

In the Vocational Assistance of
Jose L. Arroyo, Claimant
Contested Case No: 08-136H
PROPOSED & FINAL ORDER

December 26, 2008

Jose L. Arroyo, Petitioner
Liberty NW Insurance Corporation, Respondent
Before Keith Kekauoha , Administrative Law Judge

Hearing convened in Portland on October 30, 2008 before Administrative Law Judge Keith Kekauoha. Claimant was present with his attorney, Ronald Fontana. The employer, Morse Brothers, and the insurer, Liberty Mutual Insurance Company, were represented by their attorney, Phillip Nyburg. The hearing was recorded by the Administrative Law Judge. Exhibits 1-31, 5A, 9A, 9B, 11A, 17A and 17B were admitted into evidence. Testimony was taken and written closing arguments were submitted. After receipt of written closing arguments, the record closed on November 26, 2008.

ISSUES

Vocational Assistance. The insurer appealed a Director's Review and Order dated July 18, 2008, which directed the insurer to determine claimant's eligibility for vocational assistance.

Attorney Fees. Claimant's attorney requests that the Director's assessed attorney fee award of \$800 be increased to \$2,000 and that he be awarded an additional assessed attorney fee of \$1,700 for his services at hearing.

FINDINGS OF FACT

On September 11, 2007, claimant was injured while working for the employer as an asphalt roller operator. (Ex. 1). His claim was accepted for a concussion, cervical strain, lumbosacral strain, right buttock and hip contusion, right knee strain and tear of the posterior horn of the medial meniscus. The claim was classified as disabling. (Ex. 3).

Claimant's employment was terminated. (Ex. 9B-1).

Claimant came under the care of Dr. Kurian and underwent a right knee medial meniscectomy. During surgery, Kurian observed the presence of grade II chondromalacia in the patellofemoral and medial compartment. (Ex. 10).

In February 2008, Dr. Kurian released claimant for modified work with the restriction of "no kneeling on [right] knee ever." (Exs. 4, 5).

Dr. Kurian referred claimant to a physical therapist, Trevor Tash, for a physical capacity evaluation (PCE) in March 2008. Tash reported that claimant was capable of full-time work in

the “medium” range of physical demand and had various restrictions relating to use of the knee. He also reported that claimant did not display adequate capacities to perform the roller operator job. (Ex. 6).

By letter dated March 21, 2008, claimant, through his attorney, requested that the insurer determine his eligibility for vocational services. (Ex. 7). By letter dated March 24, 2008, the insurer responded that the following additional information was needed to determine claimant’s eligibility: (1) current education/work history; and (2) projected or permanent physical capacity recommendations. The letter advised that the eligibility evaluation would be completed when the additional information was received. (Ex. 8).

In response to claimant’s attorney’s request, Dr. Kurian indicated that he agreed with the PCE findings and that the findings could be used by the insurer to determine the extent of claimant’s residual permanent impairment. (Ex. 9).

By letter dated April 4, 2008, the insurer advised Dr. Kurian that the roller operator job required occasional kneeling, and asked if claimant could kneel occasionally. Dr. Kurian responded that claimant could not kneel occasionally. (Ex. 9A).

In April 2008, Dr. Kurian reported that claimant had continued right knee pain that had never really gotten better since the surgery. Kurian did not think that claimant had permanent disability, but referred claimant to Dr. Duwelius for a consultation. (Ex. 10).

Dr. Duwelius diagnosed medial compartment arthritis and grade II chondromalacia in the patellofemoral and medial compartment. He concluded that claimant had right knee pain due to some osteoarthritic changes and administered a cortisone injection. He did not believe that claimant was a candidate for total knee replacement. He reported having no work restrictions for claimant, but anticipated that job modifications would be needed. He stated that claimant’s knee condition was preexisting. He also stated that claimant might have some permanent disability, but declined to perform a permanent impairment rating. (Ex. 11).

The insurer scheduled claimant for an independent medical examination (IME) to be performed in July 2008, but claimant did not attend the IME. (Exs. 11A, 17B).

In June 2008, in response to claimant’s attorney’s inquiry, Dr. Kurian indicated that he had “no opinion” as to whether claimant’s right knee condition was medically stationary and that his previous findings could be used to rate claimant’s impairment from his right knee condition. (Ex. 12).

Claimant requested that the Director review the insurer’s failure to determine his eligibility for vocational services. (Ex. 13).

The Director’s designate, the Workers’ Compensation Division’s Rehabilitation Review Unit (RRU), issued a Director’s Review and Order on July 18, 2008, which directed the insurer to determine claimant’s eligibility for vocational assistance and to pay claimant’s attorney an assessed attorney fee of \$800. (Ex. 19).

The insurer scheduled claimant for another IME in September 2008. (Ex. 22). Claimant did not attend the IME. (Ex. 25).

On August 5, 2008, the insurer issued a Notice of Ineligibility for Vocational Assistance, which asserted that claimant's lack of suitable employment was not due to the disability caused by the injury. (Ex. 23).

CONCLUSIONS OF LAW AND OPINION

Vocational Assistance

The insurer contends that the RRU erred in ordering the insurer to determine claimant's eligibility for vocational assistance. Claimant responds that the insurer has not carried its burden of proving error in the RRU's determination. Based on the following opinion, I agree with claimant.

As the party appealing the RRU's order, the insurer has the burden of proving error in the RRU's determination. *See Marvin Wood Products v. Callow*, 171 Or App 175, 183-84 (2000). The RRU's decision may be modified only if it: (1) violates a statute or rule; (2) exceeds the statutory authority of the agency; (3) was made upon unlawful procedure; or (4) was characterized by abuse of discretion or clearly unwarranted exercise of discretion. ORS 656.283(2)(c). In determining whether there was an abuse of discretion, the inquiry is "whether discretion was exercised 'to an end or purpose not justified by, and clearly against, reason and evidence.'" *Liberty Northwest Ins. Corp. v. Jacobson*, 164 Or App 37 (1999) (quoting *Far West Landscaping, Inc. v. Modern Merchandising, Inc.*, 287 Or 653, 664 (1979)).

OAR 436-120-0320(1) provides, in relevant part, that

"the insurer must contact a worker with an accepted disabling claim * * * to begin the eligibility determination within five days of any of the following:

(a) The insurer's receipt of a request for vocational assistance from the worker. If the insurer does not know the worker's permanent limitations, the insurer must contact the attending physician within 14 days of receiving the request for vocational assistance. The insurer must notify the worker, in writing, if the eligibility determination is postponed until permanent restrictions are known or can be projected.

(b) The insurer's receipt of a medical or investigative report sufficient to document a need for vocational assistance, including medical verification of projected or actual permanent limitations due to the injury."

The RRU concluded that the insurer had received projected permanent restrictions from the PCE report and Dr. Kurian's concurrence with those restrictions and that the insurer was therefore required to determine claimant's eligibility for vocational assistance under OAR 436-120-0320(1)(a) and (b).

The insurer argues that the RRU's decision violated a statute or rule and was characterized by abuse of discretion or clearly unwarranted exercise of discretion. In particular, the insurer asserts that neither the PCE findings nor Dr. Kurian's statements accurately reported the level of claimant's impairment attributable to the accepted right knee medial meniscal tear. The insurer also asserts that the RRU abused its discretion in failing to await the results of an IME that was scheduled to address, among other things, claimant's impairment.

In response, claimant argues that, because the insurer issued a Notice of Ineligibility for Vocational Assistance after appealing the RRU's order, its appeal is now moot. Alternatively, claimant argues that the PCE findings and Dr. Kurian's concurrence with those findings provided sufficient information regarding his permanent limitations due to the injury. Claimant further argues that if the insurer doubted that those limitations were due to the accepted condition, it was incumbent on the insurer to request clarification from Dr. Kurian.

After reviewing, the record, I conclude that it is unnecessary to determine whether this appeal is moot because the insurer has not carried its burden of proving error in the RRU's decision.

The record shows that on March 21, 2008, claimant, through his attorney, faxed a letter to the insurer requesting a determination of his eligibility for vocational assistance. (Ex. 7). Consequently, under OAR 436-120-0320(1)(a), the insurer was required to begin the eligibility determination within five days of its receipt of the March 21, 2008 letter, unless the insurer did not know claimant's permanent limitations. However, if the insurer did not know claimant's permanent limitations, the insurer was required to take the following actions: (1) contact the attending physician within 14 days of its receipt of the March 21, 2008 letter; and (2) notify claimant that the eligibility determination would be postponed until permanent restrictions became known or could be projected.

The insurer did not begin the eligibility determination. Instead, the insurer sent a March 24, 2008 letter notifying claimant that his eligibility determination would be postponed until the insurer obtained some additional information, including projected or permanent physical capacity recommendations. (Ex. 8). However, the insurer did not contact the attending physician, Dr. Kurian, to request clarification of the extent of actual or projected permanent restrictions due to the accepted injury. The insurer's vocational unit supervisor, Robert Malone, testified that the insurer was in constant contact with Dr. Kurian, but, upon cross-examination, conceded that only one letter, dated April 4, 2008, was sent to the doctor asking about claimant's permanent restrictions. From my reading, that letter was not a request for actual or projected permanent restrictions due to the injury. Rather, it was a limited request for the doctor to release claimant to perform the occasional kneeling required in his regular job. (Ex. 9A). The doctor declined to do so, and there is no persuasive evidence that the insurer made any further contact

with the doctor for the specific purpose of clarifying the extent of actual or projected permanent restrictions due to the accepted injury.

Because the insurer did not comply with the requirement in OAR 436-120-0320(1)(a) that it contact claimant's attending physician to request actual or projected permanent restrictions due to the injury, I conclude that the insurer was required to determine claimant's eligibility for vocational assistance.

Furthermore, I find that at the time of claimant's request for eligibility determination the insurer was in receipt of medical reports sufficient to document a need for vocational assistance, including medical verification of permanent restrictions due to the injury. The PCE evaluator reported that claimant had restrictions relating to use of the injured right knee, (Ex. 6), and Dr. Kurian agreed with the PCE findings and indicated that they may be used by the insurer to determine the extent of claimant's residual permanent impairment. (Ex. 9). He also indicated that claimant could not perform any kneeling with the right knee, even to the occasional extent required in the roller operator job. (Exs. 4, 9A).

The insurer correctly points out that Dr. Kurian subsequently wrote the following statement in his chart note: "I do not think that [claimant] has permanent disability, but for now would like him to have a one-time consult with Dr. Duwelius." (Ex. 10). Duwelius saw claimant and concluded that there might be some permanent disability, but declined to perform an impairment rating and appeared to relate any disability to preexisting arthritis in the knee. (Ex. 11). Kurian's chart note and Duwelius's report appear to contradict Kurian's earlier concurrence with the PCE findings. However, Kurian subsequently reaffirmed that his previous findings could be used to rate claimant's impairment from his right knee condition. (Ex. 12).

I find that Dr. Kurian's concurrence with the PCE findings and his subsequent reaffirmation of those findings provided sufficient medical verification of permanent restrictions due to the accepted injury. To the extent that the insurer questioned whether the restrictions were specifically related to the accepted meniscal tear, the insurer had a duty under OAR 436-120-0320(1)(a) to contact Dr. Kurian for clarification of that issue. Because the insurer did not fulfill its duty, it may not simply defer an eligibility determination for an indefinite period based on some inconsistent statements in the medical record. For these reasons, I conclude that the insurer was required to begin the eligibility determination in accordance with OAR 436-120-0320(1)(b).

The insurer argues that it had insufficient evidence of a "substantial handicap to employment," which is required to establish claimant's eligibility for vocational assistance. *See* ORS 656.340(6). I disagree. Dr. Kurian indicated that the PCE findings could be used to determine the extent of claimant's residual permanent impairment, and subsequently reaffirmed that the findings could be used to rate impairment from the right knee condition. As discussed above, if the insurer questioned whether the PCE findings were specifically related to the accepted meniscal tear, it was incumbent on the insurer to seek clarification from Dr. Kurian.

Finally, because I am persuaded that the insurer was in receipt of sufficient medical verification of permanent restrictions due to the injury, I conclude that the RRU did not abuse its

discretion when it issued its order before an IME had been performed. An IME is not required under OAR 436-120-0320(1) to trigger the insurer's duty to begin the eligibility determination, and the RRU appropriately declined to await an IME before ordering the eligibility determination.

For the forgoing reasons, I conclude that the insurer has not carried its burden of proving that the RRU's decision violated a statute or rule or was characterized by an abuse of discretion or a clearly unwarranted exercise of discretion. Accordingly, the RRU's decision shall be affirmed.

Attorney Fees

Claimant's attorney contends that the RRU erred in awarding an assessed attorney fee of \$800 for his services in the administrative review proceeding. He argues that the fee is inadequate compensation for the 6.85 hours he devoted to the proceeding and that it should be increased to \$2,000.

Because claimant is appealing the RRU's attorney fee award, he has the burden of proving error in the award. *See Marvin Wood Products*, 171 Or App at 183-84. Based on the following opinion, I conclude that he has not carried his burden of proof.

ORS 656.385(1) provides:

“In all cases involving a dispute over compensation benefits pursuant to ORS 656.245, 656.247, 656.260, 656.327 or 656.340, where a claimant finally prevails after a proceeding has commenced, the Director of the Department of Consumer and Business Services or the Administrative Law Judge shall require the insurer or self-insured employer to pay a reasonable attorney fee to the claimant's attorney. * * * * The attorney fee must be based on all work the claimant's attorney has done relative to the proceeding at all levels before the department. The attorney fee assessed under this section must be proportionate to the benefit to the injured worker. *The director shall adopt rules for establishing the amount of the attorney fee, giving primary consideration to the results achieved and to the time devoted to the case. An attorney fee awarded pursuant to this subsection may not exceed \$2,000 absent a showing of extraordinary circumstances.*” (Emphasis added.)

The Director adopted OAR 436-120-0008(2) for establishing the amount of a reasonable attorney fee in a proceeding regarding vocational assistance. It provides, in relevant part, that

“[t]he attorney fee will be proportionate to the benefit to the injured worker. Primary consideration will be given to the results

achieved and the time devoted to the case. *Absent extraordinary circumstances or agreement by the parties, the fee may not exceed \$2000, nor fall outside the ranges for fees as provided in the following matrix.*” (Emphasis added.)

The matrix contained in the rule sets forth ranges of attorney fees to be awarded based on “estimated benefit achieved” and the “professional services devoted.”

An eligibility determination (without substantial handicap analysis) has an assigned value of \$414. See OAR 436-120-0008(2)(b)(C), 436-120-0720(3). Based on that value of the benefit achieved for claimant, and the 6.85 hours of professional services devoted to the proceeding, the matrix sets forth an attorney fee range of \$600-1,000. Claimant’s attorney has not asserted, nor do I find, that there were extraordinary circumstances involved in the proceeding. Thus, claimant’s attorney’s fee may not exceed the \$600-1,000 range set forth in the matrix. The RRU’s \$800 attorney fee award falls within that range. Accordingly, I find no error in the attorney fee award.

Because the insurer initiated this request for hearing, and I have found that the compensation awarded under ORS 656.340 (*i.e.*, eligibility determination valued at \$414) should not be disallowed or reduced, claimant’s attorney is entitled to a reasonable, assessed attorney fee for his services in this hearing. ORS 656.385(3). He represents that he devoted 6.25 hours to this proceeding and requests an attorney fee in the amount of \$1,700.

The Director’s rules do not appear to address the amount of an assessed attorney fee to be awarded by an Administrative Law Judge under ORS 656.385(3). I therefore apply the Board’s rule, OAR 438-015-0010(4), which sets forth several factors that must be considered by an Administrative Law Judge in determining a reasonable attorney fee. After considering those factors, particularly the time devoted to the case (as represented by claimant’s attorney), the complexity of the issues, the relatively low value of the interest involved and benefit secured, and the risk that claimant’s attorney’s efforts might go uncompensated, I find that the requested amount of \$1,700 is a reasonable attorney fee award.

ORDER

1. The insurer’s and claimant’s requests for relief are denied, and the Director’s Review and Order dated July 18, 2008 is affirmed.
2. Claimant’s attorney is awarded an assessed attorney fee of \$1,700, to be paid by the insurer