

Winter 2010

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New Legislation & OAR 436 Rule Changes Effective January 1, 2010

by Ron Pomeroy & Jennifer Roumell

The Legislature and DCBS made changes to the statutes and rules governing Oregon Workers' Compensation claims. Following is a brief summary of those changes that took effect January 1, 2010.

Attorney Fee Increases

ORS 656.262(11)(a): amended so maximum attorney fee awarded for unreasonable conduct is now \$3,000 instead of \$2,000. The exception for extraordinary circumstances continues to exist. The \$3,000 cap will be adjusted annually on July 1st by the same percentage increase as the State's average weekly wage increase.

ORS 656.262(12): allows attorney fees if the proceeds of a DCS are paid late. The amount will be determined by a Matrix created by the Director and as a percentage of the amount of the attorney fee that was paid late. The statute requires clear notification in writing to insurers or self-insureds of failure to pay. If payment were made in less than 5 days after notification, then no penalty would attach.

ORS 656.308: the cap for responsibility cases prosecuted without a .307 Order is now \$2,500. The extraordinary circumstances exception continues. The \$2,500 cap will increase yearly on July 1st by the same percentage as the State's average weekly wage increase.

ORS 656.382: allows attorney fees when they successfully defend a Request for Hearing contesting an OOR that set aside a NOC regardless of whether there is compensation that is then due.

ORS 656.385: amended to increase fee from \$2,000 to \$3,000 with the extraordinary circumstances exception and the \$3,000 cap will increase yearly on July 1st by the same percentage as the State's average weekly wage increase.

ORS 656.386(1)(b)(D): allows attorney fees by amending the definition of a denial to include a claim for an initial injury or occupational disease to which the insurer or self-insured does not respond within 60 days.

ORS 656.386(3): allows attorney fees if claim reclassification is requested and does not receive a response in 14 days or if insurer or self-insured requests a hearing, review appeal or cross-appeal to Court of Appeals or Supreme Court review and the case is found disabling, then agency may award an attorney fee.

All attorney fee changes go into effect regardless of date of injury and apply to all claims for which an order is issued after January 1, 2010.

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Death Benefits

Scope of benefits paid in death claims have been amended to include all expenses related to the “final disposition of the body and funeral expenses.” Therefore, the changes allow for other dispositions, like cremation, transportation of the body and memorial services to be covered, and not just the cost of burial. Those benefits are paid in an amount not to exceed 20 times the average weekly wage. If any part of that benefit remains unpaid 60 days after acceptance, the insurer or self-insured employer shall pay the remainder to the estate of the worker. Further, the statute was amended to allow payment of compensation that the worker would have received, had the worker survived, not only to statutorily defined beneficiaries but to the worker’s estate if no such beneficiaries exist. See changes to ORS 656.204, 656.218 and 656.262.

Firefighters Presumption

ORS 656.802(5) applies to nonvolunteer firefighters who have completed five or more years of employment and make a presumption that brain cancer, colon cancer, stomach cancer, testicular cancer, prostate cancer, multiple myeloma non-Hodgkin lymphoma, cancer of the throat or mouth, rectal cancer, breast cancer or leukemia are presumed to be caused by employment if diagnosed after July 1, 2009.

OAR 436 Rule

DCBS amended Division 001 attorney fee rules by raising the maximum attorney fee payable by the Director under ORS 656.385 from \$2,000 to \$3,000. Division 010 rules will now include chiropractors among those health care providers who may make findings of impairment (when serving as the worker’s attending physician) and allow them to treat for 30 days from the first visit (rather than the date of injury) or for 12 visits, whichever occurs first. Additionally, use of the Form 827 for workers to make claims for new and omitted medical conditions was approved.

Division 030 will require additional information to be included in the Notice of Closure regarding rights to legal representation and to request a vocational eligibility evaluation. Clarification of administrative claim closure procedures, changes in language for Refusals to Close and provisions allowing telephone requests for reconsideration of claim closures are part of the new rules.

Changes to Division 60 rules include penalty assessments for payment of DCS attorney fees beyond 30 days after DCS approval, modifications to issuance of claim-related notices to deceased workers, and notice to workers concerning criteria for reimbursement of claim-related expenses.

Work site modification must be related to worker limitations that resulted in EAIP eligibility or to prevent worsening of accepted conditions under amendments to Division 105. Preferred Worker Program rules in Division 110 provide more specific time limits for cost reimbursement and provide for new employment purchase type-placement assistance.

Vocational rules under Division 120 are modified for PWP workers who work at the EAI for one year who would then be considered as engaging in “suitable” work. The 120 rules also eliminated any necessity for a vocational evaluation if the worker returns to regular or “suitable” work with either the EAI or the employer at aggravation. An additional provision allows time loss in an ATP to be extended to 21 months with Director approval.

Please check our website to obtain specific details of the new changes.

All attorney fee changes go into effect regardless of date of injury and apply to all claims for which an order is issued after January 1, 2010.

Centers for Medicare & Medicaid Services (CMS) Myths and Realities

by Norm Cole

Myth #1: If a settlement meets the CMS review threshold, it must be submitted to CMS for approval.

Reality: CMS will review proposed Workers' Compensation Medicare Setaside Agreements (WCMSA) if the claimant is not yet receiving Medicare but there is a reasonable expectation claimant will become a Medicare recipient within 30 months of the settlement and the settlement amount is over \$250,000.00 or claimant is a Medicare recipient, regardless of the amount of the settlement. Technically, the review is limited to the adequacy of the WCMSA; *i.e.*, whether it adequately protects Medicare's interests. CMS does not care about the language of a DCS or CDA as long as the WCMSA protects Medicare's interests. But there is no legal requirement to submit a WCMSA to CMS for approval, even if it meets the review threshold. Whether or not the agreement meets the review threshold, it must consider and protect Medicare's interests.

Myth #2: CMS insists on full recovery of its interests, even when there is a significant chance the workers' compensation claim denial will be affirmed.

Reality: If Medicare has actually paid for medical expenses which the compensation carrier or employer would have paid if the claim had been accepted, Medicare will insist on full reimbursement. If settlement money is available and is not used to reimburse Medicare for its actual expenses, the Medicare Secondary Payer Recovery Contractor (MSPRC) will demand reimbursement. This is where Medicare has focused its enforcement effort. They *really* care about reimbursement for paid costs.

There is no legal requirement to submit a WCMSA to CMS for approval. Whether or not the agreement meets the review threshold, it must consider and protect Medicare's interests.

Obviously, it is important to find out how much Medicare has paid and what has been paid before distributing settlement proceeds. The MSPRC can be contacted at 1-866-677-7294, MSPRC WC, PO Box 33831, Detroit, MI 48232-3831. Because of disclosure and privacy rules, it is much easier for the worker's attorney to get this information. MSPRC has an on-line tutorial (at <http://www.msprc.info/index.cfm?content=main>) which the worker's attorney should access and follow to eventually secure an itemization of Medicare's conditional payments.

A WCMSA sets aside money to pay for *future* medical expenses Medicare would pay in the absence of a responsible workers' compensation insurer or employer. Reimbursement for conditional payments is not part of a WCMSA. CMS says publicly the WCMSA must be fully funded to be acceptable, but they have been known to compromise. The amount of the settlement apportioned to fund future medical expenses in lieu of Medicare's payment for these expenses must consider and protect Medicare's interests. If there

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is a legitimate risk of receiving nothing from the compensation claim, Medicare's interests could be protected by apportioning a portion of the settlement amount to the WCMSA. It depends on the circumstances. If the agreement meets the CMS review threshold, the proposed compromise settlement could be submitted to CMS seeking its approval of an otherwise less than adequately funded WCMSA. Or, the parties could fund the WCMSA based on their own formula and not bother sending it to CMS. This, after all, is what would be required if a settlement did not meet the review threshold, so it also could be done if the settlement meets the review threshold. *The allocation must be reasonable, whether or not it is submitted to CMS for approval!*

Myth #3: A WCMSA is not acceptable unless it includes a separate bank account, an administrator and a long list of specific terms and requirements.

Reality: In a complicated claim involving a significant settlement amount, it might be prudent to establish a WCMSA with all the bells and whistles preferred by CMS – but this is not a legal requirement. The insurer and employer must consider and protect Medicare's interests. Sometimes it might be sufficient to create a self-administered setaside agreement in a DCS. The DCS would require claimant to acknowledge Medicare's interest, use a designated amount of the settlement proceeds to pay for future medical expenses which otherwise would be submitted to Medicare, and keep an accurate accounting in the event Medicare requires an accounting. Remember – Medicare *really* cares about conditional payments (reimbursement for what they have already paid). Medicare is less concerned about future payments not yet claimed. If the settlement is reasonable and the allocation of the settlement amount to medical services is consistent with the risk of litigating the claim and not a consequence of an effort to prevent Medicare from securing its appropriate share, Medicare should be satisfied.

Processing Tip

by Krishna Balasubramani

Comments and actions by a workers' compensation insurer can be relevant in a claim for workers' compensation discrimination or retaliation. In a U.S. District Court case from Oregon, Magistrate Clarke issued a decision finding the employer did not discriminate against claimant. *Kelly v. Ironwood Communications, Inc.*, 2009 WL 3497811 (October 29, 2009). The judge noted that the workers' compensation adjuster and employer "exchanged a series of unprofessional emails displaying an unnecessary and unfortunately adversarial tone toward Plaintiff." Nevertheless, because the employer was not required to continue light duty indefinitely, the employer was found to not have discriminated against claimant. This case was tried directly to a judge. If a jury was involved, the outcome of the case could have been very different. In other words, the content and tone of email exchanges between a workers' compensation adjuster and employer could play a big role in a jury's determination of whether the employer retaliated against the employee.

OREGON WORKERS' COMPENSATION CASELAW UPDATE

by Steve Verotsky

Injury on parking lot in course of employment but remanded to determine if arose out of employment. *Legacy Health Systems v. Noble*, 232 Or App 93 (2009).

The worker slipped on ice and fell on an employer-controlled parking lot during a paid break while walking to a credit union on employer's campus to deposit a personal check. The Board found the claim compensable. On employer's appeal, the Court held walking to the credit union was not a social or recreational activity. Therefore, ORS 656.005(7)(b)(B) did not apply. The injury occurred "in the course of" employment under the parking lot exception to the going and coming rule, but the matter was remanded because the Board did not determine if the injury, which occurred during claimant's personal banking business, "arose out of" employment.

Fainting spell not an unexplained fall. *Bobby L. Erving, Jr.*, 61 Van Natta 2019 (2009).

Claimant was working on an out-of-town construction project in Seattle when he fainted and injured his shoulder. Claimant's physician eliminated potential idiopathic causes and attributed his loss of consciousness to skipping meals. The Board found that working at the out-of-town construction project required claimant to work very long hours, allowed irregular breaks and meals and less access to food and food storage. The Board determined the medical evidence was sufficient to establish the loss of consciousness was work related.

Compare *Erving* with *Barry M. Sheldon*, 52 Van Natta 1830 (2000). In *Sheldon*, claimant also fell at a construction work site and argued that he fainted due to low blood sugar because he had not eaten lunch on the date of injury. Claimant was provided a time to eat lunch, but regularly did not bring a lunch to eat. On the day he was injured, claimant was given time to eat lunch, but chose not to do so, as was customary for him. He had previously experienced a similar fainting episode due to low blood sugar. Under those circumstances, the Board did not find that claimant's work or his schedule was the reason he skipped lunch on the day he was injured. Accordingly, the Board concluded that skipping lunch was not a risk inherent in the claimant's occupation.

Attending physician's opinion is not given greater weight in determining disability under the vocational assistance rules. *Amber Faircloth*, 14 CCHR 44 (2009).

At the time of claim closure, claimant was awarded a permanent impairment award and work disability because her attending physician determined she could not return to regular work. The insurer generated medical evidence from other medical experts, which concluded she could return to her job at injury. Accordingly, claimant was found ineligible for vocational assistance. She challenged this decision and argued the "law of the case" was that her disability prevented her from returning to work. In addition, claimant argued her attending physician's opinion carried more weight. The judge concluded the law of the case doctrine did not apply. In addition, the judge concluded that neither the rule nor the statute which define when a worker qualifies for vocational services specify that the attending physician's opinion is controlling or entitled to particular deference. ORS 656.340(6)(a); OAR 436-120-0320(11).

Attending Physician's opinion not entitled to deference in determining vocational eligibility.

Unappealed combined condition denial justifies non-payment of medical bills for combined condition. *Gerald T. Frank, 61 Van Natta 2611 (2009).*

Employer accepted myocardial infarction *combined with* preexisting coronary artery disease. The employer also accepted an adjustment disorder with mixed emotional features *combined with* preexisting noncompensable depressive disorder. On November 9, 2007, the employer issued a denial of the current combined conditions and a NOC. Claimant did not appeal the denial or the NOC. The employer stopped paying for medication prescribed for the coronary and mental disorder conditions incurred after the date of the combined condition denial. This medical services dispute was referred to the Hearings Division to determine if a sufficient causal relationship existed between the disputed medical services and the accepted claim. Claimant argued he did not have a combined condition and his injury remained a material contributing cause of treatment.

Citing *SAIF v. Sprague*, 346 Or 661 (2009), the Board observed, for a combined condition, the carrier was responsible for only those medical services directed to medical conditions caused in major part by the injury. Because treatment here was directed to the combined condition, claimant must prove major cause. Failure to appeal the denial means the accepted combined conditions were no longer caused in major part by the injury and post November 2007 prescription no longer were compensable.

WASHINGTON WORKERS' COMPENSATION

Washington H1N1 Claims

by Lance Johnson

The Washington Department of Labor & Industries has recently published a set of guidelines on its website regarding the Department policy for handling claims for infection with the influenza virus H1N1. The following is an excerpt from L&I's guidelines:

Will L&I accept claims for employees who are exposed to — or actually contract — either seasonal or H1N1 influenza on the job?

Only if the employee:

- Was exposed to the virus on-the-job;
- Has a job that requires them to be exposed to this virus;
- Provides documentation confirming exposure to the virus at work; and
- Establishes a medical doctor has specifically diagnosed the illness as influenza.

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How will L&I decide if the influenza was caused by the employee's particular job, and not by an exposure at home or some other location?

L&I claim managers will consider the following factors:

- Did the worker have a greater risk or likelihood of contracting the influenza because of their occupation?
- Could the worker have contracted the condition anyway, if they did not work at their particular job?
- Is there documentation showing the worker was directly exposed to the influenza virus while doing required job duties – and did the examining doctor indicate it was probable (a 51 percent or more chance) that performing required job duties exposed the worker to the influenza virus? (An example of an on-the-job exposure would be a first responder or healthcare provider who was directly exposed to a patient with H1N1 while doing their job.)

What if the worker has a documented, on-the-job exposure, but does not become ill?

In this case, L&I must deny the claim but will consider paying preventative medication, on a case-by-case basis.

When would an employee's claim for influenza not be covered by workers' compensation benefits?

If an employee contracted the virus from an office co-worker at the workplace, their exposure would be deemed unrelated to the specific work they do. In these cases, L&I could not accept their claim or pay for preventative medication.

New and Significant Washington Supreme Court Case Law

by Aaron Bass

Employers maintain right to deduct preexisting permanent disability for injuries that “light up” preexisting conditions. *Tomlinson v. Puget Sound Freight Lines*, http://www.wasupremecourtblog.com/uploads/file/808112_opn.pdf.

Facts: Claimant sustained an injury to his left knee in July 1999. Medical evidence established the injury aggravated or “lit up” his preexisting degenerative arthritis, resulting in the need for significant treatment and knee replacements. The claim was closed with 75% the amputation value of the left leg. However, based on the pre-injury medical evidence, the employer was allowed to deduct 50% of the amputation value as it depicted his condition prior to the work injury.

Decision: Claimant appealed through the Court of Appeals and the case was ultimately decided by the Supreme Court of Washington. The Court determined the employer has the right to deduct permanent impairment

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resultant from preexisting degenerative arthritis from injuries that “light up” such conditions when paying PPD awards. In order to deduct the prior impairment, the Court requires the record clearly demonstrate the arthritis caused “substantial and permanent” disability prior to the work injury.

Lesson: If there is evidence of a preexisting arthritic condition, obtain an opinion from your experts regarding the nature and extent of any permanent impairment resulting from such condition and have the expert explain how the condition impacts function prior to the industrial injury. Factually, investigate all prior employment and confirm any limitations claimant may have had to establish the preexisting condition caused “substantial and permanent” disability.

Department Orders do not become final until 60 days after the Order is received by the attending physician. *Shafer v. Dep’t of Labor & Indus.*, <http://www.courts.wa.gov/opinions/pdf/810494.opn.pdf>.

Facts: Claimant sustained an industrial injury that was eventually closed in 2000. Believing further treatment was necessary, claimant returned to her attending physician in 2003 and requested her claim be reopened. The Department declined to do so and claimant appealed.

Decision: Despite the evidence establishing claimant’s condition had not worsened, the Supreme Court concluded the 2000 closing order was never final because it was never received by claimant’s attending physician. The Court noted that the RCW 51.52.050 requires the Department to serve upon the worker, beneficiary, employer, and “other person affected thereby” and grants rights of appeal to a “person aggrieved thereby.” The Court includes the attending physician in such category.

Lesson: It is important to review all Department Orders to confirm that every necessary party is served with such notice. If the Department failed to copy the attending physician, the employer should forward the order to the physician to ensure it is final and binding.

Updated Washington Adjudication Handbook ONLINE on L&I Website

Did you know the “George” book, explaining the mysteries of the Washington Department of Labor and Industries, is being added to the internet? The manual will only be available ONLINE (they will no longer provide hard copies). So far, they have the first 4 chapters and expect to add more in January.

The manual has links to specific RCWs, WACs and case law.

The link is:

<http://www.lni.wa.gov/ClaimsIns/Insurance/SelfInsure/Claims/Guidelines/Default.asp>.

For More Information

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SBH HAPPENINGS

Welcome Connor!



Congratulations to the Verotsky family! Connor arrived on August 31st. He was 7 lbs. and 20 inches. (Pictured above, big sister Avery reads Connor a story.)

Congratulations to the Perkos!



Brian Perko became a grandfather on December 24th! Owen Nicholas Wu weighed 6 lbs., 15 oz. and was 18 inches long.

About our Newsletter ...

The information contained within this newsletter is not legal advice, but a resource to help you stay informed about legal developments affecting your job. If you have a specific issue or concern, please contact your attorney for advice. SBH is a specialized firm offering comprehensive litigation and consultation services to employers, insurers, and adjusters in the Pacific Northwest. SBH assists with workers' compensation, employee policies & records, return to work programs, leave administration, OSHA compliance, discrimination, longshore, claims processing, hiring & firing, wage & hour, and more.