

In the ORS 656.340 Vocational Assistance Dispute of

**Delbert L. Satterfield, Claimant**

Contested Case No: 09-060H

**FINAL ORDER**

February 17, 2011

SAIF CORPORATION, Petitioner

DELBERT L. SATTERFIELD, Respondent

Before John Shilts, Workers' Compensation Division Administrator

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Claimant Delbert L. Satterfield (claimant) challenged insurer SAIF Corporation's (insurer) ending of his eligibility for vocational assistance. ORS 656.340. The Workers' Compensation Division's Employment Services Team (EST) issued a Director's Review and Order on April 2, 2009, reversing insurer's action. Insurer requested a hearing. Following the hearing, Administrative Law Judge (ALJ) Chuck Mundorff issued a Proposed and Final Order on November 3, 2010, affirming EST's order. Insurer requested director review.

**FACTUAL SUMMARY**

Claimant injured his wrist and ankle while performing his regular work as a carpenter. Insurer accepted the conditions of non-displaced intra-articular fracture of the right distal radius, triangular fibrocartilage complex (TFCC) tear, right, left ankle lateral puncture wound, and left ankle peroneal tendon partial tear.

Dr. Jason Tavakolian was claimant's attending physician. On June 20, 2007, Dr. Tavakolian released claimant to modified work, with restrictions of not lifting more than 30 pounds and no hammering.

Vocational rehabilitation counselor Doug Smith prepared a job analysis of claimant's job at injury on August 8, 2007. The analysis stated claimant's job required continuous walking, occasional lifting of 50 pounds, occasional lifting of over 250 pounds with assistance, and continuous use of hands while using tools.

Occupational therapist Charlotte Maloney administered a physical capacity evaluation (PCE) for claimant on August 16, 2007. Claimant underwent range of motion tests for both wrists, and had noticeably less mobility in his right wrist. His grip strength also measured lower with the right hand. Ms. Maloney recommended the following restrictions:

- Limit loads and forces to 15 pounds for bilateral tasks and 20 pounds for left hand only tasks
- Occasionally pinch, grip, and use dexterity with the right hand
- Avoid crawling and ladder climbing completely
- Avoid work at unprotected heights

Ms. Maloney reviewed the job analysis. She determined claimant could not return to his job at injury. Ms. Maloney specifically reported that the PCE results were valid based on voluntary effort tests.

Dr. Tavakolian, on September 15, 2007, stated that he concurred with the permanent impairment findings, work capacities, and validity findings in the PCE. The doctor also said claimant was “somewhat limited” in his ability to use his right wrist repetitively.

Insurer found claimant eligible for vocational assistance on October 29, 2007. Insurer referred claimant to Doug Smith for services.

On April 3, 2008, Dr. Tavakolian examined claimant’s right wrist and said he supported vocational training due to the impairment. He also agreed with claimant’s request to see Dr. Wilson about continued wrist pain.

Rob Crymes created a vocational return-to-work training plan for claimant on July 10, 2008. The vocational objective was building inspector and the plan was expected to take just under two years. Insurer approved the plan on August 7, 2008, with claimant to begin training on September 29, 2008.

Dr. Wilson examined claimant on September 26, 2008. The doctor found: S/P right TFCC arthroscopic repair; S/P right dorsal wrist ganglion removal; and symptom magnification with no evidence for an objective wrist problem. The doctor stated:

“In my opinion, he could return to full duty without restrictions at whatever job he was doing prior to his injury. I would highly recommend that he undergo an IME for additional confirmation of secondary gain behavior as there are literally no objective findings on this patient explaining his pain.”

Dr. Tavakolian responded to a November 4, 2008 letter from insurer presenting Dr. Wilson’s findings. Dr. Tavakolian did not concur with Dr. Wilson’s findings.

Doctor Christopher Swan conducted an independent medical examination (IME) on December 2, 2008. Dr. Swan did find claimant had reduced range of motion in the right wrist. However, he found there was no basis for work restrictions and believed claimant could return to his regular work as a carpenter.

Insurer sent Dr. Tavakolian a letter with the reports from doctors Wilson and Swan on December 12, 2008. Dr. Tavakolian concurred with Dr. Swan’s opinions. On January 2, 2009, insurer notified claimant it was finding him no longer eligible for vocational assistance.

Dr. Tavakolian saw claimant on January 12, 2009. He noted claimant still had wrist pain and that “[w]rist flexion and extension [were] somewhat limited . . . .”

On January 29, 2009, Dr. Tavakolian made notes following a phone conference with claimant and his attorney. Dr. Tavakolian said his concurrence with Dr. Swan’s report had been

partially in error. He said claimant had a “clearly documented” loss of wrist motion that ordinarily leads to strength loss as well. Dr. Tavakolian also noted that Ms. Maloney’s PCE had found loss of flexibility and strength in the wrist. The doctor conceded that there could be a psychological element present, but ultimately believed wrist stiffness and loss of strength were consistent with claimant’s injury and that those findings were not psychological.

Claimant’s attorney sent Dr. Tavakolian a letter confirming their conversation which Dr. Tavakolian signed in acknowledgement. The doctor agreed that claimant did have ratable strength loss, felt claimant could not return to his regular work, thought the demonstrated loss of range of motion would lead to strength loss, and felt Ms. Maloney’s PCE evaluation was the most reliable measure of claimant’s loss of flexibility and strength.

Doctors Larry Nagel, Marcia Liberatore, and Scott Miller performed a medical arbiter exam on April 1, 2009. The examiners concluded claimant had a loss of range of motion that was due to the accepted condition but that muscle strength was normal and that claimant should not be limited in repetitive use of the right wrist and forearm.

Claimant requested administrative review of insurer’s action. EST found the various doctors’ opinions, issued after insurer initially found claimant eligible for vocational services, did not constitute new information and therefore did not support insurer’s termination of eligibility. EST ordered insurer to restore claimant’s eligibility for vocational services. ALJ Mundorff affirmed EST’s order.

### CONCLUSIONS OF LAW

In this vocational services dispute I may only modify the previous order if it violates a statute or rule, exceeds the director’s statutory authority, was based on an unlawful procedure, or constitutes an abuse or unwarranted exercise of discretion. New evidence is admissible at the hearing. ORS 656.340(16)(d); OAR 436-001-0225(3). As the party asserting error, insurer bears the burden of persuasion. Where the evidence is closely balanced, the party bearing that burden will lose. *Marvin Wood Products v. Callow*, 171 Or App 175, 183-184 (2000).

An injured worker may be eligible for vocational assistance if, due to a substantial handicap that results from their accepted compensable condition, they are unable to return to the work they were performing at the time of injury, or other work for which they are qualified, and which has pay similar to what they were receiving at the time of injury. ORS 656.340(6). An insurer may end a worker’s vocational assistance eligibility if it obtains new information that satisfies the requirements of OAR 436-120-0350. That rule provides in part:

“A worker’s eligibility ends when any of the following conditions apply:  
(1) Based on new information that did not exist or that could not have been obtained with reasonable effort at the time the insurer determined eligibility, the worker no longer meets the eligibility requirements.”

EST relied on the definition of “new information” explained in *Barrett Business Services v. Stewart*, 178 Or App 145 (2001). That decision held, in addressing a slightly different legal

issue, that new medical opinions or interpretations of already-existing factual information do not constitute later obtained evidence. EST concluded the post-eligibility medical opinions that found claimant could return to work were only new evaluations of old facts, and therefore did not constitute new information.

In *Barrett*, the Court of Appeals of Oregon interpreted the phrase “later obtained evidence” found in ORS 656.262(6)(a), concerning backup denials. That statute provides in part:

“If the insurer or self-insured employer accepts a claim in good faith . . . and later obtains evidence that the claim is not compensable . . . the insurer or self-insured employer may revoke the claim acceptance and issue a formal notice of claim denial[.]”

The court pronounced several restrictions as to what information can constitute later obtained evidence. The court stated: “‘Later obtained evidence’ does not include evidence that employer either had, or in the exercise of reasonable diligence should have had, at the time of acceptance, nor does it include the restatement, reevaluation, analysis, or confirmation of such evidence.” 178 Or App 145, 151.

*Curry Educational Service Dist. v. Bengston*, 175 Or App 252 (2001), is factually very similar to the present case. In *Curry*, the claimant injured her back at work. Two doctors examined an x-ray and an MRI and attributed the diagnosed condition to the work injury. The employer accepted the claim as compensable. After accepting the claim, the employer had three other doctors review the x-ray and MRI. All three diagnosed a different condition than the one previously identified and concluded the condition was not due to the work incident. The employer then issued a backup denial of the claim.

The court said the specific issue it was considering was “whether the correction of a mistake in diagnosis, based on an x-ray and MRI that were available to employer *before* it initially accepted the claim, constitutes later-obtained evidence.” 175 Or App 252, 256 (emphasis in original). The court said that the new diagnosis was not based on information that the employer had not known at the time it issued the acceptance. The new diagnosis only re-evaluated the same information the employer had already possessed. The court said that medical opinions based on pre-acceptance tests are not later obtained evidence. A changed or corrected medical diagnosis is not later obtained if it is based on the same facts or information the employer had when it accepted the claim. *Id.*

In *In re Jeff E. Benning*, 9 CCHR 422 (2004), a Final Order, I implicitly adopted the definition of “new information” explained in the cases discussed above. The specific issue in *Benning* was whether the insurer had obtained new information upon which it could rely to end the worker’s eligibility for vocational assistance, under OAR 436-120-0350(1). EST, under its prior designation of RRU, set aside the insurer’s revocation of eligibility on the specific grounds the insurer had not obtained new information. The matter went to a hearing, and the Administrative Law Judge found the facts upon which the insurer relied did not constitute new information because they were “only a reevaluation of already existing medical evidence.” I affirmed the ALJ’s order.

It is true that *Barrett* and the related decisions did not interpret the rule that is at issue here. However, they do expressly address the issue of what facts constitute new evidence that can justify an insurer's revocation of a previous decision granting benefits.

Under the definition of new evidence established as precedent in the decisions discussed above, the facts upon which insurer relied here do not constitute new information. No new facts were developed in the examinations that occurred after insurer found claimant eligible. The only additional information that became available was the opinions from different doctors. Those opinions were only a re-evaluation of facts, including claimant's physical condition, that insurer possessed before it found claimant eligible.

Insurer argues *Barrett* should not be controlling here because it concerned a finding that an injury was not compensable, thereby denying all benefits, rather than a denial of an individual benefit, vocational services. Insurer does not explain why vocational services are not an important or valuable benefit such that decisions about its revocation should be judged by a lower standard. Insurer's argument also leads to the position where it is permitted to sequentially revoke all of a claimant's benefits under a lesser standard of proof, as long as this is done to each benefit one at a time, rather than all together in a single decision.

Insurer cites several decisions in support of its argument the post-eligibility doctors' opinions constitute new evidence. The first decision is *In re Mark Barton*, 14 CCHR 76 (2009). The question in *Barton* was whether documents that had not been presented during the administrative review could be accepted as "new evidence" at the hearing, under OAR 436-001-0225(3). That rule provides that, at a hearing "[i]n vocational assistance disputes under ORS 656.340, new evidence may be admitted . . . ." In a decision that cites no legal authorities, and does not address the authorities discussed above, the order found in that context that new evidence was any evidence not submitted for the administrative review.

The wording of the rule under discussion here is significantly different from the rule involved in *Barton*. In *Barton*, the rule simply permits the admission of new evidence. Here, we are dealing with OAR 436-120-0165. This rule expressly defines "new information" as facts that "did not exist or that could not have been obtained with reasonable effort at the time the insurer determined eligibility . . . ." The evidence offered in *Barton* did not have to meet this definition because the rule relied on there does not contain this language. The inclusive view taken in *Barton* is reasonable in light of the purpose of making the hearing as comprehensive and thorough as possible to reach a proper result. In contrast, the rule here is intentionally limiting and exclusive to encourage insurers to make a correct initial decision on vocational eligibility and to prevent injured workers from having their vocational benefits terminated after they have begun training, on the basis of information the insurer could have obtained earlier.

The issue in *In Re Jimmie R. Estes*, 62 Van Natta 76 (2010), was whether the Workers' Compensation Board should remand a case because the record was incomplete. ORS 656.295(5). A compelling reason exists to remand when there is new information that could not have been obtained prior to the hearing and that could affect the outcome. The new evidence in *Estes* concerned the results of injections that had been performed after the hearing. Clearly, providing

new medical treatment could have changed the facts. It was the claimant's changed physical condition as a result of treatment, not the resulting diagnosis or opinion, which constituted new information. There are no comparable facts here.

Insurer also relies on *In re Mary K. Greenwood*, 57 Van Natta 1632 (2005). The new evidence in that case was pay slips the claimant found in her own home after the hearing. The board found this evidence did not fall into a class of information that was not obtainable before the hearing. That decision stands for the rule that information a party could have accessed prior to a hearing is not new information. Similarly, plaintiff's physical condition, which is the factual information here, was accessible to insurer prior to making its eligibility decision.

*In re George P. Black*, 55 Van Natta 43 (2003), is another decision insurer cites. The board remanded in that case because it found the new evidence was not reasonably available prior to the hearing. The new evidence consisted of post-surgery medical reports concerning surgery that was performed after the hearing. As in *Greenwood*, and in contrast to the facts of the present case, a medical procedure was performed after the hearing that changed the claimant's physical condition. *Black* is not helpful here.

The Proposed and Final Order awarded attorney's fees to claimant's attorney. ORS 656.385(3). Insurer contends this was error because claimant was not represented at the time the order issued. In its reply to claimant's response to insurer's exceptions, insurer asserted there was not a valid retainer agreement for claimant's attorney on file, and for the first time, argued attorney fees should not have been awarded. Claimant's counsel responded by submitting a retainer agreement. In the accompanying letter of December 29, 2010, claimant's counsel challenged insurer's arguments against the attorney fee award. Insurer asked that this last response be stricken, as insurer was entitled to the final response. Insurer cites OAR 436-001-0246(2). Insurer first challenged the attorney fee award in its reply to claimant's response to insurer's exceptions. If I adhered to the procedural restriction insurer suggests, insurer would have been allowed to introduce a new issue while depriving claimant of the opportunity to respond. As insurer introduced a new issue in its reply to claimant's response, I will deny insurer's motion to strike claimant's December 29, 2010 letter.

Insurer cites *Stanley W. Talley*, 38 Van Natta 1553 (1986). See *Bischoff v. Bischoff and Strooband*, 121 Or App 529 (1993). *Talley* and *Bischoff* were both cases where claimants represented themselves through the entire proceeding and it was held *pro se* claimants cannot be paid attorney fees. These decisions do not purport to determine whether an attorney should be awarded fees under facts such as those here.

Claimant's attorney represented claimant prior to the hearing, throughout the hearing, and at a post-hearing deposition of Dr. Tavakolian. Claimant briefly terminated his relationship with that attorney during the time final arguments were submitted and the order issued. Counsel submitted a current retainer agreement in connection with his response to insurer's exceptions. As a signed attorney retainer agreement has now been filed with the director, I can award attorney fees. OAR 436-001-0400(1). I do so by affirming the fee award in the Proposed and Final Order.

**IT IS HEREBY ORDERED** the April 2, 2009 Director's Review and Order, and the November 3, 2010 Proposed and Final Order are affirmed.