hearings Division and the Board. Applying that approach, Member Curey concluded that an attorney fee award of $18,500 was reasonable for claimant’s counsel’s services at the hearing level and on board review.

Claimant requested reconsideration of the Board’s Order on Remand, asserting that her counsel was also entitled to an attorney fee award for services performed before the Board on reconsideration of the Order on Review, before the court, and before the Board on remand. Citing ORS 656.386(1), the Board noted that an attorney fee is awardable where the claimant “finally prevails” over a denial in a case involving a “denied claim.” Quoting ORS 656.386(1)(b)(A), the Board stated that a denied claim involves a refusal to pay “compensation.” Relying on Cayton v. Safelite Glass Corp., 257 Or App 188, 195 and Warren D. Duffour, 70 Van Natta 176, 181 n9 (2018), the Board reiterated that attorney fees are not “compensation.”

Turning to the case at hand, the Board explained that it had resolved the compensability dispute in its initial Order on Review and the only portion of that order that was disputed on reconsideration, on judicial review, and on remand was the amount of the attorney fee award. Under such circumstances, the Board concluded that claimant had “finally prevailed” against the denial for purposes of ORS 656.386(1) on the Board’s initial review. Further, the Board determined that, because an attorney fee award is not “compensation,” the litigation of the fee award on reconsideration, judicial review, and remand did not involve a “denied claim” and, therefore, an ORS 656.386(1) attorney fee was not awardable for services at those levels.

The Board distinguished the Supreme Court’s decision in Shearer’s Foods v. Hoffnagle, 363 Or 147 (2018). Explaining that the Hoffnagle court concluded only that an ORS 656.386(1) attorney fee award includes time spent litigating the amount of a reasonable attorney fee where the claimant is otherwise entitled to such a fee (based on that forum’s determination regarding a compensability dispute), the Board did not consider the Hoffnagle decision to mandate an attorney fee award where the sole issue was the amount of an attorney fee award. Consequently, the Board adhered to its prior order on remand.
Classification: Carrier Reclassified Claim to Disabling, While Claimant’s Hearing Request from WCD's "Nondisabling Classification" Order Was Pending - Reclassification "Finally Determined" by Board Order - Entitlement to Attorney Fee Award

New/Omitted Medical Condition: Existence/Causation Established - Broader Diagnosis Described Condition Despite More Specific Diagnoses - Employment Conditions Were Major Cause of Claimed Conditions

“De Facto Denial,” “Back-Up Denial”: Where Claim Initially Accepted as an “Injury” and Later Designated an “Occupational Disease,” the Initial Acceptance Did Not “De Facto Deny” an “Occupational Disease” Claim, and the Later Designation Did Not “Back-Up Deny” the Accepted Injury Claim

Carol J. Braun, 73 Van Natta 288 (April 15, 2021). The Board found several claimed new/omitted medical conditions to be compensable, did not award penalties or attorney fees for an allegedly unreasonable denial, an alleged de facto denial, or an alleged “back-up” denial, and, determining that claimant’s non-disabling claim should be reclassified as disabling, awarded claimant’s counsel an assessed attorney fee for services in obtaining the reclassification. The employer had accepted claimant’s subdeltoid bursitis and acromial impingement, designating the claim as an “injury” and as nondisabling. The employer later designated the claim as an “occupational disease.” After claimant requested reclassification of the claim as disabling, the employer refused to reclassify the claim and the Workers’ Compensation Division (WCD) upheld that refusal, but the carrier later reclassified the claim based on subsequently-obtained medical evidence. Additionally, the employer denied claimant’s new/omitted medical condition claims for several conditions.

Addressing the compensability dispute, the Board first addressed the carrier’s contention that claimant had not established the existence of two of the claimed conditions, as required by Maureen Y. Graves, 57 Van Natta 2380 (2005). Regarding overuse syndrome, the Board noted that the existence of the condition was persuasively supported by claimant’s treating physician and, although other physicians described the diagnosis as “vague” or “nonspecific,” they did not persuasively explain why the diagnosis was not a condition or why claimant did not have the condition. Regarding coracoid impingement, the Board noted that the claimant’s treating physician performed multiple examinations over time documenting objective findings of the coracoid impingement condition.
Moreover, the Board was not persuaded by the opinion of the carrier-requested physician, whose application of the medical literature was not sufficiently specific to claimant. Consequently, the Board found the conditions to exist.

Turning to causation, the Board found claimant’s treating physician’s opinion most persuasive, in part based on the claimant’s longitudinal history with the physician. The Board also found the physician’s opinion to be well reasoned and based on an accurate understanding of the claimant’s work activities. Acknowledging that the physician’s opinion was inconsistent regarding the compensability of claimant’s right shoulder degenerative arthritis, the Board upheld the denial of the new/omitted medical condition claim for that condition. However, based on the physician’s otherwise persuasive opinion, the Board found that employment conditions were the major contributing cause of the remaining new/omitted medical conditions.

Applying ORS 656.262(11)(a), the Board addressed claimant’s request for a penalty and attorney fee for the carrier’s allegedly unreasonable denial of the new/omitted medical condition claim. Citing Int’l Paper Co. v. Huntley, 106 Or App (1991), and Brown v. Argonaut Ins. Co., 93 Or App 588 (1988), the Board recited that whether a denial was an unreasonable resistance to the payment of compensation depends on whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability, and “unreasonableness” and “legitimate doubt” are considered in light of the evidence available at the time of the denial. Noting medical evidence that the claimed new/omitted medical conditions were preexisting degenerative conditions, the Board declined to award a penalty or attorney fee for the allegedly unreasonable denial.

The Board turned to claimant’s assertions that the carrier had de facto denied an occupational disease claim when it had accepted the claim as an injury and had “back-up” denied the accepted claim when it accepted the claim as an occupational disease. Citing Ernest R. Lyons, 69 Van Natta 688, 693 (2017), the Board noted that an initial notice of acceptance does not give rise to a de facto denial. The Board also noted that ORS 656.262(6)(d) required claimant to object to the carrier’s Notice of Acceptance before she was permitted to allege a de facto denial. The Board noted that ORS 656.262(6)(b)(F) and OAR 436-060-0140(6)(b)(D) allows for modification of a Notice of Acceptance.

Applying these principles to the case at hand, the Board concluded that the designation of the claim as an injury in the initial Notice of Acceptance did not amount to a de facto denial of an occupational disease claim. The Board noted that claimant did not follow the statutory procedure under ORS 656.262(6)(d) by providing notice of her objection before alleging a de facto denial. Consequently, the Board did not find a de facto denial. Further reasoning that there are no claim processing requirements requiring a designation of an “injury” or an “occupational disease,” and the carrier’s adjuster testified that the initial designation of the claim as an “injury” was a clerical error that was corrected by the Modified Notice of Acceptance designating the claim as an “occupational disease,” the Board concluded that the Modified Notice of Acceptance did not deny a previously accepted condition and, therefore, did not “back-up” deny a claim.
Finally, analyzing ORS 656.277 and ORS 656.386(3), and observing that the carrier had reclassified the claim as disabling based on evidence obtained after the WCD’s classification order, the Board addressed the classification dispute. Contrasting ORS 656.277 with ORS 656.268(8)(h), which limits the admissibility of evidence subsequent to a WCD reconsideration order reviewing a carrier’s Notice of Closure, the Board noted that the reclassification review process does not limit the admission of additional evidence following the WCD’s classification review. Discussing Arvidson v. Liberty Northwest Ins. Corp., the Board also noted that ORS 656.283(3)(a) and ORS 656.289(1) provide that requests for a hearing on “any matter concerning a claim” must be referred to an ALJ for a “determination,” and ORS 656.289(1) requires the ALJ to “determine the matter” within 30 days after the hearing. Analogizing the provisions of ORS 656.386(3) to ORS 656.382(2), which was discussed by the Arvidson court, and considering the context of ORS 656.283(3)(a) and ORS 656.289(1), the Board concluded that it was required to make a “determination” as to whether the claim should be classified as disabling or non-disabling.

Turning to the facts of the case, the Board noted that the Director’s decision found that the claim should be classified as non-disabling, a decision that the ALJ had affirmed. The Board observed that affirming the ALJ’s order would have affirmed the non-disabling classification, which would have been contrary to the carrier’s later concession that the claim was, in fact, disabling, and contrary to the carrier’s ultimate classification of the claim as disabling. Therefore, the Board reversed the ALJ’s order and “finally determined” that the claim should be classified as disabling. Accordingly, the Board concluded that an assessed attorney fee was awardable under ORS 656.386(3).

Member Curey dissented from those portions of the majority’s order that awarded an assessed attorney fee under ORS 656.386(3) for prevailing in the reclassification dispute and set aside the carrier’s denials of claimant’s new/omitted right shoulder condition claims.

Citing ORS 656.386(3), Member Curey reasoned that the Board did not “finally determine” that the claim should be disabling within the meaning of the statute. Member Curey reasoned that ORS 656.386(3) authorizes an attorney fee award when the Director, an ALJ, the Board, or a court “finally determines” that the claim should be disabling, not when the carrier “finally determines” that the claim should be classified as disabling. Member Curey further contrasted ORS 656.386(3) to ORS 656.386(1), which authorizes attorney fees when a claimant’s counsel is instrumental in obtaining rescission of a denial before a decision from an ALJ. Therefore, Member Curey concluded that ORS 656.386(3) does not provide for an attorney fee if a claim is finally determined to be disabling by a carrier that voluntarily reclassifies a claim. Turning to the case at hand, Member Curey concluded that the carrier, not the Board (or the Director, the ALJ, or a court), had made the final determination that the claim was disabling. Consequently, Member Curey concluded that claimant’s counsel was not entitled to an attorney fee.

Reclassification review process does not limit the admission of additional evidence following WCD review.

Although carrier had subsequently reclassified claim to disabling, Board’s review of ALJ’s order “finally determined” disabling classification.

Dissent concluded that statute does not provide for an attorney fee if carrier voluntarily reclassifies the claim.
Regarding the compensability dispute, Member Curey noted that the ALJ discounted the opinion of the treating physician for not adequately weighing the nonwork-related contributors to the claimed right shoulder conditions and for being inconsistent. Accordingly, Member Curey would have adopted and affirmed the ALJ’s opinion upholding the carrier’s denials of the right shoulder conditions.

Lump Sum: Payment Not Required When Closure Not Final By Operation of Law, Even Though Payment Requested and Appeal Waived

Vern E. Giltner, 73 Van Natta 327 (April 22, 2021). Analyzing ORS 656.230(1), OAR 436-060-0060, and ORS 656.262(11)(a), the Board held that the carrier’s denial of claimant’s application for lump sum payment of the permanent disability awarded in a Notice of Closure (NOC) was not unreasonable because, despite claimant’s agreement to waive his right to appeal the award’s adequacy, the award had not become final by operation of law. After a NOC awarded permanent disability for claimant’s bilateral hearing loss conditions, and after the carrier’s statutory 7-day appeal period for the NOC expired, but before claimant’s statutory 60-day appeal period expired, claimant applied to the carrier for approval of lump sum payment of the permanent disability award. In doing so, claimant agreed to waive his right to appeal the adequacy of the award. The carrier denied his request, asserting that the award had not become final by operation of law. Claimant requested a hearing, contending that the carrier was obligated to approve his request because he agreed to waive the right to appeal the award’s adequacy.

The Board disagreed with claimant’s contentions. Citing ORS 656.230(1) and OAR 436-060-0060(1), the Board stated that a carrier is required to make a lump sum payment of a permanent disability award in response to a claimant’s request unless one of four conditions (including that the award has not become final by operation of law, or that the worker has not waived the right to appeal the award’s adequacy), enumerated in the disjunctive, exists.

Turning to the case at hand, the Board observed that, at the time claimant submitted his application for approval of lump sum payment of his permanent disability award and agreed to waive his right to appeal the award’s adequacy, the NOC had not become final by operation of law. Because the condition set forth in ORS 656.230(1)(b) and OAR 436-060-0060(1)(b) was present, the Board found that the carrier was authorized to deny claimant’s requested lump sum payment.

In reaching its conclusion, the Board distinguished Cayton v. Safelite Glass Corp., 231 Or App 644 (2009), which addressed prior versions of ORS 656.230(1) (2005) and OAR 436-060-0060(1) (2006), under which an award becoming final either by operation of law or by a claimant’s waiver of the right to appeal the award’s adequacy triggered the requirement that a carrier make the requested lump sum payment or inform the Director of its objection. The Board explained that ORS 656.230(1) and OAR 436-060-0060(1) have since been amended to list the disjunctive conditions that create an exception to the requirement that a carrier make the requested lump sum payment.
Claimant’s waiver of the right to appeal the adequacy of the award did not preclude an appeal of whether claim was prematurely closed.

Concurring opinion noted that statute and rule render meaningless claimant’s waiver of the right to appeal the award.

Citing Robert G. Green, 66 Van Natta 414 (2014), the Board explained that the award had not become final by operation of law. In Green, the Board explained that the current versions of ORS 656.230(1) and OAR 436-060-0060(1) do not require a carrier to pay a lump sum request if the worker has not waived the right to appeal the adequacy of the award or if the award has not become final by operation of law. The Board observed that, as in Green, the carrier could have rescinded and corrected its NOC pursuant to OAR 436-030-0023, despite claimant’s lump sum payment request and attempted waiver of the right to appeal the adequacy of the award. The Board also noted that claimant’s waiver of the right to appeal the award’s adequacy did not automatically render the award final because he could still request reconsideration and allege that his claim was prematurely closed, which could result in a rescission of the NOC and its permanent disability award. Thus, the Board found that the permanent disability award was not final by operation of law and, consequently, the carrier was not required to make the requested lump sum payment.

Member Ousey offered a special concurrence agreeing with the outcome of the case (consistent with the principles of stare decisis), but expressing concern that allowing a carrier to deny a request for lump sum payment of a permanent disability award if the award “has not become final by operation of law” renders ORS 656.230(1)(a) and OAR 436-060-0060(1)(a) meaningless because a claimant does not have the right to appeal an award that has become final by operation of law. Similarly, noting that ORS 656.304 provides that a claimant’s “acceptance of a lump sum award” payment granted as a result of the claimant’s own request under ORS 656.230 triggers the waiver of “the right of hearing on any award,” Member Ousey found a claimant’s waiver of “the right to appeal the adequacy of the award,” as a condition precedent to a carrier’s obligation to make the requested lump sum payment under ORS 656.230(1)(a) and OAR 436-060-0060(1)(a), to be further rendered meaningless. Thus, Member Ousey encouraged the legislature and the Workers’ Compensation Division (WCD) to reevaluate the statutes and administrative rules concerning a carrier’s claim processing obligations of lump sum payment requests.

Penalties: "268(5)(f)" - Lack of "Chronic Condition" Award in NOC Unreasonable - Carrier Did Not Have "Legitimate Doubt" at Claim Closure - Carrier's Question Form Could Not Reasonably Be Interpreted As Consistent With the WCD's Rule or "Industry Notice" for "Significant Limitation"

Keith J. Wiggins, 73 Van Natta 352 (April 26, 2021). Analyzing ORS 656.268(5)(f), on remand, Wiggins v. SAIF, 300 Or App 319 (2019), the Board awarded a penalty for the carrier’s unreasonable Notice of Closure. Citing ORS 656.268(5)(f), the Board stated that a penalty is awardable if the carrier has closed a claim, the correctness of that closure is at issue in a hearing, and a finding is made at the hearing that the Notice of Closure was not reasonable. Relying on David J. Morley, 66 Van Natta 2052, 2056 (2014), the Board noted that the reasonableness of the Notice of Closure must be evaluated based on the information available to the carrier at the time of the closure.
Referring to OAR 436-035-0019 (March 1, 2015), the Board explained that the claimant was entitled to a chronic condition impairment value for the upper leg if a preponderance of medical opinion established that, due to a chronic and permanent medical condition, he was “significantly limited” in the repetitive use of the upper leg. Citing *Broeke v. SAIF*, 300 Or App 91, 99 (2019), the Board described the Workers’ Compensation Division’s (WCD’s) December 2014 Industry Notice, in which the agency interpreted “significant limitation” as the ability to repetitively use the body part for up to two thirds of a period of time.

Turning to the case at hand, the Board explained that the closure, which did not award a chronic condition impairment value, was based on the attending physician’s response to the carrier’s inquiry as to whether claimant had a "significant limitation" in the repetitive use of the right leg. The Board noted the court’s statement that no reasonable person could conclude that the questionnaire, which described significant limitation as “more than 2/3 of the time,” was consistent with interpretation of “significant limitation” set forth in the WCD’s 2014 Industry Notice. Based on the court’s conclusion, the Board determined that, because the questionnaire on which the carrier relied could not reasonably be interpreted as communicating the correct "significant limitation" standard to the attending physician, the carrier could not reasonably rely on the questionnaire in closing the claim without a chronic condition impairment value.

Member Curey concurred. Citing her special concurrence in *James L. Williams*, 67 Van Natta 664, 671 (2015), she reiterated her reservations regarding the Board’s decision in *Kerry Hagen*, 64 Van Natta 316, on recons, 64 Van Natta 359 (2012), which found that an ORS 656.268(5)(f) penalty was awardable for an unreasonable calculation of an impairment award. However, she adhered to the *Hagen* rationale based on the principle of *stare decisis*.

Penalties: "268(5)(f)" - Lack of "Chronic Condition" Award in NOC Unreasonable - Carrier Did Not Have "Legitimate Doubt" at Claim Closure - Carrier's Question Form Could Not Reasonably Be Interpreted As Consistent With the WCD's Rule or "Industry Notice" for "Significant Limitation"

Extent: Impairment Findings - "AP" Opinion Sufficient to Establish "Significant Limitation" - "Chronic Condition" Value Awarded

*Brit L. Broeke*, 73 Van Natta 338 (April 26, 2021). Analyzing OAR 436-035-0019 and ORS 656.268(5)(f), on remand, *Broeke v. SAIF*, 300 Or App 91 (2019), the Board awarded a chronic condition impairment value because the attending physician’s opinion supported a “significant limitation” in the repetitive use of the left and right foot/ankle. The Board also awarded a penalty, finding that the carrier could not reasonably have relied on its “significant limitation” inquiry to the physician.
Citing OAR 436-035-0019, the Board noted that a worker is entitled to a chronic condition impairment value if a preponderance of medical opinion establishes that, due to a chronic and permanent medical condition, the worker is “significantly limited” in the repetitive use of the body part at issue. Citing *Broeke v. SAIF*, 300 Or App 91, 99 (2019), the Board reiterated that the Workers’ Compensation Division’s (WCD’s) December 2014 Industry Notice interpreted “significant limitation” as the ability to repetitively use the body part for up to two-thirds of a period of time.

Turning to the case at hand, the Board reasoned that the attending physician’s opinion, particularly the assessment that the claimant could only use his ankles/feet repetitively for one-quarter of a period of time, established a significant limitation in the repetitive use of the claimant’s feet/ankles. Thus, the Board awarded a chronic condition impairment value.

Regarding the penalty issue, the Board stated that an ORS 656.268(5)(f) penalty is awardable if the carrier has closed a claim, the correctness of that closure is at issue in a hearing, and a finding is made at the hearing that the Notice of Closure was not reasonable. Relying on *David J. Morley*, 66 Van Natta 2052, 2056 (2014), the Board noted that the reasonableness of the Notice of Closure must be evaluated based on the information available to the carrier at the time of the closure. Citing *Wiggins v. SAIF*, the Board noted that, in analyzing a “significant limitation” questionnaire describing significant limitation as “more than 2/3 of the time,” the court had concluded that a reasonable person could not read the carrier’s questionnaire to have incorporated the correct “significant limitation” standard (as set forth in the WCD’s 2014 Industry Notice).

The Board noted that the “significant limitation” inquiry posed to the attending physician was identical to that analyzed by the court in *Wiggins*. Thus, the Board concluded that because the “significant limitation” question could not reasonably be interpreted as communicating the correct legal standard, the carrier’s reliance on the response to that question was unreasonable. Finding no other basis in the record to support a legitimate doubt regarding liability for the chronic condition impairment value, the Board awarded an ORS 656.268(5)(f) penalty.

Reconsideration Proceeding: ARU Authorized to Issue "Abate, Withdraw & Republish" Reconsideration Order, Even After Hearing Request from Order on Reconsideration Filed, Because the Second Order Issued Within 30 Days of First Order

*Vincente S. Martinez*, 73 Van Natta 310 (April 19, 2021). Applying OAR 436-030-0007(2), the Board held that it did not have jurisdiction to consider issues raised by claimant’s request for hearing challenging an Order on Reconsideration because the Appellate Review Unit (ARU) issued its “Abate, Withdraw & Republish of Order on Reconsideration” within the 30-day appeal period following its initial reconsideration order, and claimant did not file a hearing request challenging the subsequent reconsideration order. After an Order on Reconsideration affirmed a Notice of Closure that did not award work disability, claimant requested a hearing challenging that order.
Before the 30-day appeal period for the initial reconsideration order expired, the ARU issued an “Abate, Withdraw & Republish of Order on Reconsideration,” which supplemented its initial order based on the attending physician’s response to its request for clarification, received after its initial order was issued. Based on the attending physician’s opinion, the ARU rescinded the Notice of Closure and returned the claim to open status.

After an ALJ dismissed claimant’s request for hearing challenging the initial Order on Reconsideration for lack of jurisdiction, claimant requested review, contending that the Hearings Division retained jurisdiction because the “Abate, Withdraw & Republish of Order on Reconsideration” (which issued after he had filed his hearing request concerning the initial reconsideration order) was invalid.

The Board disagreed with claimant’s contentions. Citing OAR 436-030-0007(2), the Board stated that the ARU was expressly authorized to abate, withdraw, or amend an Order on Reconsideration during the 30-day appeal period for the Order on Reconsideration. Referring to Boydston v. Liberty NW Ins. Corp., 166 Or App 336 (2000), and Melonie Cramer, 72 Van Natta 76, recons, 72 Van Natta 183 (2020), the Board explained that, in the absence of any statutory limitation to that authority, the ARU has the discretionary authority to abate, withdraw, and reconsider its Order on Reconsideration before that order becomes final.

Turning to the case at hand, the Board observed that, although claimant had already requested a hearing challenging the initial Order on Reconsideration, the ARU retained its jurisdiction and discretionary authority to abate, withdraw, or amend that order during the statutory 30-day appeal period for the initial order. Because the ARU had issued its “Abate, Withdraw & Republish of Order on Reconsideration” within the statutory appeal period of its initial order, the Board found the ARU’s subsequent order to be valid. Finally, because the initial Order on Reconsideration was properly abated and withdrawn, and because claimant did not file a hearing request challenging the subsequent reconsideration order, the Board concluded that neither the Hearings Division nor the Board had jurisdiction to consider issues raised by claimant’s request for hearing.

Remanding: Hearing Record Insufficiently Developed - Record Did Not Establish that Pro Se Claimant was Aware of Rights Concerning the Hearing Process

Gabriela Pacheco-Martinez, 73 Van Natta 238 (2021) (April 6, 2021). Citing ORS 656.295(5), the Board remanded the case to the Hearings Division for further proceedings to take additional evidence regarding whether claimant had a sufficient understanding of her ORS 183.413 rights at the initial hearing. Claimant had appeared at the hearing pro se with an interpreter present. The ALJ explained that, before the hearing, the claimant had “perus[ed] that paper that explain[ed] [her] rights.” After the ALJ asked whether claimant had an opportunity to review “that,” she replied, “Yes.” The ALJ also explained claimant’s burden of proof and asked whether she was comfortable going forward without an attorney, to which she again replied, “Yes.”
Claimant asserted she was not adequately apprised of her hearing rights.

“Paper” provided by Administrative Law Judge to claimant was not identified in the hearing transcript.

After the ALJ ruled that claimant had not established the compensability of the denied conditions, claimant appealed that decision to the Board, seeking remand to the ALJ. In doing so, she asserted that she was not adequately apprised of her hearing rights and, consequently, that she was unable to engage in a meaningful evidentiary hearing. Citing ORS 656.295(5), the Board stated that remand is appropriate when a case has been “improperly, incompletely, or otherwise insufficiently developed.” Relying on Kienow’s Food Stores v. Lyster, 79 Or App 416 (1986), the Board reiterated that remand is appropriate upon a showing of good cause or other compelling basis.

Turning to the case at hand, the Board determined that the record did not establish whether claimant was properly advised of her rights pursuant to ORS 183.413. Rather, the record reflected that claimant was provided with a “paper,” which was not identified in the transcript, and it was unclear whether claimant had a sufficient understanding of her hearing rights. See Charles W. Brach, 52 Van Natta 1084 (2000) (remand warranted where the claimant was not read or otherwise made aware of his rights pursuant to ORS 183.413 and was not allowed to testify, despite his statement that he wished to correct inaccuracies in the record); cf. David R. McKenzie, 63 Van Natta 89 (2011) (remand not warranted where the record established that the claimant was properly advised of his rights pursuant to ORS 183.413). Consequently, the Board concluded that the case had been improperly, incompletely, or otherwise insufficiently developed. Accordingly, the Board found a compelling reason to remand the case to the Hearings Division for further proceedings, including the taking of additional evidence as to whether claimant had a sufficient understanding of her ORS 183.413 rights at the initial hearing.

**APPPELLATE DECISIONS UPDATE**

Course & Scope: “Parking Lot” Exception Applicable to “Going/Coming” Rule - “Employer Control” Over Common Area Via Lease - Right to Request Repairs/Entitlement to Abate Rent

Bruntz-Ferguson v. Liberty Mutual Insurance, 310 Or App 618 (April 14, 2021). The court reversed the Board’s order in Ashley Bruntz-Ferguson, 69 Van Natta 1531 (2017), previously noted 36 NCN 10:3, that had held that claimant’s injury, which occurred when, before her work shift began, she slipped and fell off a curb leading to a path to an office building where her employer leased office space, did not arise out of and in the course of her employment. In reaching its conclusion, the Board had found that: (1) because the employer’s landlord had “sole discretion” regarding maintenance of the “common area” (where claimant had been injured), the employer did not have sufficient control over the “common area” to satisfy the “parking lot” exception to the “going and coming” rule; and (2) the record did not establish that her injury was the product of a risk connected with the nature of her work or that her injury resulted from a risk to which she was exposed by her work environment.
On appeal, the court concluded that the Board’s findings were not supported by substantial reason. Citing Henderson v. S.D. Deacon Corp., 127 Or App 333, 336 (1994), the court reiterated that, under the “going and coming” rule, injuries sustained while going to or coming from the workplace are not compensable. Again referring to Henderson, the court identified the “parking lot exception” to the “going and coming” rule, which applies to injuries sustained by a worker travelling to or from work “on or near” the employer’s premises if the employer exercised some control over the place where the worker was injured.

Turning to the case at hand, the court noted that the employer’s lease permitted it to request repairs to maintain the “common areas” designated in the lease. Although acknowledging that maintenance of the “common areas” was subject to the landlord’s “sole management and control,” the court reasoned that such authority did not change the employer’s right to request repairs or its entitlement to an abatement of its rent if the landlord did not timely perform maintenance and repair of the “common areas.” Under such circumstances, the court concluded that, through its lease with its landlord, the employer had some control over the area where claimant was injured. Consequently, the court held that, under the “parking lot” exception to the “going and coming” rule, claimant was injured in the course of her employment.

Evaluating whether claimant’s injury “arose out of” her employment, the court reiterated that the requirement was satisfied if claimant’s injury was the product of either: (1) a risk connected with the nature of the work; or (2) a risk to which the work environment exposed her. See Redman Industries, Inc. v. Lang, 326 Or 32, 35-36 (1997); Legacy Health System v. Noble, 250 Or App 596, 603, rev den, 353 Or 127 (2012). Referring to Sheldon v. US Bank, 364 Or 831, 835 (2019), the court further stated that neutral risks of injury are neither employment or personal risks and are present where the conditions of employment put a claimant in a position to be injured.

Applying those principles to the present case, the court determined that snow and ice were neither an employment nor personal risk, but rather a neutral risk. Furthermore, the court reasoned that claimant was injured while engaged in “normal ingress,” a risk to which her work environment exposed her because she could not arrive at her work station without first entering the building. Consequently, the court also concluded that the Board’s determination that claimant’s injury did not arise out of her employment was without substantial reason. Accordingly, the court reversed and remanded to the Board.