Workers' Compensation Board

Volume XLII, Issue 12

December 2023

News & Case Notes

BOARD NEWS

Advisory Committee Meeting on January 12, 2024, to Discuss Rule Change Concept

A committee advising the Workers' Compensation Board will meet at 1:30 p.m. on Friday, January 12, 2024, in Room "G" of our Portland office at 16760 SW Upper Boones Ferry Rd., Ste. 220, Portland, OR. The agenda includes a discussion of a rule concept to simplify the mandatory denial appeal language in OAR 438-005-0055. A December 15, 2023, Memorandum regarding this meeting, and remote instructions, can be found here: https://www.oregon.gov/wcb/Documents/brdmtgs/2023/011224adviscommnt.pdf

Biennial Review/Attorney Fees/"388(4)" – December 12, 2023, Board Meeting

At its December 12, 2023, public meeting, the Board Members discussed several rules concepts and additional public comments they had received during their biennial review of the Board's attorney fee schedules pursuant to ORS 656.388(4). Those rule concepts included a concept to increase the fee caps for disputed claim settlements and claim disposition agreements under OAR 438-015-0050(1) and OAR 438-015-0052(1) and a concept to create an optional process for bifurcating an attorney fee award from the merits of the underlying dispute at the Board's Hearings Division.

After considering the public comment, the Board Members decided to refer the rule concept regarding attorney fee caps under OAR 438-015-0050(1) and OAR 438-015-0052(1) to an advisory committee. Once the committee completes its review, the Members will discuss and take public comment on the advisory committee report at a public Board meeting.

Further, regarding the concept to bifurcate the attorney fee award at the Hearings Division, the Members directed Board staff to create a memorandum detailing the bifurcation process and statistics regarding that process on Board review pursuant to OAR 438-015-0125. Once the memorandum is completed, it will be posted on the Board's website for public comment and discussed by the Members at a public meeting.

WCB 2023 ALJ Anonymous Survey

Consistent with ORS 656.724(3)(b), attorneys regularly participating in workers' compensation cases will be sent a link in early January 2024, via email, to participate in the annual anonymous survey. The survey plays an important role in our evaluation of the performance of the WCB Administrative Law Judges and your feedback is very much appreciated. Please watch for your invitation to

participate in this valuable survey tool and take a few minutes to complete the survey, which can be completed from your computer, smart phone, or tablet.

CASE NOTES

Evidence - Unnecessary to Resolve Whether Claimant (a Licensed Medical Physician) Could Testify as a Medical Expert in Her Own Case Because it Was Unlikely to Affect the Outcome of the Case Even if Considered

Brittany Deyo-Bundy, 75 Van Natta 617 (December 11, 2023). Applying ORS 656.005(7)(a) and ORS 656.266(1), the Board held that the record did not establish that the claimant's new or omitted medical condition claim for sacroiliac joint dysfunction was compensable. The Board stated that it was unnecessary to address whether the claimant, a licensed physician, could proffer her own testimony as expert medical evidence because, even if the Board considered her testimony to be an expert medical opinion, the Board would have found her opinion insufficient to establish the claimant's burden of proof. Specifically, the Board explained that although the claimant's opinion addressed the existence of the claimed condition, her opinion did not address whether the work event was a material contributing cause of the disability or need for treatment of that condition. Accordingly, the Board upheld the carrier's denial.

Medical Services - Record Did Not Establish Sufficient Causal Relationship Between Disputed Medical Services and Work Injury Because Medical Treatment was Directed to Denied Condition and Not "For" Previously Accepted Conditions – 656.245(1)(a)

Rick Sommerville, 75 Van Natta 614 (December 1, 2023). Applying ORS 656.245(1)(a), the Board held that the claimant's medical services claim for physical therapy services was not causally related to the compensable injury. The Board first reasoned that the disputed services were not causally related to the compensable injury because they were directed to a denied right femur fracture condition. Second, the Board rejected the claimant's argument that the disputed services were nonetheless causally related to the compensable injury because they would not have been necessary but for the previously accepted conditions. Citing *Edwards v. Cavenham Forest Indus.*, 312 Or App 153 (2021), the Board explained that the determinative question under ORS 656.245(1) is whether the disputed services were "for" a condition caused by the work injury, not whether they were caused by such a condition. Thus, because a physician did not opine that the disputed medical services were for the previously accepted conditions, the Board concluded that the disputed medical services were not causally related to the compensable injury.

Own Motion – No Permanent Total Disability Award - "AP" Opinion Did Not Persuasively Distinguish Between Disability That Could Be Considered From Disability That Could Not Be Considered; Penalty and Related Fees Awarded - Carrier's Two-Month Delay in Submitting "WRE" Report to "AP" Before Claim Closure Was Unreasonable – Carrier's Untimely Record Submission and Response to Board Requests Were Unreasonable

Rafael Corona-Gambino, 75 Van Natta 632 (December 12, 2023). In an Own Motion order reviewing a carrier's Notice of Closure concerning a worker's Own Motion claim for new or omitted medical conditions (right knee osteoarthritic/meniscal conditions), the Board held that the worker was not entitled to a permanent total disability award because the record did not establish that he was permanently and totally incapacitated from performing gainful and suitable employment as a result of: (1) his new or omitted medical conditions; (2) his left knee disability which "preexisted" his initial right knee compensable injury; and (3) his permanent disability attributable to his previously accepted right knee conditions that existed as of his last claim closure before the expiration of his 5-year "aggravation rights."

The Board acknowledged that the attending physician opined that the worker was "permanently and totally disabled" because of his right and left knee disability. However, the Board determined that the physician had later concurred with a "work capacity evaluation" which had concluded that the worker was capable of performing modified work. Moreover, the Board reasoned that the attending physician's opinion had not distinguished between the worker's disability that could be considered (*e.g.*, any left knee disability preexisting the compensable right knee injury; any disability for his previously accepted right knee conditions granted before the expiration of his 5-year "aggravation rights") from disability that could not be considered (*e.g.*, any left knee disability that arose after the compensable right knee injury; any disability for his previously accepted right knee conditions that arose after the expiration of his 5-year "aggravation rights"). Under such circumstances, the Board concluded that the attending physician's opinion did not persuasively establish the worker's entitlement to a permanent total disability award resulting from the closure of his Own Motion claim for his new or omitted medical conditions.

Turning to a claim processing issue, the Board held that the worker was entitled to penalties and attorney fees under ORS 656.262(11)(a) because the carrier had unreasonably delayed the closure of his Own Motion claim. Finding that the carrier had provided no explanation for its two-month delay in submitting the "work capacity evaluation" report to the attending physician, the Board concluded that the unexplained delay had unreasonably delayed the worker's permanent impairment/work disability awards granted by the eventual Notice of Closure.

Finally, the Board determined that the carrier had untimely submitted the record in response to the worker's request for review of the Own Motion Notice of Closure and had not timely responded to the Board's requests for the record. Although conceding that a second penalty based on the same "amounts then due" could not be assessed, the Board concluded that an additional attorney fee under ORS 656.262(11)(a) for the carrier's unreasonable discovery violations was assessable.

Permanent Impairment – Appellate Review Unit's Plausible Interpretation of WCD's Rule, OAR 436-035-0019(1), Entitled to Deference - Entitlement to "Chronic Condition" Value Based on Restriction From Using a Body Part For More Than Two-Thirds of a Period of Time - "Chronic Condition" Value Not Awarded

Michael Spurgeon, 75 Van Natta 648 (December 15, 2023). Analyzing OAR 436-035-0019(1), the Board held that the claimant was not entitled to a chronic condition impairment award for his lumbar strain and L4-5 disc protrusion conditions because the record did not establish that he was "significantly limited in the repetitive use of a body part." Citing *Godinez v. SAIF*, 269 Or App 578 (2015) and *SAIF v. Donahue-Birran*, 195 Or App 173 (2004), the Board found that the Appellate Review Unit's (ARU's) interpretation of OAR 436-035-0019(1) (*i.e.*, that a worker is not "significantly limited in the repetitive use of a body part" unless the worker is restricted from using the body part for more than two-thirds of a period of time) was plausible and entitled to deference. Applying the ARU's plausible interpretation of the rule, the Board concluded that the record did not establish that the claimant was "significantly limited in the repetitive use of a body part" because his attending physician had found that he was restricted from the repetitive use of his low back and left leg for only 50 percent of an 8-hour period. Accordingly, the Board found no error in a reconsideration process that did not award a chronic condition impairment value.

Member Ousey concurred. Although he agreed that the ARU's interpretation of OAR 436-035-0019 was plausible, he noted that the rule was not clear or readable. Member Ousey explained that the rule's lack of clarity was demonstrated by the ALJ's interpretation in this case and the court's interpretation in *Broeke v. SAIF*, 300 Or App 91 (2019) (*i.e.*, that OAR 436-035-0019 authorizes a chronic condition award if a worker is able to use a body part for up to, but not more than two-thirds of a period of time), which differed from that intended by the Workers' Compensation Division (WCD). Ousey noted that the rule's lack of clarity was also represented by the extensive litigation regarding the rule and the multiple industry notices necessary to explain its meaning and to respond to court decisions that had interpreted the rule differently. Finally, Member Ousey encouraged the WCD to amend OAR 436-035-0019 to clarify its meaning and to avoid further confusion.

APPELLATE DECISIONS UPDATE

Board's Own Motion Order Lacked Substantial Evidence and Reason – Board's Conclusions that Medical Arbiter's Report was Ambiguous and that "AP" Findings Were More Accurate Were Not Supported by Substantial Evidence and Reason

Gage v. Fred Meyer Stores – Kroger Co., 329 Or App 360 (December 6, 2023). Applying ORS 183.482(8)(a) and (c), the court held that a Board Own Motion Order, *Monika M. Gage*, 73 Van Natta 755 (2021), previously noted 40 NCN 10:7, which declined to award additional permanent disability for a worker's "post-aggravation rights" new or omitted medical condition claim for a L4-5 facet cyst was not supported by substantial evidence and reason. In reaching its decision, the Board had found that impairment findings from a medical arbiter were ambiguous and relied on impairment findings from the attending physician (which did not support the worker's contention that she had sustained additional permanent impairment).

Addressing the Board's "ambiguity" finding concerning the arbiter's report, the court determined that there was no ambiguity between the arbiter's statement that the worker's facet cyst condition had not contributed to her loss of lumbar motion and the arbiter's opinion that 40 percent of the worker's inability to stand for more than 2 hours in an 8-hour period was attributable to the new condition. Reasoning that the arbiter's comments concerned different topics, the court concluded that neither substantial evidence nor substantial reason supported the Board's finding that the arbiter's report was ambiguous.

Turning to the Board's finding that the attending physician's report was "more accurate and persuasive" than the arbiter's report, the court acknowledged the Board's explanation that the arbiter's report had "erroneously stated that [the worker] had no denied conditions." Nonetheless, after reviewing the arbiter's report, the court reasoned that the arbiter's failure to accurately designate certain medical conditions as "accepted" or "denied" was not relevant to its medical opinions about those conditions. Moreover, the court noted that, as had the attending physician, the arbiter had examined the worker, as well as the medical record detailing her medical history, and then reached diagnostic opinions about her conditions, potential causes for those conditions and the related levels of impairment. Under such circumstances, the court concluded that the Board's finding that the attending physician's report was "more accurate and persuasive" was not supported by substantial evidence or reason.

Occupational Disease: "Firefighter Presumption" – Rebuttable Presumption That Cancer Was Related to Firefighting Not Rebutted by Clear and Convincing Evidence

Marion County Fire District #1 v. Smith, (December 6, 2023); *North*

Douglas County Fire & EMS v. Shannon, (December 6, 2023). Analyzing the "firefighter's presumption" under ORS 656.802(5)(b), the court affirmed two Board decisions, *Stephen Smith*, 73 Van Natta 955 (2021); *Robert M. Shannon*, 73 Van Natta 949 (2021), previously noted 40 NCN12:4, which had set aside two carriers' occupational disease denials for prostate cancer, holding that the carriers had not proven by "clear and convincing medical evidence that the [claimed] condition or impairment was not caused or contributed to in material part by the firefighter's employment." Reiterating that "in material part" as used in ORS 656.802(5)(b) refers to "a fact of consequence," the court concluded that to rebut the presumption that firefighting had contributed to the firefighter's cancer required the carrier to establish by clear and convincing medical evidence that the firefighter's employment was not a fact of consequence *in any amount* in causing or contributing to his cancer.

The court disagreed with the carriers' contentions that the Board orders had: (1) erroneously accorded the "firefighter's presumption" its own "evidentiary weight" to be weighed against contrary evidence; and (2) erroneously discounted a physician's opinion on the basis that the physician considered the causes of prostate cancer to be unknown. Concerning the carriers' first contention, the court concluded that the Board decisions had correctly stated the function of the statutory "firefighter's presumption"; *i.e.*, after the firefighter had proven the predicate facts to establish the presumption, the Board had reviewed the medical opinions to determine whether the carrier had established by clear and convincing medical evidence that the firefighter's cancer was not caused or contributed to in material part by his employment.

Regarding the carriers' second contention, the court reasoned that an opinion that the cause of a condition is unknown is "a confession of an inability to identify a cause," rather than evidence that the condition was not related to employment. Applying that rationale, the court concluded that the Board's assessment of the physician's opinion was reasonable and supported by substantial evidence.

APPELLATE DECISIONS

COURT OF APPEALS

Board's Order Awarding an Attorney Fee Under ORS 656.386(1) That was Less than the Amount Requested by Claimant's Counsel was Supported by Substantial Evidence and Reason

Fillinger v. City of Portland, (December 28, 2023). In a nonprecedential memorandum opinion pursuant to ORAP 10.30, applying ORS 183.482(8)(c), the court held that a Board's attorney fee award under ORS 656.386(1) (which was based on the Board's overturning of a carrier's denial of a new/omitted medical condition claim) was supported by substantial evidence and reason. On appeal, the court acknowledged the worker's contention that her counsel's declaration of his noncontingent hourly rate "was uncontradicted and no contrary evidence was submitted to rebut it." Nonetheless, the court reiterated that, under its "substantial evidence/reason" standard of review, it looks to the whole record with respect to the issue being decided to determine whether the Board's

findings of fact are supported by substantial evidence. Furthermore, the court stated that, although the Board must *consider* a worker's counsel's fee request, it is not required to *credit* the information provided by counsel to support a proposed contingent hourly rate, even if that information was uncontradicted.

After conducting its review, the court acknowledged that the Board's attorney fee award for the worker's counsel's services on review ($7,200) was a significant departure from counsel's $19,000 request. Nevertheless, after considering the Board's explanation for its decision (*e.g.*, 10 pages of the worker's 23-page appellate briefs merely duplicated excerpts from the record and counsel's prior written objections and asserted an argument that "was not well supported and did not aid in [the Board's] analysis"), the court concluded that a reasonable person could find that the record as a whole supported both the Board's finding that the requested fee was "excessive" and that the Board's award was reasonable.