New Board Member - Moises Ceja

We are pleased to announce Gov. Brown’s appointment, and Senate confirmation, of Moises Ceja as our next “employee background” member. He will join the Board on June 28, 2021. Moises obtained both his undergraduate and law degrees from the University of California, Los Angeles (UCLA). He has a long history of representing low-wage workers, such as farmworkers, with the Oregon Law Center, a non-profit. During this time, he worked on matters that spanned employment and landlord-tenant law. Moises comes to the Board from the Oregon Health Authority where he was a civil rights investigator. He is fluent in both spoken and written Spanish. Moises enjoys spending time with his partner and two young children.

“Quarterly” Board Meeting - June 30, 2021

The Members have scheduled a public meeting for June 30, 2021 at 1:00 p.m., which will be held at the Board’s Salem office (2601 25th St. SE, Ste. 150). The agenda for the Board meeting will be:

• The Members’ quarterly meeting. OAR 438-021-0010(1)(d).

Because of the Governor’s “social distancing” requirements, arrangements have been made to allow the public to participate in the meeting by means of a “phone conference” link. Information on how to participate by phone can be found at https://www.oregon.gov/wcb/Documents/brdmtgs/2021/063021-brdmtgconfinstructions.pdf.

A formal announcement regarding this Board meeting has been electronically distributed to those individuals, entities, and organizations who have registered for these notifications at https://service.govdelivery.com/accounts/ORDCBS/subscriber/new.

ALJ Recruitment

The Workers' Compensation Board intends to fill an Administrative Law Judge position in the Salem Hearings Division. The position involves conducting workers' compensation and OSHA contested case hearings, making evidentiary and other procedural rulings, conducting mediations, analyzing complex medical, legal, and factual issues, and issuing written decisions which include findings of fact and conclusions of law. Applicants must be members in good standing of the Oregon State Bar or the Bar of the highest court of record in any other state or currently admitted to practice before the federal courts in the District of Columbia. The position requires periodic travel, including but not limited to Eugene, Roseburg, and Coos Bay, and working irregular hours. The successful candidate will have a valid driver’s license and a satisfactory driving record.

Employment
Own Motion: Residual Functional Capacity (RFC) is “Sedentary” - Work Capacity Evaluation (WCE) Established “Sedentary/Light” with “Restrictions” - PPD Redetermined Pursuant to ORS 656.278(2)(d) Limitation

Temporary Disability: Continuous Benefits Awarded from Date of Injury to Medically Stationary Date - Lederer And Dedera Cited - Open-Ended Authorization was Not Affirmatively Halted by New Attending Physicians

Requests for Hearing: Form and Designation

The Board’s Request for Hearing Form https://www.oregon.gov/wcb/Documents/wcbform/req4h5-2016.pdf gives the parties four options regarding the type of request. The types are Initial (a new request for hearing); Supplemental (adds issues to a previously submitted request for hearing); Amended (includes a correction or additional information that wasn’t on a previous request); and, Consolidated (a request set up with a new case number and consolidated with an existing active request for hearing).

An Initial request for hearing is assigned a WCB Case Number and set for hearing. Even if you have already filed a request for hearing, an appeal regarding a new date of injury or a new denial date would be an “initial” request.

Supplemental or Amended requests for hearings are treated similarly in that they are not assigned a WCB Case Number. Rather, they are forwarded to the existing file(s) that they intend to supplement or amend. An “amended” request is to correct information, or add additional information, to a previous request (correcting an address, adding defense counsel). Raising additional issues that you intend to add to an existing request for hearing (i.e., penalties, interim compensation) is a “supplemental” request.

Please note that WCB may assign a new WCB number for a “supplemental” request if the issue needs its own WCB number. An example is an appeal of a Workers’ Compensation Division order, which may have a different exhibit record.

Consolidated requests are given a new WCB Case Number and consolidated with an existing WCB Case Number that has been provided by the requesting party. “Consolidate” is a request to have two or more case numbers assigned to the same hearing event.

Annual Adjustment to Maximum Attorney Fee and Hourly Rate for Statement Fee Effective July 1, 2021

The maximum attorney fees awarded under ORS 656.262(11)(a), ORS 656.262(14)(a), and ORS 656.382(2)(d), which are tied to the increase in the state’s average weekly wage (SAWW), will rise by 14.059 percent on July 1, 2021. On May 27, 2021, the Board published Bulletin No. 1 (Revised), which sets forth the new maximum attorney fees. The Bulletin can be found on the Board’s website at: https://www.oregon.gov/wcb/Documents/wcbbulletin/bulletin1-rev2021.pdf
An attorney fee awarded under ORS 656.262(11) shall not exceed $5,471, absent a showing of extraordinary circumstances. OAR 438-015-0110(3).

An attorney fee awarded under ORS 656.262(14)(a) shall be $418 per hour. OAR 438-015-0033. This rule concerns the reasonable hourly rate for an attorney’s time spent during a personal or telephonic interview conducted under ORS 656.262(14).

An attorney fee awarded under ORS 656.308(2)(d) shall not exceed $3,946, absent a showing of extraordinary circumstances. OAR 438-015-0038; OAR 438-015-0055(5).

These adjusted maximum fees apply to attorney fees awarded under ORS 656.262(11)(a) and ORS 656.308(2)(d) by orders issued on July 1, 2021 through June 30, 2022, and to a claimant’s attorney’s time spent during a personal or telephonic interview or deposition under ORS 656.262(14)(a) between July 1, 2021 and June 30, 2022.

**CASE NOTES**

Aggravation: Forms Signed by NP and PA Were Insufficient to Perfect the Claim - Record Did Not Establish that MCO Contract Allowed Providers to Be Attending Physician - Carrier Did Not Have Obligation to Process Claim or Pay TTD

*Citing ORS 656.273(3)* and *Randy G. Simi*, 69 Van Natta 1446 (2017), the Board stated that a claim for aggravation must be in writing and signed by the worker (or the worker's representative) and the worker's attending physician. Referencing *Simi* and *Sheila K. Wentz*, 60 Van Natta 1557 (1998), the Board noted that a carrier is not obligated to process an aggravation claim or pay temporary disability benefits until the claim is perfected under ORS 656.273(3).

Turning to the case at hand, the Board observed that the record did not persuasively establish that the nurse practitioner or physician assistant were authorized to serve as claimant’s attending physician at the time they signed the aggravation claim forms. Therefore, the Board determined that claimant’s aggravation claim had not been perfected and the carrier did not have an obligation to process the claim or begin temporary disability benefit payments.

The Board disagreed with claimant's assertion that the nurse practitioner qualified as an attending physician based on claimant’s enrollment in a managed care organization (MCO). Acknowledging that certain exceptions exist for MCO...
Obligation to pay TTD is conditioned on the claim being filed in accordance with the statutory requirements.

The Board found the hours spent to be reasonable given the novelty and complexity of the issues.

Obligation to pay TTD is conditioned on the claim being filed in accordance with the statutory requirements.

Attorney Fee: Fee for Services in Obtaining a Rescission of a Denial - Rule-Based Factors Analyzed - Claimant Asserted Hours Spent and a Contingent Hourly Rate

Christopher Taylor, 73 Van Natta 439 (May 20, 2021). Applying ORS 656.386(1) and OAR 438-015-0010(4), on remand, the Board determined that $12,000 was a reasonable attorney fee for claimant’s counsel’s services related to a rescission of a denial prior to the hearing.

Citing OAR 438-015-0010(4), the Board observed that the determination of a reasonable attorney fee involves the consideration of the “rule-based” factors. Citing Karista D. Peabody, 73 Van Natta 244, recons, 73 Van Natta 322 (2021), the Board noted its previous reasoning that where the claimant’s counsel’s fee request was based on the hours spent on the case and a proposed contingent hourly rate, it was appropriate to use that information as a starting point for the application of the rule-based factors.

Turning to the case at hand, the Board used, as a starting point, claimant’s counsel’s request for a $12,000 attorney fee award based on approximately 30 reported hours and a $400 proposed contingent hourly rate. Analyzing the time reported for services related to the rescinded denial, the Board found the approximately 30 hours to be reasonable, given the novelty and complexity of the issues and the fact that the carrier did not rescind the denial until moments before the scheduled hearing. The Board further concluded that the time reported for emails and phone calls was reasonable based on claimant’s counsel’s representations that he completed at least 60 emails and 30 phone calls related to the case and his submission of a partial list of the emails.

Next, the Board considered the proposed $400 contingent hourly rate. The Board accepted counsel’s assertion that $300 represented a reasonable non-contingent hourly rate and accepted that a $400 contingent hourly rate reflected the contingent nature of the practice and the risk of going uncompensated. In doing so, the Board noted that its recent attorney fee statistics revealed that an attorney fee is awarded in about 40 percent of all contracts, the Board determined that the record did not persuasively establish that this particular MCO contract authorized the nurse practitioner to serve as claimant’s attending physician at the time she signed the form.
Claimant contended that denials were not limited to responsibility because no “307” order issued.

At hearing, the parties agreed that compensability was not contested, and that responsibility was the only issue.

Administrative Law Judge Opinions and Orders. Consequently, based on 30 hours and a $400 contingent hourly rate, the Board awarded a $12,000 attorney fee.

Attorney Fee: Responsibility Dispute - Fee Awarded Under ORS 656.308(2)(d) - Although No “307” Order Issued, Parties Agreed at Hearing that Responsibility Was the Only Issue

Bruce D. Wilson, 73 Van Natta 409 (May 12, 2021). Analyzing ORS 656.307(5), ORS 656.308(2)(d), and ORS 656.386(1), the Board held that the ALJ properly awarded an attorney fee under ORS 656.308(2)(d) where responsibility was the only issue in dispute and no “307” order issued. The carrier, on behalf of two employers, had issued responsibility denials. No party sought a “307” order.

Claimant contended that his attorney should be awarded a fee under ORS 656.386(1), rather than ORS 656.308(2)(d) or ORS 656.307(5). Claimant reasoned that the denials were not limited to only “responsibility” because the carrier did not request a "307" order, which resulted in unpaid benefits until a denial was set aside. Moreover, claimant asserted that, by their terms, ORS 656.307(5) and ORS 656.308(2)(d) were inapplicable.

Although the Board agreed that ORS 656.307(5) did not apply because no “307” order issued, it disagreed with the remainder of claimant’s contentions. Citing Liberty Northwest Ins. Corp. v. Kaleta, 173 Or App 82 (2001), the Board noted that, except for proceedings governed by ORS 656.307, attorney fees for prevailing against responsibility denials are governed by ORS 656.308(2)(d).

Turning to the case at hand, the Board found that the carrier’s denials did not suggest compensability as an issue, but instead, each specified that the claimed condition was the responsibility of another employer or insurer. At the hearing level, claimant did not contend that the denials raised any issue other than responsibility. The carrier’s attorneys also confirmed that compensability was not contested. Moreover, in his closing argument, claimant’s counsel requested an attorney fee for services related to the "responsibility case." Because responsibility was the only issue in dispute, the Board concluded that ORS 656.386(1) did not apply.

Moreover, noting that the provisions of 656.308(2)(d) are independent of the requirements in ORS 656.308(1), and because ORS 656.308(2)(d) applies to any responsibility dispute not governed by ORS 656.307, the Board found that the attorney fee was properly awarded under ORS 656.308(2)(d).
Filing: Untimely Filing - Employer Rebutted Presumption of Timely Filing - Persuasive Testimony that Notice of Claim Was Not Provided Within 90 Days of Work Injury

*Matthew Graham*, 73 Van Natta 405 (May 9, 2021). Applying ORS 656.265(1)(a), the Board held that claimant had not provided the employer with notice of his injury within 90 days and his claim was untimely filed. Claimant, who contended that he had injured his neck while working on a conveyor belt throwing heavy stacks of wet napkins into bins above his head, did not file his claim until more than ten months after the alleged work injury. The employer had denied claimant's injury/occupational claim on both timeliness and compensability grounds.

The Board observed that, under ORS 656.265(1)(a), an injured worker is required to give notice of an accident resulting in an injury within 90 days after the accident. The Board also observed that there was a rebuttable presumption of timely and sufficient notice under ORS 656.310(1)(a).

Turning to the case at hand, the Board noted that claimant initially testified that he had told his supervisors about his work injury on the night that it had happened. However, on cross-examination, claimant acknowledged that he had not told “anyone” of his injury because he did not trust his supervisors to help him and he preferred to handle his pain himself. The Board found claimant's testimony inconsistent and, thus, unreliable. The Board also found the testimony of claimant's supervisors, who testified unequivocally that claimant had not informed them of his work injury within 90 days, to be persuasive.

Medical Opinion: Medically Complex Case Requires Persuasive Opinion - *Fiester* Distinguished - No Opinion Supports Compensability

*Joseph A. Seganos*, 73 Van Natta 393 (May 6, 2021). Applying ORS 656.005(7)(a), the Board held that claimant’s injury claim for a left arm condition was not compensable because the determination was medically complex and there was no medical opinion persuasively establishing that the work incident was a material contributing cause of his need for treatment or disability.

Citing *Kathleen C. Fiester*, 52 Van Natta 1900 (2000), claimant asserted that medical opinion evidence was not required to establish the compensability of his claim. The Board disagreed with claimant’s contention. The Board noted that, in *Fiester*, there was only one work incident that was reported on the date of the injury, the claimant treated on that date, she had no similar problem previously, and there was no medical opinion evidence concluding that the work incident was not a material contributing cause of the claimant’s need for treatment or disability. Under such circumstances, *Fiester* did not involve a complex medical question requiring expert evidence to prove causation.
Claimant did not report the work incident when he sought treatment and had a history of other work injuries to the upper extremity.

Consequently, the Board concluded that this case involved a complex medical question that must be resolved by expert medical opinion. See Barnett v. SAIF, 122 Or App 279, 282 (1993). Because there was no medical opinion establishing that the work incident was a material contributing cause of his need for treatment or disability, the Board upheld the carrier’s denial.

New/Omitted Condition: Greater Weight to Treating Chiropractor and Family Physician Opinions - Opportunity to Evaluate Claimant Multiple Times - Neurologist Not More Persuasive Based Simply on Qualifications - Post-Incident Medical Records Documented Increased Complaints

Heather K. Tobey, 73 Van Natta 412 (May 13, 2021). Applying ORS 656.005(7)(a), (7)(a)(B), and ORS 656.266(1), (2)(a), the Board held that the record persuasively established the compensability of claimant’s new/omitted medical condition claim for a concussion. After the carrier denied the claim, claimant asserted that her treating specialist’s opinion (as supported by her physician’s opinion) persuasively established that the concussion condition existed and that the work event was a material contributing cause of the disability/need for treatment of that condition.

The Board explained that, under ORS 656.005(7)(a), ORS 656.266(1), Betty J. King, 58 Van Natta 977 (2006), and Maureen Y. Graves, 57 Van Natta 2380 (2005), to prevail on her new/omitted medical condition claim, claimant must prove that the concussion condition exists and that the work event was a material contributing cause of the disability/need for treatment of that condition, and, under ORS 656.005(7)(a)(B), ORS 656.266(2)(a), SAIF v. Kollias, 233 Or App 499 (2010), and Jack G. Scoggins, 56 Van Natta 2534 (2004), if claimant carries her initial burden, and the "otherwise compensable injury" combined with a statutory "preexisting condition," the carrier has the burden of establishing that the "otherwise compensable injury" was not the major contributing cause of claimant's disability or need for treatment of the combined condition. Citing Christopher Houser, 71 Van Natta 731 (2019), the Board noted that an opinion may be given greater weight if the physician had the opportunity to observe the claimant multiple times over consecutive months. Referencing Abbott v. SAIF, 45 Or App 657 (1980), and Rebecca Larsen, 66 Van Natta 1123 (2014), the Board explained that more weight may be given to an opinion based on the greater expertise of the physician, but the weight given may also be based on substance of the opinion rather than a comparison of qualifications.
Medical records were consistent with claimant’s credible testimony.

Record did not establish that chiropractor or family physician lacked expertise.

Neurologist did not adequately weigh the relative contribution of the work injury.

Turning to the case at hand, the Board noted the carrier’s challenge to the ALJ’s demeanor-based determination that claimant was credible. Acknowledging that the pre-incident medical records documented some prior complaints, the Board noted that, consistent with claimant’s testimony, the post-incident medical records recorded an increase in her prior complaints, along with the addition of new symptoms. Citing *Erck v. Brown Oldsmobile*, 311 Or 519 (1991), and *Jeff R. Lutz*, 69 Van Natta 1562 (2017), the Board did not find the references in the record highlighted by the employer sufficient to reject the ALJ’s credibility determination.

The Board also found that the opinion of claimant’s treating specialist (a chiropractic physician), which was supported by her regular physician’s opinion, persuasively established that claimant sustained a concussion as a result of the work event, despite a contrary expert’s that the concussion condition did not exist. In addition, the Board accorded greater weight to the treating specialist’s opinion because he had the opportunity to evaluate claimant’s condition multiple times over consecutive months.

In reaching its conclusion, the Board disagreed with the carrier’s contention that the neurologist’s opinion was more persuasive simply because he was a neurologist, as opposed to a chiropractor or a family physician. Based on the substance of their opinions, and their qualifications, the Board found the chiropractic specialist’s opinion (as supported by the experienced regular physician’s opinion) was more persuasive than the neurologist’s opinion. The Board observed that the regular physician had years of clinical experience treating head injuries, and that the chiropractic physician was a diplomate of the American Chiropractic Neurology Board, and practiced functional neurology at a concussion clinic.

Having found that claimant carried her initial burden to establish an “otherwise compensable injury,” the Board found that the neurologist’s opinion did not persuasively establish that the “otherwise compensable injury” was not the major contributing cause of the disability/need for treatment of a combined condition. Specifically, the Board noted that the neurologist did not adequately weigh the relative contribution of the work-related concussion. In addition, the Board observed that the neurologist’s “combined condition” opinion was based on the existence of previous concussions, which he had explicitly denied and did not assume for purposes of his “combined condition” opinion.

Accordingly, the Board concluded that the record persuasively established the compensability of claimant’s new/omitted medical condition claim for a concussion.

Member Curey dissented. Acknowledging the ALJ’s credibility determination, Curey stated that inconsistencies in the record raised such doubt that she was unable to conclude that claimant’s material testimony was reliable. Specifically, Member Curey identified inconsistencies between claimant’s testimony regarding the lack of pre-incident complaints and the pre-incident medical records that documented these complaints. Moreover, Curey was unpersuaded by the medical opinions supporting compensability because they were based on claimant’s unreliable history.
Finally, Member Curey stated that even if claimant’s testimony were deemed reliable, she would still be persuaded by the neurologist’s opinion that the claimed concussion condition did not exist. Specifically, Curey was persuaded by the neurologist’s reasoning that claimant did not have an alteration of consciousness and that her gradual worsening of symptoms was inconsistent with a concussion.

Own Motion: Residual Functional Capacity (RFC) is “Sedentary” - Work Capacity Evaluation (WCE)
Established “Sedentary/Light” with “Restrictions” - PPD Redetermined Pursuant to ORS 656.278(2)(d) Limitation

Elena L. Pena, 73 Van Natta 385 (May 4, 2021). Applying ORS 656.278(2)(d), OAR 436-035-0007(3)(a), OAR 436-035-0009(6), and OAR 436-035-0012, in “redetermining” claimant’s permanent disability for her “post-aggravation rights” new/omitted medical condition claim for a right knee condition, the Board held that claimant was entitled to an additional work disability award based on her attending physician’s concurrence with a work capacity evaluation (WCE) report that established a residual functional capacity (RFC) of “sedentary.” After an Own Motion Notice of Closure did not award additional permanent disability, a medical arbiter panel concluded that claimant had no additional impairment findings in comparison with those at the time of her last claim closure. Nevertheless, although the parties agreed that she was entitled to a work disability award because she was neither released, nor returned, to her regular work at the job held at the time of injury, they disagreed regarding claimant’s RFC.

Referring to Jeffrey L. Heintz, 59 Van Natta 419 (2007), the Board reiterated that, in redetermining a claimant’s permanent disability for a “post-aggravation rights” new/omitted medical condition, it was statutorily required to rate the current permanent impairment findings under the Director’s standards, and then apply the limitation in ORS 656.278(2)(d). Relying on OAR 436-035-0007(3)(a), the Board stated that such a “redetermination” includes the rating of the new impairment attributed to claimant’s new/omitted medical condition and the re-evaluation of her social-vocational factors.

Turning to the case at hand, the Board found that claimant’s RFC was “sedentary” because her attending physician concurred with the WCE report that stated she was capable of “sedentary/light” work and had “restrictions.” Finally, the Board explained that, because the limitation in ORS 656.278(2)(d) applied, claimant was entitled to additional permanent disability only to the extent that her current permanent disability rating exceeded that rated by the prior award. ORS 656.278(2)(d); Jerod L. Jones, 71 Van Natta 217 (2019). Because claimant’s prior work disability award was less than her current work disability award, the Board modified the Own Motion Notice of Closure to award an additional work disability award.
Temporary Disability: Continuous Benefits Awarded from Date of Injury to Medically Stationary Date - Lederer And Dedera Cited - Open-Ended Authorization was Not Affirmatively Halted by New Attending Physicians

Frank A. Monta, 73 Van Natta 463 (May 27, 2021). Applying ORS 656.262(4)(g) and citing Lederer v. Viking Freight, 193 Or App 226, recons, 195 Or App 94 (2004), the Board held that claimant was entitled to additional temporary disability compensation through the medically stationary date. After an Order on Reconsideration awarded various periods of temporary disability between the date of injury and the medically stationary date, claimant requested a hearing. Asserting that he had an attending physician’s requisite time-loss authorization, claimant sought continuous temporary disability benefits from the date of injury through the medically stationary date.

Citing Lederer, the Board explained that when an objectively reasonable carrier would understand contemporaneous medical records to excuse claimant from work, its duty to pay temporary disability benefits is triggered. Moreover, referring to Dedera v. Raytheon Eng’rs & Constr., 200 Or App 1, 7, rev den, 339 Or 406 (2005), the Board noted that an open-ended time-loss authorization continues after a change of attending physicians, as long as the new attending physician does not take affirmative steps to stop it.

Turning to the case at hand, the Board determined that an objectively reasonable carrier would understand the contemporaneous medical records to excuse claimant from work, triggering its obligation to pay temporary disability benefits. In her chart notes, claimant’s initial attending physician restricted claimant from any “heavy lifting and repetitive movements,” and the chart notes of claimant’s next attending physician reported that claimant needed additional rest and that his type of injury can take from 8 to 10 weeks to heal. Furthermore, chart notes from various other attending physicians corroborated claimant’s inability to return to his regular work duties, releasing him only to modified work. Claimant was not released to his regular work duties until his accepted conditions were found medically stationary.

Under such circumstances, the Board concluded that, from the date of injury to the medically stationary date, open-ended time-loss authorization required the carrier to pay temporary disability compensation.
Non-Cooperation” Denial: “Reasonable Cooperation” W/I 30 Days of WCD “Suspension” Order - Carrier’s Denial Procedurally Invalid - “262(15)”

Hilton Hotels Corp-Hilton Worldwide v. Yauger, 311 Or App 760 (May 19, 2021). The court affirmed without opinion the Board’s order in Basil D. Yauger, 71 Van Natta 991, on recon, 71 Van Natta 1255 (2019), previously noted in 38 NCN 11:9, which had set aside a carrier’s “noncooperation” denial under ORS 656.262(15) based on its finding that claimant had cooperated in the carrier’s claim investigation following a WCD’s “suspension” order.