

In the ORS 656.340 Vocational Assistance Dispute of

GLEN A. DEVER Claimant

Contested Case No: H05-077

PROPOSED AND FINAL ORDER

July 28, 2005

SAIF CORP., Petitioner

GLEN A. DEVER, Respondent

Before Catherine P. Cobun , Administrative Law Judge, Administrative Hearings

HISTORY OF THE CASE

Insurer appeals the Administrative Order issued on April 14, 2005 by the Rehabilitation Review Unit (RRU) of the Workers' Compensation Division (WCD), Department of Consumer and Business Services (department or director). On May 23, 2005, the department referred the matter to the Office of Administrative Hearings (OAH). On July 6, 2005, Administrative Law Judge Catherine P. Coburn conducted a hearing in Beaverton, Oregon. Attorney David L. Runner represented petitioner SAIF Corporation (insurer). Attorney James L. Edmundson represented respondent Glen A. Dever (claimant). No witnesses testified and the record remained open until July 8, 2000 for additional evidence.

ISSUE

Whether RRU correctly determined that claimant is eligible for vocational assistance.

EVIDENTIARY RULINGS

WCD Exhibits 1 through 24 and claimant's Supplementary Exhibit 17A were admitted into the record without objection.

FINDINGS OF FACT

(1) On March 24, 2003, claimant suffered a compensable injury while working as a caregiver for developmentally disabled adults. (Exs. 1 and 10-4.) A patient pushed claimant backward and down one step; claimant did not fall to the ground. (Exs. 1 and 4-3.) Insurer accepted low back strain and an L4-5 herniated disc. (Ex. 6.) In September 2003, attending physician Rees G. Freeman, MD (Neurosurgery) performed an L4-5 laminectomy and discectomy. (Exs. 4-5, 11-2 and 17A.)

(2) On January 23, 2004, John A. Melson, MD (Neurologist) and Michael R. Marble (Orthopedic Surgeon) examined claimant and found his condition medically stationary. They stated that claimant was capable of performing work in the light to light/medium class. (Ex. 4-10.) Dr. Freeman concurred with these opinions. (Ex. 5.)

(3) On March 12, 2004, insurer closed the claim with a 17 percent permanent partial disability (PPD) award for the low back. (Ex. 7.)

(4) On April 16, 2004, Jeffrey Jones, Physical Therapist, conducted a physical capacities evaluation (PCE) and determined that claimant was able to perform medium level work full time. (Ex. 8-1.) Dr. Freeman concurred. (Ex. 8-3.) The report contains an undated¹ handwritten note with illegible initials that reads, “release to non behavioral situation 0 liklyhood (sic) of combat/resistant needs.” (Ex. 8-1.)

(5) On April 26, 2004, Dr. Freeman examined claimant and noted that claimant was released to non-combative/restraint type of work. (Ex. 9-2.)

(6) On May 5, 2004, Rick Lumplugh, Vocational Consultant conducted an eligibility evaluation. He contacted the employer at injury and determined that claimant’s regular work as a caregiver was not suitable due to the possibility of restraining patients. (Ex. 10-11.) Lumplugh recommended that claimant be found eligible for vocational assistance because he was unable to return to his job at injury, the employer at injury had no suitable available work, and no other suitable jobs were identified. (Ex. 10.)

(7) On May 18, 2004, Anthony J. Smith, MD (Orthopedics) conducted a medical arbiter’s examination. (Ex. 11.) Dr. Smith opined that claimant was capable of lifting and carrying as much as 50 pounds occasionally, and 25 pounds frequently, able to sit and stand for 30 minutes, and walk for 45 minutes. Dr. Smith opined that claimant was permanently precluded from frequent stooping, twisting, kneeling, and crawling. Claimant was able to climb, reach, crouch, balance, push and pull frequently. Claimant was capable of working full time. (Ex. 11-6.) Dr. Smith apportioned the cause of claimant’s disability 55 percent to the work injury and 45 percent to pre-existing conditions. (Ex. 11-5.)

(8) On May 24, 2004, insurer notified claimant that he was eligible for vocational assistance. (Ex. 12.)

(9) Insurer received the medical arbiter’s report on May 24, 2004. (Exs. 11 and 21-1.)

(10) On May 26, 2004, Dr. Freeman prescribed “Release to non combative min restraint needed ***.”² (Ex. 13.)

(11) On May 27, 2004, insurer ended claimant’s eligibility for vocational assistance because he was hospitalized for treatment of pneumonia, a non-work related medical condition. (Exs. 14, 15-2 and 19.)

(12) In an Order on Reconsideration dated June 10, 2004, WCD increased claimant’s PPD award to 22 percent. (Ex. 16-4.)

(13) On October 1, 2004, insurer posed the following questions to Dr. Freeman:

¹ It is unclear whether this handwritten note was added before or after Dr. Freeman concurred with the PCE. (Ex. 8-1.)

² The remainder of the handwritten prescription note is illegible.

“Is working in a non combative environment with minimal restraint a **recommendation** to prevent future injury or considered a current **restriction** in regard to our accepted condition of low back strain and L4-5 disc herniation?”

Dr. Freeman checked the box indicating a recommendation. (Ex. 17-1.) (Emphasis in the original.)

“If non-combative contact is a **restriction** in regard to the accepted condition of low back strain and L4-5 disc herniation, please explain.” (Ex. 17-2.) (Emphasis in the original.)

Dr. Freeman wrote, “Continuation (illegible) exacerbation of previously injured tissue. Refer to 10/04/04 dictation.” (Ex. 17-2.)

(14) On October 4, 2004, Dr. Freeman examined claimant and reported that claimant was “progressing very adequately apparently towards returning to gainful employment.” (Ex. 17A-4.)

(15) On October 21, 2004, insurer notified claimant that he was ineligible for vocational assistance because he was able to return to his regular work. (Ex. 18.) On November 24, 2004, claimant requested administrative review. (Ex. 19.)

(16) In March 2005, RRU conducted an investigation, contacting claimant, claimant’s attorney’s office, insurer, the physical therapist, and Dr. Freeman’s office. (Ex. 20-2.) On March 28, 2005, RRU spoke by telephone with the receptionist in Dr. Freeman’s office who attempted to decipher Dr. Freeman’s handwriting on the PCE and the October 1 letter from insurer. (Ex. 20-2.)

CONCLUSION OF LAW

RRU correctly determined that claimant is eligible for vocational assistance.

OPINION

Jurisdiction lies with the director. ORS 656.340(4). Pursuant to ORS 656.283(2)(c), I may modify the administrative order if it: (A) violates a statute or rule, (B) exceeds the statutory authority of the agency, (C) was made upon unlawful procedure, or (D) was characterized by abuse of discretion or clearly unwarranted exercise of discretion. OAR 436-001-0225(5). The burden of proof falls upon the proponent of a fact or position. ORS 183.450(2). In that regard, insurer bears the burden of proving by a preponderance of the evidence that the administrative order is incorrect. *Harris v. SAIF*, 292 Or 683 (1982) (general rule regarding allocation of proof is that burden is on the proponent of the fact or position); *Cook v. Employment Div.*, 47 Or App 437 (1980) (in the absence of legislation adopting a different standard, the standard of proof in an administrative

hearing is by a preponderance of the evidence). Proof by a preponderance of evidence means that the factfinder is persuaded that the facts asserted are more likely true than false. *Riley Hill General Contractors v. Tandy Corp.* 303 Or 390 (1998).

ORS 656.340 requires an insurer to provide vocational assistance to injured workers who are eligible. OAR Chapter 436 Division 120 governs the provision of vocational services.

ORS 656.340(6) provides:

(a) A worker is eligible for vocational assistance if the worker will not be able to return to the previous employment or to any other available and suitable employment with the employer at the time of injury or aggravation, and the worker has a substantial handicap to employment.

(b) As used in this subsection:

(A) A “substantial handicap to employment” exists when the worker, because of the injury or aggravation, lacks the necessary physical capacities, knowledge, skills and abilities to be employed in suitable employment.

(B) “Suitable employment” means:

(i) Employment of the kind for which the worker has the necessary physical capacity, knowledge, skills and abilities;

Additionally, OAR 436-120-0320 provides in pertinent part:

(10) A worker entitled to an eligibility evaluation is eligible for vocational services if all the following additional conditions are met:

(c) As a result of the limitations caused by the injury or aggravation, the worker:

(A) Is not able to return to regular employment;

(B) Is not able to return to any other suitable and available work with the employer at injury or aggravation; and

(C) Has a substantial handicap to employment and requires assistance to overcome that handicap.

(d) None of the reasons for ineligibility under OAR 436-120-0350 applies under the current opening of the claim.

RRU determined that claimant is unable to perform his regular work as an adult caregiver and is eligible for vocational assistance. Insurer contends that the administrative order was made upon unlawful procedure and was characterized by abuse of discretion because RRU contacted the office of the attending physician in violation of OAR 436-120-0008(1)(b). Insurer next contends that RRU erred by applying OAR 436-120-0350(1) rather than OAR 436-120-0360 and that, under the circumstances, insurer was not required to obtain new information before terminating claimant's eligibility for vocational assistance. In the alternative, insurer argues that even if OAR 436-120-0350(1) applies, insurer did obtain new information establishing that claimant is capable of returning to his regular work. Finally, insurer requests remand to RRU for a redetermination of claimant's eligibility. In contrast, claimant contends that the case falls squarely under OAR 436-120-0320(10) and that claimant satisfies the criteria for vocational eligibility.

I. RRU Investigation

Insurer contends that the administrative order is faulty because RRU contacted the office of the attending physician in violation of OAR 436-120-0008(1)(b). On the other hand, claimant contends that RRU properly sought clarification of the attending physician's opinion.

OAR 436-120-0008 provides in pertinent part:

(1) Administrative review of vocational assistance matters: Under ORS 656.283(2) and 656.340(4), a worker wanting review of any vocational assistance matter must apply to the director for administrative review. Also, under ORS 656.340(11) and OAR 436-120-0320(11) when the worker and insurer are unable to agree on a vocational assistance provider, the insurer shall apply to the director for administrative review. Because effective vocational assistance is best realized in a nonadversarial environment, the first objective of the administrative review is to bring the parties to resolution through alternative dispute resolution procedures, including mediation conferences, whenever possible and appropriate. When a dispute is not resolved through mutual agreement or dismissal, the director shall close the record and issue a Director's Review and Order as described in subsections (f) and (g) of this section. A worker need not be represented to request or to participate in the administrative review process, which is as follows:

(a) The worker's request for review must be mailed or otherwise communicated to the department no later than the 60th day after the date the worker received written notice of the insurer's action; or, if the worker was represented at the time of the notice, within 60 days of the date the worker's representative received actual notice. Issues raised by the worker where written notice was not provided may be reviewed at the director's discretion.

(b) The worker, insurer, employer at injury, and vocational assistance provider shall supply needed information, attend conferences and meetings, and participate in the administrative review process as required by the director. Upon the director's request, any party to the dispute shall provide available information within 14 days of the request. The insurer shall promptly schedule, pay for, and submit to the director any medical or vocational tests, consultations, or reports required by the director. The worker, insurer, employer at injury, or vocational assistance provider shall simultaneously send copies to the other parties to the dispute when sending material to the director. If necessary, the director will assist an unrepresented worker in sending copies to the appropriate parties. Failure to comply with this subsection may result in the following:

(A) If the worker fails to comply without reasonable cause, the director may dismiss the administrative review as described in subsection (d); or, the director may decide the issue on the basis of available information.

(B) If the insurer, vocational assistance provider, or employer at injury fails to comply without reasonable cause, the director may decide the issue on the basis of available information.

(c) At the director's discretion, the director may issue an order of deferral to temporarily suspend administrative review. The order of deferral will specify the conditions under which the review will be resumed.

(d) The director may issue an order of dismissal under appropriate conditions.

(f) After the parties have had the opportunity to present evidence, and any meetings or conferences deemed necessary by the director have been held, the director shall issue a final order, including the notice of record contents. The parties will have 60 days from the issuance of the order to request a contested case hearing before the director.

(g) The director may on the director's own motion reconsider or withdraw any order that has not become final by operation of law. A party also may request reconsideration of an administrative order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new material evidence which could not reasonably have been discovered and produced during the review. The director may grant or deny a request for

reconsideration at the director's sole discretion. A request for reconsideration must be mailed before the administrative order becomes final, or if appealed, before the contested case order is issued.

(h) During any reconsideration of the administrative review order, the parties may submit new material evidence consistent with this rule and may respond to such evidence submitted by others.

In construing the meaning of an administrative rule, I apply the same method of analysis employed in determining the meaning of a statute. *Abu-Adas v. Employment Dept.*, 325 Or 480 (1997); *Larry Hemenway*, 5 WCSR 33 (2000). See also *PGE v. Bureau of Labor and Industries*, 317 Or 606 (1993) (court's task in determining the legislative intent is to first examine the statute, including text and context, and if the intent is clear, to proceed no further with its analysis.) Where an agency's interpretation of its own rule is plausible and not inconsistent with the wording of the rule itself, the rule's context or with any other source of law, there is no basis for asserting that the rule has been misinterpreted by the agency. *Don't Waste Oregon Com. v. Energy Siting Council*, 320 Or 132 (1994).

The text of OAR 436-120-0008(1)(b) does not prohibit RRU from contacting a medical provider in the course of an eligibility investigation. Moreover, the context of OAR 436-120-0008 assigns broad discretion to the director in addressing vocational disputes. Finally, the rule establishes that vocational assistance is best realized in a nonadversarial environment. For these reasons, I agree with RRU's interpretation of OAR 436-120-0008 allowing RRU to contact the office of a medical provider concerning a vocational dispute.

II. Applicability of OAR 436-120-0350(1)

Insurer next contends that OAR 436-120-0360 rather than OAR 436-120-0350(1) applies because claimant's eligibility had been previously ended due to pneumonia as a non-work related medical condition. Insurer further argues that under OAR 436-120-0360, it was not required to obtain new information before terminating eligibility.

OAR 436-120-0350 provides in pertinent part:

A worker is ineligible or the worker's eligibility ends when any of the following conditions apply:

(1) The worker does not or no longer meets the eligibility requirements as defined in OAR 436-120-0320. The insurer must have obtained **new information** which did not exist or which the insurer could not have discovered with reasonable effort at the time the insurer determined eligibility.

(3) The worker's lack of suitable employment is not due to limitations caused by the injury or which existed before the injury.

(Emphasis added.)

Additionally, OAR 436-120-0360 provides in pertinent part:

If a worker was previously found ineligible or the worker's eligibility ended for any of the reasons specified in sections (1) through (8), or any of the conditions described in sections (9) through (11) exists, the insurer shall redetermine eligibility upon notification of a change of circumstances. The insurer shall complete the eligibility evaluation within 35 days of the following:

(1) The worker, for reasonable cause, declined or was not available for vocational assistance, or the barrier causing the worker's lack of suitable employment could not be resolved by providing vocational assistance, and those circumstances have changed. The insurer may require the worker to provide documentation the barrier no longer exists, including medical or psychological reports relating to noncompensable conditions. If the worker declined vocational assistance to accept modified or new employment that resulted from an employer at injury activated use of the preferred worker benefits, under OAR 436-110, and the job was not suitable, the worker must request redetermination within 30 days of termination of the employment for which preferred worker benefits were provided.

In May 2004, insurer found claimant eligible and later that month, ended his claimant's eligibility due to non-work related pneumonia. The parties do not dispute that insurer properly closed claimant's eligibility pursuant to OAR 436-120-0350(3) because, at that point, his inability to work was caused by a factor other than the compensable injury. Additionally, the parties agree that once claimant recovered from pneumonia, OAR 436-120-0360(1) required insurer to reevaluate claimant's eligibility. Having properly closed eligibility and reevaluating eligibility, the issue is whether OAR 436-120-0350(1) allows insurer to deny vocational services only based on new information.

RRU interpreted the administrative scheme to mean that new information is required under these circumstances. Inasmuch as RRU's interpretation is plausible and not inconsistent with wording of the rules, I defer. Moreover, I find that RRU's interpretation is consistent with the orderly provision of vocational services to injured workers. Once an insurer issues a notification of eligibility, the injured worker is entitled to rely on that representation and to plan accordingly, absent new contrary information.

Similarly, pursuant to ORS 656.262(6)(a),³ once an insurer issues a notice of acceptance, it may retroactively deny the claim only under limited circumstances. For these reasons, I agree with

³ ORS 656.262(6)(a) provides:

Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 60 days after the employer has notice or knowledge of the claim. **Once the claim is accepted, the insurer or self-insured employer shall not revoke acceptance except as provided in this section.** The insurer or self-insured employer may revoke acceptance and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal activity by the worker. If the worker requests a hearing on any revocation of

RRU's determination that following a notice of eligibility and a temporary termination, insurer may deny vocational services only based on new information.

III. New Information

In the alternative, insurer argues that even if OAR 436-120-0350(1) applies, insurer did obtain new information which establishes that claimant is capable of performing his regular employment as a caregiver for developmentally disabled adults. Insurer relies on the medical arbiter's report and Dr. Freeman's October 2004 opinion; insurer received both of these after issuing the notice of eligibility. I find insurer's argument unpersuasive.

The main factual question is whether claimant is capable of working with combative patients. The medical arbiter's report does not address this question. Furthermore, Dr. Freeman's October 2004 opinion is ambiguous. In answering insurer's questions, Dr. Freeman indicated that the limitation was only a recommendation and not a *bona fide* work restriction. However, in answer to the question, "if non-combative contact is a **restriction**, *** please explain", Dr. Freeman provided an explanation. This response indicates that he believed the limitation was a restriction rather than merely a recommendation. Under the circumstances, I find that Dr. Freeman's April 26, 2004 and May 26, 2004 opinions are more reliable. There, Dr. Freeman unequivocally released claimant to non-combative work. Inasmuch as claimant's regular work as a caregiver requires contact with combative patients, I conclude that he is unable to return to regular work. Furthermore, inasmuch as the employer at injury offered no work, and the vocational consultant identified no other suitable jobs, I conclude that claimant is eligible for vocational assistance pursuant to ORS 656.340(6)(a) and OAR 436-120-0320(9).

In conclusion, RRU did not err by contacting a medical provider in the course of an eligibility investigation. Next, where insurer issued a notice of eligibility and the provision of vocational services was temporarily interrupted by an unrelated medical condition, insurer may subsequently terminate vocational eligibility only based upon new information. Furthermore, insurer failed to produce new information to support termination of eligibility. Finally, finding no grounds to modify the administrative order, I affirm.

acceptance and denial alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance of the evidence, the compensability of the claim. If the insurer or self-insured employer accepts a claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the worker, and later obtains evidence that the claim is not compensable or evidence that the insurer or self-insured employer is not responsible for the claim, the insurer or self-insured employer may revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of acceptance and denial is issued no later than two years after the date of the initial acceptance. If the worker requests a hearing on such revocation of acceptance and denial, the insurer or self-insured employer must prove, by a preponderance of the evidence, that the claim is not compensable or that the insurer or self-insured employer is not responsible for the claim. Notwithstanding any other provision of this chapter, if a denial of a previously accepted claim is set aside by an Administrative Law Judge, the Workers' Compensation Board or the court, temporary total disability benefits are payable from the date any such benefits were terminated under the denial. (Emphasis added.)

ATTORNEY FEES

Claimant has prevailed in a contested case hearing and is entitled to a reasonable attorney fee. ORS 656.385(1). Following the hearing, claimant's attorney submitted a statement of services requesting a fee of \$787.50 for his services before OAH. Insurer objects to the amount because RRU awarded claimant's attorney \$2,000 for his services there. In support of its position, insurer argues that, absent extraordinary circumstances, the statute and rules prohibit a fee in excess of \$2,000 in the aggregate for services rendered before WCD as well as before OAH. Insurer further argues that inasmuch as RRU ordered insurer to pay an attorney fee of \$2,000, it owes no additional fee even though claimant has prevailed in this contested case hearing. I find insurer's argument unpersuasive.

ORS 656.385(1) provides:

(1) In all cases involving a dispute over compensation benefits pursuant to ORS 656.245, 656.260, 656.327 or **656.340**, where a claimant finally prevails after a proceeding has commenced before the Director of the Department of Consumer and Business Services, the director shall require the insurer or self-insured employer to pay a reasonable attorney fee to the claimant's attorney. In such cases, where an attorney is instrumental in obtaining a settlement of the dispute prior to a decision by the director, the director shall require the insurer or self-insured employer to pay a reasonable attorney fee to the claimant or 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 by the director, or on appeal from an order of the director, 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.)

In interpreting a statute, the court's, and thus, my charge is to determine the legislative intent. ORS 174.020⁴ *PGE v. Bureau of Labor and Industries*, 317 Or 606 (1993). In order to discern the legislative intent, the first level of analysis is to examine both the text and context of the statute. 317 Or at 610-611. The test of the statute is the best evidence of the legislature's intent. If the legislature's intent is unclear, I consider legislative history, and if still unclear, I apply the general maxims of statutory construction. *Id.* In applying the foregoing method of analysis to ORS 656.385(1), I find I need proceed no further than the plain meaning of the statute.

⁴ ORS 174.020(1)(a) provides:

In the construction of a statute, a court shall pursue the intention of the legislature if possible.

Insurer takes the position that, absent extraordinary circumstances, the maximum attorney fee of \$2,000 is an aggregate amount for services before WCD and OAH. I disagree. Prior to 2003, attorney fees were not available for services before WCD. Following a statutory amendment, prevailing claimant's attorneys are compensated for their services before both WCD and OAH. Moreover, the statute contains the term "an" attorney fee, indicating that the legislature intended to limit attorney fees to \$2,000 before WCD and \$2,000 before OAH in the event that claimant prevails in both forums and absent extraordinary circumstances. Contrary to insurer's argument, the legislature did not intend for a prevailing claimant's attorney to go uncompensated before OAH merely because RRU had previously awarded a \$2,000 fee. Furthermore, OAR 436-001-0265⁵ and OAR 436-120-0008(2)⁶ contain the term "the" attorney

⁵ OAR 436-001-0265 (eff. 7/1/05) provides in pertinent part:

(1) In cases where the director is required to assess an attorney fee under ORS 656.385(1):

(a) The fee must be based on the factors listed in ORS 656.385(1).

(b) Absent a showing of extraordinary circumstances or unless otherwise agreed by the parties, the fee may not exceed \$2,000 nor fall outside the ranges provided in the following matrix: [Matrix not included. See ED. NOTE.]

(e) In cases under ORS 656.340, the factors listed in OAR 436-120-0008(2) may also be considered.

(2) Except as provided in section (3), in cases where the administrative law judge or director assesses an attorney fee, the following factors may also be considered:

(a) The complexity of the issue(s) involved;

(b) The quality of the legal representation;

(c) The value of the interest involved;

(d) The nature of the proceedings;

(e) The risk in a particular case that an attorney's efforts may go uncompensated;

(f) The assertion of frivolous issues or defenses;

(g) A statement of services, if submitted within seven days of the hearing date, unless the administrative law judge instructs otherwise; and

(h) Any other relevant consideration deemed appropriate by the administrative law judge or director.

(4) If an attorney fee has been assessed by an administrative law judge in a proposed order, the opposing parties may file written exceptions to the fee under OAR 436-001-0275.

[ED. NOTE: Matrix referenced are available from the agency.]

⁶ OAR 436-120-0008(2) (eff. 4/1/04) provides:

(2) Attorney fees: In any dispute in which a represented worker prevails after a proceeding has commenced before the director, the director will award an attorney fee to be paid by the insurer or self-insured employer as provided in ORS 656.385 (2, ch. 756, OL 2003). The 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

fee and refer to either the WCD or the OAH fee. Finally, under the circumstances and considering the factors listed in OAR 436-001-0265 and OAR 436-120-0008(2), I find that \$787.50 is a reasonable fee for claimant's attorney's services in this matter before OAH.

ORDER

IT IS HEREBY ORDERED that:

1. The Administrative Order dated April 14, 2005 is affirmed.
2. Insurer shall pay claimant's attorney a fee of \$787.50.

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: [Matrix not included. See ED. NOTE.]

(a) An attorney must submit the following to the director in order to be awarded an attorney fee:

(A) A current, valid retainer agreement, and

(B) A statement of hours spent on the case if greater than two hours. In the absence of such a statement, the director will assume the time spent on the case was 1-2 hours.

(b) In determining the value of the results achieved, the director may consider, but is not limited to the following:

(A) Where there is a return-to-work plan that includes the disputed service(s), the assumed value is the cost of the disputed service(s) as projected in the plan;

(B) Where the service(s) have not been incorporated in an existing return-to-work plan, the assumed value is the actual or projected cost of the service(s) up to the amount allowed in the fee schedule provided in OAR 436-120-0720;

(C) For the purposes of applying the matrix, the value of an eligibility determination is assumed to be the maximum allowed in the fee schedule provided in OAR 436-120-0720 for completing an eligibility evaluation; the value of vocational assistance or a training plan, unless determined to be otherwise, is assumed to fall within the highest category provided in the above matrix; or

(D) A written agreement between the parties regarding the value of the benefit to the worker submitted to the director prior to the issuance of an order.

(c) If any party believes extraordinary circumstances exist that justify a fee outside of the ranges provided in the above matrix or above \$2000, they may submit a written or faxed statement of the extraordinary circumstances to the director. Extraordinary circumstances are not established by merely exceeding eight hours or exceeding a benefit of \$6000.

(d) In order to provide parties an opportunity to inform the director of agreements, or submit statements of extraordinary circumstances or professional hours for consideration in determining the attorney fee, the director will provide the parties notice by phone or fax at least 3 business days in advance that an order or other written resolution of the dispute will be issued. Any information or statements provided to the director must simultaneously be provided to all other parties to the dispute.

(e) An assessed attorney fee will be paid within 30 days of the date the order authorizing the fee becomes final.