VAN NATTA'S
WORKERS' COMPENSATION REPORTER

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This volume is a compilation of Orders of the Oregon Workers' Compensation Board and decisions of the Oregon Supreme Court and Court of Appeals relating to workers' compensation law.

Owing to space considerations, this volume omits Orders issued by the Workers' Compensation Board that are judged to be of no precedential value.

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CITE AS

51 Van Natta ____ (1999)

In the Matter of the Compensation of
HAROLD W. CASTLE, Claimant
Own Motion No. 66-0013M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's request for medical benefits relating to his compensable September 11, 1956 injury claim. Claimant was awarded permanent total disability benefits in 1961. SAIF recommends against the payment of the requested benefits, (*i.e.* hearing aids), on the ground that the requested medical services are not related to the compensable injury.

Inasmuch as claimant sustained a compensable industrial injury prior to January 1, 1966, he does not have a lifetime right to medical benefits pursuant to ORS 656.245. *William A. Newell*, 35 Van Natta 629 (1983). However, for conditions resulting from a compensable injury occurring before January 1, 1966, the Board may authorize the payment of medical services. *See* ORS 656.278(1)(b). Claimant has the burden of proving that the requested medical services are causally related to the compensable injury. ORS 656.266; OAR 438-012-0037.

By letter dated January 21, 1999, we advised claimant of his burden of proof and requested his response within 14 days. The time allowed for response has passed and no response has been received from claimant. Therefore, we proceed with our review.

At SAIF's request, Dr. Hodgson conducted a medical file review. Dr. Hodgson opined that, because of the symmetry of the hearing loss, the sloping pattern typical of degenerative changes and the lack of any history suggesting evaluation or care for hearing loss, the major portion of claimant's hearing loss was unrelated to his 1956 injury. Acknowledging that claimant would have suffered some left ear hearing loss if the 1956 work-related injury had caused an eardrum perforation, Dr. Hodgson observed that the hearing loss would have been "conductive and resolved with self healing of the eardrum." Nonetheless, finding nothing to indicate that claimant's left ear hearing was affected by the 1956 industrial injury, Dr. Hodgson opined that "the major contributing cause of the need for hearing aids is presbycusis."

Based on Dr. Hodgson's unrebutted opinion, the record does not establish that claimant's hearing loss and need for hearing aids is causally related to his September 11, 1956 work injury. Accordingly, the request to reopen the claim for medical services allegedly related to the 1956 work injury is denied.[1]

IT IS SO ORDERED.

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[1] We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order; *i.e.* medical evidence establishing that claimant's need for medical services is attributable to his work injury (rather than to his age-related presbycusis).

In the Matter of the Compensation of
TERRY C. GASSETT, Claimant
Own Motion No. 98-0329M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable L1 compression fracture and L5-S1 disc herniation injury. Claimant's aggravation rights expired on June 14, 1990. SAIF issued a denial of the compensability of claimant's current arteriosclerotic vascular disease condition on August 5, 1998. Claimant timely appealed that denial. (WCB Case No. 98-06499). In addition, SAIF opposed authorization of temporary disability compensation, contending that: (1) it is not responsible for claimant's current condition; and (2) claimant was not in the work force at the time of disability.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

Here, claimant did appeal the August 5, 1998 denial; however, he failed to respond to the Administrative Law Judge's Order to Show Cause and an Order of Dismissal issued on February 25, 1999. That order has not been appealed. Thus, the current arteriosclerotic vascular disease condition for which claimant requests own motion relief remains in denied status. Consequently, we are not authorized to reopen claimant's claim at this time as SAIF has not accepted claimant's current condition as compensable. Should claimant's circumstances change and SAIF accept responsibility for claimant's condition, claimant may again seek own motion relief.

Accordingly, claimant's request for temporary disability compensation is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
BENTON L. KEFFER, Claimant
WCB Case No. C9-00411
ORDER DENYING RECONSIDERATION
OF CLAIM DISPOSITION AGREEMENT
Welch, et al, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On February 23, 1998, the Board approved the parties' claim disposition agreement (CDA) in the above captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant released rights to future workers' compensation benefits, except medical services, for the compensable injury.

On March 24, 1999, we received claimant's attorney's "revised" CDA,[1] which is submitted on behalf of both parties. We treat this CDA as a motion for reconsideration of the previously approved CDA. In order to be considered, a motion for reconsideration of the CDA must be received by the Board within 10 days of the date of mailing of the final order. OAR 438-009-0035(1),(2). Here, the CDA was approved and mailed on February 23, 1999. We received the revised CDA on March 24, 1999, 29 days after the CDA was approved. Inasmuch as the motion for reconsideration was untimely, we cannot consider it. OAR 438-009-0035(1),(2); *Edward C. Steele*, 48 Van Natta 2292 (1996); *Paul J. LaFrance*, 48 Van Natta 306 (1996).[2]

Moreover, we approved the CDA in a final order pursuant to ORS 656.236. The approved CDA is final and is not subject to review. ORS 656.236(2). Consequently, we lack either statutory or regulatory authority to alter the previously approved CDA.

IT IS SO ORDERED.

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[1] The "revised" CDA would retain claimant's right to seek penalties and attorney fees in relation to medical services provided for the compensable injury.

[2] We acknowledge that both parties represent that this "revised" version of the CDA accurately reflects their agreed intentions. Nonetheless, because the time for us to reconsider the approved CDA has expired, we are without authority to consider the revised agreement.

In the Matter of the Compensation of
LORETTA J. KNAPP, Claimant
Own Motion No. 99-0081M
OWN MOTION ORDER
Cole, Cary, et al, Claimant Attorneys

The insurer initially submitted claimant's request for temporary disability compensation for claimant's compensable 1990 industrial injury. Claimant's aggravation rights on that claim expired on May 1, 1997.

On January 22, 1998, the Board approved the parties' Claim Disposition Agreement (CDA), which released claimant's rights to the following workers' compensation benefits: temporary disability benefits, permanent disability benefits, vocational rehabilitation, own motion benefits under ORS 656.278, burial benefits, aggravation rights per ORS 656.273, death benefits, survivor's benefits, and all other workers' compensation benefits except compensable medical services under ORS 656.245.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

In its March 1, 1999 recommendation, the insurer conceded that claimant's current condition is compensable and that it is responsible for her current condition. Additionally, the insurer acknowledged that claimant's current condition requires surgery, which is reasonable and necessary. Therefore, the insurer has accepted claimant's medical services as compensable. However, the insurer reported that it was unknown whether claimant was in the work force at the time of her current disability.

In light of the fact that claimant has permanently relinquished her rights to all past, present and future temporary disability compensation, the work force issue is moot. In other words, as a result of the January 22, 1998 CDA, claimant is no longer entitled to any temporary disability compensation related to her October 18, 1990 work injury. *See* ORS 656.236(1); *Jack F. Stewart*, 51 Van Natta 22 (1999); *Jeffrey B. Trevitts*, 46 Van Natta 1767 (1994), *aff'd Trevitts v. Hoffman-Marmolejo*, 138 Or App 455 (1996).

Accordingly, claimant's request for temporary disability compensation is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
MIMI O. ETCHEBERRY, Claimant
WCB Case No. 98-02400
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's claim for a low back injury. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation.

The employer argues that claimant is not credible. After our review of the record, we do not find sufficient inconsistencies from which to conclude that claimant did not sustain the injury she claimed.[1] As the ALJ noted, although some of the medical evidence might suggest that claimant later exaggerated the extent or severity of her injury, the preponderance of the evidence supports the conclusion that claimant sustained a compensable injury.[2]

The employer argues that Dr. Singer's opinion is unpersuasive because she changed her opinion without explanation. We disagree. Dr. Singer concurred with the report of Drs. Howieson and Woodward. In their report, Drs. Howieson and Woodward indicated that claimant might have experienced muscle pain due to the employment activity. The doctors questioned whether claimant's symptoms would have persisted more than a few days, but their opinion nonetheless supports the conclusion that the work activities were consistent with muscle pain, such as that described by claimant. Because we find that the report is not inconsistent with Dr. Singer's opinion that the work injury was a material contributing cause of claimant's need for treatment and disability, we conclude that her concurrence with that report does not represent an unexplained change of opinion.

After reviewing the medical evidence, we are persuaded that the preponderance of the evidence supports a conclusion that claimant sustained a compensable injury. In this regard, we rely on the opinions of Drs. Singer and Boyer as supported by Dr. Conklin. We also note that Dr. Howieson's opinion also supports compensability to the extent that the doctor notes that the work activities could cause muscle pain.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated October 23, 1998 is affirmed. For services on Board review, claimant's attorney is awarded $1,000, payable by the employer.

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[1] The employer argues that the doctors had an incorrect history of claimant's injury. After our review, we find that the physicians generally had an accurate understanding of the injury. In addition, the employer notes that the chart note of the emergency department physician, Dr. Boyer, indicates that claimant's pain began on Sunday, a few days after the work incident. The chart note also states that the pain began after claimant started the work activities. Because of this, the chart note could mean that the pain was first present after the injury, but subsequently worsened on the Sunday after the injury. In any case, we are unable, based on this single unclear reference in the chart note, to conclude that claimant is not credible concerning the injury.

[2] Our decision is limited to the initial compensability of the claim. Issues pertaining to the extent of disability caused by the injury are not presently before us.

In the Matter of the Compensation of
ROBERT G. FISHER, Claimant
WCB Case Nos. 98-04668 & 97-04764
ORDER ON REVIEW
Westmoreland & Mundorff, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that affirmed an Order on Reconsideration finding that claimant was medically stationary on November 11, 1997. On review, the issue is the medically stationary date. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for cervical, thoracic and lumbar strains. The Notice of Closure found claimant medically stationary on August 5, 1997 and awarded temporary disability through that date.

Based on OAR 436-030-0035(4) and (6),[1] the Order on Reconsideration found that claimant was medically stationary on November 11, 1997 and that claimant was entitled to temporary disability through that date. The ALJ agreed and affirmed the Order on Reconsideration. SAIF contends that, because the most persuasive medical evidence shows that claimant was medically stationary on August 5, 1997, claimant should not be awarded temporary disability after that date. SAIF also argues that the rules relied upon by the Order on Reconsideration and ALJ do not apply in determining the appropriate medically stationary date.

Examining physicians Dr. Bald and Dr. Farris saw claimant on November 11, 1997. In their report, they stated that, after reviewing surveillance tapes of claimant's activities, "it would appear that [claimant] has been medically stationary at least as long as August 5 and August 6, 1997 as demonstrated on the video tape." (Ex. 20-10). The report further found that "[i]t is our opinion that the claimant is now medically stationary as it relates to the injury of April 21, 1997. * * * It is our opinion that on a medically probable basis, the claimant has been medically stationary since the beginning of August of 1997." (*Id.*)

Claimant's treating physician, Dr. Grewe, then reviewed the examining panel's report and the surveillance video. Dr. Grewe reported that, "judging from the level of performance by [claimant] it seems that he should have been able to return to his usual work at least by mid-September 1997." (Ex. 21-2). Dr. Grewe also stated that he found the examining panel's report "was appropriate and an accurate appraisal." (*Id.*)

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[1] Those rules provide:

"(4) When there is a conflict as to the date upon which a worker's compensable condition became medically stationary, the following conditions shall govern the determination of the medically stationary date. The date a worker is medically stationary is the earliest date a preponderance is established pursuant to section (2) of this rule. The date of the examination, not the date of the report, controls the medically stationary date."

"* * * * *

"(6) A worker is medically stationary on the date of the examination when so specified by a physician. When a specific date is not indicated, a worker is presumed medically stationary on the date of the last examination, prior to the date of the medically stationary opinion. Physician projected medically stationary dates cannot be used to establish a medically stationary date."

We find that, whether or not OAR 436-030-0035(4) and (6) apply, the appropriate medically stationary date is November 11, 1997. In stating that claimant probably was medically stationary as early as August 5, 1997, the examining panel was relying only on surveillance videotape rather than actual examination. We are more persuaded by their finding that claimant was medically stationary when the panel actually saw him on November 11, 1997.

Furthermore, we disagree with SAIF that the record shows that Dr. Grewe concurred with the panel's comments concerning the August 5, 1997 date. Because Dr. Grewe indicated that claimant should have returned to work by September 1997, we agree with the ALJ that "Dr. Grewe's opinion is not especially clear." His statement that the panel's report was "appropriate and an accurate appraisal" could also have been limited to its finding that claimant was medically stationary on November 11, 1997.

In sum, we find that the most persuasive medical evidence shows that the appropriate medically stationary date is November 11, 1997. Because we base this conclusion on a preponderance of evidence in the medical record, we need not decide the application of OAR 436-030-0035(4) and (6). *See* OAR 436-030-0035(1).[2]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 3, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the SAIF Corporation.

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[2] This rule provides:

"A worker's compensable condition shall be determined to be medically stationary when the attending physician or a preponderance of medical opinion declares the worker either "medically stationary," "medically stable," or uses other language meaning the same thing."

In the Matter of the Compensation of
CARRIE S. FORD, Claimant
WCB Case No. 98-05345
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order affirming an Order on Reconsideration that increased claimant's award of scheduled permanent disability for loss of use or function of the right foot from 5 percent (6.75 degrees) to 19 percent (25.65 degrees). In its appellant's brief, the employer has submitted additional documents not in the record. We treat such submission as a motion for remand. On review, the issues are remand and scheduled permanent disability.

We deny the motion and adopt and affirm the ALJ's order with the following supplementation.

The employer notes that it amended its acceptance to include an additional condition (Morton's neuroma of the third web space) after the claim was closed by a January 30, 1998 Notice of Closure. The employer has now enclosed an unappealed November 6, 1998 Notice of Closure and attached worksheet that awarded 5 percent scheduled permanent disability based on "post-closure" processing of the Morton's neuroma condition. *See* ORS 656.262(7)(c). The employer asserts that affirming the 19 percent scheduled permanent disability award in the Order on Reconsideration would result in an overpayment because, it alleges, the reconsideration order's award was based in part on the "post-

closure" accepted condition. *See William J. Barabash*, 50 Van Natta 1561, 1556 (1998) (in rating permanent disability under the current statutory scheme, the focus is on accepted conditions at the time of claim closure). We disagree.

Because our review is limited to the record developed before the ALJ, we treat the employer's submission as a motion for remand. *Judy A. Britton*, 37 Van Natta 1262 (1985). We remand only if the record is improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Here, we do not find the record insufficiently developed.[1]

The Order on Reconsideration rated claimant's permanent disability based on the conditions accepted at closure (contusion right foot and Morton's neuroma, *second* web space). (Ex. 82). Moreover, the medical arbiter, on whose report the reconsideration order based its award of 19 percent scheduled permanent disability, also correctly identified the accepted conditions at closure and made impairment findings based on those conditions. (Ex. 80-1). Accordingly, we are not persuaded that claimant's permanent disability award was based on the "post-closure" accepted condition. Finding the record to be sufficiently developed, we determine there is no compelling basis to remand. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986).

Because we have not disallowed or reduced claimant's compensation as a result of the employer's request for review, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 6, 1998 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, to be paid by the employer.

[1] In reaching this conclusion, we assume, for the sake of argument, that this "post-reconsideration record" evidence would be admissible at hearing.

In the Matter of the Compensation of
JOHN A. MAHON, Claimant
WCB Case Nos. 98-02505 & 97-08249
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

TIG Insurance Company (TIG), on behalf of its insured, Parmenter Studios, requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) set aside its denials of compensability and responsibility for claimant's right shoulder and right elbow conditions; and (2) upheld the responsibility denial of the same conditions issued by Liberty Northwest Insurance Company, on behalf of Jayzee Logging. On review, the issues are compensability and responsibility.

We adopt and affirm the ALJ's order with the following supplementation.

The ALJ set aside TIG's compensability denial pertaining to claimant's right shoulder rotator cuff condition and his right elbow epicondylitis condition. In doing so, the ALJ relied on the medical opinions of claimant's attending physicians, Drs. German and Woods. The ALJ relied on those same opinions in determining that TIG was responsible for the right shoulder and elbow conditions.

On review, TIG contends that those medical opinions are not persuasive because they were based on an incomplete and inaccurate history. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) (medical opinion that is not based on a complete and accurate history is unpersuasive). Specifically, TIG asserts that, because both Dr. German and Dr. Woods conceded that they were unaware of claimant's off-work activities (volleyball, weight lifting, and mountain biking), their opinions on the medical causation issue are not persuasive. We disagree.

Dr. German testified that claimant's off-the-job activities would be significant only if they caused additional pain and "inflamed" claimant's problems. (Ex. 71-35, 36). Dr. Woods testified similarly, stating that, if off-work activities either hurt when claimant doing them or made claimant hurt more during the day, then they were contributing to his problems. (Ex. 70-52). Claimant, however, credibly testified that his off-work activity did not cause significant discomfort. (Trs. 13, 24).

Accordingly, we conclude that the persuasiveness of Dr. German's and Dr. Woods' opinions is not seriously undermined by their lack of familiarity with claimant's off-the-job activity. Moreover, we note that both physicians continued to attribute claimant's condition to his employment activity at Parmenter even after being informed of those off-work activities. (Exs. 70-51; 71-36, 38). Therefore, we agree with the ALJ's decision to set aside TIG's compensability and responsibility denials.

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,000, payable by TIG. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 3, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by TIG.

April 2, 1999 Cite as 51 Van Natta 607 (1999)

In the Matter of the Compensation of
RONALD MILLER, Claimant
WCB Case No. C9-00698
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Michael A. Bliven, Claimant Attorney
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On March 18, 1999, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed CDA.

The first page of the proposed CDA provides that the total due claimant is $10,275 and the total due claimant's attorney is $3,225, for a total consideration of $13,500. On page 4, section 18 states that claimant's attorney is to receive 25 percent of the proceeds as a reasonable fee, or $3,225. Because the total consideration equals $13,500, 25 percent of that amount would be $3,375. Nonetheless, because the attorney fee has been expressly identified as $3,225 in two separate sections of the CDA, we rely on those specific representations. In other words, we consider the reference to a 25 percent attorney fee to be a clerical error.[1] In conclusion, we interpret the agreement as providing for a total consideration of $13,500, with $10,275 payable to claimant and $3,225 as an attorney fee.

[1] Under the current version of OAR 438-015-0052(1), an attorney fee equal to 25 percent of $13,500 would be permissible because the rule allows for a fee equal to 25 percent of the first $17,500 plus 10 percent of any amount in excess of $17,500. However, it appears the attorney fee may have been based on the former version of the rule which allowed a fee of 25 percent of the first $12,500 and 10 percent of any amount in excess of $12,500.

As clarified by this order, the CDA is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' CDA is approved. An attorney fee of $3,225, payable to claimant's counsel, is also approved.

Should the parties disagree with our interpretation of the CDA, they may move for reconsideration by filing a motion for reconsideration within 10 days of the date of mailing of this order. OAR 438-009-0035.

IT IS SO ORDERED.

April 2, 1999 Cite as 51 Van Natta 608 (1999)

In the Matter of the Compensation of
TAMARA L. OLIVER, Claimant
WCB Case No. 98-05805
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Martha Brown's order that upheld the SAIF Corporation's denial of claimant's myofascial pain syndrome condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation.

Claimant contends that the ALJ should not have limited the analysis to whether claimant proved a consequential condition under ORS 656.005(7)(a)(A). Instead, claimant argues that her myofascial pain syndrome condition is compensable under ORS 656.005(7)(a)(A) or as an occupational disease under ORS 656.802. According to claimant, the opinion of her treating physician, Dr. Colwell, is sufficiently persuasive to carry her burden under either statute.

Whether analyzed as a consequential condition or occupational disease, we agree with the ALJ that Dr. Colwell's opinion is not persuasive. In stating that claimant's "work exposure" was the major contributing cause of the myofascial pain syndrome, Dr. Colwell provided no reasoning to explain his conclusion. We further note that Dr. Colwell did not begin to treat claimant until July 1998, and thus did not see claimant until some time after her March 1997 injury and November 1997, when claimant last worked for the employer. Finally, Dr. Colwell's opinion is rebutted by claimant's initial treating physician, Dr. Jewell.

For these reasons, we conclude that claimant did not prove a consequential condition or occupational disease.

ORDER

The ALJ's order dated November 13, 1998 is affirmed.

In the Matter of the Compensation of
RONALD P. OLSON, Claimant
Own Motion No. 98-0119M
OWN MOTION ORDER ON RECONSIDERATION
Popick & Merkel, Claimant Attorneys
Williams & Fredrickson, Defense Attorneys

Claimant requests reconsideration of our March 3, 1999 Own Motion Order, which reinstated his temporary disability compensation and awarded penalties and "out-of-compensation" attorney fees. Particularly, claimant's counsel seeks an amended order which specifically awards "one-half the penalty amount as an attorney fee relative to the penalty issue," and a maximum "out-of-compensation" attorney fee of $1,500.

Penalty Amount

In our March 3, 1999 order, we found that the self-insured employer's termination of claimant's temporary disability benefits was unreasonable. Consequently, we awarded a 25 percent penalty of the amounts "then due." We further directed that the penalty be paid "in equal shares to claimant and his attorney." In other words, in accordance with ORS 656.262(11)(a), we have already determined that one-half of the penalty shall be distributed to claimant's counsel.

Attorney Fees

Claimant's counsel seeks an increase of the "out-of-compensation" attorney fee granted in our prior order from $1,050 to $1,500. In support of this request, claimant's counsel relies on *amended* OAR 438-015-0080 and claimant's retainer agreement. The retainer agreement, which claimant signed in January 1991, states in part: "If a Referee, the Board or Courts award or approve additional compensation for permanent or temporary disability, the fee shall be twenty-five percent (25%) of the increased compensation, *as limited by law.*" (emphasis supplied)

The pivotal question is the meaning of the phrase "as limited by law." If the phrase refers to the "out-of-compensation" attorney fee limitations that are applicable at the time the compensation award is granted, the maximum fee would be $1,500 (consistent with the amended version of OAR 438-015-0080, which became effective February 1, 1999 and applied to all pending cases, provided that an executed retainer agreement has been filed that allows for an attorney fee in the amount consistent with this amended rule. *See* WCB Admin. Order 1-1998, footnote 7). On the other hand, if the pivotal phrase refers to the "out-of-compensation" attorney fee limitations that were applicable when the retainer agreement was executed, the maximum fee would be $1,050 (consistent with the 1991 version of OAR 438-015-0080).

In the absence of an express provision indicating otherwise, we interpret the language "as limited by law" to refer to the limitations that were in existence at the time the agreement was signed. To reach any other conclusion would effectively supplement the agreement by adding a phrase "or by subsequent rule amendments," following the terms "as limited by law."

Our conclusion is further supported by our own interpretation of the effective date for the amendment to OAR 438-015-0080. *See* WCB Admin. Order 1-1998. Specifically, in our Order of Adoption (footnote 7, third paragraph), we provided an example which determined that a worker's counsel would be entitled to an "out-of-compensation" attorney fee equal to 25 percent of the increased temporary disability compensation awarded by a "post-February 1, 1999" Administrative Law Judge's order not to exceed $1,050, because the pre-February 1, 1999 retainer agreement set forth such a limitation. Here, based on the reasoning previously expressed, we interpret "as limited by law" as provided in the 1991 retainer agreement as though $1,050 was expressly recited in the agreement.[1]

[1] If claimant and claimant's counsel wish to submit an executed retainer agreement providing for an attorney fee consistent with the amended rule, we will reconsider our decision. Because our authority to reconsider this order expires within 30 days after the date of this order, such an amended agreement must be submitted in an expeditious manner.

Accordingly, we withdraw our March 3, 1999 order. On reconsideration, as supplemented herein, we adhere to and republish our March 3, 1999 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

April 2, 1999 Cite as 51 Van Natta 610 (1999)

In the Matter of the Compensation of
ROBERT RICE, Claimant
WCB Case No. C9-00643
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Bischoff & Strooband, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On March 15, 1999, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

On page 2, the CDA indicates that the accepted conditions subject to the CDA are "T6-T7 disc, cervical strain, bilateral numbness in arms, hands, fingers and left shoulder." The CDA further provides, on page 2: "The parties stipulate the acceptance was intended to encompass claimant's C7-T1 disc injury."

The function of a claim disposition agreement is to dispose of an accepted claim, with the exception of medical services, as the claim exists at the time the Board receives the CDA. *See* ORS 656.236(1). It is not the function of a CDA to accomplish claim processing functions under ORS 656.262 or otherwise resolve compensability issues. *See Lynda J. Thomas*, 45 Van Natta 894 (1993). There are other procedural avenues available to the parties to accomplish these objectives, such as stipulations and disputed claim settlements. *See Frederick M. Peterson*, 43 Van Natta 1067 (1991).

Here, we do not interpret the CDA as accomplishing a claim processing function. Rather, we interpret the CDA as clarifying the conditions that have already been accepted (or encompassed within an acceptance) prior to the submission of the CDA. Under such circumstances, we do not find that the CDA was intended to accept a condition or to carry out any other claim processing function.

Under such circumstances, we conclude that the agreement, as interpreted herein, is in accordance with the terms and conditions prescribed by the Board. ORS 656.236(1)(a); OAR 438-009-0020(1). Accordingly, we approve the CDA.

Should the parties disagree with our interpretation of the CDA, they may move for reconsideration by filing a motion for reconsideration within 10 days of the date of mailing of this order. OAR 438-009-0035.

IT IS SO ORDERED.

In the Matter of the Compensation of
LINO AGUILAR, Claimant
WCB Case No. 98-04723
ORDER ON REVIEW
Willner & Associates, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Hoguet's order that: (1) set aside its denial of claimant's right indirect inguinal hernia injury claim; and (2) awarded claimant's attorney an assessed fee of $3,500 for services at hearing. SAIF also moves to remand regarding the attorney fee issue. On review, the issues are compensability, remand, and attorney fees.

We adopt and affirm the ALJ's order with the following supplementation.

The ALJ awarded claimant's attorney an assessed fee of $3,500 for services at hearing. SAIF argues that the ALJ erred in failing to apply each of the factors in OAR 438-015-0010(4) and in failing to draw conclusions from those facts in awarding an assessed attorney fee. SAIF requests that we remand the case to the ALJ to "properly" apply OAR 438-015-0010(4).

We considered SAIF's argument in *Daryl L. Underwood*, 50 Van Natta 2330 (1998). There, the claimant's attorney did not submit a specific fee request and the parties did not provide any argument at hearing concerning the application of the factors in OAR 438-015-0010(4). After analyzing the Supreme Court's decision in *McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or 84, *adhered to on recon* 327 Or 185 (1998),[1] we found that the Court held that a lower body need not address facts and legal criteria that are not material to its decision and could "satisfy its obligation to make findings in a case * * * by including in its order a brief description or citation to the factor or factors on which it relies in denying an award of attorney fees." 327 Or at 188.

In short, because the statute considered by the Court in *McCarthy* contained the same requirement in OAR 438-015-0010(4) that the reviewing bodies "shall consider" certain enumerated factors, we held that it is sufficient for an ALJ to merely describe or cite the rule-based factor or factors the ALJ relied on in determining a reasonable attorney fee where there was no specific attorney fee requested and the parties did not submit to the ALJ any argument as to how the rule-based factors should be weighed in determining a reasonable fee. Based on our reasoning in *Underwood*, we continue to hold that the ALJ need not make specific findings for each rule-based factor. Furthermore, even if we considered the ALJ's explanation inadequate, because we are authorized to modify or supplement the ALJ's findings and conclusions under ORS 656.295(6), it is not necessary to remand this case to the ALJ for the supplementation of findings regarding claimant's attorney fee award. Consequently, we deny SAIF's motion to remand. *Daryl L. Underwood*, 50 Van Natta at 2332.

In determining a reasonable attorney fee, we consider the following factors: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses. OAR 438-015-0010(4).

Here, SAIF denied claimant's injury claim for his right indirect inguinal hernia. Claimant's attorney requested a hearing on this denial. The hearing took place in two sessions. The hearing transcripts totaled 65 pages. Claimant does not speak English and does not read or write English or Spanish. His native language is Mixteco, although he speaks some Spanish. Claimant's attorney located an interpreter who speaks Mixteco for the hearing. Claimant, through the interpreter, testified on his behalf, and two witnesses testified on SAIF's behalf. The record contains 16 exhibits, one of which was generated by claimant's attorney. There were no depositions.

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[1] In *McCarthy*, on its own motion, the Court reconsidered its initial decision and clarified what it required of the Court of Appeals in explaining an attorney fee award in a civil case. 327 Or at 185. However, SAIF's arguments are solely limited to the Court's initial decision, without considering its explicit clarification on reconsideration. As we explained in *Underwood*, the Court's explanation on reconsideration is also enlightening in the context of what is required to explain an attorney fee award in a workers' compensation case.

Based on disputes generally litigated before this forum, we find that the compensability issue was of average complexity regarding the legal and factual issues involved. Claimant succeeded in establishing compensability of his injury claim, for which he had undergone surgery. Thus, the value of the interest involved and the benefit secured for claimant are significant. The parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented at hearing. Finally, based on the conflicting medical evidence, there was a risk that claimant's counsel's efforts might have gone uncompensated.

After considering the factors set forth in OAR 438-015-0010(4), we find that a reasonable fee for claimant's attorney's services at hearing is $3,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel may go uncompensated.

In addition, claimant's attorney is entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

Finally, we note that claimant is not entitled to an attorney fee for services rendered defending the attorney fee award. *Dotson v. Bohemia*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated October 12, 1998 is affirmed.

April 2, 1999 Cite as 51 Van Natta 612 (1999)

In the Matter of the Compensation of
TINA M. VICTORIA, Claimant
WCB Case Nos. 95-08856 & 95-08855
SECOND ORDER ON REMAND
Rasmussen & Tyler, Claimant Attorneys
Reinisch, et al, Defense Attorneys
David L. Runner (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our March 5, 1999 Order on Remand, which found it responsible for claimant's bilateral elbow epicondylitis/overuse syndrome. SAIF contends that claimant's employment with SAIF's insured contributed only to symptoms, and not to her underlying condition. Having received Safeco Insurance Company's response, we proceed with reconsideration.

SAIF relies on *Roseburg Forest Products v. Long*, 325 Or 305 (1997), to argue that the initial assignment of responsibility must be transferred to Safeco on the ground that Safeco's employment was the sole cause of claimant's underlying condition. We disagree.

As we discussed in our previous order, an employer that otherwise would be responsible under the last injurious exposure rule may avoid responsibility if it proves either: (1) that it was impossible for conditions at its workplace to have caused the disease in this particular case or (2) that the disease was caused solely by conditions at one or more previous employments. *Long*, 325 Or at 313.

On reconsideration, we adhere to our previous conclusion that both employments contributed to claimant's bilateral elbow epicondylitis/overuse syndrome. The medical evidence establishes that claimant's employment with SAIF's insured contributed to her condition and we are not persuaded that claimant's condition was caused solely by her employment with Safeco. Furthermore, we find no evidence that it was impossible for conditions at SAIF's insured to have caused claimant's condition. Consequently, responsibility for claimant's bilateral arm condition remains with SAIF. *See Betty L. Martinez*, 50 Van Natta 1535 (rejecting the carrier's argument that it was not responsible for the claimant's right carpal tunnel syndrome because the claimant's work for that carrier did not in fact cause the condition), *on recon* 50 Van Natta 1657 (1998).

Accordingly, we withdraw our March 5, 1999 order. On reconsideration, as supplemented herein, we adhere to and republish our order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
GUSTAVO B. BARAJAS, Claimant
WCB Case Nos. 98-03824 & 98-03276
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Bostwick, et al, Defense Attorneys

Reviewed by the Board *en banc*.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that found that he was not entitled to interim compensation. On review, the issue is interim compensation. We reverse.[1]

FINDINGS OF FACT

Claimant compensably injured his right arm and shoulder on March 2, 1998. (Ex. 2). The injury occurred as he was reaching forward and his shirt sleeve was caught in a machine. Claimant went to the emergency room, where he received stitches for a laceration to his right arm. (Ex. 4).

On March 4, 1998, claimant was treated by Dr. Arthur, who diagnosed a right arm contusion and laceration, as well as a right shoulder strain. (Ex. 1). She treated claimant with medication and recommended light duty work. (*Id.*)

Claimant began treating with Dr. Nyquist on March 8, 1998. (Ex. 3). He continued claimant's light duty restrictions. (Exs. 3, 4). On March 16, 1998, Dr. Nyquist reported that claimant was becoming very anxious and depressed and was having a difficult time sleeping. (Ex. 5). His right arm laceration was healing well, but he still had significant pain and tenderness. (*Id.*) Dr. Nyquist diagnosed an "[a]cute stress reaction from work injury" and took claimant off work completely for the next week. (*Id.*)

On March 18, 1998, the self-insured employer accepted a right shoulder strain and a right arm contusion and laceration. (Ex. 7).

Dr. Nyquist reported on March 24, 1998 that claimant's arm was still painful and he was "[s]till very worried about returning to work." (Ex. 8). He noted that claimant had difficulty sleeping and was having bad dreams. Dr. Nyquist continued to diagnose an "[a]cute stress reaction from work injury." (*Id.*) Dr. Nyquist's March 31, 1998 chart note indicated he had spoken with claimant's case manager concerning his stress reaction and possible counseling for claimant. (Ex. 8).

Dr. Nyquist's March 31, 1998 report indicated claimant could perform full time sedentary work in relation to the work injury, but he noted that claimant had not worked since March 16, 1998 due to an acute stress reaction. (Ex. 10). On April 2, 1998, Dr. Nyquist reported that claimant had an acute stress reaction and "anxiety with panic attacks." (Ex. 11). He commented that claimant was released to light duty due to the work injury, but he was unable to return to work due to his current state of anxiety. (*Id.*) He took claimant off work until April 10, 1998 and recommended counseling. (Exs. 11, 12)

On April 21, 1998, Dr. Nyquist reported that although claimant could return to modified duty with respect to the arm injury, he could not return to modified work because of anxiety and panic attacks. (Ex. 14). Claimant began treating with Dr. Alkoff, a psychologist, sometime in April 1998. (Exs. 14, 14A).

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[1] We modify the ALJ's order to note that Exhibits 9A, 14A and 14B were also admitted in evidence.

On June 8, 1998, Dr. Nyquist reported that claimant's biceps laceration was resolved and he was medically stationary. (Ex. 16).

CONCLUSIONS OF LAW AND OPINION

At hearing, the parties stipulated that: (1) Dr. Nyquist referred claimant to Dr. Alkoff for treatment of his psychological condition; (2) claimant signed a light duty "return to work" agreement on March 6, 1998; (3) there has been no ORS 656.262(7) request made to the claims administrator by claimant for the acceptance of a new medical condition; and (4) Exhibits 6 and 9 were "off-work slips" from Dr. Nyquist for claimant's psychological condition and not for his laceration.

The ALJ concluded that claimant was not entitled to interim compensation. The ALJ reasoned that claimant had not filed a claim for a "new medical condition" under ORS 656.262(7)(a) and, therefore, he had not met the threshold requirement for the employer to commence the payment of interim compensation, *i.e.*, that the employer had notice or knowledge of a claim.

On review, claimant argues that the psychological condition diagnosed by Dr. Nyquist arose before claim acceptance and is not a "new medical condition" as that term is used in ORS 656.262(7)(a).

After the ALJ's order was issued, the court decided *Johansen v. SAIF*, 158 Or App 672 (1999). In that case, the court rejected the insurer's contention that a "new medical condition" claim has no existence independent of the original claim and does not give rise to a processing obligation independent of the original claim. *Id.* at 681; *see Labor Ready, Inc. v. Mann*, 158 Or App 666 (1999). In *Johansen*, the court held that a new medical condition under ORS 656.262(7)(a) "(1) arises after acceptance of an initial claim, (2) is related to an initial claim, and (3) involves a condition other than the condition initially accepted." 158 Or App at 679. *See also Mark A. Baker*, 50 Van Natta 2333, 2336 (1998) (a new medical condition under ORS 656.262(7)(a) is one that "comes into being" following issuance of the Notice of Acceptance).

Here, Dr. Nyquist diagnosed claimant with an "[a]cute stress reaction from work injury" on March 16, 1998. (Ex. 5). The employer did not accept a right shoulder strain and right arm contusion and laceration until March 18, 1998. (Ex. 7). Thus, claimant's psychological condition "existed" at the time the employer issued its Notice of Acceptance. Because the psychological condition arose *before* acceptance of the initial claim, ORS 656.262(7)(a) does not apply to this case and claimant was not required to file a "new medical condition" claim.

Claimant contends that Dr. Nyquist placed restrictions on his ability to work on March 16, 1998 and, therefore, he is entitled to receive interim compensation beginning March 20, 1998 (3 calendar days after he left work). On the other hand, the employer argues that claimant offered no proof as to when the employer or its claims administrator received the authorization for time loss.

"Interim compensation" is paid upon receipt of notice of a claim until the claim is accepted or denied, whereas temporary disability is paid after acceptance of the claim. *See Jones v. Emanuel Hospital*, 280 Or 147 (1977); *Labor Ready, Inc. v. Mann*, 158 Or App at 669-70. ORS 656.262(4)(a) provides that the "first installment of temporary disability compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim, if the attending physician authorizes the payment of temporary disability compensation." To trigger the worker's entitlement to interim compensation, the attending physician's authorization must relate the claimant's inability to work to a job-related injury or occupational disease. *See Robert W. Fagin*, 50 Van Natta 1680 (1998).

Here, Dr. Nyquist, claimant's attending physician, authorized the payment of temporary disability compensation on March 16, 1998. (Ex. 6). His March 16, 1998 chart note indicated that claimant had an "[a]cute stress reaction from work injury." (Ex. 5). Thus, Dr. Nyquist's chart note indicated that claimant's psychological condition was work-related.

We find that the employer had notice that claimant's absence from work was due to the work injury and the resulting psychological condition by at least March 31, 1998. Dr. Nyquist's March 31, 1998 chart note indicated that he had spoken with claimant's case manager regarding the availability of light duty work. (Ex. 8). Dr. Nyquist explained that claimant's current claim was for the laceration of his arm and "no claim had been submitted for an acute stress reaction and therefore they cannot use

that diagnosis to continue him off work." (*Id.*) Dr. Nyquist's chart note indicated the case manager said they had employee assistance available for a mental health evaluation through regular insurance. Based on our review of the record, we are persuaded the employer had notice of claimant's work-related psychological condition at least by March 31, 1998.[2]

The employer contends that claimant failed to establish that the employer received the time loss authorization until *after* the March 18, 1998 acceptance of a right shoulder strain and a right arm contusion and laceration and, therefore, any request for compensation had to first be made pursuant to ORS 656.262. For the reasons we explained earlier, ORS 656.262(7)(a) does not apply to this case and claimant was not required to file a "new medical condition" claim. The question remains, however, as to whether it was necessary for claimant to comply with ORS 656.262(6)(d) by notifying the employer that his psychological condition had been incorrectly omitted from the notice of acceptance in order to be entitled to interim compensation. For the following reasons, we conclude that the answer to that question is "no."

ORS 656.262(6)(d) provides:

> "An injured worker who believes that a condition has been incorrectly omitted from a notice of acceptance, or that the notice is otherwise deficient, first must communicate in writing to the insurer or self-insured employer the worker's objections to the notice. The insurer or self-insured employer has 30 days from receipt of the communication from the worker to revise the notice or to make other written clarification in response. A worker who fails to comply with the communication requirements of this paragraph may not allege at any hearing or other proceeding on the claim a de facto denial of a condition based on information in the notice of acceptance from the insurer or self-insured employer. Notwithstanding any other provision of this chapter, the worker may initiate objection to the notice of acceptance at any time."

In construing ORS 656.262(6)(d), our task is to discern legislative intent. ORS 174.020. We begin by examining the text and context of the statute. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610 (1993). The context includes other provisions of the same statute and other related statutes. *Id.* at 611. If the legislature's intent is clear from those inquiries, further inquiry is unnecessary. *Id.*

The terms of ORS 656.262(6)(d) establish that a claimant who fails to request a revised notice of acceptance may not allege a "de facto" denial of a condition at a hearing. Here, however, claimant is not alleging a "de facto" denial, nor is he attempting to establish compensability of his psychological condition at this time. Rather, he is asserting entitlement to interim compensation. We conclude that ORS 656.262(6)(d) has no effect on claimant's entitlement to interim compensation. Consequently, we conclude that claimant did not have to first comply with ORS 656.262(6)(d) in order to be entitled to interim compensation.

In *Johansen v. SAIF*, 158 Or App at 678, the court said that, under ORS 656.262(6)(d), once a claim is accepted, a claimant can object to the notice of acceptance and seek to have any omitted conditions included. In *Mark A. Baker*, 50 Van Natta at 2336, we concluded that a condition that is incorrectly omitted from a Notice of Acceptance under ORS 656.262(6)(d) is a condition that is in existence at the time of the notice, but is not mentioned in the notice or is left out. That particular condition would be part of the initial claim, rather than a "new medical condition," for which a separate claim would be required. In an initial claim for compensation, a physician's report requesting medical services for a specified condition in addition to medical treatment being provided for the accepted condition constitutes a "claim." *Safeway Stores, Inc. v. Smith*, 117 Or App 224, 227 (1992); *Garnet D. Toll*, 50 Van Natta 1346 (1998).

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[2] This case is distinguishable from *Labor Ready, Inc. v. Mann*, 158 Or App at 670. In *Mann*, the court concluded that a telephone conversation between the claimant's attending physician and the employer's attorney did not satisfy the requirements for a "new medical condition" under ORS 656.262(7)(a) by providing written notice of the new medical condition and clearly requesting acceptance of it. The court, however, did not foreclose the possibility that a telephone conversation could constitute a claim in other circumstances. *Mann*, 158 Or App at 670 ("[e]ven assuming that the conversation constituted a claim under ORS 656.005(6)"). Here, ORS 656.262(7)(a) does not apply and we find that Dr. Nyquist's March 31, 1998 chart note referring to his telephone conversation with claimant's claim manager constitutes a "claim" under under ORS 656.005(6).

Here, Dr. Nyquist's March 16, 1998 chart note indicated claimant had an "acute stress reaction" from a work injury. (Ex. 5). Dr. Nyquist's March 31, 1998 chart note indicated that he had spoken with claimant's case manager about the acute stress reaction and the fact that claimant was off work. (Ex. 8). The substance of that chart note has not been disputed. We find that the employer's duty to begin payment of interim compensation was triggered at least by March 31, 1998, when Dr. Nyquist discussed claimant's acute stress reaction with the case manager. Earlier in the month, Dr. Nyquist had authorized temporary disability because of claimant's stress reaction. (Exs. 5, 6). Under these circumstances, we conclude that the employer was required to begin payment of interim compensation by April 14, 1998, the 14th day after March 31, 1998. Payment of interim compensation shall continue until termination is authorized by law.

ORDER

The ALJ's order dated August 24, 1998 is reversed. The self-insured employer is directed to pay claimant interim compensation for the period beginning April 14, 1998 until termination is authorized by law. Claimant's attorney is awarded an attorney fee of 25 percent of the additional compensation created by this order, not to exceed $3,800, payable out of claimant's compensation and directly to claimant's attorney.

In the Matter of the Compensation of
CHERYL A. BOONE, Claimant
WCB Case No. 98-04656
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Cavanagh & Zipse, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Menashe's order that awarded 18 percent (57.6 degrees) unscheduled permanent disability for a neck condition, whereas an Order on Reconsideration awarded 11 percent (35.2 degrees) unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured her neck on March 11, 1996. She was treated conservatively. On December 17, 1997, Dr. Levitte, treating physician, declared her medically stationary and performed a closing examination. Dr. Levitte measured reduced cervical range of motion. A January 12, 1998 Determination Order closed claimant's injury claim without a permanent disability award. Claimant requested reconsideration, but waived a medical arbiter examination.

A June 5, 1998 Order on Reconsideration awarded 11 percent unscheduled permanent disability, based on an impairment value of 5 for a chronic condition. The insurer requested a hearing, and claimant cross-requested a hearing, on the extent of disability issue.

The ALJ awarded claimant 18 percent unscheduled permanent disability, including 12 percent for lost cervical range of motion. The ALJ relied on Dr. Levitte's range of motion measurements, reasoning that the measurements were valid because the doctor did not consider the findings invalid. *See* OAR 436-035-0007(27).[1] On review, the insurer contends that the ALJ's award is not supported by verified, objective findings. The insurer relies on medical reports by its examiners, an MCO Physical Capacities Evaluation (PCE), a videotape, and Dr. Levitte's reports in support of its argument.

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[1] The rule provides, in pertinent part, that "findings of impairment which are determined to be ratable pursuant to these rules shall be rated unless the physician determines the findings are invalid and provides a written opinion, based on sound medical principles, explaining why the findings are invalid."

Disability standards adopted by the Director that are in effect at the time of claim closure are used in determining claimant's permanent disability. ORS 656.283(7); ORS 656.726(3)(f)(A). Claimant's claim was closed by Determination Order dated January 12, 1998. Therefore, her claim is properly rated under WCD Admin. Order 96-027 (eff. February 15, 1997). OAR 436-035-0003(2) and (3).

Findings concerning a worker's impairment may be considered only if they come from one of three sources: (1) the attending physician at the time of claim closure; (2) findings with which the attending physician has concurred; or (3) a medical arbiter appointed pursuant to ORS 656.268(7). ORS 656.245(2)(b)(B); ORS 656.268(7); *Koitzsch v. Liberty Northwest Insurance Corporation*, 125 Or App 666 (1994); *Tektronix, Inc. v. Watson*, 132 Or App 483 (1995). Moreover, to be consistent with ORS 656.245(2)(b)(B) and ORS 656.268(7), the "preponderance of medical evidence" standard prescribed by the disability standards to determine a worker's level of impairment is limited to the above three medical sources. *Adam J. Delfel*, 50 Van Natta 1041 (1998). Thus, consideration of an examining physician's opinion regarding a worker's impairment is not appropriate, unless that opinion has been concurred with by the worker's attending physician.

Here, the first question regarding impairment is whether claimant has established a valid loss of cervical range of motion. Dr. Levitte served as claimant's attending physician at the time of claim closure. Drs. Reimer, Stanford, and Strum examined claimant on the insurer's behalf. In addition, a PCE report was produced. However, as explained above, because none of these medical reports was concurred in by Dr. Levitte, we do not consider them in deciding claimant's impairment.

Dr. Levitte's report, however, is another matter. The ALJ relied on the medical opinions of Levitte in concluding that claimant established valid range of motion impairment. The ALJ stated that Levitte "did not consider the findings invalid." The insurer contends that the ALJ misread Levitte's medical opinions. Although Levitte's medical opinions can arguably be read to support the validity of Levitte's findings, we agree with the insurer that the range of motion findings are invalid, and that claimant has failed to establish an award of permanent disability.

In his December 17, 1997 closing examination report, Levitte stated after reporting range of motion findings: "*Subjective limitations of motion due to pain* that may be permanent without objective evidence of fracture, dislocation, herniation or other orthopedic condition [sic] *Only her continued subjective symptoms support a claim for any permanent impairment resulting from her injury on 3/11/96.*" (Ex. 32). (Emphasis added.)

In a March 3, 1998 letter responding to claimant's lawyer, Levitt stated: "In my opinion *[claimant's] pain is the result of the injury* on March 11, 1996. *She has a strain and related pain syndrome.*" (Emphasis added.) He also agreed that she has a chronic condition, that she could work in "at least a Sedentary capacity," and "*her limitation of motion of cervical extension was in part due to her caution to limit this motion to avoid aggravation of her discomfort and was not consistent enough to permit an accurate measure of limitation.*" (Ex. 39). (Emphasis added.)

Finally, in a May 6, 1998 letter to the Director, Levitte stated:

> "In answer to your questions *there was some variability in the range of motion measurements* on the 12/17/97 exam. *I do not consider them invalid but I cannot say that they establish a valid measure of what she could do if she did not limit her effort in order to avoid exacerbating her condition.*
>
> "Her pain syndrome started after her injury of 3/11/96 and I did not find any evidence of any unrelated causes.
>
> "*Although she reports that she needs to limit her activities, it was not possible for me to establish a percentage of impairment based on the exam and test results.*" (Ex. 41). (Emphasis added.)

Claimant bears the burden of establishing the extent of her disability. ORS 656.266. We agree with the insurer's argument that, given Dr. Levitte's varied comments regarding claimant's range of motion measurements, a preponderance of the evidence does not support a finding that claimant has valid losses of ranges of motion. In this regard, we have previously held that the validity of range of motion testing must be determined by the medical examiner performing the tests. *Harvey Clark*, 47 Van Natta 136 (1995); *Michael D. Walker*, 46 Van Natta 1914 (1994).

Here, although Dr. Levitte stated that he did not consider claimant's variable range of motion measurements invalid, he also expressly stated that they did not establish a valid measure of what claimant could do if she had not self-limited her efforts during her exam. He also conceded that he was unable to establish a percentage of impairment based on the exam and test results. Therefore, those findings are not sufficient to establish permanent disability. *See Teri S. Callahan*, 49 Van Natta 548 (1998) (where the attending physician noted that the range of motion data did not contribute significant information about the claimant's level of disability, the Board found that the claimant failed to prove impairment); *Harvey Clark*, 47 Van Natta 136 (1995) (where the medical arbiter found the claimant's range of motion findings invalid, the claimant failed to prove impairment); *Benjamin G. Santos*, 46 Van Natta 1912 (1994) (where the medical arbiter found the claimant's lumbar flexion measurement invalid based on the SLR validity test, the measurement was excluded from calculation of the claimant's impairment).

Inasmuch as we find that the attending physician questioned the validity of claimant's range of motion measurements because she limited her efforts during examination, we conclude that the record presents no valid range of motion measurements upon which to rate impairment.

Finally, ORS 656.726(3)(f)(B) provides that "[i]mpairment is established by a preponderance of medical evidence based upon objective findings." Dr. Levitte stated: "Only [claimant's] continued subjective symptoms support a claim for any permanent impairment resulting from her injury on 3/11/96." Levitte also stated that, although claimant reported that she needed to limit her activities, he was unable to establish impairment based on his examination and test results. Therefore, we agree with the insurer that there are no "objective findings" documented in Dr. Levitte's reports to support a chronic condition award based on Levitte's unexplained response to the "chronic condition" inquiry by claimant's attorney.

Accordingly, we conclude that claimant has not established entitlement to permanent disability compensation for injury-related impairment. *See Lorenza Melendez*, 49 Van Natta 1057 (1997).

Inasmuch as there is no evidence of permanent impairment in the record, we reverse the ALJ's and Order on Reconsideration's awards of permanent disability.

ORDER

The ALJ's order dated September 29, 1998 is reversed. The ALJ's and the Order on Reconsideration's awards of unscheduled permanent disability for claimant's neck condition are reduced to zero. The ALJ's attorney fee award is reversed.

In the Matter of the Compensation of
YOLANDA J. GILL, Claimant
WCB Case No. 98-06579
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Michael Johnson's order that affirmed an Order on Reconsideration that awarded 6 percent (19.2 degrees) unscheduled permanent disability for claimant's low back condition. On review, the issue is extent of unscheduled permanent disability.

We adopt[1] and affirm the ALJ's order, with the following supplementation.

Evaluation of a worker's disability is as of the date of issuance of the reconsideration order. ORS 656.283(7). Where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. *Orfan A. Babury*, 48 Van Natta 1687 (1996). This "preponderance of the evidence" must come from the findings of the attending physician or other physicians with whom the attending physician concurs. *See Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670 (1994). We have previously held that we do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment but, rather, rely on the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

Here, we find that the medical arbiter's report is the most thorough, complete, and well-reasoned evaluation of claimant's injury-related impairment.[2] In reaching this conclusion, we note that the arbiter explained, in detail, why he believes that claimant's range of motion findings are valid. (Ex. 68-4-6).

Finally, the first sentence of the last paragraph on page 5 is supplemented to read: "Dr. Donahoo reported decreases in lumbar ranges of motion which generate impairment values of 2 percent arising from flexion losses, 2 percent arising from extension losses, and 2.2 percent arising *from lost right lateral flexion*, per the disability rating standards."

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $750, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 13, 1999 is affirmed. For services on review, claimant is awarded a $750 attorney fee, payable by the insurer.

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[1] We do not adopt the second full paragraph on page 5.

[2] We do not find that Dr. Norris, treating physician, concurred with an examining physician's report, or that Dr. Norris' opinion indicates that claimant has no injury-related lost lumbar range of motion. (*See* Exs. 42, 43).

In the Matter of the Compensation of
PATTI HALL, Claimant
WCB Case No. 98-04488
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Moscato & Hallock, Defense Attorneys

Reviewed by the Board *en banc.*

Claimant requests review of Administrative Law Judge (ALJ) Black's order that: (1) determined that her request for reconsideration of a Notice of Closure was untimely; and (2) set aside the Order on Reconsideration that had rescinded the Notice of Closure as premature. The self-insured employer moves to strike claimant's reply brief as untimely. On review, the issues are motion to strike and jurisdiction.[1]

We grant the motion to strike and adopt and affirm the ALJ's order with the following supplementation.

The employer accepted a left shoulder bicipital tendinitis condition after claimant experienced left shoulder discomfort in September 1996. The employer issued a Notice of Closure on November 28, 1997. The closure notice was mailed to claimant's Springfield, Oregon address. Although the employer had notice that claimant was represented by counsel, a copy of the closure notice was not mailed to claimant's attorney. Claim closure did not come to claimant's attorney's attention until March 1998, at which time a request for reconsideration was filed on March 10, 1998.[2]

By a March 20, 1998 letter to claimant's attorney and the employer, the Department notified the parties that it considered the request for reconsideration to have been timely made. (Ex. 16). In reaching this conclusion, the Department reasoned that the 60-day appeal period did not begin until it faxed a copy of the Notice of Closure to claimant's counsel on March 18, 1998.

On May 7, 1998, the Order on Reconsideration issued. It rescinded the November 28, 1997 Notice of Closure on the ground that the claim had been prematurely closed. (Ex. 17-2). The employer requested a hearing, contesting the Department's ruling that the request for reconsideration was timely.

The ALJ determined that claimant's reconsideration request was untimely. In making this determination, the ALJ observed that ORS 656.268(4)(e) required that a reconsideration request be made within 60 days of the Notice of Closure. Because ORS 656.268(4)(b)[3] only required that the Notice of Closure be issued to the worker and the Department, and because there was no indication that claimant did not receive the closure notice, the ALJ reasoned that claimant's failure to request reconsideration within 60 days of the Notice of Closure meant that the Department had no jurisdiction to issue the May 7, 1998 Order on Reconsideration. Accordingly, the ALJ set aside the reconsideration order and reinstated the November 28, 1997 Notice of Closure.

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[1] The Department has participated in these proceedings pursuant to ORS 656.726(3)(h).

[2] ORS 656.268(4)(e) requires that a request for reconsideration be made within 60 days of a Notice of Closure.

[3] ORS 656.268(4)(b) provides:

"Findings by the insurer or self-insured employer regarding the extent of the worker's disability in closure of the claim shall be pursuant to the standards prescribed by the Department of Consumer and Business Services. The insurer or self-insured employer shall issue a notice of closure of such a claim *to the worker and to the Department of Consumer and Business Services*. The notice shall inform the parties, in boldfaced type, of the proper manner in which to proceed if they are dissatisfied with the terms of the notice. The notice must inform the worker of the amount of any further compensation, including permanent disability compensation to be awarded; of the amount and duration of temporary total or temporary partial disability compensation; of the right of the worker to request reconsideration by the Department of Consumer and Business Services under this section within 60 days of the date of the notice of claim closure; of the aggravation rights; and of such other information as the Director of the Department of Consumer and Business Services may require." (emphasis supplied)

On review, claimant contends that there is no evidence that she, in fact, received the Notice of Closure. Moreover, claimant contends that the employer's failure to provide a copy of the Notice of Closure to her attorney invalidated the closure notice. *See Ronald D. Fuller*, 50 Van Natta 1023, *on recon* 50 Van Natta 1483 (1998), *aff'd mem SAIF v. Fuller*, 159 Or App 426 (1999). Before addressing claimant's substantive argument, we first address the employer's motion to strike claimant's reply brief.

Motion to Strike

The employer filed its respondent's brief on November 23, 1998. Claimant then had 14 days in which to file her reply brief (*i.e.*, no later than December 7, 1998). *See* OAR 438-011-0020(2). Claimant did not submit her reply brief until December 14, 1998. Accordingly, the reply brief was untimely filed. Because claimant provided no explanation for the untimely submission, we grant the employer's motion to strike. Claimant's reply brief has not been considered on review.

Procedural Validity of the Notice of Closure

In support of her argument that the Notice of Closure was invalid, claimant cites ORS 656.331(1)(b). That statute provides that, when an injured worker is represented by an attorney, the carrier shall not contact the worker without prior or simultaneous written notice to the attorney, if the contact affects the denial, reduction or termination of benefits. Subsection (2) of ORS 656.331 also authorizes the Director to adopt rules necessary to carry out the above provisions.

Even assuming that the Notice of Closure terminated benefits for the purposes of ORS 656.331(1)(b),[4] and that the employer violated the statute by failing to notify claimant's attorney that the claim was being closed (*i.e.* by providing a copy of the Notice of Closure), the statute does not provide for invalidation of a Notice of Closure. Instead, the consequence for violation of the statute is provided in OAR 436-060-0015(2), which provides for a civil penalty for violations of ORS 656.331. *See Linda D. Santacruz*, 44 Van Natta 803 (1992) (job offer under ORS 656.268(3)(c) not invalidated by the failure to give notice to claimant's attorney; however, carrier may be liable for a civil penalty assessed by the Director for an intentional or repeated failure to give the proper notice to claimant's attorney). Accordingly, we do not find claimant's argument based on ORS 656.331(1)(b) persuasive. We next address the applicability of our decision in *Fuller*.

There, we held that a Determination Order that redetermined the claimant's permanent total disability (PTD) under ORS 656.206(5) was procedurally invalid because the carrier had neglected to mail a copy of the results of the claimant's reexamination to claimant and his attorney prior to issuance of the Determination Order. Relying on *former* OAR 436-30-065(2), we concluded that the carrier was required to notify the claimant and his attorney of the results of a reexamination that it was submitting to the Department for redetermination of the claimant's PTD under ORS 656.206(5). Because the carrier had failed to provide such notification to the claimant and his attorney, we held that the Determination Order's redetermination of the claimant's PTD was invalid.

In reaching this conclusion, we disagreed with the carrier's contention that the Director exceeded his authority to promulgate the aforementioned rule. Relying on ORS 656.726(3)(g), we reasoned that the Director was authorized to prescribe procedural rules regarding hearings, investigations, and other proceedings regarding all matters other than those specifically allocated to the Board or its Hearings Division.

Here, OAR 436-030-0015(1)(a) provides that, when an insurer elects to issue a Notice of Closure, the insurer must provide a copy of the closure notice to the Department and "parties" pursuant to OAR 436-030-0020.[5] The ALJ did not interpret the rule as requiring that a copy of the closure notice be sent

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[4] A Notice of Closure does not generally deny, reduce or terminate benefits. Rather, it documents the termination of temporary disability that was previously discontinued pursuant to ORS 656.268. It also *increases* or *awards* benefits if permanent or additional temporary disability is awarded. Although we need not, and do not resolve, the issue of whether ORS 656.331(1)(b) applies to a Notice of Closure, we acknowledge serious questions in this regard.

[5] References to administrative rules are to those contained in Administrative Order 96-052, effective February 17, 1996. Those rules were in effect at the time of claim closure on November 28, 1997. *See* OAR 436-030-0003(3).

to claimant's attorney because an attorney is not generally a party in workers' compensation proceedings. *See Haskell Corporation v. Filippi*, 152 Or App 117, 120 (1998) and *Berliner v. Weyerhaeuser Company*, 92 Or App 264, 266, n. 1 (1988).

While we agree that claimant's attorney is not a "party," such a conclusion does not end our inquiry. Subsection (9) of OAR 436-030-0020 states that the original and three color coded copies of the Notice of Closure "shall" be mailed to the worker, the employer, the Department and "the worker's attorney, if represented." Therefore, the relevant administrative rules do provide for a Notice of Closure to be mailed to claimant's attorney.

However, we find that the requirements for claim closure in the preceding subsections of OAR 436-030-0020 had been satisfied. Claimant does not contend that the closure notice failed to contain the information required in subsection (8) of OAR 436-030-0020. Thus, we conclude that the Notice of Closure was substantively valid. We must, therefore, determine whether an otherwise valid Notice of Closure is invalidated by the carrier's failure to mail a copy of the closure notice to claimant's attorney. We answer that question in the negative.

Clearly, the employer in this case failed to comply with the requirement that notice be given to claimant's attorney. Nevertheless, the notice requirement does not affect the validity of the closure notice itself. In other words, the notice requirement is contained in subsection (9) of OAR 436-030-0020, which is separate from those subsections that concern the conditions under which a claim may be closed (subsections 1-4) and the content of the Notice of Closure (subsection 8).[6] In light of this, we conclude that compliance with the administrative rule's notice requirements is not essential to the validity of the closure notice, provided that the Notice of Closure is mailed to the worker and the Department as required by ORS 656.268(4)(b). By contrast, in *Fuller*, the notice to the claimant and his attorney were required elements of a valid request for redetermination of permanent total disability. *See former* OAR 436-30-065(2).[7] Because the carrier in *Fuller* failed to provide the required notice, the redetermination request was invalid, *i.e.*, no "request" for redetermination had been filed. Because the Determination Order in *Fuller* was based on an invalid redetermination request, it followed that the Determination Order was necessarily invalid.

Because we find this case distinguishable from *Fuller*, we conclude that the employer's failure to comply with the notice requirements of OAR 436-030-0020(9) did not invalidate the Notice of Closure.[8] In reaching this conclusion, we note that OAR 436-030-0020(11) provides that an insurer who intentionally or repeatedly fails to provide the worker's attorney with a copy of the Notice of Closure may be assessed a civil penalty pursuant to OAR 436-030-0580. We agree with the ALJ that this is the consequence when a carrier complies with its statutory duty to issue a Notice of Closure to claimant and the Department, but fails to provide a copy of the Notice of Closure to claimant's counsel. *See Linda D. Santacruz*, 44 Van Natta at 803.

In conclusion, we find that the employer's Notice of Closure was procedurally valid. Therefore, we affirm.

ORDER

The ALJ's order dated September 21, 1998 is affirmed.

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[6] As noted in subsection (8) of OAR 436-030-0020, the vital elements of a Notice of Closure are the appropriate dollar amount of any permanent disability, the body part awarded disability, the duration of temporary disability, the medically stationary date, the worker's aggravation rights, the worker's appeal rights, notice of the right to consult an ombudsman, and the worker's return to work status. Notice to a worker's attorney is not one these required elements of a valid Notice of Closure.

[7] That rule provided that, when requesting the Department to reduce permanent total disability, the carrier must "notify the worker, and the worker's attorney, if represented[.]"

[8] We also reject claimant's contention that she never received the Notice of Closure. There is no indication in this record that claimant did not receive the Notice of Closure. Because the matter was decided on the documentary record, claimant did not testify to the contrary. Moreover, the Notice of Closure was mailed to the same address that was shown on the request for reconsideration filed by claimant's attorney on March 10, 1998. (Exs.13,14).

Board Member Biehl dissenting.

Distinguishing *Ronald D. Fuller*, 50 Van Natta 1023, *on recon* 50 Van Natta 1483 (1998), *aff'd mem SAIF v. Fuller*, 159 Or App 426 (1999), the majority holds that the employer's failure to comply with the notice requirements of OAR 436-030-0020(9) did not invalidate the Notice of Closure. Because I would find *Fuller* controlling, and that the employer's failure to comply with that rule's mandatory notice requirements requires invalidation of the closure notice, I respectfully dissent.

As the majority correctly observes, in *Fuller*, we held that a Determination Order that redetermined the claimant's permanent total disability (PTD) under ORS 656.206(5) was procedurally invalid because the carrier had neglected to mail a copy of the results of the claimant's reexamination to the claimant and his attorney prior to issuance of the Determination Order. Relying on *former* OAR 436-30-065(2), we concluded that the carrier was required to notify the claimant and his attorney of the results of a reexamination that it was submitting to the Department for redetermination of the claimant's PTD under ORS 656.206(5). Because the carrier had failed to provide such notification to the claimant and his attorney, we held that the Determination Order's redetermination of the claimant's PTD was invalid.

Here, OAR 436-030-0015(1)(a) provides that, when an insurer elects to issue a Notice of Closure, the insurer must provide a copy of the closure notice to the Department and "parties" pursuant to OAR 436-030-0020. Subsection 9 of OAR 436-030-0020 states that the original and three color coded copies of the Notice of Closure "shall" be mailed to the worker, the employer, the Department and "the worker's attorney, if represented." Therefore, the relevant administrative rules do require that a Notice of Closure be mailed to claimant's attorney. Like the carrier in *Fuller*, the employer in this case failed to comply with an administrative rule that required that notice be given to claimant's attorney. Thus, in accordance with the *Fuller* rationale, I would conclude that the employer's failure to comply with the notice requirements of OAR 436-030-0020(9) invalidates the Notice of Closure.[1]

I recognize that OAR 436-030-0020(11) provides that an insurer who intentionally or repeatedly fails to provide the worker's attorney with a copy of the Notice of Closure may be assessed a civil penalty pursuant to OAR 436-030-0580. The ALJ reasoned that this was an injured worker's only remedy when a carrier fails to provide a Notice of Closure to counsel. This rule, however, does not preclude invalidation of a Notice of Closure in addition to a civil penalty. Moreover, the record does not establish that the employer intentionally or repeatedly failed to provide a copy of the closure notice to claimant's attorney. Thus, I would find that this rule would not preclude invalidation of the Notice of Closure.

In conclusion, I would hold that the employer's Notice of Closure is procedurally invalid. Therefore, I would reverse the ALJ's reinstatement of the closure notice. Because the majority concludes otherwise, I respectfully dissent.

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[1] The majority distinguishes *Fuller* by finding that the notice requirements of subsection (9) of OAR 436-030-0020 are not essential to the validity of the Notice of Closure. I am not persuaded. Subsection (9) clearly states that the original and three color-coded copies of the Notice of Closure "shall" be mailed to the worker, the employer, the Department and "the worker's attorney, if represented." Just as the carrier in *Fuller* failed to comply with mandatory notice requirements, so, too, did the employer in this case. The fact that the notice requirement is in a separate subsection of the administrative rule does not change the mandatory nature ("shall") of the notice requirements.

In the Matter of the Compensation of
MARVIN E. LEWIS, Claimant
WCB Case Nos. 97-05360, 97-05050 & 97-00071
ORDER ON REVIEW
Crane & Love, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by the Board *en banc*.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) set aside the Director's orders suspending compensation under ORS 656.262(15); (2) set aside its "noncooperation" denials issued under ORS 656.262(15); and (3) awarded an assessed attorney fee. In addition, the insurer argues that the ALJ should have granted its motion to dismiss claimant's hearing request. On review, the issues are jurisdiction, propriety of the suspension orders, propriety of the denials, and attorney fees. We deny the motion to dismiss and reverse.

FINDINGS OF FACT

Since February 1988, claimant has worked as a truck driver for the same employer, although that employer has undergone a series of name changes. Claimant has sustained multiple compensable injuries. Only the October 21, 1992, and August 27, 1996 low back injury claims are potentially involved in the current claims. During the relevant period, the employer was insured by Cigna Companies (Cigna), although Cigna at times operated through one of its subsidiaries.[1] (Exs. 63aaa, 68aa, 104).

On November 25, 1992, the insurer accepted claimant's October 21, 1992 injury as a cervical/lumbosacral strain. (Exs. 63, 63aaa). That claim was closed by a January 25, 1993 Determination Order. (Ex. 63B).

On October 22, 1996, the insurer accepted claimant's August 27, 1996 injury claim as a disabling sacroiliac sprain/strain. (Exs. 93, 104). Prior to that acceptance, on October 1, 1996, claimant underwent an insurer-arranged medical examination (IME) regarding the August 27, 1996 injury. (Ex. 102).

On December 9, 1996, claimant underwent a second IME regarding the August 27, 1996 injury. (Ex. 109). Drs. Wilson, neurologist, and Strum, orthopedist, performed that IME and opined that the multilevel degenerative disc disease revealed on an October 1996 MRI was preexisting and unrelated to the August 27, 1996 work injury. (Ex. 109-6-8).

On December 13, 1996, the insurer issued a partial denial of claimant's multilevel degenerative disc disease as preexisting and unrelated to the August 27, 1996 work injury. (Ex. 110). That partial denial also stated that the accepted claim for "sacroiliac sprain/strain" remained accepted and the insurer would continue to process that claim. (*Id.*). Claimant requested a hearing on that partial denial. (WCB Case No. 97-00071).

On February 12, 1997, claimant filed a new claim for an occupational disease for the degenerative disc disease condition in his low back. (Ex. 114). On February 18, 1997, Dr. Campbell, claimant's treating physician, submitted a Notice of Aggravation relating to the October 21, 1992 low back injury claim. (Exs. 115, 116).

On March 6, 1997, the insurer submitted a 1502 form deferring action on the aggravation claim filed regarding the October 22, 1992 low back injury claim. (Ex. 117a).

On March 19, 1997, claimant modified his February 12, 1997 occupational disease claim to include a claim that claimant's low back condition was caused by his 20 year truck driving career. (Ex. 118).

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[1] Hereinafter, both "Cigna" and its subsidiaries will be referred to as "the insurer."

On April 3, 1997, the insurer notified claimant to attend an April 28, 1997 IME. (Ex. 119). Irregularities in the initial notice of the April 28, 1997 examination were addressed in subsequent notices mailed April 15 and April 17, 1997. (Exs. 124, 127). Ultimately, claimant was informed that the IME would be performed by Drs. Gambee, orthopedist, and Gardner, neurologist, for the purpose of obtaining those doctors' opinions regarding the aggravation and occupational disease claims. (*Id.*).

On April 7, 1997, claimant's former attorney informed the insurer's attorney that claimant would not attend a "post-denial Independent Medical Examination [IME] unless ordered to do so by a Judge." (Ex. 120). In subsequent correspondence in April 1997, claimant's attorney notified the insurer's attorney that claimant was not available to be examined on April 28, 1997, and claimed that the insurer was not entitled to additional examinations. (Exs. 129a, 130). Claimant did not attend the April 28, 1997 IME. (Ex. 131).

On May 1, 1997, the insurer notified claimant to attend a rescheduled IME on May 15, 1997. (Ex. 133). Claimant was informed that the IME would be performed by Drs. Lohman, orthopedist, and Gardner, neurologist, for the purpose of obtaining those doctors' opinions regarding the aggravation claim filed on February 18, 1997. (*Id.*).

On May 5, 1997, claimant's attorney informed the insurer's attorney that claimant would not be attending the May 15, 1997 IME, contending that the insurer was not entitled to further examinations. (Ex. 135). Claimant did not attend the May 15, 1997 IME. (Exs. 135, 152-2).

In the meantime, on April 9, 1997, the insurer's attorney wrote to claimant's attorney requesting a deposition of claimant. (Ex. 122). Claimant's attorney initially responded that she would not make claimant available. (Ex. 123). She later stated, however, that she would make claimant available for the "post-denial" deposition if, among other things, the insurer's attorney agreed in writing to limit his question to "responsibility/aggravation issues only." (Ex. 126). The insurer's attorney refused to agree to that limitation. (Ex. 129A-2).

The deposition, which was attended by claimant, claimant's attorney, and the insurer's attorney, began on April 30, 1997. (Ex. 132). Claimant's attorney attempted to limit the deposition to one hour, but the insurer's attorney did not agree to that limitation. (Ex. 132-10, -12, -38). At one point in the deposition, the insurer's attorney asked claimant why he did not attend the scheduled April 28, 1997 IME. (Ex. 132-33). Claimant's attorney instructed claimant not to answer that question. (Ex. 132-33-34). Claimant's attorney stated the basis for the objection was that the question was "not relevant to [the] investigation as to any kind of occupational disease claim" and again instructed claimant not to answer the question. (Ex. 132-34). Based on his attorney's instruction, claimant did not answer that question. (Ex. 132-34-35).

Later in the deposition, the insurer's attorney returned to the question of why claimant failed to attend the April 28, 1997 IME. At that point, claimant's attorney ended the deposition, stating that the deposition could resume after a judge's ruling was obtained as to whether claimant was required to answer that question. (Ex. 132-38). She also stated that, under "OAR 430.360.140, asking a client as to why he did not show up to an IME is not considered under [sic] a reasonable investigation under the rules." (Ex. 132-39). When claimant and his attorney left the deposition, the insurer's attorney had not completed his questioning. (Ex. 132-38-40).

On May 2, 1997, the insurer's attorney filed a request with the Department for suspension of benefits alleging that claimant failed to cooperate with the insurer's scheduled IME and with a deposition. (Ex. 134). This sanction request involved claimant's actions regarding the two new claims that he had filed: (1) the February 12, 1997 occupational disease claim, as modified on March 19, 1997; and (2) the February 18, 1997 aggravation claim regarding claimant's October 21, 1992 low back injury claim.

As of May 2, 1997, the 90-day period for acceptance or denial of claimant's new aggravation and occupational disease claims had not yet run and those claims had neither been accepted nor denied. At that time, the only denial issued was the December 13, 1996 partial denial that denied claimant's multilevel degenerative disc disease as preexisting and unrelated to the accepted August 27, 1996 injury claim. (Exs. 104, 110). At claimant's request, the hearing on that partial denial was deferred when he made the aggravation and occupational disease claims. (Ex. 113).

On May 20, 1997, the Department issued two separate notices, one relating to the aggravation claim and one relating to the occupational disease claim. (Exs. 138, 139). These notices notified claimant that the Department had received a request to suspend compensation as a result of claimant's alleged failure to cooperate in the investigation of his claims and notified claimant that benefits would be suspended in five days unless he contacted the Compliance Section to document the reasonableness of his alleged failure to cooperate or notified the insurer that he was willing to cooperate and the insurer in turn notified the Compliance Section. The notices also informed claimant that the insurer's obligation to accept or deny the claims within 90 days was suspended effective May 2, 1997, the date of the insurer's request to the Department. Finally, the notices advised claimant that if he did not cooperate for an additional 30 days after the notices, the insurer may deny the claim due to his failure to cooperate.

On June 6, 1997, the Department issued two separate "Order[s] Suspending Compensation Pursuant to ORS 656.262(15)," one relating to the aggravation claim and one relating to the occupational disease claim. (Exs. 154, 155). Both orders rejected claimant's attorney's position that claimant did not fail to cooperate and suspended payment of claimant's compensation effective May 28, 1997. The grounds for this decision were the same in each order: (1) filing of the new claims (the aggravation and occupational disease claims) entitled the insurer to three insurer-arranged medical examinations on each claim under OAR 436-060-0095; (2) the insurer was entitled to a deposition and a medical examination under OAR 436-060-0135; and (3) by failing to cooperate with the deposition and refusing to attend and cooperate with the medical examination, claimant was in violation of the provisions of ORS 656.262(14), ORS 656.262(15), and OAR 436-060-0135. (Exs. 154, 155).

The June 6, 1997 suspension orders also advised that, if claimant did not cooperate for an additional 30 days after the Department's May 20, 1997 notices, the insurer could deny the claims because of the worker's failure to cooperate. (Exs. 154-3, 155-3). The orders advised claimant of the consequences of such a denial. (*Id.*). The orders also notified claimant that unless he appealed the orders to the Hearings Division within 60 days, the orders would become final. (*Id.*).

On June 18, 1997, claimant requested an expedited hearing on both suspension orders. (Ex. 157a). That request was denied and claimant's appeals of the suspension orders were consolidated with the previously scheduled hearing regarding the partial denial. (Exs. 159aaaaaaaa, 159aaaaaaaaaaaaa; February 12, 1998 hearing transcript, pages 2-4).

On June 18, 1997, the Director issued a Proposed and Final Order assessing a civil penalty of $250 against claimant's attorney. (Ex. 157). Claimant's attorney requested a contested case hearing. On December 30, 1997, a contested case order reversed the civil penalty. (Ex. 170). The insurer appealed that order to the court, where the court eventually granted a motion to dismiss on October 29, 1998.

During the 30-day period after the Department issued its May 20, 1997 notice under ORS 656.262(15), the insurer did not contact claimant regarding any information gathering technique.

On June 20, 1997, the insurer issued two denials based on claimant's alleged "failure to cooperate," one denial related to the aggravation claim and the other related to the occupational disease claim. (Exs. 158, 159). The grounds for both denials were the same: (1) claimant's failure to attend scheduled IMEs; and (2) his failure to cooperate at the deposition. On June 30, 1997, claimant requested a hearing regarding these "noncooperation" denials.

Following a September 18, 1997 hearing, the ALJ issued a November 13, 1997 interim order, holding that the Department had jurisdiction to issue the June 6, 1997 suspension orders. On November 24, 1997, claimant's attorney notified the insurer's attorney that claimant was willing to attend IMEs and participate in the investigation deposition. (Ex. 169). Thereafter, claimant retained other counsel.

Following a reconvened hearing on February 12, 1998, the ALJ set aside the suspension orders and the "noncooperation" denials and awarded an assessed attorney fee. The insurer requested Board review.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

As a preliminary matter,[2] we address the jurisdiction issue. At hearing, the insurer moved for dismissal, arguing that claimant did not timely request an expedited hearing regarding the two "noncooperation" denials. (Exs. 158, 159). The ALJ did not rule on the insurer's motion to dismiss. On review, the insurer renews its jurisdiction argument.

The insurer contends that ORS 656.262(15) requires that claimant explicitly request an expedited hearing under ORS 656.291 if he objects to a "noncooperation" denial. In making this assertion, the insurer relies on language in ORS 656.262(15) that, following a carrier's denial for failure to cooperate, "the worker shall not be granted a hearing or other proceeding under this chapter on the merits of the claim unless the worker first requests and establishes at an expedited hearing under ORS 656.291" certain findings. The insurer contends that, because claimant did not explicitly request an expedited hearing regarding the June 20, 1997 "noncooperation" denials until January 5, 1998,[3] more than 199 days after the denials were issued, the request for hearing was untimely and neither the Hearings Division nor the Board have jurisdiction over the matter.

We rejected a similar argument in *Jodie M. Dubose*, 50 Van Natta 1631, *on recon*, 50 Van Natta 1822 (1998). We concluded that, in challenging a "noncooperation" denial, the worker must first request a hearing from that denial before the merits of the claim can be addressed. Following that request, if appropriate, it is the *Board's* duty to assign the case to the Expedited Claims Services under ORS 656.291. 50 Van Natta at 1634. In other words, a worker is not *required* to specifically request an *expedited* hearing on a "noncooperation" denial, the worker is only required to timely request a hearing on such a denial.

Here, claimant had 60 days from the June 20, 1997 mailing date of the noncooperation denials within which to request a hearing. ORS 656.319(1)(a) and (b). On June 30, 1997, claimant filed two separate hearing requests regarding the June 20, 1997 denials. (Exs. 159aaaaaa, 159aaaaaaa). Thus, claimant's hearing requests were timely. Therefore, we find them sufficient under ORS 656.262(15).

Director's Orders Suspending Compensation Under ORS 656.262(15)

The ALJ set aside the Department's suspension orders. First, regarding claimant's alleged failure to cooperate with the deposition as a ground for the suspension orders, the ALJ found that claimant fully cooperated in the deposition or, if he did not, it was for reasons beyond his control.

Second, the ALJ found that ORS 656.325(1) governs suspension of benefits for failure to attend an IME and does not permit the carrier to deny the claim for failure to cooperate. Furthermore, because claimant's former attorney notified the insurer's attorney on November 24, 1997 that claimant would be willing to attend an IME and there was no evidence that the insurer had thereafter rescheduled such an examination, the ALJ rejected that basis for the suspension orders as well. For the following reasons, we disagree and uphold the suspension orders.

First, we note that both suspension orders were made on two grounds. If either ground is valid, then the suspension orders may be upheld on that ground alone, notwithstanding the validity of the other ground. Because we uphold the suspension orders based on claimant's failure to attend the IMEs, we need not address whether they should also be upheld on a second basis, *i.e.*, claimant's failure to cooperate at the deposition.

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[2] Another preliminary matter is the insurer's assertion that Exhibits 1 through 62 should also be part of the record. Although Exhibits 1 through 62 were not individually listed as admitted into the record, the ALJ stated that his November 13, 1997 Interim Order was incorporated by reference into his May 12, 1998 Opinion and Order. The interim order references claimant's medical history as reflected by Exhibits 1 through 62. Furthermore, claimant did not object to the insurer's assertion that Exhibits 1 through 62 should be included in the record. Accordingly, given the ALJ's comments about incorporation of his interim order, we find that Exhibits 1 through 62 are also admitted into the record.

[3] While the insurer acknowledges that, on June 18, 1997, claimant requested an expedited hearing regarding the Director's suspension orders, it contends that that expedited hearing request did not relate to the "noncooperation" denials, which were not issued until June 20, 1997. Because of our finding, as explained *infra*, that claimant's June 30, 1997 requests for hearing from the "noncooperation" denials are sufficient under ORS 656.262(15), we need not address the effect, if any, claimant's June 18, 1997 expedited hearing request regarding the Director's suspension orders might have on the jurisdiction issue.

We first examine the ground that claimant failed to cooperate with the scheduled IME's. We disagree with the ALJ's finding and claimant's argument that ORS 656.325(1)(a) rather than ORS 656.262(15) applies under the circumstances of this case, *i.e.*, where a worker refuses to submit to an IME involving an initial claim to establish a compensable injury.

Our task in interpreting a statute is to discern the intent of the legislature. *PGE v. Bureau of Labor and Industries*, 317 Or 606 (1993). At the first level of analysis, we examine both the text and context of the statute. *Id.* at 610. If the legislative intent is not clear from that inquiry, we then examine the legislative history or other extrinsic aids. *Id.* at 611-12.

Three separate statutes deal with a worker's duty to cooperate with a carrier's investigation of a claim: ORS 656.325(1)(a), 656.262(14) and (15). Thus, the context of ORS 656.325(1)(a) includes both ORS 656.262(14) and (15). In addition, where there are several provisions or particulars such construction is, if possible, to be adopted as will give effect to all. ORS 174.010.

ORS 656.325(1)(a) provides, in relevant part:

> "Any worker entitled to receive compensation under this chapter is required, if requested by * * * the insurer * * *, to submit to a medical examination at a time reasonably convenient for the worker as may be provided by the rules of the director. * * * If the worker refuses to submit to any such examination, or obstructs the same, the rights of the worker to compensation shall be suspended with the consent of the director until the examination has taken place, and no compensation shall be payable during or for account of such period. * * * *"

ORS 656.262(14) provides, in relevant part:

> "Injured workers have the duty to cooperate and assist the insurer * * * in the investigation of claims for compensation. Injured workers shall submit to and shall fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques. Injured workers who are represented by an attorney shall have the right to have the attorney present during any personal or telephonic interview or deposition. * * * *"

ORS 656.262(15) provides, in relevant part:

> "If the director finds that a worker fails to reasonably cooperate with an investigation involving an initial claim to establish a compensable injury or an aggravation claim to reopen the claim for a worsened condition, the director shall suspend all or part of the payment of compensation after notice to the worker. If the worker does not cooperate for an additional 30 days after the notice, the insurer * * * may deny the claim because of the worker's failure to cooperate. * * * *"

Claimant points out that, whereas ORS 656.325(1)(a) explicitly references IMEs, neither ORS 656.262(14) nor (15) make any such reference. In addition, claimant notes, ORS 656.262(14) specifically addresses only interviews, whether by telephone, in person, or by deposition. Nevertheless, ORS 656.262(14) also assigns a very broad duty to injured workers "to cooperate and assist the insurer * * * in the investigation of claims for compensation." Furthermore, the phrase "other formal or informal information gathering techniques" is not defined in ORS 656.262(14) or elsewhere in the statutes. An IME could certainly be considered a "formal * * * information gathering technique."

Moreover, in examining the context of the statutes, we note that the remedy provided in ORS 656.262(15) for a worker's failure "to reasonably cooperate with an investigation involving an initial claim to establish a compensable injury or an aggravation claim to reopen the claim for a worsened condition" (*i.e.*, suspension of compensation and possibility of denial of the claim) is not mutually exclusive with the remedy provided in ORS 656.325(1)(a) for failure to attend or obstructing an IME (*i.e.*, suspension of compensation). As indicated, ORS 656.262(15) specifically applies to *initial* claims that involve compensability or the reopening of an aggravation claim, whereas ORS 656.325(1)(a) contains no such restriction. In other words, ORS 656.325(1)(a) could apply to any failure to attend an IME at any time. In this regard, IMEs are not requested solely regarding issues of initial compensability, they also may be requested regarding other issues, such as the propriety of proposed treatment.

We note that, assuming the legislature intended to include failure to attend an IME as a "failure to reasonably cooperate with an investigation" in ORS 656.262(15), ORS 656.325(1)(a) and ORS 656.262(15) would provide sanctions that may differ for the same act of failing to attend an IME. In this regard, the possible sanction in ORS 656.325(1)(a) is suspension of compensation by the Director until the claimant attends the IME, with no possibility of later recovery of those suspended benefits, whereas the possible sanction in ORS 656.262(15), although beginning with suspension of compensation by the Director, might extend to an ALJ affirming a denial of the claim, with no possibility of reaching the merits of the claim.

Nonetheless, we do not find that these differences necessarily determine that only ORS 656.325(1)(a), and not ORS 656.262(15), applies to a failure to attend an IME. More is at risk for the carrier when a worker fails to cooperate with an investigation of an initial claim because only *initial* claims for compensability or aggravation may require the payment of compensation (in the form of interim compensation or possibly medical benefits, if a Managed Care Organization (MCO) is involved) before the compensability of the claim has been determined, accepted, or denied. *See* ORS 656.262(2), ORS 656.262(4)(a), ORS 656.245(4)(b)(B). Therefore, it is reasonable that the legislature might have intended to provide a separate, potentially more severe, sanction for a worker's failure to cooperate with a carrier's *initial* investigation, including failure to attend an IME.

Thus, based on examination of the text and context, we conclude that the "information gathering techniques" and the "investigation" referenced in ORS 656.262(14) and (15) include IMEs. But even if these statutes were considered ambiguous, we find that the legislative history supports our conclusion.

ORS 656.262(14) and (15) were added to ORS Chapter 656 in 1995 as part of Senate Bill 369. While our research reveals little legislative history regarding ORS 656.262(14) and (15), a statement from Representative Kevin Mannix (a co-author of the bill) indicates that the legislature intended to include attendance at IMEs in a worker's duty to cooperate with a carrier's investigation in ORS 656.262(14) and (15). Specifically, in discussing Section 28, the section containing ORS 656.262(14) and (15), Representative Mannix stated:

> "And finally, there is the cooperation provision on page 33 that tries to grapple with the issue as to what the worker has to do to cooperate with investigation, *what the worker has to do to cooperate in terms of following through with the medical evaluation.*" (Testimony of Representative Mannix, House Committee on Labor, March 6, 1995, Tape 46, Side A) (Emphasis added).

We do not find persuasive claimant's argument that, because most of the legislative history discussing ORS 656.262(14) and (15) dealt with requiring a worker to participate in an interview or a deposition, the scope of ORS 656.262(14) and (15) is limited to interviews and depositions. There is no question that the legislature considered significant the addition of a requirement that a worker attend an interview or deposition possibly without his or her attorney being present. Nevertheless, as quoted above, Representative Mannix clearly indicated that the scope of ORS 656.262(14) and (15) include cooperation in medical evaluations. Furthermore, Representative Mannix's statement was unchallenged. Therefore, interviews and depositions were not the entire subject of ORS 656.262(14) and (15). Accordingly, we conclude that the legislature intended ORS 656.262(14) and (15) to include the duty to cooperate with an IME in a worker's duty to cooperate and assist a carrier in an investigation involving an *initial* claim to establish compensability of an injury or aggravation claim.[4]

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[4] We note that the Director has reached the same conclusion. In this regard, the Director enacted OAR 436-060-0135, which applies ORS 656.262(14) and (15) and provides for suspension of benefits "under ORS 656.262(15) for noncooperation during an investigation of a claim resulting from a worker's failure to attend an insurer medical examination[.]" OAR 436-060-0135(5). OAR 436-060-0135 applies "only in claims where there has been no acceptance or denial issued." OAR 436-060-0135(3). On the other hand, the Director also enacted OAR 436-060-0095, which applies ORS 656.325(1)(a) and provides for suspension of benefits under ORS 656.325 "on accepted claims, deferred claims and on denied claims in which the worker has appealed the insurer's denial." OAR 436-060-0095(2), (5)(h), and (8). Furthermore, like the interplay between ORS 656.325(1)(a) and 656.262(14) and (15), there is interplay between the two rules. In this regard, OAR 436-060-0135(5) provides that the requirements regarding notification of the worker about an IME listed in OAR 436-060-0095(5) must be met, although the paragraph notifying the worker about the consequences of failing to attend the IME is replaced with a paragraph that includes the following: "If you fail to attend or fail to cooperate, and do not have a good reason for not attending, payment of your compensation benefits may be suspended and your claim may be denied in accordance with ORS 656.262 and OAR 436-060." OAR 436-060-0135(5); *compare* OAR 436-060-0095(5)(h).

Here, the insurer sought suspension of claimant's compensation under ORS 656.262(15) based on his failure to attend the scheduled IME. Because this is an initial claim for compensability of a new occupational disease claim or, in the alternative, a new aggravation claim relating to the August 27, 1996 accepted low back condition, we find that ORS 656.262(14) and (15) apply.[5]

ORS 656.262(15) provides that, if the Director finds that a worker failed to "reasonably cooperate with an investigation" involving an initial claim for compensability or aggravation, the Director shall suspend compensation. OAR 436-060-0135(1) provides that the Director may determine whether "special circumstances" exist that would not warrant suspension of compensation for failure to cooperate with an investigation. Furthermore, OAR 436-060-0135(7) and (8) provide that a worker must establish that any "failure to cooperate was reasonable" or the Director will suspend compensation.

An IME is allowed by statute and rule; therefore, the investigative demand of submitting to an IME is not unreasonable. ORS 656.325(1)(a); OAR 436-060-0095; OAR 436-060-0135. Claimant refused to attend the initial and rescheduled IMEs; thus, claimant did not fully and completely cooperate with the insurer's investigation. Therefore, the issue is whether claimant established that he failed to cooperate for reasons beyond his control. ORS 656.262(15); OAR 436-060-0135(1). For the following reasons, we find that claimant did not meet his burden of proof.

Two reasons were given for claimant's failure to attend the IMEs. First, it was contended that the insurer was not entitled to an additional IME because claimant had already submitted to more than the three IMEs he could be required to attend. But that contention is not supported by the facts of this case. When the insurer requested the initial April 28, 1997 IME and the rescheduled May 15, 1997 IME, claimant had not undergone any IME related to his occupational disease and aggravation claims. Although no more than three medical examinations may be requested during each open period of a claim except after notification and authorization by the Director, the current occupational disease and aggravation claims are new claims; thus, the insurer is entitled to three IMEs on each new claim. ORS 656.325(1)(a); OAR 436-060-0095(3); *Brian W. Johnston*, 39 Van Natta 1026, 1028-29 (1987), *on recon* 40 Van Natta 58, *aff'd mem* 94 Or App 343 (1988) (a carrier may require a claimant to attend another three IMEs under ORS 656.325(1) each time a claimant presents an aggravation claim arising from a new aggregate of operative facts).

Second, it was contended that the insurer was not entitled to a "post-denial" IME. But the scheduled IMEs were *not* "post-denial" IMEs because the insurer had not denied claimant's new occupational disease and aggravation claims. The only denial issued at the time of the scheduled IMEs was the December 13, 1996 partial denial of claimant's multilevel degenerative disc disease.[6] (Ex. 110).

Having found invalid both bases for claimant's failure to attend the scheduled IMEs, we find that claimant failed to establish that his failure to cooperate with the IMEs was for reasons beyond his control. ORS 656.262(15); OAR 436-060-0135(1). Therefore, we find that the suspension orders were properly issued on the basis of claimant's unreasonable failure to attend the IMEs.

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[5] Under the circumstances of this case, either ORS 656.325(1)(a) or ORS 656.262(15) could apply. The process of suspending benefits for failure to cooperate with a carrier's investigation (including refusal to attend or obstruction of an IME) is an optional process made available to the carrier by the legislature to compel cooperation with the investigation. In other words, a carrier may choose to initiate the process, but is not required to do so. *See* ORS 656.262(15); 656.325(1)(a); OAR 436-060-0095; 436-060-0135. Furthermore, although the suspension provisions in ORS 656.325(1)(a) apply to any alleged noncooperation based on a refusal to attend or obstructing on IME, the suspension provisions in ORS 656.262(15) apply only to failure to cooperate with an *initial* compensability investigation. But, again, the process is optional. Thus, where a worker refuses to attend an IME in an *initial* compensability investigation, a carrier could choose to initiate a suspension process under either ORS 656.262(15) or ORS 656.325(1)(a). On the other hand, at any other time in the life of a claim, the suspension process for refusal to attend or obstructing on IME is available only under ORS 656.325(1)(a). Here, the insurer chose to initiate the suspension process under ORS 656.262(15).

[6] In any event, the premise that an insurer is not entitled to a "post-denial" IME is not correct. *See Ronald C. Fuller*, 49 Van Natta 2067 (1997) (Board adhered to its long-standing holding that a claimant's failure to attend a "post-denial" IME may be grounds for a postponement of a scheduled hearing).

The Insurer's "Noncooperation" Denials

On June 20, 1997, the insurer issued two denials based on claimant's alleged "failure to cooperate," one denial related to the aggravation claim involving the October 21, 1992 low back injury and the other related to the occupational disease claim. (Exs. 158, 159). The grounds for both denials were the same: (1) claimant's failure to cooperate at the deposition; and (2) his failure to attend scheduled IMEs. The ALJ found both grounds invalid.

First, regarding claimant's alleged failure to cooperate in the deposition, the ALJ interpreted ORS 656.262(15) as staying the insurer's ability to issue a 30-day post-notice denial where, as here, the claimant files a request for hearing within that initial 30-day period. Second, the ALJ found, and claimant argues, that claimant's failure to attend an IME was not a proper basis for a denial because the sanction for such behavior is governed by ORS 656.325(1), which does not provide for the denial of the claim as a sanction. Therefore, the ALJ set aside both "noncooperation" denials and remanded the claims to the insurer for processing in accordance with law.

For the following reasons, we find that both "noncooperation" denials were properly issued based on claimant's failure to attend the IMEs. Therefore, we need not address the issue of whether the "noncooperation" denials were properly issued on the basis of claimant's alleged failure to cooperate in the deposition, nor do we need to address the ALJ's theory that the insurer's ability to issue a denial on that basis was somehow "stayed."

As addressed above, we find that ORS 656.262(14) and (15) apply to claimant's claims; thus, the insurer's denials are permitted under those statutes. Furthermore, in *Mark S. Lehman*, 51 Van Natta 3 (1999), we addressed a similar issue and upheld a carrier's "noncooperation" denial under ORS 656.262(15). There, the claimant left the state after filing an injury claim and retaining an attorney. During the five month period that the claimant was out-of-state, he did not contact his attorney or the insurer or provide either with an address or telephone number. The carrier attempted to take the claimant's recorded statement, but was unable to do so because the claimant had moved without leaving a mailing address. Consequently, the carrier requested a suspension order for the claimant's failure to cooperate and subsequently issued a "noncooperation" denial.

We affirmed the Department's order suspending the claimant's compensation. Noting that injured workers have a duty to cooperate and assist the carrier in the investigation of their claims under ORS 656.262(14), we found that the claimant had failed to fully cooperate in the investigation for a reason within his control. In this regard, we found that the claimant had not contacted the carrier or his attorney while he was out of state and the carrier was attempting to investigate the claim nor had he provided a new mailing address, all of which were within his control.

We also upheld the carrier's "noncooperation" denial, finding that the claimant's reasons for his noncooperation remained the same during the 30 days following the Director's suspension notice, *i.e.*, the claimant was unable to cooperate with the carrier's investigation because he was out-of-state and he failed to provide a new mailing address to the carrier or his attorney, an act that was within his control. In reaching this conclusion, we distinguished *Jodie M. Dubose*, 50 Van Natta at 1822-23. In *Dubose*, the claimant *had* a reasonable explanation for failing to cooperate with the initial investigation, so it was necessary to evaluate whether there was a "*post*-suspension" failure to cooperate to determine whether the "noncooperation" denial was appropriate. In contrast, in *Lehman*, the claimant's explanation was inadequate to challenge the suspension order or the denial; therefore, it was not necessary for the carrier to instigate a "new" investigation, nor was it necessary to make an independent "noncooperation" determination during the 30-day period following the suspension notice to support the denial.

Here, claimant's failure to cooperate with the IMEs before the Director issued the suspension notices was unreasonable and within his control, *i.e.*, the scheduled IMEs were reasonable, claimant refused to attend the IMEs, and he failed to establish that his failure to attend was for reasons beyond his control. Moreover, like *Lehman*, claimant's reasons for his noncooperation remained the same during the 30 days following the suspension notices. Furthermore, both the suspension notices and the suspension orders advised claimant of his duty to cooperate with the insurer's investigation and the consequences of any failure to cooperate. (Exs. 138, 139, 154, 155). Therefore, as in *Lehman*, because claimant's explanation is inadequate to challenge the suspension orders or the denials, no new investigation and "noncooperation" determination is necessary during the 30-day period following the suspension notices to support the denials.

Accordingly, because claimant has not established that the insurer's investigative demands were unreasonable or that he failed to cooperate with those demands for reasons beyond his control, we reinstate the insurer's denials.

Attorney Fees

The ALJ awarded attorney fees under ORS 656.386(1) for claimant's current attorney's efforts at hearing in setting aside the "noncooperation" denials. Because we have reinstated the insurer's denials, we reverse the ALJ's attorney fee award.

ORDER

The ALJ's order dated May 12, 1998 is reversed. The June 6, 1997 Orders Suspending Compensation are affirmed. The June 20, 1997 denials are reinstated and upheld. The ALJ's attorney fee award is reversed.

Board Member Biehl dissenting.

I agree with the majority's reasoning and conclusions that claimant's hearing requests were timely under ORS 656.262(15) and, therefore, we have jurisdiction of this claim. But I disagree that ORS 656.262(14) and (15) apply to IMEs. Like the ALJ, I find that only ORS 656.325 deals with the possible consequences for failing to attend an IME. Although I ultimately find that those portions of the suspension orders based on claimant's failure to attend the May 15, 1997 IME were proper, because the sanction for such conduct under ORS 656.325(1)(a) is limited to suspending compensation until claimant attends the IME, I would set aside those portions of the denials based on claimant's failure to attend the IMEs. In addition, regarding claimant's allegedly unreasonable failure to cooperate at the deposition, I find that claimant has met his burden of proving that any failure to cooperate was for reasons beyond his control. Therefore, I would set aside those portions of both the sanctions and the denials issued on that basis. Because the majority finds otherwise, I must respectfully dissent.

Both suspension orders were made on two grounds: (1) claimant's allegedly unreasonable failure to cooperate with the deposition; and (2) claimant's allegedly unreasonable failure to attend IMEs. Like the majority, I begin my review by examining the ground that claimant allegedly unreasonably failed to attend IMEs.

Director's Suspension Orders and Insurer's Denials Issued Under ORS 656.262(15) for Failure to Attend IMEs

The clear language of ORS 656.325(1)(a) establishes that it provides the potential sanction for a worker's refusal to attend or obstruction of an IME. Furthermore, that potential sanction is explicitly limited to suspending compensation with consent of the Director until the IME has taken place. *Id.* As the majority finds, the initial question is whether ORS 656.262(14) and (15) also apply to provide a potential sanction regarding failure to attend an IME. For the following reasons, I find that they do not.

In interpreting a statute, the first task is to discern the intent of the legislature. *PGE v. Bureau of Labor and Industries*, 317 Or 606 (1993). At the first level of analysis, both the text and context of the statute are examined. *Id.* at 610. If the legislative intent is not clear from that inquiry, then the legislative history or other extrinsic aids are examined. Id. at 611-12. Even assuming that the context of ORS 656.325(1)(a) includes ORS 656.262(14) and (15), I do not agree with the majority's interpretation of these statutes.

ORS 656.262(14) provides, in relevant part:

> "Injured workers have the duty to cooperate and assist the insurer * * * in the investigation of claims for compensation. Injured workers shall submit to and shall fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques. Injured workers who are represented by an attorney shall have the right to have the attorney present during any personal or telephonic interview or deposition. * * * "

The remainder of ORS 656.262(14) pertains to the potential consequences when a carrier "has cause to believe that [a claimant's attorney's] unwillingness or unavailability [to attend an interview] is unreasonable and is preventing the worker from complying within 14 days of the request for interview[.]" Those potential consequences include assessment of a civil penalty against the attorney by the Director. *Id.* Thus, the entire text of ORS 656.262(14) deals with various aspects of interviews and depositions. Nothing in the text alludes to medical examinations.

Several common maxims used in interpreting the text of a statute support the conclusion that the legislature intended ORS 656.325(1)(a) to provide the sole sanction for a worker's obstruction or failure to attend an IME. First, a textual maxim provides that, where general words follow the enumeration of particular classes of things, the general words are to be construed as applicable to things of the same general nature or class (*ejusdem generis*). *Gaston v. Parsons*, 318 Or 247, 253 (1994); *Bellikka v. Green*, 306 Or 630, 636 (1988) ("But when the legislature chooses to state both a general standard and a list of specifics, the specifics do more than place their particular subjects beyond the dispute; they also refer the scope of the general standard to matters of the same kind, often phrased in Latin as '*ejusdem generis*.'").

In ORS 656.262(14), injured workers are directed to "fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques." ORS 656.262(14). Thus, applying the maxim of *ejusdem generis*, the general term "other formal or informal information gathering techniques" is to be construed as applying to things of the same general nature as "personal and telephonic interviews." While depositions are certainly included in the same general nature as personal and telephonic interviews, a medical examination is not. Although a medical examination may include a "personal interview" with a physician, the examination of one's body can hardly be considered to be of the same general nature as a deposition or an interview, whether personal or telephonic. No interview or deposition would require disrobing or the myriad of potential tests and instruments a medical examination might require. Thus, I find that the term "other formal or informal information gathering techniques," does not include medical examinations.

Furthermore, neither I, nor the majority, is at liberty to read into a statute an additional requirement that simply is not there. ORS 174.010; *Deluxe Cabinet Works v. Messmer*, 140 Or App 548, 555, *rev den* 324 Or 305 (1996). ORS 656.262(14) and (15) do not refer to medical examinations in any manner. By concluding that the phrase "other formal or informal information gathering techniques" includes IMEs, the majority is inserting a term into ORS 656.262(14) that the legislature did not include. ORS 174.010. This is especially evident considering the specific examples provided by the legislature indicating that their general terminology "information gathering techniques" referred to similar "personal and telephonic interviews."

Examination of ORS 656.325(1)(a) provides further evidence that the legislature intended that statute to supply the sole sanction regarding failure to cooperate with an IME. In this regard, ORS 656.325(1)(a) explicitly requires an injured worker to cooperate with a medical examination and provides for a specific sanction when a worker refuses to submit to or obstructs such an examination. Specifically, ORS 656.325(1)(a) provides that:

> "Any worker entitled to receive compensation under this chapter is required, if requested by the Director of the Department of Consumer and Business Services, the insurer or self-insured employer, to submit to a medical examination at a time reasonably convenient for the worker as may be provided by the rules of the director. * * * If the worker refuses to submit to any such examination, or obstructs the same, the rights of the worker to compensation shall be suspended with the consent of the director until the examination has taken place, and no compensation shall be payable during or for account of such period. The provisions of this paragraph are subject to the limitations on medical examinations provided in ORS 656.268."

Thus, the legislature has already provided a carrier with a remedy if a worker refuses to cooperate with an IME. In contrast, neither ORS 656.262(14) nor (15) refer to a "medical examination." A common textual maxim provides that the use of a term in one section and not in another section indicates a purposeful omission (*expressio unius est exclusio alterius*). *Fisher Broadcasting, Inc. v. Department of Revenue*, 321 Or 341, 353 (1995). If the legislature had intended ORS 656.262(14) and (15) to include medical examinations, it would have so stated.

Moreover, in ORS 656.325(1)(a), the legislature provided a severe sanction for a worker's failure to cooperate with an IME in that the worker's benefits may be suspended and are not recoverable at a later date. On the other hand, the sanction provided in ORS 656.262(15) is even more severe. In this regard, ORS 656.262(15) includes the possibility of a worker's claim being denied and that denial being upheld without any chance to prove the merits of the claim, a sanction not provided for in ORS 656.325(1)(a). Given the more severe sanction in ORS 656.262(15) and the legislature's intent that the Workers' Compensation Law "be interpreted in an impartial and balanced manner" and "provide a fair and just administrative system for delivery of medical and financial benefits to injured workers," it is reasonable to assume that the legislature would have provided clear notice that ORS 656.262(14) and (15) applied to IMEs, if that was their intent. They did not do so.

In addition, ORS 656.325(1)(a), with its explicit reference to sanctions for failing to cooperate with an IME, was in existence when the legislature enacted ORS 656.262(14) and (15) as part of Senate Bill 369 in 1995. Thus, another sanction for the same conduct makes ORS 656.262(15) redundant. A result the legislature could not have intended. The majority argues that the legislature provided for a more severe sanction in ORS 656.262(15) because that statute deals with initial claims. I disagree with that reasoning. It does not follow that, because ORS 656.262(15) deals with initial claims, its sanction provisions must include failure to attend IMEs. Especially when ORS 656.325(1)(a) explicitly provides a sanction for that conduct. On the other hand, if the legislature had intended to provide a separate, more severe, sanction for failing to cooperate with an IME in an initial claim, they would have done so. Examination of the language in ORS 656.262(14) and (15) shows that they did not.

Furthermore, ORS 656.325(1)(a) provides that "the limitations on medical examinations provided in ORS 656.268" apply. Neither ORS 656.262(14) nor (15) provide this limitation. If the legislature had intended both statutes to include medical examinations, it is reasonable to assume that both statutes would have included this reference to the limitations on medical examinations. But the limitation is provided only in ORS 656.325(1)(a).

Finally, in those instances when two statutes cannot be harmonized, the specific provision shall govern over the general. ORS 174.020; *State v. Guzek*, 322 Or 245, 268 (1995). This is true even if the general statute was enacted later. *Davis v. Wasco IED*, 286 Or 261, 272 (1979). Applying these rules of statutory construction, I conclude that, to the extent these two provisions are inconsistent, the specific provisions dealing with the duty to cooperate with an IME set forth in ORS 656.325(1)(a) control over the general duty to cooperate with an investigation set forth in ORS 656.262(14) and (15).

For all of these reasons, I would find that the text and context of ORS 656.325(1)(a), 656.262(14), and (15) indicate that only ORS 656.325(1)(a) applies to medical examinations. Because the legislative intent is clear from the text and context of these statutes, I need not resort to examining the legislative history or other extrinsic aids. *PGE*, 317 Or at 611-12. In any event, I would find that the legislative history supports my interpretation of legislative intent.

As the majority states, there is very little legislative history regarding ORS 656.262(14) and (15). But what legislative history there is shows that the legislature was concerned about compelling workers' participation in interviews and depositions as part of carriers' investigations of claims.

The majority quotes only a small portion of one comment of Representative Kevin Mannix (a co-author of the bill) in support of their position that ORS 656.262(14) and (15) were intended to include IMEs. But the complete text of that comment shows that Representative Mannix's emphasis was on compelling worker participation in interviews, not IMEs:

> "And finally, there is the cooperation provision on page 33 that tries to grapple with the issue as to what the worker has to do to cooperate with investigation, *what the worker has to do to cooperate in terms of following through with the medical evaluation.* I should emphasize that although there has been criticism of this provision, there is a statutory obligation that we have imposed on employers and insurers to investigate the claim, and there have been many cases where part of the investigation, the criticism was, well why didn't you interview the worker? Well, if the worker is represented by counsel, often counsel will say I want to participate in the taking of a statement. This says fine, you can, but you have to make yourself reasonably available to participate in the taking of

> that statement. Often the insurer is paying interim compensation and now may well be paying for managed care in the MCO while awaiting a decision about whether to accept or deny the claim and by the mere device of not being available for some time, a worker can continue to get interim compensation and can continue to get medical services. This says, wait a minute, there is a procedure and a timeline in which you have to cooperate and make yourself available to take a statement and if you don't cooperate, then there is a provision that allows them to kick in to begin cutting off the compensation. That's the end of the section." (Testimony of Representative Mannix, House Committee on Labor, March 6, 1995, Tape 46, Side A) (Emphasis added).

While the majority relies solely on the emphasized language to support their theory, it is clear that Representative Mannix was stressing participation in an interview process. In addition, Representative Brown expressed great concern about that portion of section 28 that would allow an investigator to depose a worker without the worker's lawyer being present. (Testimony of Representative Brown, House Committee on Labor, March 13, 1995, Tape 57, Side B).

Furthermore, when asked what would constitute non-cooperation, Representative Mannix replied:

> "Screw your investigator. I'm not going to talk to you. It's your job to investigate this. Non-witnessed injury. Or I won't sign an 801, which is a claim form. I won't sign a medical release. I'm just telling you I got injured on the job, and of course the statute says if you make a claim, that's an authority to get records. But say there some esoteric records in another state where they need a signed release and you won't give them a signed release and they can't get the records." (Testimony of Representative Mannix, House Committee on Labor, March 6, 1995, Tape 46, Side A).

Thus, when specifically asked what would constitute "non-cooperation" under ORS 656.262(14) and (15), Representative Mannix did not mention failure to attend or cooperate with an IME. Instead, he gave examples of types of "other formal or informal information gathering techniques" similar to "personal and telephonic interviews" -- talking with an investigator, signing an 801 form, signing a medical release form, and obtaining a written release for out of state records. Given the legislative history as a whole, I would find that the legislature intended ORS 656.262(14) and (15) to apply to information gathering techniques similar to interviews and depositions, and did *not* intend to include IMEs within those techniques.

I acknowledge that the Director, like the majority, interpreted ORS 656.262(14) and (15) as providing sanctions for a worker's failure to attend or cooperate with an IME on an initial claim. As a result, in enacting OAR 436-060-0135 to apply ORS 656.262(14) and (15), the Director included a section that applied the sanctions in ORS 656.262(15) to a worker's failure to attend or cooperate with an IME. *See* OAR 436-060-0135(5). But an administrative rule cannot expand a statute. *See Forney v. Western States Plywood*, 66 Or App 155 (1983) (In the event that there is a conflict between the administrative rule and the statute, it is the statute rather than the rule which controls); *Lee R. Jones*, 46 Van Natta 2179 (1994). Accordingly, to the extent that OAR 436-060-0135(5) impermissibly expands ORS 656.262(14) and (15), I give no effect to that rule.

Having found that ORS 656.325(1)(a) applies to claimant's failure to attend the scheduled IMEs, I apply that statute to the facts of this case. First, ORS 656.325(1)(a) does not authorize issuing a denial for failure to attend an IME. Therefore, I would set aside the insurer's denials issued on that basis.

Second, as for the suspension orders, there is no dispute that claimant failed to attend the scheduled IMEs. There is also no dispute that the insurer complied with the requirements in OAR 436-060-0095(5) regarding notification of claimant and his attorney about the IMEs. (Exs. 119, 124, 127, 133). The dispute centers on whether claimant had "special circumstances" that would not warrant suspension of compensation for failure to attend or obstruction of an IME. OAR 436-060-0095(1).

Regarding the initial IME scheduled to take place on April 28,1997, I would find that claimant established "special circumstances" for not attending that IME. Specifically, on April 18, 1997, claimant's attorney notified the insurer that claimant would not be able to attend that IME because he had two previously scheduled doctors appointments on April 28, 1997. (Ex. 129a).

On May 1, 1997, the insurer notified claimant and his attorney that it had rescheduled the IME to occur on May 15, 1997. On May 5, 1997, claimant's attorney notified the insurer that claimant would not attend this "post-denial" IME, contending that the insurer was not entitled to further IMEs. (Ex. 135). For the reasons explained by the majority, I agree that this IME was not a "post-denial" IME and, in any event, a worker may properly be required to attend a "post-denial" IME. Nor did this IME exceed the insurer's limit of three IMEs. Thus, I would find that claimant did not establish "special circumstances" for failing to attend the rescheduled IME. Thus, the suspension orders were properly issued on this basis.

But that does not end the inquiry. The next question is the duration of the suspension orders. On November 24, 1997, claimant's attorney notified the insurer's attorney that claimant was willing to attend IMEs and participate in the investigation deposition. (Ex. 169). There is no evidence that the insurer attempted to reschedule an IME after that date.

Nevertheless, ORS 656.325(1)(a) provides that "[i]f the worker refuses to submit to any such examination, or obstructs the same, the rights of the worker to compensation shall be suspended with the consent of the director *until the examination has taken place* * * *." (Emphasis added). Thus, the language of the statute is clear that suspension of benefits continues until the IME takes place.[1] Here, as of the hearing date, the IME had not taken place. Therefore, the suspension orders continue in effect until the IME takes place. Under these circumstances, the benefit to claimant is that, at some point in time, he can go forward on the merits of his claim.

Director's Suspension Orders Issued Under ORS 656.262(15) for Alleged Failure to Cooperate at the Deposition

The second basis for both suspension orders was claimant's allegedly unreasonable failure to cooperate with the deposition. I agree with the majority that ORS 656.262(14) and (15) clearly apply to this issue. But I find that claimant's failure to cooperate at the deposition was not unreasonable in that he failed to cooperate for reasons beyond his control. ORS 656.262(15).

At the deposition, claimant's attorney insisted on an artificial and unexplained one hour limit. The insurer's attorney did not agree to such a limitation. Then, even before that one hour was up, claimant's attorney left the deposition because of an objection to a single question. Claimant left with his attorney. At the time that they left, the insurer's attorney was not finished with his questioning. Based on these facts, I find that claimant did not fully and completely cooperate with the insurer's investigation.

The next question is whether claimant's failure to fully cooperate was "for reasons beyond the worker's control." ORS 656.262(15). The phrase "for reasons beyond the worker's control" is not explained in ORS 656.262(15). Therefore, I examine the text and context of the statute to determine the legislature's intent. *PGE*, 317 Or at 610.

Under the particular facts of this case, contextual guidance can be found in ORS 656.262(14), which provides that "[i]njured workers who are represented by an attorney shall have the right to have the attorney present during any personal or telephonic interview or deposition." In addition, and most importantly, by its terms, ORS 656.262(14) provides that a worker's attorney's unwillingness to timely participate in a deposition may have the effect of "preventing the worker from complying" with the deposition. Therefore, ORS 656.262(14) contemplates that a worker's attorney's unwillingness to participate in a deposition is deemed to prevent the worker from participating, since the worker has a right to have the attorney present during the deposition. Furthermore, if a worker is *prevented* from complying with a deposition, then he has failed to comply for reasons beyond his control.

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[1] Although OAR 436-060-0095(10) provides the insurer with the duty to assist the worker in meeting requirements necessary for the resumption of compensation payments, it also provides that compensation will be reinstated after the worker has undergone the IME. In any event, as addressed above, a rule cannot expand a statute, and ORS 656.325(1)(a) expressly provides for reinstatement of compensation only after the worker attends the medical examination.

ORS 656.262(14) provides a remedy for a worker's attorney's unreasonable conduct. Specifically, if the Director determines that the attorney's unwillingness or unavailability is unreasonable, ORS 656.262(14) provides for possible sanctions against the attorney in order to, presumably, prompt "compliance" by the attorney. Here, that remedy was sought. Although claimant's attorney was initially sanctioned under ORS 656.262(14), in part, for her conduct at the deposition, that sanction was ultimately reversed. Nonetheless, the fact that the insurer's sanction remedy ultimately failed does not affect the outcome of this proceeding.

Therefore, I would find that any failure to cooperate during the deposition was for reasons beyond claimant's control and, thus, not unreasonable. ORS 656.262(15). Accordingly, I would set aside that portion of the suspension orders issued on that basis.

Insurer's Denials Issued Under ORS 656.262(15) for Alleged Failure to Cooperate at the Deposition

Having found that any failure to cooperate during the deposition was for reasons beyond claimant's control, I find that *Jodie M. Dubose*, 50 Van Natta at 1822-23, controls the issue of the validity of that portion of the insurer's "noncooperation" denials based on claimant's failure to cooperate with the deposition.

As found in *Dubose*, ORS 656.262(15) requires a worker to cooperate with an *investigation*. Here, as in *Dubose*, there is no evidence that claimant failed to cooperate with an investigation during the 30 days after the suspension notices, which issued on May 20, 1997. In this regard, there is no evidence that claimant was contacted by the insurer regarding any information gathering technique after the May 20, 1997 suspension notices were issued. Accordingly, I would find that the "noncooperation" denials are improper and set them aside.[2] *Compare Mark S. Lehman*, 51 Van Natta at 5 (where the claimant's explanation was inadequate to challenge the suspension order or the denial, no new investigation and "noncooperation" was necessary to support the denial).

In summary, I would uphold that portion of the suspension orders based on claimant's failure to attend the May 15, 1997 IME, with that portion of the suspension orders remaining in effect until claimant undergoes the IME. I would set aside the remaining portions of the suspension orders. In addition, I would set aside the insurer's denials and remand the case to the insurer for processing according to law.

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[2] Given this result, I need not address claimant's argument that the insurer was "stayed" from issuing a denial under ORS 656.262(15) because claimant had requested a hearing on the Director's suspension orders within 30 days from the date of the suspension notices. In other words, even if the denials were not "stayed," I would find them improper and set them aside.

In the Matter of the Compensation of
JEFFREY S. MECHAM, Claimant
WCB Case No. 98-07113
ORDER ON REVIEW
Black, Chapman, Webber & Stevens, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl, Bock and Moller.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order that: (1) directed it to recalculate claimant's rate of temporary disability benefits; and (2) assessed a penalty for its allegedly unreasonable calculation of temporary disability rate. On review, the issues are rate of temporary disability and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with one exception. We find that claimant had earnings in 38 of the 52 weeks prior to his injury. We summarize the pertinent facts as follows:

Claimant, a carpenter, sustained a compensable, disabling injury on April 28, 1998. During the 52 weeks prior to his injury, claimant was paid varying amounts, based upon an hourly rate and any overtime hours worked. Because of "down-times" when no work was available, claimant did not have earnings during 14 of the 52 weeks prior to his injury.[1]

In August 1998, SAIF advised claimant that it had recalculated his temporary disability compensation rate to $383.58 per week, based on an average weekly wage of $544.89. In recalculating claimant's time loss rate, SAIF included those 14 weeks when claimant had no earnings from the employer due to "down-times."[2]

Claimant requested a hearing, challenging the temporary disability rate and seeking a penalty for SAIF's allegedly unreasonable calculation of his temporary disability rate.

CONCLUSIONS OF LAW AND OPINION

Relying on *Bradley R. Kubik*, 50 Van Natta 989 (1998), the ALJ found that claimant's periods of no earnings from the employer during the 52 weeks preceding his April 28, 1998 injury constituted "extended gaps" to be excluded from the calculation of his average weekly earnings under OAR 438-060-0025(5)(a)(A) (WCD Admin. Order 96-070).[3] The ALJ further found that, because SAIF's recalculation of claimant's temporary disability rate was inconsistent with the procedure outlined in *Kubik* and occurred more than two months after that order had issued, SAIF's conduct was unreasonable and warranted assessment of a penalty under ORS 656.262(11)(a).

On review, SAIF challenges the Board's interpretation of the phrase "extended gaps" in OAR 436-060-0025(5)(a)(A) in cases such as *Kubik*, *Pedro Frias*, 50 Van Natta 463 (1998), *Brian M. Fitzsimmons*, 50 Van Natta 433 (1998) and *Earin J. Hadley*, 49 Van Natta 1101 (1997), and the ALJ's determination that such gaps existed in this case. We find no reason to reconsider our interpretation of OAR 436-060-0025(5)(a)(A), and we affirm the ALJ's conclusion that claimant's temporary disability rate should be based upon only those weeks he actually worked in the 52 weeks prior to his injury.

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[1] The record establishes that no work was available to claimant for a two week period in September 1997, a three week period in December 1997, one week in January 1998, the week of February 8-14, 1998 and a seven week period between February 22, 1998 and April 11, 1998. (Exs. 5, 6).

[2] Claimant's gross earnings for the 52 week period preceding his injury were $28,334.37.

[3] OAR 436-060-0025(5)(a)(A) provides, in pertinent part:

"(a) For workers employed seasonally, on call, paid hourly, paid by piecework or with varying hours, shifts or wages:

"(A) Insurers shall use the worker's average weekly earnings with the employer at injury for the 52 weeks prior to the date of injury. For workers employed less than 52 weeks or where extended gaps exist, insurers shall use the actual weeks of employment (excluding any extended gaps) with the employer at injury up to the previous 52 weeks."

In *Hadley* and its progeny, we used the following approach to determine whether gaps in employment constitute "extended gaps" to be excluded from the temporary disability rate calculation: We identified the appropriate period to be used as the basis for determining a worker's "average weekly earnings" calculation (currently 52 weeks, unless the worker was employed with the employer less than a year prior to injury), and identified any gaps when work was not available to the worker. We then added the gap periods together, and compared the total period of unavailable work to the basis period to determine whether the gap period was sufficiently "drawn out in length" to be excluded from the actual weeks of employment. 49 Van Natta at 1103; *see also, Kubik*, 50 Van Natta 989 (where the claimant had three weeks of no work available during his approximately eight weeks of total employment prior to injury, the unemployment period of 36 percent constituted "extended gaps" under OAR 436-060-0025(5)(a)); *Frias*, 50 Van Natta at 464 (nearly five weeks of unemployment during the 31.6 week period of employment preceding the claimant's injury constituted an "extended gap" under the rule); *Fitzsimmons*, 50 Van Natta 433 (fifteen weeks of unemployment during the 52-week period preceding the claimant's injury constituted "extended gaps" within a former version of the rule); *Ken T. Dyer*, 49 Van Natta 2086 (1997) (twelve weeks of unemployment during the 52-week period preceding the claimant's injury, or 23 percent of the 52 weeks, constituted "extended gaps").

Here, claimant's 14 weeks of no earnings due to the employer's "down-times" during the 52 weeks preceding his injury (26.9 percent of 52 weeks) is comparable to the unemployment gaps in *Frias*, *Fitzsimmons* and *Dyer*. Consequently, like the ALJ, we conclude that the 14 weeks of "down-times" constitute "extended gaps" within the meaning of OAR 436-060-0025(5)(a)(A) which should be excluded from the calculation of claimant's average weekly earnings.

We also agree with the ALJ that SAIF's recalculation of temporary disability in this case was unreasonable in light of the line of Board cases discussed above (particularly *Frias* and *Kubik*, which interpret the same version of OAR 436-060-0025(5) at issue in this case).[4] Indeed, as SAIF concedes, there is currently no Board or court case that supports SAIF's position that the "down-time" gaps in claimant's employment were not "extended gaps" under OAR 436-060-0025(5)(a)(A). In light of such circumstances, we find that SAIF did not, from a legal standpoint, have a legitimate doubt regarding the proper calculation of claimant's temporary disability rate. Consequently, we affirm the ALJ's penalty assessment.

Claimant's attorney is entitled to an assessed fee for services on review.[5] ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the temporary disability issue is $1,200, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for his counsel's services on review regarding the penalty issue. *Saxton v. SAIF*, 80 Or App 631 (1986).

ORDER

The ALJ's order dated October 12, 1998, as amended October 16, 1998, is affirmed. For services on review, claimant is awarded an assessed fee of $1,200, payable by SAIF.

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[4] Claimant is entitled to a penalty if the carrier "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. *International Paper Co. v. Huntley*, 106 Or App 107 (1991). "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the information available to the carrier at the time it denies benefits. *Brown v. Argonaut Insurance Company*, 93 Or App 588 (1988).

[5] Although we have found that claimant earned wages in 38 of the 52 weeks prior to his injury and the ALJ's opinion indicated that claimant earned wages during 37 weeks, we do not consider our order as reducing or disallowing the compensation awarded to claimant. In reaching this conclusion, we note that the ALJ's order directed SAIF to recalculate claimant's temporary disability rate "based on the *actual weeks worked* by the claimant in the 52 week period preceding his compensable injury."

Board Member Moller dissenting.

I acknowledge that in cases such as *Earin J. Hadley*, 49 Van Natta 1101 (1997), and *Pedro Frias*, 50 Van Natta 463 (1998), we have determined whether a worker has "extended gaps" in employment for purposes of OAR 436-060-0025(5)(a)(A) by identifying the periods when work was not available to the claimant, *adding those periods together regardless of their length,* and comparing the *total* period of unavailable work to the appropriate basis period to determine whether the "gap period" was sufficiently extended or drawn out in length to be excluded from the "average weekly earnings" calculation. Although the majority adopts this approach in affirming the ALJ's order, I believe it is inappropriate to add all of the periods of unemployment together to determine whether the sum is extended in light of the total employment period. Because the majority's approach is inconsistent with the policy underlying OAR 436-060-0025(5)(a)(A) (*i.e.*, to provide fair, adequate and reasonable income benefits to an injured worker -- ORS 656.012(2)(a) -- by replacing loss of wages due to the injury), I respectfully dissent.

OAR 436-060-0025(5)(a)(A) applies to workers employed seasonally, on call, paid hourly, paid by piecework or with varying hours, shifts or wages. When such a worker has established an entitlement to temporary disability compensation, the carrier is required to calculate the worker's "average weekly earnings" with the employer at injury for the 52 weeks prior to the date of injury. The rule further provides: "For workers employed less than 52 weeks or where extended gaps exist, insurers shall use the actual weeks of employment (excluding any extended gaps) with the employer at injury up to the previous 52 weeks." Accordingly, under the rule, the first step is to determine whether the worker either was employed for less than 52 weeks or whether extended gaps in employment existed during the 52-week period.

A prior version of the rule was addressed by the Court of Appeals in *Hadley v. Cody Hindman Logging*, 144 Or App 157 (1996) (interpreting *former* OAR 436-60-025(5)(a)). In *Hadley*, the court rejected the Board's interpretation of the phrase "extended gaps" that required a break in the performance of work activities that causes a change in the employment relationship between the claimant and the employer. The court held that the Board's interpretation added a requirement to the rule, *i.e.*, a change in the employment relationship, that was inconsistent with the rule's intended result. The court concluded that the Board's interpretation "constitutes an unauthorized limitation on the Director's authority granted from the legislature to prescribe methods of establishing wages at the time of injury." 144 Or App at 162. The case was remanded to the Board for reconsideration.

On remand in *Hadley*, the Board held that an "extended gap" is one that is drawn out in length and that a determination as to whether a gap in employment is "drawn out in length" depends on the particular circumstances of each case. I agree with this basic principle, but, as I noted above, I do not think it is appropriate to add all of the periods of unemployment together, regardless of the length of each period, to determine whether the total gap in employment is extended or drawn out in length. On the contrary, I believe that the rule requires that we examine each gap in employment separately and determine whether that particular gap is "extended" in light of the base period and the circumstances of the worker's employment. If the gap is "extended," then, under the current version of the rule, it should be excluded from the calculation of the claimant's average weekly wage as set forth in the rule. On the other hand, if a particular gap -- or hiatus -- in employment is not sufficiently drawn out in length, then that time off work should not be excluded from the calculation of the worker's average weekly wage.

In this regard, I agree with Member Haynes' dissent in *Hadley* insofar as she opined that a particular gap in employment must be of an unexpected duration to constitute an "extended gap" under the rule. Like Member Haynes, I find the approach used in *Hadley* and its progeny (including this case) to be overly simplistic and potentially unfair to employers and insurers.

In *Hadley*, a majority of the Board rejected the Director's interpretation of the term "extended gaps," finding that the Director's interpretation as asserted on review improperly added the requirement that the hiatus in employment be "unexpected" as well as drawn out in length.[1] If I were deciding the issue on a clean slate, I would rely on and apply the Director's interpretation of the term, as I believe it

[1] As set forth in *Hadley*, the Director contended that the term "extended gaps" means periods of unemployment that were "unexpected" in the normal occurrence of an employment or were of "unexpected" duration. 49 Van Natta at 1102.

advances what the rule was meant to accomplish, *i.e.*, to approximate as closely as possible the workers true average weekly wage as intended by the parties. *See* OAR 436-060-0025(5)(a)(A) (intent of the wage earning agreement used for workers employed less than four weeks). Moreover, such reliance on the Director's interpretation would seemingly comport with the court's holding in *Hadley* that the Board may not limit the Director's authority to prescribe methods of establishing wages at the time of injury. At a minimum, I do not think it is appropriate to exclude all gaps of unemployment from the calculation of the worker's average weekly wage unless the record establishes that the gap was sufficiently extended when considered in light of the base period and the circumstances of the worker's employment.

In this case, as the majority notes, the record establishes that claimant, a carpenter, had no work available (due to "down times") for a two-week period in September 1997, a three-week period in December 1997, a one week in January 1998, the week of February 8-14, 1998 and a seven-week period between February 22, 1998 and April 11, 1998. In comparing these gaps in employment to the 52-week base period, I would not find claimant's one and two week periods of unemployment sufficiently "drawn out in length" to constitute an "extended gap," under the rule.[2] I would, however, consider the three week gap in December 1997 and the seven week gap between late February and mid-April 1998 as sufficiently extended, so that these two periods of unemployment should be excluded from the actual weeks of employment used to calculate claimant's average weekly wage.[3]

I recognize that my approach employs a somewhat "ad hoc" method to determining whether a particular gap in employment is extended (*i.e.*, under the facts of this case a three-week period is "extended" but a two-week gap is not), but I think this procedure is fairer to the parties and in keeping with the central purpose of temporary disability compensation, which is to replace loss of wages due to the compensable injury. *See, e.g., Cutright v. Weyerhaeuser*, 299 Or 290 (1985).

Consequently, for the reasons set forth herein, I would modify the ALJ's order. In lieu of directing SAIF to recalculate claimant's temporary disability rate based on the actual weeks worked (*i.e.*, 38 out of 52), I would direct SAIF to calculate claimant's temporary disability rate based on the worker's average weekly earnings for 42 weeks of employment out of the 52 weeks prior to the date of injury.[4]

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[2] Although I do not necessarily approve of a simple mathematical approach, I note that a one to two week gap in employment represents less than 3 percent of the 52 week base period.

[3] Again, although the relative percentage is not dispositive, I note that a three-week gap represents more than 5 percent of the base period, and the 7-week gap represents more than 13 percent of the base period.

[4] In other words, I would exclude from the calculation of claimant's average weekly earnings the three-week and seven-week extended gaps.

April 7, 1999 Cite as 51 Van Natta 641 (1999)

In the Matter of the Compensation of
GERALD A. GLENN, Claimant
WCB Case No. 96-01649
SECOND ORDER ON REMAND
Scott McNutt, Sr., Claimant Attorney
Hornecker, Cowling, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's April 2, 1999 order, we have been directed to consider the parties' settlement. The parties have submitted two documents entitled "Stipulation and Order of Settlement Pursuant to ORS 656.289(4) (Disputed Claim Settlement)," which are designed to resolve "the compensability of claimant's current back conditions and symptoms" as unrelated to his accepted lumbar strain, as well as "the compensability of the claimant's L4-5 disc and post-surgical condition."

Pursuant to the settlement of claimant's current low back condition, the parties agree that the self-insured employer's denial, as set forth in the agreement, "shall be affirmed." That settlement

further provides that "claimant's request for hearing shall be dismissed with prejudice as to all issues raised or raisable therein." Pursuant to the settlement of claimant's L4-5 herniated disc condition, claimant agrees that he "will not further contest the employer's denial of an L4-5 disc herniation." Finally, claimant stipulates that his appeal of the Board's order (insofar as it found his L4-5 herniated disc condition not compensable) "shall be dismissed with prejudice."[1]

We have approved the parties' settlements, thereby fully and finally resolving these disputes. Accordingly, these matters are dismissed with prejudice.

IT IS SO ORDERED.

[1] The parties agree that claimant's counsel shall be paid the $4,000 attorney fee award for services previously rendered in prevailing on the compensability of claimant's lumbosacral strain claim.

April 7, 1999 Cite as 51 Van Natta 642 (1999)

In the Matter of the Compensation of
GERALD A. GLENN, Claimant
WCB Case No. 97-09571
ORDER OF DISMISSAL
Scott McNutt, Sr., Claimant Attorney
Hornecker, Cowling, et al, Defense Attorneys

The self-insured employer requested review of Administrative Law Judge (ALJ) Nichols' order that: (1) set aside its "back-up" denial of claimant's L4-5 herniated disc condition; and (2) awarded a $3,000 carrier-paid attorney fee. The parties have submitted a proposed "Stipulation and Request for Dismissal."

The stipulation provides that the parties have participated in an appellate settlement conference. That conference pertains to claimant's petition for judicial review of the Board's order in WCB Case No. 96-01649 which had found that claimant's L4-5 herniated disc condition was not compensable. In accordance with their "settlement conference agreement," the employer moves for dismissal of its request for review in this case. The parties further stipulate that claimant's attorney shall be paid the $3,000 carrier-paid attorney fee granted by the ALJ's order.

We have approved the parties' stipulation, thereby fully and finally resolving this dispute, in lieu of the ALJ's order.[1] Accordingly, this matter is dismissed.

IT IS SO ORDERED.

[1] In granting this approval, we note that we have also approved the parties' disputed claim settlements in WCB Case No. 96-01649, which resolve the compensability of claimant's L4-5 herniated disc condition and current low back condition. In light of our approval of the parties' settlements in that case, it necessarily follows that the "back-up" denial of claimant's L4-5 herniated disc condition in this case has been rendered moot.

In the Matter of the Compensation of
ROBERT A. WILLENBERG, Claimant
WCB Case No. 97-03333
ORDER ON REVIEW
Lonergan & Lonergan, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's left knee condition. On review, the issues are jurisdiction, the procedural validity of the denial and compensability. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable injury on January 2, 1996 when two large tires struck his left knee. Claimant eventually came under the care of Dr. Baskin, who diagnosed a probable tear of the left medial meniscus. The employer accepted a torn left medial meniscus. Dr. Baskin surgically removed the tear on February 7, 1996. (Ex. 12). Dr. Baskin performed another arthroscopic surgery in August 1996 to remove an additional tear of the left medial meniscus. (Ex. 27). Despite the surgeries, claimant continued to complain of left knee pain.

Dr. Baskin declared claimant's left knee condition medically stationary on February 5, 1997. (Ex.45). That same day, claimant sought treatment from Dr. Berselli, who surmised that claimant might have an "anterior cruciate deficient knee." (Ex. 44). Dr. Berselli recommended an MRI scan, which was taken on February 12, 1997 and interpreted as showing a grade 3 tear of the posterior horn and mid segment of the medial meniscus. (Ex. 46). The cruciate ligament was considered "intact." *Id.*

Based on the MRI findings, Dr. Berselli recommended additional arthroscopic surgery. (Ex. 44). After obtaining an opinion from Dr. Baskin that claimant's left knee condition was no longer caused in major part by the compensable injury (Ex. 49-2), the employer issued a denial on March 31, 1997 pursuant to ORS 656.262(7)(b). The basis for the denial was that claimant's ongoing need for treatment was not compensably related to the January 2, 1996 injury. (Ex. 51). Claimant requested a hearing.

Thereafter, a Determination Order closed the claim on April 18, 1997. It awarded claimant 11 percent scheduled permanent disability for the left knee injury and determined that claimant was medically stationary on February 5, 1997. *Id.* The record does not indicate that reconsideration of the Determination Order was requested.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the employer's denial. Citing *Donna Babcock*, 49 Van Natta 2083 (1997), and *Elizabeth B. Berntsen*, 48 Van Natta 1219 (1996), the ALJ reasoned that the employer could not deny a current condition while the claim was open unless the employer had accepted a combined condition or the current condition was a consequential condition. Finding no evidence that the employer accepted a combined or consequential condition or that it was denying a consequential condition, the ALJ found that claimant's current left knee condition was the same condition as had been accepted. The ALJ then determined that the denial was improper.

On review, the employer first contends that we do not have jurisdiction over this matter because the only issue raised was claimant's entitlement to medical services (surgery) for the compensable injury. *See SAIF v. Shipley*, 326 Or 557 (1998). Alternatively, the employer asserts that claimant has not carried his burden of showing that he has an objective condition caused in major part by the accepted injury.

For the following reasons, we find that we have jurisdiction over this dispute. Moreover, we conclude that the employer's was procedurally proper. Finally, we determine that claimant's current left knee condition is properly analyzed as a "consequential condition" and is not compensable under ORS 656.005(7)(a)(A).

Jurisdiction

Under ORS 656.245(6), we have jurisdiction over a medical services claim only if the claim was disapproved because of a formal denial of compensability of the underlying claim.[1] Otherwise, jurisdiction over medical services claims lies with the Director of the Department of Consumer and Business Services.

In *Shipley*, the claimant had originally disputed the carrier's denial of his aggravation claim but, at hearing, he withdrew the aggravation claim and conceded that he had suffered no new compensable injury. 326 Or at 560. Instead, the claimant contended that his medical treatment was materially related to the original compensable condition and that he was, therefore, entitled to benefits for those medical services, based on the accepted claim. *Id.* The Supreme Court held that once the issue had thus been reframed, the ALJ and the Board had no authority to decide it under ORS 656.245(6) and, therefore, the claim should have been dismissed. *Id.* at 565.

In this case, we find that the issue is not one of medical services based on the accepted medial meniscus claim. Although the employer denied the claim on the ground that claimant's ongoing need for treatment was not related to the compensable injury, the issue to be litigated was further refined at hearing. The employer's counsel described the issue as whether claimant "currently has a medial meniscus tear that requires surgery." (Tr. 11, 12). Claimant's counsel stated that the issue was whether the meniscus tear existed and, if so, whether surgery was warranted. (Tr. 12). Based on these comments, we conclude that the existence and, necessarily, the compensability of an alleged new meniscus tear, was at issue. Therefore, compensability of the underlying claim was at issue.

As further support for this conclusion, we note the ALJ's statement regarding his understanding of the issue. The ALJ described the issue as whether claimant had a "condition" that was "sufficiently related to his work or industrial injury such that additional compensation should be awarded." (Tr. 14). Claimant's attorney was then asked by the ALJ "if we can do that?" Claimant's counsel replied: "Yeah. we can do that." (Tr. 14).

Considering this exchange between the ALJ and claimant's counsel (uncontested and undisputed by the employer), we are further persuaded the compensability of the underlying claim, *i.e.*, the existence and work relation, if any, of claimant's current diagnosed meniscus tear was at issue. *See SAIF v. Pendergast-Long*, 152 Or App 780, *on recon* 155 Or App 633, 637 (1998) (where the parties disputed whether the condition for which the claimant sought treatment was compensable, the compensability of the underlying condition was at issue, and the Board had jurisdiction over the claim).

Procedural Validity of the Denial

The ALJ stated that a carrier may not deny a current condition while a claim is "open" unless the employer has accepted a combined or consequential condition. In an order issued after the ALJ's decision, we held that a carrier is no longer required to have accepted a "combined condition" before it can issue a combined condition denial. *Tracey A. Blamires*, 50 Van Natta 1793, 1796 (1998). Therefore, we disagree with the ALJ's determination that acceptance of a combined condition must have preceded the insurer's denial. Having said this, we nevertheless find that the medical evidence does not establish the presence of a combined condition. In other words, we do not find evidence that claimant's compensable injury combined at any time with a "preexisting conditon" so that ORS 656.005(7)(a)(B) applies.

Moreover, the employer's denial issued prior to claim closure. Generally, preclosure denials are disfavored but, if they pertain to a condition separate or severable from the accepted condition, they are procedurally valid. *See Connie L. Birrer*, 51 Van Natta 163 *on recon* 51 Van Natta 467 (1999); *Zora A. Ransom*, 46 Van Natta 1287 (1994) (preclosure denial was proper where the medical evidence "unequivocally" indicated that the claimant's current condition was not related to the accepted condition).

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[1] ORS 656.245(6) provides:

"If a claim for medical services is disapproved for any reason other than the formal denial of the compensability of the underlying claim and this disapproval is disputed, the injured worker, the insurer or self-insured employer shall request administrative review by the director pursuant to this section, ORS 656.260 or 656.327. The decision of the director is subject to the contested case review provisions of ORS 183.310 to 183.550."

Here, the medical evidence does not unequivocally indicate that claimant's current left knee condition is unrelated to the accepted left knee injury. Dr. Berselli stated that, while it was impossible to state to a degree of medical probability that claimant's compensable injury is the major contributing cause of claimant's current left knee condition, the compensable injury and resulting surgeries were likely playing a role in claimant's current left knee condition. (Ex. 54-2).

Despite Dr. Berselli's opinion, we still find that the employer's preclosure denial was valid. Dr. Baskin declared claimant medically stationary on February 5, 1997, prior to issuance of the employer's March 31, 1997 denial. In addition, the April 18, 1997 Determination Order found claimant's condition to have been medically stationary as of February 5, 1997 (prior to the employer's denial). As previously noted, there is no indication in this record that the Determination Order was appealed. Thus, the uncontested medically stationary date was prior to the date the employer denied the claim.

Under these circumstances, although the employer's denial preceded claim closure, we do not find that the employer was attempting to bypass the normal process of claim closure. Accordingly, we conclude that the March 31, 1997 denial was not an invalid preclosure denial. *See Chaffee v. Nolt*, 94 Or App 83, 85 (1988) (denial issued before claim closure valid where the claimant's condition was medically stationary and the employer's conduct was not intended to shortcut the ordinary process of claim closure or was otherwise unreasonable); *Cf. David E. Horton*, 50 Van Natta 514, *on recon* 50 Van Natta 795, 796 (1998) (where no combined condition had ever been accepted by the insurer, and the record did not support a conclusion that claimant's accepted strain was either separable from his current condition or *medically stationary*, a denial of the current condition was improper until the claim qualified for claim closure). We now proceed to the merits of the compensability issue.

Compensability

We first determine the applicable legal standard. As previously noted, the parties do not argue, and the evidence does not establish, that claimant's compensable injury "combined" with a preexisting condition. Thus, ORS 656.005(7)(a)(B) does not apply. Dr. Berselli opined, however, that claimant's surgeries most likely made claimant more susceptible to a repeat left knee medial meniscus tear. (Ex. 54-2). In addition, Dr. Jones, an examining physician, opined that, while he did not believe that claimant had a medial meniscus tear, he would attribute the changes on claimant's MRI to "post surgical changes." (Ex. 48).

While the evidence is not a model of clarity, we nevertheless conclude that claimant's current left knee condition is a consequence of the compensable injury and resulting surgeries, rather than the industrial accident itself. Under these circumstances, we find that the consequential condition statute, ORS 656.005(7(a)(A), applies. *See Albany General Hospital v. Gasperino*, 113 Or App 411 (1992) (when a condition is caused by the compensable injury, as opposed to the industrial accident, the major contributing cause standard of ORS 656.005(7)(a)(A) applies). Pursuant to that statute, claimant must prove that the compensable injury is the major contributing cause of the consequential condition, *i.e.*, either a new medial meniscus tear or the post-surgical changes in claimant's left knee.

Two physicians directly addressed the causation question: Dr. Baskin and Dr. Berselli. Dr. Baskin agreed that, as of February 5, 1997, the compensable injury was no longer the major contributing cause of claimant's left knee condition. (Ex. 49-2). Dr. Berselli agreed that, while the compensable injury and resulting surgeries were likely playing some role in claimant's current left knee condition, it was impossible to state to a degree of medical probability that the compensable left knee injury was the major cause of the current knee condition. (Ex. 54-2).

Based on these medical opinions, we are unable to conclude that claimant's current consequential knee condition is compensable under ORS 656.005(7)(a)(A).

ORDER

The ALJ's order dated May 20, 1998 is reversed. The employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

In the Matter of the Compensation of
SUSAN K. CLIFT, Claimant
WCB Case No. 97-02975
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board members Haynes, Bock and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hoguet's order that modified an Order on Reconsideration's reference to claimant's aggravation rights date on the closure of her consequential psychological condition claim. On review, the issue is the proper date for claimant's aggravation rights. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact (with the exception of the ultimate finding of fact) and briefly summarize the pertinent facts as follows:

In December 1989, the employer accepted claimant's claim for bilateral carpal tunnel syndrome. The claim was first closed on March 29, 1991 with awards for temporary and scheduled permanent disability. After claimant attended an authorized training program, the claim was reclosed in April 1992. An October 1992 Order on Reconsideration awarded additional temporary and permanent disability benefits.

Meanwhile, in 1991, claimant began treating for anxiety and depression. In 1994, the employer was directed by litigation order to accept claimant's psychological condition and process it as a consequential condition of her accepted carpal tunnel syndrome.

Claimant's consequential psychological condition claim was closed by a November 19, 1996 Determination Order, which found her medically stationary as of June 19, 1995 and awarded no additional temporary or permanent disability compensation. The Determination Order also retained aggravation rights dating from the original 1991 claim closure.

Claimant requested reconsideration, raising a number of issues. A March 21, 1997 Order on Reconsideration affirmed the November 1996 Determination Order in its entirety. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant challenged only the aggravation rights date set forth in the November 19, 1996 Determination Order. Claimant argued that the aggravation rights for her entire claim, or at least for the psychological condition component of the claim should run from the date of the November 1996 Determination Order rather than from the original March 1991 claim closure. The ALJ agreed, concluding that, insofar as claimant's claim was reopened in compliance with the provisions of ORS 656.262(7)(c),[1] claimant was entitled to new aggravation rights applicable solely to the psychological condition component of her claim.

On review, the employer asserts that the ALJ's decision is inconsistent with the provisions of ORS 656.273(4)(a) as well as established case law. The employer further contends that claimant's aggravation rights for all aspects of her claim should continue to run from the original March 1991 claim closure. We agree.

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[1] This section, as amended in 1997, provides in pertinent part as follows: "If a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition." We have held that this amendment applies retroactively to all claims existing or arising on or after the July 25, 1997 effective date, regardless of the date of injury or the date a claim is presented. *See Mario R. Castaneda*, 49 Van Natta 2135 (1997).

Prior to the July 1997 enactment of ORS 656.262(7)(c), it was well established that a post-closure acceptance of a consequential medical condition did not extend or modify the aggravation rights flowing from the original injury claim. *See, e.g., Mark D. Fuller*, 46 Van Natta 63 (1994) (holding that the Board had no authority to "relinquish" its exclusive own motion jurisdiction where the claimant's consequential psychological condition was found compensable after the claimant's aggravation rights had expired); *Mary K. Karppinen*, 46 Van Natta 678 (1994) (rejecting claimant's contention that the carrier's subsequent acceptance of her consequential chondromalacia condition entitled her to extended aggravation rights); *see also Alka Thornsberry, Jr.*, 49 Van Natta 569 n.1 (1997) (noting that although a new medical condition had subsequently been accepted, that condition was a component of the claimant's original 1986 injury claim, and maintained the same aggravation rights); *Rex A. Howard*, 46 Van Natta 1265 (1994). In deciding these cases, we observed that ORS 656.273(4)(a), which establishes the limitations period for aggravation claims, specifically requires that the claim "be filed within five years of the *first* determination or *first* notice of closure made under ORS 656.268." (Emphasis added).

Although ORS 656.262(7)(c) now requires an insurer or self-insured employer to "reopen the claim for processing" when a condition is found compensable after claim closure, the statute says nothing about modifying or extending the aggravation rights on the claim. In other words, even though the law has changed and a worker may now obtain additional compensation for a new medical or consequential condition accepted after closure of the initial claim,[2] it does not necessarily follow that the reopening and processing mandated by ORS 656.262(7)(c) also entails a resetting of the aggravation rights established at the initial claim closure.[3]

Indeed, to construe the claim processing requirements of ORS 656.262(7)(c) as entitling the worker to new aggravation rights on the subsequent closure of the consequential condition claim would bring ORS 656.262(7)(c) in direct conflict with ORS 656.273(4)(a), which, as noted above, specifically limits the aggravation period to five years from the *first* determination or closure. As a rule, statutes should be construed in a manner that gives validity to all provisions whenever possible. ORS 174.010; *see also Circuit Court v. AFSCME*, 295 Or 542, 545 (1983) (whenever possible, court construes statutes so as to achieve consistency); *Davis v. Wasco IED*, 286 Or 261, 272 (1979) (if possible, court construes statutes on same subject in harmony with each other). Consequently, in this case, we decline to construe the provisions of ORS 656.262(7)(c) as trumping the express language of ORS 656.273(4)(a). The "post-closure" reopening and processing for a consequential condition claim does not impact the aggravation rights established at the closure of the original claim.

ORDER

The ALJ's order dated September 21, 1998 is reversed. The March 21, 1997 Order on Reconsideration, which affirmed the November 19, 1996 Determination Order, is reinstated and affirmed in its entirety. The ALJ's "out-of-compensation" attorney fee is also reversed.

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[2] *See, e.g., Johansen v. SAIF*, 158 Or App 672 (1999) (holding that a "new medical condition" claim is subject to the processing requirements of ORS 656.262(4)(a) for the payment of compensation); *Labor Ready, Inc. v. Mann*, 158 Or App 666 (1999) (holding that the employer had a duty to pay interim compensation pending acceptance or denial of the claimant's "new medical condition" claim); *see also Candace Marsden*, 50 Van Natta 1361 (1998) (the claimant's entitlement to procedural temporary disability benefits for a condition accepted after closure of the initial claim was not barred by res judicata based on the prior closure order); *Mario R. Castaneda*, 49 Van Natta at 2137 (same).

[3] In *Johansen*, the court held that a new medical condition relates to the initial claim but is distinct from the condition initially accepted. (Slip op. at 8). The court also held that a new medical condition is "distinct from an aggravation claim because it involves a condition other than the one initially accepted, rather than a worsening of the accepted compensable condition." *Id.* at 10. The court concluded that a new medical condition claim is entitled to its own classification determination, and is not affected by the classification of the initial claim. *Id.*

Although *Johansen* indicates that a consequential condition/new medical condition is distinct from the original claim, we do not read the court's opinion to suggest that, upon closure, a new medical condition/consequential condition claim is also entitled to its own, independent aggravation rights period. Indeed, not only does such an interpretation run contrary to the plain language of ORS 656.273(4)(a), it is also inconsistent with the language of ORS 656.262(7)(c) itself, which specifically requires the carrier to "*re*open" the claim for processing of the new condition. The term "*re*open," indicates that any subsequent processing regarding that condition would entail a "*re*closure" or "*re*determination" under ORS 656.268, as opposed to a first closure or determination with new aggravation rights.

Special concurrence by Board Member Bock.

I share the majority's conclusion that claimant's 5-year "aggravation rights" under ORS 656.273(4)(a) extend from the date of the first closure of the claim, irrespective of a subsequently accepted "new medical condition" claim. I write separately to express my concerns regarding the interplay between a "new medical condition" claim under ORS 656.262(7)(a) and a claimant's 5-year "aggravation rights" under ORS 656.273(4)(a).

My concerns are primarily based on a recognition that the majority's interpretation of the statutory scheme and the holding of *Johansen v. SAIF,* 158 Or App 672 (1999) are by no means indisputable. As articulated in the dissenting opinion, the *Johansen* court described a "new medical condition" claim as distinct from an initial claim or an aggravation claim. In doing so, the court observed that the limitations set forth in ORS 656.277 and 656.273 for reclassification of claims and aggravation claims were not applicable to a "new medical condition" claim.

Thus, if viewed expansively, *Johansen* can be interpreted as implicitly ruling that the 5-year "aggravation rights" limitation of ORS 656.273(4)(a) has no application to a "new medical condition" claim and, therefore, a separate 5-year "aggravation rights" period attaches to the "new medical condition" claim on its closure. Conversely, *Johansen* can also be analyzed based on the precise holding rendered in the decision. In other words, as expressly identified by the court, the "ultimate issue here is whether the new medical condition claim is subject to the processing requirements of ORS 656.2622(4)(a) for the payment of compensation." The court answered that question in the affirmative, rejecting the carrier's contention that the claimant must satisfy the requirements of the aggravation statute (ORS 656.273) to gain entitlement to temporary disability compensation. When viewed in this context, although there is certainly *dicta* supportive of the dissent's position, the *Johansen* holding has no effect on the specific question posed in the case presently before us.

Had the precise issue raised in this case been present in *Johansen*, the court may well have determined that a "new medical condition" claim has separate 5-year "aggravation rights." Nonetheless, the fact remains that the court was not presented with that question and, therefore, did not address the interplay between the 5-year "aggravation rights" limitation of ORS 656.273(4)(a) and the "reopening" of a claim under ORS 656.262(7)(c) for a "new medical condition" claim. That responsibility rests with this forum and, in part, with this member.

When confronted with these potentially conflicting statutes, I have chosen to adopt the majority's analysis of the statutory scheme, which applies each statute to the greatest extent possible. In doing so, I am also guided by my reluctance to interpret the amendment of ORS 656.262(7)(a), the creation of a "new medical condition" claim, and the requirement to "reopen" a claim for a "post-closure" accepted condition under ORS 656.262(7)(c) in a manner that would effectively legislatively overrule a longstanding case precedent that applied a worker's 5-year "aggravation rights" limitation to all conditions (whether initially or subsequently accepted). In the absence of an express intention (either from the statute or legislative history) to alter this established principle, I am not prepared to overturn this well-established interpretation of the statutory scheme based on these statutory amendments.

In conclusion, for the reasons expressed above, I concur with the majority's conclusion that claimant's "new medical condition" claim is subject to the same 5-year "aggravation rights" limitation that was placed on the initial claim following its first closure.

Board Member Biehl dissenting.

The majority concludes that the statutorily mandated "post-closure" reopening and processing for a consequential condition or new medical condition claim does not entitle claimant to new aggravation rights on the claim. Because I believe that, under the current law, a consequential condition/new medical condition is a distinct claim that is entitled to its own, independent processing, payment of compensation *and aggravation rights*, I respectfully dissent.

As the majority notes, in *Johansen v. SAIF.* 158 Or App 672 (1999), the court determined that a "new medical condition" claim relates to the initial claim but is distinct from the condition initially accepted. The court explained that a new medical condition claim is one that "(1) arises after acceptance of an initial claim, (2) is related to an initial claim, and (3) involves a condition other than the condition initially accepted." *Id* at 679. In holding that a new medical condition claim is entitled to its own classification determination and is not affected by the classification of the initial claim, the court

specifically rejected SAIF's contention that such a claim has no existence independent of the original claim and does not give rise to a processing obligation independent of the original claim. *Id.* at 681. The court concluded:

> "Thus, contrary to SAIF's contention, the limitations set forth in ORS 656.277 and ORS 656.273 for reclassification claims *and aggravation claims* are not affected or negated by our conclusion that a new medical condition claim must be processed as any other claim, *because they are not applicable to the new condition claim.*" *Id.* (emphasis added)

Unlike the majority, I believe this passage does suggest that, as part of its independence from the initial claim, a consequential condition/new medical condition claim is entitled to its own aggravation rights period. If nothing else, this comment indicates the court's understanding that the five year aggravation period imposed on the initial claim by ORS 656.273(4)(a) is *not applicable to the new condition claim.*

Furthermore, I disagree with the majority's contention that to construe the processing requirements of ORS 656.262(7)(c) as entitling the worker to new aggravation rights on the subsequent closure of the consequential condition/new medical condition claim brings the statute in direct conflict with ORS 656.273(4)(a). Although ORS 656.273(4)(a) requires that an aggravation claim be filed within five years of the *first* determination or closure, the statute does not specify that this "first" limitation applies only to the closure *of the initial claim.* In other words, bearing in mind that a consequential condition/new medical condition claim is an independent entity, there would be no conflict with the provisions of ORS 656.273(4)(a) so long as the aggravation rights established on closure of the consequential condition/new medical condition claim are limited to five years from the first closure of that particular claim.

In summary, I would find that just as a worker may be entitled to additional temporary or permanent disability benefits on the processing of his or her consequential condition/new medical condition claim, *see, e.g., Labor Ready, Inc. v. Mann,* 158 Or App 666 (1999); *Johansen v. SAIF,* 158 Or App at 681; *Daniel I. Vanwelchel,* 50 Van Natta 844 (1998), the worker is also entitled (at closure) to a new determination of aggravation rights on that claim.

April 7, 1999 Cite as 51 Van Natta 649 (1999)

In the Matter of the Compensation of
RANDY S. LAY, Claimant
WCB Case No. 97-09838
ORDER ON REVIEW
Kasia Quillinan, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Johnson's order that set aside as premature an Order on Reconsideration and Determination Order that closed claimant's claim for a right shoulder Grade II acromialclavicular joint separation. On review, the issues are premature closure and, if the claim was not closed prematurely, extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, which we supplement and summarize as follows.

On October 18, 1996, claimant compensably injured his right shoulder in a fall at work. X-rays revealed a widening of the acromioclavicular joint with subluxation on the right and some mild winging of the scapula. On November 12, 1996, the insurer accepted claimant's claim as a disabling right shoulder contusion. Dr. Wilson diagnosed a right AC joint strain. Dr. Lantz reported a grade 2 acromioclavicular separation.

On January 22, 1997, claimant was referred by Dr. Wilson to Dr. Straub, orthopedist. Straub mentioned a possible surgery, but chose to continue conservative treatment. (Ex. 12). In March 1997, the insurer accepted claimant's shoulder condition as an acromioclavicular separation.

On June 16, 1997, Dr. Straub declared claimant medically stationary. (Ex. 16). A July 28, 1997 Determination Order found claimant medically stationary on June 16, 1997 and awarded no permanent disability compensation. Claimant requested reconsideration, raising the issues of medically stationary status and unscheduled permanent disability.

On September 18, 1997, Dr. Straub noted worsened symptoms and recommended an MRI, which revealed AC separation and shoulder joint impingement. On September 26, 1997, Straub recommended surgery.

On October 17, 1997, Dr. Davis performed a medical arbiter examination. (Ex. 23). A November 24, 1997 Order on Reconsideration issued. The Director did not consider the medical arbiter's report because the insurer refused to consent to a postponement of the reconsideration process. (Ex. 24). Claimant was deemed medically stationary as of June 16, 1997, and was awarded no unscheduled permanent partial disability compensation. (*Id.*)

CONCLUSIONS OF LAW AND OPINION

Premature Closure

The ALJ concluded that claimant was not medically stationary on the date the Notice of Closure issued and set aside the Order on Reconsideration on the basis that the claim was prematurely closed. On review, the insurer challenges this conclusion, asserting that claimant failed to prove that he was not medically stationary at closure. We agree.

A claim may not be closed unless the claimant's condition is medically stationary.[1] *See* OAR 438-012-0055(1). It is claimant's burden to prove that he was not medically stationary on July 28, 1997, the date of claim closure, considering claimant's condition *at the time of closure and not on subsequent developments.* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985); *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981).

Dr. Straub, claimant's attending physician at the time of claim closure, declared claimant medically stationary on June 16, 1997, remarking that "it is possible that he could require additional treatment including surgery in the future, but this is not anticipated at the present time." (Ex. 16-2). Claimant sought no further treatment prior to the closure date.

On September 18, 1997, claimant returned to Straub with increased right shoulder complaints. Straub recommended surgery. (Ex. 20). Straub's subsequent letter clarifying his June 16, 1997 report supports his declaration that claimant was medically stationary as of that date. Straub indicated that, in June 1997, he "did not anticipate that claimant would require additional treatment." He explained that he mentioned that surgery was a possibility, but it "was not anticipated at that time." He felt that claimant's condition had stabilized, that his condition might wax and wane, and that claimant was medically stationary as of that date. (Ex. 25). Straub also noted that it was claimant's presentation with a worsened condition (AC separation with impingement) that led to the surgical intervention after September 1997. (*Id.*)

We do not interpret Straub's letter to anticipate that claimant would improve with treatment or the passage of time as of the time of claim closure. Moreover, Straub's explanation of a worsening in claimant's condition *after* the June 1997 closure is not relevant to claimant's condition at closure, which is the appropriate period in which to determine the propriety of the closure. *Sullivan*, 73 Or App at 697. Therefore, because the evidence regarding claimant's condition at the time of claim closure establishes that he was medically stationary at that time, we conclude that claimant has failed to prove that his claim was prematurely closed.

Therefore, we find that the July 28, 1997 Determination Order was not prematurely issued and reverse the ALJ's decision setting aside the claim closure.

Extent of Permanent Disability

As discussed above, Dr. Straub, claimant's treating physician, declared claimant medically stationary with no permanent impairment in June 1997. The July 1997 Determination Order awarded no permanent disability. Following claimant's request for reconsideration, a medical arbiter's examination took place on October 17, 1997.

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[1] "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17).

The arbiter, Dr. Davis, indicated in his report that claimant reported that he recently had an MRI and his treating physician was requesting surgery. Davis stated that he did not consider that information in his evaluation, which he based on a record review and a physical examination. Davis recorded his examination findings of permanent restrictions based on loss of range of motion and limitation in repetitive use.

In the Order on Reconsideration, the Director stated: "The record now shows the worker's condition may not be medically stationary." Because the insurer did not consent to postpone the reconsideration process under ORS 656.268(7)(h), the Director disregarded the arbiter report in its determination of impairment. The Order on Reconsideration awarded no permanent disability compensation.

The insurer asserts that we should affirm the November 24, 1997 Order on Reconsideration, contending that, because claimant's condition was no longer medically stationary as of September 1997, we should not utilize the medical arbiter's impairment findings to rate impairment. The insurer cites *Georgina F. Luby*, 49 Van Natta 1828 (1997), and *Phyllis G. Nease*, 49 Van Natta 195, *on recon* 49 Van Natta 301, *on recon* 49 Van Natta 494 (1997) to support its position. Claimant relies on the arbiter's October 17, 1997 report. We agree with the insurer for the following reasons.

Claimant is entitled to an award of permanent disability for conditions that are permanent and caused by the accepted condition. Claimant has the burden of proving the extent of his permanent disability. ORS 656.266. A worker is entitled to a value under these rules only for those findings of impairment that are permanent and were caused by the compensable injury or disease. OAR 436-035-0007(1).

In evaluating claimant's permanent disability, we do not automatically rely on a medical arbiter's opinion in evaluating permanent impairment. *See Raymond L. Owen*, 45 Van Natta 1528 (1993), *aff'd Roseburg Forest Products v. Owen*, 129 Or App 442 (1995) (impairment is established by a preponderance of medical evidence, considering the medical arbiter's findings and any prior impairment findings). Instead, we rely on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment. *See Carlos S. Cobian*, 45 Van Natta 1582 (1993).

In June 1997, Dr. Straub declared claimant medically stationary with no permanent impairment. (Ex. 16-2). Subsequently, Straub opined that claimant was medically stationary on June 16, 1997, but in September 1997, he found that claimant's condition had worsened and claimant need surgery. (Exs. 22, 25). Dr. Davis, the medical arbiter, examined claimant on October 24, 1997, after claimant's condition had worsened. Although Davis stated that he did not consider the September 25, 1997 MRI or the pending surgery in his evaluation, he based his impairment findings on a physical examination performed that day. (Ex. 23).

After reviewing the medical evidence, consisting of Dr. Straub's findings of no impairment at the time of claim closure, and Dr. Davis' impairment findings four months later, after claimant's condition had changed, we find that Dr. Straub provided the most thorough, complete and well-reasoned evaluation of claimant's permanent injury-related impairment. Under these circumstances, we decline to rate claimant's permanent impairment based on Dr. Davis' findings. *See generally Lindon E. Lewis*, 46 Van Natta 237, *aff'd mem Morgan Manufacturing v. Lewis*, 131 Or App 267 (1994); *see also Georgina F. Luby*, 49 Van Natta 1828 (1997); *Phyllis G. Nease*, 49 Van Natta 195, *on recon* 49 Van Natta 301, *on recon* 49 Van Natta 494 (1997) (rejecting impairment findings of medical arbiter who believed that the claimant was not medically stationary and was in need of further medical treatment).

In sum, based on Dr. Straub's impairment findings when claimant was medically stationary, claimant's unscheduled permanent disability award is zero.

ORDER

The ALJ's order dated November 30, 1998 is reversed. The November 24, 1997 Order on Reconsideration is reinstated and affirmed. The ALJ's attorney fee award is reversed.

In the Matter of the Compensation of
SHERREY L. BERRY, Claimant
WCB Case No. 97-07843
ORDER ON REVIEW
David C. Force, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order that affirmed an Order on Reconsideration that awarded no scheduled permanent disability for loss of use or function of the right forearm/wrist. In his brief, claimant argues that the ALJ's application of the disability rating standards violates the Oregon and U.S. Constitutions. On review, the issues are extent of scheduled permanent disability and constitutionality.

We adopt and affirm the ALJ's order with the following supplementation.

Claimant contests only that portion of the ALJ's order that declined to award scheduled permanent disability for loss of strength under OAR 436-035-0110(8)[1] and 436-035-0007(18) (WCD Admin. Order 96-072). Relying on prior Board cases, including *Barbara Barber*, 49 Van Natta 1923 (1997), and *Terrance L. Moore*, 49 Van Natta 1787 (1997), the ALJ found that because the medical arbiter did not report claimant's loss of strength under the zero to five grading system as required by OAR 436-035-0007(18), no award for loss of strength could be made under the standards.

The medical arbiter, Dr. Stanford, indicated that: "Strength testing in the upper extremities from her shoulders to and including the intrinsic muscles of her hands is normal. However, her grip strength is somewhat less on the right at 22/30 pounds compared to 60/53 pounds on the left." In further describing claimant's muscle strength, Dr. Stanford stated: "It was felt her muscle strength was normal clinically, although there was some decrease of grip strength on the right. This did not necessarily correlate with the rest of her testing and I could not determine that there was any focal weakness."[2]

On review, claimant argues that the ALJ applied the statutes and administrative rules in such a way as to violate Article I, Sections 10 and 20 of the Oregon Constitution and the 14th Amendment of the U.S. Constitution.

Claimant's constitutional arguments are raised for the first time on Board review. Claimant asserts that the constitutional arguments could not have been raised prior to the ALJ's order. We disagree. Both the medical arbiter's report, the administrative rule, and the case law, which claimant argues represents an unconstitutional application of the administrative rules and statutes, existed *prior to the ALJ's order*. That the medical arbiter's report was insufficient under the disability rating standards and the case law to support an award under OAR 436-035-0007(18) was evident *prior* to the request for hearing. In other words, claimant should have been aware that, in order to receive an award for loss of strength, the rule required that a *physician* measure the impairment under the 0 to 5 rating system, and that the medical arbiter report did not meet this standard. If claimant objected on constitutional grounds to the arbiter's report, the Director's disability standards or the Board's case law interpreting the standards, she should have raised those arguments to the ALJ.

Moreover, because the Appellate Unit did not make an award in the Order on Reconsideration, presumably the Appellate Unit also found the medical arbiter's rating of loss of strength inadequate under the standards. Thus, the constitutional issue was apparent prior to the issuance of the ALJ's order. Under these circumstances, claimant should have first raised the constitutionality arguments to the ALJ. *See Eugenio Gonzalez*, 45 Van Natta 921 (1993) (a constitutional challenge must be raised at the hearing level before it can be argued on review).

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[1] OAR 436-035-0007(18) provides, in relevant part: "To determine impairment due to loss of strength, the 0 to 5 international grading system and 0 to 5 method as noted in the AMA Guides to the Evaluation of Permanent Impairment, 3rd Ed. Revised, 1990 shall be used."

[2] Although Dr. Stanford appeared to question claimant's findings of reduced grip strength, he indicated that his findings were "valid." *See* OAR 436-035-0007(27) (findings of impairment deemed ratable under the rules shall be rated unless the physician determines the findings are invalid and provides a written opinion, based on sound medical principles, explaining why the findings are invalid).

Even if the issue was properly before us, we would decline to find the administrative rule or our cases interpreting the rule to be unconstitutional. To begin, we do not agree with claimant that the ALJ's application of the law violated Article I, Section 10[3] of the Oregon Constitution. Claimant argues that the statutes provide for an award of permanent impairment because she has loss of strength, but because the medical arbiter's report did not describe the impairment in the manner required by the standards, no award can be made. On this basis, claimant argues that she has no remedy for her injury.

First, we are persuaded that there were mechanisms available to claimant to correct the arbiter's report. In this regard, when the report was received, the failure to correctly report the loss of strength could have been brought to the Appellate Unit's attention and the arbiter could have been asked by the Appellate Unit to clarify his report. In addition, even after the Order on Reconsideration issued, the Director has discretion to abate, withdraw, or amend the Order on Reconsideration prior to requesting a hearing if certain procedural time limits have not elapsed. OAR 436-035-0008(1)(b). In any case, permanent disability benefits are only one type of benefit available once a compensable injury is established. The statutes do not guarantee that a claimant's disability will be ratable under the Director's disability rating standards. The fact that one type of benefit is unavailable for a compensable injury does not persuade us that there is *no* remedy for claimant's injury. Accordingly, we do not find that the ALJ's order applying the standards violates Article I, Section 10 of the Oregon Constitution.[4]

Claimant next argues that Article I, Section 20 of the Oregon Constitution and the Fourteenth Amendment of the U.S. Constitution have been violated. Specifically, claimant argues that the medical arbiter's grading of claimant's impairment has deprived her of the privilege of compensation for her injury. Claimant asserts that our interpretation of the standards in the cases applied by the ALJ "deprives claimant of equal privileges and grants to SAIF unequal immunities."

Here, because all injured workers are subject to the same criteria (the Director's disability standards), we are not persuaded that the standards (or the application of the standards by the ALJ) violates equal protection principles. *See Gregory J. Backer*, 48 Van Natta 2098 (1996).[5]

ORDER

The ALJ's order dated September 25, 1998 is affirmed.

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[3] Article I, Section 10 provides: "No court shall be secret, but justice shall be administered, openly and without purchase, completely and without delay, and every man shall have remedy by due course of law for injury done him in his person, property, or reputation."

[4] Claimant also cites Article I, Sections 21 and 22 of the Oregon Constitution and argues that those provisions have also been violated. Specifically, claimant argues that ORS 656.214 was suspended by the medical arbiter's incorrect reporting of claimant's loss of strength. We disagree. The Director's disability rating standards do not "suspend" ORS 656.214. Rather, the standards are authorized by statute and effectuate the evaluation of disability. The fact that the arbiter did not report the impairment in the manner required by the standards did not "suspend" the operation of any law.

[5] Claimant also argues that she has been deprived of property without due process of law. Specifically, claimant argues that she is entitled to an opportunity to prove an improper application of the standards in a hearing regarding the reconsideration order. Although a claimant's entitlement to permanent disability is a constitutionally significant property interest, the procedures afforded during the reconsideration process are sufficient to guard against an erroneous deprivation of that interest. *See Koskela v. Willamette Industries, Inc.*, 159 Or App 229 (1999) (unavailability of opportunity to provide in-person testimony in extent of permanent disability process not violation of due process rights). In addition to the reconsideration process, claimant had an opportunity to raise her arguments regarding the arbiter report to the ALJ and to pursue a further appeal to the Board and court. Under such circumstances, we are not persuaded that claimant has been denied due process. *Id.*

In the Matter of the Compensation of
KENNETH W. EMERSON, Claimant
WCB Case No. 98-04279
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Herman's order that: (1) affirmed an Order on Reconsideration award of 38 percent (72.96 degrees) scheduled permanent disability for loss of use or function of claimant's right arm; and (2) awarded a $1,500 attorney fee under ORS 656.382(2). On review, the issues are extent of scheduled permanent disability and attorney fees. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, and offer the following summary.

SAIF accepted claimant's right upper extremity injury claim for "fracture, right radial head, dislocation of the right elbow, right hamate fracture, right pisiform fracture, Essex Lopresti lesion, right shoulder impingement, fracture right wrist base of third metacarpal, capitellum fracture, trochlea fracture, and capitate fracture." (*See* Exs. 6, 6, 14, 26).

A January 9, 1998 Notice of Closure closed the claim with an award of 19 percent scheduled permanent disability for the right arm.

Claimant requested reconsideration and appointment of a medical arbiter. Dr. Bills performed a medical arbiter's examination on April 23, 1998.

A May 8, 1998 Order on Reconsideration awarded claimant a total of 38 percent scheduled permanent disability for the right arm and 14 percent unscheduled permanent disability for the right shoulder. SAIF requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Scheduled Permanent Disability

The ALJ affirmed the Order on Reconsideration, reasoning that the medical arbiter's impairment findings were consistent with the compensable injury and not attributed to other causes. The ALJ relied on *SAIF v. Danboise*, 147 Or App 550 (1997).

SAIF first argues that *Danboise* does not support disability ratings for loss of right finger and thumb range of motion, in particular, because these losses are not "due to" the accepted injury, nor are they a direct medical sequelae of the accepted conditions. *See* ORS 656.214(2);[1] ORS 656.268(16).[2] Second, assuming that claimant's finger and thumb findings are injury-related, SAIF argues that the Department improperly rated claimant's right hand and wrist range of motion without comparing it to his contralateral (left) joints. *See* OAR 436-035-0007(22) (text at n.5, *infra*).

Claimant responds that his fingers and thumb are part of his hand, his injuries included fractures at the base of his fingers, he had symptoms of finger swelling and lost grip strength, and therefore his finger and thumb findings are consistent with the compensable injury and ratable under *Danboise*. Claimant also argues that SAIF should not be permitted to raise its "contralateral joint" argument for the first time on review.

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[1] ORS 656.214(2) provides that "the criteria for the rating of [scheduled] disability shall be the permanent loss of use or function of the injured member *due to* the industrial injury.* * * *" (emphasis added). Cf. n.4, *infra* (The accepted condition determines what is ratable).

[2] ORS 656.268(16) requires that conditions that are "direct medical sequelae to the original accepted condition" be included in rating permanent disability of the claim unless they have been specifically denied.

The *Danboise* court held that when a treating doctor or medical arbiter makes impairment findings consistent with a claimant's compensable injury and does not attribute the impairment to causes other than the compensable injury, such findings may be construed as showing that the impairment is due to the compensable injury. 147 Or App at 553. But, in *Danboise*, the *medical evidence* described the disputed impairment as consistent with the compensable injury. Here, there is no such evidence and *Danboise* does not apply. *See David D. Couture*, 50 Van Natta 1181 (1998) (where no evidence established that loss of cervical range of motion was consistent with low back injury, *Danboise* was inapplicable).

The record here indicates that the accepted fracture of the right radial head, dislocation of the right elbow, and capitellum fracture are conditions of the right elbow. (*See* Exs. 4, 5, 13-2). The record also indicates that claimant's hamate fracture, pisiform fracture, Essex Lopresti lesion, fracture of the right wrist base of third metacarpal, trochlea fracture, and capitate fracture are conditions of the right hand and wrist. (Exs. 9-2, 9-3, 10-2, 13-2, 21-2, 31-2). Considering claimant's multiple diagnoses, we find that the etiology of his symptoms and conditions involves complicated medical questions requiring expert medical evidence for resolution. *See Uris v. Compensation Dept.*, 247 Or 420, 424 (1967); *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985), *rev den* 300 Or 546 (1986).

But we find no medical evidence indicating that the accepted conditions include conditions of the right fingers or thumb and no evidence that finger or thumb conditions are direct medical sequelae of the accepted conditions.[3] *See SAIF v. Calder*, 157 Or App 224 (1998) (we may not rely on evidence outside the record to answer a medical question). To the contrary, in response to a question about limitations due to the accepted condition or any direct medical sequelae, the medical arbiter reported "no restriction in *handling*, seeing, *fingering*, feeling, talking, or hearing." (Ex. 31-6) (Emphasis added). Accordingly, in the absence of expert medical evidence relating claimant's finger or thumb findings to the accepted conditions (directly or as sequelae), we conclude that claimant is not entitled to disability ratings for his finger and thumb findings. *See Donald D. Davis*, 50 Van Natta 357 (1998); *Julio C. Garcia-Caro*, 50 Van Natta 160 (1998).[4]

SAIF also argues that claimant's right wrist range of motion should be "compared to and valued proportionately to the contralateral joint," under OAR 436-035-0007(22) (WCD Admin. Order 96-072)[5], because claimant's contralateral joint (his left wrist) does not have "a history of injury or disease." Assuming that SAIF could properly raise this argument on review, we reject it.

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[3] Reference to medical dictionaries does not persuade us that the accepted hand fractures involved claimant's right fingers or thumb. *See SAIF v. Calder*, 157 Or App 224 (1998).

[4] In *Julio C. Garcia-Caro*, we held that the *accepted* condition determines what is ratable in determining permanent disability. In that case, the accepted condition was right shoulder tendinitis. We found that, even though the medical evidence established that the claimant suffered a loss of range of motion of the cervical spine, cervical impairment was not ratable because the carrier had not accepted a cervical condition and the record did not establish that the impairment was a direct medical sequelae of the accepted condition.

Similarly, in *Donald D. Davis*, the claimant had an accepted claim for "left elbow contusion." An Order on Reconsideration awarded permanent disability for an epicondylitis condition, which the Appellate Review Unit determined was a sequela of the accepted condition. We found that although the medical evidence showed that the claimant's epicondylitis condition may be a sequela of the accidental injury, that condition was not a "direct medical sequela" of the accepted contusion *condition*. Consequently, the claimant was not entitled to impairment for the epicondylitis condition under ORS 656.268(16). *See also, Donald A. Westlake*, 50 Van Natta 1213 (1998) (where the medical evidence failed to show that the claimant's distal clavicle condition was accepted or that it constituted direct medical sequelae to the accepted condition of acute impingement syndrome, the claimant was not entitled to a permanent disability award based on the distal clavicle resection).

[5] OAR 436-035-0007(22) provides in part:

"The range of motion or laxity (instability) of an injured joint shall be compared to and valued proportionately to the contralateral joint except when the contralateral joint has a history of injury or disease or when either joint's range of motion is zero degrees or is ankylosed. Except for the elbow and knee, contralateral joint comparisons shall not be used to determine extension range of motion findings. * * *

" * * * * *

"(b) When the contralateral joint has a history of injury or disease, the findings of the injured joint shall be valued based upon the values established under these rules."

The record includes several references to left-sided abnormal findings consistent with prior left wrist injury or disease -- specifically, abnormal radiotracer activity in the left wrist (evident in a 1996 nuclear bone scan) "most consistent with stress" or "due to minor trauma." (Exs. 9-4 and 13-2). Accordingly, we find it more likely than not that claimant's left hand did have "a history of injury or disease", such that a contralateral wrist joint comparison would be inappropriate under the rule. Consequently, we conclude that the Order on Reconsideration did not improperly fail to compare claimant's reduced right wrist range of motion with his left wrist range of motion.

Accordingly, we recalculate claimant's scheduled permanent disability for loss of use or function of his right arm as follows.

Claimant is entitled to 16 percent and 5 percent right arm ratings, for lost right elbow range of motion and for his inability to use his right arm repetitively. (*See* Ex. 31). His 10 percent rating for lost right wrist range of motion is converted to 8 percent of the right hand. *See* OAR 436-035-0090 (WCD Admin. Order 96-072). These three values are combined for a total of 27 percent scheduled permanent disability. *See* OAR 436-035-0007(17). Because claimant has already received 19 percent scheduled permanent disability for his right arm, he is entitled to an additional 8 percent scheduled permanent disability.

Accordingly, the ALJ's and the Order on Reconsideration's additional award of 19 percent scheduled permanent disability is reduced to 8 percent. Finally, the 10 percent attorney fee granted by the Order on Reconsideration is modified to 10 percent of claimant's 8 percent scheduled permanent disability award. *See Roberto Rodriguez*, 46 Van Natta 2530, 2531 (1994).

Attorney Fees

As a preliminary matter, we address SAIF's motion for remand to supplement the record regarding the attorney fee issue. We deny the motion, because we may modify or supplement the ALJ's order on review and we do not find the record to be improperly, incompletely, or otherwise insufficiently developed. *See Daryl L. Underwood*, 50 Van Natta 2330, 2332 (1998).

The ALJ affirmed the reconsideration order's awards of scheduled and unscheduled permanent disability. The ALJ then assessed a $1,500 attorney fee under ORS 656.382(2), having considered the factors set forth in OAR 438-015-0010(4).[6]

On review, SAIF contends that *Schoch v. Leupold & Stevens*, 325 Or 112 (1997), and *McCarthy v. Oregon Freeze Dry*, 327 Or 84, *adhered to on recon* 327 Or 185 (1998), required the ALJ to: (1) make findings for each factor in OAR 438-015-0010(4); (2) draw conclusions from those findings of fact; and (3) demonstrate how the conclusions are weighed in determining a reasonable attorney fee. Because the ALJ did not provide such reasoning, SAIF argues that we should remand the case "with instructions to take evidence and properly apply OAR 438-015-0010(4)."

We considered the same argument in *Underwood*, 50 Van Natta 2330. There, the claimant's attorney did not submit a specific fee request at hearing and the parties did not provide any argument at hearing concerning the application of the factors in OAR 438-015-0010(4). After analyzing the Court's entire decision in *McCarthy*, we found that the Court held that a lower body need not address facts and legal criteria that are not material to its decision and could "satisfy its obligation to make findings in a case * * * by including in its order a brief description or citation to the factor or factors on which it relies in denying an award of attorney fees." 327 Or at 188.

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[6] OAR 438-015-0010(4) provides that "[i]n any case where an Administrative Law Judge or the Board is required to determine a reasonable attorney fee, the following factors shall be considered:" (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved;" (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses.

In short, because the statute considered by the Court in *McCarthy* contained the same requirement in OAR 438-015-0010(4) that the reviewing bodies "shall consider" certain enumerated factors, we held that it is sufficient for an ALJ to merely describe or cite the rule-based factor or factors the ALJ relied on in determining a reasonable attorney fee where there was no specific attorney fee requested and the parties did not submit to the ALJ any argument as to how the rule-based factors should be weighed in determining a reasonable fee. Thus, we rejected the carrier's argument in *Underwood* that the ALJ was required to make findings for each rule-based factor.

Here, as in *Underwood*, claimant's attorney did not submit a statement of services or make a specific attorney fee request to the ALJ. We have determined that, under such circumstances, the ALJ is not obligated to make specific findings regarding the rule-based factors, in order to have a reviewable order.[7]

Nonetheless, because SAIF has now advanced arguments challenging the sufficiency of the ALJ's order and because SAIF has now prevailed on its hearing request regarding the scheduled permanent disability issue, we provide the following supplementation and modification to the ALJ's order.

The issue at hearing was the extent of claimant's scheduled and unscheduled permanent disability. Pursuant to our order and the unchallenged portions of the ALJ's order, claimant successfully defended his unscheduled permanent disability award, but not his scheduled permanent disability award. Therefore, claimant is entitled to an attorney fee for services at hearing relating only to his unscheduled award. *See* ORS 656.382(2).

With regard to the time factor, we note that there was no hearing and the record consists of 33 exhibits. Based on the "extent of disability" disputes generally presented to the Hearings Division for resolution, we find the legal and medical issues to be of average complexity. The benefits obtained and the value of the interest involved (claimant's 14 percent unscheduled permanent disability award) were in the average range. There was a slight risk that claimant's attorney would go uncompensated (if claimant's unscheduled award was reduced due to his prior unscheduled award for same body part). Finally, both attorneys presented their cases in a skillful manner.

Based on these factors, especially the complexity of the issues and the value of the interest involved, we find that $1,000 is a reasonable attorney fee for claimant's counsel's successful defense of claimant's unscheduled permanent disability award at the hearings level. The ALJ's $1,500 attorney fee award is modified accordingly.

ORDER

The ALJ's order dated October 12, 1998 is modified in part and affirmed in part. In lieu of the ALJ's and the Order on Reconsideration's scheduled permanent disability awards, and in addition to claimant's Notice of Closure award of 19 percent (36.48 degrees) scheduled permanent disability for loss of use or function of his right arm, claimant is awarded 8 percent (15.36 degrees) scheduled permanent disability, for a total of 27 percent (51.84 degrees) scheduled permanent disability for loss of use or function of his right arm. The 10 percent attorney fee granted by the Order on Reconsideration is modified to 10 percent of the 8 percent increase in claimant's scheduled permanent disability award. In lieu of the ALJ's attorney fee award, claimant is awarded a $1,000 attorney fee for successfully defending his unscheduled permanent disability award at the hearings level. The remainder of the order is affirmed.

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[7] *See Steven D. Sambuceto*, 50 Van Natta 1812, 1813-14 (1998); *Russell L. Martin*, 50 Van Natta 313 (1998) (finding that the absence of a fee request or argument on the rule-based factors distinguishes a case from *Schoch v. Leupold & Stevens*, 325 Or 112, *on remand* 49 Van Natta 788 (1997), which required a "sufficient explanation" of how the rule-based factors were weighed in deciding that a "reasonable" fee was substantially less than the amount requested).

In the Matter of the Compensation of
MARTHA C. HALLER, Claimant
WCB Case No. 98-07020
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Spangler's order that: (1) declined to direct the insurer to pay temporary total disability compensation after September 9, 1998; and (2) declined to assess a penalty for the insurer's allegedly unreasonable refusal to pay temporary disability. On review, the issues are temporary total disability and penalties.

We adopt and affirm the ALJ's opinion, with the following supplementation.

The insurer provided claimant with two written job offers, the first dated August 19, 1998 and the second dated September 9, 1998. When claimant failed to begin the initial offered employment, the insurer unilaterally ceased the payment of temporary total disability benefits on August 19, 1998.

Finding that the August 19, 1998 job offer was invalid, the ALJ awarded claimant temporary total disability compensation from August 19 through September 9, 1998. The ALJ also concluded that, because claimant refused a valid offer of modified employment on September 10, 1998, the insurer properly ceased payment of temporary total disability benefits as of that date. The ALJ also declined to award a penalty for the insurer's allegedly unreasonable refusal to pay temporary disability benefits.

On review, claimant contends that she is entitled to temporary disability benefits beyond September 9, 1998, because the insurer failed to strictly comply with OAR 436-060-0030(5)(c), which requires that the employer "confirm the offer of employment in writing to the worker stating * * * that the attending physician has found the job to be within the worker's capabilities." Specifically, claimant argues that the written job offer from the employer that she received on September 9, 1998, did not state that the *attending* physician had reviewed a description of the job and found the job to be within her capabilities. Claimant also argues that a penalty should be awarded for the insurer's unreasonable failure to pay temporary disability compensation after that date. Finally, claimant contends that she is entitled to a penalty based on the insurer's unreasonable failure to pay temporary disability compensation from August 19, 1998 through September 9, 1998.

Here, Dr. French, claimant's attending physician, had been notified by the employer of the physical tasks to be performed by claimant and agreed that the employment appeared to be within her capabilities. (Exs. 18, 20, 24, 24A). On September 8, 1998, the employer provided claimant with a written notice of employment that stated, among other things, that the job "adheres to the restrictions given to us by your physician on 8/13/98 and again on September 3, 1998." The notice also named Dr. Gulick, who initially treated claimant, and Dr. French, to whom Gulick referred claimant for treatment, as the physicians.[1] Although the notice does not specifically use the word "attending" physician, the words "your physician" in conjunction with the names of Dr. Gulick and Dr. French, claimant's present attending physician, we conclude that the employer strictly complied with the requirements of OAR 436-060-0030(5)(c). Therefore, because claimant failed to begin wage earning employment on September 10, 1998, the insurer was authorized to terminate temporary total disability compensation and start paying temporary partial disability compensation as of that date. ORS 656.268(3)(c).[2]

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[1] We note that Dr. French documented in writing that he released claimant to modified work, without repetitive use of the right upper extremity, after examining her on June 23, 1998. (Ex. 16).

[2] ORS 656.268(3) provides in pertinent part:

"Temporary total disability benefits shall continue until whichever of the following events first occurs:

* * * * *

"(c) The attending physician advises the worker and documents in writing that the worker is released to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment[.]"

Turning to the penalty issue, we are not persuaded that the carrier's failure to pay temporary disability compensation from August 19, 1998, through September 9, 1998 was unreasonable. A penalty can be assessed under ORS 656.262(11)(a) if the carrier's failure to pay benefits was unreasonable. Whether a carrier's actions are unreasonable is determined by whether it had a legitimate doubt, from a legal standpoint, about its liability. *Brown v. Argonaut Insurance Co.*, 93 Or App 588 (1988).

Here, we find that the insurer had a legitimate doubt regarding its liability to pay temporary disability following the written job offer mailed to claimant on August 19, 1998 (the beginning date of the offered modified job).[3] That job offer strictly complied with the requirements of OAR 436-030-0030(5)(c). (Ex. 21A). Claimant failed to begin employment. Under these circumstances, it was not unreasonable for the carrier to take the position that, when claimant failed to begin employment, it was authorized under ORS 656.268(3)(c) to cease payment of temporary total disability.

ORDER

The ALJ's order dated November 2, 1998 is affirmed.

[3] We recognize that claimant did not receive notice of the job offer until after August 19, 1998 (the date the modified mob was scheduled to begin). Nonetheless, because the statute is premised on the existence of a written *offer* and the worker's failure to begin such employment, we do not consider the insurer's conduct to have been *unreasonable* when it terminated claimant's temporary disability as of the date of the offer when she subsequently failed to begin the offered employment.

In the Matter of the Compensation of
BERNARD O. GROVER, Claimant
WCB Case No. 98-03326
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that declined to authorize an offset for an alleged overpayment of temporary disability. In his brief, claimant contends that we should assess a penalty because of the insurer's allegedly unreasonable claim processing. On review, the issues are offset and penalties.

We adopt and affirm the ALJ's order with the following supplementation.

Claimant contends that a penalty is warranted because of the insurer's allegedly unreasonable claim processing. We do not address this issue because it was raised for the first time on review. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991); *see also Fister v. South Hills Health Care*, 149 Or App 214, 218-19 (1997) (Board's own decisions establish the rule that it will consider only issues raised at hearing).

Had the insurer prevailed in its contention that it was entitled to an overpayment, we find that there would have been a reduction in claimant's compensation. Thus, we conclude that claimant is entitled to an assessed fee pursuant to ORS 656.382(2). *See SAIF v. Coburn*, 159 Or App 413 (1999); *Bowman v. Esam, Inc.*, 145 Or App 46 (1996). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the overpayment issue is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 18, 1998, as reconsidered December 17, 1998, is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
ANDREW HUSSEY, Claimant
WCB Case No. 98-03579
ORDER ON REVIEW
Bischoff, Strooband, et al, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) admitted Exhibit 5; (2) set aside its denial of claimant's occupational disease claim for left leg infrapatellar tendinitis; and (3) awarded an attorney fee of $3,600. On review, the issues are evidence, compensability and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change. In the second finding of fact, we change the last sentence to read: "Dr. McMahon agreed with Dr. Chamberlain's diagnosis of infrapatellar tendinitis. (Ex. 5)."

CONCLUSIONS OF LAW AND OPINION

Evidence

The insurer argues that Exhibit 5 was hearsay and should not have been admitted. Exhibit 5 is a letter from claimant's attorney signed by Dr. McMahon in which he agreed with Dr. Chamberlain's diagnosis of left infrapatellar tendinitis. At hearing, the insurer's attorney contended that the exhibit was hearsay because there was no medical evidence from Dr. Chamberlain and also argued that Exhibit 5 "violates" ORS 656.266 in that the causation statement was based on a lack of prior symptoms. (Tr. 1-2). In Exhibit 5, Dr. McMahon also agreed, among other things, that claimant had denied any previous knee problems.

We review the ALJ's evidentiary ruling for abuse of discretion. *See James D. Brusseau II*, 43 Van Natta 541 (1991). In the present case, we do not agree that the ALJ abused his discretion by admitting Exhibit 5. Hearsay evidence is generally admissible in workers' compensation proceedings, although such evidence may be excluded when it is in the interest of substantial justice to do so. *Armstrong v. SAIF*, 67 Or App 498, 501 n.2 (1984). We agree with the ALJ that the insurer's objections to Exhibit 5 go to the weight accorded the evidence, not to its admissibility.

Compensability

We adopt and affirm the portion of the ALJ's order concerning compensability with the following changes and supplementation. In the last paragraph beginning on page 2 and continuing on page 3, we change the last sentence to read: "Based on claimant's testimony, we are persuaded that his left knee pain began in February 1998."

The insurer argues that the ALJ ignored the primary issue concerning claimant's credibility. According to the insurer, claimant testified that he told the employer that his knee pain was caused by an old injury and that he never told the employer that his work caused the knee pain.

Although the ALJ found claimant credible, he made no express credibility findings based upon claimant's demeanor. When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. *Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987).

On January 6, 1998, claimant began working for the employer as a furniture store warehouseman/delivery person. (Tr. 3-4). He testified that he did not have any knee problems before he began working for the employer. (Tr. 5). Claimant had received some medical treatment for his left knee when he was 12 after a bicycle accident. (Tr. 6). Claimant said he had "a little road rash" and it was sore for awhile. (*Id.*) He did not have any further problems with his knee until working for the employer. (*Id.*)

Claimant testified that his left knee began hurting in February 1998 when he stepped up or down carrying furniture. (Tr. 7). His knee condition worsened when he was carrying a solid oak dresser up two flights of stairs. (Tr. 8).

Claimant testified that he told the owner of the company that he had "hurt it before." (Tr. 10-11, 17). He was referring to the injury when he was 12 years old. (Tr. 11). Claimant said he told the owner that he did not know if the knee condition was work-related; claimant said he was not a doctor. (Tr. 17, 19).

Although claimant admitted that he told the owner of the company that he had hurt his knee before, he was referring to the injury that occurred when he was 12 years old, which had resolved. (Tr. 10, 11). There was no evidence of any other prior knee injury. Under these circumstances, we are not persuaded that claimant's knee pain was caused by a preexisting problem. We agree with the ALJ that claimant was a credible witness. We also agree with the ALJ's reasoning and conclusion that claimant established "objective findings" of his left knee condition to satisfy ORS 656.005(19).

Attorney Fees

The ALJ awarded claimant's attorney a $3,600 attorney fee under ORS 656.386(1).

In determining whether the attorney fee award is reasonable, we apply the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The issue in dispute was compensability of claimant's left leg infrapatellar tendinitis and whether he had established "objective findings" of that condition. Five exhibits were received into evidence, one of which was generated by claimant's counsel. There were no depositions. The hearing lasted 50 minutes and the transcript consists of 22 pages. Claimant testified on his own behalf. Claimant's counsel did not submit a statement of services or an affidavit describing counsel's time expenditures.

As compared to typical compensability cases, the issue here was of below average complexity. The claim's value and the benefits secured were of average proportions. The hearing was not lengthy, lasting only 50 minutes. Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated.

After considering these factors, we consider the ALJ's $3,600 award to be excessive. Specifically, after consideration of the aforementioned factors, we conclude that $2,500 is a reasonable assessed attorney fee for claimant's counsel's services at hearing. In particular, we have considered the complexity of the issue, the value of the interest involved, the nature of the proceeding and the risk that claimant's counsel might go uncompensated.

Finally, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $750, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 25, 1998 is affirmed in part and modified in part. In lieu of the ALJ's $3,600 attorney fee award, claimant's counsel is awarded a $2,500 attorney fee, payable by the insurer. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded $750, payable by the insurer.

In the Matter of the Compensation of
RANDALL L. PARR, Claimant
WCB Case No. 98-03527
ORDER ON REVIEW
Max Rae, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that: (1) increased claimant's unscheduled permanent disability award for a low back condition from 43 percent (137.6 degrees), as awarded by an Order on Reconsideration, to 44 percent (140.8 degrees); and (2) increased claimant's scheduled permanent disability award for loss of use or function of the right leg from 9 percent (13.5 degrees), as awarded by an Order on Reconsideration, to 22 percent (33 degrees). On review, the issue is extent of unscheduled and scheduled permanent partial disability (PPD). We modify.

FINDINGS OF FACT

We adopt the ALJ's findings, with the exception of the finding that the medical arbiters concluded that claimant's lumbar flexion measurement was invalid.

CONCLUSIONS OF LAW AND OPINION

In rating claimant's PPD, we apply the "standards" set forth in WCD Administrative Order 97-072 (effective February 15, 1997), which were in effect at the time of the November 13, 1997 Notice of Closure. *See* OAR 436-035-0003(2). Because a medical arbiter panel was used, claimant's impairment is determined by the arbiters except where a different level of impairment is established by a preponderance of medical opinion from the attending physician or other physicians with whom the attending physician concurs. ORS 656.245(2)(b)(B); ORS 656.268(7); *former* OAR 436-035-0007(12) and (13); *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670 (1994).

Unscheduled PPD

Claimant contends that the ALJ erred in not awarding an impairment value for reduced lumbar flexion. The ALJ concluded that the record did not establish *valid* reduced lumbar flexion measurements under *former* OAR 436-035-0007(27), which provides in pertinent part:

> "Validity shall be established for findings of impairment according to the criterion noted in the AMA Guides to the Evaluation of Permanent Impairment (Guides), 3rd Ed., Rev., 1990, *unless the validity criterion for a particular finding* is not addressed in this reference, is not pertinent to these rules, or *is determined by physician opinion to be medically inappropriate for a particular worker.* * * * When findings are determined invalid, the findings shall receive a value of zero. *If the validity criterion are not met but the physician determines the findings are valid, the physician must provide a written rationale, based on sound medical principles, explaining why the findings are valid.*" (Emphasis provided).[1]

Here, claimant relies on Dr. Tiley's October 1997 closing examination measurement of 17 degrees lumbar flexion, and the arbiters' April 1998 measurement of 22 degrees lumbar flexion. Under *former* OAR 436-035-0360(19), claimant would be entitled to a 7 percent impairment value based on either measurement. While nothing in Dr. Tiley's report suggests that he questioned the validity of claimant's lumbar flexion measurement, the arbiters' opinion notes that claimant's lumbar flexion measurement was invalid under the AMA Guides.

Specifically, the arbiters noted that "[t]he straight leg raising angle as measured invalidates the lumbar flexion angle, and indeed we feel that the supine straight leg raising angle is more restricted than would be expected from a sitting straight leg raising angle of 90 degrees." However, the arbiters elsewhere opined that "[t]he limitation of range of motion of the lumbar spine is probably realistic considering that the examinee has a fusion from the third lumbar vertebra to the sacrum, and this

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[1] Under the AMA Guides, "[t]he measurements of true lumbar flexion are invalid if the tightest straight leg raising (SLR) angle is not equal to or within 10 degrees of the sum of the lumbar extension and flexion measured at midsacrum." Bulletin 242 (Rev. February 1, 1995), page 7.

restriction of lumbar motion we attribute entirely to the accepted operations." We read this latter statement as *"a written rationale, based on sound medical principles, explaining why the [lumbar flexion] findings are valid"* and why *"the validity criterion [are] medically inappropriate for [this] particular worker."* *See* OAR 436-035-0007(27). For this reason, we are persuaded that the arbiters ultimately concluded that claimant's lumbar flexion measurement was valid.[2]

Accordingly, based on Dr. Tiley's closing examination report and the arbiters' opinion, claimant is entitled to a 7 percent impairment value for reduced lumbar flexion under *former* OAR 436-035-0360(19). This value is added to the values for lumbar extension and lateral flexion, for a 21 percent impairment value for reduced range of motion. *Former* OAR 436-035-0360(22). This value is combined with the 23 percent surgery value, for a total impairment value of 39 percent. *Former* OAR 436-035-0360(23). This impairment value is added to the +10 age/education/adaptability factor, for a total award of 49 percent unscheduled PPD. *Former* OAR 436-035-0280.

Scheduled PPD

At his closing examination on October 14, 1997, Dr. Tiley opined that residual permanent impairment from claimant's compensable injury included 3/5 right tibialis anterior strength and 2/5 right extensor hallucis longus strength. Based on these strength ratings, the ALJ awarded claimant 22 percent scheduled PPD of the right leg. The ALJ calculated this impairment value under *former* OAR 436-035-0230(9), which addresses loss of strength due to "peripheral nerve injury." On review, claimant contends that he is entitled to the higher impairment value for loss of strength due to "[i]njuries to unilateral spinal nerve roots" under *former* OAR 436-035-0230(8). In response, SAIF argues that the record does not establish that claimant's strength loss is due to an injury to one or more unilateral spinal nerve roots. In the alternative, SAIF contends that the ALJ erred in deferring to Dr. Tiley's strength findings over the higher strength ratings of the medical arbiters.[3]

We agree with the ALJ's reliance on Dr. Tiley's strength ratings for the reasons discussed by the ALJ. But we do not agree with the ALJ's treatment of claimant's reduced strength as a peripheral nerve injury under *former* OAR 436-035-0230(9).

We, instead, conclude that claimant's strength impairment is due to injury to multiple spinal nerve roots within the meaning of *former* OAR 436-035-0230(8). Numerous surgical reports document involvement of the L4, L5 and S1 nerve roots, with significant scar tissue at these levels. Furthermore, claimant previously received a final award of 4 percent scheduled PPD based on Dr. Tiley's identification of S1 nerve damage resulting in 4/5 dorsi-extension of the right foot and great toe.[4] In addition, there is nothing in Dr. Tiley's October 1997 closing examination to suggest that claimant's current right leg strength loss is due to anything other than injury to the lumbar nerve roots. Finally, there is no expert medical opinion that claimant's injury resulted in permanent peripheral nerve damage, or that claimant has right foot strength loss due to peripheral nerve damage.

Based on this record, we conclude that the reduced strength in claimant's right tibialis anterior and extensor hallucis longus muscles is the result of lumbar nerve root injury.[5] Accordingly, we proceed to rate claimant's right leg strength loss under *former* OAR 436-035-0230(8).

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[2] We also question whether the arbiters' SLR measurement would be a persuasive basis for invalidating the lumbar flexion measurement. The arbiters reported that claimant's right SLR angle varied between 26 and 36 degrees, and the left SLR varied from 42 to 60 degrees. These measurements may not meet the validity criterion under the AMA Guides because three consecutive measurements of both legs did not fall within plus or minus 10 percent or 5 degrees (whichever is greater) of each other. Bulletin 242 at pp. 2 and 7.

[3] SAIF does not request a decrease in claimant's scheduled PPD award.

[4] This award by a prior ALJ in a May 28, 1996 Opinion and Order was not appealed and became final.

[5] We are not persuaded by SAIF's argument that this case is controlled by the rationale expressed in *SAIF v. Calder*, 157 Or App 224 (1998). In *Calder*, the court concluded that the record did not support an award of permanent disability for right arm weakness due to injury to the coracobrachial ligament because the medical record did not establish an injury to that ligament, or a permanent loss of right arm strength. In reaching that decision, the court noted that the board is not an agency with specialized medical expertise entitled to take official notice of technical facts with its specialized knowledge. ORS 183.450(4). In contrast to the record in *Calder*, the medical evidence in the present case affirmatively established spinal nerve root injury in right leg weakness. For this reason, the present case is distinguishable from *Calder*.

The spinal nerve root which supplies (innervates) certain muscles may be identified by referencing current anatomy texts or the AMA Guides. *Former* OAR 436-035-0007(18)(b). Here, according to Table 5-5 of K. L. Moore, Clinically Oriented Anatomy, 3rd ed. (1992), the tibialis anterior muscle (ankle dorsiflexion) is ennervated by the deep peroneal nerve from L4-5, and the extensor hallucis longus muscle (toe extension) is ennervated by the deep peroneal nerve from L5 and S1. *Id.* at pp. 444-445.[6]

On the record before us, we cannot determine whether claimant's reduced tibialis anterior muscle strength is due to nerve root injury at L4, L5, or both levels. Nor can we determine whether his reduced extensor hallucis longus muscle strength is due to nerve root injury at L5, S1, or both levels. Consequently, claimant is entitled to the lower 17 percent impairment value for L4 tibialis anterior muscle weakness (the 34 percent value for L4 nerve root injury multiplied by the 50 percent value for 3/5 grade strength), and the lower 15 percent impairment value for S1 extensor hallucis longus muscle weakness (the 20 percent value for S1 nerve root injury multiplied by the 75 percent value for 2/5 grade strength. *Former* OAR 436-035-0007(18)(a) and 436-035-0230(8)(a).[7] The 17 percent and 15 percent impairment values are combined, for a final award of 29 percent scheduled PPD. *Former* OAR 436-035-0007(20).

ORDER

The ALJ's September 25, 1998 order is modified. In addition to the ALJ and the Order on Reconsideration awards of 44 percent (140.8 degrees) unscheduled permanent disability (PPD), claimant is awarded an additional 5 percent (16 degrees), for a total award of 49 percent (156.8 degrees) unscheduled PPD for his low back condition. In addition to the ALJ and the Order on Reconsideration awards of 22 percent (33 degrees) scheduled PPD, claimant is awarded an additional 7 percent (10.5 degrees), for a total award of 29 percent (43.5 degrees) scheduled PPD for loss of use or function of the right leg. Claimant's attorney is awarded an attorney fee equal to 25 percent of the additional compensation awarded by this order, payable by the SAIF Corporation directly to claimant's attorney, provided that the total of fees approved by the ALJ's order and this order shall not exceed $3,800.

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[6] D. J. Magee, Orthopedic Physical Assessment (1987), Table 8-3, p. 186, and S. Hoppenfeld, Physical Examination of the Spine and Extremities (1976), pp. 250-252, suggest that the tibialis anterior muscle is ennervated solely by the L4 nerve root, and that the extensor hallucis longus muscle is ennervated solely by the L5 nerve root. We defer, instead, to Moore's Clinically Oriented Anatomy because it is the more current anatomy text, and because it is consistent with information presented in Luciano, Vander and Sherman, Human Function and Structure (1978), Table 7-20, pp. 238-239.

[7] L5 tibialis anterior muscle weakness would result in a 19 percent impairment value (the 37 percent value for L5 nerve root injury multiplied by the 50 percent value for 3/5 grade muscle strength). *Former* 436-035-0007(18)(a) and OAR 436-035-0230(8)(a). L5 extensor hallucis longus weakness would result in a 28 percent impairment value (the 37 percent value for L5 nerve root injury multiplied by the 75 percent value for 2/5 grade muscle strength). *Id.* Weakness in both the tibialis anterior and extensor hallucis longus muscles due to L5 nerve root injury would result in a 24 percent impairment value (the average of the 19 percent and 28 percent impairment values). *Former* OAR 436-035-0007(19). Finally, tibialis anterior muscle weakness due to both L4 and L5 nerve root injury and extensor hallucis longus weakness due to both L5 and S1 nerve root injury would result in a 46 percent impairment value (the combined value of the 24 percent, 17 percent and 15 percent impairment values). *Former* OAR 436-035-0007(20).

In the Matter of the Compensation of
DONALD G. THOM, JR., Claimant
WCB Case No. 98-00579
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that upheld the insurer's denial of his occupational disease claim for a right shoulder condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation.[1]

Claimant has worked for a school district since August 1984. Since 1985, claimant has been employed as a "working" warehouse manager, with duties including receiving supplies and delivering them to schools. The supplies are unloaded from delivery trucks with a fork lift, stored in the warehouse, and eventually reloaded by hand, using hand trucks, onto trucks for delivery to the schools. These supplies include boxes of frozen food weighing from 10 to 40 pounds and boxes of paper weighing from 50 to 72 pounds. Claimant works 40 hours per week and does this loading and unloading activity about six hours a day, four days a week. The hearing on this compensability issue was held on October 23, 1998.

Only Dr. Brenneke, claimant's treating surgeon, and Dr. Fuller, examining orthopedist, offered opinions regarding the cause of claimant's right shoulder condition. Dr. Fuller provided a written opinion and was deposed on April 14, 1998. Both physicians had an accurate history regarding claimant's work activities and agreed that claimant has degenerative joint disease (arthritis) at the right acromioclavicular (AC) joint, which is the condition Dr. Brenneke surgically treated on February 12, 1998. (Exs. 24, 28-14, -17).

Claimant's attorney and Dr. Brenneke had a conversation regarding the cause of claimant's right shoulder condition. On April 13, 1998, Dr. Brenneke agreed with claimant's attorney's summary of that conversation, with the exception of two sentences, which he crossed out. (Ex. 27). Those two rejected sentences had indicated that claimant had no evidence of degenerative arthritis and that claimant had no significant arthritic degeneration that was unrelated to his work activities. (Ex. 27-2, -4). In addition, Dr. Brenneke opined that his observations during surgery revealed a right shoulder pathology that was inconsistent with the natural aging process. (Ex. 27-4). Read as a whole, we find that Dr. Brenneke opines that, although off work factors contributed to claimant's right shoulder pathology, claimant's work activities were the major contributing cause of claimant's disability and need for treatment regarding that pathology. Thus, we do not find that, because he interlineated two sentences, Dr. Brenneke's opinion lacks clarity.

On the other hand, we agree with the ALJ that Dr. Fuller's opinion is more persuasive. (Exs. 18, 28). At his deposition, Dr. Fuller clarified that the surgical report showed that claimant's calcific tendinopathy was fairly minor. (Ex. 28-37). He opined that it is not medically probable that claimant's work activities caused claimant's AC arthritis condition or pathologically worsened any preexisting arthritis condition.[2] He explained that arthritis is a gradual wearing out of the surface of a joint, with the gradual formation of spurs over time as the body seeks to immobilize the joint. (Ex. 28-29). He opined that, after the arthritis process begins, any movement causes irritation of the joint capsule. (Ex. 28-29-30). He agreed it was possible that a combination of rough joint surfaces and work activities could cause the joint surfaces to rub together more vigorously than with sedentary activities. (Ex. 28-30-31). But he found that work only made the condition symptomatic. (Ex. 28-26).

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[1] Inasmuch as claimant has not opposed the insurer's request for consideration of its respondent's brief (but instead has submitted a reply brief), we have considered all of the parties' appellate briefs in conducting our review.

[2] Because this is an occupational disease claim, claimant must prove that employment conditions were the major contributing cause of the disease, or, if the claim is based on the worsening of a preexisting disease, claimant must prove that the employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(a) and (b).

Dr. Fuller also explained that there are a number of causes of arthritis in a joint, including post-traumatic causes (*i.e.*, an injury to the joint that occurred years earlier and altered the mechanics of the joint, which leads to wear and tear of the joint surfaces), age-related causes (*i.e.*, the articular surface fissures and cracks with the aging process), a combination of post-traumatic and age-related causes, systemic causes, and idiopathic (unknown) causes. (Exs. 28-18, -19). Although Dr. Fuller noted that claimant had previously had treatment for hip pain and left shoulder pain, he found that claimant had not had sufficient work-up to determine whether he had systemic arthritis. (Ex. 18-21). He also noted that claimant did not report any specific injury to his right shoulder. (Ex. 28-28). Dr. Fuller opined that using a joint does not cause arthritis and lifting 50 pounds on a regular basis with the shoulders abducted does not put "extraordinary" stress on the shoulder and would not constitute "microtrauma." (Ex. 28-19, -22). Given all of this, Dr. Fuller concluded that the cause of claimant's arthritis was idiopathic (unknown).

Dr. Fuller was aware that Dr. Brenneke noted that his observations during surgery revealed a right shoulder pathology that was inconsistent with the natural aging process; however, Dr. Fuller disagreed with Dr. Brenneke's conclusion that, although some of the changes in the shoulder were due to aging, more than 50 percent of the pathology was due to claimant's employment. (Exs. 27-4, 28-39-42). Dr. Fuller explained that, although a surgeon would have an expectation of what a shoulder joint of a certain age should look like, nothing is presented during shoulder surgery that would enable a surgeon to distinguish between findings caused by the natural aging process and findings caused by employment. (Ex. 28-35-36, -39-41). He noted that, in such circumstances, all one could do is say that the joint is arthritic, and any opinion regarding causation would be mere speculation. (*Id.*). Instead, Dr. Fuller found the advanced arthritic changes in claimant's right shoulder to be idiopathic. (Ex. 28-40-42).

Dr. Brenneke does not respond to Dr. Fuller's deposition opinion, which raises several questions as to the persuasiveness of Dr. Brenneke's reasoning. Thus, at best, the medical evidence regarding causation is in equipoise, and claimant has failed to carry her burden of proof. ORS 656.266.

ORDER

The ALJ's order dated November 17, 1998 is affirmed.

April 8, 1999 Cite as 51 Van Natta 666 (1999)

In the Matter of the Compensation of
SIRIVAISHNOV K. REID, Claimant
WCB Case No. 98-03541
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board members Haynes and Biehl.

Claimant, *pro se*,[1] requests review of those portions of Administrative Law Judge (ALJ) Crumme's order that: (1) upheld the insurer's denial of claimant's injury claim for chemical exposure; and (2) declined to assess penalties for an allegedly unreasonable denial. Asserting that claimant has abandoned her appeal, the insurer seeks dismissal of claimant's request for review. On review, the issues are dismissal, compensability, and penalties.

We adopt and affirm the ALJ's order with the following supplementation regarding the insurer's motion to dismiss.

Apparently based on claimant's failure to file an appellant brief, the insurer contends that her request for review should be dismissed. We disagree. There is no dispute that claimant timely

[1] Although represented at hearing and when she requested review of the ALJ's order, claimant's attorney of record withdrew his representation by letter dated February 11, 1999.

requested review of the ALJ's order. We have previously held that a party's failure to submit an appellate brief does not result in the dismissal of that party's request for Board review. OAR 438-011-0020(1); *Arthur R. Schooley*, 46 Van Natta 2227 (1994); *Mike D. Sullivan*, 45 Van Natta 990 (1993); *Bonnie A. Heisler*, 39 Van Natta 812 (1987). Consequently, we deny the insurer's motion to dismiss.

ORDER

The ALJ's order dated February 17, 1999 is affirmed.

April 9, 1999 Cite as 51 Van Natta 667 (1999)

In the Matter of the Compensation of
DAVID L. ASHFORD, Claimant
WCB Case No. 98-03978
ORDER ON REVIEW
Juli Point, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Mongrain's order that set aside its "de facto" denial of claimant's injury claim for a right hip condition. Claimant cross-requests review of those portions of the ALJ's order that: (1) upheld the insurer's "de facto" denial of his right ankle injury claim; and (2) declined to award a penalty for the insurer's allegedly unreasonable claim processing. On review, the issues are compensability and penalties.

We adopt and affirm the ALJ's order with the following supplementation regarding the right hip claim.

The insurer argues that the ALJ should not have found claimant's right hip claim compensable. It specifically notes the absence of right hip complaints in contemporaneous medical records of Dr. McAndrew, claimant's attending physician. Although claimant testified that he allegedly fell on his right hip, Dr. McAndrew's July 11, 1997 chart note, documenting claimant's initial treatment three days after his alleged fall at work, does not mention right hip complaints and further states that claimant landed on his coccyx. (Ex. 11-3).

Claimant, however, completed a form 801 on July 15, 1997. There, claimant reported that he fell on his right side "butt/hip." (Ex. 13). Moreover, claimant listed the right hip as one of the body parts allegedly affected by the injury. *Id.* Thus, we find that there is contemporaneous evidence to support claimant's contention that he injured his right hip in the fall. In addition, the insurer does not contest the ALJ's conclusion that the right hip claim is supported by "objective findings." Given the medical evidence cited by the ALJ that supports compensability, we agree that claimant sustained his burden of proving that the July 1997 fall was a material contributing cause of a right hip injury.[1] Accordingly, we affirm.

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability of the right hip claim. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the right hip claim is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and counsel's statement of services), the complexity of the issue, and the value of the interest involved). Claimant is not entitled to an attorney fee for services on review regarding the penalty issue. *Saxton v. SAIF*, 80 Or App 631 (1986).

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[1] The insurer also asserts that claimant's witnesses undermined his case. While we find that those witnesses did not significantly aid claimant's case, they also did not, in our view, seriously undermine it. Based on our *de novo* review of the entire record, we are persuaded that claimant satisfied his burden of proving a compensable right hip claim.

ORDER

The ALJ's order dated December 11, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
PATTY S. COXEFF, Claimant
WCB Case No. 98-05621
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Herman's order that modified an Order on Reconsideration to award claimant additional temporary disability benefits. On review, the issue is temporary disability benefits. We reverse.

FINDINGS OF FACT

We adopt the "Findings of Fact" set forth in the ALJ's order.

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the relevant facts. On February 9, 1997, claimant sustained a right ankle injury when a co-worker stepped on her foot. She reinjured her right ankle on March 18, 1997, while attempting to move out of the way of a dolly. Thereafter, claimant filed a claim asserting that her right ankle injury was work-related.

Claimant sought medical treatment for her right ankle injury from Dr. Trapp, D.C., who released claimant from work from March 18, 1997 through April 15, 1997. On June 4, 1997, claimant sought treatment from Dr. Smith-Cupani, M.D., who diagnosed a right foot injury and anxiety and depression. Dr. Smith-Cupani's June 4, 1997 chart note stated that a "[n]ote is written to return to work on June 9."

On October 16, 1997, SAIF initially accepted claimant's claim as a nondisabling right ankle strain. Thereafter, SAIF reclassified claimant's claim as disabling. Claimant's claim was closed by an April 15, 1998 Notice of Closure that awarded temporary disability benefits from March 18, 1997 through April 15, 1997. Claimant requested reconsideration. An Order on Reconsideration issued on June, 17, 1998 that affirmed the award of temporary disability granted by the Notice of Closure. Thereafter, claimant requested a hearing, contending that she was entitled to temporary disability benefits from April 16, 1997 through June 8, 1997.

Relying on our decision in *Kenneth P. Bundy*, 48 Van Natta 2501 (1996), the ALJ concluded that claimant did not need a physician's authorization to establish entitlement to temporary disability benefits from April 16, 1997 through June 8, 1997. On the merits, the ALJ found that Dr. Smith-Cupani's June 4, 1997 chart note implied that claimant was unable to work, as a result of the compensable injury, from April 16, 1997 through June 8, 1997.

Subsequent to the ALJ's order, the court, *en banc*, reversed our decision in *Kenneth P. Bundy* that had held that the 14-day statutory limitation on "retroactive" temporary disability authorization from an attending physician (as prescribed in former ORS 656262(4)(f), now subsection (g)) was not applicable because the claim had been closed. *Fred Meyer, Inc. v. Bundy*, 159 Or App 44 (1999). After reviewing the legislative history in light of the text and context of the applicable statutes, the court concluded that the reference in ORS 656.262(4) to ORS 656.268 was intended to limit the award of retroactive time loss to 14 days, regardless of whether the claim was open or was pending closure. *Id.*

Here, the record contains no temporary disability authorization, from an attending physician, for the time period during which claimant seeks temporary disability benefits. The only reference to claimant's work status is contained in a June 4, 1997 chart note from Dr. Smith-Cupani noting that claimant could return to work on June 9, 1997. (Ex 3). We do not find this sufficient to constitute time loss authorization, particularly when Dr. Smith-Cupani's diagnoses included "anxiety and depression" a noncompensable condition. (Id).[1] Accordingly, claimant has not established entitlement to temporary disability benefits between April 16, 1997 and June 8, 1997.

ORDER

The ALJ's order dated December 3, 1998 is reversed. The Order on Reconsideration, dated June 17, 1998, is reinstated and affirmed. The ALJ's award of an out-of-compensation attorney fee is also reversed.

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[1] Even assuming Dr. Smith-Cupani's chart note was sufficient, time loss cannot be authorized more than 14 days prior to the issuance of the authorization. ORS 656.262(4)(g). Consequently, no time loss could be authorized for a time period more than 14 days prior to June 4, 1997. *Fred Meyer, Inc. v. Bundy*, 159 Or App at 53.

In the Matter of the Compensation of
ROBERT L. EUBANK, Claimant
Own Motion No. 99-0013M
OWN MOTION ORDER
Liberty Northwest Ins. Co., Insurance Carrier

On January 20, 1999, we authorized reopening of claimant's claim for the payment of temporary disability compensation beginning November 24, 1998. Claimant requests enforcement of our January 20, 1999 order, contending that the insurer had unilaterally terminated his temporary disability benefits. Specifically, claimant requests reinstatement of his benefits.

In response, the insurer relies on ORS 656.268(3)(b), which states that temporary disability compensation may be terminated when "the attending physician advises the worker and documents in writing that the worker is released to return to regular employment." The insurer contends that claimant has been released to regular work and submits a December 9, 1998 chart note and its "concurrence" letter to Dr. Purtzer in support of its contention.

Temporary disability compensation shall be paid on an "open" own motion claim until one of the following event occurs: (1) the claim is closed pursuant to OAR 438-012-055; (2) a claim disposition agreement (CDA) is submitted to the Board pursuant to ORS 656.236(1); or (3) termination of such benefits is authorized by the terms of ORS 656.268(3)(a) through (c). *See* OAR 438-012-0035(4); *Brian Lutz*, 50 Van Natta 1421 (1998); *Jeffrey T. Knudson*, 48 Van Natta 1708 (1996).

Here, the insurer relies on ORS 656.268(3)(b) to support its termination of claimant's temporary disability benefits. ORS 656.268(3)(b) provides that an insurer may terminate temporary disability benefits when "the attending physician advises the worker and documents in writing that the worker is released to return to regular employment." Those requirements were not met here.

Claimant was not released to return to regular employment. In the December 9, 1998 chart note, Dr. Purtzer, claimant's attending physician, does not release claimant to return to work. To the contrary, Dr. Purtzer recommended that claimant "be off work at this time, and at least for the next month and possibly longer."

The insurer also offers its January 26, 1999 letter to Dr. Purtzer in support of its contention that claimant's temporary disability should be terminated. We disagree with the insurer's contention.

First, the insurer asked Dr. Purtzer if only four weeks timeloss had been authorized. Although the response to the question was "yes," such a reply does not justify the insurer's termination of benefits under the applicable Board rules. Unlike benefits payable under ORS 656.268, temporary

disability benefits payable under ORS 656.278 arise by means of voluntary reopening by the carrier or Board authorization. *See* OAR 438-012-0035(1). Board authority to award temporary disability benefits under ORS 656.278 is not contingent on an attending physician's time loss authorization. *Jeffrey T. Knudson*, 48 Van Natta 1708 (1996).

In *Knudson*, we reasoned that, since an attending physician's time loss authorization is not required for commencement of temporary disability benefits pursuant to ORS 656.278, the lack of such authorization is not a basis for termination such benefits. Here, claimant's attending physician responded to a question regarding the limits of claimant's time loss authorization. Based on the *Knudson* rationale, such a response does not constitute a ground to terminate claimant's temporary disability benefits under OAR 438-012-0035(1).

The insurer's letter also asks Dr. Purtzer when would claimant be released to work and the answer was "unknown." As with the physician's response to the insurer's other question, such a response does not support the insurer's position that claimant was released to work. As such, the "unknown" response does not provide grounds to terminate temporary disability compensation.

Finally, there is no evidence that claimant was informed that he was released to regular work nor did he receive any documents which would demonstrate such a release. Consequently, a written release to regular work was not given to claimant as required by ORS 656.268(3)(b). *Cameron v. Norco Contract Service*, 128 Or App 422 (1994); *Trevor E. Shaw*, 46 Van Natta 1821 (1994).

In conclusion, we find that the termination of claimant's temporary disability benefits was not warranted. Accordingly, the insurer is directed to recommence temporary disability compensation beginning January 5, 1999 when it terminated claimant's compensation. These benefits shall continue until they can be lawfully terminated under the Board's rules.

IT IS SO ORDERED.

In the Matter of the Compensation of
KRIS KERN, Claimant
WCB Case No. 98-01537
ORDER ON REVIEW (REMANDING)
Hollander & Lebenbaum, Claimant Attorneys
Randy Rice, Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that upheld the insurer's denial of claimant's low back injury claim. Claimant argues that the ALJ erred in declining to grant his motion to postpone the hearing.[1] On review, the issues are the postponement ruling and, alternatively, compensability. We reverse and remand.

FINDINGS OF FACT

Claimant requested a hearing contesting the insurer's denial of his low back injury claim. A hearing was set for May 13, 1998, then postponed on May 11, 1998, based on claimant's unopposed motion.[2]

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[1] The insurer argues that claimant's request for hearing should have been dismissed as abandoned, because claimant has not communicated with his attorney since joining the military. We disagree, because the lack of communication between claimant and his attorney did not affect claimant's ability to attend the hearing or alter the circumstances justifying postponement in this case. *See* OAR 438-006-0071.

[2] Claimant's counsel represented that claimant was at Marine Corps boot camp at that time.

The hearing was reset for November 9, 1998. During the week before the hearing, claimant's attorney requested a second postponement because claimant was assigned to military duty in the Middle East. The insurer opposed claimant's motion to postpone.

After a November 6, 1998 teleconference with the parties' attorneys, the Assistant Presiding ALJ (APALJ) denied the motion to postpone. The APALJ's notes indicated:

> "clmt in military 'about 10 time zones away' cl has a 2 year military commitment. [Claimant's attorney]. . . last spoke w/cl in 3/98. pp denied because cl's counsel has not had contact w/cl since 3/98. No evidence that cl still pursuing claim. pp denied."

Claimant's attorney appeared at the November 9, 1998 hearing and renewed his motion to postpone. Claimant did not appear.

CONCLUSIONS OF LAW AND OPINION

The APALJ denied claimant's pre-hearing motion to postpone the hearing before the November 9, 1998 hearing convened. Claimant did not appear at the hearing. His attorney renewed his postponement request, arguing that claimant's absence due to military duty in the Middle East was an extraordinary circumstance that justified postponement of the hearing.

The ALJ stated that he would not rule on the motion to postpone because the APALJ had already denied it. The ALJ reasoned that he was neither "at liberty to second guess" the APALJ, nor would he allow "the moving party a second shot at postponement with the trial ALJ based on the same evidence" previously considered by the APALJ. (Tr. 5). Thus, the ALJ effectively upheld the APALJ's pre-hearing denial of claimant's motion.

On review, claimant continues to argue that his military duty overseas was an extraordinary circumstance justifying postponement of the hearing. The insurer responds that unavailability due to military duty is an entirely ordinary and expected consequence of enlistment and that voluntary enlistment is a matter within claimant's control. The insurer further argues that military service is an occupation or professional endeavor excluded from among extraordinary circumstances justifying postponement, under OAR 438-006-0081.

The rule provides, in relevant part:

> "A scheduled hearing shall not be postponed except by order of an Administrative Law Judge upon a finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement. 'Extraordinary circumstances' shall not include:
>
> "* * * * *
>
> "(2) Unavailability of a party, witness (other than a medical expert witness) or representative due to nonemergency medical or dental appointment, occupational, personal or professional business or appointments, or unwillingness to appear, provided that a postponement may be granted if the unavailable person is a worker who is temporarily working out of state and is reasonably expected to return to the state within a time certain * * *"

The insurer does not dispute claimant's counsel's representation that claimant was unavailable to attend the scheduled hearing because he was performing military duty in the Middle East. Thus, the question is whether unavailability due to overseas military duty justifies postponement. We have previously held that if, the claimant's spouse's testimony was probative on the compensability issue, that spouse's absence from the hearing due to military service in the Middle East would be an extraordinary circumstance justifying postponement *See Wonder Windom-Hall*, 43 Van Natta 1723 (1991).

This case differs from *Wonder Windom-Hall* in two particulars, but the result is the same. First, in *Windom-Hall*, neither the claimant nor her attorney appeared at the hearing.[3] Here, claimant's attorney appeared on claimant's behalf.

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[3] *See Jose Arisqueta-Martinez*, 42 Van Natta 2071 (1990) (where a worker's attorney appears on his behalf at a hearing, dismissal of the worker's request for hearing for failure to appear is not appropriate).

Second, the claimant's spouse in *Windom-Hall* was absent from the hearing because he had been called to involuntary active military duty, just one day before the scheduled hearing. *Id.* Under those circumstances, we did not equate the claimant's spouse's absence due to overseas military duty with "occupational, personal or professional business or appointments" as expressed in *former* OAR 438-06-081(2). Instead, we concluded that the circumstances there amounted to extraordinary circumstances beyond the claimant's control.[4]

Here, the parties agree that claimant enlisted voluntarily. Assuming without deciding that claimant's absence due to voluntary active military duty constitutes "occupational, personal or professional business or appointments", we conclude that postponement was nevertheless appropriate under the portion of the rule providing that:

> "a postponement may be granted if the unavailable person is a worker who is temporarily working out of state and is reasonably expected to return to the state within a time certain." OAR 438-006-0081(2).

Here, the insurer's denial asserts that claimant "did not sustain an injury" during the course and scope of his employment for the insured. (Ex. 16). Considering the denial's basis, we find that claimant's testimony about the claimed injury would likely be probative on the compensability issue. In addition, the circumstances of claimant's absence indicate that, when the hearing convened, he was "temporarily working out of state and [] reasonably expected to return to the state within a time certain" (*i.e.*, after his two year military duty commitment). Accordingly, we conclude that claimant's overseas military duty was a circumstance justifying postponement under the rule. Consequently, we reverse the ALJ's order and remand the case for further proceedings consistent with this order. The ALJ shall have the discretion to proceed in any manner that will achieve substantial justice for all parties.[5]

ORDER

The ALJ's order dated December 8, 1998 is reversed. This matter is remanded to ALJ Thye for further proceedings consistent with this order.

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[4] Because the record was inadequately developed to determine whether two witnesses' testimony would be probative on the underlying compensability issue, we remanded the case with instructions to decide if such testimony would be probative and whether dismissal was justified. We explained that dismissal would not be justified if the witnesses' testimony would be probative, because the claimant had otherwise established extraordinary circumstances justifying postponement. *Id.*

[5] Before re-scheduling the hearing, the ALJ may wish to consider directing claimant's counsel to attempt to contact claimant to determine when he would be available to attend a hearing (*e.g.*, if claimant is still serving in the military, perhaps the hearing could be scheduled when he is in the state on leave). A hearing date could then be scheduled upon receipt of such information.

April 13, 1999 Cite as 51 Van Natta 672 (1999)

In the Matter of the Compensation of
JERRY L. BROWN, Claimant
WCB Case No. 98-05265
ORDER ON RECONSIDERATION
Pozzi, Wilson, et al, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

It has come to our attention that our March 29, 1999 Order on Review contains a clerical error. Specifically, claimant's counsel's attorney fee amount is erroneously stated as "$3,600" in the fourth paragraph on page 1 and the first full paragraph on page 2. To correct this oversight, we replace all references in our prior order to "$3,600" with "$3,000."

Accordingly, our March 29, 1999 order is withdrawn. On reconsideration, as supplemented and modified herein, we republish our March 29, 1999 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICKY D. MICHAEL, Claimant
WCB Case No. 98-03676
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that increased claimant's unscheduled permanent disability from 7 percent (22.4 degrees), as awarded by an Order on Reconsideration, to 21 percent (67.2 degrees). Claimant cross-requests review of that portion of the ALJ's order that declined to award an attorney fee pursuant to ORS 656.382(2). On review, the issues are extent of unscheduled permanent disability and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Disability

We adopt the ALJ's reasoning and conclusions regarding this issue with the following supplementation.

Citing *Cindy M. Penturf*, 50 Van Natta 1718 (1998), claimant argues that the ALJ allowed SAIF to raise a "new issue" by seeking a reduction in claimant's permanent disability award in its written closing argument. We find *Penturf* distinguishable.

In *Penturf*, as in the present case, the parties submitted the case to the ALJ on the written record and no formal hearing was held. The claimant's written closing argument addressed the issues of extent of permanent disability and offset. The insurer addressed those issues, but also, for the first time, disputed the claimant's entitlement to temporary disability after March 19, 1996. Considering that the insurer had specifically requested that the reconsideration order be affirmed, including an award of temporary disability from February 6, 1996 through April 11, 1997, we found that the insurer untimely raised the new issue of temporary disability after March 19, 1996 in its written closing argument.

Unlike the new temporary disability issue raised in *Penturf*, the issue of the extent of claimant's unscheduled permanent disability raised by SAIF in the present case was not a "new" issue, but was an issue that had already been placed before the ALJ by virtue of claimant's hearing request. *See Pacific Motor Trucking Co. V. Yeager*, 64 Or App 28 (1983). Under such circumstances, we find the facts of *Penturf* to be distinguishable from those in the present case.

SAIF also argues that claimant was released to perform his regular work and that, consequently, he should only receive an award for the impairment factor. ORS 656.726(3)(f)(D)(ii) provides: "(D) Notwithstanding any other provision of this section, impairment is the only factor to be considered in evaluation of the worker's disability under ORS 656.214(5) if * * * (ii) The attending physician releases the worker to regular work at the job held at the time of injury and the job is available, but the worker fails or refuses to return to that job."

Here, we have adopted the ALJ's reasoning and conclusion that the medical arbiter's report is the most persuasive evidence regarding claimant's impairment. Based on the arbiter's report, which addresses claimant's limitations from the injury, we are persuaded that claimant was unable to return to his regular work.

Attorney Fees

The ALJ found that claimant was not entitled to an attorney fee pursuant to ORS 656.382(2) because SAIF did not formally appeal the Order on Reconsideration's award of permanent disability. Claimant argues that he is entitled to an attorney fee. We agree.

An attorney fee is warranted under ORS 656.382(2) whenever a claimant's compensation award is challenged at hearing, regardless of whether that challenge arises in the carrier's formal cross-request or informally at hearing, and the claimant successfully defends against it. *Kordon v. Mercer Industries*, 308 Or 290 (1989); *Roger R. Powers*, 49 Van Natta 1388 (1997). Consequently, because claimant successfully defended against SAIF's request for reduction or disallowance of claimant's unscheduled permanent disability award, claimant is entitled to a carrier-paid attorney fee for services at hearing and on review.

Claimant seeks an attorney fee of $4,000 for services at hearing and on review under ORS 656.382(2). SAIF argues that a fee of $4,000 is excessive based on the complexity of the issue involved and the value of the interest (claimant's permanent disability award). Although it asserts the requested fee is excessive, SAIF argues that the case should be remanded to the ALJ to make specific findings of fact regarding each factor in OAR 438-015-0010(4) to determine the amount of the attorney fee.[1]

Because the ALJ did not award a fee under ORS 656.382(2), she did not address the factors in OAR 438-015-0010(4). Nevertheless, because we are authorized to modify or supplement the ALJ's order under ORS 656.295(6), it is not necessary to remand this case to the ALJ for supplementation regarding claimant's attorney fee award. Consequently, we deny SAIF's motion to remand and proceed to consider the factors in OAR 438-015-0010(4) in determining a reasonable attorney fee for services at hearing.

In determining a reasonable attorney fee, we consider the following factors: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) The value of the interest involved; (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses. OAR 438-015-0010(4).

Claimant's attorney asserts that 12 hours were spent on the case at the hearing level and 15 hours were spent at the Board review level. The issue at hearing was limited to the extent of unscheduled permanent disability, while, on review, the issues involved extent and attorney fees.[2]

We find that the permanent disability issue was of average complexity. The value of the interest involved was limited to the value of claimant's unscheduled permanent disability award. The parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented. Finally, given SAIF's request that the award be reduced, there was some risk that claimant's counsel's efforts might have gone uncompensated.

After considering the factors set forth in OAR 438-015-0010(4), we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding SAIF's challenge to claimant's unscheduled permanent disability award is $3,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Although we have awarded less than requested by claimant's attorney, we find that $3,000 is a reasonable fee given that the sole issue was permanent disability, an issue for which claimant's attorney has already been awarded an out-of-compensation attorney fee at the hearing level for services regarding claimant's increased permanent disability award (25 percent of the increased compensation from 7 percent unscheduled permanent disability to 21 percent).

ORDER

The ALJ's order dated October 15, 1998 is reversed in part and affirmed in part. That portion of the ALJ's order that declined to award an attorney fee pursuant to ORS 656.382(2) for the hearing level is reversed. For services at hearing and on Board review, claimant's attorney is awarded $3,000, payable by SAIF. The remainder of the ALJ's order is affirmed.

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[1] We have held that an ALJ need not make findings for each rule-based factor where there was no specific fee request and the parties did not provide any argument at hearing concerning the application of the factors in OAR 438-015-0010(4). *Daryl L. Underwood*, 50 Van Natta 2330 (1998).

[2] Claimant is not entitled to an attorney fee on review for his counsel's services regarding the ALJ's attorney fee award. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

In the Matter of the Compensation of
DIANE C. PENN, Claimant
WCB Case Nos. 98-05985 & 98-05865
ORDER ON RECONSIDERATION
Edward J. Harri, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

The self-insured employer requests reconsideration of that portion of our February 17, 1999 order that referred to claimant's attorney's "services on review" as the basis for a $750 attorney fee under ORS 656.382(2). The employer contends that the "Order" section of our opinion should be corrected to be consistent with the previous paragraph that awarded an attorney fee of $750 for claimant's attorney's services *at hearing* for successfully defending against the employer's request for reduction of claimant's scheduled permanent disability award. In order to further consider the matter, we abated our order. Having received claimant's response and the employer's reply, we proceed with our reconsideration.

We first address claimant's argument that she is entitled to an attorney fee for her attorney's services on review. For the following reasons, we disagree.

In October 1996, claimant filed a claim for elbow problems. (Ex. 2). The employer accepted disabling bilateral epicondylitis. (Ex. 32). On June 10, 1998, the claim was closed by Notice of Closure that awarded only temporary disability. (Ex. 94). Claimant requested reconsideration and a July 10, 1998 Order on Reconsideration awarded claimant 5 percent scheduled permanent disability for loss of use or function of each forearm (wrist). (Exs. 101, 106). The employer requested a hearing, asserting that claimant's scheduled permanent disability award should be reduced to zero. Claimant also requested a hearing, arguing that the scheduled permanent disability award should be increased. The ALJ modified the Order on Reconsideration to award claimant 5 percent scheduled permanent disability for loss of use or function of each elbow/arm.

The employer requested review, contending that claimant was not entitled to an award of scheduled permanent disability for a chronic condition of her elbows. The employer also argued that the ALJ erred by changing the permanent disability rating from a wrist to an arm.

Under ORS 656.382(2), if a request for review is initiated by an employer or insurer, and the Board finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee. In our February 17, 1999 order, we modified the ALJ's order and reinstated the July 10, 1998 Order on Reconsideration, thereby reducing claimant's scheduled permanent disability award. Because our order on review reduced claimant's scheduled permanent disability award as granted by the ALJ's order, we conclude that she is not entitled to an attorney fee under ORS 656.382(2) for services on review.

Both parties agree that claimant is entitled to an attorney fee under ORS 656.382(2) for claimant's attorney's services *at hearing*. Claimant argues that we should affirm the ALJ's $1,000 attorney fee award, while the employer asserts on reconsideration that the award should be reduced to $750.[1] After further review and after considering the factors in OAR 438-015-0010(4) and applying them to this case, we find that $1,000 is a reasonable attorney fee award under ORS 656.382(2) for claimant's attorney's services at hearing. Therefore, we modify the last two paragraphs of our previous order to read:

> "After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing for successfully defending against the employer's request for reduction of her scheduled permanent disability award is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's brief), the complexity of the issue, and the value of the interest involved.

[1] We note that the employer did not challenge the amount of the ALJ's attorney fee award on review.

ORDER

The ALJ's order dated October 22, 1998 is modified. In lieu of the ALJ's award, the Order on Reconsideration award of 5 percent (7.5 degrees) scheduled disability for loss of use or function of each forearm (wrist) is reinstated and affirmed. For services at hearing regarding the self-insured employer's attempt to reduce claimant's scheduled permanent disability award, claimant's attorney is awarded a $1,000 attorney fee, payable by the employer."

Accordingly, on reconsideration, as modified herein, we adhere to and republish our February 17, 1999 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

April 12, 1999 Cite as 51 Van Natta 676 (1999)

In the Matter of the Compensation of
DEBRA L. TAYLOR, Claimant
WCB Case No. 98-06058
ORDER ON REVIEW
Lawrence A. Castle, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Moller and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Marshall's order that set aside its denial of claimant's right shoulder injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant provided cleaning services for the insured from May 1998 until June 17, 1998. She filed a claim for a right shoulder injury on June 12, 1998 and sought treatment for her shoulder on June 17, 1998. Dr. Maher, D.C., diagnosed bicipital tendinitis and a transverse ligament strain.

Claimant raised horses and participated in rodeos off work. Before June 1998, she sustained numerous injuries with horse-related activities, including injuries to her back, neck, knees, and left shoulder.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant credibly testified that her right shoulder injury occurred on June 12, 1998, when a vacuum cleaner cord got stuck under a door and she jerked her right shoulder while leaving the room with the vacuum in hand. Further finding that claimant's testimony was supported by the "801" forms filled out on the date of the incident, and consistent with claimant's contemporaneous history to Dr. Maher, the ALJ found the claim compensable. We disagree.

Dr. Maher, treating chiropractor, opined that claimant's right shoulder condition resulted from the work incident, noting that the mechanism of the injury described by claimant was consistent with his diagnosis. (Exs. 5, 6). Thus, the persuasiveness of Dr. Maher's causation opinion depends on the accuracy and reliability of claimant's reporting to the doctor.

The ALJ found claimant to be a credible witness based on her demeanor. We generally defer to the ALJ's demeanor-based credibility finding. *See International Paper Co. v. McElroy*, 101 Or App 61 (1990). However, we are in as good a position as the ALJ to evaluate the credibility of a witness based on an objective review of the substance of the record. *See Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987); *Davies v. Hanel Lumber Co.*, 67 Or App 35 (1984); *Rob R. Hartley*, 49 Van Natta 2011 (1997). Inconsistencies in the record may be a sufficient basis to disagree with the ALJ's credibility finding if they raise such doubt that we are unable to conclude that material testimony is credible. *See Gail A. Albro*, 48 Van Natta 41, 42 (1996); *Angelo L. Radich*, 45 Van Natta 45 (1993). Where a claimant's reporting is inconsistent or incomplete, a medical opinion based on that reporting is unpersuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) ("[The doctor's] conclusions are valid as to the matter of causation only to the extent that the underlying basis of those opinions, the reports of

claimant as to the circumstances of the accident and the extent of the resulting injury, are accurate and truthful."); *James D. Shirk*, 41 Van Natta 90, 93 (1989) (a physician's opinion based on a patient's history is only as reliable as the history is accurate).

In this case, claimant's testimony is both internally inconsistent and inconsistent with testimony of her co-workers.

Dr. Maher treated claimant's low back on March 20, 1998, noting that claimant had "fixed [a] gate." (Ex. 2a). At hearing, claimant stated that she had "never been hurt by a gate," explaining that her low back hurt in March 1998 after a horse smashed her "against a wall," not a gate. (Tr. 17). Later, claimant described the March 1998 low back injury as happening when a horse smashed her "up against a gate." (Tr. 36). Although the March 1998 low back injury is not implicated as contributing to claimant's recent shoulder problems, her inconsistent reporting about that injury is unexplained and it casts some doubt on the accuracy and reliability of her reporting generally.[1]

We also find inconsistencies within claimant's testimony about events in June 1998 and between claimant's reporting and her co-workers' recollection, particularly concerning events on June 11, 1998.

It is undisputed that claimant was late for work on Thursday, June 11, 1998 because she had to fix a gate at home after one of her horses got loose. But we note that claimant first testified that the June 1998 gate incident happened on *Friday*, and later acknowledged that it happened the day before, on Thursday. (*See* Tr. 12, 58-59).

We also note that claimant testified that she was "positive" that she had not told any of her co-workers that she injured her right arm or shoulder while working on the gate Thursday morning. (Tr. 32). But two of claimant's co-workers testified that claimant complained of a "sore" right shoulder or arm on *that day* -- the day before the alleged June 12, 1998 vacuum cleaner incident. One co-worker remembered that claimant could only do light work all day Thursday, because she had hurt her shoulder before coming to work that day. (Tr. 48-49). The other co-worker remembered that claimant's arm was "sore" on Thursday, June 11, 1998 from lifting the gate at home. (Tr. 52). Considering claimant's inconsistent reporting about the timing of events, we cannot say that claimant's reporting is accurate or reliable or that Dr. Maher probably had a complete and accurate history about the onset of claimant's right upper extremity problems or the relationship between claimant's activities and her symptoms.

Under these circumstances, we decline to rely on Dr. Maher's causation opinion and conclude that the claim must fail for lack of persuasive medical evidence.

ORDER

The ALJ's order dated November 13, 1998 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[1] We also note Dr. Maher's history that, on February 27, 1998, claimant had injured her "lumbar and cervical spine and infraspinitis and posterior deltoid muscles when 'squished' *between two horses*." (Ex. 5-1, emphasis added).

In the Matter of the Compensation of
ROBERT L. FOWLER, Claimant
Own Motion No. 98-0300M
OWN MOTION ORDER ON RECONSIDERATION
Kryger, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant seeks Board authorization of an approved fee for his attorney's services culminating in our March 31, 1999 Own Motion Order. We received the retainer agreement submitted by claimant's attorney. An amount of 25 percent of the increased temporary disability compensation is awarded under this order, not to exceed $1,500, payable by the SAIF Corporation directly to claimant's attorney. *See* 438-015-0080.

Accordingly, our March 31, 1999 order is abated and withdrawn. As amended herein, we adhere to and republish our March 31, 1999 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LINDA L. LINNETT, Claimant
WCB Case No. 98-05027
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that affirmed an Order on Reconsideration that awarded no scheduled or unscheduled permanent disability for claimant's right wrist and right shoulder injuries. On review, the issue is extent of scheduled and unscheduled permanent disability.

We adopt and affirm the ALJ's order with the following supplementation.

The ALJ found no medical evidence sufficient to support an award of permanent disability. On review, claimant asserts that the medical arbiters and examining physicians Kirschner and Jones (whose report was concurred in by the attending physician) incorrectly concluded that the impairment findings noted in their exams were invalid. Claimant relies on OAR 436-035-0007(27) which provides, in pertinent part, that "findings of impairment which are determined to be ratable pursuant to these rules shall be rated unless the physician determines the findings are invalid and provides a written opinion, based on sound medical principles, explaining why the findings are invalid." (WCD Admin. Order 96-072).

Contrary to claimant's argument, all of the physicians who may make findings of impairment have provided written opinions based on sound medical principles which explain why the findings of impairment are invalid. Specifically, Drs. Kirschner and Jones noted "many discrepancies in strength, motion and effort, along with pain behavior that could be distracted and overcome during our examination which all points to either a possible psychological or psychiatric diagnosis which would give an explanation for this patient's disability." (Ex. 16-9).

The medical arbiter panel also found that claimant's impairment findings were invalid. Specifically, they indicated that when claimant was asked to remove her pullover to measure the circumference of her upper arm and forearm, they observed that claimant was able to internally rotate, abduct and adduct the right shoulder to an equal degree on the right shoulder as the left. The arbiters also noted that, while claimant was removing the pullover, the extension of both wrists was normal and symmetrical. The arbiters further noted that the medical record indicated that claimant had demonstrated a great deal of variation in range of motion measured by different examiners in the past.

The arbiters also noted no objective findings of orthopedic or neurological injury that could explain the limitation of motion that claimant displayed. Finally, the arbiters stated that claimant's motor examination showed an invalid pattern of give-way and ratchety weakness and that the muscle groups that demonstrated weakness were inconsistent with the muscle groups involved with the limitation of motion that claimant displayed. For these reasons, the arbiter panel concluded that claimant's impairment findings were invalid.

After our review, we find that the physicians who rated impairment determined that the findings were invalid and provided written opinions, based on sound medical principles, explaining why the findings were invalid. Under such circumstances, we disagree with claimant's assertion that the impairment findings should be rated pursuant to OAR 436-035-0007(27).

ORDER

The ALJ's order dated November 30, 1998 is affirmed.

In the Matter of the Compensation of
DONNA R. GRIERSON, Claimant
WCB Case No. 98-05742
ORDER ON REVIEW
Pozzi Wilson & Atchison, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl, Moller and Bock.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Mills' order that assessed a $1,250 fee for claimant's counsel's services at hearing. SAIF also moves for remand. On review, the issues are remand and attorney fees.

We deny SAIF's motion for remand, and adopt and affirm the ALJ's order with the following supplementation.

Claimant requested a hearing challenging the scope of SAIF's acceptance of her claim. Following the hearing, the ALJ directed SAIF to expand its acceptance to include a right arm strain. The ALJ also assessed an attorney fee of $1,250 "based on the principles and factors set forth in OAR 438-015-0010."

On review, SAIF asserts that the ALJ failed to provide a sufficient explanation for the assessed fee, and seeks remand to the ALJ. Contrary to SAIF's contention, an ALJ is not required to make specific findings regarding each of the factors set forth in OAR 438-015-0010(4) where, as here, there is no specific attorney fee requested and the parties did not submit arguments at hearing addressing the factors to be weighed in determining a reasonable fee. *Daryl L. Underwood*, 50 Van Natta 2330 (1998). The ALJ satisfies his or her obligation to make findings in a case by including in the order a brief description or citation to the rule-based factor or factors the ALJ relied on in determining the attorney fee awarded. *Id.* (*citing McCarthy v. Oregon Freeze Dry*, 327 Or 84, *adhered to on recon*, 327 Or 185 (1998)).

Here, although the ALJ cited the applicable rule (OAR 438-015-0010(4)), he did not identify the factors he considered in awarding the attorney fee. In other words, the ALJ did not discuss any of the specific rule-based factors, such as the value of the interest involved, the time devoted to the case, the complexity of the issue, the benefit secured, the skill of the attorneys, the nature of the proceedings or the risk that the claimant's counsel's efforts might go uncompensated. Because the ALJ's order is devoid of any explanation of his application of the factors in determining the attorney fee in this case, we find the ALJ's reasoning insufficient to determine how he arrived at $1,250 as a reasonable fee. *Compare Weyerhaeuser Co. v. Fillmore*, 98 Or App 567 (1989) (Board not required to making finding as to each factor, however Board's explanation must be detailed enough to establish reasonable basis for its decision); *see also Leslie D. Custer*, 51 Van Natta 390 (1999) (in the absence of a specific request or objection, ALJ's particular consideration of certain enumerated factors satisfies the *Underwood* rationale); *William J. Kephart*, 51 Van Natta 291 (1999) (the ALJ applied the proper standard in determining a reasonable fee were he specifically indicated that the assessed fee was based upon the factors set forth in OAR 438-015-0010 *and* identified the factors considered, *i.e.*, the time devoted to the case, the complexity of the issue, the value of the interest and benefit to claimant and risk that counsel may go uncompensated).

Even though we find the ALJ's attorney fee discussion lacking in this case, we do not find the record to be improperly, incompletely or otherwise insufficiently developed. *See* ORS 656.295(5). In other words, because we are authorized to modify or supplement the ALJ's findings and conclusions under ORS 656.295(6), it is not necessary to remand this case to the ALJ for supplementation of findings regarding the attorney fee award. Consequently, we deny SAIF's motion to remand.

We provide the following additional reasoning concerning the attorney fee award for claimant's counsel's services at hearing. A hearing convened that lasted approximately one half hour. Claimant was the only witness to testify. The record consists of 22 exhibits, all of which were submitted by SAIF. Based on "scope of acceptance" disputes generally litigated before this forum, we find the issue presented in this case of modest complexity. The value of the interest involved and the benefit secured for claimant are material, however, because SAIF has been directed to accept a right arm strain condition (potentially rateable as a scheduled body part) in addition to the previously accepted cervical and right shoulder conditions, which are unscheduled body areas. The attorneys involved in this matter are skilled litigators with substantial experience in worker's compensation law. Furthermore, there was a risk that claimant's counsel might go uncompensated, given Dr. Hickerson's opinion that SAIF's initial acceptance was sufficient to advise claimant and her providers of the nature of her compensable conditions.

Consequently, after considering the factors set forth in OAR 438-015-0010(4), including the relatively minimal time expended (as represented by the record at hearing) and the modest complexity of the legal issue involved, we agree with the ALJ that $1,250 is a reasonable fee for claimant's counsel's services at hearing. We therefore affirm the ALJ's attorney fee award.[1]

ORDER

The ALJ's order dated October 23, 1998 is affirmed.

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[1] Because SAIF challenged only the attorney fee award on review and attorney fees are not "compensation" for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for his counsel's services on review. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

Board Chair Bock specially concurring.

I agree with the majority that the attorney fee award made by the ALJ is reasonable and should be affirmed. Unlike the majority, however, I would find the ALJ's explanation for the $1,250 attorney fee award sufficient under the standard set by the Court in *McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or 84, *adhered to on recon* 327 Or 185 (1998), and our lead decision in *Daryl L. Underwood*, 50 Van Natta 2330 (1998). Therefore, I write separately.

As the majority notes, an ALJ is *not* required to make specific findings regarding the factors set forth in OAR 438-015-0010(4) where, as in this case, there was no specific attorney fee requested and the parties did not submit arguments at hearing addressing the factors to be weighed in determining a reasonable fee. *Daryl L. Underwood*, 50 Van Natta 2330 (1998). The ALJ satisfies his or her obligation to make findings in a case by including in the order a brief description or citation to the rule-based factor or factors the ALJ relied on in determining the attorney fee awarded. *Id.*

Here, the ALJ specifically stated that the $1,250 assessed attorney fee was based on the principles and factors set forth in OAR 438-015-0010. Although the ALJ did not discuss any particular rule-based factor, he did indicate that he considered the factors in determining a reasonable fee. In the absence of a specific attorney fee request and any arguments at hearing addressing the factors to be considered in determining the fee, I would find that the ALJ is not obligated to make specific findings regarding the rule-based factors. I believe it is sufficient to cite the applicable rule and state that the attorney fee is based upon the factors and principles set forth therein.

In the Matter of the Compensation of
KENNETH D. JOHNSON, Claimant
WCB Case No. 98-04489
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that increased claimant's unscheduled permanent disability award for a low back injury from 1 percent (3.2 degrees), as awarded by an Order on Reconsideration, to 11 percent (35.2 degrees). In its brief, the insurer requests that we take "administrative notice" of the questions presented to the medical arbiter. On review, the issues are administrative notice and extent of unscheduled permanent disability. We deny the insurer's request and reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for the last paragraph.

CONCLUSIONS OF LAW AND OPINION

Administrative Notice

The insurer requests that we take administrative notice of the questions presented to the medical arbiter in this case. We deny the insurer's motion because our consideration of the Appellate Unit's instructions to the medical arbiter would not effect our ultimate disposition in this case. *See Celia Barrera*, 50 Van Natta 462 (1998).

Extent of Unscheduled Permanent Disability

The insurer challenges the ALJ's award of 11 percent unscheduled permanent disability. For the following reasons, we reverse the ALJ's award and reinstate the Order on Reconsideration award of 1 percent.

Claimant compensably injured his low back on March 14, 1997. (Ex. 4). The insurer accepted a lumbar strain. (Ex. 18). A December 2, 1997 MRI showed a fusion mass involving L2 and L3, which was related to a lumbar fusion claimant had at age 14. (Exs. 1, 12). The MRI also showed multilevel disc disease, most notable at L5-S1. (Ex. 12). Dr. George performed a closing examination on January 14, 1998, finding claimant medically stationary. (Ex. 17).

On reconsideration, where a medical arbiter is used, impairment is established by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. OAR 436-035-0007(13). We do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment but, rather, rely on the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

Here, we conclude that Dr. Farris, who performed a medical arbiter examination on April 30, 1998, provides the most reliable evaluation of claimant's low back impairment as of the date of issuance of the Order on Reconsideration. Dr. Farris found that claimant had reduced range of motion in his lumbar spine. (Ex. 24-4). The findings for lumbar extension and right and left lateral extension were valid, but claimant's lumbar flexion test was invalid. (*Id.*) Dr. Farris diagnosed an accepted condition of lumbar strain, idiopathic and preexisting degenerative changes of the lumbar spine, and preexisting two-level spinal fusions and an L2 compression fracture with scoliosis. (Ex. 24-5). She reported that the impairment findings were "due to the injury and due to the previous conditions[.]" (*Id.*) Dr. Farris explained:

> "The percentage of impairment related to the accepted condition would be in the range of less than 5%. The rationale for that decision is that multiple previous examinations by a chiropractor, orthopedic surgeons, neurologist, and neurosurgeon have all indicated normal straight leg raising and normal ranges of motion. They have also noted no tenderness most of the time." (Ex. 24-5, -6).

The May 28, 1998 Order on Reconsideration indicated that, based on the medical arbiter's findings, the total range of motion loss in the lumbar spine due to the accepted condition was 11 percent. (Ex. 25-2). The Order on Reconsideration relied on the medical arbiter's statement that the "percentage of impairment related to the accepted condition would be in the range of less than 5%" and determined that claimant was entitled to 5 percent of the 11 percent impairment, which was rounded to 1 percent. (*Id.*) We agree with the Order on Reconsideration's interpretation of Dr. Farris' statement. We reinstate the Order on Reconsideration award of 1 percent (3.2 degrees).

ORDER

The ALJ's order dated December 16, 1998 is reversed. The Order on Reconsideration award of 1 percent (3.2 degrees) is reinstated and affirmed. Claimant's attorney fee award is reversed.

In the Matter of the Compensation of
MARK T. KAWAMURA, Claimant
WCB Case No. 98-05177
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board members Biehl and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order that: (1) upheld the insurer's denial of claimant's aggravation claim for a current left wrist ganglion cyst condition; and (2) declined to award penalties or attorney fees for the insurer's allegedly unreasonable claim processing. On review, the issues are aggravation, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The insurer accepted claimant's claim for a left wrist ganglion cyst as a nondisabling April 8, 1997 injury. On May 12, 1997, Dr. Bitter excised the cyst. An August 8, 1997 Notice of Closure closed the claim and awarded temporary disability benefits only. A December 16, 1997 Order on Reconsideration modified claimant's temporary disability award, but otherwise affirmed the Notice of Closure.

Claimant terminated his employment in September 1997 and began taking courses to become a certified nurse's aide. He sought treatment for left hand problems in January, March, and June, 1998. In January 1998, Dr. Bitter diagnosed thumb pain, but prescribed no treatment. On March 11, 1998, Dr. Bitter diagnosed a recurrent ganglion cyst, discussed treatment options, and filed an aggravation claim on claimant's behalf. On June 8, 1998, Dr. Bitter aspirated the cyst. On June 16, 1998, the insurer denied claimant's aggravation claim. Claimant requested a hearing.

Aggravation

The ALJ upheld the insurer's denial, finding no direct medical evidence that the recurrent ganglion cyst represented an actual or pathological worsening of the accepted cyst condition. We disagree.

To prove his aggravation claim, claimant must establish a worsened condition resulting from his original injury.

> "A worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings." ORS 656.273(1).

An "actual worsening" is established by medical evidence of a pathological worsening or medical evidence that a symptomatic worsening amounts to a worsening of the condition. *See SAIF v. Walker*, 145 Or App 294, 305 (1996), *rev allowed* 325 Or 367 (1997) (In order for a symptomatic worsening to constitute an "actual worsening," a medical expert must conclude that the symptoms have increased to the point that it can be said that the condition has worsened). In addition, claimant must show that he has lost use or function of his left wrist as a result of this worsening. *See Fred Meyer, Inc. v. Farrow*, 122 Or App 164, 167 (1993) (quoted in *Intel Corp. v. Renfro*, 155 Or App 447, 451 (1998)).

Here, the initial claim was closed in August 1997 without permanent disability after the cyst was excised. Then, at the June 1998 examination, Dr. Bitter observed a "recurrent cyst" related to the original cyst and opined that it was due to the same work activities that caused the original problem. (Exs. 10, 17). Based on Dr. Bitter's observation of the cyst and his opinion relating the recurrent cyst to the original (compensable) cyst, we find that claimant has established an actual (pathological[1]) worsening of his compensable condition since the initial claim was closed.

The remaining question is whether claimant has lost left wrist use or function as a result of his worsened condition.

Dr. Bitters examined claimant three times after the August 1997 Notice of Closure. On January 5, 1998, the doctor detected no mass at the cite of the previous cyst, but diagnosed "thumb pain of uncertain etiology." (Ex. 8). On March 11, 1998, he observed a "recurrent mass," noting that it was sore, but not interfering with claimant's activities. (*Id*). Then, on June 8, 1998, Dr. Bitters reported, without expressing any skepticism, claimant's history that his left wrist became achy and painful with use. (Ex. 10). Dr. Bitters discussed the history of the cyst and treatment options with claimant, and used a needle to "aspirate the mass completely." (Ex. 10).

Based on Dr. Bitters' March 1998 observation of the recurrent cyst (coincident with claimant's complaints of soreness) and his June 1998 aspiration of the cyst (coincident with the physician's reference to *use-related* problems, which claimant did not have in January or March), we find that claimant experienced lost use or function of his wrist due to his compensable condition. Accordingly, we conclude that claimant has established a compensable aggravation.

Penalties and Attorney Fees

The ALJ declined to award penalties or attorney fees based on the insurer's allegedly unreasonable denial and its allegedly untimely payment for medical services, because he upheld the denial.

Penalties may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(11)(a). The reasonableness of a carrier's denial of compensation must be gauged based upon the information available to the carrier at the time of its denial. *Brown v. Argonaut Insurance Company*, 93 Or App 588 (1988); *Price v. SAIF*, 73 Or App 123, 126 n. 3 (1985). A carrier's "refusal to pay is not unreasonable if it has a legitimate doubt about its liability." *International Paper Co. v. Huntley*, 106 Or App 107, 110 (1991) (*citing Castle & Cook, Inc., v. Porras*, 103 Or App (1990)).

Here, considering the scant evidence regarding a pathological worsening and of a loss of use or function of claimant's left hand/wrist, we conclude that the insurer had a legitimate doubt about its liability. Therefore, its denial was not unreasonable. Consequently, we deny claimant's request for a penalty on this basis.

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[1] "Pathology" is defined as:

"1. that branch of medicine which treats of the essential nature of disease, especially of the structural and functional changes in tissues and organs of the body which cause or are caused by disease. 2. the structural and functional manifestations of disease." *Dorland's Illustrated Medical Dictionary*, 1243, 1244 (28th ed. 1994).

With the above definition in mind, we find that Dr. Bitter's observation and description of claimant's 1998 recurrent cyst supports a conclusion that claimant's compensable condition has "pathologically" worsened.

Claimant also argues entitlement to a penalty based on the insurer's allegedly untimely payment of a medical billing which the insurer received on June 16, 1998, the same day it denied the claim.[2]

Payment of compensation is not required on a denied claim. Moreover, the Director's rules provide that payment of medical bills is required "within 45 days of the action causing the service to be payable, or within 45 days of the insurer's receipt of the bill, *whichever is later.*" OAR 436-009-0030(3) (WCD Admin. Order 97-064) (emphasis added). This rule applies in certain situations, including "[w]hen there is an Opinion and Order or Order on Review that has become final which overturns a claim denial[.]:" OAR 436-009-0030(3)(d). The payment in question here would not become "due" under the rule until 4 days of the date our Order on Review (overturning the denial) becomes final (because that is the later of the two dates addressed by the rule). But the parties agree that the bill *was* paid on August 12, 1998. Under these circumstances, we cannot say that payment was untimely and we deny claimant's request for a penalty on this basis as well.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the aggravation issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. Claimant is not entitled to an attorney fee for services devoted to the penalty and attorney fee issues.

ORDER

The ALJ's order dated September 28, 1998, as reconsidered October 14, 1998, is reversed in part and affirmed in part. That portion of the order that upheld the insurer's denial of claimant's aggravation claim is reversed. The denial is set aside and the claim is remanded to the insurer for processing according to law. The remainder of the order is affirmed. For services at hearing and on review, claimant is awarded a $3,000 attorney fee, payable by the insurer.

[2] The insurer paid the bill on August 12, 1998. (*See* Exs. 18, 19).

In the Matter of the Compensation of
JAMES M. DAVIS, Claimant
WCB Case No. 98-05848
ORDER ON RECONSIDERATION
Cole, Cary, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Claimant requests reconsideration of our March 26, 1999 Order on Review affirming the Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's denial of his occupational disease claim for low back degenerative disc disease. Alleging that we misinterpreted the opinion of his current attending physician, Dr. Goodwin, claimant contends that the only reasonable conclusion to draw from that opinion is that the totality of claimant's work history and his compensable 1992 low back injury are the major contributing cause of a pathological worsening of his degenerative disc disease.

Even assuming claimant is correct, we based our conclusion that his 1997 degenerative disc disease condition is not related in major part to his overall 15-year employment (including the compensable 1992 low back injury) on a *de novo* review of the entire record. That record included opinions from an examining physician, Dr. James, as well as Dr. Edmonds, a consulting neurologist, and Dr. Daskalos, a former attending physician. Based on the medical record in its entirety, we continue to find that the medical evidence does not establish that employment conditions were the major contributing cause of the "combined condition" and pathological worsening of the degenerative disc disease. ORS 656.802(2)(b). Thus, we continue to conclude that claimant's occupational disease claim is not compensable.

Accordingly, we withdraw our March 26, 1999 order. On reconsideration, as supplemented herein, we adhere to and republish our order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ALBERT H. OLSON, Claimant
WCB Case Nos. 98-03311 & 97-07561
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
Hoffman, Hart, et al, Defense Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer, Freightliner Corporation (Freightliner), requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its denial of compensability and responsibility for claimant's current low back condition; (2) upheld the compensability and responsibility denials of the same condition issued by CF Motorfreight (CF); and (3) set aside Freightliner's denial of claimant's low back aggravation claim. On review, the issues are responsibility and aggravation. We reverse.

FINDINGS OF FACT

Claimant injured his low back on December 11, 1974, while working for CF. He was diagnosed with possible spondylolisthesis. As a result of that injury, claimant underwent three surgeries (an L4-5 laminectomy and fusion extending from L4 to the sacrum in 1977, a refusion of the L4-5 level in 1978, and a second refusion at L4-5 in 1981).

On January 20, 1992, while working for Freightliner, claimant performed work which was heavier than that to which he was restricted and, consequently, experienced increased low back and left leg and groin pain. Claimant underwent a decompression and laminotomy at L3-4.

Claimant filed an "aggravation" claim with CF and a "new injury" claim with Freightliner. Following their denials, claimant requested a hearing.

A prior ALJ found Freightliner responsible for claimant's back condition. In doing so, the prior ALJ relied on the opinion of Dr. Smith, claimant's then-attending physician and surgeon, who reported that claimant's major finding at surgery was a preexisting osteophyte at L3-4 compressing the L4 nerve root. Interpreting Dr. Smith's opinion to mean that there had been a pathological worsening of the preexisting condition, the ALJ found that the January 1992 "injury" contributed to the worsening. (Ex. 32-5).

We affirmed, concluding that claimant had suffered a new injury on January 20, 1992 that combined with the preexisting osteophyte. *Albert H. Olson*, 46 Van Natta 172, 174 (1994). Because the 1992 injury was the major contributing cause of claimant's disability and need for treatment, we found Freightliner was responsible for claimant's then current low back condition. (Ex. 37-3).

In April 1995, claimant sought treatment from Dr. Lorish for increasing low back and leg pain. (Ex. 40). Dr. Lorish diagnosed probable "failed low back syndrome." In March 1996, an examining physician, Dr. Watson, diagnosed "failed lumbar surgery syndrome" and opined that the 1974 injury was the major contributing cause of claimant's current low back condition. (Ex. 49)

Dr. Flemming began treating claimant in June 1996 and diagnosed chronic lumbar radicular syndrome with acute exacerbation. (Ex. 54-2). After diagnostic testing was performed, Dr. Flemming recommended conservative treatment, but referred claimant to a neurosurgeon, Dr. Berkeley, for an evaluation that occurred in December 1996. (Exs. 60, 74, 75).

Dr. Berkeley recommended further surgery at L3-4 and L4-5, which was performed on February 6, 1997. (Ex. 76). In the meantime, Dr. Flemming had filed a "Notice of Claim for Aggravation" on December 26, 1996. (Ex. 78). This prompted Freightliner to deny the December 1996 aggravation claim on March 19, 1997. (Ex. 82). Claimant requested a hearing from the denial, but later withdrew the request. This resulted in a July 10, 1997 Order of Dismissal. (Ex. 87).

In May 1997, however, Dr. Berkeley had filed an aggravation claim form. (Ex. 84). Freightliner again issued a denial of aggravation on August 13, 1997, noting that CF might be responsible for claimant's current condition under its 1974 claim. (Ex. 90). Claimant requested a hearing from that denial.

On March 20, 1998, CF denied compensability and responsibility for claimant's low back condition. (Ex. 97). Claimant also request a hearing from that denial.

CONCLUSIONS OF LAW AND OPINION

Concluding that claimant had suffered from a "failed back syndrome" since the mid-1980's, the ALJ found that claimant's current low back condition was the "same condition" as Freightliner accepted as a result of litigation regarding the 1992 injury claim. Thus, the ALJ determined that ORS 656.308(1) governed the responsibility issue.[1] Applying that statute, the ALJ reasoned that Freightliner remained responsible for claimant's low back condition unless he sustained a subsequent "new injury." Finding no evidence of a "new injury," the ALJ determined that responsibility for claimant's low back condition remained with Freightliner. Moreover, the ALJ held that claimant's compensable condition of "failed back syndrome" had compensably worsened, thus entitling claimant to claim reopening. *See* ORS 656.273(1).

On review, citing *Michael C. Reddin*, 50 Van Natta 1396 (1998), Freightliner first argues that ORS 656.308(1) does not apply because claimant's current low back condition is not the same condition as that accepted in the 1974 CF claim or in its own 1992 claim. Thus, Freightliner asserts that responsibility must be assigned to CF because the medical evidence establishes that the 1974 injury is the major contributing cause of claimant's current consequential low back condition under ORS 656.005(7)(a)(A). In addition, Freightliner argues that claimant is precluded from pursuing the current aggravation claim because his low back condition had not changed after the first aggravation denial on March 19, 1997, which became final after claimant withdrew his hearing request regarding that denial. Finally, Freightliner contends that claimant's aggravation claim is not compensable on the merits.

For the following reasons, we find Freightliner's arguments persuasive on the responsibility issue. Because we conclude that CF is responsible for claimant's current low back condition, we do not address Freightliner's preclusion and aggravation arguments.

In *Reddin*, we noted that ORS 656.308(1) does not apply to an initial claim for a previously unaccepted condition caused by earlier work-related injuries. *See Conner v. B & S Logging*, 153 Or App 354 (1998). Thus, we noted, the proper inquiry is to determine whether the current claim is for a condition that was previously "accepted." Because the claimant's current condition was not previously "accepted" in *Reddin*, we held that ORS 656.308(1) did not apply to the claim. *Reddin*, 50 Van Natta at 1398. Therefore, in accordance with the court's reasoning in *Connor*, we held that, when determining responsibility for an unaccepted condition between carriers with prior accepted injuries, it was permissible to apply the last injury rule and the "rebuttable presumption" in *Industrial Indemnity Co. v. Kearns*, 70 Or App 583 (1984) when the medical evidence establishes that the prior injuries "in combination" were the major contributing cause of the claimant's current condition. We recognized, however, that the *Connor* court had applied ORS 656.005(7)(a)(A) in determining that a particular carrier who had accepted a prior injury was responsible for the claimant's current condition because the prior injury was the major contributing cause of the current consequential condition. 50 Van Natta at 1398.

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[1] ORS 656.308(1) provides:

"When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer. The standards for determining the compensability of a combined condition under ORS 656.005 (7) shall also be used to determine the occurrence of a new compensable injury or disease under this section."

In contrast to *Conner*, we found in *Reddin* that the medical evidence did not establish that either one of the claimant's prior accepted injuries alone was the major contributing cause of his current consequential condition. In light of such circumstances, we concluded that the responsibility issue must be resolved by application of the last injury rule and the rebuttable presumption in *Kearns*. Finding that the claimant's most recent injury independently contributed to his current condition, we determined that the most recent carrier had failed to rebut the presumption under the *Kearns* rationale that it was responsible for the claimant's current condition. *Id.*

Accordingly, *Reddin* requires that we first determine whether claimant's current low back condition is a condition that was previously accepted. If so, then ORS 656.308(1) applies. If not, then the responsibility issue is resolved under either the *Kearns* presumption or ORS 656.005(7)(a)(A). That determination turns on whether medical evidence establishes that either one of the claimant's prior accepted injuries alone is the major contributing cause of his current condition.

We first examine the issue of whether the responsibility issue is determined under ORS 656.308(1). In this regard, the record does not contain a Notice of Acceptance for the 1974 injury, but, as a result of that injury, claimant underwent three surgeries: an L4-5 laminectomy and fusion extending from L4 to the sacrum in 1977, a refusion of the L4-5 level in 1978, and a second refusion at L4-5 in 1981. Claimant's subsequent injury in 1992 affected the L3-4 level of the lumbar spine, a level different from that involved in the 1974 claim. The ALJ, however, found that, as a result of the prior ALJ's order and our previous order in 1994, Freightliner was responsible for claimant's entire low back condition, including that resulting from the 1974 injury. We disagree.

The prior ALJ specifically noted that claimant had a preexisting osteophyte at the L3-4 level. (Ex. 32-5). Moreover, the prior ALJ determined that claimant's compensable 1992 injury had worsened the preexisting osteophyte condition at L3-4. *Id.* The prior ALJ held that, because claimant's injury at Freightliner had independently contributed to a pathological worsening of the preexisting condition, it was responsible for claimant's low back condition. *Id.* However, it is clear from the prior ALJ's order that the condition at issue was limited to the worsening the preexisting osteophyte at L3-4. Given this, we decline to more broadly construe the prior ALJ's order as finding Freightliner responsible for claimant's entire low back condition, including the abnormalities/surgeries at L4-5, which were the subject of the 1974 CF claim.

Our prior order does not alter this conclusion. There, we found that claimant's 1992 injury had "combined" with the preexisting osteophyte at L3-4 and that the injury was the major contributing cause of the need for treatment and disability for the "combined condition" under ORS 656.005(7)(a)(B). (Ex. 37-3). Although we concluded that Freightliner was responsible for "claimant's current condition," the "current condition" to which we referred was the combined condition consisting of the compensable 1992 injury and the L3-4 osteophyte. We did not find Freightliner responsible for claimant's entire back condition including those conditions resulting from the 1974 injury that primarily affected the L4-5 level.

Having determined the accepted conditions resulting from the prior claims, we now determine the nature of claimant's current condition and whether it is the same as any of the prior accepted conditions. We conclude that it is not.

The preponderance of the medical evidence establishes that claimant's current condition is "failed back syndrome."[2] This condition was not diagnosed until 1995, when Dr. Lorish evaluated claimant's low back condition. This, of course, was *after* the 1974 and 1992 claims. Inasmuch as failed back syndrome was not previously accepted in either the 1974 or 1992 claim, we find that ORS 656.308(1) does not apply.

Responsibility must, therefore, be determined either under the *Kearns* presumption or under ORS 656.005(7)(a)(A). For the following reasons, we find CF responsible in its 1974 claim because we conclude that the medical evidence establishes that the 1974 injury alone is the major contributing cause of claimant's consequential low back condition, *i.e.*, the "failed back syndrome."

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[2] Claimant's condition has been referred to as "failed low back syndrome" and "failed lumbar surgery syndrome." For the purposes of this order, we find that the references are to the same condition.

Because of the multiple possible causes of claimant's disability or need for treatment, the causation issue presents a complex medical question that must be resolved on the basis of expert medical evidence. *See Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 281 (1993). We rely on those medical opinions which are well-reasoned and based on accurate and complete histories. *Somers v. SAIF*, 77 Or App 259 (1986). Three physicians' opinions are relevant to the causation issue: those of Dr. Watson, the examining physician, Dr. Flemming, a former attending physician, and Dr. Berkeley, the neurosurgeon that performed claimant's most recent surgery.

Dr. Watson concluded in his report of March 26, 1996 that the 1974 CF injury was the major contributing cause of claimant's current low back condition which he had diagnosed as "failed lumbar surgery syndrome." (Ex. 49-8). Dr. Watson re-examined claimant on July 29, 1997 and once again identified the 1974 injury as the major contributing cause of claimant's need for treatment. (Ex. 87A-10).

Dr. Watson was later deposed, at which time he explained that "failed lumbar surgery syndrome" was a phrase used to describe multiple surgical procedures that do not provide significant pain relief or do not improve whatever impairment that may be present. (Ex. 96-12). Dr. Watson disagreed with Dr. Berkeley's decision to operate in 1997 and noted that he had an advantage over Dr. Berkeley in determining causation because he had examined claimant several times over a period of years and had reviewed all of claimant's medical record, whereas Dr. Berkeley admitted he did not have claimant's medical records. (Exs. 96-40, 41).

Dr. Watson testified that fusion procedures, such as those performed in connection with the 1974 injury, place an artificial strain on levels above and below the fusion. (Ex. 96-43). On the other hand, Dr. Smith's surgery in 1992, according to Dr. Watson, involved removing an osteophyte to take pressure off the L4 nerve root. It did not produce stress at other lumbar levels. (Ex. 96-47). Dr. Watson identified once more the 1974 injury and failed fusions as the major contributing cause of the bone and scar build-up that Dr. Berkeley's 1997 surgery removed. (Ex. 96-48).

Based on our review of Dr. Watson's opinion, we find it well-reasoned and based on an accurate history. Thus, we find it persuasive. In addition, we find Dr. Flemming's opinion supportive of our conclusion that the 1974 injury is the major contributing cause of claimant's consequential back condition.

Dr. Flemming also explained that "failed back syndrome" was a descriptive term for a patient who has had back surgery, but still has pain that can not attributed to an obvious cause. (Ex. 98-36). Although Dr. Flemming testified at one point that he could not determine the major contributing cause of claimant's current low back condition (Ex. 98-8), other portions of his deposition support a finding that the 1974 injury is the major factor in claimant's consequential low back condition. Specifically, Dr. Flemming testified that the bony material removed by Dr. Berkeley was due to degeneration of the fusions. Dr. Flemming opined that the 1997 surgery was more than 50 percent due to the prior fusions. (Ex. 98-30, 31, 39).

When Dr. Berkeley first examined claimant in December 1996, he did not have any of claimant's prior medical records. (Ex. 75-1). Dr. Berkeley subsequently opined in April 1997 that the 1992 injury was the major contributing cause of claimant's current condition and need for treatment. (Ex. 83). Dr. Berkeley provided little reasoning to support this conclusion. In June 1998, Dr. Berkeley agreed with a letter documenting a discussion he had with counsel representing CF. (Ex. 95). The letter indicated that Dr. Berkeley had reviewed unidentified medical records and that it was his opinion that the 1992 injury was the major contributing cause of the 1997 surgery he had performed. Once again little reasoning was provided and it is not clear what medical records Dr. Berkeley reviewed. The letter did not mention claimant's previous history of lumbar surgeries performed in connection with the 1974 injury.

Dr. Berkeley's final report was issued on July 23, 1998 in which he once again concluded that the 1992 injury was the major contributing cause of claimant's current need for treatment. Although briefly acknowledging claimant's history of prior lumbar surgeries, Dr. Berkeley nevertheless opined that claimant had "good results" from his prior surgeries and that the primary deterioration in claimant's condition had occurred after the 1992 surgery. (Ex. 97).

Our review of Dr. Berkeley's medical reports leads us to conclude that his opinion is less persuasive than those of Dr. Watson and Dr. Flemming. It is not clear what medical records Dr. Berkeley reviewed, but his reports give scant consideration to claimant's long history of back problems/surgeries. We find Dr. Berkeley's reports to be inadequately explained. In addition, we

question the reasoning on which they are based. In particular, we are not persuaded by Dr. Berkeley's statement that claimant had "good results" from prior surgeries related to his 1974 injury in light of the diagnoses of "failed back surgery syndrome" and claimant's long history of low back problems.

For these reasons, we rely on the medical opinions of Drs. Watson and Dr. Flemming. Based on those opinions, we are persuaded that the 1974 injury alone is the major contributing cause of claimant's consequential back condition. Thus, responsibility for claimant's current consequential low back condition rests with CF. *Conner*, 153 Or App at 358 n 2. Because the ALJ concluded otherwise, we reverse. Furthermore, because CF is now responsible for the claim, it is also responsible for the ALJ's Attorney fee award.

Finally, because the ALJ's order addressed the compensability of claimant's condition, claimant's attorney is entitled to an assessed fee under ORS 656.382(2) for services on Board review regarding the compensability issue which was potentially at risk by virtue of our *de novo* review of the ALJ's order. *See Dennis Uniform Manufacturing v. Teresi*, 115 Or App 252-53 (1992), *mod* 119 Or App 447 (1993); *Paul R. Huddleston*, 48 Van Natta 4 (1996). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $500, payable by CF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated September 8, 1998 is reversed. CF's denial of compensability and responsibility is set aside and the claim is remanded to CF for processing in accordance with law. Freightliner's denial is reinstated and upheld. The attorney fee awarded by the ALJ is to be paid by CF instead of Freightliner. For services on review, claimant's attorney is awarded an attorney fee of $500, to be paid by CF.

In the Matter of the Compensation of
JENISE L. ANGELES, Claimant
WCB Case No. 97-08720
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Miller, Nash, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Podnar's order that set aside its denial of claimant's occupational disease claim for a right elbow strain. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant, age 31 at the time of hearing, began working for the employer in November 1996. As an assembler in the "M1" station, her job duties included repetitively opening boxes and removing and inspecting 6 pound printer mechanisms. In June 1997, claimant developed right elbow pain. She advised her supervisor of her pain and was moved to a lighter duty assembly position.

Claimant's elbow pain remained despite the lighter duties and, about a week later, on July 8, 1997, she sought treatment with Dr. Pierson. Dr. Pierson found some reproducible tenderness in the medial part of the elbow, but did not make any diagnosis. On July 14, 1997, Dr. Pierson referred claimant to an orthopedist, noting that her elbow pain was in a very unusual area. Claimant saw Dr. Grossenbacher on July 16, 1997 and August 13, 1997. He found diffuse pain and some swelling but no specific epicondylar tenderness. Claimant continued working in the light duty assembler position.

In late August 1997, claimant began treating with Dr. Fisher, who referred her to another orthopedist, Dr. Lohman. Claimant saw Dr. Lohman on September 5, 1997. He found tenderness to palpation over the lateral epicondyle and diagnosed lateral epicondylitis. On September 23, 1997, Dr. Lohman injected claimant's elbow with medication.

Claimant quit working in October 1997 because her elbow pain was not resolving. Her elbow symptoms improved after she stopped working.

CONCLUSIONS OF LAW AND OPINION

Based primarily on the opinion of Dr. Grossenbacher, the ALJ determined that claimant's right elbow condition was caused in major part by her work activity as an assembler. On review, the employer contends that the medical opinions supporting compensability are not persuasive, because they are based on an inaccurate history and a misunderstanding of the nature and extent of claimant's light duty work activities. For the reasons set forth below, we agree with the employer.

Claimant has the burden of affirmatively proving the compensability of her claim. ORS 656.266. Because this matter involves an occupational disease, claimant must establish that her employment conditions are the major contributing cause of her right elbow condition. ORS 656.802(2)(a).

Although Dr. Grossenbacher and Dr. Lohman attributed claimant's elbow pain to her repetitive work activity, both physicians understood that claimant's light duty assembly work required highly repetitive pinching, grasping and twisting with the right hand and arm. (Exs. 23, 26, 27). But the record establishes that claimant's light duty assembly work was not so intensive. Indeed, claimant's leadperson, Ms. Lethrud, testified that the light duty assembly job involved handling very light, small pieces of plastic (measuring less than an inch and weighing less than an ounce) and did not require any forceful gripping, grasping or twisting with the hand or arm. (Tr. 56-58). Claimant also admitted that this light duty position involved only fine movements of the hands, and did not entail forceful gripping, pinching or grasping or much involvement of the arm. (Tr. 45-46). Because the opinions of Drs. Grossenbacher and Lohman are based on a faulty history, they are entitled to little weight. *Miller v. Granite Construction Co.*, 28 Or App 473, 478 (1977).

Further, neither Dr. Grossenbacher nor Dr. Lohman adequately explained the relationship between claimant's work activity and her migrating elbow symptoms. Dr. Grossenbacher acknowledged that claimant's right elbow complaints migrated to different anatomical spots as she was seen by various physicians. For example, Dr. Grossenbacher's findings differed from those of Dr. Pierson, as Dr. Pierson found tenderness more in the medial part of the elbow than the lateral part.[1] Dr. Grossenbacher's findings and diagnosis also differed from the later findings and diagnosis of Dr. Lohman. In his two examinations of claimant's right elbow in July and August 1997, Dr. Grossenbacher found very diffuse, generalized complaints and no specific epicondyle tenderness.[2] He diagnosed a strain at the brachial radialis. In contrast, Dr. Lohman found tenderness over the lateral epicondylar muscle mass and diagnosed lateral epicondylitis. Because neither doctor offered an explanation for claimant's migrating complaints, their causation opinions are unpersuasive and insufficient to sustain claimant's burden of proof.

ORDER

The ALJ's order dated November 3, 1998 is reversed. The ALJ's attorney fee award is also reversed. The employer's denial of claimant's right elbow injury is reinstated and upheld.

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[1] In fact, Dr. Pierson opined that, when he saw claimant in early July 1997, she had a basically normal exam except for some tenderness in the brachial radialis muscle. He could find no occupationally-related condition. (Exs. 3, 10).

[2] On August 13, 1997, Dr. Grossenbacher noted that, because of the diffuse tenderness about the elbow, he did not believe that claimant would respond to an injection. (Ex. 11).

In the Matter of the Compensation of
ARNOLD E. FORD, Claimant
Own Motion No. 99-0101M
OWN MOTION ORDER

The self-insured employer has voluntarily reopened claimant's claim pursuant to ORS 656.278 for his compensable left subtalar arthrosis. Claimant's aggravation rights expired on July 31, 1996. The employer asks us to authorize the reopening of claimant's claim.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time claimant is actually hospitalized or undergoes outpatient surgery. *Id.*

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

The employer contends that claimant was retired at the time of the current disability and therefore not in the work force. In response to an inquiry from the Board's staff, the employer has clarified that it is only seeking reopening to provide medical benefits. Furthermore, claimant has not replied to the Board's staff's inquiry nor to the employer's clarification.[1]

Claimant has the burden of proof to establish that he was in the "workforce" at the time of his current worsening. To do so, he must provide evidence on that issue (*e.g.*, copies of paycheck stubs, income tax forms, unemployment compensation records, a list of employers where claimant looked for work and dates of contact, a letter from the prospective employer, or a letter from a doctor stating that a work search would be futile because of claimant's compensable condition for the period in question).

Here, the present record does not demonstrate claimant's presence in the work force at the relevant time. While payment of claimant's medical benefits is not in dispute, he is not entitled to temporary disability compensation. Consequently, insofar as the request can be interpreted as seeking temporary disability benefits, it is denied.

Claimant's entitlement to medical expenses pursuant to ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

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[1] The Board's staff's March 23, 1999 letter requested that, within 14 days, claimant provide evidence that he was in the work force at the time of the current worsening. Inasmuch as the 14-day period has expired, we have proceeded with our review.

In the event that claimant disagrees with our decision that he has withdrawn from the work force, he may request reconsideration. However, because our authority to further consider this matter expires within 30 days of this order, he should submit his information as soon as possible.

In the Matter of the Compensation of
RODRIGO R. MANCILLA, Claimant
WCB Case No. 98-06466
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorneys
Garrett, Hemann, et al, Defense Attorneys

Reviewed by the Board *en banc.*

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that affirmed an Order on Reconsideration award of 30 percent (96 degrees) unscheduled permanent disability for low back strain and herniated disc conditions. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings."

CONCLUSIONS OF LAW AND OPINION

Claimant's January 29, 1997 injury claim was accepted for a "lumbar strain." When claimant became medically stationary, his then-attending physician opined that a herniated disc caused his impairment. (Ex. 3). The employer's claims processor issued an "Updated Notice of Acceptance at Closure" that indicated the accepted condition to be a disabling "lower back strain." (Ex. 4). A Notice of Closure issued the same day which awarded 7 percent unscheduled permanent disability for lost range of motion. (Ex. 5). Claimant requested reconsideration and a medical arbiter was appointed. The medical arbiter stated that claimant failed the "straight leg raising" validity test and concluded that claimant's range of motion findings were invalid. (Ex. 8). However, the arbiter also opined that claimant had a herniated disc and "because of this he has a limited loss of the ability to repetitively use his back." Based on the arbiter's report, a February 5, 1998 Order on Reconsideration reduced claimant's award to 5 percent unscheduled permanent disability (for a "chronic condition"). The Order on Reconsideration was not contested by either party and became final.

Claimant then requested acceptance of his "central L4-5 disc prolapse." The employer amended its acceptance to include the disc condition, reopened the claim pursuant to ORS 656.262(7)(c), then closed it by Notice of Closure with no additional permanent disability award. Claimant requested reconsideration. The employer objected, contending claimant was not entitled to "redetermination" of his permanent disability award because his prior award was, in fact, for the disc condition -- even though that condition was not accepted until after the prior award.

Dr. Maukonen performed a medical arbiter's examination. He rated claimant's "lumbar strain with L4-5 disc herniation," but attributed claimant's pain and impairment findings to the strain only. He found claimant's impairment findings (including range of motion) valid and stated, "The patient has a chronic and permanent lumbar strain and asymptomatic bulging disc at L4-5 from his injury of January 29, 1997 which limits his ability to repetitively use his lumbar spine area." (Ex. 15). An August 6, 1998 Order on Reconsideration awarded 25 percent unscheduled permanent disability (based on the arbiter's report) in addition to the prior reconsideration order's 5 percent award, for a total award of 30 percent unscheduled permanent disability for claimant's low back condition.

The employer requested a hearing, contending that claimant was not entitled to "redetermination" of his permanent disability award upon closure of his "new medical condition" claim because the "new" condition, the herniated disc, had already been rated by the first Order on Reconsideration (*i.e.*, before it was accepted).

The ALJ reasoned that only the accepted strain was rated at the first closure, "as a matter of law," and concluded that claimant was entitled to correct evaluation of his newly accepted condition under ORS 656.262(7)(c).[1] Thus, the ALJ disagreed with the employer's position that "redetermination" was precluded.

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[1] The ALJ relied on *Julio Garcia-Caro*, 50 Van Natta 160 (1998), where we stated that ORS 656.262(7)(c) supported "our conclusions that the accepted condition determines what is rated in extent determinations and the statutory scheme contemplates that compensability determinations will be made separately from extent determination." 50 Van Natta at 162-63.

On review, the employer asks us to set aside the August 6, 1998 Order on Reconsideration, for several reasons. First, it argues that "redetermination" is impermissible because claimant's condition did not worsen between the first and second reconsideration proceedings, citing *Stepp v. SAIF*, 304 Or 375 (1987). The employer also argues that the second proceeding is precluded by "issue preclusion." And the employer contends that the second award, if allowed, would be "redundant," because the disc herniation was actually rated as of the first reconsideration and the prior rating was "sufficiently inclusive." Finally, the employer argues that claimant may not receive additional permanent disability for his strain condition, because that should have been previously rated (and claimant's condition has not changed).

Claimant responds that closure of his "new medical condition" claim under ORS 656.268(7)(a) is mandatory after claim reopening under ORS 656.262(7)(c), regardless of the conditions rated at the first closure. Because he disagreed with the April 1, 1998 Notice of Closure's lack of impairment findings, he contends that he was entitled to Dr. Maukonen's arbiter's examination and determination of permanent disability based on that examination.[2]

We agree that claimant was entitled to *processing* of his "new medical condition" claim, including claim closure and permanent disability determination, under ORS 656.262(7)(c). But we conclude that he is not entitled to a permanent disability award for his "new medical condition," because he did not have impairment due to *that* condition as of the August 1998 reconsideration proceeding. We reach these conclusions based on the text and context of ORS 656.262(7)(c) and the following reasoning.

The employer argues that the *Stepp* case forecloses a second reconsideration in this case because claimant's condition did not worsen after the first closure. But *Stepp* only addressed permanent disability determinations after claim reopening under ORS 656.273,[3] *i.e.*, for an *aggravation*. Here, there is no aggravation claim and ORS 656.262 does not require a worker's condition to worsen as a prerequisite for processing, including claim closure and permanent disability evaluation and determination. *See Johansen v. SAIF*, 158 Or App 672 (1999) (Unlike aggravation claims, "new medical condition claims" must be processed independently under ORS 656.262 and 656.268); *see also Labor Ready, Inc. v. Mann*, 158 Or App 666 (1999) (discussing *Johansen* as rejecting "the insurer's contention that a new medical condition claim has no existence independent of the original claim and does not give rise to a processing obligation independent of the original claim.").

The employer also makes alternative arguments about the effect of two reconsideration awards in this case: First, it contends that the second Reconsideration Order's 30 percent award, if allowed, would be "redundant," because the disc herniation was actually rated as of the first reconsideration. Alternatively, the employer argues that the first award was for the strain only (as a "matter of law," because that was the only accepted condition at the time) and the current award impermissibly awards additional permanent disability for the strain (as a matter of *fact*, based on arbiter Maukonen's causation comments). In other words: Because the first "strain award" became final and claimant's condition has not changed, he may not receive a second permanent disability award for his strain. We agree that claimant is not entitled to a permanent disability award for his "new medical condition," but we reach this conclusion for different reasons.[4]

ORS 656.262(7)(c) provides, in pertinent part that, if a "new medical condition" claim is found compensable (*i.e.* accepted) after initial claim closure, "the insurer or self-insured employer shall reopen the claim for processing regarding *that condition.*" (Emphasis added).

Under the statute, a claimant *is* entitled to appropriate claim processing, including closure of his open "new medical condition" claim.[5] But ORS 656.262(7) addresses only "new medical condition"

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[2] *See Art Wetzel*, 50 Van Natta 1127, 1128 (1998) ("Having reopened the claim [for a new medical condition] for processing necessarily implies that the employer's processing duties include re-closing the accepted injury claim under ORS 656.268 when the conditions of the statute are met.")

[3] "The holding in *Stepp* was later codified in ORS 656.273(8). . . ." *SAIF v. Frank*, 153 Or App 514, 520 (1998).

[4] In light of this conclusion, we need not expressly resolve the employer's contention that the second reconsideration was precluded by "issue preclusion".

[5] *See James Mack*, 50 Van Natta 338 (1998) (Evaluation of a "post closure" accepted condition must await the reopening and processing of the claim for that new condition).

claims, not initial claims. Subsection (c) of the statute mandates reopening and processing of the "new medical condition" claim: It refers to "that condition" and "that condition" is the "new medical condition," not the initial claim that was previously closed. Nothing about the text or context of ORS 656.262(7) suggests that processing of a "new medical condition" claim includes "re-processing" or "redetermination" of the initial claim.

Accordingly, based on the unambiguous text and context of ORS 656.262(7)(c), we conclude that claimant is only entitled to permanent disability rating for his "new medical condition" -- his herniated disc -- upon closure of his "new medical condition" claim. Because the medical arbiter related *none* of claimant's August 6, 1998 low back impairment to his herniated disc, claimant has not established entitlement to permanent disability for his "new medical condition." Accordingly, we reinstate the Notice of Closure that awarded no permanent disability for claimant's herniated disc condition.

ORDER

The ALJ's order dated December 9, 1998 is reversed. In lieu of the August 6, 1998 Order on Reconsideration, the April 1, 1998 Notice of Closure is reinstated and affirmed. The ALJ's attorney fee award is reversed.

In the Matter of the Compensation of
DANIEL R. SMITH, Claimant
WCB Case Nos. 97-10115 & 97-05411
ORDER ON REVIEW
Black, Chapman, Webber & Stevens, Claimant Attorneys
Bruce Bornholdt (Saif), Defense Attorney
Bostwick, et al, Defense Attorneys

Reviewed by the Board *en banc*.

Medite Corporation (Medite), a self-insured employer, requests review of those portions of Administrative Law Judge (ALJ) Nichols' order that: (1) determined that the SAIF Corporation, on behalf of the City of Medford, was not prohibited from disputing responsibility because its denial was not issued in a timely manner; (2) set aside Medite's responsibility denial of claimant's current right shoulder condition; and (3) upheld SAIF's responsibility denial of the same condition. SAIF cross-requests review of that portion of the ALJ's order that awarded claimant an attorney fee of $1,500 for the rescission of SAIF's compensability denial. On review, the issues are responsibility and attorney fees.

We adopt and affirm the ALJ's order with the following changes and supplementation.[1]

In the second full paragraph on page 4, we change the first sentence to read: "On July 30, 1998, SAIF issued an amended denial of responsibility, indicating that compensability was no longer in dispute. (Ex. 51A)." In the second paragraph on page 5, we change the first sentence to read: "In October 1996, claimant returned to Dr. Saviers."

In the fourth paragraph on page 6, we change the last two sentences to read:

> "Dr. Galt indicated that claimant's prior injury, the resulting surgery, the continued inflammation and the possible existence of scar tissue in the surgical area all contributed to the current right shoulder condition. If claimant had continuing shoulder problems, Dr. Galt felt it was less likely that the current work activities would be the major problem, although those activities would have some effect on claimant's shoulder condition."

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[1] We modify the ALJ's order to note that Exhibit 46A was also admitted in evidence.

Responsibility

Medite contends, among other things, that SAIF was prohibited from disputing responsibility for this claim because its denial was not issued timely pursuant to ORS 656.308(2)(a) and 656.262. Medite argues that the plain meaning of ORS 656.308(2)(a) requires that a carrier who disputes responsibility must issue a denial within 90 days of the claim. According to Medite, if a denial is not issued within 90 days, a carrier cannot dispute responsibility by arguing that another carrier is responsible. We disagree.

In construing ORS 656.308(2), our task is to discern the intent of the legislature. The first level of analysis is to examine both the text and the context of the statute, including other provisions of the same statute. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-11 (1993). If the legislature's intent is clear, it is not necessary to examine legislative history. *Id.* at 611.

Under *former* ORS 656.308(2), if a carrier issued a proper notice of intent to disclaim responsibility, it could assert a responsibility defense, even if the claimant had not actually filed claims against other carriers. On the other hand, failure to follow the requirements of *former* ORS 656.308(2) precluded a carrier from asserting a responsibility defense. *Norstadt v. Murphy Plywood*, 148 Or App 484, 494-95, *adhered to as modified* 150 Or App 245 (1997), *rev den* 327 Or 432 (1998).

In *Norstadt*, the court discussed *Donald A. James*, 46 Van Natta 1898 (1994). In *James*, we interpreted *former* ORS 656.308(2), which provided, in part:

> "Any employer or insurer which intends to disclaim responsibility for a given injury or disease claim on the basis of an injury or exposure with another employer or insurer shall mail a written notice to the worker as to this position within 30 days of actual knowledge of being named or joined in the claim. The notice shall specify which employer or insurer the disclaiming party believes is responsible for the injury or disease. The worker shall have 60 days from the date of mailing of the notice to file a claim with such other employer or insurer. *Any employer or insurer against whom a claim is filed may assert, as a defense, that the actual responsibility lies with another employer or insurer, regardless of whether or not the worker has filed a claim against that other employer or insurer, if that notice was given as provided in this subsection.*" (Emphasis added).

In *James*, a carrier argued that its failure to comply with the disclaimer requirements did not prevent it from asserting that one of the other insurers was responsible for the claim. *Id.* at 1898. We reviewed the language in *former* ORS 656.308(2) that allowed a responsibility defense if an insurer issued a timely disclaimer, even if the claimant had not actually filed claims against other insurers. We reasoned that, based on that statutory language, a carrier that did not comply with the disclaimer requirements was precluded from asserting a responsibility defense. *Id.* Because the claimant was no longer asserting a claim against other insurers, we concluded the carrier's failure to comply with the disclaimer notice of *former* ORS 656.308(2) precluded it from asserting as a defense that actual responsibility lies with another carrier. *Id.* at 1899; *see Norstadt*, 148 Or App at 494-95 (discussing the *James* case).

In 1995, the legislature amended ORS 656.308(2) and omitted the language that we relied on in *James* to conclude that a carrier that did not comply with the disclaimer requirements was precluded from asserting a responsibility defense. Here, because claimant's claim was filed and the denials were issued after June 7, 1995, the effective date of Senate Bill 369, the amended version of ORS 656.308(2) applies to this case. ORS 656.308(2) now provides, in part:

> "(a) Any insurer or self-insured employer who disputes responsibility for a claim shall so indicate in or as part of a denial otherwise meeting the requirements of ORS 656.262 issued in the 90 days allowed for processing of the claim. The denial shall advise the worker to file separate, timely claims against other potentially responsible insurers or self-insured employers, including other insurers for the same employer, in order to protect the right to obtain benefits on the claim. The denial may list the names and addresses of other insurers or self-insured employers. Such denials shall be final unless the worker files a timely request for hearing pursuant to ORS 656.319. All such requests for hearing shall be consolidated into one proceeding.
>
> "(b) No insurer or self-insured employer, including other insurers for the same employer, shall be joined to any workers' compensation hearing unless the worker has first filed a timely, written claim against that insurer or self-insured employer, or the insurer or self-

> insured employer has consented to issuance of an order designating a paying agent pursuant to ORS 656.307. An insurer or self-insured employer against whom a claim is filed may contend that responsibility lies with another insurer or self-insured employer, including another insurer for the same employer, regardless of whether the worker has filed a claim against that insurer or self-insured employer."

The current version of ORS 656.308(2)(a) provides that a carrier who disputes responsibility "shall so indicate in or as part of a denial otherwise meeting the requirements of ORS 656.262 issued in the 90 days allowed for processing of the claim." We agree with Medite that SAIF's denial was issued more than 90 days after claimant filed a claim with SAIF. Unlike *former* ORS 656.308(2), there is nothing in the text of the amended version of ORS 656.308(2) to establish that a carrier that does not comply with the denial requirements is precluded from asserting a responsibility defense. ORS 656.308(2)(b) provides that a carrier against whom a claim is filed "may contend" that responsibility lies with another carrier, regardless of whether the worker has filed a claim against that carrier. The words "may contend" are not qualified. In the present case, a claim has been filed against SAIF and the terms of ORS 656.308(2)(b) provide that SAIF may contend that responsibility lies with another carrier.

In conclusion, although SAIF's denial was issued more than 90 days after claimant filed a claim with SAIF, we find no statutory authority to support a conclusion that SAIF is thereby precluded from asserting a responsibility defense. In interpreting a statute, we are "not to insert what has been omitted[.]" ORS 174.010. The current version of ORS 656.308(2) does not preclude a carrier from asserting a responsibility defense, whether or not it complied with the timing requirements of ORS 656.308(2) and ORS 656.262. On the other hand, a carrier's failure to accept or deny a claim in a timely manner may result in penalties. Here, the ALJ directed SAIF to pay claimant's attorney a fee of $1,000 pursuant to ORS 656.382 for its delay in timely issuing its denial. We agree with the ALJ's conclusion that SAIF may assert a responsibility defense. Furthermore, we adopt and affirm the ALJ's reasoning and conclusion that Medite remains responsible for claimant's current right shoulder condition.

Attorney Fee

SAIF cross-requests review of that portion of the ALJ's order that awarded claimant an attorney fee of $1,500 for the rescission of SAIF's compensability denial. SAIF contends that, based on *Schoch v. Leupold & Stevens*, 325 Or 112 (1997), and *McCarthy v. Oregon Freeze Dry*, 327 Or 84, *adhered to on recon* 327 Or 185 (1998), the ALJ's order is insufficient with regard to the attorney fee award. SAIF argues that the ALJ was required to make specific findings of fact for each of the factors in OAR 438-015-0010(4)[2] and, because the order failed to do so, asks the Board to remand the case.

As we have in previous cases, we reject SAIF's argument. It is sufficient for an ALJ to describe or cite the rule-based factor or factors upon which the ALJ relied in determining a reasonable attorney fee when the parties at hearing do not dispute or submit argument to the ALJ concerning the weighing of the rule-based factors. *See McCarthy*, 327 Or at 188; *Daryl L. Underwood*, 50 Van Natta 2330 (1998).

Here, because the ALJ indicated that the attorney fee was based on the factors in OAR 438-015-0010(4), we find the order, as well as the record, sufficient for review. *Jerome O. Johnson*, 50 Van Natta 2412 (1998). Thus, we deny SAIF's motion to remand.

In addition to the ALJ's discussion, we note the following. SAIF does not contend that claimant's attorney was not instrumental in obtaining rescission of the compensability denial before hearing. Claimant's attorney filed a claim with SAIF on July 3, 1997. (Ex. 36). SAIF did not issue a denial of responsibility and claim denial until February 25, 1998. (Ex. 46). On July 30, 1998, approximately three weeks before the August 19, 1998 hearing, SAIF issued an amended denial, disputing only responsibility. (Ex. 51A). In the meantime, claimant's attorney had filed a hearing request regarding SAIF's compensability denial, prepared medical evidence to defend against the compensability denial at hearing and had participated in a deposition of Dr. Galt, which lasted almost two hours. The case involved complex medical and legal issues. The value of the interest and benefit secured for claimant was significant in that surgery has been recommended for his right shoulder.

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[2] In determining a reasonable attorney fee, the rule requires the ALJ to consider the following factors: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

After considering these factors, we find that $1,500 is a reasonable attorney fee for claimant's counsel's services in obtaining the pre-hearing rescission of SAIF's compensability denial. Accordingly, we affirm that portion of the ALJ's order. We note that claimant's attorney is not entitled to an attorney fee for defending the attorney fee on review. *Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated September 17, 1998 is affirmed.

Board Member Biehl dissenting.

The majority rejects Medite's argument that SAIF was prohibited from disputing responsibility for this claim because its denial was not issued timely pursuant to ORS 656.308(2)(a) and 656.262. Because I disagree with the majority's interpretation of ORS 656.308(2), I respectfully dissent.

I agree with the majority that the amended version of ORS 656.308(2) applies to this case. In *Norstadt v. Murphy Plywood*, 148 Or App 484, 490, *adhered to as modified* 150 Or App 245 (1997), the court discussed the amended version of ORS 656.308(2), noting that the legislature eliminated the requirement for the issuance of a separate disclaimer and also expressly provided that the period for denying responsibility is 90 days from the date of knowledge of the claim. The statute retains the requirement that a claim be filed against each employer or insurer before the employer or insurer can be joined in a hearing. *Id.*

Furthermore, the amended version ORS 656.308(2)(a) specifically provides that a carrier "who disputes responsibility for a claim shall so indicate in or as part of a denial otherwise meeting the requirements of ORS 656.262 issued in the 90 days allowed for processing of the claim." The denial "*shall* advise" a claimant to file separate, timely claims against other potentially responsible carriers in order to protect the right to obtain benefits on the claim. Thus, as in *former* ORS 656.308(2), any carrier who disputes responsibility is required to timely notify a claimant of other potentially responsible carriers.[1] This required notification is now in the "denial," whereas it was previously required in the "disclaimer."

Here, SAIF failed to issue a responsibility denial within the required time limits. Under ORS 656.308(2)(a), because SAIF was disputing responsibility, it was required to "so indicate in or as part of a denial otherwise meeting the requirements of ORS 656.262 issued in the 90 days allowed for processing of the claim." Claimant's attorney filed a claim with SAIF on July 3, 1997. (Ex. 36). On August 11, 1997, SAIF notified claimant that his claim was in "deferred status." (Ex. 38). On February 25, 1998, SAIF issued a "disclaimer of responsibility and claim denial" (Ex. 46), more than 90 days after claimant had filed a claim with SAIF.

Because SAIF did not dispute responsibility "in or as part of a denial" within the 90 days allowed for processing the claim, I would conclude that SAIF did not comply with the requirements of ORS 656.308(2). The provisions of ORS 656.308(2) require timely notification to claimant as a prerequisite. The plain meaning of ORS 656.308(2) is that if a denial is not issued within 90 days, a carrier cannot dispute responsibility by arguing that another carrier is responsible. Based on the mandatory language of ORS 656.308(2), I would conclude that SAIF is precluded from disputing responsibility for the claim.

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[1] *Former* ORS 656.308(2) provided, in part:

"Any employer or insurer which intends to disclaim responsibility for a given injury or disease claim on the basis of an injury or exposure with another employer or insurer shall mail a written notice to the worker as to this position within 30 days of actual knowledge of being named or joined in the claim. The notice shall specify which employer or insurer the disclaiming party believes is responsible for the injury or disease. The worker shall have 60 days from the date of mailing of the notice to file a claim with such other employer or insurer. Any employer or insurer against whom a claim is filed may assert, as a defense, that the actual responsibility lies with another employer or insurer, regardless of whether or not the worker has filed a claim against that other employer or insurer, if that notice was given as provided in this subsection."

In the Matter of the Compensation of
ROSE M. ACOSTA, Claimant
WCB Case No. 98-01893
ORDER ON RECONSIDERATION
Craine & Love, Claimant Attorneys
Miller, Nash, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests reconsideration of our March 18, 1999 Order on Review that reversed an Administrative Law Judge's (ALJ's) order that set aside the self-insured employer's denial of claimant's occupational disease claim for a right wrist and elbow tendonitis condition. Specifically, claimant argues that our conclusion that the claim is not supported by objective findings is inconsistent with *Scott D. Bruce*, 50 Van Natta 694 (1998).

In *Bruce*, the physician elicited the claimant's complaints of tenderness (with palpation) more than once and commented that the testing was "pretty consistent." 50 Van Natta 694. The physician *also* reported markedly reduced pinch strength and reduced grip strength and ultimately opined that the claimant's symptoms were due to his work activity. Based on the medical evidence recording the claimant's subjective responses to clinical testing (tenderness upon palpation) and his measurable reduced grip and pinch strength, we found the claim established by medical evidence supported by objective findings.

Here, in contrast, Dr. Flemmer merely recorded claimant's complaints; she did not say that claimant's symptoms were elicited in response to clinical testing (*e.g.*, palpation), and claimant had *no* physical findings whatsoever. Under these circumstances, *Bruce* is distinguishable.

In addition, as we explained in our initial order, nothing about Dr. Flemmer's chartnotes or opinion suggests that she did more than record claimant's reported symptoms or that those symptoms were reproducible, measurable or observable. Moreover, Dr. Pierson examined claimant on two occasions, recorded her pain complaints, described them as inconsistent, and concluded that claimant's first examination was "normal" and there was "no objective evidence of a condition" as of the second examination. (Exs. 3-1, 5).

We acknowledge that a physician's interpretation of a worker's verifiable subjective response to clinical testing *may* be sufficient objective findings to support a claim, if they are reproducible, measurable or observable. *See Tony C. Houck*, 48 Van Natta 2442, 2448-49 (1996), *aff'd mem* 151 Or App 200 (1997). Here, considering Dr. Pierson's opinion that claimant's subjective responses were *inconsistent* and Dr. Flemmer's failure to do more than record claimant's complaints (and the absence of physical findings), we continue to find the claim is not established by medical evidence supported by objective findings. Accordingly, our March 18, 1999 order is abated and withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our March 18, 1999 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONNIE L. ALLEN, Claimant
WCB Case No. 96-03496
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Moller and Bock.

The SAIF Corporation requests review, and claimant cross-requests review, of those portions of Administrative Law Judge (ALJ) Mills' order that: (1) awarded 14 percent (26.88 degrees) scheduled permanent disability for the loss or use of function of the left arm; and (2) awarded 30 percent (96 degrees) unscheduled permanent disability for a head condition. On review, the issues are extent of scheduled and unscheduled permanent disability. We modify in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the addition that claimant's accepted claim is for a right parietal contusion with delayed hemorrhagic event. (Ex. 21).

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for a head injury resulting from a March 2, 1993 work accident. On September 24, 1996, SAIF issued a Notice of Closure that awarded no permanent disability. The Order on Reconsideration affirmed that award.

Citing to a report from Dr. Klecan, examining psychiatrist, which the ALJ found was concurred in by claimant's treating psychiatrist, Dr. Rice, the ALJ decided that claimant was entitled to a 10 percent impairment value under OAR 436-035-0390(10), and awarded 30 percent unscheduled permanent disability for a brain condition. The ALJ also found that claimant was entitled to 14 percent scheduled permanent disability under OAR 436-035-0110(11)(a) for claimant's left arm.

SAIF disputes these conclusions, asserting that the record fails to establish any impairment due to the accepted injury. Claimant contends that the most persuasive evidence of impairment is from a February 1994 report from Northwest Occupational Health Medicine Center. Based on this report, claimant contends that he is entitled to 70 percent unscheduled permanent disability and 100 percent scheduled permanent disability.

With the exception of a medical arbiter, findings concerning a claimant's impairment can be made only by the attending physician at the time of claim closure. ORS 656.245(2)(b)(B), OAR 436-035-0007(12), (13). Reports of insurer-arranged medical examiners may not be considered in rating impairment unless those findings are ratified by the claimant's attending physician. *Tektronix, Inc. v. Watson*, 132 Or App 483 (1995). Here, because claimant declined to be examined by a medical arbiter, we consider whether the treating physicians rated claimant's impairment or concurred in any such findings from examining physicians.

The February 1994 report relied upon by claimant indicated decreased range of motion for the left shoulder and a Class III brain condition. (Ex. 62-12, 62-13). In March 1994, claimant's treating physicians, Dr. Sternfeld and Dr. Rice, concurred with the report. (Exs. 67, 68). We find such evidence to be of limited value in determining claimant's impairment.

Evaluation of the worker's disability shall be as of the date of issuance of the reconsideration order. ORS 656.283(7), 656.295(5). The February 1994 report was provided over two years before the December 19, 1996 Order on Reconsideration. Furthermore, as explained below, more recent evidence from Dr. Rice and Dr. Sternfeld is not consistent with their concurrences with the February 1994 report. Consequently, we find more persuasive evidence concerning claimant's impairment provided closer in time to the Order on Reconsideration. We turn to whether claimant is entitled to permanent disability for a brain condition.

Unscheduled Permanent Disability

We adopt the relevant portions of the ALJ's order concerning this issue (specifically, page 8 through the first paragraph of page 9). Thus, we agree with the ALJ that claimant is entitled to 10 percent impairment under OAR 436-035-0390(10). SAIF contends that, if we agree with the ALJ that claimant is entitled to impairment, his adaptability factor should be 2 rather than 5, as applied by the ALJ.

Under OAR 436-035-0310(8), when a worker has ratable impairment pursuant to OAR 436-035-0380 through 436-035-0450, an adaptability scale applies. For those workers entitled to impairment between 10 and 19 percent, the adaptability factor is 2. Thus, because claimant has 10 percent impairment pursuant to OAR 436-035-0390, we agree with SAIF that adaptability is a value of 2.

SAIF does not challenge the remaining factors of 1 for age and 3 for SVP. Adding these values results in a factor of 4. OAR 436-035-0280(4). Multiplying that value with the adaptability factor of 2 results in a value of 8. OAR 436-035-0280(6). Impairment is then added to result in a value of 18 percent unscheduled permanent disability. OAR 436-035-0280(7).

Scheduled Permanent Disability

On May 1, 1996, examining physicians Dr. Nehler, Dr. Taylor, and Dr. Moneta provided a report stating that claimants "attempts at various exam findings of diminished strength in his left upper extremity are clearly inconsistent and variable depending on how you examine him." (Ex. 139-2). The report further stated that claimant "has a large give away component to his left upper extremity weakness." (*Id.* at 2-3). Dr. Sternfeld was asked to review these comments and respond. According to Dr. Sternfeld, "their findings are independent and valid." (Ex. 145AA-1).

The only other evidence from Dr. Sternfeld concerning left upper extremity impairment is an earlier comment in response to SAIF's questionnaire asking if claimant had permanent impairment as a result of his injury. Dr. Sternfeld noted that permanent impairment "has been documented ad nauseum." (Ex. 120A-2).

Although such evidence shows that Dr. Sternfeld may consider claimant as having left upper extremity impairment, like Dr. Rice, Dr. Sternfeld neither directly provided, nor concurred in, such findings. Instead, the most recent evidence shows that Dr. Sternfeld agreed with the examining physicians that claimant showed inconsistent findings. Thus, we find an absence of persuasive evidence showing that claimant has ratable left upper extremity impairment as a result of his work injury and conclude that he also is not entitled to scheduled permanent disability.

ORDER

The ALJ's order dated October 19, 1998 is modified in part, reversed in part, and affirmed in part. In lieu of the ALJ's award of 30 percent (96 degrees) unscheduled permanent disability, claimant is awarded 18 percent (57.6 degrees) unscheduled permanent disability. The ALJ's attorney fee award is modified accordingly. That portion of the ALJ's order awarding scheduled permanent disability is reversed and the Order on Reconsideration is affirmed to the extent that it awarded no scheduled permanent disability. The ALJ's attorney fee award insofar as it concerned the scheduled permanent disability award is also reversed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
TRACIE M. BRUMLEY, Claimant
WCB Case No. 98-05672
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that affirmed a Workers' Compensation Division (WCD) order that dismissed the parties' respective requests for reconsideration of a Determination Order. On review, the issue is the propriety of WCD's Order of Dismissal.

We adopt and affirm the ALJ's order with the following supplementation.

In September 1993, claimant filed a claim for elbow, shoulder and right arm pain. On December 3, 1993, the insurer accepted bilateral carpal tunnel syndrome and right shoulder tendinitis. The claim was closed pursuant to a September 6, 1994 Determination Order that awarded temporary disability only. The claim was reopened and closed again on May 30, 1995, with an additional award of temporary disability.

Claimant's right shoulder symptoms continued and, in December 1996, claimant was referred to Dr. Galt. He diagnosed impingement syndrome, myofascial syndrome, and derangement of the AC joint of the right shoulder. On January 7, 1997, Dr. Galt proposed right shoulder surgery and completed an aggravation claim on claimant's behalf.

The insurer denied claimant's aggravation claim on March 18, 1997, asserting that her condition had not worsened since the claim was last closed. Claimant requested a hearing.

In a November 20, 1997 Opinion and Order, ALJ Hoguet set aside the insurer's denial. The ALJ determined that claimant's then-current right shoulder condition was related to her compensable right shoulder tendinitis and represented a temporary worsening of her compensable condition. The insurer requested Board review.

On April 1, 1998, while the aggravation litigation was pending before the Board, the insurer issued an "Updated Notice of Acceptance at Closure" pursuant to ORS 656.262(7)(c).[1] The insurer advised claimant that it had accepted his claim for myofascial pain of the right shoulder, derangement of the right shoulder AC joint, right shoulder impingement syndrome and bilateral carpal tunnel syndrome. The aggravation claim was then closed pursuant to an April 8, 1998 Determination Order, which awarded claimant additional temporary disability and 15 percent unscheduled permanent disability. Both parties requested reconsideration.

On June 19, 1998 (while the parties' reconsideration requests were pending), the Board reversed ALJ Hoguet's order. *Tracie M. Brumley*, 50 Van Natta 1142 (1998). The Board found that claimant had not established a compensable aggravation claim because she had not sustained any pathological worsening of her right shoulder condition since the claim was last closed in May 1995.

Thereafter, on June 24, 1998, the insurer advised the WCD Appellate Review Unit that the Board had reinstated its aggravation denial. The insurer requested that the April 8, 1998 Determination Order be vacated and the reconsideration requests dismissed. On July 2, 1998, WCD declared the Determination Order a nullity and dismissed the requests for reconsideration. Claimant requested a hearing.

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[1] This section provides, in pertinent part, that when a carrier determines that the claim qualifies for closure, the carrier "shall issue at claim closure an updated notice of acceptance that specifies which conditions are compensable."

At hearing, claimant argued that because the insurer's updated notice of acceptance identified conditions other than the right shoulder tendinitis and bilateral carpal tunnel conditions originally accepted in 1993 (*i.e.*, right shoulder impingement syndrome, AC joint derangement and myofascial pain), WCD erred in vacating the Determination Order and dismissing the requests for reconsideration. Claimant also asserted that these newly accepted conditions should have been processed pursuant to ORS 656.262(7)(c)[2] notwithstanding the Board's reinstatement of the aggravation denial.

The ALJ disagreed, concluding that, because Dr. Galt's diagnosis of right shoulder impingement syndrome, AC joint derangement and myofascial pain formed the basis for claimant's aggravation claim, the Board's order reinstating the aggravation denial mooted the insurer's processing and updated acceptance of those conditions.

On review, claimant renews his contention that the Determination Order was procedurally proper and the requests for reconsideration were valid because the insurer accepted new conditions on April 1, 1998. Like the ALJ, we find to the contrary.

At issue before ALJ Hoguet and the Board was whether claimant's right shoulder impingement syndrome, AC joint derangement and myofascial pain constituted an actual worsening of her compensable condition under ORS 656.273(1). When ALJ Hoguet determined that claimant had established an actual worsening and set aside the aggravation denial, the insurer was statutorily obligated to process the claim as an accepted aggravation notwithstanding its request for Board review.[3] It was that processing obligation that resulted in the updated notice of acceptance and the April 8, 1998 Determination Order. But when we subsequently reversed ALJ Hoguet's order and reinstated and upheld the insurer's aggravation denial, the insurer had no further duty to process the claim. In other words, our order mooted the insurer's processing and WCD's closure of the aggravation claim.[4]

We also reject claimant's contention that, notwithstanding the Board's order reinstating and upholding the aggravation denial, the insurer's April 1, 1998 "Updated Notice of Acceptance at Closure" requires the insurer to process the right shoulder impingement, AC joint derangement and myofascial syndrome conditions.[5] First, this question is not properly before us because the only issue raised by claimant's request for hearing was the propriety of the Department's Order of Dismissal.[6] Second, we find no evidence that claimant has made "new medical condition" claims for these conditions. ORS 656.262(7)(a) sets forth very specific requirements for making a new medical condition claim. A claimant is obligated to "clearly request formal written acceptance" of the claimed new medical conditions. Such claims are not made by the receipt of a medical claim billing for the provision of, or requesting permission to provide, medical treatment for the new condition. *See Diane S. Hill*, 48 Van Natta 2351, 2352-53 (1996), *aff'd mem Hill v. Stuart Andersons*, 149 Or App 496 (1997). In the absence of a clear,

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[2] This section also provides that "[i]f a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition."

[3] *See, e.g., SAIF v. Maddox*, 295 Or 448 (1983), *see also Thomas W. Clark*, 51 Van Natta 95, 97 (1999) (holding that a claim is considered accepted, albeit involuntarily, on the issuance of a litigation order finding the claim compensable); *Robert E. Wolford*, 45 Van Natta 573 (carrier obligated to process claim to closure pending its appeal of Board's order finding that claim should be reclassified as disabling).

[4] *See generally, Ronald G. Miller*, 47 Van Natta 277 (1995) (holding that a final WCD order finding that an alleged employer was not a subject employer rendered the carrier's statutory obligation to process the claim moot, notwithstanding the carrier's previous acceptance of the claim); *David A. Vanasen*, 44 Van Natta 1576 (1992) (same).

[5] We note that, upon receiving the April 1, 1998 updated notice of acceptance, claimant did not move for dismissal of the insurer's request for review of ALJ Hoguet's order. Claimant also did not appeal or request reconsideration of the Board's June 1998 order by asserting that the updated notice of acceptance rendered the aggravation dispute moot. *Cf. SAIF v. Mize*, 129 Or App 636 (1994).

[6] At hearing, claimant's counsel confirmed that claimant was appealing only the order dismissing the reconsideration proceeding. (Tr. 2).

formal written request from claimant for the acceptance of her right shoulder impingement syndrome, AC joint degeneration and myofascial syndrome as new medical conditions, the insurer has no further processing obligations under ORS 656.262(7)(c).[7]

ORDER

The ALJ's order dated November 5, 1998 is affirmed.

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[7] Although it is the "law of the case" that claimant did not sustain an aggravation of her compensable right shoulder condition, she is not hereafter precluded from making a new medical condition claim related to her initial claim, as a new medical condition claim is distinct from an aggravation claim. *See Johansen v. SAIF*, 158 Or App 672 (1999) (explaining that an aggravation claim is an actual worsening of the originally accepted condition, whereas a new medical condition claim involves "a new condition not originally accepted"). ORS 656.262 authorizes a worker to initiate a new medical condition claim at any time.

April 16, 1999 Cite as 51 Van Natta 703 (1999)

In the Matter of the Compensation of
PAMELA R. BRYANT, Claimant
WCB Case No. 97-10268
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) set aside its denial of claimant's occupational disease claim for bilateral deQuervain's syndrome; and (2) awarded claimant's attorney an assessed fee of $3,000 for services at hearing. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exception, supplementation, and summary. We do not adopt the last paragraph of the ALJ's findings of fact.

Claimant, 47 years old at the time of the hearing, has worked as a service coordinator for the Housing Authority of Portland since May 16, 1988. Her job is to establish eligibility for the Section 8 program, a program that provides housing assistance to low income people. Claimant testified that, in the course of a work day, she spends 35 to 50 percent of her time at a computer, handles files 20 to 25 percent of the time, and interacts with clients 25 to 30 percent of her time. (Tr. 10, 12-13, 25, 43-44). While interacting with clients, she is either on the computer and/or accessing a file. Claimant's testimony regarding her work duties was not available to any physician, including Dr. Adams, M.D., claimant's treating physician.

Claimant is right handed and receives her primary health care from Kaiser Permanente. She first experienced right-sided thumb pain at the time of an incident that occurred in April or May 1997 when she was holding some files with both hands, accidentally dropped them from her left hand, and squeezed them with her right hand to prevent them from falling.

On June 12, 1997, claimant first treated for right wrist and thumb symptoms with Ms. Krider, a nurse practitioner. (Ex. 1). At that time, claimant did not report any specific work incident. Instead, she reported complaints of numbness and pain in the right hand and forearm for eight weeks. (Ex. 1-1).

On August 25, 1997, claimant treated with Dr. Page, M.D., and first reported left thumb and wrist pain, which she attributed to compensating with her left hand because her right hand had been in a spica splint for a week and a half. (Ex. 4). Dr. Page diagnosed left thumb tenosynovitis, "most likely overuse injury." (*Id.*).

Claimant began to treat with Dr. Adams on August 26, 1997, at which time she first reported an incident lifting some files at work. (Ex. 5). Dr. Adams recorded that claimant was apparently "well until a few months ago when she was lifting a stack of heavy files and she felt acute onset of pain of the proximal aspect of her right thumb." (Ex. 5-2). He also recorded that claimant "states that the left wrist was recently worsened primarily from overuse of that guarding against the right wrist." (*Id.*). Dr. Adams recorded that claimant's primary work duties involved a "lot of keyboarding, filing, and writing." (*Id.*). On the "First Medical Report" form, claimant provided Dr. Adams with the following statement of her injury: continuous typing, filing, using the computer "mouse," and writing. (Ex. 5-1). Dr. Adams released claimant to modified work. (Ex. 5-2). He prescribed continued splinting, medication, and physical therapy. (Exs. 5, 8, 15, 23, 34).

Because no modified work was available, claimant was off work from August 27, 1997, until about November 6, 1997, at which time she returned to work with limitations of no cumulative keyboarding in excess of four hours per day. (Exs. 5, 8, 21-2, 34, Tr. 17-20).

On October 20, 1997, Dr. Reimer, neurologist, and Dr. Marble, orthopedist, examined claimant on behalf of the insurer. (Ex. 21). Dr. Reimer dictated the report and responded to subsequent inquiries. (Exs. 21-1, 29, 32, 38, 41). Claimant reported an incident when she was moving some files, lost support with the left hand, and held onto the files with her right wrist, causing it to flex. (Ex. 21-1). Claimant attributed her left-sided symptoms to the fact that she was compensating with her left hand for the decreased use of her right hand. (Ex. 21-2). Her work duties were described as including "writing, typing on a computer keyboard, obviously doing some mouse operation, primarily with her right hand." (*Id.*).

Drs. Adams, Reimer, and Marble were all provided with a copy of claimant's job description, which described claimant's job duties, equipment used, and the percentages of time spent performing various physical tasks in an eight-hour work day. (Exs. 29, 32, 42-2).

On November 21, 1997, Dr. Adams found claimant medically stationary. (Ex. 34). He found her permanently impaired regarding prolonged keyboarding and limited her to four hours of keyboarding in an eight hour work day. He found that, despite rest, splinting, and extensive occupational therapy, claimant had progressed very little and continued to be symptomatic with excessive keyboarding. (*Id.*).

On December 5, 1997, Dr. Adams concurred with the report issued by Drs. Reimer and Marble. (Ex. 35).

On March 3, 1998, Dr. Smith, neurosurgeon, performed a record review for the insurer. (Ex. 37).

On March 16, 1998, Dr. Tilson, consulting orthopedist, examined claimant. (Ex. 40).

CONCLUSIONS OF LAW AND OPINION

Relying on Dr. Adams' opinion, as supported by the opinions of Drs. Page and Tilson, the ALJ found claimant's occupational disease claim compensable. We disagree and find that Dr. Adams' opinion is not persuasive. Therefore, we find that claimant failed to prove a compensable occupational disease claim.

To prove a compensable occupational disease claim, claimant must establish that her work activity for the employer is the major contributing cause of the onset or worsening of her bilateral deQuervain's syndrome and not merely her symptoms. ORS 656.802(2)(a) and (b); *Aetna Casualty v. Aschbacher*, 107 Or App 494, *rev den* 312 Or 150 (1991). Resolution of these issues involves complex medical questions that must be resolved with expert medical opinion. *Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993). Special deference is generally given to the opinion of a treating physician absent persuasive reasons to do otherwise. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to the opinion of claimant's treating physician, Dr. Adams.

The medical record includes relevant opinions from Drs. Page, Adams, Reimer, Marble, and Smith. Dr. Page treated claimant one time, diagnosed left thumb tenosynovitis, and stated that it was "most likely [an] overuse injury." (Ex. 4). Because Dr. Page did not explain her opinion, we do not find it persuasive. *See Somers v. SAIF*, 77 Or App 259 (1986) (greatest weight given to well-reasoned opinions based on complete and accurate information). Furthermore, although Dr. Tilson examined claimant, reviewed her Kaiser outpatient record, diagnosed bilateral deQuervain's syndrome, and presented treatment options, he offered no opinion as to the cause of claimant's condition. (Ex. 40). Therefore, we do not find that Drs. Page and Tilson support compensability of claimant's claim.

On December 5, 1997, Dr. Adams concurred with the opinion of Drs. Reimer and Marble, who opined that claimant's work activities were not responsible for her deQuervain's syndrome. (Exs. 21, 35). Specifically, Drs. Reimer and Marble found that claimant did nothing particularly strenuous or repetitious in her job as far as the tendon function of the first dorsal compartment and that operation of a computer on a part time daily basis and the movement of a computer mouse would not create acute tendinitis in that area. (Ex. 21-5).

Subsequently, in response to claimant's attorney's questions, Dr. Adams offered a different opinion. (Ex. 42). As to claimant's right hand condition, Dr. Adams agreed that, although unusual, deQuervain's syndrome can develop as a result of the type of trauma claimant described (involving the file incident) with the addition of repetitive handling of files as well as data entry and other paperwork. (Ex. 42-2). Dr. Adams stated that the "[i]njury was probably the inciting incident and repetitive nature of job contributing to worsening." (*Id.*). Dr. Adams also agreed that claimant developed deQuervain's syndrome in her left hand due to overuse of the left hand when the right hand became symptomatic. (*Id.*). He stated that the primary cause of claimant's condition was the combination of the injury and work. Finally, he explained his prior concurrence with the opinion of Drs. Reimer and Marble by stating that he "felt that the job alone may not be primary cause. However, the job in combination with the injury were, more probably than not, the cause of her medical condition." (*Id.*).

We do not find Dr. Adams' opinion persuasive. In the first place, the file incident was not new information to Dr. Adams. Claimant told Dr. Adams about that incident when she first treated with him on August 26, 1997. (Ex. 5-2). In addition, Drs. Reimer and Marble included claimant's report of that incident in their report. (Ex. 21-1). Therefore, Dr. Adams was aware of the file incident when he agreed with the opinion of Drs. Reimer and Marble. (Exs. 21, 35). Moreover, Dr. Adams' opinion is internally inconsistent. In this regard, he states that claimant's work activities alone would not cause deQuervain's syndrome, but those activities *in combination with* the file incident injury caused the syndrome. But this would only explain the right hand condition. As to the left hand condition, Dr. Adams finds that the work activities caused that condition, which contradicts his earlier statement that claimant's work activities alone would not cause deQuervain's syndrome.

In addition, Dr. Adams' opinion is conclusory and does not explain why claimant's work activity is the primary cause of claimant's condition, as distinct from the precipitating cause. *See Robinson v. SAIF*, 147 Or App 157 (1997); *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995); *Somers v. SAIF*, 77 Or App at 262. Given these inconsistencies, we do not find Dr. Adams' causation opinion persuasive.

Claimant contends that Drs. Reimer, Marble, and Smith did not review all of claimant's medical record and had an inaccurate understanding of claimant's work activities. We disagree with both contentions.

Dr. Reimer dictated the report that resulted from his and Dr. Marble's examination of claimant. (Ex. 21-1). Furthermore, Dr. Reimer responded to subsequent inquiries regarding claimant's condition. Although initially stating that he was unable to document any medical records before August 1997, Dr. Reimer subsequently reviewed all of claimant's medical records and stated that his opinion remained unchanged. (Ex. 21-1, 38, 41). The record also indicates that Dr. Smith reviewed all of the medical record. (Ex. 37).

Claimant relies on her testimony at hearing to contend that Drs. Reimer and Smith did not have an accurate work history. But, because all medical reports were authored before claimant's hearing testimony, it is clear that none of the physicians, including Dr. Adams, were provided with claimant's

hearing testimony. Dr. Adams and the examining physicians had essentially the same history regarding claimant's work activities. All received information from claimant, either directly through interviews at examination or indirectly through reports that included claimant's statements regarding her work activities. In addition, Drs. Adams and Reimer received and reviewed a copy of claimant's job description.[1] (Exs. 29, 32, 42-2). Therefore, we find that the physicians had an accurate history of claimant's job activities in rendering their causation opinions.

After reviewing the written job description, Dr. Reimer opined that claimant did not perform the type of work that would be responsible for deQuervain's syndrome. (Ex. 32). He explained that one does not develop deQuervain's syndrome simply by using one's hands, and claimant's job did not involve repetitive stressful activity affecting the area involved in deQuervain's syndrome. (Exs. 21-5, 41). He also found that the file incident injury was not the type of mechanism that would produce deQuervain's syndrome. (Exs. 32, 41). Instead, he found the cause of claimant's onset of bilateral deQuervain's syndrome was an idiopathic process. (Ex. 41). Dr. Smith's opinion also does not support compensability of claimant's occupational disease claim. (Exs. 37, 43).

In summary, we find persuasive reasons not to defer to the opinions of Drs. Adams and Page, and we conclude that the medical record does not otherwise establish that claimant's work activity is the major contributing cause of her bilateral deQuervain's syndrome. Consequently, claimant has not satisfied her burden of establishing a compensable occupational disease claim. ORS 656.266; ORS 656.802(2)(a).

ORDER

The ALJ's order dated October 13, 1998 is reversed. The insurer's November 19, 1997 denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[1] Claimant testified that, in the course of a work day, she spends 35 to 50 percent of her time at a computer, handles files 20 to 25 percent of the time, and interacts with clients 25 to 30 percent of her time. (Tr. 10, 12-13, 25, 43-44). This list of activities is less inclusive of specific physical activities and the ranges of percentages are actually less than those dealing with these types of activities in the written job description. That job description provides that, in an eight hour day, among other activities, claimant inputs computer data and spends 67 to 100 percent of her day typing/writing, lifts one to ten pounds 34 to 66 percent of the time, and does telephone work 34 to 66 percent of the time. (Ex. 29-2). Thus, the written job description considered by the physicians in rendering their causation opinions actually presents a more strenuous job description than did claimant's testimony. In addition, the written job description provides a more complete picture of claimant's job duties than her testimony.

In the Matter of the Compensation of
MELISSA GOLDSMITH, Claimant
WCB Case No. 98-06230
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) set aside its "de facto" denial of claimant's request to amend its acceptance to include an annular tear at L4-5; and (2) upheld its "de facto" denial of claimant's request to amend its acceptance to include lumbar spondylosis and mechanical instability of the lumbar spine. On review, the issues are claim processing and compensability.

We adopt and affirm the ALJ's order with the following supplementation.

Claimant sustained a compensable low back injury on August 22, 1996. On September 10, 1996, the employer accepted a disabling low back strain. After the claim was closed on August 25, 1997, the employer expanded its acceptance on November 19, 1997 to include a psychological condition.

On June 24, 1998, claimant requested that the employer accept lumbar spondylosis with annular tear at L4-5 pursuant to ORS 656.262. (Ex. 86A). Pursuant to the same statute, claimant requested on August 4, 1998 that the employer accept mechanical instability of the lumbar spine at L4-5. (Ex. 90). After receiving no response from the employer, claimant filed hearing requests, alleging "de facto" denial of the disputed conditions.

The ALJ set aside the employer's "de facto" denial of the L4-5 annular tear condition. In doing so, the ALJ determined that claimant's August 1996 injury was a material, and probably the major, contributing cause of this condition. Accordingly, the ALJ concluded that the employer's acceptance should be amended to include the annular tear. The ALJ, however, upheld the employer's "de facto" denial of lumbar spondylosis, finding that the condition was included within the alleged annular tear condition, and, thus, that no separate acceptance was necessary. Finally, the ALJ upheld the "de facto" denial of mechanical instability of the lumbar spine, finding that this condition was reasonably included within the acceptance of the lumbar strain condition. Therefore, the ALJ once again determined that a separate acceptance was unnecessary.

On review, the employer asserts that the L4-5 annular tear is not compensable. We agree, however, with the ALJ's reasons for finding this condition compensable. The employer, nevertheless, contends that claimant's request for a specific acceptance of lumbar spondylosis should be denied, not because it is included within the alleged annular tear condition, but rather because "there is absolutely no medical opinion attributing the lumbar spondylosis to the claimant's work." Additionally, the employer asserts that claimant's request for specific acceptance of mechanical instability of the lumbar spine should be denied, not because the condition is included within the accepted lumbar strain, but because the opinion of Dr. Belza, who diagnosed the condition, is inconsistent. For the following reasons, we disagree with the employer's contentions.

We first consider the lumbar spondylosis condition. On March 23, 1998, an MRI scan revealed lumbar spondylosis with degenerative changes at L4-5. (Ex. 77). Based on the MRI, Dr. Belza, a consulting physician, diagnosed lumbar spondylosis at L4-5. (Ex. 78). On July 22, 1998, Dr. Belza opined that the compensable August 1996 injury was the major contributing cause of claimant's "present condition," disability and need for treatment. (Ex. 88-1). Further, after weighing the impact of claimant's degenerative condition at L4-5, Dr. Belza concluded that the compensable injury was the major factor in claimant's need for treatment. (Ex. 88-2). Considering Dr. Belza's prior diagnosis of lumbar spondylosis, we are persuaded that at least a portion of claimant's "present condition" includes the spondylosis condition. Thus, Dr. Belzas's opinion supports a finding that the compensable injury is the major contributing cause of the lumbar spondylosis condition.

Moreover, Dr. Moore, one of claimant's attending physicians, discussed the degenerative changes revealed by the MRI. As previously noted, those degenerative changes included lumbar spondylosis. (Ex. 77). Dr. Moore stated that it was "very likely that the degenerative changes did follow the annular tear." (Ex. 92). In addition, noting claimant's ability to function prior to the compensable injury, Dr. Moore concluded that the degenerative changes "did stem from her annular tear." *Id.*

Based on our *de novo* review of the record, we are persuaded that claimant's work injury was the major contributing cause of claimant's lumbar spondylosis and, further, that the ALJ correctly concluded that this condition was reasonably included within the compensable annular tear condition.[1]

Finally, we reject the employer's contention that lumbar mechanical instability is not a compensable condition because this diagnosis is inconsistent with other diagnoses made by Dr. Belza.[2] We acknowledge that Dr. Belza has used several different diagnoses to describe claimant's current low back condition. (Exs. 78, 81, 87, 88). "Mechanical instability of the lumbar spine at L4-5" is among them. (Ex. 88). We are nonetheless persuaded that claimant's current low back condition, however it may be diagnosed, is compensable based on the persuasive medical opinions of Drs. Belza, Moore and Lowengart.[3] *See Boeing Aircraft Co. v. Roy*, 112 Or App 10, 15 (1992) (a claimant need not prove a specific diagnosis if he proves that his symptoms are attributable to his work).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated December 7, 1998 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, to be paid by the employer.

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[1] Claimant does not contest the ALJ's conclusion that a separate acceptance of the lumbar spondylosis is not necessary. *See* ORS 656.262(7)(a).

[2] We do not adopt the ALJ's definition of "mechanical instability" as "back pain due to joint movement resulting from ligament or other soft tissue damage." (Opinion and Order p. 6).

[3] Claimant also does not dispute the ALJ's conclusion that specific acceptance of mechanical instability of the lumbar spine at L4-5 is unnecessary.

In the Matter of the Compensation of
ROGER W. KERCHAL, Claimant
WCB Case Nos. 98-01637 & 97-06531
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Reinisch, MacKenzie, et al, Defense Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Nichols' order that: (1) upheld Unocal-Pacific Northwest's (Unocal's) compensability and responsibility denial of claimant's occupational disease claim for bilateral hearing loss; and (2) upheld Travelers Insurance's compensability and responsibility denial of claimant's occupational disease claim for the same condition. In its brief on review, Travelers challenges that portion of the ALJ's order that found that claimant's occupational disease claim was filed in a timely manner. On review, the issues are timeliness of claim filing, evidence, compensability and responsibility.

We adopt and affirm the ALJ's order with the following supplemental rationale.

Evidentiary Issue. At hearing, Unocal sought to admit a document which it identified as environmental noise level studies for various workers at its Portland terminal, conducted by its Health Environment & Safety Department between November 1983 and October 1996. The document itself does not identify the methodology used or the source of the document. Claimant argued that Unocal had not provided a proper foundation for the noise study, and he objected to the admission of the document on that basis. (Tr. 6-11).

In a subsequent deposition, Dr. Hodgson explained that he was familiar with this type of noise study and was comfortable using it as a basis for his causation opinion. Dr. Hodgson further explained that the noise study was the basis of his March 30, 1998 opinion letter. (Ex. 29). Unocal then sought to admit both the noise study and Dr. Hodgson's deposition, and claimant objected to both on the ground that Unocal had not provided an adequate foundation for the noise study. The ALJ admitted the document into evidence as Exhibit A and provided the following rationale for that ruling in a September 9, 1998 letter to the parties:

> "Dr. Hodgson did interpret the data in Exhibit A and explain how he used that data in his analysis in this matter. Exhibit A will be admitted as a deposition exhibit and the reliability of that document can be argued at closing."

On review, claimant reiterates his argument at hearing regarding the admission of Unocal's noise level study and Dr. Hodgson's deposition testimony regarding that study. We review the ALJ's evidentiary ruling for abuse of discretion. *See James D. Brusseau II*, 43 Van Natta 541 (1991). The ALJ is not bound by common law or statutory rules of evidence, or by technical or formal rules of procedure, and may conduct the hearing in any manner that will achieve substantial justice. ORS 656.283(7).

As explained by the ALJ, a sufficient foundation for the noise level studies was provided by Dr. Hodgson in his deposition. (Ex. 34, pp. 10-13). Furthermore, the record lacks evidence that the studies are not an accurate representation of claimant's noise exposure at work. Under these circumstances, we find no abuse of discretion in the ALJ's admission of the noise level studies.

Compensability/Untimely Claim Filing/Responsibility. We adopt and affirm the ALJ's compensability decision and related rationale, with the exception of the first paragraph of page six of the Opinion and Order. In light of our conclusion on the compensability issue, we need not address the responsibility issue, or Travelers' assertion that claimant's occupational disease claim was not filed in a timely manner.

ORDER

The ALJ's October 29, 1998 order is affirmed.

In the Matter of the Compensation of
DEBORAH J. LAUDERMILK, Claimant
WCB Case Nos. 98-06022 & 98-02848
ORDER ON REVIEW
McGill & Kapranos, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

CNA Insurance Co. requests review of those portions of Administrative Law Judge (ALJ) Podnar's order that: (1) set aside its denial of responsibility for claimant's right carpal tunnel syndrome condition; and (2) upheld the SAIF Corporation's denial of responsibility of the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant worked for Sealy Corporation (whose claims were processed by CNA) from June 1994 to August 1997. On November 17, 1997, claimant began working for A-1 Coupling (SAIF's insured). On November 28, 1997, claimant first sought treatment for her right wrist.

After finding that claimant proved the compensability of her right carpal tunnel syndrome condition, the ALJ addressed responsibility. Because claimant first sought treatment during her work with A-1, the ALJ found SAIF initially responsible. The ALJ further decided that, because the most persuasive evidence showed that it was impossible for employment at A-1 to have caused or contributed to claimant's carpal tunnel syndrome, A-1 successfully shifted responsibility to Sealy (CNA). CNA challenges this conclusion, asserting that the medical evidence shows that work at A-1 contributed to claimant's condition and, thus, responsibility should not shift.

There is no dispute that the last injurious exposure rule applies for determining responsibility or that, under that rule, A-1 is initially responsible. The parties also agree that, in order for A-1 to shift responsibility back to Sealy, it must show that it was impossible for work at A-1 to have caused the condition or that a prior period of employment was the sole cause of the condition. *Roseburg Forest Products v. Long*, 325 Or 305, 313 (1997).

The record contains two medical opinions that address this issue. According to the examining hand surgeon, Dr. Nolan, work at A-1 was the type of employment that most likely caused or contributed to a worsening of the carpal tunnel syndrome. (Exs. 12, 18-21).

Treating physician Dr. Browning thought that the employment at A-1 caused only an exacerbation or recurrence of symptoms without causing an actual pathophysiologic worsening of the condition. (Ex. 19-19, -23, -31). Dr. Browning based this opinion on the fact that work at A-1 was not highly repetitive; involved no heavy lifting or forceful pinch-gripping; was for a short period and not full-time; claimant wore a wrist brace; and her nerve conduction studies were performed within a few weeks of beginning her work at A-1. (*Id.* at 38). In short, Dr. Browning agreed that it was impossible for work at A-1 to have caused or contributed to the carpal tunnel syndrome condition. (*Id.* at 26).

In evaluating the persuasiveness of medical opinions, we defer to those that are based on an accurate history and are well-reasoned. *See Somers v. SAIF*, 86 Or App 259 (1986). Based on this standard, we find that Dr. Browning provided the most persuasive opinion. Unlike Dr. Nolan, Dr. Browning fully explained why she thought that it was impossible for work at A-1 to have caused or contributed to the right carpal tunnel syndrome. In contrast, Dr. Nolan's opinion was conclusory, even when based on an accurate history.

Based on Dr. Browning's opinion, we agree with the ALJ that A-1 (SAIF) successfully shifted responsibility to Sealy (CNA).

Finally, because the ALJ's order also addressed the compensability issue, compensability technically remained at issue on review by virtue of our *de novo* review authority. *Dennis Uniform Manufacturing v. Teresi*, 115 Or App 248, 252-53 (1992), *mod on recon* 119 Or App 447 (1993). Consequently, claimant's counsel is entitled to an assessed attorney fee for services on Board review regarding the potential compensability issue, payable by CNA. *International Paper Co. v. Riggs*, 114 Or App 203 (1992). After considering the factors set forth in OAR 438-015-0010(4), particularly the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved, we find that a reasonable attorney fee for such services is $500, to be paid by CNA.

ORDER

The ALJ's order dated November 20, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $500, to be paid by CNA.

April 19, 1999 Cite as 51 Van Natta 711 (1999)

In the Matter of the Compensation of
PAUL H. McNEIL, Claimant
WCB Case No. 98-07145
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order finding that the insurer's termination of his temporary disability benefits was proper. On review, the issue is temporary disability benefits.

We adopt and affirm the ALJ's order with the following supplementation.

Claimant was compensably injured on April 27, 1998, his first day of work with the employer. He had been hired as a delivery driver, and was assigned to work out of the employer's Portland warehouse. Although the Portland warehouse contained a separate room with a time clock, desk and telephone for the use of the drivers, the employer did not maintain any business offices at that location. The business office was located in Salem.

Claimant's attending physician, Dr. Spisak, released claimant for light duty work on July 10, 1998. Dr. Spisak restricted claimant from lifting more than 20 pounds, stooping, squatting, and pulling more than 50 pounds for a period of two weeks. The employer sent Dr. Spisak a job description for a light duty clerical assistant job, which set forth the physical demands for the job. Dr. Spisak approved the clerical job on July 14, 1998, indicating that claimant could perform the described tasks for 6 to 8 hours per day.

The next day, July 15, 1998, the employer sent claimant a written job offer for the light duty clerical assistant job and attached to that offer a copy of Dr. Spisak's approval of the temporary light duty job. The job offer stated the job's beginning time (8:00 am), date (July 20, 1998) and place (the employer's business office in Salem), wage ($6.10 per hour), as well as the hours per day (8) and per week (40), and a description of the job duties (including answering phones, taking messages, stuffing envelopes, and alphabetizing papers). The job offer also advised claimant that the duration of the job was unknown.

On July 17, 1998, claimant notified the insurer that he would not be reporting to the light duty job on July 20, 1998 because he believed it was unreasonable to ask him to drive to Salem from Portland. On August 10, 1998, the employer terminated claimant's employment for not accepting the light duty offer. The insurer terminated claimant's temporary total disability benefits pursuant to ORS 656.268(3)(c).[1]

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[1] This section allows a carrier to cease paying temporary total disability benefits if the attending physician advises the worker and documents in writing that the worker is released to modified work, such employment is offered in writing to the worker and the worker fails to begin such employment.

At some point in August 1998, claimant obtained a note from Dr. Spisak indicating that he could not drive to Salem for at least a month because of his back condition. Claimant testified that did not want to work in Salem because he did not want to incur the expense or commuting time. He also doubted his vehicle's reliability for the commute, because the car was experiencing transmission problems at the time.

On September 21, 1998, Dr. Spisak opined that claimant could do a 30-minute drive to Salem, but questioned whether the drive would take at least 45 minutes.

The ALJ found that the insurer properly terminated claimant's temporary total disability benefits in compliance with ORS 656.268(3) and the provisions of OAR 436-060-0025(5) and (8). Specifically, the ALJ determined that Dr. Spisak's limitation on claimant's driving time was not persuasive and, even if it was persuasive, that restriction had nothing to do with claimant's ability to perform the light duty clerical job which Dr. Spisak had previously approved. In addition, the ALJ found that, because claimant was terminated based on his failure to report to modified work, he was not entitled to have his temporary total disability reinstated on his termination.

Claimant raises three arguments on review. First, claimant asserts that the offer of modified work did not strictly comply with the requirements of OAR 436-060-0030(5)(c).[2] Second, claimant contends that the travel requirements of the job offer were unreasonable and exceeded his physician's release. Finally, claimant renews his contention that he was entitled to reinstatement of his temporary total disability as of his August 10, 1998 termination. We reject each contention.

Claimant asserts that the employer's modified job offer did not include an accurate description of the physical requirements of job and did not state that the attending physician had found the job to be within his capabilities. We disagree. As noted above, the employer sent claimant a written job offer stating, among other things, that his doctor had released him for light/modified work. The employer also referenced and attached a document entitled "Temporary Light Duty Task Release" that set forth the physical demands of the job and Dr. Spisak's approval of the job. Under these circumstances, we find that the employer's job offer (including the attached attending physician's approval) strictly complied with the requirements of OAR 436-060-0025(5)(c).

As for claimant's second contention, the record establishes that the employer offered claimant the light duty, clerical position in Salem because that was the only office where such work was performed. The Portland warehouse did not have a business office. Further, although claimant ultimately obtained a restriction on his driving time from Dr. Spisak, we are persuaded that claimant refused the light duty offer primarily because he did not want to commute to Salem.[3] We agree with the ALJ that, although it may have been inconvenient for claimant to travel to the Salem location for the modified job, the insurer was entitled to terminate claimant's temporary total disability benefits when claimant refused the job offer. *See, e.g. Robert E. Dixon*, 48 Van Natta 46 (1996) (the insurer properly

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[2] This rule provides, in pertinent part, as follows:

"(5) An insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (2) as if the worker had begun the employment when an injured worker fails to begin wage earning employment pursuant to ORS 656.268(3)(c), under the following conditions:

"* * * * *

"(c) The employer has confirmed the offer of employment in writing to the worker stating the beginning time, date and place; the duration of the job, if known; the wages; an accurate description of the physical requirements of the job and that the attending physician has found the job to be within the worker's capabilities."

The law requires strict compliance with the provisions of this rule as a prerequisite to terminating a worker's temporary total disability benefits. *See, e.g., Fairlawn Care Center v. Douglas*, 108 Or App 698 (1991); *Marie E. Kendall*, 46 Van Natta 2520 (1994) *on recon*, 47 Van Natta 335 (1995).

[3] In this regard, we agree with the ALJ's conclusion that Dr. Spisak's driving restriction, issued after claimant had already refused the offer of modified work as unreasonable and inconvenient, is not reliable or persuasive.

terminated the claimant's temporary disability benefits under ORS 656.268(3) where the claimant refused the offer of modified work on the basis of an inability to arrange transportation to the work location, which was 35 miles from the claimant's home); *Rhonda Stockwell*, 46 Van Natta 446 (1994) (where the claimant was offered a job, approved by her physician as within her capabilities, and the claimant refused the offer because it was geographically inconvenient, the carrier was entitled to terminate temporary disability benefits). As we explained in *Robert E. Dixon*, a limitation on driving or the need for transportation to the job location is not a work-related restriction because it does not pertain to matters directly affecting claimant's performance of the modified job while on the work site.

Finally, we adopt and affirm the ALJ's determination that claimant's subsequent termination from employment did not entitle him to a reinstatement of temporary total disability benefits. Claimant was terminated for failing to report to the modified job, which we consider the equivalent of "termination for violation of work rules or other disciplinary reasons." Therefore, the employer's termination of claimant does not constitute a withdrawal of the job offer for purposes of OAR 436-0060-0030(8).

ORDER

The ALJ's order dated November 2, 1998 is affirmed.

Board Chair Bock specially concurring.

Given the Board's *en banc* decision in *Robert R. Dixon*, 48 Van Natta 46 (1996), holding that an employer is not responsible for providing transportation to the modified work site and that a physician's limitation on driving is not a job-related restriction, I am bound by principles of *stare decisis* to conclude that the employer in this case properly terminated claimant's temporary disability benefits upon claimant's refusal of the modified job offer. I write separately, however, explain that if I were deciding the issue on a clean slate, I might find that a claimant's inability to drive an extended distance, such as between Portland and Salem, to a modified job site could render the modified job offer outside of the claimant's work restrictions.

Contrary to the ALJ's finding, I am not persuaded that Dr. Spisak was notified at the time he approved the clerical assistant job for claimant that the job was in Salem. Although the employer's July 15, 1998 letter/job offer to claimant states that the modified job was located in Salem, nothing on the "Temporary Light Duty Task Release" form approved by Dr. Spisak on July 14, 1998 indicates that claimant would need to commute to Salem from Portland. I realize that, in light of *Dixon*, this fact is not relevant to the temporary disability entitlement analysis, but, as a practical matter, I believe that when the modified job offer is at a location different from the claimant's assigned work site (particularly when the modified job is in a different city more than 40 miles away), the employer should advise the attending physician of the changed job location as part of the job description.

In short, if I were not bound by Board precedent and if I was persuaded that claimant was unable to make the drive between Portland and Salem, I would construe that inability to drive to the work site as a component of the work release. But on this record, I am not persuaded that claimant cannot make the commute. Thus, I concur with the majority that the employer properly terminated claimant's temporary total disability benefits.

Board Member Biehl dissenting.

Based on *Robert R. Dixon*, 48 Van Natta 46 (1996), the majority concludes that the insurer was entitled to terminate claimant's temporary disability benefits because claimant declined to commute from Portland to Salem for a light duty, reduced wage position. Unlike the majority, I am persuaded by Dr. Spisak's comments that claimant is unable to make the drive to and from Salem on a daily basis. Also, I believe that it is bad policy to hold that a limitation on driving or a need for transportation to a modified job location is not a work-related restriction. Therefore, I respectfully dissent.

Like Chair Bock, I would find that if a claimant is unable to drive an extended distance to a modified job site due to his or her compensable condition, that circumstance should render an otherwise acceptable modified job unacceptable and outside the claimant's capabilities. Unlike Chair Bock, I believe that we should disavow *Robert R. Dixon*. We should instead conclude, under facts such as those presented in this case, that a physician's limitation on driving is a job-related restriction even though the

claimant's job duties do not otherwise involve driving. Stated differently, I believe that a carrier should not be permitted to terminate payment of temporary total disability benefits under ORS 656.268(3)(c) by arranging for an offer of modified employment at a distant, inconvenient location for the claimant, especially when the claimant is otherwise restricted from driving extended distances. Thus, in this case, I would find that the modified job offer in Salem did not accommodate claimant's work restrictions, and claimant's refusal of that job offer did not give rise to termination of his temporary total disability benefits.

April 19, 1999 Cite as 51 Van Natta 714 (1999)

In the Matter of the Compensation of
TODD A. PURDY, Claimant
WCB Case No. 98-05818
ORDER ON REVIEW
Dobbins, McCurdy & Yu, Claimant Attorneys
Neil W. Jones, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Safeco Insurance Company (Safeco), on behalf of Action Auto Glass, requests review of Administrative Law Judge (ALJ) Hazelett's order that set aside its compensability and responsibility denials of claimant's "new injury" claim for a low back strain. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

On October 14, 1993, claimant injured his low back while working for Harvest States Cooperative. (Exs. 1, 2, 3). He was treated by Dr. Rischitelli, who diagnosed a lumbar strain and recommended physical therapy and medication. (Ex. 2). On October 28, 1993, claimant told Dr. Rischitelli he was "approximately 50% improved." (Ex. 4). Dr. Murphy reported on December 2, 1993 that claimant's strain was "resolved" and he was medically stationary with no permanent impairment. (Ex. 6). Harvest States Cooperative accepted a disabling acute lumbar strain. (Ex. 7).

Claimant began working for Action Auto Glass in 1994. (Ex. 10-2). On May 2, 1995, he was injured in a motor vehicle accident while in the course and scope of his employment. (Exs. 10, 16). The SAIF Corporation, on behalf of Action Auto Glass, accepted a disabling disc herniation at L5-S1. (Ex. 16). On June 10, 1995, Dr. Ordonez performed a laminectomy and discectomy at L5-S1. (Ex. 14). Dr. Ordonez reported on July 5, 1995 that claimant was doing "excellently" after surgery. (*Id.*) At the end of August 1995, claimant told Dr. Ordonez that he was "95% better than before the surgery." (Ex. 18). Dr. Ordonex performed a closing examination on October 26, 1995, reporting that claimant had no lower back or leg pain. (Ex. 20). He said that claimant was medically stationary and was able to return to work full time. (Ex. 20-2).

Claimant testified that he did not have pain in his back or lower extremities again until April 1997. (Tr. 17). He signed an "827" form on May 5, 1997, indicating that he had been cutting a windshield out and hurt his lower back on April 1, 1997. (Ex. 20A). Claimant was working for Action Auto Glass, which was apparently insured by SAIF at that time. (*Id.*) Dr. Eubanks diagnosed a lumbar strain. (Ex. 20B-1). Claimant was on modified duty until May 28, 1997, when Dr. Eubanks released him to return to work without restriction. (Ex. 20B-3).

Claimant testified that he had no further back symptoms until January 26, 1998, when he injured his back while installing a windshield at work. (Tr. 13, 18, Ex. 21). At that time, Action Auto Glass was insured by Safeco. (Exs. 21, 31). Claimant's symptoms increased during the week and he sought emergency room treatment on February 1, 1998. (Tr. 19, 20). Dr. King diagnosed a low back sprain. (Exs. 21). Claimant sought follow-up treatment from Dr. Eubanks, who diagnosed an acute low back strain. (Ex. 23). Dr. Eubanks recommended modified work. (Ex. 24).

Claimant was examined by Dr. Rosenbaum on February 24, 1998. (Ex. 25). He diagnosed musculoskeletal symptoms and concluded that claimant did not have any neurologic symptoms. (Ex. 25-2).

On April 28, 1998, Dr. Gambee examined claimant on behalf of Safeco. (Ex. 29).

Safeco, on behalf of Action Auto Glass, denied claimant's January 26, 1998 claim. (Ex. 31). Claimant requested a hearing on Safeco's denial.

CONCLUSIONS OF LAW AND OPINION

At hearing, the parties agreed that compensability and responsibility were at issue. (Tr. 2-6). The ALJ found that claimant's low back injury arose out of and in the course of employment and was compensable. The ALJ relied on Dr. Rosenbaum's opinion to conclude that claimant had sustained a "new injury" for which Safeco was responsible.

Compensability

Claimant has two prior accepted claims. Harvest States Cooperative accepted a disabling lumbar strain resulting from an October 1993 injury. (Ex. 7). SAIF, on behalf of Action Auto Glass, accepted a disabling disc herniation at L5-S1 resulting from claimant's May 2, 1995 motor vehicle accident. (Ex. 16). Neither of these carriers were joined in this proceeding and there is no evidence in the record regarding the closure of either the 1993 or 1995 claims. In addition, claimant signed an "827" form regarding an injury on April 1, 1997, while working for Action Auto Glass, which was apparently insured by SAIF at that time. (Ex. 20A). There is no evidence in the record as to whether claimant pursued a claim for an April 1, 1997 injury.

On review, Safeco argues that the ALJ failed to consider the significance of claimant's April 1997 low back injury. According to Safeco, claimant's April 1997 low back condition must be treated as a noncompensable preexisting condition that "combined" with the 1998 injury. Safeco asserts that, under ORS 656.005(7)(a)(B), claimant must establish that the 1998 injury was the major contributing cause of disability and need for treatment of the combined condition. Safeco contends that none of the physicians adequately commented on the "significance" of the 1997 injury and, therefore, claimant did not meet his burden of proving compensability.

We are not persuaded that claimant's April 1997 back injury was particularly "significant." Claimant signed an "827" form on May 5, 1997, indicating that he had been cutting a windshield out and hurt his lower back on April 1, 1997. (Ex. 20A). At that time, claimant was working for Action Auto Glass, which was apparently insured by SAIF. (*Id.*) Dr. Eubanks diagnosed a lumbar strain and prescribed medication. (Ex. 20B). Claimant was on modified duty until May 28, 1997, when Dr. Eubanks released him to return to work without restriction. (Ex. 20B-3). On that date, Dr. Eubanks described claimant's strain as "resolving." (*Id.*) Claimant testified that he had no further back or leg symptoms until January 26, 1998. (Tr. 18).

Based on Dr. Eubanks' release of claimant to regular work without restriction and his description of claimant's lumbar strain as "resolving," as well as claimant's testimony that he had no further back or leg symptoms until January 1998, we are not persuaded that the 1997 incident was particularly "significant." Furthermore, even if we assume, without deciding, that claimant's April 1997 low back condition should be treated as a noncompensable preexisting condition, we find no medical evidence establishing that the "1997 condition" combined with claimant's 1998 injury. In any event, we find that claimant's January 1998 low back injury is compensable, under either a material or major contributing cause standard.

Claimant testified that he injured his back on January 26, 1998 while installing a windshield at work. (Tr. 13, Ex. 21). His symptoms increased during the week and he sought emergency room treatment on February 1, 1998. (Tr. 19, 20). He was diagnosed with a low back sprain and received follow-up care from Dr. Eubanks. (Exs. 21, 23, 24).

Considering the passage of time before claimant sought treatment and because there are multiple potential causes for his low back condition, determination of the cause of claimant's low back injury is complex and requires expert medical opinion. *Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279 (1993).

There are three medical opinions on causation. On April 28, 1998, Dr. Gambee, orthopedic surgeon, examined claimant on behalf of Safeco. (Ex. 29). He felt that claimant's current low back strain combined with the preexisting disc herniation and surgery to form a new combined condition, *i.e.*, a low back strain "superimposed on the scar tissue of prior surgery." (Ex. 29-5). Dr. Gambee believed that, although the January 1998 lifting incident contributed to claimant's back condition, the preexisting scar tissue was "significantly more contributory" than the lifting episode. (*Id.*)

Dr. Eubanks, claimant's attending physician, disagreed with Dr. Gambee's opinion on causation. Dr. Eubanks believed that claimant's low back surgery had healed and lifting the piece of glass on January 26, 1998 was the major cause of his low back strain. (Ex. 30).

Dr. Rosenbaum, neurosurgeon, examined claimant on February 24, 1998. (Ex. 25). He reported that claimant had obtained "good relief" from the 1995 lumbar laminectomy and did well until approximately May 1997, when he had an onset of low back pain while installing windshields. (Ex. 25-1). Dr. Rosenbaum reported that claimant was treated by Dr. Eubanks and again did well until January 26, 1998 when he injured his back while carrying a windshield. (*Id.*) Dr. Rosenbaum diagnosed musculoskeletal symptoms and concluded that claimant did not have any neurologic symptoms. (Ex. 25-2).

Although Dr. Rosenbaum initially concurred with Dr. Gambee's opinion on causation (Ex. 32), he later explained that he had reviewed additional medical records and changed his opinion on causation. (Ex. 36). *See Kelso v. City of Salem*, 87 Or App 630, 633 (1987) (medical opinion that provided a reasonable explanation for the change of opinion was persuasive). Dr. Rosenbaum reported that after the 1995 lumbar laminectomy, claimant had a good result with no interval difficulty aside from a brief period of discomfort in 1997. (*Id.*) He explained:

> "[Claimant] then had an apparent specific incident in January of 1998 causing the onset of low back pain. The diagnosis by multiple physicians has been a musculoskeletal strain. It is not a recurrence of his disk herniation. There is no indication that there is any interaction with this patient's prior laminectomy nor scar tissue. In the absence of the patient having multiple episodes or chronicity to his complaints of pain since 1995, it would be my opinion that this a new injury with a new pathologic entity." (*Id.*)

Dr. Gambee reviewed Dr. Rosenbaum's report and adhered to his previous conclusion. Dr. Gambee said that he was "absolutely convinced" that the scar tissue from claimant's first surgery was the major "contributory" cause of his need for treatment and disability. (Ex. 38).

In evaluating medical evidence concerning causation, we rely on opinions that are well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). We generally rely on the opinion of a claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). Here, we are persuaded by the opinions of claimant's treating physicians, Drs. Eubanks and Rosenbaum, that the claim is compensable.

Dr. Gambee was "convinced" that claimant had scar tissue from the 1995 low back surgery, which he felt was the major contributing cause of his need for treatment and disability. (Ex. 38). He did not explain, however, how he determined that claimant actually had scar tissue from the previous surgery. Furthermore, Dr. Gambee did not explain why, if claimant had such scar tissue, he had not been having continuing low back symptoms since 1995, nor did he explain why the "scar tissue" was "significantly more contributory" to the strain than the lifting incident on January 26, 1998. We are not persuaded by Dr. Gambee's conclusory opinion.

In contrast, Dr. Rosenbaum's opinion is thorough, well-reasoned and based on complete information. He reported that claimant had a good result from the 1995 lumbar laminectomy, with no interval difficulty aside from a brief period of discomfort in 1997. (Ex. 36). He found no indication that the January 1998 work incident "interacted" with claimant's prior laminectomy or scar tissue. (*Id.*) He felt that claimant had sustained a "new injury" in January 1998. Likewise, Dr. Eubanks, claimant's attending physician, believed that claimant's January 26, 1998 work incident was the major cause of his low back strain. (Ex. 30). Based on the opinions of Drs. Rosenbaum and Eubanks, we conclude that claimant's January 26, 1998 injury at Safeco's insured was the major contributing cause of claimant's low back strain.

Responsibility

Safeco argues that, even if the claim is compensable, it is not responsible for claimant's condition. Safeco contends that Harvest States Cooperative has the last accepted condition involving the same condition and it cannot shift responsibility to Safeco under ORS 656.308. Alternatively, Safeco contends that SAIF has the last applicable accepted claim and it cannot shift responsibility to Safeco.

A carrier with an accepted injury or occupational disease remains "responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition." ORS 656.308(1).

As we discussed above, we find that Drs. Rosenbaum and Eubanks have provided the most persuasive medical opinions on causation. Based on their reports, we conclude that the January 26, 1998 injury at Safeco's insured is the major cause of claimant's need for treatment and disability of a low back strain and, therefore, he has sustained a "new compensable injury." Consequently, Safeco is responsible for claimant's January 26, 1998 low back strain.

Claimant's attorney is entitled to an assessed fee for services on review concerning compensability. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by Safeco. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 16, 1998 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by Safeco.

April 19, 1999 Cite as 51 Van Natta 717 (1999)

In the Matter of the Compensation of
MARK SIMMONS, Claimant
WCB Case No. C9-00686
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Industrial Indemnity, Insurance Carrier

Reviewed by Board Members Biehl and Haynes.

On March 17, 1997, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

Parties may dispose of all matters concerning a claim, except for medical services, with a CDA "subject to such terms and conditions as the Workers' Compensation Board may prescribe." ORS 656.236(1). The worker, insurer or self-insured employer may request disapproval of the disposition within 30 days of its submission to the Board. ORS 656.236(1)(a)(C). Notwithstanding this provision, however, the CDA may provide for waiver of the 30 day period if the worker was represented by an attorney at the time the worker signed the disposition. ORS 656.236(1)(b); *Jeanne P. Morgan*, 47 Van Natta 1062 (1995).

The first page of the agreement includes the required statement indicating that the parties do not wish to waive the "30-day" cooling off period. Separate from the CDA, claimant has submitted a letter requesting the Board waive the "30-day" cooling-off period based on his "hardship." Nonetheless, because claimant is unrepresented, the Board is without statutory authority (regardless of the basis for the request) to waive the 30-day statutory period and has, thus, allowed the "cooling-off period" to expire before considering the agreement for approval.

We conclude the agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved.

Should the parties disagree with our interpretation of the CDA, they may move for reconsideration by filing a motion for reconsideration within 10 days of the date of mailing of this order. OAR 438-009-0035.

IT IS SO ORDERED.

In the Matter of the Compensation of
LINDA M. DePAOLO, Claimant
WCB Case Nos. 98-06482 & 98-04991
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Gilroy Law Firm, Defense Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Liberty Northwest Insurance Corporation (Liberty), on behalf of Brown and Williamson Tobacco Company, requests review of those portions of Administrative Law Judge (ALJ) Peterson's order that: (1) assessed a 25 percent penalty for an allegedly unreasonable denial; and (2) awarded an assessed fee of $5,000. On review, the issues are penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Penalties

The ALJ assessed a 25 percent penalty, finding that Liberty's denial was unreasonable. On review, Liberty argues that it had legitimate doubt regarding its liability for claimant's cervical condition. We agree.

A penalty is available if the carrier "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. *International Paper Co. v. Huntley*, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available to the carrier. *Brown v. Argonaut Insurance Company*, 93 Or App 588, 591 (1988).

Here, Liberty accepted an injury that claimant sustained in 1984, involving the right shoulder and neck. After claimant experienced increased cervical pain in 1997 and 1998 while working for another employer, Liberty issued a denial on June 18, 1998, on the basis of insufficient evidence that claimant's condition "diagnosed as Cervical Spondylstic (sic) changes, C5-6 with Canal Stenosis and some Thecal Compression, is the result either of an injury or disease precipitated by your occupational exposure at [Liberty's insured]." (Ex. 100).

Before Liberty's denial, a panel of examining physicians, Drs. Dinneen and Platt, had opined on June 9, 1998 that claimant's neck symptoms were due to degenerative rather than "industrial" causes. (Ex. 99-9). Moreover, in May 1998, claimant and her attending physician, Dr. Long, had completed forms indicating that her cervical condition was not related to employment. (Exs. 94, 95). Based on this evidence, we conclude that Liberty had "legitimate doubt" regarding its liability for claimant's cervical condition prior to issuance of its denial. Therefore, we reverse the ALJ's penalty assessment.

Attorney Fees

Liberty contends that the ALJ's attorney fee award of $5,000 was excessive. On *de novo* review, we consider the amount of an attorney fee for services at the hearings level by applying the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceeding; (6) the benefit secured for the represented party; (7) the risk in a particular case that any attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The issues were the compensability of and responsibility for claimant's neck condition. Approximately 113 exhibits were admitted, with two exhibits generated by claimant's counsel. There were no depositions. The hearing was almost two hours in length, with claimant as the only witness.

When compared with other compensability and responsibility disputes reviewed by this forum, we find that the case involved issues of average legal and medical complexity. The claim's value and benefits are significant, but are reduced because the Liberty claim is in "Own Motion" status. The parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented. Finally, considering the conflicting medical evidence regarding the compensability of claimant's current neck condition, there was a risk that claimant's counsel's efforts might have gone uncompensated.

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $5,000 is a reasonable and appropriate attorney fee for services at hearing. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the record), the value of the interest involved, and the risk that claimant's counsel might go uncompensated. Because we do not consider this case to have presented "extraordinary circumstances," $1,000 of this $5,000 attorney fee award has been apportioned to claimant's counsel for active and meaningful participation at the hearings level in finally prevailing over Liberty's responsibility denial. ORS 656.308(2)(d); *Foster-Wheeler Constructors, Inc. v. Smith*, 151 Or App 155 (1997); *Darold E. Perry*, 50 Van Natta 788 (1998). Therefore, we affirm the ALJ's attorney fee award.[1]

ORDER

The ALJ's order dated December 1, 1998 is reversed in part and affirmed in part. That portion of the ALJ's order that assessed a 25 percent penalty is reversed. The remainder of the order is affirmed.

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[1] Claimant is not entitled to an attorney fee for services on Board review related to the attorney fee issue. *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

In the Matter of the Compensation of
STEPHEN L. DOKEY, Claimant
WCB Case No. 98-01524
ORDER ON REVIEW
Linerud Law Firm, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that upheld the SAIF Corporation's denial of claimant's claim for an upper back and neck injury. In its brief, SAIF requests review of that portion of the order that awarded a $300 attorney fee for claimant's counsel's services in obtaining SAIF's "pre-hearing" concession that claimant was a subject worker at the time of his injury. On review, the issues are compensability and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the ALJ's opinion on this issue, with the following supplementation.

Claimant testified that he had not had neck or upper back problems or treatment for "probably ten years" before his December 16, 1997 motor vehicle accident (MVA). (Tr. 13-14). This history is contradicted by the medical records: Claimant did have prior neck injuries and treatment beginning in 1972 and continuing intermittently until September 22, 1997. (Ex. 10-deposition Ex. 1).

Dr. Wielenga treated claimant in January and February, 1998 for an unrelated angina condition. (Ex. 3A, 4A, 5A, 6A; *see* Ex. 8). Claimant complained of mid and upper back pain and Dr. Wielenga diagnosed a neck and thoracic back strain resulting from the MVA, based entirely on claimant's reporting. (Exs. 9, 10-16). Claimant did tell Dr. Wielenga that he had previous injuries, but there is no indication that the doctor was aware of the nature and extent of claimant's prior upper back problems or that claimant had treated for neck symptoms only three months before the 1997 MVA. Considering claimant's long history of pre-MVA cervical problems, in light of his at-hearing denial of such problems (during the last ten years), we are not persuaded that claimant provided Dr. Wielenga a complete and accurate history or that the doctor's causation opinion is based on such a history. Therefore, we decline to rely on Dr. Wielenga's opinion and we agree with the ALJ that claimant has not carried his burden of establishing the compensability of his claim.[1]

Attorney fees

The ALJ awarded a $300 attorney fee under ORS 656.386(1) for claimant's counsel's services in obtaining SAIF's "pre-hearing" concession that claimant was a subject worker at the time of the MVA. But the statute only allows an attorney fee when the claimant *prevails on a claim.*[2] Here, because claimant has not prevailed on a claim, the ALJ's attorney fee award must be reversed.

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[1] We would reach the same result under ORS 656.005(7)(a) --even if claimant did not have a "preexisting condition" within the meaning of ORS 656.005(7)(a)(B) and 656.005(24). And we would reach the same result even if he did have "objective findings" as defined by ORS 656.005(19) (*e.g.*, reduced neck range of motion), because Dr. Wielenga did not have an adequate history.

[2] *See SAIF v. Allen*, 320 Or App 192, 205-206 (1994) (discussing *Shoulders v. SAIF*, 300 Or 606, 611-12 (1994)) (To be entitled to an attorney fee under ORS 656.386(1), the claimant must prevail on the compensability issue); *Donna R. Roberts*, 51 Van Natta 103, 109 (1999) (Where a carrier's denial was upheld and the claimant did not prevail against the carrier's denial of compensability, no attorney fee was authorized against the carrier under ORS 656.386(1)); *Anthony J. Colistro*, 43 Van Natta 1835 (1991) (The rescission of one portion of a carrier's denial did not entitle the claimant to a carrier-paid attorney fee under ORS 656.386(1) when the remainder of the denial was upheld.)

ORDER

The ALJ's order dated November 23, 1998 is reversed in part and affirmed in part. That portion of the order that awarded a $300 attorney fee is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
JERI L. HANSON, Claimant
WCB Case No. 97-01845
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Myzak's order that set aside its denial of claimant's occupational disease claim for a right carpal tunnel syndrome (CTS) condition.[1] On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following correction.

The second sentence in the second paragraph on page 2 is corrected to indicate that Dr. Macha considered claimant's prior compensable *right* shoulder claim, among other things, in evaluating the cause of claimant's right CTS.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,600, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated October 23,1998 is affirmed. For services on review, claimant is awarded a $1,600 attorney fee, payable by the insurer.

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[1] Alternatively, the insurer requests remand for admission of additional evidence regarding claimant's 1994 right shoulder and 1995 left wrist claims. However, there is no indication that any such evidence was unobtainable at hearing and we cannot say that it would likely affect the result in the present case. Under these circumstances, remand is not appropriate. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

In the Matter of the Compensation of
LOREN E. FARLEY, Claimant
WCB Case Nos. 97-05800 & 96-11337
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

AIG Claim Services, Inc. (AIG) requests review of those portions of Administrative Law Judge (ALJ) Myzak's order that: (1) set aside its denial of claimant's occupational disease claim for a hearing loss condition; and (2) upheld Cigna Insurance Company's (Cigna's) denial for the same condition. On review, the issue is responsibility.

We adopt and affirm the ALJ's order with the following corrections and supplementation.

We replace the next to the last sentence in the second paragraph of the findings of fact with the following: After eliminating the test/retest variability, there was no change in claimant's work-related hearing loss in the period of 1989 to 1991 (the period of claimant's employment with Cigna's insured). (Ex. 40-3). The date in the next to the last paragraph of the ALJ's opinion should read December 1996, not December 1986.

Compensability of claimant's hearing loss condition is not disputed. From 1964 to May 1989, claimant worked for AIG's insured. From May 1, 1989 to August 1991, the date he retired, claimant worked for Cigna's insured. Claimant's work for both employers as a truck driver exposed him to noise. He rarely wore ear plugs and only when mandated.

In January 1990, while employed by Cigna's insured, claimant sought medical treatment for progressive binaural hearing loss, left worse than right, that he had been noticing since the late 1970's; he was fitted with a hearing aid for the left ear. He was never disabled by his hearing loss. On June 14, 1996, claimant was examined by Dr. Traynor, treating otolaryngologist, who stated his opinion regarding the cause of claimant's hearing loss in terms of possibility only. (Ex. 38). In the summer of 1996, claimant began wearing hearing aids in both ears. On October 7, 1996, claimant was examined by Dr. Hodgson, otolaryngologist, on behalf of Cigna. (Ex. 40).

Relying on the opinion of Dr. Hodgson, the ALJ found that, whether responsibility is decided on the basis of "actual cause" or under the last injurious exposure rule, AIG is the responsible insurer. AIG argues that the last injurious exposure rule applies and, under that rule, initial responsibility is assigned to and remains with Cigna. We agree with the ALJ and write only to address AIG's arguments on review regarding application of the last injurious exposure rule.

It is undisputed that claimant first sought medical treatment for his hearing loss while he was working for Cigna's insured. Thus, for purposes of the last injurious exposure rule, the "onset of disability" (i.e., the triggering date for determining which employment is the last potentially causal employment) occurred during claimant's employment with Cigna. *Bracke v. Baza'r*, 293 Or 239, 248 (1982); *Timm v. Maley*, 125 Or App 396 (1993). Consequently, initial responsibility rests with Cigna.

Cigna can transfer responsibility to AIG (the insurer for claimant's prior employer) by establishing that it was impossible for its employer to have caused claimant's hearing loss or that claimant's employment for AIG's insured was the sole cause of claimant's condition. *Roseburg Forest Products v. Long*, 325 Or 305, 308 (1997); *Reynolds Metals v. Rogers*, 157 Or App 147 (1998).

As the ALJ found, the cause of claimant's hearing loss condition is a complex medical question, the resolution of which requires expert medical opinion. *Uris v. Compensation Department*, 247 Or 420 (1967). Furthermore, because Dr. Traynor stated his causation opinion in terms of possibility only, his opinion is not persuasive evidence of causation. *Gormley v. SAIF*, 52 Or App 1055, 1059-60 (1981) (probability, not possibility, is the requisite standard of proof). Dr. Hodgson presents the only other medical opinion regarding causation. For the reasons addressed by the ALJ, we agree that Dr. Hodgson's opinion is persuasive.

Dr. Hodgson examined claimant, performed an audiogram, and reviewed the medical records, including prior audiograms. (Ex. 40). In comparing claimant's March 14, 1989 hearing test, which was close to the beginning of claimant's employment with Cigna's insured, with the test done on August 2,

1991, at the time of his retirement, Dr. Hodgson noted that "only 0.04% [of claimant's total hearing handicap as of the August 2, 1991 test] *could be* attributed to his work-related noise exposure." (Ex. 40-3 (emphasis added)). But Dr. Hodgson concluded that the difference between claimant's March 1989 and August 1991 hearing tests, *i.e.*, the 0.04%, was "caused by the test/retest variability and this would indicate to me that there was no change in that period of 1989 to 1991." (*Id.*). Thus, although noting that there was a *possible* contribution of 0.04 percent to claimant's hearing loss by his work at Cigna's insured, Dr. Hodgson ultimately concluded that there was *no change* due to work-related causes for the period of 1989 to 1991. Furthermore, Dr. Hodgson concluded that "the major contributing cause for [claimant's] hearing loss is his occupational noise exposure prior to May 1, 1989 [the date of his employment with Cigna's insured]." (Ex. 40-4).

Reading Dr. Hodgson's opinion as a whole, we find that he opined that no hearing loss occurred while claimant was employed by Cigna's insured. *See SAIF v. Paxton*, 154 Or App 259, 265 (1998) (citing *Long*, court found that, read as a whole, the medical record established that the claimant sustained no hearing loss while employed by a particular employer and, thus, that employer could not legally be the responsible employer on the claim); *on remand Conrid J. Paxton*, 50 Van Natta 1709 (1998). Instead, the sole work-related cause of claimant's hearing loss was his employment prior to May 1, 1989, at which time he was employed by AIG's insured.

AIG alleges that, based on its analysis of the medical record, Dr. Hodgson's opinion is not persuasive. We disagree.

There is no dispute that this case is complex and, thus, requires expert medical evidence. Here, the only persuasive medical opinion provides that the sole cause of claimant's hearing loss is from employment occurring before May 1, 1989. Dr. Hodgson's opinion is based on an accurate history and provides a well-reasoned explanation in support of his conclusion. We disagree that AIG's lay analysis of the medical evidence provides a persuasive basis to disregard Dr. Hodgson's medical opinion. Rather, we find more persuasive the opinion of Dr. Hodgson, who has medical expertise and reviewed the medical record, including audiograms. *See Richard V. French*, 50 Van Natta 1013 (1998) (Board found ALJ's lay analysis of audiograms unpersuasive and relied on examining otolaryngologist's causation opinion to assign responsibility for hearing loss condition).

Consequently, having found Dr. Hodgson's opinion persuasive, we conclude that Cigna has established that the prior employment at AIG's insured was the sole work-related cause of claimant's hearing loss. Therefore, responsibility shifts to AIG. *See Long*, 325 Or at 308.

ORDER

The ALJ's order dated September 9, 1998 is affirmed.

April 20, 1999 Cite as 51 Van Natta 723 (1999)

In the Matter of the Compensation of
ROBERT A. LEWIS, Claimant
WCB Case Nos. 98-05813 & 95-01577
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Mannix, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Kekauoha's order that upheld the insurer's denial, on behalf of Kettle Foods, Inc., of claimant's occupational disease claim for right carpal tunnel syndrome. On review, the issues are compensability and responsibility.

We adopt and affirm the ALJ's order with the following comment.

On review, claimant contends that the opinions of Drs. Shaw and Mayhall establish the compensability of claimant's occupational disease claim. In upholding the insurer's denial of this claim, the ALJ relied on the contrary opinion of Dr. Gambee. We assume, for the sake of argument, that the

opinion of Dr. Gambee is less persuasive for the reasons discussed in claimant's brief on review. Nevertheless, the opinion of Dr. Shaw is also unpersuasive for the reasons discussed by the ALJ. And the opinion of Dr. Mayhall is unpersuasive because it is equivocal and only establishes a *possible* relationship between claimant's work activity and his right carpal tunnel syndrome. Consequently, claimant has not carried his burden of proving a compensable occupational disease claim.

ORDER

The ALJ's order dated November 13, 1998 is affirmed.

In the Matter of the Compensation of
LATOY E. HAMILTON, Claimant
WCB Case No. 98-05738
ORDER ON REVIEW
Cathcart & Borden, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) awarded claimant's counsel an attorney fee pursuant to ORS 656.386(1) for prevailing over the employer's allegedly "de facto" denial of claimant's L5-S1 disc condition; and (2) assessed a $500 attorney fee under ORS 656.382(1) for allegedly unreasonable claim processing. On review, the issues are attorney fees and penalties. We reverse.

FINDINGS OF FACT

In July 1997, claimant made a claim for right-sided back pain, which she related to her work activity in the "FAB" department on June 23, 1996. Following an examination by Dr. Bald at the employer's request, the employer accepted a lumbar strain on October 23, 1997.

An October 29, 1997 MRI revealed "minimal focal disk protrusion or broad-based disk bulging" laterally at L5-S1. Thereafter, in January 1998, claimant's attending physician, Dr. Waldram, diagnosed chronic back strain and a small herniated disc at L5-S1.

On March 3, 1998, claimant was examined by Dr. Mayhall at the employer's request. Dr. Mayhall diagnosed a small-broad based disc bulge at L5-S1 and lumbosacral strain. He found claimant medically stationary and did not recommend further medical treatment. Dr. Waldram concurred with Dr. Mayhall's report.

Claimant's claim was closed by a May 20, 1998 Notice of Closure, which awarded temporary disability and 8 percent unscheduled permanent disability for the low back. In its Updated Notice of Acceptance At Closure, the employer accepted a lumbar strain and L5-S1 disc bulge.

On June 12, 1998, claimant's counsel wrote the employer's claim processor and requested acceptance of claimant's "L5-S1 facet dysfunction, L5-S1 disk bulge/protrusion/herniation condition," asserting that such condition had been incorrectly omitted from the Notice of Acceptance. This letter was received by the claims processor on June 15, 1998.

On July 10, 1998, the claims processor responded to claimant's counsel's request and enclosed an amended acceptance that included a lumbar strain, L5-S1 disc bulge and L5-S1 facet dysfunction. The claims processor's response letter indicated that the accepted disc bulge condition encompassed the disc protrusion condition and explained:

> "[W]e have requested clarification from the claimant's attending physician, David Waldram, M.D., in regards to the disc herniation diagnosis. Upon receipt of his response, we will update you with the status of that condition."

That same day, the claims processor wrote to Dr. Waldram, asking whether claimant had a L5-S1 disc herniation or if L5-S1 disc bulge was the appropriate diagnosis for claimant's condition.

On July 21, 1998, claimant requested a hearing, alleging the "de facto" denial of L5-S1 disc herniation/protrusion. The employer's response to issues asserted that claimant's request for hearing was premature.

On August 19, 1998, Dr. Waldram responded that "sometimes it is difficult to discern whether something is a small herniation or bulge." He also noted that "it is fair to the patient to say that she has a small herniation" although claimant's small disc condition would likely resolve over time without surgical intervention.

After receiving Dr. Waldram's response, the employer issued a Modified Updated Notice of Acceptance At Closure on September 2, 1998, accepting a lumbar strain, L5-S1 disc bulge, L5-S1 facet dysfunction and L5-S1 small disc herniation.

On October 13, 1998, Dr. Waldram confirmed his opinion that claimant experienced a herniated disc at L5-S1 as opposed to a mere disc bulge.

CONCLUSIONS OF LAW AND OPINION

In awarding an attorney fee under ORS 656.386(1), the ALJ determined that the employer's July 10, 1998 response to claimant's request for acceptance amounted to a denial because the employer deferred action on the disc herniation diagnosis pending further investigation. In addition, in assessing a penalty-based attorney fee pursuant to ORS 656.382(1), the ALJ determined that the insurer did not timely process claimant's request, which amounted to an unreasonable resistance to the payment of compensation.

On review, the employer contends that claimant is not entitled to an attorney fee or a penalty arising out of its processing of claimant's post-closure request for acceptance. We agree, for the reasons set forth below.

ORS 656.262(6)(d) provides, in pertinent part, as follows:

> "An injured worker who believes that a condition has been incorrectly omitted from a notice of acceptance * * * must first communicate in writing to the insurer or self-insured employer the worker's objections to the notice. The insurer or self-insured employer has 30 days from receipt of the communication from the worker *to revise the notice or to make other written clarification in response.*" (Emphasis added)

ORS 656.386(1), the attorney fee statute, only authorizes a fee in cases involving "denied claims." In this context, ORS 656.386(1)(b)(B) defines a "denied claim" as a claim for compensation for a condition omitted from a notice of acceptance "which the insurer or self-insured employer does not *respond to* within 30 days." (Emphasis added)

Here, we find no "denied claim" for purposes of ORS 656.386(1)(b)(B) because the employer responded to claimant's claim for compensation within the 30-day period. Claimant requested acceptance of a "L5-S1 facet dysfunction, L5-S1 disk bulge/protrusion/herniation condition" on June 12, 1998.[1] In its July 10, 1998 response, the employer revised the notice of acceptance (to include L5-S1 facet dysfunction) and clarified its position with regard to the disc diagnoses. The employer asserted that the previously accepted disc bulge encompassed the disc protrusion diagnosis, and explained that it was seeking further information from Dr. Waldram regarding the disc herniation diagnosis.[2] Although the employer did not specifically accept a L5-S1 disc herniation as a distinct condition until it received clarification from Dr. Waldram, its July 10, 1998 clarification and response to claimant's request complied with the processing requirements of ORS 656.262(6)(d) and 656.386(1)(b). *See Kris Henricksen*, 51 Van Natta 401 (1999) (finding that the carrier's response to the claimant's request for an expanded acceptance complied with ORS 656.262(6)(d)).

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[1] Claimant's counsel's letter referred to claimant's "L5-S1 facet dysfunction, L5-S1 disc bulge/protrusion/herniation" as a singular condition that had been incorrectly omitted from the Notice of Acceptance.

[2] The insurer's July 10, 1998 letter to Dr. Waldram noted that there was some "discrepancy" whether or not claimant had a L5-S1 disc herniation, and asked whether an L5-S1 disc bulge was an appropriate diagnosis for claimant's condition.

Indeed, contrary to claimant's contention, it was not clear from the medical evidence in existence at the time of the employer's May 20, 1998 Updated Notice of Acceptance at Closure whether claimant's L5-S1 disc condition was best described as a bulge, protrusion or herniation. The October 29, 1997 MRI report identified a small "protrusion or bulge" laterally at L5-S1. Although in January 1998 Dr. Waldram read the imaging study as showing a "small, herniated disc at L5-S1 to the right," he also concurred with Dr. Mayhall's March 3, 1998 closing examination, which referred to claimant's L5-S1 disc problem as both a "small broad-based bulge" and as a herniation. In fact, it was not until August or September 1998 (months after claimant's June 1998 objection to the updated notice of acceptance) that Dr. Mayhall opined that claimant had a herniated disc at L5-S1 *as opposed to* a bulge or protrusion. (Exs. 32A, 35). Under these circumstances, we do not consider the employer's timely response to, and its further processing of, claimant's objection to the updated notice of acceptance to constitute a denied claim.[3]

Furthermore, unlike the ALJ, we find nothing in the insurer's July 10, 1998 response letter which indicates a "disagreement" with claimant's stated objections to the notice of acceptance giving rise to the requirements of OAR 438-005-0050.[4] To the contrary, in acknowledging the need for clarification concerning the disc herniation diagnosis, the employer's letter showed an agreement that claimant's L5-S1 facet dysfunction and L5-S1 disc condition were compensable and accepted. Therefore, the absence of hearing rights does not invalidate the employer's timely response for purposes of ORS 656.262(6)(d) and 656.386(1).

Finally, we also find no basis for a penalty-related attorney fee under ORS 656.382(1).[5] The record establishes that no compensation is due on the claim. Because the employer cannot unreasonably resist the payment of compensation that has been paid, *SAIF v. Condon*, 119 Or App 194, *rev den* 317 Or 162 (1993), no basis exists for a penalty or attorney fee. *See also Michael E. Pelcin*, 47 Van Natta 1380 (1995) (in the absence of any evidence of unpaid compensation at the time the carrier failed to forward written notice of claim acceptance to claimant, no fee was warranted under ORS 656.382(1)).

ORDER

The ALJ's order dated October 30, 1998 is reversed.

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[3] In other words, because the medical records in existence at the time of claim closure and claimant's objection to the updated notice of acceptance appeared to use the terms "bulge," "protrusion" and "herniation" interchangeably to describe claimant's L5-S1 disc condition, the employer was not required to accept each and every diagnosis or condition with particularity, so long as the acceptance tendered reasonably apprised the claimant and medical providers of the nature of the compensable condition. *See* ORS 656.262(7)(a); *Kris Henricksen*, 51 Van Natta at 402.

Moreover, to the extent claimant's June 12, 1998 letter can be interpreted as a request for acceptance of a L5-S1 disc herniation as a "new medical condition," (distinct from the already accepted disc bulge) we note that the employer responded to the claim and accepted the herniation condition within 90 days in compliance with ORS 656.262(7)(a). Therefore, there has been no "denied claim" in the new medical condition context, either. *See Mark A. Baker*, 50 Van Natta 2333 (1998).

[4] This rule provides, in pertinent part, as follows:

"In the event that the insurer or self-insured employer disagrees with all or any portion of a worker's objection to a notice of claim acceptance under ORS 656.262(6)(d), the insurer's or self-insured employer's written response shall specify the reasons for the disagreement and shall contain a notice, in prominent of bold-face type as follows:"

[5] ORS 656.382(1) provides that a carrier shall be liable for a reasonable attorney fee if it "unreasonably resists the payment of compensation."

In the Matter of the Compensation of
WILLIAM B. BARRETT, Claimant
WCB Case No. 98-06791
ORDER ON REVIEW
Ronald A. Fontana, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that affirmed an Order on Reconsideration awarding no unscheduled permanent partial disability (PPD) for a low back condition. On review, the issue is extent of unscheduled PPD.

We affirm the ALJ's order with the following supplementation.

We make the following additional "Findings of Fact."

Claimant requested reconsideration from SAIF's March 25, 1998 Notice of Closure. (Ex. 24) At the time of that closure, SAIF had accepted claimant's injury as a thoracolumbar strain. (Exs. 3, 21) After claimant requested reconsideration from the March 25, 1998 closure, SAIF issued an amended acceptance of the additional conditions of lumbosacral strain, L4-5 disc bulge, right L3-4 disk herniation, and bilateral lumbar radiculopathy. (Ex. 27) Following this amended acceptance, SAIF issued a second Notice of Closure on June 12, 1998. (Ex. 28)

We offer the following supplemental analysis in support of the ALJ's "Conclusions and Opinion."

The scope of the present case is limited to impairment due to the thoracolumbar strain accepted prior to the March 25, 1998 Notice of Closure. (Exs. 30, 33). On review, claimant contends that he is entitled to an award of unscheduled PPD based on reduced ranges of lumbar motion. In declining to award unscheduled PPD, the Appellate Reviewer relied on the findings of Dr. Lawlor, the treating physician. Dr. Lawlor opined that claimant's lumbar ranges of motion were normal for claimant "based upon subjective pain complaints, pre-existing obesity." The Appellate Reviewer rejected the lumbar motion measurements reported by the medical arbiters because they did not perform a validity check based on claimant's straight leg raising test. (Ex. 37)

The ALJ concluded that claimant was not entitled to an impairment value for reduced lumbar motion even if the arbiters' measurements were considered to be valid. We agree. The arbiters opined that claimant's accepted lumbar strain condition had resolved, and that "the examinee made a full recover[y] from the injury of July 25, 1997, and we attribute his present condition to subsequent factors and not to the injury of July 25, 1997." (Ex. 34). Thus, the arbiters' opinion does not support a finding that the reported reduced lumbar motion was due to the accepted strain condition. Moreover, as discussed above, the opinion of the treating physician does not support an impairment value for claimant's reduced motion. Consequently, claimant has not established that he is entitled to an unscheduled PPD award based on reduced lumbar motion.

ORDER

The ALJ's order dated December 8, 1998 is affirmed.

In the Matter of the Compensation of
JESUS M. DELATORRE, Claimant
WCB Case No. 97-07795
ORDER ON REVIEW
Juli Point, Claimant Attorney
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that: (1) declined to admit Dr. Bert's expert testimony into evidence; and (2) upheld the self-insured employer's denial of claimant's occupational disease claim for a low back condition. On review, the issues are evidence and compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

The January 7, 1998 hearing was continued for the second half of the deposition of Dr. Kirschner, who had earlier written two reports based on his examination of claimant and review of the medical records. Thereafter, the documentary record was closed (with the exception of matters flowing from Exhibit 22). (Tr. 8, 11). The remainder of the deposition took place on April 16, 1998. On July 31, 1998, claimant provided notice that Dr. Bert would testify as an expert witness at the reconvened hearing.

The parties appeared before the ALJ on August 20, 1998 to receive Kirschner's deposition and to hear additional oral testimony. At the reconvened hearing, the employer objected to Bert's testimony on two grounds: (1) claimant's disclosure of expert testimony was untimely; and (2) the ALJ had frozen the medical record during the January 7, 1998 hearing. The ALJ declined to consider Bert's testimony on the basis that the parties had agreed on the record that *all* medical evidence (not merely the documentary evidence) would be limited to that provided at the January 7, 1998 hearing (up to and including Exhibit 25), with the exception of the second portion of Dr. Kirschner's deposition and any materials that might pertain to Exhibit 22.

On review, claimant challenges the ALJ's ruling to freeze the medical record as of January 7, 1998, the originally scheduled date of hearing, and to exclude Dr. Bert's expert testimony. Claimant argues that the ALJ should not have stricken Dr. Bert's testimony, as the parties' agreement at hearing was to freeze only the documentary record and not expert testimony. He also argues that, because the ALJ made a finding that "there was no express prohibition of expert testimony," but inferred from the record that a prohibition against additional reports would also exclude live testimony, Dr. Bert's testimony should be admitted into the record.

ALJs are not bound by common law or statutory rules of evidence or by technical or formal rules of procedure and may conduct a hearing in any manner that will achieve substantial justice. ORS 656.283(7); *Armstrong v. SAIF*, 67 Or App 498 (1984). We review the ALJ's evidentiary ruling for abuse of discretion. *See James D. Brusseau II*, 43 Van Natta 541 (1991). Moreover, where an ALJ leaves the record open for a limited purpose, it is within the ALJ's discretion to exclude evidence that does not comport with that purpose. *See Clifford L. Conradi*, 46 Van Natta 854 (1994); *Darrel L. Hunt*, 44 Van Natta 2582, 2583 (1992).

At the time of the January 7, 1998 hearing, expert testimony was not contemplated. Had there been time to complete the case at the time of the original hearing, the parties would have gone forward with the January 7, 1998 hearing without the testimony of Dr. Bert. Moreover, we agree with the ALJ's interpretation of the discussion at hearing between the ALJ and the parties regarding the admission of evidence and closure of the record as an agreement that *all* medical evidence (not merely the *written* medical evidence) would be limited to that admitted at the time of hearing (Exs. 1-25), with the exception of the continuation of Dr. Kirschner's deposition and any materials that might pertain to Exhibit 22. (*See* Tr. 8-12; *see also* Ex. 29-68).

Moreover, even if we were to assume that the medical record had not been frozen on January 7, 1998, claimant had not timely disclosed that she would be calling Dr. Bert as an expert witness. OAR 438-007-0016.[1] Therefore, it was within the ALJ's discretion to exclude Dr. Bert's testimony. Consequently, we do not disturb the ALJ's exclusion of that testimony.

Compensability

In order to prevail on an occupational disease claim, claimant must establish that the employment conditions were the major contributing cause of the disease. ORS 656.802(2)(a). If the occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005(7), the worker must prove that the employment conditions were the major contributing cause of the combined condition and the pathological worsening of the disease. ORS 656.802(2)(b).

The medical evidence does not establish that the disputed condition, an L5-S1 herniated disc, preexisted claimant's work at the employer, which began in 1990. *E.g., Esther L. Mace*, 48 Van Natta 1168 (1996). Therefore, we conclude that there is no herniated disc condition that preexisted the initial onset of this claim. Because claimant's occupational disease claim is not based on the worsening or combining of a preexisting disease or condition, ORS 656.802(2)(b) does not apply.

To establish compensability under ORS 656.802(2)(a), claimant must prove that his work activities for the employer were the major contributing cause of his herniated disc at L5-S1. Claimant relies on his treating physician's opinion to establish compensability of the disc condition. In evaluating medical opinions, absent persuasive reasons to the contrary, we generally defer to the treating physician. *Weiland v. SAIF*, 64 Or App 810 (1983). In evaluating the medical evidence concerning causation, we rely on opinions that are well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986).

Here, however, we find that the dispute (*i.e.*, whether claimant's herniated disc is compensable) involves expert analysis rather than expert external observations; therefore, the status of treating physician confers no special deference. *See Allie v. SAIF*, 79 Or App 284 (1986); *Hammons v. Perini Corp.*, 43 Or App 299 (1979).

On May 7, 1997, claimant reported to Dr. Brazer that about eight months earlier, he had been knocked to the ground while playing baseball and had been experiencing persistent pain in the left posterior thigh and gluteal area that sometimes went into his calf and that the pain was not going away. (Ex. 1-2). Brazer recommended an orthopedic consultation. (*Id.*)

On July 31, 1997, claimant sought treatment from Dr. Brazer for acute left low back pain with radicular symptoms. Claimant reported that his low back symptoms had begun about two months earlier and had become markedly worse over the last four days. (Exs. 2, 3). Claimant was subsequently diagnosed with a herniated disc at L5-S1 by Dr. Whitney, who recommended surgery. The surgery was performed by Dr. Bert on October 9, 1997.

Medical opinions regarding the cause of claimant's herniated disc were provided by Dr. Kirschner, who examined claimant and reviewed the medical record, and Dr. Bert, claimant's treating surgeon.

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[1] OAR 438-007-0016 provides:

"Within the times provided for the initial exchanges of exhibits and indexes under OAR 438-007-0018 each party shall disclose to all other parties the identity of each expert witness the party will call to testify at the hearing. A statement by a party that the party "reserves the right," or similar language, to call as a witness any expert whose opinion has been included in the documents filed in the case is not compliance with this rule. At the hearing the Administrative Law Judge may, in his or her discretion, allow the testimony of expert witnesses not disclosed as required by this rule. In the exercise of this discretion, the Administrative Law Judge shall determine whether material prejudice has resulted from the timing of the disclosure and, if so, whether there is good cause for the failure to timely disclose that outweighs the prejudice to the other party or parties."

After our *de novo* review of the record, we agree with the ALJ that Dr. Kirschner's opinion that claimant's clinical presentation on May 7, 1997 was clearly consistent with a long-standing herniated disc condition is more persuasive than Dr. Bert's opinion that an MRI revealed that the disc herniation was too recent to have been caused by the 1996 baseball incident. Dr. Kirschner's opinion is supported by claimant's contemporary report to Dr. Brazer that he had had persistent aching, shooting pains to the left posterior thigh, gluteal region and calf since the baseball injury, and his wife's testimony that, when claimant saw Dr. Brazer, he was experiencing severe pain in the back of his leg, which continued, spread into his low back, and worsened, requiring consultation with Dr. Whitney. Consequently, we conclude that claimant has failed to prove that his work activities were the major contributing cause of his low back condition.

ORDER

The ALJ's order dated October 23, 1998 is affirmed.

April 23, 1999 Cite as 51 Van Natta 730 (1999)

In the Matter of the Compensation of
GEORGE A. MacDONALD, Claimant
WCB Case No. 98-04744
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Davis' order that set aside its denial of claimant's neck injury claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation.

In deciding that claimant proved compensability, the ALJ relied on *Donald Converse*, 50 Van Natta 1830 (1998). According to the insurer, our decision in that case misinterpreted ORS 656.005(7)(b)(A). We reject the insurer's request to reconsider the *Converse* case.[1]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated October 22, 1998 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,000, to be paid by the insurer.

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[1] Although a signatory of this order based on *stare decisis*, Member Haynes directs the parties to her dissent in *Converse*.

In the Matter of the Compensation of
MARIETTA Z. SMITH, Claimant
WCB Case Nos. 98-04425, 97-06269 & 96-11437
SECOND ORDER ON RECONSIDERATION
Darris K. Rowell, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

On March 26, 1999, the Board issued an Order on Reconsideration that republished, as supplemented and modified, the Board's February 25, 1999 Order on Review that: (1) adopted and affirmed that portion of an Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's November 26, 1996 denial of claimant's right knee occupational disease (OD) claim on the ground that "work activity [was] not the major contributing cause of the development of [the] condition diagnosed as degenerative joint disease, bilateral knees"; and (2) affirmed that portion of the ALJ's order that upheld SAIF's April 30, 1998 denial of claimant's OD claim for the same condition on the ground that the condition "has not resulted in any treatment or disability."[1] Asserting that the Board erred in finding that "the issue of SAIF's November 26, 1996 denial of claimant's right knee occupational disease claim on causation grounds was raised for the first time on reconsideration," claimant seeks abatement and reconsideration of the Board's decision.

Claimant's contention is apparently based on a reference in the Board's March 26, 1999 Order on Reconsideration that stated that because the "substantive merits of SAIF's causation denial" was "raised for the first time on reconsideration," the Board was not inclined to consider the argument. Because that comment followed a prior statement that claimant had not raised that substantive argument "in her cross-appellant's brief on review," it is apparent that the Board was referring to the fact that the first raising of the substantive causation issue *on Board review* occurred on reconsideration of the Board's initial order. In other words, the statement was not intended to suggest that claimant did not raise the substantive "causation" argument at the hearing.

In any event, regardless of these "timeliness" concerns, the Board's March 26, 1999 order addressed claimant's substantive "causation" argument. Specifically, concluding that the record did not establish that claimant's right knee condition required treatment or resulted in disability, the Board reasoned that the right knee occupational disease claim would not be compensable "even if the requisite causal relationship was established."

In light of such circumstances, it is unnecessary to further address claimant's argument. In other words, regardless of whether claimant's right knee occupational disease claim was denied on causation grounds, the claim would not be compensable because the condition neither required medical treatment nor resulted in disability.

Accordingly, we withdraw our prior orders. On reconsideration, as supplemented herein, we republish our March 26, 1999 Order on Reconsideration. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] We acknowledge that SAIF has filed a petition for judicial review of the Board's February 25, 1999 order. Nevertheless, because the February 25, 1999 order was abated within 30 days of its issuance and because the 30 day period under ORS 656.295(8) from the Board's March 26, 1999 Order on Reconsideration has not expired, the Board retains jurisdiction to further consider this case. *See Haskell Corporation v. Filippi*, 152 Or App 117 (1998); *SAIF v. Fisher*, 100 Or App 288 (1990).

In the Matter of the Compensation of
GUSTAVO B. BARAJAS, Claimant
WCB Case Nos. 98-03824 & 98-03276
ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
Bostwick, et al, Defense Attorneys

Claimant requests reconsideration of that portion of our April 6, 1999 order that directed the self-insured employer to pay claimant interim compensation for the period beginning April 14, 1998 until termination is authorized by law.[1] Claimant requests that we amend our order to direct the employer to pay interim compensation for the period beginning March 31, 1998 until termination is authorized by law.

We agree with claimant that the "Order" section of our opinion is inconsistent with our earlier statement in the order that "We find that the employer's duty to begin payment of interim compensation was triggered at least by March 31, 1998, when Dr. Nyquist discussed claimant's acute stress reaction with the case manager." We modify the last two paragraphs of our previous order to read:

> "Here, Dr. Nyquist's March 16, 1998 chart note indicated claimant had an 'acute stress reaction' from a work injury. (Ex. 5). Dr. Nyquist's March 31, 1998 chart note indicated that he had spoken with claimant's case manager about the acute stress reaction and the fact that claimant was off work. (Ex. 8). The substance of that chart note has not been disputed. We find that the employer's duty to begin payment of interim compensation was triggered at least by March 31, 1998, when Dr. Nyquist discussed claimant's acute stress reaction with the case manager. Earlier in the month, Dr. Nyquist had authorized temporary disability because of claimant's stress reaction. (Exs. 5, 6). Under these circumstances, we conclude that the employer is required to pay claimant interim compensation for the period beginning March 31, 1998 until termination is authorized by law.

ORDER

> "The ALJ's order dated August 24, 1998 is reversed. The self-insured employer is directed to pay claimant interim compensation for the period beginning March 31, 1998 until termination is authorized by law. Claimant's attorney is awarded an attorney fee of 25 percent of the additional compensation created by this order, not to exceed $3,800, payable out of claimant's compensation and directly to claimant's attorney."

Accordingly, on reconsideration, as modified herein, we adhere to and republish our April 6, 1999 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] We note that the employer has filed a Petition for Judicial Review of our order with the Court of Appeals. Nonetheless, because the 30-day period of ORS 656.295(8) has not expired, we retain authority to reconsider our decision. *See Haskell Corporation v. Filippi*, 152 Or App 117 (1998); *SAIF v. Fisher*, 100 Or App 288 (1990).

In the Matter of the Compensation of
FELICIA M. FRANCO, Claimant
WCB Case No. 98-05875
ORDER ON REVIEW
Richard M. Walsh, Claimant Attorney
Neil W. Jones, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the insurer's denial of her low back condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation.

We change the first paragraph of the findings of fact to read:

"Claimant, 37 years old at hearing, began working for the employer on March 3, 1998. (Ex. 9). She initially performed receptionist/clerical duties for approximately one month. (Tr. 13-14). Claimant had back and left leg symptoms at that time. (Tr. 13, Ex. 11A-9). The employer transferred claimant to a retirement center, where she worked as a dining room attendant. (Tr. 7, 14). Claimant testified that her low back and left leg symptoms worsened while working in that position. (Tr. 14-15). She filed a claim for leg and back pain on May 6, 1998. (Ex. 9). Claimant had previously experienced low back and 'SI region' pain in December 1997, before working for the employer. (Exs. 2-2, 4-1)."

We adopt and affirm the ALJ's conclusion that claimant did not sustain her burden of proving compensability. We supplement the ALJ's order to address claimant's argument that the ALJ erred by analyzing the claim as an occupational disease. Claimant acknowledges that she has underlying chronic low back changes that preexisted her employment with the employer. She contends, however, that she sustained a compensable injury on or about May 6, 1998, while working as a dining room attendant.

We agree that claimant had a preexisting degenerative condition in her low back. A lumbar MRI on May 29, 1998 showed degeneration and desiccation of the L4-5 and L5-S1 discs, with mild lateral recess stenosis at L4-5 secondary to facet hypertrophy. (Ex. 12). In December 1997, before claimant started working for the employer, she sought medical treatment for low back and "SI region" pain. (Exs. 2-2, 4-1). On December 30, 1997, Dr. Cook reported that claimant's pain was not associated with bending, twisting or lifting and the etiology of her pain was unclear. (Ex. 4-1).

In determining the appropriate standard for analyzing compensability, we note that an occupational disease stems from conditions that develop gradually over time. *Mathel v. Josephine County*, 319 Or 235, 240 (1994); *Active Transportation Co. v. Wylie*, 159 Or App 12 (March 10, 1999). In contrast, an injury is sudden, arises from an identifiable event, or has an onset traceable to a discrete period of time. *Wylie*, 159 Or App at 15; *Valtinson v. SAIF*, 56 Or App 184, 188 (1982).

Here, the onset of claimant's symptoms did not correspond to a specific "event." Claimant did not recall a specific injury or incident while working in either position for the employer. (Tr. 15). In a statement to the insurer, claimant said she felt that the back pain started while she was working as a receptionist for the employer. (Ex. 11A-9). Claimant had back and left leg symptoms at that job. (Tr. 13, Ex. 11A-9). The employer transferred claimant to a retirement center, where she worked as a dining room attendant. (Tr. 7, 14). Claimant testified that her low back and left leg symptoms worsened while working in that position. (Tr. 14-15).

We find that claimant's symptoms arose gradually and she was unable to identify a specific event that precipitated the onset of her symptoms. Furthermore, we are not persuaded that the onset of her symptoms was traceable to a discrete period of time. Therefore, we agree with the ALJ that the claim is most appropriately characterized as an occupational disease.

For the reasons expressed by the ALJ, we agree that claimant has not established compensability. We also note that Dr. Cook's opinion is not persuasive because he did not have an

accurate history of the onset of claimant's low back and left leg symptoms. On May 4, 1998, Dr. Cook reported that claimant had experienced "profound total body pain" after working three days as a dining room attendant. (Ex. 5). In a concurrence letter from claimant's attorney, Dr. Cook agreed that claimant suffered an "acute episode" of neuralgia/neuritis on or about May 6, 1998 while working as a dining room attendant. (Ex. 20-1). He agreed that, when he examined claimant on May 4, 1998, it had been approximately five months since she had reported any back pain or pain radiating into her lower extremities. (Ex. 20-2). Claimant's testimony and her previous statement to the insurer indicated that she had experienced back and left leg symptoms while performing the receptionist job for the employer. (Tr. 13, Ex. 11A-9). In a statement to the insurer, claimant felt that the back pain started while she was working as a receptionist. (Ex. 11A-9). Based on claimant's testimony, we find that Dr. Cook's opinion is not persuasive because he had an inaccurate history of the onset of claimant's symptoms. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) (medical opinions that are not based on a complete and accurate history are not persuasive).

ORDER

The ALJ's order dated November 13, 1998 is affirmed.

April 26, 1999 Cite as 51 Van Natta 734 (1999)

In the Matter of the Compensation of
MICHAEL J. McDERMITT, Claimant
Own Motion No. 98-0519M
ORDER POSTPONING ACTION ON OWN MOTION REQUEST
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted a request for temporary disability compensation for claimant's compensable neck and low back conditions. Claimant's aggravation rights expired on February 20, 1986. SAIF recommends against reopening on the grounds that: (1) claimant's current condition does not require surgery or inpatient hospitalization; (2) it is unknown whether the current condition is causally related to the accepted condition; (3) it is unknown whether SAIF is responsible for the current condition; (4) it is unknown whether surgery or hospitalization is reasonable and necessary for the compensable injury; and (5) claimant was not in the workforce at the time of the current disability. Pursuant to ORS 656.327, this medical services issue is within the Director's jurisdiction. Claimant has requested Director's review of the requested medical treatment. (Medical Review Case No. 3974).

It is the Board's policy to postpone action until pending litigation on related issues has been resolved. Therefore, we defer action on this request for own motion relief and request that the Director send to the Board a copy of the order(s) issued under ORS 656.327[1].

IT IS SO ORDERED.

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[1] SAIF has submitted its "recommendation" under OAR 438-012-0030(1). Nonetheless, it has indicated that questions regarding the compensability and responsibility for claimant's condition as well as the propriety of the surgery are in "deferred status." Because the propriety of claimant's surgery must be resolved, we have issued this order. SAIF is reminded, however, pending Director's review, that it must also file a fully *completed* own motion recommendation form; *i.e.* indicate whether or not it agrees that claimant's condition is causally related to his accepted condition and that SAIF is responsible for that condition.

In the Matter of the Compensation of
RONALD W. LINDLEY, Claimant
WCB Case No. 98-06164
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability.

We adopt and affirm the ALJ's order.[1]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's attorney's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 23, 1998 is affirmed. For services on Board review, claimant's attorney is awarded $1,500, payable by the employer.

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[1] The employer argues that Dr. Pribnow, on whose opinion the ALJ relied, had an inaccurate history of claimant's off-work activities, as described in Dr. Farris' report. We disagree. After our review of the record, we find that Dr. Pribnow reviewed Dr. Farris' report and was aware of the off-work activities listed in Farris' report. Exhibit 11 is a letter from the insurer to Dr. Barnhouse enclosing Dr. Farris' report and asking whether the doctor concurred or disagreed with the report. Although the letter was addressed to Dr. Barnhouse, it was apparently received and reviewed instead by Dr. Pribnow, who signed the letter and whose comments and signature appear on the letter. The signature of Dr. Pribnow on Exhibit 11 matches his signature on Exhibit 12, a letter that was prepared by Dr. Pribnow. On this basis, we find that Dr. Pribnow had an accurate history of claimant's off-work activities, had reviewed Dr. Farris' report and indicated that he disagreed with her conclusions.

In the Matter of the Compensation of
ALEXANDER TONIATTI, Claimant
WCB Case No. 98-04984
ORDER DENYING MOTION TO DISMISS
Meyers, Radler, et al, Defense Attorneys

Claimant, *pro se*, has requested Board review of Administrative Law Judge (ALJ) Mills' February 9, 1999 Order of Dismissal. Asserting that claimant is precluded from filing a request for review because the compensability issue was already litigated, the self-insured employer seeks dismissal of his appeal. The motion is denied.

FINDINGS OF FACT

On October 8, 1998, ALJ Thye issued an order upholding the employer's denial of claimant's occupational disease claim for a chronic lung condition. ALJ Thye's order stated that the "Issues" at hearing included a May 30, 1997 "de facto" denial and June 15, 1998 written denial.

According to statements at hearing by the ALJ in this case, the Hearings Division assigned a new case number for the June 15, 1998 written denial and scheduled a new hearing to litigate that denial. The ALJ further stated that, prior to the new hearing, claimant, through his then-attorney, moved to dismiss the case. Nonetheless, a hearing convened on January 29, 1999 where only the employer's attorney appeared.

On February 9, 1999, the ALJ issued a "Dismissal Order" that dismissed claimant's request for hearing on the basis that "the issues raised by the request for hearing in this matter have been litigated in prior litigation" and "based upon claimant's failure to appear and to otherwise prosecute his claim[.]"

On March 1, 1999, the Board received claimant's February 22, 1999 letter requesting review of the ALJ's dismissal order.

CONCLUSIONS OF LAW AND OPINION

The employer moves to dismiss claimant's request for review on the basis that claimant is precluded from litigating this claim because the issue was actually litigated in the proceeding before ALJ Thye.

The employer does not argue that claimant's request for review was procedurally defective. That is, the employer does not assert that claimant untimely filed his request for review or failed to serve the parties with copies of his request. After examining claimant's request for review, we find that it was timely filed with the Board and indicated that copies were sent to all parties. Thus, we are authorized to examine the propriety of the ALJ's decision to dismiss claimant's hearing request. *See Elvia H. Hillner*, 49 Van Natta 567, *on recon* 49 Van Natta 584 (1997).

Whether or not the employer's issue preclusion argument has merit, because claimant timely and properly requested Board review of the ALJ's order, resolution of that substantive question must await completion of the parties' briefing schedule and our formal review. Consequently, we deny the employer's motion to dismiss claimant's request for review.

The briefing schedule shall continue as previously implemented. In other words, claimant's appellant's brief must be filed by May 11, 1999 (with a copy mailed to the insurer's attorney). The insurer's respondent's brief must be filed within 21 days from the date of mailing of claimant's brief. Claimant's reply brief must be filed within 14 days from the date of mailing of the insurer's brief. Thereafter, we will proceed with our review.

IT IS SO ORDERED.

In the Matter of the Compensation of
MERLE E. TOWNLEY, Claimant
WCB Case No. 97-08606
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order that: (1) declined to admit Exhibit 62 into evidence; (2) upheld the insurer's denial of claimant's neurogenic bladder and T12-L1 disc conditions; and (3) upheld the insurer's denial of claimant's aggravation claim. On review, the issues are evidence, compensability and aggravation.

We adopt and affirm the ALJ's order with the following supplementation.

The ALJ declined to admit Exhibit 62, an October 8, 1998 report from Dr. Carter that was submitted "post-hearing," because it was "obtainable" at the time of hearing. On review, claimant contends that the ALJ improperly excluded the disputed medical report.

ORS 656.283(7) provides that the ALJ is not bound by common law or statutory rules of evidence and may conduct a hearing in any manner that will achieve substantial justice. That statute gives the ALJ broad discretion on determinations concerning the admissibility of evidence. *See, e.g., Brown v. SAIF*, 51 Or App 389, 394 (1981). We review the ALJ's evidentiary rulings for abuse of discretion. *Rose M. LeMasters*, 46 Van Natta 1533 (1994), *aff'd mem* 133 Or App 258 (1995).

In this case, we agree with the ALJ that the substance of Dr. Carter's report was obtainable prior to the hearing. We need not, however, resolve the issue of whether the ALJ abused her discretion in declining to admit the document in question. That is, even if we considered Dr. Carter's medical report, we agree with the ALJ's reasons for finding that claimant failed to satisfy his burden of proving the compensability of his claim for neurogenic bladder disorder, a T12-L1 disc condition and aggravation.

ORDER

The ALJ's order dated November 30, 1998 is affirmed.

In the Matter of the Compensation of
MICHAEL R. GALLAGHER, Claimant
WCB Case Nos. 97-04683 & 96-04320
ORDER ON REMAND
Cobb & Woodworth, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's April 8, 1999 order, we have been directed to consider the parties' settlement. The parties have submitted a proposed "Stipulated Order of Dismissal," which is designed to resolve their pending dispute regarding claimant's "entitlement to temporary disability benefits from June 15, 1993 to April 4, 1996."

Pursuant to the stipulation, the parties agree that the temporary disability benefits issue is "resolved through the payment by the employer/carrier of the total sum of $1,500, said sum to include reasonable attorney fees."[1] The parties further stipulate that claimant's request for Board review is "dismissed with prejudice."

We have approved the parties' stipulation, thereby fully and finally resolving this dispute. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] Although the stipulation does not expressly provide for a maximum "out-of-compensation" attorney fee, we have interpreted the phrase "reasonable attorney fees" to mean "pursuant to the Board's attorney fee rules." Based on this interpretation, we find that a reasonable attorney fee is 25 percent of the $1,500 in stipulation proceeds, or $375. *See* OAR 438-015-0055(1).

In the Matter of the Compensation of
HAROLD W. CASTLE, Claimant
Own Motion No. 66-0013M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

On April 1, 1999, we declined to reopen claimant's 1956 claim for the payment of medical services. We took this action because the record did not establish that claimant's hearing loss and need for hearing aids was causally related to his 1956 work injury.

The SAIF Corporation requests reconsideration of our April 1, 1999 order contending that the order had not addressed its request to reopen claimant's claim under our own motion jurisdiction to provide reimbursement for a medical file review to determine the compensability of requested medical services as they relate to his compensable 1956 injury.

Inasmuch as claimant sustained a compensable industrial injury prior to January 1, 1966, he does not have a lifetime right to medical benefits pursuant to ORS 656.245. *William A. Newell*, 35 Van Natta 629 (1983). However, the Board has been granted own motion authority to authorize medical services for compensable injuries occurring before January 1, 1966. *See* ORS 656.278(1).

We have previous held that diagnostic medical services are compensable when the services are reasonable and necessary in order to establish a causal relationship between the compensable condition and the current condition. *Carl Hight*, 44 Van Natta 224 (1992) and *Cordy A. Brickey*, 44 Van Natta 220 (1992). In keeping with our holdings in *Hight, supra* and *Brickey, supra*, we find that the medical report generated as result of the medical file review an integral part of a medical service provided to an injured worker. As such, we conclude the medical file review report qualifies as compensation under ORS 656.005(8) and ORS 656.625.

Accordingly, we find that the requested medical file review is reasonable and necessary and is justified by special circumstances. Therefore, we authorize SAIF's request for reimbursement for the costs of a medical file review. By this order, the claim is again closed.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES P. SUTER, Claimant
Own Motion No. 99-0106M
OWN MOTION ORDER
Welch, Bruun, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable medial and lateral tear, right knee condition. Claimant's aggravation rights expired on August 6, 1976. SAIF initially opposed reopening of claimant's claim, contending that he was not in the work force at the time of the current worsening.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

On December 16, 1998, Dr. Yates, claimant's attending physician, advised that he had scheduled a right total knee replacement due to a worsening of claimant's compensable right knee condition. Thus, we conclude that claimant's compensable injury worsened requiring hospitalization.

However, in order to be entitled to temporary disability compensation upon a worsening of a work-related injury, a claimant must be in the work force at the time of disability. *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

In response to the Board's staff's inquiry, claimant submitted a March 29, 1999 affidavit stating that: (1) he periodically sought work within his physical restrictions since his condition worsened; (2) it has always been his intention to return to gainful employment "when [his] physical condition permits"; and (3) he continues to seek work and has submitted application for employment with "governmental agencies and ranches within driving distance of [his] residence." Based on claimant's unrebutted statements, we conclude that he has established that he was willing to work and was making a reasonable effort to find work at the time of his current worsening.[1]

Accordingly, we authorize the reopening of the claim to provide temporary total disability compensation beginning the date claimant is hospitalized for the proposed surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by SAIF directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

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[1] SAIF responded to claimant's submission and asserted that it "is not disputing [claimant's] right to timeloss benefits."

In the Matter of the Compensation of
VIRGIL ADAMSON, Claimant
WCB Case No. 98-06037
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its partial denial of claimant's "new medical condition" claim for a fracture of the L2 transverse process. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation, beginning with a summary of the pertinent facts.

Claimant suffered a compensable low back strain injury on August 10, 1997. The injury occurred when he twisted his back while lifting two cases of soda pop. Claimant's injury-related symptoms did not resolve despite conservative treatment.

A December 17, 1997 Notice of Closure closed his claim with temporary, but not permanent, disability.

A December 29, 1997 MRI revealed abnormally increased signal uptake indicative of muscle strain and claimant's chronic pain was diagnosed as "muscle spasm and muscle strain." (Exs. 50, 53). By March 31, 1998, claimant's back was giving out "from time to time." X-rays showed the possibility of an "old" fracture through the right L2 and L3 transverse process. (Ex. 55). April 7, 1998 bone imaging confirmed the diagnosis of a fracture of the right L2 process. (Exs. 56, 57).

Claimant filed a "new medical condition" claim for that condition. The employer issued a partial denial of the "new medical condition" claim, acknowledging that claimant's original claim for a low back strain "remained accepted." (Ex. 64). Claimant requested a hearing.

The ALJ set aside the employer's partial denial because he found the opinions of Drs. Keenen and Sedgewick, treating physicians, more persuasive than that of Dr. Farris.

The employer argues that the ALJ improperly allocated the burden of proof, because he noted that claimant was involved in no traumatic events or injuries other than the lifting incident at work and because the ALJ discounted Dr. Farris' reasoning for failing to provide any explanation of how when or where claimant's fracture could have occurred. The employer also contends that the medical evidence does not persuasively establish that the lifting incident at work caused claimant's fracture, because that would be medically improbable (based on Dr. Farris' opinion).[1]

The ALJ did not improperly allocate the burden of proof. The lack of off-work causes does not "carry claimant's burden," but it does "corroborate" the claim: It lends support for the treating doctors' conclusion that claimant's ongoing post-injury back problems, including those emanating from his L2 fracture area, are injury-related. The absence of "noncompensable" contributing causes is also consistent with claimant's clinical history: Claimant had no back problems whatsoever before the work injury and he has had ongoing pain ever since the injury.[2] Moreover, we agree with the ALJ that the opinions of Drs. Sedgewick and Keenen are persuasive, in part because they are the most consistent with claimant's history before and after his August 10, 1997 compensable back injury.

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[1] Alternatively, the employer argues that the claim is not compensable because there is no persuasive evidence relating claimant's disability or need for treatment to the L2 fracture. We do not reach this argument because it was not raised at hearing. *See Kim P. Kennedy*, 49 Van Natta 1859 (1997) (Board did not consider whether work injury caused disability or required medical treatment where that issue was not raised at hearing).

[2] Claimant did report increasing low back pain after exiting a car off work on December 17, 1997. But he was already suffering injury-related symptoms at the time and no medical opinion relates claimant's L2 fracture to this incident.

Finally, we note Dr. Farris' opinion that the lifting incident was not traumatic enough to cause the L2 transverse process fracture. We do not find Dr. Farris' reasoning in this regard particularly persuasive, because it is inconsistent with claimant's history and the contrary medical evidence. *See Allen B. White, Sr.*, 46 Van Natta 1779, 1780 (1995) ("No matter how rarely a condition might occur in the general population, such a statistical improbability is insufficient to defeat a claim where the medical evidence establishes that the condition did occur in a claimant's particular case.").

Accordingly, on this record, we agree with the ALJ that the opinions of Drs. Sedgewick and Keenen persuasively establish that claimant's work injury was a material cause of his L2 transverse process fracture. (*See* Exs. 58, 59; *see also* Ex. 60).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 2, 1998 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the self-insured employer.

April 28, 1999 Cite as 51 Van Natta 742 (1999)

In the Matter of the Compensation of
JOHN P. SCHRIBER, Claimant
Own Motion No. 98-0490M
OWN MOTION ORDER OF DISMISSAL
Westmoreland, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation requested suspension of claimant's temporary disability benefits awarded by our December 9, 1998 Own Motion Order. Contending that claimant had not complied with its instructions to seek treatment from a Managed Care Organization (MCO) physician, SAIF sought suspension of his compensation.

Following a series of correspondence between the Board's staff and the parties, SAIF notified the Board that if Dr. Freemen had assumed responsibility for claimant's treatment as his attending physician, its "suspension" request was a "moot issue." In response, claimant confirmed that Dr. Freeman was claimant's attending physician. Consequently, claimant sought dismissal of SAIF's suspension request. In reply, SAIF confirmed that Dr. Freeman (a MCO physician) was claimant's attending physician.

In light of such circumstances, the basis for SAIF's "suspension" request (*i.e.* his alleged noncompliance with a MCO requirement) has been rendered moot. Accordingly, the request for relief is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARY A. JACKSON, Claimant
WCB Case No. 98-04094
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's left wrist injury claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation.[1]

We agree with the ALJ that Dr. Ferguson's opinion persuasively relates claimant's recent left wrist problems to the January 27, 1998 work incident. (*See* Ex. 12).

Dr. Nye provides the only arguably contrary opinion. He initially opined that claimant's 1998 left wrist problems were probably due to preexisting arthritis. (Ex. 8-2). However, Dr. Nye later admitted that arthritis had not been diagnosed at the location of claimant's current symptoms. (*See* Ex. 11-18-19, 11-24, 11-31, 11-35). Although he disagreed with Dr. Ferguson's tendinitis diagnosis[2] and continued to suspect that claimant does have contributory arthritis, Dr. Nye acknowledged that the "distinct event" at work could have caused her sudden symptoms.[3] (Ex. 11-1; *see* Exs. 11-16, 11-27, 11-35). Dr. Nye also commented that the work injury, "[w]hatever it was, it wasn't too much of a deal" (considering claimant's quick recovery). (Ex. 11-20-21; *see* Ex. 11-28).

Considering the doubtful evidence of a contributory preexisting condition, the nature and mechanism of injury, and claimant's quick recovery, we find that Dr. Nye's reasoning does not refute Dr. Ferguson's conclusion that the reported work incident caused claimant's 1998 left wrist problems.[4] Accordingly, we rely on Dr. Ferguson's opinion and conclude that claimant has established that her January 27, 1998 work injury was a material cause of her subsequent left wrist condition. *See* ORS 656.005(7)(a).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $750, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 25, 1998 is affirmed. For services on review, claimant is awarded a $750 attorney fee, payable by the self-insured employer.

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[1] We acknowledge the employer's contention that the ALJ erred in admitting Exhibit 12, a "post-hearing" concurrence letter from Dr. Ferguson. However, after reviewing the circumstances surrounding the admission of the "post-hearing" letter, we find no abuse of discretion in the ALJ's evidentiary ruling.

[2] Claimant need not prove a specific diagnosis (*e.g.*, tendinitis) in order to have a compensable claim.

[3] Claimant reported that she experienced extreme pain and her left wrist "locked" when she pulled and twisted a "bag of groceries off rack" at work on January 27, 1998. (Ex. 2).

[4] We do not rely on Dr. Ferguson's opinion due to his arguable "treating physician status," because neither he nor any doctor saw claimant for this injury more than once or twice. (*See* Exs. 9, 12).

In the Matter of the Compensation of
ROBERT S. JESSIMAN, Claimant
WCB Case Nos. 98-06718, 98-06115 & 98-06114
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Mannix, et al, Defense Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Howell's order that: (1) set aside its denials of compensability and responsibility, on behalf of American Transport, Inc. (American), of claimant's occupational disease claim for a low back degenerative condition; (2) upheld SAIF's compensability and responsibility denials, on behalf of Traughber Oil Company (Traughber), of the same condition; and (3) upheld SAIF's partial denial, on behalf of Cascade Disposal (Cascade), of the same condition. In his respondent's brief, claimant contests that portion of the ALJ's order that awarded a $3,500 attorney fee. On review, the issues are compensability, responsibility, and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt and affirm the ALJ's opinion on this issue, with the following supplementation and modification.

Claimant worked for Cascade as a garbage collector, beginning in 1984. On August 15, 1988, he compensably injured his low back and SAIF accepted his claim as a nondisabling lumbosacral sprain. Claimant missed about three weeks of work and treated with Dr. Goulart, chiropractor. His low back pain did not resolve.

In December 1988, claimant began working as a petroleum salesperson for Traughber. His work duties included driving a truck and loading and unloading cases and barrels or oil. Although claimant's low back continued to hurt, he did not seek treatment again until 1991. In 1991, Dr. Stewart noted that claimant had L4-5 degenerative disc disease, but related his ongoing problems to the 1988 injury. Claimant treated conservatively, from 1993 into 1996, ending in about June 1996.

In January 1997, American bought Traughber and claimant moved to a position in American's dispatch office. His work was primarily sedentary, but his back still hurt. In November 1997, claimant sought treatment and reported a significant increase in pain, as well as radiating left leg pain and weakness. Dr. Stewart diagnosed acute left L5 radiculopathy.

In January 1998, claimant became "bulk plant manager" for American, a position that required some loading and unloading of product.

Dr. Stewart referred claimant to Dr. Kendrick, who recommended low back surgery for claimant's degenerative condition.

Claimant filed an aggravation claim with Cascade and occupational disease claims against Traughber and American. SAIF issued compensability and responsibility denials on behalf of all three employers and claimant requested a hearing.

The ALJ found claimant's degenerative condition compensable under the "last injurious exposure rule," based on the opinions of Drs. Kendrick, Rosco, and Goulart. We agree with the ALJ that the latter opinions are the most persuasive because they are well-reasoned and consistent with claimant's work and clinical history.[1] (*See* Exs. 30A, 35A, 38, 41A, 42, 43).

[1] We also agree that the current condition, degenerative disease, is not the "same condition" as the 1988 lumbosacral strain. Therefore, ORS 656.308(1) does not apply.

We also agree that the contrary opinions of Drs. Stewart and Rosenbaum are unpersuasive, but for reasons other than those expressed by the ALJ. Specifically, we do not find that Drs. Stewart and Rosenbaum relied on an inaccurate history regarding the onset of claimant's radicular symptoms.[2]

Dr. Stewart consistently related claimant's ongoing low back problems and need for medical treatment to the accepted 1988 injury (with Cascade) *until* November 1997. (*See* Exs. 7, 8, 17, 18, 22, 26, 28).[3] When claimant presented with decreased tendon reflexes (left medial hamstring jerk) and weakness of the left extensor hallucis longus, toe extensors, and ankle evertor on November 18, 1997, Dr. Stewart stated:

> "At present the most appropriate diagnosis for the patient's chronic low back pain would be chronic idiopathic low back pain meaning only that we do not have a strong objective explanation for the patient's discomfort." (Ex. 28-3).

Thus, Dr. Stewart simply did not know what caused claimant's low back condition as of November 18, 1997. He restated this conclusion regarding claimant's "chronic idiopathic low back pain" on October 22, 1998, and agreed with Dr. Rosenbaum (by concurrence) that claimant's degenerative disease and radiculopathy were not work-related. (Ex. 42A). The former opinion is not helpful and the latter opinion is not persuasive, for the same reasons that Dr. Rosenbaum's opinion is unpersuasive, as explained below.

Dr. Rosenbaum noted that no leg pain was documented in the medical records until November 1997. He acknowledged that claimant had a chronic lumbar strain in 1988 that "persisted," and that claimant had developed degenerative changes in his spine over time. (Ex. 35-4). Despite the "physical" nature of claimant's work, Dr. Rosenbaum stated, "it does not appear that this altered the patient's overall condition." (Ex. 35-7). Without further explanation, Dr. Rosenbaum concluded that "there is no occupational component" to claimant's degenerative condition and related radiculopathy. (*Id*).

Dr. Rosenbaum did not mention that claimant was 32 years old when he first injured his back at work and he had no "preexisting" degeneration at that time. The doctor did not address the fact that claimant had no low back problems before the 1988 compensable injury, but unrelenting and worsening pain since that injury, while he continued performing essentially uninterrupted physically demanding work activities (including heavy lifting). Under these circumstances, we find Dr. Rosenbaum's opinion that claimant's work "does not appear" to have altered or contributed to his low back condition unpersuasive as it is inadequately explained.

Accordingly, based on the more persuasive opinions of Drs. Kendrick, Rosco, and Goulart, we agree with the ALJ that claimant has proven that his entire work exposure was the major contributing cause of his low back degenerative condition. Consequently, we also agree with the ALJ that the claim is compensable under the "last injurious exposure rule" of proof. *See* ORS 656.802(2).[4]

Responsibility

We adopt the ALJ's opinion on this issue, with the following comments.[5]

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[2] Even though claimant credibly testified that he had left leg pain as early as 1991, Dr. Stewart did not characterize his symptoms as "radicular" until November 1997. (*See* Ex. 28). Dr. Stewart's reports and chartnotes suggest that he believes that radiculopathy requires findings of lower extremity weakness, sensory loss, and/or reflex changes, which claimant did not exhibit until November 1997. (*See* Exs. 20, 21, 28-2).

[3] Dr. Stewart's opinion about the cause of claimant's low back condition until November 1997 is essentially uncontradicted. Dr. White offered a contrary opinion in 1995, but it is not persuasive because he inaccurately characterized the 1988 injury as "trivial" and "minor." (*See* Ex. 23A).

[4] We also agree that claimant need not satisfy ORS 656.802(2)(b), because there is no evidence that a low back condition preceded his employment exposure. *See New Portland Meadows v. Dieringer*, 153 Or App 383, *modified* 157 Or App 619 (1998); *Ruth L. Easley*, 51 Van Natta 8 (1999).

[5] We agree with the ALJ that ORS 656.308(1) does not apply because there is no accepted claim for claimant's degenerative condition. *See SAIF v. Yokum*, 132 Or App 18, 22-23 (1994) ("[For ORS 656.308] to be triggered, there must be an accepted claim for the condition, for which some employer is responsible. In an initial claim context, no employer is responsible until responsibility is fixed."

We find, as did the ALJ, that claimant first sought treatment for his *degenerative condition* (as distinct from 1988 lumbosacral sprain) while working for American in 1997. Before that, claimant's low back problems were uniformly diagnosed as a sprain and consistently related to his 1988 work injury. (*See* notes 1-3). However, when claimant's symptoms changed significantly in late 1997, his diagnosis changed, as did the cause of his low back condition from then on. Beginning in November 1997, claimant's condition was degenerative disease --no longer a sprain. Because claimant's symptoms and diagnosis materially changed in 1997, we agree with the ALJ that claimant's current condition is medically distinct from his prior condition and he first sought treatment for *this condition* after his symptoms changed--in 1997, while working for American.[6] (*See* Exs. 28, 29).

Attorney fees

The ALJ assessed a $3,500 attorney fee (payable by SAIF/American) for claimant's counsel's services in prevailing over SAIF/American's compensability and responsibility denials.

On review, claimant submits a statement of services from his counsel,[7] seeking a fee for services at the hearings level of $10,001.25 for 38.1 hours of services at a rate of $175 per hour, applying a 1.5 "multiplier." SAIF objects to claimant's increased fee request,[8] contending that it is excessive.

We review the attorney fee issue *de novo*, considering the specific contentions raised on review, in light of the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that any attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The issues in dispute were the compensability of, and responsibility for, claimant's low back condition.

Approximately 58 exhibits were received into evidence, including at least 3 important medical reports generated by claimant. The hearing lasted about 2 1/2 hours with a transcript consisting of approximately 41 pages. Claimant was the only witness who testified.

On review, claimant's counsel submits a detailed statement of services, attesting to 38.1 hours of legal services at hearings level.[9]

The case involved issues of above average medical and legal complexity, considering the range of cases generally submitted to this forum (*i.e.*, an occupational disease claim for a low back condition, involving three employers and medical evidence forcefully disputing causation). The claim's value and the benefits secured are also above average, because substantial medical services (including surgery) are involved. The parties' respective counsels presented their positions in a thorough, well-reasoned and

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[6] The dispositive date for assigning initial responsibility under the "last injurious exposure rule" is the date the claimant first sought treatment for symptoms of the compensable condition, even if the condition was not correctly diagnosed until later. *SAIF v. Kelly*, 130 Or App 185, 188 (1994). Here, the medical evidence does not indicate that claimant's degenerative disease diagnosis was delayed or that he in fact sought treatment for symptoms of his degenerative condition before it was identified as causing his problems. *Compare SAIF v. Luhrs*, 63 Or App 78, 81 (1983) (where a 1981 doctor's opinion indicated that the claimant's work in 1976-1977 caused his carpal tunnel syndrome symptoms, responsibility was assigned with the 1976-1977 carrier). Instead, the medical evidence indicates that claimant's symptoms and diagnosis changed in 1997, as did the persuasive evidence addressing causation.

[7] On Board review, under OAR 438-015-0029(1), a claimant's attorney may file a request for a specific attorney fee for services at the hearing level and/or for services on Board review. *See William F. Davis*, 51 Van Natta 257 (1999).

[8] SAIF also argues that the ALJ's attorney fee award was not adequately supported. We disagree. *See Leslie D. Custer*, 51 Van Natta 390 (1999).

[9] Claimant's counsel devoted a significant number of hours skillfully advocating claimant's claim in the face of a vigorous defense. Nonetheless, the amount of time expended in litigating a claim is but one of many factors to be considered in determining a reasonable attorney fee award under OAR 438-015-0010(4).

skillful manner. Claimant's counsel filed a hearing request contesting SAIF/American's denial and he has prevailed over that denial. No frivolous issues or defenses were presented. Finally, there was a significant risk that claimant's counsel's efforts might have gone uncompensated, particularly considering SAIF's vigorous defense.[10]

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we agree with the ALJ that $3,500 is a reasonable attorney fee for claimant's counsel's services on the compensability and responsibility issues at the hearings level.[11] In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and evaluating claimant's counsel's submission in light of SAIF's objection), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Claimant's counsel also submits a statement of services seeking a $1,916.25 fee for 7.3 hours of services on review, at the same rate, with the same "multiplier."

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue[12] is $1,200, payable by SAIF, on behalf of American. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's brief and claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for his counsel's efforts in either seeking an increased attorney fee or in defending the ALJ's attorney fee award. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986); *Amador Mendez*, 44 Van Natta 736 (1994).

ORDER

The ALJ's order dated November 25, 1998 is affirmed. For services on review, claimant is awarded a $1,200 attorney fee, payable by the SAIF Corporation on behalf of American Transport, Inc.

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[10] *See Schoch v. Leupold & Stevens*, 144 Or App 259 (1996) (The risk in a particular case that an attorney's efforts may go uncompensated is a factor to be considered in setting a reasonable attorney fee under OAR 438-015-0010(4)). Nevertheless, we do not apply a contingency factor or "multiplier" in a strict mathematical sense. *E.g., Lois J. Schoch*, 49 Van Natta 788, 790, n 1 (1997). Rather, in accordance with OAR 438-015-0010(4)(g), in arriving at our determination of a reasonable attorney fee award, we have taken into consideration the risk (particularly in light of the complexity of the issues and SAIF's vigorous defense) that claimant's attorney's efforts might have gone uncompensated for the services rendered in this case.

[11] This fee is apportioned as follows: $2,500 for services on the compensability issue and $1,000 for services on the responsibility issue. *See* ORS 656.308(2)(d). We note that ORS 656.308(2)(d) limits claimant to a maximum $1,000 attorney fee for "finally prevailing against a responsibility denial," absent a showing of extraordinary circumstances. Claimant does not argue that extraordinary circumstances warrant an increased award under ORS 656.308(2)(d). *See Foster-Wheeler Constructors, Inc. v. Smith*, 151 Or App 155 (1997); *Tammy Locke*, 48 Van Natta 250 (1996) (concluding that the legislature intended, in cases in which a claimant finally prevails against a responsibility denial, to authorize a maximum cumulative attorney fee of $1,000 for services at all levels of litigation, except in cases involving extraordinary circumstances).

[12] *See* notes 10 and 11, *supra*.

In the Matter of the Compensation of
ED LONG, Claimant
WCB Case No. 98-02853
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Crumme's order that set aside an Order Denying Reconsideration and a Notice of Closure as procedurally invalid. On review, the issue is whether the Order Denying Reconsideration and the Notice of Closure are valid.[1] We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" and "Discussion of Findings," except for the second sentence of Finding number 6.

CONCLUSIONS OF LAW AND OPINION

Claimant injured his left ankle at work on October 1, 1997. The insurer closed claimant's injury claim with a Notice of Closure on January 20, 1998. That day, the insurer mailed a copy of the Notice of Closure to claimant,[2] but not to claimant's attorney.

Claimant's attorney first received a copy of the Notice of Closure on March 24, 1998. She mailed a request for reconsideration to the Workers' Compensation Division (WCD) that day. On March 30, 1998, WCD issued an order denying the request for reconsideration because the request was untimely. Claimant requested a hearing.

The ALJ set aside the Notice of Closure and the Order Denying Reconsideration, reasoning that the insurer's failure to mail a copy of the Notice of Closure to claimant's attorney rendered the closure and WCD's subsequent order invalid. The ALJ relied on *Ronald D. Fuller*, 50 Van Natta 1023, *on recon* 50 Van Natta 1483 (1998), *aff'd mem SAIF v. Fuller*, 159 Or App 426 (1999), where we held that a Determination Order that redetermined the claimant's permanent total disability under ORS 656.206(5) was procedurally invalid because the carrier neglected to mail a copy of the results of the claimant's reexamination to claimant and his attorney before the Determination Order issued.

However, since the ALJ's order, we found the notice requirements in *Fuller* inapplicable in a case involving essentially the same facts as here. In *Patti Hall*, 51 Van Natta 620 (1999), we held that an otherwise (substantively) valid Notice of Closure was *not* invalidated by the carrier's failure to mail a copy of the closure notice to the claimant's attorney.[3]

Here, as in *Hall*, the Notice of Closure is substantively valid. Claimant contends that claim closure is invalid based solely on the insurer's failure to send a copy of the closure notice to his attorney. Because this is not a basis for invalidating a Notice of Closure, we uphold the closure here as we did in *Hall*. In addition, because claimant did not mail his request for reconsideration within 60 days of January 20, 1998 (the date the Notice of Closure was mailed to claimant), we conclude that WCD properly denied his request. *See* ORS 656.268(4)(e); OAR 436-030-0005(9)(b); 436-030-0115(2).

ORDER

The ALJ's order dated October 9, 1998 is reversed. The Order Denying Reconsideration and the Notice of Closure are reinstated and affirmed. The ALJ's attorney fee award is reversed.

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[1] The Workers' Compensation Division has participated in these proceedings pursuant to ORS 656.726(3)(h).

[2] The parties do not dispute the fact that the Notice of Closure was mailed on January 20, 1998. (*See* Ex. 26).

[3] We distinguished *Fuller*, because notice to the worker and the worker's attorney were required elements of a valid request for a PTD redetermination under the applicable administrative rules, but notice to the claimant's attorney was not essential to the validity of the closure, under different rules, in *Hall*. *See* 51 Van Natta 620.

In the Matter of the Compensation of
LEE H. MURPHY, Claimant
WCB Case No. 98-04313
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
William J. Blitz, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that affirmed an Order on Reconsideration that reduced claimant's scheduled permanent disability award for loss of use or function of his right forearm (thumb) from 15 percent (22.5 degrees) as awarded by a Notice of Closure, to 7 percent (10.5 degrees). On review, the issue is validity of the Order on Reconsideration (timeliness). We affirm.

FINDINGS OF FACT

Claimant injured his right hand and wrist at work on April 4, 1997. A December 11, 1997 Notice of Closure awarded 15 percent scheduled permanent disability for lost right thumb range of motion. (A January 5, 1998 Corrected Notice of Closure corrected the "aggravation rights end date" in the first Notice.) Claimant requested reconsideration of the Notice of Closure and appointment of a medical arbiter. The Department received claimant's request for reconsideration on February 9, 1998 and acknowledged receipt of that request on February 11, 1998.

On March 6, 1998, the Department notified the parties that the reconsideration proceeding would be postponed for a medical arbiter's examination and report. Dr. Colleti performed a medical arbiter's examination on April 11, 1998. Based on the medical arbiter's report, an April 29, 1998 Order on Reconsideration reduced claimant's scheduled permanent disability award to 7 percent.

Claimant requested a hearing on May 29, 1998.

CONCLUSIONS OF LAW AND OPINION

The ALJ affirmed the Order on Reconsideration, finding that it issued within the time limits of ORS 656.268(6)(d). The ALJ reasoned that the reconsideration process "began" under the statute on February 11, 1998, when the Appellate Unit notified claimant to that effect. Further reasoning that the Department postponed its reconsideration proceeding within 18 working days, on March 6, 1998, the ALJ concluded that the April 29, 1998 Order on Reconsideration timely issued. We agree that the Order on Reconsideration was timely, based on the following reasoning.

ORS 656.268(6)(d) provides:

> "The reconsideration proceeding shall be completed within 18 working days from the date the reconsideration proceeding begins, and shall be performed by a special evaluation appellate unit within the department. The deadline of 18 working days may be postponed by an additional 60 calendar days if within the 18 working days the department mails notice of review by a medical arbiter. If an order on reconsideration has not been mailed on or before 18 working days from the date the reconsideration proceeding begins, or within 18 working days plus the additional 60 calendar days where a notice for medical arbiter review was timely mailed, or within such additional time as provided in subsection (7) of this section when reconsideration is postponed further because the worker has failed to cooperate in the medical arbiter examination, reconsideration shall be deemed denied and any further proceedings shall occur as though an order on reconsideration affirming the notice of closure or the determination order was mailed on the date the order was due to issue."

ORS 656.268(6)(e) provides, in pertinent part:

> "The period for completing the reconsideration proceeding described in paragraph (d) of this subsection shall begin as follows:

"(A) When a worker objects to a notice of closure pursuant to subsection (4)(e) of this section, the period begins upon receipt of the worker's request * * **"

Subsection (6)(e) provides that the 18-day reconsideration "period begins upon receipt of the worker's request [for reconsideration from a Notice of Closure]." In this case, the Department's date stamp indicates receipt of claimant's request for reconsideration on February 9, 1998. (Ex. 8A; *see* Ex. 14). Therefore, the reconsideration proceeding period began on that date.

Under ORS 656.268(6)(d), the reconsideration proceeding must be completed "within 18 working days from the date the reconsideration proceeding begins."

We compute the 18-day time period by "excluding the day or the act or event from which the designated period of time begins to run, and including the last day[.]" *Randy D. Boydston*, 46 Van Natta 2509, 2510, n. 1 (1994). Accordingly, in this case, the eighteenth working day (beginning with February 9, 1998, but not counting Monday February 16, 1998, President's Day--a non-working day), was March 6, 1998. On that date, the Department notified the parties that the reconsideration proceeding would be postponed for a medical arbiter's examination and report. After the arbiter's examination, an April 29, 1998 Order on Reconsideration issued.

We conclude that the Order on Reconsideration was timely (and therefore valid) because the reconsideration proceeding was postponed within 18 working days after it began and the Order on Reconsideration issued within 60 days of the (timely) postponement.[1] *Compare George L. Allenby*, 50 Van Natta 1844, 1846 (1998) (although the Department had subject matter jurisdiction to issue an untimely Order on Reconsideration, such an order was both appealable to the Hearings Division and voidable on timeliness grounds).

ORDER

The ALJ's order dated September 18, 1998, as reconsidered November 6, 1998, is affirmed.

[1] We also note that claimant's May 29, 1998 request for hearing from the Order on Reconsideration was timely because it was filed within 30 days (of the reconsideration order).

In the Matter of the Compensation of
ERNEST W. MERCER, Claimant
Own Motion No. 96-0253M
OWN MOTION ORDER ON RECONSIDERATION POSTPONING ACTION
Cummins, Goodman, et al., Defense Attorneys

On January 13, 1999, we issued an Own Motion Order of Abatement which abated our December 16, 1998 Own Motion Order, which had set aside the insurer's June 15, 1998 Notice of Closure as premature. In our Order of Abatement we requested the parties' position regarding the status of the claim. In response, the insurer has denied the compensability of claimant's current condition on which claimant has filed a request for hearing with the Hearings Division. (WCB Case No. 99-02511).

It is the Board's policy to postpone action until pending litigation on related issues has been resolved. Therefore, we defer action on this request for own motion relief and request that the assigned Administrative Law Judge (ALJ) in WCB Case No. 99-02511 submit a copy of the eventual order to the Board. In addition, if the matter is resolved by stipulation or disputed claim settlement, the ALJ is requested to submit a copy of the settlement document to the Board. After issuance of the order or settlement document, the parties should advise the Board of their respective positions regarding claimant's request for own motion relief.

IT IS SO ORDERED.

In the Matter of the Compensation of
DELILAH J. PARKER, Claimant
WCB Case No. 97-08419
ORDER OF DISMISSAL
Ronald A. Fontana, Claimant Attorney
Bostwick, et al, Defense Attorneys

The self-insured employer requested review of Administrative Law Judge (ALJ) Thye's order that: (1) set aside its "pre-closure" denial of claimant's current psychological condition; (2) assessed penalties for allegedly unreasonable claim processing; and (3) awarded a $15,000 employer-paid attorney fee under ORS 656.386(1). The parties have submitted a proposed "Disputed Claim Settlement," that is designed to resolve all issues raised or raisable between them, in lieu of the ALJ's order.

Pursuant to the settlement, the parties agree that the ALJ's order "shall be set aside." The parties further stipulate that the employer's denial, as supplemented in the agreement, "shall be affirmed in its entirety."

We have approved the parties' settlement, thereby fully and finally resolving this dispute, in lieu of the ALJ's order.[1] Accordingly, this matter is dismissed.

IT IS SO ORDERED.

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[1] In granting this approval, we provide the following clarification regarding two provisions of the parties' agreement. On Page 3 of the settlement, the total proceeds are twice described as "$17,500.00," whereas in a prior paragraph they are described as "$17,5000.00." Because the former two references to "$17,500" are consistent with the proposed allocation of proceeds between claimant and his attorney, we have interpreted the reference in the prior paragraph to the settlement proceeds as a typographical error. In other words, our approval of the parties' settlement is granted based on the assumption that the total proceeds of the agreement equal $17,500.

Secondly, a statement on Page 6 of the settlement provides that the agreement "conforms to ORS 656.236(6)." Inasmuch as that statutory provision expressly pertains to Claim Disposition Agreements under ORS 656.236, it has no application to this Disputed Claim Settlement under ORS 656.289(4). Thus, our approval of the parties' settlement should not be interpreted as an indication that we concur with the aforementioned erroneous statement. Because the agreement is in conformance with the statutory and administrative requirements regarding disputed claim settlements, it has received our approval.

In the Matter of the Compensation of
TOMMY E. HANDSAKER, Claimant
WCB Case No. 98-05704
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that upheld the SAIF Corporation's denial of his injury claim for a low back condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation.

Applying ORS 656.005(7)(a)(B), the ALJ upheld SAIF's denial of claimant's low back injury claim. In doing so, the ALJ reasoned that claimant's alleged injury in late February or early March 1998 "combined" with preexisting low back conditions. Finding no persuasive medical evidence to satisfy the major contributing cause standard of the statute, the ALJ concluded that claimant's "combined" low back condition was not compensable.

On review, claimant urges that we reconsider our holding in *Curtiss N. Smith*, 51 Van Natta 197 (1999), and find that he sustained a compensable injury independent of ORS 656.005(7)(a)(B).[1] In making this argument, claimant contends that the ALJ upheld SAIF's denial on a legal basis that SAIF failed to assert in its denial. Finally, claimant asserts that, even if ORS 656.005(7)(a)(B) applies, he has established the compensability of a "combined condition."

After considering claimant's argument, we find no reason to depart from our analysis in *Smith*. Moreover, we reject claimant's contention that SAIF did not raise application of ORS 656.005(7)(a)(B) as an issue. In its June 30, 1998 denial, SAIF stated one basis for its denial was that "[y]our injury is not the major contributing cause of your need for treatment and disability." (Ex. 10). Moreover, at hearing, SAIF's counsel stated:

> "I think [claimant's counsel] has set out the issues that you're going to be looking at today. It clearly will be, is there a *combining* and if so, what's the major cause, the preexisting condition or the incident at work." (Tr. 3, emphasis added).

Claimant's counsel did not object to SAIF's counsel's description of the issues. Accordingly, based on the language of its denial and the comments of its legal counsel, we find that SAIF did raise application of ORS 656.005(7)(a)(B) as an issue. In addition, we agree for the reasons the ALJ cited that claimant failed to satisfy his burden of proof under that statute.[2]

ORDER

The ALJ's order dated December 23, 1998 is affirmed.

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[1] In *Smith*, we applied our reasoning in *Charles L. Grantham*, 48 Van Natta 1094 (1996), and held that, when a work injury combines with a preexisting condition at the outset of the claim, compensability of the claim is determined under ORS 656.005(7)(a)(B).

[2] Claimant argues that, in finding the medical opinion of Dr. Bert unpersuasive, the ALJ improperly focused on the major contributing cause of the "combined condition," rather than the major cause of his need for treatment. *See SAIF v. Nehl*, 148 Or App 101 (1997). We disagree. The ALJ stated: "Dr. Bert reached his conclusion that claimant's injury was the major contributing cause of his need for *treatment* based on upon faulty reasoning." (O&O p. 4, emphasis added). Given this comment, we are persuaded that the ALJ sufficiently considered whether the alleged injury was the major contributing cause of claimant's need for treatment. Moreover, claimant offers no explanation why the major cause of claimant's need for treatment should be considered different from the major cause of the combined condition. *See SAIF v. Nehl, on recon* 149 Or App 309, 313 (1997).

In the Matter of the Compensation of
WARREN K. McCANN, Claimant
WCB Case Nos. 98-06225 & 97-08575
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that upheld the SAIF Corporation's denial of his occupational disease claim for a mental disorder (adjustment disorder with mixed anxiety and depressed mood). On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, which we supplement and summarize as follows.

Claimant, age 36, began working at the employer, a remanufacturer of wood products, in February 1988 as a cleanup person and worked his way up to plant manager. In March 1992, claimant was diagnosed with severe ulcerative colitis for which he was hospitalized in September 1993 and May 1995 as a result of acute exacerbations of symptoms. In November 1995, claimant had a substantial portion of his colon surgically removed. Two more surgeries were required by May 1996. Meanwhile, in February 1995, claimant's younger brother was killed in a motor vehicle accident. Shortly thereafter, his girl friend died, and in about March or April 1997, a high school friend who was also a former employee committed suicide.

Claimant's direct supervisor was Mr. Hetfeld, part owner of the plant. Hetfeld's management style was aggressive and verbal and included yelling and profanity. Most of the interactions between claimant and Hetfeld were by telephone, usually two or three times a day. About once a week Hetfeld would come to the plant in The Dalles from Portland.

Hetfeld verbally and publicly corrected claimant's handling of a work situation that resulted in an OSHA fine. He also urged claimant to show less favoritism at work to claimant's friends and to be more consistent in his application of discipline.

On July 2, 1997, claimant suspended a driver for three days because he believed that the driver had mixed up loads on trucks. Claimant informed Hetfeld of the situation during a phone call when Hetfeld was on a speaker phone. Another person was in the room with Hetfeld at the time. Claimant believed that that person overheard their discussion regarding this matter. After the telephone call was terminated, claimant called Hetfeld back. A verbal altercation ensued and claimant "snapped," after which he quit his job because of his anger at Hetfeld.

On July 7, 1997, claimant sought treatment from Dr. Czarnecki, osteopath, who diagnosed anxiety and depression, and, on July 22, 1997, a claim was filed for depression, anxiety and stress as a result of the July 2, 1997 telephone call with Hetfeld.

On August 5, 1997, claimant was diagnosed by Dr. Lyon, psychologist, with "Adjustment Disorder with Mixed Anxiety and Depressed Mood" (DSM IV code 309.28). On August 21, 1997, Dr. Turco, psychiatrist, examined claimant for SAIF. Turco diagnosed a preexisting paranoid personality disorder.

SAIF denied the claim and claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant had failed to prove by clear and convincing evidence that his mental disorder arose out of employment conditions, because claimant did not produce direct evidence that employment conditions existed in a real and objective sense. On review, claimant contends that he satisfied each of the statutory requirements to establish a compensable mental disorder. Whether or not

claimant provided direct evidence regarding his employment conditions, we agree with the ALJ that claimant failed to prove by clear and convincing evidence that his mental disorder arose out of employment conditions, reasoning as follows.

Claimant has the burden of affirmatively proving a compensable mental disorder claim. ORS 656.266. To satisfy his burden of proof, claimant must establish that he has been diagnosed with a mental disorder generally recognized in the medical or psychological community; that employment conditions are the major contributing cause of his disorder, and that there is clear and convincing evidence his condition arose out of and in the course of employment. ORS 656.802(2)(a); 656.802(3)(c) and (d). In meeting this burden of proof, claimant cannot rely on: job stresses associated with conditions generally inherent in every working situation; reasonable disciplinary, corrective or job performance evaluation actions by the employer; or cessation of employment or employment decisions attendant upon ordinary business or financial cycles. ORS 656.802(3)(b).

The medical record establishes that claimant experienced a stressful and serious medical condition and the deaths of several people close to him during his employment prior to the date he "snapped." Because of the multiple possible causes of claimant's mental disorder, this issue presents a complex medical question that must be resolved on the basis of expert medical evidence. *Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993).

Here, even considering Dr. Lyon's and Dr. Turco's references to claimant's description of his interactions with his supervisor, the preponderance of evidence does not satisfy all of the requirements for a compensable mental disorder.

Dr. Turco noted that claimant "takes things personally" and has "low self esteem." He opined that claimant's "work situation has produced some degree of stress," which he attributed to a combination of claimant's underlying sense of inferiority and his supervisor's overbearing behavior. Turco also opined that the major contributing cause of the exacerbation of claimant's personality traits was his interaction with his supervisor. Finally, based on claimant's extreme reaction to his supervisor, Turco diagnosed an underlying, preexisting paranoid personality disorder. But he also stated that claimant's preexisting personality problem had not been worsened by work. (Exs. 58, 64).

We read Turco's reports as making a distinction between claimant's personality *traits* (oversensitivity and low self-esteem), which were exacerbated by his interactions with his supervisor, and his underlying paranoid personality *disorder*, which preexisted his employment. Accordingly, claimant has failed to prove a worsening of his preexisting mental disorder.

Moreover, although Dr. Lyon initially opined that claimant's symptoms "are at least in part a result of his interactions with his supervisor" and subsequently stated that claimant's treatment by his supervisor was the major contributing cause of his adjustment disorder, he did not offer an independent, relative evaluation of the effects of claimant's severe health problems and the loss of persons close to him. (Exs. 61, 62, 63, 65). Rather, he relied primarily on claimant's own history and evaluation that his psychological condition was due to his interactions with his supervisor. We find such an analysis insufficient to establish that claimant's working conditions were the major contributing cause of his mental disorder by clear and convincing evidence. *See, e.g., Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev den* 321 Or 416 (1995), (an evaluation of the relative contribution of different causes of an injury required in deciding which is the primary cause).

Consequently, based on this record, we conclude that claimant has failed to establish, by clear and convincing evidence, that his mental disorder arose out of and in the course of employment.

ORDER

The ALJ's order dated November 6, 1998 is affirmed.

In the Matter of the Compensation of
TRICIA C. WAGNER, Claimant
WCB Case No. 94-12676
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Black's order that: (1) declined to admit Exhibit 21aa; and (2) set aside its denial of claimant's occupational disease claim for a mental disorder. On review, the issues are evidence and compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact from the August 17, 1995 Opinion and Order, as supplemented by the October 16, 1998 findings of fact, with the following changes.

We change the August 17, 1995 findings of fact as follows. On page 3, we change the last line to read: "and began counseling with Jeannine Guardalabene, who had participated in the seminar." In the third full paragraph on page 4, we change the first sentence to read: "On June 21, 1994, claimant was treated in the emergency room." In the fourth full paragraph on page 4, we change the date in the third sentence to "August 17, 1994." We do not adopt the findings of ultimate fact in the August 17, 1995 Opinion and Order.

In the October 16, 1998 Opinion and Order, we adopt only the first two paragraphs of the findings of fact and the first four sentences in the third paragraph of the findings of fact. In the second paragraph, we change the date in the third sentence to "October 6, 1994." We do not adopt the findings of ultimate fact in the October 16, 1998 Opinion and Order.

CONCLUSIONS OF LAW AND OPINION

We briefly review the procedural history of this case. The previous proceedings in this case were held on May 1, 1995, May 25, 1995 and June 15, 1995. On August 17, 1995, ALJ Black issued an Opinion and Order finding that claimant had established compensability of her mental disorder claim. SAIF requested review and the Board adopted and affirmed the ALJ's order. SAIF requested reconsideration, contending that it had recently obtained newly discovered evidence arising out of claimant's civil action that warranted remand of the matter to the ALJ. The Board found that, in light of Dr. Heck's statements regarding the newly obtained evidence, the recent "post-hearing" evidence was reasonably likely to affect the outcome of the case. *Tricia C. Wagner*, 48 Van Natta 2175 (1996). The Board granted SAIF's motion to remand for the admission of additional evidence regarding claimant's recent deposition from her civil case and Dr. Heck's subsequent report.

On remand, the ALJ conducted a hearing on March 11, 1998 and admitted additional evidence. The ALJ concluded that claimant's working conditions were the major contributing cause of the acute onset of a mental disorder in June 1994.

Evidence

SAIF argues that the ALJ erred by declining to admit Exhibit 21aa. Exhibit 21aa is the jury verdict in claimant's civil lawsuit against the employer and her supervisor. SAIF contends, among other things, that the jury verdict is relevant and goes to the "heart" of this case. SAIF also requests that the Board take administrative notice of the jury verdict.

We need not address SAIF's evidentiary argument because, even if it is well-taken, Exhibit 21aa would not affect the outcome of this case. Therefore, we need not consider whether the ALJ abused his discretion by excluding the exhibit. *See Karen A. Maben*, 49 Van Natta 1591 (1997) (Board declined to consider whether the whether the ALJ abused his discretion by not admitting particular exhibits because it would not affect the outcome of the case); *Grace E. Cassidy*, 48 Van Natta 602 (1996) (even if the claimant's criminal conviction was not given preclusive effect, the claimant would not prevail on the merits), *on recon* 48 Van Natta 1091 (1996). For the same reason, we decline to take administrative notice of the jury verdict.

Compensability

After the initial proceedings in May and June 1995, the ALJ found that claimant's need for treatment in June 1994 was caused in major part by compensable work-related stressors. On remand, the ALJ reviewed claimant's deposition testimony from her U.S. District Court case against the employer and her supervisor. In a July 23, 1996 deposition, claimant disclosed that she had been involved in a sexual relationship with Mr. Warrick, a coworker and a witness in the 1995 workers' compensation proceedings. On remand, the ALJ found that claimant's sexual relationship with Mr. Warrick began around Christmas 1994. Although claimant's July 23, 1996 deposition testimony indicated she had about three months of "binge" alcohol abuse in fall 1993, the ALJ found that the correct year for that episode was 1994. For these reasons, the ALJ concluded that the history given to Dr. Heck in October 1994, which did not include either of these considerations, was essentially an accurate history. The ALJ adhered to his previous conclusion that claimant's employment conditions were the major contributing cause of a mental disorder in June 1994.

To establish the compensability of a mental disorder, claimant must prove that employment conditions were the major contributing cause of the mental disorder. ORS 656.802(2)(a). In addition, the employment conditions producing the mental disorder must exist in a real and objective sense and must be conditions other than those generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment, or employment decisions attendant upon ordinary business or financial cycles. Furthermore, there must be a diagnosis of a mental or emotional disorder that is generally recognized in the medical or psychological community and there must be clear and convincing evidence that the mental disorder arose out of and in the course of employment. ORS 656.802(3)(a)-(d). Because of the multiple potential causes of claimant's mental disorder, the causation issue involves a complex medical question that must be resolved with expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993).

On review, SAIF argues that the evidence establishes that claimant's affair with Mr. Warrick began in 1993, rather than 1994 as found by the ALJ. SAIF contends that, among other things, claimant did not prove by clear and convincing evidence that her mental disorder arose out of and in the course of employment. For the following reasons, we agree with SAIF.[1]

We first address some discrepancies in the record regarding occurrences of certain events. As we discussed earlier, the ALJ found that claimant's sexual relationship with Mr. Warrick began around Christmas 1994. Although claimant's July 23, 1996 deposition testimony indicated she had about three months of "binge" alcohol abuse in fall 1993, the ALJ found that the correct year for that episode was 1994. For these reasons, the ALJ concluded that the history given to Dr. Heck in October 1994 was essentially an accurate history. For the following reasons, we agree with SAIF that the preponderance of evidence establishes that claimant's affair with Mr. Warrick began in 1993, rather than 1994 as found by the ALJ.

In claimant's July 23, 1996 deposition for her civil case, she testified that she first had sex with Mr. Warrick about Christmas 1994. (Ex. 26-225, -226). She said their close friendship had begun approximately four months before that time. (Ex. 26-229).

At the March 11, 1998 hearing, however, claimant agreed she first became physically intimate with Mr. Warrick in Christmas 1993. (Tr. IV-59, -60). The second time she was physically intimate with him was in January 1994. (Tr. IV-60, -61).

Ms. Guardalabene, claimant's counselor, treated claimant from March 3, 1994 until September 1996. (Ex. 23-1). She testified that she became aware of claimant's relationship with Mr. Warrick shortly after she began treating claimant. (Exs. 27-10, -17). She believed claimant had reported a sexual relationship to her in March 1994. (Ex. 27-11). She explained that when the subject of Mr. Warrick was

[1] Because we find that claimant did not prove by clear and convincing evidence that her mental disorder arose out of and in the course of employment and we find this issue dispositive, we need not address whether claimant has established the other elements of a mental disorder claim.

first discussed, it was in the matter of disclosure and claimant was having ambivalent and conflicted feelings. (*Id.*) Ms. Guardalabene's chart notes begin on March 3, 1994 and the first reference to Mr. Warrick was on March 16, 1994, where Ms. Guardalabene reported that "co-worker [Mr. Warrick] is supportive. Describes conflicted re: [Mr. Warrick] & relation to feelings of autonomy." (Ex. 6B-2). Ms. Guardalene's chart notes also referred to Mr. Warrick on March 22, 1994, April 5, 1994 and June 7, 1994. (Exs. 6B-3, -4, -5). On June 7, 1994, Ms. Guardalene reported that claimant was "[a]nxious re: strain on relationship w/[claimant's husband]. Conflict with [Mr. Warrick] * * * some recognition of victim scripting and giving self away." (Ex. 6B-5). Ms. Guardalene acknowledged that her chart notes did not expressly refer to the sexual nature of the relationship. (Ex. 27-11).

Based on claimant's March 11, 1998 testimony, as supported by Ms. Guardalene's testimony and chart notes, we conclude that claimant's sexual relationship with Mr. Warrick began about December 1993. We note further that, although Dr. Brown did not begin treating claimant until August 1994, he reported that claimant "has indicated that she indeed had a consensual sexual relationship with one of her co-workers beginning in the fall of 1993." (Ex. 22-1).

Another issue involving inconsistent dates concerns the timing of claimant's three-month alcohol "binge." The ALJ found that the correct year for that episode was in 1994. Other evidence in the record indicates that the episode occurred in 1993, before claimant was examined by Dr. Heck.

In 1986, claimant was in a residential treatment program for methamphetamines as well as alcohol. (Tr. IV-38, -39). At the July 23, 1996 deposition, claimant testified she had used alcohol since 1986, but she had stopped drinking about six months previously, *i.e.*, approximately January 1996. (Ex. 26-200, -201). Claimant said she had been "drinking constantly" for about three months in fall 1993. (Ex. 26-201). She said it occurred "after I complained to Cynthia and after the summer went through." (*Id.*) Claimant guessed that had occurred around October 1993. (*Id.*) "Cynthia" apparently refers to Ms. Walden, the human resources director for the employer. (Tr.II-66). Ms. Walden testified that claimant had spoken to her about sexual harassment issues at work in February 1993. (Tr. II- 66, -67). Ms. Walden wrote claimant a letter concerning those issues on February 17, 1993. (Ex. 4A).

At the March 11, 1998 hearing, however, claimant testified her drinking "binge" occurred in "October or November, December of 1994," rather than October 1993 as stated in her previous deposition testimony. (Tr. IV-37). Claimant felt that the binge occurred in 1994 rather than 1993 because she had been released to work by Dr. Brown and she had been taking a lot of prescription drugs at that time. (Tr. IV-38, -84, -85). Claimant was confident the drinking binge occurred *after* she had seen Dr. Heck on October 6, 1994. (Tr. IV-49, -86).

Claimant testified that Drs. Cary and Patricelli were aware that she had been through a treatment program. (Tr. IV-54). Dr. Cary performed an annual exam on April 29, 1993 and reported, among other things, that claimant had a past history of alcoholism, but she had been abstinent for years. (Ex. 3-4). Dr. Cary noted that claimant felt her alcohol program had been handled successfully, "but knows not to relax her vigilance, or to drink at all, and will continue to attend classes." (*Id.*) Claimant sought treatment from Dr. Patricelli on December 31, 1993 for influenza symptoms. (Ex. 3-5). He reported that claimant was "recovering from methamphetamine abuse. She is an active drinker, however, and doesn't think that is a problem." (*Id.*)

Although claimant testified on March 11, 1998 that her drinking binge occurred in 1994 rather than 1993 (Tr. IV-38, -84, -85), we find that the preponderance of evidence indicates that claimant's "binge" occurred in fall 1993, rather than in 1994. Claimant's July 23, 1996 deposition testimony indicated that her drinking "binge" occurred in fall 1993. (Ex. 26-201). She said it occurred "after I complained to Cynthia and after the summer went through." (*Id.*) Claimant guessed that had occurred around October 1993. (*Id.*) Claimant's July 23, 1996 testimony is consistent with other evidence indicating claimant first complained to Ms. Walden ("Cynthia") in February 1993. (Ex. 4A, Tr. II-66, -67). Claimant's July 23, 1996 testimony concerning her "binge" is also consistent with Dr. Patricelli's December 31, 1993 chart note, which indicated that claimant was recovering from methamphetamine abuse and was "an active drinker, however, and doesn't think that is a problem." (Ex. 3-5). Furthermore, although Ms. Guardalabene treated claimant in October and November 1994, Ms.Guardalabene did not recall whether claimant had told her about the alcohol relapse. (Ex. 27-13, -14, -15). If claimant's relapse occurred in fall 1994, it seems likely Ms.Guardalabene would have been aware of it since she was treating claimant during that period. In particular, we rely on Dr. Patricelli's December 31, 1993 chart note to conclude that claimant's drinking "binge" occurred in late 1993.

In evaluating the medical evidence concerning causation, we rely on those opinions which are both well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). In addition, as noted above, we generally rely on the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). There are three opinions on causation. Claimant relies on the opinions of Dr. Brown, her treating psychiatrist, and Ms. Guardalabene, her counselor, to establish compensability. SAIF relies on the opinion of Dr. Heck, psychiatrist. On *de novo* review, we are most persuaded by Dr. Heck's opinion because it is well-reasoned and based on a complete and accurate history.

Dr. Heck initially examined claimant on October 6, 1994 and diagnosed major depression, mild, in full remission, and adjustment disorder with anxiety, resolved. (Ex. 17-15). He also felt that claimant had a mixed personality disorder, noting that claimant had a history of maladaptive interpersonal relationships that had been marked by verbal and physical abuse. (Ex. 17-15, -16). Dr. Heck specifically noted that claimant "did not date or have any romantic relationships with fellow employees." (Ex. 17-2). He explained that claimant had referred to only one non-work-related stressor, which was abdominal pain for which she had surgery on June 10, 1994. (Ex. 17-16). Dr. Heck concluded that, "[p]rovided the Claimant was reporting an honest and reliable history," the major contributing cause of her depression was the stress that resulted from her supervisor's harassing interactions. (*Id.*) Dr. Heck noted, however, that if claimant's allegations could not be substantiated, there was a possibility she was misperceiving and/or overreacting to her employment conditions, based on her history of dysfunctional relationships with men. (Ex. 17-16, -17). In our previous opinion, we noted that we had agreed with the ALJ that Dr. Heck had provided the most persuasive opinion regarding causation of claimant's psychological condition. *Tricia C. Wagner*, 48 Van Natta at 2175.

Dr. Heck later changed his opinion on causation after reviewing a portion of claimant's July 23, 1996 deposition testimony from her civil case and listening to her March 11, 1998 testimony. He did not believe claimant was a reliable and accurate historian. (Tr. IV-111). Dr. Heck explained that it would have been "very important" to have known that claimant had been having an extramarital affair several months before her need for treatment in June 1994. (Tr. IV-120). He noted that claimant had not disclosed to him that she had been treated at a facility for alcohol and methamphetamine abuse. (Tr. IV-114, -119). Instead, claimant told him she had quit both those substances "on her own." (Tr. IV-114, -119). Also, Dr. Heck commented that, although claimant told him in October 1994 there was no marital distress, she testified at the March 1998 hearing that she had separated from her husband in November 1994. (Tr. IV-119). Dr. Heck felt that, under these circumstances, it was likely there was some marital distress taking place in October 1994. (*Id.*) In fact, Dr. Brown reported that claimant told him in August 1994 that her marriage was probably ending. (Ex. 28-1).

Dr. Heck believed that claimant's July 23, 1996 deposition testimony indicated she had guilt, anger and shame about her relationship with Mr. Warrick and he noted that those feelings could certainly bring about symptoms of anxiety and depression. (Tr. IV-131). In light of the new information, Dr. Heck could no longer say that claimant's employment conditions were the major contributing cause of her psychological condition. (Tr. IV-131, -132, -134). He said that claimant had additional stressors that he was not previously aware of, including her guilt feelings concerning her relationship with Mr. Warrick, a "violent" episode with Mr. Warrick in a motel room and her marital stress. (Tr. IV-132, -133). He felt that the guilt, anger and shame over her relationship with Mr. Warrick provided the most significant stress. (Tr. IV-150).

In contrast, Dr. Brown, claimant's treating psychiatrist, continued to believe that claimant's employment conditions were the major contributing cause of her psychological condition. (Exs. 22, 28). He reported that claimant's sexual relationship with Mr. Warrick was "at best, a minor stressor[.]" (Ex. 22-2). Dr. Brown explained:

> "First, [claimant] has indicated that she indeed had a consensual sexual relationship with one of her co-workers beginning in the fall of 1993. She has indicated that while there was some stress associated with this inasmuch as this relationship was taking place while she was married to someone else, it was not otherwise that stressful of a relationship. Certainly the relationship had its ups and downs, but it was nowhere near as threatening to her as the ongoing harassment issues she was subjected to by her supervisor." (Ex. 22-1).

For the following reasons, we are not persuaded by Dr. Brown's conclusion that claimant's extramarital relationship was a "minor stressor." Although claimant's relationship with Mr. Warrick began in December 1993, she did not begin treating with Dr. Brown until August 1994. Furthermore, Dr. Brown acknowledged that claimant had informed him of the sexual relationship only after the claim had initially gone to hearing, which was in May and June 1995. (Ex. 28-2). Unlike Dr. Heck, we find no evidence that Dr. Brown had reviewed claimant's July 23, 1996 deposition testimony or her March 11, 1998 testimony.

Claimant's March 11, 1998 testimony indicated that she first became physically intimate with Mr. Warrick in Christmas 1993. (Tr. IV-59). She testified that the second time they were intimate was in January 1994, in a motel room. (Tr. IV-60, -61). During that incident, claimant said Mr. Warrick became extremely aggressive. (Tr. IV-62). She testified that Mr. Warrick was extremely frustrated and angry with her and she admitted it "probably was a violent act." (Tr. IV-101, -102). Claimant testified that she was fearful of the situation and she subsequently became afraid of Mr. Warrick after a phone conversation with him two months before the July 1996 deposition. (Tr. IV-63, -64).

Claimant testified that she had experienced guilt because of her relationship with Mr. Warrick. (Tr. IV-68, Ex. 26-246, -247). Although claimant said she did not tell her husband about the sexual relationship until 1996 (Tr. IV-74, Ex. 26-234), she testified her husband had "suspected it and kept accusing me of it all the time[.]" (Ex. 26-234). Claimant explained that she and Mr. Warrick had discussed leaving their respective spouses. (Ex. 26-233). She was angry at herself for having the affair. (Tr. IV-99, -100). Claimant explained that she had a strong feeling of dependency on Mr. Warrick and she felt that if she did not become physically intimate with him, he would pull away from her. (Tr. IV-93). She felt her ability to survive at work was easier when Mr. Warrick became her friend. (Tr. IV-94). Claimant agreed that she felt like a "whore," because she slept with Mr. Warrick in order to stay in her job. (Tr. IV-94, Ex. 26-230).

We are not persuaded by Dr. Brown's opinion that claimant's extramarital relationship was a "minor stressor." Claimant did not even disclose that relationship to Dr. Brown until sometime after June 1995. Rather, we are more persuaded by the testimony of Dr. Heck, who reviewed claimant's July 23, 1996 deposition testimony and attended the March 11, 1998 hearing and concluded that claimant's guilt over her relationship with Mr. Warrick provided significant stress. (Tr. IV-150). Ms. Guardalabene also bellieved claimant's guilt about her extramarital relationship caused "significant stress." (Ex. 27-21).

Furthermore, we are not persuaded by Dr. Brown's opinion because he had an inaccurate understanding of when claimant's three-month drinking "binge" occurred. Dr. Brown was aware that claimant had a preexisting alcohol problem, but he reported that it was under control until late 1994. (Ex. 22-2). As discussed earlier, we find that claimant's drinking binge started in fall 1993. At the July 23, 1996 deposition, claimant testified she was "drinking constantly" after work and on her days off. (Ex. 26-201, -202). She explained that the binge on alcohol was an attempt to kill herself. (Ex. 26-204). She also had another extramarital affair during that period. (Ex. 26-243, Tr. IV-106). In sum, we are not persuaded by Dr. Brown's opinion on causation because he did not have an accurate and complete history of claimant's non-work-related stressors. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) (medical opinion that is not based on a complete and accurate history is unpersuasive). We note further that Dr. Brown's opinion is not well-reasoned. Dr. Brown commented that "[w]hether [claimant] was truthful in providing this history (or failing to provide it) is first not very important and second explainable." (Ex. 22-4). Unlike Dr. Brown, we find the accuracy of claimant's history to be very important in deciding causation.

Claimant also relies on the opinion of Ms. Guardalabene, her counselor, to establish compensability. Ms. Guardalene treated claimant from March 1994 until September 1996. (Ex. 23-1). She initially was a "consultant" to claimant until she finished her master's degree in marriage and family therapy in June 1994. (Ex. 27-5, -6). She said she did not perform psychological counseling with claimant until she received her degree. (Ex. 27-7). She explained that her work with claimant was "somewhat sporadic in nature" in that she saw her for awhile and then claimant would see Dr. Brown. (Ex. 27-13). Ms. Guardalabene believed that the primary source of claimant's stress was from her problems at work. (Exs. 23, 27-18, -28, -29). She felt that claimant's affair with a coworker and the use of alcohol were "coping mechanisms" to alleviate the work stress (Ex. 23-2).

We are more persuaded by the opinion of Dr. Heck, psychiatrist, in light of his special expertise in this area and because his opinion is well-reasoned and is based on an accurate history. Based on claimant's guilt, anger and shame concerning her relationship with Mr. Warrick, the "violent" episode with Mr. Warrick in a motel room and her marital stress, Dr. Heck no longer believed that claimant's employment conditions were the major contributing cause of her psychological condition. (Tr. IV-131 to -134). He explained that claimant also had stress because of her abdominal pain and surgery and he also noted claimant's personality disorder in which she had a tendency to feel victimized and to overreact to perceived victimization based on her past history of relationships with men. (Tr. IV-132, -133). Based on Dr. Heck's opinion, we are unable to find by clear and convincing evidence that claimant's mental disorder arose out of and in the course of her employment. Accordingly, based on this record, claimant has not established that her work activities were the major contributing cause of her mental disorder.[2] ORS 656.802(2)(a).

Although claimant does not specifically raise the issue on review, she argued in the previous proceedings that, in the event the record does not support compensability under ORS 656.802, but would be sustainable under some lesser standard, the matter should be reviewed for preemption by the Americans with Disabilities Act (ADA). We have previously held that we lack jurisdiction to consider a claimant's ADA challenge to the worker's compensation statutes. *Sandra J. Way*, 45 Van Natta 876 (1993), *aff'd on other grounds Way v. Fred Meyer, Inc.*, 126 Or App 343 (1994). We continue to hold, for the reasons expressed in *Sandra J. Way*, that the Board is not the proper forum for claimant's ADA challenge. Furthermore, the court has rejected a similar challenge to ORS 656.005(7)(a)(B) and ORS 656.005(24) and concluded that those statutes were neither in violation of nor preempted by the ADA. *Brown v. A-Dec, Inc.*, 154 Or App 244 (1998); *Bailey v. Reynolds Metals*, 153 Or App 498, *rev den* 327 Or 432 (1998).

ORDER

The ALJ's order dated October 16, 1998 is reversed. The SAIF Corporation's denial of claimant's mental disorder claim is reinstated and upheld. The ALJ's attorney fee award is also reversed.

[2] In light of our conclusion, we need not address claimant's cross-appeal requesting an increased attorney fee award.

In the Matter of the Compensation of
ERNEST W. MERCER, Claimant
Own Motion No. 98-0327M
OWN MOTION ORDER ON RECONSIDERATION POSTPONING ACTION
Cummins, Goodman, et al., Defense Attorneys

On January 13, 1999, we issued an Own Motion Order of Abatement which abated our December 16, 1998 Own Motion Order, which had dismissed claimant's current request for reopening of his claim. In our Order of Abatement, we requested the parties' position regarding the status of the claim. In response, the insurer has denied the compensability of claimant's current condition on which claimant has filed a request for hearing with the Hearings Division. (WCB Case No. 99-02511).

It is the Board's policy to postpone action until pending litigation on related issues has been resolved. Therefore, we defer action on this request for own motion relief and request that the assigned Administrative Law Judge (ALJ) in WCB Case No. 99-02511 submit a copy of the eventual order to the Board. In addition, if the matter is resolved by stipulation or disputed claim settlement, the ALJ is requested to submit a copy of the settlement document to the Board. After issuance of the order or settlement document, the parties should advise the Board of their respective positions regarding claimant's request for own motion relief.

IT IS SO ORDERED.

In the Matter of the Compensation of
SHARON L. ERICKSON, Claimant
WCB Case No. 98-05853
ORDER OF DISMISSAL
Patrick K. Mackin, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requested review of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's occupational disease claim for a bilateral carpal tunnel condition. Claimant then moved for dismissal of SAIF's request for review, as well as for an award of sanctions under ORS 656.390 and attorney fees under ORS 656.382(2) and ORS 656.386(1). Based on the following reasoning, we deny claimant's request for attorney fees, but grant the request for sanctions under ORS 656.390.[1]

We begin by briefly recounting the procedural background of this matter. In a March 5, 1999 order, the ALJ set aside SAIF's denial of claimant's occupational disease claim and awarded an assessed fee pursuant to ORS 656.386(1). On March 23, 1999, SAIF requested "Board review of Administrative Law Judge John Mark Mills' order dated March 5, 1999." The request of review noted that compensation would not be stayed under ORS 656.313.

On April 2, 1999, claimant moved to dismiss SAIF's request for review. In addition, claimant requested that sanctions be imposed under ORS 656.390 and that attorney fees be awarded pursuant to ORS 656.382 and ORS 656.386. Attached to the motion were an affidavit from claimant's counsel as well as claim processing documents from SAIF. The submitted material revealed that, on March 16, 1999 (prior to the filing of its request for review), SAIF had issued a Notice of Claim Acceptance and had written a letter to claimant informing her that her claim had been accepted.

In his affidavit, claimant's counsel averred that SAIF's adjuster had contacted him on March 16, 1999 regarding the possibility of settling the claim by claim disposition agreement (CDA) and that SAIF had paid the ALJ's attorney fee award in full. According to claimant's counsel, on March 17, 1999, he contacted SAIF and informed the adjuster that claimant was not interested in a CDA. As previously noted, SAIF filed its request for review on March 23, 1999.

In reply to claimant's motion, SAIF requested that the motion to dismiss be denied and asserted that only the ALJ's attorney fee award was being appealed. On April 13, 1999, however, SAIF withdrew its request for Board review. SAIF has conceded that it has paid the ALJ's attorney fee award in full due to a "mis-communication" between its legal division and its claims adjuster.

We first address claimant's request for attorney fees. Claimant asserts that he is entitled to an assessed fee under ORS 656.382(2) because SAIF failed to reduce or disallow claimant's compensation through its request for review. Although SAIF contended that its request for review pertained only to the ALJ's attorney fee award, claimant notes that SAIF's request for review was not limited to attorney fees and was of the ALJ's entire order. Inasmuch as SAIF ultimately withdrew its request for review, claimant's counsel contends that he is entitled to an assessed fee under the statute.

We are without authority to grant claimant's request. The insurer withdrew its request for review. Therefore, there was no decision on the merits and no finding "that the compensation to a claimant should not be disallowed or reduced" under ORS 656.382(2).[2] Thus, claimant is not entitled to

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[1] SAIF has now withdrawn its request for review. Although a withdrawal of a request for review may initiate the dismissal process, it is the dismissal order which terminates our appellate review authority. Therefore, until our dismissal order issues, we retain jurisdiction to address claimant's motion for sanctions and attorney fees. *See Mary J. McFadden*, 44 Van Natta 2414 (1992); *Sharon E. Kelly (VanGorder)*, 39 Van Natta 467 (1987).

[2] We acknowledge claimant's "cross-request" for review. However, claimant does not challenge the ALJ's attorney fee award, nor is she an "aggrieved" party with respect to the ALJ's compensability finding. *See generally, Eugene E. McNutt*, 41 Van Natta 164, 165 (1989); *Orville L. Carlson*, 37 Van Natta 30, 32 (1985). Accordingly, we also dismiss claimant's "cross-request" for review.

a carrier-paid attorney fee award under ORS 656.382(2). *Terlouw v. Jesuit Seminary*, 101 Or App 493, 494 (1990); *Liberty Northwest Ins. Corp. v. McKellips*, 100 Or App 549, 550 (1990); *Timothy L. Williams*, 46 Van Natta 2274, 2276 (1994).[3]

We now turn to claimant's counsel's request for sanctions. ORS 656.390(1) provides that if a party requests review by the Board of an ALJ's decision and the Board finds that the appeal was frivolous or was filed in bad faith or for the purpose of harassment, the Board may impose an appropriate sanction upon the attorney who filed the request for review. "Frivolous" means that the matter is not supported by substantial evidence or is initiated without reasonable prospect of prevailing. ORS 656.390(2); *see also Winters v. Woodburn Carcraft Co.*, 142 Or App 182 (1996).

In *SAIF v. Mize*, 129 Or App 636 (1994), before the carrier petitioned for judicial review of a Board order, it accepted the claimant's claim by a clear and unqualified Notice of Acceptance. The court held that the carrier's acceptance rendered moot any controversy over the compensability of the claimant's claim and dismissed the carrier's petition for judicial review. *Id.* at 640.

In this case, SAIF unequivocally and clearly accepted claimant's bilateral carpal tunnel condition by its March 16, 1999 Notice of Acceptance and letter to claimant. We agree with claimant that SAIF's acceptance was not contingent upon the result of an appeal. *Cf. Valerie Barbeau*, 49 Van Natta 1189 (1997) (given the carrier's explanation on the 1502 for accepting the claim when the case was on appeal and its reference to its appeal on a Notice of Closure, the carrier's acceptance was not clear and unqualified). In accordance with *Mize* rationale, SAIF's acceptance rendered moot any controversy over the compensability of claimant's carpal tunnel condition. *See Gaye E. Whitehead*, 50 Van Natta 2425, 2446 (1998).

Accordingly, we conclude that, when SAIF requested review of the ALJ's order, it had no reasonable prospect of prevailing in light of its clear and unequivocal acceptance of claimant's carpal tunnel condition. SAIF contends, however, that its request for review was limited to the issue of attorney fees. Because SAIF's request for review did not specify that it was only challenging the ALJ's attorney fee award, we do not concur with SAIF's contention. In any event, even if we agreed with SAIF's interpretation of its request for review, we would still find its request for review was "frivolous" given its concession that it had paid claimant's attorney fee in full.[4] In reaching this conclusion, consistent with the *Mize* rationale, we find that SAIF's unequivocal "pre-appeal" payment of the ALJ's attorney fee award rendered the issue moot.[5]

In summary, we find that SAIF's request for review was "frivolous," *i.e.*, was made without reasonable prospect of prevailing. Therefore, we conclude that imposition of sanctions pursuant to ORS 656.390 is appropriate.

ORS 656.390(1) provides that the sanction "may include an order to pay to the other party the amount of the reasonable expenses incurred by reason of the request for hearing, request for review, appeal or motion, including a reasonable attorney fee."

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[3] We likewise reject claimant's attorney's request for an assessed fee under ORS 656.386(1) because claimant has not finally prevailed after an appeal of an ALJ's order that initially upheld a denial. To the contrary, the ALJ *set aside* SAIF's denial. Therefore, claimant was appropriately awarded a carrier-paid attorney fee under ORS 656.386(1) for services at the hearing level.

[4] In light of its allegedly mistaken payment of the attorney fee, SAIF asserts that its request for review was not filed in bad faith or for the purposes of harassment. Even if SAIF's assertion is true, ORS 656.390 is stated in the disjunctive, *i.e.*, that the appeal was "frivolous *or* was filed in bad faith *or* for the purpose of harassment***." (emphasis supplied). Thus, even if SAIF's request for review was not filed in bad faith or for purposes of harassment, sanctions may still be imposed if the request for review was "frivolous," *i.e.*, without reasonable prospect of prevailing. Under these particular circumstances, we find that SAIF's request for review was filed without reasonable prospect of prevailing because its payment of the ALJ's attorney fee award prior to the request for review (which was not required under ORS 656.313) rendered the appeal moot.

[5] The dissent argues that, before this decision, there was no case or statutory authority that necessarily precluded SAIF from litigating the attorney fee issue even though the fee had been paid in full. We disagree. We find no meaningful distinction between the clear and unequivocal "pre-appeal" acceptance of a condition (which, under *Mize*, moots an appeal) and the unequivocal "pre-appeal" payment of the ALJ's attorney fee award. In both instances, there is no reasonable prospect of prevailing under the *Mize* rationale.

In accordance with the statute, we order SAIF to pay claimant's counsel the amount of reasonable expenses incurred by reason of the request for review. In addition, we find that an appropriate sanction should include a reasonable attorney fee. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee is $500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the "sanction" issue (as represented by claimant's motion and written submissions), the complexity of the issue, and the value of the interest involved.

Accordingly, SAIF's request for review is dismissed. The motion for attorney fee awards under ORS 656.382(2) and ORS 656.386(1) is denied. The motion for sanctions is granted.

IT IS SO ORDERED.

Board Member Haynes dissenting.

The majority finds that SAIF's request for review was "frivolous" and imposes sanctions under ORS 656.390. Because I disagree with that conclusion, I would not impose sanctions. For this reason, I respectfully dissent.

At the outset, I note that I agree with the majority that SAIF's request for review was not limited to the issue of attorney fees. Moreover, I also agree that SAIF had no reasonable prospect of prevailing on the compensability issue given its clear and unequivocal acceptance of the bilateral carpal tunnel condition prior to its request for review. Having said that, this does not necessarily lead to the conclusion that SAIF's request for review was frivolous. *See Arlene J. Bond,* 50 Van Natta 2426, 2427 (1998) (even though one issue is raised without reasonable prospect of prevailing, if one aspect of a request for review has a reasonable prospect of prevailing, then overall request for review is not frivolous).

ORS 656.390(2) defines "frivolous" as a "matter initiated without reasonable prospect of prevailing." As SAIF notes, we have already held that the basis for SAIF's appeal of the attorney fee award (that the ALJ failed to provide a sufficient basis for his fee award and that, therefore, the case should be remanded) is not frivolous. *See Randal C. Chatman,* 50 Van Natta 2409 (1998).

Moreover, the majority's primary objection to SAIF's request for review regarding the attorney fee issue is that SAIF had apparently paid the fee in full prior to the review request. Yet, until today's decision, no case precedent existed that extended the *Mize* rationale to an appeal of a fully paid ALJ's attorney fee award.

Under such circumstances, I would not consider SAIF's appeal to be frivolous and, thus, I would not impose sanctions. Consequently, I respectfully dissent.

In the Matter of the Compensation of
CHARLES L. CHITTIM, JR., Claimant
WCB Case No. 98-02890
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Scheminske, et al., Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that upheld the insurer's denial of his low back aggravation claim. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld the insurer's denial of claimant's aggravation claim. In doing so, the ALJ found that claimant did not perfect an aggravation claim under ORS 656.273(3) because the aggravation claim form was not accompanied by an attending physician's report establishing by written medical evidence supported by objective findings that claimant had suffered a worsened condition attributable to the compensable injury. Citing *Donald P. James*, 48 Van Natta 424 (1996), the ALJ determined that claimant's failure to perfect the aggravation claim required the upholding of the insurer's denial.

On review, claimant contends that he perfected his aggravation claim. While we disagree with that contention, we, nevertheless, set aside the insurer's denial as a nullity. We reason as follows.

Under ORS 656.273(3), there are two essential elements for a "claim for aggravation": the completed Director's form and the accompanying attending physician's report establishing by written medical evidence supported by objective findings that the claimant has suffered a worsened condition attributable to the compensable injury.[1] *Ted B. Minton*, 50 Van Natta 2423, 2424 (1998). Although, in *Minton*, the claimant and his attending physician submitted a completed Director's form to the carrier, we held that the record failed to establish that the claim form was accompanied by the required written medical report. Specifically, we noted that the attending physician indicated on the Director's form that time loss was authorized from July 1, 1997 and that the claimant was limited to bed rest with no lifting, bending or twisting, but we found no companion medical report documenting objective findings of a worsened condition attributable to the accepted condition.

Accordingly, based on the statutory requirement that an aggravation claim form be accompanied by an attending physician's report documenting a worsened condition (and because the carrier had challenged the validity of the claim on this basis), we found that the claimant's aggravation claim in *Minton* was procedurally defective. In light of this, we further held that the carrier's aggravation denial was a nullity and without legal effect. *Id.* at 2425.

Here, claimant and his attending physician, Dr. Welch, submitted a completed Director's aggravation form to the insurer on November 21, 1997. (Ex. 44). With that document, claimant also submitted a change of attending physician form which referred to attached notes. (Ex. 43). However, there is no evidence of attached notes. Moreover, neither form contained objective findings of a worsened condition attributable to the accepted condition. Claimant's attending physician later responded to inquiries from claimant's attorney on January 22, 1998 and reported that claimant had experienced an acute worsening of his low back condition on November 12, 1997 as evidenced by increased pain, limited range of motion and muscle spasm. (Ex. 45A). The insurer, however, apparently did not receive that report until sometime on or before March 5, 1998. (Ex. 47).

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[1] Claimant asserts that the statute merely "suggests" that an aggravation claim be accompanied by the attending physician's report. To the contrary, the statute does more than merely "suggest"; it states that the claim for aggravation "must be" accompanied by the attending physician's report.

In accordance with *Minton*, and because the insurer has challenged the procedural validity of the aggravation claim, we find that claimant's aggravation claim was procedurally defective because the Director's aggravation form was not accompanied by a physician's report documenting objective findings of a worsened condition attributable to the compensable condition.[2] Therefore, we conclude that the insurer's aggravation denial is a nullity and without legal effect.[3]

ORDER

The ALJ's order dated December 16, 1998 is reversed. The insurer's aggravation denial is set aside as a nullity.[4]

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[2] Claimant contends that our holding in *Minton* would prevent a claimant from curing any defective aggravation claim. We disagree. Nothing in *Minton* prevents a claimant from filing another aggravation claim if the attending physician initially fails to satisfy the statutory requirements for a valid aggravation claim. The significance of *Minton* is that a carrier is not obligated to process an aggravation claim until it is perfected pursuant to ORS 656.273(3).

[3] We recognize that, in *Donald P. James*, we upheld a carrier's aggravation denial after we determined that the claimant had not perfected an aggravation claim. 48 Van Natta at 426. That aspect of our decision in *James* has been implicitly disavowed by *Minton*, which issued subsequent to the date of the ALJ's order. The ALJ cited our decision in *Rogella Rocha-Barajas*, 50 Van Natta 1502 (1998) as another example of our upholding an aggravation denial when a claimant failed to perfect an aggravation claim. We disagree, however, with the ALJ's interpretation of *Rocha-Barajas*. We did not uphold an aggravation denial in that case; rather, we held that the carrier's claim processing obligations were not triggered because no aggravation claim had been perfected. *Id.* at 1502.

[4] Though we have reversed the insurer's denial, claimant's attorney is not entitled to an award of attorney fees for services on Board review. *See Stephenson v. Meyer*, 150 Or App 300, 304 (1997) (because no claim was made, the legal predicate for an award of attorney fees did not exist).

In the Matter of the Compensation of
WILLIAM W. CLUNAS, Claimant
WCB Case Nos. 98-05239, 98-03289 & 98-02836
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Mannix, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys
Gilroy Law Firm, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Liberty Northwest Insurance Corporation, on behalf of Fred Shearer, requests review of those portions of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) set aside its compensability and responsibility denials of claimant's occupational disease claim for a cervical condition; and (2) upheld the denials of Liberty Northwest Insurance Corporation, on behalf of Ron Construction, and Home Insurance/GAB, on behalf of Performance Contracting, of the same condition. On review, the issues are compensability and responsibility.

We adopt and affirm the ALJ's order with the following modification[1] and supplementation.

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[1] We note that Home Insurance/GAB was not on the risk when claimant injured his neck in Washington in 1987. (*See* first sentence of second paragraph of "Findings of Fact," Opinion and Order, p. 3).

We agree with the ALJ that claimant's cervical condition is due in major part[2] to his twenty year construction work exposure, particularly carrying and holding heavy sheetrock on his head. (*See* Exs. 53, 86). Consequently, claimant's occupational disease claim is compensable under the last injurious exposure rule of proof.

We substitute the following for the first full paragraph on page 7:

Under the last injurious exposure rule of assignment, responsibility is initially assigned with the last employment that could have caused claimant's condition.[3] *See Boise Cascade Corp. v. Starbuck*, 296 Or 238, 241 (1984); *Betty L. Martinez*, 50 Van Natta 1535 (1998). On this record, the last work that could have contributed to claimant's cervical condition was his Fred Shearer job, because claimant did not carry and hold sheetrock on his head thereafter. (*See* Tr. 41-43, 48-49, 51; *see also* Ex. 64-4-7). Therefore, responsibility is initially assigned with Fred Shearer.

Finally, because Fred Shearer has not established that a prior employment was the sole cause of claimant's cervical condition or that its exposure could not have caused the condition, responsibility remains with Fred Shearer. *See Roseburg Forest Products v. Long*, 325 Or 305, 313 (1997); *Multnomah County School Dist. v. Tigner*, 113 Or App 405, 407 (1992). (If conditions at the "presumptively responsible" employment "actually contributed" to the claimant's disease, the carrier on the risk at that time cannot avoid responsibility.)

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,750, payable by Liberty on behalf of Fred Shearer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 15, 1998 is affirmed. For services on review, claimant is awarded a $1,750 attorney fee, payable by Liberty Northwest Insurance Corporation on behalf of Fred Shearer.

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[2] We find that Dr. Puziss' opinion persuasively establishes that claimant's work exposure contributed more to his "premature" cervical degeneration than did nonwork factors, such as age. We also note that Dr. Puziss considered claimant's 1987 neck injury to be a contributing factor and that injury does not weigh against the claim because it happened at work. And we acknowledge that Dr. Puziss inaccurately reported that claimant continued hanging sheetrock "on top of his head" until his 1994 carpal tunnel surgery, (Ex. 53-2), but this does not affect our conclusion that claimant's work activities up to and including his work for Fred Shearer (until April 1992) were the major contributing cause of his cervical condition.

[3] The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. *Bracke v. Baza'r*, 293 Or 239, 248 (1982). If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date the claimant first began to receive treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim (unless the subsequent employment contributes independently to the cause or worsening of the condition). *Timm v. Maley*, 125 Or App 396, 401 (1993), *rev den* 319 Or 81 (1994). Here, claimant first sought treatment for his cervical degenerative condition in 1996 or 1997, after he stopped working for Fred Shearer. (*See Exs.* 37, 41, 42, 52, 53; *see also Ex.* 64-7-8,-12). However, as we explain herein, the last employment (before the first treatment) that could have caused the condition was the Fred Shearer job. *Compare Craig A. McIntyre*, 51 Van Natta 34, 35, (1999) (where there was undisputed medical evidence that the claimant's later self-employment contributed to his condition, the last joined carrier successfully invoked defensive use of the last injurious exposure rule).

In the Matter of the Compensation of
JULIE L. JOHNSON, Claimant
WCB Case No. 97-09458
ORDER ON REVIEW
Juli Point, Claimant Attorney
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Howell's order that upheld the self-insured employer's denial of her occupational disease claim for urticaria. In her brief, claimant argues that Dr. Montanaro's testimony should be stricken in its entirety. On review, the issues are evidence and compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation.

In the second paragraph on page 2, we change the first sentence to read: "Exhibit 2, pages 1 and 3, and Exhibits 4, 6, 7 and 8 are documents related to medical conditions, such as the flu, which have no bearing on the issues in this case." In the third paragraph on page 2, we change the first sentence to read: "Exhibit 2, pages 1 and 3, Exhibits 3 through 10 and Exhibit 12 are irrelevant."

Evidence

Claimant argues that Dr. Montanaro's testimony should be stricken in its entirety. She relies on her November 20, 1998 letter to the ALJ that outlined reasons for striking the testimony.

Before issuing the Opinion and Order, the ALJ had indicated that he would exclude the testimony, report and curriculum vitae of Dr. Montanaro. His ruling was in response to the employer's attorney's failure to comply with, or even acknowledge the ALJ's directives in previous letters. In a November 16, 1998 letter to the parties, the ALJ noted that his initial ruling was premised on the assumption that Dr. Montanaro had, to some extent, relied upon a medical journal article he had authored and a book he had co-authored. At closing arguments, the employer asked the ALJ to reconsider his ruling. On further consideration, the ALJ reversed his earlier ruling to exclude Dr. Montanaro's testimony, report and curriculum vitae.

Claimant's attorney responded on November 20, 1998, disagreeing with the ALJ's conclusion. Claimant's attorney explained:

> "Dr. Montanaro is employer's expert witness. Employer submitted Dr. Montanaro's curriculum vitae. In that curriculum vitae, Dr. Montanaro lists the qualifications that ostensibly make him an expert to testify on the effects of wood dust. (Ex. 40A-3). Dr. Montanaro wrote and published at least one chapter in a book and a journal article wherein this particular topic is discussed (referenced Ex. 40A-3). That information is not available to me in a bookstore, or via computer, and was not made available to me by employer * * *." (Claimant's November 20, 1998 letter at 1-2; emphasis in original).

Claimant's attorney asserted that she had requested this information and the ALJ had ordered its discovery. She argued that the employer failed to produce the documents and, therefore, the testimony of Dr. Montanaro and his curriculum vitae should be stricken from the record.[1]

ORS 656.283(7) provides that the ALJ is not bound by common law or statutory rules of evidence and may conduct a hearing in any manner that will achieve substantial justice. That statute gives the ALJ broad discretion on determinations concerning the admissibility of evidence. *See, e.g., Brown v. SAIF*, 51 Or App 389, 394 (1981). We review the ALJ's evidentiary rulings for abuse of discretion. *Rose M. LeMasters*, 46 Van Natta 1533 (1994), *aff'd mem* 133 Or App 258 (1995).

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[1] The ALJ noted that the employer had provided claimant's attorney with a copy of the requested medical journal article.

In this case, we find no abuse of discretion. After reviewing the record, we agree with the ALJ's conclusion that it was not shown that Dr. Montanaro relied on the book *Occupational Asthma* in formulating his opinion in this case and it was not shown that the book was otherwise relevant or that it would have led to relevant evidence. The ALJ noted that the book was related to asthma, which was not at issue in this case.

ORDER

The ALJ's order dated December 30, 1998 is affirmed.

April 30, 1999 Cite as 51 Van Natta 768 (1999)

In the Matter of the Compensation of
FELIPE GONZALEZ, Claimant
WCB Case No. AF-98010
ORDER ON REVIEW
Stanley Fields, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Garaventa's order that declined to approve his request for an out-of-compensation attorney fee. In its brief, the self-insured employer requests sanctions for claimant's allegedly "frivolous" request for review. In his reply brief, claimant moves to strike the employer's respondent's brief. On review, the issues are jurisdiction, attorney fees, motion to strike and sanctions.

We adopt and affirm the ALJ's order with the following supplementation.

Claimant moves to strike the employer's brief on the ground that the employer never previously raised an objection to his fee petition and thus should not be permitted to present opposing arguments on review. We need not resolve claimant's procedural motion because, even if the employer's contentions were considered, we would reach the same decision.[1]

With respect to the merits of claimant's request for an "out-of-compensation" attorney fee, we have previously rejected similar arguments. *Karen Stean*, 50 Van Natta 374 (1998); *Larry D. Simmons*, 50 Van Natta 107 (1998); *Julie A. Johnson*, 48 Van Natta 29 (1996). Moreover, the Court of Appeals recently held that ORS 656.385(5) and ORS 656.388(1) preempted and precluded us from awarding "out-of-compensation" fees in a matter litigated within the Director's review jurisdiction. *Shook v. Pacific Communities Hospital*, 159 Or App 604 (1999). Thus, we decline claimant's request for an "out-of-compensation" attorney fee.

ORDER

The ALJ's order dated December 22, 1998 is affirmed.

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[1] Moreover, sanctions would not be warranted. ORS 656.390(1) provides that, if a party requests review by the Board of an ALJ's decision and the Board finds that the appeal was frivolous or was filed in bad faith or for the purpose of harassment, the Board may impose an appropriate sanction upon the attorney who filed the request for review. "Frivolous" means that the matter is not supported by substantial evidence or is initiated without reasonable prospect of prevailing. ORS 656.390(2); *see also Winters v. Woodburn Carcraft Co.*, 142 Or App 182 (1996). Claimant has presented a colorable argument on review that is sufficiently developed so as to create a reasonable prospect of prevailing on the merits. While claimant's argument on review did not ultimately prevail, it was not "frivolous."

In the Matter of the Compensation of
BRENDA M. LINKER, Claimant
WCB Case No. 98-04211
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) upheld the insurer's denial of her aggravation claim for a left shoulder condition; and (2) upheld the insurer's denial of her claim for a "new" left shoulder condition (myofascial syndrome). On review, the issues are aggravation and compensability.

We adopt and affirm the ALJ's order with the following supplementation.

On review, claimant contends that her aggravation and new condition claims should be analyzed under an occupational disease theory rather than an injury theory. For the following reasons, we conclude that, whether analyzed as an occupational disease or an injury, claimant's claims would fail.

ORS 656.273(1) entitles an injured worker to "additional compensation for worsened conditions resulting from the original injury." The statute provides that a worsened condition is established by medical evidence of an "actual worsening" of the compensable condition supported by objective findings. An "actual worsening" is established by direct medical evidence that a condition has pathologically worsened. *SAIF v. Walker*, 145 Or App 294, 305 (1996), *rev allowed* 325 Or 367 (1997). Moreover, to prove compensability of a new occupational disease, claimant must prove that employment conditions were the major contributing cause of the disease, or, if the occupational disease claim is based on the worsening of a preexisting disease or condition, the worker must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2).

Here, the insurer accepted "subscapular bursitis" as a result of claimant's industrial exposure. There is no medical evidence that that condition has worsened since the claim was closed in November 1993, even if the term "subscapular bursitis" refers to muscle pain in the levator scapulae muscle in the left posterior shoulder area. (Exs. 18; 79-13, -18 through -20). Moreover, there is no medical evidence that claimant's myofascial syndrome was caused or pathologically worsened by her repetitive work activities at the employer. *See* ORS 656.802.

The sole medical opinion that is arguably supportive of claimant's claims is that of Dr. Webb. Webb stated that it was likely that claimant had an underlying preexisting myofascial condition prior to her beginning work at the employer, which was materially worsened by the high production work there. Webb's conclusory opinion is insufficient to carry claimant's burden of proof. *Somers v. SAIF*, 77 Or App 259 (1986) (we are persuaded by opinions that are well-reasoned and based on accurate and complete information). Furthermore, Webb also stated that he did not have enough information about claimant's job duties at either the Forest Service or at the employer to render an opinion regarding the cause of her current neck and shoulder complaints. (Ex. 75). Finally, in the face of Dr. Woodward's opinions that claimant's soft-tissue overuse condition would have resolved by the summer of 1993 and that the myofascial diagnosis does not apply, Webb felt that he had too little information regarding claimant's upper back condition to either agree or disagree with Woodward's opinion. (Ex. 78).

Consequently, on this record, claimant has failed to prove an aggravation of her compensable subscapular bursitis condition or compensability of her myofascial syndrome.

ORDER

The ALJ's order dated November 11, 1998 is affirmed.

In the Matter of the Compensation of
BRIAN S. MacDONALD, Claimant
WCB Case Nos. 98-07189 & 98-03528
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Howell's order that awarded an assessed fee of $2,600 for claimant's counsel's services at hearing. SAIF also moves for remand. On review, the issues are remand and attorney fees.

We deny SAIF's motion for remand, and adopt and affirm the ALJ's order with the following supplementation.

Claimant requested a hearing challenging SAIF's denial of his injury claim. Following the hearing, the ALJ found that claimant had established the compensability of his mid back injury, and directed SAIF to accept and process the claim. The ALJ also assessed an attorney fee of $2,600 after considering the factors set forth in OAR 438-015-00010(4) and applying them to the case.

On review, SAIF argues that the ALJ failed to make specific findings with regard to the factors set forth in the rule and that his explanation for the $2,600 fee award is insufficient. Contrary to SAIF's contention, the ALJ was not required to make findings for each rule-based factor. As we explained *Daryl L. Underwood,* 50 Van Natta 2330 (1998), where there is no specific argument at hearing concerning the application of the factors in OAR 438-015-0010(4), an ALJ satisfies his or her obligation to make findings concerning the attorney fee award by including in the order a brief description or citation to the rule-based factor or factors relied upon in determining the fee award. Furthermore, because we are authorized to modify or supplement the ALJ's order on review under ORS 656.295(6), remand is not an appropriate remedy. *Daryl L. Underwood,* 50 Van Natta at 2332.

Here, the ALJ cited to the applicable rule and identified the factors he considered in determining the fee. The ALJ explained that, in awarding the $2,600 fee, he particularly considered the skill of the attorney, the complexity of the case, the benefit secured for the party, and the value of the interest involved. This explanation for the ALJ's attorney fee award is consistent with the *Underwood* rationale. *See, e.g., Leslie D. Custer,* 51 Van Natta 390 (1999); *compare Donna R. Grierson,* 51 Van Natta 679 (1999) (ALJ's reasoning insufficient to determine how he arrived at reasonable fee where order was devoid of any explanation of application of the rule-based factors).[1]

ORDER

The ALJ's order dated November 20, 1998 is affirmed.

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[1] Because SAIF challenged only the attorney fee award on review and attorney fees are not "compensation" for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for his counsel's services on review. *See Dotson v. Bohemia, Inc.,* 80 Or App 233 (1998).

In the Matter of the Compensation of
LINN R. MENZIE, Claimant
Own Motion No. 98-0506M
OWN MOTION ORDER ON RECONSIDERATION
Great American Ins., Insurance Carrier

On February 4, 1999, we abated our January 11, 1999 Own Motion Order, which declined to reopen claimant's 1983 claim for the payment of temporary disability compensation because he failed to establish he was in the work force at the time of his current disability (his December 22, 1998 hospitalization for a December 23, 1998 surgery). We took this action to consider claimant's request for reconsideration. Having received the insurer's response and claimant's further submission of a December 23, 1998 operative report, we proceed with our reconsideration. After completing our reconsideration, we withdraw our prior order and replace it with the following order.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

It is undisputed that claimant's compensable condition has worsened requiring surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work *and* is seeking work; or (3) not working but willing to work, *and* is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

In seeking reconsideration, claimant submitted a letter from his employer indicating that he was employed during November and December of 1998. Acknowledging receipt of claimant's "proof of employment," the carrier further states that "time loss has been authorized for the period 12-22-98 thru 1-3-99, a total of 11 work days."[1]

In light of such circumstances, we are persuaded that, at the time of his current disability (*i.e.* the December 22, 1998 hospitalization for a December 23, 1998 surgery), claimant was engaged in regular gainful employment and remained in the work force.

Accordingly, in lieu of our January 11, 1999 order, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning the date he was hospitalized for surgery and to continue until such compensation can be terminated under OAR 438-012-0035(4). When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[1] The beginning date of this authorization coincides with claimant's December 22, 1998 hospitalization, as noted in the December 23, 1998 operative report from Dr. Thompson, claimant's attending surgeon.

In the Matter of the Compensation of
REBECCA S. MOAR, Claimant
WCB Case No. 98-03874
ORDER ON REVIEW
Cathcart & Borden, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that declined to reclassify claimant's occupational disease claim as disabling. On review, the issue is claim reclassification.

We adopt and affirm the ALJ's order with the following supplementation.

The ALJ concluded that there was no medical evidence within one year from the date of injury of a reasonable expectation that permanent disability would result from claimant's injury. On review, claimant contends that the ALJ erred in excluding from consideration medical reports by Dr. Nash and Dr. Nolan that had been generated more than a year after the date of injury. (Exs. 5, 13, 15). We conclude that, whether or not we consider these reports, the outcome would not change. The issue before us is whether claimant's injury claim was disabling within a year from the January 17, 1996 date of injury. ORS 656.005(7)(c);[1] ORS 656.277(2);[2] *Donald Dodgin*, 45 Van Natta 1642 (1993). An examination performed after a year from the date of injury or a report generated after that date might be relevant to the issue of whether a claimant's claim became disabling within a year from the date of injury, if the analysis contained in the examination or report addressed that issue. *See Carol D. Courtright*, 50 Van Natta 1770, 1771 (1998).

Here, however, neither Dr. Nash nor Dr. Nolan addressed whether claimant's carpal tunnel condition became disabling within a year from the date of injury. Their medical reports, therefore, are not relevant to whether claimant was permanently disabled within one year of the date of injury.

ORDER

The ALJ's order dated November 27, 1998 is affirmed.

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[1] ORS 656.005(7)(c) provides:

"A 'disabling compensable injury' is an injury which entitles the worker to compensation for disability or death. An injury is not disabling if no temporary benefits are due and payable, unless there is a reasonable expectation that permanent disability will result from the injury."

[2] ORS 656.277(2) provides:

"A claim that a nondisabling injury originally was or has become disabling, if made more than a year after the date of injury, shall be made pursuant to ORS 656.273 as a claim for aggravation."

In the Matter of the Compensation of
HUMBERTO F. NAMBO, Claimant
WCB Case No. 98-07387
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that upheld the SAIF Corporation's denial of claimant's right ankle injury claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation.

On a hot day in July 1998, claimant, a pipe changer for an irrigation farming operation, decided to go for a swim in a nearby river during unpaid time between shifts. Approximately 30 feet from the river, claimant slipped and fell, fracturing his right ankle. The ALJ upheld SAIF's denial, first concluding that the injury did not arise out of and in the course of employment under ORS 656.005(7)(a). Alternatively, the ALJ determined that the injury was not compensable under ORS 656.005(7)(b)(B), finding that claimant was engaged in recreational activity primarily for his personal pleasure when injured.

On review, claimant contends that his injury did arise in the course and scope of employment and that his primary reason for going to the river was to benefit the employer. Thus, claimant asserts that ORS 656.005(7)(b)(B) does not preclude a finding that his injury is compensable.

Under ORS 656.005(7)(b)(B), a "compensable injury" does not include any injury incurred while engaging in recreational activity primarily for the worker's personal pleasure. *See Julie A. Garcia*, 48 Van Natta 776 (1996); *Michael W. Hardenbrook*, 44 Van Natta 529, *aff'd mem Hardenbrook v. Liberty Northwest Insurance Corporation*, 117 Or App 543 (1992). However, the statute does not automatically exclude those recreational activities that have a close work nexus and are not performed "primarily" for the worker's personal pleasure. *Garcia*, 48 Van Natta at 776.

We have previously held that the statutory exclusion analysis under ORS 656.005(7)(b)(B) must precede any unitary work connection analysis. *Hardenbrook*, 44 Van Natta at 530; *see Andrews v. Tektronix, Inc.*, 323 Or 154, 161 n. 1 (1996) (Regarding ORS 656.005: "Paragraph (7)(a) is the primary definition of compensability. Paragraph (7)(b) states grounds for exclusion that are additional to those that are inherent in the primary definition found in paragraph (7)(a)."); *see also Theodore A. Combs*, 47 Van Natta 1556, 1557 (1995) (where the claim was not compensable under ORS 656.005(7)(b)(B), Board did not reach the "work connection" test). "The proper inquiry under ORS 656.005(7)(b)(B) is, what is the primary purpose of the activity [at the time of injury]?" *Kaiel v. Cultural Homestay Institute*, 129 Or App 471, 478 (1994).

Here, we find the evidence sufficient to establish that claimant's primary purpose for going to the river for a swim was personal pleasure. Claimant testified that it was too hot for him to stay inside his trailer during the break between shifts and that he wanted to refresh himself at the river "to work better." (Tr. 33). Claimant also explained that "***it would kind of refresh me. It would make me feel better. So then I would go back to work." *Id.* While we do not dispute that claimant was motivated to some extent by a desire to work better during the next shift (and thus that there was some causal nexus between the injury and work), we, nevertheless, agree with the ALJ that the primary reason for claimant's trip to the river was personal pleasure in the form of relief from the heat. Moreover, we note that claimant's injury occurred approximately one and one-half hours prior to the likely recommencement of work. (Trs. 33, 37). This fact further attenuates any causal nexus between claimant's recreational activity and his employment.

Under these circumstances, we conclude that claimant's right ankle injury is excluded from the definition of compensable injuries under ORS 656.005(7)(b)(B).[1] Therefore, we do not address the question whether claimant's injury otherwise arose out of and in the course of his employment.

ORDER

The ALJ's order dated December 30, 1998 is affirmed.

[1] Claimant cites *Mike R. Armstrong*, 50 Van Natta 54 (1998) as support for his argument that ORS 656.005(7)(b)(B) does not exclude his injury from the definition of compensable injuries. In *Armstrong*, we found that the claimant's injury incurred while riding a snowboard was not statutorily excluded because his recreational activity was part of his regular work duties. By contrast, claimant's recreational activity here was not part of his work duties, and the connection between claimant's recreational activity in this case and his employment is significantly less than that in *Armstrong*. Accordingly, we do not find *Armstrong* controlling.

In the Matter of the Compensation of
DORIS A. MOE (PACE), Claimant
Own Motion No. 99-0037M
OWN MOTION ORDER
Whitehead & Klosterman, Claimant Attorneys
Fidelity & Casualty of NY, Insurance Carrier

The insurer has submitted a request for temporary disability compensation for claimant's compensable right shoulder condition injury. Claimant's aggravation rights expired on December 5, 1994. The insurer recommends that we authorize the payment of temporary disability compensation.[1]

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

We are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning September 17, 1998, the date claimant was hospitalized for the proposed surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

Finally, claimant's attorney is entitled to a reasonable attorney fee, payable out of the increased compensation awarded by this order. However, we cannot approve such a fee unless claimant's attorney files a current retainer agreement. *See* OAR 438-015-0010(1). Because no retainer agreement has been received to date, an attorney fee shall not be approved.

IT IS SO ORDERED.

[1] Claimant originally requested own motion relief, with the same insurer, under a different claim with a date of injury of October 28, 1990 and claim number 246N7350. The insurer responded to claimant's original request by recommending reopening of this claim with a date of injury of November 6, 1988 and a claim number of 246M4547. After several inquiries, both parties concede that claimant's request for own motion benefits should be processed under this November 1988 claim. Accordingly, by separate order, we have dismissed claimant's prior request pertaining to the October 1990 claim.

In the Matter of the Compensation of
JEWELL REICHLEIN, Claimant
WCB Case No. 98-05876
ORDER ON REVIEW
Richard M. Walsh, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order that awarded an assessed fee of $3,000 pursuant to ORS 656.386(1). SAIF also moves to remand regarding the attorney fee issue. On review, the issues are attorney fees and remand.

We adopt and affirm the ALJ's order with the following supplementation.

The ALJ awarded claimant's attorney an assessed fee of $3,000. SAIF argues that the ALJ erred in failing to apply each of the factors in OAR 438-015-0010(4) and in failing to make specific findings of fact in regard to each factor in determining the amount of the attorney fee. SAIF requests that we remand the case to the ALJ to make reviewable findings supporting the attorney fee award.

We considered similar arguments in *Daryl L. Underwood*, 50 Van Natta 2330 (1998); *see also Garry L. Mercer*, 51 Van Natta 322 (1999). In *Underwood*, the claimant's attorney did not submit a specific fee request and the parties did not provide any argument at hearing concerning the application of the factors in OAR 438-015-0010(4). After analyzing the Supreme Court's decision in *McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or 84, *on recon* 327 Or 185 (1998), we found that the Court held that a lower body need not address facts and legal criteria that are not material to its decision and could "satisfy its obligation to make findings in a case * * * by including in its order a brief description or citation to the factor or factors on which it relies in denying an award of attorney fees." 327 Or at 188.

In short, because the statute considered by the Court in *McCarthy* contained the same requirement in OAR 438-015-0010(4) that the reviewing bodies "shall consider" certain enumerated factors, we held that it is sufficient for an ALJ to merely describe or cite the rule-based factor or factors the ALJ relied on in determining a reasonable attorney fee where there was no specific attorney fee requested and the parties did not submit to the ALJ any argument as to how the rule-based factors should be weighed in determining a reasonable fee. Based on our reasoning in *Underwood*, we continue to hold that the ALJ need not make findings for each rule-based factor.

Here, however, the ALJ simply stated: "Claimant's attorney is awarded a reasonable attorney fee of $3,000, to be paid by SAIF." Because the ALJ did not describe or cite the specific factor or factors within OAR 438-015-0010(4), we agree with SAIF that the ALJ did not provide reasoning sufficient for review. *See Donna R. Grierson*, 51 Van Natta 679 (1999); *James M. Myers*, 51 Van Natta 451 (1999); *John P. O'Connor*, 51 Van Natta 312 (1999); *Carol E. Brown*, 51 Van Natta 58 (1999). Nevertheless, because we are authorized to modify or supplement the ALJ's order under ORS 656.295(6), it is not necessary to remand this case to the ALJ for supplementation regarding claimant's attorney fee award. Consequently, we deny SAIF's motion to remand and proceed to consider the factors in OAR 438-015-0010(4) in determining a reasonable attorney fee for services at hearing. *Daryl L. Underwood*, 50 Van Natta at 2330.

In determining a reasonable attorney fee, we consider the following factors: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses. OAR 438-015-0010(4).

The record contains no statement of services documenting the time claimant's attorney spent on the case. The issue was compensability of claimant's cervical disc conditions at C3-4 and C6-7. The hearing lasted 1 hour and 10 minutes and generated 41 pages of transcript. Claimant was the only witness. The record contains approximately 51 exhibits, two of which were submitted by claimant's attorney. There were no depositions. Claimant succeeded in establishing the compensability of only the C3-4 disc condition.

Based on compensability disputes generally litigated before this forum, we find the compensability issue was of average complexity regarding the legal and factual issues involved. Because claimant's cervical condition at C3-4 has been found compensable, she is entitled to workers' compensation benefits, and the value of the interest involved and the benefit secured for claimant are significant. The parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented. Finally, in light of the conflicting medical opinions, there was a risk that claimant's counsel's efforts might have gone uncompensated.

After considering the factors set forth in OAR 438-015-0010(4), we find that a reasonable fee for claimant's attorney's services at hearing is $3,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the C3-4 disc condition issue (as represented by the record), the nature of the proceedings, the value of the interest involved, the benefit obtained, and the risk that counsel may go uncompensated.[1]

ORDER

The ALJ's order dated December 23, 1998 is affirmed.

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[1] Claimant is not entitled to an attorney fee on review for her counsel's services regarding the ALJ's attorney fee award. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

In the Matter of the Compensation of
JAN MOHAMMAD, Claimant
WCB Case No. 98-07280
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the self-insured employer's denial of claimant's new medical condition claim for a L5-S1 disc condition. On review, the issues are claim preclusion and, alternatively, compensability.

We adopt and affirm the ALJ's order.[1]

ORDER

The ALJ's order dated December 17, 1998 is affirmed.

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[1] In affirming the ALJ's order, we take administrative notice of a prior, final Board order upholding the insurer's denial of claimant's aggravation claim involving the same L5-S1 disc herniation at issue in this case. *See Jan Mohammad*, 51 Van Natta 67 (1999).

In the Matter of the Compensation of
LISA M. SMITH, Claimant
WCB Case No. 98-04729
ORDER ON REVIEW
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the insurer's denial of her claim for a low back condition. In its brief, the insurer moves to strike those portions of claimant's brief that referred to matters outside the hearing record. The insurer also contends that the Board should not address claimant's argument regarding alleged untimely processing of her claim because it was raised for the first time on review. On review, the issues are the motion to strike, untimely processing and compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the second paragraph in the findings of fact on page 1, we change the second sentence to read: "In 1994, claimant began working for the employer through a temporary agency and was later hired by the employer." On page 2, we delete the last paragraph of the findings of fact. We also delete the last paragraph on page 4 regarding the 1995 amendments.

Motion to Strike

The insurer moves to strike those portions of claimant's brief that referred to matters outside the hearing record. We grant the insurer's motion. Accordingly, in our review of this matter, we have not considered any arguments based on material that was not admitted into evidence at hearing. *See* ORS 656.295(5); *Maria Leyva*, 48 Van Natta 288 (1996) (Board will not consider any evidence that was not previously made a part of the record).

Timely Processing

In her brief, claimant asserts that the insurer did not respond to her claim for over five months. The insurer contends that claimant raises this procedural issue for the first time on review.

To the extent claimant is raising the untimeliness of claim processing as a basis for a penalty, we decline to consider the issue for the first time on review. *See Stevenson v. Blue Cross*, 108 Or App 247, 252 (1991) (Board may decline to consider an issue raised for the first time on appeal). In any event, even if the issue were properly raised, we would decline to award penalties based on our conclusion that the low back claim is not compensable. In light of our disposition, there are no "amounts then due" on which to base a penalty. *See Boehr v. Mid-Willamette Valley Food*, 109 Or App 292 (1991); *Randall v. Liberty Northwest Ins. Corp.*, 107 Or App 599 (1991).

ORDER

The ALJ's order dated October 14, 1998 is affirmed.

In the Matter of the Compensation of
LESTER B. LEWIS, Claimant
WCB Case No. 98-08546
ORDER ON REVIEW
Jean M. Fisher, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) determined that claimant's claim should be classified as disabling; and (2) awarded an assessed attorney fee of $2,000. Claimant cross-requests review of that portion of the ALJ's order that summarized the parties' stipulation regarding entitlement to time loss. On review, the issues are claim classification, attorney fees, and clarification of a stipulation. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exception, supplementation, and summary. We do not adopt the ultimate findings of fact.

On May 22, 1997, claimant sustained a compensable injury when he fell from a ladder while at a height of about three feet. The claim was ultimately accepted as a nondisabling injury for the following conditions: a tiny avulsion fracture of the left wrist, abrasions to the right lower extremity and left elbow, left hip contusion, and low back strain. (Exs. 8, 13, 26, 28).

Claimant received treatment for these injuries from Dr. Weeks, M.D., who eventually referred him to Dr. Zirschky, orthopedist, who became his attending physician. (Exs. 6, 10, 11, 14, 17, 18). Dr. Johnson, chiropractor, also provided treatment for a period of time.

On November 7, 1997, claimant was examined by Drs. Wilson, neurologist, and Strum, orthopedist, on behalf of the insurer. They found claimant medically stationary and without objective evidence of permanent impairment as a result of his work injuries. (Ex. 27-6). Drs. Weeks and Zirschky concurred with Drs. Wilson's and Strum's report. (Exs. 29, 30). On January 7, 1998, the insurer "closed" claimant's claim. (Ex. 31).

Claimant requested the reclassification of his claim as a disabling injury. On May 7, 1998, the Department issued a Determination Order affirming the nondisabling claim status. (Ex. 33-3). Thereafter, claimant requested reconsideration and a medical arbiter examination.

On August 27, 1998, the medical arbiter, Dr. Neumann, orthopedist, examined claimant regarding the likelihood of permanent disability resulting from the accepted conditions as a result of the work injury. (Ex. 32-7). Dr. Neumann concluded that he did "not find evidence of the likelihood of permanent loss of function in the left wrist from [claimant's] avulsion fracture, or from the abrasions, which have healed." (*Id.*). Dr. Neumann opined that the accepted low back strain condition was not medically stationary and, in light of claimant's positive response to recent low back treatment, it was too early to assess permanent disability for that condition. (Ex. 32-6-7).

A September 25, 1998 Order on Reconsideration rescinded the Determination Order and reclassified claimant's claim as disabling. (Ex. 33). Based on a left hip range of motion finding in Dr. Neumann's report, the Appellate Reviewer found that the accepted left hip contusion condition resulted in residual impairment and concluded that there was a likelihood of impairment to at least the left hip. (Ex. 33-2). The insurer requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Stipulation

The ALJ stated that the "parties stipulate that claimant is not entitled to time loss because he left work for reasons not related to the compensable injury." Claimant objects to that summary of the parties' stipulation, contending that it is overbroad and could be interpreted to encompass entitlement to all possible future time loss. We agree.

The parties agreed that for the time period they were dealing with at hearing, claimant was not entitled to time loss. (Tr. 4). The stipulation did not deal with any future entitlement to time loss. Consequently, we modify the ALJ's summary of the parties' stipulation.

Claim Classification

In affirming the Order on Reconsideration, the ALJ relied on a left wrist range of motion measurement made by Drs. Wilson and Strum to conclude that claimant had established a reasonable likelihood of permanent impairment regarding the left wrist injury, although Drs. Wilson and Strum explicitly found claimant medically stationary and without objective evidence of permanent impairment as a result of his work injuries (and Drs. Weeks and Zirschky concurred with those findings). On review, the insurer argues that the record does not contain the requisite expert medical opinion to establish a reasonable expectation of permanent disability. We agree and reverse.

A "disabling compensable injury" entitles the worker to compensation for disability or death, whereas an injury is not disabling if no temporary disability benefits are due and payable, unless there is a reasonable expectation that permanent disability will result from the injury. ORS 656.005(7)(c). Here, because there is no dispute that claimant was not entitled to temporary disability benefits during the period in question, claimant's claim is disabling only if there is proof of a reasonable expectation of permanent disability. Claimant has the burden of proving that a claim is misclassified. *Normandeau v. Aetna Casualty & Surety Co.*, 120 Or App 184, 189 (1993). In addition, in construing ORS 656.005(7)(c) and determining whether a compensable injury is disabling, we require expert medical opinion indicating that a permanent disability award is likely or expected. *See, e.g., Thomas G. Dobson*, 50 Van Natta 2390 (1998); *Gerasimos Tsirimiagos*, 50 Van Natta 1627 (1998).

On September 6, 1997, Dr. Johnson, claimant's treating chiropractor, stated that, in addition to the left wrist fracture and the left hip contusion, claimant had sustained a lumbosacral joint sprain as a result of the work injury. (Ex. 24). Dr. Johnson stated that the lumbosacral joint sprain "should be accepted as disabling in that [claimant] exhibits reduced left hip ROM [range of motion] with flexion and external rotation as well as a diminished lumbosacral ROM as reflected in my chart notes." (*Id.*). We do not find Dr. Johnson's opinion persuasive evidence of a reasonable expectation of permanent disability. In this regard, Dr. Johnson does not address the issue of the likelihood of *permanent* disability, he merely relies on the fact that claimant demonstrated reduced range of motion during his current treatment. It does not necessarily follow that such impairment is reasonably expected to be permanent.

On November 7, 1997, claimant was examined by Drs. Wilson and Strum on behalf of the insurer. They found claimant medically stationary and without objective evidence of permanent impairment as a result of his work injuries. (Ex. 27-6). In December 1997, claimant's treating physicians, Drs. Weeks and Zirschky, concurred with Drs. Wilson's and Strum's report. (Exs. 29, 30).

In addition, Drs. Weeks and Zirschky did not later dispute their concurrence or provide any other opinion regarding the issue of the likelihood of permanent impairment. On May 12, 1998, claimant returned to Dr. Zirschky, who noted that he appeared to be developing some acetabular cysts in his left hip associated with his work injury. (Ex. 31A). Although Dr. Zirschky continued to treat claimant, his focus was on diagnosis and treatment, he gave no further opinion regarding the potential for permanent impairment. (Ex. 31D).

Finally, Dr. Neumann, medical arbiter, examined claimant on August 27, 1998. (Ex. 32). At that time, claimant had recently undergone a sacroiliac injection, which Dr. Neumann noted had relieved 90 percent of claimant's sacroiliac and left hip pain. (Ex. 32-2). Dr. Neumann was aware of the accepted conditions and opined that, in addition, claimant had a left-sided sacroiliac strain associated with the work injury. (Ex. 32-1, -6). He opined that all conditions were stationary, except the sacroiliac strain condition. (Ex. 32-6). When requested to give his "best estimate" of the likelihood of permanent disability as a result of the work injury, Dr. Neumann responded he did not find evidence of permanent disability in claimant's left wrist from the avulsion fracture, or from his abrasions, which had healed. (Ex. 32-7). Regarding the low back and sacroiliac conditions, he found that it was "too early to assess permanent loss in this area of injury, in light of [claimant's] recent treatment and positive response." (*Id.*).

Claimant argues that Dr. Neumann's findings establish the likelihood of permanent impairment. First, claimant notes that Dr. Neumann's range of motion measurements would result in a rating under the disability rating standards of 2.1 percent for the left hip and 1 percent for the left wrist. Claimant also notes that the Appellate Reviewer determined that the loss of range of motion in the left hip was due to the accepted hip contusion. Nevertheless, Dr. Neumann specifically found no find evidence of permanent disability in claimant's left wrist from the avulsion fracture, or from his abrasions, which he determined had healed. Regarding this discrepancy, claimant argues that the disability rating standards control over a doctor's opinion.[1] We disagree.

We addressed this argument in *Gerasimos Tsirimiagos*, 50 Van Natta at 1627. There, we rejected the ALJ's conclusion that a medical arbiter panel's valid findings of reduced range of motion under the disability rating standards were more persuasive than their conclusion that they anticipated no permanent disability due to the accepted conditions. We determined that expert medical opinion is required to determine whether there is a reasonable expectation of permanent disability resulting from the accepted injury. Citing *SAIF v. Danboise*, 147 Or App 550 (1997), we recognized that, in "extent" cases, if a treating doctor or medical arbiter makes impairment findings consistent with a claimant's compensable injury and does not attribute the impairment to causes other than the compensable injury, such findings may be construed as showing that the impairment is due to the compensable injury. But we found such reasoning did not apply to the present case, where the medical arbiter panel was not asked to determine whether claimant was medically stationary or to make impairment findings for the purpose of rating claimant's permanent disability due to the compensable injury; instead, they were specifically asked to provide their "best estimate of the likelihood of permanent loss of use or function of any of the accepted body parts as a result of this injury" for purposes of classifying claimant's claim.[2] Therefore, based on the medical arbiters' opinion, we found that the claimant failed to meet his burden of proof. *See also Thomas G. Dobson*, 50 Van Natta at 2392 (in the absence of medical evidence supporting a finding of a reasonable expectation of permanent disability resulting from an accepted knee injury, we declined to find that the claimant's compensable knee surgery itself satisfied claimant's burden of proof, although impairment due to knee surgery is rated under the disability rating standards).

The same reasoning applies here. Dr. Neumann was specifically asked to give his "best estimate of the likelihood of permanent loss of use or function of any of the accepted body parts as a result of this injury," and he responded that permanent disability was not likely regarding all conditions except the low back condition, for which it was too early to assess permanent impairment. (Ex. 32-7). In addition, Drs. Wilson, Strum, Weeks, and Zirschky found no evidence of permanent impairment due to the work injuries. (Exs. 27-6, 29, 30). Expert medical opinion is required to determine whether permanent impairment is reasonably expected to result from a work injury. We do not have the medical expertise to analyze the record and make what is essentially a medical judgment. *See SAIF v. Calder*, 157 Or App 224 (1998) (Board is not an agency with specialized medical expertise entitled to take official notice of technical facts within its specialized knowledge; rather, the findings must be based on medical evidence).

Finally, claimant argues that Dr. Neumann's statement that it was "too early to assess permanent loss" in the low back establishes that reclassification is required so that the impairment can be rated when all of the compensable conditions are medically stationary. We disagree.

Dr. Neumann specifically stated that it was too early to assess permanent impairment in the low back. That statement clearly does not mean that claimant is likely to have permanent impairment in his low back, especially since Dr. Neumann noted that recent medical treatment had significantly improved claimant's low back and left hip pain. *See Thomas G. Dobson*, 50 Van Natta at 2391-92 (where treating surgeon indicated that it was "undetermined" whether the work injury would cause permanent impairment, we found that claimant had not met his burden of proving a disabling injury).

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[1] Claimant makes the same argument regarding a wrist range of motion measurement made by Drs. Wilson and Strum. Specifically, claimant argues that the range of motion measurement results in a 1 percent impairment under the standards, notwithstanding the opinion of Drs. Wilson and Strum (as concurred with by Drs. Weeks and Zirschky) that claimant had no objective evidence of permanent impairment as a result of his work injuries. (Exs. 27-6, 29, 30).

[2] For the same reason, claimant's reliance on *Justeen L. Parker*, 49 Van Natta 334 (1997), is misplaced. The issue in *Parker* was extent of disability, not whether an injury should be classified as disabling. Thus, *Parker* is distinguishable.

Claimant has the burden of proving the nature and extent of disability. ORS 656.266. On this record, we are not persuaded that there is a reasonable expectation that permanent disability will result from the injury. *See* ORS 656.005(7)(c).

Attorney Fees

Because we find that claimant failed to meet his burden of proving a disabling injury, we reverse the ALJ's attorney fee award.

ORDER

The ALJ's order dated December 31, 1998 is reversed. The attorney fee award is also reversed.

April 30, 1999 Cite as 51 Van Natta 781 (1999)

In the Matter of the Compensation of
BERT VIECELI, Claimant
WCB Case No. 98-04454
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Davis' order that upheld the insurer's denial of claimant's current low back condition. The insurer also challenges the ALJ's ruling not to admit the medical arbiter's report. On review, the issues are evidence and compensability.

We adopt and affirm the ALJ's order[1] with the following supplementation addressing the insurer's evidentiary argument.

The insurer contends that the ALJ erred in not admitting the medical arbiter's report. According to the insurer, because the report issued shortly after the hearing, it was not available at the time of hearing. The insurer also asserts that the report is reasonably likely to affect the outcome because it "will help the Board see that claimant's ongoing low back complaints are not due to his accepted strain."

By affirming the ALJ's decision that claimant failed to prove the compensability of his current low back condition, we agree that the medical evidence is not sufficient to prove compensability. Consequently, we find that admission of the medical arbiter's report will not change the outcome of the hearing. Thus, we decline to resolve the ALJ's evidentiary ruling.

ORDER

The ALJ's order dated November 23, 1998 is affirmed.

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[1] We do not adopt the fifth full paragraph on page 3.

In the Matter of the Compensation of
DALE R. NICKERSON, Claimant
WCB Case No. 98-02615
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
Hitt, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Dan Hoskin (Hoskin), a noncomplying employer, requests review of Administrative Law Judge (ALJ) Stephen Brown's order that dismissed his request for hearing concerning the SAIF Corporation's acceptance of claimant's left knee injury claim on the basis that the hearing request was untimely. On review, the issue is jurisdiction. We affirm.

FINDINGS OF FACT

On March 5, 1997, claimant injured his left knee while working for Hoskin. On September 2, 1997, the Workers' Compensation Division issued a Proposed and Final Order finding Hoskin to be a noncomplying employer. (Ex. 5). On the same day, the Division referred claimant's claim to SAIF for processing, as required by *former* ORS 656.054. (Ex. 12). The bottom of the letter stated "cc: w/notice: Dan Hoskin," and "By copy of this letter, DAN HOSKIN is advised that a notice of rights on tinted paper has been enclosed with this letter." (*Id.*)

By Notice of Claim Acceptance dated October 30, 1997, SAIF notified claimant that it was accepting his claim for "left lateral meniscus tear." The bottom of the letter stated: "A copy of this acceptance notice has also been sent to: Dan Hoskin, NCE." (Ex. 13).

On January 19, 1998, Hoskin faxed an appeal to the Division, stating that he requested a hearing "for a claim that was made against me." The hearing request referred to the NCE order number. (Ex. 9).

On April 1, 1998, the Division forwarded the hearing request to the Board, requesting that it consolidate the hearing with the challenge to the order finding Hoskin to be an NCE.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that Hoskin had knowledge of claimant's claim on August 29, 1997. Therefore, the ALJ concluded that Hoskin's April 1, 1998 request for hearing on the compensability of claimant's claim was untimely and dismissed his request for hearing for lack of jurisdiction.[1] Alternatively, the ALJ concluded that, were he to reach the merits, he would not disturb SAIF's acceptance of the claim. We agree with the ALJ that the Board had no jurisdiction over Hoskin's request for hearing for the following reasons.

Assuming proper notice is given, a noncomplying employer has 90 days after the claim is referred to an assigned claims agent (here, SAIF) to request a hearing objecting to the claim. ORS 656.054(1);[2] 656.262(6)(a);[3] *Thomas R. Lee*, 46 Van Natta 69, 70 (1994) (reading ORS 656.054(1) and ORS 656.262(6)(a) together, a noncomplying employer has 90 days after the claim is referred to [the assigned claims agent] by the Director to request a hearing objecting to a claim).

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[1] The issue regarding claimant's noncomplying status was withdrawn at hearing. (Tr. 1).

[2] ORS 656.054(1) provides in relevant part:

"A compensable injury to a subject worker while in the employ of a noncomplying employer is compensable to the same extent as if the employer had complied with this chapter. The Director of the Department of Consumer and Business Services shall refer the claim for such an injury to an assigned claims agent within 60 days of the date the director has notice of the claim. At the time of the referral of the claim, the director shall notify the employer in writing regarding the referral of the claim and the employer's right to object to the claim. * * * At any time within which the claim may be accepted or denied as provided in ORS 656.262, the employer may request a hearing to object to the claim."

[3] ORS 656.262(6)(a) provides that, "[w]ritten notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the employer has notice or knowledge of the claim."

Assuming that the April 1, 1998 request for hearing was an objection to the compensability of the claim, it was not filed within 90 days of the September 2, 1997 referral of the claim to SAIF.[4] Under such circumstances, Hoskin's request for hearing is untimely. *See* ORS 656.054(1).

Claimant's attorney is entitled to an assessed fee for services on review. *See* ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, to be paid by SAIF on behalf of Hoskin. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 12, 1998 is affirmed. For services on review, claimant's counsel is awarded a fee of $1,000, to be paid by SAIF on behalf of Dan Hoskin.

[4] Claimant testified that he went to the SAIF offices in November 1997, at which time he was shown the Division's September 1997 Noncomplying Employer Order and its September 1997 claim referral letter to SAIF.

In the Matter of the Compensation of
GREGORY M. NEWELL, Claimant
WCB Case No. 98-07489
ORDER OF DISMISSAL
Popick & Merkel, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that affirmed an Order on Reconsideration that did not award any permanent disability. On review, the issue is extent of permanent disability. In his brief, claimant refers to another case before the Board, WCB Case No. 98-02430, which involves his request for review of another ALJ's order that upheld the SAIF Corporation's partial denial of his wrist injury claim. Claimant agrees to withdraw the appeal in this case, WCB Case No. 98-07489, if SAIF will stipulate that it will redetermine disability and process all benefits payable in the event the board sets aside the partial denial in WCB Case No. 98-02430.

In response, SAIF agrees that if the Board sets aside its April 17, 1998 partial denial, the claim would be reopened for processing pursuant to ORS 656.262(7)(c).[1] In light of such circumstances, we interpret SAIF's response as agreeing to claimant's proposal. Consequently, in accordance with claimant's proposal, and because we have affirmed the ALJ's order in WCB Case No. 98-02430 that upheld SAIF's partial denial of claimant's right wrist injury claim, we interpret his request to mean that he wishes to withdraw the appeal in this case (WCB Case No. 98-07489).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

[1] On March 12, 1999, we adopted and affirmed the ALJ's order in WCB Case No. 98-02430 that upheld SAIF's denial.

In the Matter of the Compensation of
ROSE GRAMENZ, Claimant
WCB Case No. 97-03216
ORDER ON REVIEW
Bryant, Emerson, et al, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's occupational disease claim for a mental disorder. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation.

The insurer argues that at least part of claimant's reactions were related to disappointment over not being chosen for a promotion and that this amounts to a condition that is generally inherent in all workplaces.

Claimant described meeting with her manager on her day off to discuss the manager's offer of a promotion. Claimant agreed to meet with the manager to discuss the promotion even though he had previously made offensive sexual remarks to her. During the meeting, the manager made sexual advances to claimant that claimant rebuffed. Claimant testified that, after the meeting, when another employee was given the promotion, claimant felt that the manager never intended to give her the promotion and suspected that his motive for offering the job to her was related to the harassment.

In light of these circumstances, we are persuaded that the cause of claimant's distress was the inappropriate and misleading behavior of the manager, rather than disappointment over not being chosen for the promotion. Thus, we disagree with the insurer's argument that part of claimant's stress was due to a statutorily excluded condition.

The insurer also argues that the delay of a month to six weeks between the stressful events at work and the date claimant first sought medical treatment makes it likely that the work events were not the cause of claimant's treatment. In the same vein, the insurer argues that Dr. Whitehead's failure to explain the delay in treatment renders her opinion less persuasive than that of Dr. Glass.

Although Dr. Glass opined that with an adjustment disorder diagnosis (the diagnosis made by Dr. Whitehead), the onset of symptoms and treatment usually occur soon after the stress, this is not always the case. (Ex. 8-13). Given Dr. Glass' statement that a delay between the stress and the treatment is not always inconsistent with the diagnosis of an adjustment disorder, we are not persuaded by the insurer that the delay renders Dr. Whitehead's opinion unpersuasive or establishes that claimant's condition was caused by something other than the work-related events.

The insurer points to claimant's conduct in meeting the manager to argue that there is no clear and convincing evidence that the mental condition arose out of claimant's employment.

Claimant testified that she was interested in moving into other parts of the store and was hoping the manager was serious about giving her the job. Consequently, she decided to "set that [the manager's prior remarks] aside" and meet him to discuss the job. While claimant's decision to meet with the manager, who had previously displayed offensive behavior, might have been ill-advised, we are not persuaded that claimant's conduct in agreeing to meet with the manager to discuss the promotion establishes that the manager's behavior was not the cause of claimant's condition.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 2, 1998 is affirmed. For services on Board review, claimant's attorney is awarded $1,000, payable by the insurer.

May 4, 1999 Cite as 51 Van Natta 785 (1999)

In the Matter of the Compensation of
KRIS KERN, Claimant
WCB Case No. 98-01537
ORDER ON RECONSIDERATION (REMANDING)
Hollander & Lebenbaum, Claimant Attorneys
Randy Rice, Defense Attorney

The insurer requests reconsideration of our April 9, 1999 Order on Review that reversed an Administrative Law Judge's (ALJ's) order that denied claimant's motion to postpone the hearing. We reasoned that claimant's absence from the hearing due to overseas military duty was a circumstance justifying postponement and remanded the case to the ALJ for further proceedings.

In our prior order, we found that the circumstances of claimant's absence from the hearing indicated that he was "temporarily working out of state and [] reasonably expected to return to the state within a time certain" (*i.e.*, after his two year military duty commitment). OAR 438-006-0081(2).[1] Accordingly, we concluded that claimant's overseas military duty was a circumstance justifying postponement under the rule. In reaching our conclusion, we specifically noted that the lack of communication between claimant and his attorney did *not* affect claimant's ability to attend the hearing or alter the circumstances justifying postponement.

The insurer argues that our order is inconsistent with *William H. Pauley*, 49 Van Natta 702 (1997), where we held that the claimant's failure to maintain contact with his attorney did not establish extraordinary circumstances beyond his control sufficient to justify postponement of the hearing or reopening of the record after the hearing. At the *Pauley* hearing, the claimant's attorney stated that he had not been in contact with the claimant for about two months. Later, with his post-hearing motion to reopen the record, the claimant averred that he was working out of state on the day of the scheduled hearing and he did not receive notice of the hearing until he spoke with his attorney about three weeks after the hearing convened. Finding no explanation for the claimant's failure to contact his attorney before the hearing (to determine the status of his hearing request or to take steps to ensure that he received his mail during this time period), we agreed with the ALJ that the claimant had not demonstrated "extraordinary circumstances beyond his control" justifying his postponement/reopening request.

Here, claimant was absent from the hearing because he had been assigned to military duty in the Middle East -- not because he failed to maintain contact with his attorney. *Pauley* is distinguishable on this basis. In other words, the postponement request is based on claimant's overseas military duty and *Pauley* is not controlling. Consequently, based on the reasoning set out in our initial order, we continue to find that postponement of the hearing in this case was appropriate under OAR 438-006-0081(2).

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[1] OAR 438-006-0081 provides, in relevant part:

"A scheduled hearing shall not be postponed except by order of an Administrative Law Judge upon a finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement. 'Extraordinary circumstances' shall not include:

"* * * * *

"(2) Unavailability of a party, witness (other than a medical expert witness) or representative due to nonemergency medical or dental appointment, occupational, personal or professional business or appointments, or unwillingness to appear, provided that a postponement may be granted if the unavailable person is a worker who is temporarily working out of state and is reasonably expected to return to the state within a time certain * * *"

Accordingly, we withdraw our April 9, 1999 order. On reconsideration, as supplemented herein, we adhere to and republish our April 9, 1999 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LEE R. PARKER, Claimant
Own Motion No. 94-0653M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Darris K. Rowell, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's May 26, 1998 Notice of Closure which closed his claim with an award of temporary disability compensation from May 11, 1995 through July 18, 1997. SAIF declared claimant medically stationary as of July 18, 1997. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed. Specifically, claimant contends that, because his physician recommended additional surgery for the compensable condition, his claim was prematurely closed. We affirm SAIF's Notice of Closure.

FINDINGS OF FACT

On April 26, 1968, claimant sustain a compensable injury to his right knee. SAIF subsequently accepted claimant's back condition as a compensable component in this claim. Claimant's aggravation rights expired on February 6, 1974.

On May 11, 1995, claimant underwent excision of the patella component of his right knee. On May 24, 1995, we issued an order reopening claimant's claim for the provision of temporary disability compensation. SAIF closed the claim on June 14, 1996.

Claimant appealed that closure, which we set aside the closure as premature. In doing so, we found that claimant's physician planned further treatment for claimant's back condition.

On June 26, 1997, Dr. Grewe, claimant's attending surgeon, opined that claimant was not medically stationary because of proposed L5-S1 refusion surgery. When the Managed Care Organization (MCO) declined to authorize the proposed surgery, Dr. Grewe requested Director's review. Pending Director resolution of the disputed surgery, Dr. Grewe concluded that if "[claimant] is ultimately denied surgical intervention, then I am unaware of any other specific new treatment options and therefore, he would be considered 'medically stationary'." Dr. Weintraub, claimant's orthopedic physician, declared claimant's knee condition medically stationary on July 18, 1997.

On May 1, 1998, the Medical Dispute Section issued an Administrative Order finding the proposed surgery to be inappropriate medical treatment. On May 28, 1998, SAIF closed the claim, declaring claimant medically stationary as of July 18, 1997. Claimant requested Board review of the claim closure.

On January 11, 1999, the Medical Review Unit issued a Proposed and Final Contested Case Hearing Order. In that order, the Workers' Compensation Division affirmed the Medical Dispute Section's Administrative Order that found the proposed L5-S1 surgery to be inappropriate medical treatment. That order was not appealed.

CONCLUSIONS OF LAW AND OPINION

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981).

The propriety of the closure turns on whether claimant was medically stationary at the time of the May 26, 1998 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

In determining whether a claim was properly closed, medical evidence that becomes available post-closure may be considered as long as it addresses claimant's condition at the time of closure, not subsequent changes in claimant's condition. *Scheuning v. J.R. Simplot & Co.*, 84 Or App 622 (1987). When a claimant's medically stationary status is contingent upon the claimant undergoing a recommended surgery, the claim is prematurely closed if the record establishes that the recommended surgery is reasonable and necessary for the claimant's compensable condition and it would materially improve claimant's compensable condition. *Bill H. Davis*, 47 Van Natta 219 (1995); *Richard Uhing*, 48 Van Natta 465 (1996).

Here, claimant contends that he was not medically stationary at the time SAIF closed his claim because Dr. Grewe proposed further surgery in the form of a refusion at L5-S1. As noted above, Dr. Grewe opined that if the proposed surgery was not approved, he had nothing further to offer claimant and, therefore, would consider claimant to be medically stationary.

The proposed surgery has subsequently been found to be inappropriate treatment for claimant's compensable condition. In the absence of the proposed surgery, Dr. Grewe has concluded that claimant's condition would be medically stationary. Likewise, Dr. Weintraub determined that claimant's knee condition was medically stationary on July 18, 1997.

Based on the uncontroverted medical evidence, we find that claimant's compensable conditions were medically stationary when his claim was closed on May 26, 1998. Therefore, we conclude that SAIF's closure was proper.

Accordingly, we affirm SAIF's May 26, 1998 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
DOUGLAS NIEMI, Claimant
WCB Case No. 98-02887
ORDER ON REMAND
James E. Dodge, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's April 8, 1999 order, we have been directed to consider the parties' settlement. The parties have submitted a proposed "Stipulation and Order" that is designed to resolve the attorney fee issue raised by the self-insured employer's petition for judicial review of the Board's December 10, 1998 order.

Pursuant to the stipulation, the parties agree that claimant's attorney "shall not be entitled to an attorney fee in relation to the employer's acceptance of the cervical disc herniation." Claimant further stipulates that the "attorney fee awarded by the Opinion and Order and Order on Review should be vacated." Finally, the stipulation provides that "this matter shall be dismissed."

We have approved the parties' stipulation, thereby fully and finally resolving the parties' dispute, in lieu of all prior orders. Accordingly, this matter is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
JESSE J. ANDREWS, Claimant
WCB Case No. 98-07603
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Mannix, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the insurer's denial of his left hand injury claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following modification and supplementation.

The ALJ upheld the insurer's denial of claimant's injury claim for a left hand contusion. In so doing, the ALJ concluded that claimant failed to sustain his burden of proving that he sustained a compensable left hand injury as a result of an incident at work in which he allegedly caught his hand between the fork of a lift truck and a wooden pallet. Among his findings, the ALJ determined that the claim was not supported by "objective findings" of injury. *See* ORS 656.005(7)(a); *John G. Gesner*, 49 Van Natta 2147, 2148 (1997).

The insurer concedes, and we find, however, that Dr. Mickel's report of his emergency room examination on the date of injury does contain an "objective" finding consisting of a "little bit of swelling" on the dorsal side of claimant's hand. (Exs. 2, 16); *See* ORS 656.005(19) ("'objective findings' does not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable."); *Tony D. Houck*, 48 Van Natta 2443 (1996).

Thus, we do not adopt that portion of the ALJ's order that found that the claim was not supported by "objective findings."[1] Having made this determination, we, nevertheless, agree with the ALJ's conclusion that claimant failed to prove a compensable injury.

Although Dr. Mickel agreed that the minor amount of swelling he observed was consistent with a pinching injury, he also indicated that he could not determine the causation of the swelling noted in his examination. (Ex. 16). Dr. Mickel noted that a pinching incident such as claimant reported would usually lead to bruising and discoloration, but that no discoloration was present. *Id.* Moreover, Dr. Mickel agreed that physical findings do not define the nature of the injury incident. *Id.*

Based on this evidence, we are not persuaded that the sole "objective finding" of swelling was causally related to an injury occurring in the course and scope of claimant's employment. Accordingly, we affirm.

ORDER

The ALJ's order dated January 11, 1999 is affirmed.

---

[1] Claimant contends that the employer never raised the issue of the lack of "objective findings" and, thus, that the ALJ erred in addressing the issue. We need not decide whether claimant is correct given that the employer concedes, and we find, that the claim was supported by an observable "objective" finding consisting of swelling.

In the Matter of the Compensation of
TEENA M. HEADDING, Claimant
WCB Case No. 98-07794
ORDER ON REVIEW
Susan L. Frank, Claimant Attorney
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Menashe's order that increased claimant's scheduled permanent disability award to 5 percent (7.5 degrees) for loss of use or function of both forearms, whereas an Order on Reconsideration awarded no permanent disability. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

In July 1997, claimant, a production worker, sought treatment for numbness and tingling in her hands. The insurer accepted her claim for bilateral carpal tunnel syndrome.

On April 16, 1996, claimant's attending physician, Dr. Nolan, reported that claimant was "healed" following her carpal tunnel release surgery and that she could return to work without restriction. He indicated that claimant had reduced grip strength, but he described the finding as non-physiological and unrelated to her carpal tunnel releases. Dr. Nolan also reported that claimant was medically stationary and without measurable permanent impairment. (Ex. 28).

Based on Dr. Nolan's report, the claim was closed by way of a May 11, 1998 Notice of Closure, which awarded temporary disability only. (Ex. 41) Claimant requested reconsideration and a medical arbiter examination.

On September 2, 1998, claimant was evaluated by a medical arbiter panel consisting of Drs. MacD. Watson, Laycoe and Staver. They found, among other things, that claimant had normal muscle strength, sensation and wrist range of motion. The panel also reported as follows:

> "The letter [from the Appellate Review Unit] also asked whether there is significant limitation in the ability to repetitively use the hand relative to a diagnosed chronic and permanent medical condition. The answer to this is affirmative, in the sense that she developed carpal tunnel compression symptoms associated with bilateral hand activity of employment." (Ex. 52-3).

A September 30, 1998 Order on Reconsideration affirmed the Notice of Closure in all respects, finding no persuasive evidence of any wrist impairment or any significant limitation on claimant's ability to repetitively use her hands. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Based on the arbiter's comments, the ALJ concluded that claimant had established a chronic condition in her forearms. On review, the insurer argues that the arbiter's report does not indicate that claimant presently has any difficulty or significant limitation in the repetitive use of her hands, and therefore, on this record, claimant is not entitled to any chronic condition award. We agree with the insurer.

Claimant has the burden of proving the extent of her permanent disability. ORS 656.266. OAR 436-035-0010 provides, in relevant part, as follows:

> "A worker is entitled to a 5% scheduled chronic condition impairment value for each applicable body part, stated in this section, when a preponderance of medical opinion establishes that, due to a chronic and permanent medical condition, the worker is significantly limited in the repetitive use of one or more of the following four body parts:
>
> "* * * * *

"(c) Forearm (below elbow/hand/wrist)[.]"

In reconsidering the Notice of Closure and declining to award a chronic condition value under OAR 437-035-0010(5), the Appellate Reviewer determined that the arbiters' affirmative answer to the chronic condition inquiry did not address claimant's current symptomology or findings. The Appellate Reviewer reasoned that the arbiters' remark related more to the development of claimant's condition than her status at closure. We agree with this assessment. We find nothing in the arbiters' report to persuade us that claimant remains "significantly limited" in the ability to repetitively use her forearms as a result of her compensable condition.

Indeed, although the arbiters' comments may imply that claimant's carpal tunnel compression symptoms could recur if she returns to hand intensive work, this prediction, without more, cannot sustain the chronic condition award. *See Rena L. Rose*, 49 Van Natta 2007 (1997) (holding that a restriction on repetitive use to prevent reinjury or an increase in symptoms does not constitute persuasive evidence of a chronic condition impairment); *see also David A. Kamp*, 46 Van Natta 389, 390 (1994); *Rae L. Holzapfel*, 45 Van Natta 1748 (1993) *aff'd mem Holzapfel v. M. Duane Rawlins, Inc.*, 127 Or App 208 (1994). Consequently, in the absence of any persuasive evidence that claimant is significantly limited in the repetitive use of her forearms, the chronic condition awards cannot stand.[1]

ORDER

The ALJ's order dated January 27, 1999 is reversed. In lieu of the ALJ's award, the Order on Reconsideration is reinstated and affirmed in its entirety. The ALJ's "out-of-compensation" attorney fee is also reversed.

[1] As noted above, claimant's attending physician indicated that claimant had healed and had no measurable permanent impairment as a result of the carpal tunnel releases.

May 7, 1999 Cite as 51 Van Natta 790 (1999)

In the Matter of the Compensation of
BRENT L. BUNDY, Claimant
Own Motion No. 99-0153M
OWN MOTION ORDER
Bruce W. Brewer, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer has submitted a request for temporary disability compensation for claimant's compensable disc herniation L5-S1 condition. Claimant's aggravation rights expired on February 8, 1999. The insurer opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *Blakely v. SAIF*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work *and* is seeking work; or (3) not working but willing to work, *and* is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

The insurer contends that claimant was not in the work force at the time of the current disability. Claimant has not responded to the insurer's contention.[1] Claimant has the burden of proof on this issue and must provide evidence, such as copies of paycheck stubs, income tax forms, unemployment compensation records, a list of employers where claimant looked for work and dates of contact, a letter from the prospective employer, or a letter from a doctor stating that a work search would be futile because of claimant's compensable condition for the period in question.

Accordingly, claimant's request for temporary disability compensation is denied. *See id.* We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

Claimant's entitlement to medical expenses pursuant to ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

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[1] The insurer contends that claimant was not in the work force due to a noncompensable motor vehicle accident. Claimant has not submitted proof to rebut the insurer's representation.

In the Matter of the Compensation of
ANDREW HUSSEY, Claimant
WCB Case No. 98-03579
ORDER ON RECONSIDERATION
Bischoff, Strooband & Ousey, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

The insurer requests reconsideration of our April 8, 1999 Order on Review that set aside its denial of claimant's occupational disease claim for left leg infrapatellar tendinitis. The insurer asserts that our order incorrectly indicated that the insurer had argued claimant was not credible.

After our reconsideration, we make the following clarification. We change the second paragraph of the "Compensability" section on page 2 of our order to read:

> "The insurer argues that the ALJ ignored the primary issue raised by the denial. The insurer asserts that the ALJ did not comment on the fact that claimant never told the employer that his work activities were causing his knee pain, and had actually told the employer his knee pain was caused by an old injury."

After considering the insurer's remaining arguments, we have nothing further to add to our prior order.

Accordingly, our April 8, 1999 order is withdrawn. On reconsideration, as supplemented herein, we republish our April 8, 1999 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES R. DUFF, Claimant
WCB Case No. 98-04963
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that: (1) affirmed an Order on Reconsideration that awarded no unscheduled permanent disability for claimant's head injury; and (2) declined to remand claimant's claim to the Director for promulgation of a temporary rule amending the standards for rating disability. On review, the issues are unscheduled permanent disability and remand.

We adopt and affirm the ALJ's order with the following supplementation.

The ALJ declined to award unscheduled permanent disability for claimant's head injury under OAR 436-035-0390(10), finding that claimant had failed to sustain his burden of proving that he suffered permanent impairment due to the compensable injury. The ALJ also rejected claimant's alternative argument that the claim should be remanded to the Director for promulgation of a temporary rule to address claimant's permanent disability. The ALJ reasoned that, even assuming he had authority to do as claimant requested, it was not necessary to do so because claimant had failed to prove that he suffered permanent impairment.

On review, claimant argues that he is entitled to an award of permanent disability under OAR 436-035-0390(10) and that, alternatively, the case should be remanded for promulgation of a temporary rule pursuant to OAR 436-035-0500.

We agree with the ALJ's reasons for finding that claimant is not entitled to an award of unscheduled permanent disability under OAR 436-035-0390(10). Moreover, we reject claimant's alternative request for remand.

ORS 656.726(3)(f)(C) provides that, during reconsideration before the Director, when "it is found that the worker's disability is not addressed by the standards," the Director must stay the proceeding and "adopt temporary rules amending the standards to accommodate the worker's impairment." The Board may remand a claim to the Director for promulgation of a temporary rule when a disability is not addressed by the existing standards. *Gallino v. Pontiac-Buick-GMC*, 124 Or App 538, 541-42 (1993). Claimant has the burden of proving that his disability is not addressed by the standards. *See* ORS 656.266; *Robert W. Wilmot*, 48 Van Natta 1525, 1526 (1996); *Terry J.Hockett*, 48 Van Natta 1297, 1298 (1996).

Here, the Director expressly found that claimant's disability is addressed by the applicable standards. (Ex. 21-3). Moreover, while we agree with the ALJ that claimant does not qualify for an award of permanent disability under OAR 436-035-0390(10), that rule does address claimant's alleged disability. Consequently, we do not find that claimant has proven that his disability is not addressed in the standards. *See Robert W. Wilmot*, 48 Van Natta at1526; *Terry J. Hockett*, 48 Van Natta at 1298. Therefore, we find that the ALJ properly declined to remand this matter to the Director to adopt a temporary rule.

ORDER

The ALJ's order dated December 18, 1998 is affirmed.

In the Matter of the Compensation of
KELLEIGH R. DUNCAN, Claimant
WCB Case No. 97-09013
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Brazeau's order that affirmed an Order on Reconsideration that awarded 3 percent (4.5 degrees) scheduled permanent disability for loss of use or function of claimant's right arm (wrist and elbow), 13 percent (19.5 degrees) scheduled permanent disability for loss of use or function of claimant's left leg (knee), and 36 percent (115.2 degrees) unscheduled permanent disability for claimant's cervical and right shoulder conditions. The insurer argues that the ALJ erred in declining to admit Exhibits 1-43, 45-52, 63, 65, 67, 70, 76, 78, and 81.[1] On review, the issues are evidence and extent of permanent disability, scheduled and unscheduled. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

On April 7 and 9, 1998, the insurer submitted 81 documents to the ALJ for inclusion in the record. On June 10 and June 23, 1998, the insurer and claimant notified the ALJ of their agreement to submit the case on the documentary record. Claimant informed the ALJ that he was not willing to submit written closing arguments. On June 26, 1998, the ALJ acknowledged the parties' agreement to submit the matter on the record and scheduled closing arguments. The parties and the ALJ exchanged additional correspondence. On July 21, 1998, claimant reminded the ALJ that he had not agreed to submit written arguments. The insurer timely submitted written closing arguments on July 23, 1998. Then, on September 3, 1998, the ALJ heard oral closing arguments. During those arguments, claimant objected to admission of proposed Exhibits 1-43, 45-52, 63, 65, 67, 70, 76, 78, and 81 (because they were not included in the reconsideration record).

On September 18, 1998, the ALJ granted claimant's motion to exclude the disputed documents. He reasoned that claimant's objection was timely raised at the "beginning" of closing arguments and that amounted to raising it at the beginning of the "hearing."[2] The ALJ then concluded the disputed exhibits should be excluded because they were not part of the reconsideration record. We disagree.

We have previously interpreted the presentation of the record to be the "hearing," where the parties elect to present their case based solely on the documentary record. *See Cindy M. Penturf*, 50 Van Natta 1718, 1720, n. 3 (1998). We have also held that an issue or evidentiary objection raised for the first time during closing arguments is untimely in such cases (as it would be in cases where hearings convened). *See Bruce A. Waggoner*, 50 Van Natta 2175, 2176 (1998); *Cindy M. Penturf*, 50 Van Natta at 1720; *see also Fister v. South Hills Health Care*, 149 Or App 214 (1997), *rev den* 326 Or 389 (1998) (where evidence was admitted at hearing, the employer's post-hearing "ORS 656.283(7) objection" was untimely).

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[1] Proposed Exhibits 1-33 are medical reports and chartnotes from October 1984 to the middle of October 1989; 34, 35 and 38 are 1993 "827" and "801" forms; 36, 37 and 39 are 1993 medical reports; 40 is a letter from the insurer to Dr. Dunn; 41 and 42 are medical records from December 1993 and January 1994; 43 is a hospital billing statement; 45-52 are medical reports from June 1996 into October 1996; 63 is the insurer's December 29, 1996 acceptance notice; 65, 70 and 76 are 1997 medical reports and chartnotes by Dr. Dunn; 67 is a letter from claimant's counsel to the insurer; 78 is the insurer's August 1997 updated notice of acceptance; and 81 is a 1998 chartnote by Dr. Dunn.

[2] We note that the proposed exhibit packet was disclosed and submitted 5 months before claimant's closing argument objection. During this time, there was no dispute about the parties' agreement to submit the matter on the documentary evidence. Moreover, the insurer complied with the ALJ's schedule for written closing arguments and submitted its argument *before* claimant objected to the disputed documents. Considering these events, we cannot say that claimant raised her evidentiary objection at the "beginning of the hearing."

Here, claimant did not raise her evidentiary objection until closing arguments. Under these circumstances, the ALJ should not have granted the untimely objection and excluded evidence based on the untimely motion. *See id.* Accordingly, we treat the disputed documents as if they were admitted, as proposed and submitted by the insurer.

Permanent Disability

A June 10, 1997 Notice of Closure closed claimant's October 11, 1996 injury claim with temporary, but not permanent, disability. Claimant requested reconsideration. Dr. Neumann performed a medical arbiter's examination on September 19, 1997. Based on the arbiter's examination, an October 10, 1997 Order on Reconsideration awarded 3 percent scheduled permanent disability for claimant's right arm (elbow and wrist), 13 percent scheduled permanent disability for claimant's left leg (knee), and 36 percent unscheduled permanent disability for claimant's cervical and right shoulder conditions. The employer requested a hearing.

The ALJ affirmed claimant's permanent disability awards, based on the medical arbiter's report. He found that the arbiter persuasively assessed the various causes of claimant's impairment and noted that the arbiter's examination was conducted closest to reconsideration. The ALJ considered the arbiter's report to be "exceptionally complete," stating that the arbiter "took into account any and all prior medical records." We rely on the medical arbiter's findings with regard to some but not all of claimant's impairment.

Claimant was medically stationary on May 6, 1997 and her October 11, 1996 injury claim was closed on June 10, 1997. Accordingly, we apply the rules in WCD Admin. Order 96-051 (effective February 16, 1996) and 96-072 (effective February 15, 1997) in evaluating claimant's permanent disability.

Scheduled Permanent Disability

The ALJ affirmed reconsideration awards of scheduled permanent disability for loss of use or function of claimant's right arm and left leg, based on the medical arbiter's impairment findings regarding claimant's left knee and right wrist and elbow.

Where a medical arbiter is used, impairment is determined by the arbiter except where a preponderance of medical opinion, from the attending physician or other physicians with whom the attending physician concurs, establishes a different level of impairment. ORS 656.245(2)(b)(B) and 656.268(7); OAR 436-035-0007(13); *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670 (1994).

Here, Dr. Dunn, treating physician, made no impairment findings regarding claimant's left knee or right hand, wrist, or elbow. Therefore, we may only rate claimant's scheduled permanent disability for loss of use or function of these body parts based on the medical arbiter's report and findings. *See Snyder v. Barrett Business Services, Inc.*, 147 Or App 619, 625 (1997) (Board erred in relying on treating doctor's opinion which did not address the condition to be rated, because it was not an "evaluation of impairment * * * that was 'different' from and could be weighed against the arbiter's evaluation.")

The arbiter took "valid" measurements of claimant's bilateral elbow and wrist and bilateral knee range of motion. Although he found no "unrelated causes" contributing to claimant's elbow or wrist "conditions," he related claimant's bilateral knee "limitation" to obesity. (*See* Ex. 79-8). On this evidence, we conclude that claimant is not entitled to a scheduled permanent disability award for loss of use or function of her left knee, because her left knee impairment is not injury-related. However, based on the arbiter's report, we agree with the ALJ that claimant is entitled to a 3 percent scheduled permanent disability award for loss of use or function of her right arm.

Unscheduled Permanent Disability

The ALJ affirmed the reconsideration order's unscheduled permanent disability awards for claimant's right shoulder and neck conditions, based on the medical arbiter's report. The insurer argues that the medical arbiter's report is not persuasive evidence of injury-related unscheduled permanent disability. Specifically, the insurer contends that the arbiter's medical history was incomplete because

claimant inaccurately denied prior neck injuries at his examination and the arbiter did not consider the fact that emotional problems contribute to claimant's disability.[3]

Claimant did deny prior neck or shoulder problems at the medical arbiter's examination. (Ex. 79-2). And the record indicates that claimant *did* have neck problems. (*See* Exs. 38, 40, 64). On the other hand, Dr. Dunn was aware that claimant had prior neck injuries and he nonetheless concurred with a report concluding that *no* preexisting conditions contributed to claimant's injury-related permanent disability. (Exs. 64-6-7, 65).

We acknowledge that Dr. Dunn opined that claimant's emotional/ psychological/social problems may have prolonged her recovery. (Exs. 62, 66-2, 68-1, *see* Ex. 73). But Dr. Dunn agreed that there were no preexisting conditions contributing to claimant's permanent disability. And the medical arbiter did not relate claimant's unscheduled impairment to causes other than the work injury. Accordingly, based on *both* doctors' reports, we find that claimant has established injury-related unscheduled permanent impairment.

We rely on the medical arbiter's unscheduled impairment findings, because a preponderance of the relevant medical evidence does not establish a different level of impairment. *See* ORS 656.245(2)(b)(B) and 656.268(7); OAR 436-035-0007(13); *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670 (1994); *Snyder v. Barrett Business Services, Inc.*, 147 Or App at 625. And, based on the medical arbiter's findings, we agree with the ALJ that the Order on Reconsideration properly rated claimant's unscheduled impairment.

We acknowledge the insurer's argument that claimant's adaptability factor should be "1" because she was medically limited to light work before and after her October 11, 1996 work injury. But the adaptability factor in this case depends on a comparison between the jobs performed before and after the injury. While it is true that claimant had medically imposed work restrictions when she fell at work on October 11, 1996, the standards require a comparison of "before and after" *jobs*, based on the appropriate DOT job descriptions and strength ratings --not on temporary medical restrictions. *See* OAR 436-035-0310(4). Here, claimant's pre-injury work was "heavy," with a base functional capacity of "5"; her post-injury work is restricted to "light," with a residual functional capacity of "1"; and the Order on Reconsideration therefore properly determined her adaptability value as "5." *See* OAR 436-035-0310(3)-(7). Accordingly, because we agree with the ALJ that the Order on Reconsideration properly evaluated claimant's unscheduled permanent disability, we affirm that portion of the order and adopt the reconsideration order's unscheduled findings and conclusions as our own.

Attorney Fees

The ALJ awarded a $2,500 attorney fee under ORS 656.382(2) for claimant's counsel's services in prevailing against the insurer's request for hearing. Pursuant to our order, claimant's scheduled permanent disability award is reduced. Therefore, claimant is entitled to attorney fees under the statute for successfully defending his unscheduled permanent disability award, but not his scheduled award, at the hearings level. *Roseburg Forest Products v. Boqua*, 147 Or App 197 (1997). Accordingly, after considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at the hearings level regarding the unscheduled permanent disability issue is $1,800, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may have gone uncompensated.

Claimant's attorney is also entitled to an assessed fee for services on review in successfully defending the unscheduled permanent disability award. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the unscheduled permanent disability issue is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

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[3] The insurer also contends that the arbiter attributed some of claimant's symptoms to unaccepted right elbow lateral epicondylitis and right shoulder impingement syndrome conditions. However, considering the arbiter's report as a whole, we are not persuaded that the arbiter's "impressions," or suspected diagnoses, suggest that he evaluated conditions other than the accepted conditions.

ORDER

The ALJ's order dated October 26, 1998, as reconsidered November 13, 1998, is reversed in part and affirmed in part. That portion of the order that affirmed the reconsideration order's 13 percent (19.5 degrees) scheduled permanent disability for loss of use or function of claimant's left leg (knee) is reversed. In lieu of the ALJ's $2,500 attorney fee, claimant is awarded an $1,800 attorney fee for services at the hearings level, payable by the insurer. The remainder of the ALJ's order is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the insurer.

In the Matter of the Compensation of
RANDY JOHNSON-TAYLOR, Claimant
Own Motion No. 99-0169M
OWN MOTION ORDER

The self-insured employer has submitted claimant's request for temporary disability compensation for claimant's compensable left knee condition. Claimant's aggravation rights expired on March 18, 1997. The employer recommends that we authorize the payment of temporary disability compensation.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

We are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, we authorize the reopening of the claim to provide temporary total disability compensation beginning April 14, 1999, the date claimant was hospitalized for the proposed surgery.[1] When claimant is medically stationary, the employer shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[1] Pursuant to a June 18, 1996 Claim Disposition Agreement (CDA), claimant released certain enumerated "non-medical service" benefits related to his January 1991 claim. The CDA expressly provides that claimant retained his right to "temporary disability benefits that would be payable in relation to an Own Motion reopening of his claim, pursuant to ORS 656.278, for any compensable Own Motion aggravation that occurs after March 19, 1997." Inasmuch as the current Own Motion claim satisfies the exclusion described in the CDA, claimant is entitled to temporary disability compensation under ORS 656.278.

In the Matter of the Compensation of
HILARIO C. GARCIA, Claimant
WCB Case No. 98-03144
ORDER ON REVIEW
Max Rae, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Livesley's order that affirmed an Order on Reconsideration awarding no unscheduled permanent disability. Claimant also contests a prehearing ruling denying claimant's motions to cross-examine the medical arbiter and testify at hearing. On review, the issues are constitutionality and extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for low back contusion and strain. A Notice of Closure awarded no permanent disability. After claimant's examination with the medical arbiter panel, the Order on Reconsideration also found that claimant was not entitled to permanent disability.

Constitutionality

Before the hearing, claimant requested the opportunities to testify at hearing and depose the medical arbiter. An ALJ (different from the ALJ who issued the order) denied those motions. On review, claimant reiterates his argument that he was denied his constitutional rights under the 14th Amendment of the United States Constitution and Article I, section 10 of the Oregon Constitution and asserts that the case should be remanded to allow him to testify and cross-examine the medical arbiter.

We find no merit to claimant's constitutional arguments. *Koskela v. Willamette Industries, Inc.*, 159 Or App 229 (1999) (the administrative review and hearing structure of ORS 656.283(7), which prohibits the admission of evidence at hearing that was not submitted during the reconsideration proceeding, did not violate the claimant's right to due process of law under the 14th Amendment to the U.S. Constitution); *Rogue Valley Medical Center v. McClearen*, 152 Or App 239 (1998) (under ORS 656.283(7), any evidence not submitted during the reconsideration process is inadmissible at a subsequent hearing, including the claimant's testimony).

Having found no constitutional error, there is compelling reason to remand. *See Compton v. Weyerhaeuser*, 301 Or 641, 646 (1986).

Extent of Unscheduled Permanent Disability

Claimant continues to assert that he proved impairment due to his compensable condition and, thus, is entitled to an award of unscheduled permanent disability.

In determining impairment under the standards, we may rely on the findings of the attending physician at the time of closure, and the subsequent findings of the medical arbiter. ORS 656.245(2)(b)(B), 656.268(7)(a), 656.268(7)(b); OAR 436-035-0007(12), (13). Where the findings of the arbiter and the treating physician differ, we defer to the medical arbiter unless a preponderance of the evidence establishes a different level of impairment. In other words, we do not automatically defer to a medical arbiter's opinion but rely on the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. *E.g., Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

Claimant's treating physician, Dr. Buza, indicated that claimant "suffered no permanent impairment due to his January 10, 1997 low back injury." (Ex. 37-1).

In addressing the percentage of impairment due to the accepted condition, the medical arbiter panel reported that "our physical examination is very non-objective, with no objective physical findings, and a significant amount of pain behavior and subjective complaints not substantiated by objective findings." (Ex. 43-5). The panel also found that claimant's range of motion findings were "invalid." (*Id.*). The panel noted that "there is the possibility that there are psychological factors or functional overlay, which are retarding his recovery, and contributing to his subjective complaints." (*Id.*)

We agree with the ALJ that claimant failed to prove impairment due to his accepted condition. First, the treating physician found no permanent impairment. Although the medical arbiter panel found limited range of motion, it also indicated that such findings were invalid and, furthermore, that claimant had no objective findings.[1] Thus, we conclude that claimant failed to show entitlement to unscheduled permanent disability.

ORDER

The ALJ's order dated December 28, 1998 is affirmed.

[1] In light of the panel's report that range of motion findings are "invalid," we also agree with the ALJ that the panel's indication of a "possibility" of functional overlay does not prove any impairment due to the accepted condition.

In the Matter of the Compensation of
ROSEMARY J. HYNEMAN, Claimant
WCB Case No. 98-05281
ORDER ON REVIEW
Westmoreland & Mundorff, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that affirmed an Order on Reconsideration that awarded no unscheduled permanent disability for claimant's low back condition. On review, the issue is extent of unscheduled permanent disability.

We adopt and affirm the ALJ's order. *See Margo A. Readye, Jr.*, 50 Van Natta 177 (1998) (the standards may not be applied "loosely or by analogy," because they are specific and precise) (*citing Terry W. Prater*, 43 Van Natta 1288, 1291 (1991)).

ORDER

The ALJ's order dated December 7, 1998 is affirmed.

In the Matter of the Compensation of
RYAN T. LePAGE, Claimant
WCB Case Nos. 98-03638 & 98-02233
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the self-insured employer's denial of claimant's aggravation claim for left foot condition. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings."

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for left foot anterior tibialis tendonitis. The ALJ found that claimant failed to prove an actual worsening and, thus, did not carry his burden of showing a compensable aggravation. Claimant challenges this conclusion, asserting that his treating physician's opinion was sufficient to prove a compensable aggravation.

Claimant's treating physician, Dr. Sampson, was the only physician to provide an opinion concerning causation. He first concurred with a letter from the claims processor stating that claimant "returned [for treatment] with worsening of his symptoms after working extended hours" and "the increase in his work activity [was] the cause of his condition worsening and need for treatment." (Ex. 12).

Dr. Sampson then concurred with a report stating that claimant's "left foot condition is the same condition" as his accepted claim and "the major contributing cause for [claimant's] need for disability and/or medical treatment is due to his previous [accepted] claim." (Ex. 15A).

Dr. Sampson next concurred with a report from the employer's attorney explaining that claimant's "left foot condition has been fluctuating symptomatically according to his level of activity, but the underlying condition has not changed at all." (Ex. 16). The report further stated that claimant "has not developed any new injuries, conditions or pathological changes in the left foot" and he "continues to experience the same, intermittent left foot pain and related symptoms according to his level of activity." (*Id.*)

Finally, Dr. Sampson was deposed, where he explained that, when claimant sought treatment for increased left foot symptoms, he had "continued waxing and waning of the symptoms he had from before * * * only it got worse." (Ex. 17-6). He also stated that "waxing and waning of symptoms, I would say that's not a pathological change, that is just kind of coming and going." (*Id.* at 9). According to Dr. Sampson, when claimant's symptoms increased, inflammation increased, resulting in actual structural change. (*Id.* at 9-10).

ORS 656.273(1) entitles an injured worker to "additional compensation for worsened conditions resulting from the original injury." A worsened condition is established by medical evidence of an "actual worsening" of the compensable condition supported by objective findings. An "actual worsening" is proven with direct medical evidence that a condition has pathologically worsened. *SAIF v. Walker*, 145 Or App 294, 305 (1996); *Intel Corporation v. Renfro*, 155 Or App 447, 451 (1998).

Here, Dr. Sampson consistently characterized claimant's "worsened" condition as a waxing and waning of symptoms and not a pathological worsening. Thus, we consider claimant's condition as only symptomatically worsened and not pathologically worsened. Based on such medical evidence, we agree with the ALJ that claimant did not prove an "actual worsening."

ORDER

The ALJ's order dated October 30, 1998 is affirmed.

In the Matter of the Compensation of
ANA M. MARTINEZ, Claimant
WCB Case No. 98-01006
ORDER ON RECONSIDERATION
Charles L. Lisle, Claimant Attorney
Gilroy Law Firm, Defense Attorneys

On April 15, 1999, the Board withdrew its March 18, 1999 Order on Review which affirmed an Administrative Law Judge's (ALJ's) order that: (1) upheld the self-insured employer's denial of claimant's injury claim for a cervical condition; and (2) declined to award penalties for the employer's allegedly unreasonable denials of claimant's cervical and thoracic injury claims. This action was taken to consider claimant's requests for reconsideration and remand for admission of "post-hearing" medical evidence. Having received the employer's response, we now proceed with our reconsideration.

In its initial order of March 18, 1999, the Board adopted an ALJ's order (with exceptions) that upheld the employer's denial of claimant's cervical injury claim. Claimant argues that we should rely on the opinions of Drs. Long, Berkeley, and Scheiber and conclude that the claim is compensable. For the following reasons, we disagree.

As explained in the Board's initial order,[1] the medical evidence is insufficient to establish that the claimed September 13, 1997 work incident was the major contributing cause of claimant's cervical condition or her disability and/or need for treatment therefore. Considering claimant's well-documented and long-standing preexisting cervical degeneration, (*see e.g.*, Exs. 73-5, 96-1, 100-2), we continue to find the medical evidence supporting the claim unpersuasive because it does not consider or evaluate the preexisting condition. Accordingly, we adhere to the reasoning and conclusion set out in the Board's prior order. We proceed to consider claimant's alternative motion to remand.

With her motion, claimant submits the following documents: a December 1998 medical report (8 pages), a January 14, 1999 chartnote (1 page), a February 3, 1999 operative report (4 pages), and a March 11, 1999 post-operative chartnote (1 page)--all authored by Dr. Grewe, and radiology reports by Drs. Urman, Veverka, and Greene (5 pages). We consider the proposed evidence only for the purpose of determining whether remand is appropriate.

Under ORS 656.295(5), we may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. *Bailey v. SAIF*, 296 Or 41, 45 n 3 (1983). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of the case; and (3) is reasonably likely to affect the outcome. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986).

Here, we find that the "post-hearing" evidence submitted on reconsideration would not likely affect the outcome because it does not address causation or evaluate the relative causal contributions of claimant's noncompensable preexisting cervical degeneration and the September 1997 work incident. Under these circumstances, we find no compelling basis for remanding and we conclude that the case has not been improperly, incompletely, or otherwise insufficiently developed without the additional evidence. Consequently, remand is not appropriate.

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[1] As we have previously explained, by adopting and affirming an ALJ's order, we have found the order sufficient for appellate review. The facts and conclusions set forth in an adopted ALJ's order also express the Board's opinion of the case. *See, e.g., Sherri L. Williams*, 51 Van Natta 75, 76 (1999); *see also* ORS 656.295(6) (Board may affirm, reverse, modify or supplement the ALJ's order and make such disposition of the case as it determines to be appropriate).

In this case, the ALJ's opinion was adopted, including his reasoning regarding medical causation, with three exceptions. Claimant argues that our exceptions from the ALJ's order strengthen her case. Be that as it may, we continue to find the medical evidence supporting the claim insufficient to carry claimant's burden because Drs. Scheiber, Berkeley, and Long did not mention (or weigh) the nature and extent of claimant's preexisting cervical degeneration in reaching their causation opinions.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish the Board's March 18, 1999 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

May 11, 1999 Cite as 51 Van Natta 801 (1999)

In the Matter of the Compensation of
MICHAEL A. PETERSON, Claimant
WCB Case No. 98-04301
ORDER ON REVIEW
G. Joseph Gorciak III, Claimant Attorney
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the insurer's denial of claimant's occupational disease claim for a mental disorder. On review, the issue is compensability.

We adopt and affirm the ALJ's order except for the next-to-last sentence, with the following supplementation regarding the expert evidence.

Dr. Griffin, treating psychiatrist, diagnosed mood and obsessive-compulsive disorders and prescribed medication about a month before the May 1998 work incidents. After the work incidents, Dr. Griffin diagnosed post traumatic stress disorder (PTSD), stating that claimant's symptoms and complaints after the work incidents were not consistent with his prior "mood disorder" diagnosis. On this basis, Dr. Griffin opined that "there was not a formal combining of the two diagnosed conditions." (Ex. 18-2; *see* Ex. 20-2). We understand the *two* diagnoses discussed to be mood disorder and PTSD. Thus, in our view, Dr. Griffin did not consider or rule out claimant's previously diagnosed obsessive compulsive disorder as a potential contributor once he diagnosed PTSD. And Dr. Griffin did not otherwise explain how or why claimant's preexisting diagnoses became less significant in May 1998. Under these circumstances, we do not find Dr. Griffin's causation opinion particularly persuasive.

Dr. Glass, examining psychiatrist, and Mr. Bryan, consulting psychologist, evaluated claimant's current condition in light of his preexisting diagnoses and related his current condition to undisputed preexisting personality traits and problems, rather than his work. (Exs. 16-17-18, 17-7-9, 19-3-5). In our view, these opinions are more thorough than Dr. Griffin's opinion, because they consider both of claimant's preexisting diagnoses, rather than just his mood disorder. Accordingly, because we find Griffin's and Bryan's opinions well-reasoned and based on complete and accurate histories, we conclude that claimant has not established by clear and convincing evidence that work is the major contributing cause of his condition. *See* ORS 656.802(3)(d). *See also SAIF v. Brown*, 159 Or App 440 (1999).

ORDER

The ALJ's order dated January 15, 1999 is affirmed.

In the Matter of the Compensation of
DOYCE G. PRINCE, Claimant
WCB Case Nos. 98-01443 & 97-09627
ORDER ON REVIEW
Flaxel & Nylander, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Brazeau's order that: (1) set aside its denial of claimant's "new injury" claim for a left wrist condition; and (2) set aside its denial of a consequential condition claim for a left wrist condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation.

The ALJ found that claimant, a meat department manager, sustained a "new injury" to his left wrist in December 1996 while attempting to retrieve a 25-pound package of hot dogs in a meat locker. In doing so, the ALJ rejected the employer's argument that the claim was made in retaliation for the employer's termination of claimant's employment a short time after the alleged incident. Specifically, the ALJ found claimant to be a credible witness based both on his demeanor and on the substance of his testimony.

During his testimony, claimant noted that a meat wrapper, Beth Shade, was present at the time of the alleged incident in December 1996. (Tr. 13). Ms. Shade, however, was not presented as a witness by either claimant or the employer. The employer contends that claimant's failure to call the witness should be construed against him.

We acknowledge that there have been instances where we have viewed a claimant's testimony with distrust when there was a failure to call a corroborating witness. *E.g., Narciso Renteria*, 49 Van Natta 2176, 2177 n. 2 (1997) (because the claimant's injury was unwitnessed and because there was testimony contradicting portions of the claimant's testimony, it was crucial for the claimant to call the corroborating witness). However, we are not inclined to do so in this case because, as claimant notes, there was no testimony presented that contradicted his account of how the December 1996 injury allegedly occurred. *See Joseph M. Stransky*, 51 Van Natta 143, 144 (1999) (given the absence of testimony contradicting the claimant's testimony, his failure to call a potentially corroborating witness was not fatal to the claim). Moreover, based on our review of the record, we agree with the ALJ's stated reasons for setting aside the employer's denial. Accordingly, we affirm.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated December 4, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the employer.

In the Matter of the Compensation of
ANNE E. SMITH, Claimant
WCB Case No. 98-07225
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Martha J. Brown's order that set aside its denial of claimant's injury claim for a cervical condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation.

Analyzing the claim under ORS 656.005(7)(a)(B), the ALJ determined that claimant had satisfied her burden of proving that a June 1998 injury at work was the major contributing cause of her disability and need for treatment for the "combined condition." Thus, the ALJ set aside the insurer's denial.

On review, in addition to contesting the ALJ's interpretation of the medical evidence, the insurer contends that the ALJ should have analyzed the claim as one for an occupational disease. We disagree.

In determining the appropriate standard for analyzing compensability, we focus on whether claimant's cervical condition occurred as an "event," as distinct from an ongoing condition or state of the body, and whether the onset was sudden or gradual. *Mathel v. Josephine County*, 319 Or 235, 240(1994); *James v. SAIF*, 290 Or 343, 348 (1981); *Valtinson v.SAIF*, 56 Or App 184, 187 (1982). The phrase "sudden in onset" refers to an injury occurring during a short, discrete period, rather than over a long period of time. *Donald Drake Co. v. Lundmark*, 63 Or App 261, 266 (1983), *rev den* 296 Or 350 (1984).

In this case, claimant testified that she experienced a severe onset of symptoms in mid-June 1998 as a result of working 3 ten-hour shifts. (Trs. 7, 9, 19). That history is supported elsewhere in the record. (Exs. 8, 9, 31-2, 35-1). Because claimant's symptoms were sudden in onset and occurred over a discrete, identifiable period of time, we conclude that the claim should be analyzed as one for an accidental injury.

Moreover, we agree with the ALJ's reasons for finding claimant's injury claim compensable. Accordingly, we find that the ALJ properly set aside the insurer's denial.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 30, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
SALVADOR T. CERVANTES, Claimant
WCB Case No. 98-06125
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Wallace Klor & Mann, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) set aside its denial of bicipital tendinitis, right shoulder impingement syndrome, chest wall strain, thoracic strain and left shoulder strain; and (2) assessed a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties. We reverse.

FINDINGS OF FACT

Claimant injured his left arm at work on March 12, 1992 when he was struck by a piece of wood. On August 10, 1992, claimant sought treatment for pain in both hands and arms which had been present for the previous year and a half. Claimant underwent bilateral carpal tunnel releases. In November 1993, claimant sought treatment at a hospital emergency room for chronic complaints of joint pains, stiffness in the morning, swelling of the hands, numbness and tingling in the left arm and shoulder, neck pains, low back pains, fatigue and poor sleep. The physician's impression was "chronic musculoskeletal pains consistent with fibromyalgia." In February 1994, claimant saw Dr. Becker, who suspected possible thoracic outlet type symptomatology.

On February 26, 1997, claimant sought treatment for low back pain after falling off a scaffold. Claimant filed a claim which was accepted for low back strain. On August 1, 1997, claimant fell from the roof of a house through the skylight. Claimant sought treatment on August 14, 1997. The emergency room doctor reported that claimant had landed on his hands and his knee and was sore all over for up to a week. Claimant's right shoulder pain persisted and was worse. Following the injury, claimant was treated by Dr. Gulick and he continued to have soreness in the muscles adjacent to the right shoulder.

In November 1997, claimant was referred by Dr. Gulick to Dr. Nonweiler, who diagnosed right shoulder strain with possible rotator cuff tendinitis. The insurer accepted the claim for right shoulder strain. In December 1997, claimant underwent an MRI of the right shoulder which was normal. On December 12, 1997, Dr. Nonweiler diagnosed "right shoulder pain -- etiology still uncertain." In February 1998, Dr. Nonweiler referred claimant to Dr. Moore. Dr. Moore diagnosed right shoulder pain and possible bicipital tendinitis. On March 17, 1998, Dr. Moore diagnosed bicipital tendinitis, resolving and chronic pain behavior. The doctor also noted that although claimant asserted that he had significant disability, there were no objective findings to support the level of disability that claimant claimed.

Claimant was evaluated by Dr. Stringham in March 1998. Dr. Stringham diagnosed cervical strain, thoracic strain, anterior chest wall strain and bilateral shoulder strain. On April 1, 1998, Dr. Stringham diagnosed "possible reactivation of fibromyalgia."

Claimant was examined by Dr. Duff, on behalf of the insurer. Dr. Duff diagnosed neck and right shoulder strains. Dr. Duff opined that claimant did not have bicipital tendinitis, but rather had a generalized strain of the entire right shoulder girdle.

On July 28, 1998, the insurer amended its acceptance to accept right shoulder strain and cervical strain. On the same day, the insurer partially denied bicipital tendinitis, right shoulder impingement syndrome, chest wall strain, thoracic strain and left shoulder strain.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the insurer's denial and assessed a penalty pursuant to ORS 656.262(11), finding that the denial was unreasonable. On review, the insurer argues that its denial should be upheld and that no penalty should be assessed. Claimant argues that, based on Dr. Stringham's opinion, the ALJ's order setting aside the denial of the conditions should be affirmed.

After reviewing the record, we are not persuaded by the opinion of Dr. Stringham. Dr. Stringham did not examine claimant until more than 7 months after the injury. His diagnoses of chest wall strain, thoracic strain and left shoulder strain are not supported by the contemporaneous medical

records which indicated that after approximately a week, claimant's problems were confined to the right shoulder.[1] Additionally, although Dr. Stringham suspected that claimant had reactivated a preexisting fibromyalgia condition, Dr. Stringham did not discuss the contribution from this preexisting condition to the other diagnoses he attributed to the injury.

We rely instead on the opinion of Dr. Moore. Dr. Moore's opinion that claimant had a right shoulder strain due to the injury, is consistent with the medical record and the focus of the treatment that claimant received. Moreover, Dr. Moore's opinion is based on complete information and is well-reasoned. Thus, we find it persuasive. *See Somers v. SAIF*, 77 Or App 259 (1986) (where medical experts disagree, we rely on those opinions that are both well reasoned and based on complete information). Dr. Moore opined that claimant had multiple pain complaints which cannot be substantiated by objective findings. Dr. Moore further opined that claimant's August 1997 injury was not the major or a material contributing cause of a thoracic strain, anterior chest wall strain, rotator cuff tendinitis, or cervical strain and that these diagnoses were not substantiated by Dr. Moore's exams or a review of claimant's records. In addition, Dr. Moore's opinion is generally supported by that of Dr. Duff, although Dr. Duff diagnosed a cervical strain in addition to a right shoulder strain.[2]

We likewise find that insurer's denial was appropriate with respect to the condition of bicipital tendinitis. We note that Dr. Moore diagnosed only "possible" bicipital tendinitis. When asked, Dr. Moore indicated that claimant's only diagnosis due to the injury was a right shoulder strain. Under such circumstances, we conclude that claimant did not have bicipital tendinitis.[3]

With regard to an impingement syndrome, Dr. Nonweiler has indicated that the impingement syndrome diagnosis was a "provisional" diagnosis due to claimant's lack of significant, symptomatic relief from his impingement test. Based on this evidence, we are not persuaded that claimant has an impingement syndrome that is caused by the injury. Accordingly, we find that the insurer's denial should be upheld.

In light of our decision to uphold the denial, we reverse the ALJ's assessment of a penalty.

ORDER

The ALJ's order dated November 17, 1998 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award and penalty assessment are also reversed.

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[1] Although the record indicates muscle soreness adjacent to the right shoulder, there was no diagnosis of a strain in the contemporaneous medical records other than a right shoulder strain.

[2] Unlike the ALJ, we are not persuaded that the fact that the insurer decided to accept cervical strain (a condition not identified by Dr. Moore), renders Dr. Moore's opinion unpersuasive.

[3] To the extent that the ALJ found that the insurer's denial of bicipital tendinitis was not an appropriate response to claimant's request for modification of its acceptance, we disagree. *See Teresa Kersey-Sherbina*, 49 Van Natta 563, *on recon* 49 Van Natta 639 (1997) (denial is a legally permissible response under ORS 656.262(6)(d) to a claimant's "objection" to a Notice of Acceptance).

In the Matter of the Compensation of
DORIS A. MOE (PACE), Claimant
Own Motion No. 99-0037M
OWN MOTION ORDER ON RECONSIDERATION
Whitehead & Klosterman, Claimant Attorneys
Fidelity & Casualty of NY, Insurance Carrier

Claimant seeks Board authorization of an approved fee for her attorney's services culminating in our April 30, 1999 Own Motion Order. We received the retainer agreement submitted by claimant's attorney. An amount of 25 percent of the increased temporary disability compensation is awarded under this order, not to exceed $1,050, payable by the carrier directly to claimant's attorney. *See* OAR 438-015-0080.

Accordingly, our April 30, 1999 order is abated and withdrawn. On reconsideration, as amended herein, we adhere to and republish our April 30, 1999 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
AMMER A. ALEXANDER, Claimant
Own Motion No. 66-0063M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

On December 2, 1993, we issued an Own Motion Order, which authorized the reopening of claimant's December 3, 1954 neck injury claim with the SAIF Corporation for the ongoing provision of Home Care Supplemental Allowance. When claimant's condition became medically stationary, SAIF was directed to close the claim.

On March 31, 1999, the SAIF Corporation submitted claimant's request for additonal medical benefits relating to his claim. SAIF recommended reopening of this claim under our own motion authority to provide medical care for his compensable injury. In addition, SAIF recommended that the claim remain open until medical services are no longer required.

Inasmuch as claimant sustained a compensable industrial injury prior to January 1, 1966, he does not have a lifetime right to medical benefits pursuant to ORS 656.245. *William A. Newell*, 35 Van Natta 629 (1983). However, the Board has been granted own motion authority to authorize medical services for compensable injuries occurring before January 1, 1966. *See* ORS 656.278(1).

As previously noted, pursuant to our December 2, 1993 order, claimant's claim is currently open for the provision of a monthly Home Care Supplemental Allowance *per diem*. Inasmuch as claimant's condition has not become medically stationary since that reopening, SAIF has not reclosed the claim. Nonetheless, claimant's condition requires medical services that were not previously authorized; *i.e.*, he needs to be placed in a facility that will provide him full-time care and medical services. Under such circumstances, we treat SAIF's present request to reopen claimant's claim for the provision of housing at an assisted living residence as a request for reconsideration of our prior order that approved a Home Care Supplemental Allowance.

In extraordinary circumstances, we may, on our own motion, reconsider a prior order. OAR 438-012-0065(2). Under the facts of this case (*i.e.*, a claimant's need for different medical services under a previously reopened "pre-1966" injury claim), we find that extraordinary circumstances exist that justify reconsideration of our prior order. Therefore, we withdraw our prior order and issue the following order in its place.

After conducting a review of the record, we conclude that the provision of a monthly Home Care Supplemental Allowance is no longer appropriate. Therefore our previous authorization of these medical services is terminated, effective this date.

However, we further find that the requested medical care in the form of housing in an assisted living residence is appropriate treatment for claimant's current condition. Consequently, we authorize the payment of those medical services, effective the date claimant was, or is, admitted to an assisted living residence.

Finally, the claim shall remain reopened to provide medical services that are found to be reasonable and necessary and causally related to the compensable injury. Authorization for these medical services shall continue on an ongoing basis for an indefinite period of time, until there is a material change in treatment or other circumstances. After those services are provided, SAIF shall close the claim pursuant to OAR 438-012-0055.

Accordingly, on reconsideration, as supplemented and modified herein, we republish our December 2, 1993 order. The parties' rights of appeal and reconsideration shall begin to run from the date of this order.

IT IS SO ORDERED.

May 13, 1999 Cite as 51 Van Natta 807 (1999)

In the Matter of the Compensation of
LAURENCE R. AITES, Claimant
WCB Case Nos. 98-03990 & 97-03364
ORDER ON REVIEW
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Garaventa's order that: (1) upheld the SAIF Corporation's denials of his claim for a low back injury; (2) upheld SAIF's denial of a myofascial pain syndrome condition; (3) upheld SAIF's denial of claimant's aggravation claim; (4) upheld SAIF's denial of claimant's current cervical and thoracic condition; and (5) declined to assess penalties or attorney fees for an allegedly unreasonable denial. With his briefs, claimant submits copies of several documents. We treat such a submission as a motion to remand. On review, the issues are compensability, aggravation, remand and penalties and attorney fees.

We adopt and affirm the ALJ's order with the following supplementation.

Claimant submits copies of several documents with his brief. We treat this submission as a motion for remand to the ALJ for further development of the hearings record. *Judy A. Britton*, 37 Van Natta 1262 (1985). Our review is limited to the record developed at hearing. ORS 656.295(5). However, we may remand to the ALJ should we find that the hearings record has been "improperly, incompletely or otherwise insufficiently developed." *Id.* Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

With his briefs, claimant submitted documents numbered 81 to 95A. Claimant also submitted two other documents with his reply brief. The documents numbered 81 through 91 and the documents submitted with the reply brief are dated prior to the August 18, 1998 hearing. There has been no showing that these documents were not obtainable with due diligence at the time of the hearing. The remaining documents consist primarily of medical reports/letters from Drs. Adams, Morris and Balter. The record already contains reports from these physicians. Thus, the post-hearing reports are cumulative. Additionally, we are not persuaded that similar reports from these physicians could not have been obtained with due diligence at the time of hearing. In any case, none of the post-hearing documents are reasonably likely to affect the outcome of this case.

Accordingly, for all of these reasons, we deny claimant's motion for remand.

Claimant seeks an attorney fee. Because claimant has not prevailed over any of SAIF's denials, no attorney fee can be awarded under ORS 656.386(1).[1]

ORDER

The ALJ's order dated September 17, 1998 is affirmed.

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[1] In addition, even if claimant had prevailed, he could not receive an attorney fee for representing himself on review. *See Stanley W. Talley*, 38 Van Natta 1553, 1554 (1986) (a claimant who appears *pro se* is not entitled to an attorney fee).

In the Matter of the Compensation of
AMADOR R. GALLARDO, Claimant
WCB Case No. 98-05579
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Peterson's order that: (1) found that the issue of the Department's suspension of claimant's disability benefits should not be considered because it was not timely raised; (2) concluded that the Hearing's Division did not have jurisdiction over the propriety of the Department's suspension of benefits; and (3) affirmed an Order on Reconsideration that declined to award unscheduled permanent partial disability for claimant's neck and back injury. On review, the issues are evidence/remand, scope of review, jurisdiction, suspension of disability benefits and extent of unscheduled permanent partial disability (PPD). We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the findings in the "Findings of Facts" and "Ultimate Findings of Facts" sections of the ALJ's order. We also adopt the findings presented in the first four sentences of the "Conclusions of Law and Opinion" section of the ALJ's order. We make the following additional findings.

Claimant's July 8, 1998 request for hearing did not include any annotation regarding the Department's suspension of claimant's disability benefits.

Prior to the scheduled hearing, the parties moved to submit the extent issue on the record with written closing arguments, and the ALJ granted the motion.

CONCLUSIONS OF LAW AND OPINION

Evidence. The employer objects to documentary evidence included and discussed in claimant's "reply brief" that is not part of the hearing record. Our review must be based on the record certified to us. *See* ORS 656.295(5). Thus, to the extent claimant's brief includes or discusses evidence not in the record, we treat it as a motion to remand to the ALJ for the taking of additional evidence. We may remand if we find that the record has been insufficiently developed, and if the evidence claimant seeks to admit was not obtainable with due diligence at the time of the hearing. *Id. See also Compton v. Weyerhaeuser Co.*, 301 Or 641 (1986). Here, we find that the new material included and discussed in claimant's "reply brief" was obtainable at the time of the hearing. Consequently, we deny claimant's motion to remand, and we do not consider this new material in reaching our decision in this case.

Scope of Review/Jurisdiction/Suspension of Disability Benefits. Based on the following rationale, we affirm the ALJ's decision not to address the suspension of benefits issue because it was not timely raised. We offer no opinion regarding the ALJ's alternative jurisdictional ruling.

We will not consider an issue raised for the first time during closing argument. *Lawrence E. Millsap*, 46 Van Natta 2112, 2112-13 (1995). Where the parties elect to present their case based on the written record, we consider it appropriate to interpret the presentation of that record as the "hearing"; and we will not consider an issue raised for the first time in closing argument where, as here, an in-person hearing is not held and the matter is presented on the documentary record. *Mark A. Klouda*, 51 Van Natta 265 (1999); *Cindy M. Penturf*, 50 Van Natta 1718 (1998). In this way, the closing arguments (whether written or oral) will be treated in the same consistent manner, regardless of whether an "in-person" hearing was convened. *Id.* Consequently, we affirm the ALJ's decision not to address the suspension of claimant's disability benefits because the issue was first raised by claimant in his written closing argument at hearing.

Unscheduled PPD. We adopt and affirm the ALJ's conclusion and rationale on the unscheduled PPD issue.

ORDER

The ALJ's order dated December 18, 1998 is affirmed.

May 13, 1999 Cite as 51 Van Natta 809 (1999)

In the Matter of the Compensation of
HILDA GARCIA, Claimant
WCB Case No. 98-04305
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that upheld the self-insured employer's denial of her injury claim for a cervical condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation.

The ALJ upheld the employer's denial of a "cervical condition with right facial, right arm and right leg numbness." (Ex. 23). In doing so, the ALJ found unpersuasive the medical opinion of Dr. Long, a physical medicine and rehabilitation specialist, who opined that claimant's right-sided numbness was a symptom of a cervical disc injury sustained during her compensable October 5, 1995 injury. (Ex. 28-9).

On review, claimant contends that Dr. Long's opinion is persuasive and that the opinion of an examining physician, Dr. Rosenbaum, also supports Dr. Long's opinion that claimant sustained a compensable cervical injury. We disagree with claimant's contentions.

First, we agree with the ALJ's reasons for finding Dr. Long's opinion insufficient to satisfy claimant's burden of proof. Second, Dr. Rosenbaum opined that claimant did not have evidence of a neurological injury in her cervical spine. (Ex. 25-6). Moreover, Dr. Rosenbaum stated that the "minor" changes on claimant's cervical MRI scan were not significant enough to indicate trauma and could not explain claimant's right-sided paresthesia. *Id.* Dr. Rosenbaum concluded: "I can not explain [claimant's] paresthesia on the basis of a specific neurologic injury related to her fall." *Id.*

Accordingly, based on our *de novo* review the record, we conclude that the medical evidence is insufficient to establish a compensable cervical disc injury as asserted by Dr. Long. Thus, we affirm.

ORDER

The ALJ's order dated January 14, 1999 is affirmed.

In the Matter of the Compensation of
KOFFE L. HARRAL, Claimant
Own Motion No. 97-0389M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Malagon, Moore, et al., Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests review of the insurer's January 11, 1999 Notice of Closure, as amended January 15, 1999, which closed his claim with an award of temporary disability compensation from September 4, 1997 through July 1, 1998. The insurer declared claimant medically stationary as of July 1, 1998. Claimant requests review of the insurer's closure, contending that the insurer had not furnished documentation supporting its contention that claimant was medically stationary on July 1, 1998.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981).

The propriety of the claim closure turns on whether claimant was medically stationary at the time of the January 11, 1999 Notice of Closure, as amended January 15, 1999, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

In a March 15, 1999 letter, we requested that the insurer submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. The insurer submitted its response on March 26, 1999, however, no further response has been received from claimant. Therefore, we will proceed with our review.

Typically, there are only two issues to be raised when a claimant requests review of an insurer's claim closure. The most common issue raised is that the claimant was not medically stationary at claim closure. A second issued raised less often, is that, although medically stationary at claim closure, the claimant asserts entitlement to additional temporary disability compensation during the time the claim was open.

Here, claimant requested review because the insurer had not provided documentation supporting its medically stationary date. We interpret claimant's request for review as a challenge to the "closure" and timeloss awarded. The evidence in the record supports the conclusion that claimant was medically stationary at the time of closure and temporary disability compensation was appropriately terminated.

Dr. Walton, claimant's attending physician, supports the insurer's contention that claimant was medically stationary at the time it closed his claim. In his June 3, 1998 letter, Dr. Walton opined that claimant was "ready to be established as medically stationary." In October 1998, Dr. Walton opined that claimant was medically stationary as of July 1, 1998 because "[claimant] would have maximized the ACL injury." These opinions are unrebutted.

Based on the uncontroverted medical evidence, we find that claimant was medically stationary on July 1, 1998. Inasmuch as temporary disability was paid through July 1, 1998 and because the claim was closed on January 11, 1999, we conclude that claimant is not entitled to additional temporary disability and that the insurer's claim closure was proper.

Accordingly, we affirm the insurer's January 11, 1999 Notice of Closure, as amended on January 15, 1999, in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
JASPER OSBORN, Deceased, Claimant
WCB Case No. 97-04717
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant[1] requests review of Administrative Law Judge (ALJ) Herman's order that upheld the insurer's denial of an occupational disease claim for pancreatic cancer. In its brief, the insurer argues that the ALJ erred by admitting Exhibits 59 and 60. On review, the issues are evidence and compensability.

We adopt and affirm the ALJ's order with the following supplementation.

Evidence

The insurer contends that the ALJ erred by admitting Exhibits 59 and 60.[2] Citing ORS 656.310(2), the insurer argues that Exhibit 59, a report from Dr. Schecter, is inadmissible because it was authored by an out-of-state physician who was neither an examining nor a treating physician. The insurer also asserts that Exhibit 60 is inadmissible because it is a concurrence with an inadmissible report.

We need not address the insurer's evidentiary argument because, even if we disregard Exhibits 59 and 60, it would not affect the outcome of this case. Therefore, we decline to consider whether the ALJ abused her discretion by admitting Exhibits 59 and 60. *See Mario F. Torres*, 49 Van Natta 2074 (1997); *Jose L. Duran*, 47 Van Natta 449 (1995).

Compensability

We adopt and affirm the ALJ's reasoning and conclusion on the compensability issue.

ORDER

The ALJ's order dated December 17, 1998 is affirmed.

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[1] Claimant is deceased and represented in these proceedings by his beneficiary. For ease of reference, however, we shall use the word "claimant" rather than "claimant's beneficiary" in our order.

[2] Claimant objects to the employer raising the evidence issue on the basis that it did not cross-request review. It is well-settled that a non-appealing party may raise additional issues in its respondent's brief, and we are authorized to address those issues, provided that the formal request for review has not been withdrawn. *Eder v. Pilcher Construction*, 89 Or App 425 (1988). Here, because claimant did not withdraw the request for review and the ALJ decided the evidence issues, we may consider the insurer's arguments.

In the Matter of the Compensation of
DONNA J. STANWOOD, Claimant
WCB Case Nos. 98-02024 & 97-06372
ORDER ON REVIEW
Edward J. Harri, Claimant Attorneys
Randy Rice, Defense Attorneys
Kryger, et al, Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that awarded a $4,000 attorney fee for claimant's counsel's services at hearing. SAIF also moves for remand. On review, the issues are remand and attorney fees.

We deny SAIF's request for remand, and adopt and affirm the ALJ's order with the following supplementation.

Claimant requested a hearing regarding the denial of her current low back condition. The ALJ set aside SAIF's denial and awarded claimant's attorney an assessed fee of $4,000 for services at hearing, "based on the factors set forth in OAR 438-015-0010(4)."

On review, SAIF argues that the ALJ erred in failing to apply each of the factors in OAR 438-015-0010(4) and in failing to draw conclusions from those facts in awarding an assessed attorney fee. SAIF requests that we remand the case to the ALJ to "properly" apply OAR 438-015-0010(4). Contrary to SAIF's contention, an ALJ is not required to make specific findings for each rule-based factor, where, as here, there is no specific attorney fee requested and the parties did not submit arguments at hearing addressing the factors to be weighed in determining a reasonable fee. *Daryl L. Underwood*, 50 Van Natta 2330 (1998). An ALJ satisfies his or her obligation to make findings in a case by including in the order a brief description or citation to the rule-based factor or factors the ALJ relied on in determining the attorney fee awarded. *Id.* (*citing McCarthy v. Oregon Freeze Dry*, 327 Or 84, *adhered to on recon* 327 Or 185 (1998)).

Here, although the ALJ cited the applicable rule (OAR 438-015-0010(4)), she did not identify the factors she considered in awarding the attorney fee. In other words, the ALJ did not discuss any of the specific rule-based factors, such as the value of the interest involved, the time devoted to the case, the complexity of the issue, the benefit secured, the skill of the attorneys, the nature of the proceedings or the risk that the claimant's counsel's efforts might go uncompensated. Because the ALJ's order is devoid of any explanation of her application of the factors in determining the attorney fee in this case, we find the ALJ's reasoning insufficient to determine how she arrived at $4,000 as a reasonable fee. *Compare Weyerhaeuser Co. v. Fillmore*, 98 Or App 567 (1989) (Board not required to make finding as to each factor; however Board's explanation must be detailed enough to establish reasonable basis for its decision); *see also Leslie D. Custer*, 51 Van Natta 390 (1999) (in absence of a specific request or objection, ALJ's particular consideration of certain enumerated factors satisfies the *Underwood* rationale); *William J. Kephart*, 51 Van Natta 291 (1999) (the ALJ applied the proper standard in determining a reasonable fee where he specifically indicated that the assessed fee was based upon the factors set forth in OAR 438-015-0010(4) *and* identified the factors considered, *i.e.*, the time devoted to the case, the complexity of the issue, the value of the interest and benefit to claimant and risk that counsel may go uncompensated).

Even though we find the ALJ's attorney fee discussion lacking in this case, we do not find the record to be improperly, incompletely or otherwise insufficiently developed. *See* ORS 656.295(5). In other words, because we are authorized to modify or supplement the ALJ's findings and conclusions under ORS 656.295(6), it is not necessary to remand this case to the ALJ for supplementation of findings regarding the attorney fee award. Consequently, we deny SAIF's motion to remand.

We provide the following additional reasoning concerning the attorney fee award for claimant's counsel's services at hearing. A hearing convened that lasted approximately one and one-half hours. Claimant was the only witness to testify. The record consists of 54 exhibits, 12 of which were submitted by claimant. Based on "current condition" disputes generally litigated before this forum, we find the

issues presented in this case of average complexity. The value of the interest involved and the benefit secured for claimant are material, because SAIF has been directed to accept claimant's current low back condition, which includes medical services (including the 1996 low back surgery) and potential time loss related to the surgery.[1] The attorneys involved in this matter are skilled litigators with substantial experience in workers' compensation law. Furthermore, there was a risk that claimant's counsel might go uncompensated, given Dr. Dickenson's and Dr. Fuller's opinions that claimant's current condition was unrelated to her prior injuries at either employer.

Consequently, after considering the factors set forth in OAR 438-015-0010(4), including the time expended by claimant's counsel (as represented by the record at hearing), the complexity of the issue, the value of the interest involved, the skill of the litigators, and the risk that claimant's counsel might go uncompensated, we agree with the ALJ that $4,000 is a reasonable fee for claimant's counsel's services at hearing. We therefore affirm the ALJ's attorney fee award.[2]

ORDER

The ALJ's order dated November 23, 1998, as reconsidered December 11, 1998, is affirmed.

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[1] Claimant's claim has been in own motion status since May 1993; therefore, no additional permanent partial disability may be awarded. *See* ORS 656.278(1)(a).

[2] Because SAIF challenged only the attorney fee award on review and attorney fees are not "compensation" for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for her counsel's services on review. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

In the Matter of the Compensation of
LARRY A. RICKER, Claimant
WCB Case Nos. 98-05902 & 98-05450
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Herman's order that set aside its denial of compensability of and responsibility for claimant's occupational disease claim for a bilateral carpal tunnel syndrome (CTS) condition. Claimant cross-requests review of that portion of the ALJ's order that upheld Reliance National Indemnity Company's (Reliance's) partial denial of claimant's claim for C7-T1 disc pathology. On review, the issues are compensability and responsibility.

We adopt and affirm the ALJ's order with the following correction. Claimant's compensable cervical condition with Reliance is not limited to C5-7 but also includes C4-5. (Tr. 5, Exs. 15, 18, 36).

Claimant's attorney is entitled to an assessed fee for services on review regarding claimant's bilateral CTS condition. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,400, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the bilateral CTS condition issue (as represented by claimant's attorney's statement of services and respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated October 26, 1998 is affirmed. For services on review regarding the bilateral CTS condition, claimant's attorney is awarded $1,400, payable by the SAIF Corporation.

In the Matter of the Compensation of
ALBERT D. AVERY, Claimant
WCB Case No. 98-07247
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
David L. Runner (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that directed it to accept claimant's "dementia" condition. On review, the issue is claim processing.

We adopt and affirm the ALJ's order with the following modification and supplementation.

Claimant was compensably injured on June 19, 1993 when he was caught on a cart and dragged into a dehumidifier oven. The claim was accepted by SAIF for burns. Subsequently, claimant began to complain of memory loss that he believed was related to the injury and filed a claim for that condition. SAIF denied the claim and claimant requested a hearing arguing that SAIF had "de facto" denied a brain injury. A prior ALJ set aside SAIF's denial, finding that the parties were litigating compensability of claimant's dementia condition. SAIF requested Board review of the prior ALJ's order and the Board affirmed. *Albert D. Avery*, 49 Van Natta 1771 (1997). SAIF requested reconsideration of the Board's order, submitting new evidence, and the Board denied reconsideration. *Albert D. Avery*, 50 Van Natta 849 (1998). SAIF filed a petition for judicial review of the Board's order and the case is currently pending before the court.

SAIF began to process the claim pending the appeal. It submitted a request for a Determination Order to the Department seeking closure of the claim. The Department issued a Determination Order on March 27, 1998, finding that the claim did not qualify for closure. Claimant requested reconsideration and a June 18, 1998 reconsideration order affirmed the Determination Order.

SAIF issued a partial denial on July 30, 1998, asserting that claimant's hypoxic brain injury had combined with a preexisting condition and that the brain injury was no longer the major contributing cause of claimant's disability or need for treatment. Claimant requested a hearing regarding the denial.

The ALJ set aside the denial, concluding that the Board's prior order had already determined that there was no preexisting condition. The ALJ ordered SAIF to accept and process claimant's dementia condition.

Citing *SAIF v. Mize*, 129 Or App 636 (1994), SAIF seeks modification of that portion of the ALJ's order that requires it to accept claimant's dementia condition. SAIF argues that acceptance of the dementia condition would render its petition for judicial review regarding compensability of the condition moot and result in dismissal of the case.[1]

In *Mize*, a condition was found compensable by litigation order and SAIF accepted the claim without indicating that the acceptance was contingent on its right to appeal the compensability decision. The court stated that acceptance of a claim is not required by statute or rule in order to process the claim while the compensability issue is being litigated. The court then held that SAIF's unqualified acceptance of the claim rendered the compensability controversy moot and dismissed the petition for judicial review.

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[1] To the extent that SAIF argues that mere references to the dementia condition as being "accepted" are contrary to *SAIF v. Mize*, we disagree. We have previously held that, on the issuance of a litigation order finding the claim compensable, the claim is considered accepted, albeit involuntarily, and the carrier is obligated to process the claim as an accepted injury pending appeal. *Thomas W. Clark*, 51 Van Natta 95 (1999); *see also SAIF v. Maddox*, 295 Or 448 (1983).

Subsequent to *Mize* the legislature enacted ORS 656.262(7)(c), which provides, in pertinent part, that: "When an insurer or self-insured employer determines that the claim qualifies for claim closure, the insurer or self-insured employer *shall issue at claim closure an updated notice of acceptance that specifies which conditions are compensable.*" (Emphasis added). Similarly, OAR 436-030-0015(2)(B)(i) provides that an updated Notice of Acceptance *at closure* "shall contain the following information and language: (i) all compensable conditions that have been accepted, even if the accepted condition was ordered by litigation and is under appeal." Thus, unlike the law in effect when *Mize* issued, the current statutory and administrative scheme require carriers to issue an updated notice of acceptance at closure that includes conditions found compensable by litigation order.[2]

Here, however, the Department has declined to close the claim. Thus, at this point, at least, the claim is still open and, consequently, SAIF is not currently required by the statute to issue an updated Notice of Acceptance at closure (qualified or otherwise) specifying which conditions are "compensable." Thus, we modify solely that portion of the ALJ's order that directs SAIF to "accept" the dementia condition. We note, however, that (regardless of the present existence of a Notice of Closure) the dementia condition is considered an accepted condition pending appeal of the prior ALJ's order regarding compensability. As such the condition must continue to be processed as an accepted condition unless and until the court reverses our prior order.

Finally, SAIF argues that the ALJ incorrectly identified the condition to be accepted as "dementia." SAIF argues that it should be allowed to limit its "acceptance" to the condition of "brain injury." We disagree. The prior ALJ found that the issue presented by the parties was the compensability of claimant's dementia condition and found that condition compensable on the merits. (Ex. D-7). On review of the prior ALJ's order, we also referred to the condition at issue as memory loss/dementia.

Both the prior ALJ's order and our order affirming the prior ALJ's order identified the condition in dispute as "dementia." If SAIF did not agree with the identification of the issue as compensability of "dementia," that was an issue for the prior proceeding, not for this proceeding.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated October 28, 1998, as reconsidered on November 20, 1998, is modified in part. In lieu of that portion of the ALJ's order directing SAIF to accept dementia, SAIF is directed to process the claim for dementia in accordance with law. The remainder of the ALJ's order is affirmed. For services on Board review, claimant's attorney is awarded $1,000, payable by SAIF.

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[2] To the extent that SAIF asserts that any acceptance of the dementia condition would render its petition for judicial review moot, we disagree. A carrier that has been directed by litigation order to accept a claimant's claim may issue a "qualified" acceptance of the claim and continue to assert on appeal of that order that the claimant's condition is not compensable. *Valerie Barbeau*, 49 Van Natta 189 (1997); *Donna J. Calhoun*, 47 Van Natta 454 (1996). Thus, issuance of a "qualified" acceptance would preserve the viability of an appeal regarding compensability.

In the Matter of the Compensation of
ELBERT A. CORTRIGHT, Claimant
WCB Case Nos. 98-07114 & 98-05003
ORDER ON REVIEW
Geoffrey G. Wren, Claimant Attorney
David L. Jorling, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Thye's order that upheld the self-insured employer's denial of his occupational disease claim for a low back condition. In his brief, claimant contends the record is incomplete and not adequate for review, and requests remand for a new evidentiary hearing. On review, the issues are remand and compensability.

We deny the request for remand and adopt and affirm the ALJ's order with the following supplementation on the remand issue.

In his brief on review, claimant asserts that because there are various points in the hearing transcript indicating that the witness being questioned offered "no audible response," to the question asked, we should infer a problem with the transcription equipment.[1] Alternatively, claimant contends that even if there was no problem with the transcription equipment (and therefore transcript accurately reflects the witnesses' failure to audibly respond to certain questions) the record is nevertheless incomplete or otherwise insufficiently developed. We find to the contrary.

Pursuant to ORS 656.295(5), we may remand a case to the ALJ if we find that the case has been improperly, incompletely, or otherwise insufficiently developed or heard by the ALJ. In this case, however, we find no evidence of a technical malfunction.[2] Rather, after reviewing the transcript of hearing and considering the 12 "no audible response" notations in context, we are persuaded that the witnesses simply did not verbally respond before counsel asked the next question.[3] We also find that, notwithstanding the witnesses' lack of audible responses at these times, the record is sufficiently developed for adjudication. Indeed, as the employer notes, each question that is preceded by a "no audible response" notation is ultimately answered by the witness at another point in the transcript.[4] Consequently, we find the record complete and adequate for review.

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[1] In the 32 pages of claimant's recorded testimony, the transcript reflects "no audible response" following ten questions, one asked by his counsel on direct examination and nine posed by the employer's counsel on cross-examination. (Tr. pp. 16, 18, 21, 24, 25, 30, 35). And, in the 37 pages of Dr. Jones' recorded testimony, the transcript reflects "no audible response" to two questions. (Tr. 52, 61).

[2] *Compare Susanne E. Stark*, 49 Van Natta 759 (1997) (remand warranted where the second of two tapes used to record the hearing was blank, and the parties could not reach a stipulation regarding the relevant facts developed by the testimony presented during the unrecorded part of the hearing).

[3] We offer the following exchange as an example of a "no audible response" in context:

"Q. [By employer's counsel] How often do you garden at home?

"A. [By claimant] (no audible response)

"Q. What kind of activity do you do at home?

"A. Probably about twice a week.

"Q. Okay. Usually on weekends?

"A. No, an hour here, and hour there. I mean I guess when I'm saying twice a week, if you blocked it together, it would be twice a week. But I'm kind of putzing in here and there at different times. Big chunks of time would probably be on the weekend, yes." (Tr. at 21).

[4] For example, although claimant initially did not audibly respond to the question whether he was feeling worse in 1996 or in 1998, his next response indicates that his pain was about the same during both periods, although maybe more frequent in the earlier time period. (Tr. at 35). Similarly, although Dr. Jones did not immediately respond to the question whether a certain doument set forth a distinction between chronic and acute radiculitis, he answered the question six lines later in the transcript, when it was reasked by counsel. (Tr. at 61).

ORDER

The ALJ's order dated January 12, 1999 is affirmed.

May 14, 1999 Cite as 51 Van Natta 817 (1999)

In the Matter of the Compensation of
MICHAEL A. WAGONER, Claimant
WCB Case No. 98-06411
ORDER ON REVIEW
Cole, Cary, et al., Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) McWilliams' order that awarded a $2,400 attorney fee for services at hearing. SAIF also moves for remand. In his brief, claimant requests sanctions under ORS 656.390 based on SAIF's allegedly frivolous request for review. On review, the issues are remand, attorney fees, and sanctions.

We deny SAIF's motion for remand and claimant's motion for sanctions, and adopt and affirm the ALJ's order with the following supplementation.

SAIF requested a hearing, challenging an Order on Reconsideration's permanent disability award. The ALJ affirmed the Order on Reconsideration award and awarded a $2,400 attorney fee under ORS 656.382(2). The ALJ mentioned the applicable rules regarding attorney fees, but did not discuss them. *See* OAR 438-015-0010(4).[1]

On review, SAIF contends that *Schoch v. Leupold & Stevens*, 325 Or 112 (1997), and *McCarthy v. Oregon Freeze Dry*, 327 Or 84, *adhered to on recon* 327 Or 185 (1998), required the ALJ to: (1) make findings for each factor in OAR 438-015-0010(4); (2) draw conclusions from those findings of fact; and (3) demonstrate how the conclusions are weighed in determining a reasonable attorney fee. Because the ALJ did not provide such reasoning, SAIF argues that we should remand the case "with instructions to take evidence and properly apply OAR 438-015-0010(4)."

We considered the same argument in *Daryl L. Underwood*, 50 Van Natta 2330 (1998). There, the claimant's attorney did not submit a specific fee request and the parties did not provide any argument at hearing concerning the application of the factors in OAR 438-015-0010(4). After analyzing the Court's entire decision in *McCarthy*, we found that the Court held that a lower body need not address facts and legal criteria that are not material to its decision and could "satisfy its obligation to make findings in a case * * * by including in its order a brief description or citation to the factor or factors on which it relies in denying an award of attorney fees." 327 Or at 188.

In short, because the statute considered by the Court in *McCarthy* contained the same requirement in OAR 438-015-0010(4) that the reviewing bodies "shall consider" certain enumerated factors, we held that it is sufficient for an ALJ to merely describe or cite the rule-based factor or factors the ALJ relied on in determining a reasonable attorney fee where there was no specific attorney fee requested and the parties did not submit to the ALJ any argument as to how the rule-based factors should be weighed in determining a reasonable fee. Thus, we rejected the carrier's argument in *Underwood* that the ALJ was required to make findings for each rule-based factor.

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[1] OAR 438-015-0010(4) provides that "[i]n any case where an Administrative Law Judge or the Board is required to determine a reasonable attorney fee, the following factors shall be considered: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses."

Here, as in *Underwood*, SAIF did not (and continues not to) provide any discussion or argument concerning the application of the rule-based factors. Nevertheless, in light of the Court's discussion in *McCarthy*, the award of a reasonable attorney fee requires "a brief description or citation to the factor or factors" relied on in arriving at such a fee. Although the ALJ's order contains no such citation or discussion, unlike the courts' review authority, our review is *de novo* based on the entire record. Because we may modify or supplement the ALJ's order on review, and because we do not find the record to be improperly, incompletely, or otherwise insufficiently developed, we deny SAIF's motion for remand. *Daryl L. Underwood*, 50 Van Natta at 2332.

Finally, we provide the following reasoning on *de novo* review. With regard to the time factor, we note that the matter was decided on the record with no recorded proceedings. The parties presented telephonic closing arguments. The record is made up of approximately 35 exhibits, including 25 documents submitted by claimant's attorney.

We find the issue to be of average complexity. The value of the interest involved and the benefit secured for claimant were within the range of permanent disability claims considered by the Hearings Division. Because SAIF presented a colorable argument, based on Board precedent, there was a risk claimant's attorney would go uncompensated (*i.e.*, if SAIF carried its burden of proving that claimant's permanent disability award should be reduced). Finally, both attorneys presented their cases in a skillful manner.

Based on these factors, we agree with the ALJ that $2,400 is a reasonable attorney fee.

We turn to claimant's request for sanctions against SAIF for a frivolous request for review. "Frivolous" means the matter is not supported by substantial evidence or is initiated without reasonable prospect of prevailing. ORS 656.390(2).

SAIF has presented a colorable argument on review that is sufficiently developed so as to create a reasonable prospect of prevailing on the merits. While the argument on review did not ultimately prevail, we cannot say it is "frivolous." *Jack B. Hooper*, 49 Van Natta 669 (1997); *Donald M. Criss*, 48 Van Natta 1569 (1996). Accordingly, we deny claimant's request for sanctions.

Finally, because SAIF challenged only the attorney fee award on review and attorney fees are not "compensation" for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for his counsel's services on review. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1998).

ORDER

The ALJ's order dated January 4, 1999 is affirmed.

In the Matter of the Compensation of
MARTI J. COLEMAN, Claimant
WCB Case No. 97-08771
ORDER ON REVIEW
Willner & Associates, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Lipton's order that set aside its partial denial of claimant's sacroiliac condition. Claimant also moves for waiver of the Board's rules for acceptance of her untimely filed respondent's brief. On review, the issues are claimant's procedural motion and compensability. We grant claimant's motion and reverse.

FINDINGS OF FACT

Claimant worked as a development coordinator for SAIF's insured. (Ex. 22). On January 26, 1996, she sought treatment from Dr. Kirchem, chiropractor. (Ex. 12). He reported that claimant had experienced neck, midback and left lower back pain as a result of lifting heavy bags of clothing. (Exs. 12, 14). Dr. Kirchem diagnosed cervical, thoracic and left sacroiliac strains and recommended physiotherapy and manipulation. (*Id.*) He released claimant to light duty. (Ex. 11).

Dr. Woods, neurologist, examined claimant on March 5, 1996. (Ex. 19). He reported that claimant's cervical and thoracic strains had responded well to chiropractic treatment. (Ex. 19-3). He also explained that claimant had also experienced left hip/sacroiliac pain and toe numbness since the third or fourth week of work at her job. (Ex. 19-1). Dr. Woods felt that claimant's left hip and toe numbness symptoms were work-related. (Ex. 19-3).

Claimant signed an "801" form on April 1, 1996, indicating she had injured her left hip and toes in December 1995. (Ex. 22).

Claimant began treating with Dr. Milam, D.C., in April 1996. (Ex. 25). He initially diagnosed a cervicothoracic sprain/strain and lumbosacral sprain/strain, secondary to occupational exposure. (Exs. 25, 26). On April 26, 1996, Dr. Milam's diagnosis included a lumbosacral/sacroiliac sprain/strain. (Ex. 27).

On May 15, 1996, Dr. Wilson, neurologist, examined claimant on behalf of SAIF. (Ex. 29). He diagnosed a "resolving left trochanteric bursitis" and a possible Morton neuroma on her left foot. (Ex. 29-5). He did not believe claimant's conditions were related to her work activities, although he felt her work may have been a factor in developing symptoms. (Ex. 29-5, -6). Dr. Wilson found no evidence of a lumbosacral strain. (Ex. 30).

On May 30, 1996, SAIF issued a denial of claimant's "alleged occupational disease" to her left hip and foot that occurred on or about December 1, 1995. (Ex. 30A). SAIF asserted that claimant's work activities were not the major contributing cause of the bursitis or neuroma conditions. (*Id.*)

Dr. Smith examined claimant on August 14, 1996 and agreed that she had resolving trochanteric bursitis of her left hip that was caused in some measure by her work activity. (Ex. 33-2). He felt claimant's Morton's neuroma of the left foot was not related to her work activity. (*Id.*)

On October 24, 1996, an ALJ approved a Stipulation and Order. (Ex. 35). The parties agreed that claimant had "filed a claim for her left hip and left foot sustained on or about December 1, 1995" and SAIF had denied the claim. (Ex. 35-1). The parties agreed to "settle all issue(s) raised or raisable at this time[.]" SAIF agreed to accept left trochanteric bursitis, but the denial of Morton's neuroma of the left foot remained in effect. (*Id.*) SAIF subsequently accepted left trochanteric bursitis. (Ex. 36).

Claimant sought treatment for her left hip pain from Dr. Rusch, orthopedic surgeon, on February 4, 1997. He diagnosed trochanteric bursitis and "[l]eft trochanteric and buttock pain due to a nonspecific lumbar nerve root irritation[.]" (Ex. 39-2). He recommended lumbar stabilization exercises. (*Id.*) On February 25, 1997, Dr. Rusch reported that claimant's left trochanteric pain had lessened, but she had bilateral lumbar and sacroiliac pain. (Ex. 41-1). Dr. Rusch found that claimant's left trochanteric pain was medically stationary as of April 4, 1997. (Ex. 42-1). He commented that her

trochanteric condition was vulnerable to recurrence because "a significant portion of her trochanteric complaints have been, and may continue to be, a portion of her non specific lumbar nerve root irritation with left leg sciatica." (*Id.*)

Claimant wrote to SAIF on June 12, 1997, requesting that SAIF amend its acceptance to include her sacroiliac condition. (Ex. 44).

Dr. Rusch reported to SAIF that claimant's sacroiliac condition and bursitis condition were both "pain symptom complex" of a lumbosacral back strain with irritation of the lumbar nerve roots. (Ex. 47). He explained:

> "The 'bursitis condition' has not contributed to a pathological worsening of the 'sacroiliac condition.' The symptoms of pain in the left sacroiliac area, as stated above, are in my opinion a manifestation of the lumbosacral back strain and are the same symptoms that are manifested alternately or at the same time in the trochanteric area. In this respect the 'trochanteric condition' is related to the 'sacroiliac condition' only in that [their] point of origin is from the lumbosacral spine. One condition does not in and of itself contribute to a pathological worsening or worsening of symptoms than to the other." (*Id.*)

Dr. Marble examined claimant on behalf of SAIF on August 25, 1997. (Ex. 48). He found that claimant's presentation was consistent with chronic, low grade lumbar strain with mild lumbar root irritation. (Ex. 48-6). He agreed with Dr. Rusch that there was no significant pathology involving either sacroiliac joint. (*Id.*) Dr. Marble felt the trochanteric bursitis was currently a "non-existent entity[.]" (Ex. 48-7). He believed claimant's complaints originated in the lumbar spine. (*Id.*)

On September 9, 1997, SAIF issued a partial denial of claimant's sacroiliac condition on the basis that it was not related to the December 1, 1995 injury. (Ex. 50). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Motion for Waiver of Rules

Although claimant's respondent's brief was initially rejected as untimely, claimant seeks reconsideration of that decision. We interpret claimant's request as a waiver of the Board's rules for acceptance of her untimely filed brief. *See* OAR 438-011-0030. SAIF does not object to claimant's motion. In light of SAIF's position, we grant claimant's motion for waiver of the Board rules. *See Anthony J. Telesmanich*, 49 Van Natta 49, 50, *on recon* 49 Van Natta 166 (1997).

Compensability

The issue on review is whether claimant's claim for a sacroiliac[1] condition is precluded by the parties' October 24, 1996 Stipulation and Order. The ALJ noted that SAIF was not "arguing a lack of medical relationship." The ALJ found that neither the parties nor the stipulation contemplated a claim for a sacroiliac condition. The ALJ interpreted Dr. Rusch's opinion to find that the trochanteric and sacroiliac conditions were essentially unrelated. Citing *Liberty Northwest Ins. v. Bowen*, 152 Or App 549 (1998), the ALJ concluded that the October 24, 1996 stipulation did not preclude claimant's sacroiliac claim.

SAIF argues that the claim for a sacroiliac condition is barred by the "all issue(s) raised or raisable" language in the stipulation. SAIF asserts that a left sacroiliac strain was diagnosed on January 29, 1996 and claimant made a "claim" for that condition *before* the parties entered into the stipulation. According to SAIF, the left sacroiliac condition was a "raisable" and negotiable issue and is now barred by the stipulation.

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[1] SAIF's September 9, 1997 denial referred to claimant's "sacroiliac" condition. (Ex. 50). Claimant's brief on review refers to her "sciatica" claim. She notes that the medical records refer to the "sciatica" condition using various terms, *i.e.*, sacroileitis, sacroiliac strain, but she asserts that for purposes of litigation they encompass the same diagnosis, namely sciatic or lumbar nerve root irritation, In this order, we will refer simply to claimant's sacroiliac condition.

On the other hand, claimant contends that the "sciatica" condition is not barred by the "raised or raisable" language in the stipulation. She argues that she only made a claim for trochanteric bursitis and Morton's neuroma before entering into the stipulation.

Neither party contends that the October 24, 1996 stipulation is ambiguous, and we agree that it is not. Therefore, interpreting the stipulation is a matter of law. *Good Samaritan Hospital v. Stoddard*, 126 Or App 69, 72, *rev den* 319 Or 572 (1994).

On May 30, 1996, SAIF issued a denial of claimant's "alleged occupational disease to your left hip and foot which you believe occurred on or about December 1, 1995[.]" (Ex. 30A). SAIF's denial asserted that claimant's work activities were not the major contributing cause of her left trochanteric bursitis or Morton's neuroma conditions. (*Id.*) The Stipulation and Order approved on October 24, 1996 provided, in part:

> "Claimant filed a claim for her left hip and left foot sustained on or about December 1, 1995. SAIF Corporation denied the claim on May 30, 1996. Claimant filed a Request for Hearing to appeal the denial and raise other issues.
>
> "The parties agree to settle all issue(s) raised or raisable at this time as follows:
>
> "SAIF Corporation agrees to accept the following conditions: left trochanteric bursitis.
>
> "The parties further stipulate that the denial of the Morton's neuroma of the left foot shall remain in full force and effect." (Ex. 35-1).

The parties agreed that the request for hearing would be dismissed with prejudice. (*Id.*)

For the following reasons, we find that the issue of claimant's sacroiliac condition and its compensability *could* have been negotiated before approval of the October 24, 1996 stipulation. *See Stoddard*, 126 Or App at 73.

On January 26, 1996, Dr. Kirchem, chiropractor, examined claimant and reported that claimant had experienced neck, midback and left lower back pain as a result of lifting heavy bags of clothing. (Exs. 12, 14). He diagnosed cervical, thoracic and left sacroiliac strains and recommended physiotherapy and manipulation. (*Id.*) On claimant's "827" form, Dr. Kirchem included a diagnosis of a left sacroiliac strain. (Ex. 14). In Dr. Woods' March 5, 1996 report, he referred to claimant's "left hip/sacroiliac pain." (Ex. 19). In April 1996, Dr. Milam diagnosed, among other things, a lumbosacral/sacroiliac sprain/strain. (Ex. 27). In contrast, Dr. Wilson examined claimant on May 15, 1996 and found no evidence of a lumbosacral strain. (Ex. 30).

Thus, the record establishes that before the parties entered into the October 24, 1996 stipulation, claimant had been diagnosed with a "left sacroiliac strain" and a "lumbosacral/sacroiliac sprain/strain." Her "827" form referred to "left lower back pain," "left SI joint pain," and diagnosed a "L. Sacroiliac Strain." (Ex. 14).

Furthermore, we find that claimant's sacroiliac condition resulted from work activities that had been identified at the time of the October 1996 stipulation, for which SAIF accepted left trochanteric bursitis. (Ex. 36). Dr. Rusch, one of claimant's treating physicians, reported to SAIF that claimant's sacroiliac condition and bursitis condition were both "pain symptom complex" of a lumbosacral back strain with irritation of the lumbar nerve roots. (Ex. 47). He explained that the "symptoms of pain in the left sacroiliac area, as stated above, are in my opinion a manifestation of the lumbosacral back strain and are the same symptoms that are manifested alternately or at the same time in the trochanteric area." (*Id.*) He felt that the "trochanteric condition" was related to the "sacroiliac condition" in that their point of origin was from the lumbosacral spine. (*Id.*)

Dr. Milam, who also treated claimant, believed that claimant originally sustained a lower back/sacroiliac condition arising out of the December 1995 occupational exposure. (Ex. 56). He felt that her bursitis and sacroiliac conditions arose out of the same exposure. (*Id.*) Likewise, Dr. Scalone felt that claimant's lumbosacral, sacroiliac and sciatic nerve problems, as well as the trochanteric bursitis, were present from the beginning and the problems occurred more or less simultaneously. (Ex. 58). In addition, Dr. Kirchem reported that his initial diagnosis in January 1996 was a cervico-thoracic strain and left sacroiliac strain. (Ex. 59). He believed that abnormal mechanics resulting from the left sacroiliac strain contributed to the trochanteric bursitis. (*Id.*)

Based on these medical reports, we conclude that claimant's sacroiliac condition resulted from work activities that had been identified at the time of the parties' October 1996 stipulation, which resulted in the acceptance of left trochanteric bursitis. *Compare Liberty Northwest Ins. v. Bowen*, 152 Or App at 554-55 (prior stipulation regarding permanent disability for a thoracic compression fracture did not preclude the claimant's current occupational disease claim for degenerative cervical disc disease, which was unrelated to the thoracic compression fracture). The October 24, 1996 stipulation settled "all issue(s) raised or raisable at this time[.]" (Ex. 35-1). Because claimant's sacroiliac condition had been diagnosed and resulted from work activities that had been identified before the stipulation, we conclude that the sacroiliac condition was an issue that could have been negotiated before approval of the October 24, 1996 stipulation. Consequently, we conclude that her sacroiliac claim is barred by the stipulation. *See Stoddard*, 126 Or App at 72-73.

Although claimant cites *Trevisan v. SAIF*, 146 Or App 358 (1997), to support her argument that her sacroiliac claim is not barred, we find that her reliance on that case is misplaced. *Trevisan* did not involve a stipulation. Rather, that case involved a Disputed Claim Settlement (DCS), which may only be used to settle denied claims. *Id.* at 362. The DCS in *Trevisan* provided, in part, that the parties "agree that a bona fide dispute exists between them as to the compensability of the condition(s) and/or services *which have been denied.*" *Id.* at 360-61 (emphasis supplied.) After examining the statutory and administrative requirements for a DCS, the court held that, as a matter of law, "the DCS did not settle [the] claimant's headache claim, because the headache claim was not denied at the time that the parties entered into the DCS." *Id.* at 361-62.

Here, in contrast, the terms of the stipulation were not limited to conditions or services that had been *denied*. Unlike *Trevisan*, the fact that SAIF did not specifically deny a sacroiliac condition is not dispositive. This case involved a stipulation, which may resolve *any* contested matter. *See Trevisan*, 146 Or App at 362. The issue, as we discussed earlier, is whether claimant's sacroiliac condition and its compensability *could* have been negotiated before approval of the October 24, 1996 stipulation, not whether that condition was actually denied by SAIF. *See Stoddard*, 126 Or App at 73.

ORDER

The ALJ's order dated November 19, 1998 is reversed. SAIF's partial denial of claimant's sacroiliac condition is reinstated and upheld. The ALJ's attorney fee award is reversed.

May 17, 1999 Cite as 51 Van Natta 822 (1999)

In the Matter of the Compensation of
THOMAS J. AYERS, Claimant
WCB Case No. 97-06958
ORDER ON REVIEW
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Claimant, *pro se*,[1] requests review of Administrative Law Judge (ALJ) Livesley's order that upheld the insurer's denial of claimant's left shoulder condition as an injury claim or an occupational disease claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following clarification.

On October 30, 1997, Dr. Fuller, orthopedist, examined claimant on behalf of the insurer. (Exs. 12, 14). Although Dr. Fuller did not have available claimant's June 5, 1997 x-rays at the time of his initial examination, he reviewed those x-rays before his December 9, 1997 deposition. (Exs. 16-4-7, -32-33). During that deposition, Dr. Fuller explained the significance of claimant's June 5, 1997 x-ray findings and opined that those findings were very significant in understanding the cause of claimant's left shoulder condition. (Exs. 16-4-7, -13, -30, -33).

[1] Although unrepresented on review, claimant was represented at hearing.

ORDER

The ALJ's order dated January 9, 1999 is affirmed.

May 17, 1999 Cite as 51 Van Natta 823 (1999)

In the Matter of the Compensation of
MARK A. KLOUDA, Claimant
WCB Case No. 97-02961
ORDER ON RECONSIDERATION
G. Joseph Gorciak III, Claimant Attorney
Reinisch, et al, Defense Attorneys

Claimant requests reconsideration of that portion of our February 12, 1999 Order on Review that reversed an Administrative Law Judge's (ALJ's) order that awarded a $3,500 insurer-paid attorney fee. Contending that he is entitled to an insurer-paid attorney fee award under ORS 656.386(1) and 656.382(1), claimant seeks reconsideration of our decision.

On March 15, 1999, we abated our February 12, 1999 order to allow the insurer an opportunity to respond. Having received the insurer's response, we proceed with our reconsideration.

On November 12, 1996, claimant sustained a compensable left forearm injury. The insurer accepted a disabling left shrapnel injury with left radial nerve lesion, disruption of the left extensor digitorum communis, left hand extensor tendon adhesions, and anxiety with phobic response. On April 8, 1997, claimant requested a hearing raising, *inter alia*, the issues of rate of temporary disability, penalties and attorney fees.

On June 26, 1997, claimant requested that the insurer amend its acceptance to include post traumatic stress disorder (PTSD). On June 30, 1997, claimant began treating with Dr. Kolilis, psychologist, for PTSD. As we found in our initial order, there is no persuasive evidence that the insurer failed to timely pay Dr. Kolilis' medical bills. On October 1, 1997, claimant submitted a supplemental hearing request raising, *inter alia*, compensability of the PTSD condition.

On February 4, 1998, the claim was closed by a Determination Order that awarded, *inter alia*, 9 percent unscheduled permanent disability and 1 percent scheduled permanent disability for loss of use of the left forearm.

On February 9, 1998, the parties entered into a stipulation that resolved the issues regarding claimant's temporary total disability (TTD) rate and penalties and attorney fees related to that rate. The Stipulation noted that the insurer "reassessed claimant's average weekly wage and increased claimant's TTD rate on July 10, 1997," and agreed to pay a penalty of 25 percent of all past due temporary disability benefits (predating July 10, 1997), with the penalty being equally divided between claimant and his attorney.

On February 24, 1998, the day before the hearing was set, the insurer amended its notice of acceptance to include PTSD. (Ex. 53).

In our initial order, we determined that *former* ORS 656.386(1) applied to claimant's claim because his request that the insurer amend the notice of acceptance to include the PTSD condition occurred on June 30, 1997, prior to the July 25, 1997 effective date of *amended* ORS 656.386(1). Furthermore, we noted that the court has interpreted *former* ORS 656.386(1) as requiring an explicit response from the carrier that can be interpreted as a refusal to pay on the express ground that the condition for which compensation is claimed is not compensable before a carrier's actions can be deemed to constitute an express denial of compensation under that statute. *See Galbraith v. L.A. Pottsratz Const.*, 152 Or App 790 (1998); *Kimberly Quality Care v. Bowman*, 148 Or App 292 (1997). Applying that interpretation, we concluded that claimant failed to prove a "denied claim" as defined in *former* ORS 656.386(1) and, thus, was not entitled to an insurer-paid attorney fee under that statute.

On reconsideration, claimant again argues that the insurer's actions can be deemed to constitute a "denied claim" under *former* ORS 656.386(1).[1] After reconsideration, we continue to reject that argument based on the reasoning in our initial order. Claimant also contends that he is entitled to an insurer-paid attorney fee under *former* ORS 656.386(1) based on our holding in *Chancey F. James*, 50 Van Natta 1370 (1998). But *James* is clearly distinguishable in that it applied *amended* ORS 656.386(1), not *former* ORS 656.386(1). Therefore, *James* does not support claimant's position. *See also SAIF v. Varah*, 160 Or App 254 (1999) (withdrawal of word "resolved" from accepted condition does not constitute a "denied condition" under *amended* ORS 656.386(1) because, at most, there has been an *implied*, rather than an *explicit*, denial of future benefits). Thus, after reconsideration, we continue to hold that claimant is not entitled to an insurer-paid attorney fee under *former* ORS 656.386(1).

Claimant also argues that he is entitled to the insurer-paid attorney fee awarded by the ALJ under ORS 656.382(1). Although finding no amounts then due, the ALJ concluded that the insurer's processing of the PTSD claim constituted an unreasonable resistance to the payment of compensation and awarded a $3,500 insurer-paid attorney fee under ORS 656.382(1). After reconsideration, we continue to find that claimant has failed to establish any unreasonable resistance to payment of compensation upon which to base an insurer-paid attorney fee under ORS 656.382(1).

ORS 656.382(1) authorizes the award of a carrier-paid attorney fee if a carrier "unreasonably resists the payment of compensation," provided that there are no amounts of compensation then due upon which to base a penalty or the unreasonable resistance is not the same conduct for which a penalty has been assessed under ORS 656.262(11).[2] *Corona v. Pacific Resource Recycling*, 125 Or App 47 (1993); *Oliver v. Norstar, Inc.*, 116 Or App 333 (1993); *Martinez v. Dallas Nursing Home*, 114 Or App 453, *rev den* 315 Or 271 (1992).

On the other hand, there is no "unreasonable resistance to payment of compensation" if all compensation was paid, even if a carrier does not timely accept a claim. Under such circumstances, no attorney fee would be available under ORS 656.382(1). *See SAIF v. Condon*, 119 Or App 194, *rev den* 317 Or 163 (1993) (where carrier did not timely accept the claim but paid all compensation due, there was no unreasonable resistance to payment of compensation and, thus, no liability for attorney fees under ORS 656.382(1)).

We first determine whether there are "amounts then due" upon which to base a penalty under ORS 656.262(11)(a) for the insurer's late acceptance of the PTSD condition. In making that determination, we have held that the penalty basis for an untimely denial or acceptance includes that compensation which was due but unpaid during the delay period, *i.e.*, between the date when the denial or acceptance became untimely (the 91st day after notice of the claim) and the date when the denial or acceptance was actually issued. *Melody L. Rivers*, 48 Van Natta 2089 (1996); *Jeffrey D. Dennis*, 43 Van Natta 857 (1991). In other words, the delay period is the "then" with regard to the term "amounts then due" in ORS 656.262(11)(a). *Jeffrey D. Dennis*, 43 Van Natta at 858; *George Violett*, 42 Van Natta 2647 (1990).

On review, the only basis for claimant's argument that the insurer unreasonably resisted payment of compensation was his contention that some of Dr. Kolilis' medical bills were paid late or unpaid, a contention that we continue to reject after our reconsideration. Indeed, on reconsideration, claimant does not dispute our conclusions regarding the payment of medical bills.

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[1] On reconsideration, claimant does not dispute our conclusion that *former* ORS 656.386(1) applies to his claim. Therefore, we consider claimant's citations to "ORS 656.386(1)" to refer to "*former* ORS 656.386(1)."

[2] ORS 656.262(11)(a) provides, in relevant part:

"If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due."

Here, there are two separate acts upon which to base a penalty and insurer-paid attorney fee: (1) the late payment of TTD; and (2) the late acceptance of the PTSD condition. Therefore, if there are no amounts of compensation "then due" upon which to base a penalty under ORS 656.262(11), and it is found that the insurer unreasonably resisted the payment of compensation, claimant would be entitled to an insurer-paid attorney fee under ORS 656.382(1), notwithstanding the fact that the Stipulation assessed a penalty under ORS 656.262(11) for the unreasonable late payment of TTD.

Instead, on reconsideration, claimant makes two arguments. First, claimant contends that the late paid TTD, as evidenced by the parties' February 9, 1998 Stipulation, represents "resisted compensation" that serves as the basis for an assessed attorney fee under ORS 656.382(1). Second, he contends that the "resisted compensation" is evidenced by a subsequent award of unscheduled permanent disability for the PTSD condition.[3]

In support of his first contention, claimant argues that our decision in *Kenneth A. Meyer*, 50 Van Natta 2302 (1998), *on recon*, 51 Van Natta 319 (1999), supports an attorney fee award under ORS 656.382(1) in the present case. We disagree.

In *Meyer*, the employer recalculated the claimant's TTD rate to include overtime pay. Based on this recalculation, on January 26, 1998, the employer paid the claimant additional TTD for the period July 28, 1997 through January 12, 1998. The claimant alleged, *inter alia*, several discovery violations and untimely acceptance of his left and right carpal tunnel syndrome (CTS) conditions. First, we found that the employer acted unreasonably in failing to produce its TTD ledger after October 8, 1997, the date it was required to do so following the claimant's discovery request, and that the claimant was entitled to a penalty if there were "amounts then due" during this delay period. 50 Van Natta at 2307. We then found that the employer's January 26, 1998 TTD payment was an "amount then due" for purposes of assessing a penalty under ORS 656.262(11)(a) for the employer's failure to produce its TTD ledger. On that basis, we assessed a maximum penalty in the amount of 25 percent of the January 26, 1998 TTD payment.

We also found that the employer's late acceptances of the left and right CTS were unreasonable. 50 Van Natta at 2308-09. Those late acceptances occurred during the period from July 28, 1997 through January 12, 1998, the dates the TTD was underpaid. Because we had already assessed the maximum penalty against the employer's January 26, 1998 TTD payment and there was no additional unpaid TTD during the relevant delay period, we had no authority to assess an additional penalty. Nevertheless, we found that each of those actions was a separate unreasonable resistance to the payment of compensation within the meaning of ORS 656.382(1) and assessed a $100 fee for each late acceptance. 50 Van Natta at 2308-09.

Here, the parties' February 9, 1998 Stipulation deals with the insurer's initial calculation of claimant's average weekly wage, which resulted in underpaid temporary disability. The insurer reassessed and increased claimant's temporary disability rate on July 10, 1997. The parties agreed that the insurer would pay a penalty of 25 percent on all past due temporary disability benefits (predating July 10, 1997), to be divided equally between claimant and his attorney. Given the language of the Stipulation, we find that the late paid temporary disability was paid on July 10, 1997, whereas the penalty for that late payment was paid at the time of the February 1998 Stipulation.

On June 26, 1997, approximately two weeks before the late paid temporary disability was paid, claimant made his written request to the insurer to amend the notice of acceptance to include PTSD. Claimant argues that his written request seeks correction of the notice of acceptance to include a condition that was incorrectly omitted, and the insurer had 30 days to revise the notice or make other written clarification under ORS 656.262(6)(d). The insurer argues that claimant's written request was a claim for a new medical condition, and it had 90 days to accept or deny the claim under ORS 656.262(7)(a). We need not resolve this argument because, under either statute, the insurer failed to timely respond to claimant's written request.

Nevertheless, the award of attorney fees is governed by statute. *Forney v. Western States Plywood*, 297 Or 628, 632 (1984). Unless specifically authorized by statute, we have no authority to award attorney fees. *Id.*

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[3] In support of this argument, claimant submits a copy of a June 25, 1998 Order on Reconsideration, which he asserts was not appealed and has become final by operation of law. The insurer does not challenge this assertion. Claimant requests that we either take administrative notice of this order or remand the case to the ALJ for further proceedings. Although objecting to remanding the case to the ALJ, the insurer concedes that the June 25, 1998 Order on Reconsideration is the type of document the Board may take administrative notice of. *See Groshong v. Montgomery Ward Co.*, 73 Or App 403 (1985); *Brian M. Eggman*, 49 Van Natta 1835 (1997) (we may take administrative notice of agency orders involving the same claimant); *Gaspar Lopez*, 48 Van Natta 1774, 1775 (1996) (we may take administrative notice of an Order on Reconsideration because it is "an act of a state agency"). Therefore, we take administrative notice of the June 25, 1998 Order on Reconsideration.

Here, whether we find that the delay period extended from the 31st day or the 91st day after claimant's June 26, 1997 request that the insurer accept his PTSD condition, there are no "amounts then due" during that delay period upon which to base a penalty under ORS 656.262(11)(a). In this regard, the insurer paid the late paid temporary disability on July 10, 1997, about two weeks after claimant's request to accept his PTSD condition, and well before the "delay period" within which to calculate any penalty began.

In reaching this conclusion, we note that, although the *penalty* assessed by the Stipulation was not paid until the time of the Stipulation in February 1998, well after the running of even the 90 day period to accept or deny the claim under ORS 656.262(7)(a), penalties are not considered "compensation." *Benjamin G. Parker*, 42 Van Natta 2476 (1990). Therefore, the payment of the stipulated penalty after the expiration of the timely response period would not satisfy the requirements of an unreasonable delay or resistance to the payment of "compensation" under either ORS 656.262(11)(a) or ORS 656.382(1). Accordingly, we find that all compensation was paid before the "delay period" began to run. Under such circumstances, there are neither "amounts then due" nor "unreasonable resistance to the payment of compensation" upon which to base a penalty or an attorney fee. ORS 656.262(11)(a); ORS 656.382(1); *Lloyd A. Humpage*, 49 Van Natta 1784 (1997) (Because the record did not support a finding that there were amounts due at the time of the unreasonable delay, there was no basis for a penalty).

Furthermore, claimant's reliance on *Kenneth A. Meyer* is misplaced. Although apparently not an issue in that case, the facts in *Meyer* make it clear that there was unpaid compensation during the "delay period" upon which to base a penalty under ORS 656.262(11)(a) and an attorney fee under ORS 656.382(1) for separate unreasonable acts. Therefore, *Meyer* is distinguishable.

As to claimant's argument that the "resisted compensation" is evidenced by a subsequent award of unscheduled permanent disability for the PTSD condition, we reject that argument based on the following reasoning.

We have previously determined that, under the statutory scheme involving "new medical conditions" found compensable (*i.e.*, accepted) after claim closure, a claimant is entitled to appropriate claim processing, including reopening and processing the "new medical condition" claim to closure. ORS 656.262(7); *Rodrigo R. Mancilla*, 51 Van Natta 692 (1999); *see also James Mack*, 50 Van Natta 338 (1998) (Evaluation of a "post closure" accepted condition must await the reopening and processing of the claim for that new condition). Thus, if a "new medical condition" claim is accepted post-closure, it is not rated until it is actually closed (subsequent to reopening).

On the other hand, an Order on Reconsideration is based on conditions accepted at the time of claim closure. Here, the PTSD condition was not accepted until after claim closure. Therefore, even if it appears that the permanent disability award included an award for the "post-closure" accepted PTSD condition, the award is legally limited to conditions accepted at the time of claim closure. Consequently, even considering the Order on Reconsideration award, that award would not support resistance to the payment of PTSD permanent disability compensation as claimant alleges.

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our February 12, 1999 order effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
PEGGY SHIPMAN, Claimant
WCB Case No. 98-07409
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Hoguet's order that set aside its denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome (CTS) condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for the "Ultimate Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

The ALJ found claimant's bilateral CTS condition compensable, reasoning that she did not have a "preexisting condition" and her symptoms "are the disease." Accordingly, based on Dr. Brown's opinion that claimant's work caused her symptoms, the ALJ set aside the insurer's denial. We disagree.

The medical evidence regarding causation is provided by Dr. Madey, treating physician, Dr. Brown, consulting neurologist, and Drs. Dordevich and Fuller, examining physicians.[1] The examining physicians opined that claimant's CTS results from multiple factors, including obesity and the anatomical structure of her wrist. (Ex. 15-5).

Dr. Brown offered the only medical description of CTS. He explained that "CTS results from narrowing of an area under a thick fascial band through which the median nerve transverses." (Ex. 13-1). Dr. Brown distinguished between claimant's anatomical condition and her symptoms. He explained that the *condition* is not job-related, but the *symptoms* "are oftentimes related to repetitive use in the course of a job." (Ex. 13-2). Considering Dr. Brown's opinion, which we find well-reasoned and persuasive (as well as undisputed in this regard), we cannot say that the "symptoms are the disease" in this case.[2] *See Wendy R. Bye*, 49 Van Natta 636 (1997); *Donald M. Lewis*, 48 Van Natta 950 (1996); *Matthew R. Ross*, 47 Van Natta 698 (1995); *see also Dennis Rauschert*, 50 Van Natta 524 (1998) ("[C]laimant may not establish that his symptoms are the disease, by relying on medical records and conclusions reached in other cases.").

Dr. Madey opined that claimant's work was the major contributing cause of her CTS, noting that she had performed repetitive work activities for the insured for "a long enough duration" (five years) and her symptoms were "concurrent with her occupation." (Ex. 14). Considering Dr. Brown's persuasive and unrefuted distinction between the underlying condition and the symptoms, Dr. Madey's observation that claimant's symptoms concurred with her work does not persuade us that work caused the *condition*. Moreover, Dr. Madey did not address or refute Dr. Brown's and the examining physicians' opinion that claimant's weight contributed to her CTS.[3] Under these circumstances, we do not find Dr. Madey's opinion particularly persuasive. Accordingly, based on the opinions of Drs. Brown

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[1] Dr. Yarusso found claimant's CTS symptoms consistent with her job, before ruling out other potential contributing causes. (Ex. 4). Under these circumstances, we do not find Dr. Yarusso's preliminary opinion helpful in resolving the causation dispute.

[2] We find the examining physicians' opinion that claimant's work activities "played no role in the etiology of her carpal tunnel *entrapment*," consistent with Dr. Brown's distinction between the anatomical condition and the work-related symptoms. (*See* Ex. 15-6, emphasis added).

[3] The ALJ reasoned that claimant's CTS is not weight-related, because her CTS symptoms did not abate when she lost 30 pounds. We do not agree, because the *medical* evidence implicating claimant's weight as a contributing cause is unrebutted.

and the examining physicians, we conclude that claimant has not established that her work exposure was the major contributing cause of her CTS condition and her claim must fail under ORS 656.802(2)(a).[4]

ORDER

The ALJ's order dated January 8, 1999 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

[4] We need not determine whether the "claim is based on a worsening of a preexisting disease or condition" under ORS 656.802(2)(b). Even if it is not, we conclude herein that the claim must fail because claimant has not established major causation under ORS 656.802(2)(a).

May 17, 1999 Cite as 51 Van Natta 828 (1999)

In the Matter of the Compensation of
PAMELA S. SMITH, Claimant
WCB Case Nos. 98-04087, 98-04085 & 97-08948
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Brazeau's order that: (1) upheld the self-insured employer's partial denial of claimant's right shoulder condition as part of an accepted 1994 injury claim; and (2) upheld the employer's denial of claimant's claim for a separate 1998 injury to the right wrist and right shoulder. On review, the issues are scope of review, course and scope and compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings with the following corrections.

In lieu of the ALJ's finding that "[c]laimant did not mention right shoulder symptoms" at the time of her May 20, 1994 injury, we find that the contemporaneous emergency room report notes complaints of "pain in right wrist radiating up into right shoulder."[1]

CONCLUSIONS OF LAW AND OPINION

1994 Injury Claim - Right Shoulder Condition

The ALJ upheld the employer's October 2, 1997 partial denial of claimant's right shoulder condition as part of her accepted 1994 injury claim. We adopt and affirm that portion of the ALJ's order with the following supplementation.

On review, claimant relies on the opinion of Dr. Melson (Ex. 52, Ex. 57, pp. 17-18) and Dr. Ewald (Ex. 38C, Ex. 40, Ex. 53, Ex. 56, pp. 7-8, 14, 24, 30-31, 34-35, 42-45) that the 1994 injury caused claimant's right shoulder condition, variously diagnosed as right shoulder biceps tendinitis, myofascial pain syndrome and impingement syndrome. Dr. Ewald, M.D., began treating claimant in October 1996. Dr. Melson, neurologist, examined claimant for the employer. The record includes contrary opinions from Dr. Wenner, a treating orthopedic surgeon (Ex. 33, Ex. 58, pp. 6-8, 16, Ex. 67, pp. 9-10) and a number of other medical experts who examined claimant for the employer, including Dr. Neumann, orthopedic surgeon (Ex. 52, Ex. 59, pp. 13, 17-21) and Dr. Button, hand surgeon (Ex. 39).

[1] The exhibit list erroneously attributes Exhibit 55B to Dr. Wenner. The author of that exhibit is Dr. Ewald.

The ALJ discounted Dr. Ewald's opinion because it was based on a history of right shoulder symptoms at the time of the 1994 fall. In concluding that Dr. Ewald's opinion was not persuasive, the ALJ found that claimant "did not focus on the right shoulder for several months after the fall." We agree with this finding, notwithstanding the fact that the contemporaneous emergency room chart notes reference complaints of pain "in right wrist radiating up into right shoulder." (Ex. 2A). In so doing, we note that there is no further contemporaneous report of pain radiating into the right shoulder, and there is no report at all of pain emanating *from* the right shoulder, or any specific right shoulder diagnosis or treatment.[2] The first reference to specific right shoulder pain does not occur until March 1995. (Ex. 16A). Furthermore, claimant's testimony does not persuade us that she has an accurate recollection of the date of onset of her right shoulder symptoms. (Tr. 62-67).

Moreover, we are not persuaded by Dr. Ewald's rationale that any delayed onset of right shoulder pain could be the result of muscle atrophy as a result of claimant "guarding" her right arm following the 1994 injury. The record is devoid of any evidence that claimant has experienced atrophy in her shoulder area. Finally, we note that Dr. Ewald did not begin treating claimant until October 1996 and, thus, did not have the opportunity to observe claimant's condition following the 1994 injury.

We turn to the opinion of Dr. Melson, neurologist, who examined claimant for the employer, along with Dr. Neumann, orthopedic surgeon. The ALJ discounted Dr. Melson's opinion in light of Dr. Neumann's contrary opinion, and Dr. Melson's acknowledgment that Dr. Neumann was "more expert as to the shoulder disorder [b]y a factor of a thousand." We agree with the ALJ's reasoning, and we also note that Dr. Melson's opinion is not persuasive because it is conclusory and based on an inaccurate history of "especially prominent right shoulder complaints at the time of the 1994 injury."

In summary, as supplemented above, we adopt and affirm the ALJ's conclusion and opinion that claimant has not established a compensable right shoulder condition as a result of her 1994 injury.

1998 Injury Claim - Right Shoulder and Right Wrist Conditions

The ALJ concluded that the 1998 injury claim was not compensable because claimant had not carried her burden of establishing that the injury occurred within the course and scope of her employment. On review, claimant challenges the merits of the ALJ's course and scope ruling. Alternatively, claimant contends that the ALJ's ruling was not within the proper scope of his review.

We adopt and affirm the ALJ's conclusion that the record does not establish that claimant's 1998 injury occurred within the course and scope of her employment. We turn to claimant's argument that the course and scope issue was beyond the proper scope of the ALJ's review. Specifically, claimant argues that the course and scope denial was not identified in the employer's formal written denial or at the commencement of the hearing, and was not discussed by the employer until after the conclusion of opening remarks and the commencement of testimony. Claimant further contends that the employer did not seek to amend its denial at hearing to include the course and scope issue. Alternatively, claimant argues that any mid-hearing attempt to amend the denial would have been improper because the employer is required to state in writing the factual and legal basis for its denial. *See* OAR 438-005-0055.

We are not persuaded by claimant's argument. The court decided in *SAIF v. Ledin*, 149 Or App 94 (1997), that a carrier may amend its denial at hearing. And our rules expressly provide that amendments to the issues raised and relief requested at hearing "shall be freely allowed." OAR 438-006-0031, OAR 438-006-0036. Where such an amendment is permitted, the responding party must be given an opportunity to respond to the new issues raised to afford due process. OAR 438-006-0091(3); *Larry L. Ledin*, 50 Van Natta 115 (1998); *Gregg Muldrow*, 49 Van Natta 1866 (1997). A party's remedy for surprise and prejudice created by a late-raised issue is a motion of continuance. *Id.*; OAR 438-006-0031, OAR 438-006-0036. Accordingly, an employer is not prevented from amending its denial at hearing, provided that the claimant has the opportunity to request a continuance to cure any surprise or prejudice.[3]

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[2] We recognize that a July 6, 1994 bone scan report states "[p]ain radiates up arms into shoulder." (Ex. 10). However, we are unable to conclude that this is a report of current symptoms, rather than a reiteration of the symptoms reported in the ER chart note.

[3] We also note that the sanction for failing to issue a timely written denial is the assessment of a penalty, where appropriate, for unreasonable claims processing. ORS 656.262(11). The sanction does not include a prohibition against raising affirmative defenses, provided that those defenses are timely raised at hearing, and the claimant has the opportunity to request a continuance to cure any surprise or prejudice.

Here, the employer did not specifically raise the course and scope issue in its written denial or in opening remarks at hearing. But, during the course of claimant's testimony, the employer confirmed that its denial put at issue every element of a compensable claim, including whether the injury occurred on work property during work time. (Tr. 41). We interpret the employer's remarks as an attempt to amend its written denial. Moreover, the employer made these remarks *after* claimant's attorney litigated the course and scope issue by asking questions on direct examination regarding the employer's control over the sidewalk on which claimant fell. (Tr. 17-18, 40-41). At no time during the hearing did claimant object to litigation of the course and scope issue or contend that she was surprised by the issue. Nor did claimant request a continuance of the hearing to present further evidence on the issue. Under these circumstances, we conclude that claimant waived any procedural defect in the employer's denial. *Accord Mary K. Phillips*, 50 Van Natta 519 (1998) (the claimant's failure to request continuance to develop record on medical causation moots effect of rule requiring specificity in denials).[4]

ORDER

The ALJ's order dated September 29, 1998 is affirmed.

[4] *See also Weyerhaeuser Co. v. Bryant*, 102 Or App 432, 435 (1990) (when it is apparent from the record that the parties tried a case by agreement with a particular issue in mind, it was improper for the ALJ and Board not to decide that issue); *Sandra M. Goodson*, 50 Van Natta 1116 (1998) (employer may raise affirmative defense for first time at hearing where the claimant did not contend that she was surprised or prejudiced by the issue and did not request a continuance); *Gary M. Emmerson*, 49 Van Natta 1080 (1997) (where the parties tried the issue of causation by implicit agreement, *i.e.*, without objection, the issue was properly before the ALJ).

May 17, 1999 Cite as 51 Van Natta 830 (1999)

In the Matter of the Compensation of
JULIE A. TREGUBOFF, Claimant
WCB Case No. 98-05747
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Michael Johnson's order that awarded 16 percent (24 degrees) scheduled permanent disability for loss of use or function of each of claimant's wrists, whereas an Order on Reconsideration had awarded none. On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

The ALJ found claimant entitled to 3 percent scheduled permanent disability for each wrist, based on lost range of motion, and 5 percent scheduled permanent disability for each wrist, for bilateral chronic conditions under OAR 436-035-0010(5).[1]

[1] OAR 436-035-0010(5) provides:

"A worker is entitled to a 5% scheduled chronic condition impairment value for each applicable body part, stated in this section, when a preponderance of medical opinion establishes that, due to a chronic and permanent medical condition, the worker is significantly limited in the repetitive use of one or more of the following four body parts:

(a) Lower leg (below knee/foot/ankle);

(b) Upper leg (knee and above);

(c) Forearm (below elbow/hand/wrist);and/or

(d) Arm (elbow and above)."

We agree with regard to the range of motion impairment and adopt the ALJ's "Opinion" through the third full paragraph on page 5. However, we disagree that claimant is entitled to impairment values for chronic wrist conditions, based on the following reasoning.

Dr. Ellison, medical arbiter, provides the only medical evidence regarding claimant's permanent impairment. He opined that claimant:

> "will have continuing symptomatology with repetitive activity. I believe this is secondary to her diagnosed chronic medical condition and it specifically involves the hands and the wrists. Impairment is functional and there is no true measurable impairment from an objective standpoint, I do not believe that any further treatment is indicated, that she is medically stationary, and that symptoms should be controlled with a control of activities--principally the lack of necessity of persistent, repetitive activities." (Ex. 28-2).

Dr. Ellison's opinion indicates that claimant should avoid repetitive hand and wrist activity to avoid symptomatology. We have previously held that a physician's suggestion that the worker avoid repetitive upper extremity work activities *as a means of symptom control* insufficient to support an impairment value for a chronic condition. *See Kathleen L. Hofrichter*, 45 Van Natta 2368 (1993), *aff'd mem* 129 Or App 304 (1994); *Rae L. Holzapfel*, 45 Van Natta 1748 (1993), *aff'd mem* 127 Or App 208 (1994). Accordingly, because the record here does not establish a repetitive use limitation other than to avoid symptomatology, we conclude that claimant has not established entitlement to scheduled impairment values for chronic wrist conditions under the standards.

ORDER

The ALJ's order dated December 16, 1998 is modified. In lieu of the ALJ's scheduled permanent disability awards, claimant is awarded 3 percent (4.5 degrees) scheduled permanent disability for loss of use or function of her right wrist and 3 percent (4.5 degrees) scheduled permanent disability for loss of use or function of her left wrist. The ALJ's attorney fee award is modified accordingly.

May 18, 1999 Cite as 51 Van Natta 831 (1999)

In the Matter of the Compensation of
CLIFFORD A. MITCHELL, Claimant
WCB Case No. 98-07660
ORDER ON REVIEW
Hilary E. Berkman, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that upheld the SAIF Corporation's denial of his injury claim for an osteoporotic L5 compression fracture. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following comment.

We agree with the ALJ that claimant has not established that his work injury was the major contributing cause of his L5 compression fracture. On this record, we also find that claimant has not established that his work injury was the major contributing cause of his need for treatment for that condition. Accordingly, we conclude, as did the ALJ, that claimant has not carried his burden of proof under ORS 656.005(7)(a)(B). *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 321 Or 416 (1995) (persuasive medical opinion must evaluate the relative contribution of causes and explain why work injury contributes more to the claimed condition than all other causes combined).

ORDER

The ALJ's order dated January 15, 1999 is affirmed.

In the Matter of the Compensation of
ROGER A. VORPAHL, Claimant
WCB Case No. 98-04713
ORDER ON REVIEW
Max Rae, Claimant Attorney
Snarskis, Yager, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Livesley's order that affirmed an Order on Reconsideration that awarded claimant permanent total disability (PTD) benefits. Claimant cross-requests review, contending that the ALJ erred in refusing to allow testimony at hearing. Alternatively, if he is not PTD, claimant seeks permanent disability in addition to the 46 percent (147.2 degrees) unscheduled permanent disability awarded by a Determination Order. On review, the issues are evidence and extent of permanent disability, including permanent total disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

Claimant argues that the ALJ erred in refusing to allow testimonial evidence on the grounds that "post-reconsideration" evidence is prohibited by ORS 656.283(7). Claimant contends that this application of the statute violates his constitutional right to due process. However, since the ALJ's order, the court has considered and rejected the same argument. *Koskela v. Willamette Industries, Inc.*, 159 Or App 229 (1999). Accordingly, the ALJ did not err in refusing to allow testimony at hearing and claimant's request for remand on this basis is denied.

Permanent Total Disability

We begin with a brief summary of pertinent facts.

Claimant tore his right rotator cuff placing a ladder at work on May 1, 1995. He had preexisting psoriatic arthritis and numerous injuries before the 1995 injury. Although none of claimant's preexisting problems were disabling when he injured his right shoulder in 1995, he was permanently and totally disabled due to his arthritis by April 1996. (*See* Ex. 12-2).

A February 28, 1998 Determination Order closed claimant's 1995 injury claim with an award of 46 percent unscheduled permanent disability. Both parties requested reconsideration and a June 11, 1998 Order on Reconsideration granted claimant PTD benefits. The insurer requested a hearing.

The ALJ noted that claimant's "post-1995" disabling arthritis could not be considered in evaluating his entitlement to PTD. Further noting that claimant was ineligible for vocational training because of his arthritis-related disability, the ALJ found the insurer's vocational expert unpersuasive and concluded that no job had been identified within claimant's physical restrictions. Therefore, the ALJ found claimant PTD under the "odd lot" doctrine. We disagree.

"Permanent total disability" is statutorily defined as "the loss * * * of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation." ORS 656.206(1)(a).

In determining whether claimant is permanently and totally disabled, we consider only disability that preexisted or was caused by his compensable injury. Subsequent, noncompensable conditions are not considered. *Nyre v. F & R Leasing*, 106 Or App 74 (1991); *Elder v. Rosboro Lumber Co.*, 106 Or App 16 (1991); *Emmons v. SAIF*, 34 Or App 603 (1978). We first consider the extent of claimant's medical disability.

Claimant was permanently and totally disabled by arthritis after his work injury. (*See* Ex. 22-6). Although the arthritis preexisted the 1995 work injury, it was not disabling until after the injury and there is no evidence that it became disabling as a result of the injury. (*See* Ex. 15D-1). Under these

circumstances, claimant's presently disabling arthritis is not a cognizable "preexisting condition" for purposes of evaluating entitlement to PTD benefits. *See Elder v. Rosboro Lumber*, 106 Or App at 19 ("[A]ny disability that developed as a result of the [preexisting] condition after the injury, but not as a result of the employment, may not be considered.").[1] Dr. Schader and the medical arbiter provide the primary evidence addressing claimant's medical disability.

On March 14, 1997, Dr. Schader, treating physician, opined that, but for the psoriatic arthritis,

> "simply from the standpoint of his right shoulder, he would be capable of performing work which involved use of his right arm at the side, with no repetitive lifting or rotational movement of the arm." (Ex. 15).

Dr. Schader also stated that a 2 pound lifting restriction was "reasonable," considering claimant's shoulder condition only, but that claimant was essentially disabled and incapable of work, considering his entire body.[2] (Ex. 19).

On January 27, 1998, Dr. Schader opined,

> "considering his entire body, [claimant] is essentially disabled and incapable of work. * * * * With respect to his shoulder, he is suitable for sedentary work only, with use of his right arm at his side." (*Id*).

Thus, Dr. Schader distinguished claimant's partial injury-related right shoulder disability from his total "entire body" disability.

The medical arbiter addressed only claimant's right shoulder disability. He limited claimant's right arm lifting and carrying to 5 pounds and opined that claimant could perform sedentary work with no repetitive reaching or overhead use of his right arm and no climbing, reaching, pushing, or pulling. (Ex. 31). Based on both doctors' opinions, we conclude that claimant's residual functional capacity is "sedentary/restricted" and he is not PTD based on his injury-related medical condition alone. (*See* Exs. 15, 19, 31).

The closer question is whether claimant is entitled to PTD benefits under the "odd lot" doctrine.

> "If a worker retains 'some residual functional capacity and is not medically permanently and totally disabled,' the worker must prove, using 'competent written vocational' evidence, that he or she is unable regularly to perform work at a gainful and suitable occupation. OAR 436-030-0055(4)." *Koskela v. Willamette Industries, Inc.*, 159 Or App at 239.

The nonmedical factors to be considered in an "odd-lot" analysis include age, education, adaptability to nonphysical labor, mental capacity and emotional condition, as well as the conditions of the labor market. *Welch v. Bannister Pipeline*, 70 Or App 699, 701 (1984). As in the "medical only" analysis, we must disregard the noncompensable contribution of claimant's disabling arthritis, including its effect on retraining. *Nyre v. F & R Leasing*, 106 Or App at 76. However, because there is no evidence regarding the availability of employment *requiring* retraining, there is also no evidence establishing that claimant could perform any such employment regularly in the hypothetically normal labor market. Absent such evidence, we do not consider any of the proposed jobs that would require pre-employment training in evaluating claimant's employability.[3]

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[1] *See Margie J. Garcia, on recon* 46 Van Natta 1028 (1996) (absent evidence that the claimant's preexisting conditions interfered with her ability to work prior to her compensable injury, those conditions were not disabling as of the work injury); *see also Darlene E. Parks*, 47 Van Natta 2404, 2408 (1995), *recon den* 48 Van Natta 190 (1996) (the claimant must prove that his or her permanent total disability is due to her compensable injury).

[2] We note that there is earlier evidence indicating that claimant was totally disabled, but none addressing claimant's permanent injury-related medical disability. (*See* Ex. 12-1-2).

[3] Because there is no showing that jobs requiring retraining are available in the labor market, we do not reach the parties' arguments addressing *Edward H. Fox, Sr.*, 48 Van Natta 416 (1996) (Board declined to eliminate the claimant's PTD award where potential employability was speculative because there was no evidence that retraining would have improved the deceased claimant's employability).

The vocational evidence in this case is provided by Kathryn Whitcombe, claimant's vocational expert, and Susan Potter, the insurer's expert. Potter identified several jobs within claimant's injury-related restrictions, but she only conducted a labor market survey for one--Telephone Solicitor. Potter concluded that claimant could perform telemarketing work, it would be suitable for him, and her survey indicated that this work was available in the labor market. (*See* Exs. 22, 28).

The ALJ found Potter's opinion unpersuasive, reasoning that Potter relied on an inaccurate understanding of claimant's restrictions. Specifically, the ALJ interpreted Dr. Schader's requirement that claimant's right arm use be "at his side" to mean that claimant is restricted form *all* lifting with his right arm. Finding no evidence that claimant could occasionally lift up to 10 pounds, the ALJ concluded that claimant could not perform sedentary level work. He also concluded that three of the identified telemarketing jobs were beyond claimant's restrictions because they required hand writing and/or hand telephone dialing. We disagree.

Dr. Schader stated that, based on his injury-related limitations, claimant "would be capable of performing work which involved use of his right arm at the side, with no repetitive lifting or rotational movement of the arm." (Ex. 15-1). He did not say that claimant could do *no* lifting. On the contrary, the doctor's restriction against *repetitive* lifting suggests that claimant *could* do some lifting, as long as it is not repetitive. Moreover, there is no evidence that the available Telephone Solicitor job requires bilateral lifting or any activity that claimant could not perform with his left arm and his right arm at his side. (*See* Exs. 19, 28-1-3). We also note that claimant writes with his left hand and there is no evidence that his injury-related restrictions interfere with handwriting or other use of his *left* hand or arm. (*See* Exs. 22-4, 31-3). Under these circumstances, we find Potter's vocational opinion persuasive.[4]

Kathryn Whitcombe, claimant's vocational expert, noted that claimant had successfully worked for the insured as a cable splicer-installer-repairman for 17 years -- until the 1995 work injury. Whitcombe opined that claimant is now unable to work, because no potential job would accommodate his lack of training, physical restrictions, and other vocational limitations. We find Whitcombe's reasoning and conclusions less persuasive than Potter's, for several reasons.

First, as we have explained, the record indicates that telephone solicitation work is within claimant's injury-related restrictions and available without pre-employment training. Second, Whitcombe's opinion that claimant's prescribed medications interfere with his ability to concentrate and maintain focus in a work-like setting does not reference *injury-related* disability, because these medications are prescribed for his noncompensable arthritis, as well as his shoulder condition. (*See* Ex. 30-8). Similarly, if claimant lacks the stamina and cognitive and mental alertness necessary for telemarketing, any such disability is not injury-related (and it did not precede the work injury). Accordingly, to the extent that claimant is mentally disabled, such disability is not injury-related and it is not legally cognizable in evaluating his PTD claim. In sum, because Whitcombe relied on noninjury-related factors,[5] her opinion does not support a conclusion that claimant's disability is injury-related or that he is PTD.[6] *See Nyre*, 106 Or App 74; *Elder*, 106 Or App 16.

Consequently, we rely on the opinions of the medical arbiter, Dr. Schader, and Ms. Potter. Based on their opinions, we conclude that there is suitable gainful employment available to claimant within his injury-related restrictions. *See Veronica M. Strackbein*, 49 Van Natta 880 (1997). Thus, because cognizable disabilities would not prevent claimant from working regularly working as a telephone solicitor, he is not entitled to PTD benefits.

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[4] No vocational evidence contradicts Potter's conclusion that telemarketing jobs exist in the hypothetically normal labor market within a reasonable geographic distance. There is no suggestion that telemarketing would not be gainful employment.

[5] To the extent that Whitcombe felt that claimant was unable to work because he is ineligible for retraining, her opinion does not support the claim. As we have explained, claimant's ineligibility is due to "*post-injury*" disability, *unrelated* to the compensable injury, and it may not be considered in evaluating his ability to work.

[6] We note that Potter recorded *claimant's* opinion that the telemarketing work environment would not be suitable for him. (*See* Ex. 30-7). However, claimant's opinion is not competent vocational evidence supporting the claim. *See* OAR 436-030-0055(4). We also acknowledge Potter's opinion that claimant's employment experience has not given him the opportunity to gain effective customer service skills useful in telemarketing. (Ex. 30-8). We do not find the latter conclusion particularly persuasive because claimant's long work history as a cable installer *did* include customer service and public contact. (*See* Ex. 22-10).

Permanent Partial Disability

Claimant alternatively seeks additional unscheduled and scheduled permanent disability awards for his right shoulder and right hand conditions.

The parties agree that claimant's social and vocational factor is 2 and they agree that his adaptability was incorrectly determined on reconsideration. With this in mind, we apply the standards for rating claimant's permanent partial disability on *de novo* review.

Claimant was medically stationary on January 1, 1998 and a Determination Order closed his claim on February 2, 1998. Therefore, we apply the rules for rating permanent disability contained in WCD Admin. Order 96-072.

Claimant's adaptability value is determined by comparing his base functional capacity to his residual functional capacity. Claimant worked for 17 years as a "Line Installer-Repairer" before his work injury. DOT 822.381-014. (*See* Exs. 11, 22). Therefore, his base functional capacity was "heavy." Claimant's residual functional capacity is "sedentary/light." Consequently, his adaptability factor is 7 and his vocational total is 14 (2x7).

We rely on the arbiter's report to determine claimant's impairment generally[7] because it is the most thorough and complete evaluation of claimant's injury-related impairment and the arbiter's examination was conducted closest to reconsideration. *See e.g., Carlos S. Cobian*, 45 Van Natta 1582 (1993). We also rely on Dr. Schader's lost strength findings, because the arbiters did not measure lost strength. On this evidence, we find that claimant is entitled to ratings of 10 percent (lost strength), 5 percent (right shoulder surgery), and 28 percent (lost shoulder range of motion), and 5 percent (chronic condition limiting repetitive use of the right shoulder), for a combined total of 41 percent impairment. Claimant's impairment total, 41, and his vocational factor, 14, are added together for a total of 55 percent unscheduled permanent disability.

Claimant argues entitlement to a 5 percent scheduled permanent disability award for his right hand, based on the arbiter's measurements of lost right pinch and grip strength. Claimant reasons that the muscles responsible for grip and pinch functions appear to enervated by the median, ulnar, and interosseous nerves (based on a medical text). Therefore, he contends that losses of ulnar and median strength should be rated as a 5 percent loss of use or function of his right hand. *See* OAR 436-035-0007(18)(a) and 436-035-0110(8). However, no medical evidence indicates that claimant's slightly decreased pinch and grip strength is directly or indirectly related to his right shoulder injury or that he has ratable and injury-related median, ulnar or interosseous nerve impairment or disability. (*See* Ex. 31-2). Consequently, claimant has not established entitlement to a scheduled permanent disability award on this basis.

ORDER

The ALJ's order dated November 30, 1998 is reversed. The ALJ's attorney fee award is reversed. The Order on Reconsideration is reversed. In addition to the Determination Order award of 46 percent (147.2 degrees) unscheduled permanent disability, claimant is awarded 9 percent (28.8 degrees) unscheduled permanent disability, for a total award to date of 55 percent (176 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney, not to exceed $3,800.

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[7] We note that the arbiters attributed an estimated 60 percent of claimant's impairment to his "accepted condition" and the remainder to "pre-existing" impairment. (Ex. 31-3). The insurer does not contend that claimant had preexisting right shoulder impairment and Dr. Schader's reports do not indicate that any of claimant's current right shoulder impairment preexisted the work injury. Under these circumstances, we do not rely on the arbiters' opinion in this regard and we do not reduce claimant's impairment ratings on this basis. We are similarly unpersuaded by the arbiters' suggestion that the May 13, 1998 range of motion measurements may have been influenced by secondary gain because their measurements differed from Dr. Switlyk's January 1998 measurements. (Ex. 31-2-3). First, we are restricted to the arbiter's report and the attending physician's opinion in evaluating impairment and Dr. Schader, not Dr. Switlyk, was claimant's attending physician at claim closure. Second, the arbiters thought claimant's impairment findings were *valid* based on their examination and claimant's "straightforward" presentation. (Ex. 31-2). Under these circumstances, we conclude that the arbiters' findings represent valid injury-related impairment and we rely on them.

In the Matter of the Compensation of
DENISE N. BROWN, Claimant
WCB Case No. 97-10395
ORDER ON REVIEW
Myrick, Seagraves, et al, Claimant Attorneys
Wallace, Klor & Mann, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of claimant's occupational disease claim for a lumbar spondylolisthesis condition. In her respondent's brief, claimant argues that the ALJ erred in upholding the employer's denial of her injury claim for the same condition. The employer moves the Board to strike the issue raised by claimant in her brief, inasmuch as claimant did not formally cross-request review. On review, the issues are motion to strike and compensability. We deny the motion to strike, affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exception and summary. We do not adopt the ALJ's last finding of fact.

Since June 4, 1990, claimant has worked as a delivery person. She worked at this job full-time in California. After moving to Oregon in September 1996, she worked at this job part-time. Her job in California regularly involved lifting 60 to 70 pound parcels out of large trucks into bins, and then from the bins into delivery trucks. She then drove a route, making 75 to 105 stops per day and handling between 120 and 180 parcels. She did this ten hours per day, five to six days per week. After moving to Oregon, claimant worked for the same employer, 30 to 32 hours per week, doing more driving with fewer stops. The range of weights remained the same; the Oregon truck was more awkward to enter and exit, but she only had to do it 40 times per day.

Claimant has spondylolisthesis of L4 on L5 that preexisted her employment with the employer. Claimant had no difficulty with her back until her first work injury in 1992. Since then, her symptoms have waxed and waned with activity. She has received intermittent chiropractic care since 1992.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike; Compensability of Low Back Injury Claim

The ALJ found that claimant failed to meet her burden of proving that a compensable low back injury occurred on April 7, 1997. In her Respondent's Brief, claimant raises the issue of compensability of this back injury claim. In its Reply Brief, the employer moves the Board to strike this issue, inasmuch as claimant did not formally cross-request review. We deny the employer's motion. We have the authority to consider a respondent's contentions notwithstanding its failure to cross-request review. *Destael v. Nicolai Co.*, 80 Or App 596 (1986); *William E. Wood*, 40 Van Natta 999 (1988).

Nevertheless, we agree with the ALJ that the record does not support compensability of claimant's low back injury claim. Although raising the issue, claimant makes no argument in support of her back injury claim. Furthermore, there is little evidence in the record regarding compensability of a work injury occurring on April 7, 1997. Claimant sought treatment on April 11, 1997. (Ex. 70). At that time, however, claimant did not report any work injury; instead, she reported that she was doing rock work at home. (Ex. 70). Given this, Dr. Dinneen, examining orthopedist, and Dr. Melson, examining neurologist, opined that it was not medically probable that claimant sustained a work injury on April 7, 1997. (Exs. 103).

Furthermore, there is no dispute among the medical opinions that claimant has preexisting spondylolisthesis at L4-5. (Exs. 78, 79, 94, 97, 98, 100, 101). In addition, Dr. Van Horne, treating orthopedist, who provides the only other medical opinion regarding compensability of a work injury, opined that claimant's preexisting L4-5 spondylolisthesis condition combined with an April 7, 1997 work incident. (Exs. 94, 97).

Where an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or need for treatment, the applicable statute is ORS 656.005(7)(a)(B). Under that section, "the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition."

Here, however, Dr. Van Horne was unable to conclude that the April 7, 1997 work incident was the major contributing cause of the disability or need for treatment of claimant's combined condition. (Exs. 94, 97). Thus, the medical opinions do not support compensability of claimant's low back injury claim.

Compensability of Occupational Disease Claim

The ALJ found that the opinion of Dr. Inkrote, claimant's treating chiropractor, established the compensability of claimant's occupational disease claim for a L4-5 spondylolisthesis condition. We disagree.

Claimant does not dispute that she has a preexisting spondylolisthesis condition, as established by the medical record. Instead, she contends that her spondylolisthesis condition has worsened as the result of the repetitive lifting she did at the employer. Because claimant's occupational disease claim is based on a worsening of a preexisting disease, she must prove that "employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease." ORS 656.802(2)(b). Major causation requires that the work exposure contribute more to the claimed condition that all other causes or exposures combined. In addition, the worsening of the preexisting spondylolisthesis condition must be established by medical evidence supported by objective findings. ORS 656.802(2)(d).

Furthermore, the fact that work activities are the immediate or precipitating cause of a claimant's condition does not necessarily mean that the work activities are the major contributing cause of the condition. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995); *see also Robinson v. SAIF*, 147 Or App 157 (1997). Instead, determination of the major contributing cause involves evaluating the relative contribution of different causes of claimant's need for treatment of the combined condition and deciding which is the primary cause. *Id.*

Whether claimant's work activities were the major contributing cause of her combined condition and pathological worsening of her preexisting spondylolisthesis condition presents a complex medical question requiring expert medical analysis. *See Uris v. Compensation Department*, 247 Or 420, 424-26 (1965); *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985). Moreover, as the question before us requires expert medical analysis rather than expert observation, claimant's treating physician is entitled to no special deference. *See Hammons v. Perini Corp.*, 43 Or App 299, 301 (1979).

Here, Drs. Van Horne, Inkrote, Dinneen, Melson, and White, a neurologist who performed a record review on behalf of the employer, offer medical opinions as to cause of claimant's condition. Only the opinions of Drs. Van Horne and Inkrote might support compensability of claimant's occupational disease claim.

Dr. Van Horne opined that claimant had a preexisting L4-5 spondylolisthesis condition that was not caused by her work. (Ex. 97-1). He noted that she had a long-standing problem; however, it did "all appear to be during the time she worked for [the employer]." (Ex. 94-1). He also stated that she "may have had an underlying degenerative disease of her back but clearly her back has been aggravated by the type of work she does." (*Id.*). He believed that claimant's work "has to be 51% of the cause of her problem." (Exs. 94-1, 97-1). He based this opinion on the fact that claimant had worked at the employer for more than seven years, had reported that she had no back pain before that time, and had evaluations and exacerbations of her back all during her employment with the employer. (*Id.*). Finally, he stated that he was unable to provide an opinion regarding what happened to claimant's spine pathologically over the last few years of her employment with the employer. (Ex. 97-2).

Dr. Inkrote offered several opinions regarding causation. (Exs. 96, 100, 104, 105, 106, 107). Dr. Inkrote first examined claimant on September 12, 1996, and did not review any of claimant's medical reports before that date and few, if any, medical reports after that date. She also did not review claimant's x-rays and MRI. Dr. Inkrote stated that she would defer to Dr. Van Horne's opinion regarding whether there was a pathological worsening of the spondylolisthesis condition. (Ex. 106-2).

Several of Dr. Inkrote's opinions focus on claimant's increased symptoms. She opined that claimant's delivery route was a "definite factor in the worsening of her symptoms" and that the work activities were the major contributing cause that "precipitated the increased low back pain." (Exs. 100, 104). However, as explained above, claimant must establish that the work activities were the major contributing cause of the combined condition and pathological worsening of the preexisting spondylolisthesis. ORS 656.802(2)(b). The fact that the work activities increased claimant's low back symptoms is not sufficient to meet claimant's burden of proof.

Dr. Inkrote also stated that claimant's work activities were the major contributing cause of the need for treatment and the actual worsening of her spondylolisthesis condition. (Ex. 105-1, 106-3, -4, 107). Although Dr. Inkrote did not review Drs. Dinneen's and Melson's report, claimant's attorney informed her about the "diagnostic imaging studies" portion of that report in which Dinneen and Melson noted that they reviewed x-rays from 1994 through 1998 and agreed "there is obvious spondylolisthesis of L4 on L5 with some increase in those intervening years. There has also been decreasing intervertebral space between L3 and L4." (Exs. 101-5, 105-1-2, 106-1-2, -4). Based on that statement, Dr. Inkrote opined that claimant's preexisting spondylolisthesis condition had materially worsened over the last few years and the major contributing cause of that worsening was her work activities. (*Id.*, Ex. 107).

For the following reasons, we do not find that the opinions of Drs. Van Horne and Inkrote meet claimant's burden of proof. Dr. Van Horne was unable to provide an opinion regarding whether claimant's preexisting condition had pathologically worsened. ORS 656.802(2)(d). In addition, Dr. Inkrote admittedly reviewed little, if any, of the medical record. Therefore, she has little basis for her opinion. Most importantly, however, Drs. Van Horne and Inkrote offer no explanation of their opinions and no evaluation of the relative contribution of the preexisting spondylolisthesis condition and claimant's work activities. Instead, it appears that they were simply relying on a precipitating cause, or a "but for" analysis, *i.e.*, claimant's preexisting condition was asymptomatic before beginning work with the employer and became symptomatic with work activities, so the work activities must be the major contributing cause of claimant's worsened condition. But a precipitating cause, or a "but for" analysis, without the required *Dietz* analysis, is not sufficient to establish the work activities as the major contributing cause of the combined condition and pathological worsening of the spondylolisthesis condition. *Georgia Barklow*, 49 Van Natta 1261 (1997); *Alec E. Snyder*, 47 Van Natta 838 (1995) (persuasive medical opinion must weigh the relative contribution of different causes; "but for" analysis not well reasoned).

Furthermore, none of the other medical opinions support compensability of claimant's claim. Therefore, on this record, we find that claimant failed to establish a compensable occupational disease claim.

ORDER

The ALJ's order dated November 11, 1998 is reversed in part and affirmed in part. That portion of the order that set aside the employer's denial of claimant's occupational disease claim is reversed. The denial of the occupational disease claim is reinstated and upheld. The ALJ's award of attorney fees is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
LINDA K. DICKENSON, Claimant
WCB Case No. 96-05441
ORDER ON REVIEW
Kryger, et al, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that awarded an assessed attorney fee of $5,000. On review, the issue is attorney fees.

We adopt and affirm the ALJ's order with the following supplementation.

After finding that claimant had established compensability of her bilateral carpal tunnel syndrome, the ALJ decided that "after considering the factors set forth in OAR 438-015-0010(4), SAIF shall pay claimant's attorney an assessed fee of $5,000 for his services in setting aside its denial, to be paid in addition to claimant's compensation."

On review, SAIF contends that, based on *Schoch v. Leupold & Stevens*, 325 Or 112 (1997), and *McCarthy v. Oregon Freeze Dry*, 327 Or 84, *adhered to on recon* 327 Or 185 (1998), the ALJ's order is insufficient with regard to the attorney fee award. Specifically, SAIF contends that the ALJ was required to make findings for each of the factors contained in OAR 438-015-0010(4) and, because the order failed to do so, asks the Board to vacate and remand.

As we have in previous cases, we reject SAIF's argument. It is sufficient for an ALJ to merely describe or cite the rule-based factor or factors upon which the ALJ relied in determining a reasonable attorney fee when the parties at hearing do not dispute or submit argument to the ALJ concerning the weighing of the rule-based factors. *See Daryl L. Underwood*, 50 Van Natta 2330 (1998). An ALJ satisfies his or her obligation to make findings in a case by including a brief description or citation to the rule-based factor or factors the ALJ relied on in determining the attorney fee awarded. *Id.* (citing *McCarthy v. Oregon Freeze Dry*, 327 Or 84, *adhered to on recon*, 327 Or 185 (1998)).

Here, although the ALJ cited the applicable rule (OAR 438-015-0010(4))[1], none of the specific rule-based factors were identified or particularly considered in awarding an attorney fee. Under such circumstances, we consider the ALJ's reasoning insufficient to determine the basis for the attorney fee award. *Donna R. Grierson*, 51 Van Natta 679 (1999). Consequently, we provide the following supplementation. In doing so, we reject SAIF's contention that remand for further development of the record is warranted. *Id.*

The issue in dispute was compensability of claimant's bilateral carpal tunnel syndrome. In the first proceeding, the parties also litigated the ALJ's decision declining to postpone/continue claimant's scheduled hearing to compel her to attend a "post-denial" insurer-arranged medical examination. After the first proceeding, SAIF requested review. On review, we found that SAIF was entitled to a postponement of a scheduled hearing in order to obtain a "post-denial" insurer-arranged medical examination. We vacated the ALJ's decision and remanded the case for further proceedings. *Linda K. Dickenson*, 50 Van Natta 41, *on recon* 50 Van Natta 108 (1998). On remand, the ALJ admitted additional evidence and the parties stipulated to additional facts. The parties provided written closing arguments.

Our review of the record provides the following information. Nine exhibits were received in evidence, two of which were submitted or generated by claimant's counsel. There were no depositions. The transcript for the September 5, 1996 hearing consists of 75 pages. Claimant testified on her own behalf.

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[1] OAR 438-015-0010(4) provides that "[i]n any case where an Administrative Law Judge or the Board is required to determine a reasonable attorney fee, the following factors shall be considered: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses."

On Board review, claimant's counsel submitted a 7-page respondent's brief. Claimant's attorney submitted a statement of services, indicating that he spent 8.2 hours devoted to services before the Board and requesting an attorney fee of $1,230. On remand, claimant's counsel submitted a 4-page opening brief and a 2-page reply brief. In addition, claimant's counsel submitted several letters to the ALJ regarding the issues on remand.

As compared to typical compensability cases, we find the compensability issue was of average medical complexity. The legal issue regarding the "post-denial" insurer-arranged medical examination, however, was of above average legal complexity. The claim's value and the benefits secured were of average proportions. No frivolous issues or defenses were presented. Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated.

After considering the factors set forth in OAR 438-015-0010(4) (particularly those previously described) and considering the parties' arguments, we agree with the ALJ that $5,000 is a reasonable attorney fee. Because the only issue on review was attorney fees, claimant is not entitled to an attorney fee on review for her counsel's services regarding the ALJ's attorney fee award. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated February 8, 1999 is affirmed.

In the Matter of the Compensation of
STEVEN FOX, Claimant
WCB Case Nos. 98-07361 & 98-04435
ORDER ON REVIEW
Larson & Owen, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that upheld the SAIF Corporation's denial of claimant's aggravation claim for a current back strain condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for the "Ultimate Findings of Facts."

CONCLUSIONS OF LAW AND OPINION

Claimant worked for the insured as a truck driver. He suffered a compensable thoracolumbar strain/sprain injury, when a box of freight fell on him on March 25, 1997. He was off work for a week and treated conservatively. SAIF closed his claim with a May 8, 1997 Notice of Closure that awarded temporary disability but no permanent disability.

Claimant's mid to low back pain persisted and he continued truck driving. On December 18, 1997, he sought treatment for back pain and Dr. Burns restricted him to light duty work. SAIF denied claimant's aggravation claim and claimant requested a hearing.

The ALJ found that claimant's accepted thoracolumbar sprain/strain did not worsen, because only Drs. Burns and Jones addressed whether claimant's accepted condition objectively worsened and only Dr. Burns made objective findings of a worsening. We reverse.

Dr. Burns first examined claimant on December 18, 1997 and noted claimant's history of persistent right-sided thoracolumbar pain since the March 1997 work injury, as well as his lack of prior back injuries. (Ex. 19-1-2). December 1997 examination findings included muscular hypertonicity, consistent with persistent chronic muscle spasm; tenderness to low back palpation; and thoracic forward flex to 63 degrees. (Ex. 19-2). Dr. Burns opined that claimant's work was the most likely cause of his current symptoms (because claimant had no off work contributing activities). (Ex. 19-3).

Dr. Burns was unable to determine whether claimant's December 1997 condition was an "objective pathological worsening of his accepted condition" until he reviewed the closing examination report from the initial injury claim. (*See* Ex. 19-2). After examining that report, Dr. Burns opined that claimant *had* sustained an objective pathological worsening of his accepted condition. He explained that claimant had normal range of motion and no palpable muscle spasm at claim closure, but, as of January 1998, he had palpable muscle spasm in the right parathoracic area and decreased range of motion of the thoracolumbar spine. (Ex. 20-1). Dr. Burns again noted that claimant had persistent problems in the right "thoraco lumbar" area since at least June 1997, but "absolutely no neurosurgical indications." (Ex. 21-2).

Dr. Jones examined claimant on SAIF's behalf on March 30, 1998. He opined that claimant had not sustained "any objective pathological worsening of his accepted condition" since the May 1997 claim closure.[1] (Ex. 24-5; *see* 26B). Dr. Jones later opined that claimant's accepted strain probably resolved well within a six to twelve week period, because muscle strains normally do resolve within that time frame. (Ex. 27-2). Considering the nature of the injury, the lack of important preexisting complicating features, and Dr. Hosko's work release on April 2, 1997, Dr. Jones opined that it was unlikely that the March 3, 1997 incident materially contributed to claimant's subsequent problems. (*Id*).

To the extent that Dr. Jones believed that claimant's strain resolved because it "should have" resolved, we do not find his reasoning persuasive because it is essentially general, rather than specific to claimant. In this regard, we note Dr. Burns' observation that *claimant* had requested that his work restrictions be "lifted" soon after the injury (so he could get back to work) and the doctor's suggestion that his initial claim was closed "without an adequate trial at regular duty work." (Exs. 19-1, 20-2). Moreover, because Dr. Burns' opinion is more consistent with claimant's history of ongoing back symptoms (beginning with the accepted strain), we conclude that Dr. Burns' opinion is persuasive and we rely on it.[2] Accordingly, based on Dr. Burns' opinion, we find that claimant has established that he sustained an actual worsening of his accepted thoracolumbar strain/sprain since the initial claim was closed. Because we also find that the claim is established by medical evidence supported by objective findings, (Exs. 19, 20), we conclude that claimant has carried his burden under ORS 656.273.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record, claimant's appellate briefs, and claimant's counsel's fee request on review), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated December 15, 1998 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant is awarded a $3,000 attorney fee, payable by SAIF.

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[1] Dr. Burns disagreed with Dr. Jones, stating that claimant *did* have a pathological worsening, as explained in his prior (January 20, 1998) report. (Ex. 26; *see* Exs. 20, 26D-2).

[2] We also note that Dr. Turner examined claimant on March 2, 1998 and opined that claimant's examination findings were consistent with claimant's work related accident. (Ex. 23A-2).

In the Matter of the Compensation of
TIMOTHY A. HARDIN, Claimant
WCB Case No. 98-06398
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Kekauoha's order that: (1) set aside its denial of claimant's injury claim for a cervical-thoracic strain; and (2) awarded a $3,200 attorney fee. SAIF also moves for remand. On review, the issues are remand, compensability, and attorney fees.

We deny SAIF's motion for remand and adopt and affirm the ALJ's order with the following supplementation.

Claimant requested a hearing challenging SAIF's denial of his injury claim for a cervical-thoracic strain. Following the hearing, the ALJ found that claimant had proven his claim and directed SAIF to accept and process it. The ALJ also awarded an attorney fee of $3,200 after considering the factors set forth in OAR 438-015-0010(4) and applying them to the case.

On review, SAIF argues that the ALJ failed to make specific findings with regard to the factors set forth in the rule and that his explanation for the $3,200 fee award is insufficient. Contrary to SAIF's contention, the ALJ was not required to make findings for each rule-based factor. As we explained *Daryl L. Underwood*, 50 Van Natta 2330 (1998), where there is no specific argument at hearing concerning the application of the factors in OAR 438-015-0010(4), an ALJ satisfies his or her obligation to make findings concerning the attorney fee award by including in the order a brief description or citation to the rule-based factor or factors relied upon in determining the fee award. Furthermore, because we are authorized to modify or supplement the ALJ's order on review under ORS 656.295(6), remand is not an appropriate remedy. *Daryl L. Underwood*, 50 Van Natta at 2332.

Here, the ALJ cited to the applicable rule and identified the factors considered in determining the fee. The ALJ explained that, in awarding the $3,200 fee, the following factors were particularly considered: the above-average time devoted to the compensability issue (as represented by the record); the above-average complexity of the compensability issue (given SAIF's vigorous defense); the average value of the interest involved and benefits obtained; and the substantial risk that claimant's attorney's efforts may go uncompensated. This explanation for the ALJ's attorney fee award is consistent with the *Underwood* rationale. *See Leslie D. Custer*, 51 Van Natta 390 (1999).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Finally, we note that claimant is not entitled to an attorney fee for services related to the attorney fee issue. *See Dotson v. Bohemia*, 80 Or App 223 (1986).

ORDER

The ALJ's order dated January 8, 1999 is affirmed. For services on review, claimant is awarded an $1,000 attorney fee, payable by the SAIF Corporation.

In the Matter of the Compensation of
MARVIN D. HOLBERT, Claimant
WCB Case No. 98-08628
ORDER ON REVIEW
Edward J. Harri, Claimant Attorney
Hitt, et al, Defense Attorneys
Kryger, et al, Claimant Attorneys

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) affirmed an Order on Reconsideration awarding 8 percent (12 degrees) scheduled permanent disability for loss of use or function of claimant's left forearm/wrist and 8 percent (12 degrees) scheduled permanent disability for loss of use or function of the right forearm/wrist; and (2) awarded an employer-paid attorney fee under ORS 656.382(2). On review, the issues are scheduled permanent disability and attorney fees. We modify in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's "findings of Fact" with the exception of the finding that claimant is significantly limited in repetitive use of the bilateral wrist/forearms and that Dr. Dodds did not conduct a closing examination as defined in the administrative rules.

CONCLUSIONS OF LAW AND OPINION

Claimant's compensable bilateral carpal tunnel claim was closed without permanent disability by a June 2, 1998 Notice of Closure. An Order on Reconsideration awarded 8 percent scheduled permanent disability for each wrist/forearm. The employer requested a hearing, challenging the reconsideration order's award of bilateral scheduled permanent disability.

The ALJ affirmed the Order on Reconsideration's award of scheduled permanent disability for claimant's bilateral carpal tunnel condition. In doing so, the ALJ first determined that Dr. Ellison's medical arbiter's examination should be used to rate claimant's permanent disability instead of the closing examination of claimant's attending physician, Dr. Dodds. The ALJ reasoned that Dr. Dodds did not conduct a closing examination in accordance with the Department's rules and that his examination was "cursory." With respect to the merits of the scheduled permanent disability issue, the ALJ found, based on Dr. Ellison's examination, that claimant had reduced range of motion bilaterally that supported the reconsideration order's award of 3 percent scheduled permanent disability for each wrist. Finally, the ALJ determined that Dr. Ellison's examination supported the reconsideration order's bilateral award of 5 percent scheduled permanent disability for a "chronic condition."

On review, the employer contends that permanent disability should be rated using Dr. Dodds' closing report in which Dr. Dodds concluded that claimant had no permanent impairment. Alternatively, the employer asserts that Dr. Ellison's arbiter's report does not support a finding of scheduled permanent disability.

Evaluation of a worker's disability is as of the date of issuance of the reconsideration order. ORS 656.283(7). Where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. *See Orfan A. Babury*, 48 Van Natta 1687 (1996). This "preponderance of the evidence" must come from the findings of the attending physician or other physicians with whom the attending physician concurs. *See Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670 (1994). We do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment but, rather, rely on the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

In this case, we find that Dr. Ellison provided the most thorough, complete and well reasoned evaluation of claimant's permanent disability. In reaching this conclusion, we agree with the ALJ that Dr. Dodds' closing examination was somewhat cursory in comparison to Dr. Ellison's report. Given this conclusion, we need not decide whether the ALJ correctly discounted Dr. Dodds' closing report on the ground that it did not sufficiently comply with the Department's requirements for a closing examination.

Turning to the merits of the scheduled permanent disability issue, we agree with the ALJ's reasons for finding that claimant has reduced range of motion bilaterally in his wrists sufficient to justify an award of 3 percent bilateral permanent disability. However, we disagree with the ALJ's conclusion that Dr. Ellison's report supports a bilateral "chronic condition" award.

Dr. Ellison reported: "I do believe that he will have continued symptomatology, and perhaps recurrent carpal tunnel symptoms, with repetitive activity in which he is not given appropriate breaks. I believe that is present on a permanent basis. Otherwise, I find no evidence of any impairment." (Ex. 25-2)

The administrative rule that is applicable, OAR 436-035-0010(5) (WCD Admin. Order 96-072), provides, in relevant part:

> "A worker is entitled to a 5% scheduled chronic condition impairment value for each applicable body part, stated in this section, when a preponderance of medical opinion establishes that, due to a chronic and permanent medical condition, the worker is significantly limited in the repetitive use of one or more of the following four body parts: * * * "(c) Forearm (below elbow/hand/wrist)[.]"

Here, we are not persuaded that Dr. Ellison's statement that claimant will have continued symptoms, and perhaps recurrent carpal tunnel, if he is not given appropriate breaks establishes that he is "significantly" limited in the repetitive use of his wrists.[1] Under such circumstances, we do not believe that claimant is entitled to a chronic condition award for each wrist.

Accordingly, we find that claimant is entitled to 3 percent scheduled permanent disability for each wrist. Because we have found that the compensation awarded by the Order on Reconsideration should have been reduced as a result of the employer's hearing request, we reverse the ALJ's award of an attorney fee pursuant to ORS 656.382(2).

ORDER

The ALJ's order dated February 5, 1999 is modified in part and reversed in part. In lieu of the Order on Reconsideration's bilateral wrist award of 8 percent (12 degrees), claimant is awarded 3 percent (4.5 degrees) scheduled permanent disability for each wrist. The ALJ's attorney fee award is reversed.

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[1] In reaching this conclusion, we reject claimant's assertion that Dr. Ellison's opinion means that he will be unable to use his upper extremities as he had before his injury. Dr. Ellison's opinion merely means that claimant will have continued symptoms if he is not given appropriate breaks. We have no reason, however, to conclude that he will not be given appropriate breaks. Under these circumstances, we do not find that claimant is "significantly" limited in repetitive use of his wrists.

In the Matter of the Compensation of
LLOYD A. HUMPAGE, Claimant
WCB Case Nos. 98-07119 & 98-07037
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Schwabe, Williamson & Wyatt, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order that: (1) reduced an Order on Reconsideration's 7 percent (22.4 degrees) unscheduled permanent disability (PPD) award for a low back condition to 5 percent (16 degrees); (2) declined to award scheduled permanent disability; and (3) awarded no attorney fee. On review, the issues are extent of unscheduled and scheduled permanent disability and attorney fees.

We adopt and affirm the ALJ's order with the following supplementation.

The ALJ found that claimant was entitled to rating only for impairment because he was released to return to his job at injury and his employment was terminated for cause unrelated to the injury (*i.e.*, the job was not available and claimant relocated elsewhere). ORS 656.726(3)(f)(D)(iii).[1]

Citing *Anna Tate*, 51 Van Natta 184 (1999) and *Manuel G. Dimas*, 48 Van Natta 2577 (1996), claimant contends that, because his at-injury job was not available at the time he was released to regular work, he is entitled to values for age, education and adaptability.

After our *de novo* review of the record, we conclude that the ALJ correctly applied ORS 656.726(3)(f)(D)(iii) to the circumstances of this case. Accordingly, because the terms of that subsection were met (claimant was released to regular work at his job at injury but his employment was terminated for cause unrelated to the injury), claimant has failed to establish that he is entitled to an increased PPD award for non-impairment factors. *Anna Tate*, 51 Van Natta at 185 (subsection applies if its terms are met). Moreover, because impairment is the only factor to be considered if the terms of any one of subsection (i), (ii), or (iii) are met, we need not address the parties' arguments on review regarding the applicability of subsections (i) and (ii).

ORDER

The ALJ's order dated January 8, 1999 is affirmed.

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[1] ORS 656.726(3)(f)(D) provides: [I]mpairment is the only factor to be considered in evaluating the worker's disability if:

"(i) The worker returns to regular work at the job held at the time of injury;

"(ii) The attending physician releases the worker to regular work at the job held at the time of injury and the job is available but the worker fails or refuses to return to that job; or

"(iii) The attending physician releases the worker to regular work at the job held at the time of injury but the worker's employment is terminated for cause unrelated to the injury."

In the Matter of the Compensation of
JOHN M. BOWHAN, Claimant
WCB Case No. 98-04968
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Myzak's order that increased claimant's scheduled permanent disability award for loss of use or function of each wrist from zero, as awarded by an Order on Reconsideration, to 13 percent (19.5 degrees). On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, which we summarize and supplement as follows.

Claimant, age 34, has an accepted occupational disease claim for bilateral carpal tunnel syndrome. Dr. Macha, orthopedist, performed a right carpal tunnel release in May 1997 and a left carpal tunnel release in August 1997. Dr. Macha declared claimant medically stationary on November 25, 1997 and performed a closing examination, reporting impairment related to reduced range of motion and a 4/5 loss of strength in each wrist, caused by median nerve damage. He opined that these findings were permanent. The claim was closed by a January 14, 1998 Determination Order, which awarded 13 percent scheduled permanent disability for each wrist (9 percent for loss of strength and 4 percent for reduced range of motion).

SAIF requested reconsideration, contesting the scheduled permanent disability awards and requesting an arbiter examination. Dr. Dupuis performed an arbiter examination on May 6, 1998. Based on Dr. Dupuis' findings, a May 28, 1998 Order on Reconsideration reduced claimant's scheduled permanent disability awards to zero for each wrist.

CONCLUSIONS OF LAW AND OPINION

The ALJ modified the May 28, 1998 Order on Reconsideration and reinstated the January 14, 1998 Determination Order's awards of 13 percent scheduled permanent disability for each wrist. In doing so, the ALJ found that, based on Dr. Macha's attending physician's report, there was persuasive evidence that claimant experienced permanent impairment due to his compensable bilateral carpal tunnel syndrome (CTS).

On review, SAIF contests the ALJ's reliance on the findings of claimant's attending physician over those of the medical arbiter, Dr. Dupuis, who examined claimant closer in time to the reconsideration order and found no objective evidence of permanent impairment related to the compensable injury. Specifically, SAIF asserts that Dr. Macha's reduced range of motion and loss of strength findings do not constitute evidence of permanent disability.

Evaluation of a worker's disability is as of the date the reconsideration order issues. ORS 656.283(7). Where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. OAR 436-035-0007(13). This "preponderance of the evidence" must come from the findings of the attending physician or other physicians with whom the attending physician concurs. *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670 (1994). Moreover, we do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment but, rather, rely on the most thorough, complete, and well- reasoned evaluation of the claimant's injury-related impairment. *Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

In this case, we find that the medical arbiter provided the most persuasive opinion addressing claimant's permanent impairment. Dr. Dupuis documented grip strength results as ranging from 50 to 80 for the right arm and from 55 to 80 for the left arm. In finding 5/5 muscle power of the upper extremities, with the exception of grip strength, Dr. Dupuis noted that claimant's grip strength measurements were highly variable and that there was non-physiologic ratchet-like movement of the

arm with shaking of the entire arm during completion of the maneuver. He explained that, because of the discrepancy of the measurements and the nonphysiologic movements observed, the measurements he recorded were invalid for purposes of measuring impairment. Moreover, because he found 5/5 strength in testing the median nerve innervated thenar muscles, including the abductor pollicis brevis, Dupuis concluded that there was no muscle strength loss due to the accepted condition. (Ex. 13-3, -4).

Dr. Macha, claimant's attending physician, noted reduced range of motion and a loss of strength when he declared claimant medically stationary in November 1997 (6 months prior to the May 1998 Order on Reconsideration). Five months after Dr. Macha's findings, Dr. Dupuis specifically tested claimant's muscle strength and wrist range of motion and found no ratable permanent impairment. Because Dr. Dupuis provided a thorough, well-reasoned report regarding his findings regarding claimant's loss of strength and because those findings were rendered 5 months after the findings made by Dr. Macha, and shortly before the Order on Reconsideration, we find Dr. Dupuis' findings more persuasive.[1] We accordingly find that claimant suffered no permanent impairment. Therefore, we reverse the ALJ's order and reinstate the Order on Reconsideration's awards of zero for claimant's bilateral CTS condition.

ORDER

The ALJ's order dated January 4, 1999 is reversed. The May 28, 1998 Order on Reconsideration is affirmed. The ALJ's attorney fee award is reversed.

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[1] The fact that the arbiter examination is performed closer in time to the reconsideration order is not always decisive. *E.g., Charlene L Vinci*, 47 Van Natta 1919 (1995). In this case, however, given the five month gap between Dr. Macha's closing examination (in which he found reduced ranges of motion) and Dr. Dupuis' arbiter examination (finding no reduction in range of motion), we consider Dr. Dupuis' findings (based on a thorough and well-reasoned explanation) to be more reflective of claimant's permanent impairment at the time of the May 29, 1998 Order on Reconsideration.

In the Matter of the Compensation of
TIMOTHY R. KUBAS, Claimant
WCB Case No. 98-03590
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
Reinisch, et al, Defense Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the SAIF Corporation's denial of claimant's right ankle injury claim. On review, the issue is whether claimant's injury claim was timely filed.

We adopt and affirm the ALJ's order with the following corrections and supplementation.

The second sentence of the "Findings of Fact" is corrected to read: "Claimant began work at James Heating and Air Conditioning, a Eugene firm, on about November 1, 1997."

The second sentence of the quotation on page 3 is corrected to read:

> "These factors include, but are not limited to: whether the person who was aware of the accident exercised supervisory authority over the claimant or others, whether the supervisory authority was of a kind as to lead a reasonable injured employe to conclude that this was a person to whom a report of injury should be made, whether there were established procedures for reporting accidents and whether and to what extent the injured employe had any knowledge concerning the employer's supervisory structure and handling of workers' compensation matters."

Considering the above factors and applying them to this case, we agree with the ALJ that the employer did not have timely knowledge of claimant's injury and his claim was not timely filed. *See Jeffrey E. Henderson*, 50 Van Natta 2340 (1998). In reaching this conclusion, we note that the employer had established procedures for reporting work accidents and claimant knew that he should have reported his injury as soon as possible. (*See* Tr. 50-51). We also find that claimant did not believe that he had "reported" a work injury when he told a co-worker *not* to inform the employer about the November 19, 1997 incident.

ORDER

The ALJ's order dated December 17, 1998 is affirmed.

In the Matter of the Compensation of
GARNETTE D. CONE, Claimant
WCB Case No. 98-06537
ORDER ON REVIEW
Douglas L. Minson, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Podnar's order that set aside its denial of claimant's back, neck and right knee injury claim. On review, the issue is course and scope of employment. We reverse.

FINDINGS OF FACT

Claimant is employed by the State Judicial Department as a clerk/bailiff at the Washington County Circuit Court. On May 13, 1998, as she was returning to work from her lunch break, claimant slipped and fell on a patch of mud on the ground, sustaining injuries to her neck, back and right knee.

Claimant lost her footing in an area within the Justice Center campus, just adjacent to the employee entrance to the Justice Services Building. This entrance, and the area where claimant fell, are not accessible to the general public. Unlike the other entrances to the Justice Services Building, this entrance was accessible only by "mag-card" and did not have security personnel or metal detectors. Claimant and other state court employees were directed to use this particular entrance as a means of expediency and to avoid unnecessary contact with the public, particularly parties and witnesses. To access this entrance, claimant is required to walk across a driveway and a sidewalk within the Justice Center campus.

Claimant's employer does not own the grounds where claimant was injured, although it exercises some control over conditions inside the Justice Services Building.[1] The Justice Center campus, including the area adjacent to the employee entrance where claimant was fell, is maintained by Washington County.

SAIF does not dispute that claimant slipped and fell and sustained injuries. Rather, SAIF denied the claim on the grounds that claimant was not in the course and scope of employment when she fell.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that, although the employer did not have any ownership or leasehold interest in the Justice Center campus, it did have a "right of passage" or the equivalent of an easement

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[1] By statute, the county in which a circuit court is located is required to provide suitable and sufficient courtrooms, offices and jury rooms as well as maintenance and utilities for those courtrooms offices and jury rooms. *See* ORS 1.165.

over the area where claimant fell sufficient to establish control for purposes of "parking lot" exception to the "coming and going" rule.[2]

On review, SAIF contends that claimant has failed to prove that she was injured "in the course of" her employment, because her employer (the State Judicial Department) does not own, lease or maintain the premises, and does not have the right to require anyone else to maintain the premises. SAIF also asserts that, to the extent the employer had any authority to control security on the premises, that control was limited to the building itself and did not extend to the grounds outside the Justice Services building. For the reasons set forth below, we agree with SAIF. On this record, claimant has not shown that she was injured "in the course of" her employment.

As noted above, when an employee traveling to or from work sustains an injury "on or near" the employer's premises, the "in the course of" portion of the work-connection test may be satisfied if "the employer exercises some 'control' over the place where the injury is sustained." *Cope v. West American Ins. Co.*, 309 Or at 239; *Henderson v. S.D. Deacon Corp.*, 127 Or App 333, 336 (1994).

Here, although claimant's injury resulted from a neutral hazard (mud) on the route she customarily traveled to get to her work location inside the Justice Services Building, we find no persuasive evidence that her employer had control over the grounds where she lost her footing. Indeed, the record establishes that claimant's employer did not own the premises or have any leasehold interest in the place where the injury occurred. (Tr. 50-52). *Compare Henderson* at 127 Or App 336 (employer's lease agreement gave it some control over the building's elevator where claimant was injured); *Montgomery Ward v. Cutter*, 64 Or App 759 (1983) (tenant employer paid a common area fee and could require the property owner to make repairs); *John R. Benson*, 50 Van Natta 273 (1998) (employer's sublease agreement gave it some control over the lobby area where claimant was injured).

Furthermore, although ownership or a leasehold interest is not required to establish control, the employer must, at a minimum, have some right to require maintenance of the grounds where the injury occurred. *See Henderson*, 127 Or App at 337. Yet, in this case, there is no persuasive evidence that the employer has any right to require that the county maintain the grounds outside the building adjacent to the employee entrance. The testimony of Judge Milnes establishes that the employer (through the Presiding Judge or the Washington County Court Security Committee) has the right to control conditions and security within the Justice Center Building itself, but the record does not establish that the employer had any responsibility for, or control over, the grounds outside of the building.[3] Consequently, in the absence of such evidence, claimant has not satisfied the "in the course of" element of the work-connection test. *See, e.g., Adamson v. The Dalles Cherry Growers, Inc.*, 54 Or App 52 (1981) (because the employer exercised no control over traffic, use or maintenance of the street on which the claimant slipped in fell while walking from her car to the employer's premises, her injuries did not arise out of and in the course of employment, even though the street was the only way claimant could get to her work location); *Janet V. Dollens*, 42 Van Natta 2004 (1990) (where the employer did not own property within the complex and was not responsible for performing or sharing in the cost of maintenance of the area where the claimant was injured, the claimant had shown none of the manifestations of employer control that would allow her to avoid the general rule that injuries incurred while coming to and going from work are not compensable).

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[2] As a general rule, injuries sustained by employees when going to and coming from their regular workplace are not deemed to arise out of and in the course of their employment. One exception to this rule is the "parking lot exception," which provides that, if an injury occurs in a parking lot or other off-premises area over which the employer has some control, the injury may be compensable. *Cope v. West American Ins. Co.*, 309 Or 232 (1990). As the Supreme Court explained in *Norpac Foods v. Gilmore*, 318 Or 363 (1994), "some form of employer control of the area demonstrates the work-connection necessary to make the injury compensable."

[3] Although claimant's co-worker, Ms. Spencer, testified that when she made complaints to the Judge or court administrator about leaves or debris on the grounds adjacent to the employee entrance, the problem was taken care of "most of the time," (Tr. 25) this testimony does not persuade us that the employer had a legal or contractual right to require that the county maintain that area. This is especially true in light of the testimony of Mr. Crampton, the Director of Management Services for the State Judicial Department. Mr. Crampton testified that, to his knowledge, the employer had no right to control the premises outside the courthouse building. (Tr. 51, 56-58).

ORDER

The ALJ's order dated November 24, 1998 is reversed. SAIF's denial of claimant's back, neck and right knee injury is reinstated and upheld. The ALJ's attorney fee award is also reversed.

Board Member Biehl dissenting.

The majority concludes that claimant's claim is not compensable because she has not satisfied the "in the course of" element of the work-connection test. I dissent, because I believe that claimant has shown that she was injured in an area over which her employer has some control, which would bring her injuries within the parking lot exception to the going and coming rule. *See Cope v. West American Ins. Co.*, 309 Or 232 (1990) (explaining that employer control over the premises is the rationale supporting the parking lot exception).

I recognize that, in this case, there is no leasehold interest or any contractual agreement between claimant's employer (the State Judicial Department) and the owner of the premises where claimant was injured. Rather, as the majority notes, the property arrangement in this case is a creature of statute. Washington County has a statutory obligation to provide and maintain courtrooms, offices and jury rooms for the state to hold court. *See* ORS 1.165. But the absence of a contractual agreement between the employer and the owner of the premises is not fatal to claimant's case, so long as she can show that the area where she fell is sufficiently within the employer's control to be treated as a part of its premises. *See, e.g., Montgomery v. State Ind. Acc. Com.*, 224 Or 380 (1960) (claimant was injured while crossing a public street on his way from work; because the employer had influenced the city to install a traffic signal in front of its gate and thereafter exercised a certain amount of control over traffic and pedestrians using or crossing the street, the thoroughfare was considered an extension of the employer's plant); *Willis v. State Acc. Ins. Fund*, 3 Or App 565 (1970) (the claimant, a university professor, slipped and fell in a city-owned park on his way to his office from his car; the claimant's injury was compensable because of the extent and nature of the control which the employer exercised over the park and because university employees were more exposed to the risk of injury while crossing the park than were members of the general public).

The record establishes that claimant was injured in close proximity to the employer's premises (just adjacent to the Justice Services Building's employee entrance) while using a customary means of ingress and egress. The area where she fell is part of the Justice Center "campus." The area is secure and not subject to public access. The employer preferred that claimant (and other employees) access the building by way of this employee-only entrance. This same area is also regularly used by the employer as a place for jurors to gather and take smoking breaks.

Judge Milnes testified that the employer, through the Presiding Judge or the Washington County Court Security Committee, has some control over the conditions in Justice Services Building itself. The employer has required that the county improve the lighting and also that the county make other changes to bring the entrances in compliance with federal ADA standards. Judge Milnes also testified that he directed the county to change maintenance personnel when certain items came up missing. Although the Judge did not explicitly testify regarding the employer's right to control the area outside the employee entrance where claimant fell, I believe it is reasonable to infer that, if Judge Milnes had brought hazardous conditions in this area to the attention of the county maintenance people, the county would have taken care of the problem.[1] Because the employer regularly used this area for employee access and juror breaks, it had an interest in keeping the area free of hazards and debris.

Given the county's responsiveness to the maintenance requests of Judge Milnes and other courthouse employees and the fact that the area adjacent to the building's employee entrance not accessible to the general public but is regularly used by courthouse employees and jurors, I am persuaded that the employer (through Judge Milnes and others) had at least some control over the area where claimant was injured, sufficient to treat this area as a part of its premises. Consequently, I would find that claimant's injuries occurred "in the course of" her employment and that her injuries are compensable.

[1] Indeed, as the majority notes, claimant's co-worker, Ms. Spencer testified that when she complained about leaves or debris on the ground adjacent to the employee entrance, the problem was addressed.

In the Matter of the Compensation of
BEN E. CONRADSON, Claimant
WCB Case No. 98-04567
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests, and claimant cross-requests, review of that portion of Administrative Law Judge (ALJ) Herman's order that awarded a $4,500 attorney fee. On review, the issue is attorney fees.

We adopt and affirm the ALJ's order with the following supplementation.

The ALJ awarded $4,500 as a reasonable assessed fee for claimant's counsel's services in setting aside the employer's denial of claimant's low back injury claim. The ALJ noted that claimant's counsel's efforts included: obtaining medical reports from Drs. Taylor and Jacobsen; participating in the post-hearing arguments; attending a post-hearing deposition of Dr. Taylor, and participating in a half-day hearing with three witnesses. The ALJ also found both attorneys to be skilled and the value of the claim and benefits obtained to be significant.

On review, the employer argues that the attorney fee award was excessive. Claimant responds that the fee should be increased to approximately $6,000 based on a statement of services attesting to 18.8 hours of legal services at $160 per hour and using a multiplier of 2.[1]

We first find that the ALJ's explanation for the fee award sufficiently complied with the Supreme Court's instruction in *Schoch v. Leupold & Stevens*, 325 Or 112, *on remand* 49 Van Natta 788 (1997) because the hearings record contains only a general attorney fee request and no argument as to how the rule-based factors should be weighed in determining a reasonable fee. *See also Daryl L. Underwood*, 50 Van Natta 2330 (1998); *Russell L. Martin*, 50 Van Natta 313 (1998).

Nonetheless, we review the attorney fee issue *de novo*, considering the specific contentions raised on review, in light of the factors set forth in OAR 438-015-0010(4) and the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that any attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The issue in dispute was the compensability of claimant's injury claim for a low back condition. Approximately 30 exhibits were received into evidence with 2 medical reports submitted by claimant. The record also includes a deposition with a transcript of 38 pages (lasting 50 minutes). The hearing lasted about three hours with a transcript consisting of approximately 64 pages. Three witnesses, including claimant, testified. Credibility was a significant issue. Closing arguments were given telephonically. As previously noted, claimant's counsel has submitted on review a detailed statement of services, showing 18.8 hours of legal services.[2]

The parties agree that the case involved issues of average complexity, considering the range of cases generally submitted to this forum, although, considering the credibility issue, we would rate the complexity level as somewhat above average. The claim's value and the benefits secured are significant. The parties' respective counsels presented their positions in a thorough, well-reasoned and skillful manner. No frivolous issues or defenses were presented. Finally, there was a significant risk that

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[1] The employer contends that we cannot consider the statement of services submitted for the first time on review regarding counsel's services at hearing. We have, however, previously considered such statements. *E.g. Wayne L. Reed*, 50 Van Natta 2437 (1998). We find no reason to depart from this practice.

[2] Claimant's counsel devoted a significant number of hours skillfully advocating claimant's claim in the face of a vigorous defense. Nonetheless, the amount of time expended in litigating a claim is but one of many factors to be considered in determining a reasonable attorney fee award under OAR 438-015-0010(4).

claimant's counsel's efforts might have gone uncompensated, particularly considering the employer's vigorous defense.[3]

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $4,500 is a reasonable attorney fee for services at the hearings level.[4] In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record and claimant's statement of services), the medical and factual complexity of the issue, the value of the interest involved, the nature of the proceeding (including a deposition), and the risk that claimant's counsel might go uncompensated. Finally, we note that claimant is not entitled to an attorney fee for services related to the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated January 8, 1999 is affirmed.

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[3] *See Schoch v. Leupold & Stevens*, 144 Or App 259 (1996) (the risk in a particular case that an attorney's efforts may go uncompensated is a factor to be considered in setting a reasonable attorney fee under OAR 438-015-0010(4)). Nevertheless, we do not apply a contingency factor or "multiplier" in a strict mathematical sense. *E.g., Lois J. Schoch*, 49 Van Natta 788, 790, n. 1 (1997). Rather, in accordance with OAR 438-015-0010(4)(g), in arriving at our determination of a reasonable attorney fee award, we have taken into consideration the risk (particularly in light of the nature of the proceedings, and the employer's vigorous defense) that claimant's attorney's efforts might have gone uncompensated for the services rendered in this case.

[4] The employer cites two similar cases in which smaller attorney fee awards were granted as support for its argument that claimant's counsel's fee should be reduced. *See Jerome O. Johnson*, 50 Van Natta 2412 (1998) and *Randal C. Chatman*, 50 Van Natta 2409 (1998). While comparing and contrasting other cases can be of some assistance in determining a reasonable fee, each case must ultimately be evaluated based on its own particular circumstances. Here, for the reasons expressed above, we share the ALJ's assessment that a $4,500 fee was reasonable, taking into consideration the factors set forth in OAR 438-015-0100(4).

In the Matter of the Compensation of
ROGER D. LANSDEN, Claimant
Own Motion No. 99-0134M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted a request for temporary disability compensation for claimant's compensable fractured jaw, multiple facial lacerations and facial fractures, and bilateral temporomandibular joint (TMJ) dysfunction conditions. Claimant's aggravation rights expired on September 3, 1992. SAIF opposes the reopening of the claim on the grounds that surgery or hospitalization is not reasonable and necessary[1].

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

Here, the record does not establish that claimant requires surgery or hospitalization. As a result, we are not authorized to grant claimant's request to reopen the claim.

Accordingly, we deny the request for own motion relief. *Id.* We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

Claimant's entitlement to medical expenses under ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

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[1] SAIF contends that claimant is not ready to undergo TMJ surgery at this time. Claimant has not submitted proof to rebut SAIF's representation.

In the Matter of the Compensation of
SONJA K. MILSTEAD, Claimant
WCB Case Nos. 98-04615 & 98-00155
ORDER ON RECONSIDERATION
Juli Point, Claimant Attorney
Reinisch, MacKenzie, et al, Defense Attorneys

On April 27, 1999, the Board withdrew its March 31, 1999 Order on Review that adopted and affirmed an Administrative Law Judge's (ALJ's) order that found claimant's neck claim compensable and awarded an assessed attorney fee of $9,645. This action was taken to consider the self-insured employer's contention that the Board erroneously adopted the ALJ's opinion regarding claimant's counsel's attorney fee award. After further considering the parties' respective positions, we issue the following order.

In granting a $9,645 attorney fee award, the ALJ cited to OAR 438-015-0010(4) and noted that the factors set forth in that rule had been considered, particularly the 64.3 hours devoted to the case (as represented by claimant's counsel's uncontested statement of services), the above-average complexity of the issues, the above-average value of the interest involved and benefit obtained, and the substantial risk that claimant's attorney's services might have gone uncompensated.

On review, the employer challenged "the unusually large attorney fee" granted by the ALJ's order. Asserting that the legal issue "was not complicated," the medical issues were "potentially complicated, but not unusual," and the risk of losing the claim "was no greater than the conventional 'combined condition' claim involving preexisting spinal conditions and a disc bulge / herniation," the employer argued that the ALJ's attorney fee award was inordinately based on the time devoted to the case that had been "largely the result of claimant's counsel's own insistence on engaging in unnecessarily lengthy depositions of the experts at which she adduced information that was largely redundant of the written information." Consequently, the employer requested that the ALJ's attorney fee award be reduced in the area of $3,500 to $4,000. After considering the employer's arguments and claimant's response, the Board adopted and affirmed the ALJ's order.

On reconsideration, the employer contends that, because the ALJ's order contains "inadequate boilerplate language regarding claimant's counsel's entitlement to such an extraordinarily large fee," the Board's order should "include findings that are sufficient on which to base judicial review of [the ALJ's attorney fee] award." In response, claimant notes that the employer did not object to her counsel's statement of services at the hearings level and devoted approximately 3/4 of a page from a 16-page appellant's brief to the attorney fee issue on Board review. Reasoning that the ALJ specifically identified the rule-based factors that were weighed in determining claimant's counsel's attorney fee award, claimant asks that the award be affirmed.

To begin, the Board is authorized to consider a carrier's appeal of an ALJ's attorney fee award even if the carrier neglects to object to the claimant's counsel's attorney fee request at the hearings level. *Hays v. Tillamook County General Hospital*, 160 Or App 55 (1999). Therefore, the employer's failure to challenge claimant's counsel's statement of services at the hearing does not preclude it from seeking Board review of the ALJ's eventual attorney fee award.

Nonetheless, the Board's adoption of the ALJ's order (including the attorney fee award), after considering the employer's arguments and claimant's response, does not mean that the order is insufficient for purposes of judicial review. To the contrary, such an action signified that the Board found the ALJ's order sufficient for appellate review and that the facts and conclusions reached in that order express the Board's opinion. *Jorge Pedraza*, 49 Van Natta 1019 (1997).

After reviewing the employer's contentions on reconsideration, we continue to adhere to the Board's initial opinion concerning the ALJ's attorney fee award. In reaching this conclusion, we note that the ALJ referred to the applicable administrative rule and specifically identified the rule-based factors that were particularly considered in arriving at a reasonable attorney fee determination. Such an explanation is consistent with prior case precedent regarding the sufficiency of an attorney fee award for purposes of appellate review. *See Daryl L. Underwood*, 50 Van Natta 2330, 2332 (1998); *Leslie D. Custer*, 51 Van Natta 390 (1999); *compare Donna R. Grierson*, 51 Van Natta 679 (1999) (Although the ALJ's order cited Board attorney fee rule, the order did not specifically identify any of the rule-based factors that had been particularly considered in determining the claimant's attorney fee award and, as such, the order was insufficient for appellate review).

Accordingly, on reconsideration, as supplemented, we republish the Board's March 31, 1999 order.[1] The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

[1] Chair Bock's concurrence with this decision should not necessarily be interpreted as her agreement with the Board's initial decision. Rather, her signature denotes her agreement that, based on the prior decision from two Board members (one of whom is no longer with the Board), this reconsideration order is the appropriate response. *Fe D. Delariarte*, 49 Van Natta 39, n. 1 (1997); *John A. Hoffmeister*, 47 Van Natta 1688, *on recon* 47 Van Natta 1891 (1994), *aff'd mem Hoffmeister v. City of Salem*, 134 Or App 414 (1995).

May 19, 1999 Cite as 51 Van Natta 854 (1999)

In the Matter of the Compensation of
TRACY A. WHITESIDE, Claimant
WCB Case No. 98-06879
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Gilroy Law Firm, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that affirmed an Order on Reconsideration's award of 10 percent (32 degrees) unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability.

We adopt and affirm the ALJ's order with the following comment.

Claimant argues that the arbiter's statement regarding claimant's activity on the day of injury as being "very light" conflicts with the law of the case. However, the arbiter's reference to "very light" was based on claimant's statement to him that, on the day of injury, he was lifting products weighing between ten and twelve pounds, not that his base functional capacity was very light. (Ex. 12-1). Based on claimant's statement, the arbiter reasoned that the mechanism of injury would not have produced significant impairment in the thoracic spine, which gave credence to his conclusion that the reduced motion in claimant's thoracic spine was not due to the accepted thoracic strain condition. (Ex. 12-7).

ORDER

The ALJ's order dated January 21, 1999 is affirmed.

In the Matter of the Compensation of
LINDA A. ROGERS, Claimant
WCB Case No. 98-07415
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Otto's order that set aside its denial of claimant's claim for a right shoulder injury. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant is a school bus driver. In 1984, she dislocated her right shoulder after falling while cross country skiing. Claimant sought treatment and her arm was placed in a sling for six to eight weeks. Claimant's symptoms resolved and she did not have any right shoulder treatment or symptoms until September 1997. On September 30, 1997, claimant's school bus was broad-sided by a van. Claimant mainly felt neck and back pain after the accident, but at the impact, she tensed up and felt her right arm and shoulder tighten. Claimant filed a claim which was accepted for cervical and lumbar strains.

Claimant's back and neck improved with treatment, but she experienced grinding and discomfort in her right shoulder. On March 11, 1998, claimant awoke with her right arm hanging over the edge of her bed. She had extreme pain in her shoulder which had dislocated. She was able to pop the shoulder back into place, but sought medical treatment from Dr. McWeeney, who placed the shoulder into a sling. Claimant filed a claim for the right shoulder condition and the insurer denied the claim on July 24, 1998. Claimant requested a hearing.

The ALJ set aside the insurer's denial relying on the opinions of Dr. McWeeney, claimant's treating physician, and Dr. Puziss, a consulting physician. On review, the insurer argues that Drs. Marble and Gardner are more persuasive and that the denial should be upheld.

Drs. Marble and Gardner concluded that the work injury resulted in some damage to the capsule and ligaments which stabilize claimant's right shoulder, but that claimant has lax ligaments and a history of trauma involving the right shoulder. Marble and Gardner opined that the work injury was the "last straw and the weak camel's back," but was not the major factor in claimant's current need for treatment. Dr. McWeeney initially concurred with the report of Drs. Marble and Gardner.

Dr. McWeeney later opined: "[Claimant] does have ligamentous injury throughout and she did have a previous shoulder injury 14 years ago, however, that shoulder injury healed and she was having no difficulties until this most recent injury. Therefore, if I have to assign a predominant cause of the injury, I am inclined to say it was the motor vehicle accident." Because Dr. McWeeney's opinions are inconsistent in that he first concurred with Drs. Marble and Gardner that the work related motor vehicle accident was not the major cause of claimant's need for treatment, but then, without explanation offered an opinion that the accident was "a predominant cause," we do not find his opinion persuasive. Consequently, unlike the ALJ, we do not rely on Dr. McWeeney's opinion.

We, instead, rely on Dr. Puziss' opinion. Dr. Puziss saw claimant in consultation. He opined that, although claimant had preexisting bilateral shoulder muti-directional instability, she had no problems following the 1984 shoulder dislocation. Dr. Puziss disagreed with the opinion of Drs. Marble and Gardner that the preexisting condition was the major contributing cause on the basis that their opinion did not explain the lack of symptoms or need for treatment prior to the work-related accident.

After reviewing the record, we are most persuaded by the opinion of Dr. Puziss. Claimant had no symptoms between 1984 (after recovering from the original dislocation) and the September 1997 work injury. The insurer argues that Dr. Puziss failed to explain how the September 1997 injury could have caused the March 1998 dislocation. We do not find this argument persuasive, however, because all of the physicians who offer opinions in this case, including the examining physicians, Drs. Marble and Gardner, concede that the September 1997 work injury contributed to the dislocation. We find Dr. Puziss' opinion that the September 1997 injury, as opposed to the preexisting condition and the 1984 dislocation, was the major contributing cause of claimant's disability and need for treatment to be the most logical and persuasive opinion in the record. Thus, we rely on his opinion to conclude that claimant has established compensability of her right shoulder condition under ORS 656.005(7)(a)(B).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 7, 1999 is affirmed. For services on Board review, claimant's attorney is awarded $ 1,500, payable by the insurer.

May 19, 1999 Cite as 51 Van Natta 856 (1999)

In the Matter of the Compensation of
JANET D. TALBOTT, Claimant
WCB Case No. 97-09232
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Thaddeus J. Hettle, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that upheld the self-insured employer's denial of claimant's injury claim for cervical, thoracic, and lumbar spine conditions. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation.

Assuming, without deciding, that claimant suffered cervical, thoracic and lumbar strains at work on September 3, 1997, we nonetheless agree with the ALJ that claimant has not carried her burden of proof on this record.

The medical evidence indicates that claimant's back condition probably involves a combination of preexisting noncompensable degeneration[1] and one or more strain injuries.[2] (Exs. 53-6-7, 59AA-7, 60-11, 60-24, 61-5, 62). Therefore, claimant must establish that the claimed September 3,1997 work injury is (or was) the major contributing cause of her condition or her disability and/or need for treatment for that condition. ORS 656.005(7)(a)(B).

Dr. Bartley treated claimant for back problems, beginning on September 9, 1997. (Exs. 33, 48-52, 56, 57A, 58A). Although Dr. Bartley noted that claimant had an "injury at work 9/3/97," (Ex. 49-1), there is no indication that the doctor considered whether or to what extent claimant's degenerative condition contributed to her disability or need for treatment. Under these circumstances, Dr. Bartley's reports are not helpful in evaluating the cause of her combined condition.

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[1] Although there is some evidence relating claimant's contributory degeneration to her bus driving work, (Ex. 59AA-9-10), we find it persuasively rebutted by Dr. Farris, who opined that claimant's 4 years of bus driving could not have produced her significant degeneration. (Ex. 62; *see also* Ex. 61-7).

[2] We find no persuasive evidence that claimant's disability or need for treatment on or after September 3, 1997 resulted from the work incident *alone*.

Dr. Farris opined that the September 1997 incident caused a soft tissue strain "at the very most." (Ex. 62-1; *see* Ex. 60-22). He did not otherwise address the cause of claimant's condition before he examined her on November 3, 1997 and, as of his examination, Dr. Farris believed that claimant's back symptoms were due to preexisting degeneration. (Ex. 53-8).

Dr. Jones similarly opined that causes other than the injury, such as claimant's "obvious degenerative changes throughout her entire spine," could have caused her complaints. (Tr. 80-81; *see* Ex. 61).

Dr. Gritzka examined claimant on February 2, 1998 and acknowledged that she does have degenerative changes in her cervical, thoracic, and lumbar spine. He opined that claimant's degeneration was work-related and opined that the "work injury or injuries were the major contributing cause of her disability and need for medical treatment after the incident of 9/3/97." Dr. Gritzka reasoned that claimant's "treatments" provided after the September 1997 injury are "probably best viewed as an aggravation of her antecedent" degenerative changes. (Ex. 59AA-9-10). But we are not persuaded that claimant's degeneration is work-related. *See* note 1, *supra.* Because Dr. Gritzka apparently bases his causation opinion in part on a belief that claimant's contributory degeneration *is* work-related, we cannot say that his reasoning or conclusions support the claim.

Under these circumstances, we conclude that the medical evidence is insufficient to establish that the September 1997 work incident was the major contributing cause of claimant's subsequent back condition, or her disability or need for treatment for that condition. Consequently, we agree with the ALJ that the claim must fail.

ORDER

The ALJ's order dated November 30, 1998 is affirmed.

In the Matter of the Compensation of
ANTHONY J. WHITE, Claimant
WCB Case Nos. 98-07209 & 98-06911
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
Scheminske, et al, Defense Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Herman's order that: (1) awarded a $3,000 assessed attorney fee under ORS 656.386(1) for claimant's counsel's services at hearing; and (2) awarded a $1,000 attorney fee pursuant to ORS 656.308(2)(d). SAIF also moves for remand. On review, the issues are attorney fees and remand.

We deny SAIF's motion for remand and adopt and affirm the ALJ's order with the following supplementation.

Claimant requested a hearing challenging SAIF's compensability and responsibility denial of claimant's low back condition claim. Following the hearing, the ALJ set aside the denial and directed SAIF to process the claim. The ALJ also assessed an attorney fees of $3,000 pursuant to ORS 656.386(1) and $1,000 pursuant to ORS 656.308(2)(d).

On review, SAIF argues that the ALJ failed to make specific findings with regard to the factors set forth in the rule and that her explanation for the $3,000 fee award under ORS 656.386(1) is insufficient. Contrary to SAIF's contention, the ALJ was not required to make findings for each rule-based factor. As we explained *Daryl L. Underwood,* 50 Van Natta 2330 (1998), where there is no specific argument at hearing concerning the application of the factors in OAR 438-015-0010(4), an ALJ satisfies

his or her obligation to make findings concerning the attorney fee award by including in the order a brief description or citation to the rule-based factor or factors relied upon in determining the fee award. Furthermore, because we are authorized to modify or supplement the ALJ's order on review under ORS 656.295(6), remand is not an appropriate remedy. 50 Van Natta at 2332.

Here, the ALJ cited to the applicable rule and identified the factors considered in determining the fee. The ALJ explained that, in awarding the $3,000 fee, the time devoted to the case and the risk that claimant's attorney's efforts may go uncompensated were particularly considered. This explanation for the ALJ's attorney fee award is consistent with the *Underwood* rationale. *See Leslie D. Custer*, 51 Van Natta 390 (1999).

With regard to the ALJ's award of a $1,000 attorney fee under ORS 656.308(2)(d), SAIF argues that the ALJ provided no justification for awarding the maximum attorney fee of $1,000 pursuant to ORS 656.308(2)(d).[1]

Two carriers were joined at the hearing. The hearing lasted approximately one hour and 15 minutes. Claimant testified on his own behalf. One hundred and thirty exhibits were admitted. The responsibility issue was of average complexity. The value of the interest and benefit obtained were significant. Claimant's counsel took the position that SAIF was the responsible carrier and his arguments were successful. The attorneys were skilled and presented their positions in a thorough and well reasoned manner.

After reviewing the factors in OAR 438-015-0010(4) (particularly those previously discussed), we find that $1,000 was a reasonable attorney fee for claimant's counsel's services at hearing regarding the responsibility issue. Consequently, we affirm.[2]

ORDER

The ALJ's order dated December 31, 1998 is affirmed.

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[1] ORS 656.308(2)(d) limits claimant to a maximum $1,000 attorney fee for "finally prevailing against a responsibility denial," absent a showing of extraordinary circumstances.

[2] Because SAIF challenged only the attorney fee award on review and attorney fees are not "compensation" for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for his counsel's services on review. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1998).

In the Matter of the Compensation of
LILLIAN A. WILKINSON, Claimant
WCB Case No. 97-07765
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Davis' order that set aside its denial of claimant's occupational disease claim for a right shoulder/arm condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order, with the following supplementation.

Dr. Puziss concluded that claimant's work activities were the major contributing cause of her right shoulder condition for several reasons. First, he opined that claimant probably has an (anatomical) Type III acromion on the left as well as the right. But he noted that claimant only has *right* shoulder impingement and tendinitis. (Ex. 72-3). Dr. Puziss also noted that claimant's short stature required "more than average" overhead reaching during her cosmetology activities; her symptoms increased with work activity; and *degenerative* impingement would be unusual at claimant's age. (Ex. 72-3-4). With these circumstances in mind, Dr. Puziss reasoned that activities, rather than acromial morphology, were probably the major contributing cause of claimant's combined right shoulder condition. (*Id*). Considering claimant's "raised arm" cosmetology work, her right hand dominance, and Dr. Puziss' well-explained opinion, we agree with the ALJ that Dr. Puziss' causation opinion is the most persuasive.[1] Accordingly, based on that opinion, we also conclude that claimant has carried her burden of proof.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $2,100, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and her attorney's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 23, 1998 is affirmed. For services on review, claimant is awarded a $2,100 attorney fee, payable by the self-insured employer.

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[1] In reaching this conclusion, we also note that claimant's right shoulder labral tear (discovered at surgery) was degenerative and probably overuse-related, based on Dr. Puziss reasoning that claimant is relatively young and she has never had major right shoulder trauma. (*See* Ex. 72-3-4).

In the Matter of the Compensation of
THOMAS I. ABEL, Claimant
Own Motion No. 91-0386M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Pozzi, Wilson, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's February 24, 1999 Notice of Closure which closed his claim with an award of temporary disability compensation from May 27, 1982 through February 12, 1999. SAIF declared claimant medically stationary as of February 12, 1999.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonable be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981).

The propriety of the closure turns on whether claimant was medically stationary at the time of the February 24, 1999 Notice of Closure, considering claimant's condition at the time of closure and not subsequent events. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980).

Here, claimant relies on Dr. Smith's February 14, 1999 "check-the-box" letter. In answer to SAIF's representative's question regarding the need for future surgery, Dr. Smith indicated that he "anticipated placement of a vagus nerve stimulator." Thus, claimant contends that he was not medically stationary as his attending physician has opined that he is need of additional surgery.

However, in the same report on which claimant relies, in answer to the question of whether "[Claimant] is medically stationary as of February 16, 1999", Dr. Smith checked the box "Yes." (He also modified the medically stationary date to reflect February 12, 1999). Finally, Dr. Smith confirmed that claimant was not receiving curative treatment.

Although Dr. Smith opined that he "anticipated" the need for future surgery, his report does not support a conclusion that further improvement in claimant's condition was anticipated. Moreover, even if Dr. Smith's medical opinion could be interpreted as supporting a conclusion that claimant may require future ongoing care for his compensable condition, such ongoing care does not necessarily establish that claimant was not medically stationary. *See Maarefi v. SAIF*, 60 Or App 527, 531 (1984). Finally, Dr. Smith's opinion regarding claimant's future surgery is couched in terms of possibility rather than probability which is not legally sufficient nor persuasive. *Gormley v. SAIF*, 52 Or App 1055 (1981) (opinions in terms of medical possibility rather than medical probability are not persuasive).

In conclusion, the record establishes that claimant's condition was "medically stationary" when SAIF closed his claim. Therefore, we find that SAIF's closure was proper.

Accordingly, we affirm SAIF's February 24, 1999 Notice of Closure in its entirety.[1]

IT IS SO ORDERED.

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[1] Should claimant's compensable condition subsequently worsen to the extent that surgery and/or inpatient hospitalization is eventually required, he may again request reopening of his claim for the payment of temporary disability. *See* ORS 656.278(1).

In the Matter of the Compensation of
SHARON L. ERICKSON, Claimant
WCB Case No. 98-05853
SECOND ORDER OF DISMISSAL
Patrick K. Mackin, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our April 30, 1999 Order of Dismissal that granted claimant's request for an award of sanctions under ORS 656.390. In our prior order, we held that SAIF's "pre-appeal" payment of the Administrative Law Judge's (ALJ's) attorney fee award rendered the attorney fee issue moot and that, therefore, SAIF's request for review was "frivolous," *i.e.*, made without reasonable prospect of prevailing under ORS 656.390(2).

Citing *Transamerica Insurance Group v. Adams*, 62 Or App 419 (1983), SAIF contends that its request for review was not frivolous because it could have demanded repayment of the ALJ's attorney fee award had it prevailed in its argument on the attorney fee issue. SAIF's contentions notwithstanding, we find *Adams* distinguishable.

In *Adams*, the carrier sought to recover proceeds of a settlement paid to a claimant and his attorney after the Board set aside the settlement. A portion of the settlement had been retained by claimant's counsel as an attorney fee. The court held that the carrier was entitled to recover the portion of the settlement proceeds that the carrier paid to claimant's attorney as a fee. In doing so, the court noted that the attorney knew that the settlement was subject to Board approval pursuant to ORS 656.388(1), and that he knew or should have known that, when the settlement was set aside by the Board, his fee, as a part of that settlement, was also set aside. 62 Or App at 423.

In contrast to *Adams*, where payment of the attorney fee was contingent upon Board approval of the settlement, payment of the attorney fee in this case was unequivocal. Therefore, under the rationale of *SAIF v. Mize*, 129 Or App 636 (1994), SAIF's clear and unequivocal "pre-appeal" payment of the ALJ's attorney fee award rendered the attorney fee issue moot.

Finally, SAIF argues that, even assuming that the payment of the attorney fee rendered the fee issue moot, a "reasonable lawyer" would have concluded that, under existing law, an attorney fee award could be appealed in spite of the payment of the fee. *See Westfall v. Rust International*, 314 Or App 553, 559 (1992) (adopting a "reasonable lawyer" standard for *former* ORS 656.390). We disagree. As noted in our original order, we find no meaningful distinction between the clear and unequivocal "pre-appeal" acceptance of a condition (which, under *Mize*, moots an appeal) and the unequivocal "pre-appeal" payment of the ALJ's attorney fee award. In both instances, we are persuaded that there is no reasonable prospect of prevailing under *Mize*.

Accordingly, we withdraw our April 30, 1999 order. On reconsideration, as supplemented herein, we adhere to and republish our order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Member Haynes dissenting.

For the reasons expressed in my previous dissenting opinion, I would continue to find that SAIF's appeal was not frivolous. Consequently, I respectfully dissent.

In the Matter of the Compensation of
LESLIE D. MARCUM, Claimant
Own Motion No. 98-0426M
OWN MOTION ORDER ON RECONSIDERATION
Dennis W. Skarstad, Claimant Attorney
Saif Legal Department, Defense Attorney

On November 25, 1998, we issued our Own Motion Order, which authorized the reopening of claimant's 1984 injury claim to provide temporary disability compensation beginning the date claimant was hospitalized for the proposed surgery. We concluded that there were no issues in the own motion claim for which claimant would need to avail himself of "administrative remedies" pursuant to OAR 438-012-0050 and that claimant satisfied the criteria necessary for his claim to be reopened. In that order, we also instructed SAIF to close the claim pursuant to OAR 438-012-0055 when claimant became medically stationary.[1]

SAIF requests reconsideration of our November 25, 1998 order, enclosing a copy of the parties' stipulation in which SAIF accepts claimant's current low back condition as compensably related to his "new injury" claim (SAIF Claim No. 7315140F). Asserting that claimant's time loss costs belong in his "new injury" claim, SAIF seeks the issuance of "an order which disallows time loss in this Own Motion claim." In response, claimant opposes the issuance of an order disallowing time loss awarded in this Own Motion claim.[2] Instead, claimant suggests that SAIF be granted authorization to apply an "internal adjustment" between the timeloss it has previously paid under this Own Motion claim and the time loss payable under his "new injury" claim.

SAIF's request, made more than 90 days after our November 25, 1998 order, is untimely. OAR 438-012-0065(3). However, in extraordinary circumstances, the Board may, on its own motion, reconsider any prior Board order. OAR 438-012-0065(3).

Here, the parties did not resolve the compensability of claimant's current condition insofar as it pertained to his 1998 "new injury" claim until February 24, 1999, when Administrative Law Judge (ALJ) Hoguet approved the aforementioned "Stipulation and Order," which memorialized SAIF's acceptance of claimant's current condition under his 1998 injury claim. Considering this situation (particularly in light of the comments contained in our prior order), we find that extraordinary circumstances exist to allow reconsideration of our November 25, 1998 order. *See* OAR 438-012-0065(2). Therefore, we withdraw our prior order and issue the following order in its place.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

In light of the parties' stipulation, we conclude that claimant's current L5-S1 disc condition is not compensably related to his May 1984 compensable injury. Thus, we are without authority to reopen claimant's 1984 claim. *See* ORS 656.278(1)(a).

Accordingly, on reconsideration, claimant's request for own motion relief is denied.

IT IS SO ORDERED.

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[1] In our prior order, we further advised that if SAIF was ultimately found responsible for claimant's current condition under his "new injury" claim with SAIF, reconsideration of that decision could be requested under OAR 438-012-0065(3).

[2] Claimant is apparently concerned that SAIF might deny eligibility for time loss under the "new injury" claim and seek recovery of its Own Motion "overpayment" against claimant's future permanent disability award under the "new injury" claim. Yet, we note that SAIF represents its intention to apply its time loss payments to its obligations under the "new injury" claim. Moreover, such an offset is statutorily permissible, with or without Board approval. *See* ORS 656.268(15)(a). Inasmuch as the temporary disability previously paid under this Own Motion claim was ultimately found not to have been based on a compensable condition related to claimant's 1984 accepted injury, we are not authorized to award such compensation under ORS 656.278(1)(a). Rather, such compensation is payable under the accepted "new injury" claim. Should claimant disagree with SAIF's processing of that claim, including the future calculation of benefits, that is a matter for the Hearings Division under ORS 656.283(1), not this forum under ORS 656.278.

In the Matter of the Compensation of
MELVIN R. TEFFT, Claimant
Own Motion No. 98-0368M
OWN MOTION ORDER ON RECONSIDERATION
Pozzi, Wilson, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

On October 21, 1998, we withdrew our September 24, 1998 Own Motion Order, which denied claimant's request for own motion relief on the ground that he was not in the work force at the time of his current worsening. We took this action to consider claimant's submissions (an affidavit, a 1997 W-2 form, and a doctor's letter) in support of his contention that he was in the work force. Having considered the SAIF Corporation's response and the parties' respective positions, we adhere to our prior order with the following supplementation.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

It is undisputed that claimant's compensable condition has worsened requiring surgery or hospitalization. Specifically, on August 24, 1998, claimant underwent left total knee replacement surgery for his compensable left leg injury. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the "time of disability." *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the "time of disability" if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work *and* is seeking work; or (3) not working but willing to work, *and* is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[1] is the date he enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). Here, the relevant time period for which claimant must establish he was in the work force is the time prior to his August 24, 1998 surgery, when his condition worsened requiring that surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270 (1990); *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997); *Michael C. Batori*, 49 Van Natta 535 (1997); *Kenneth C. Felton*, 48 Van Natta 725 (1996)

SAIF contends that claimant fails to meet any of the criteria set forth in *Dawkins*. In support of its contentions, SAIF submits: (1) chart notes from Dr. Bainbridge, claimant's treating orthopedist; (2) an Education/Work History Form completed by claimant on August 21, 1998; and (3) a transcript of a taped interview taken on August 31, 1998, a week after claimant's August 24, 1998 surgery. In the taped interview, claimant stated that he was not currently employed and that his most recent employment was in either 1995 or 1996. (Ex. C-2, -3).[2] Claimant also stated that, sometime in 1996 or 1997, he had been on supplemental security income until it was determined he was ineligible due to his wife's earnings. (Ex. C-5). Claimant further stated that he had not worked in the last two years and had been living off his wife's income during that period. (Ex. C-5, -15). Claimant made this same statement regarding living off his wife's income in the August 21, 1998 Education/Work History Form. (Ex. A-2).

In response, claimant submits an affidavit, a copy of his 1997 W-2 form and a January 4, 1999[3] letter from Dr. Bainbridge. This submission is presented in support of his position that, although he

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[1] The Board in its own motion jurisdiction can only authorize temporary disability from the time of surgery or hospitalization. *See* ORS 656.278(1)(a).

[2] Exhibit numbers are taken from SAIF's submittals.

[3] Although this letter is dated "January 4, *1998*," it is clear from the text of the letter that this is a typographical error and the date should be "January 4, *1999*." Therefore, we refer to the date as January 4, 1999.

was not working at the time of his current disability, he was willing to work and seeking work. In his affidavit, claimant attests that: (1) he worked in July and August 1997 as a truck driver for Winkle Alfalfa during harvest season and left when the season ended; (2) he made inquiries into other work, but no one would hire him; (3) from January 1998 to April 1998, he worked providing home care; and (4) he has been available and willing to work, but no one would hire him.

In order to satisfy the second *Dawkins* criterion, claimant must show that, although he is not working, he is willing to work and was seeking work. In claimant's affidavit, he attests that "I have been available and willing to work, but no one has hired me." Yet, claimant's assertion that he is willing to seek employment is directly contrary to the assertions he previously made in his taped statement. Specifically, claimant provides no explanation why he states in his August 1998 taped interview that he had not sought work and had been living "off my wife's income for the last two years." Claimant also included this lack of work search and his "living off [his] wife" statement in the August 21, 1998 Education/Work History Form. Likewise, claimant has not explained why he did not mention in his August 1998 interview that he worked as a home care provider in early 1998. Furthermore, claimant provides no supporting documentation regarding this home care provider work.

The submission of his 1997 W-2 form provides corroboration that claimant was in the work force in 1997. Nonetheless, in light of his prior inconsistent statements in the August 1998 interview and work history form and in the absence of corroborating evidence regarding his work search and work activities in 1998, we are not prepared to conclude that claimant was willing to seek work at the time of his August 1998 surgery.

In addition, Dr. Bainbridge's chart notes and January 4, 1999 letter do not support claimant's contention that he was in the work force at the time of disability. In this regard, prior to his current worsening, claimant had not seen Dr. Bainbridge since October 1996, although he had made repeated requests for pain medication in the interim. (Ex. D). On January 28, 1998, claimant returned to Dr. Bainbridge; however, that visit appears to focus on his low back condition, which Dr. Bainbridge concludes is not an operative problem. There is no mention of claimant's left knee condition during the January 28, 1998 visit. Claimant next returned to Dr. Bainbridge on July 30, 1998, at which time his chief complaint was left knee pain and instability; however, Dr. Bainbridge does not discuss claimant's ability to work. (Ex. E). Therefore, those chart notes do not support claimant's position.

In his January 4, 1999 letter, Dr. Bainbridge states that he has treated claimant since April 1985, and opines that claimant "during the period of April 1998 through August 1998, was willing to work but unable to secure employment due to his medical condition." Even assuming that Dr. Bainbridge's last statement establishes that claimant's work-related injury made efforts to seek work futile as of April 1998, that statement does not establish claimant's willingness to work. *Dawkins v. Pacific Motor Trucking*, 308 Or at 258. In this regard, the issue of whether a work-related injury makes efforts to seek work futile presents a medical question that must be answered by expert medical opinion; however, the issue of willingness to work does not present a medical question. Instead, willingness to work is established by a preponderance of the evidence based on the whole record.

In conclusion, on this record, we hold that claimant has not demonstrated his willingness to work nor demonstrated that he was making a reasonable effort to find work at the time of his current worsening. Nor has he established that such a work search was rendered futile by the work injury. Therefore, we find that claimant was not in the "work force" at the time of his disability.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our September 24, 1998 order in its entirety. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARIE C. ARNESON, Claimant
WCB Case No. 98-07817
ORDER ON REVIEW
Thomas A. Andersen, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial insofar as it pertained to claimant's low back injury claim. In her "brief," claimant, *pro se*, has submitted a "post-hearing" medical report from her treating physician. We treat this submission as a motion for remand to the ALJ for presentation of additional evidence. On review, the issues are remand and compensability.

We deny the motion and adopt and affirm the ALJ's order with the following supplementation.

Our review is based on the record developed by the ALJ. *See Nancy B. Fast*, 50 Van Natta 1210 (1998). Consequently, we treat claimant's submission of the additional report as a motion to remand to the ALJ for the taking of additional evidence. *See Judy A. Britton*, 37 Van Natta 1262 (1985). We consider the proffered evidence only for the purpose of determining whether remand is appropriate.

We may remand to the ALJ if the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of hearing. *Compton v. Weyerhaeuser Co.*, 301 Or 641 (1986). Although evidence that is not generated until after the hearing is "unavailable," it may still have been "obtainable" at the time of hearing. *Compton*, 301 Or at 648-49.

Here, although the report from the attending physician is dated after the hearing, claimant has not shown that a similar report was unobtainable with due diligence at the time of hearing. Under such circumstances, we deny the motion for remand.

We now proceed to the merits of the insurer's appeal. The ALJ set aside the insurer's denial of her low back injury claim. In doing so, the ALJ determined that the medical evidence did not establish that claimant's June 1998 injury "combined" with a preexisting condition and, therefore, that the major contributing cause standard of ORS 656.005(7)(a)(B) did not apply. Applying a material contributing cause standard instead, the ALJ found that claimant had sustained her burden of proving a compensable low back injury.

On review, the insurer contends that the medical evidence establishes the presence of a "combined condition" within the meaning of ORS 656.005(7)(a)(B). Thus, the insurer asserts that the ALJ should have applied the major contributing cause standard of that statute. Moreover, the insurer argues that, when that standard is applied, claimant failed to satisfy her burden of proof. We disagree with the insurer's contentions.

Assuming, without deciding, that claimant's injury "combined" with a preexisting low back condition, we find that the unrebutted medical opinion of Dr. Lewis, the only physician to address causation, establishes that claimant's injury was the major contributing cause of claimant's need for medical treatment or disability. (Ex. 65-3). In reaching this conclusion, we do not find that Dr. Lewis' later opinion modifies or alters his prior causation opinion. (Ex. 76).

ORDER

The ALJ's order dated January 19, 1999 is affirmed.

In the Matter of the Compensation of
MICHAEL J. BENSON, Claimant
WCB Case No. 98-06253
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Miller, Nash, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Peterson's order that: (1) awarded temporary total disability compensation from June 21, 1998 through October 16, 1998; and (2) assessed a penalty for allegedly unreasonable claim processing. On review, the issues are temporary total disability benefits and penalties.

We adopt and affirm the ALJ's order with the following supplementation to address the employer's arguments on review.

Claimant has compensable, disabling right rotator cuff tendonitis. On August 26, 1997, Dr. Hurty, claimant's then-attending physician, released him to modified work. (Ex. 19). The employer called claimant the same day and left a message notifying him that he had been released to modified duty and that he was to report to his supervisor that afternoon to schedule work. Claimant did not return to work and did not call the employer as required by its written attendance policy, which provides that "three days of unreported absences is considered a voluntary termination." (Ex. 19B). On August 29, 1997, the employer advised claimant by letter that he was terminated effective August 30, 1997 under its attendance policy. (Ex. 19B). On September 2, 1997, claimant changed his attending physician to Dr. Puziss. On September 8, 1997, claimant began working for a different employer.

Claimant continued to have right shoulder problems. On April 6, 1998, Dr. Puziss performed right shoulder surgery. Claimant was taken off work for surgery from April 6, 1998 until Dr. Puziss released him to light duty work on June 17, 1998. (Ex. 47). The employer paid temporary total disability from the date of surgery through June 20, 1998. On October 16, 1998, Dr. Puziss released claimant to full duty work. The employer paid no temporary disability compensation between June 21, 1998 and October 16, 1998. Claimant did not work between those dates, with the exception of two days of temporary work. The employer has a written policy of offering modified work to injured workers at their regular rate of pay. On October 27, 1998, Dr. Puziss concurred with a letter from the employer that listed several light duty positions that the employer stated were available on June 17, 1998, one day after he had released claimant to light duty work. (Ex. 51).

The ALJ concluded that, because it was not until October 27, 1998 that Dr. Puziss approved employment in a modified job that would have been offered to the worker if the worker had remained employed, the employer was obligated to continue paying temporary total disability benefits under ORS 656.325(5)(b) until claimant became medically stationary on October 16, 1998.

On review, the employer asserts that it satisfied the statutory requirements for ceasing payment of temporary disability. Specifically, the employer argues that claimant was terminated for violation of work rules; because Dr. Hurty released claimant for modified work on August 26, 1997, it had fulfilled its responsibilities under the statute and had no further responsibility to follow the statute a second time. Alternatively, the employer argues that Dr. Puziss' release to modified work on June 17, 1998, plus his concurrence letter signed on October 27, 1998, is just an explanation that the jobs that would have been offered to claimant had he remained employed were within the terms of the June 17, 1998 release. We disagree with both of the employer's arguments for the following reasons.

ORS 656.325(5)(b) provides:

> "If the worker has been terminated for violation of work rules or other disciplinary reasons, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 [temporary total disability] and commence payments pursuant to ORS 656.212 [temporary partial disability] when the attending physician approves employment in a modified job that would have been offered to the worker if the worker had remained employed, provided that the employer has a written policy of offering modified work to injured workers."

The administrative rules implementing ORS 656.325(5)(b) are set forth at OAR 436-060-0030(6), which provides in pertinent part:

> "Pursuant to ORS 656.325(5)(b), the insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (2) as if the worker had begun the employment when the attending physician approves employment in a modified job that would have been offered to the worker if the worker had not been terminated from employment for violation of work rules or other disciplinary reasons, under the following conditions:
>
> "(a) The employer has a written policy of offering modified work to injured workers:
>
> "(b) The insurer has written documentation of the hours available to work and the wages that would have been paid if the worker had returned to work in order to determine the amount of temporary partial disability compensation under section (2);
>
> "(c) The attending physician has been notified by the employer or insurer of the physical tasks to be performed by the injured worker; and
>
> "(d) The attending physician agrees the employment appears to be within the worker's capabilities."

In *Deanna L. Rood*, 49 Van Natta 285, 286 (1997), we held that, in order for a carrier to cease paying TTD pursuant to ORS 656.325(5)(b), the attending physician must approve the same modified job that would have been offered to the worker had the worker not been terminated. We found that it is not sufficient for the attending physician to merely release the worker to modified employment; the physician must review and consent to the specific modified job.

Moreover, the actual cessation of temporary total disability under ORS 656.325(5)(b) does not correspond to the date of employment termination, but occurs when the attending physician approves employment in a modified job that would have been offered to the worker if the worker had remained employed. *See Ricardo Chavez*, 50 Van Natta 90 (1998).

Here, although Dr. Hurty, who was claimant's attending physician in August 1997, released claimant to modified work, he at no time reviewed and consented to a specific modified job. Therefore, the employer had no authority to cease the payment of temporary total disability based on Dr. Hurty's release to modified work. OAR 436-060-0030(6)(b) through (d). Moreover, Dr. Puziss had not approved a specific modified job by the date that the employer "ceased payments" of TTD (June 20, 1998). Dr. Puziss did not concur that the four possible jobs[1] were within claimant's restrictions until October 27, 1998. We accordingly conclude that the employer did not comply with the requirements of ORS 656.325(5)(b).

Finally, because the employer failed to strictly comply with the statute and rule, as required by law, we agree that the ALJ's penalty award was appropriate. *See SAIF v. Robertson*, 120 Or App 1 (1993) (when a rule specifically and unambiguously requires the employer to follow a certain procedure, substantial compliance is not sufficient); *see also Eastman v. Georgia Pacific Corp.*, 79 Or App 610 (1986) (employer must strictly comply with the applicable administrative rule before it can unilaterally terminate TTD).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to the temporary disability issue, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.[2]

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[1] Because our analysis turns on the date of Dr. Puziss' concurrence, we need not decide whether the concurrence with four "possible" jobs strictly complies with OAR 436-060-0030(6)(b) through (d).

[2] Claimant is not entitled to an attorney fee on review in regard to the employer's appeal of the ALJ's penalty assessment. *See Saxton v. SAIF*, 80 Or App 631 (1986); *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated November 2, 1998 is affirmed. For services on review, claimant's attorney is awarded a $1,000 fee, to be paid by the self-insured employer.

May 21, 1999 Cite as 51 Van Natta 868 (1999)

In the Matter of the Compensation of
LANNY W. LACEY, Claimant
WCB Case No. 98-10098
ORDER OF DISMISSAL
Lundeen, et al, Defense Attorneys

Claimant, *pro se*, has requested review of Administrative Law Judge (ALJ) Davis' order that dismissed claimant's request for hearing. Because the record does not establish that all parties received timely notice of claimant's request, we dismiss.

FINDINGS OF FACT

On April 7, 1999, the ALJ issued an Order of Dismissal that dismissed claimant's request for hearing. The order contained a statement that any party dissatisfied with the order could request Board review by mailing copies of such request "to all other parties to this proceeding" within 30 days of the ALJ's order.

On May 12, 1999, the Board received claimant's May 7, 1999 letter stating that claimant was "dissatisfied with this order." Claimant's letter did not indicate that copies had been provided to the other parties to the proceeding.

On May 13, 1999, the Board mailed a computer-generated letter to the parties, acknowledging claimant's "request" for Board review.

CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. *See* ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request be mailed or actual notice be received within the statutory period. *Argonaut Insurance Co. v. King*, 63 Or app 847, 852 (1983).

The failure to timely file and serve all parties with a request for Board review requires dismissal. *Mosley v. Sacred Heart Hospital*, 113 Or App 234 (1992). "Party" means the claimant for compensation, the employer of the injured worker at the time of injury, and the insurer, if any, of such employer. ORS 656.005(21).

Here, the 30th day following the ALJ's April 7, 1999 order is May 7, 1999. There is no indication that claimant timely served a copy of his request for Board review on the employer, Western States Truck Lines, or the insurer, Liberty Northwest Insurance by May 7, 1999.[1] Consequently, we conclude that we lack jurisdiction to review the ALJ's order.

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[1] In the event that claimant can establish that he provided notice of his request for Board review to the insurer within 30 days of the ALJ's April 7, 1999 order, he may submit written information for our consideration. However, we must receive such written information in sufficient time to permit us to reconsider this matter. Because our authority to consider this order expires within 30 days after the date of this order, claimant must file his written submission as soon as possible. Claimant is further admonished that any document he submits to the Board for its review must be simultaneously served on all other parties to this proceeding.

Finally, we are mindful that claimant has apparently requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. Nonetheless, instructions for requesting review were clearly stated in the ALJ's order. Moreover, we are not free to relax a jurisdictional requirement. *Alfred F. Puglisi*, 39 Van Natta 310 (1987); *Julio P. Lopez*, 38 Van Natta 862 (1986).

Accordingly, claimant's request for Board review is dismissed.

IT IS SO ORDERED.

May 21, 1999 Cite as 51 Van Natta 869 (1999)

In the Matter of the Compensation of
JAMES B. WOOD, Claimant
WCB Case Nos. 98-01990 & 98-01989
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Safeco Legal, Defense Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Hoguet's order that awarded a $3,500 fee for claimant's counsel's services at hearing. SAIF also moves for remand. On review, the issues are remand and attorney fees. We deny the motion for remand and modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following supplementation and summary.

On June 20, 1991, claimant compensably injured his right knee while working as a carpenter for SAFECO's insured. SAFECO accepted the claim for a disabling right knee strain injury. Subsequently, claimant underwent arthroscopic surgery. In December 1991, his claim was closed with a five percent permanent disability award for the right knee surgery. In August 1991, claimant returned to his regular work as a carpenter for SAFECO's insured and continued working there until 1995.

In 1995, claimant began working as a carpenter for SAIF's insured. On October 27, 1997, claimant twisted his right knee while working for SAIF's insured. Subsequently, claimant sought medical treatment for his right knee. Claimant filed an injury claim with SAIF and an aggravation claim with SAFECO. On February 18, 1998, SAIF denied compensability of and responsibility for claimant's right knee condition. On February 23, 1998, SAFECO denied responsibility only for claimant's right knee condition.

Following a hearing on these denials, the ALJ: (1) set aside SAIF's denial as to compensability and upheld it as to responsibility; and (2) set aside SAFECO's denial as to responsibility. Thus, claimant's right knee condition remains the responsibility of SAFECO. In his order language, the ALJ also awarded an assessed attorney fee of $3,500 payable by SAIF, stating that "[for] prevailing against the compensability portion of said denial and after considering the factors set forth at OAR 438-015-0010(4) claimant's attorney is hereby awarded a reasonable assessed attorney fee of $3,500.00."

At hearing, claimant's attorney did not request any specific attorney fee and the parties did not submit arguments addressing the factors to be weighed in determining a reasonable fee. SAIF requested Board review regarding only that portion of the ALJ's order that awarded the $3,500 attorney fee.

CONCLUSIONS OF LAW AND OPINION

On review, SAIF asserts that the ALJ failed to provide a sufficient explanation for the assessed fee, and seeks remand to the ALJ. Contrary to SAIF's contention, an ALJ is not required to make specific findings regarding each of the factors set forth in OAR 438-015-0010(4) where, as here, there is

no specific attorney fee requested and the parties did not submit arguments at hearing addressing the factors to be weighed in determining a reasonable fee. *Daryl L. Underwood*, 50 Van Natta 2330 (1998). The ALJ satisfies his or her obligation to make findings in a case by including in the order a brief description or citation to the rule-based factor or factors the ALJ relied on in determining the attorney fee awarded. *Id.* (*citing McCarthy v. Oregon Freeze Dry*, 327 Or 84, *adhered to on recon*, 327 Or 185 (1998)). Nonetheless, a simple citation to OAR 438-015-0010(4) is not sufficient; the ALJ must identify, discuss, or explain the application of the rule-based factor or factors relied on in determining the attorney fee awarded. *See Donna R. Grierson*, 51 Van Natta 679 (1999) (Board found ALJ's reasoning insufficient where ALJ merely cited applicable rule without providing any explanation of his application of the rule-based factors in determining attorney fee amount)

Here, the ALJ stated that "after considering the factors set forth at OAR 438-015-0010(4) claimant's attorney is hereby awarded a reasonable assessed attorney fee in the amount of $3,500.00." The ALJ did not identify the factor or factors considered in awarding the attorney fee. In other words, the ALJ did not discuss any of the specific rule-based factors, such as the value of the interest involved, the time devoted to the case, the complexity of the issue, the benefit secured, the skill of the attorneys, the nature of the proceedings or the risk that the claimant's counsel's efforts might go uncompensated. Because the ALJ's order is devoid of any explanation of his application of the factors in determining the attorney fee in this case, we find the ALJ's reasoning insufficient to determine how he arrived at $3,500 as a reasonable fee. *Compare Weyerhaeuser Co. v. Fillmore*, 98 Or App 567 (1989) (Board not required to making finding as to each factor; however, Board's explanation must be detailed enough to establish reasonable basis for its decision); *see also Leslie D. Custer*, 51 Van Natta 390 (1999) (in the absence of a specific request or objection, ALJ's particular consideration of certain enumerated factors satisfies the *Underwood* rationale); *William J. Kephart*, 51 Van Natta 291 (1999) (the ALJ applied the proper standard in determining a reasonable fee were he specifically indicated that the assessed fee was based upon the factors set forth in OAR 438-015-0010 *and* identified the factors considered, *i.e.*, the time devoted to the case, the complexity of the issue, the value of the interest and benefit to claimant and risk that counsel may go uncompensated).

Even though we find the ALJ's attorney fee discussion lacking in this case, we do not find the record to be improperly, incompletely or otherwise insufficiently developed. *See* ORS 656.295(5). In other words, because we are authorized to modify or supplement the ALJ's findings and conclusions under ORS 656.295(6), it is not necessary to remand this case to the ALJ for supplementation of findings regarding the attorney fee award. Consequently, we deny SAIF's motion to remand.

On review, SAIF argues that, if we deny its motion to remand, we should reduce the assessed attorney fee to reflect the value of the ALJ's compensability decision to claimant. After considering the factors in OAR 438-015-0010(4), as discussed below, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing regarding SAIF's compensability denial is $2,250.

A hearing convened that lasted 50 minutes. Claimant was the only witness to testify. The record consists of 27 exhibits, none of which were submitted by claimant's counsel. At SAFECO's request, the hearing was held open for a deposition of Dr. Hayes, claimant's treating physician.[1] This deposition lasted approximately an hour and a half and involved questions regarding both compensability and responsibility. Based on compensability disputes generally litigated before this forum, we find the issue presented in this case of average complexity. Because the ALJ found that SAFECO remains responsible for claimant's right knee condition, the value of the interest involved and the benefit secured for claimant as a result of prevailing against SAIF's compensability denial is minimal. Nevertheless, because only SAIF denied compensability, claimant's attorney protected claimant's interests in pursuing the compensability issue against SAIF. The attorneys involved in this matter are skilled litigators with substantial experience in worker's compensation law. No frivolous issues or defenses were asserted. Finally, there was a risk that claimant's counsel might go uncompensated, given the varying medical opinions from claimant's treating physician and the fact that claimant had a preexisting right knee condition that combined with his work injuries.

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[1] This deposition took place on July 21, 1988, and is identified in the hearing record as Exhibit 24. Although the ALJ did not include "Exhibit 24" in his listing of the exhibits admitted at hearing, he refers to Dr. Hayes' deposition in his order. Therefore, we find that Dr. Hayes' deposition (Exhibit 24) was admitted into the hearing record.

Consequently, after considering the factors set forth in OAR 438-015-0010(4), including the time expended on the compensability issue (as represented by the record at hearing), the average complexity of the legal issue involved, the value of the benefit secured, and the risk that claimant's counsel might go uncompensated, we find that $2,250 is a reasonable fee for claimant's counsel's services at hearing in prevailing over SAIF's compensability denial. We therefore modify the ALJ's attorney fee award.[2]

ORDER

The ALJ's order dated January 8, 1999 is modified. For prevailing over SAIF's compensability denial, in lieu of the $3,500 assessed attorney fee awarded by the ALJ, claimant's attorney is awarded an assessed fee of $2,250 payable by SAIF.

[2] Because SAIF challenged only the attorney fee award on review and attorney fees are not "compensation" for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee on review. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

In the Matter of the Compensation of
KENNETH J. MENCL, Claimant
WCB Case No. 98-05982
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Biehl and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Black's order that reduced claimant's unscheduled permanent disability award for a low back condition from 30 percent (96 degrees), as awarded by an Order on Reconsideration, to 18 percent (57.6 degrees). On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

The sole issue on review is adaptability -- specifically, the proper value for claimant's residual functional capacity under the standards.

Claimant's March 13, 1997 low back injury claim was closed by a May 1, 1998 Notice of Closure. Therefore, we apply the rules for rating claimant's permanent disability contained in WCD Administrative Order 96-072.

Under OAR 436-035-0310(5), residual functional capacity is the worker's greatest physical capacity, evidenced by:

"(a) The attending physician's release; or

"(b) A preponderance of medical opinion which includes but is not limited to a second-level PCE or WCE as defined in OAR 436-010-0005 and 436-009-0020(30) or any other medical evaluation which includes but is not limited to the worker's capability for lifting, carrying, pushing/pulling, standing, walking, sitting, climbing, balancing, stooping, kneeling, crouching, crawling and reaching. If multiple levels of lifting and carrying are measured, an overall analysis of the worker's lifting and carrying abilities should be provided in order to allow an accurate determination of these abilities. Where a worker fails to cooperate or use maximal effort in the evaluation, the medical opinion of the evaluator may establish the worker's likely RFC had the worker cooperated and used maximal effort."

ORS 656.005(12)(b) defines "Attending Physician" as "a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury." *See* OAR 436-010-0005(1). The identity of a worker's attending physician is a question of fact. *See Sandra K. Bowen*, 48 Van Natta 1474, 1475 (1996); *Paula J. Gilman*, 44 Van Natta 2539 (1992).

In this case, a July 14, 1998 Order on Reconsideration rated claimant's residual functional capacity as sedentary based on Dr. Sharp's release to sedentary work. In reducing claimant's unscheduled permanent disability award from 30 percent to 18 percent, the ALJ concluded that claimant's residual functional capacity was medium, based on the opinion of Dr. Freeman, treating surgeon. The ALJ found that Dr. Freeman was claimant's attending physician, reasoning that Dr. Sharp's deferral to Dr. Freeman "on the very question of release" was persuasive. We disagree.

Dr. Freeman performed low back surgery for claimant twice, on April 7, 1997 and July 9, 1997. He apparently saw claimant once before the first surgery and once after the second surgery, for a total of 4 examinations (counting the two surgeries). (*See* Exs. 4, 5, 9, 15). Dr. Sharp, on the other hand, saw claimant once a month for at least a year following the March 19, 1997 work injury. (*See* Exs. 13-3, 14).

After claimant was medically stationary on February 4, 1998, Dr. Sharp noted claimant's low back and radiating pain, paraspinal muscle spasm, decreased range of motion, decreased sensation, decreased patellar reflex, and increased Achilles' reflex, as well as positive straight leg raising on the right. Dr. Sharp stated that claimant was released to sedentary work "for an additional four weeks until he follows up with me." (Ex. 14). He noted that claimant would see Dr. Freeman and he deferred "the remaining medical management to Dr. Freeman." (*Id*). Thus, although Dr. Sharp deferred to Dr. Freeman with regard to possible future low back "management," he specifically retained authority regarding claimant's appropriate work level. Considering Dr. Sharp's longevity as claimant's treating physician and his notation that claimant would follow up with *him* regarding work status, we conclude that Dr. Sharp was claimant's attending physician.

Moreover, even if Dr. Freeman was claimant's attending physician, we would not find his opinions persuasive regarding claimant's physical capacity.

On February 11, 1998, Dr. Freeman found "no disability" on examination, but agreed that claimant should maintain "his present sedentary level" because of his fear and subjective complaints. He noted that claimant's nerve may be "irritated in scar" and stated that he planned to obtain an L5-S1 EMG and an MRI.[1] (Ex. 15). Dr. Freeman then responded to inquiries from the insurer, indicating agreement with the independent examiners' February 4, 1998 opinion limiting claimant sedentary work, with one exception: Dr. Freeman believed that claimant was more able "to get up and about and walk" than the examiners' proposed limitations suggested. (Ex. 19; *see* Ex. 13). Finally, on April 13, 1998, Dr. Freeman responded to further inquiries from the insurer, indicating that claimant could perform work "at the medium level." (Ex. 20). Thus, although Dr. Freeman initially agreed that claimant should be limited to sedentary work (with less than constant sitting), he ultimately opined that claimant could perform medium work, without explanation. We find Dr. Freeman's ultimate conclusion unpersuasive, because its inconsistency with his prior opinions is unexplained.

Under these circumstances, we rely on Dr. Sharp's opinion[2] and conclude that claimant's residual functional capacity was sedentary, as determined on reconsideration. Accordingly (because the reconsideration award is otherwise unchallenged), we reinstate the Order on Reconsideration award of 30 percent unscheduled permanent disability.

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[1] The record does not indicate whether claimant had an EMG or MRI thereafter.

[2] We note that claimant attended a March 30, 1998 Physical Capacities Evaluation, but the examination was not completed due to claimant's high blood pressure. Based solely on the objective findings the examiners related to the compensable injury, the PCE report concluded that claimant could perform medium work with restrictions. (Ex. 18-5). We do not rely on the PCE examiners' conclusions regarding claimant's residual functional capacity because we are not persuaded that their incomplete examination accurately reflects claimant's lifting and carrying abilities. *See* OAR 436-035-0310(5)(b).

Because we have affirmed the 30 percent unscheduled permanent disability awarded by the Order on Reconsideration, our order results in increased compensation. Therefore, claimant's attorney is entitled to an out-of-compensation fee equal to 25 percent of the "increased" compensation created by this order (*i.e.*, the 12 percent unscheduled permanent disability "increase" between the ALJ's 18 percent award and our 30 percent award), not to exceed $3,800. In the event that all or a portion of this substantively increased permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in *Jane A. Volk*, 46 Van Natta 681, *on recon* 46 Van Natta 1017 (1994), *aff'd Volk v. America West Airlines*, 135 Or App 565 (1995).

Because claimant's award of compensation was not ultimately disallowed or reduced by the employer's hearing request challenging the Order on Reconsideration's permanent disability award, claimant's attorney is also entitled to an assessed fee for services at hearing. ORS 656.382(2); *see also Patricia A. Cheathem*, 51 Van Natta 199 (1999). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing is $1,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The ALJ's order dated January 6, 1999 is reversed. The Order on Reconsideration is affirmed. Claimant's counsel is awarded an assessed fee of $1,500 for services at hearing, payable by the insurer. In addition, claimant's attorney is awarded an "out-of-compensation" attorney fee equal to 25 percent of the "increased" permanent disability compensation awarded by this order (the 12 percent unscheduled permanent disability "increase" between the ALJ's award and this award), not to exceed $3,800. In the event that all or a portion of this "increased" unscheduled permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in accordance with the procedures set forth in *Jane A. Volk*.

In the Matter of the Compensation of
EARL C. PORTER, Claimant
WCB Case No. C9-01166
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Kasubhai & Sanchez, Claimant Attorneys
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Member Biehl and Haynes.

On May 10, 1999, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

The first page of the proposed CDA provides that the total amount due claimant is $38,625 and the total due claimant's attorney is $6,375. This would equal a total consideration of $45,000. However, the total consideration recited on the third page of the CDA is "$44,950" instead of $45,000. On page four of the CDA, the total consideration (*i.e.*, the amounts payable to claimant and his attorney) is consistent with the first page. Thus, the lone reference on page three of the CDA to a total consideration of $44,950 appears to be typographical error. Accordingly, we interpret the agreement as providing for a total consideration of $45,000, with $6,375 payable as an attorney fee.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee of $6,375, payable to claimant's counsel, is also approved.

Should the parties disagree with our interpretation of the CDA, they may move for reconsideration by filing a motion for reconsideration within 10 days of the date of mailing of this order. OAR 438-009-0035.

IT IS SO ORDERED.

May 25, 1999 Cite as 51 Van Natta 874 (1999)

In the Matter of the Compensation of
PAULETTE SHEPARD, Claimant
WCB Case No. 98-06268
ORDER ON REVIEW
Scott M. McNutt, Sr., Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant, *pro se*, requests review of that portion of Administrative Law Judge (ALJ) Marshall's order that found that the Hearings Division did not have jurisdiction over claimant's request for reclassification of her occupational disease claim for chronic back and neck pain. On review, the issues are jurisdiction and reclassification.

We adopt and affirm the ALJ's order as supplemented and modified below.

Pursuant to ORS 656.277, a claimant has one year from the "date of injury" in which to seek claim reclassification. As a general rule, if a request for reclassification is not made within the one-year time period, the claim cannot be reclassified and must be made as an aggravation claim. ORS 656.277(1) and (2). But a claimant must be notified of the classification of the claim and the right to challenge that classification within sufficient time to permit the claimant to challenge reclassification within the statutory one-year period. ORS 656.262(6)(b) and (c); *DeGrauw v. Columbia Knit, Inc.*, 118 Or App 277 (1993).

Here, the ALJ concluded that the Hearings Division did not have jurisdiction to consider claimant's reclassification request because it was not filed within the statutory one-year period. In reaching that conclusion, the ALJ relied on a finding that claimant's "date of injury" was July 8, 1997, when she filed a Form 801 for progressive upper back and neck pain. The ALJ also found that claimant first requested reclassification on July 10, 1998, when her attorney wrote the Department requesting that it review the employer's classification of the claim as nondisabling.

On review, claimant contends that she requested reclassification when she informed the employer in writing on November 30, 1997 that she was appealing its "denial" of her claim. (Ex. 7). We disagree. The employer's November 24, 1997 denial does not address the nondisabling claim classification. (Ex. 5). And claimant's November 30, 1997 letter does not otherwise reference the nondisabling claim status. Nor does the letter request review of the November 24, 1997 Notice of Claim Acceptance classifying the claim as nondisabling. (Ex. 4). Consequently, the November 30, 1997 letter is not a request for reclassification within the meaning of ORS 656.277.[1]

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[1] Claimant also relies on a December 1, 1997 letter informing the Board that she is appealing the employer's "denial". While claimant has submitted a copy of that letter with her argument on review, it is not a part of the record developed at hearing. Claimant has also submitted other materials on review that are not included in the hearing record. Pursuant to ORS 656.295(5), the Board's review is based upon the record developed at hearing. Remand for the inclusion of additional material is appropriate if the record has been insufficiently developed, and if the additional material was not obtainable with due diligence at the time of the hearing. *Id.*; *Compton v. Weyerhaeuser Co.*, 301 Or 641 (1986).

Here, we decline to remand because claimant has not established that these materials were not available at the time of hearing, and our consideration of this additional evidence would not effect our ultimate disposition of this case. In particular, we do not regard the December 1, 1997 letter as a request for reclassification for the same reason that the November 30, 1997 letter is not such a request.

We next consider claimant's contention that the ALJ erred in calculating the one-year reclassification period from the July 8, 1997 Form 801. Claimant argues that the one-year period should run from November 24, 1997 (when claimant first received notice that the employer was accepting the claim as nondisabling), or July 17, 1997 (when claimant informed the employer in writing that she was receiving treatment for disabling chronic back and neck pain related to her work activity with the employer).

As discussed above, the express terms of ORS 656.277 mandate a one-year reclassification period that runs from the "date of injury." We have previously held that, for purposes of ORS 656.277, the "date of injury" in occupational disease claims is either the date of disability or the date when medical treatment is first sought. *Douglas B. Robbins*, 47 Van Natta 806 (1995); *Donald G. Stacy*, 45 Van Natta 2360 (1993), *aff'd mem Stacy v. Corrections Division*, 131 Or App 610 (1994) (citing *Papen v. Willamina Lumber Company*, 123 Or App 249 (1993).

Here, there is no evidence that claimant's neck and back condition was disabling prior to July 8, 1997, when she filed a Form 801. Thus, the "date of injury" for purposes of ORS 656.277 is when claimant first sought medical treatment on January 30, 1997. (Ex. 1-1). Consequently, the July 10, 1998 reclassification request was filed more than one year after the "date of injury." Based on this finding, we affirm the ALJ's ultimate conclusion that the Hearings Division did not have jurisdiction to consider claimant's reclassification request. In so doing, we are aware that claimant did not receive notice of the employer's nondisabling claim classification until November 24, 1997. Nevertheless, claimant still had more than two months to request reclassification prior to the expiration of the statutory one-year period. On the record before us, claimant has not established that this was not a sufficient period within which to file a reclassification request.

In summary, we conclude that the record supports the ALJ's finding that claimant did not request claim reclassification until July 10, 1998. We further conclude that claimant's medical treatment in January 1997 establishes the "date of injury" for purposes of ORS 656.277. Accordingly, we find that claimant's reclassification request was filed more than one year after the date of injury. Based on this finding, we affirm the ALJ's ultimate conclusion that the Hearings Division did not have jurisdiction to consider claimant's request for reclassification.[2]

ORDER

The ALJ's order dated January 12, 1999 is affirmed.

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[2] Claimant asserts that the employer failed to provide her former attorney with a copy of its July 8, 1998 acceptance of claimant's C5-6 and C6-7 disk herniations as nondisabling conditions. (Ex. 19) Nevertheless, as the one-year period for requesting reclassification expired in January 1998, claimant's attorney could not have filed a timely reclassification request even if he had received a copy of the July 8, 1998 acceptance. Claimant also notes that the employer failed to provide her with a copy of its brief on review. Nevertheless, claimant obtained a copy of the employer's brief and filed a timely response. Consequently, we are not persuaded that our disposition in this case would have been different had the employer copied claimant on its brief. Finally, claimant argues that the question of her claim classification is a medical issue that cannot be determined by the employer and must, instead, be decided by competent medical evidence. We decline to address this argument because we do not have jurisdiction to consider the reclassification request.

In the Matter of the Compensation of
LINDA M. STORNS, Claimant
WCB Case No. 98-04839
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order finding that claimant is not entitled to temporary disability compensation. On review, the issue is temporary disability benefits.

We adopt and affirm the ALJ's order[1] with the following supplementation to address claimant's argument on review.

The ALJ found that, although claimant was willing to work, she had not established that she had made reasonable efforts to seek work or that it was futile for her to make reasonable efforts to seek work. Claimant contends that her work search efforts were reasonable, as demonstrated by her testimony. We disagree.

In order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work *and* is seeking work; or (3) not working but willing to work, *and* is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989) (emphasis added).

Here, claimant offered only uncorroborated testimony that she had always looked for work since she was laid off by the employer in December 1995 or January 1996. We find such testimony unpersuasive and insufficient by itself to establish that she was in the work force at the relevant time, particularly in light of claimant's inability to offer any details regarding her job-seeking activities during the period in question.

ORDER

The ALJ's order dated December 23, 1998 is affirmed.

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[1] We correct the citation in the last sentence on page 2 to: *Janet F. Behorst*, 50 Van Natta 1578 (1998).

In the Matter of the Compensation of
DONALD T. BEAM, Claimant
WCB Case No. 98-07024
ORDER ON REVIEW
Richard M. Walsh, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Howell's order that awarded a $2,600 fee for claimant's counsel's services at hearing. SAIF also moves for remand. On review, the issues are remand and attorney fees.

We deny SAIF's motion for remand, and adopt and affirm the ALJ's order with the following supplementation.

SAIF accepted claimant's injury claim for a left knee strain, left knee medial meniscus tear, and left knee lateral meniscus tear. On July 17, 1998, SAIF issued a current combined condition denial of claimant's disability and need for treatment for his left knee condition on or after December 19, 1997, contending that, as of that date, claimant's compensable injuries ceased to remain the major contributing cause of his combined condition and the disability and need for treatment resulting therefrom. Claimant requested a hearing challenging that denial. Following the hearing, the ALJ set aside SAIF's denial and remanded claimant's left knee injury claim to SAIF for continued acceptance and payment of compensation due. The ALJ also ordered that claimant's attorney "is awarded $2,600 as a reasonable assessed fee for services related to SAIF's denial."

On review, SAIF asserts that the ALJ failed to provide a sufficient explanation for the assessed fee, and seeks remand to the ALJ. Contrary to SAIF's contention, an ALJ is not required to make specific findings regarding each of the factors set forth in OAR 438-015-0010(4) where, as here, there is no specific attorney fee requested and the parties did not submit arguments at hearing addressing the factors to be weighed in determining a reasonable fee. *Daryl L. Underwood*, 50 Van Natta 2330 (1998). The ALJ satisfies his or her obligation to make findings in a case by including in the order a brief description or citation to the rule-based factor or factors the ALJ relied on in determining the attorney fee awarded. *Id.* (*citing McCarthy v. Oregon Freeze Dry*, 327 Or 84, *adhered to on recon*, 327 Or 185 (1998)).

Here, the ALJ neither cited the applicable rule (OAR 438-015-0010(4)) nor identified the factor or factors he considered in awarding the attorney fee. In other words, the ALJ did not discuss any of the specific rule-based factors, such as the value of the interest involved, the time devoted to the case, the complexity of the issue, the benefit secured, the skill of the attorneys, the nature of the proceedings or the risk that the claimant's counsel's efforts might go uncompensated. Because the ALJ's order is devoid of any explanation of his application of the factors in determining the attorney fee in this case, we find the ALJ's reasoning insufficient to determine how he arrived at $2,600 as a reasonable fee. *Compare Weyerhaeuser Co. v. Fillmore*, 98 Or App 567 (1989) (Board not required to making finding as to each factor, however Board's explanation must be detailed enough to establish reasonable basis for its decision); *see also Donna R. Grierson*, 51 Van Natta 679 (1999) (Board found ALJ's reasoning insufficient where ALJ merely cited applicable rule without providing any explanation of his application of the rule-based factors in determining attorney fee amount).

Even though we find the ALJ's attorney fee discussion lacking in this case, we do not find the record to be improperly, incompletely or otherwise insufficiently developed. *See* ORS 656.295(5). In other words, because we are authorized to modify or supplement the ALJ's findings and conclusions under ORS 656.295(6), it is not necessary to remand this case to the ALJ for supplementation of findings regarding the attorney fee award. Consequently, we deny SAIF's motion to remand.

We provide the following additional reasoning concerning the attorney fee award for claimant's counsel's services at hearing. A hearing convened that lasted approximately 45 minutes. Claimant was the only witness to testify. The record consists of 25 exhibits, with claimant's counsel submitting one of those exhibits. The exhibit submitted by claimant's counsel, however, provided a well-reasoned explanation as to why Dr. Blake, claimant's treating surgeon, changed his opinion regarding causation and ultimately concluded that the work injury remained the major contributing cause of the disability and need for treatment of the combined condition.

Based on compensability disputes generally litigated before this forum, we find the issue presented in this case of average complexity. The value of the interest involved and the benefit secured for claimant are material because SAIF's combined current condition denial has been set aside, rendering claimant's treatment (including the December 19, 1997 surgery) and any temporary and/or permanent disability for claimant's current combined condition compensable. The attorneys involved in this matter are skilled litigators with substantial experience in worker's compensation law. Furthermore, there was a risk that claimant's counsel might go uncompensated, given Dr. Blake's earlier opinion that any symptoms after claimant's first surgery (on December 20, 1996) were related to his preexisting knee arthritis.

Consequently, after considering the factors set forth in OAR 438-015-0010(4), including the time expended (as represented by the record at hearing), the average complexity of the legal issue involved, the value of the benefit secured, and the risk that claimant's counsel might go uncompensated, we agree with the ALJ that $2,600 is a reasonable fee for claimant's counsel's services at hearing. We therefore affirm the ALJ's attorney fee award.[1]

ORDER

The ALJ's order dated February 4, 1999 is affirmed.

[1] Claimant did not submit a brief on review. In any event, because SAIF challenged only the attorney fee award on review and attorney fees are not "compensation" for purposes of ORS 656.382(2), claimant would not have been entitled to an attorney fee even if his counsel had rendered any services on review. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

In the Matter of the Compensation of
DALE F. CECIL, Claimant
WCB Case No. 97-10401
ORDER ON REVIEW
Max Rae, Claimant Attorney
Mannix, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Davis' order that set aside its partial denial of claimant's occupational disease claim for a tendinitis condition in the flexor and extensor tendons of the right hand and wrist. Claimant cross-requests review of those portions of the ALJ's order that: (1) upheld the employer's partial denial of his occupational disease claim for a right wrist condition involving a "scapholunate" ligament tear with related synovitis; and (2) awarded an assessed attorney fee of $3,000 for services at hearing regarding compensability of the tendinitis condition. On review, the issues are compensability and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exception. We do not adopt the ALJ's second ultimate finding of fact.

CONCLUSIONS OF LAW AND OPINION

From June 1993 to February 1994, claimant worked for a temporary employment agency and was assigned to work in a computer manufacturing operation. He assembled small computers on an assembly line, which included nine work stations, with each station requiring hand-intensive work such as snapping plastic parts together and inserting very small parts with tweezers. Every two hours claimant would change work stations.

After about half a year on the job, claimant's wrists began to ache and burn following a day's work. He was laid off in the first part of February 1994. In spring and summer of 1994, claimant was self-employed and did some construction work. In about August 1994, he began working as a truck driver for a cement-truck business.

In January 1995, claimant saw a physician for bilateral hand and arm pain. In April 1995, Dr. Carter, M.D., performed decompression of the right median nerve at the wrist. Claimant had a protracted period of recovery. Following litigation, the employer accepted a claim for nondisabling bilateral carpal tunnel syndrome (CTS).

In January 1996, Dr. Carter found claimant medically stationary regarding the CTS and without impairment. Dr. Carter noted that claimant was still having difficulty with extensor tendinitis in the right hand and wrist. He opined that the condition causing claimant's discomfort was extensor tendinitis, which he found medically stationary and required palliative care.

When claimant saw Dr. Carter in late 1996 he had significant impairment of the right hand and wrist because of tendinitis and tenosynovitis in both the flexor and extensor tendons. The bilateral CTS claim was closed by a March 25, 1997 Determination Order that was subsequently affirmed following litigation.

On September 5, 1997, Dr. MacKenzie performed diagnostic arthroscopy, synovectomy and debridement of scaphoid lunate ligament for synovitis of the right wrist, with partial scaphoid lunate ligament tear. On December 22, 1997, the employer issued a partial denial that denied compensability of: (1) tendinitis and tenosynovitis in the flexor and extensor tendons of the right hand and wrist; and (2) scaphoid lunate ligament tear of the right wrist with related synovitis.

Compensability of Tenosynovitis and Scaphoid Lunate Ligament Tear with Related Synovitis

We adopt the ALJ's reasoning and conclusions regarding this issue with the following supplementation.

On review, claimant argues that, if there is no traumatic injury, then claimant's testimony and the medical evidence from Drs. Carter and MacKenzie establish compensability of the scaphoid lunate ligament tear. We disagree.

The opinions from Dr. Carter that claimant relies on are either conclusory or only state the possibility of a causal relationship. (Exs. 82A, 86). In addition, although allowing that it was possible repetitive work activity could cause a scaphoid lunate ligament tear, Dr. MacKenzie continued to conclude that work activities were not the cause of the tear. (Exs. 79, 87, 89-29-35, -37, -39-41).

Compensability of Tendinitis in Flexor and Extensor Tendons of Right Hand and Wrist

Relying on the opinion of Dr. Carter, the ALJ found claimant's tendinitis condition compensable. On review, the employer argues that Dr. Carter's opinion is not persuasive. For the following reasons, we agree with the employer.

Claimant asserts that the denied conditions are the result of his repetitive hand activity while working for the employer. Thus, he makes a claim for occupational disease under ORS 656.802(1)(a)(C). In order to establish a compensable occupational disease claim, claimant must prove that employment conditions were the major contributing cause of his tendinitis condition involving the flexor and extensor tendons of his right hand and wrist. ORS 656.802(2)(a). Claimant must establish the existence of the occupational disease by medical evidence supported by objective findings. ORS 656.802(2)(d). Furthermore, claimant must establish that his tendinitis condition is causally connected to his work activities on the basis of medical probability, rather than possibility. *See Miller v. SAIF*, 60 Or App 557 (1982); *Gormley v. SAIF*, 52 Or App 1055 (1981). Given the conflicting medical opinions regarding the claimant's tendinitis condition, the causation question is medically complex and requires expert medical opinion to resolve. *Barnett v. SAIF*, 122 Or App 279, 282 (1993); *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985). It is claimant's burden to prove that his alleged occupational disease is compensable. ORS 656.266.

Dr. Reimer, examining neurologist, Dr. MacKenzie, treating surgeon, and Dr. Carter, treating surgeon, provide medical opinions regarding claimant's occupational disease claim. Dr. Reimer, however, did not address the tendinitis condition.

Dr. MacKenzie explained that tendinitis has a propensity to come and go and is sometimes aggravated by repetitive movement. (Ex. 89-17). He also noted that he did not see any evidence of tendinitis in his evaluation and treatment of claimant. (Exs. 89-17, -42). In addition, he found that claimant's MRI did not show any tendinitis, although an MRI can show that condition. (Ex. 89-37, -42).

He also noted that he did not mention tendinitis in his operative report. (Exs. 67, 89-37). Nevertheless, Dr. MacKenzie was aware of prior issues involving tendinitis. But, since claimant did not have tendinitis when he treated him, Dr. MacKenzie assumed the tendinitis condition had vanished, at least temporarily. (Ex. 89-42). Thus, Dr. MacKenzie's opinion does not support compensability.

Dr. Carter offered several opinions regarding the tendinitis condition. (Exs. 26, 38, 78-2, 82A, 86-2). Although the Board generally gives greater weight to the conclusions of a treating physician, it will not so defer when there are persuasive reasons to do otherwise. *See Weiland v. SAIF*, 64 Or App 810, 814 (1983). Here, we find persuasive reasons not to defer to the opinions of Dr. Carter.

Initially, on January 8, 1996, Dr. Carter opined that claimant's tendinitis condition was "probably a long standing condition." (Ex. 26). Subsequently, on October 23, 1996, Dr. Carter concurred with a telephone conversation summary in which he stated that claimant had tendinitis in his wrists, but that the condition was not attributable to his employment. (Ex. 38-1). In an October 16, 1997 response to another telephone conversation summary, Dr. Carter added the comment that "[t]he ongoing symptoms of r wrist pain are not directly related to carpal tunnel syndrome but may arise from the same condition that initiated the carpal tunnel syndrome." (Ex. 78-2). He did not identify the "same condition" to which he referred. In addition, his opinion is expressed in terms of possibility, rather than medical probability.

On December 22, 1997, Dr. Carter addressed the question as to whether claimant's current symptoms and treatment "have been a result of his on-the-job injury or not."[1] (Ex. 82A). He noted that this is "very difficult to determine." (*Id.*). Nevertheless, he stated that claimant's description of his work activities assembling hard plastic cases "could result in synovitis, could result in chronic attrition tear injury to the scaphoid lunate ligament, as well as contributing to the peripheral synovium, causing carpal tunnel syndrome." (*Id.*). Even assuming that this opinion includes the tendinitis condition, Dr. Carter again expressed his opinion in terms of possibility.

Finally, on February 5, 1998, Dr. Carter stated, without explanation, that the occupational history given by claimant "is more likely than not the cause for tendonitis and synovitis of the wrist which led to the symptoms of pain and tenderness." (Ex. 86-2).

We do not find Dr. Carter's opinions persuasive. He initially indicated that claimant's tendinitis condition was a long standing problem that was not attributable to his employment. (Exs. 26, 38-1). Subsequently, without explanation, he changed his opinion and indicated that there was a *possibility* that the tendinitis condition was related to the work activity. (Exs. 78-2, 82A). Later, again without explanation, Dr. Carter changed his opinion and found that claimant's work activities were the cause of claimant's tendinitis condition. (Ex. 86-2). We do not find these unexplained changes of opinion persuasive. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of opinion renders physician's opinion unpersuasive). Furthermore, we do not find Dr. Carter's ultimate conclusion that the work activities caused the tendinitis condition persuasive because it is entirely unexplained. *See Blakely v. SAIF*, 89 Or App 653, 656, *rev den* 305 Or 972 (1988) (Physician's opinion lacked persuasive force because it was unexplained); *Somers v. SAIF*, 77 Or App 259 (1986). Accordingly, in the absence of persuasive medical evidence supporting compensability, we conclude that the claim must fail.

ORDER

The ALJ's order dated November 18, 1998 is reversed in part and affirmed in part. That portion of the order that set aside the employer's partial denial of claimant's occupational disease claim for a tendinitis condition in the flexor and extensor tendons of the right hand and wrist is reversed. The denial is reinstated and upheld. That portion of the order that awarded claimant's attorney a fee of $3,000 for prevailing at hearing over the employer's denial of the tendinitis condition is reversed. The remainder of the order is affirmed.

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[1] Although Dr. Carter used the terms of an "on-the-job injury," claimant did not sustain a discrete work injury. Instead, the claim is one for an occupational disease. It is clear from Dr. Carter's later statements in this opinion that he understood the nature of the claim, *e.g.*, he focused on a particular work activity, not any discrete work injury. (Ex. 82A).

In the Matter of the Compensation of
BRADY N. LITTLE, Claimant
WCB Case No. 98-08312
ORDER ON REVIEW
Hilary E. Berkman, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that upheld the SAIF Corporation's denial of his right knee injury claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation.

The ALJ discounted the testimony of claimant's girlfriend and one of claimant's co-workers, based exclusively on demeanor. The ALJ then found that, because he was unable to assess the credibility of the remaining witnesses, including claimant, that claimant did not meet his burden to prove compensability. On review, claimant contends that he injured his right knee during an incident at work. SAIF continues to contest claimant's credibility and, based on inconsistencies in the record and testimony at hearing, asserts that claimant failed to prove compensability.

When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. *Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987).

There is no dispute that, at the time of the alleged incident on July 20, 1998, claimant was a member of a three-person crew who were "walking" a garage wall about 23 feet long and a little under 10 feet high from a horizontal position, where it was supported by two sawhorses spanned by a two-by-six and the two-and-a-half foot high concrete stem wall, to a standing position on the wall. There is also no dispute that, when the wall had been raised to about a 45-degree angle, it got hung up on some rebar, and, when Mr. Diehl tried to help lift the wall over the rebar, the wall slipped toward him and fell back toward the "walkers."

Claimant testified that he was the middle person on the lift, and, when the wall fell, he was struck on the top of his right knee. (Tr. 18). By the end of the day, his knee was bruised a little. (*Id.*) Claimant stated that he reported the incident to Mr. Diehl, the superintendent, at the time, and to Mr. Crichton, the employer, on a number of subsequent occasions. (*Id.*) On August 14, 1998, claimant sought treatment for a sore right knee. He filled out a Form "827" in which he reported that the last day he worked was August 10, 1998. He also reported that the three lifters fell to the ground. (Ex. 1). However, claimant testified that he had been fired from his job the day after he went to the doctor because he hurt his knee, and that "[I] didn't say that it knocked me down." (Tr. 21, 22, 23).

Mr. Diehl stated that claimant was on the street end of the wall, and, when the wall fell, it fell back on the sawhorses. He also stated that the wall fell on the three lifters when they were getting out from under it, and that claimant, who was on the end closest to the street, jumped out of the way. (Tr. 56). Diehl asked if anyone was hurt, and they all said no. (Tr. 57, 65). Diehl also stated that, although the wall might have hit claimant in the knee, he did not think that it fell far enough to reach his knee because the sawhorses and the stem wall were both over 30 inches high. (Tr. 57). Diehl reported that he had seen claimant wearing an Ace bandage on his knee sometime in about the last two weeks claimant worked. (Tr. 65).

Mr. Crichton stated that he was not aware of claimant's knee problem until he was informed by the clinic regarding the workers' compensation claim on or about August 17, 1998, when he returned from a trip that began on August 13, 1998. (Tr. 90). Crichton also stated that, on or before August 14, 1998, when claimant was no longer his employee, claimant had come to him on the job stating that his knee was hurt, but did not tell him that it was related to the July 20, 1998 incident. (Tr. 98). Crichton reported on a Form "801" that claimant's last day of work was August 12, 1998. (Ex. 5). He testified that he fired claimant on August 6, 1998. (Tr. 91).

Here, we find sufficient inconsistencies in the documentary and testimonial record to render claimant's credibility questionable. First, claimant's report that he was fired because he filed a workers' compensation claim on August 14, 1998 was not consistent with his own report on the "827" that his last day at work was August 10, 1998, prior to filing a claim. Moreover, his testimony was contradicted by Mr. Crichton, who reported that he had fired claimant prior to his making a claim.[1]

Claimant's testimony that he reported his knee injury was contradicted by both Mr. Diehl and Mr. Crichton. According to these witnesses, claimant never reported a job injury. Moreover, although claimant stated that he kept telling his boss and coworkers about his knee and that he needed to go to the doctor (Tr. 18), claimant offered no witnesses to corroborate his report.

Claimant has the burden to prove that his claim is compensable by a preponderance of the evidence. ORS 656.266; *Hutcheson v. Weyerhaeuser*, 288 Or 51 (1980). We find that, at best, the evidence is in equipoise concerning the purported incident. Thus, we conclude that claimant did not carry his burden of proving, as a factual matter, that he injured his right knee at work.

ORDER

The ALJ's order dated February 10, 1999 is affirmed.

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[1] Although Mr. Crichton reported different dates as claimant's last day of work, both of those dates were prior to claimant's filing of the claim.

In the Matter of the Compensation of
EDDARINE S. ROACH, Claimant
WCB Case No. 98-08910
ORDER ON REVIEW
Westmoreland & Mundorff, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that reduced an Order on Reconsideration's scheduled permanent disability award of 25 percent (37.5 degrees) for the loss of use or function of the left leg (knee) to zero. On review, the issue is extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for left knee contusion. A Notice of Closure awarded no permanent disability. Based on the medical arbiter's findings, an Order on Reconsideration awarded 25 percent scheduled permanent disability for the left leg (knee).

Dr. Ho, the medical arbiter, stated that claimant's "reduced strength at the quadriceps muscle of the left knee was apparently related to discomfort whereas reduced strength at the flexors of the left knee was related to relative disuse atrophy not related to any pathology in the peripheral nerves intravading the hamstring muscles[.]" Dr. Ho also made findings limiting repetitive use due to patello-femoral chondritis. (Ex. 16). Subsequently, in response to a query from the Appellate Review Specialist, Dr. Ho stated: "I believe the patello-femoral chondritis is a direct sequela of the accepted left knee contusion," and "[t]he decreased strength is due to pain and disuse of the accepted condition or any direct sequela." (Ex. 17).

The ALJ concluded that such evidence did not warrant an award for loss of strength of the left leg, finding that it did not "establish a permanent condition due to the injury." Claimant challenges the ALJ's order, asserting that the medical arbiter's impairment findings were consistent with claimant's compensable injury and the direct medical sequelae of that injury, because Dr. Ho established that the patello-femoral chondritis was a direct medical sequela of the accepted left knee contusion and, because the loss of strength resulted from the compensable injury or its sequelae, any impairment from loss of strength should also be considered as due to the industrial injury.

As noted above, claimant's accepted condition is "left knee contusion." Under ORS 656.268(16), impairment from conditions that are "direct medical sequela to the original accepted condition" are rated. We have construed the statute as applying when the record shows that an unaccepted condition is a "direct medical sequela" of the accepted condition, as opposed to the accidental injury from which the accepted condition arose. *See Julio C. Garcia-Caro*, 50 Van Natta 160 (1998); *Donald D. Davis*, 49 Van Natta 2100 (1997), *recon* 50 Van Natta 357 (1998). Consequently, if claimant's "patello-femoral chondritis" in her left knee is a "direct medical sequela" of the left knee contusion, then she is entitled to a scheduled permanent disability award.

Here, we find that the preponderance of medical evidence shows that claimant's patello-femoral chondritis condition may be a "direct medical sequela" of the accidental *injury*, but the patello-femoral chondritis condition is not a "direct medical sequela" of the accepted *condition* of left knee contusion. Although Dr. Ho stated that the patello-femoral chondritis condition "is a direct sequela of the accepted left knee contusion" (Ex. 17), his opinion fails to distinguish between sequela of the accepted condition and the accidental injury. *See Davis*, 50 Van Natta at 357. Under such circumstances, we do not find Dr. Ho's assessment to be persuasive.

Thus, because claimant did not show that the patello-femoral chondritis condition is a "direct medical sequela" of the accepted left knee contusion condition, we conclude that he is not entitled to impairment based on the patello-femoral chondritis condition. *See* ORS 656.268(16); *Garcia-Caro*, 50 Van Natta at 163.

Moreover, Dr. Ho indicated that claimant's loss of strength was due to pain and disuse of "the accepted condition *or* any direct sequela." (Ex. 17). His opinion is insufficient to establish that claimant's loss of strength was due to the accepted left knee contusion.

ORDER

The ALJ's order dated February 2, 1999 is affirmed.

In the Matter of the Compensation of
CLIFTON L. SWEEM, Claimant
WCB Case Nos. 98-07434 & 98-03731
ORDER ON REVIEW
Daniel J. Denorch, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the self-insured employer's denials of claimant's aggravation, new injury, and occupational disease claims for a low back condition. In his brief, claimant asserts that the ALJ abused his discretion by declining to continue the hearing to enable claimant to obtain rebuttal evidence. On review, the issues are the propriety of the ALJ's continuance ruling and compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings with the following correction, supplementation, and summary. The date in the first sentence should read March 2, *1989*, not March 2, *1998*.

During all relevant periods, claimant worked as a truck driver for the same self-insured employer, although different claims processing agents were apparently involved over the years, including GAB and Crawford & Company. (Tr. 1-2; Ex. 53A, 57). On March 2, 1989, claimant compensably injured his low back when he slipped and fell while working. This injury resulted in a February 8, 1990 left L5-S1 partial hemilaminectomy and discectomy performed by Dr. Hummel, neurosurgeon. The claim was closed by an October 8, 1990 Determination Order that awarded no permanent disability.

On April 7, 1998, claimant sought treatment with Dr. Yarusso, M.D., with complaints of low back pain and right sciatica. The reported mechanism of injury was a problem over time with his truck, including a tire problem that caused the truck to vibrate, which caused problems with his orthopedic seat, and a seat belt problem that caused his lower back to twist.[1] (Ex. 20-1). X-rays revealed degenerative disc disease at L5-S1 and D12-L1. (Ex. 21). On April 13, 1998, an MRI scan revealed mild to moderate lumbar spondylosis, including a small contained central disc herniation at L4-5. (Ex. 27).

Although Dr. Yarusso continued to treat claimant, he also referred him to Dr. Hummel, who examined him on May 5, 1998. (Ex. 35). Dr. Hummel interpreted the MRI to reveal a more significant protrusion of the disc material on the right at L4-5. (Ex. 35-2). He thought that claimant would improve with conservative treatment. In addition, he stated that claimant "has been off work since April 20th because of an industrially related injury." (Ex. 35-1).

On June 22, 1998, claimant returned to Dr. Hummel and informed him that the claim for a "new injury" had been denied. (Ex. 51). Dr. Hummel stated that his records clearly showed that, in February 1990, he operated on claimant on the left side at L5-S1, whereas claimant's current symptoms were related to the right side at L4-5 and his right leg pain had improved progressively with conservative treatment. (*Id.*).

On June 23, 1998, claimant was examined by Dr. Rosenbaum, neurosurgeon, on behalf of the employer. (Ex. 50). Dr. Rosenbaum noted that claimant's current symptoms were not in the same area as his prior back surgery, with the current disc abnormality located at L4-5 on the right side, while the prior disc herniation was at L5-S1 on the left side. He concluded that claimant's current low back condition was not an exacerbation of his prior disc problem, nor was it a new injury or occupational disease. (Ex. 50-4). On July 8, 1998, Dr. Yarusso checked a box indicating that he concurred with Dr. Rosenbaum's opinion. (Ex. 53).

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[1] Based on this same reported mechanism of injury, claimant eventually made claims under theories of aggravation, new injury, and new occupational disease, all of which the employer eventually denied.

On July 20, 1998, claimant's attorney advised the employer's attorney that claimant reserved the right to depose Dr. Rosenbaum. (Ex. 53A). Claimant's attorney also noted that, because Crawford & Company was considering this matter as an own motion claim, it might be appropriate to see what action was taken in that regard before scheduling the deposition. (*Id.*).

On July 24, 1998, Dr. Hummel wrote to Dr. Yarusso that claimant's attorney had asked claimant to come in and see if Dr. Hummel "could not restate the fact that his recent problem was related to an industrial injury." (Ex. 54). Dr. Hummel stated that:

> "[Claimant] has been very straight forward and honest with me and I have no reason to disbelieve him. I gave him a copy of my May 5, 1998 consultation note that clearly describes in a letter to you that he presented with an 'industrially related injury April 20th.'
>
> "I do not see how I can restate this any more emphatically. [Claimant] understands that I have a clear belief in his description, but apparently an insurance closing exam did not agree with the position, or his claim has been otherwise denied." (*Id.*).

On September 9, 1998, the employer recommended that the Board deny reopening claimant's own motion claim for the March 2, 1989 injury claim, contending that, *inter alia*, claimant's current condition was not related to the accepted condition. (Ex. 57).

On November 16, 1998, the employer's attorney notified claimant's attorney that the employer intended to call Dr. Rosenbaum as an expert witness. (Ex. 58). On December 14, 1998, the hearing convened.

In his opening remarks at hearing, claimant's attorney requested a continuance to secure a rebuttal report from Dr. Hummel to respond to Dr. Rosenbaum's scheduled testimony on behalf of the employer. (Tr. 2). He noted that Dr. Hummel had been out of his office since November 13, 1998, and was not due to return until December 21, 1998. The employer's attorney objected to that request, contending that Dr. Rosenbaum was there as a result of claimant's attorney's July 20, 1998 letter "demanding cross-examination of him." (Tr. 3). The employer's attorney asserted that he scheduled Dr. Rosenbaum's cross-examination for hearing "because it's just as easy for everyone to accomplish here today as it is to do depositions." (*Id.*)

When Dr. Rosenbaum was called as a witness, the employer's attorney again stated that the doctor was there on claimant's attorney's demand to cross-examine him. (Tr. 24). Claimant's attorney disputed that characterization, contending that Dr. Rosenbaum was there as the employer's expert witness per the employer's attorney's November 16, 1998 notice. (Tr. 25). The ALJ agreed with the employer's attorney. (*Id.*). Accordingly, claimant's attorney began the questioning.

At the end of Dr. Rosenbaum's testimony, claimant's attorney renewed his request for a continuance to allow Dr. Hummel to rebut Dr. Rosenbaum's testimony. (Tr. 48-49). In response to the ALJ's questions, claimant's attorney agreed that he had asked claimant to see Dr. Hummel, on July 24, 1998, in response to Dr. Rosenbaum's report. (Tr. 49). He also agreed that he had an opportunity to rebut Dr. Rosenbaum's report through Dr. Hummel, who saw the report. (*Id.*). In addition, he agreed that he had an opportunity at hearing to cross-examine Dr. Rosenbaum. Finally, he responded that Dr. Rosenbaum's testimony presented nothing in addition to or different from what was contained in his report. (Tr. 49-50). Based on these responses, the ALJ denied claimant's attorney's motion, reasoning that "unless there's something new here today, there's nothing new to offer [Dr.] Hummel to rebut." (Tr. 50).

CONCLUSIONS OF LAW AND OPINION

Propriety of Denial of Continuance

Claimant argues that the ALJ erred in denying his motion to continue the hearing to allow him to obtain final rebuttal evidence from Dr. Hummel, treating neurosurgeon, regarding the testimony of

Dr. Rosenbaum, examining neurosurgeon. Specifically, claimant argues that claimant is entitled to the last presentation of evidence.[2] For the following reasons, we disagree.

OAR 438-006-0091(3) provides that an ALJ "may continue a hearing * * * [u]pon a showing of due diligence if necessary to afford a reasonable opportunity for the party bearing the burden of proof to obtain and present final rebuttal evidence[.]" Because the rule gives discretion to the ALJ in deciding whether to continue a hearing for presentation of rebuttal evidence, we review the ALJ's ruling for abuse of discretion. *See, Donna J. Ball-Gates*, 46 Van Natta 1080 (1994); *James D. Brusseau II*, 43 Van Natta 541 (1991).

We have found no abuse of discretion in denying a continuance for rebuttal evidence when claimant could have obtained such evidence prior to hearing. In *Sharron D. Lemley*, 49 Van Natta 1365 (1997), reports from two examining physicians were received into evidence when the hearing first convened. Both examining physicians testified when the hearing reconvened about three months later. At the end of the employer's case on the third scheduled day of hearing, the claimant's attorney moved to continue the hearing to obtain rebuttal testimony from her treating physicians. The claimant's attorney explained that he had not subpoenaed any rebuttal witnesses because he had assumed that the employer's defense would not be finished until the end of the third scheduled day of hearing and he did not see any reason to make people come to the hearing if they were not going to testify. The ALJ refused to allow a continuance for the testimony of claimant's treating physicians.

On review, the claimant did not assert that any of the employer's experts testified at hearing to new or different opinions in comparison to their earlier reports, which were provided well in advance of the initial convening of the hearing. In addition, their testimony was consistent with the opinions expressed in their reports. Under these circumstances, we concluded that the claimant had the opportunity before hearing to provide expert rebuttal evidence. Because the claimant did not exercise that opportunity, we further concluded that she failed to show due diligence sufficient to continue the hearing.[3]

In addition, the court recently decided a case that presented facts similar to those in the case now before us. *See SAIF v. Kurcin*, 160 Or App 489 (1999). In *Kurcin*, well before the hearing, the carrier provided the claimant with a copy of its expert's medical report. A month before the hearing, the carrier notified the claimant of its intent to call its expert as a witness. On the day of the hearing and prior to the expert's testimony, claimant requested a continuance to prepare rebuttal to the testimony of the carrier's expert. The claimant cited a single ground for the continuance -- as the party with the burden of proof, she was entitled to present the last evidence. The ALJ allowed the continuance and we upheld the ALJ's decision. The court reversed.

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[2] The employer repeats the argument it made at hearing, contending that Dr. Rosenbaum's testimony represents the cross-examination of Dr. Rosenbaum that claimant's attorney requested when he reserved the right to depose the doctor in his July 20, 1998 letter. (Ex. 53A). We disagree. The employer's November 16, 1998 letter states that the employer intended to call Dr. Rosenbaum as an expert witness. (Ex. 58). Furthermore, it was not until the date of hearing that the employer "notified" claimant's attorney that Dr. Rosenbaum's testimony would serve as his deposition. Claimant did not agree to this arrangement. (Tr. 2-3, 24-25, 48-50). Moreover, there is no evidence that a deposition of Dr. Rosenbaum was considered after claimant's attorney's letter that "reserved the right to depose Dr. Rosenbaum." (Ex. 53A). In that letter, claimant's attorney also stated that it might be appropriate to wait to see what action Crawford & Company took regarding the own motion matter before scheduling the deposition. (Ex. 53A). Although the own motion recommendation was made on September 9, 1998, no request for or scheduling of a deposition of Dr. Rosenbaum subsequently occurred. (Ex. 57). Therefore, we find that Dr. Rosenbaum was called as an expert witness on behalf of the employer. Nevertheless, for the reasons discussed *infra*, we find that the ALJ did not abuse his discretion in denying claimant's request for continuation of the hearing.

[3] In reaching our decision in *Lemley*, we relied on our reasoning in *Larry E. Fournier*, 47 Van Natta 786 (1995), and *Robert L. Armstrong*, 47 Van Natta 1399 (1995). In *Fournier*, the claimant moved for a continuance to obtain rebuttal testimony from his attending physician in response to deposition testimony from examining physicians. We acknowledged that the depositions occurred too close in time to the hearing for the claimant to rebut such evidence before the hearing. We further found, however, that the basic conclusions expressed in the depositions did not differ from earlier reports from the examining physicians that were submitted well in advance of the hearing, giving the claimant an opportunity to provide rebuttal evidence at that time. We concluded that the claimant had not shown due diligence and the ALJ did not abuse her discretion in denying the motion for continuance. 47 Van Natta at 787. In *Armstrong*, we concluded that there was no abuse of discretion in denying a continuance to obtain rebuttal testimony in response to deposition evidence that was presented in earlier medical reports. 47 Van Natta at 1400.

The court held that, by the terms of OAR 438-006-0091(3), to obtain a continuance, a claimant must establish "due diligence" and the necessity of the continuance "to afford a reasonable opportunity * * * [to] present final rebuttal evidence." The court also determined that the claimant made no such showing, noting that the claimant did not explain why the advance copy of the expert's medical report did not afford her a reasonable opportunity to prepare for cross-examination or rebuttal. Slip opinion at 2. The court held that simply having the right to present final rebuttal evidence did not satisfy the requirement that the claimant must establish the required "due diligence" to be entitled to a continuance under OAR 438-006-0091(3).[4] The court reasoned that the rules provide for the possibility that an expert may change his or her testimony at hearing, noting that, if a claimant is reasonably surprised by such a change, then the claimant would have little difficulty establishing the need for a continuance at that time. Slip opinion at 5. The court concluded that, because the claimant made no showing of diligence, which OAR 438-006-0091(3) requires as a predicate to obtaining a continuance, the Board erred in upholding the ALJ's decision to allow the continuance. Slip opinion at 6.

We find the holdings in *Kurcin*, *Lemley*, *Fournier* and *Armstrong* applicable in this case. Dr. Rosenbaum's report was provided well in advance of the hearing.[5] Furthermore, his testimony was consistent with the opinions expressed in his reports.[6] Moreover, at hearing, claimant's attorney acknowledged that Dr. Rosenbaum's testimony did not present any new or different opinions in comparison to his earlier report. Thus, we conclude that claimant had the opportunity before hearing to provide expert rebuttal evidence.[7] Because he did not exercise that opportunity, we further conclude that he failed to show due diligence sufficient to continue the hearing. Accordingly, we find that the ALJ did not abuse his discretion in denying claimant's motion to continue the hearing.

Compensability

We adopt the ALJ's reasoning and conclusions regarding the compensability issue.

ORDER

The ALJ's order dated December 29, 1998 is affirmed.

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[4] Thus, the court rejected the argument that claimant makes here, *i.e.*, that as the party with the burden of proof, he has an absolute right to the last presentation of evidence.

[5] Dr. Rosenbaum wrote his report on June 23, 1998. (Ex. 50). As noted above, on July 20, 1998, claimant's attorney reserved the right to depose Dr. Rosenbaum, although he suggested waiting to see what action was taken regarding the own motion matter before scheduling the deposition. (Ex. 53A). Action was taken on the own motion matter on September 9, 1998, and Dr. Hummel did not become unavailable until November 13, 1998. (Ex. 57, Tr. 2). Thus, there were more than two months to schedule Dr. Rosenbaum's deposition following the own motion action and get Dr. Hummel's response to that deposition before he became unavailable. But no effort was made to have Dr. Rosenbaum's deposition scheduled during this period.

[6] As in *Lemley*, we distinguish this case from *Diane H. Kuran*, 49 Van Natta 715 (1997), where we found no abuse of discretion in an ALJ's decision to continue a hearing to allow the claimant to present her treating physician's response to testimony from a carrier's medical expert. In reaching our conclusion, we noted that the ALJ had found that it would not have been possible for the claimant to have known the substance of the opinion of the carrier's expert witness prior to the hearing. Here, in contrast, the employer's medical expert had provided a medical report well in advance of the hearing and his testimony was consistent with his prior opinion. Under such circumstances, we find no abuse of discretion in the ALJ's denial of claimant's continuance motion.

[7] At hearing, claimant's attorney acknowledged that he had an opportunity to rebut Dr. Rosenbaum's report through Dr. Hummel, who saw the report. (Tr. 49). In fact, claimant's attorney had asked claimant to see Dr. Hummel in response to Dr. Rosenbaum's report. Moreover, that visit resulted in Dr. Hummel providing a report to claimant's attorney regarding causation. (Tr. 49, Ex. 54). Thus, claimant actually presented rebuttal evidence regarding Dr. Rosenbaum's report.

In the Matter of the Compensation of
PAMELA BILLICK, Claimant
WCB Case No. 98-04396
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Mannix, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) McWilliams' order that: (1) set aside its denial of claimant's aggravation claim for a right carpal tunnel condition; and (2) awarded an assessed fee of $3,800. On review, the issues are aggravation and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Aggravation

We adopt and affirm the ALJ's reasoning and conclusions regarding this issue.

Attorney Fees

The employer contends that, should we affirm the ALJ's decision regarding the compensability of the aggravation claim, the assessed fee of $3,800 should be reduced. We agree.

On *de novo* review, we consider the amount of claimant's counsel's attorney fee for services at the hearings level by applying the factors set forth in OAR 438-015- 0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The issue in dispute was the compensability of claimant's aggravation claim. Approximately 80 exhibits were received into evidence. However, several exhibits solicited by claimant's counsel pertained to the compensability of a reflex sympathetic dystrophy condition, an issue that claimant withdrew at hearing. (Exs. 43A, 51A, 53A). There was one brief deposition, lasting 15 minutes. The hearing was also brief, also lasting 15 minutes. The transcript consists of 15 pages and claimant was the only witness.

As compared to typical aggravation cases, the issue here was of average complexity. The claim's value and the benefits secured are of average proportions. Given the conflicting medical evidence, there was a risk that claimant's counsel's efforts might have gone uncompensated. There were no frivolous defenses or issues. Both attorneys skillfully presented their cases.

After consideration of the aforementioned factors, we conclude that $3,000 is a reasonable assessed attorney fee for claimant's counsel's services at hearing regarding the compensability of claimant's aggravation claim. In particular, we have considered the complexity of the issue, the value of the interest involved, the benefits obtained, the nature of the proceeding and the risk that claimant's counsel might go uncompensated.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the aggravation issue is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee on review for her counsel's services regarding the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated February 5, 1999 is affirmed in part and modified in part. In lieu of the ALJ's attorney fee award, claimant's counsel is awarded an assessed fee of $3,000 for services at hearing regarding the aggravation issue. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the employer.

In the Matter of the Compensation of
DARRELL A. PFAFF, Claimant
Own Motion No. 99-0105M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted a request for temporary disability compensation for claimant's compensable bilateral carpal tunnel syndrome claim. Claimant's aggravation rights expired on November 12, 1996. SAIF opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work *and* is seeking work; or (3) not working but willing to work, *and* is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989); *SAIF v. Blakely*, 160 Or App at 244.

Contending that claimant has not submitted any wage documentation for the years 1998 and 1999, SAIF asserts that "it does not appear [claimant] is in the work force." In response, claimant asserts that he sustained a work-related knee injury in May 1998 and underwent a September 1998 surgery. As a result of that surgery, he argues that he was unable to work.

We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force under the Board's own motion jurisdiction,[1] is the date he enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). In other words, the relevant time period for which claimant must establish that he was in the work force is the time prior to when his compensable condition worsened requiring surgery and/or inpatient hospitalization. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990); *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997).

Here, on November 25, 1998, Dr. Thompson, claimant's attending physician, recommended that claimant undergo a right carpal tunnel release. At that time, claimant was receiving temporary disability under an accepted knee claim with another carrier.

SAIF argues that claimant voluntarily left his job on July 31, 1998 and did not begin receiving temporary disability compensation in the other claim until October 1998. Because claimant quit his job in July 1998 and was not working prior to Dr. Thompson's November 1998 surgery recommendation, SAIF contends that he was not in the work force at the time of his November 1998 carpal tunnel disability.

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[1] The Board in its own motion jurisdiction can only authorize temporary disability from the time of surgery or hospitalization. *See* ORS 656.278(1)(a).

However, as noted above, the date of disability focuses on the time when claimant's compensable condition worsened requiring surgery and/or inpatient hospitalization. Here, Dr. Thompson recommended surgery on November 25, 1998, not in July 1998. Thus, for the purpose of determining whether claimant was in the work force, the "date of disability" is November 25, 1998. Since claimant was receiving temporary disability compensation in another workers' compensation claim at the time of his disability in this claim, he is considered to be in the work force. *See Michael C. Johnstone*, 48 Van Natta 761 (1996); *William L. Halbrook*, 46 Van Natta 79 (1994).

Therefore, we conclude that claimant did not voluntarily remove himself from the work force, but, rather, sustained another compensable injury which prevented him from working at the time of his current disability. Consequently, we find that claimant has established that he was in the work force at the time of disability.

Accordingly, we authorize the reopening of claimant's 1990 claim to provide temporary disability compensation beginning the date he is hospitalized for the proposed surgery.[2] When claimant is medically stationary, SAIF shall closed the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[2] In making this authorization, we note that claimant sustained a separate work injury for which he received time loss benefits. Claimant is not entitled to receive double the statutory sum for the same period of time loss because he has two separate disabling injuries. *Fischer v. SAIF*, 76 Or App 656, 661 (1985); *Petshow v. Portland Bottling Co.*, 62 Or App 614 (1983), *rev den* 296 Or 350 (1984). Therefore, if claimant is hospitalized for the proposed carpal tunnel surgery during a period that he is entitled to time loss for his 1998 knee injury claim, SAIF is free to petition the Compliance Division for a pro rata distribution of payments between the two claims. *See* OAR 436-060-0020(8); *Leroy R. Fowler*, 41 Van Natta 1468 (1989).

In the Matter of the Compensation of
TIMOTHY O. SCHRICK, Claimant
WCB Case No. 98-05549
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Phillips Polich, Bock and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's aggravation claim for a cervical condition. On review, the issue is aggravation.

We adopt and affirm the ALJ's order with the following changes and supplementation.

In the first paragraph of the findings of fact on page 1, we add the following sentence after the fifth sentence: "The employer amended the acceptance to include C6 radiculopathy. (Ex. 30)." In the first full paragraph on page 3, we change the fourth sentence to read: "Dr. Silver found that claimant had weakness of the right wrist extensors, an absent reflex of the right brachioradialis and a loss of sensation of the right thumb and index finger. (Ex. 62)." In the second full paragraph on page 3, we change the first sentence to refer to "Exhibit 65B," rather than "Exhibit 65D." Also in the second paragraph on page 3, we change the date in the third sentence to read: "April 1997." In the paragraph beginning at the bottom of page 3 and continuing on page 4, we replace the fourth sentence with the following: "We are more persuaded by Dr. Silver's opinion that documented new objective findings since the last arrangement of compensation."

We agree with the ALJ's reasoning and conclusion that claimant has suffered an actual worsening of his compensable condition that is supported by objective findings. The employer argues that the ALJ focused only on the worsening issue and did not address the cause of any worsening. We

disagree. The ALJ explained that Drs. Silver and Gritzka had opined that claimant had an objective worsening of the compensable condition and that the major cause of the current need for treatment was the 1996 injury. The ALJ concluded that preponderance of evidence established that claimant's original compensable injury remained the major contributing cause of the need for treatment and disability.

Furthermore, although the employer relies on *Marcum v. City of Hermiston*, 149 Or App 392 (1997), we find that case inapposite. Under ORS 656.273(1), if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable. In *Marcum*, the court held that the carrier did not have to prove that the off-the-job injury was the major contributing cause of the claimant's worsened condition because the Board had concluded that the claimant had not met her threshold burden of proving she had suffered a compensable aggravation. *Id.* at 395. Here, in contrast, we agree with the ALJ that claimant has suffered an actual worsening of his compensable condition that is supported by objective findings. We also agree with the ALJ that claimant's original compensable injury remains the major contributing cause of the need for treatment and disability.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 20, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the self-insured employer.

Board Member Haynes dissenting.

The majority concludes that claimant sustained a worsening of his compensable condition and that the original compensable injury remains the major contributing cause of the need for treatment and disability. Because I do not believe the record supports that conclusion, I respectfully dissent.

I agree with the employer that the medical evidence is insufficient to establish an actual worsening of claimant's accepted conditions. Moreover, even assuming there was an actual worsening, the major contributing cause of that worsening was claimant's noncompensable slip and fall at home, *not* the compensable injury.

Claimant relies on the opinions of Drs. Silver and Gritzka to establish a compensable aggravation. Claimant's reliance on Dr. Gritzka's opinion is misplaced. In Dr. Gritzka's August 12, 1998 report, he opined that claimant's accepted conditions had not worsened in a pathological sense since October 8, 1997. (Ex. 65a-8). On the other hand, Dr. Gritzka later concurred with Dr. Silver's September 1, 1998 report, which found that claimant had a worsening of his underlying condition. (Exs. 65B, 71). Because Dr. Gritzka did not explain his apparent change of opinion regarding the worsening issue, his opinion is not persuasive. *See Kelso v. City of Salem*, 87 Or App 630 (1987).

Furthermore, Dr. Silver's opinion is not persuasive because it is not well-reasoned and lacks adequate explanation. Before claimant's slip and fall at home in January 1998, his symptoms from the compensable injury had become negligible. After the new incident, however, claimant said that the pain and stiffness in his neck and shoulder returned, as did the firey, achy feeling in his forearm. (Tr. 8). Dr. Silver's conclusory opinion that a work injury was the major cause of claimant's current condition is simply not persuasive. I agree with the employer that the facts in this case are similar to *Marcum v. City of Hermiston*, 149 Or App 392 (1997).

Because I find the opinions of Drs. Gritzka and Silver insufficient to establish a compensable aggravation claim, and in light of the other medical opinions to the contrary, I respectfully dissent.

In the Matter of the Compensation of
SHIRLEY M. CARDEN, Claimant
Own Motion No. 99-0145M
OWN MOTION ORDER
Travelers Insurance, Insurance Carrier

The insurer has submitted a request for temporary disability compensation for claimant's left shoulder condition. Claimant's aggravation rights expired on June 29, 1997. The insurer contends that claimant has withdrawn from the work force.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work *and* is seeking work; or (3) not working but willing to work, *and* is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

The insurer contends that claimant was terminated from her employment in November 1997 and has not returned to work. It relies on the following evidence.

In April 1998, Dr. Lawton, one of her attending physicians, reported that claimant was terminated from her job because of a seizure disorder. In October 1998, Dr. Switlyk, on referral from Dr. Lawton, stated that claimant lost her job because of her problems with seizures and was not working. In December 1998, claimant informed an independent medical examiner that she had lost her job because of her seizure problem. Finally, in a January 25, 1999 hospital report, Dr. Switlyk states that "[Claimant] has other medical problems. [Claimant] is not working anymore because of her medical problems."

Additionally, a copy of the insurer's May 5, 1999 recommendation was furnished to claimant which contained a notice advising her that she needed to prove that she was in the work force at the time her condition worsened requiring surgery. Claimant did not respond the notice nor did she provide any documentation that would demonstrate that she was in the work force when her condition worsened.

Based on this record, we find that claimant has neither worked nor sought work since November 1997. In light of such circumstances, we conclude that claimant was not in the work force at the time of her current worsening. Consequently, we are not authorized to award temporary disability. Accordingly, claimant's request for temporary disability compensation is denied.[1] *See id.*

Claimant's entitlement to medical expenses pursuant to ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

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[1] If claimant wishes to submit evidence demonstrating that she was in the work force at the time of her April 6, 1999 disability, she is entitled to do so. However, because the Board's authority to reconsider its decision may expire within 30 days of the date of this order, it is recommended that any such evidence be submitted as soon as possible.

In the Matter of the Compensation of
RICHARD R. ELIZONDO, Claimant
Own Motion No. 98-0339M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Andrew H. Josephson, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's January 19, 1999 Notice of Closure which closed his claim with an award of temporary total disability (TTD) benefits from September 18, 1998 through November 12, 1998. SAIF declared claimant medically stationary as of January 7, 1999. Claimant does not contend that SAIF's closure was premature. Rather, he contends that he is entitled to additional temporary disability compensation payable to January 7, 1999.

In support of his contention, claimant submits a December 22, 1998 Form 828, completed by Dr. Grewe, his attending physician, which released him to modified duty effective November 12, 1998. Claimant argues that this modified release entitled him to temporary disability benefits until he was declared medically stationary. In response, SAIF has submitted a November 27, 1998 Form 828, also completed by Dr. Grewe, which released claimant to regular work effective November 12, 1998.

Temporary disability compensation shall be paid on an "open" own motion claim until one of the following event occurs: (1) the claim is closed pursuant to OAR 438-012-0055; (2) a claim disposition agreement (CDA) is submitted to the Board pursuant to ORS 656.236(1); or (3) termination of such benefits is authorized by the terms of ORS 656.268(3)(a) through (c). *See* OAR 438-012-0035(4); *Brian Lutz*, 50 Van Natta 1421 (1998); *Jeffrey T. Knudson*, 48 Van Natta 1708 (1996).

Here, SAIF relies on ORS 656.268(3)(b) as support for its termination of claimant's temporary disability benefits prior to closure. ORS 656.268(3)(b) provides that an insurer may terminate temporary disability benefits when "the attending physician advises the worker and documents in writing that the worker is released to return to regular employment."

Dr. Grewe's November 27, 1998 release to regular work as of November 12, 1998, is unequivocal and was issued shortly after his November 12, 1998 examination. Prior to Dr. Grewe's December 22, 1998 report there is no indication that claimant was re-examined or that Dr. Grewe had any further contact with him. Yet, in that December 22, 1998 report, listing November 12, 1998, as the "last date treated," Dr. Grewe released claimant to modified work effective November 12, 1998. Because no explanation is provided for this change of opinion (and no intervening examination occurred between the November 27 and December 22 reports), we do not consider Dr. Grewe's December 22, 1998 report to be persuasive. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of physician's opinion found unpersuasive). Thus, we are not persuaded that claimant was entitled to additional temporary disability compensation after the November 12, 1998, date SAIF terminated those benefits because claimant was released to regular work.

Accordingly, we affirm SAIF's January 19, 1999 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
VINA HANKEN, Claimant
Own Motion No. 99-0191M
OWN MOTION ORDER
Industrial Indemnity, Insurance Carrier

The insurer has submitted a request for temporary disability compensation for claimant's right knee condition. Claimant's aggravation rights expired on September 17, 1985. The insurer contends that claimant has withdrawn from the work force.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work *and* is seeking work; or (3) not working but willing to work, *and* is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

In an April 6, 1999 chart note, Dr. Harris, claimant's attending physician, states that claimant "is no longer working." In addition, prior to submitting its May 5, 1999 recommendation, the insurer represents that it forwarded claimant a letter advising her of the need for "work force" information. Finally, a copy of the insurer's recommendation was furnished to claimant, which further advised her that she needed to prove that she was in the work force when her condition worsened. Claimant has not responded to either notice from the insurer or submitted any documentation which would demonstrate that she was in the work force at the time of her April 6, 1999 disability.

Therefore, the record does not establish that claimant was in the work force when her condition worsened requiring surgery. Consequently, we are not authorized to award temporary disability. Accordingly, claimant's request for temporary disability compensation is denied.[1] *See id.*

Claimant's entitlement to medical expenses pursuant to ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

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[1] If claimant wishes to submit evidence demonstrating that she was in the work force at the time of her April 6, 1999 disability, she is entitled to do so. However, because the Board's authority to reconsider its decision may expire within 30 days of the date of this order, it is recommended that any such evidence be submitted as soon as possible.

In the Matter of the Compensation of
STEVEN L. KLAHN, Claimant
Own Motion No. 99-0073M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

On May 11, 1999, we issued our Own Motion Order, which declined to authorize the reopening of claimant's 1986 injury claim for the payment of temporary disability compensation. We based our order on claimant's failure to appeal the SAIF Corporation's February 22, 1999 denial of claimant's exostosis of his left fourth metatarsal condition. Reasoning that claimant's current left fourth metatarsal condition was not compensable, we concluded that we were without authority to reopen claimant's claim.

Announcing that it "recently rescind[ed] the February 22, 1999 partial denial due to new medical information received," SAIF requests the issuance of an Own Motion order reopening claimant's 1986 claim for the payment of temporary disability compensation. We treat SAIF's submission as a request for reconsideration of our May 11, 1999 order. On reconsideration, we withdraw our prior order and issue the following order in its place.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

Based on SAIF's rescission of its partial denial of claimant's left fourth metatarsal condition, claimant's current left foot condition has been determined to be compensable under his 1986 injury claim. Consequently, we address claimant's request for temporary disability compensation under ORS 656.278(1)(a).

On December 28, 1998, claimant underwent a removal of exostosis of the left fourth metatarsal. Thus, we conclude that claimant's compensable injury worsened requiring surgery.

However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

SAIF initially contended that claimant was not in the work force at the time of his current worsening. However, with its request for reconsideration, SAIF submitted copies of claimant's paystubs for the period from July 1, 1998 through December 31, 1998. Based on SAIF's submission, we find that claimant was in the work force at the time of his current worsening which required surgery.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning December 28, 1998, the date he was hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
RODNEY SULLIVAN, Claimant
Own Motion No. 99-0135M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted a request for temporary disability compensation for claimant's compensable left knee condition. Claimant's aggravation rights on that claim expired March 16, 1993. SAIF opposed authorization of temporary disability compensation, contending that claimant had withdrawn from the work force.

We may authorize, on our own motion authority, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

In response to SAIF's contention, claimant submitted several documents to support his position that he was in the work force at the time of his current worsening.[1] However, we need not resolve that issue.

On June 11, 1996, we issued an Own Motion Order authorizing the provision of temporary disability compensation beginning the date claimant was hospitalized for the proposed surgery. The record does not establish that the previously "reopened" claim has been closed pursuant to OAR 438-012-0055. Consequently, the claim remains in open status.

In light of such circumstances, claimant's current request for reopening of his claim has been rendered moot. In other words, SAIF remains obligated to pay temporary disability to claimant as provided by our prior order and to continue the payment of those benefits until such compensation can be terminated under OAR 438-012-0055.

IT IS SO ORDERED.

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[1] With his submissions, claimant includes several documents which relate to vocational assistance issues. Pursuant to ORS 656.340, these vocational issues are within the Director's jurisdiction. Because we are not authorized to address such matters, claimant may wish to refer his questions to the Director. Regarding the vocational issues, claimant may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers. Claimant may contact the Workers' Compensation Ombudsman, free of charge, at 1-800-927-1271, or write to:

DEPT OF CONSUMER & BUSINESS SERVICES
WORKERS' COMPENSATION OMBUDSMAN
350 WINTER ST NE
SALEM OR 97310

In the Matter of the Compensation of
RANDY B. WATSON, Claimant
WCB Case Nos. 98-01822 & 96-11284
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Marshall's order that awarded an assessed attorney fee of $3,000. SAIF also moves for remand regarding the attorney fee. Claimant cross-requests review of that portion of the ALJ's order that upheld SAIF's denial of his current cervical, dorsal and lumbar conditions. On review, the issues are compensability, remand and attorney fees.

We adopt and affirm the ALJ's order with the following changes and supplementation. We replace the first paragraph on page 6 with the following:

> "The only medical evidence that arguably supports compensability of claimant's current condition claim comes from Dr. Stringham. On January 6, 1998, Dr. Stringham reported that claimant's February 5, 1997 fall' and the subsequent consequence of losing his job of 20 years, is the major contributing cause of [his] current global disability and need for treatment * * *.' (48A-6). Similarly, Dr. Stringham opined on February 7, 1998 that the fall of February 5, 1997 and 'subsequent loss of job because of the consequence of that fall' were the major contributing cause of claimant's current need for treatment. (Ex. 49A-4). Because Dr. Stringham's opinion implicates a non-compensable factor (claimant's job loss) as well as the work injury, his opinion is not sufficient to carry claimant's burden of proving that the work injury is the major cause of his need for treatment or disability for the combined current condition. *See Dietz v. Ramuda*, 130 Or App at 401."

Attorney Fees

The ALJ awarded claimant's attorney a $3,000 attorney fee under ORS 656.386(1) for prevailing against SAIF's denial of claimant's right knee condition. The ALJ noted that he had considered the factors set forth in OAR 438-015-0010(4) in awarding the attorney fee.

On review, SAIF argues that the ALJ failed to apply each of the factors in OAR 438-015-0010(4), failed to draw conclusions from those facts and failed to demonstrate how he weighed those conclusions in determining a reasonable attorney fee. SAIF seeks remand to the ALJ to properly apply OAR 438-015-0010(4).

Contrary to SAIF's contention, an ALJ is not required to make specific findings regarding each of the factors set forth in OAR 438-015-0010(4) where, as here, there is no specific attorney fee requested and the parties did not submit arguments at hearing addressing the factors to be weighed in determining a reasonable fee. *SAIF v. Bacon*, 160 Or App 596 (1999); *Daryl L. Underwood*, 50 Van Natta 2330, 2332 (1998). The ALJ satisfies his or her obligation to make findings by including a brief description or citation to the rule-based factor or factors the ALJ relied on in determining the attorney fee awarded. *Underwood*, 50 Van Natta at 2332 (*citing McCarthy v. Oregon Freeze Dry*, 327 Or 84, *adhered to on recon*, 327 Or 185 (1998)).

Here, although the ALJ cited OAR 438-015-0010(4), he did not identify the factors considered in awarding the attorney fee. Because the ALJ's order lacks an explanation of those factors in determining the attorney fee in this case, we find the ALJ's reasoning insufficient to determine how he arrived at $3,000 as a reasonable fee. *See Donna R. Grierson*, 51 Van Natta 679 (1999); *compare Leslie D. Custer*, 51 Van Natta 390 (1999) (in the absence of a specific request or objection, ALJ's particular consideration of certain enumerated factors satisfies the *Underwood* rationale).

Although we find the ALJ's attorney fee discussion lacking in this case, we do not find the record to be improperly, incompletely or otherwise insufficiently developed. *See* ORS 656.295(5). In other words, because we are authorized to modify or supplement the ALJ's findings and conclusions under ORS 656.295(6), it is not necessary to remand this case to the ALJ for supplementation of findings regarding the attorney fee award. Consequently, we deny SAIF's motion to remand.

We provide the following additional reasoning concerning the attorney fee award. The issues at hearing included the timeliness of claimant's request for hearing concerning SAIF's denial of his right knee claim and compensability of his right knee condition. The hearing lasted one hour. Claimant was the only witness to testify. The record consists of 62 exhibits. Seven of the exhibits were generated or submitted by claimant's attorneys,[1] five of which pertained to the right knee claim. We find the timeliness and right knee issues were of average complexity. Because claimant's right knee condition has been found compensable, he is entitled to workers' compensation benefits, and the value of the interest involved and the benefit secured for claimant are significant. The attorneys involved in this matter are skilled litigators with substantial experience in worker's compensation law. No frivolous issues or defenses were presented at hearing. Furthermore, given the contradictory medical opinions, there was a risk that claimant's counsel might go uncompensated.

Consequently, after considering the factors set forth in OAR 438-015-0010(4), we agree with the ALJ that $3,000 is a reasonable fee for claimant's attorney's services at hearing regarding the timeliness and the right knee compensability issues. We therefore affirm the ALJ's attorney fee award. Because SAIF challenged only the attorney fee award on review and attorney fees are not "compensation" for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for his counsel's services on review regarding this issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

Compensability - Current Condition

We adopt and affirm that portion of the ALJ's order that upheld SAIF's denial of claimant's current cervical, dorsal and lumbar conditions with the change noted above.

ORDER

The ALJ's order dated January 13, 1999 is affirmed.

[1] We note that claimant was initially represented by a different attorney in this case.

May 27, 1999 Cite as 51 Van Natta 898 (1999)

In the Matter of the Compensation of
PHILIP TAYLOR, Claimant
WCB Case No. 98-05728
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
John M. Pitcher, Defense Attorney

Reviewed by Board Members Biehl and Haynes. Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the self-insured employer's denial of claimant's occupational disease claim for hearing loss. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation.

On review, claimant continues to argue that he does not have a "combined condition" under ORS 656.802(2)(b) because, according to the medical evidence, his preexisting and age-related hearing loss were separate processes from hearing loss from industrial exposure. Claimant contends that "the claim should be allowed for noise-induced hearing loss because the medical evidence established that industrial exposure was the major cause of Claimant's binaural loss of hearing due to noise."

As we have previously explained, we consider the "claim" to consist of claimant's entire hearing loss, and not just any portion that can be attributed to industrial exposure. *E.g., Henry F. Downs*, 48 Van Natta 2049, *on recon* 48 Van Natta 2200 (1996). Thus, whether or not claimant has a "combined condition," because the medical evidence shows that preexisting hearing loss and age-related hearing loss, rather than industrial exposure, were the major contributing causes of claimant's entire hearing loss claim, claimant did not prove compensability. ORS 656.802(2).

ORDER

The ALJ's order dated January 19, 1999 is affirmed.

In the Matter of the Compensation of
CARI M. PICKETT, Claimant
WCB Case No. 98-08802
ORDER ON REVIEW
Scott M. McNutt, Sr., Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that awarded a $1,500 insurer-paid attorney fee under ORS 656.382(2) regarding her counsel's successful defense against SAIF's request for hearing from an Order on Reconsideration award. SAIF also moves for remand. On review, the issues are remand and attorney fees.

We deny SAIF's request for remand, and adopt and affirm the ALJ's order with the following supplementation.

Claimant requested a hearing on the extent of scheduled permanent disability for the loss of use and function of her left knee. The ALJ affirmed the Order on Reconsideration and awarded claimant's attorney an assessed fee of $1,500 for services at hearing, "based on the factors set forth in OAR 438-015-0010(4)."

On review, SAIF argues that the ALJ erred in failing to apply each of the factors in OAR 438-015-0010(4) and in failing to draw conclusions from those facts in awarding an assessed attorney fee. SAIF requests that we remand the case to the ALJ to "properly" apply OAR 438-015-0010(4). Contrary to SAIF's contention, an ALJ is not required to make specific findings for each rule-based factor, where, as here, there is no specific attorney fee requested and the parties did not submit arguments at hearing addressing the factors to be weighed in determining a reasonable fee. *SAIF v. Bacon*, 160 Or App 596 (1999); *Daryl L. Underwood*, 50 Van Natta 2330 (1998).

Here, although the ALJ cited the applicable rule (OAR 438-015-0010(4)), he did not identify the factors he considered in awarding the attorney fee. In other words, the ALJ did not discuss any of the specific rule-based factors, such as the value of the interest involved, the time devoted to the case, the complexity of the issue, the benefit secured, the skill of the attorneys, the nature of the proceedings or the risk that the claimant's counsel's efforts might go uncompensated. Because the ALJ's order is devoid of any explanation of his application of the factors in determining the attorney fee in this case, we find the ALJ's reasoning insufficient to determine how he arrived at $1,500 as a reasonable fee. *Donna R. Grierson*, 51 Van Natta 679 (1999).

Even though we find the ALJ's attorney fee discussion lacking in this case, we do not find the record to be improperly, incompletely or otherwise insufficiently developed. *See* ORS 656.295(5). In other words, because we are authorized to modify or supplement the ALJ's findings and conclusions under ORS 656.295(6), it is not necessary to remand this case to the ALJ for supplementation of findings regarding the attorney fee award. Consequently, we deny SAIF's motion to remand.

We provide the following additional reasoning concerning the attorney fee award for claimant's counsel's services at hearing. Because the parties relied on the reconsideration record, no hearing took place. The record consists of 30 exhibits, all of which were submitted by SAIF. Based on "extent of permanent disability" disputes generally litigated before this forum, we find the issues presented in this case of modest complexity. The value of the interest involved and the benefit secured for claimant are material, however, because the Order on Reconsideration's award of 28 percent scheduled permanent disability for loss of use and function of the left knee was affirmed. The attorneys involved in this matter are skilled litigators with substantial experience in workers' compensation law. Furthermore, there was a risk that claimant's counsel might go uncompensated, given Dr. Bert's and Dr. Smith's differing findings regarding claimant's permanent disability.

Consequently, after considering the factors set forth in OAR 438-015-0010(4), particularly the value of the interest involved, the benefit secured for claimant, the nature of the proceedings, the complexity of the issue and the risk that claimant's counsel might go uncompensated, we agree with the

ALJ that $1,500 is a reasonable fee for claimant's counsel's services at hearing. We therefore affirm the ALJ's attorney fee award.[1]

ORDER

The ALJ's order dated March 1, 1999 is affirmed.

[1] Because SAIF challenged only the attorney fee award on review and attorney fees are not "compensation" for putposes of ORS 656.382(2), claimant is not entitled to an attorney fee for her counsel's services on review. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

June 2, 1999 Cite as 51 Van Natta 900 (1999)

In the Matter of the Compensation of
GLEN A. BERGERON, Claimant
WCB Case No. 98-04297
ORDER ON REVIEW
Kryger, et al, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Garaventa's order that denied his petition for approval of attorney fees arising out of compensation. On review, the issue is attorney fees.

We adopt and affirm the ALJ's order with the following supplementation.

Citing *Karen Stean*, 50 Van Natta 374 (1998), *Larry D. Simmons*, 50 Van Natta 107 (1998), and *Julie A. Johnson*, 48 Van Natta 29 (1996), the ALJ denied claimant's request for approval of an "out-of-compensation" fee for services performed in obtaining reclassification by the Department of the claim from nondisabling to disabling. While acknowledging that claimant's counsel was instrumental in gaining compensation for claimant, the ALJ reasoned that, because the matter arose under the Department's jurisdiction, the Hearings Division had no authority to award an approved fee under ORS 656.386(2). *See* ORS 656.385(5).[1]

On review, claimant contends that the cited decisions were incorrectly decided. Claimant argues that the Board has jurisdiction to award "out-of-compensation" attorney fees in reclassification cases under ORS 656.386(2), which provides, in part, that "[i]n all other cases, attorney fees shall be paid from the increase in claimant's compensation***." In making this argument, claimant notes that he was not before the Director under ORS 656.245, 656.260, 656.327 or 656.340, which are the statutory provisions cited in ORS 656.385(1) as providing the basis for a "Director-ordered" attorney fee.[2] Thus, claimant

[1] ORS 656.385(5) provides:

"Notwithstanding any other provision in ORS 656.382 or 656.386, an Administrative Law Judge or the Workers' Compensation Board may not award penalties or attorney fees for matters arising under the review jurisdiction of the director. Penalties and attorney fees awarded pursuant to this section by the director or the courts shall be paid for by the employer or insurer in addition to compensation found to be due to the claimant.

[2] ORS 656.385(1) provides:

"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 in a contested case order by 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, after a contested case hearing request by the claimant, where an attorney is instrumental in obtaining a settlement of the dispute prior to a decision by the director, the director may require the insurer or self-insured employer to pay a reasonable attorney fee to the claimant or claimant's attorney."

asserts that the limitations of ORS 656.385(5) do not apply because, when that statute refers to matters arising under the "review jurisdiction" of the Director, it is only referring to claims involving disputes under ORS 656.245, 656.260, 656.327 or 656.340.[3]

Claimant's arguments are not persuasive. ORS 656.385(5) provides that "[n]otwithstanding any other provision in ORS 656.382 or *656.386*, an Administrative Law Judge or the Workers' Compensation Board may not award penalties or attorney fees for matters arising under the review jurisdiction of the director." (emphasis supplied). The plain language of the statute proscribes "out-of-compensation" attorney fees under ORS 656.386(2) when a matter arises under the Director's review jurisdiction. Because the reclassification matter in this case arose under the Director's review jurisdiction pursuant to ORS 656.277(1), ORS 656.385(5) prohibits us from awarding an "out-of-compensation" fee. *See Shook v. Pacific Communities Hospital*, 159 Or App 604 (1999) (656.385(5) and ORS 656.388(1) preempt and preclude the Board from awarding "out-of-compensation" fees in a matter litigated within the Director's review jurisdiction); *Larry D. Simmons*, 50 Van Natta at 108.[4] Had the legislature intended to encompass only those specific statutory examples cited in ORS 656.385(1) within the broader terminology of "review jurisdiction" in ORS 656.385(5), it would have done so by specifically citing them within the latter section. Because the legislature did not do so, we decline to interpret "review jurisdiction" in the narrow manner claimant urges.

ORDER

The ALJ's order dated January 12, 1999 is affirmed.

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[3] Claimant also cites the heading of ORS 656.385 as evidence of the kinds of disputes for which the Director has authority to award attorney fees. The heading to ORS 656.385 states: "Attorney fees in cases regarding certain medical service or vocational rehabilitation matters;***." Captions and headings provided by Legislative Counsel, however, are simply for the reader's convenience. They are not part of the statute and are of no value in determining legislative intent. ORS 174.540; *Mitchell v. Board of Education*, 64 Or App 565, 568 n. 2, *rev den* 296 Or 120 (1983).

[4] Noting that his request for approval of an "out-of-compensation" fee has been declined by both the Department and the Hearings Division, claimant argues that, if we also decline his request, he has no other avenue available to gain approval. While we sympathize with claimant's plight, attorney fees may be awarded only as specifically authorized by statute. *SAIF v. Allen*, 320 Or 192, 200 (1994); *Forney v. Western States Plywood*, 297 Or 628, 632 (1984). Lacking statutory authority in this case, we are unable to grant claimant's request.

In the Matter of the Compensation of
TIMOTHY R. VANZANT, Claimant
WCB Case No. 98-10180
ORDER ON REVIEW
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Otto's order that dismissed his hearing request. On review, the issue is the propriety of the ALJ's dismissal.[1] We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the following supplementation and summary.

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[1] Although a standard briefing schedule has not been implemented, the parties have nevertheless availed themselves of opportunities to advance their respective written arguments. Therefore, we consider it to be in the interests of substantial justice to proceed with our review at this time.

On August 14, 1981, while operating a 3-wheeled vehicle, claimant sustained multiple work-related injuries that were accepted by the insurer.[2] The claim was ultimately closed with a five percent permanent disability award. Claimant's aggravation rights expired on February 8, 1988. ORS 656.273(4).

On December 31, 1998, claimant requested a hearing, challenging the constitutionality of the Workers' Compensation Law as it pertained to his August 14, 1981 work injury claim. Traveler's was joined to the proceeding as the insurer for claimant's 1981 injury. On March 8, 1999, Traveler's filed a Motion to Dismiss claimant's hearing request. Claimant responded that he had no objection to dismissing Traveler's from the proceeding but did not want his hearing request dismissed. Accordingly, by interim order dated March 22, 1999, the ALJ dismissed Traveler's from the proceeding.[3]

On March 25, 1999, a hearing was convened and concluded. No exhibits were submitted; however, claimant testified in support of his challenge to the constitutionality of the Workers' Compensation Law.

On April 7, 1999, the ALJ issued an order dismissing claimant's hearing request. Claimant timely requested Board review of that order.

CONCLUSIONS OF LAW AND OPINION

We adopt the ALJ's reasoning and conclusions regarding the dismissal issue with the following supplementation.

At hearing and on review, claimant raises a constitutional challenge to ORS 656.018,[4] which provides that the Workers' Compensation Law is the exclusive remedy for on-the-job injuries sustained by subject workers. In addition, claimant argues that the Workers' Compensation Law deprives him of his due process right to a jury trial.

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[2] At the date of injury, Aetna Casualty and Surety Company [Aetna] served as the employer's insurer. Subsequently, Travelers Insurance Company [Traveler's] became the successor to Aetna.

[3] As a preliminary matter, we note that Traveler's questions why it was sent an acknowledgment of claimant's request for review in this matter. It contends that it was dismissed by the ALJ's March 22, 1999 order and, thus, was not a party to the hearing. However, the March 22, 1999 order was an interim order, not a final order. A final order is one which disposes of a claim so that no further action is required. *Price v. SAIF*, 296 Or 311, 315 (1984). A decision that neither denies the claim, nor allows it and fixes the amount of compensation, is not an appealable final order. *Lindamood v. SAIF*, 78 Or App 15, 18 (1986). The March 22, 1999 order did none of that; instead, it simply notified the parties that Traveler's was dismissed from the hearing. *See Joseph C. Hackler*, 45 Van Natta 1450 (1993).

Although the March 22, 1999 order contained appeal rights, it was still an interim order because it did not finally dispose of the claim. Moreover, even though not explicitly stated, the interim order (which, in effect, advised Traveler's that it was not necessary to appear at the scheduled hearing) became part of the ALJ's final order issued on April 7, 1999. Thus, this case dealt with only one final order. In addition, if an ALJ's decisions are contained in one final order, we retain jurisdiction to consider all matters contained therein. *Riley E. Lott, Jr.*, 42 Van Natta 239 (1990); *William E. Wood*, 40 Van Natta 999 (1988); *compare Jerry R. Miller*, 44 Van Natta 1444 (1992) (If a party has been dismissed from a proceeding and its dismissal as a party is not contained in the appealed ALJ's order, it is not considered a party for purposes of Board review). Therefore, we retain jurisdiction to consider the dismissal issue involving Traveler's, which is why Traveler's has continued to receive notice of the proceeding. As a practical matter, however, claimant's review request has no impact on Traveler's because he does not contest the ALJ's "interim" order that "dismissed" Traveler's as a party.

[4] Specifically, ORS 656.018(1)(a) provides:

"The liability of every employer who satisfies the duty required by ORS 656.017(1) is exclusive and in place of all other liability arising out of injuries, diseases, symptom complexes or similar conditions arising out of and in the course of employment that are sustained by subject workers, the worker's beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such conditions or claims resulting therefrom, specifically including claims for contribution or indemnity asserted by third persons from whom damages are sought on account of such conditions, except as specifically provided otherwise in this chapter."

Claimant essentially requests that we issue a declaratory judgment finding ORS 656.018 unconstitutional. This request does not present a justiciable controversy. As such, we have no authority to issue such a judgment.

As the Court explained in *Brown v. Oregon State Bar*, 293 Or 446, 449 (1982):

> "Justiciability is a vague standard but entails several definite considerations. A controversy is justiciable, as opposed to abstract, where there is an actual and substantial controversy between parties having adverse legal interests. * * * The controversy must involve present facts as opposed to a dispute which is based on future events of a hypothetical issue. * * * A justiciable controversy results in specific relief through a binding decree as opposed to an advisory opinion which is binding on no one." (Citations omitted.)

Here, claimant presents no justiciable controversy. The alleged dispute regarding the interpretation of ORS 656.018 will become actual and present only if claimant files a civil lawsuit and the exclusive remedy provisions of ORS 656.018 are raised as a defense.[5] *See Lawson for Lawson v. Coos County School Dist. No. 13*, 81 Or App 358 (1986) (no justiciable controversy where plaintiff brought declaratory judgment action to determine whether potential negligence claim against school district was time barred).

Along this same line of reasoning, under the Workers' Compensation Law [ORS Chapter 656], the Hearings Division and the Board have jurisdiction only over "matters concerning a claim." ORS 656.283(1); 656.295; 656.704. Matters concerning a claim are "those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue." ORS 656.704(3); *EBI Companies v. Kemper Group Insurance*, 92 Or App 319, 322, *rev den* 307 Or 145 (1988) (Board lacked jurisdiction over a reimbursement dispute between two carriers, because the dispute was not a "matter concerning a claim"). Given this statutory limitation, we do not have jurisdiction to decide any question that is not a "matter concerning a claim."

Here, there is no right to receive compensation, or the amount thereof, directly at issue. In this regard, claimant points to no denial or other action or inaction by Traveler's affecting any compensation allegedly due him under the Workers' Compensation system. Under these circumstances, claimant's argument that the "exclusive remedy" statute is unconstitutional does not present a "matter concerning a claim." *See Ignacio Saucedo*, 50 Van Natta 106, 107 (1998) (Board has no jurisdiction to decide any question concerning common law and/or Employer's Liability Law theories of liability in response to the claimant's challenge to ORS 656.018, the "exclusive remedy" statute, because such questions do not concern "matters concerning a claim"). Therefore, under these circumstances, we have no jurisdiction to address claimant's argument regarding the constitutionality of ORS 656.018.

Furthermore, because the aggravation rights have expired on claimant's 1981 injury claim, that claim is within the Board's own motion jurisdiction. ORS 656.273(4); 656.278; *Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988).[6] Thus, neither the Hearings Division nor the Board in its "regular" jurisdiction have authority to address claimant's request (to the extent that it pertains to entitlement to temporary or permanent disability benefits), even if it did present a justiciable controversy.

Finally, claimant argues that he has a due process right to a jury trial, and the amendments to the Workers' Compensation Law deprive him of that constitutional right. Because we lack jurisdiction over this matter, we decline to address that argument. *See, e.g., Mary S. Leon*, 45 Van Natta 1023, 1024 (1993) (because Board lacked jurisdiction over former ORS 656.245(1)(b) dispute, it lacked authority to address the claimant's equal protection and due process arguments).

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[5] In *Donald P. James*, 48 Van Natta 424 (1996), the claimant alleged that the exclusivity provision of *amended* ORS 656.018 deprived him of a remedy in violation of the Constitution. We held that, in order to prove his allegation, the claimant must first demonstrate that he had been injured by operation of *amended* ORS 656.018. *See McKinney v. Watson*, 74 Or 220, 223 (1915); *Jim M. Greene*, 47 Van Natta 2245 (1995). In other words, the claimant had to obtain a legal ruling that, under *amended* ORS 656.018, he was prohibited from bringing a civil action. Because claimant had not done so, we concluded that his constitutional challenge on that basis must fail. 48 Van Natta 426 fn 1. The same reasoning applies here.

[6] In making this statement, we do not intend to imply that the Board in its own motion jurisdiction would be able to address the issue claimant presents. As discussed above, claimant does not present a justiciable controversy.

Accordingly, we affirm the ALJ's order dismissing claimant's hearing request.

ORDER

The ALJ's order dated April 7, 1999 is affirmed.

June 2, 1999 Cite as 51 Van Natta 904 (1999)

In the Matter of the Compensation of
BARBARA C. WATERS, Claimant
WCB Case No. 98-08159
ORDER ON REVIEW
Edward J. Harri, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Martha Brown's order that awarded an assessed attorney fee of $3,800. SAIF also moves for remand. On review, the issues are remand and attorney fees.

We deny SAIF's motion for remand, and adopt and affirm the ALJ's order with the following supplementation.

Claimant requested a hearing challenging SAIF's denial of her occupational disease claim for a bilateral upper extremity condition. The ALJ found that claimant had established the compensability of her upper extremity condition, and directed SAIF to accept and process the claim. The ALJ also awarded an attorney fee of $3,800 after considering the factors set forth in OAR 438-015-00010(4) and applying them to the case.

On review, SAIF argues that the ALJ failed to apply each of the factors in OAR 438-015-0010(4) and failed to make specific findings of fact regarding each factor in awarding the assessed attorney fee. Contrary to SAIF's contention, the ALJ was not required to make findings for each rule-based factor. As we explained *Daryl L. Underwood*, 50 Van Natta 2330 (1998), where there is no specific argument at hearing concerning the application of the factors in OAR 438-015-0010(4), an ALJ satisfies his or her obligation to make findings concerning the attorney fee award by including a brief description or citation to the rule-based factor or factors relied upon in determining the fee award. *See also SAIF v. Bacon*, 160 Or App 596 (1999). Furthermore, because we are authorized to modify or supplement the ALJ's order on review under ORS 656.295(6), remand is not an appropriate remedy. *Daryl L. Underwood*, 50 Van Natta at 2332.

Here, the ALJ cited OAR 438-015-0010(4) and identified the factors she considered in determining the fee. The ALJ explained that, in awarding the $3,800 fee, she particularly considered the time devoted to the case, the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney's efforts may go uncompensated.[1] This explanation for the ALJ's attorney fee award is consistent with the *Underwood* rationale. *See Leslie D. Custer*, 51 Van Natta 390 (1999); *compare Donna R. Grierson*, 51 Van Natta 679 (1999) (ALJ's reasoning insufficient to determine how he arrived at reasonable fee where order was devoid of any explanation of application of the rule-based factors). Because SAIF challenged only the attorney fee award on review and attorney fees are not "compensation" for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for his counsel's services on review. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated January 29, 1999 is affirmed.

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[1] We note that SAIF is not contending at this point that the $3,800 attorney fee award is excessive.

In the Matter of the Compensation of
DEBBY R. COLDIRON, Claimant
WCB Case No. 98-07837
ORDER OF DISMISSAL
Cole, Cary, et al, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Claimant requests review of Administrative Law Judge (ALJ) Black's February 12, 1999 "Order Denying Reconsideration." Contending that the ALJ lacked authority to issue an Order Denying Reconsideration of a December 29, 1998 Order of Dismissal, the self-insured employer moves to dismiss the appeal. After considering the employer's motion and claimant's response, we grant the employer's motion to dismiss.

FINDINGS OF FACT

Claimant filed a claim for a bilateral wrist condition. The employer denied the claim on September 21, 1998. Claimant requested a hearing regarding the denial. A hearing was scheduled for December 29, 1998. A hearing convened on that date and claimant's former counsel and the employer's counsel were present. Claimant did not appear at the hearing. The ALJ issued an Order of Dismissal dismissing the hearing request.

Claimant retained a new attorney who filed a motion for reconsideration of the ALJ's dismissal order on January 28, 1999, the 30th day after the issuance of the ALJ's December 29, 1998 Order of Dismissal. The motion did not come to the ALJ's attention until the following day. On February 1, 1999, the ALJ wrote claimant's counsel explaining that his dismissal order was not abated within 30 days and he had lost jurisdiction over the hearing request. Claimant's attorney again requested reconsideration of the ALJ's dismissal order. On February 12, 1999, the ALJ issued an Order Denying Reconsideration of his dismissal order.

On February 23, 1999, the Board received claimant's request for review of the ALJ's February 12, 1999 Order Denying Reconsideration.

CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual be received within the statutory period. *Argonaut Insurance Co. v. King*, 63 Or App 847, 852 (1983).

Here, the 30th day after the ALJ's December 29, 1998 dismissal order was January 28, 1999. Claimant's request for Board review of the ALJ's order was received by the Board on February 23, 1999. Inasmuch as claimant's request was not filed within 30 days of the ALJ's December 29, 1998 order, it is untimely. Consequently, we lack authority to consider claimant's appeal.

We note that the ALJ issued an Order Denying Reconsideration of his dismissal order on February 12, 1999. That order contained a statement explaining the parties' rights of appeal. Claimant argues that her request for review from the ALJ's February 12, 1999 order vested jurisdiction with the Board. We disagree.

Because the 30-day statutory appeal period from the ALJ's December 29, 1998 order had expired prior to issuance of his February 12, 1999 order, the December 29, 1998 order became final by operation of law. Consequently, the ALJ lacked authority to issue the February 12, 1999 order and that order is a nullity. *Geer v. SAIF*, 121 Or App 647 (1993); *Jess H. Knowland*, 46 Van Natta 1008, n 1 (1994).[1]

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[1] Claimant asks that we consider her request a "post-dismissal motion for postponement." Citing *Teresa Marion*, 50 Van Natta 1165 (1998), claimant seeks remand to allow her to provide an explanation for her non-appearance at the December 29, 1998 hearing. *Marion* is distinguishable, however, there, the claimant filed a timely appeal of the ALJ's dismissal order and the Board retained jurisdiction to review the order. Here, in contrast, the ALJ's December 29, 1998 dismissal order has become final by operation of law.

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

June 3, 1999 Cite as 51 Van Natta 906 (1999)

In the Matter of the Compensation of
JOHN W. HAMMOND, Claimant
WCB Case No. 98-06224
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Podnar's order that found that the self-insured employer's denial solely pertained to claimant's aggravation claim. On review, the issue is the scope of the employer's denial and compensability.

We adopt and affirm the ALJ's order with the following supplemental rationale.

Claimant has an accepted injury claim with the employer for right shoulder sprain, right arm sprain and right carpal tunnel syndrome. After the claim was closed, claimant's treating physician filed a formal claim for aggravation on July 16, 1998. The employer responded by issuing a July 31, 1998 denial which read in pertinent part:

> "You filed a claim for a work-related injury to your Rt. Arm which occurred on 7/10/95 while you were employed at [the employer]. That claim was accepted and medical and disability benefits were paid.
>
> "We have recently received information that you wish to reopen your claim because of an aggravation of your Rt. Shoulder and Rt. Arm sprain and your Rt. Carpal Tunnel Syndrome injury of 7/10/95.
>
> "Based on the information contained in your file, we find insufficient evidence to substantiate that your current condition and any related disability is related to, or has caused a worsening of your 7/10/95 Rt. Shoulder and Rt. Arm sprain or your Rt. Carpal Tunnel Syndrome. Therefore, we are denying your claim for aggravation.
>
> "In addition we feel that your current employer maybe [sic] responsible for your current condition and within 60 days of the date of this letter you should file a claim with them.
>
> "Your employer will continue to make medical payments related to your original injury[.]"

At hearing, claimant identified the issue as the employer's July 31, 1998 denial "of both [claimant's] current condition and an aggravation claim." In response, the employer took the position that the denial was not a current condition denial and only encompassed claimant's aggravation claim.[1] The ALJ concluded that "[a]lthough the denial is somewhat verbose in the third paragraph and does mention current condition, I am persuaded that the denial was issued solely to deny claimant's aggravation claim." Consequently, the ALJ did not address whether claimant had carried his burden of establishing a compensable claim for his current condition. On review, claimant challenges the ALJ's ruling and further contends that the record establishes a compensable claim for claimant's current condition.

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[1] The employer did not "amend" its denial at hearing to include claimant's current condition. Nor did the parties expressly or implicitly agree to litigate that issue. *See Weyerhaeuser Co. v. Bryant*, 102 Or App 32, 435 (1990) (parties to a workers' compensation proceeding may, by express or implicit agreement, try an issue that falls outside the express terms of a denial).

We acknowledge that the use of the term "current condition" in the employer's denial is confusing and suggestive of a current condition denial. Nevertheless, the language of the denial as a whole tracks the aggravation statute at ORS 656.273(1), which provides that "[a]fter the last award or arrangement of compensation" an injured worker is entitled to additional compensation for an aggravation "established by medical evidence of an actual worsening of the compensable condition supported by objective findings." The employer's July 31, 1998 denial clearly states that it was issued in response to claimant's request to "reopen his claim because of an aggravation of his accepted conditions." And it further states that the employer is denying claimant's "claim for aggravation," not claimant's current condition. Finally, the denial is based on insufficient evidence that claimant's condition and disability "is related to, or has caused a worsening of" his accepted conditions. Based on this reading of the denial as a whole, we agree with the ALJ's conclusion that it is limited to claimant's aggravation claim.

ORDER

The ALJ's order dated November 20, 1998 is affirmed.

June 3, 1999 Cite as 51 Van Natta 907 (1999)

In the Matter of the Compensation of
DONALD L. HALVORSEN, JR., Claimant
WCB Case No. 98-08559
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that upheld the self-insured employer's denial of claimant's aggravation claim for a current cervical condition. On review, the issue is aggravation.

We adopt and affirm the ALJ's order with the following supplementation.

To the extent that Dr. Wilson's opinion suggests that claimant's compensable condition worsened, it does not indicate that any such worsening occurred *since* the last award of compensation. (*See* Ex. 60). Accordingly, on this record, we agree with the ALJ that claimant has not established an "actual worsening" under ORS 656.273(1). *See Beverly J. Hotch*, 48 Van Natta 2080, 2081 (1996) ("actual worsening" must occur since the last award or arrangement of compensation).

ORDER

The ALJ's order dated March 1, 1999 is affirmed.

In the Matter of the Compensation of
LUCRECIA HUERTA-NUNEZ, Claimant
WCB Case No. 98-05459
ORDER ON REVIEW
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Myzak's order that affirmed an Order on Reconsideration that awarded 5 percent (16 degrees) unscheduled permanent disability for claimant's low back condition. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the last sentence of the first paragraph.

CONCLUSIONS OF LAW AND OPINION

Claimant strained her low back at work on May 2, 1997. The employer accepted her claim and claimant became medically stationary on October 23, 1997. A Notice of Closure dated January 19, 1998, corrected February 3, 1998, awarded no permanent disability. Claimant requested reconsideration.

A June 11, 1998 Order on Reconsideration awarded 5 percent unscheduled permanent disability for lost lumbar extension. The insurer requested a hearing.

The ALJ affirmed claimant's permanent disability award based on the medical arbiter's lumbar extension measurements, reasoning that claimant's failed straight leg raising (SLJ) test invalidated her lumbar flexion findings, but not her lumbar extension findings. The ALJ also reasoned that Dr. Scheinberg's observation of claimant's inconsistent "speed of performance" was not a sound medical principle supporting a conclusion that claimant's lumbar findings were invalid. We disagree.

Dr. Scheinberg, the medical arbiter, reported that claimant

> "was noted to move extremely slowly, with all range of motion testing during the examination. However, when she left the clinic, and was unaware of our observation, she was noted to appear to move normally, and to enter her vehicle without any obvious difficulty." (Ex. 24-4).

The Department asked Dr. Scheinberg to express an opinion regarding whether claimant's findings were invalid and to state whether they were due to the accepted condition. Dr. Scheinberg responded:

> "According to the straight leg raising validity check, the measured flexion [a]nd extension of the lumbar spine is [sic] not valid for the purpose of rating. Her movements during her physical examination were slow to the extreme. This was in contrast to the movements observed while she was entering her vehicle." (Ex. 24-5).

Thus, Dr. Scheinberg questioned the validity of claimant's reduced range of motion, based on the SLR test results, her "slow to the extreme" movements during range of motion testing, *and* her inconsistent (normal) movements entering her vehicle when she was unaware of being observed.

We have previously held that the validity of range of motion testing must be determined by the medical examiner performing the tests. *Harvey Clark*, 47 Van Natta 136 (1995). Here, Dr. Scheinberg questioned claimant's range motion findings because claimant failed the SLR test *and* because her reduced range of motion upon examination was inconsistent with her unobserved normal movements. Thus, in our view, Dr. Scheinberg's report supports a conclusion that claimant's impairment findings were due to noninjury related factors *or* invalid.[1]

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[1] *See Cheryl A. Boone*, 51 Van Natta 616 (1999) (No valid range of motion measurements where the attending physician questioned their validity based on the claimant's limited efforts during examination); *Larry A. Ward*, 50 Van Natta 2198 (1998) (No entitlement to permanent disability compensation for injury-related impairment where the medical arbiter supported and explained his conclusion that the claimant's findings were either invalid or unrelated the compensable condition).

We also note that Dr. Jura, treating physician, stated that claimant had no impairment and no work restrictions when she was medically stationary. (Ex. 18). Under these circumstances, we conclude that claimant's findings do not establish valid injury-related permanent impairment and she is not entitled to permanent disability compensation. *See Sandoval v. James Kjelde Dairy*, 156 Or App 430 (1998) (No entitlement to permanent disability compensation where the arbiter reported an invalid SLR test, contributing psychological factors, and no objective injury-related loss).[2]

ORDER

The ALJ's order dated February 22, 1999 is reversed. The ALJ's and the Order on Reconsideration's awards of unscheduled permanent disability for claimant's low back condition are reversed. The ALJ's attorney fee award is reversed.

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[2] *Compare Fred R. Countryman*, 50 Van Natta 2202, 2203 (1998) (Arbiter's inadequately explained conclusion that condition "resolved" less persuasive than treating physician's impairment findings).

June 3, 1999 Cite as 51 Van Natta 909 (1999)

In the Matter of the Compensation of
KELLY JURASEVICH, Claimant
WCB Case No. 98-02014
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Black's order that set aside its denial of claimant's injury claim for a low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the second paragraph of the findings of fact on page 1, we change the date in the second sentence to "November 21, 1997." In the first paragraph on page 2, we replace the first three sentences with the following: "When claimant's symptoms did not improve, she was referred to Dr. Matteri, who first examined her on January 15, 1998." (Exs. 5, 17-5). We change the fifth paragraph on page 2 to read: "The insurer issued a denial on February 20, 1998." We replace the first paragraph on page 3 with the following: "The parties deposed Drs. Rice and Matteri. (Exs. 16, 17)." We do not adopt the ALJ's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

In December 1995, claimant was hired as a housekeeper for the employer. (Tr. 21-22, Ex. 3). Her work involved making beds, cleaning rooms, lifting items, throwing linen into hampers and handling recycling bins. (Tr. 22-28). Some of the wet linens and recycling bins were quite heavy. (Tr. 25-27). Claimant had no low back problems before working for the employer. (Tr. 32).

During most of the time claimant worked for the employer, she worked with Ms. Cunningham. (Tr. 22). Ms. Cunningham was pregnant in 1997 and claimant performed most of the heavier work for her during part of the year. (Tr. 6, 36-37, 43). Claimant testified that she had low back pain for a month or two before she sought treatment on November 24, 1997. (Tr. 34-35). She said her back had been bothering her on October 16, 1997 when she sought treatment for wrist pain from Dr. Rice. (Tr. 63). Claimant did not have a specific single injury to her back. (Tr. 56).

On November 24, 1997, Dr. Rice diagnosed a lumbar strain and took claimant off work. (Ex. 1-1A). By December 31, 1997, Dr. Rice suspected a disk problem and referred claimant to Dr. Matteri. (Ex. 3AA-3).

Dr. Matteri examined claimant on January 15, 1998 and reported that claimant had "injured herself on November 21, 1997." (Ex. 5-1). He noted that claimant had been doing most of the lifting for one of her coworkers who was pregnant. (*Id.*) An MRI on January 19, 1998 showed a tiny protrusion of the L5-S1 disk at the level of the annular fissure, and also showed degenerative change of the disk. (Ex. 5A). On January 21, 1998, Dr. Matteri did not believe the small disk protrusion at L5-S1 was producing any neurological symptoms. (Ex. 5B).

Dr. Matteri reported on March 9, 1998 that claimant continued to have difficulty with intermittent radiculitis. (Ex. 10). He noted that the extent of claimant's abnormal disk was subject to question and he recommended a discogram. (*Id.*) Dr. Matteri has not examined claimant since March 9, 1998. (Ex. 17-5).

The medical evidence establishes that claimant has preexisting degenerative disk disease at L5-S1. (Exs. 6-4, 12, 16-11, 17-19). Dr. Matteri believed that claimant's work activity combined with her preexisting low back condition to cause her disability or need for treatment. (Ex. 12). Therefore, ORS 656.005(7)(a)(B) applies and claimant must establish that her work injury was the major contributing cause of her disability or need for medical treatment for her combined condition.

In light of claimant's preexisting low back condition and the multiple possible causes of her low back injury, the causation issue presents a complex medical question that must be resolved on the basis of expert medical evidence. *Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279 (1993). Claimant relies on the opinions of Drs. Matteri and Rice to establish compensability of her low back injury. In evaluating the medical evidence concerning causation, we rely on opinions that are well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). We generally rely on the opinion of a claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). For the following reasons, we are not persuaded by the opinions of Drs. Matteri and Rice.

We agree with the insurer that Dr. Matteri did not have an accurate history of the onset of claimant's low back symptoms. Claimant said that she began having low back pain a month or two before she sought treatment on November 24, 1997. (Tr. 34-35). She said her back had been bothering her on October 16, 1997 when she sought treatment for wrist pain from Dr. Rice. (Tr. 63). Dr. Rice understood that claimant's back symptoms had preceded the November 24, 1997 office visit by 1 to 2 months. (Exs. 15, 16-6).

During Dr. Matteri's deposition, claimant's attorney presented a summary of claimant's symptoms to Dr. Matteri and asked whether he still agreed that the disk rupture was probably a result of claimant's work in November 1997. (Ex. 17-43, -44, -45). Claimant's attorney told Dr. Matteri that "in approximately November" claimant had begun to experience the onset of low back symptoms. (Ex. 17-43, -44). On review, claimant argues that "November" is sufficiently precise as the time frame for onset of symptoms. We disagree.

Dr. Matteri testified that he had no history that claimant's back pain had started one to two months before November 21, 1997 and he agreed that claimant's history was negative for back problems before the week of November 21, 1997. (Ex. 17-6, -10). His impression was that claimant had injured herself on November 21, 1997. (Ex. 17-14). Dr. Matteri said that claimant's testimony at hearing that her back pain had begun one to two months before November 21, 1997 did not correspond to his history. (Ex. 17-16, -17). In an earlier report, Dr. Matteri had concluded that claimant's "work activity *during the work week of November 21, 1997* is the material contributing cause and temporary functional disability." (Ex. 12;, underline in original; emphasis added in italics). In light of Dr. Matteri's testimony, we are not persuaded that he had an accurate understanding of the onset of claimant's low back symptoms. *See Miller v. Granite Construction Co.*, 28 Or App 473, 478 (1977) (medical opinions based on an inaccurate history entitled to little or no weight).

Furthermore, Dr. Matteri's opinion on causation is not persuasive because he did not adequately evaluate the relative contribution of other causal factors and explain why the work exposure contributed more to claimant's condition than all other causes or exposures. The fact that a work injury is the immediate or precipitating cause of a claimant's disability or need for treatment does not necessarily mean that the injury was the major contributing cause of the condition. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995). Dr. Matteri was not aware of any of claimant's off-work

activities and he relied only on her history that she had injured her back at work. (Ex. 17-14, -15). Dr. Matteri explained that his reasoning for concluding that claimant's industrial exposure was contributing to her back condition was that before the industrial exposure she was not having any back symptoms and she became symptomatic after the industrial exposure. (Ex. 17-11). We find that Dr. Matteri's explanation is no more than the "precipitating cause" analysis that was rejected in *Dietz v. Ramuda,* 130 Or App at 401.

Moreover, Dr. Matteri did not adequately explain the contribution of claimant's preexisting degenerative disk disease at L5-S1. He testified that a diskogram would have helped him determine if claimant had an acute injury or if she was suffering from a degenerative disk and a superimposed lumbar strain.[1] (Ex. 17-24). Because Dr. Matteri's testimony indicates that he may have needed further diagnostic testing to determine causation and there is no evidence that a diskogram was performed, his opinion on causation lacks adequate explanation.

Finally, we are not persuaded by Dr. Matteri's opinion because he lacked an understanding of claimant's work activities that resulted in her injury. He was aware that claimant was a housekeeper for the employer and that she had been doing most of the lifting for one of her coworkers who was pregnant. (Exs. 5-1; 17-7). Nevertheless, he had not seen a job description for claimant and he did not have any other information about her job. (Ex. 17-7, -10, -12). He had no understanding of the time period of the coworker's pregnancy and "no concept" of the work housekeepers performed at the hospital. (Exs. 17-10, -38, -39). Thus, although Dr. Matteri attributed claimant's low back condition to her "industrial exposure" in November 1997 (Ex. 12), we are not persuaded that he understood the details of her work exposure. For the foregoing reasons, we conclude that Dr. Matteri's opinion is not sufficient to establish compensability.

Claimant also relies on Dr. Rice's opinion to establish compensability. Dr. Rice had concurred with Dr. Duff, who had concluded that the major contributing cause of claimant's need for treatment and/or disability was the preexisting lumbar degenerative disk disease. (Exs. 6-5, 13). In a deposition, however, Dr. Rice indicated that he agreed with Dr. Matteri's May 20, 1998 report, which found that claimant's work activity during the week of November 21, 1997 was the material contributing cause of her condition. (Exs. 12, 16-10). Dr. Rice understood that Dr. Matteri felt that claimant had a preexisting degenerative condition, but her work activity had caused a disk rupture. (Ex. 16-11, -12). Because Dr. Rice did not offer an adequate explanation for his change of opinion, his opinion on causation is not persuasive. *See Kelso v. City of Salem,* 87 Or App 630 (1987). In addition, because we are not persuaded by Dr. Matteri's opinion, we are not persuaded by Dr. Rice's agreement with his opinion.

We conclude that the opinions of Drs. Matteri and Rice are insufficient to establish that claimant's work injury was the major contributing cause of her disability and/or need for treatment. Because there are no other medical opinions that support compensability of claimant's low back condition, we conclude that claimant has failed to sustain his burden of proving compensability.

ORDER

The ALJ's order dated January 8, 1999 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

---

[1] Dr. Matteri explained that he had wanted to obtain a diskogram because of claimant's continuing symptoms:

"If I can get a diskogram on her, produce concordant symptomatology, then it is likely that that fissure -- the development of that fissure through some sort of trauma has acutely caused her to become symptomatic.

"If a diskogram does not produce the concordant symptomatology, and there is no clear-cut communication with the spinal canal from the dye, then I would say that she is suffering from a degenerative disk and super-imposed lumbar strain, send her for a physical capacities evaluation, and move her towards claim closure." (Ex. 17-24, -25).

Dr. Matteri also said that he wanted a diskogram so he could decide if he should continue to alter his opinion from that of Dr. Duff. (Ex. 17-32).

In the Matter of the Compensation of
TINA M. VANDERBURG, Claimant
WCB Case No. 98-00196
ORDER ON REMAND
Robert J. Guarrasi, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's December 16, 1998 order, we have been directed to consider the parties' settlement. The self-insured employer has now announced that a settlement "will not take place." In addition, because it "does not wish to reinstate its appeal" of the Board's September 18, 1998 Order on Review, the employer declares that this "case does not need to be sent back to the Court of Appeals."

In dismissing the employer's petition for judicial review, the court's order expressly grants "leave to seek reinstatement if the Board should fail to approve the settlement." Thus, because no settlement will be forthcoming for our approval, the employer is authorized to request reinstatement of its appeal. Nonetheless, based on its announcement, the employer has no intention of availing itself of this "reinstatement of appeal" opportunity. Under such circumstances, we interpret the employer's statement as an express waiver of its "leave to seek reinstatement" of its petition for judicial review.

Accordingly, this matter is dismissed.[1]

IT IS SO ORDERED.

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[1] We have previously ruled that, when a dispute arose between the parties subsequent to the court's dismissal and remand order, we were not authorized to resolve the matter. *See Keith Thomas*, 48 Van Natta 1292 (1996). Reasoning that our authority was expressly limited to consideration of the parties' settlement, we concluded that the court had expressly provided the parties with a remedy; *i.e.*, leave to seek reinstatement of the petition for judicial review. Here, as in *Thomas*, no proposed settlement has been submitted for our consideration and approval. Nonetheless, unlike the situation presented in *Thomas* (where the appealing party was not relinquishing its "leave to seek reinstatement" of its court appeal, but rather the parties were seeking Board resolution of further issues arising subsequent to the court's remand order), the employer in this case (the party that previously petitioned the court for judicial review of our original order) has expressly and unequivocally declined to seek reinstatement of its court appeal. In light of such circumstances, we conclude that it is appropriate to issue this order documenting these events and memorializing the appealing party's decision.

In the Matter of the Compensation of
DIRK A. PETERSON, Claimant
WCB Case No. 98-05399
ORDER ON REVIEW
Dobbins, McCurdy & Yu, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The insurer requests review of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's concussion and post-concussion syndrome. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the last paragraph on page 4, we change the citations after the first sentence to read: "Exs. 12-8, 12-9, 24-5" including the footnotes. In the third paragraph on page 3, we change the first sentence to read: "Dr. Weller examined claimant two days after the motor vehicle accident. (Ex. 1)." In the same paragraph, we change the last sentence to read: "Dr. Weller expected claimant's symptoms to resolve slowly. (Ex. 1-3)."

We agree with the ALJ's reasoning and conclusion that claimant has established compensability of his concussion and post-concussion syndrome. We write only to address the insurer's argument that Dr. Woods' opinion is not persuasive because he incorrectly assumed that claimant had hit his head during the accident.

We agree with the insurer that the initial medical reports indicated claimant did not hit his head during the accident and there was no mention of an injury at or near claimant's ear. (Exs. A, B, 1). On November 25, 1996, Dr. Woods recorded a history that claimant hit his head on the door jamb over the left ear during the accident. (Ex. 6-1). Dr. Woods noted, however, that there were points of claimant's history that were "probably of questionable reliability and there is vagueness in response to some questions as the patient states that his memory of recollection of events is unclear." (*Id.*) At the end of the report, Dr. Woods said he wanted to see claimant's EEG reports as well as the "full records from Dr. Weller's office[.]" (Ex. 6-4). Two days after the accident, Dr. Weller had reported that claimant did not believe he had hit his head. (Ex. 1-1). In a February 18, 1997 report, Dr. Woods noted that he had previously asked for claimant's prior studies, including an EEG. (Ex. 8). In that report, he discussed the details of the previous EEG report, which indicates that he had received the requested reports. In light of Dr. Woods' initial questions regarding the accuracy of claimant's history and his request for additional records, we are not persuaded that Dr. Woods relied on claimant's statement that he hit his head on a door jamb during the accident.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,250, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated March 2, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,250, payable by the insurer.

In the Matter of the Compensation of
BRANDON R. CRAWFORD, Claimant
WCB Case No. 98-07378
ORDER ON REVIEW
Burt, Swanson, Lathen, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Phillips Polich.

The insurer requests review of Administrative Law Judge (ALJ) Myzak's order that set aside its denial of claimant's gunshot injuries. On review, the issue is whether the injury occurred in the course and scope of employment. We reverse.

FINDINGS OF FACT

Claimant, age 17 at hearing, began working as a stock associate for the employer's store in November 1997. (Tr. 10, Ex. 2). His duties included unloading, stacking, sorting and hanging clothes. (Tr. 11). Claimant's best friend, Justin Christensen, also worked for the employer. (Tr. 49).

Claimant and Justin worked together from 8:00 a.m. to 4:00 p.m. on May 2, 1998. (Tr. 13, 36). They had each obtained a gun because a couple of people in their neighborhood had been "harassing" them and wanting to fight. (Tr. 17, 35, 54).

Claimant and Justin brought the guns to work on May 2, 1998 to show them to Dustin Phillips, a coworker. (Tr. 20, 35-36). They brought the guns into work about 2:00 p.m., after they had been on their last break. (Tr. 19, 36). After claimant and Justin showed the guns to Dustin, they kept the guns with them. (Tr. 36).

Both claimant and Justin knew it was against the rules to have guns at work and neither of them let the supervisors know about the guns. (Tr. 22-23, 56). Claimant's job duties had nothing to do with guns and he was aware he would be fired if he was found with a gun. (Tr. 22, 23). The supervisors were not aware that they had guns in the store until after claimant was injured. (Tr. 61-64, 67).

Claimant denied that he and Justin were playing with the guns or waving them around at work on May 2, 1998. (Tr. 19, 20, 132). Although Justin initially denied playing with the guns (Tr. 36, 45), he later testified that he and claimant had pointed the guns at each other "once or twice." (Tr. 45-46). Justin agreed that they had the guns out a couple of times between the break and the time claimant was injured. (Tr. 47).

Dustin Phillips worked with claimant and Justin on May 2, 1998 (Tr. 110), and said he first saw their guns in the break room and later saw the guns about one half-hour later in the stock room when he walked back to obtain something. (Tr. 111, 116, 119). Dustin said that claimant and Justin were waving the guns around and pointing them, pretending to aim. (Tr. 112, 119). Dustin went back to the stock room on another occasion and saw Justin pointing his gun, but did not remember whether claimant was pointing or waving his gun at that time. (Tr. 121, 127).

Claimant was injured at approximately 3:40 p.m. on May 2, 1998 when a bullet from Justin's gun entered claimant's upper arm and went into his chest. (Tr. 13, 96-98). Claimant and Justin were the only two people present in the stock room at the time claimant was shot. (Tr. 13, 19). Justin took claimant to the hospital. (Tr. 16).

Officer Dunihoo investigated the incident and spoke to Justin the day of the shooting. Justin told the officer that he and claimant had been working in the back room when claimant tapped Justin on the shoulder. (Tr. 75, 86). Justin said he looked up and claimant had his pistol in his hand with the clip partially ejected. (*Id.*) Claimant "worked the slide action" as if cocking the pistol. (*Id.*) Justin took his pistol out and loosened the clip by partially removing it and held the pistol toward claimant. (Tr. 75, 76, 86). Justin said he released the slide and the gun fired, injuring claimant. (Tr. 76, 86). Officer Dunihoo also spoke to claimant on May 2, 1998, when he was in the operating room and had been sedated. (Tr. 78). Claimant told Officer Dunihoo he did not remember what happened and then said the incident had happened the way Justin said it happened. (Tr. 78, 79).

At hearing, claimant said he told Officer Dunihoo he did not know what had happened because he was trying to protect Justin. (Tr. 17, 21). Claimant admitted he had lied to the police officer. (Tr. 21). Justin admitted that he lied to the officer about how the gun was fired and also lied when he told the officer he had thrown the guns away. (Tr. 37, 38, 48, 50).

Claimant testified that the injury occurred as he was following Justin back to obtain some hangers. (Tr. 14-15). According to claimant and Justin, Justin had leaned over to obtain some hangers when his gun fell out of his pants and the gun went off. (Tr. 13-15, 36, 42, 53). They both said that claimant had not threatened Justin or pulled his gun and had not done anything that caused Justin to draw his gun. (Tr. 18, 53). Justin did not shoot claimant intentionally. (Tr. 17, 26, 54, 80).

The insurer denied claimant's injury claim on the basis that the gunshot wound did not arise out of or in the course and scope of employment. (Ex. 4).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that, in violation of the employer's rules and without its acquiescence, claimant and Justin had guns at work on May 2, 1998. The ALJ determined that claimant and Justin had engaged in horseplay sometime before the shooting incident. Although the ALJ found that Justin was engaged in horseplay at the time of the shooting incident, she concluded that claimant was not an active participant in the horseplay at the time of the incident. The ALJ determined that claimant's injury occurred in the course and scope of his employment.

The insurer concedes that claimant's injury occurred in the course of his employment, but argues that the injury did not "arise out of" employment. The insurer contends that claimant's injury is not compensable because he was an active participant in the horseplay incident that caused his injury.

ORS 656.005(7)(a) provides that a "'compensable injury' is an accidental injury * * * arising out of and in the course of employment[.]" Under Oregon case law, an active participant or instigator in horseplay who is injured may not receive compensation unless the employer knew or should have known of and acquiesced in the behavior. *Liberty Northwest Ins. Corp. v. Johnson*, 142 Or App 21, 25-26 (1996); *Kammerer v. United Parcel Service*, 136 Or App 200, 204 (1995). The theory behind excluding active participants in horseplay from coverage is that, in engaging in the horseplay, a claimant may have engaged in a "voluntary stepping-aside from the employment." *Kammerer*, 136 Or App at 204.

Here, there is no evidence that the employer knew or should have known and acquiesced in claimant and Justin bringing guns to work. Therefore, the issues are whether claimant was injured as a result of horseplay and if so, whether he was an active participant in the horseplay incident that caused his injury.

Claimant argues that the shooting was purely an accident. He contends that Justin was reaching for hangers when his gun fell out of the waistband of his pants and discharged. He asserts that he was not involved in horseplay with Justin and did not take his gun out except to show it to Dustin and perhaps to change pockets.

The pivotal question presented on review is claimant's credibility. The ALJ found that claimant lied to Officer Dunnihoo on the day he was injured because he was trying to protect his best friend. The ALJ also found that claimant was "less than candid" at the hearing when he testified that he had not spoken to Justin about testifying. The ALJ found the conflict between claimant's testimony that he had never waved or pointed the gun at work on May 2, 1998 and the contradictory testimony of Justin and Dustin Phillips "troublesome." Nevertheless, the ALJ found that claimant's testimony of rounding the table, not seeing the gun and hearing the bang had the "ring of truthfulness to it in substance and manner and demeanor of testifying." The ALJ found that claimant was not an active participant in Justin's horseplay at the time of the shooting incident.

Although we generally defer to the ALJ's demeanor-based credibility findings, we are equally qualified to make our own determination of credibility based on the substance of a witness' testimony. *Erck v. Brown Oldsmobile*, 311 Or 519, 528 (1991); *Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987). Following our *de novo* review of the record, we find that claimant was not a credible witness.

Claimant admitted he lied to Officer Dunihoo when he told the officer he did not remember how the injury occurred. (Tr. 20-21). Claimant explained that he was trying to protect Justin and did not want him to go to jail. (Tr. 21). On review, claimant asserts that he was not "under oath" when he spoke to the police officer and his statements were "understandable." Even if we accept that argument, however, we are not persuaded that claimant's testimony at hearing "under oath" was credible.

Claimant testified that he had last seen Justin a few weeks ago and had not spoken to Justin at all about testifying. (Tr. 24). On the other hand, Justin (who had not heard claimant's testimony) said he had spoken to claimant about testifying the previous night. (Tr. 34, 44). Justin said claimant had called him to let him know that "they" were not "after" him in the hearing and were not going to sue him. (Tr. 35, 52). In light of Justin's testimony, claimant's testimony is not credible.

Similarly, we are not persuaded by claimant's testimony that he and Justin had not been "playing" with the guns or waving them around on the afternoon of May 2, 1998. (Tr. 19, 20, 132-33). Although Justin initially denied playing with the guns (Tr. 36, 45), he later testified that he and claimant had pointed the guns at each other "once or twice." (Tr. 45-46). Justin agreed they had the guns out a couple of times between the break and the time claimant was injured. (Tr. 47). In addition, Dustin Phillips, who had worked with claimant and Justin on May 2, 1998, said he first saw their guns in the break room and later saw the guns about one half-hour later in the stock room when he walked back to get something. (Tr. 111, 116). Dustin said that claimant and Justin were waving the guns around and pointing them, pretending to aim. (Tr. 112, 119). Dustin went back to the stock room on another occasion and saw Justin pointing his gun, but did not remember whether claimant was pointing or waving his gun at that time. (Tr. 121, 127). Based on the testimony of Dustin and Justin, we find that claimant and Justin were engaged in horseplay on the afternoon of May 2, 1998.

Claimant testified that the injury occurred as he was following Justin back to obtain some hangers. (Tr. 14-15). According to claimant and Justin, Justin had leaned over to obtain some hangers when his gun fell out of his pants and the gun went off. (Tr. 13-15, 36, 42, 53). They both said that claimant had not threatened Justin or pulled his gun and had not done anything that caused him to draw his gun. (Tr. 16, 18, 53). Justin said that his pants did not have a button and the zipper was loose and the gun "just like fell out." (Tr. 42). He said that he had been bending over with the gun before this incident and it had slipped, but he put it back. (Tr. 42, 43).

We are not persuaded by claimant's and Justin's version of how the injury occurred. Officer Dunihoo explained that a bullet travels in a straight line until it is deflected by something else. (Tr. 101). He had seen claimant's bandaged arm and chest wounds at the hospital and he felt that the gun had been held roughly at that level. (Tr. 105, 106). He explained that, given the location of claimant's wounds, the bullet would have been in a straight line having come from waist high or above. (Tr. 100). In light of Officer Dunihoo's testimony and because of other inconsistencies with the testimony of claimant and Justin, we are not persuaded that the gun discharged when it fell out of Justin's pocket. Rather, we find it is more likely that the gun discharged when Justin was engaged in horseplay.

Claimant contends that, even assuming he had been waving his gun around and pointing it at Justin, there is no evidence he was doing so at the time he was injured. He asserts that he was not an active participant in horseplay.

Under ORS 656.266, claimant has the burden of proving that an injury is compensable. In light of the significant discrepancies between claimant's testimony and other witnesses, we are not persuaded by claimant's explanation of the circumstances surrounding his injury. Although claimant asserts that he and Justin had never played with the guns or waved them around, the testimony of Justin and Dustin was contradictory. Justin testified that they had the guns out a couple of times between the break and the time claimant was injured and he said that claimant had pulled his gun out and had pointed it around. (Tr. 46, 47). Dustin Phillips testified that he saw claimant and Justin waving guns around and pointing them. Claimant and Justin both said they had lied to Officer Dunnihoo when they said the injury occurred when claimant had tapped Justin on the shoulder, had his pistol in his hand and Justin took his pistol out and the gun fired. Given all the inconsistencies with claimant's testimony on different issues, we afford little probative weight to claimant's assertion that he was not an active participant in horseplay at the time he was injured. We are not persuaded that claimant was credible and because we do not rely on his version of the injury, claimant has not sustained his burden of proving that his injury arose out of and in the course of his employment. Accordingly, we conclude that he has failed to establish compensability.

ORDER

The ALJ's order dated January 11, 1999 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

Board Member Phillips Polich dissenting.

The majority rejects the ALJ's finding that claimant's testimony about the injury was credible and it concludes that claimant failed to establish compensability. For the following reasons, I respectfully dissent.

The ALJ found that claimant's testimony concerning the gunshot incident had the ring of truthfulness to it in substance, as well as the manner and demeanor of testifying. In *Erck v. Brown Oldsmobile*, 311 Or 519, 526 (1991), the Supreme Court agreed that on *de novo* review, it is good practice for an agency or court to give weight to the factfinders' credibility assessments. The Board generally defers to the ALJ's determination of credibility when it is based on the ALJ's opportunity to observe the witnesses. *Coastal Farm Supply v. Hultberg*, 84 Or App 282, 285 (1987).

In this case, the ALJ had an opportunity to observe the demeanor of claimant and other witnesses. The ALJ specifically addressed the credibility issues raised by both the written and oral record in this case and determined claimant was not engaged in horseplay at the time of the gunshot incident. I believe the ALJ is in a much better position to assess the credibility of claimant and other witnesses and the ALJ's determination is entitled to considerable weight. I would defer to the ALJ's credibility findings and adopt and affirm the ALJ's order.

June 4, 1999 Cite as 51 Van Natta 917 (1999)

In the Matter of the Compensation of
DARRIN J. McGEE, Claimant
WCB Case No. 98-07503
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Tenenbaum's order that directed it to pay interest under ORS 656.313(1)(b) on claimant's entire permanent disability award. On review, the issue is claim processing.

We adopt and affirm the ALJ's order. *See James J. Hinkley*, 46 Van Natta 91, 94 (1994) ("[T]he interest payment requirement of ORS 656.313(1)(b) replaces the value of the PPD award that has been lost during the period payment was stayed."; *citing Marcus M. Tipler*, 45 Van Natta 216 (1993), where the Board stated "that the insurer is required to pay interest on the entire permanent disability award which has been stayed pending review.").[1]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $950, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and his attorney's statement of services), the complexity of the issue, and the value of the interest involved.

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[1] The court affirmed the Board's *Hinkley* decision, *Hinkley v. Oregon State Police*, 131 Or App 382, 385 (1994), holding that permanent partial disability awards paid in installments do not constitute benefits withheld under ORS 656.313 and interest does not accrue during the period the insurer is making installment payments.

ORDER

The ALJ's order dated January 7, 1999 is affirmed. For services on review, claimant is awarded a $950 attorney fee, payable by the SAIF Corporation.

In the Matter of the Compensation of
JUDITH E. PRINCEHOUSE, Claimant
WCB Case No. 98-07398
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's occupational disease claim for a right shoulder condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the insurer's denial of claimant's occupational disease claim for right shoulder impingement syndrome that allegedly resulted from her employment as an insurance clerk. In doing so, the ALJ found that employment conditions were the major contributing cause of the right shoulder condition. In making this finding, the ALJ relied on the medical opinions of an attending physician, Dr. Coe, and an examining physician, Dr. Neumann.

On review, the insurer contends that claimant failed to sustain her burden of proof. It asserts that the opinions of Drs. Coe and Neumann are not persuasive and that we should instead rely on the medical opinion of another examining physician, Dr. Bald. Dr. Bald opined that a preexisting "type II acromion and an inferior-projecting spur from the distal clavicle" were the major contributing cause of claimant's right shoulder impingement syndrome. (Ex. 10-5). For the following reasons, we agree with the insurer's contentions.

To establish compensability under ORS 656.802(2)(a), claimant must prove that her work activities for the employer were the major contributing cause of her right shoulder condition. In evaluating the medical evidence concerning causation, we rely on opinions that are well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). When the medical evidence is divided, we tend to give greater weight to the conclusions of a claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). For the following reasons, we find persuasive reasons not to give greater weight to Dr. Coe's opinion.

Dr. Coe saw claimant on several occasions. On August 6 , 1998, Dr. Coe noted that claimant had a spur underneath the right distal clavicle that he believed contributed to the impingement syndrome in claimant's right shoulder. (Ex. 6-2). Dr. Coe subsequently concurred with Dr. Neumann's report in which the latter physician diagnosed an impingement syndrome that was, by claimant's history, related to an "incident of 3/23/98." (Exs. 7-3, 9). Dr. Coe, however, provided no explanation for his concurrence. Although Dr. Coe subsequently agreed that claimant's work activity was the major cause of the right shoulder impingement syndrome, that report, too, contained no reasoning. (Ex. 13). Because Dr. Coe's opinion is conclusory, we do not find it persuasive. *See Moe v. Ceiling Systems*, 44 Or App 429 (1980) (rejecting conclusory medical opinion). The lack of reasoning is especially significant given Dr. Coe's previous statement that the preexisting clavicle spur was contributing to claimant's condition.[1]

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[1] We note the ALJ's statement that Dr. Coe had not identified the prexisting clavicle spur as a contributing cause to the impingement syndrome. (O&O p. 3). This statement is contrary to Dr. Coe's comment that the clavicle spur contributed to claimant's impingement syndrome.

This leaves the opinions of the examining physicians, Drs. Neumann and Bald. Dr. Neumann related claimant's right shoulder condition to an incident of March 23, 1998. (Ex. 7-3). Claimant, however, did not testify to a specific incident of injury. Rather, claimant testified that her shoulder symptoms developed gradually in March 1998. (Tr. 13). In addition, Dr. Neumann diagnosed a preexisting degenerative spur beneath the distal clavicle. (Ex. 7-3). Nevertheless, at other times in his report, Dr. Neumann specifically stated that claimant had no preexisting condition. (Ex. 7-4, 5). Given these defects in Dr. Neumann's report, we find his report inconsistent and not based on an accurate history. Therefore, we do not find it persuasive medical evidence supporting compensability.

By contrast, Dr. Bald provided a persuasive analysis of the causation issue. Dr. Bald weighed the relative contribution of claimant's work activities and her preexisting type II acromion and clavicle spur and concluded that the preexisting conditions were the major contributing cause of claimant's impingement syndrome. (Ex. 10-5). *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995) (determination of major contributing cause involves evaluating the relative contribution of different causes and deciding which is the primary cause). Dr. Bald also considered the potential contribution of off-the-job activities and concluded that they were unlikely to have caused claimant's right shoulder condition. (Ex. 10-7). Because Dr. Bald weighed and considered all potential contributing factors and provided a well-reasoned and thorough analysis of the causation issue, we find his opinion is the most persuasive.

Accordingly, based on our *de novo* review of the medical record, we conclude that claimant failed to sustain her burden of proving a compensable occupational disease claim. Therefore, we reverse.

ORDER

The ALJ's order dated February 24, 1999 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

In the Matter of the Compensation of
BOBBY G. ATHEY, JR., Claimant
Own Motion No. 98-0258M
OWN MOTION ORDER
Bottini, Bottini, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted a request for temporary disability compensation for claimant's compensable lumbar and thoracic strains. Claimant's aggravation rights expired on October 4, 1994. SAIF opposed reopening contending that the proposed L4-5 and L5-S1 fusions were inappropriate treatment for his compensable condition. Claimant requested Director's review of the requested medical treatment. (Medical Review Case No. 8048).

On August 11, 1998, we postponed action on the Own Motion matter pending resolution of the medical services issue. On March 11, 1999, the Medical Review Unit (MRU) for the Workers' Compensation Division (WCD) found that the proposed fusion at L5-S1 was inappropriate for claimant's current condition. However, it also determined that the proposed L5-S1 laminectomy and discectomy was medically reasonable and necessary for claimant's compensable condition.

Following the issuance of MRU's order, SAIF agreed that the requested L5-S1 laminectomy and discectomy were a compensable component of claimant's claim and requested an Own Motion order authorizing temporary disability benefits. SAIF also noted that claimant had appealed the March 11, 1999 MRU order as it related to the proposed fusion.

On April 27, 1999, claimant announced that he had withdrawn his appeal of the March 11, 1999 MRU order. He further reported that he had undergone the proposed laminectomy and discectomy on April 16, 1999. As SAIF acknowledged that these procedures were appropriate, claimant requested an Own Motion order reopening his claim for the provision of temporary disability benefits.

Under ORS 656.278(1)(a), we may exercise our own motion authority to reopen a claim for additional temporary disability compensation when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

Here, on April 16, 1999, claimant underwent an L5-S1 laminectomy and discectomy. As noted above, SAIF accepted the compensability of claimant's current lumbar and thoracic conditions and acknowledged that the surgery performed was appropriate medical treatment. Therefore, we conclude that claimant's compensable thoracic and lumbar conditions worsened requiring surgery in the form of a L5-S1 laminectomy and discectomy.

Accordingly, we authorize the reopening of the claim to provide temporary total disability compensation beginning April 16, 1999, the date claimant was hospitalized for the proposed surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by SAIF directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

In the Matter of the Compensation of
PETER VOORHIES, Claimant
Own Motion No. 97-0530M
OWN MOTION ORDER
The St. Paul, Insurance Carrier

On October 15, 1998, we set aside the insurer's May 14, 1998 Notice of Closure and directed the insurer to recommence temporary disability benefits. Claimant requests enforcement of our October 15, 1998 order, contending that the insurer has not complied with our order to resume the payment of his temporary disability benefits. Specifically, claimant requests reinstatement of his benefits, as well as penalties for unreasonable claim processing.

In response, the insurer contends that: (1) claimant was released to regular work on March 25, 1998; and/or (2) it has not received valid timeloss authorizations from claimant's attending physician. For these reasons, the insurer asserts that claimant is not entitled to temporary disability compensation beyond the March 25, 1998 work release and that penalties are not warranted.

Entitlement to Temporary Disability Compensation

Temporary disability compensation shall be paid on an "open" own motion claim until one of the following event occurs: (1) the claim is closed pursuant to OAR 438-012-0055; (2) a claim disposition agreement (CDA) is submitted to the Board pursuant to ORS 656.236(1); or (3) termination of such benefits is authorized by the terms of ORS 656.268(3)(a) through (c). *See* OAR 438-012-0035(4).

Here, the insurer's May 14, 1998 Notice of Closure was set aside by our October 15, 1998 order and the claim remains in open status. Additionally, a claim disposition agreement has not been filed pursuant to ORS 656.236(1). The insurer argues that because claimant was released to work with restrictions that are within his job description, then essentially he was released to full duty. Relying on ORS 656.268(3)(b)[1], the insurer contends that Dr. Winquist's, claimant's attending physician, March 25, 1998 report released claimant to regular employment and thus it was justified in not resuming payment of temporary disability benefits as directed by our October 15, 1998 order. We disagree.

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[1] The insurer cites ORS 656.268(3)(c) in support of its contention. That statute states, in part, that temporary disability benefits may be terminated when an attending physician authorizes a worker to return to modified duty, documents it in writing and the claimant is offered a modified job and does not accept it. Here the insurer is interpreting Dr. Winquist's March 25, 1998 report as a release to *regular* duty. The applicable statute for a "regular work" release is ORS 656.268(3)(b).

The insurer relies on an undated "fill-in-the-blanks" letter submitted by Dr. Winquist. In response to the question "If yes, is [claimant] currently able to return to the work force?," Dr. Winquist replied "Yes." However, in answer to the question "If no, when do you feel [claimant] will be able to return to work and what objective findings dictate waiting?," Dr. Winquist answered "light sitting and standing work." His responses to the insurer's questions demonstrate that he released claimant to work with limitations. Considering that Dr. Winquist's opinion refers to a work release with restrictions, we are not persuaded that claimant was released to his regular work (real estate and property management).

When a claimant is released to modified duty, the applicable criteria for terminating temporary disability compensation is found in ORS 656.268(3)(c), which states that a physician must advise the claimant and document in writing that he is released to modified employment, that such employment is offered in writing to the claimant and that the claimant fails to begin such employment. *See generally Anthony R. Holder*, 50 Van Natta 1760 (1998). The record before us does not indicate that claimant was offered, in writing, modified employment and that he failed to begin such employment. Thus, we find that the necessary criteria has not been met and that claimant's temporary disability compensation should not have been terminated.

Finally, the insurer contends that Dr. Winquist has not authorized additional timeloss. Such a contention does not justify the insurer's termination of benefits under the applicable Board rules. Unlike benefits payable under ORS 656.268, temporary disability benefits payable under ORS 656.278 arise by means of voluntary reopening by the carrier or the Board's authorization in its own motion capacity. *See* OAR 438-012-0035(1). Board authority to award temporary disability benefits under ORS 656.278 is not contingent on an attending physician's time loss authorization. *Robert L. Eubank*, 51 Van Natta 669 (1999); *Jeffrey T. Knudson*, 48 Van Natta 1708 (1996).

Accordingly, we conclude that claimant is entitled to reinstatement of his temporary disability compensation beginning March 25, 1998, to continue until such benefits can be lawfully terminated under OAR 438-012-0035(4).

Penalties

Claimant requests penalties for the insurer's allegedly unreasonable claim processing. Under ORS 656.262(11)(a), if the carrier unreasonably delays or unreasonably refuses to pay compensation, the carrier shall be liable for an additional amount of 25 percent of the amounts "then due." The insurer's refusal to pay compensation is not unreasonable if it has a legitimate doubt about its liability. *Castle & Cook, Inc. v. Porras*, 103 Or App 65 (1990).

Here, our October 15, 1998 order directed the insurer to recommence temporary disability benefits on the date it previously had terminated them and to continue paying said benefits until the insurer could lawfully terminate such benefits. The question becomes whether the circumstances on which the insurer based its termination of claimant's benefits provided it with a legitimate doubt regarding its continuing liability to pay such benefits.

On this record, we are not persuaded that the insurer had a legitimate doubt regarding its continued obligation to pay compensation on claimant's own motion claim in accordance with our prior order. As previously noted, a release to work with restrictions does not constitute a release to "regular work." Moreover, the law is well-established that the criteria for terminating a claimant's temporary disability under ORS 656.268(3)(d) is inapplicable in claims under our own motion jurisdiction. *See Frank L. Bush*, 48 Van Natta 1744 (1996) (Application of ORS 656.268(3)(d), which allows termination of temporary disability compensation under the criteria found in ORS 656.262(4), is not permissible in claims reopened under our own motion authority pursuant to ORS 656.278).

Likewise, the insurer's reliance on ORS 656.262(4)(a) and (f) (which outlines the need for a doctor's timeloss authorization in order to commence and terminate temporary disability compensation) is not applicable to the processing of Own Motion claims under ORS 656.278(1). *See Robert L. Eubank*, 51 Van Natta at 670; *Jeffrey T. Knudson*, 48 Van Natta at 1709-10. As noted above, temporary disability benefits payable under ORS 656.278 arise by means of voluntary reopening by the carrier or Board authorization. *See* OAR 438-012-0035(1). In other words, Board authority to award temporary disability benefits under ORS 656.278 is not contingent on an attending physician's time loss authorization. *Jeffrey T. Knudson*, 48 Van Natta at 1710.

In light of such circumstances, we find that the insurer did not have a legitimate doubt regarding its continuing liability to provide claimant with temporary disability when it terminated such benefits effective March 25, 1998. Therefore, the insurer's termination of claimant's temporary disability benefits was unreasonable. Consequently, claimant is entitled to a 25 percent penalty of the amounts "then due" as a result of this order. *See John R. Woods*, 48 Van Natta 1016 (1996); *Jeffrey D. Dennis*, 43 Van Natta 857 (1991).

Accordingly, the insurer is directed to recommence claimant's temporary disability compensation beginning March 25, 1998 when it terminated this compensation, and continuing until it can lawfully terminate such benefits under OAR 438-012-0035(4). In addition, as a penalty, claimant is awarded 25 percent of his compensation resulting from this order: the unpaid temporary disability compensation made payable by this order between March 25, 1998, the date of the insurer's unreasonable termination, and the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
EDWARD B. GROGAN, Claimant
WCB Case No. 96-09233
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Herman's order that set aside its denial of claimant's occupational disease claim for a thoracic condition. Claimant cross-requests review of that portion of the ALJ's order that upheld the insurer's denial of claimant's current thoracic condition. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant worked as a driller and powderman; as a driller, claimant worked in a large drilling machine. Claimant has an accepted claim for a thoracolumbar strain resulting from an August 1994 injury. In January 1996, claimant's symptoms began increasing and, in May 1996, worsened when he stepped into a hole and twisted his back.

The ALJ analyzed the claim as one for occupational disease. Furthermore, relying on the opinions of Dr. Gritzka and Dr. Hacker, the ALJ found that claimant proved that his employment conditions were the major contributing cause of his condition. Finally, the ALJ decided that claimant did not prove that the August 1994 injury was the major contributing cause and, thus, claimant did not prove compensability under ORS 656.005(7)(a)(B).

The insurer challenges the ALJ's reasoning and conclusion that claimant proved an occupational disease claim. Specifically, the insurer contends that the opinions of Dr. Gritzka and Dr. Hacker do not persuasively establish that work conditions were the major contributing cause of claimant's thoracic condition. Claimant contends that we should reverse that portion of the order upholding the insurer's current condition denial, asserting that he proved that his August 1994 injury is the major contributing cause of his current need for treatment.

The record is voluminous. First, consulting neurosurgeon, Dr. Hacker, thought that claimant had a degenerative thoracic disc disease that was the result of "vibratory loads." (Ex. 21-1). He indicated that the major contributing cause of claimant's condition was the August 1994 and May 1996 incidents. (*Id.* at 2).

Examining physicians Drs. Rich and Gambee reported that claimant had a degenerative disc condition but could not say when it began. (Ex. 29-8). They thought that the injuries had combined with the degenerative condition and that the current contributing cause was the "progressive disease." (*Id.* at 7). They also indicated that claimant's "very heavy work" had a "direct effect" on his back condition. (*Id.* at 8).

Dr. Gritzka saw claimant at his attorney's request. He diagnosed thoracic degenerative disc disease and a disc lesion/bulge/herniation at T8-9, and attributed the latter condition to the August 1994 injury. (Ex. 46-10). He also thought that claimant had a "preexisting condition" and this "antecedent condition" combined with injuries and work activities; Dr. Gritzka reported that the major contributing cause of the need for treatment of the combined condition was work activities. (*Id.* at 11). Dr. Gritzka also talked about the effects from vibration on degenerative disc disease. (*Id.*)

Dr. Thompson, orthopedic surgeon, performed a record review at the insurer's attorney's request. He diagnosed degenerative changes due to "old Scheurman's" and thought this condition was the major contributing cause of claimant's need for treatment. (Ex. 50-2). According to Dr. Thompson, the vibration theory reported by Gritzka was inconsistent with the fact that claimant had findings only in his thoracic spine. (*Id.* at 4). In summary, Dr. Thompson thought that "the work activity may have caused some acceleration of the degenerative process in the thoracic spine, [but] the major contributing factor in the development of the thoracic spondylosis is the natural progression of the degenerative changes which started with a Scheurman's epiphysitis during his adolescent years." (*Id.* at 6).

Dr. Densmore, claimant's former treating physician, concurred with a letter stating that claimant's preexisting degenerative condition had combined with a lumbosacral strain and, by July 1996, the strain had resolved, leaving the preexisting condition as the major contributing cause of the need for treatment. (Ex. 51).

Dr. Long, claimant's current treating physician, concurred with Dr. Gritzka's report. (Ex. 53).

Dr. Farris examined claimant at the insurer's request. He agreed with Dr. Thompson's diagnosis of Scheuermann's disease and also found diffuse idiopathic skeletal hyperostosis (DISH). (Ex. 59-11). Dr. Farris thought that both conditions preexisted employment and "predisposed" claimant to the thoracic strains. (*Id.* at 12). Finally, Dr. Farris found the preexisting conditions to be the major contributing cause of claimant's current thoracic condition and agreed with Dr. Thompson that vibrations at work were not a likely cause because claimant's lumbar spine was not affected. (*Id.*)

Dr. Gritzka then reviewed the reports generated after his exam. He again disagreed with the diagnosis of Scheuermann's disease, as well as Dr. Farris' DISH diagnosis. (Ex. 61-5). He also provided a fuller discussion defending his theory that whole body vibration was a cause in the "accelerated development of degenerative changes in the cervical, thoracic, and lumbar spines." (*Id.*) Dr.Gritzka reported that, based on "a complete analysis incorporating orthopedic ergonomics and orthopedic biomechanics, in short an analysis that does not discount or ignore the probable mechanism of injury, indicates that the major contributing cause of [claimant's] thoracic condition are his work activities[.]" (*Id.* at 6).

Dr. Thompson was deposed and essentially reiterated his opinion contained in his report. (Ex. 62).

Dr. Gritzka submitted another report discussing the low statistical occurrence of Scheuermann's disease and DISH. (Ex. 63-1). He again addressed the whole body vibration theory, stating that the "human spine, of course, is one functional unit, and it is reasonable to conclude that conditions affecting the lumbar spine will affect the rest of the spine as well." (*Id.* at 7). Although acknowledging that studies of the cervical and thoracic spine were not as developed as those for the lumbar, according to Dr. Gritzka "because the spine is one functional unit, any conclusion that vibration would affect the lumbar spine exclusively does not seem to square with biomechanical principles." (*Id.*) Dr. Gritzka concludes:

> "In [claimant's] case, I think the reasons whole-body vibration was concentrated in its effect in the thoracic spine was because he has a thoracic kyphosis at the upper limits of normal. I think the effect of this increased kyphosis would be to concentrate any of the whole-body, vibratory, resonance effect at the apex of the thoracic spine. I believe the

> major contributing cause of the 'degenerative' changes that were seen in [claimant's] mid-thoracic spine were probably the result of whole-body vibration over time, with the effect of the vibration concentrated in the region of the apex of his thoracic curve." (*Id.* at 8).

Dr. Thompson then provided a report outlining his research of whole-body vibrations; according to him, only one study mentioned problems with the thoracic spine. (Ex. 63a-3). He thought that such findings "substantiate my position; namely that it is medically improbable for the lumbar spine to be uninvolved with any type of degenerative changes due to whole body vibration and to have only the thoracic spine involved as Dr. Gritzka opines in [claimant's] case." (*Id.*)

Dr. Farris testified at hearing. He continued to attribute the cause of claimant's condition to a natural progression of Scheuermann's disease. (Tr. 172, 180). He also continued to find that vibration did not play a role because the lumbar spine was normal. (*Id.* at 175). He disagreed with Dr. Gritzka's vibration theory because "the greatest amount of vibration is going to occur at the area closest to the source" so the lower lumbar spine would receive the greatest concentration, lessening as it went higher up the spine. (*Id.* at 177).

Following the hearing, Dr. Gritzka provided a final report. In examining claimant, Dr. Gritzka found "a significant round-back, or thoracic kyphosis, which, although not quite enough to qualify in and of itself as an impairment, was certainly at the upper range of normal." (Ex. 70-3). Dr. Gritzka also thought that the kyphosis was not the result of work activities and preexisted employment. (*Id.* at 4). This condition "tends to concentrate stresses that are applied across [claimant's] thoracic spine in the region of the thoracic kyphosis." (*Id.* at 5). The condition also "has a thoracic spinal construct that puts him at risk for increased thoracic apical loading." (*Id.*)

Dr. Gritzka explained that claimant experienced two forces: "vibratory mechanisms and sudden longitudinal loads." Although he could not point to studies in support, Dr. Gritzka thought it "reasonable to conclude that forces applied at the lumbar or cervical end of the spine would have some effect on the thoracic spine, since the spine is a functional unit[.]" (*Id.* at 7). Because of the kyphosis and the vibration, Dr. Gritzka found that the "vibratory forces" claimant experienced at work "have caused degenerative changes in his thoracic spine[.]" (*Id.* at 8).

Dr. Gritzka then addressed the effect of the August 1994 injury on "a posterior space-occupying mass" found on the MRI. Dr. Gritzka found it unclear whether "this represents a posterior osteocartilginous bar, which is a degenerative condition that develops over time (and, for the reasons described above, would probably be the result of long-term vibratory exposure) or whether it represents a true intervertebral disc herniation. In either case, this abnormality is probably related to [claimant's] work activities" because, if a bar, it was caused by vibration and, if a disc, it was related to the August 1994 injury. (*Id.* at 9).

Dr. Gritzka summarizes his opinion:

> "* * * I think he has an antecedent condition, which, in and of itself, would have remained asymptomatic, absent any other insult or provocation. He was exposed to a chronic vibration which * * * was transmitted from the pelvis and distal tuberosities to the thoracic spine. The effects of these stresses were concentrated, for biomechanical reasons, in the region of the claimant's thoracic kyphosis. This resulted in a worsening of an antecedent condition. Superimposed on this was an acute injury on August 22, 1994, which aggravated the underlying condition. I therefore believe that [claimant's] work activities * * * were the major contributing cause of the pathological worsening of his antecedent condition, and the major contributing cause of his present symptoms and need for treatment." (*Id.* at 20).

In assessing the persuasiveness of medical opinions, we rely on those that are well-reasoned and based on an accurate history. *Somers v. SAIF*, 77 Or App 259 (1986). Furthermore, absent persuasive reasons to the contrary, we generally defer to the treating physician's opinion. *Weiland v. SAIF*, 64 Or App 810 (1983).

We first find that Dr. Hacker's opinion is inconsistent because he attributed claimant's condition to "vibratory loads" and then the August 1994 and May 1996 injuries. His opinion also provides little reasoning to support its conclusions. Thus, we find Dr. Hacker's opinion unpersuasive.

For the most part, Dr. Gritzka attributed claimant's thoracic condition to "work activities," including previous injuries and "whole-body vibration." As we understand Dr. Gritzka's reports, claimant's "significant round-back" or "thoracic kyphosis" was a preexisting condition that combined with "work activities," resulting in degenerative changes in the thoracic spine. In defending his opinion concerning the effect of "whole-body vibrations," Dr. Gritzka stated that the human spine is "one functional unit" and that claimant's thoracic kyphosis concentrated the vibrations in the thoracic area of the spine, resulting in a pathological worsening.

Dr. Thompson also found that claimant had a preexisting condition but thought that it was Scheurmann's disease. Dr. Farris agreed with this finding and also reported that claimant had a preexisting diffuse idiopathic skeletal hyperostos (DISH). Both physicians found that the major contributing cause of claimant's need for treatment was the preexisting condition and disagreed with Dr. Gritzka that "whole-body vibrations" was a causal factor. According to Dr. Thompson and Dr. Farris, the fact that studies had revealed no findings in claimant's lumbar spine showed that "whole-body vibrations" was not a factor. As Dr. Farris explained at hearing, because the lumbar spine would have been the first part of the body to absorb vibrations, claimant's lumbar spine would not show normal findings.

Dr. Gritzka and Dr. Farris both saw claimant one time. Dr. Thompson reviewed the records. Consequently, we find that, between this group, none are entitled to more deference based on a greater opportunity to examine claimant.

Furthermore, we are not more persuaded by Dr. Gritzka's "whole-body vibration" theory. Although characterizing the back as "one functional unit," Dr. Gritzka never explained why claimant's lumbar spine would continue to be normal and the effect of the vibrations would be isolated in the thoracic spine. By stating only that claimant's thoracic kyphosis concentrated vibration in the thoracic spine, we find no explanation for the normality of the lumbar spine when, as Dr. Farris explained, that area of the spine would be the first to be affected by vibration. In short, we find Dr. Gritzka's opinion at best in equipoise with the opinions of Dr. Thompson and Dr. Farris. That is, we find that Dr. Gritzka's reasoning is not more persuasive than Dr. Thompson and Dr. Farris.

Having found that Dr. Gritzka's opinion is not more persuasive, we conclude that claimant did not prove compensability, whether we apply ORS 656.802 or 656.005(7)(a)(B). With regard to the latter statute, although Dr. Gritzka referred to the August 1994 injury as a factor in causation, as explained above, he did not isolate this event as the major contributing cause of claimant's need for treatment of the combined condition. Dr. Hacker also implicated the August 1994 injury but, as found above, we do not find his opinion persuasive. The only other opinion supporting compensability is Dr. Long, who only concurred with one of Dr. Gritzka's reports. Because we have found Dr. Gritzka's opinion insufficient to prove compensability, we also find Dr. Long's concurrence to be unpersuasive. Thus, in the absence of persuasive medical opinion showing that the August 1994 injury is the major contributing cause, claimant did not prove compensability under ORS 656.0005(7)(a)(B).[1]

Similarly, we find insufficient persuasive medical opinion evidence establishing that employment conditions were the major contributing cause of claimant's combined condition and pathological worsening. Therefore, claimant also did not prove an occupational disease. ORS 656.802(2).

ORDER

The ALJ's order dated November 18, 1998 is reversed. The insurer's denial of an occupational disease claim is reinstated and upheld. The ALJ's attorney fee award also is reversed. The remainder of the order is affirmed.

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[1] We also reject claimant's argument that ORS 656.005(7)(a) should apply because there is no evidence of a condition preexisting claimant's employment. Even Dr. Gritzka found that claimant's need for treatment was in part caused by a condition preexisting employment when he found that claimant's thoracic kyphosis was part of the combined condition in need of treatment and the kyphosis preexisted employment.

In the Matter of the Compensation of
JUDY L. MAGILL, Claimant
WCB Case No. 98-04335
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) found that claimant's claim had not been prematurely closed; and (2) affirmed an Order on Reconsideration that did not award scheduled permanent disability for the right foot. On review, the issues are premature closure and extent of scheduled permanent disability.

We adopt and affirm the ALJ's order[1] with the following supplementation.

The ALJ concluded that claimant had not carried her burden to establish that she was not medically stationary at the time of the January 8, 1997 claim closure. Claimant contends that Dr. Grewe's February 6, 1998 and March 3, 1998 reports establish that Dr. Grewe changed his prior opinion that claimant was medically stationary as of October 29, 1997. We do not agree.

In the February 6, 1998 letter, Dr. Grewe explained that claimant had continued to require "somewhat more than average upkeep medical attention" since he declared her medically stationary. He concluded that claimant was having increased pain from her low back joints from the loss of her disc support, which he proposed to stabilize with a spinal fusion. He explained that the epidural stimulator controlled claimant's neuropathic pain residual from the nerve injury affecting her right leg, but that the pain across claimant's back and hips came largely from the joint where the disc was removed. (Ex. 132). This letter does not indicate that Dr. Grewe had changed his mind regarding claimant's medically stationary status, or that the surgery was intended as other than palliative care to address claimant's pain complaints.

It was not until Dr. Grewe's March 5, 1998 "check-the-box" response to claimant's attorney, when he agreed that claimant's low back condition was not medically stationary when her claim was closed "in retrospect," that he indicated that he had changed his opinion. For the following reasons, we do not find his "check-the-box" change of opinion persuasive.

Dr. Grewe's "check-the-box" opinion contradicts all his prior written explanations regarding claimant's medically stationary status, but offers no explanation for his change of opinion. Absent explanation, we conclude that it is insufficient to overcome his prior opinions and reports and for that reason find his March 5, 1998 opinion unpersuasive. *Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of physician's opinion found unpersuasive); *Moe v. Ceiling Systems*, 44 Or App 429 (1980) (same).[2]

ORDER

The ALJ's order dated January 22, 1999 is affirmed.

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[1] We modify the finding of fact in the fourth full paragraph on page 2 to read: On December 10, 1997, Grewe advised the carrier that the medically stationary date should be October 29, 1997 and discussed claimant's continued problems. (Ex. 119).

[2] We also find Dr. Grewe's "check-the-box" response to be ambiguous. In February 1998, he had proposed a fusion surgery to modify residual pain complaints. In the March 1998 letter, Dr. Grewe was asked to concur with a definition of "medically stationary" that erroneously implied that the additional fusion treatment precluded a conclusion that claimant was stationary. It is, therefore, unclear whether Dr. Grewe is agreeing with a need for the palliative surgery he proposed, or if he actually intended to contradict his prior statements. For this additional reason, we give no weight to Dr. Grewe's opinion. *See Marta I. Gomez*, 46 Van Natta 1654 (1994) (Board will give little, if any weight, to conclusory, poorly reasoned opinions, such as unexplained "check-the-box" reports).

In the Matter of the Compensation of
ALBERT D. AVERY, Claimant
WCB Case No. 98-07247
ORDER ON RECONSIDERATION
Doblie & Associates, Claimant Attorneys
David L. Runner (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our May 14, 1999 order that affirmed the Administrative Law Judge's (ALJ's) order that set aside SAIF's denial of claimant's dementia condition, but modified the ALJ's order to the extent that it directed SAIF to issue an unqualified acceptance of "dementia."[1] On reconsideration, SAIF disagrees with that portion of our order that awarded claimant's attorney a fee under ORS 656.382(2).

SAIF's first argument is that we disallowed or reduced claimant's award of compensation by modifying that portion of the ALJ's order that directed SAIF to issue an acceptance of claimant's dementia condition. On the basis of this argument, SAIF argues that claimant is not entitled to an attorney fee. We disagree.

Our May 14, 1999 order did not disallow or reduce claimant's compensation. We affirmed the portion of the ALJ's order that set aside SAIF's denial of claimant's dementia condition. We modified the ALJ's order solely to the extent that we found that SAIF was not presently required to issue an unqualified acceptance of the dementia condition pending appeal of the prior ALJ's order finding that condition compensable. We rejected SAIF's argument that the compensable condition should be narrowed from dementia to "brain injury." Because the denial was set aside, we held that the dementia condition was considered accepted and must be processed as an accepted condition. Because SAIF remains responsible for the processing of precisely the same claim and condition found compensable by the prior ALJ's order and enforced by the ALJ's order in this case, no compensation was disallowed or reduced by our order.[2]

SAIF next argues that claimant's attorney is not entitled to the fee because he did not render any legal services regarding the "nature" of claimant's medical condition. Claimant's attorney argued that the ALJ's order should be affirmed. Inherent in this position was that the nature of the condition considered compensable should not be limited. We affirmed the ALJ's order. Thus, we find that claimant's attorney rendered legal services regarding the compensability issue and prevailed.

Finally, SAIF argues that, if an attorney fee is appropriate under ORS 656.382(2), our award of a $1,000 fee is excessive. Again, we disagree with SAIF's argument.

Our initial order specified that we particularly considered the factors of time, complexity of the issue and the value of the interest involved in determining a reasonable attorney fee under OAR 438-015-0010(4). We believe that our initial discussion of the attorney fee was sufficient. However, assuming that further discussion is necessary, we offer the following supplementation to our initial order.

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[1] In reaching our decision, we stated that a June 18, 1998 Order on Reconsideration had affirmed a March 27, 1998 Determination Order that had found that the claim did not qualify for closure. In actuality, the Order on Reconsideration "rescinded" the Determination Order, found the "newly accepted condition of 'memory loss due to hypoxic brain injury'" to be medically stationary as of February 13, 1998, and "remanded" the claim to SAIF for "necessary action." With the exception of this clarification and the further supplementation of our decision that is contained in the remaining portions of this order, we adhere to the conclusions and reasoning expressed in our May 14, 1999 order.

[2] The only difference between the ALJ's order and our order is that SAIF is not expressly directed to accept a "dementia condition." Nonetheless, as noted in our order, SAIF is statutorily obligated to process the claim for that condition as though it was accepted, notwithstanding its appeal of the prior ALJ's compensability decision. Moreover, should that condition become medically stationary while its appeal of the compensability decision remains pending, SAIF is also statutorily and administratively required to issue an updated Notice of Acceptance at Claim Closure acknowledging the compensability of that condition (albeit subject to its pending appeal). In light of such circumstances, we disagree with SAIF's contention that our order has resulted in a reduction or disallowance of the compensation awarded by the ALJ's order.

Claimant's counsel submitted a five page Respondent's brief addressing the issues raised by SAIF's appeal. The issue was the processing of claimant's dementia condition, including what condition was considered compensable. The legal issue was of average complexity, but was complicated by the procedural posture of the case and the protracted litigation involved in the claim. The value of the interest involved is significant. The attorneys representing both parties are experienced in workers' compensation law. The benefit secured for claimant was substantial and there was a risk that claimant's counsel's efforts would go uncompensated. No frivolous issues or defenses were asserted. After consideration of the factors listed in OAR 438-015-0010(4), we continue to find that a $1,000 attorney fee is reasonable.

Accordingly, we withdraw our May 14, 1999 order. On reconsideration, as supplemented herein, we republish our May 14, 1999 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

June 14, 1999 Cite as 51 Van Natta 928 (1999)

In the Matter of the Compensation of
JUNE E. BRONSON, Claimant
WCB Case No. 97-05563
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hoguet's order that: (1) set aside its partial denial of claimant urticaria and dyspnea symptoms; (2) assessed a $500 attorney fee under ORS 656.382(1) for its allegedly unreasonable denial of claimant's latex sensitivity (allergy) condition; (3) awarded a $4,500 attorney fee for claimant's counsel's services in obtaining the "pre-hearing" acceptance of claimant's allergy condition; and (4) awarded a $5,150 attorney fee for prevailing on the claim for urticaria and dyspnea at hearing. On review, the issues are compensability[1] and attorney fees. We reverse in part, modify in part, and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the "Ultimate Findings of Fact," with the following supplementation.

Claimant worked for many years as an emergency room nurse. She worked for the employer in this capacity from 1994 until May 1, 1997.

Claimant wore 20 to 30 pairs of latex gloves at work every shift. (Ex. 37Aa-3).

CONCLUSIONS OF LAW AND OPINION

Compensability

It is undisputed that claimant is allergic to latex and her allergy is compensable: The employer accepted claimant's "latex sensitivity" condition the day before the hearing.

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[1] Claimant argues that we should not address compensability on review, because the employer did not raise the issue in the specification of issues attached to its request for review. It is well-settled that OAR 438-011-0005(3) (which provides that a request for Board review "should contain a brief statement of the reasons review is requested") is not jurisdictional. *See Kimberly L. Murphy*, 41 Van Natta 847 (1989). In other words, because ORS 656.295(1) merely requires the filing of a request for Board review, a violation of the administrative rule does not invalidate a timely filed appeal. *See Destael v. Nicolai Co.*, 80 Or App 596, 600-601 (1986). Likewise, ORS 656.295(6) authorizes the Board to affirm, reverse, modify or supplement the ALJ's order or make such disposition of the case it determines appropriate. Finally, claimant has had an opportunity to fully respond to the employer's compensability arguments as presented in its appellant's brief. Accordingly, we have considered the compensability issue.

We agree with the ALJ that claimant's urticaria (skin rash) and dyspnea (difficulty breathing) symptoms are also compensable and we adopt his opinion on this issue, with the following supplementation.

The employer argues that claimant has not satisfied ORS 656.802(1), because she has not proven (and cannot prove) that latex is a substance to which she "is not ordinarily subjected or exposed other than during a period of regular actual employment." Based on evidence that numerous household products contain latex, the employer apparently contends that claimant is exposed to latex off work and therefore her urticaria and dyspnea symptoms are not compensable.[2] We disagree.

We first note that claimant's sensitivity to latex is a compensable cause of her exposure-related symptoms. Therefore, to the extent that claimant's symptoms are due in major part to her compensable sensitivity, or to work exposure *and* the compensable sensitivity, they are also compensable. Because the persuasive medical evidence relates claimant's symptoms to her sensitivity and her work exposure, rather than to off work causes or exposure, we agree with the ALJ that claimant's latex exposure-related symptoms are compensable.[3] *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995) (determining the "major contributing cause" involves evaluating the relative contributions of different causes; the precipitating cause of symptoms is not necessarily the major cause of those symptoms). We offer the following evaluation of the medical evidence addressing causation.

Dr. Bardana opined that claimant's skin and respiratory symptoms were idiopathic, because not all persons with latex sensitivity have these symptoms and latex exposure-related skin symptoms are usually localized, unlike claimant's.

Dr. Kelly explained that latex allergy symptoms are not always localized, in part because the exposure is not always by direct skin contact. Dr. Kelly also acknowledged that a very small percentage of those with latex glove allergy do not have urticaria. Nonetheless, considering claimant's work and medical history (demonstrating a direct relationship between claimant's urticaria and work exposure to latex, particularly gloves), Dr. Kelly concluded that claimant's symptoms were work related. His conclusion was based on examination of claimant, test results, ruling out nonwork related contributors, and his evaluation of the relationship between claimant's exposure, symptoms, and treatment. (*See* Exs. 37Ac, 37Af, 37Ah, 48).

We find Dr. Kelly's causation opinion persuasive because it is well-reasoned, based on a complete and accurate history, and most consistent with claimant's clinical history and test results. Accordingly, based on Dr. Kelly's opinion, we agree with the ALJ that claimant has established that her work exposure to latex and her compensable sensitivity to latex were the major contributing cause of her urticaria and dyspnea symptoms.

Attorney Fees

The ALJ assessed a $500 attorney fee under ORS 656.382(1), reasoning that the employer's denial of claimant's latex sensitivity became unreasonable when Dr. Bardana agreed that the allergy condition was probably work-related. (*See* Ex. 44-7).

Claimant may be entitled to attorney fee awards under ORS 656.382(1) if the employer unreasonably delayed or resisted payment of compensation under the "latex sensitivity" claim. However, claimant does not dispute the employer's contention that there are no amounts due under the claim. Consequently, there is no proof of resistance to the payment of compensation that would authorize the assessment of a penalty-related attorney fee under ORS 656.382(1). *See SAIF v. Condon*, 119 Or App 194, *rev den* 317 Or 163 (1993); *Aetna Casualty Co. v. Jackson*, 108 Or App 253 (1991); *Margaret J. Franks*, 51 Van Natta 62, 63 (1999); *Dennis J. Burns*, 50 Van Natta 2136 (1998). Accordingly, the ALJ's $500 penalty-related attorney fee is reversed.

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[2] The employer relies on *Brenda Dodson*, 50 Van Natta 1387 (1998), where we held that the allergic claimant did not establish that the majority of her exposure was work-related and therefore her occupational disease claim for an allergic condition was not compensable. Here, unlike the situation in *Dodson*, claimant's latex *allergy* is accepted and it contributes to her symptoms (along with her exposures on and off work). Therefore, the fact that claimant may be exposed to latex off work does not necessarily mean that her symptoms at any given time are not compensable. More importantly, we are not persuaded on this record that the symptoms claimed were due to off work exposure.

[3] We note that the employer acknowledges that claimant has not had these symptoms since she stopped working for the employer on May 1, 1997.

The ALJ awarded a $4,500 attorney fee for services related to obtaining the employer's "pre-hearing" acceptance of claimant's latex sensitivity and a $5,150 attorney fee for services relating to prevailing over the employer's denial of her urticaria and dyspnea symptoms. The ALJ noted that claimant's counsel submitted a statement of services with her reply brief after the hearing and the employer did not dispute the hourly rate or number of hours claimed at hearing. The ALJ found the fees requested reasonable, after considering "the statement of services, the comments regarding attorney fees in the written closing arguments and the factors in OAR 438-015-0010(4)."

The employer argues that claimant is not entitled to a fee based on its "pre-hearing" acceptance of claimant's latex sensitivity, because claimant never made a claim for that condition. But the parties treated the sensitivity claim as filed and denied until the claim was accepted the day before the hearing. Moreover, the employer did not contend that claimant had not filed a claim for her allergy condition before, during, or after the hearing--until its brief on review. Moreover, the employer stated at hearing that it did not dispute claimant's entitlement to an assessed fee related to the "pre-hearing" acceptance. (Tr. 3-4). Under these circumstances, we are not inclined to consider the employer's argument in this regard. In any event, considering the terms of the employer's acceptance and its partial denial, the medical evidence, and the parties' positions at hearing, we are persuaded that claimant *is* entitled to an attorney fee, based on the employer's "pre-hearing" acceptance of the previously denied sensitivity condition.

The employer also argues that the fee award for services relating to the claim for symptoms was excessive considering the minimal value of the claim and speculative benefit secured. Finally, the employer contends that claimant's counsel's 30 hours spent briefing the case at the hearings level was unreasonable because it amounted to reiterating what was already in the record.

Claimant responds that her attorneys spent 69 hours on the case at the hearings level; one attorney's hourly rate is $150, the other attorney's hourly rate is $100. Claimant contends that the value of the claim is not speculative or minimal, considering claimant's condition.

We review the attorney fee issue *de novo*, considering the specific contentions raised on review, in light of the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that any attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The issues in dispute were the compensability of claimant's occupational disease claim for a latex allergy condition and dyspnea and urticaria symptoms of that condition. The employer denied the claim in June 1997. Claimant retained her attorney soon thereafter and the attorney promptly filed a hearing request.

Approximately 79 exhibits were received into evidence, including pre-hearing deposition of Dr. Bardana. (The deposition lasted about 1 1/2 hours, with a transcript of about 70 pages.) Approximately 15 of the exhibits were submitted by claimant. The hearing lasted about an hour, with a transcript consisting of approximately 28 pages. Claimant was the only witness who testified. Claimant's counsel submitted 39 pages of written argument to the ALJ.

Claimant's counsel submitted a detailed statement of services, showing 69 hours of legal services at the hearings level.[4]

The case involved issues of above average medical and legal complexity, considering the range of cases generally submitted to this forum (*i.e.*, a "bifurcated" occupational disease claim, with the underlying condition accepted the day before the hearing and the partial denial of symptoms of the condition set aside after the hearing). The claim's value and the benefits secured are also above average, because claimant's compensable condition appears to render her unable to work as a nurse. The parties' respective counsels presented their positions in a thorough and skillful manner. No

[4] Claimant's counsel devoted a significant number of hours skillfully advocating claimant's claim in the face of a vigorous defense. Nonetheless, the amount of time expended in litigating a claim is but one of many factors to be considered in determining a reasonable attorney fee award under OAR 438-015-0010(4).

frivolous issues or defenses were presented. Finally, there was a significant risk that claimant's counsel's efforts might have gone uncompensated, particularly considering the employer's vigorous defense.[5]

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we agree with the ALJ that $5,150 is a reasonable attorney fee for services regarding the compensability of claimant's dyspnea and urticaria symptoms at the hearings level.

After applying the same factors and considering the parties' arguments, we conclude that a reasonable fee for services related to the "pre-hearing" acceptance of the claim for a latex sensitivity condition is $2,500. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and evaluating claimant's counsel's submission in light of the employer's objection), the complexity of the issue, the value of the interest involved, the nature of the proceeding (*i.e.* the latex sensitivity condition was accepted prior to hearing), and the risk that claimant's counsel might go uncompensated.

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $2,750, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and her counsel's statement of services on review), the complexity of the issue, and the value of the interest involved. Finally, we note that claimant is not entitled to an attorney fee for services related to the ALJ's "penalty-related" attorney fee award, other attorney fee awards, or the unsuccessful procedural defense to the compensability issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated January 13, 1999 is reversed in part, modified in part, and affirmed in part. That portion of the order that assessed a $500 "penalty based" attorney fee is reversed. In lieu of the ALJ's $4,500 attorney fee award regarding the employer's "pre-hearing" acceptance of claimant's latex sensitivity condition, claimant is awarded a $2,500 attorney fee, to be paid by the self-insured employer. The remainder of the ALJ's order is affirmed. For services on review, claimant is awarded a $2,750 attorney fee, payable by the employer.

[5] *See Schoch v. Leupold & Stevens*, 144 Or App 259 (1996) (The risk in a particular case that an attorney's efforts may go uncompensated is a factor to be considered in setting a reasonable attorney fee under OAR 438-015-0010(4)). Nevertheless, we do not apply a contingency factor or "multiplier" in a strict mathematical sense. *E.g., Lois J. Schoch*, 49 Van Natta 788, 790, n 1 (1997). Rather, in accordance with OAR 438-015-0010(4)(g), in arriving at our determination of a reasonable attorney fee award, we have taken into consideration the risk (particularly in light of the medical complexity of the issue, the nature of the proceedings, and the employer's vigorous defense) that claimant's attorney's efforts might have gone uncompensated for the services rendered in this case.

In the Matter of the Compensation of
MICHELLE LIGHTFOOT, Claimant
WCB Case No. 98-01247
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Crumme's order that set aside its denials of claimant's current neck, right shoulder and headache conditions. On review, the issue is compensability.

We adopt and affirm the ALJ's order.[1]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 7, 1998, as reconsidered January 20, 1999, is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the insurer.

[1] The insurer has filed a motion for an extension of time to provide a reply brief. The insurer explained that claimant's attorney sent the respondent's brief to the insurer's attorney's former address and it was not received until April 20, 1999. Claimant's attorney has no objection to the Board's consideration of the insurer's reply brief. Under these circumstances, we accept the insurer's reply brief. *See* OAR 438-011-0030.

In the Matter of the Compensation of
BUDDY S. CARLOW, Claimant
Own Motion No. 99-0055M
OWN MOTION ORDER DENYING RECONSIDERATION
Saif Legal Department, Defense Attorney

On February 17, 1999, we authorized the reopening of claimant's 1984 claim for the provision of temporary disability benefits. On April 12, 1999, claimant submitted a letter requesting that a "settlement" also be awarded. We interpret claimant's request as a request for reconsideration of our February 17, 1999 Own Motion Order.[1]

Pursuant to OAR 438-012-0065(2), a reconsideration request must be filed within 30 days after the mailing date of the order, or within 60 days after the mailing date if there was good cause for the failure to file within 30 days. We received claimant's request for reconsideration on April 14, 1999, more than 30 days after the issuance of our February 12, 1999 Own Motion Order. Therefore, the request was untimely filed. *See* OAR 438-005-0046(1)(b) and (c). Additionally, claimant does not provide good cause for his failure to file his request within 30 days. Under such circumstances, we are without authority to reconsider our prior decision.

However, even if we were to reconsider our previous order, we would continue to adhere to our prior decision. We interpret claimant's request for a "settlement award" as a request for other workers' compensation benefits (permanent disability).[2] We are without authority to award further permanent disability in this claim. Effective January 1, 1988, the legislature removed our authority to grant additional permanent disability compensation in our Own Motion capacity. *Independent Paper Stock v. Wincer*, 100 Or App 625 (1990). As noted in footnote 1, claimant's aggravation rights expired in 1989. Thus, he is not statutorily entitled to a permanent disability award under this reopening of his own motion claim. Accordingly, claimant's request for reconsideration is denied.

IT IS SO ORDERED.

[1] Claimant's March 13, 1984 claim was accepted as a nondisabling claim. Thus, claimant's aggravation rights expired on March 13, 1989. ORS 656.273(4)(a). When claimant's condition worsened requiring surgery in December 1998, claimant's claim was under our own motion jurisdiction. ORS 656.278(1)(a). Consistent with our statutory authority, on February 17, 1999, we issued our own motion order authorizing the payment of temporary disability compensation and noted that when claimant was medically stationary, the SAIF Corporation should close the claim pursuant to OAR 438-012-0055.

[2] Because of claimant's reference to being compensated for "a permanent 'bow-legged' effect," we interpret his request as a request for a permanent partial disability award.

In the Matter of the Compensation of
LINDA K. HOLCOMB, Claimant
WCB Case No. 96-08941
ORDER ON REMAND
Robert E. Nelson, Claimant Attorney
Lundeen, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. *Liberty Northwest v. Holcomb*, 159 Or App 308 (1999). The court has reversed our prior order, *Linda K. Holcomb*, 49 Van Natta 1491 (1997), that awarded claimant temporary disability benefits from December 22, 1994 through March 28, 1995 and awarded an "out-of-compensation" attorney fee payable from increased compensation over and above that awarded by the ALJ.[1] In *Holcomb*, we concluded that the lack of a contemporaneous authorization of time loss from claimant's attending physician (as required by *former* ORS 656.262(4)(f), now subsection (g)), did not preclude her entitlement to "substantive" temporary disability following the closure of her claim. Citing *Fred Meyer, Inc. v. Bundy*, 159 Or App 44 (1999), the court has remanded for reconsideration.

The court, *en banc*, in *Bundy* reversed our decision in *Kenneth P. Bundy*, 48 Van Natta 250 (1996) that had held that the 14-day statutory limitation on "retroactive" temporary disability authorization from an attending physician (as prescribed in former ORS 656262(4)(f), now subsection (g)) was not applicable because the claim had been closed. After reviewing the legislative history in light of the text and context of the applicable statutes, the court concluded that the reference in ORS 656.262(4) to ORS 656.268 was intended to limit the award of retroactive time loss to 14 days, regardless of whether the claim was open or was pending closure.

Here, the record contains no contemporaneous temporary disability authorization from an attending physician for the time period from December 22, 1994 through March 28, 1995. The only reference to claimant's work status during this period is contained in a November 5, 1996 report from Dr. Miller, claimant's treating neurosurgeon, who stated that claimant's time loss from December 22, 1994 through March 28, 1995 was due to her compensable back condition. Because *former* ORS 656.262(4)(f) limited a retroactive award of temporary disability to 14 days, it follows that Dr. Miller's November 5, 1996 report is insufficient to authorize temporary disability during the disputed period. Therefore, in light of the court's *Bundy* decision, claimant has not established entitlement to temporary disability benefits between December 22, 1994 and March 28, 1995.

Accordingly, on reconsideration, the ALJ's "substantive" award of temporary disability from December 22, 1994 through February 7, 1995 is reversed. The award of temporary disability in the May 8, 1996 Determination Order (as affirmed by the September 12, 1996 Order on Reconsideration) is affirmed. Inasmuch as claimant's compensation has not been increased, the ALJ's "out-of-compensation" attorney fee award is also reversed. The ALJ's January 15, 1997 order, as amended on February 4, 1997, is otherwise affirmed.[2]

IT IS SO ORDERED

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[1] The ALJ had awarded temporary disability from December 22, 1994 through February 7, 1995 and an "out-of-compensation" attorney fee.

[2] Because claimant's award of temporary disability has ultimately been reduced as a result of the insurer's cross-request for review, we rescind the $500 attorney fee awarded in our prior order pursuant to ORS 656.382(2).

In the Matter of the Compensation of
BETTY L. MARSHALL, Claimant
Own Motion No. 97-0118M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Rasmussen & Tyler, Claimant Attorneys
EBI Insurance, Insurance Carrier

Claimant requests review of the insurer's June 2, 1998 Notice of Closure which closed her claim with an award of temporary disability compensation from May 29, 1997 through April 21, 1998. The insurer declared claimant medically stationary as of April 21, 1998. We affirm the Notice of Closure.

FINDINGS OF FACT

On March 11, 1997, we issued an Own Motion order authorizing the reopening of claimant's 1984 left knee injury claim for the payment of temporary disability compensation. On May 29, 1997, claimant underwent a total left knee replacement.

Claimant was examined by Dr. Mohler, claimant's attending physician, on January 12, 1998. Reporting that claimant needed insoles for a left foot condition that was affecting her compensable left knee condition, Dr. Mohler concluded that claimant would not be medically stationary until she received the insoles.

On April 30, 1998, the insurer's representative received confirmation from the insole manufacturer that claimant had received her insoles on April 21, 1998. On June 2, 1998, the employer closed claimant's 1984 claim, declaring her medically stationary as of April 21, 1998.

On June 12, 1998, Dr. Mohler re-examined claimant. Reporting that claimant still suffered from left foot pain and that her orthoses needed to be modified, Dr. Mohler declared that claimant was not medically stationary and had not been medically stationary since her May 1997 knee surgery.

Dr. Mohler later reported that he had no record of claimant receiving her insoles. Nonetheless, Dr. Mohler reiterated that, if claimant had received her insoles,[1] she was medically stationary as of the date she received them.

The insurer denied claimant's left foot condition on June 27, 1998. Claimant requested a hearing regarding the employer's denial. On October 16, 1998, we postponed action in this own motion matter pending resolution of the litigation involving the compensability of claimant's left foot condition.

Claimant underwent an insurer-arranged medical examination (IME) by Dr. Duff on August 24, 1998. Dr. Duff reported that: (1) claimant was not receiving any treatment; (2) she had no further foot pain; (3) no further treatment was planned; and (4) she was medically stationary as of April 1998.

In October 1998, claimant was once again examined by Dr. Mohler, who opined that claimant was in need of further left foot treatment. This additional treatment would include orthotics and possibly require a revision of the left knee. Inasmuch as claimant continued to require medical treatment, Dr. Mohler declared that claimant should not be considered medically stationary.

The insurer subsequently rescinded its denial of claimant's left foot condition and accepted it as a compensable component of claimant's left knee claim. As a result, claimant withdrew her request for hearing and an Order of Dismissal issued on January 13, 1999.

CONCLUSIONS OF LAW

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981).

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[1] Dr. Mohler contradicts his prior report which indicated that claimant had been wearing insoles, however, they were in need of modification.

The propriety of the closure turns on whether claimant was medically stationary at the time of the June 2, 1998 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

The insurer contends that claimant's now accepted left foot condition was medically stationary effective the date she received her insoles (April 21, 1998). Consequently, the insurer argues that its June 2, 1998 Notice of Closure was proper. In response, claimant asserts that she was not medically stationary at the time of closure because she required further medical treatment for her left foot condition. We disagree with claimant's assertion.

It is well-established that the term "medically stationary" does not mean that there is no longer a need for continuing medical care. *Maarefi v. SAIF*, 69 Or App 527, 531 (1984). Rather, claimant bears the burden of proving that there is a reasonable expectation that further or ongoing medical treatment would "materially improve" her compensable condition at claim closure. *Lois Brimblecom*, 48 Van Natta 2312 (1996).

Here, prior to claim closure, Dr. Mohler opined that claimant was medically stationary as of the date she received her insoles. The record establishes that claimant received her insoles on April 21, 1998.

Following claim closure, Dr. Mohler's opinion regarding claimant's medically stationary status changed three different times. In June 1998, he stated that claimant required additional treatment for her left foot condition and, thus, was not medically stationary. A month later, Dr. Mohler reported that if claimant had received her insoles, she was medically stationary. In October 1998, he opined that claimant required additional treatment for her left foot condition and was not medically stationary.

We generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). In addition, we give the most weight to opinions that are both well-reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259 (1986).

Based on these principles, we decline to rely on the opinions authored by Dr. Mohler. Although evidence that was not available at the time of closure may be considered to the extent the evidence addresses the condition at the time of closure, we find Dr. Mohler's October 1998 opinion a "post-closure" development which does not focus on claimant's condition at the time of the June 2, 1998 closure. *See Scheuning v. J.R. Simplot & Co.*, 84 Or App 622, 625 (1987). Moreover, in light of Dr. Mohler's unexplained reversals of opinion, we do not find his conclusions persuasive. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of physician's opinion found unpersuasive).

Rather, we look to the only other medical opinion regarding claimant's medically stationary status. In August 1998, Dr. Duff reported that claimant was not receiving any medical treatment (either for her left foot or left knee conditions) and that no further treatment was planned. He explained that claimant was without pain and was not expected to materially improve with further treatment or the passage of time. Thus, Dr. Duff concluded that claimant was medically stationary at the time the insurer closed her claim. We find this thorough and well-reasoned opinion to be persuasive.

Based on Dr. Duff's opinion, we find that claimant was medically stationary on the date her claim was closed.[2] Therefore, we conclude that the insurer's closure was proper.

Accordingly, we affirm the insurer's June 2, 1998 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[2] Should claimant's compensable conditions subsequently worsen to the extent that surgery and/or inpatient hospitalization is eventually required, she may again request reopening of her claim for the payment of temporary disability. *See* ORS 656.278(1).

In the Matter of the Compensation of
EILEEN M. OSTER, Claimant
Own Motion No. 96-0233M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE

Claimant requests review of the self-insured employer's April 6, 1999 Notice of Closure which closed her claim with an award of temporary disability compensation from May 22, 1997 through January 12, 1999. The employer declared claimant medically stationary as of January 12, 1999. Claimant contends that he is entitled to additional benefits as she was not medically stationary when her claim was closed.

In an April 22, 1999 letter, we requested that the employer submit copies of materials it considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. Having received the parties' submissions and respective positions, we proceed with our review.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981).

The propriety of the closure turns on whether claimant was medically stationary at the time of the April 6, 1999 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

Claimant contends that she was not medically stationary at the time of closure because she continues to seek medical treatment in the form of physical therapy. In addition, she asserts that she has been advised by her doctor that she will be unable to return to her regular work.

Dr. Carr, claimant's attending physician, examined claimant on January 12, 1999. Dr. Carr concluded that, although claimant was still having significant problems with her back, these problems had not changed over time. Consequently, Dr. Carr declared claimant medically stationary as of January 12, 1999. Dr. Carr's opinion is unrebutted.

Under such circumstances, we are persuaded by Dr. Carr's opinion that claimant was medically stationary on January 12, 1999. In reaching this conclusion, we note that, in the absence of medical evidence providing a reasonable expectation that medical treatment or the passage of time would result in material improvement of claimant's condition, the need for continuing medical care in the form of physical therapy does not establish that claimant's condition is not medically stationary. *See Maarefi v. SAIF*, 69 Or App 527, 531 (1984); *Lois Brimblecom*, 48 Van Natta 2312 (1996).

Further, the definition of medically stationary outlines the criteria by which a physician must determine a claimant's medically stationary status. *See* ORS 656.005(17). Therefore, although claimant asserts that she is unable to work and is disabled, the pivotal question is whether her condition was medically stationary. In other words, has her condition, in the opinion of the medical experts, reached a state where it will not improve with further treatment or the passage of time? Based on Dr. Carr's unrebutted opinion, the answer to that question is "yes."

In conclusion, based on the uncontroverted medical evidence (*i.e.* the opinion of her attending physician), we find that claimant was medically stationary on the date her claim was closed. Therefore, the employer's closure was proper.

Accordingly, we affirm the employer's April 6, 1999 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD E. ROGERS, Claimant
WCB Case Nos. 95-01825, 94-14661 & 93-11544
ORDER ON REMAND
Pozzi, Wilson & Atchison, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Cobb & Woodworth, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. *Reynolds Metals v. Rogers*, 157 Or App 147 (1998). The court has reversed that portion of our prior order, *Ronald E. Rogers*, 48 Van Natta 2107 (1996), *on recon* 49 Van Natta 267 (1997), affirming that portion of an ALJ's order that: (1) set aside Cigna Insurance Company's (Cigna's) denial of claimant's occupational disease claim for a right shoulder condition; and (2) upheld Liberty Northwest Insurance Corporation's (Liberty Northwest's) denial for the same condition. In reaching our conclusion, we affirmed the ALJ's reliance on the court's decision in *Beneficiaries of Strametz v. Spectrum Motorwerks*, 135 Or App 67, *mod* 138 Or App 9 (1995), and did not address whether claimant had suffered a worsening of his condition at the subsequent insurer as required by *Boise Cascade Corp. v. Starbuck*, 296 Or 238 (1994). Noting that the Supreme Court had reversed the *Strametz* decision, 325 Or 439 (1997), the court has remanded for reconsideration under the correct standard.

FINDINGS OF FACT

We adopt the "Findings of Fact" set forth in the ALJ's order and briefly summarize the relevant facts.

Claimant began working for the employer in 1967. In 1979, claimant sought medical treatment from Dr. Manley for right shoulder pain. At that time, Liberty Northwest provided workers' compensation insurance for the employer. In a letter to Liberty Northwest, Dr. Manley diagnosed claimant's condition as degenerative osteoarthritis of the right shoulder and indicated that the condition was work-related.

In 1985, Cigna became the employer's workers' compensation insurer. In May 1990, claimant sought treatment for right shoulder pain and was diagnosed with bicipital tendinitis. Thereafter, claimant filed a workers' compensation claim for his right shoulder condition. Cigna accepted claimant's claim as a disabling injury, but did not specify what condition was accepted.

Claimant quit working for the employer in 1991.

In May 1993, claimant had another onset of right shoulder pain and returned to Dr. Manley. Dr. Manley recommended surgery and requested authorization for the surgery from Cigna. On September 22, 1993, Cigna denied claimant's right shoulder condition on the basis that it was unrelated to the 1990 accepted claim. By letter dated June 27, 1995, Cigna amended its denial to include responsibility.

By letter dated January 30, 1996, Liberty Northwest denied claimant's right shoulder condition on both compensability and responsibility grounds.

CONCLUSIONS OF LAW AND OPINION

Relying on the court's decision in *Beneficiaries of Strametz v. Spectrum Motorwerks*, 135 Or App 67, *mod* 138 Or App 9 (1995), the ALJ concluded that Cigna was responsible for claimant's right shoulder condition. We adopted and affirmed the ALJ's conclusions and reasoning with regard to the responsibility issue. *Ronald E. Rogers*, 48 Van Natta 2107 (1996), *on recon* 49 Van Natta 267 (1997).

Noting that the Supreme Court had reversed the *Strametz* decision, 325 Or 439 (1997), the court has remanded for reconsideration under the last injurious exposure rule (LIER) as set forth in *Boise Cascade*, 296 Or at 244. Therefore, we proceed with our analysis of the responsibility issue applying LIER.

Once a condition has been found work related, LIER assigns initial responsibility to the last period of employment where conditions might have caused the disability. *Boise Cascade*, 296 Or at 244.

The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. *Bracke v. Baza'r*, 293 Or 239, 248 (1982). If an injured worker receives medical treatment before experiencing time loss due to the condition, the date of first medical treatment is determinative for assigning initial responsibility for the claim. *Timm v. Maley*, 125 Or App 396, 401 (1993), *rev den* 319 Or 81 (1994). The initially responsible insurer can transfer liability to a subsequent insurer by establishing that the subsequent employment actually contributed to a worsening condition. *Oregon Boiler Works v. Lott*, 115 Or App 70, 74 (1992).

Here, as noted by the court, claimant first sought treatment for his right AC joint condition in 1979, while Liberty Northwest was on the risk. Therefore, initial responsibility is assigned to Liberty Northwest. *Timm v. Maley*, 125 Or App at 401. Liberty Northwest can shift responsibility to Cigna if it is established that claimant's employment, while Cigna was at risk, actually contributed to a worsening of claimant's right shoulder arthritis condition. Based on the following reasoning, we conclude that responsibility for claimant's right shoulder arthritis condition should remain with Liberty Northwest.

There is no medical evidence in the record that establishes that claimant's employment, after Cigna came on the risk in 1985, actually contributed to a worsening of claimant's right shoulder condition.[1] Dr. Manley, claimant's treating physician, indicated that claimant's work activities, as a whole, were the major contributing cause of claimant's right shoulder arthritic condition. (Exs. 131, 133-28). Although Dr. Manley does indicate that right shoulder x-rays taken in 1993 showed marked changes from x-rays taken in 1979, he does not address the question of whether there was a worsening after 1985. (Ex. 133-41). On this record, Liberty Northwest has not established that claimant's employment, while Cigna was at risk, actually contributed to a worsening of claimant's condition. Consequently, responsibility for claimant's right shoulder arthritic condition remains with Liberty Northwest.

ORDER

The ALJ's order dated September 29, 1995 is reversed in part, modified in part, and affirmed in part. That portion of the ALJ's order which set aside Cigna's June 17, 1994 denial of responsibility is reversed. Cigna's denial is reinstated and upheld. That portion of the ALJ's order which upheld that portion of Liberty Northwest Insurance Corporation's January 30, 1995 denial which denied responsibility is reversed. Liberty Northwest's denial is set aside and the claim is remanded to Liberty Northwest for processing according to law. That portion of the of the ALJ's order which awarded an $1,000 assessed attorney fee, payable by Cigna, for services related to the assignment of responsibility is modified to be payable by Liberty Northwest. The remainder of the ALJ's order is affirmed.

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[1] We note that the Court indicated that there was medical evidence from Dr. Manley that claimant's right shoulder arthritic condition had worsened while Cigna was at risk. 157 Or App 154 n. 5. This reference may be in response to Dr. Manley's comments regarding the "marked changes" in claimant's 1993 right shoulder x-rays from those displayed in 1979. However, it does not appear that Dr. Manley specifically addressed claimant's condition after July 1985, when Cigna came on the risk. Consequently, the record does not support a finding that claimant's right shoulder arthritic condition *worsened* after July 1985.

In the Matter of the Compensation of
HEIDI L. SWALWELL, Claimant
WCB Case No. 98-07327
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that found that claimant's left knee injury claim was prematurely closed. On review, the issues are premature closure and, if the claim was not prematurely closed, extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change. In the second full paragraph on page 3 of the Opinion and Order, we change the citation after the first sentence to read: "(Ex. 43)."

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant argued that her left knee claim was prematurely closed. The ALJ relied on the opinions of Dr. Krieg, claimant's attending physician, and Dr. Gritzka, the medical arbiter, to conclude that claimant's condition was not medically stationary.

To establish that her claim was prematurely closed, claimant has the burden of proving by a preponderance of the evidence that the accepted conditions were not medically stationary on the date of claim closure. *See Berliner v. Weyerhaeuser Co.*, 54 Or App 624, 628 (1981). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17).

Citing *James L. Mack*, 50 Van Natta 338 (1998), the insurer argues that the ALJ erred by relying on Dr. Gritzka's opinion because the only treatment he recommended was for a noncompensable condition. The insurer also contends that the ALJ erred by relying on Dr. Krieg's opinion.

In *James L. Mack*, we concluded that a determination of whether a claim has been prematurely closed must focus only on those conditions accepted at the time of closure. In reaching this conclusion, we relied on the legislature's 1997 adoption of ORS 656.262(7)(c), which provides, in part, that "[i]f a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition."

Here, the insurer initially accepted a left knee strain and later accepted an acute lateral subluxation of the left patella. (Ex. 36). Dr. Gritzka performed a medical arbiter examination on July 28, 1998. (Ex. 48). He did not believe claimant's symptoms were related to the patellar subluxation. (Ex. 48-7). Dr. Gritzka felt that claimant's diagnosis included disruption of the left medial patellar retinaculum with chronic recurrent patellar instability. (*Id.*) He concluded that claimant needed further evaluation and treatment, including arthroscopy of her left knee to observe her patellar tracking. (*Id.*)

Dr. Gritzka did not believe claimant's symptoms related to the patellar subluxation, which was an accepted condition. Rather, he felt she had torn the medial retinaculum of her left patella and she needed further evaluation and treatment. Assuming that was an appropriate diagnosis, the disruption of claimant's left medial patellar retinaculum was not an accepted condition at the time of claim closure. Therefore, the issue of whether this condition was medically stationary at the time of claim closure is not relevant to a determination of whether the claim for an acute lateral subluxation of the left patella has been prematurely closed. *See Joseph A. Gerber*, 51 Van Natta 278 (1999); *James L. Mack*, 50 Van Natta at 339. Consequently, we find that Dr. Gritzka's opinion is entitled to little probative weight.

Claimant relies on the opinion of Dr. Krieg, her attending physician, to establish that her condition was not medically stationary at the time of closure. Claimant began treatment with Dr. Krieg shortly after the December 4, 1996 injury. (Ex. 3). On September 25, 1997, he reported that claimant

had continued left knee pain with essentially all activity and also had pain when sitting for prolonged periods of time. (Ex. 26). Dr. Krieg recommended that claimant continue to work aggressively on her quad strengthening exercises and continue to wear her patellofemoral sleeve when needed. (*Id.*) At that time, he released claimant to work for eight hours a day, two days a week. (*Id.*)

On October 9, 1997, Dr. Krieg reported that claimant had continued complaints of left knee pain with all activity, including going up and down stairs, arising from a squatting position and any activity in which she was required to use knee flexion. (Ex. 30). He said claimant would continue to work on her "straight leg raise" exercises, but he noted that claimant was "coming close to plateauing in her recovery." (*Id.*) He wanted claimant to see Dr. Grewe to discuss any possible surgical intervention. (*Id.*)

In a letter to the insurer on October 20, 1997, Dr. Krieg reported that claimant was not medically stationary. (Ex. 31). He indicated he was working with claimant to bring her back to a rehabilitated state. He explained that claimant continued to perform exercises to strengthen the left quadriceps and she had a brace to use as needed. (Ex. 31-1). He explained further:

> "She has recently been released to return to modified duties part-time. I will be re-evaluating this over the next several months, with the expectation that she will gradually increase her time at work and responsibilities.
>
> "I have reached an understanding with [claimant] regarding her graduated return to work. I will re-evaluate her monthly, attempting to increase her time at work and duties correspondingly. If at any point she fails to respond, then we will consider her medically stationary. Otherwise, I would anticipate her reaching medically stationary status within the next two to three months." (Ex. 31-1, -2).

On the other hand, Dr. Farris examined claimant on October 6, 1997 and concluded that she was medically stationary with regards to the December 4, 1996 injury. (Ex. 29-6). He could think of no further treatment other than a self-directed isometric quadriceps strengthening program. (*Id.*) He noted that claimant may some day require a lateral retinacular relase or a tibial tubercle osteotomy, but the future need for either surgery would be claimant's preexisting patellofemoral malalignment, not the industrial injury. (*Id.*)

Absent persuasive reasons to do otherwise, we generally rely on the opinion of a worker's treating physician, because of his or her opportunity to observe the claimant over an extended period of time. *See Weiland v. SAIF*, 64 Or App 810, 814 (1983). Here, we find no persuasive reason not to rely on the assessment of Dr. Krieg, who had been treating claimant since December 1996. In October 1997, Dr. Krieg reported that claimant continued to have left knee complaints and he was still working with her to bring her back to a rehabilitated state. (Exs. 30, 31). He explained that claimant should continue to perform exercises to strengthen the left quadriceps and she also had a brace to use as needed. Although the insurer argues that the exercises are preventative in nature, not curative, we disagree. Dr. Krieg's reports indicate that further strengthening exercises were designed to rehabilitate claimant's left knee.

There are two other medical opinions in the record. Dr. Grewe felt that claimant needed surgery, but he believed it was related to a preexisting patellar malalignment, not her work injury. (Exs. 40, 42). Similarly, Dr. Schader felt that claimant needed a patellar realignment procedure. (Ex. 34). Because the patellar malalignment condition had not been accepted at claim closure, the medically stationary status of that condition is not relevant to our current inquiry. *See James L. Mack*, 50 Van Natta at 339. Moreover, Dr. Grewe deferred to Dr. Krieg's opinion as to whether claimant was medically stationary. (Ex. 42).

In sum, we agree with the ALJ that Dr. Krieg's opinion is more persuasive than that of Dr. Farris, who examined claimant on only one occasion. Based on Dr. Krieg's opinion, we conclude that further material improvement in claimant's accepted condition would reasonably be expected from medical treatment, or the passage of time.[1]

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[1] In light of our conclusion, we need not address claimant's alternative argument that if the claim was properly closed, she was entitled to 11 percent scheduled permanent disability for loss of use or function of her left leg.

Attorney Fee

Claimant's attorney is entitled to an assessed fee for services on review concerning the premature closure issue. ORS 656.382(2). Claimant's attorney has submitted a statement of services indicating that he devoted 11 hours to services on review and he requests a fee of $1,650. Claimant's attorney asserts that Board statistics indicate that over half of all denials are upheld and he urges the Board to consider this contingent factor in awarding a fee.

The insurer contends that a fee of $1,650 is excessive. In particular, the insurer objects to the use of "denial statistics" because this is not a denial case. The insurer suggests that a fee of $1,000 is more reasonable.

In determining a reasonable attorney fee, we apply the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

The issues in this case were whether claimant's left knee injury claim was prematurely closed and, alternatively, extent of scheduled permanent disability. Claimant's counsel indicated that he devoted 11 hours to services before the Board. Claimant's respondent's brief is 8 pages in length (6 pages of which were devoted to the premature closure issue, with the remaining 2 pages addressing the "alternative" extent of permanent disability issue). Although the insurer argues that the fee request is excessive, there is no indication that claimant's attorney did not, in fact, spend the time asserted working on claimant's brief. Moreover, we note that time devoted to the case is only one of the eight factors to be considered in determining a reasonable fee.

The issue of premature closure presents a medical question of a complexity similar to those generally submitted. The value of the interest involved and the benefit to claimant are substantial, in that claimant requires further treatment for her compensable condition before claim closure. Considering the medical opinions, there was some risk that claimant's counsel might go uncompensated. Finally, claimant's counsel and defense counsel are skilled litigators with substantial experience in workers' compensation law, and no frivolous issues or defenses were raised.

After considering the factors set forth in OAR 438-015-0010(4) and the insurer's objection to the fee request, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief, her attorney's statement of services, the insurer's objections, and claimant's attorney's reply), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated January 5, 1999, as supplemented February 2, 1999, is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the insurer.

In the Matter of the Compensation of
MARIA Y. ALVAREZ, Claimant
WCB Case No. 98-04529
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) set aside its denial of claimant's lumbar and dorsal strain conditions; (2) assessed a penalty for an allegedly unreasonable denial; and (3) directed it to process claimant's claim, including the payment of temporary disability benefits. On review, the issues are compensability, penalties, and claims processing. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the "Findings of Fact" set forth in the ALJ's order.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the conclusions and reasoning concerning the compensability of claimant's current lumbar and dorsal strain condition as set forth in the ALJ's order with the following supplementation.

Assuming arguendo that claimant is required to show "objective findings" in this case, we conclude that the medical record contains evidence of such findings. Dr. Versosa, claimant's current treating physician, opined that the major contributing cause of claimant's low back condition was the March 3, 1998 work incident. (Ex. 55). There is no contrary evidence concerning the causation of claimant's low back condition. In addition, both Dr. Versosa, and Dr. Armstrong, who provided chiropractic treatment, reported reduced lumbar range of motion and lumbar tenderness. (Exs. 54, 55). Such findings are considered "objective findings" under ORS 656.005(19). *See Tony D. Houck*, 48 Van Natta 2443 (1996). Inasmuch as the record establishes that the work injury is the major contributing cause of claimant's current low back condition, it necessarily follows that the objective findings were also caused, in major part, by the work incident.

Penalty

The ALJ found that evidence of a lack of objective findings was not the appropriate legal standard for a current condition denial and therefore concluded that the insurer's denial was unreasonable. We disagree.

A denial is unreasonable if the carrier does not have a legitimate doubt as to its liability. *Brown v. Argonaut Insurance Company*, 93 Or App 588 (1988). The reasonableness of a carrier's denial of compensation must be gauged based upon the information available to the carrier at the time of its denial. *Price v. SAIF*, 73 Or App 123, 126 n. 3 (1985).

The insurer's denial of claimant's current dorsal and lumbar strain condition was not based solely on a lack of objective findings. (Ex. 49). In addition, the insurer also denied claimant's current condition on the basis that it was related to the intervening motor vehicle accident. (Ex. 49). At the time of the June 3, 1998 denial, the insurer possessed medical reports from Dr. Versosa, claimant's treating physician, and the Impartial Medical Opinions physicians which indicated that the motor vehicle accident contributed to claimant's lumbar condition. (Exs. 35, 45). Because these reports implicated the intervening motor vehicle accident as a cause of claimant's condition, we find that the insurer had a legitimate doubt as to its continuing liability for claimant's accepted conditions. Consequently, a penalty is not warranted.

Claims Processing

The insurer takes issue with the "Order" portion of the ALJ's order that directed the insurer to process claimant's claim "pursuant to law including, but not limited to, payment of temporary disability

compensation." (Opinion and Order at p. 4). We do not interpret the ALJ's order as directing the insurer to pay specific temporary disability benefits as that issue was not before the ALJ. Rather, we interpret the ALJ's order as directing the insurer to process claimant's lumbar and dorsal sprain condition in accordance with law. Whether claimant is owed any temporary disability benefits is a determination that would be made during the processing of claimant's claim.

Finally, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 18, 1998 is reversed in part and affirmed in part. That portion of the ALJ's order which assessed a 25 percent penalty is reversed. The remainder of the order is affirmed. For services on review concerning the compensability issue, claimant's counsel is awarded $1,000, as reasonable assessed attorney fee, payable by the insurer.

June 16, 1999 Cite as 51 Van Natta 943 (1999)

In the Matter of the Compensation of
GAYLE A. BRIGGS, Claimant
WCB Case Nos. 98-03080, 97-05463 & 97-00644
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Wallace Klor & Mann, Defense Attorneys
Randy Rice, Defense Attorney

Reviewed by Board Members Haynes, Bock, and Phillips Polich.

Kemper Insurance Company requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its denial of compensability for a low back injury claim; (2) set aside its denial of compensability for a left knee and right groin injury claim; and (3) assessed a penalty for allegedly unreasonable denials. Safeco Insurance Company requests review of that portion of the ALJ's order that found it responsible for "temporary worsening of the symptoms of claimant's compensable low back condition in 1996." On review, the issues are compensability and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Low Back Treatment in 1996

Claimant has worked for the employer since 1965. In August 1991, claimant sustained a compensable low back injury. Safeco, the employer's carrier at that time, accepted a nondisabling low back strain.

In May 1996, claimant complained to his treating orthopedist, Dr. Sedgewick, about ongoing low back symptoms. (Ex. 12). In particular, claimant stated that, when coughing, he has "some radicular symptoms down the right lower extremity" and "pain in the left flank." (Ex. 13). Dr. Sedgewick submitted a notice of an aggravation claim. (Ex. 15). Safeco eventually denied the aggravation claim.

Although the ALJ upheld the aggravation denial, he found that claimant experienced a "temporary waxing and waning" of his compensable injury and, thus, was entitled to medical services in 1996. We agree with Safeco that the medical evidence does not establish that claimant's need for treatment in 1996 was in major part due to his compensable injury.

After submitting the notice of aggravation, Dr. Sedgewick reported that claimant's current condition "was secondary to musculoligamentous strain and not related to degenerative disc disease." (Ex. 23).

Examining physician, Dr. Jones, saw claimant on November 4, 1996. According to Dr. Jones, claimant sustained a lumbar strain in August 1991 that had resolved. (Ex. 26-3). Instead, Dr. Jones attributed claimant's current need for treatment to "degenerative osteoarthritis and degenerative disc disease of the lumbosacral spine." (*Id.*) Dr. Jones further stated that claimant's "work may impact this to a small degree, however, the major contributing cause to a combined condition is the degenerative pre-existing constitutional issue of degenerative osteoarthritis and degenerative disc disease." (*Id.*)

Dr. Sedgewick concurred with Dr. Jones' report. (Ex. 27). Additionally, after seeing claimant on January 14, 1997, Dr. Sedgewick stated that claimant told him that "his low back claim no longer relates to his 1991 injury per IME" and Dr. Sedgewick thought this was "reasonable in that his MRI showed degenerative disc disease." (Ex. 33). Dr. Sedgewick further stated that claimant intended to "file a new claim for musculoligamentous strain for the new injury" and if "it doesn't relate to his 1991 injury then the new musculoligamentous strain is a separate entity and should be treated as such." (*Id.*)

The only other medical evidence concerning claimant's 1996 treatment is from examining orthopedic surgeon, Dr. Gritzka, who saw claimant at his attorney's request on July 1, 1998. Dr. Gritzka diagnosed "degenerative disc disease L5-S1 with superimposed lumbosacral strain" and thought such condition "is due to the injury of 8/2/91 on a more probable than not basis." (Ex. 51-9).

We find such evidence does not show that the 1991 injury was the major contributing cause of claimant's need for treatment in 1996. According to Dr. Jones, the major contributing cause was preexisting degenerative conditions. Although Dr. Sedgewick concurred with this opinion, he also indicated that claimant sustained a "new" musculoligamentous strain that, in light of the degenerative disc disease, likely was not related to the 1991 injury.

Although Dr. Gritzka implicated the 1991 injury as the major contributing cause of a "combined condition," we are more persuaded by Dr. Sedgewick's opinion. Dr. Sedgewick treated claimant for his low back condition in 1991 and, thus, was more familiar with claimant's condition than Dr. Gritzka, who saw claimant only one time. Furthermore, Dr. Gritzka's opinion is summary in that he does not explain why the 1991 injury is the major contributing cause, as opposed to a "new" strain, as Dr. Sedgewick indicated.

Thus, we conclude that claimant failed to prove that the 1991 injury was the major contributing cause of his need for treatment and disability in 1996 and we reinstate Safeco's denial.

April 3, 1997 Injury

Claimant also contended that he sustained injuries to his low back, left knee and right groin on April 3, 1997, while performing work activities. At that time, Kemper was the employer's carrier. The ALJ concluded that claimant carried his burden of proving compensability of all three injuries. Kemper challenges these portions of the order, asserting that the medical evidence does not support compensability.

On April 2, 1997, claimant saw his chiropractor; the chartnote for that date states that "everything is out" and claimant had "pain in both legs into feet, tired and weak." (Ex. 36).

On April 7, 1997, claimant submitted a Form 801 indicating that, on April 3, 1997, he "was placing back panel in an enclosure when he felt pain in lower back." (Ex. 38). Claimant returned to his chiropractor on April 9 and April 15. (Exs. 39, 40).

Claimant did not again seek treatment until December 3, 1997, when he saw Dr. Sedgewick for left knee pain. The chartnote states that "there was no trauma" and "no onset in symptoms." (Ex. 42). The chartnote further states that claimant "has had radiated pain in the left extremity from his back, but this appears to be more knee centered." (*Id.*) After an MRI, claimant was diagnosed with a medial meniscus tear. (Ex. 43).

On December 30, 1997, claimant sought treatment from Dr. Baron for a hernia. Dr. Baron referred claimant to Dr. Johnson, surgeon. Dr. Johnson recorded that, "while lifting a heavy electrical panel on the job [claimant] sustained a low back injury and pain in his groin and left knee." (Ex. 45-1). Dr. Johnson diagnosed a "right inguinal hernia sustained on the job." (*Id.* at 2). Claimant underwent surgery for the hernia.

On January 27, 1998, claimant submitted a second Form 801 stating that he "was lifting when I strained my low back, right groin and my left knee." (Ex. 47).

Dr. Gritzka then examined claimant and diagnosed a probable herniated disc at L4-5 and L5-S1 superimposed on degenerative disc disease at L5-S1. (Ex. 51-9). According to Dr. Gritzka, this was a "new" condition and was caused in major part by the April 3, 1997 event. (*Id.* at 10). Dr. Gritzka explained that the "degenerative conditions predating the injury may have interacted with the 4/3/97 injury by causing mechanical dysfunction in the low back resulting in abnormal torques and stresses on the intervertebral disc resulting in a rupture of the annulus fibrosis." (*id.* at 10-11).

Dr. Gritzka also thought that claimant's left knee condition was related to the April 3, 1997 event, apparently because claimant "had the acute onset of left knee pain" at that time. (*Id.* at 10, 11). Finally, although finding that the right inguinal hernia was "probably related to the lifting incident of 4/3/97," Dr. Gritzka indicated that such conditions were not within the expertise of an orthopedic surgeon and recommended consulting with the operating surgeon. (*Id.* at 9).

Dr. Johnson then submitted a report stating that the question of whether or not claimant's "hernia was the result of heavy lifting is not clear to me" and that he could only "say that it is known that heavy lifting or straining can result in inguinal hernia." (Ex. 52).

Dr. Gritzka was deposed. Dr. Gritzka reiterated that he was not an expert in inguinal hernias and thought the general surgeon should provide the opinion concerning that condition. (Ex. 53-6).

Dr. Gritzka further explained why he attributed the left knee condition to a lifting incident at work. According to Dr. Gritzka, claimant had a combined condition in his knee; he thought the MRI showed a tear that "went through to the external surface of the meniscus," which is the type of pathology not typical for "wear and tear attrition." (*Id.* at 7). Along with claimant's description of an injury that "sounded reasonable for injuring his knee," Dr. Gritzka concluded that the major contributing cause of the left knee condition was the April 1997 incident. (*Id.*) Dr. Gritzka also noted that, typically, such injuries would be immediately felt. (*Id.* at 9).

In addressing the low back condition, Dr. Gritzka explained that he understood that claimant experienced "sudden back pain and pain in his left leg, and also right groin pain." (*Id.* at 10). Although Dr. Gritzka was not aware of claimant's chiropractic treatment, he did not think that such information would change his opinion if claimant's back pain "was kind of a grumbling recurrent problem without any substantial leg pain." (*Id.* at 11).

Examining orthopedic surgeon, Dr. Tesar, saw claimant at Kemper's request. Dr. Tesar diagnosed preexisting degenerative disc disease in the lumbar spine that combined with a lumbosacral strain sustained on April 3, 1997. (Ex. 54-8). Dr. Tesar further reported that the initial major contributing cause of the combined condition was the lumbosacral strain; once the strain resolved, the preexisting conditions would be the major contributing cause of the need for treatment. (*Id.*) Dr. Tesar disagreed with Dr. Gritzka that claimant sustained a herniated disc, explaining that claimant's symptoms were not typical of radiculopathy. (*Id.* at 9).

With regard to the left knee, however, Dr. Tesar did not think that claimant sustained an injury to that body part on April 3, 1997. (*Id.* at 9). Dr. Tesar relied on the medical record showing that claimant did not complain of left knee symptoms at that time and, when claimant sought treatment for his left knee in December 1997, he stated that there was no trauma. (*Id.*) Dr. Tesar also explained that claimant had a "horizontal cleavage tear" and "this type of tear is usually a degenerative tear" and commonly presents "with the onset of pain without trauma." (*Id.*)

Finally, examining surgeon, Dr. Braun, examined claimant with regard to the inguinal hernia. Dr. Braun reported that "claimant provides a long history of vigorous lifting and states the pain in his groin was coincident with physical exertion on-the-job in April 1997." (Ex. 54-12). Dr. Braun thought that, "from this history, with no other information, I would have to state that the inguinal hernia is related to his on-the-job activities either chronically acquired over a period of time and/or acutely precipitated by the event of April 1997." (*Id.*)

We first address the low back condition. In assessing the persuasiveness of medical opinions, we rely on those that are based on an accurate history and well-reasoned. *Somers v. SAIF*, 77 Or App 259 (1986). In applying this standard to Dr. Gritzka's opinion, we first note that he did not have a complete history. Significantly, Dr. Gritzka was not aware of claimant's chiropractic treatments before the April 3, 1997 event; such treatment shows that, on April 2, 1997, claimant was complaining of low back pain with pain into both legs. Furthermore, as early as May 1996, claimant reported symptoms into his right leg and left flank.

As Dr. Gritzka explained in his deposition, in finding that the April 3, 1997 event was the major contributing cause of claimant's need for treatment in his low back, Dr. Gritzka was relying on a history that, on that date, claimant had the sudden onset of low back pain that radiated into his legs and also commented that a history that included prior radiating pain could change his opinion. As explained above, claimant did previously complain of low back pain with symptoms into both legs. For this reason, we find that Dr. Gritzka relied on an inaccurate history and we do not find his opinion concerning the low back condition to be particularly persuasive.

Dr. Tesar, however, was aware of claimant's medical history, including the chiropractic treatments. Because his opinion is based on an accurate history and well-reasoned, we rely on his opinion in concluding that claimant proved that he sustained a lumbosacral strain that combined with preexisting degenerative conditions and that, at least for a period of time, the major contributing cause of the need for treatment of the combined condition was the lumbosacral strain. Thus, claimant proved compensability with regard to his low back condition following the April 3, 1997 event.[1] ORS 656.005(7)(a)(B).

We turn to the left knee condition. Again, we find that Dr. Gritzka did not rely on an accurate history. Claimant's first Form 801 reported only low back pain and he did not seek treatment for his left knee until December 3, 1997, when he reported "no trauma" or "onset of pain." Thus, we are not convinced that Dr. Gritzka relied on an accurate history when he based his opinion on a history that claimant had the sudden onset of left knee pain on April 3, 1997.

Rather, we agree with Dr. Tesar that the medical record shows that claimant's left knee symptoms arose without trauma and we find his opinion more persuasive that claimant's left knee condition is due to a degenerative condition that is unrelated to work activities. Consequently, we conclude that claimant did not prove compensability of his left knee condition.

Finally, we also conclude that claimant did not prove compensability of his inguinal hernia. The physician in the best position to provide an opinion is Dr. Johnson because he treated claimant for the condition and performed the surgery. Dr. Johnson, however, was unable to state that the lifting incident caused the hernia condition. Although Dr. Gritzka indicated that the April 1997 event caused the hernia, he also deferred to Dr. Johnson because Dr. Gritzka lacked the expertise of Dr. Johnson. Based on this admission, we do not find Dr. Gritzka's opinion more persuasive than that of Dr. Johnson.

Dr. Braun also indicated that the hernia was caused by the April 3, 1997 event, explaining that such opinion was based on the history of sudden onset on that date. Like the left knee, we are not persuaded by the accuracy of such a history. Claimant's first Form 801 did not refer to hernia symptoms and he did not seek treatment for such condition until December 30, 1997.

At best, based on Dr. Johnson's opinion, claimant proved only that the lifting incident could have caused his hernia. Such an opinion does not carry his burden of showing that the incident probably caused his hernia. Consequently, we conclude that claimant did not carry his burden in proving the hernia condition to be compensable. ORS 656.005(7)(a).

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[1] We emphasize that we do not decide whether claimant sustained only a strain, as Dr. Tesar found, or a herniated disc, as Dr. Gritzka postulated. Rather, based on Dr. Tesar's persuasive opinion, we conclude only that claimant proved that the April 3, 1997 injury was the major contributing cause of the need for treatment and disability of his combined condition, whether a strain or herniated disc.

Penalties and Attorney Fees

The ALJ assessed penalties against Kemper after finding that its denials were not reasonable. We first note that, because we have found that claimant did not prove compensability of the left knee and right inguinal hernia, claimant is not entitled to any penalty based on the denial of those conditions. *See* ORS 656.262(11)(a).[2]

A carrier is liable for a penalty when it "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). In determining whether a denial is unreasonable, the question is whether the carrier had a legitimate doubt as to its liability at the time of its denial. *Brown v. Argonaut Insurance Company*, 93 Or App 588, 591 (1988). "Unreasonableness" and "legitimate doubt" are to be considered in light of all the evidence available at the time of the denial. *Id.*

Kemper issued its denial for the low back on June 25, 1997. Apparently, the denial was in response to the Form 801 filed by claimant on April 7, 1997. The form indicated that the body part had been previously injured and it was "thought to be re-injury of 91." (Ex. 38). The form also stated that claimant was "placing back panel in an enclosure when he felt pain in lower back." (*Id.*)

The denial stated that it was "apparent that the major contributing cause of your current low back problems is degenerative osteo arthritis and degenerative disc disease of the lower back." (Ex. 41). By referring to preexisting conditions, it appears that Kemper was relying on Dr. Jones' November 4, 1996 report indicating that claimant's "current problem is exclusively related to a constitutional problem of degenerative osteoarthritis and degenerative disc disease of the lumbosacral spine." (Ex. 26-3). As explained above, on January 14, 1997, Dr. Sedgewick considered it "reasonable" that claimant's "low back claim no longer relates to his 1991 injury" and also thought it "reasonable" for claimant to "file a new claim for musculoligamentous strain for the new injury." (Ex. 33).

Thus, as of the date of the denial, the record is devoid of any medical evidence relating claimant's condition to an April 3, 1997 work injury. That is, although Kemper evidently was relying on medical evidence generated months before its denial, there is nothing in the record showing that claimant's need for treatment was caused by an April 3, 1997 work injury at the time Kemper issued its denial. Furthermore, the 801 itself indicated that claimant had sustained a "reinjury" of his 1991 condition.

Based on evidence that claimant had preexisting conditions, the absence of evidence at the time of the denial relating claimant's condition to an April 3, 1997 event, and the reference in the 801 to the 1991 injury, we conclude that Kemper had legitimate doubt as to its liability when it issued the denial.

Finally, claimant's counsel is entitled to an assessed fee for services on review with regard to the compensability of the low back condition. ORS 656.382(2); *Laura Maderos*, 48 Van Natta 538, *on recon* 48 Van Natta 838 (1996) (even though overall compensation reduced on review, attorney fee awarded pursuant to ORS 656.382(2) because compensation was not reduced with respect to a particular condition). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review with regard to the compensable condition is $750, payable by Kemper. In reaching this conclusion, we have particularly considered the time devoted to this compensability issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 30, 1998 is reversed in part and affirmed in part. Those portions setting aside Safeco's denial and Kemper's denial of the left knee and right inguinal hernia conditions are reversed. Those denials are reinstated and upheld. The ALJ's penalty awards and the

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[2] In reaching our conclusions regarding the non-compensability of claimant's left knee and hernia conditions, we acknowledge the ALJ's demeanor-based credibility finding concerning claimant's testimony. As a general rule, we defer to such findings. Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991). Nonetheless, where, as here, the critical issue is dependent on the persuasive weight to be accorded to the medical opinions addressing claimant's conditions and their relationship to its work activities, as well as the accuracy and completeness of the histories provided to those medical experts, we do not consider the ALJ's credibility finding to be determinative.

attorney fee awards for overturning Safeco's denial and Kemper's denial of the left knee and right inguinal hernia conditions are also reversed. The remainder of the order is affirmed. For services on review concerning the low back condition, claimant's attorney is awarded an assessed fee of $750, to be paid by Kemper.

Board Member Polich dissenting in part.

I disagree with the majority that claimant did not prove compensability of his left knee and right groin injuries. I would affirm the ALJ's conclusions that claimant carried his burden of proof for these conditions. Thus, I dissent from those portions of the majority's order that find to the contrary.

First, the ALJ explicitly found claimant to be "a credible witness based on his demeanor and manner of testifying." Generally, the Board defers to the ALJ's determination of credibility when based on demeanor. *E.g., Erck v. Brown Oldsmobile*, 311 Or 519, 526 (1991). Because the ALJ had the opportunity to observe claimant's testimony, he is in the best position to assess credibility and, thus, the ALJ's determination is entitled to considerable weight. *See, e.g., Bragger v. Oregon Trail Savings*, 275 Or 219, 221 (1976).

Here, claimant testified that he felt acute pain in the low back, lower abdomen, and left knee at the time of the April 3, 1997 event. (Tr. 17). Claimant further stated that, although the low back pain became better, symptoms in his right groin and left knee eventually worsened, and he sought treatment for those conditions. (*Id.* at 21, 22).

In finding that the April 3, 1997 injury was the major contributing cause of the left knee and right groin conditions, Dr. Gritzka and Dr. Braun relied on a history that claimant felt the onset of pain in these areas on April 3, 1997. Because this history is consistent with claimant's credible testimony, the physicians relied on an accurate history in rendering their opinions. Thus, these physicians provided persuasive opinions and establish the compensability of claimant's left knee and right groin conditions.

In the Matter of the Compensation of
KIMBERLY A. COX, Claimant
WCB Case No. 98-06824
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's occupational disease claim for a bilateral hand, wrist, forearm and shoulder condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation.

The ALJ set aside the employer's denial of claimant's occupational disease claim. In doing so, the ALJ determined that employment conditions were the major contributing cause of claimant's condition and need for treatment. *See Tripp v. Ridge Runner Timber Services*, 89 Or App 355, 358 (1988). As support for this determination, the ALJ relied on the medical opinions of claimant's current attending physician, Dr. Coe, and an examining physician, Dr. Hunt.

On review, the employer contends that Dr. Hunt's opinion does not support the ALJ's compensability finding because he changed his opinion on causation. We disagree.

On February 13, 1998, Dr. Hunt initially concluded that claimant's work activities were the major contributing cause of claimant's symptoms. (Ex. 27-8). The question presented by the employer is whether Dr. Hunt's subsequent opinion in November 1998 represents a change of opinion . We do not believe so. At that time, Dr. Hunt was asked to review the opinion of another attending physician, Dr. Mara, who opined that claimant experienced pain because she was not suited for the kind of work activity she performed. Dr. Hunt replied:

> "I find that if Dr. Mara does concur with the statements in the letter to him dated 11/25/98, that they are not unreasonable as to an opinion. My problem is that we have no science to support his reasonable opinion or a contrary opinion." (Ex. 46-2).

We find that, while Dr. Hunt acknowledged that Dr. Mara's opinion was reasonable, Dr. Hunt did not retreat from his prior opinion. Thus, we conclude that the November 1998 report does not represent a change in Dr. Hunt's previous opinion . Accordingly, we agree with the ALJ that Dr. Hunt's opinion as a whole supports compensability.

Moreover, we further find that Dr. Mara's opinion is not incompatible with the ALJ's compensability finding. Dr. Mara opined that claimant had pain because she was performing work she was not capable of physically performing (an opinion shared by another attending physician, Dr. Stewart). (Exs. 45, 47-2). Implicit within this opinion is an acknowledgment that claimant's work activity did provoke symptomatology. Those symptoms in turn prompted claimant to seek medical treatment for a condition variously diagnosed as radial tunnel syndrome, carpal tunnel syndrome, tendinitis, and overuse syndrome. However claimant's condition is diagnosed, we agree with the ALJ that claimant's work activities are the major contributing cause of her condition and need for treatment and, thus, that the occupational disease claim is compensable. *See Tripp v. Ridge Runner Timber Services*, 89 Or App at 358 (lack of a definitive diagnosis does not defeat an occupational disease claim); *see also Frances M. McLaughlin*, 49 Van Natta 1112, *on recon* 49 Van Natta 1786 (1997).

Accordingly, we affirm.[1]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief, including counsel's representation of the time spent on the case), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 22, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,500.

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[1] The employer alleges that a videotape of claimant engaging in various off-the-job activities supports a finding that work was not the major contributing cause of her bilateral upper extremity condition. We disagree. After viewing the surveillance film, we are not persuaded that this evidence fatally undermines the medical evidence supporting the ALJ's findings in light of claimant's testimony at hearing. (Trs. 74-78).

In the Matter of the Compensation of
ELEANOR I. CROCKETT, Claimant
WCB Case No. 98-08382
ORDER ON REVIEW
Cathcart & Borden, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its current condition denial as procedurally invalid; and (2) assessed a penalty for an allegedly unreasonable denial. On review, the issues are the procedural validity of the denial, if valid, compensability, and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except we correct the ALJ's findings regarding the October 5, 1998 Notice of Acceptance to read: "This letter is to advise you that we are accepting your claim for cervical/thoracic strain with degenerative disc disease or [sic] the cervical and thoracic spine." (Ex. 25-2).

CONCLUSIONS OF LAW AND OPINION

Scope of Acceptance/Procedural Validity of Denial

The employer's claim examiner issued a Notice of Acceptance for "cervical/thoracic strain with degenerative disc disease." At hearing, the claim examiner testified that this notice was sent in error and that the condition intended to have been accepted was "cervicodorsal strain combined with degenerative disc disease of the cervical spine."

After the acceptance, the claim examiner issued a denial stating that claimant's "current condition requiring treatment and disability is a result of your preexisting degenerative disc disease." The ALJ agreed with claimant that, based on the Notice of Acceptance received by claimant, the accepted condition was "cervical/thoracic strain with degenerative disc disease." The ALJ further found that the denial did not comply with ORS 656.262(7)(b) because there was no evidence that the accepted condition combined with a preexisting condition. Consequently, the ALJ set aside the denial as procedurally invalid.

On review, the employer continues to argue that, because the record shows that it intended to accept a combined condition, it should not be held to the erroneously issued Notice of Acceptance. According to the employer, having accepted a combined condition, its denial is procedurally proper.

As a general rule, whether an acceptance occurs is an issue of fact. *SAIF v. Tull*, 113 Or App 449, 454 (1992). "Acceptance" has been defined as an act through which the insurer acknowledges responsibility for the claim and obligates itself to provide the benefits due under the law. *Gene C. Dalton*, 43 Van Natta 1191 (1991).

Here, there is no dispute that the employer issued an acceptance for "cervical/thoracic strain with degenerative disc disease." Although there also is evidence it intended to accept a different condition, this was the condition for which it acknowledged responsibility and obligated itself to provide benefits. Consequently, we find that, as a factual matter, the employer accepted "cervical/thoracic strain with degenerative disc disease." In the absence of evidence that it accepted any other condition (by providing notice of responsibility and obligation to provide benefits), we agree with the ALJ that the acceptance is limited to this condition.

Under ORS 656.262(7)(b), after a worker's claim has been accepted, the carrier "must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed." In *Tracey A. Blamires*, 50 Van Natta 1793, *on recon* 50 Van Natta 2273 (1998), we construed the statute as providing that, whether or not the carrier has accepted a combined condition, the carrier may avail itself of the "pre-closure" denial procedure in ORS 656.262(7)(b) whenever the medical evidence establishes that a claimant's accepted injury has combined with a preexisting condition to cause or prolong disability or a need for treatment on an open

claim. In so holding, we explained that if the medical evidence establishes a combined condition, the carrier is authorized and statutorily required to issue a denial when the accepted injury is no longer the major cause of the worker's combined condition before the claim may be closed.

The medical record in this case shows that claimant's degenerative disc disease combined with an initial soft tissue injury and that the degenerative condition is the major contributing cause of claimant's current need for treatment. (Ex. 27). We agree with the ALJ that such evidence does not show that the accepted condition of "cervical/thoracic strain with degenerative disc disease" combined with a "preexisting condition." Thus, we also conclude that ORS 656.262(7)(b) does not allow for a "pre-closure" denial in this case and set aside the denial as procedurally invalid.

Penalty

The ALJ also assessed a penalty on the basis that the denial was unreasonable. Specifically, the ALJ found that a penalty was appropriate because "there was no medical evidence in this record that provided any 'legitimate doubt' of the liability of this claim because there was no evidence that any other condition had combined with the condition which the claims representative had accepted (cervical/thoracic strain with degenerative disc disease)." The employer challenges this conclusion, asserting that, because the acceptance was not intended, the denial was not unreasonable.

A carrier is liable for a penalty when it "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). In determining whether a denial is unreasonable, the question is whether the carrier had a legitimate doubt as to its liability at the time of the denial. *Brown v. Argonaut Insurance Company*, 93 Or App 588, 591 (1988). "Unreasonableness" and "legitimate doubt" are to be considered in light of all the evidence available at the time of the denial. *Id.*

Here, the claim examiner testified that she had intended to accept a claim for "cervicodorsal strain combined with degenerative disc disease of the cervical spine" and that the acceptance that actually issued was in error. (Tr. 20-22). The claim examiner also testified that she was not aware that the incorrect acceptance had issued until the day of hearing. (*Id.* at 21). That testimony is supported by "Activity Notes" indicating that the accepted condition was "cervicodorsal strain combined with degenerative disc disease of the cervical spine." (Ex. 22A-1).

Based on the unrebutted evidence showing that the condition actually accepted was in error and that the intended acceptance would have allowed the employer to issue a proper denial under ORS 656.262(7)(b), we find that the employer had "legitimate doubt" when it issued the denial. That is, we find that the employer was not aware of its mistake in processing the claim and, along with medical evidence showing that the "preexisting condition" was the major cause of the combined condition, it had "legitimate doubt" of its liability when it issued the current condition denial. Therefore, we conclude that the denial is not unreasonable and a penalty is not warranted.

Finally, claimant's attorney is entitled to an assessed fee for services on review with regard to the issue of scope of acceptance/procedural validity of the denial. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding this issue is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 20, 1999 is affirmed in part and reversed in part. That portion assessing a penalty is reversed. The remainder of the order is affirmed. For services on review concerning the issue of scope of acceptance/procedural validity of the denial, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the self-insured employer.

Board Member Phillips Polich dissenting in part.

I disagree with that portion of the majority's order reversing the ALJ's assessment of a penalty. Specifically, I would not conclude that the claim examiner's ignorance concerning the acceptance that actually issued provides the employer with "legitimate doubt." Whether or not the claim examiner intended to issue the acceptance, the fact remains that the acceptance it issued was not the kind that allowed the employer to then deny claimant's current condition.

In other words, I would not include the claim examiner's intentions or mistaken belief when determining "legitimate doubt." Based on the *facts* of this case, the employer could not have a "legitimate doubt" that it was liable for claimant's current condition in light of its acceptance. The fact that the claim adjuster referred to her computer activity notes, which were inaccurate, versus the claims file does not equate to "legitimate doubt." Thus, I would conclude that the denial was unreasonable and the employer should be assessed a penalty.

Because the majority comes to a different conclusion, I dissent.

In the Matter of the Complying Status of
O.T. SHAW and ROY W. HAUSER, Employer
WCB Case No. 98-06724

and, In the Matter of the Compensation of
WCB Case No. 98-06725
CURTIS W. CROFT, Claimant
ORDER ON REVIEW
Daniel Simcoe, Attorney

Reviewed by Board Members Biehl and Haynes.

The noncomplying employer, O.T. Shaw and Roy W. Hauser, requests review of Administrative Law Judge (ALJ) Stephen D. Brown's order that dismissed as untimely its request for hearing concerning the SAIF Corporation's acceptance of claimant's injury claim. On review, the issues are jurisdiction and timeliness. We affirm.

FINDINGS OF FACT

In late May or early June 1995, claimant was hired by O.T. Shaw and Roy W. Hauser to perform logging work. On June 15, 1996, as he was bucking a tree with a chain saw, claimant lost his footing. He fell forward and amputated the distal end of his left middle finger with the saw blade.

Claimant completed an 801 form on September 22, 1996. (Ex. 5). The Department investigated the claim and, on October 23, 1996, issued an order declaring O.T. Shaw and Roy Hauser a noncomplying employer during the period from May 15, 1996 to October 11, 1996. (Exs. 6, 6AA).

The claim was referred to SAIF, which accepted the claim as a disabling injury on November 4, 1996. (Ex. 6A).

Following the Department's noncompliance order, O.T. Shaw and Roy Hauser requested a hearing, which was designated as WCB Case Nos. 97-00302 and 97-00303. On December 26, 1996, the employer and the Department entered into an agreement to reduce the civil penalty amount. (Exs. 6C, 7).

In a January 23, 1997 letter to the Department referencing Case No. 97-00302, the noncomplying employer's counsel acknowledged that the matter had been resolved and that the hearing request should be dismissed. The noncomplying employer's counsel expressed his intention to "get this matter removed from the docket" unless there were other issues outstanding which would prevent dismissal of the hearing request. (Ex. 6C). Thereafter, on January 31, 1997, the Department filed a motion for dismissal in WCB Case No. 97-00303, based upon the parties' agreement to reduce the civil penalty amount. (Ex. 7).

On March 18, 1997, ALJ Mongrain issued an Order of Dismissal, dismissing WCB Case Nos. 97-00302 and 97-00303. The order indicated that WCB Case No. 97-00303 had been resolved by a stipulated agreement and that the request for hearing in WCB Case No. 97-00302 had been withdrawn.

Claimant's claim was closed pursuant to a March 26, 1997 Notice of Closure, awarding temporary disability and 68 percent (14.96 degrees) scheduled permanent disability for the left middle finger.

On July 27, 1998, O.T. Shaw and Roy W. Hauser requested a hearing challenging claimant's right to receive compensation and SAIF's processing of the claim.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the noncomplying employer's July 27, 1998 request for hearing was not timely under ORS 656.054(1). On review, the noncomplying employer contends that it has preserved its right to object to the claim because it previously requested a hearing on the compensability issue in December 1996. Like the ALJ, we find the noncomplying employer's request for hearing is untimely.

ORS 656.054(1) specifically limits the time in which a noncomplying employer may object to the claim: the noncomplying employer may request a hearing "anytime within which the claim may be accepted or denied as provided in ORS 656.262." ORS 656.262(6)(a) gives a carrier 90 days to accept or deny the claim. Thus, in this case, pursuant to ORS 656.054(1) and 656.262(6)(a), the noncomplying employer had 90 days from the date the claim was referred to SAIF (sometime between October 23, 1996 and November 4, 1996) to challenge the compensability of claimant's injury.[1]

Although the noncomplying employer requested a hearing in late1996, the record does not disclose whether it raised an objection to the compensability of the claim. But the noncomplying employer's counsel's January 23, 1997 letter to the Department's counsel (which referenced WCB Case No. 97-00302), indicated that the parties' agreement to reduce the civil penalty amount "resolves the pending hearing." (*See* Ex. 6C). In other words, this correspondence suggests that the noncompliance order was the only outstanding issue. In any event, the noncomplying employer did not object to the Department's Motion to Dismiss (which referenced WCB Case No 97-00303), nor did it appeal ALJ Mongrain's order, which dismissed both matters (WCB Case Nos. 97-00302, based on a "withdrawal of the request for hearing" and 97-00303, based on a "stipulated agreement.").

Furthermore, even if the noncomplying employer had raised the compensability issue in connection with its December 1996 request(s) for hearing, ALJ Mongrain's order does not indicate that this (or any) issue was preserved for later adjudication. Thus, even assuming that the noncomplying employer challenged compensability in its initial request for hearing and that the request for hearing was timely under ORS 656.054(1) and 656.262(4)(a), that hearing request has been dismissed by a final, appealable order. Because that order was not appealed, the dismissal of the hearing request has become final. ORS 656.289(3); ORS 656.740(4). The noncomplying employer cannot "revive" its right to object to the claim by requesting another hearing after the 90 day time period has passed.

Citing *Linda M. Harper*, 50 Van Natta 416 (1998), the noncomplying employer argues that, notwithstanding ORS 656.054(1), it is entitled to request a hearing "at any time" under ORS 656.283(1). Alternatively, the noncomplying employer asserts that its request is timely under ORS 656.319(6).[2] Neither contention has merit.

First, *Linda M. Harper* is legally distinguishable. There, we held that the 1991 amendments to ORS 656.054(1) (including the time limit in which a noncomplying employer may request a hearing objecting to the claim) did not apply to the claimant's claim because her injuries occurred prior to the statute's effective date. We concluded that, in the absence of any other applicable provision limiting the noncomplying employer's right to contest compensability, the noncomplying employer could request a hearing "at any time" under ORS 656.283. 50 Van Natta at 418-19.

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[1] The noncomplying employer does not assert that it did not receive proper notice of the referral to SAIF or that it was unaware of its right to object to the claim. *See Thomas R. Lee*, 46 Van Natta 2269 (1994) (where proper notice of the referral is given to the noncomplying employer, the noncomplying employer has 90 days after the claim is referred to SAIF to request a hearing objecting to the claim; a hearing request filed more than 90 days from the referral is not timely).

[2] This provision, which was enacted in 1995, provides as follows:

"A hearing for failure to process or an allegation that the claim was processed incorrectly shall not be granted unless the request for hearing is filed within two years after the alleged action or inaction occurred."

The noncomplying employer asserts that SAIF incorrectly processed the claim in November 1996 by accepting an allegedly noncompensable injury.

In this case, however, claimant's injury occurred (and the claim was filed and accepted) in 1996, well after the September 1991 effective date of the amendments to ORS 656.054(1). Therefore, unlike *Harper*, ORS 656.054(1) is applicable and the noncomplying employer's right to challenge compensability is limited to 90 days from the date the Department referred the claim to SAIF. *See Thomas R. Lee*, 46 Van Natta 69 (1994) (applying amended ORS 656.054(1) to a 1992 injury claim).

Second, although ORS 656.319(6) sets a two year limitation for requesting a hearing pertaining to incorrect claim processing, we do not construe this provision as extending the time limitation on a noncomplying employer's challenge to compensability. ORS 656.054(1) deals specifically with the time limitation on a noncomplying employer's request for hearing to object to a claim; therefore, it governs over the more general provisions of ORS 656.319(6).[3] ORS 174.020 ("when a general and particular provision are inconsistent, the latter is paramount to the former"); *see also Smith v. Multnomah County Board of Commissioners*, 318 Or 302, 309 (1994) (explaining that a specific statute takes precedence over an inconsistent general statute related to the same subject).

Accordingly, as the ALJ found, the noncomplying employer's July 27, 1998 request for hearing objecting to SAIF's November 1996 acceptance of claimant's claim is untimely.

ORDER

The ALJ's order dated December 17, 1998 is affirmed.

[3] As discussed in Member Haynes special concurrence in *Linda L. Harper*, 50 Van Natta at 420, a noncomplying employer's request for hearing challenging compensability could be construed as "an allegation that the claim was processed incorrectly." But, because application of ORS 656.319(6) would lead to a different (two year) time limitation, the rules of statutory construction require us to give effect to the more specific provision, ORS 656.054(1).

In the Matter of the Compensation of
MICHAEL S. DOLAN, Claimant
WCB Case No. 98-05111
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that awarded a $3,500 attorney fee for claimant's counsel's services at hearing. SAIF also moves for remand. On review, the issues are remand and attorney fees.

We deny SAIF's motion for remand and adopt and affirm the ALJ's order with the following supplementation.

Claimant requested a hearing from SAIF's aggravation/current condition denial of his claim for a herniated lumbar disk. The ALJ set aside SAIF's denial and awarded claimant's attorney a $3,500 assessed attorney fee. The ALJ provided no rationale in support of the attorney fee award. On review, SAIF asserts that the ALJ failed to provide a sufficient explanation for the assessed fee, and it seeks remand to the ALJ. Specifically, SAIF argues that the ALJ must make findings regarding each of the eight factors in OAR 438-015-0010(4), draw conclusions from those findings, and demonstrate how he weighed those conclusions in determining a reasonable assessed attorney fee.[1]

[1] SAIF did not waive its right to object to the attorney fee award by failing to raise that issue before the ALJ. *Hays v. Tillamook County General Hospital*, 160 Or App 55 (1999) (Board is authorized to consider a carrier's appeal of an ALJ's attorney fee award even if the carrier does not object to the attorney fee request at the hearings level).

We reject SAIF's argument, as we have in prior cases. At hearing, the parties did not submit to the ALJ any argument as to how the rule-based factors should be weighed in determining a reasonable fee. Nor did claimant made any specific attorney fee request. Under these circumstances, the ALJ would have satisfied OAR 438-015-0010(4) by citing that rule and briefly discussing the rule-based factors he particularly considered in determining the amount of the fee. *See Donna R. Grerson,* 51 Van Natta 679 (1999); *Daryl L. Underwood*, 50 Van Natta 2330 (1998). *Accord McCarthy v. Oregon Freeze Dry*, 327 Or 84, *adhered to on recon*, 327 Or 185 (1998).

Because the ALJ failed to include even this limited rationale, his order does not provide a sufficient basis for determining how he arrived at $3,500 as a reasonable fee. Nevertheless, remand is not warranted because the record is sufficiently developed to review the ALJ's attorney fee award, and we have the authority to modify or supplement the ALJ's findings and conclusions. ORS 656.295(5) and (6); *Underwood*, 50 Van Natta at 2332.

We affirm the ALJ's attorney fee award based on the following supplementary rationale based on the rule-based factors in OAR 438-015-0010(4).[2] The documentary record consists of more than fifty exhibits, including a dispositive September 16, 1998 medical opinion from Dr. Brett that was generated by claimant's attorney. The hearing lasted one hour and forty minutes and involved claimant's attorney's direct examination of claimant and two other witnesses. Based on "compensability" disputes generally litigated before this forum, we find the issue presented in this case to be of average complexity. The value of the interest involved and the benefit secured for claimant are substantial. Finally, there was a risk that claimant's counsel might go uncompensated, given the "major contributing cause" burden of proof, and the opinion of Drs. Williams and Mass that claimant's compensable injury is no longer the major contributing cause of his current symptoms and need for treatment.

In summary, after particularly considering the amount of time devoted to the compensability issue, the nature of the proceedings, the complexity of the issue, the value of the interest and benefit to claimant, and the risk that claimant's counsel might go uncompensated, we find that $3,500 is a reasonable fee for claimant's attorney's services at hearing.[3]

ORDER

The ALJ's order dated December 10, 1998 is affirmed.

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[2] The enumerated rule-based factors are: the time devoted to the case; the complexity of the issue involved; the value of the interest involved; the skill of the attorneys; the nature of the proceedings; the benefit secured for the represented party; the risk in a particular case that an attorney's efforts may go uncompensated; and the assertion of frivolous issues or defenses.

[3] Because SAIF challenged only the attorney fee award on review and attorney fees are not "compensation" for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for his counsel's services on review. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

In the Matter of the Compensation of
RICHARD ENSINGER, Claimant
WCB Case No. 98-07535
ORDER ON REVIEW (REMANDING)
Pozzi, Wilson, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order dismissing his request for hearing and, on reconsideration, declining to postpone the hearing. On review, the issues are postponement and dismissal. We vacate the ALJ's order and remand.

FINDINGS OF FACT

Claimant requested a hearing on a denial. A hearing was scheduled for December 16, 1998 at 9:00 a.m.

At the time and place specified for hearing, attorneys for claimant and the insurer appeared. Claimant was not present.

Claimant's attorney indicated that he had expected claimant to attend and had no explanation for his failure to arrive. At 10:00 a.m., the insurer moved to dismiss the case as being abandoned pursuant to OAR 438-006-0071(2). Claimant's attorney requested postponement. On January 7, 1999, the ALJ issued an Order of Dismissal, granting the insurer's motion to dismiss.

On January 22, 1999, claimant requested reconsideration. Claimant had received the hearing notice and expected to attend the hearing as scheduled. Attached affidavits explained that, because of a misunderstanding regarding an alarm clock, claimant had overslept, missing the hearing. Because the home where claimant was staying did not have outgoing long distance service, it was not until 11:00 a.m. before claimant contacted his attorney.

On February 2, 1999, the ALJ reconsidered his order of dismissal and denied claimant's request for postponement of the hearing on the basis that claimant had failed to establish good cause for his failure to appear at the hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ's orders interpreted OAR 438-006-0071 to require dismissal of a request for hearing, unless a postponement is appropriate, whenever claimant appears through counsel at hearing but does not personally attend the hearing.

OAR 438-006-0071(2) provides:

> "Unjustified failure of a party or the party's representative to attend a scheduled hearing is a waiver of appearance. If the party that waives appearance is the party that requested the hearing, the Administrative Law Judge shall dismiss the request for hearing as having been abandoned unless extraordinary circumstances justify postponement or continuance of the hearing."

Here, claimant personally failed to appear. However, claimant did appear by counsel. OAR 438-006-0071 does not provide authority for dismissal of a hearing request for failure of a claimant to appear at hearing if claimant's attorney appears on his or her behalf. *E.g., Randall E. Hug,* 45 Van Natta 1802 (1993); *Mary E. Williams,* 42 Van Natta 2765, 2767 (1990); *Jose Arisqueta-Martinez,* 42 Van Natta 2072 (1990). *See also Williams v. SAIF,* 99 Or App 367 (1989), *reversed and remanded Williams v. SAIF,* 310 Or 320 (1990) (neither *former* OAR 438-06-071[1] nor ORS 656.283(7) require a claimant to personally attend a hearing; therefore, an ALJ is not authorized to dismiss a hearing request for the failure of a claimant to appear if claimant's counsel appears on his or her behalf).

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[1] *Former* OAR 438-06-071 has been renumbered as OAR 438-006-0071.

Inasmuch as claimant's attorney appeared to prosecute claimant's case, we conclude that the request for hearing should not have been dismissed. Therefore, we remand for a hearing.

We have held that the procedure for conduct of the hearing on remand in cases such as this one depends on whether or not a postponement should have been granted. If a postponement should have been granted, then the hearing should be conducted as any other hearing. If, however, a postponement should have been denied, then no exhibit may be received which was not submitted in connection with the prior hearing and no witness, including claimant, may testify if that witness was not available to testify at the prior hearing. *See Mario Miranda*, 42 Van Natta 405 (1990).

In *Lynette K. Norton*, 42 Van Natta 621 (1990), we stated that, although *former* OAR 438-06-081 (since renumbered to OAR 438-006-0081) allowed postponements only in extraordinary circumstances, the rule must not be applied with unforgiving rigidity. We noted that the rule listed a number of circumstances that did not justify postponement. We observed that a claimant's mistake concerning the time of, and late arrival at the hearing, was not one of those exclusions. Therefore, we reasoned that the justification for a postponement under such circumstances must be considered in light of the facts of the particular situation.

Here, we conclude that the circumstances in this case did not warrant postponement. As the ALJ observed, although the sequence of events that led to claimant's failure to appear are complicated, essentially he overslept. Even assuming that claimant's mistake in oversleeping was due to a good faith expection that he would be awakened in time to appear at the hearing, the fact remains that claimant should have been aware of the importance of arriving to attend the hearing at the appropriate time or to notify his counsel or the ALJ of his situation in advance of the hearing. We conclude that, under the circumstances of this case, the ALJ properly declined to allow a postponement. Accordingly, the effect of this decision is that claimant has waived his right to testify at the hearing. *Anthony B. Beardslee*, 42 Van Natta 965 (1990); *Denette D. Dale*, 41 Van Natta 2179 (1989).

Consequently, we vacate the ALJ's orders and remand to ALJ Otto for a hearing. At that hearing, the ALJ will determine what exhibits should be received, but no exhibits shall be received that were not prepared for submission as evidence at the prior hearing, nor shall any witness, including claimant, be permitted to testify who was not prepared to testify at the prior hearing. Thereafter, the ALJ shall issue a final, appealable order.

ORDER

The ALJ's order, dated January 7, 1999, as reconsidered February 2, 1999, is vacated. This case is remanded to ALJ Otto for further proceedings consistent with this order.

In the Matter of the Compensation of
LADONNA H. FITZ, Claimant
WCB Case No. 98-04985
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Mills' order that assessed a $3,750 fee for claimant's counsel's services at hearing. SAIF also moves for remand. On review, the issues are remand and attorney fees.

We deny SAIF's motion for remand, and adopt and affirm the ALJ's order with the following supplementation.

Claimant requested a hearing challenging SAIF's denial of her right wrist tenosynovitis claim. Following the hearing, the ALJ set aside SAIF's denial and assessed an attorney fee of $3,750 "based upon the principles and factors set forth in OAR 438-015-0010."

On review, SAIF asserts that the ALJ failed to provide a sufficient explanation for the assessed fee, and seeks remand to the ALJ. Contrary to SAIF's contention, an ALJ is not required to make specific findings regarding each of the factors set forth in OAR 438-015-0010(4) where, as here, there was no specific attorney fee requested and the parties did not submit arguments at hearing addressing the factors to be weighed in determining a reasonable fee. *See SAIF v. Bacon*, 160 Or App 596 (1999); *Daryl L. Underwood*, 50 Van Natta 2330 (1998). The ALJ satisfies his or her obligation to make findings in a case by including in the order a brief description or citation to the rule-based factor or factors the ALJ relied on in determining the attorney fee awarded. *Id.* (citing *McCarthy v. Oregon Freeze Dry*, 327 Or 84, *adhered to on recon*, 327 Or 185 (1998)).

Here, although the ALJ cited the applicable rule (OAR 438-015-0010(4)), he did not identify the factors he considered in awarding the attorney fee. In other words, the ALJ did not discuss any of the specific rule-based factors, such as the value of the interest involved, the time devoted to the case, the complexity of the issue, the benefit secured, the skill of the attorneys, the nature of the proceedings or the risk that the claimant's counsel's efforts might go uncompensated. Because the ALJ's order is devoid of any explanation of his application of the factors in determining the attorney fee in this case, we find the ALJ's reasoning insufficient to determine how he arrived at $3,750 as a reasonable fee. *See Donna R. Grierson*, 51 Van Natta 679 (1999) (Board Chair Bock specially concurring).

Even though we find the ALJ's attorney fee discussion lacking in this case, we do not find the record to be improperly, incompletely or otherwise insufficiently developed. *See* ORS 656.295(5). In other words, because we are authorized to modify or supplement the ALJ's findings and conclusions under ORS 656.295(6), it is not necessary to remand this case to the ALJ for supplementation of findings regarding the attorney fee award. Consequently, we deny SAIF's motion to remand.

We provide the following additional reasoning concerning the attorney fee award for claimant's counsel's services at hearing. A hearing convened that lasted approximately one hour and 50 minutes. Claimant and two defense witnesses testified. The record consists of 13 exhibits, one of which claimant submitted. Based on compensability disputes generally litigated before this forum, we find the issue presented in this case to be of average complexity. The value of the interest involved and the benefit secured for claimant are significant. The attorneys involved in this matter skillfully litigated the compensability issue. Furthermore, there was a risk that claimant's counsel might go uncompensated, given the testimony of the witnesses SAIF presented.

Consequently, after considering the factors set forth in OAR 438-015-0010(4), including the time expended (as represented by the record at hearing), the benefit secured, the complexity of the issue involved, and the risk that claimant's counsel might go uncompensated, we agree with the ALJ that $3,750 is a reasonable fee for claimant's counsel's services at hearing. We, therefore, affirm the ALJ's attorney fee award.[1]

ORDER

The ALJ's order dated March 1, 1999 is affirmed.

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[1] Because SAIF challenged only the attorney fee award on review and attorney fees are not "compensation" for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for his counsel's services on review. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

In the Matter of the Compensation of
JOAN L. FISHER, Deceased, Claimant
WCB Case No. 97-01390
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Bottini, Bottini & Oswald, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The deceased claimant (claimant) requests review of Administrative Law Judge (ALJ) Black's order that: (1) found that the Workers' Compensation Department (WCD) had authority to issue a corrected Determination Order; and (2) denied claimant's request to reinstate a prior Determination Order. On review, the issues are propriety of the corrected Determination Order and scope of review. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant had long-standing claims for bilateral hand injury. In September 1996, a Determination Order closed her claim and awarded 32 percent scheduled permanent disability for the left forearm and, (after a 20 percent offset for a prior award), 6 percent scheduled permanent disability for the right forearm. Claimant's right arm award was increased to 12 percent on reconsideration (offsetting the same 20 percent).

Claimant had right hand surgery in March 1997. Her claim was reopened for vocational training, but she died in October 1997. Claim processing continued. A November 25, 1997 Determination Order awarded 35 percent scheduled permanent disability for claimant's right forearm (and directed the employer to pay $11,433.65). That order did not indicate that the Department considered or offset claimant's prior awards for her preexisting disability.

On December 3, 1997, the employer asked the Department to correct the Determination Order, seeking a 32 percent offset (based on the previous 20 percent and 12 percent awards). Claimant responded, contending that the "after offset" award should be 23 percent.

On December 11, 1997, a corrected Determination Order issued, awarding 18 percent scheduled permanent disability. (Ex. 77). Neither party requested reconsideration, but claimant requested a hearing with the Board's Hearings Division.

The ALJ held that the Department had authority to correct the November 1997 Determination Order under OAR 436-030-0030(13) (WCD Admin. Order 96-052).[1]

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[1] OAR 436-030-0030(13) provides:

"The department may change or cancel any order it issues if it has made an inadvertent error or omission which affects the order only if request for reconsideration pursuant to these rules has not been made and the appeal rights have not expired. Determination Orders may be corrected or rescinded when:

"(a) The Determination Order contains a typographical or clerical error which includes discrepancies between the worksheet and the order;

"(b) Additional information has been received pertaining to the worker at or prior to the Determination Order including, but not limited to, wages or unemployment benefits previously paid the worker, actual time worked, periods of time loss, or medically stationary status at the time the Order was issued;

"(c) Additional information has been received pertaining to the permanent disability that pertains to the worker's condition prior to closure or was generated before the closure.

"(14) Requests for reconsideration of a Determination Order corrected pursuant to section (13) of this rule must be received within the statutory period. Requests for reconsideration of a corrected Determination Order may only address those areas changed by the corrected Order."

Claimant contends that the Department lacked jurisdiction to correct the November 1997 Determination Order under the rule and under ORS 656.268(5).[2] The employer responds that the Department had authority to correct errors or omissions affecting the Determination Order under OAR 436-030-0030(13) -- because the corrected order issued before the reconsideration appeal period expired and neither party had requested reconsideration. The employer also argues that the Hearings Division lacks authority to consider any issue relating to the December 11, 1997 corrected Determination Order, because it became final without a request for reconsideration.

We find that the November Determination Order contained a clerical error (because it failed to consider claimant's prior permanent disability awards) and therefore the Department properly issued the December 1997 corrected Determination Order. OAR 436-030-0030(13)(a); *see John L. Desmond*, 47 Van Natta 1575, 1576 (1995) (Where no one party requested reconsideration of the original order and the corrected order issued within the statutory time frame, the corrected order controls).

In addition, we agree with the employer that claimant was barred from challenging the corrected Determination Order, because she did not first request Department reconsideration.[3] ORS 656.268(8);[4] 656.283(7).[5] If claimant was dissatisfied with December 1997 corrected Determination Order, her remedy was to request Department reconsideration. ORS 656.268(5)(b). Because claimant did not request reconsideration of the corrected Determination Order before requesting a hearing, she is barred from challenging the order before the Board's Hearings Division. *See Edmund D. Moore*, 49 Van Natta 1426, 1427 (1997) (Where no one requested reconsideration of a Notice of Closure's temporary disability award, the parties were barred from "further litigating" that award under ORS 656.283(7) and 656.268(8)).

ORDER

The ALJ's order dated December 28, 1998 is affirmed.

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[2] ORS 656.268(5)(b) provides:

"If the worker, the insurer or self-insured employer objects to a determination order issued by the department, the objecting party must first request reconsideration of the order. The request for reconsideration must be made within 60 days of the date of the determination order."

[3] *See e.g., Roger R. Powers*, 49 Van Natta 1388, 1390, n.6 (1997) (*Former* "ORS 656.268(5) does not relate to jurisdiction to conduct a hearing, but to preservation of issues that may be raised at the hearing."); *see also Franzen v. Liberty Mut. Fire Ins. Co.*, 154 Or App 502, 506 (1998) ("The text of ORS 656.268(5) [(1993)] is clear: A party that objects to a determination order must request reconsideration of the order. If a party fails to raise an issue on reconsideration, it is foreclosed from objecting to the determination order for the first time at hearing.") (quoting *Guardado v. J.R. Simplot*, 137 Or App 95 (1995), *rev dis* 324 Or 177 (1996); *Diane's Foods v. Stephens*, 133 Or App 707, 708 (1995).

[4] ORS 656.268(8) provides:

"*No hearing shall be held* on any issue that was not raised and preserved before the department at reconsideration. However, issues arising out of the reconsideration order may be addressed and resolved at hearing." (Emphasis added).

[5] ORS 656.283(7) provides:

"Evidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, and *issues that were not raised by a party to the reconsideration may not be raised at hearing* unless the issue arises out of the reconsideration order itself. However, nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present the reconsideration record at hearing to establish by a preponderance of that evidence that the standards adopted pursuant to ORS 656.726 for evaluation of the worker's permanent disability were incorrectly applied in the reconsideration order pursuant to ORS 656.268." (Emphasis added).

In the Matter of the Compensation of
TINA M. HANSEN, Claimant
WCB Case No. 98-08333
ORDER ON REVIEW
Patrick K. Mackin, Claimant Attorney
Ronald W. Atwood & Associates, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Menashe's order that affirmed an Order on Reconsideration awarding 40 percent (76.8 degrees) scheduled permanent disability for loss of use or function of the right arm. The insurer also moves to remand the case for admission of additional evidence. On review, the issues are remand and extent of scheduled permanent disability.

We adopt and affirm the ALJ's order with the following supplementation addressing the insurer's motion for remand.

The insurer first issued a Notice of Acceptance for "(R) elbow radial head dislocation combined w/ preexisting chronic subluxation of radial head & a pseudoarticulation." Subsequent to the Notice of Closure, the insurer provided an updated Notice of Acceptance for "right elbow radial head dislocation combined with pre-existing chronic."

The ALJ characterized the updated notice as "incomplete" and read it "in conjunction with the original acceptance." The insurer contends that we should remand to the ALJ to admit evidence "explaining the discrepancy between the two Notices of Acceptance."

There are numerous problems with the insurer's argument. First, there is no indication that the insurer raised this issue at hearing. Generally, we do not consider issues that are not raised at hearing *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991) (Board can refuse to consider issues on review that are not raised at hearing).

Furthermore, there is no indication, or contention, that any evidence submitted on remand to the ALJ was not available at the time of hearing. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986) (to merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing). Finally, there is no indication, or contention, that, even if not available at time of hearing, any evidence to be submitted was part of the reconsideration record and, thus, admissible at hearing. *See Rogue Valley Medical Center v. McClearen*, 152 Or App 239, *rev den* 327 Or 123 (1998) (under ORS 656.283(7), in determining permanent disability, any evidence not submitted during the reconsideration process is inadmissible at a subsequent hearing).

For all these reasons, we deny the insurer's motion for remand.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 7, 1999 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
KEITH L. HART, Claimant
WCB Case No. 98-06541
ORDER OF DISMISSAL
Richard M. Walsh, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Claimant has requested review of Administrative Law Judge (ALJ) Kekauoha's April 26, 1999 order. We have reviewed this request to determine if we have jurisdiction to consider this matter. Because the record does not establish that the Board received a timely request for review within 30 days of the ALJ's order, we dismiss.

FINDINGS OF FACT

On April 26, 1999, the ALJ issued an order that upheld the self-insured employer's denial of compensability of claimant's current cervical disc condition. Claimant requested review of the ALJ's order. The request was accompanied by a certificate of service and mailing stating that claimant had mailed copies of the request to the Board and the parties on June 1, 1999. The Board received the request on June 3, 1999.

On June 4, 1999, the Board issued a computer-generated letter acknowledging receipt of claimant's request for review.

CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. *See* ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request be mailed or actual notice be received within the statutory period. *Argonaut Insurance Co. v. King*, 63 Or App 847, 852 (1983).

"Filing" of a request for review is the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing. OAR 438-005-0046(1)(a). If the request is not mailed by registered or certified mail and the request is actually received by the Board after the date for filing, it shall be presumed that the mailing was untimely unless the filing party establishes that the mailing was timely. OAR 438-005-0046(1)(b). Failure to timely file the request for review requires dismissal of the request for review. *Mosley v. Sacred Heart Hospital*, 113 Or App 234, 237 (1992).

Here, the 30th day after the ALJ's April 26, 1999 order was May 26, 1999. The Board did not receive the request for review until June 3, 1999, more than 30 days after the ALJ's order. Consequently, claimant's request for review was not timely "filed" with the Board. Accordingly, claimant's request for Board review is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARTIN HERNANDEZ, Claimant
WCB Case No. 98-06854
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that awarded 17 percent (25.5 degrees) scheduled permanent disability for loss of use or function of claimant's right upper extremity, whereas an Order on Reconsideration awarded none. On review, the issue is extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings."

CONCLUSIONS OF LAW AND OPINION

The insurer accepted claimant's claims for right hand tendonitis and neuritis (in 1992) and right upper extremity reflux sympathetic dystrophy (RSD) (in 1997). Claimant was medically stationary following a 1997 aggravation claim, on December 1, 1997. A March 20, 1998 Notice of Closure closed the aggravation claim and awarded 17 percent scheduled permanent disability for loss of use or function of the right wrist, based on claimant's findings at claim closure. Claimant requested reconsideration and appointment of a medical arbiter.

Dr. Farris, medical arbiter, examined claimant on June 27, 1998. Based on Dr. Farris' report, an Order on Reconsideration reduced claimant's permanent disability award to zero. Claimant requested a hearing.

The ALJ declined to rely on the medical arbiter's opinion. Although we disagree with the ALJ's reasoning and analysis, we reach the same result for different reasons.

Evaluation of a worker's disability is as of the date of issuance of the reconsideration order. ORS 656.283(7). Where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. *Orfan A. Babury*, 48 Van Natta 1687 (1996). This "preponderance of the evidence" must come from the findings of the attending physician or other physicians with whom the attending physician concurs. *See Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670 (1994). We have previously held that we do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment but, rather, rely on the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

Here, the insurer contends that claimant is entitled to *no* permanent disability. It does not argue that its own Notice of Closure incorrectly applied the standards for rating permanent disability, but that claimant's findings should not be rated because they are not due to the accepted conditions. We disagree.

Dr. Farris performed a medical arbiter's examination on June 27, 1998. She reported inconsistencies, variable responses, and lack of cooperation. Dr. Farris found claimant's right palm calluses and right arm musculature inconsistent with his "professed" decreased ability to use his right hand and opined that claimant's only injury-related objective finding was his surgical incision. Consequently, Dr. Farris concluded that claimant had no impairment due to his compensable tendonitis, neuritis, and RSD conditions.

We find Dr. Grant's opinion regarding claimant's permanent impairment more persuasive than Dr. Farris', for several reasons. First, Dr. Farris examined claimant only once, whereas Dr. Grant examined and treated claimant on numerous occasions beginning in January 1996. Second, as Dr. Grant explained (and Dr. Farris does not refute), RSD symptoms wax and wane. (Exs. 28, 32). Under these circumstances, considering Dr. Grant's opportunities to observe and treat claimant over time, we find that Dr. Grant was in a much better position to accurately evaluate the extent of claimant's injury-

related impairment. Third, because claimant kept working, despite his compensable conditions, we do not find his medically documented decreased ability to use his right hand inconsistent with calluses and muscle size. In other words, claimant's conditions did not *prevent* right upper extremity use (*e.g.*, work activities), but they did result in impairment -- *partial* loss of use or function of the upper extremity -- based on Dr. Grant's objective findings. In this regard, we also note that Dr. Grant's reasoning and conclusions relating claimant's findings and limitations to his work were materially consistent over time. (*See e.g.*, Exs. 11, 14, 18, 20, 21, 23, 24, 26, 28).

Finally, we note that Dr. Grant recorded findings of lost right upper extremity function on numerous occasions and he consistently related claimant's findings and limitations to his work exposure and diagnoses.[1] Under these circumstances, we conclude that Dr. Farris' conclusion of no impairment is not particularly persuasive (even if claimant did exhibit inconsistencies and/or nonphysiologic responses at Farris' examination[2]). Accordingly, we conclude that Dr. Grant's opinion supporting injury-related permanent impairment is based on objective findings, a complete and accurate history, and the doctor's expertise (including his understanding of the nature and variability of RSD symptoms). We also find Dr. Grant's opinion consistent with claimant's clinical course and diagnoses. Under these circumstances, we find Dr. Grant's opinion to be the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. Accordingly, we conclude that a preponderance of the medical evidence supports the Notice of Closure's permanent disability award.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 23, 1998 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the insurer.

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[1] (*See* Exs. 11, 14, 18, 20, 21, 23, 24, 26, 28; *see especially* Ex. 18-1, diagnosing right upper extremity RSD, "related to" previous right ulnar neuropathy at Guyan's canal).

[2] We also note Dr. Farris' comment that claimant's reporting was "incoherent to the point of not making sense." (Ex. 37-4). Considering Dr. Grant's (and the independent examiners') recommendation that claimant be evaluated by a Spanish-speaking physician (and the absence of evidence that Dr. Farris speaks Spanish), we interpret this reference to claimant's "incoherence" to be explained by language limitations.

In the Matter of the Compensation of
WILLIAM D. HOLMAN, Claimant
WCB Case Nos. 98-06014 & 98-05603
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that: (1) found that claimant's injury claim was untimely filed; and (2) upheld the SAIF Corporation's denial of his occupational disease claim for a left knee condition. On review, the issues are timeliness and compensability.

We adopt and affirm the ALJ's order with the following supplementation.

Claimant's counsel has submitted a letter indicating that claimant's whereabouts are unknown and that he has not kept in touch with his attorney. The letter also indicates that claimant's counsel believes that claimant has abandoned his claim. We have received SAIF's response to claimant's attorney's letter, as well as claimant's counsel's reply.

A timely request for review was filed by the attorney who represented claimant at hearing. Unlike the administrative rules pertaining to the hearing level, there is no rule allowing for dismissal of a request for Board review based on abandonment of the claim. Under such circumstances, in light of the fact that the timely-filed request for review has not been withdrawn, we have proceeded with our review and have adopted the ALJ's order.

ORDER

The ALJ's order dated February 8, 1999 is affirmed.

In the Matter of the Compensation of
JAMES J. LASCARI, Claimant
WCB Case No. 98-08048
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Thomas A. Andersen, Defense Attorney

Reviewed by Board Members Haynes, Bock and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that found his injury claim time-barred under ORS 656.265. On review, the issue is timeliness of the claim.

We adopt and affirm the ALJ's order with the following supplementation.

Claimant was injured on April 16, 1997 when a scaffolding on which he was standing fell to the ground.[1] He was taken to the hospital by ambulance and treated for left leg pain and contusions. On April 20, 1998, more than a year after this incident, he completed an 801 form asserting an injury to his left knee.

The insurer denied the claim asserting, among other things, that the claim filing was untimely under ORS 656.265(4). Claimant requested a hearing. In response to claimant's hearing request, the insurer moved to dismiss on the grounds the claim was untimely filed. A hearing was held to determine whether claimant provided some form of written notice to the employer within a year of the accident.

At the hearing, claimant testified that he recorded his accident in a construction project log book, which he turned over to Mr. Patterson, the employer's owner. (Tr. 15-16). Mr. Patterson testified that the log book reflected building notes and/or materials acquisition problems at the construction site, but did not document personnel matters or employee injuries. (Tr. 8-9). Mr. Patterson also testified that he did not retain the log book after the project was completed. (Tr. 9).

Claimant also testified that, in June 1997, he faxed three pages to the employer's business office--a copy of the ambulance bill and a hospital bill.[2] (Tr. 12-13, 22-24). In response, Mr. Patterson asserted that he did not receive any such bills by fax from claimant. (Tr. 32). Mr. Patterson also testified that the phone number reflected on Exhibit E (the two undated fax transmission reports) was not the employer's fax line, but rather the business office number. (Tr. 31)

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[1] Although the issue of claimant's status as a subject worker remains undetermined, the parties assumed, for purposes of the employer's motion to dismiss, that claimant was an employee rather than an independent contractor at the time of his injury. (Tr. 2).

[2] In support of this contention, claimant offered into evidence two *undated* fax "Transaction Reports." Both reports indicated that one page had been transmitted to a particular number. (Ex. E).

After considering the evidence presented, the ALJ was not persuaded that claimant provided timely written notice of the claim, as required by ORS 656.265.[3] The ALJ found that the claim was untimely filed.

On review, claimant contends that he was denied a full hearing, and that the ALJ should have made an express credibility determination concerning his testimony and that of Mr. Patterson. Alternatively, claimant maintains that he has established that the employer had timely written notice of the claim. We disagree with each contention.

As a preliminary matter, we note that an ALJ is not required to make an express credibility finding. *See, e.g., Samantha L. Spencer*, 49 Van Natta 280 (1997); *Lynn M. Elliott*, 41 Van Natta 2063 (1989) (an ALJ need not always make a credibility assessment to avoid remand). In this case, although the ALJ did not explicitly address the credibility issue, he found that claimant's uncorroborated testimony was insufficient to establish that timely written notice was given. After our review of the testimony and documentary evidence, we agree with the ALJ's assessment.

Claimant has the burden to prove by a preponderance of the evidence that the employer received some form of written notice of the claim within one year of the accident.[4] ORS 656.265(4). He has not done so. Indeed, even if we were to accept claimant's testimony that he noted the accident in the project log book, this fact, without more, does not prove timely notice. Claimant has not shown that the log book entry described when, where and how the injury occurred, as required by ORS 656.265(2).[5] Similarly, even if we accept claimant's testimony that he faxed two medical bills to the employer in June 1997, this fact, without more does not prove timely notice under the statute. The record does not establish that the allegedly faxed billings described when, where and how the injury occurred. Consequently, even if we found claimant's testimony credible, we would not be persuaded by this testimony alone that the employer received timely written notice of the claim.

ORDER

The ALJ's order dated January 14, 1999 is affirmed.

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[3] ORS 656.265(1) requires that the worker notify the employer of an accident resulting in an injury within 90 days of the accident. ORS 656.265(2) requires that the notice be in writing and apprise the employer when and where and how the worker's injury occurred. ORS 656.265(3) requires that the notice be given to the employer by mail (addressed to the employer at the last-known place of business of the employer) or by personal delivery to the employer or to a foreman or other supervisor of the employer. In addition, ORS 656.265(4)(a) provides as follows:

> "Failure to give notice as required by this section bars a claim under this chapter unless the notice is given within one year after the date of the accident and:
>
> "(a) The employer had knowledge of the injury or death;"

Finally, ORS 656.265(6) provides, in pertinent part, that a worker's failure to use a specified form (such as an 801 form) shall not, in itself, defeat the worker's claim if the worker has complied with the requirement that the claim be presented in writing.

[4] In *Allied Systems Co. v. Nelson*, 158 Or App 639 (1999), the court held that the written notice requirement of ORS 656.265 may be satisfied by a written report from the claimant or the claimant's doctor concerning the accident.

[5] Obviously, the log book itself would be the best evidence on this point, but it is not part of the record. According to Mr. Patterson, the project log book was not retained after construction at that site was completed and therefore no longer exists. (Tr. 9). Nevertheless, we decline claimant's invitation to presume, based upon the unavailability of the log book itself, that the contents therein were adverse to the employer's interest and sufficient to satisfy the notice requirement of ORS 656.265(2), particularly in light of the lack of testimony regarding what was recorded in the book; *i.e.* no testimony that it reflected how, when and where the injury occurred. *Compare* OEC 311(1)(c) (the willful suppression of evidence raises an unfavorable presumption against the party who suppressed it). Here, the record does not establish that the employer willfully destroyed the log book or otherwise suppressed evidence concerning its receipt of written notice of the claim.

Board Member Phillips Polich dissenting.

The majority concludes that claimant's testimony, without more, is insufficient to show that the employer received timely written notice of the claim. I respectfully dissent.

Here, it is undisputed that the employer had actual knowledge that claimant was injured on the job almost immediately. In regards to the written notice requirement, I am persuaded by claimant's testimony that he recorded his accident in the project log book that was turned over to, and reviewed by, his employer, Mr. Patterson, shortly after the incident. Also, I am willing to infer from the fact that claimant recorded his accident in the log book that the entry sufficiently apprised the employer when, where and how the injury occurred. Consequently, unlike the majority, I would find that the notation in the log book, in conjunction with the employer's undisputed and immediate actual knowledge of the injury, satisfies the notice requirements of ORS 656.265. I would therefore reverse the ALJ's order.

In the Matter of the Compensation of
IVAN R. McDANIEL, JR., Claimant
WCB Case No. 98-01028
ORDER ON REVIEW
Scott M. McNutt, Jr., Claimant Attorney
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Peterson's order that: (1) found that claimant had demonstrated good cause for his failure to file a timely request for hearing from the insurer's partial denial of claimant's current low back condition; and (2) set aside that denial. On review, the issues are timeliness of claimant's hearing request and compensability. We reverse.

FINDINGS OF FACT AND ULTIMATE FACT

On October 10, 1997, the insurer sent claimant a partial denial of his current low back condition by certified mail, return receipt requested. The denial was addressed to claimant at "P.O. Box 455" in John Day, Oregon. Claimant has received mail at this post office box since 1986 or 1987. This was the address claimant provided on his most recent Form 801 in January 1997, and it was claimant's personal mailing address at all relevant times herein. Claimant sometimes waited as long as three weeks to check this post office box for mail.

The post office at John Day placed notices of the insurer's certified mailing in claimant's post office box on October 14, 19 and 29, 1997. Claimant did not claim the mailing, and it was returned to the insurer. Claimant first became aware that the insurer had issued a denial of his current low back condition when he was so informed by his attorney on January 14, 1998. Claimant filed his request for hearing on February 6, 1998.

CONCLUSIONS OF LAW AND OPINION

It is undisputed that claimant requested a hearing from the insurer's denial more than 60 days and less than 180 days after the mailing of the denial. Consequently the hearing request confers jurisdiction only if claimant had "good cause" for the late filing. ORS 656.319(1); *Anderson v. Publishers Paper Co.*, 93 Or App 516, 518 (1988). Good cause in this context means "mistake, inadvertence, surprise or excusable neglect" as those terms are used in ORCP 71B. *Hempel v. SAIF*, 100 Or App 68, 70 (1990). Claimant has the burden of proving good cause. *Cogswell v. SAIF*, 74 Or App 234, 237 (1985).

Here, the ALJ concluded that claimant had demonstrated "good cause" for his untimely hearing request. In so doing, the ALJ reasoned that there was absolutely no evidence in the record that claimant ever received the denial letter or that he did anything else to avoid receiving it. On review, the insurer

argues that the record does not establish that claimant did not receive a copy of the denial. In the alternative, assuming that claimant did not receive actual notice of the denial, the insurer asserts that claimant still did not have "good cause" for his untimely hearing request.[1]

We are persuaded that claimant has not carried his burden of establishing good cause for his untimely hearing request.[2] We acknowledge that the record supports the ALJ's finding that claimant did not receive actual delivery of the insurer's denial.[3] Nevertheless, claimant must also establish that his failure to receive the denial was not due to "mistake, inadvertence, surprise or excusable neglect" as those terms are used in ORCP 71B. *Hempel v. SAIF*, 100 Or App at 70. A claimant's failure to file a request for hearing based on lack of actual knowledge of a denial is sufficient to establish "good cause" if the claimant proves reasonable diligence. *See Giusti Wine Co. v. Adams*, 102 Or App 329, 332 (1990); *Anastacio L. Duran, Sr.*, 45 Van Natta 71 (1993).

Here, the record establishes that the insurer's certified mailing was received by the post office at John Day, addressed to claimant's correct post office box.[4] Furthermore, there is unrebutted documentary evidence that the post office put notices of the certified mailing in claimant's post office box on three separate occasions. Moreover, claimant acknowledged that he sometimes waited as long as three weeks to check the contents of his post office box. Finally, there is no evidence of any supervening event that prevented claimant from checking his post office box during the relevant period.[5] On this record, we are persuaded that claimant did not receive actual delivery of the certified mailing because he did not exercise due diligence in monitoring the mail addressed to his post office box. *Accord Geoff McClellan*, 50 Van Natta 43 (1998) (the claimant who failed to monitor his mail for correspondence concerning a claim could not establish that he failed to cooperate in the investigation of the claim for reasons beyond his control).

In reaching this decision, we distinguish the present case from *James G. Adams*, 41 Van Natta 1234 (1989). The *Adams* Board concluded that a claimant had good cause for an untimely hearing request because he did not receive the post office notices of the certified denial letter. In reaching that conclusion, the Board expressly found that the claimant had exercised reasonable diligence. Here, the record is devoid of any evidence that claimant exercised reasonable diligence in monitoring his mail. To the contrary, claimant testified that he sometimes waited as long as three weeks to check the contents of his post office box. Consequently, claimant did not exercise reasonable diligence, and this case is distinguishable from *Adams* on this basis.

In summary, because claimant has not demonstrated due diligence in monitoring his mail, he cannot rely on lack of actual knowledge of the denial to establish good cause for his untimely hearing request. *See Giusti Wine Co. v. Adams*, 102 Or App at 332. Consequently, this matter must be dismissed on jurisdictional grounds.

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[1] In his brief on review, claimant raises an objection to "new arguments" on the timeliness issue raised in the insurer's brief on review. As a general rule, we do not consider issues or legal theories raised for the first time on review where prejudice would result to one of the parties. *See Stevenson v. Blue Cross*, 108 Or App 247 252 (1991); *Gunther H. Jacobi*, 41 Van Natta 1031, 1032 (1989); *Fister v. South Hills Health Care*, 149 Or App 214 (1997). Here, however, claimant objects to new *arguments*, as distinct from new issues or legal theories. Moreover, claimant had the opportunity to submit a reply brief in which he responded to the new arguments; and claimant does not contend that further development of the record would affect our ultimate disposition of this matter. Under these circumstances, we have considered the insurer's arguments and claimant's reply in reaching our decision.

[2] In light of our jurisdictional ruling, we decline to address the merits of the compensability issue.

[3] The post office returned the certified mailing to the insurer, unclaimed; there is no evidence that claimant ever received the separate copy of the denial the insurer contends it sent by regular mail to claimant at his business address; and claimant credibly testified that he did not remember receiving the denial and could not find the denial in the file he kept on workers' compensation matters.

[4] This was the address claimant had provided on his most recent Form 801 in January 1997, and claimant received other correspondence from the Department that was addressed to this same post office box. Furthermore, claimant acknowledged that he had received mail at this address since 1986 or 1987, and that this was his personal mailing address at all relevant times herein.

[5] In particular, there is no evidence that the insurer took any action that would have led claimant to believe that it was not denying the claim, or that claimant did not need to request a hearing from that denial. *Compare Voorhies v. Wood, Tatum, Mosser*, 81 Or App 336, *rev den* 302 Or 342 (1986).

ORDER

The ALJ's order dated December 15, 1998 is reversed. The insurer's denial is reinstated. The ALJ's assessed attorney fee award is reversed. Claimant's hearing request is dismissed.

June 16, 1999 Cite as 51 Van Natta 969 (1999)

In the Matter of the Compensation of
TIMOTHY M. MORRIS, Claimant
WCB Case No. 98-07023
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that affirmed an Order on Reconsideration that awarded 18 percent (57.6 degrees) unscheduled permanent disability for a low back condition. On review, the issue is extent of unscheduled permanent disability.

We adopt and affirm the ALJ's order with the following supplementation.

Claimant argues that his job at injury was "heavy" and that the ALJ incorrectly applied OAR 436-035-0310(4)(a) to conclude that claimant's BFC (Base Functional Capacity) for his job at injury was medium under the applicable DOT (Dictionary of Occupational Titles) code. Claimant argues that if the strength given in the applicable DOT code conflicts with claimant's actual job at injury, the "facts should control."

Pursuant to OAR 436-035-0310(4)(a), a worker's BFC is determined by the highest strength category assigned in the DOT for the most physically demanding job that the worker has successfully performed in the five years prior to determination. While we consider the record as a whole, including the job duties and physical demands of the relevant job, the fact remains that the most applicable DOT code or combination of DOT codes determines the strength category for that job. *See* OAR 436-035-0005(17); 436-035-0310(4)(a); *Gloria J. Wiley*, 50 Van Natta 781 (1998). While a claimant's sworn statement is relevant to a determination of the most appropriate DOT code, it cannot be used to determine that no DOT accurately describes the job duties. *Kathyron D. Parsons*, 45 Van Natta 954 (1993).

Here, claimant does not argue that another DOT code or combination of codes more accurately describes his job duties. Instead, claimant argues that the DOT strength category should not apply because his job at injury was actually heavy instead of medium as described in the DOT. As explained above, however, the standards require that the BFC be determined by the DOT.

Claimant cites *James I. Dorman*, 50 Van Natta 1773 (on reconsideration) (1998) to argue that the DOT is a factor that may be relevant only if it is consistent with the job held at the time of injury. *Dorman*, however, did not address the same issue raised in the present case. Rather, *Dorman* involved a determination of whether the claimant had returned to his regular work such that only the impairment factor would be considered pursuant to ORS 656.726(3)(f)(D)(i)[1] in rating his unscheduled permanent disability. The present case involves the issue of whether the DOT code determines claimant's BFC under the standards. The parties are in agreement that claimant did not return to the job at injury. Thus, *Dorman* is not helpful in deciding the present case.

Accordingly, we agree with the ALJ that claimant's BFC is determined by the DOT code and that claimant's BFC is medium under the applicable DOT code.

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[1] ORS 656.726(3)(f)(D)(i) provides: "(D) Notwithstanding any other provision of this section, impairment is the only factor to be considered in evaluation of the worker's disability under ORS 656.214(5) if: (i) The worker returns to regular work at the job held at the time of injury."

ORDER

The ALJ's order dated February 9, 1999 is affirmed.

In the Matter of the Compensation of
JAY D. PERKINS, Claimant
WCB Case No. 98-03972
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of claimant's aggravation claim. The employer argues that: (1) the ALJ abused his discretion in granting claimant's motion for postponement; (2) the current claim is precluded by a prior denial; and (3) claimant's herniated disc is not injury-related. On review, the issues are postponement, claim preclusion, and aggravation (compensability). We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings."

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the pertinent facts. Claimant has a long history of intermittent low back problems, beginning with an oil field injury about ten years ago and including two subsequent low back strains. On March 12, 1996, claimant injured his low back lifting at work. After the employer accepted claimant's claim for a 1996 low back strain, an MRI revealed a small herniation at claimant's lowest lumbar disc.[1] For almost two years, Dr. Amstutz provided epidural steroid injections and pain medication for claimant's symptoms. Eventually, the examining and treating physicians agreed that claimant's strain resolved in May 1997 and they opined that continuing problems were due to preexisting degeneration (spondylosis).

The employer denied claimant's "lumbar spondylosis" on June 19, 1997. A Determination Order closed claimant's strain injury claim on July 7, 1997 (with a 1 percent unscheduled permanent disability award). The denial and Determination Order became final without challenge.

On April 7, 1997, Dr. Amstutz filed an aggravation claim on claimant's behalf, which the employer denied on causation grounds.

Dr. Purtzer operated on claimant's herniated disc on July 14, 1998. Afterwards, Dr. Purtzer opined that the 1996 work injury caused claimant's need for surgery. Claimant requested a hearing.

Postponement

The employer argues that the ALJ abused his discretion in granting claimant's "at hearing" motion to postpone the hearing for the purpose of obtaining medical evidence from Dr. Purtzer, treating surgeon.

Dr. Purtzer first examined claimant in May, 1998. (Ex. 56a-1). He performed a laminectomy and diskectomy at the last movable segment of claimant's lumbar spine on July 14, 1998,[2] less than 6 weeks before the scheduled August 25, 1998 hearing. Claimant's counsel made an appointment to

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[1] Claimant has six lumbar vertebrae. Surgery for the L6 disc was not recommended until the current aggravation claim was filed.

[2] Dr. Purtzer apparently saw claimant twice, including during surgery. (*See* Ex. 57b).

consult with Dr. Purtzer on Friday, August 21, 1998. The doctor canceled the conference that day because he was in surgery. When the hearing convened the next Monday, claimant requested and the ALJ granted (over the employer's objection), postponement to obtain a report from Dr. Purtzer. When the hearing reconvened on February 2, 1999, the ALJ admitted all exhibits offered, including a chartnote, operative report, and opinions from Dr. Purtzer.

Considering the timing of claimant's surgery, the fact that claimant had scheduled a conference with Dr. Purtzer before the hearing, and the fact that the conference was canceled by the doctor on the last business day before the hearing, we find that the ALJ did not abuse his discretion in granting the requested postponement. We specifically find that claimant *did* exercise due diligence in preparing for the hearing[3] (by making arrangements to obtain evidence from Dr. Purtzer), but the postponement was nevertheless necessary for case preparation, due to extraordinary circumstances beyond claimant's control (the last minute appointment cancellation). Accordingly, we conclude that the ALJ's postponement ruling was proper under OAR 438-006-0081.[4]

Claim Preclusion

On June 19, 1997, the employer denied claimant's "lumbar spondylosis," stating:

> "In review of medical information received it has been noted [that] you have lumbar spondylosis which pre-existed your injury of 3-12-96. Further[,] as indicated above[,] your physician has advised that the lumbar strain of 3-12-96 has resolved and that any current symptoms and/or need for treatment is related to the pre-existing lumbar spondylosis. Therefore, at this time we must issue a denial of your lumbar spondylosis as not being related to the accepted low back strain." (Ex. 47).

Claimant did not challenge the denial and it became final. The employer argues that it denied claimant's "current condition" and therefore the current claim is precluded. We disagree.

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[3] *Compare SAIF v. Kurcin*, 160 Or App 489 (1999) (Where the claimant made no showing of diligence or necessity, the Board erred in upholding the ALJ's decision to allow a continuance under OAR 438-006-0091(3)).

[4] OAR 438-006-0081 provides:

"A scheduled hearing shall not be postponed except by order of an Administrative Law Judge upon a finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement. Extraordinary circumstances shall not include:

"(1) Failure of the insurer or self-insured employer to refer or delay in referring the case or any pertinent information to its representative;

"(2) Unavailability of a party, witness (other than a medical expert witness) or representative due to nonemergency medical or dental appointment, occupational, personal or professional business or appointments, or unwillingness to appear, provided that a postponement may be granted if the unavailable person is a worker who is temporarily working out of state and is reasonably expected to return to the state within a time certain or is a person who has been duly subpoenaed and has failed to comply with the subpoena;

"(3) An attorney's, party's, representative's or witness' conflict with administrative proceedings scheduled more than three days after mailing of the notice of hearing;

"(4) Incomplete case preparation, unless the Administrative Law Judge finds that completion of the record could not be accomplished with due diligence. A subpoena of a medical expert witness is not required to satisfy due diligence.

"(5) For purposes of this rule, due diligence shall include, but not be limited to, the unavailability of a medical or vocational expert witness for cross-examination by deposition/interrogatories prior to a scheduled hearing, provided that the request for cross-examination was made no later than seven (7) days after the requesting party received from another party a copy of a report from the medical or vocational expert witness accompanied by written notice that the sending party is submitting the report as a proposed exhibit for admission into evidence at a scheduled hearing."

In order for a denial to have preclusive effect, there must have been an opportunity to litigate the denied claim before the denial issued. *See Popoff v. Newberrys*, 117 Or App 242, 244 (1992) (Claim preclusion applied when there was a prior opportunity to litigate a denied claim). In this case, no medical evidence related claimant's disability and/or need for treatment to his herniated disc until *after* the denial.[5] Thus, there was no claim for a herniated disc when the denial issued and no prior opportunity to litigate a claim for that condition. *See Robert W. Fleming*, 48 Van Natta 1151 (1996) ("The res judicata effect [of a] denial is limited to the conditions denied as they existed on or before the date of the denial.") (*quoting Sharon E. Mack*, 42 Van Natta 1562, 1564 (1990)). Under these circumstances, the unappealed denial does not preclude the claim for a herniated disc condition.

Aggravation

The employer denied claimant's aggravation claim on causation grounds. (Ex. 54). The ALJ set aside the denial, based on the opinion of Dr. Purtzer, treating surgeon.

Dr. Purtzer opined that claimant needed disc surgery in July 1998, because of "a recent injury, not a preexisting injury." (Ex. 58). Based on the medical records, the history claimant provided, and his surgical findings, Dr. Purtzer specified that the March 12, 1996 work incident caused disc injury. He explained that his causation opinion was based on radicular symptoms that began with the 1996 injury and continued thereafter; surgical findings consistent with discal injury-- not degenerative changes; and the fact that claimant's radicular symptoms "got better" after surgery. (Ex. 59).

The employer contends that Dr. Purtzer's opinion is not persuasive because he did not see claimant until May 1998 (over two years after the 1996 injury), and then had very limited "involvement." The employer also argues that Dr. Purtzer had an incomplete history and his opinion is based on nothing more than a temporal relationship between claimant's symptoms and his disc findings. We disagree.

We first note that Dr. Purtzer referenced claimant's "extensive medical record that is well outlined in my chart at the office." (Ex. 57B). Second, the fact that claimant had low back strains before 1996 and *some* degenerative findings does not mean that a preexisting condition caused (or even contributed to) his recent need for disc surgery. The record in this case indicates that claimant's prior strains resolved and his degenerative findings were minimal or mild. (*See* Exs. 1-3, 6-2, 13A, 26-2; *see also* Ex. 23). However, after the 1996 injury, claimant's symptoms were not relieved until Dr. Purtzer repaired his herniated disc. Under these circumstances, we are not persuaded that Dr. Purtzer's history was deficient or that the contrary medical opinions benefited from treatment longevity.

Moreover, Dr. Purtzer had the advantage of observing claimant's disc firsthand during surgery. And, based on his surgical findings, Dr. Purtzer specifically opined that the 1996 injury, *not* degeneration, caused the need for surgery. With this in mind, we find that Dr. Purtzer's causation opinion is consistent with claimant's clinical course and his findings,[6] but the medical opinions relating claimant's current condition to "degeneration" are *not* consistent with Dr. Purtzer's unequivocal finding that claimant's disc herniation was post-traumatic and recent, not degenerative. Accordingly, on this record, we agree with the ALJ that Dr. Purtzer's opinion is the most persuasive and, based on that opinion, we also agree that the employer's denial must be set aside.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,800, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

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[5] We also note that the denial did not mention the herniated disc.

[6] We again note that claimant's degeneration has been consistently described as minimal or mild, the herniated disc was first diagnosed after the 1996 work injury, and claimant's low back symptoms were not successfully treated after the injury until the disc was repaired.

ORDER

The ALJ's order dated March 5, 1999 is affirmed. For services on review, claimant is awarded an $1,800 attorney fee, payable by the self-insured employer.

In the Matter of the Compensation of
RICHARD RADFORD, Claimant
Own Motion No. 98-0351M
OWN MOTION ORDER

The self-insured employer has submitted a request for temporary disability compensation for claimant's compensable right hand condition. Claimant's aggravation rights expired on December 8, 1982. The employer recommended against reopening on the grounds that: (1) no surgery or hospitalization has been requested; (2) surgery or hospitalization is not reasonable and necessary; and (3) claimant is not in the work force. The employer requested Director's review of the requested medical treatment. (Medical Review Case No. 12911).

On September 15, 1998, we postponed action on this own motion matter pending resolution of medical issues that were before the Medical Review Unit (MRU). On January 14, 1999, the MRU determined that there were no outstanding medical issues that required any further action.

In light of the MRU's decision, the employer announced that it continued to oppose reopening of the claim on the basis that surgery and/or hospitalization has not been recommended and that claimant is not in the work force. Claimant has not responded to the employer's contentions.[1]

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

Here, the record does not establish that claimant requires surgery or hospitalization. As a result, we are not authorized to award temporary disability benefits.[2] Accordingly, we deny the request for own motion relief. *Id.*[3]

Claimant's entitlement to medical expenses under ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

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[1] We implemented a briefing schedule to allow the parties to submit their written positions regarding claimant's request for own motion benefits and the effect, if any, the MRU's decision had on that request. In response, the employer continued to oppose the reopening of the claim. Claimant has not replied to the employer's response.

[2] Inasmuch as we have concluded that we are without authority to grant claimant's request for own motion benefits, we need not address the employer's contention regarding claimant's "work force" status.

[3] In the event that claimant disagrees with our decision, he may request reconsideration. However, because our authority to further consider this matter expires within 30 days of this order, he should submit his information as soon as possible.

In the Matter of the Compensation of
GRACE I. SORIANO, Claimant
WCB Case No. 98-08598
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Howell's order that awarded an assessed attorney fee of $3,000 for services at hearing. SAIF also moves for remand. On review, the issues are remand and attorney fees.

We deny SAIF's motion for remand, and adopt and affirm the ALJ's order with the following supplementation.

Claimant requested a hearing challenging SAIF's denial of her low back injury claim. The ALJ found that claimant had established the compensability of her injury, and directed SAIF to accept and process the claim. The ALJ also assessed an attorney fee of $3,000 after stating the following:

> "Claimant's attorney is entitled to an assessed fee for services related to SAIF's denials. He is a skilled and experienced workers' compensation attorney. His fee was contingent upon prevailing against SAIF's denials. He solicited important evidence which [sic] tended to prove the compensability of claimant's claim. Other factors were largely neutral. The hearing was of average length and the issues of average complexity. It appears likely that the benefits to claimant will be relatively modest. Under such circumstances, and considering the factors set forth at OAR 438-015-0010, I find that a fee of $3,000 is appropriate."

On review, SAIF argues that the ALJ failed to apply each of the factors in OAR 438-015-0010(4)[1] and failed to make specific findings of fact regarding each factor in awarding the assessed attorney fee. Contrary to SAIF's contention, the ALJ was not required to make findings for each rule-based factor. As we explained *Daryl L. Underwood*, 50 Van Natta 2330 (1998), where there is no specific argument at hearing concerning the application of the factors in OAR 438-015-0010(4), an ALJ satisfies his or her obligation to make findings concerning the attorney fee award by including a brief description or citation to the rule-based factor or factors relied upon in determining the fee award. *See also SAIF v. Bacon*, 160 Or App 596 (1999). Furthermore, because we are authorized to modify or supplement the ALJ's order on review under ORS 656.295(6), remand is not an appropriate remedy. *Daryl L. Underwood*, 50 Van Natta at 2332.

Here, the ALJ cited OAR 438-015-0010(4) and made findings concerning some of the factors.[2] This explanation for the ALJ's attorney fee award is consistent with the *Underwood* rationale. *See Leslie D. Custer*, 51 Van Natta 390 (1999); *compare Donna R. Grierson*, 51 Van Natta 679 (1999) (ALJ's reasoning insufficient to determine how he arrived at reasonable fee where order was devoid of any explanation of application of the rule-based factors). Finally, because SAIF challenged only the attorney fee award on review and attorney fees are not "compensation" for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for his counsel's services on review. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated February 25, 1999 is affirmed.

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[1] The rule provides that, when an ALJ or the Board is required to determine a reasonable attorney fee, the following factors shall be considered: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses.

[2] We note that SAIF is not contending that the $3,000 attorney fee award is excessive.

In the Matter of the Compensation of
JAMES E. TEMPLETON, Claimant
WCB Case No. 98-06720
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Moscato & Hallock, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the insurer's denial of claimant's "new medical condition" claims for cervical and thoracic strains. On review, the issues are claim preclusion and, if the claims are not precluded, compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant was injured when he was tossed from a yarder and thrown to the ground at work on September 29, 1994. The insurer accepted claims for comminuted fracture of the left radial head, multiple facial abrasions, lacerations, and bilateral thigh contusions on November 21, 1994.

Claimant experienced neck and upper back pain and reported these symptoms to Drs. Gancher and Coletti on August 5, 1995. Dr. Kim diagnosed cervical and thoracic strains on August 21, 1995. The insurer received Dr. Kim's report with the August diagnoses on October 11, 1995.

Claimant's former attorney wrote to the insurer requesting acceptance of claimant's cervical complaints (among other things, but not including thoracic complaints) on October 23, 1995. The attorney filed a request for hearing alleging an unreasonable *de facto* denial on December 19, 1995.

Claimant's former attorney withdrew the request for hearing on March 29, 1996. A prior ALJ dismissed claimant's request for hearing with prejudice on April 3, 1996. The dismissal order became final.

Claimant's current attorney wrote to the insurer requesting acceptance of claimant's cervical and thoracic strains on July 8, 1996. The insurer denied the request, contending that the claims were precluded by the prior dismissal. Claimant requested a hearing.

Claim Preclusion

The ALJ held that both claims were precluded. The ALJ reasoned that claimant's 1995 request for hearing was premature initially (because 90 days had not passed between the request for acceptance and the request for hearing), but no longer premature when the request was dismissed. Further reasoning that the claims were perfected and *de facto* denied by the time claimant's former attorney requested dismissal, and determining that the present claim was based on the same evidence as the prior claims, the ALJ concluded that they were precluded. We agree regarding the claim for a cervical strain, but disagree regarding the claim for a thoracic strain.

> "Claim preclusion bars litigation of a claim based on the same factual transaction [that] was or could have been litigated between the parties in a prior proceeding that has reached a final determination."

Messmer v. Deluxe Cabinet Works, 130 Or App 254, 257 (1994), *rev den* 320 Or 507 (1995).

The threshold question is whether the claims could have been litigated in a prior proceeding. We conclude that the cervical claim, but not the thoracic claim, could have been litigated previously, based on the following reasoning.

The claims for cervical and thoracic strains are (and were) "new medical condition" claims.[1] A claim for a "new medical condition" must precede a request for hearing on an alleged denial of that condition.[2]

Here, because claimant did not file a "new medical condition" claim for a thoracic strain before the 1996 dismissal order, there was no such claim and no denial thereof. Consequently, claimant's 1995 request for hearing regarding a thoracic strain was premature and "void." *See Barr v. EBI Companies*, 88 Or App 132, 135 (1987) (*quoting Syphers v. K-W Logging, Inc.*, 51 Or App 769, 771, *rev den* 291 Or 151 (1981)). Under these circumstances, claimant could not have litigated a claim for a thoracic strain when his prior request for hearing was dismissed[3] and the 1996 dismissal does not preclude the current "new medical condition" claim for a thoracic strain.[4]

The cervical strain claim presents a different question: Claimant did file a "new medical condition" claim for a cervical strain in 1995. (Ex. 10). Although his 1995 request for hearing regarding the 1995 cervical claim was premature initially, the request was *not* premature when his former attorney withdrew it and a former ALJ dismissed the request with prejudice.[5] Moreover, the insurer did not object to the request for hearing (as premature) before claimant withdrew the request and the ALJ dismissed it.[6] Under these circumstances, the "new medical condition" claim for a cervical condition was perfected and *de facto* denied before claimant withdrew his prior hearing request and claimant *could* have litigated the compensability of his claimed and *de facto* denied cervical condition at a prior proceeding (*i.e.*, but for his withdrawn hearing request and the subsequent dismissal order). Finally,

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[1] The 1995 amendments to ORS Chapter 656 apply to the 1995 claims, as well as the 1996 claims, because the 1994 initial injury claim existed when the amendments became effective on June 7, 1995. *See e.g., Shannon E. Jenkins*, 48 Van Natta 1482 (1996) *aff'd mem* 135 Or App 436 (1997). The 1995 cervical and thoracic strain claims were "new medical condition" claims because the record does not establish that either condition was identified or diagnosed before the initial claim was accepted. *See William B. Barrett*, 51 Van Natta 286, 287 (1999); *Mark A. Baker*, 50 Van Natta 2333, 2337 (1998).

[2] *See Ralph L. Morris*, 50 Van Natta 69 (1998); *Diane S. Hill*, 48 Van Natta 2351, *aff'd mem* 149 Or App 496 (1997).

[3] *See Tracie M. Brumley*, 51 Van Natta 701, 701 (1999) (Absent a "clear, formal written request" for acceptance of a new medical condition, the insurer has no further processing obligations); *Eston Jones, on recon*, 50 Van Natta 1582 (1998) (Absent a request to accept a new medical condition, the statutory requirement to deny a new medical condition claim within 90 days was not triggered).

[4] *See e.g., Troy M. Garner*, 48 Van Natta 1594-96 (1996) (Where the claimant withdrew his claim *before* the 90-day claims processing period under ORS 656.262(6), subsequent denial of that claim was "null and void" and the claimant was not precluded from reasserting the same claim later); *William C. Becker*, 47 Van Natta 1933 (1995) (same).

[5] We reach this conclusion because 90 days passed after the filing of the "new medical condition" claim and before the withdrawal of the hearing request.

[6] Claimant contends that there is no authority for the proposition that the passage of the statutory 90-day time period "cures" an otherwise premature request for hearing. We disagree. *See Jack N. Anderson*, 46 Van Natta 850, 851 (1994) (Where the claim was filed at least 90 days before hearing, it was *de facto* denied by hearing and the ALJ had jurisdiction to reach the compensability issue); *Neil M. Walker*, 45 Van Natta 1597, 1598 (1993) (Where a claim was *de facto* denied by the time of hearing, it was "ripe for adjudication"). Moreover, as the court explained in *Thomas v. SAIF*, 64 Or App 193, 196 (1983):

> "Our holding in *Syphers* does not deprive the referee or Board of jurisdiction when the employer or insurer fails to object in any manner to proceeding with a hearing that is conducted as a result of a premature request. We held only that the employer has the absolute right to object and that, if it does so, the referee may not proceed with the hearing."

(*Compare* text accompanying notes 3 and 4, *supra*).

We specifically note that the insurer did not object to claimant's 1995 request for hearing as premature. *See Brian M. Eggman*, 49 Van Natta 1835 (1997) ("It is well-established that failure to raise a procedural defect is a waiver of any procedural error."); *see also Ronda G. Prewitt*, 49 Van Natta 831, 833 (1997) (It is permissible to proceed to the merits of a claim if the carrier does not challenge a premature hearing request).

because the dismissal order became final[7] and claimant has not shown that his cervical condition changed since it was *de facto* denied in 1995, there is no new set of operative facts that could not have been previously litigated. For these reasons, we agree with the ALJ that the "new medical condition" claim for a cervical strain is barred by claim preclusion.[8]

Compensability/Thoracic strain

The medical evidence relates claimant's thoracic strain to the 1994 compensable injury and the insurer does not contend otherwise. Accordingly, we set aside the insurer's denial of claimant's current claim for a thoracic strain.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding the thoracic strain claim. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding the thoracic strain claim is $3,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record, claimant's appellate briefs, and his attorney's statement of services), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated December 31, 1998 is reversed in part and affirmed in part. That portion of the order that upheld the insurer's denial of claimant's claim for a thoracic strain is reversed. The denial is set aside and the thoracic strain claim is remanded to the insurer for processing according to law. The remainder of the order is affirmed. For services at hearing and on review regarding the thoracic strain claim, claimant is awarded a $3,000 attorney fee, payable by the insurer.

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[7] Because the prior order dismissed claimant's request for hearing *with prejudice* (apparently per claimant's request), and the order became final without challenge, it is preclusive as to claims that could have been litigated at the time, including the cervical claim. *See Michael E. Morrison*, 44 Van Natta 372, 373 (1992) (Where the claimant's request for hearing was dismissed with prejudice and the order became final, the claimant was precluded from litigating matters that could have been litigated at the time of the dismissal); *Compare Robert G. Edwards*, 47 Van Natta 795 (1995), *aff'd mem* 138 Or App 704 (1996) (Where the prior judgment was "merely a procedural dismissal," it did not bar reassertion of the same claim in a subsequent proceeding) (quoting *Hellesvig v. Hellesvig*, 294 Or 769, 776 (1983) (discussing *Rennie v. Freeway Transport*, 294 Or 319, 330-331 (1982).

[8] *See Oreste A. Chorney*, 50 Van Natta 498, 499 n.1 (1998) (where the claimant withdrew his hearing request from a denial and a dismissal order issued, the denial became final as if it had not been challenged); *Johnny J. Forrest*, 45 Van Natta 1798, 1799 (1993) (claim precluded where the claimant failed to show that his condition changed since dismissal of his prior request for hearing regarding the same condition).

In the Matter of the Compensation of
TINA M. VANDERBURG, Claimant
WCB Case No. 98-00196
SECOND ORDER ON REMAND
Robert J. Guarrasi, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

Claimant requests reconsideration of our June 3, 1999 Order on Remand. Specifically, claimant contends that her counsel is entitled to an assessed fee pursuant to ORS 656.382(2). For the following reasons, we disagree.

In *Terlouw v. Jesuit Seminary*, 101 Or App 493, *rev den* 310 Or 282 (1990), the court declined to award a fee under ORS 656.382(2) because the Board had dismissed the carrier's appeal on the carrier's motion without a decision on the merits. Similarly, in *Agripac, Inc. v. Kitchel*, 73 Or App 132 (1985), the court held that, because the carrier's petition for judicial review had been dismissed on the claimant's motion without a finding "that the compensation to a claimant should not be disallowed or reduced," the claimant was not entitled to a fee under ORS 656.382(2). *See also Timothy L. Williams*, 46 Van Natta 2274 (1994).

In this case, prior to a decision on the merits of the employer's appeal of our order reducing claimant's unscheduled permanent disability award, the court remanded this case so that we could consider the parties' settlement. The employer, however, subsequently announced that a settlement would not take place. Moreover, the employer stated that it did not wish to reinstate its appeal of our order. Thus, interpreting the employer's announcement as a waiver of its right to seek reinstatement of its court appeal, we dismissed the matter. Neither the court's order nor our order on remand contain a finding on the merits that claimant's compensation should not be disallowed or reduced. Under such circumstances, we do not have statutory authority under ORS 656.382(2) to award an assessed fee. *Terlouw v. Jesuit Seminary*, 101 Or App at 494.[1]

Accordingly, we withdraw our June 3, 1999 order. On reconsideration, as supplemented herein, we adhere to and republish our June 3, 1999 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] Claimant asserts that our June 3, 1999 order, together with the employer's failure to seek reinstatement of its appeal, are "an explicit finding" that the amount of compensation awarded to claimant should not be disallowed or reduced. We disagree. No such finding was explicitly or implicitly made, nor were we authorized to make such a finding in light of the court's instructions on remand.

In the Matter of the Compensation of
MARK A. WILEY, Claimant
WCB Case No. C9-01386
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Glen J. Laskin, Claimant Attorney
James Booth (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

On June 4, 1999, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

Here, the first page of the agreement provides a total consideration of $22,000. Originally, the agreement provided that claimant's attorney would receive an attorney fee of $4,825, payable out of the settlement proceeds. By handwritten revision, the attorney fee has been revised to $3,000, thereby increasing the total amount due claimant to $19,000. However, page 3, lines 24 and 25, have not been revised; *i.e.* the $22,000 in proceeds still provides that $4,825 will be distributed to claimant's counsel with the remaining $17,175 payable to claimant.

Upon review of the document as a whole, we find that the parties' intent is for the disposition proceeds to be distributed as follows:

$3,000	Total Due Attorney
$19,000	Total Due Claimant

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' CDA is approved. An attorney fee of $3,000, payable to claimant's counsel, is also approved.

Should the parties disagree with our interpretation of the CDA, they may move for reconsideration by filing a motion for reconsideration within 10 days of the date of mailing of this order. OAR 438-009-0035.

IT IS SO ORDERED.

In the Matter of the Compensation of
ELIZABETH WILLIS, Claimant
WCB Case No. 98-02513
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that upheld the self-insured employer's denial of her back, neck, left shoulder and right wrist injury claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order, with the following modification and supplementation.

Claimant contends that she injured her back, neck, left shoulder and right wrist in an incident that allegedly occurred on January 25, 1998, when she slipped and fell while mopping the deli floor at the employer, a grocery chain. The ALJ found that claimant was not credible and that she had failed to establish compensability by a preponderance of the evidence. On review, claimant contends that her testimony, coupled with the medical evidence, supports the compensability of her January 25, 1998 injuries.

The ALJ cited several reasons for finding that claimant failed to satisfy her burden of proof. The ALJ first concluded that claimant's testimony that her fall had been witnessed by her supervisor, "John," was unreliable because her supervisor, John Arenz, stated on the Form 801 that he filled out that there were no witnesses to the incident, and claimant failed to call any witnesses to testify at the hearing.

Claimant contends that she did not testify that her fall was witnessed by her supervisor. According to claimant, she testified that her supervisor's son, whose name is John, was mopping by the bakery shelves and may have seen the incident. Claimant's testimony, however, fails to make such a connection. When asked whether anyone saw the incident, claimant said that the deli supervisor's son was standing by the deli shelves mopping. (Tr. 19). When asked why the "801" claim form stated that there were no witnesses to the incident, claimant's reply was unresponsive to the question. (Tr. 19, 20). Under further questioning about the document, claimant's testimony is, at best, confusing. Claimant stated that she was present when John Arenz filled out the "801" for her. (Tr. 31). She also stated that John Arenz, manager, did not write it for her, but the manager of the store wrote it, whose name she could not remember. She continued: "He was the manger (sic), but John was there when I fell, and he saw me." There was no further clarification regarding the identities of the store manager and the "John" who witnessed claimant's fall. Absent such clarification, we decline to infer that the deli supervisor's son was the "John" who witnessed claimant's fall, particularly in light of her failure to call him as a witness.

The ALJ also cited claimant's denial of prior injuries to the same body parts to cast distrust on her testimony. Although claimant did not specifically deny prior injuries, she equivocated. In her first response to the employer's question, "Had you hurt any of [the areas of the body that you claim] before at any time prior to January of 1998," claimant replied, "I could have." She continued, "That's a possibility * * * [b]ut I wasn't hurt that day * * * I fell." (Tr. 13, 14). Her second response to the same question was the same: "There's a possibility." (Tr. 16, 17). She also discussed the circumstances regarding a December 1997 cut on her right knee, admitted she slipped down some stairs in 1987 while employed at a different employer, and agreed that the medical records of her past treatment were a more accurate reflection of injuries to the body parts than trying to remember at hearing. (Tr. 28).

Finally, the ALJ cited the inconsistencies between her testimony and what she had told her doctor at the time of injury regarding the mechanism of the injury.

Claimant testified that, on January 25, 1998, she was mopping the deli floor in preparation for closing. (Tr. 23). Water she had left running in the deli sink had overflowed, and, as she was trying to get back to the sink, she slipped on the wet floor and fell on her back, causing injury. (Tr. 5, 6, 7). She also testified that she had seen trash underneath a counter, tried to get to it and slipped on the wet floor after she took a couple of steps. (Tr. 18, 19). According to claimant, when she slipped she tried to brace herself and landed on her back, left elbow and right wrist. (Tr. 6, 7). Claimant continued to finish her shift; she did not report the incident to the employer. (Ex. 42).

In evaluating the reliability of claimant's testimony, we first note that, because the ALJ relied on the "preponderance of evidence," his credibility finding was not based only on demeanor. Although we generally defer to the ALJ's credibility finding, when the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. *Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987).

Here, the medical record reveals that claimant did not seek treatment for her alleged injury until about 5:00 p.m. the next evening. She reported that she slipped and fell on the wet deli floor. (Ex. 40). On a form "827," she stated: "[C]losing deli, I was moping (sic) deli floor near the double sinks turned around reach for broom to sweep up under table against back wall & took 2 steps & slipped & fell" and "I injured whole left side of neck, shoulder & back." (Ex. 41). Physician Assistant Pype found tenderness at C5 and left paraspinous muscles, occipital tenderness, and tenderness at the volar aspect of the radial right wrist. (*Id.*)

Here, when we assess the record as a whole (claimant's failure to report the injury at work coupled with her failure to seek treatment until 5:00 p.m. the next evening and failure to call her witness, as well as her unresponsiveness and equivocation when questioned, in addition to the discrepancies in her reports of the mechanism of injury), we agree with the ALJ that claimant has failed to establish that her claim is compensable.

ORDER

The ALJ's order dated December 28, 1998 is affirmed.

In the Matter of the Compensation of
ARLINE F. LINK, Claimant
WCB Case No. 98-07088
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock, and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that upheld the SAIF Corporation's partial denial of her left carpal tunnel condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated December 31, 1998 is affirmed.

Board Member Phillips Polich dissenting.

The majority finds that claimant failed to sustain her burden to prove a compensable injury claim. I do not agree, however, with their finding that claimant has a preexisting condition as defined by ORS 656.005(24). Dr. McHan, claimant's treating physician, and Dr. Mundall, claimant's treating neurosurgeon, both state that claimant had no preexisting carpal tunnel condition. (Exs. 5-3, 12, 13, 14A-4). Only Dr. Gabr and Dr. Dickerman, who performed medical file reviews for SAIF but did *not* examine claimant, conclude that there was a preexisting condition. (Exs. 9-2, 16). The reports of those physicians are conclusory and do not convince me that claimant's median nerve slowing preexisted her motor vehicle accident (MVA) or her employment. Therefore, I must respectfully dissent.

Claimant worked as a bus driver for this employer from 1974 to the present. Dr. McHan has been claimant's treating physician since 1971 and his records document no prior carpal tunnel complaints. Dr. McHan reviewed all the medical records in this case and still concludes that the MVA caused the left carpal tunnel condition. Dr. McHan appropriately considers the temporal relationship of claimant's condition and the injury in reaching his opinion on causation. His consideration of the temporal relationship is only one factor in his opinion and is *not* the dispositive element.

Dr. Mundall performed the nerve conduction studies. The studies showed mild to moderate changes, but nothing that had generated symptoms prompting claimant to seek earlier treatment. Dr. Mundall took into account the testing *he performed* in concluding that there was no preexisting carpal tunnel condition.

In sum, based on their evaluation of claimant's condition and the medical record, what claimant's treating physicians are saying is that *the sole cause of her carpal tunnel and need for treatment* is the MVA. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995) (determination of major contributing cause involves evaluating the relative contribution of different causes and deciding which is the primary cause). Because there is no evidence that claimant's median nerve slowing preexisted her employment, and no persuasive medical evidence that it preexisted her MVA, I find no persuasive reasons not to defer to the opinions of claimant's treating physicians. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). Thus, I would find that claimant has met her burden of proof in this case as required under ORS 656.005(7)(a)(A).

In the Matter of the Compensation of
DONALD D. PAUL, Claimant
WCB Case No. 98-08592
ORDER ON REVIEW
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Thye's order that dismissed his requests for hearing. On review, the issue is the propriety of the dismissal order.

We adopt and affirm the ALJ's order with the following supplementation.

The ALJ dismissed claimant's hearing request on the ground that all matters raised by the requests for hearing had been resolved by a claim disposition agreement (CDA) approved by the Board on January 25, 1999.

Claimant requested Board review of the ALJ's dismissal order and sought reconsideration of the CDA approved on February 24, 1999. On March 11, 1999, the Board denied claimant's request for reconsideration of the CDA because the motion was untimely. *Donald D. Paul*, 51 Van Natta 419 (1999). On March 22, 1999, we received a second motion for reconsideration. We issued a Second Order Denying Reconsideration on March 30, 1999. *Donald D. Paul*, 51 Van Natta 495 (1999). By letter dated March 16, 1999, the Board wrote the parties and implemented a briefing schedule. After expiration of that schedule and receipt of the parties' written arguments, we have proceeded with our review.[1]

Turning to claimant's appeal of the ALJ's order, we make the following findings. Claimant's hearing request raised the issue of an aggravation of the compensable injury. In the CDA, which was approved by the Board on January 25, 1999, claimant, who was represented by an attorney, specifically released his rights to all workers' compensation benefits in the claim including aggravation rights. In exchange for his release of benefits, claimant received $12,500, less a $1,000 attorney fee. The CDA

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[1] The insurer mentions that claimant's allegations regarding the insurer's processing of the CDA have been assigned a new WCB Case Number as a new hearing request. That statement is inaccurate. Claimant's "CDA Processing" arguments have been considered in the context of his appeal of the ALJ's dismissal order. For the reasons expressed in this order, we find that the ALJ's dismissal of claimant's hearing request (which was based on the Board's approval of the parties' CDA) was appropriate. Likewise, because the "CDA processing" allegations would have no effect on the issue of whether the ALJ's dismissal order was properly issued, it is unnecessary to return this case to the ALJ for further development of the record. In the event that claimant believes that the insurer's conduct in processing the CDA was contrary to administrative requirements, he may bring those concerns to the attention of the Director. For further assistance in understanding his rights under the workers' compensation law, claimant can contact the Ombudsman at 1-800-927-1271.

specifically extinguished claimant's rights to the workers' compensation benefits that were raised by the hearing request before the ALJ; *i.e.*, his aggravation claim. Likewise, the approved CDA contained another provision that expressly stated that, on Board approval, the request for hearing in this case (WCB Case No. 98-08592) "shall be dismissed." Under such circumstances, because the CDA extinguished claimant's rights to the benefits which were the subject of the hearing request and expressly provided for the dismissal of claimant's hearing request, the ALJ's dismissal of the hearing request was appropriate. *See Edward C. Steele*, 49 Van Natta 119 (1997); *Brian A. Haskie*, 47 Van Natta 2171 (1995); *Russell C. Terry*, 47 Van Natta 304 (1995).

The Board approved a CDA in final order pursuant to ORS 656.236. Such an order would not issue if the Board found the agreement unreasonable as a matter of law, or based on an intentional misrepresentation, or if either of the parties had requested disapproval within 30 days of submission of the CDA to the Board. ORS 656.236(1)(a)(A),(B) and (C). Because we approved the CDA, we conclude there was no evidence of impropriety regarding the terms of the CDA. Once we issued our order approving the CDA, the agreement became final. Our order approving the CDA is not subject to review. ORS 656.236(2). Accordingly, as stated in our CDA orders denying reconsideration, we are without authority to further address the CDA.[2]

ORDER

The ALJ's order dated January 26, 1999 is affirmed.

[2] Claimant raises issues concerning the mailing of his CDA payment to an incorrect address and payment of medical and travel expenses. As we previously explained in a footnote in our Second Order Denying Reconsideration of the CDA, these issues are not within the Board's jurisdiction and are issues over which the Director has jurisdiction.

June 17, 1999 Cite as 51 Van Natta 982 (1999)

In the Matter of the Compensation of
SHAWN M. SPRING, Claimant
WCB Case No. 98-06132
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Podnar's order that: (1) declined to allow the insurer to depose Dr. Tanabe; and (2) set aside the insurer's denial of claimant's claim for a low back condition. On review, the issues are evidence and compensability.

We adopt and affirm the ALJ's order with the following supplementation.

The insurer contends that the ALJ erred in denying its motion to continue the hearing for the deposition of Dr. Tanabe. We disagree.

ORS 656.283(7) provides that the ALJ is not bound by common law or statutory rules of evidence and may conduct a hearing in any manner that will achieve substantial justice. We review the ALJ's ruling on a motion for continuance for abuse of discretion. *See, e.g., Jerry D. Thatcher*, 50 Van Natta 888 (1998); *Sharron D. Lemley*, 49 van Natta 1365 (1997).

OAR 438-006-0091(2) provides that a hearing may be continued "[u]pon a showing of due diligence if necessary to afford reasonable opportunity to cross-examine on documentary medical or vocational evidence."[1] In order for a hearing to be continued, the party requesting the continuance must establish "due diligence." *See SAIF v. Kurcin*, 160 Or App 489 (1999).

[1] The Board's rules concerning postponement of hearings, set forth in OAR 438-006-0081, are incorporated into OAR 438-006-0091 and can also serve as the basis for a continuance. *See* OAR 438-006-0091(4).

Here, Dr. Tanabe's report was forwarded to the insurer under claimant's counsel's cover letter of September 15, 1998. (Ex. 29A). The cover letter indicated that the report would be submitted as an exhibit at hearing and requested the insurer to contact claimant's counsel immediately if it wished to depose Dr. Tanabe. (Ex. 29A). The insurer did not request Dr. Tanabe's deposition until September 29, 1998. (Tr. 3).

Relying on OAR 438-006-0081(5)[2], the ALJ found that the insurer had not exercised due diligence in requesting the deposition of Dr. Tanabe. Because the insurer did not request Dr. Tanabe's deposition within 7 days of receiving the medical report, the insurer's conduct does not automatically constitute "due diligence" as described in OAR 438-006-0081(5). Nevertheless, a party's failure to request cross-examination within the parameters of the seven-day period does not eliminate an ALJ's discretion to find "due diligence" under the facts of a particular case. *See* Admin. Order 1-1997, p. 5, n. 3 (March 19, 1997). In any event, under the circumstances of this particular case, we conclude that the ALJ did not abuse his discretion in declining to grant a continuance of the hearing for the deposition of Dr. Tanabe.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is $900, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 20, 1998 is affirmed. For services on review, claimant's counsel is awarded $900, to be paid by the insurer.

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[2] OAR 438-006-0081(5) provides, "For purposes of this rule, 'due diligence' shall include, but not be limited to, the unavailability of a medical or vocational expert witness for cross-examination by deposition/interrogatories prior to a scheduled hearing, provided that the request for cross-examination was made no later than seven (7) days after the requesting party received from another party a copy of a report from the medical or vocational expert witness accompanied written notice that the sending party is submitting the proposed exhibit for admission into evidence at a scheduled hearing."

In the Matter of the Compensation of
CYNTHIA J. THIESFELD, Claimant
WCB Case Nos. 99-00054 & 98-07403
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Wallace, Klor & Mann PC, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Otto's order that: (1) declined to direct the insurer to amend its acceptance of claimant's right shoulder strain to include rotator cuff tendinitis, subacromial tendinitis/bursitis, myofascial shoulder pain, parathesis in the right upper extremity and right shoulder impingement; (2) declined to award an attorney fee for the insurer's "de facto" and formal written denial of claimant's claimed shoulder conditions; (3) upheld the insurer's denial of her claim for a consequential depression condition; and (4) declined to assess a penalty for an allegedly unreasonable denial of the claimed right shoulder, hand and wrist conditions. On review, the issues are compensability, scope of acceptance, attorney fees and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the last finding of ultimate fact. We summarize the pertinent facts as follows:

Claimant was hired by the employer as a desk clerk on September 8, 1995. On August 7, 1997, she tripped and fell over some cash drawers that were piled on the floor. She fell with her right arm outstretched and hit a metal container. Claimant initially experienced right wrist discomfort and later pain in the right shoulder.

Claimant sought treatment the day of her injury and was diagnosed with a right hand contusion, right wrist strain and right shoulder strain. (Exs. 1, 2). Claimant's right shoulder symptoms continued and, by early September 1997, Dr. Walton suspected a significant right shoulder injury. A MRI scan showed the presence of rotator cuff tendinitis. (Exs. 8, 9, 9A, 12).

On September 30, 1997, claimant was examined by Dr. Stanford at the insurer's request. He diagnosed subacromial tendinitis/bursitis of the right shoulder related to claimant's fall at work. Dr. Stanford also found significant pain behavior. (Ex. 10).

In October 1997, claimant was referred to Dr. Fechtel for a neurological evaluation. Dr. Fechtel diagnosed a right shoulder injury with rotator versus subacromial bursa inflammation and myofascial pain with depression. (Exs. 11B, 14A, 15).

Dr. Walton released claimant to work without restrictions on April 28, 1998. He believed claimant was medically stationary without permanent impairment. (Ex. 20). On May 18, 1998, the insurer issued an Updated Notice of Acceptance at Closure again indicating that it had accepted a disabling right shoulder strain. (Ex. 21). Thereafter, the claim was closed by a June 3, 1998 Determination Order that awarded temporary disability only. (Ex. 22).

On July 31, 1998, claimant's counsel wrote the insurer requesting that the following conditions be accepted pursuant to ORS 656.262(6)(d): Right hand contusion, right wrist strain, rotator cuff tendinitis, subacromial tendinitis/bursitis of right shoulder, myofascial pain syndrome with depression, parathesis in right upper extremity, and right shoulder impingement. (Ex. 22A). The insurer did not respond to this correspondence within 30 days and, on September 16, 1998, claimant requested a hearing alleging a "de facto" denial and seeking penalties and attorney fees.

On October 23, 1998, Dr. Walton agreed that claimant's accepted right shoulder strain encompassed the other right shoulder conditions (*i.e.*, rotator cuff tendinitis, subacromial tendinitis/bursitis, myofascial pain and impingement) mentioned in the medical reports. Dr. Walton also concurred that the parathesia of the right upper extremity would also be encompassed within the diagnosis of shoulder strain. (Ex. 24)

Thereafter, on December 9, 1998, the insurer denied compensability of the seven conditions listed in claimant's July 31, 1998 request. The insurer asserted that these conditions "are not compensably related to [claimant's] industrial injury of August 7, 1997." (Ex. 25). Claimant requested another hearing challenging the December 9, 1998 denial.

CONCLUSIONS OF LAW AND OPINION

Scope of Acceptance/Right Shoulder Conditions

Relying on the opinion of Dr. Walton that the diagnosis of right shoulder strain would encompass the other diagnosed right shoulder and right upper extremity conditions, the ALJ concluded that the insurer's acceptance was sufficient to apprise claimant and her medical providers of the nature of her compensable right shoulder condition. We adopt and affirm this determination. ORS 656.262(7)(a) (a carrier is not required to accept each and every diagnosis or medical condition with particularity, so long as the acceptance tendered reasonably apprises the claimant and medical providers of the nature of the compensable conditions).

Attorney Fee/Right Shoulder Conditions

At hearing, claimant asserted an entitlement to an attorney fee arising out of the insurer's "de facto" and subsequent formal written denial of the compensability of her claimed right shoulder conditions. Finding that the claimed right shoulder conditions were subsumed within the insurer's acceptance of a right shoulder strain, the ALJ upheld the insurer's denial. Likewise, the ALJ declined to award an attorney fee in connection with the insurer's "de facto" and December 9, 1998 denial of these conditions.

On review, claimant asserts that, even if the claimed right shoulder conditions were encompassed by the acceptance of a right shoulder strain, she is entitled to an attorney fee based upon the insurer's "de facto" and formal denial of those conditions. Under the circumstances of this case, we agree with claimant.[1]

ORS 656.262(6)(d) directs a claimant who believes that a condition has been incorrectly omitted from a notice of acceptance to communicate his or her objections to the notice in writing to the carrier. The same statute then directs the carrier to revise the notice of acceptance or make other written clarification in response within 30 days from receipt of the claimant's written communication. ORS 656.386(1), the attorney fee statute, authorizes a fee in cases involving "denied claims." But in the context of an objection to a notice of acceptance, ORS 656.386(1)(b)(B) defines a "denied claim" as a claim for compensation for a condition omitted from a notice of acceptance "which the insurer or self-insured employer does not respond to within 30 days."

Here, on July 31, 1997, claimant wrote to the insurer objecting to the updated notice of acceptance and requesting, among other things, that the insurer accept a number of right shoulder and right upper extremity conditions. Therefore, under ORS 656.262(6)(d), the insurer was required to either revise the notice of acceptance or make other written clarification in response. *See, e.g., Latoy E. Hamilton*, 51 Van Natta 724 (1999) (the carrier's response within 30 days of the claimant's request for an expanded acceptance complied with ORS 656.262(6)(d) and 656.386(1)(b)); *see also Kris Henrickson*, 51 Van Natta 401 (1999). But the insurer in this case did not issue any response to claimant's July 31, 1997 letter within 30 days of its receipt of the communication. This inaction resulted in a "denied claim" under ORS 656.386(1)(b).

Further, when the insurer did respond to claimant's communication by issuing the December 9, 1998 denial, the insurer did not clarify its position that the claimed right shoulder conditions were subsumed within its acceptance of a right shoulder strain. To the contrary, the insurer specifically denied that these conditions were compensably related to claimant's August 7, 1997 injury.

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[1] Because the diagnosed right shoulder and right upper extremity conditions are encompassed within the insurer's prior acceptance, we also reverse that portion of the ALJ's order that upheld the insurer's denial of those diagnosed conditions.

Because this case involves a denied claim under ORS 656.386(1), and we have determined that claimant's claimed right shoulder conditions are compensable (even though the various right shoulder and right upper extremity diagnoses are encompassed by the insurer's acceptance of a right shoulder strain), claimant is entitled to a reasonable attorney fee for prevailing over the denial of the otherwise compensable right shoulder conditions.

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review for prevailing over the insurer's denial of her right shoulder and right upper extremity conditions is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to this issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Compensability/Depression Condition

We adopt and affirm the ALJ's determination that claimant failed to prove by a preponderance of the evidence that her August 6, 1997 industrial injury was the major contributing cause of her depression condition or any worsening of a preexisting depression condition. *See* ORS 656.005(7)(a)(A).

Penalty

The ALJ found that the insurer's denial was not unreasonable and declined to award a penalty under ORS 656.262(11)(a). Alternatively, the ALJ found that even if the insurer's denial was unreasonable, claimant had not establish any compensation due, therefore no penalty could be assessed.

On review, claimant does not dispute that there are no "amounts then due" on which to base a penalty. Rather, claimant maintains that the insurer's December 9, 1998 denial was unreasonable and requests a penalty-related attorney fee under ORS 656.382(1). In response, the insurer asserts that claimant neither raised nor preserved this issue at hearing, and, alternatively, even if claimant had raised the issue, there is no evidence of unreasonable resistance to the payment of compensation.

After reviewing the record, we agree with the insurer that claimant did not raise the issue of a ORS 656.382(1) penalty-related attorney fee at hearing. We therefore decline to consider the issue for the first time on appeal. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991).

ORDER

The ALJ's order dated February 10, 1999 is affirmed in part and reversed in part. That part of the ALJ's order that upheld the insurer's December 9, 1998 denial of compensability of claimant's right shoulder rotator cuff tendinitis, subacromial tendinitis/bursitis, parathesis in the right upper extremity and right shoulder impingement is reversed. That part of the order that declined to award an attorney fee pursuant to ORS 656.386(1)(b)(B) for claimant's counsel's services regarding the right shoulder and right upper extremity conditions is also reversed. For services at hearing and on Board review regarding the denial of the right shoulder and right upper extremity conditions, claimant's attorney is awarded $1,000, to be paid by the insurer. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
RANDOLPH KING, Claimant
WCB Case No. 98-03799
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that upheld the self-insured employer's denial of claimant's back injury claim. On review, the issue is compensability.[1] We affirm.

We adopt the ALJ's order, except for the last two sentences of the last full paragraph on page 3 and the first full paragraph on page 4. In addition, we offer the following supplementation.

The claim is for an April 20, 1998 unwitnessed back injury. The medical evidence generated that day indicates that claimant reported that he had been having headaches off and on for a month. (Ex. 2a). It does *not* indicate that claimant told the doctor that he hurt himself at work that day. *(Id)*. In addition, the emergency room diagnosis was *chronic* neck pain. *(Id)*. Claimant testified that he could not remember what he told the doctor that day and he never had neck problems before the April 20, 1998 incident. (Tr. 49-50). However, the emergency room doctor clearly distinguished between claimant's headaches and neck symptoms and we cannot reconcile the discrepancy between the chronic neck pain diagnosis, claimant's testimony, and the fact that the report fails to mention the alleged very recent work incident.

We also note that claimant testified that he applied for unemployment benefits on May 12, 1998 even though he was not laid off from his "job-at-injury" until May 20, 1998.[2] (*See* Tr. 25, 32-33). He also testified that he started a new job on June 25, 1998, but later acknowledged that he started it on May 12. (*See* Tr. 32, 53-54). We find claimant's testimony regarding these employment matters unresponsive and implausibly uncertain, because the unemployment application, lay-off, and re-employment all occurred within three months of the hearing. Consequently, we agree with the ALJ that claimant's testimony regarding collateral matters was evasive. Under these circumstances, we conclude that claimant's reporting is not generally reliable and we are not persuaded that he suffered an injury at work on April 20, 1998.

ORDER

The ALJ's order dated September 8, 1998 is affirmed.

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[1] Claimant also argues that the ALJ abused her discretion in admitting claimant's May 12, 1998 application for Oregon unemployment benefits. (Ex. A). Claimant contends that the application is not relevant (because it does not bear on the circumstances of his injury) and that its probative value is outweighed by its prejudicial effect. We do not reach the evidentiary issue, because we reach the same result without considering the application.

[2] Claimant's attorney asked him if he was laid off from the first job when he applied for unemployment benefits on May 12, 1998 and claimant responded "that could possibly be about the date," but he "thought it was about May 20th." (Tr. 33).

In the Matter of the Compensation of
JENNY LONGORIA, Claimant
WCB Case No. 98-07977
ORDER ON REVIEW
Pozzi, Wilson & Atchison, Claimant Attorneys
SAFECO Legal, Defense Attorney

Reviewed by Board Members Haynes, Bock, and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Menashe's order that: (1) set aside its denial of claimant's occupational disease claim for a right shoulder condition; and (2) assessed a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant has a right shoulder condition for which she seeks benefits as an occupational disease. The record contains two medical opinions concerning causation; both physicians agree that claimant has preexisting calcification and a Type III acromion that combined with her work activities. (Exs. 9, 11-6). Thus, claimant must prove that "employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease." ORS 656.802(2)(b).

Here, the sole report supporting compensability is from claimant's treating orthopedic surgeon, Dr. Mandiberg. He stated:

> "[Claimant] does have some calcification in her coracoacromial ligament which is indeed the result of some degeneration and could be causing her problem, although I cannot state that that is the major reason for her problem. I think that the major reason for her present problem is the work activities superimposed upon a preexisting calcification with the coracoacromial ligament and the previously mentioned Type III acromion." (Ex. 9).

Absent persuasive reasons to the contrary, we defer to the treating physician's opinion. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find reasons not to defer to Dr. Mandiberg's opinion. First, his opinion is conclusory in that it provides no explanation why claimant's work activities, as opposed to the preexisting conditions, are the major contributing cause. Furthermore, Dr. Mandiberg does not address the cause of any pathological worsening of the disease. Thus, even if otherwise persuasive, his report does not fully satisfy claimant's burden under ORS 656.802(2)(b).

The remaining opinion from examining orthopedic surgeon, Dr. Fuller, finds that the preexisting conditions are the major contributing cause of claimant's need for treatment. Consequently, whether or not Dr. Fuller's opinion is reliable, because we are not persuaded by Dr. Mandiberg's opinion, claimant did not carry her burden of proving compensability. *See* ORS 656.802(2)(b).

Penalty

Having decided that the claim is not compensable, there are no "amounts then due" upon which to base a penalty. *See* ORS 656.262(11)(a).

ORDER

The ALJ's order dated January 19, 1999 is reversed. The self-insured employer's denial is reinstated and upheld. The penalty and attorney fee awards also are reversed.

Board Member Phillips Polich dissenting.

I disagree with the majority that claimant did not prove compensability. Thus, I dissent from the majority's order reversing the ALJ's order.

I agree with the ALJ's evaluation that Dr. Mandiberg provided the most convincing opinion when he found that, after considering claimant's preexisting conditions, work was the major contributing cause of her right shoulder condition. Unlike Dr. Fuller, Dr. Mandiberg relied on an accurate history. As the ALJ explained, there is insufficient evidence to support Dr. Fuller's opinion that claimant's "sleeping activities" for one night preceded her symptoms. Rather, the record shows that claimant began experiencing pain while working and her symptoms gradually increased to the point that she had difficulty sleeping on her shoulder. This was the history relied upon by Dr. Mandiberg in stating that work activities were the major cause of claimant's right shoulder condition. Consequently, like the ALJ, I would defer to Dr. Mandiberg's opinion and conclude that claimant carried her burden of proving compensability.

June 18, 1999 Cite as 51 Van Natta 989 (1999)

In the Matter of the Compensation of
LISA E. ALLEN, Claimant
WCB Case No. 98-04958
ORDER OF DISMISSAL
Carney, et al, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

The insurer requested review of that portion of Administrative Law Judge (ALJ) Tenenbaum's order that set aside its denial of claimant's occupational disease claim insofar as it pertained to claimant's right carpal tunnel syndrome. The parties have submitted a proposed "Disputed Claim Settlement Agreement" that is designed to resolve all issues raised or raisable between them, in lieu of the ALJ's order.

Pursuant to the settlement, the parties agree that the insurer's denial, as supplemented in the agreement, "shall forever remain in full force and effect." The parties further stipulate that "claimant's Request for Hearing thereon shall be dismissed with prejudice as to all issues raised or raisable between the parties."

We have approved the parties' settlement, thereby fully and finally resolving this dispute, in lieu of the ALJ's order.[1] Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] In reciting a list of outstanding bills from medical service providers that were in the insurer's possession on the date the settlement terms were agreed on, the agreement states that the amounts to be reimbursed from the settlement in partial payment of those bills "are equivalent to 50 percent of the total billings in possession of the employer/carrier at the time the settlement was reached, and do not exceed 40 percent of the total settlement amount, in accordance with the reimbursement formula prescribed in ORS 656.313(4)(d)." Pursuant to ORS 656.313(4)(d), reimbursement to medical service providers "shall be made at one-half the amount provided under ORS 656.248." Because the parties acknowledge that the proposed reimbursement is "in accordance with the reimbursement formula prescribed in ORS 656.313(4)(d)," we conclude that the "total billings" listed in the agreement are synonymous with the phrase "the amount provided under ORS 656.248." As so interpreted, the agreement's reference to payments for outstanding medical bills equal to "50 percent of the total billings" constitutes reimbursement to the medical service providers in a manner consistent with the statutory formula. Based on this analysis, we have approved the parties' settlement. *See* OAR 438-009-0010(2)(g).

In the Matter of the Compensation of
ROY H. McDONALD, Claimant
WCB Case Nos. 98-01225 & 98-00507
ORDER ON REVIEW
Kryger, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Liberty Northwest Insurance Corporation requests review of those portions of Administrative Law Judge (ALJ) Howell's order that set aside its denial of claimant's occupational disease claim for left lateral epicondylitis. Liberty also requests remand for further development of the record. On review, the issues are remand, "back-up" denial, and compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" with the following modification and additions.

We do not adopt the ALJ's finding that Liberty accepted and processed claimant's left elbow claim.

In lieu of the ALJ's finding that claimant first sought treatment on July 28, 1996, we find that the first treatment was on July 28, 1997.

We make the following additional finding. Claimant's objective examination findings included left elbow swelling, reduced left elbow motion and reduced left grip strength.

CONCLUSIONS OF LAW AND OPINION

On review, Liberty contends that the ALJ erred in concluding that the record established the compensability of claimant's occupational disease claim under ORS 656.802(2)(a) and (d). Liberty also challenges the ALJ's alternative conclusion that its denial is an impermissible "back-up" denial of a previously accepted condition. *See* ORS 656.262(6)(a). Liberty requests remand for further development of the record on this procedural issue. *See* ORS 656.295(5).

As supplemented below, we adopt and affirm the ALJ's conclusion and rationale that claimant's occupational disease claim is compensable on the merits. We affirm the ALJ's order solely on this basis without addressing the alternative "back-up" denial rationale.

Claimant must establish the existence of his left lateral epicondylitis with medical evidence supported by objective findings. ORS 656.802(2)(d). "Objective findings" are "verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength and palpable muscle spasm." ORS 656.005(19).

We agree with the ALJ's conclusion that the requisite "objective findings" are established by Dr. Orton's July 28, 1997 examination finding of slight left elbow swelling, and Dr. Dodds' September 17, 1998 findings of 1+ left elbow swelling and reduced left elbow extension. (Exs. 3-1 and 34). We also note that the ALJ's conclusion is supported by Dr. Watanabe's October 17, 1999 finding of reduced elbow range of motion of 0 to 135, and the physical therapist's December 9, 1997 finding of reduced left grip strength and reduced left elbow flexion of 145 degrees. (Exs. 10, 21, 22). We are not persuaded by Liberty's argument that this evidence is not probative because Drs. Watanabe and Arbeene did not appreciate significant objective findings. (Exs. 14, 18, 25, 26, 28, 28A, 30-1, 31-2). These doctors were only considering their own examination findings without regard to the objective findings reported by the physical therapist and Drs. Orton and Dodds. Moreover, Dr. Watanabe examined claimant after he left his strenuous work activity, and Dr. Arbeene examined claimant after he left employment, and after his left elbow condition improved with conservative treatment. As noted by the ALJ, the absence of objective findings is explained by the waxing and waning of claimant's symptoms with treatment and decreased activity.

We also agree with the ALJ's conclusion that the medical record establishes that claimant's work activity is the major cause of his left lateral epicondylitis. *See* ORS 656.802(2)(a). In so doing, we do not share the ALJ's characterization of Dr. Arbeene's opinion as supporting a major causal relationship. (Ex. 29-1).[1] Furthermore, Dr. Dodds' opinion that claimant's condition is "consistent" with his work activity does not satisfy the requisite major contributing cause standard. (Ex. 34-2). Nevertheless, we agree with the ALJ's conclusion and rationale that Dr. Watanabe's opinion supports a *probable* major causal relationship between claimant's work activity and his left lateral epicondylitis. (Exs. 13, 30, 31). Moreover, as noted by the ALJ, there is no contrary medical opinion. Finally, we are not persuaded by Liberty's reliance on claimant's off-work symptoms. Specifically, Liberty notes that claimant's elbow hurt more after he quit work, and more at night when he was working. (Tr. 21, 28). This evidence is not persuasive because the causation issue in this case is a complex medical question, and no medical expert has identified claimant's off-work symptoms as a significant factor in determining causation. *See Barnett v. SAIF*, 122 Or App 279, 283 (1993) (cases involving complex medical issues must be resolved by expert medical opinion). *See also Uris v. Compensation Department*, 247 Or 420 (1967).

In summary, for the reasons discussed above, we affirm the ALJ's order setting aside Liberty's denial of claimant's occupational disease claim. Consequently, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $800, payable by Liberty. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 8, 1999 is affirmed. For services on review, claimant's counsel is awarded $800, payable by Liberty Northwest Insurance Corporation.

[1] Dr. Arbeene agreed that "if [claimant's] upper extremity conditions (left and right) were work related, the major contributing cause of both the left elbow and right biceps condition would be the work exposure with [Liberty]." We do not interpret this statement as an opinion that the work activity was probably the major contributing cause of claimant's left lateral epicondylitis. Rather, Dr. Arbeene was merely assuming compensability for the limited purpose of rendering an opinion on the responsibility issue.

June 21, 1999 Cite as 51 Van Natta 991 (1999)

In the Matter of the Compensation of
DEBBY R. COLDIRON, Claimant
WCB Case No. 98-07837
ORDER ON RECONSIDERATION
Cole, Cary, et al, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Claimant requests reconsideration of our June 3, 1999 order that dismissed her request for Board review. Claimant asserts that neither she nor her attorney received a copy of the Board's order and requests republication of our order.

The Board may republish an order if it finds that it failed to *mail* a copy of its prior order to a party. *Berliner v. Weyerhaeuser Company*, 92 Or App 264, 266-67 (1988); *Mary J. Gates*, 42 Van Natta 1813 (1990).[1] Here, claimant and her attorney assert that they did not *receive* a copy of our order. Yet, the finality of a Board order is premised on whether the order was *mailed* to all parties to the proceeding, not on whether all parties *received* the order. *See Lee R. Jones*, 48 Van Natta 1286 (1996).

In light of such circumstances, we do not consider our order to be invalid. In any event, based on the circumstances presented in claimant's motion, we have withdrawn our June 3, 1999 order for reconsideration.

[1] Attorneys are not considered "parties." *See Haskell Corporation v. Filippi*, 152 Or App 117 (1998). Thus, an attorney's failure to receive a copy of the order does not necessitate republication. *See Lee R. Jones*, 48 Van Natta 1286, 1287 (1996).

On reconsideration, as supplemented herein, we republish our June 3, 1999 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

June 18, 1999 Cite as 51 Van Natta 992 (1999)

In the Matter of the Compensation of
PHILIP M. NEMEC, Claimant
WCB Case No. 98-07548
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Marshall's order that: (1) set aside its denial of claimant's injury claim for a cervical and thoracic condition; and (2) awarded an assessed fee of $3,000 for claimant's counsel's services at hearing. SAIF also moves for remand. On review, the issues are remand, compensability and attorney fees.

We deny SAIF's motion for remand and adopt and affirm the ALJ's order with the following supplementation regarding the attorney fee and remand issues.

The ALJ set aside SAIF's denial of claimant's thoracic and cervical condition and assessed a $3,000 attorney fee, having "considered the factors set forth in OAR 438-015-0010(4)."[1]

On review, SAIF contends that *Schoch v. Leupold & Stevens*, 325 Or 112 (1997), and *McCarthy v. Oregon Freeze Dry*, 327 Or 84, *adhered to on recon* 327 Or 185 (1998), required the ALJ to: (1) make findings for each factor in OAR 438-015-0010(4); (2) draw conclusions from those findings of fact; and (3) demonstrate how the conclusions are weighed in determining a reasonable attorney fee. Because the ALJ did not provide such reasoning, SAIF argues that, in the event we affirm the ALJ's compensability finding, we should remand the case "with instructions to take evidence and properly apply OAR 438-015-0010(4)."

We considered the same argument in *Daryl L. Underwood*, 50 Van Natta 2330 (1998). There, the claimant's attorney did not submit a specific fee request and the parties did not provide any argument at hearing concerning the application of the factors in OAR 438-015-0010(4). After analyzing *McCarthy*, we found that the Court held that a lower body need not address facts and legal criteria that are not material to its decision and could "satisfy its obligation to make findings in a case * * * by including in its order a brief description or citation to the factor or factors on which it relies in denying an award of attorney fees." 327 Or at 188.

In short, because the statute considered by the Court in *McCarthy* contained the same requirement in OAR 438-015-0010(4) that the reviewing bodies "shall consider" certain enumerated factors, we held that it is sufficient for an ALJ to merely describe or cite the rule-based factor or factors the ALJ relied on in determining a reasonable attorney fee where there was no specific attorney fee requested and the parties did not submit to the ALJ any argument as to how the rule-based factors should be weighed in determining a reasonable fee. Thus, we rejected the carrier's argument in *Underwood* that the ALJ was required to make findings for each rule-based factor.

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[1] OAR 438-015-0010(4) provides that "[i]n any case where an Administrative Law Judge or the Board is required to determine a reasonable attorney fee, the following factors shall be considered: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses."

Here, as in *Underwood*, claimant's attorney did not submit a statement of services or make a specific attorney fee request and SAIF did not (and continues not to) provide any discussion or argument concerning the application of the rule-based factors. Thus, we disagree with SAIF's contention that the ALJ was required to make findings and render conclusions on each rule-based factor. *See SAIF v. Bacon*, 160 Or App 596 (1999) (detailed findings and elaborate explanation of attorney fee award unnecessary in absence of objection to reasonableness of award).

Furthermore, having found the ALJ's order sufficient and because we may modify or supplement it on review, we do not find the record to be improperly, incompletely, or otherwise insufficiently developed. Consequently, we deny SAIF's motion for remand. *Daryl L. Underwood*, 50 Van Natta at 2332; *William G. Ballew*, 51 Van Natta 195 (1999).

Finally, we provide the following additional reasoning. With regard to the time factor, we note that the hearing lasted one hour and two witnesses, including claimant, testified. The record consisted of approximately 40 exhibits, including at least one medical report generated by claimant's attorney.

Compared with compensability disputes presented to this forum for resolution, we find that the compensability issue is of average complexity. The value of the interest involved and the benefit secured for claimant are also average. Because the medical reports concerning causation were divided, there was a risk claimant's attorney might go uncompensated. Finally, both attorneys were experienced and skillful.

Based on these factors, especially the complexity of the issues, the value of the interest involved and the risk that claimant's counsel might go uncompensated, we agree with the ALJ that $3,000 is a reasonable attorney fee. Because attorney fees are not "compensation" for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for his counsel's services on Board review regarding the defense of the ALJ's attorney fee award. *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

Claimant's attorney is, however, entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated February 8, 1999 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by SAIF.

In the Matter of the Compensation of
JON E. BALL, Claimant
WCB Case No. 99-00312
ORDER ON REVIEW
James E. Dodge, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that set aside an Order on Reconsideration that rescinded a Notice of Closure as prematurely issued. On review, the issue is premature closure.

We adopt and affirm the ALJ's order with the following supplementation.

Citing *Estella M. Rogan*, 50 Van Natta 205 (1998), the ALJ set aside an Order on Reconsideration that rescinded a Notice of Closure as premature because the claim had been closed without sufficient information to determine the extent, if any, of claimant's disability. (Ex. 10-2). The ALJ determined that, under *Rogan*, the Department had no authority to rescind the closure notice.

On review, claimant argues that *Rogan*, and a more recent case following *Rogan*, *Frankie Laverdure*, 51 Van Natta 334 (1999), are distinguishable because, unlike those cases, the attending physician here indicated that claimant has permanent impairment. Claimant urges us to carve out an exception to the *Rogan* rationale and require a closing examination before claim closure, even though the claimant is medically stationary and released to return to work, where the attending physician states that the claimant has permanent impairment. For the following reasons, we decline claimant's invitation to depart from our reasoning in *Rogan*.

We held in *Rogan* that the Department is not authorized to set aside a carrier's closure notice as premature on the basis that the carrier did not obtain adequate closing information pursuant to OAR 436-030-0020(1) through (4). There, the carrier closed the claimant's claim by Notice of Closure based on the attending physician's declaration that the claimant's condition was medically stationary without permanent residuals. On reconsideration, the Department rescinded the closure notice, reasoning that, because no closing examination had been performed, the carrier did not obtain adequate closing information. The ALJ affirmed the Order on Reconsideration. On review, we reversed, finding that neither the statutes nor the rules require a closing examination report as a prerequisite for issuance of a carrier's closure notice.

In reaching this conclusion, we explained that ORS 656.268(4)(a) sets forth only two prerequisites for a carrier's claim closure. The claim may be closed when: (1) the worker's condition has become medically stationary and the worker has returned or been released to work; or (2) the accepted injury is no longer the major contributing cause of the worker's combined or consequential condition. We reasoned that, because a closing examination report is not a condition precedent to issuance of a closure notice, the absence of such a report was not grounds for setting aside a closure notice as "premature." We also noted that, to the extent OAR 436-030-0020(4)(a) could be read to require a closing examination prior to issuance of a valid closure notice, the rule exceeded the terms of ORS 656.268 and should be given no effect. *Rogan*, 50 Van Natta at 205.

After considering claimant's arguments, we decline to depart from our holding in *Rogan*, which was based on a thorough analysis of the relevant statute. Here, the medical evidence established that claimant's accepted condition was medically stationary and that claimant was released for modified work prior to the employer's issuance of the Notice of Closure. (Exs. 4-10, 5-7, 6). Thus, the statutory conditions precedent to issuance of the closure notice were satisfied in this case. *See* ORS 656.268(4)(a). Because the employer's Notice of Closure was authorized by statute, it is valid. The Department had no authority to rescind the Notice of Closure. *Rogan*, 50 Van Natta at 206.

ORDER

The ALJ's order dated April 30, 1999 is affirmed.

In the Matter of the Compensation of
TONY L. BENNETT, Claimant
WCB Case No. 98-07730
ORDER ON REVIEW
James E. Dodge, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock, and Phillips Polich.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Davis' order that upheld the SAIF Corporation's partial denial of claimant's injury claim for a current right knee condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order, with the following supplementation.

This case is medically complex: Claimant had two right knee injuries at work (in 1996, in Maryland, and in 1997, in Oregon); two right knee surgeries (by Dr. Friedler in Maryland in 1996 and Dr. Harris in Oregon in 1998); multiple right knee diagnoses -- including chondromalacia of the medial femoral condyle, loose bodies, synovial overgrowth, a torn medial meniscus, and a torn anterior cruciate ligament (ACL).

SAIF accepted claimant's September 27, 1997 injury claim for a disabling right knee sprain and a torn medial meniscus. After Dr. Harris removed claimant's right medial meniscus on March 4, 1998, Dr. Brenneke recommended ACL reconstruction, and SAIF denied claimant's current condition and need for treatment.

The ALJ upheld SAIF's denial, finding that questions about claimant's credibility made it difficult to know what claimant's condition was prior to the Oregon injury. Considering claimant's videotaped activities, (*see* Ex. 50), and several doctors' reactions to the video, the ALJ concluded that claimant misrepresented his disability to his doctors. Therefore, the ALJ upheld the denial, reasoning that medical opinions supporting the claim were not persuasive because they were based on claimant's unreliable history. We agree.

The pivotal question is whether claimant's 1997 injury was the major contributing cause of his current condition, disability, and/or need for treatment for his right knee.[1]

The dissent argues that we should rely on Dr. Brenneke's opinion and conclude that the video surveillance tape does not contradict claimant's reporting regarding his right knee disability.[2] We are not persuaded by Dr. Brenneke's opinion for several reasons.

First, Dr. Brenneke reasoned that claimant's current need for treatment "has to be related" related to the 1997 injury, rather than the preexisting condition, because claimant did not have a complete ACL tear or ACL insufficiency, until after the later injury. (Ex. 40-2). Dr. Brenneke's reasoning is not persuasive because it is based on little more than a temporal relationship between claimant's current condition and the 1997 injury. *See Theresa Harrison*, 50 Van Natta 1350 (1998) (physician's opinion inadequately explained and unpersuasive because based on temporal relationship without weighing relative contributions of injury and preexisting condition).

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[1] The ALJ and the parties agreed that claimant has a "combined" condition involving a preexisting ACL condition and the 1997 work injury-- and he is therefore subject to the "major contributing cause" standard of proof under ORS 656.005(7)(a)(B).

[2] The dissent also argues that Dr. Friedler's opinion persuasively supports the claim. But Dr. Friedler did not examine claimant after February 1997. Consequently, he was not in a good position to compare claimant's condition before and after the September 1997 injury. Moreover, Dr. Friedler reasoned that the latter injury is the major cause of claimant's current condition only because claimant's right knee was not unstable at the time of the 1996 surgery, but he has right knee laxity now. (Ex. 47). We find Dr. Friedler's opinion inadequately explained because it is based on nothing more than a temporal relationship between the 1997 injury and claimant's right knee laxity. *See Bradshaw v. SAIF*, 69 Or App 587, 589 (1984) (causation not logically inferred from temporal sequence unless all other explanations excluded); *Donald A. Cook*, 51 Van Natta 112, 115 (1999).

Second, we disagree with Dr. Brenneke's impression of the June 1998 surveillance video. The video shows claimant carrying a 110 pound woman on his back down a flight of stairs without difficulty.[3] The video also shows claimant kneeling on his knees later and walking normally at all times.[4] We observed no indication of right knee discomfort or disability in the video.

Dr. Brenneke watched the same video and stated, "I did see one time when [claimant's] lady friend was on his back for a few steps and it was quite obvious that when she was let down that he had significant limping and troubles with his knee." (Ex. 46-1). Claimant testified that he carried his girlfriend a "couple feet" on that occasion and "clearly when I dropped her off my back I rubbed my knee. The first thing I grabbed was my knee." (Tr. 23). But we observed no such conduct and no sign of right knee discomfort or disability. We also note that Drs. Harris, Stanford, and Dineen watched the video and concluded that claimant misrepresented his right knee condition and disability to them, based on the video.[5] (*See* Exs. 39-2, 48A, 49). Under these circumstances, we do not find Dr. Brenneke's interpretation of the video persuasive and we conclude that claimant's reporting is unreliable.

Finally, we note that Dr. Harris was in a particularly advantageous position to assess the nature of claimant's current condition because he performed claimant's March 4, 1998 surgery. Dr. Harris observed that claimant had a prior partial ACL tear and reported that the ACL "appeared to have been avulsed at some time in the past." (Ex. 31). After viewing the video, Dr. Harris stated that claimant had misrepresented his actual abilities and reported more restrictions than shown on the video. (Ex. 41-2). Considering claimant's preexisting condition and his misrepresentations, Dr. Harris could not say that claimant's 1997 injury was the major cause of his current need for treatment. (Ex. 48). We find Dr. Harris' opinion more persuasive than Dr. Brenneke's, because it is better reasoned. *See Richard R. Rinehart*, 51 Van Natta 173 (1999) (physician's opinion unpersuasive because it inadequately explained contribution of work injury as compared to preexisting condition) (citing *Deitz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 321 Or 416 (1995)).[6] Accordingly, based on Dr. Harris' opinion, we agree with the ALJ that claimant has not established that his 1997 work injury was the major contributing cause of his current right knee condition or his disability and/or need for treatment for that condition.

ORDER

The ALJ's order dated January 19, 1999 is affirmed.

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[3] Claimant testified that this occurred when he was leaving Dr. Harris' office --presumably on June 18, 1997, the date shown on the video. (*See* Tr. 22-23; Ex. 35-2).

[4] At one point, claimant unwrapped a bandage from his right knee before walking some distance to a swimming area.

[5] Dr. Stanford stated that claimant's level of activity on the video "was not only different than what he showed in the office today, but different from what he has told me he can do." (Ex. 48A-8).

[6] *See also Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) ("[The doctor's] conclusions are valid as to the matter of causation only to the extent that the underlying basis of those opinions, the reports of claimant as to the circumstances of the accident and the extent of the resulting injury, are accurate and truthful."); *James D. Shirk*, 41 Van Natta 90, 93 (1989) (a physician's opinion based on a patient's history is only as reliable as the history is accurate).

Member Phillips Polich dissenting.

Claimant suffered a right knee injury at work in 1996 (outside Oregon). Dr. Friedler operated on claimant's right knee and discovered severe chondromalacia of the medial femoral condyle, loose bodies, and fibers torn in the anterior cruciate ligament (ACL), as well as an intact meniscus, in September 1996.

On September 27, 1997, while working as a pipelayer in Oregon, claimant again injured his right knee and sought medical treatment. The insurer accepted a disabling right knee strain.

Dr. Harris operated on a torn medial meniscus and an ACL tear on March 4, 1998. Claimant's right knee complaints continued and Dr. Brenneke recommended ACL reconstruction.

On August 20, 1998, the insurer amended its acceptance to include a torn right medial meniscus. On August 26, 1998, the insurer issued a partial denial of claimant's right ACL tear, contending that the accepted Oregon injury did not cause claimant's current disability or need for treatment for his right knee. On August 27, 1998, a Notice of Closure awarded temporary disability and 10 percent scheduled permanent disability for loss of use or function of the right knee. Claimant requested a hearing.

The majority upholds the insurer's "current condition" denial, reasoning that claimant's history to physicians is unreliable because he misrepresented his condition to them. The majority relies on a surveillance video and "several doctors' reactions to it." I would reach the opposite result, for the following reasons.

First, I disagree with the majority's description of the video and I would finding it insignificant in any event, based on Dr. Brenneke's reasoning.

I observed claimant favoring his right knee throughout the video. I watched him carry a woman down some stairs "piggy back" style, and I agree with Dr. Brenneke that claimant "had significant limping and troubles with his knee" after that. Moreover, most of the video footage shows claimant relaxing in a park, performing very little physical activity. Even under those circumstances, I observed claimant changing his posture frequently, to accommodate and stretch his knee. In my view, claimant's conduct on the surveillance video supports, rather than refutes, his history.

Dr. Brenneke viewed the video and clearly stated that it did *not* contradict the physical capacities claimant demonstrated in the office and it did not affect the doctor's causation opinion. He explained that claimant *was* capable of working (despite his ACL condition), but not of doing such things as climbing up and down ladders, jumping in and out of holes, or performing vigorous activities on construction sites. (Ex. 46-1). The video does not show claimant doing any activities that Dr. Brenneke feels claimant cannot do and it does not therefore contradict claimant's demonstrated physical capacities. I would find Dr. Brenneke's interpretation persuasive and conclude that the video is insignificant to the medical question. I would also note that neither Dr. Harris nor the examiners explain why or how they rely on it.

Under these circumstances, I would find claimant's condition compensable, based on the well-reasoned opinions of Drs. Brenneke and Dr. Friedler. Dr. Brenneke correctly reported that claimant successfully returned to work after his 1996 right knee surgery and was able to participate in a very vigorous lifestyle. He also correctly noted that claimant's prior partial ACL tear was *not* considered significant in 1996, further noting that claimant's ACL was "reasonably intact" and functioning normally before the 1997 injury. (Ex. 40; *see* Ex. 3). Because claimant's closing examination after the 1996 surgery did not indicate significant ACL deficiency, but he had ongoing knee problems and "a well defined ACL insufficiency" after the 1997 injury, Dr. Brenneke reasoned that the 1997 injury was the major contributing cause of current need for treatment.[1]

Dr. Friedler, former treating surgeon, reviewed claimant's records in September 1998 and compared his current right knee condition to his condition at the time of the 1996 surgery. He noted that claimant had an intact medial meniscus in 1996 and his right knee was not then "found to be unstable." (Ex. 47). After reviewing the additional medical records, Dr. Friedler opined:

> "It is obvious that the patient did have tear of his medial meniscus and *now* has enough damage to his anterior cruciate ligament that he has a laxity. I would state at this point that at least 51% of [claimant's] difficulty with his knee is not due to his tear of the medial meniscus and the damage he has done to the anterior cruciate ligament from the accident of September 27, 1997. In summary, [claimant's] major contributing factor and need for surgery *at this time* was the accident of September 27, 1997." (*Id.* Emphasis added).[2]

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[1] The majority inappropriately characterizes Dr. Brenneke's opinion as "temporal."

[2] Considering Dr. Friedler's opinion as a whole, I conclude that the last sentence reflects his intended opinion and the prior sentence contains a scrivener's error: The word "not," which should logically be read as "now." Accordingly, I would interpret the letter as internally consistent, and delete the unintended negative.

Thus, considering the undisputed material changes in claimant's right knee condition since his 1996 surgery (*i.e.*, a torn medial meniscus and damage to the ACL sufficient to cause laxity), Dr. Friedler concluded that the (accepted) 1997 injury was the major cause of claimant's current need for right knee surgery. I would find Dr. Friedler's opinion persuasive, particularly considering his unique advantage as claimant's former treating surgeon.

I also disagree with the majority because the remaining medical evidence addressing causation is not helpful. Dr. Stanford opined that the major cause of claimant's ACL laxity was the 1996 injury (because partially frayed tendons usually progress to incompetency), but he was unable to assess the contribution from the 1997 injury. (Ex. 48A-7). After viewing the video, Drs. Dineen and Harris stated that claimant misrepresented his "actual abilities and level of impairment" upon examination, and Dr. Harris could not say that the 1997 injury contributed more than did claimant's preexisting condition. (*See* Ex. 39, 41, 48-2). But these doctors did not explain what aspect of the video "changed" their opinion. In fact, I would not say that the video *did* change their opinion, because Drs. Dineen and Harris did not support compensability even before they watched the video.

Moreover, Dr. Brenneke persuasively explained why the video is not significant to the causation issue and why the 1997 injury *is* the major contributing cause of claimant's current need for ACL reconstruction. Once the video is properly discounted, Drs. Brenneke and Friedler provide the only persuasive medical evidence addressing causation. Again, because the opinions of these doctors are well-reasoned and based on accurate and complete histories, I would rely on them and conclude that the claim is compensable. Accordingly, I must respectfully dissent.

In the Matter of the Compensation of
FREDERICK A. BURNSED, Claimant
WCB Case Nos. 98-04763 & 98-03402
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) upheld the SAIF Corporation's denial of his low back degenerative disc disease issued on behalf of its insured, HPS Construction; (2) upheld SAIF's compensability denial of claimant's current low back condition; and (3) upheld Liberty Northwest's compensability and responsibility denial of claimant's current low back condition issued on behalf of its insured, Grimmett Enterprises. On review, the issues are compensability and (potentially) responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant sustained a compensable low back injury on May 16, 1995, while lifting a pipe and working for Liberty's insured. Liberty accepted a nondisabling lumbosacral strain. A May 16, 1995 series of x-rays revealed no abnormalities in the lumbosacral spine. (Ex. 2). A subsequent MRI scan of November 5, 1996 was interpreted as revealing "diskogenic degenerative change--ventral annulus bulging" at L4-5. (Ex. 4).

In May 1997, claimant began working for SAIF's insured. In August 1997, a lumbar myelogram and CT scan showed "nonencroaching" disc bulges at L3-4 and L4-5. (Ex. 11-2).

On January 5, 1998, claimant filed a claim with SAIF for an injury that occurred on December 31, 1997 when he twisted and experienced increased low back pain while installing a large valve. X-rays taken on December 31st were interpreted as normal. (Ex. 18). An MRI of January 13, 1998 showed no significant change at L4-5 from the prior MRI. (Ex. 22-2).

On February 24, 1998, examining physicians Tiley and Platt identified "preexisting" degenerative disc disease as claimant's major problem. SAIF then accepted a lumbar strain, but denied lumbar degenerative disc disease on the ground that it was a "preexisting condition" and unrelated to the December 1997 injury. (Ex. 33). Claimant requested a hearing from the denial.

On May 7, 1998, Liberty issued a denial of compensability and responsibility for claimant's current low back condition in relation to the May 1995 claim. (Ex. 41cc). On June 23, 1998, SAIF issued another denial, this time of claimant's current low back condition after February 24, 1998, on the ground that the compensable lumbosacral strain was no longer the major contributing cause of claimant's need for treatment or disability of the "combined condition." (Ex. 45). Claimant requested a hearing from both denials.

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld SAIF's and Liberty's denials. In doing so, the ALJ found that claimant had a degenerative condition in his low back that pre-dated his compensable injuries. Deciding that claimant had "acquiesced" in the compensability issue being determined under ORS 656.005(7)(a)(B), the ALJ held that the 1995 Liberty injury was not the major contributing cause of claimant's current low back condition. The ALJ also determined that the medical evidence did not establish that claimant's compensable December 1997 injury (for which SAIF was responsible) was the major contributing cause of claimant's low back condition. In making this determination, the ALJ discounted the medical opinion of Dr. Gritzka, an examining physician, who opined that the December 1997 injury was the major contributing cause of instability or internal disc derangement at L4-5.

On review, claimant contends that there is no evidence that he had a degenerative condition that preexisted his May 1995 injury with Liberty's insured. Further, claimant asserts that Dr. Gritzka provided the most persuasive medical opinion and that it establishes that the December 1997 SAIF injury is the major contributing cause of his need for treatment. Accordingly, claimant argues that his current low back condition is compensable. For the following reasons, we agree with claimant's contentions.

Initially, based on our review of the written closing arguments, we agree with claimant that he did not "acquiesce" in the application of ORS 656.005(7)(a)(B). Moreover, we agree with claimant that the medical evidence does not establish that claimant had a back condition prior to the 1995 Liberty injury. In this regard, we note that the initial x-rays in 1995 were entirely normal. (Ex. 2). While subsequent medical reports and diagnostic studies have noted the presence of degenerative disc disease, there is no medical opinion that states that it preexisted the 1995 injury. As proof of the existence of a "preexisting" low back condition, however, the carriers point to claimant's reported statement to an ambulance driver that he had prior back problems for 20 years due to overuse in the construction business. Claimant, nevertheless, credibly testified that he told the ambulance driver that, after 20 years in construction work, a back injury was bound to happen. (Tr. 26). In light of claimant's credible testimony and our review of the medical record, we conclude that the existence of a low back condition prior to the May 1995 injury has not been established.

We need not definitively decide, however, whether this case involves a "combined" condition under ORS 656.005(7)(a)(B). That is, even if we were to apply ORS 656.005(7)(a)(B), we would still find that claimant satisfied his burden of proof under that statute. We reason as follows.

Under ORS 656.005(7)(a)(B), if an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition.

To satisfy the "major contributing cause" standard, claimant must establish that his compensable injury contributed more to the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). In other words, the persuasive medical opinion must evaluate the relative contribution of different causes and explain why the compensable injury to claimant's low back contributed more to the claimed conditions than all other causes or exposures combined. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). Furthermore, the fact that a work injury precipitated the symptoms of a condition does not necessarily mean that the injury was the major contributing cause of the condition. *Id.; see also Robinson v. SAIF*, 147 Or App 157, 162 (1997).

Because of claimant's multiple injuries, this claim presents a complex question of medical causation which requires expert medical evidence for its resolution. *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985); *Uris v. Compensation Department*, 247 Or 420, 424 (1967). We give greater weight to medical opinions that are well-reasoned and based on complete and accurate histories. *Somers v. SAIF*, 77 Or App 259 (1986).

In this case, Dr. Gritzka performed a comprehensive evaluation of claimant's low back condition and reviewed the relevant medical records, including the numerous imaging studies taken during the course of the two claims. (Ex. 42). Based on the above information, Dr. Gritzka diagnosed post-traumatic instability and internal disc derangement at L4-5. According to Dr. Gritzka, claimant's need for treatment was not due to a degenerative process that predated the May 1995 injury. Rather, the December 1997 injury was the major contributing cause of claimant's current low back condition and need for treatment. (Ex. 42-11). Dr. Gritzka explained that claimant's lumbar stress films showed instability at L4-5 and that the MRI scan showed a disc protrusion compatible with instability. Moreover, according to Dr. Gritzka, claimant's symptoms were compatible with L4-5 instability. In this regard, we note that a consulting physician, Dr. Nash, also diagnosed L4-5 instability. (Exs. 30, 39). This opinion supports Dr. Gritzka's conclusion that claimant's current low back condition is attributable to post-traumatic instability at L4-5.

Because Dr. Gritzka's opinion is thorough, well-reasoned and based on an accurate history, we find it persuasive. In addition, we find it more persuasive than the opinions of several examining physicians (Drs. Platt, Tiley, Podemski and Scheinberg), who opined that "preexisting" degenerative disc disease is the major contributing cause of claimant's need for treatment. (Exs. 28-7, 43-3, 48-4). As previously noted, x-rays taken on May 16, 1995, after the initial injury with Liberty, were entirely negative. (Ex. 2). Thus, we agree with claimant that there is no evidence that any degenerative disc disease preexisted the May 1995 injury. In addition, other diagnostic studies were not interpreted by radiologists as showing substantial degenerative disc disease. (Exs. 4, 11, 18, 22, 25, 41). This evidence supports Dr. Gritzka's opinion that, to the extent that claimant has degenerative disease, it is minimal.[1]

Accordingly, we conclude, based on our *de novo* review of the record, that the compensable December 1997 injury with SAIF, not degenerative disc disease, is the major contributing cause of claimant's current condition and need for treatment. Therefore, we conclude that claimant's current low back condition is compensable as to SAIF.[2]

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $5,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated December 17, 1998 is reversed in part and affirmed in part. SAIF's denials of compensability are set aside and the claim is remanded to SAIF for processing in accordance with law. The remainder of the ALJ's order is affirmed. For services at hearing and on review, claimant's counsel is awarded an assessed fee of $5,000, to be paid by SAIF.

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[1] A consulting neurosurgeon, Dr. Grewe also stated that diagnostic studies showed a "very minimal" amount of degenerative changes. (Ex. 41D-1). Dr. Grewe further opined that it was impossible to conclude that degenerative disc changes were the cause of claimant's back pain. *Id.*

[2] SAIF did not deny responsibility should we find that claimant's current low back condition is compensable. Even if we engaged in a responsibility analysis, however, we would find SAIF responsible for claimant's current low back condition because the medical evidence does not establish that the 1995 Liberty injury contributes to his current low back condition.

In the Matter of the Compensation of
ROY R. GARBER, Claimant
WCB Case Nos. 98-06096 & 98-05084
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that upheld the self-insured employer's denial of his injury claim for a low back condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation.[1]

We write only to address claimant's argument that the ALJ erred by ignoring the opinion of Dr. McDonald, who examined claimant on one occasion approximately three weeks after the May 4, 1998 work incident. (Ex. 30). Dr. McDonald diagnosed a lumbosacral strain and noted that claimant was tender in the area of his scar from a previous laminectomy. (*Id.*) In a January 1999 concurrence letter from claimant's attorney, Dr. McDonald agreed that claimant's work accident on May 4, 1998 was the major contributing cause of his need for treatment. (Ex. 38).

Because Dr. McDonald examined claimant on only one occasion, his opinion is not entitled to any particular deference as a treating physician. Moreover, we are not persuaded that Dr. McDonald had a complete history of claimant's low back symptoms. The concurrence letter signed by Dr. McDonald indicates that claimant did not seek any medical treatment from 1981 until 1997. There is no evidence that Dr. McDonald was aware that claimant was experiencing chronic low back pain before 1997. We conclude that Dr. McDonald's opinion is not persuasive because it is conclusory and is based on an incomplete history. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) (medical opinion that is not based on a complete and accurate history is unpersuasive).

ORDER

The ALJ's order dated March 2, 1999 is affirmed.

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[1] We modify the ALJ's order to note that Exhibit 37A was also admitted in evidence.

In the Matter of the Compensation of
BRENT HARPER, Claimant
WCB Case No. 97-05103
ORDER ON REVIEW
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Peterson's order that affirmed an Order on Reconsideration which awarded claimant 29 percent (92.8 degrees) unscheduled permanent disability for a low back injury. In his appellant's brief, claimant requests that the matter be remanded for the submission of further evidence. On review, the issues are remand and extent of permanent disability. We decline to remand and affirm.

FINDINGS OF FACT

We adopt the "Findings of Fact" set forth in the ALJ's order.

CONCLUSIONS OF LAW AND OPINION

Remand

In his appellant's brief, claimant requests that he be provided with a "current" medical arbiter examination and the right to call further witnesses on his behalf. We treat claimant's request as a motion for remand for the submission of further evidence.

We may remand to the ALJ if the record has been improperly, incompletely, or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 70 Or App 416 (1986).

Claimant's request for hearing concerned the extent of permanent disability that was determined by a May 23, 1997 Order on Reconsideration. Pursuant to ORS 656.283(7), the extent of an injured worker's permanent disability is determined as of the date of issuance of the reconsideration order. Therefore, "post-reconsideration" evidence concerning an injured worker's condition cannot be considered. In addition, ORS 656.283(7) prohibits the admission of any evidence that was not contained in the reconsideration record. *See Joe R. Ray*, 48 Van Natta 325, *on recon* 48 Van Natta 458 (1996). Because the evidence claimant seeks to submit necessarily concerns his low back condition after the date of the reconsideration order, and because such evidence was not in the reconsideration record, it would not be admissible at hearing. Since the evidence would not be admissible, there is no compelling reason to remand this matter to the ALJ for further proceedings. Consequently, we decline to remand this matter to the ALJ.

In his appellant's brief, claimant also appears to raise issues concerning either procedural temporary disability benefits or enforcement of the Order on Reconsideration's award of temporary disability benefits. Neither of these issues were raised at hearing and we decline to address these issues on review. *See Janice A. Talevich*, 48 Van Natta 2318, 2319 (1996).

Permanent Disability Benefits

We adopt the conclusions and reasoning, concerning the extent of claimant's unscheduled permanent disability, set forth in the ALJ's order.

ORDER

The ALJ's order dated February 8, 1999 is affirmed.

In the Matter of the Compensation of
DAVE A. HUMPHREY, Claimant
WCB Case Nos. 98-01418 & 97-07880
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Black's order that: (1) set aside its "de facto" denial of claimant's L5-S1 disc condition; (2) upheld Liberty Northwest's denial of claimant's claim for the same condition; and (3) awarded a $4,250 attorney fee. On review, the issues are compensability, responsibility and attorney fees.

We adopt and affirm the ALJ's order with the following supplementation.

SAIF argues that the ALJ should not have relied on the opinion of Dr. Karasek because the doctor phrased his opinions in terms of a possibility rather than a medical probability. We disagree. After reading Dr. Karasek's opinions, including his deposition testimony, we find that he opined that the 1987 injury at SAIF's insured *probably* caused claimant's L5-S1 condition. (Ex. 77-12; 77-18).

SAIF also argues that the major contributing cause standard of ORS 656.005(7)(a)(B) applies. Even assuming that the major contributing cause standard applies rather than a material contributing cause standard, we would conclude that Dr. Karasek's opinion satisfies this standard. *See Liberty Northwest Ins. Corp. v. Cross*, 109 Or App 109 (1991) (no incantation of "magic words" or statutory language is required in a physician's report). In this regard, after reviewing Dr. Karasek's opinions as a whole, including his deposition testimony, we are persuaded that he believed that the 1987 low back injury was the major contributing cause of the L5-S1 disc condition.

SAIF also argues that Dr. Karasek's causation opinion was based solely on a temporal relationship. We disagree. In addition to the temporal relationship, that Dr. Karasek believed was compelling, the doctor also reasoned that claimant's course was consistent with the current knowledge regarding the progression of a disk injury. (Ex. 77-11). Thus, we are persuaded that Dr. Karasek's opinion was not based solely on the temporal relationship between the injury and claimant's symptoms. We find, therefore, that Dr. Karasek's opinion is not legally insufficient under ORS 656.266. *See Bronco Cleaners v. Velazquez*, 141 Or App 295 (1996) (a claimant may not rely solely on exclusionary analysis to prove compensability).

Finally, SAIF contests the ALJ's award of a $4,250 attorney fee. SAIF asserts that the ALJ failed to provide a sufficient explanation for the assessed fee and seeks remand to the ALJ. Specifically, SAIF argues that the ALJ must make findings regarding each of the eight factors in OAR 438-015-0010(4), draw conclusions from those findings, and demonstrate how he weighed those conclusions in determining a reasonable assessed attorney fee.

We reject SAIF's argument, as we have in prior cases. At hearing, the parties did not submit to the ALJ any argument as to how the rule-based factors should be weighed in determining a reasonable fee. Nor did claimant made any specific attorney fee request. Under these circumstances, an ALJ satisfies OAR 438-015-0010(4) by citing that rule and briefly discussing the rule-based factors he particularly considered in determining the amount of the fee. *See Donna R. Grierson*, 51 Van Natta 679 (1999); *Daryl L. Underwood*, 50 Van Natta 2330 (1998). *Accord McCarthy v. Oregon Freeze Dry*, 327 Or 84, *adhered to on recon*, 327 Or 185 (1998).

Here, the ALJ cited to the applicable rule and identified the factors considered in determining the fee. In awarding the fee, the ALJ particularly noted and discussed the complexity of the issue, the value of the interest, the benefit secured for claimant, the time devoted to the issue and the skill of the attorneys. OAR 438-015-0010(4).[1] This explanation for the ALJ's attorney fee award is consistent with the *Underwood* rationale. *See Leslie D. Custer*, 51 Van Natta 390 (1999).

[1] The enumerated rule-based factors are: the time devoted to the case; the complexity of the issue involved; the value of the interest involved; the skill of the attorneys; the nature of the proceedings; the benefit secured for the represented party; the risk in a particular case that an attorney's efforts may go uncompensated; and the assertion of frivolous issues or defenses.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for his counsel's services on review regarding the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated February 2, 1999, is affirmed. For services on Board review, claimant's attorney is awarded $1,000, payable by SAIF.

June 22, 1999 Cite as 51 Van Natta 1004 (1999)

In the Matter of the Compensation of
EDGAR A. HALLIFAX, Claimant
WCB Case No. 98-08707
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the SAIF Corporation's denial of his claim for a left arm and neck injury. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation.

The ALJ found that Dr. McDowell's opinion was unpersuasive because she did not discuss claimant's history of cervical symptoms prior to 1995. Claimant argues that Dr. McDowell was aware of claimant's prior history, including the 1989 injury and the February 1998 symptoms.

Even assuming that Dr. McDowell was aware of these prior symptoms, we would still find her opinion unpersuasive because she did not discuss or evaluate the relative contributions to claimant's condition of the injury versus the preexisting symptoms. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995) (determining the "major contributing cause" involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause).

ORDER

The ALJ's order dated February 10, 1999 is affirmed.

In the Matter of the Compensation of
PAUL J. OLSON, Claimant
WCB Case No. C9-01394
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Minor, Yeck & Beeson, Claimant Attorneys
Mannix, Nielsen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

On June 4, 1999, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

On page 4, the CDA provides that claimant has settled a third party lawsuit for over $32,000 out of which the employer has a statutory right to recover at least $14,000. The CDA further provides that the self-insured employer waives recovery of at least $4,000 of the $14,000 in consideration for the CDA.

Generally, we disapprove CDAs in which the consideration consists of a carrier's reduction of a lien, but the CDA contains no information concerning the amount of the third party settlement or judgment and /or the amount of the carrier's lien. *E.g., Michael Salber*, 48 Van Natta 757 (1996). We reach this conclusion because we are unable to ascertain the "value" of any consideration flowing to the claimant as a result of the third party settlement and the carrier's waiver of its lien. *Id.*

In *Anthony G. Allen*, 49 Van Natta 460 (1997), the sole consideration for the CDA was the carrier's waiver of $80,000 of its $250,000 statutorily recoverable third party lien. The CDA did not provide the specific amount of the third party settlement. However, the parties expressly stipulated that the insurer's statutory share would be approximately $250,000. Although the exact amount of the third party lien was not known, the amount of the insurer's otherwise recoverable lien and the amount of its waiver were known. Under those circumstances, we found that the "value" of the consideration flowing to claimant under the CDA ($80,000) was sufficiently ascertainable to gain our approval.

In the present case, the CDA provides the approximate amount of the third party settlement, but does not expressly identify the total amount of the carrier's lien. However, the parties have indicated that the employer has a statutory right to recover at least $14,000 and that it intends to waive $4,000 of that amount as consideration for the CDA.

Although the exact amount of the employer's lien is not expressly identified, we interpret the parties' representation that the employer has a statutory right to recover at least $14,000 to mean that the insurer would otherwise be able to recover most, if not all of that specified amount from the third party settlement. Under such circumstances, we find that the "value" of the consideration flowing to claimant under the agreement (*i.e.* the employer's $4,000 waiver of its otherwise recoverable third party lien) is sufficiently ascertainable to gain our approval. *See Carol Van De Hey*, 50 Van Natta 1187 (1998).

Accordingly, as interpreted herein, the CDA is in accordance with the terms and conditions prescribed by the Board. Therefore, the parties' CDA is approved.

Should the parties disagree with our interpretation of the CDA, they may move for reconsideration by filing a motion for reconsideration within 10 days of the date of mailing of this order. OAR 438-009-0035.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLIAM M. WHITFIELD, Claimant
WCB Case No. 98-07688
ORDER ON REVIEW
Heiling & Associates, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock, and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that affirmed an Order on Reconsideration that: (1) found that claimant's accepted injury claim was not prematurely closed; and (2) declined to award scheduled permanent partial disability for that injury. On review, the issues are premature closure and extent of scheduled permanent partial disability (PPD).

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated January 27, 1999 is affirmed.

Board Member Biehl dissenting.

The majority has adopted and affirmed the ALJ's conclusion that claimant's right great toe condition was medically stationary when his claim was closed on June 1, 1998. *See* ORS 656.268(1) (a claim closure is premature and must be set aside if the claimant's condition was not medically stationary at closure).[1] I, instead, conclude that the thorough and well-reasoned opinion of the medical arbiter satisfies claimant's burden of proving that his condition was not stationary at closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). For this reason, I respectfully dissent.

The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981). Here, the ALJ deferred to the June 1, 1998 closing examination report of Dr. Eusterman, the treating physician. In that report, Dr. Eusterman opined that claimant's right great toe condition had resolved without permanent impairment. But Dr. Eusterman did not offer any supporting findings or other explanation to support that opinion. In fact, there is no evidence in the record that Dr. Eusterman made any attempt to thoroughly assess claimant's medically stationary status and residual impairment.

The record contains a contrary opinion from the medical arbiter, Dr. Stewart, that is well-reasoned and based on a thorough evaluation of claimant's symptoms and findings. In that report, Dr. Stewart noted decreased ranges of motion in the right great toe, and he opined that claimant was not medically stationary because his symptoms and range of motion would continue to improve with treatment and the passage of time. The ALJ acknowledged that Dr. Stewart's opinion was "much more thorough, well-reasoned and objective" than the contrary opinion of the treating physician. Nevertheless, the ALJ did not consider the arbiter's opinion because it did not expressly relate claimant's condition at the time of the medical arbiter examination back to the June 23, 1998 closure.

I disagree with the ALJ's rationale. In determining whether a claim was properly closed, medical evidence that becomes available post-closure may be considered so long as it addresses the claimant's condition at the time of closure, not subsequent changes in that condition. *Schuening v. J.R. Simplot & Co.*, 84 Or App 622, *rev den* 303 Or 590 (1987); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985). Here, Dr. Stewart does not indicate that there has been a change in claimant's condition since claim closure. Furthermore, there is no other evidence in the record of a post-closure worsening. *Compare Agustin Dominguez*, 50 Van Natta 1208 (1998) (post-closure medical arbiter opinion establishes that the claimant was not medically stationary at closure; arbiter does not indicate that there has been a change in claimant's condition since claim closure). *See also Ronald Gilderoy*, 50 Van Natta 815 (1998).

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[1] "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17).

Moreover, Dr. Stewart's opinion was much more thorough, well-reasoned and objective than the contrary opinion of Dr. Eusterman. *See Somers v. SAIF*, 77 Or App 259(1986) (the greatest weight is generally given to those opinions that are well-reasoned and based on accurate and complete information). On this record, I would conclude that the medical arbiter's thorough, well-reasoned and objective evaluation establishes that claimant's injury claim was prematurely closed.

In so concluding, I reject the ALJ's reasoning that this case is controlled by the Board's decision in *Brian A. Bundy*, 46 Van Natta 382 (1994). In *Bundy*, the Board rejected an opinion regarding the claimant's medically stationary status because it was based on a post-closure examination, and the record otherwise established that claimant's condition had changed since closure. Consequently, the *Bundy* decision is distinguishable on its facts from the present case. *See also Patti E. Bolles*, 50 Van Natta 1694 (1998) (arbiter's post-closure opinion pertained to change in the claimant's condition after closure and, therefore, failed to prove that the claim was prematurely closed).

For these reasons, I would defer to the arbiter's opinion, conclude that claimant was not medically stationary at claim closure, and reverse the ALJ's determination that claimant's injury claim was not prematurely closed.

June 22, 1999 Cite as 51 Van Natta 1007 (1999)

In the Matter of the Compensation of
RICHARD T. JESSEE, Claimant
WCB Case No. C9-01423
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

On June 8, 1999, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

The first page of the proposed CDA provides that the total amount due claimant is "$15,540" and the total due claimant's attorney is $3,800. This would equal a total consideration of $19,340. However, the total consideration recited both on the first page, as well as page 2, number 12, of the CDA is "$19,250." On page 3, number 14 provides that the amount payable to claimant's attorney is $3,800, which is consistent with the first page.

Thus, the reference on the first page of the CDA to a distribution to claimant of $15,540 appears to be a typographical error and should be $15,450, which would be consistent with a total consideration of $19,250 and an attorney fee of $3,800. Accordingly, we interpret the agreement as providing for a total consideration of $19,250, with claimant receiving $15,450, and claimant's counsel an attorney fee of $3,800.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee of $3,800, payable to claimant's counsel, is also approved.

Should the parties disagree with our interpretation of the CDA, they may move for reconsideration by filing a motion for reconsideration within 10 days of the date of mailing of this order. OAR 438-009-0035.

IT IS SO ORDERED.

In the Matter of the Compensation of
JANET F. BERHORST, Claimant
Own Motion No. 99-0030M
OWN MOTION ORDER
Malagon, Moore, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

On March 24, 1999, we authorized reopening of claimant's claim for the payment of temporary disability compensation beginning September 18, 1998. Claimant requests enforcement of our March 24, 1999 order (in addition to penalties and attorney fees), contending that the SAIF Corporation unreasonably failed to pay benefits as directed by our order.[1]

In response, SAIF relies on ORS 656.268(3)(d), which states that temporary disability compensation may be terminated upon the occurrence of "any other event that causes temporary disability benefits to be lawfully suspended, withheld or terminated under ORS 656.262(4)." SAIF contends that it delayed payment of claimant's temporary disability benefits because it had not received any medical documentation authorizing said benefits. Pending receipt of this authorization, SAIF asserts that, on May 7, 1999, it paid the "out-of-compensation" attorney fee and a "token amount" of temporary disability benefits due between September 18, 1998 and January 3, 1999). On May 18, 1999, when it received medical reports from claimant's attending physician, SAIF explains that it paid the remaining outstanding benefits awarded as a result of our March 24, 1999 order.

Temporary disability compensation shall be paid on an "open" own motion claim until one of the following event occurs: (1) the claim is closed pursuant to OAR 438-012-055; (2) a claim disposition agreement (CDA) is submitted to the Board pursuant to ORS 656.236(1); or (3) termination of such benefits is authorized by the terms of ORS 656.268(3)(a) through (c). *See* OAR 438-012-0035(4); *Brian Lutz*, 50 Van Natta 1421 (1998); *Jeffrey T. Knudson*, 48 Van Natta 1708 (1996).

Unlike benefits payable under ORS 656.268, temporary disability benefits payable under ORS 656.278 arise by means of voluntary reopening by the carrier or Board authorization. *See* OAR 438-012-0035(1). Board authority to award temporary disability benefits under ORS 656.278 is not contingent on an attending physician's time loss authorization. *Knudson*, 48 Van Natta at 1708. In *Knudson*, we reasoned that, because an attending physician's time loss authorization is not required for commencement of temporary disability benefits pursuant to ORS 656.278, the lack of such authorization is not a basis for the termination such benefits.

Here, claimant's attending physician did not provide SAIF with written time loss authorizations. Nonetheless, based on the *Knudson* rationale, such a failure does not constitute grounds to delay the payment of claimant's temporary disability benefits under OAR 438-012-0035(1).

A carrier is required to make the first payment of temporary disability compensation within 14 days from the date of an order reopening the claim. OAR 438-012-0035. However, we have previously made the distinction between "prospective" and "retroactive" temporary disability for the purposes of analyzing the reasonableness of carrier's conduct in processing a claim. *Lee R. Parker*, 48 Van Natta 2473 (1996); *Larry P. Karr*, 48 Van Natta 2183 (1996); *Knudson*, 48 Van Natta at 1708.

Because OAR 438-012-0035 does not make the distinction between "prospective" and "retroactive" temporary disability, we rely on OAR 436-060-0150(5)(h) which provides that timely payment of temporary disability means that payment has been made no later than 14 days from the date of any order which authorizes "retroactive" temporary disability becomes final; *i.e.*, within 44 days from the date of its issuance. *Christopher L. Camara*, 50 Van Natta 355 (1998); *Parker*, 48 Van Natta at 2474; *Karr*, 48 Van Natta at 2184. The rule further provides that temporary disability accruing from the date of the order ("prospective" TTD) shall begin no later than 14 days from the date of the order. *Id.*

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[1] Because SAIF has subsequently complied with our March 24, 1999 order, it is unnecessary to address claimant's "enforcement" request. Consequently, we confine our review to the question of whether SAIF's claim processing actions were unreasonable.

Thus, SAIF was required to pay claimant's "prospective" temporary disability benefits (timeloss benefits that began to accrue from the date of issuance of our order) within 14 days from our March 24, 1999 order or April 7, 1999. SAIF was also obligated to pay claimant's "retroactive" temporary disability benefits (timeloss that accrued prior to the date of issuance of our order; *i.e.*, time loss due from September 18, 1998 through March 23, 1999) within 14 days after our March 24, 1999 order became final or May 7, 1999. SAIF made a payment on May 7, 1999. However, it was a partial payment of the "retroactive" timeloss due and owing; *i.e.*, temporary disability due from September 18, 1998 to January 3, 1999.

We conclude that SAIF failed to comply with our order in two respects. First, SAIF neglected to pay "prospective" temporary disability payable from the date of our March 24, 1999 order within 14 days of that order. Second, SAIF did not fully pay claimant's "retroactive" temporary disability (specifically benefits due from January 4, 1999 through March 23, 1999) within 14 days from the date our March 24, 1999 order became final; *i.e.*, May 7, 1999.

To be entitled to a penalty, claimant must establish that SAIF unreasonably refused the payment of temporary disability compensation. Under ORS 656.262(11)(a), if the carrier "unreasonably delays or unreasonably refuses to pay compensation," it shall be liable for an additional amount of 25 percent of the amounts "then due." *International Paper Co. v. Huntley*, 106 Or App 107 (1991); *Brown v. Argonaut Insurance Company*, 93 Or App 588, 591 (1988).

Here, SAIF's reliance on ORS 656.268(4), in support of its delay in payment of claimant's temporary disability benefits, is contrary to existing case law and Board rules. *Robert L. Eubank*, 51 Van Natta 669 (1999); *Jeffrey T. Knudson*, 48 Van Natta at 1709-10. SAIF's "grounds" (the need for a physician's authorization before paying temporary disability benefits) for its delay in payment of claimant's temporary disability benefits is neither authorized by Board rule or case precedent. *See Id.*; OAR 438-012-0035(1). Thus, we find that SAIF's reasons for failing to timely comply with our March 24, 1999 order did not provide it with a legitimate doubt regarding its liability to pay claimant compensation as granted by our order.

Therefore, under ORS 656.262(11)(a), we assess a 25 percent penalty of the temporary disability benefits paid by SAIF on May 18, 1999 (when it fully paid the then-current benefits authorized by our March 24, 1999 order). This penalty is payable in equal shares to claimant and her attorney.

IT IS SO ORDERED.

In the Matter of the Compensation of
JESSIE A. KELLOGG, Claimant
WCB Case No. C9-01406
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Ernest M. Jenks, Claimant Attorney
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

On June 7, 1999, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

The first page of the proposed CDA provides for a total consideration of $500; $375 payable to claimant and $125 to her attorney. However, the body of the CDA, (page 4), provides for an attorney fee of $375, with the remaining $125 payable to claimant. Inasmuch as a $187.50 attorney fee is consistent with OAR 438-015-0052(1), and because the agreement does not set forth "extraordinary circumstances" to justify a larger attorney fee, we conclude that the reference on page three of the CDA to an attorney fee of "$375" is a typographical error. Accordingly, we interpret the agreement as providing for a total consideration of $500; $375 payable to claimant and $125 as an attorney fee.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee of $125, payable to claimant's counsel, is also approved.

Should the parties disagree with our interpretation of the CDA, they may move for reconsideration by filing a motion for reconsideration within 10 days of the date of mailing of this order. OAR 438-009-0035.

IT IS SO ORDERED.

June 23, 1999 Cite as 51 Van Natta 1010 (1999)

In the Matter of the Compensation of
DALE F. CECIL, Claimant
WCB Case No. 97-10401
ORDER ON RECONSIDERATION
Max Rae, Claimant Attorney
Mannix, et al, Defense Attorneys

Claimant requests review of our May 26, 1999 Order on Review that reversed in part and affirmed in part the Administrative Law Judge's (ALJ's) order that: (1) upheld the self-insured employer's partial denial of his occupational disease claim for a right wrist condition involving tenosynovitis and scaphoid lunate ligament tear with related synovitis; and (2) set aside the employer's partial denial of his occupational disease claim for a right wrist condition involving tendinitis in flexor and extensor tendons of the right hand and wrist. Regarding the first issue, we adopted the ALJ's reasoning and conclusions and added a brief supplementation regarding our analysis of the medical evidence. Regarding the second issue, we reversed the ALJ and found that the medical evidence did not meet claimant's burden of proof under ORS 656.802. In reaching this conclusion, we explained why we found the medical evidence was inadequate to meet claimant's burden of proof.

On reconsideration, claimant argues that we did not properly assess the persuasiveness of the medical evidence and requests that we again review the medical record and come to a conclusion that supports his assertion that both conditions are compensable. We have received the employer's response to claimant's request for reconsideration.

In addition, claimant requests that reconsideration be undertaken *en banc*, arguing that this reconsideration "invites the Board to evaluate how it considers evidence and how it addresses factual disputes in its orders." Claimant also requests that oral arguments be allowed, asserting that oral arguments on these matters will "assist the Board to better assess the facts and explain its reasoning in future cases." For the following reasons, we deny both requests.

Although the Board may sit *en banc* in rendering a decision, the act or decision of any two members shall be deemed the act or decision of the Board. ORS 656.718(2). Whether a case is reviewed *en banc* is a matter solely within our own discretion. *E.g., Brian W. Andrews*, 48 Van Natta 2532 (1996); *Ralph L. Witt*, 45 Van Natta 449 (1993).

We note that, in the exercise of our *de novo* review, we select for *en banc* review those cases which raise issues of first impression that would have a widespread impact on the workers' compensation system or cases requiring disavowal of prior Board case law. This "significant case" review standard is applied to all cases before the Board. Thus, before issuing our Order on Review, we considered whether this case warranted *en banc* review and decided it was more appropriate for review by a panel.

Our conclusion is not changed by claimant's arguments. The proper standards for reviewing the persuasiveness of medical evidence are well-established by case law. Furthermore, contrary to claimant's arguments, after reconsideration, we continue to find that we appropriately applied those standards in reviewing the medical evidence in this case. Consequently, although we recognize the importance of this matter to claimant, we do not consider this case to be sufficiently significant to warrant *en banc* reconsideration.

For the same reasons, we deny claimant's request for oral argument.[1] We will not ordinarily entertain oral argument. OAR 438-011-0015(2). We may allow oral argument, however, where the case presents an issue of first impression that could have a substantial impact on the workers' compensation system. *See* OAR 438-011-0031(2); *Joe R. Ray*, 48 Van Natta 325, *on recon* 48 Van Natta 458 (1996); *Jeffrey B. Trevitts*, 46 Van Natta 1767 (1994). The decision to grant such a request is solely within our discretion. OAR 438-011-0031(3). Here, through their briefs on reconsideration, the parties have adequately addressed the issues before the Board and we are not persuaded that oral argument would assist us in reaching our decision. Accordingly, we decline to grant the request for oral argument. *See Raymond L. Mackey*, 47 Van Natta 1 (1995). Therefore, we proceed with our reconsideration.

Claimant's arguments regarding the compensability of his occupational disease claim for a right wrist condition involving tenosynovitis and scaphoid lunate ligament tear with related synovitis focus solely on the brief supplementation we made regarding that issue in our initial order. We remind claimant that we also adopted the ALJ's reasoning and conclusions regarding that issue.[2] As the ALJ noted, part of Dr. MacKenzie's opinion would support compensability of claimant's claim. In this regard, Dr. MacKenzie stated that, assuming claimant had no prior trauma, he would assume that the work activities caused claimant's problems.[3] (Ex. 89-35). Claimant focuses on this statement to argue that Dr. MacKenzie's opinion meets his burden of proof. But, as the ALJ explained, Dr. MacKenzie's opinion read *as a whole* does not meet claimant's burden. Although making the above statements, Dr. MacKenzie ultimately could not accept the assumption that there was no prior history of trauma and continued to find that work activities were not the cause of the tear. (Exs. 39-33-34, -41). *R. K. Lock*, 51 Van Natta 128 (1999) (although isolated parts of physician's opinion supported the claimant's position, when read as a whole, his opinion was insufficient to establish compensability); *Diana Traver*, 47 Van Natta 8 (1995) (while parts of physician's opinion supported compensability, when read as a whole, it did not meet the claimant's burden of proof). After reconsideration, we find that the ALJ's reasoning, along with our supplementation, adequately explains why we find that the opinions of Drs. Carter and MacKenzie are both unpersuasive and insufficient to meet claimant's burden of proof.

In addition, claimant argues that, on page 3 of our order, we made the "assumption" that claimant had no other right wrist injuries. Claimant's Request for Reconsideration, page 1. Claimant further argues that, "once the Board made that assumption, it limited itself to considering only those of

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[1] Furthermore, we note that claimant did not make this request before we issued our Order on Review, when it would have been more appropriate to consider oral argument.

[2] Dr. MacKenzie is claimant's treating surgeon for his right wrist synovitis and partial scaphoid-lunate ligament tear. The ALJ thoroughly explained why he deferred to Dr. MacKenzie's opinion over that of Dr. Carter, claimant's treating surgeon for his earlier CTS condition. The ALJ also thoroughly summarized the record and explained his reasons for finding that Dr. MacKenzie's opinion did not meet claimant's burden of proof as to the scaphoid-lunate ligament tear condition. Specifically, the ALJ explained, in part:

> "Dr. MacKenzie has board certification in general surgery. He did a fellowship in hand surgery. He is board eligible in plastic surgery (Exhibit 89-5, -6). He performed the arthroscopic evaluation of claimant's right wrist. (Exhibit 67). He was examined fairly extensively in deposition. There is something for both sides in his comments. To summarize: He finds in claimant's work activity an unlikely cause of claimant's conditions discovered with arthroscopy (Exhibit 89-34). He has reviewed the literature on the subject, in which he does not appear to find support for compensability (Exhibit 89-29). On the other hand, in the absence of trauma, he would assume that activities at work caused claimant's difficulties (Exhibit 89-35). He states, however, that he is not comfortable making the assumption that claimant had no prior traumatic injury (Exhibit 89-33), and with a 'neutral assumption' about whether or not there was a prior traumatic wrist injury, he thinks it very unlikely that work was the cause of claimant's condition (Exhibit 89-34).
>
> "I do not find that Dr. MacKenzie's opinion, read in its entirety, supports the claim. He essentially does not believe the work activities would cause the tear. He is not comfortable assuming that there was no history of trauma. He does not identify support for the claim in the literature." Opinion and Order, page 6.

[3] Dr. MacKenzie also agreed with a telephone conversation summary that stated: (1) it is not uncommon for patients not to recall prior traumatic wrist injuries; and (2) assuming an accurate history of no prior traumatic right wrist injury, it was medically probable that claimant's work activities at the employer was the cause of his dorsal right wrist condition. (Exs. 87-1; 89-41).

Dr. MacKenzie's opinions based on that assumption." *Id.* at page 3. Furthermore, claimant argues that "[g]iven the assumption that claimant had had no other right wrist injuries, the Board can only logically conclude that Dr. MacKenzie supports claimant on medical causation." *Id.* at page 4. Finally, quoting from *Drew v. Psychiatric Security Review Board*, 322 Or 491, 499-501 (1996), claimant contends that we have failed to demonstrate reasoning that lead from the facts we found (and from the "assumption" we made) to the conclusion that we drew therefrom. Moreover, claimant argues that this "assumption" compels a conclusion that Dr. MacKenzie's opinion supports compensability. We disagree.

The problem with claimant's argument is twofold. First, we did not make any such "assumption." Instead, we simply summarized the argument that claimant made at hearing and on review (and continues to make on reconsideration) and stated that we disagreed with that argument.[4] Second, we explained why the medical evidence claimant relied on, including selected portions of Dr. MacKenzie's opinion that might support compensability, did not persuasively meet claimant's burden of proof. As noted above, our explanation included the ALJ's reasoning and conclusions on this issue.

In addition, because we did not make the "assumption" claimant contends that we made, claimant's argument based on our making that "assumption" necessarily fails. Furthermore, as explained above, we thoroughly explained why we found that the medical evidence did not support compensability of claimant's claim. Thus, contrary to claimant's contention, we demonstrated reasoning that lead from the facts we found to the conclusion that we drew therefrom. After reconsideration, we continue to find that our reasoning, in combination with that of the ALJ, adequately explains why we find that the medical evidence does not meet claimant's burden of proof regarding compensability of this condition.

Regarding the compensability of claimant's occupational disease claim for a right wrist condition involving tendinitis in flexor and extensor tendons of the right hand and wrist, the only opinion that might support compensability was rendered by Dr. Carter, claimant's treating surgeon for the compensable carpal tunnel syndrome condition. On reconsideration, claimant argues that we failed to properly "weigh" the medical evidence in this case. We disagree.

We thoroughly explained why we did not find Dr. Carter's opinions persuasive. Specifically, Dr. Carter offered several unexplained changes of opinion regarding causation, at first agreeing that claimant's tendinitis condition was *not* attributable to his employment, then stating that there was a *possibility* that the tendinitis condition was related to the work activity, and finally stating, without explanation, that claimant's work activities *caused* his tendinitis condition. Relying on several cases, including *Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of opinion renders physician's opinion unpersuasive), *Blakely v. SAIF*, 89 Or App 653, 656, *rev den* 305 Or 972 (1988) (physician's opinion lacked persuasive force because it was unexplained), and *Gormley v. SAIF*, 52 Or App 1055 (1981) (opinions in terms of medical possibility rather than medical probability are not persuasive), we found Dr. Carter's opinions unpersuasive.

Thus, we thoroughly weighed Dr. Carter's opinions and found them unpersuasive. After reconsideration, we continue to find Dr. Carter's opinions unpersuasive. Furthermore, because Dr. Carter presented the only opinion that might have supported claimant's claim for the tendinitis condition, we continue to find that claimant failed to meet his burden of proof.[5]

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[4] Claimant apparently is referring to the following paragraph on page three of our initial order:

"On review, claimant argues that, if there is no traumatic injury, then claimant's testimony and the medical evidence from Drs. Carter and MacKenzie establish compensability of the scaphoid lunate ligament tear. We disagree."

[5] Claimant argues that, because Dr. Carter's causation opinions regarding the tendinitis condition are unopposed, they are persuasive as a matter of law. Specifically, claimant contends that Dr. Carter's final opinion (that work activities caused claimant's condition) "must be accorded some weight and is, hence, persuasive as a matter of law. In the absence of contrary evidence, it would carry claimant's burden of proof on medical causation." Claimant's Request for Reconsideration, page 15. We disagree. *See Moe v. Ceiling Systems, Inc.*, 44 Or App 429 (1980) (court found that the claimant failed to meet his burden of proving causation where only medical opinion, although unrebutted, was unexplained); *Leah A. Boyd*, 50 Van Natta 263 (1998) (persuasive reasons not to defer to unrebutted medical opinions from treating physician).

Accordingly, we withdraw our May 26, 1999 order. On reconsideration, as supplemented herein, we republish our May 26, 1999 Order on Review. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
VIRETT R. ENGLISH, Claimant
Own Motion No. 98-0026M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE

Claimant requests review of the self-insured employer's March 24, 1999 Notice of Closure which closed his claim with an award of temporary disability compensation from January 15, 1998 through April 7, 1998. The employer declared claimant medically stationary as of February 22, 1999.

In his request for review, claimant requests that his claim be kept "open till my back is stable and I know for sure that I can continue working with out any difficulties." We interpret such a statement as a contention that claimant was not medically stationary at claim closure.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he/she was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981).

The propriety of the closure turns on whether claimant was medically stationary at the time of the March 24, 1999 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

Claimant contends that he has continued pain and needs additional medical treatment to insure that his back remains stable. Claimant relies on these contentions to support his position that he was not medically stationary at the time of claim closure. The term "medically stationary" does not mean that there is no longer a need for continuing medical care. *Maarefi v. SAIF*, 69 Or App 527, 531 (1984). Rather, the record must establish that there is a reasonable expectation that further or ongoing medical treatment would "materially improve" claimant's compensable condition at claim closure. *Lois Brimblecom*, 48 Van Natta 2312 (1996).

Dr. Buza, claimant's attending physician, opines that claimant's compensable condition was stable as of February 22, 1999. He expands on this opinion in a March 31, 1999 chart note, reporting that claimant's condition had not changed since April 7, 1998 and would be considered stable. Although prescribing additional medications and physical therapy, Dr. Buza does not indicate that this ongoing medical care will materially improve claimant's compensable condition.

Based on this uncontroverted medical evidence, we find that claimant was medically stationary on the date his claim was closed.[1] Therefore, we conclude that the employer's closure was proper.[2]

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[1] In reaching this conclusion, we again emphasize that the need for continuing medical treatment to address fluctuating symptoms does not establish that claimant's condition is not medically stationary. *Maarefi*, 69 Or App at 531.

[2] Should claimant's compensable condition subsequently worsen to the extent that surgery and/or inpatient hospitalization is eventually required, he may again request reopening of his claim for the payment of temporary disability. *See* ORS 656.278(1).

Accordingly, we affirm the employer's March 24, 1999 Notice of Closure in its entirety.

IT IS SO ORDERED.

June 24, 1999 Cite as 51 Van Natta 1014 (1999)

In the Matter of the Compensation of
MICHAEL A. BAIER, Claimant
WCB Case No. 98-00881
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the self-insured employer's denial of his claim for a respiratory condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation.

Claimant, age 41 at the time of hearing, works as a machinist. His work involves use of a spray welder to weld and repair machinery. Claimant is also a smoker, and has smoked approximately a pack of cigarettes a day for the past 20 years.

When claimant used "Alcro" wire in his spray welder, he sometimes experienced headaches and a sore throat from the exposure. But, on October 7, 1997, he began using a new product in his spray welder called "Aluminum S." The Aluminum S product required twice as much air pressure in the spray welder as the Alcro wire and, when in use, produced smoke and a noticeable, metallic odor. Claimant was the only person who was used the spray welder and worked with the Aluminum S on October 7, 1997, although others in the shop noted the smoke and odor. Claimant used the spray welder with Aluminum S for approximately two hours and wore a paper dusk mask for respiratory protection.

When he finished the spray welding project, claimant did not feel well. He had a sore throat, blurry eyes, a metallic taste in his mouth and a tightness in his chest. He continued to feel poorly throughout the evening and the next morning.

Claimant returned to work the next day but did not complete his shift because he had a pounding headache, sore throat and tightness in his chest. Over the next few days, claimant developed a cough and shortness of breath. He stayed home from work. On October 12, 1997, he sought emergency treatment complaining of a sore throat, tight chest and painful cough. He was diagnosed with pharyngitis/bronchitis and prescribed Erythromycin and Tylenol 3.

Claimant's respiratory symptoms continued and he sought additional treatment from his regular clinic on October 14, 1997. The examining physician noted an inflamed throat and pulmonary wheezes, and prescribed Prednisone, Azmacort and other medications. Claimant returned to the clinic on October 21, 1997 and was seen by Dr. Corn, who diagnosed chemical bronchitis and sinusitis secondary to bacterial infection. He prescribed CIPRO and Prednisone and advised claimant to avoid cigarettes. Dr. Corn also released claimant from work until October 27, 1997.

Claimant went back to work on October 27 and 28, 1997 but, on both days, he experienced a severe headache and shortness of breath after being exposed to the shop's fumes. On October 29, 1997, claimant was examined by Dr. Anderson, who diagnosed acute rhinitis secondary to inhalation of heated metal powder. Dr. Anderson also removed a small fleck of metal (less than 1 mm. in size) from inside claimant's nose, and placed claimant on nasal corticosteriods.

Claimant returned to work on Friday, November 7, 1997 but, by the following Monday, he had shortness of breath and a headache. On November 11, 1997, claimant saw Dr. Corn, who authorized additional time loss. Claimant was then referred to Dr. Fisher, who examined him on November 14, 1997. Dr. Fisher diagnosed an irritant bronchitis with persisting symptoms. Dr. Fisher found no

significant airway obstruction, and suspected a cough variant asthma syndrome or RADS type problem. He prescribed steroid treatment. Claimant returned to Dr. Fisher on November 21, 1997. Dr. Fisher prescribed a steroid inhaler with tapered reduction of Prednisone.

Claimant tried returning to work in early December 1997 but again experienced shortness of breath, chest tightness and coughing within the first few days. He sought follow up treatment with Dr. Fisher on December 8, 1997.

On December 9, 1997, claimant was examined by Dr. Barker at the employer's request. After reviewing claimant's medical records and diagnostic testing results, Dr. Barker concluded that claimant experienced a viral upper respiratory infection in October 1997 that coincided with, and was exacerbated by, his exposure to aluminum dust on October 7, 1997. Dr. Barker found no evidence of occupational asthma. He opined that claimant's long history of cigarette smoking and his exposure to wood smoke at home contributed to his persistent symptoms. Dr. Barker concluded that claimant was medically stationary and capable of returning to work with better respiratory protection and ventilation. Dr. Corn concurred with Dr. Barker's report. In a supplemental report, Dr. Barker opined that claimant had preexisting chronic obstructive pulmonary disease (COPD) related to his 20 years of smoking.

In January 1998, the employer denied the compensability of claimant's claimed respiratory condition as an occupational disease, asserting that his work exposure was not the major contributing cause of his condition. The employer also asserted that claimant's condition was caused, in major part, by an unrelated upper respiratory viral infection.

Claimant returned to work and began using a respirator whenever he was exposed to welding fumes. During February 1998, he had one occasion in which he had a sore throat and breathing difficulties after exposure to fumes. Dr. Fisher referred claimant to Dr. Keppel.

Dr. Keppel examined claimant on two occasions, during March and April 1998. He diagnosed asthma, worsened after exposure to irritants in the work place. Dr. Keppel understood (incorrectly) that claimant had been exposed to nickel and chrome at work.

The ALJ analyzed the compensability of claimant's respiratory condition as an occupational disease. Finding that the persuasive medical evidence in the record did not establish that claimant's workplace exposure to Aluminum S was the major contributing cause of his condition, the ALJ concluded that claimant's respiratory condition was not compensable under ORS 656.802.

On review, claimant asserts that the ALJ erred in analyzing his condition as an occupational disease. Citing *Melvin C. Woda*, 50 Van Natta 672 (1998), claimant argues that his respiratory condition is due to a work exposure occurring over a discrete, identifiable period of time and is, therefore, an injury rather than a disease or infection under the occupational disease statute.[1] Claimant further contends that, contrary to Dr. Barker's opinion, he did not have a preexisting condition and, even if he did have a preexisting condition that combined with his work exposure to produce his disability or need for treatment, his work exposure to Aluminum S was the major contributing cause.

We first note that, at hearing, claimant did not assert the compensability of his respiratory condition as an accidental injury. Instead, claimant argued that his work exposure caused an "upper respiratory airways disease problem" and consented to the analysis of his condition under an occupational disease theory. (*See* Tr. 4-6). Because claimant has raised the accidental injury theory for the first time on review, we are not inclined to consider this argument. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247, 252 (1991). On the other hand, we are obligated to apply the appropriate legal standards to determine the compensability of a worker's claim. *Dibrito v. SAIF*, 319 Or 244, 248 (1994). In any event, we need not resolve the question of whether claimant is precluded from raising *Woda* and the accidental injury theory in this case because, even if the claim is analyzed as an injury, claimant has not sustained his burden of proof.

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[1] In *Woda*, we held that the claimant's irritant reaction should be analyzed as an injury because the onset of symptoms occurred within hours of his initial exposure to sawdust, and continued to worsen during work hours. We found that when the legislature amended ORS 656.802 to address diseases or infections caused by exposure to dust and fumes, it did not intend to abandon the traditional "disease versus injury" analysis in regard to toxic exposures. Therefore, we concluded that where an irritant reaction is due to an event occurring over a discrete, identifiable period of time due to a specific work activity, the acute reaction constitutes an injury under ORS 656.005(7)(a) rather than a disease or infection under ORS 656.802(1)(a)(A).

We are persuaded by Dr. Barker's opinion (as well as other medical evidence in the record) that claimant's upper respiratory condition and need for treatment resulted from a combination of his work exposure and preexisting conditions.[2] Therefore, compensability for claimant's claim under an "injury" theory would be analyzed under the major contributing cause standard of ORS 656.005(7)(a)(B).

Like the ALJ, we find that Dr. Barker offers the most complete and well-reasoned assessment of claimant's respiratory condition. Dr. Barker notes the other factors and/or exposures that likely contributed to claimant's disability or need for treatment, including his cigarette smoking and resultant COPD as well as his exposure to wood smoke at home. Although Dr. Barker acknowledges that aluminum dust is an irritant and that claimant's work exposure probably played a role in claimant's rhinitis, he persuasively explained why this exposure was not the major contributing cause of claimant's need for treatment. Dr. Barker opined that claimant had an upper respiratory tract infection related to his cigarette smoking, preexisting esophageal reflux that accounted for his persistent cough and a hyper responsive airway.

In supplemental reports, Dr. Barker acknowledged that it is oftentimes difficult to distinguish a respiratory tract infection from an irritative process or allergic rhinosinusitis. He concluded, however, that claimant had a respiratory tract infection at the time of his work exposure based on the treatment and management directions of claimant's treating physicians during October and November 1997. Dr. Barker noted that the emergency room physician prescribed Erythromycin, and that Dr. Corn prescribed Cipro and trimethoprim/sulfa for claimant's symptoms. He explained that antibiotics are the usual treatment course for an infection but not for a chemical irritation. Therefore, Dr. Barker concluded that claimant probably had a respiratory tract infection that was unrelated to his work exposure but which contributed to his condition and need for treatment during the fall of 1997.

Unlike Dr. Barker, the other physicians who offered opinions concerning the cause of claimant's respiratory condition did not adequately address the contribution of claimant's 20 year history of cigarette smoking and resultant COPD, his preexisting esophageal reflux or his hyper responsive airway. Therefore, even if we were to reject Dr. Barker's opinion that claimant had an unrelated respiratory tract infection that coincided with his work exposure to Aluminum S, the remaining medical opinions do not address why the work exposure was more of a cause of his need for treatment than the other contributing factors (such as claimant's smoking history and COPD) combined.[3] *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995) (medical opinion must evaluate the relative contribution of different causes and explain why the work exposure or injury contributes more to the claimed condition than all other causes or exposures combined).

Consequently, on this record, we conclude that claimant has not established the compensability of his respiratory condition as an occupational disease under ORS 656.802 or, alternatively, as an injury under ORS 656.005(7)(a)(B).

ORDER

The ALJ's order dated January 28, 1999 is affirmed.

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[2] For example, claimant's 20 year, pack a day, smoking habit is undisputed. Dr. Barker explained that because of his many years as a smoker, claimant had preexisting early stage COPD. Also, Dr. Fisher agreed with Dr. Barker that claimant had a hyper responsive airway, as demonstrated by the Mecholyl challenge test.

[3] Indeed, as the ALJ noted, Dr. Fisher's opinion is based on the temporal coincidence of claimant's work exposure and subsequent symptoms. But, considering the other factors contributing to claimant's condition, a mere temporal relationship is insufficient to prove causation. *See Allie v. SAIF*, 79 Or App 284 (1986) (causation cannot be inferred from temporal relationship alone). Also, because Dr. Keppel had an inaccurate understanding of claimant's exposure (*i.e.*, that claimant was exposued to nickel and chrome), his assessment is unpersuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) (medical opinions that are not based on a complete and accurate history are not persuasive).

In the Matter of the Compensation of
STEVEN J. CLUM, Claimant
WCB Case No. 97-09218
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Howell's order that: (1) set aside its denial of claimant's current low back condition; (2) found that claimant's radicular symptoms were compensably related to his low back condition; and (3) awarded claimant's attorney a fee for its rescission of the November 4, 1997 current condition denial. In his brief, claimant contends that the employer should formally accept his radiculopathy "condition." On review, the issues are compensability, claim processing, and attorney fees.

We adopt and affirm the ALJ's order with the exception of the citation to ORS 656.262(6)(d) in the third paragraph of section "B" on page 6, for which we substitute ORS 656.262(7)(a).[1]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,000 payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.[2]

ORDER

The ALJ's order dated March 3, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,000, to be paid by the employer.

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[1] *See Mark A. Baker*, 50 Van Natta 2333 (1998) (a new medical condition under ORS 656.262(7)(a) is one that comes into being following the issuance of the Notice of Acceptance; a condition that was incorrectly omitted from a Notice of Acceptance under ORS 656.262(6)(d) is one that was in existence at the time of the notice, but is not mentioned in the notice or is left out). Because claimant's radiculopathy was not identified or diagnosed until after the employer issued the Notice of Acceptance, (Exs. 3, 4, 27, 39), the conditions are most appropriately processed as "new medical conditions" under ORS 656.262(7)(a) rather than conditions incorrectly omitted from the notice pursuant to ORS 656.262(6)(d). Finally, we agree with the ALJ that claimant's radiculopathy and/or radiculitis were *symptoms* of his compensable low back combined condition; therefore, the employer was not required to formally accept claimant's radiculopathy and/or radiculitis.

[2] Claimant's attorney is not entitled to an attorney for his services on review concerning the attorney fee issue. *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

In the Matter of the Compensation of
KIM E. COOK, Claimant
WCB Case Nos. 98-08038 & 98-05140
ORDER ON REVIEW
Westmoreland & Mundorff, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that upheld the insurer's denials of claimant's aggravation and "new injury" claims for a current cervical condition. On review, the issues are compensability and aggravation. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the "Findings of Ultimate Facts."

CONCLUSIONS OF LAW AND OPINION

Claimant worked as a cook and dietary supervisor for the employer, a hospital, beginning in 1993. On March 27, 1997, claimant fell backward onto a recently mopped storeroom floor at work, striking her head and upper back. She experienced immediate neck and upper back pain, headaches, and tingling in her fingertips. She treated conservatively, but her symptoms did not abate.

On June 11, 1997, the insurer accepted claimant's claim for a nondisabling cervical and thoracic strain/sprain with headaches.

On January 25, 1998, claimant jammed her left hand on a freezer door handle at work. Dr. Fax diagnosed a contusion of the left wrist and the insurer accepted claimant's claim for a disabling contusion of the radial aspect of the left wrist on April 20, 1998.

Claimant continued to receive treatment for upper back pain. Dr. Long first treated claimant in April 1998. He took her off work and recommended cervical epidural injections for diagnostic and treatment purposes in June 1998.

The insurer denied claimant's aggravation and "new injury" claims for her current cervical condition on August 17 and August 25, 1998. Claimant requested a hearing, contending that her current cervical condition is compensable as an aggravation of the March 27, 1997 injury or as a "new injury" arising out of the January 25, 1998 incident.

January 25, 1998 "New Injury" Claim

We agree with the ALJ that claimant has not established that her 1998 left wrist injury was the major contributing cause of her current cervical condition and we adopt his opinion and conclusion on this issue, in the section entitled "Incident of January 1998." *See* ORS 656.005(7)(a)(B).

Aggravation Claim (March 27, 1997 Injury)

The ALJ upheld the insurer's denial of claimant's aggravation claim, based on "indications" that her current cervical condition is unrelated to the 1997 fall at work or that it does not represent a worsening of the accepted condition. The ALJ relied on various physicians' inability to diagnose or treat claimant's symptoms and their inability to identify objective findings supporting her complaints. The ALJ found no evidence of a worsening between claimant's April 1997 and May 1998 MRIs and stated that claimant is not a surgical candidate. He discounted Dr. Long's opinion that the 1997 incident included C4-6 disc injury, because he found it difficult to understand in the context of the entire medical record. We disagree.

To prove an aggravation of the March 1997 injury, claimant must show a worsened condition resulting from that injury. ORS 656.273(1). Because there is evidence that preexisting bone spurs at the C4-5 and C5-6 discs contribute to claimant's current cervical condition (*see* Exs. 88-11, 88-19-26, 88-44-45), claimant must prove that the 1997 work injury was the major contributing cause of her current condition or her disability and/or need for treatment for that condition. *See SAIF v. Nehl*, 148 Or App 101, *recon* 149 Or App 309 (1997), *rev den* 326 Or 389 (1998); *William R. Shapton*, 49 Van Natta 1369, 1371 (1997). She must also show that her cervical condition actually worsened.

Compensability

Claimant's cervical problems began with her March 1997 fall at work and they have continued and worsened since the injury.[1] Most of the examining and treating physicians have been unable to diagnose her ongoing problems and conservative treatment has been unsuccessful to date. The medical experts do agree that claimant probably does not have a herniated cervical disc or discs and therefore surgery may not be appropriate. (*See* Ex. 93-2; *cf.* Ex. 88-18). However, it does not necessarily follow that claimant's condition is not compensable or that it has not worsened. *See Tripp v. Ridge Runner Timber Services*, 89 Or App 355 (1988) (A claimant need not establish a specific or certain diagnosis in order to have a compensable claim).

Dr. Long provides the primary medical evidence supporting the claim. Although Dr. Long did not treat claimant for 13 months after 1997 injury, he obtained an accurate and complete history regarding all relevant matters. He acknowledged that claimant had small preexisting bone spurs at C4-5 and C5-6, but opined that they contribute little to her current problems because of their nature and because claimant led a physically active life, without neck symptoms, before the work injury. (*See* Exs. 88-25; 88-31; 88-44-45).

Based on claimant's symptom history, Dr. Long initially opined that claimant suffered "cervical disc injury," when she fell at work in 1997. Dr. Long noted the physical therapist's finding that claimant had "significant segmental irritability at C5-6," and current MRI findings of "slight posterior annulus bulging at C5-6 with subtle thecal impression,"[2] which he found consistent with the therapist's assessment of discogenic pain. Dr. Long diagnosed C5-6 disc injury, with secondary myofascial pain. (Ex. 59).

Dr. Long examined claimant again on June 11,1998, took her off work, and referred her to Dr. Slack for epidural steroid injections, which Dr. Slack provided on June 24, 1998. (Exs. 69, 74). Based on claimant's response to the injections, Dr. Slack opined that claimant's C4-5 and C5-6 levels were her primary pain generators. (Ex. 74-2). Dr. Long examined claimant again on July 23 and August 31, 1998 and prescribed additional injections for "cervical spine diagnosis," as well as a discography to clarify the location of disc injury. (Exs. 77-2, 85-1; *see* Exs. 79A-2, 86). Dr. Slack performed the procedures and noted that claimant's responses to the discography:

> "were felt to be entirely appropriate. There was no evidence of symptom magnification or exaggerated pain behavior. Accordingly, this is felt to be a valid study." (Ex. 86-2).

Based on the study results, Drs. Slack and Long concluded that claimant's C4-5 and C5-6 discs were abnormal and painful. (Ex. 86-2; *see* Ex. 88-14).

Dr. Long explained that claimant's cervical discs are probably producing neurological symptoms because of an inflammatory reaction to disc injury, rather than because of "actual physical compression." (Ex. 88-23-24). Based on claimant's symptom history, her injury history, physical findings, including her chiropractor's findings (particularly claimant's left upper extremity tingling symptoms, radiating into the left thumb, index, and middle fingers), the medical record, MRI films, and the discography, Dr. Long opined that claimant suffered injury to her C4-5 and C6-7 discs when she fell at work in 1997. (Exs. 88-7-9, 88-12-19; 88-35-40). Considering the nature of the 1997 injury, claimant's lack of prior significant upper body problems despite her physical lifestyle, and her post-injury ongoing problems, Dr. Long concluded that claimant's 1997 injury produced "disc injuries at C4-5 and C5-6 that never resolved and probably got a little worse as a result of the 1-25-98 injury."[3] (Ex. 88-31; *see* Ex. 32-33). Dr. Long also opined that the 1997 injury might have resolved sooner:

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[1] Although claimant had some upper back and shoulder problems before the 1997 work injury, they were not a particularly big problem for her and they were not associated with major periods of disability. (Ex. 88-21).

[2] Dr. Long also noted the study had been interpreted to show mild spurring at C4-5 and C5-6, with mild central prominence of the annuli at C5-6 and C6-7, and the study was slightly compromised "by motion artifact." (Ex. 59-2; *see* Ex. 62).

[3] We would find Dr. Long's opinion persuasive even if the 1998 injury did not contribute to claimant's current condition.

> "if we had recognized what the injury was on 3-28-97 and had restricted [claimant] from work, put her in a cervical collar, taught her disc management techniques, and said, 'Baby your neck like everything until the injury heals[.]' * * * * * Essentially what I'm saying--essentially she sustained a fairly substantial sprain to the C4-5 and C5-6 disks analogous to a bad ankle sprain. What we know is that she was still symptomatic with that on 1-24-98, but, in retrospect, we hadn't really treated her for that condition." (Ex. 88-33)

We find Dr. Long's opinion regarding the cause of claimant's current neck condition persuasive because it is well-reasoned, based on an accurate and complete history, and consistent with that history. Accordingly, we conclude that claimant's compensable 1997 injury is the major contributing cause of her current cervical condition and her need for treatment for that condition.[4] (*See* Ex. 88-37-39).

Worsening

To prove her aggravation claim, claimant must also establish that her cervical condition actually worsened.

Because of the poor quality of the 1997 MRI,[5] Dr. Long could not say that claimant's disc condition worsened since that MRI, *based on the films alone.* (Exs. 88-10-11, -20). However, comparing claimant's symptoms before the 1998 injury to her symptoms after the injury, Dr. Long opined that the condition worsened, but the cause of the worsened condition (and the worsening) was still the 1997 injury. (Ex. 88-34; *see* Ex. 88-42).

The insurer argues that Dr. Long's opinion is not persuasive because he had an inaccurate history. In this regard, the insurer notes that Dr. Long did not acknowledge the fact that claimant sought treatment for worsened neck symptoms *before* the March 1998 left wrist/freezer door incident. We do not find this argument persuasive, because claimant's symptoms worsened progressively throughout the course of the claim and Dr. Long's opinion establishes that claimant's worsened symptoms represented a worsened condition, at least since the 1998 injury. *See SAIF v. Walker*, 145 Or App 294 (1996), *rev allowed*, 325 Or 367 (1997). We find Dr. Long's opinion that claimant's cervical condition worsened persuasive, because it is well-reasoned, based on a materially accurate history, and consistent with that history.[6] Because Dr. Long also made objective findings supporting the claim, we rely on his opinion and conclude that claimant has proven her aggravation under ORS 656.273.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review for prevailing on the aggravation claim. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding the aggravation issue is $3,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate brief), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

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[4] The contrary opinions are provided by Drs. Scheinberg, Rich, Reimer, and Gripkoven. (Exs. 43, 81). Drs. Scheinberg and Rich examined claimant on March 17, 1998. They found the etiology of claimant's pain "unclear," with "no good objective findings to relate her current complaints" to her work injuries. (Ex. 43-6). We find the doctors' inability to diagnose or explain claimant's condition unhelpful, particularly in light of Dr. Long's well-reasoned opinion.

Drs. Reimer and Gripkoven examined claimant on August 10, 1998 and diagnosed a cervical strain and degenerative disc disease at C5-6 and C6-7 (as well as a left wrist contusion). (Ex. 81-5). They found no objective findings to explain claimant's ongoing pain and suspected a "very strong psychological component." They also opined that claimant's "early degenerative changes" do not explain "her ongoing pathological pain." (Ex. 81-6). Dr. Long disagreed, stating that claimant's pain is not "psychologically determined," based on historical data, findings from physical therapy assessment, response to epidural injections, and physical and discographic findings. (Ex. 90-2; *see* Ex. 88-40).

[5] Dr. Long opined that claimant's 1997 MRI films were of such poor quality that they did not support accurate diagnosis. (Ex. 54-7).

[6] We also note that Dr. Long is the only physician who explains the relationship between claimant's injuries, symptoms, and findings.

ORDER

The ALJ's order dated February 22, 1999 is reversed in part and affirmed in part. That portion of the order that upheld the insurer's denial of claimant's aggravation claim is reversed. The denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant is awarded a $3,000 attorney fee, payable by the insurer. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
SAMUEL R. DIGATI, Claimant
Own Motion No. 98-0370M
OWN MOTION ORDER
Thomas J. Dzieman, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for claimant's compensable back sprain/strain condition. Claimant's aggravation rights on that claim expired on May 15, 1984. SAIF recommended against reopening on the grounds that: (1) claimant's current condition is not causally related to the accepted condition; (2) SAIF is not responsible for claimant's current condition; and (3) surgery or hospitalization is not reasonable and necessary for the compensable injury.

On September 3, 1998, SAIF denied the current care, treatment and possible surgery for claimant's current multilevel spondylosis and multilevel compressive disease condition. Claimant requested a hearing. (WCB Case No. 98-06450). The Board postponed action on the own motion matter pending resolution of that litigation.

By Opinion and Order dated February 17, 1999, Administrative Law Judge (ALJ) Mongrain set aside SAIF's September 3, 1998 denial "insofar as [it denied] treatment for the claimant's L5-S1 herniated disc." That order was not appealed. In light of such circumstances, the grounds for SAIF's opposition to the reopening of the claim have either been resolved or no longer advanced.[1]

Under ORS 656.278(1)(a), we may exercise our own motion authority to reopen a claim for additional temporary disability compensation when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization.

On February 4, 1998, claimant underwent a two level surgical procedure for his low back condition. Thus, we conclude that claimant's compensable injury has worsened requiring surgery.

Accordingly, we authorize the reopening of claimant's 1978 injury claim to provide temporary disability compensation beginning the date claimant is hospitalized for the proposed surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[1] On May 25, 1999, we requested the parties' positions regarding the effect, if any, ALJ Mongrain's February 17, 1999 Opinion and Order had on claimant's request for own motion relief. In response, claimant asserted that SAIF's grounds for recommending denying the reopening of the claim were no longer valid because of the ALJ's decision. SAIF has not replied.

In the Matter of the Compensation of
JERRIN L. HICKMAN, Claimant
WCB Case No. 98-08562
ORDER ON REVIEW
Pozzi, Wilson & Atchison, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Mills' order that awarded an assessed attorney fee of $3,250 for services at hearing. SAIF also moves for remand. On review, the issues are remand and attorney fees. We modify.

FINDINGS OF FACT

Claimant requested a hearing challenging SAIF's denial of his low back claim. The ALJ found that claimant had established the compensability of the low back strain condition, and directed SAIF to accept and process the claim. The ALJ also assessed an attorney fee of $3,250 "[b]ased on the principles and factors set forth in OAR 438-015-0010."[1]

Following the hearing, SAIF requested abatement and reconsideration, arguing that the "record in this case is not sufficiently developed for the ALJ to make findings on all eight factors" and "those factors which are subject to findings, conclusions and weighing reveals that a fee of $3,250 is clearly excessive." The ALJ denied the request.

CONCLUSIONS OF LAW AND OPINION

On review, SAIF continues to argue that the ALJ failed to provide sufficient explanation for the assessed attorney fee and seeks remand to the ALJ. Alternatively, SAIF asks that we modify the ALJ's attorney fee award to no more than $1,500.

Subsequent to the ALJ's order, we addressed a case with similar facts. In *Donna R. Grierson*, 51 Van Natta 679 (1999), the ALJ also awarded an attorney fee "based on the principles and factors set forth in OAR 438-015-0010." We found that, by not discussing any of the specific rule-based factors, the ALJ's order was "devoid of any explanation o fhis application of the factors in determining the attorney fee in this case[.]" 51 Van Natta at 679. Consequently, we found the ALJ's reasoning insufficient to support the attorney fee award. *Id.*

For the same reason, we find that the ALJ's order in this case also is insufficient to support the attorney fee award. Specifically, because the ALJ only cited the rule without citing or discussing any of the factors, the ALJ's order is not adequate with regard to the attorney fee award. Like *Grierson*, however, because we are authorized under ORS 656.295(6) to modify or supplement the ALJ's findings and conclusions, it is not necessary to remand the case to the ALJ for supplementation of findings. Thus, we deny the motion to remand.

In applying the factors listed in OAR 438-015-0010(4), we first note that claimant did not submit a statement of services indicating the time devoted to the case. The hearing lasted approximately 40 minutes; only claimant testified. Out of a record of 52 exhibits, claimant's attorney submitted one. We recognize that claimant's attorney must, of course, review the exhibits submitted so we have taken this into consideration.

In comparison to compensability disputes litigated before this forum, the issue here was of average complexity and included analyzing the persuasiveness of two medical opinions. The value of the interest involved and the benefit secured for claimant appear to be minimal in that claimant was treated only for a strain and, at the time of hearing, there were no "amounts then due" for the low back condition.

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[1] The rule provides that, when an ALJ or the Board is required to determine a reasonable attorney fee, the following factors shall be considered: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses.

The attorneys were skillful and, in light of SAIF's denial, there was a risk that claimant might go uncompensated. Finally, there is no assertion of frivolous issues and defenses.

After considering the factors set forth in OAR 438-015-0010(4), including the relatively minimal time devoted to the issue (as represented by the record at hearing), the minimal value involved and benefit secured, and the average complexity of the compensability issue, we find that a reasonable attorney fee is $2,500 for claimant's attorney's services at hearing.[2]

ORDER

The ALJ's order dated February 11, 1999 is modified in part and affirmed in part. In lieu of the ALJ's attorney fee award, for services at hearing, claimant's attorney is awarded an assessed fee of $2,500, to be paid by the SAIF Corporation. The remainder of the ALJ's order is affirmed.

[2] Because the sole issue on review was attorney fees, claimant's attorney is not entitled to a fee on review. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

In the Matter of the Compensation of
KATHY J. HEITZ, Claimant
WCB Case Nos. 98-07384 & 98-02592
ORDER ON REVIEW
Coughlin, Leuenberger & Moon PC, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys
Ronald W. Atwood & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Mills' order that upheld Liberty Northwest Insurance Corporation's denial of claimant's occupational disease claim for a left thumb arthritis condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order, with the following supplementation.

To prove her occupational disease claim for left thumb arthritis, claimant must establish that work activities were the major contributing cause of that condition. *See* ORS 656.802(2)(a); *Peggy Shipman*, 51 Van Natta 827 (1999) (Work-related symptoms insufficient to prove occupational disease).

Dr. Sandefur provides the only medical opinion arguably supporting the claim. He opined that claimant's symptoms are "consistent with early degenerative arthritis which *could be* directly related to her work activities" with Liberty's insured. (Ex. 24-2; *see* Exs. 5, 8, 16) (emphasis added). But work-related symptoms and the mere possibility of a work-related condition are insufficient to establish a compensable occupational disease. *See id.; Betty J. Skinner-Loven*, 51 Van Natta 385 (1999); *Willard A. Hirsch*, 49 Van Natta 1311, n.1 (1997), *aff'd mem*, 159 Or App 681 (1999). Under these circumstances, we agree with the ALJ that the claim must fail.

ORDER

The ALJ's order dated January 8, 1999 is affirmed.

In the Matter of the Compensation of
SALLY J. JOHNSON, Claimant
WCB Case Nos. 97-04526 & 97-02758
ORDER ON REVIEW
Bottini, Bottini & Oswald, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's aggravation claim for a current neck condition. Claimant cross-requests review of that portion of the order that upheld the employer's denial of her claim for a consequential psychological condition. On review, the issues are aggravation and compensability.

We adopt and affirm the ALJ's order, with the following supplementation regarding the claim for a psychological condition.

To prove her claim for a consequential psychological condition, claimant must establish that the compensable injury was the major contributing cause of the psychological condition. ORS 656.005(7)(a)(A). Emotional responses to claim processing "are collateral to the injury" and they may not therefore "be considered as caused by the compensable injury." *Roseburg Forest Products v. Zimbelman,* 136 Or App 75, 79 n.2 (1995).

In this case, claimant's complaints to her treating psychologists indicate that her emotional state resulted in part from frustration with the employer's claim processing. (Exs. 69, 78A, 80A, 82A, 84A). Although claimant's treating psychologists related her condition "directly" to the injury or to the injury "and its sequella," (Exs. 84D-2, 93-2), their opinions are based in part on causes collateral to the injury and those causes may not be considered in evaluating major causation. *Zimbelman,* 136 Or App at 79 n.2. Under these circumstances, we cannot say that claimant has carried her burden of proof under ORS 656.005(7)(a)(A). *See* ORS 656.802(3)(d). Consequently, even if claimant has a mental disorder under ORS 656.802(3)(c), we would reach the same result.

Claimant's attorney is entitled to an assessed fee for services on review regarding the aggravation claim (involving her compensable cervical condition). ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated February 23, 1999 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the self-insured employer.

In the Matter of the Compensation of
SANDRA L. KAY, Claimant
WCB Case No. 98-07524
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Martha Brown's order that: (1) denied its motion to strike claimant's untimely written closing arguments; (2) set aside its denial of claimant's aggravation claim for a low back condition; and (3) awarded an assessed fee of $3,500. On review, the issues are motion to strike, aggravation and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

The insurer moved to strike claimant's closing arguments on the ground that the arguments were not timely submitted pursuant to the schedule set by the ALJ. The ALJ found that claimant's attorney had provided an excuse for untimeliness and she noted that there are no rules pertaining to closing arguments at the hearings level. Consequently, the ALJ denied the insurer's motion to strike.

The insurer argues that the ALJ erred in denying its motion to strike claimant's untimely written closing arguments. The insurer contends that claimant did not provide any excusable reason for the untimeliness and it asserts that it should not have to pay an attorney fee for claimant's counsel's "imperfect service."

We agree with the ALJ that there are no specific rules relating to time tables for closing arguments. We are not persuaded that the ALJ erred in denying the insurer's motion to strike.

Aggravation

Claimant was working as a secretary for the employer when she compensably injured her low back on July 29, 1992. The insurer accepted a nondisabling lumbosacral strain. (Ex. 7). Claimant continued to have low back and right leg pain, and on December 1, 1992, Dr. Serbu performed a lumbar laminectomy at L5-S1. (Ex. 10). On March 23, 1993, Dr. Serbu performed a second laminectomy at L5-S1 to remove a disc fragment. (Ex. 13). A Notice of Closure issued on August 12, 1994, awarding claimant 20 percent unscheduled permanent disability. (Ex. 22).

In 1995, claimant experienced increased low back and leg symptoms. On October 13, 1995, the insurer denied claimant's request to reopen the claim due to a worsening of her low back condition. (Ex. 43). A March 6, 1996 Opinion and Order set aside the insurer's aggravation denial. (Ex. 47). The Board affirmed the Opinion and Order. (Ex. 51).

A February 26, 1997 Determination Order increased claimant's unscheduled permanent disability to 25 percent. (Ex. 55). Claimant requested reconsideration and was examined by a panel of medical arbiters on June 3, 1997. (Ex. 60). An Order on Reconsideration issued on July 18, 1997, reducing claimant's unscheduled permanent disability to 20 percent. (Ex. 61). A December 18, 1997 Opinion and Order increased the unscheduled permanent disability award, but the Board reversed and affirmed the Order on Reconsideration. (Exs. 64, 65).

On July 17, 1998, Dr. White submitted an aggravation form and reported that claimant's work had to be restricted due to her low back pain. (Exs. 66, 67). The insurer denied the aggravation claim on the basis that claimant's condition had not worsened since the last award of compensation. (Ex. 70). Claimant requested a hearing.

The ALJ relied on the opinion of Dr. White to conclude that claimant had established a compensable aggravation. On review, the insurer argues that Dr. White's opinion is not persuasive and there are no objective findings to show that claimant's condition has actually worsened.

To prove a compensable aggravation, claimant must establish an "actual worsening" of the compensable condition since the last award of compensation. ORS 656.273(1). In *SAIF v. Walker*, 145 Or App 294, 305 (1996), *rev allowed* 325 Or 367 (1997), the court interpreted the "actual worsening" language in ORS 656.273(1) to require direct medical evidence that a condition has worsened. The court held that proof of a pathological worsening is required to prove an aggravation and that it is no longer permissible, as it was under the former law, to infer a worsened condition from evidence of increased symptoms alone. *Id.* Claimant must also prove diminished wage-earning capacity in order to prove a worsened condition involving an unscheduled body part. *Intel Corp. v. Renfro*, 155 Or App 447, 450 (1998). Claimant's last award of compensation was the July 18, 1997 Order on Reconsideration that awarded 20 percent unscheduled permanent disability. (Exs. 61, 65).

Claimant relies on the opinion of Dr. White, her treating physician, to establish a compensable aggravation. She also relies on Dr. Hacker's report.

Claimant testified that after the 1997 closure, her pain was worse and the doctor kept increasing her pain medication. (Tr. 11, 12). She had trouble functioning with the increased medication. (*Id.*) Claimant explained that she had "[t]he same low back, same pains in my leg, down into my foot. I get the same sharp -- sharp pains." (Tr. 11). Her leg would feel numb and she had sharp pains in her back. (*Id.*)

On July 17, 1998, Dr. White submitted an aggravation form and a report stating that claimant's work had to be restricted due to her low back pain. (Exs. 66, 67). He reported that the MRI scan showed fibrosis of the nerve roots following claimant's laminectomies. (Ex. 66). Dr. White indicated that claimant's "actual worsening" was based on increased symptoms that required more pain medication. (*Id.*) In a later report, Dr. White said it was "impossible to show that the fibrosis is 'more constricting' in 1997 than in 1995 but her clinical cause [sic] would support this conclusion as she has had increasing pain and decreasing work capacity." (Ex. 74). He reported that claimant had tenderness in her incision and right paraspinous tenderness and he felt that her symptoms were compatible with epidural fibrosis. (*Id.*) Dr. White noted, however, that claimant's reflexes, strength and sensory exam were unchanged. (*Id.*) Because of claimant's increasing pain, Dr. White had prescribed larger doses of narcotic pain medications, which had interfered with claimant's "sensorium and ability to work." (*Id.*).

Although Dr. White said that claimant needed more pain medication, other medical experts said that claimant's pain medication was excessive and inappropriate for her condition. Dr. Schilperoort examined claimant on behalf of the insurer and could not document any material worsening in claimant's condition since the last closure. (Ex. 68-4). He found that claimant had *improvement* in lateral flexion and extension since the 1997 arbiter evaluation, but some of the range of motion testing was invalid. (*Id.*) In addition, he found evidence of functional overlay and felt that claimant should discontinue using narcotics. (Ex. 68-4, -5). In a later report, Dr. Schilperoort reported that it was impossible to determine if there was any change in the level or amount of claimant's epidural fibrosis and he said it was not possible to objectively isolate scarring as the cause of claimant's pain. (Ex. 72-3).

In August 1998, Dr. Bardana reported that claimant's use of methadone, vicodin, prozac and non-steroidal anti-inflammatory drugs was excessive. (Ex. 67A-5). Similarly, a comprehensive pain evaluation report prepared on December 9, 1998 concluded that claimant had findings consistent with mild nerve root irritation, but she had no objective findings that would indicate the use of chronic long-term narcotics. (Ex. 75-8). The report found no evidence of a worsening of claimant's condition over time. (Ex. 75-13). The report also concluded that claimant's response to her injury was in excess of objective physical findings. (*Id.*)

When medical opinions are divided, we give the most weight to opinions that are well-reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259 (1986). We generally defer to the treating physician, unless there are persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). Here, we find persuasive reasons not to defer to Dr. White's opinion.

Dr. White said that claimant's "actual worsening" was based on her increased pain, need for more pain medication and her decreased work capacity. (Exs. 66, 74). Nevertheless, he said it was impossible to show if claimant's fibrosis was more constricting than at the time of closure and he acknowledged that claimant's reflexes, strength and sensory exam were unchanged. (Ex. 74). In fact,

Dr. Schilperoort found that some of claimant's range of motion findings had actually improved. Although Dr. White indicated claimant had "tenderness" in certain areas, he did not state whether that had changed since the last closure. Dr. White's conclusory opinion is not sufficient to establish that claimant's symptoms have increased to the point that it can be said that the compensable condition has worsened. *See SAIF v. Walker*, 145 Or App at 305. We conclude that Dr. White's opinion that claimant had increased pain that required increased pain medication is not sufficient to establish an "actual worsening" of the compensable condition, particularly in light of the medical reports indicating that claimant's pain medication was excessive and inappropriate for her condition.

Claimant also relies on Dr. Hacker's report as physical evidence of a worsening. Although Dr. Hacker agreed that claimant had epidural fibrosis, he said it was impossible to make an objective determination of whether claimant's scar was more constrictive, had significantly increased in severity or was even the cause of claimant's pain. (Ex. 69-1). He could not state that claimant's epidural fibrosis was the objective cause of her increased symptoms. (Ex. 69-2). We conclude that Dr. Hacker's report is not sufficient to establish a compensable aggravation.

After reviewing the record, we are not persuaded that claimant has established an "actual worsening" of her compensable condition. Therefore, we conclude that claimant has not established a compensable aggravation claim under ORS 656.273(1).[1]

ORDER

The ALJ's order dated March 10, 1999 is reversed in part and affirmed in part. That portion of the ALJ's order that set aside the insurer's denial of claimant's aggravation claim for a low back condition is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

[1] In light of our determination, we need not address the insurer's argument that the attorney fee award for services at hearing should be reduced.

In the Matter of the Compensation of
LEROY JAMES, JR., Claimant
WCB Case No. 98-08931
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that upheld the SAIF Corporation's denial of his low back injury claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order.[1]

ORDER

The ALJ's order dated March 11, 1999 is affirmed.

[1] Claimant contends that the Act should be liberally construed in this case in favor of compensation, citing *Liberty Northwest Ins. Corp. v. Short*, 102 Or App 495, 499 (1990); *Satterfield v. Compensation Dept.*, 1 Or App 524, 528 (1970). Although previous case law provided that the Workers' Compensation Law was to be liberally construed in favor of the injured worker, *see also Reynaga v. Northwest Farm Bureau*, 300 Or 255, 262 (1985), we note that ORS 656.012(3) now requires the interpretation of Chapter 656 "in an impartial and balanced manner."

In the Matter of the Compensation of
JOSE LOPEZ, Claimant
WCB Case No. 98-08979
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order that upheld the SAIF Corporation's denial of claimant's chest injury claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation.

On review, claimant asserts that medical opinion evidence is not necessary to carry his burden of proof because this case is not complex. *See Uris v. Compensation Department*, 247 Or 420 (1967). Thus, whether or not the medical evidence is persuasive, he proved compensability.

Expert medical testimony establishing causation is not required when "there is nothing very complicated about [the] injury and its cause." *Id.* at 427. The relevant factors for determining whether expert testimony of causation is required include: (1) whether the situation is complicated; (2) whether symptoms appear immediately; (3) whether the worker promptly reports the occurrence to a superior; (4) whether the worker previously was free from disability of the kind involved; and (5) whether there was any expert testimony that the alleged precipitating event could not have been the cause of the injury. *Id.* at 426.

Here, we find that claimant's injury and its cause are sufficiently complex to require medical opinion evidence. First, it is questionable that claimant's symptoms appeared immediately. Although claimant later stated that he had chest pains at the time of the work incident, he did not report such symptoms to the emergency room physician, who saw claimant shortly after the event. (Ex. 1).

Furthermore, there is medical evidence that the "alleged precipitating event" did not cause a chest injury. The emergency room physician, Dr. El-Attar, thought that claimant sustained a "severe anxiety reaction with hyperventilation causing the carpal pedal spasm." (Ex. 6). Claimant's current treating physician, Dr. Matheson, reported that he could not "say" whether claimant had experienced a "specific industrial injury" and that, in the absence of chest symptoms while being treated at the emergency room, it appeared that claimant did not sustain a "rib injury or problem" at that time. (Ex. 8B).

Finally, because we conclude that medical opinion evidence is necessary to prove compensability and we agree with the ALJ's analysis of the medical evidence, we also conclude that claimant failed to carry his burden of proof.

ORDER

The ALJ's order dated March 3, 1999 is affirmed.

In the Matter of the Compensation of
ERIC L. PIERCY, Claimant
WCB Case No. 98-07803
ORDER ON REVIEW
Kirkpatrick & Zeitz, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Menashe's order that increased claimant's unscheduled permanent disability award for a low back condition from 5 percent (16 degrees), as awarded by an Order on Reconsideration, to 17 percent (38.4 degrees). On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, and briefly summarize the pertinent facts as follows:

Claimant, age 23 at the time of hearing, compensably injured his back on August 17, 1997. He sought treatment, and Dr. Winjum diagnosed a back strain. The employer accepted a thoracic/lumbar strain.

Claimant was evaluated by Dr. Stewart at the employer's request on January 7, 1998. Dr. Stewart diagnosed a chronic dorsal lumbar pain, history of lumbar strain with residual symptoms, history of apparent mild scoliosis with a short right leg (unrelated to the compensable injury) and history of congenital fusion neck and lumbosacral interval (also unrelated to the compensable injury). Dr. Stewart found reduced lumbar range of motion, but he related 20 percent of the restriction to claimant's preexisting lumbosacral fusion. Dr. Winjum concurred with Dr. Stewart's report and findings.

The claim was closed by a April 27, 1998 Determination Order, that awarded temporary disability and 5 percent unscheduled permanent disability. Claimant requested reconsideration and a medical arbiter examination.

Dr. Peterson conducted a medical arbiter examination on August 19, 1998. She diagnosed lumbar strain injury, congenital defect of the lumbar spine, leg length discrepancy, and high arched foot with hammer toes and vibratory sensation loss in a peripheral neuropathy distribution. Dr. Peterson measured a loss of thoracic and lumbar range of motion, that she related in part to the accepted strain and in part to preexisting, underlying causes. Dr. Peterson agreed with Dr. Stewart that 20 percent of claimant's loss of lumbar motion was due to his lumbar fusion, although she thought claimant would be best served by further neurological evaluation and diagnostic testing to rule out a possible underlying congenital neuropathy condition.

Dr. Peterson also noted that her examination findings were different from those of Dr. Stewart, in that claimant's range of motion had deteriorated since the time of Dr. Stewart's evaluation. She reported that "[t]his [deterioration] is difficult to explain on the basis of a chronic thoracolumbar strain and I suspect that today's range of motion values may be due to other conditions rather than simply the residuals of the accepted condition."

A September 10, 1998 Order on Reconsideration affirmed the Determination Order in all respects. The Appellate Reviewer found that claimant's condition had changed since claim closure, and declined to consider the medical arbiter's report in evaluating claimant's permanent disability on reconsideration.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the medical arbiter's range of motion findings were valid and due to claimant's injury and increased claimant's unscheduled permanent disability award to 17 percent. On review, the employer contends that the medical arbiter's findings are not persuasive evidence of claimant's injury-related impairment, and therefore the ALJ's decision to increase claimant's unscheduled permanent disability award should be reversed. As set forth below, we agree with the employer.

Claimant has the burden of proving the extent of any disability resulting from the compensable injury. ORS 656.266. The criteria for rating unscheduled disability is the permanent loss of earning capacity *due to* the compensable injury, as calculated using the standards. ORS 656.214(5); OAR 436-035-0007(1). Although evaluation of a worker's disability is as of the date of issuance of the reconsideration order, *see* ORS 656.283(7), we do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment. Rather, we rely on the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

Here, claimant was seen by Dr. Stewart for a closing examination on January 7, 1998. Although he found reduced lumbar motion,[1] Dr. Stewart opined that 20 percent of claimant's restricted motion was due to his preexisting, congenital L5-S1 fusion. Claimant's attending physician, Dr. Winjum, specifically agreed with Dr. Stewart's report and findings. Thereafter, claimant was awarded 5 percent unscheduled permanent disability at claim closure.[2]

Although the medical arbiter (Dr. Peterson) found that claimant's range of motion had "deteriorated" by August 1998, she did not relate this deterioration to claimant's compensable injury. To the contrary, Dr. Peterson opined that it would be difficult to explain the deterioration on the basis of claimant's chronic thoracolumbar strain. Dr. Peterson indicated that claimant's current range of motion measurements were due to other (noncompensable) conditions rather than the residuals of his accepted injury.

The fact that the medical arbiter's examination was performed closer in time to the issuance date of the reconsideration order is not always decisive. *See, e.g., Charlene L. Vinci*, 47 Van Natta 1919 (1995). This is especially true where, as here, the medical arbiter determined that claimant's condition had changed, but does not attribute that change to the compensable injury. Indeed, we have previously held that where a medical arbiter expressly relates a claimant's impairment to causes other than the compensable injury, the medical arbiter's opinion is not persuasive evidence of injury-related impairment.[3] *See, e.g., Julie A. Widby*, 46 Van Natta 1065 (1994); *see also Patti E. Bolles*, 50 Van Natta 1694 (1998); *Manuel G. Garcia*, 48 Van natta 1139 (1996).

Because Dr. Peterson did not specifically ascribe a percentage of impairment due to claimant's accepted injury and instead indicated that claimant's deteriorated condition was likely due to conditions other than the compensable injury, her opinion is not persuasive evidence of claimant's injury-related permanent impairment. The only other evidence that we may consider in rating claimant's permanent impairment is the closing examination by Dr. Stewart, because Dr. Stewart's findings were ratified by claimant's attending physician, Dr. Winjum. *See* ORS 656.245(2)(b)(B); OAR 436-035-0007(12) and (13); *see also Tektronix, Inc. v. Watson*, 132 Or App 483 (1995). Consequently, based on Dr. Winjum's concurrence with Dr. Stewart's findings, claimant is entitled to 5 percent unscheduled permanent disability due to his accepted injury. We therefore affirm the September 10, 1998 Order on Reconsideration.

ORDER

The ALJ's order dated February 17, 1999 is reversed. The September 10, 1998 Order on Reconsideration is affirmed. The ALJ's "out-of-compensation" attorney fee award is also reversed.

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[1] Dr. Stewart made the following range of motion measurements: forward flexion 42 degrees; extension 20 degrees, side bending right, 26 degrees; side bending left, 24 degrees.

[2] Because claimant was released to his regular employment, impairment was the only factor considered in determining his permanent disability award. *See* ORS 656.726(3)(f)(D).

[3] Because the medical arbiter identified other, underlying conditions that contributed to claimant's impairment (including a leg length discrepancy and a congenital fusion of the lumbar spine) this case is distinguishable from *SAIF v. Danboise*, 147 Or App 550 (1997). In *Danboise*, the court held that when a treating doctor or medical arbiter makes impairment findings and describes those findings as consistent with a claimant's compensable injury, and the medical record does not attribute the impairment to causes other than the compensable injury, such findings may be construed as showing that the impairment is due to the compensable injury. 147 Or App at 553.

In the Matter of the Compensation of
JAMES M. STEELE, Claimant
WCB Case No. 98-02215
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the SAIF Corporation's denials of his claim for an internal disc disruption condition at L4-5 and L5-S1. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation.

Claimant, age 37 at the time of hearing, has a history of back injuries dating back to 1990. On August 13, 1990, he experienced pain in the low back when he lifted an engine out of a truck. He filed an injury claim, which was accepted as a lumbar strain by his then employer's carrier. The "non-medical service" portion of this claim was subsequently resolved by a May 1992 Claim Disposition Agreement.

In September 1993, claimant sought emergency treatment for an acute exacerbation of his low back pain. He reported that, while at home, he bent over and experienced acute pain and was unable to straighten up. He was diagnosed with an acute lumbosacral strain and degenerative disc disease. In March 1994, claimant again sought treatment for recurrent back pain after lifting a heavy object.

In March 1995, while claimant was employed as a painter, he again experienced the onset of acute low back pain while bending over. He filed an injury claim, which was accepted as a muscle strain. An April 1995 MRI showed moderate disc disease at multiple lumbar levels but no frank herniations. The muscle strain claim was closed in late 1995 with an award of 11 percent unscheduled permanent disability.

Meanwhile, claimant's low back symptoms continued to wax and wane. In April 1996, Dr. Tearse attributed claimant's low back pain to a combination of disc disease and facet arthropathy. Dr. Tearse also reported that claimant's chronic lumbar strain was synonymous with his lumbar spondylosis, and described the March 1995 strain as a symptomatic exacerbation of the lumbar spondylosis.

Claimant made another claim for low back pain, asserting a July 1, 1996 injury. Claimant also injured his neck in a different incident that resulted in a cervical discectomy. SAIF denied that claimant sustained a low back injury on July 1, 1996, and also denied the compensability of his current low back condition.

In November 1996, claimant and SAIF entered into a series of Disputed Claim Settlement (DCS) Agreements. In the first DCS, claimant received $2,000 in connection with his July 1, 1996 injury claim. The parties agreed that SAIF's denial of the July 1996 injury remained in full force and effect, and that claimant's preexisting low back condition, including degenerative disc disease, lumbar spondylosis with facet and disc damage and degenerative arthritis was the major cause of his current symptomatology and need for treatment. (Ex. 76). The second DCS addressed claimant's August 1990 claim. Claimant received $2,000 and the parties agreed that claimant accepted strain had not objectively worsened and was therefore not compensable. (Ex. 77). The third DCS covered claimant's March 1995 claim and SAIF's August 1996 denials of claimant's diagnosed conditions, including, among other things, lumbar spondylosis, degenerative disc disease, probable herniated inner vertebral disc and radiculitis L4, S1 right. Claimant received $3,000 and the parties agreed that claimant's current low back condition was not compensable and that SAIF's current condition denials remained in full force and effect. (Ex. 78).

In February 1997, claimant experienced a recurrence of low back pain after bending over while working on his car. In April 1997, he was referred to Dr. Hacker, who diagnosed chronic low back pain of uncertain etiology, probably related to an injury. Dr. Hacker recommended a discography. In August 1997, Dr. Karasek performed a three level discography that showed multi-level intradiscal disease, most severe at L4-5 and L5-S1, as well as a large focal herniation at L5-S1.

Claimant's low back symptoms continued to worsen during August, September and October 1997. In early November 1997, claimant was referred to Dr. Golden. During that examination, claimant was relatively asymptomatic and Dr. Golden was hesitant to recommend surgery. Dr. Golden recognized, however, that if claimant's symptoms recurred, then claimant would be a candidate for surgery at the L5-S1 level.

On November 25, 1997, claimant returned to his primary care doctor, Dr. Pollack, complaining of severe back pain. On December 1 and 5, 1997, claimant sought emergency treatment for low back and left leg pain. On both occasions, he was given an injection and pain pills.

Claimant returned to Dr. Hacker on December 8, 1997. He diagnosed a painful disc disruption with abnormal disc at L5-S1 and L4-5, and recommended that claimant proceed with surgery. Claimant saw his primary care physician for follow up examinations on December 11 and 17, 1997, and reported that his low back pain continued to worsen.

In early January 1998, claimant made a claim for his current low back condition, either as an injury or an occupational disease. He also asserted that he experienced an acute onset of symptoms while sanding at work on December 2, 1997. SAIF subsequently denied the December 1997 injury as well as the compensability of claimant's current low back condition.

Meanwhile, on January 15, 1998, Dr. Hacker performed a discectomy and anterior interbody fusion at L4-5 and L5-S1. Thereafter, claimant's symptoms improved.

The ALJ concluded that the alleged December 2, 1997 work incident was not the major contributing cause of claimant's low back condition or the major cause of claimant's need for treatment thereafter. The ALJ further determined that claimant had not established a compensable occupational disease claim because the medical evidence did not show that his work exposure subsequent to his March 1995 injury was the major contributing cause of his low back condition or its worsening.

On review, claimant contends that the ALJ erred in focusing on claimant's work exposure subsequent to March 1995 and in declining to consider his prior injuries and overall work exposure in evaluating the occupational disease claim. Specifically, claimant asserts that neither his prior receipt of compensation nor the disputed claim settlements should preclude the ALJ from considering his prior injuries and total work exposure under ORS 656.802. We disagree.

In support of his contention, claimant relies on *Kepford v. Weyerhaeuser*, 77 Or App 363 (1986), where the court held that the claimant could establish compensability of an occupational disease claim by proving that his overall work activities, including his prior compensable back injuries, were the major cause of his worsened degenerative disc disease. But claimant overlooks a crucial distinction between his claim and *Kepford* --here, unlike *Kepford*, claimant's low back condition and his prior injuries were the subject of a series of Disputed Claim Settlements. As part of those Disputed Claim Settlements, the parties agreed that claimant's low back condition as of November 1996 (including his degenerative lumbar disc disease, lumbar spondylosis with facet and disc damage and degenerative arthritis) was the result of noncompensable causes. The parties also agreed that claimant's August 1990 and March 1995 strains and the claimed July 1, 1996 incident did not cause any worsening of his low back condition.

The parties are bound by their agreement that there is no compensable relationship between claimant's prior injuries and his low back condition as it existed in November 1996. *See Gilkey v. SAIF*, 113 Or App 314 (1992) (where the parties have agreed in a DCS that there is no relationship between an injury and a condition, they are bound by that agreement and cannot relitigate the issue). Therefore, unless claimant can show that his current need for treatment is for a condition different from his condition in November 1996 or establish that his work exposure since that time is the major contributing cause of his combined condition and its worsening, he cannot avoid the preclusive effect of the disputed claim settlements. *See, e.g., Judy A. Tuttle*, 45 Van Natta 165, 166 (1993) (a claimant may avoid the preclusive effect of a DCS only if she establishes that her current need for treatment is for a condition different from the condition at the time of the DCS); *see also Stacy v. Corrections Division*, 131 Or App 610 (1994) (to establish that his current condition was a new occupational disease, claimant must show that his work activities after acceptance of his prior claim were the major contributing cause of current condition).

Here, as the ALJ noted, neither Dr. Hacker nor Dr. James (who examined claimant at SAIF's request on March 10, 1998) related claimant's current disability or need for treatment to his recent work exposure or to a specific work incident in December 1997. Rather, Dr. James related claimant's need for fusion surgery at two levels to the natural progression of his degenerative disc disease at multiple levels of the lumbar spine. Similarly, Dr. Hacker related claimant's "painful disc disruption" condition to his lifetime of heavy work, including the 1990 and 1995 strain injuries. He specifically indicated that any injury occurring in December 1997 would not be a major contributing cause to claimant's need for treatment. Therefore, on this record, claimant has not established that his work exposure subsequent to the November 1996 DCS was the major cause of a new occupational disease.

In addition, claimant has not shown that his current low back condition is distinct from his condition at the time of the DCS. As noted above, claimant had been diagnosed with degenerative lumbar disc disease, lumbar spondylosis with facet and disc damage and degenerative arthritis of the lumbar spine before the parties agreed in November 1996 that claimant's then-current low back condition was not compensable and unrelated to his prior accepted injuries. Therefore, notwithstanding Dr. Hacker's opinion that claimant's painful disc condition in late 1997 was due to his lifetime of heavy work and his prior injuries, the parties are bound by their agreement to the contrary. *See Gilkey*, 113 Or App at 316. Accordingly, SAIF's denials must be upheld.

ORDER

The ALJ's order dated January 14, 1999 is affirmed.

June 25, 1999 Cite as 51 Van Natta 1033 (1999)

In the Matter of the Compensation of
PAUL M. EGGER, Claimant
WCB Case No. 98-09968
ORDER OF DISMISSAL
Ernest M. Jenks, Claimant Attorney
James B. Northrop, Defense Attorney

The SAIF Corporation requested Board review of Administrative Law Judge Podnar's April 2, 1999 order. SAIF has withdrawn the request for review.

Accordingly, the request for Board review is dismissed.[1]

IT IS SO ORDERED.

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[1] Claimant requests that Board review continue regarding the issues he raised in his respondent's brief, *i.e.*, sanctions and increased assessed attorney fees. Although claimant characterized these issues as a "cross-request" for Board review, he did not formally request review of the ALJ's order. Instead, SAIF was the sole party to formally request review of the ALJ's order within the time period prescribed in ORS 656.289(3). When a non-appealing party raises other issues in its respondent's brief, we are authorized to address those issues, provided that the formal request for review has not been withdrawn. *Eder v. Pilcher Construction*, 89 Or App 425 (1988); *Neely v. SAIF*, 43 Or App 319, 323, *rev den* 288 Or 493 (1980); *Jimmie Parkerson*, 35 Van Natta 1247, 1250 (1983). Here, however, SAIF has withdrawn its formal request for review. Therefore, we are without authority to address the issues claimant raised in his respondent's brief.

In the Matter of the Compensation of
ROSENDO M. VALENCIA, Claimant
WCB Case Nos. 97-07805 & 96-08301
ORDER ON REVIEW
Max Rae, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Spangler's order that: (1) found that claimant's left shoulder injury claim was prematurely closed; and (2) awarded an attorney fee of $5,000 for services at hearing. SAIF also moves for remand. Claimant cross-requests review of that portion of the order that declined to assess a penalty for an allegedly unreasonable denial of claimant's aggravation claim. On review, the issues are premature claim closure, attorney fees and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Premature Claim Closure

Claimant has an accepted claim for both shoulders. As the ALJ explained, on April 26, 1996, claimant's treating physician, Dr. Rand, found claimant medically stationary. On May 15, 1996, a Notice of Closure closed the claim. The ALJ found more persuasive the July 27, 1996 report from the medical arbiter indicating that claimant was not medically stationary and, thus, concluded that the claim was prematurely closed.

SAIF contends that the medical arbiter report is not sufficient to carry claimant's burden of showing he was not medically stationary at the time of closure because its finding relates to the date of examination (July 27, 1996) rather than the date of claim closure (May 15, 1996). According to SAIF, Dr. Rand provided the more persuasive evidence and, based on his report, claimant did not prove premature claim closure.

A claim for compensation shall not be closed if the worker's condition has not become medically stationary. ORS 656.268(1). The test for determining whether a worker is medically stationary is whether "further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17).

Dr. Rand's report provided range of motion and noted "some tenderness over the anterior aspect of the left shoulder." (Ex. 61-1). The report further stated that claimant "can be considered medically stationary in regards to his left and right shoulders at this juncture." (*Id.* at 2). Dr. Rand also indicated, however, that claimant "would respond to prolonged therapy regimen and would eventually gain strength, endurance and decrease his pain in regards to his shoulder." (*Id.* at 1).

We find this last statement is evidence of a reasonable expectation of further material improvement from medical treatment. That is, despite his indication that claimant could be considered medically stationary, by stating that a "prolonged therapy regimen" would allow claimant to increase his strength and endurance, as well as decrease his pain, we find that Dr. Rand reasonably expected further material improvement from medical treatment.[1] Thus, we conclude that such evidence establishes that claimant was not medically stationary and the claim was prematurely closed.[2]

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[1] We recognize that fluctuating symptoms and/or a need for continuing medical treatment does not necessarily mean that a claimant's condition is not medically stationary. *Maarefi v. SAIF*, 69 Or App 527 (1984). In reaching our conclusion, we do not consider Dr. Rand's reference to a "prolonged therapy regimen" to be merely a statement regarding continuing treatment for fluctuating symptoms.

[2] Because we agree that the claim was prematurely closed, like the ALJ, we do not reach the issues of permanent disability and aggravation.

Claimant's attorney is entitled to an assessed fee for services on review concerning the premature closure issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding this issue is $500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

Attorney Fees and Penalty

After finding that claimant proved compensability of an additional left shoulder condition, the ALJ awarded a $5,000 attorney fee, stating that he had "considered and applied to this case the factors set forth in OAR 438-015-0010(1) [sic]." SAIF argues that the ALJ failed to apply each of the factors in OAR 438-015-0010(4)[3] and failed to make specific findings of fact regarding each factor in awarding the assessed attorney fee.[4]

Here, although the ALJ referred to OAR 438-015-0010(1), we understand him as citing to the applicable rule (OAR 438-015-0010(4)). The ALJ, however, did not identify the factors he considered in awarding the attorney fee. In other words, the ALJ did not discuss any of the specific rule-based factors, such as the value of the interest involved, the time devoted to the case, the complexity of the issue, the benefit secured, the skill of the attorneys, the nature of the proceedings or the risk that the claimant's counsel's efforts might go uncompensated. Because the ALJ's order is devoid of any explanation of his application of the factors in determining the attorney fee in this case, the ALJ's reasoning is insufficient to support the $5,000 attorney fee award. *Donna R. Grierson*, 51 Van Natta 679 (1999).

We provide the following reasoning concerning the attorney fee award for claimant's counsel's services at hearing. We first note that claimant's counsel submitted a statement of services to the ALJ; that statement, however, did not provide the specific amount of time devoted to the compensability issue or ask for a specific attorney fee for the compensability issue. Thus, we find the statement of limited help. The hearing lasted approximately one hour and 30 minutes. Only claimant testified. The record consists of approximately 119 exhibits, some of which claimant submitted. Claimant's attorney also provided an extensive closing argument brief.

Numerous issues were in dispute at hearing, including premature claim closure, permanent disability, aggravation, penalties, and compensability of the left shoulder condition. Consequently, only part of the time represented by the hearing transcript and record was devoted to the compensability issue. The compensability dispute, in comparison to those generally litigated before this forum, was of average complexity. The value of the interest involved and the benefit secured for claimant are significant, as shown by the fact that claimant underwent two surgeries for the condition found compensable and claimant may now be entitled to permanent disability for the condition.

The attorneys involved in this matter skillfully litigated the compensability issue. Furthermore, because there was conflicting medical evidence, there was a risk that claimant's counsel might go uncompensated. Finally, there is no assertion of frivolous issues or defenses.

Consequently, after considering the factors set forth in OAR 438-015-0010(4), particularly the value of the interest involved, the benefit secured for claimant, the nature of the proceedings, the complexity of the issue and the risk that claimant's counsel might go uncompensated, we agree with the ALJ that $5,000 is a reasonable fee for claimant's counsel's services at hearing concerning the compensability issue. We therefore affirm the ALJ's attorney fee award.

Finally, claimant cross-requests review of that portion of the order that declined to assess a penalty after the ALJ found that SAIF's denial of the aggravation claim was not unreasonable. Although the ALJ set aside the denial, he did so based on having found that the claim was prematurely closed,

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[3] The rule provides that, when an ALJ or the Board is required to determine a reasonable attorney fee, the following factors shall be considered: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses.

[4] Although providing some argument that the factors do not justify the $5,000 attorney fee, because SAIF does not ask for a reduction and limits its argument to the ALJ's reasoning, we understand SAIF as not contending that the attorney fee is excessive.

thus rendering null the aggravation denial. As the ALJ explained, this action meant that he was not ordering SAIF to accept the aggravation claim.

The ALJ's treatment of the aggravation denial means that there are no "amounts then due" because SAIF has not been ordered to process the aggravation claim. Thus, whether or not the denial is unreasonable, there is no basis for assessing a penalty. *See* ORS 656.262(11)(a).

ORDER

The ALJ's order dated January 14, 1999 is affirmed. For services on review concerning the premature claim closure issue, claimant's attorney is awarded an assessed fee of $500, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
LORRAINE G. ROGERS, Claimant
WCB Case No. 98-08854
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order that: (1) upheld the SAIF Corporation's denial of her current combined low back condition at L4-5; and (2) declined to award penalties and attorney fees for an allegedly unreasonable denial. In her reply brief, claimant moves for remand for admission of additional medical evidence. SAIF moves to strike the proffered evidence. On review, the issues are remand, motion to strike, compensability, penalties and attorney fees.

We deny the motion for remand, grant SAIF's motion to strike, and adopt and affirm the ALJ's order with the following supplementation regarding the various motions.

In upholding SAIF's denial, the ALJ found the medical opinion of Dr. Karasek, a consulting physician, unpersuasive. Claimant has now submitted a "post-hearing" medical report from Dr. Karasek in which he reiterates his opinion that claimant's disc condition at L4-5 is related to her January 19, 1998 injury, accepted as a lumbar strain. Claimant moves for remand to the ALJ or, alternatively, requests that we consider Dr. Karasek's report on review. SAIF opposes remand and, further, moves to strike Dr. Karasek's "post-hearing" report.

Our review must be based on the record certified to us. *See* ORS 656.295(5). We may remand to the ALJ if the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Under ORS 656.295(5), we may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. *Bailey v. SAIF*, 296 Or 41, 45 n. 3 (1985). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986).

Here, the proposed evidence is cumulative inasmuch as Dr. Karasek's report is a reiteration of his prior opinion. Moreover, claimant has not established that the proposed evidence was unobtainable at the time of hearing. Finally, admission of the proposed evidence would not likely affect the outcome of the case because we agree with the ALJ's reasons for finding Dr. Karasek's opinion unpersuasive. Therefore, remand is inappropriate. *Id.* at 646.[1]

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[1] Because our review is limited to the record developed before the ALJ, we may not consider Dr. Karasek's "post-hearing" report on review. Thus, we grant SAIF's motion to strike it. *See Maria Leyva*, 48 Van Natta 288, 289 (1996) (Board will not consider evidence not previously made a part of the record).

ORDER

The ALJ's order dated March 4, 1999 is affirmed.

In the Matter of the Compensation of
WILMA J. YOUNG, Claimant
WCB Case No. 98-06322
ORDER ON REVIEW
Scott M. McNutt, Sr., Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Marshall's order that awarded a $3,600 fee for claimant's counsel's services at hearing. SAIF also moves for remand. On review, the issues are remand and attorney fees.

We deny SAIF's motion for remand, and adopt and affirm the ALJ's order with the following supplementation.

On November 15, 1997, claimant sustained a work-related injury to her low back that SAIF accepted as a disabling lumbar strain. On July 8, 1998, SAIF denied claimant's lumbar degenerative changes and disc herniations at L4-5 and L5-S1 on the basis that the November 15, 1997 injury was not the major cause of those conditions. Claimant requested a hearing challenging that denial. Following the hearing, the ALJ set aside SAIF's denial to the extent that it denied claimant's L5-S1 disc condition and remanded the claim to SAIF for processing according to law.

The ALJ also found claimant entitled to an assessed attorney fee under ORS 656.386(1) for prevailing over SAIF's denial of the L5-S1 condition and awarded a fee of $3,600. In awarding that fee, the ALJ considered the factors set forth in OAR 438-015-0010(4) and "particularly considered the time devoted to the case, as represented by the record and claimant's counsel's unchallenged statement of services."[1]

On review, SAIF does not contend that the assessed fee awarded is unreasonable. Instead, it asserts that the ALJ failed to provide a sufficient explanation for the assessed fee, and seeks remand to the ALJ. We disagree.

Regarding the remand issue, we do not find the record to be improperly, incompletely or otherwise insufficiently developed. *See* ORS 656.295(5). Furthermore, as explained below, we find the ALJ adequately explained the basis for the assessed fee. In any event, even if the ALJ had not sufficiently explained his reasoning, because we are authorized to modify or supplement the ALJ's findings and conclusions under ORS 656.295(6), it would not be necessary to remand this case to the ALJ for supplementation of findings regarding the attorney fee award. Consequently, we deny SAIF's motion to remand. *Daryl L. Underwood*, 50 Van Natta 2330, 2332 (1998).

In *SAIF v. Bacon*, 160 Or App 596 (1999), the court rejected the argument that SAIF now makes, *i.e.*, in *every* case in which fees are warranted the ALJ and the Board must make findings on each of the eight rule-based factors listed in OAR 438-015-0010(4) and explain how those findings support the amount of the fee awarded, even when the parties do not dispute the amount of the assessed attorney fee award. In *Bacon*, the carrier did not challenge the reasonableness of the attorney fee award. Instead, relying on OAR 438-015-0010(4), the carrier argued that the Board did not provide a sufficient explanation of its findings.

The court disagreed with the carrier's argument. Citing *Schoch v. Leupold & Stevens*, 325 Or 112 (1997), the court noted that the issue on review was not whether the Board's order was sufficient to resolve a specific objection to its attorney fee award. Rather, as framed in the carrier's brief, the court

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[1] Claimant's counsel submitted a request for attorney fees for his services at hearing. Based on his experience and the time devoted to the case, claimant's counsel requested a $3,600 attorney fee award.

stated that the issue was whether the Board's explanation was sufficient in the absence of any specific objection to the attorney fee award.

The court also rejected the carrier's alternative contention that the Board's order required "special findings to support or explain the order under review." *See McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or 84, 95, *adhered to on recon* 327 Or 185 (1998). Relying on *McCarthy*, the court reasoned that the need for findings as a prerequisite for appellate review arises only if there is something to review; *i.e.*, if there is no substantive objection to the fee award, there is nothing to review.

Finally, the court disagreed with the carrier's assertion that the Board was obligated by administrative law principles to provide more specific findings of fact and reasoning. After reviewing the Supreme Court's decisions in *Schoch* and *McCarthy*, the court determined that when neither party objects to the reasonableness of the attorney fee award, the need to ensure meaningful appellate review is absent. Although general administrative law principles would still require the Board to explain the basis for its attorney fee award, the court reasoned that the need for specificity diminishes in the absence of any substantive objection to the fee award itself. In reaching its conclusion, the court emphasized that if either party had submitted specific evidence challenging either the ALJ's or Board's awards, the Board's explanation would have to comply with the *Schoch* standard.

The same reasoning applies in the present case. Here, as in *Bacon*, SAIF did not challenge the reasonableness of the attorney fee award. Instead, it makes the same arguments regarding an abstract obligation to make detailed findings even in the absence of any specific disagreement with the assessed fee awarded. As the *Bacon* court found, such detailed findings are not required in absence of some objection to the fee awarded.

We reached the same conclusion in *Daryl L. Underwood*, 50 Van Natta at 2332, where we found that an ALJ is not required to make specific findings regarding each of the factors set forth in OAR 438-015-0010(4) where there is no specific attorney fee requested and the parties did not submit arguments at hearing addressing the factors to be weighed in determining a reasonable fee. In *Underwood*, we determined that the ALJ satisfies his or her obligation to make findings in a case by including in the order a brief description or citation to the rule-based factor or factors the ALJ relied on in determining the attorney fee awarded. *Id.* (*citing McCarthy v. Oregon Freeze Dry*, 327 Or at 188-89).

SAIF argues that the reasoning in *Underwood* does not apply to the present case because, unlike *Underwood*, claimant's attorney here submitted a specific request for attorney fees. Therefore, SAIF argues, the ALJ was bound by the Court's holding in *Schoch v. Leupold & Stevens*, 325 Or at 118-120, to make express findings of fact as to each of the eight factors in OAR 438-015-0010(4), and to draw conclusions from those facts, in determining a reasonable attorney fee. We do not find that a specific request for attorney fees, in and of itself, results in the requirement of making express findings of fact as to each of the eight factors in OAR 438-015-0010(4).

In *Schoch*, we awarded the claimant's attorney a fee of $3,000 under ORS 656.386(1).[2] The claimant's attorney requested reconsideration and submitted an affidavit and summary of services that detailed counsel's experience in workers' compensation law, documented 75.8 hours of time devoted to the case, and requested the Board to increase the attorney fee award to $19,897.50. On reconsideration, we adhered to the reasoning and conclusions of our prior order without further explanation. *Lois J. Schoch*, 47 Van Natta 280 (1995). The Court of Appeals affirmed without opinion. *Schoch v. Leupold & Stevens*, 137 Or App 633 (1995). The Supreme Court allowed review.

The Court began by noting the discrepancy between the amount of the attorney fee that the claimant sought and the amount that the Board awarded. The Court noted the Board did not explain how any of the rule-based factors that it considered, including the four factors that it "particularly

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[2] In making this award, we stated:

"After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing, on Board review and on remand concerning the validity of the Director's July 16, 1992 order is $3,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. We note that claimant is not entitled to an attorney fee for services rendered subsequent to the insurer's concession concerning the attorney fee issue." *Lois J. Schoch*, 47 Van Natta 71, 73 (1995).

considered," weighed in its decision-making process and led to the fee that it awarded. The Court found that the factors listed by the Board could have supported an award for the full amount of counsel's request, up to the date of the carrier's concession, yet, for reasons that were not apparent, the Board awarded a much lower amount. The Court also found that there were several factors present under the facts of the case that could justify a lower fee than that requested by the claimant's counsel. But, since the Board did not address those factors, the Court was unwilling to assume that the Board relied on them in awarding the reduced attorney fee. Therefore, the Court concluded that the Board's order did not contain a sufficient explanation to permit an appellate court to review the Board's exercise of discretion in setting a reasonable attorney fee. Accordingly, the Court remanded the case to the Board for reconsideration of the order awarding attorney fees.

Contrary to SAIF's argument, the Court in *Schoch* did not hold that the Board is required to explicitly address each of the eight factors in OAR 438-015-0010(4) in explaining how it reached a reasonable attorney fee. Instead, "[n]oting the discrepancy between the amount of the attorney fee that claimant sought and the amount that the Board awarded," the Court concluded that the Board's explanation was insufficient "to permit an appellate court to review the Board's exercise of discretion in setting a reasonable attorney fee." *Schoch*, 325 Or at 118-20.

The *Bacon* court found that the "reasoning in *Schoch* makes clear that its holding is driven in large part by the need for meaningful appellate review. When, however, neither the claimant nor the employer objects to the reasonableness of the fee award, the need to ensure meaningful review is absent." *Bacon*, 160 Or App at 604. Thus, the *Bacon* court found *Schoch* distinguishable in that, whereas neither party in *Bacon* objected to the reasonableness of the fee award, the claimant in *Schoch* made such an objection and submitted specific evidence challenging the fee award. Based on that distinction, the *Bacon* court held that the Board's explanation of the attorney fee award was adequate.[3]

Here, like *Bacon*, and unlike *Schoch*, neither party objected to the reasonableness of the fee award. In the case before us, claimant's attorney requested a specific fee and, after considering the rule-based factors, particularly the time spent on the case, the ALJ found that the requested fee was reasonable and awarded the requested amount. Moreover, SAIF did not dispute the requested amount or submit any argument at hearing or on Board review addressing the factors to be weighed in determining a reasonable fee.

Under these circumstances, we find that the reasoning in *Bacon, Underwood* and *McCarthy* applies. *See also Weyerhaeuser Co. v. Fillmore*, 98 Or App 567 (1989) (Board not required to making finding as to each factor, however Board's explanation must be detailed enough to establish reasonable basis for its decision); *William J. Kephart*, 51 Van Natta 291 (1999) (the ALJ applied the proper standard in determining a reasonable fee where he specifically indicated that the assessed fee was based upon the factors set forth in OAR 438-015-0010 *and* identified the factors considered, *i.e.*, the time devoted to the case, the complexity of the issue, the value of the interest and benefit to claimant and risk that counsel may go uncompensated); *compare Donna R. Grierson*, 51 Van Natta 679 (1999) (Board found ALJ's reasoning insufficient where ALJ merely cited applicable rule without providing any explanation of his application of the rule-based factors in determining attorney fee amount).

Accordingly, we find sufficient the ALJ's explanation as to how he reached his conclusion that $3,600 represents a reasonable attorney fee for services at hearing in this case. Furthermore, after considering the factors in OAR 438-015-0010(4) (particularly the time devoted to the case as represented by the record and claimant's counsel's unchallenged statement of service) we agree with the ALJ that $3,600 is a reasonable fee for claimant's counsel's services at hearing. We therefore affirm the ALJ's attorney fee award.[4]

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[3] Although going into more detail in explaining why it considered the ALJ's fee award of $2,000 reasonable and in awarding a $1,000 fee to the claimant's attorney for defending the ALJ's order on review, the Board explained: "In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue and the value of the interest involved." *Frank D. Bacon*, 50 Van Natta 1591 (1998).

[4] Because SAIF challenged only the attorney fee award on review and attorney fees are not "compensation" for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee on review. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated February 3, 1999 is affirmed.

In the Matter of the Compensation of
LINDA M. ANGEL, Claimant
WCB Case No. 97-07573
ORDER ON REVIEW
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for her neck, shoulder, back, hip, upper extremity and lower extremity conditions. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings with the following correction and supplementation.[1]

Following her 1986 injury, claimant experienced chronic complaints in her neck, rib cage, spine, hips, upper extremities, and lower extremities. These complaints were variously diagnosed as rib cage contusion, cervical and shoulder strain, cervical myofascitis, thoracic costal post-traumatic syndrome with dyspnea, thoracic hyperkyphosis complicated by thoracic spondylosis and myofascitis, lumbosacral sprain with sciatica, lumbosacral joint complex instability, disc bulging at L4-5, disc space narrowing at L5-S1, osteophytic spurring in the hips, left brachial plexus insult with para/anathesias to fingertips, left knee sprain, fibromyalgia, somatoform pain disorder and functional overlay. (Exs. 1 thru 7, 17, 19, 24, 26, 27, 28, 36, 38, 43, 45, 46-2/3 and 60).

Claimant currently complains of symptoms in her neck, shoulders, back, hips, upper extremities and lower extremities. Claimant's current symptoms have been variously diagnosed as cervical and lumbosacral strain, lumbosacral instability with arthritic changes, bilateral hip joint osteoarthritis, thoracic outlet syndrome, bilateral medial epicondylitis, myofascitis, myofibrositis, fibromyalgia and functional overlay. (Exs. 49, 49A, 50, 51, 53, 56, 59, 60, 61A, 65).

Dr. Schroeder was treating claimant on a regular basis when she began working for the employer in December 1996.

On June 4, 1997, claimant was evaluated and treated by Dr. Russo, D.O.

On July 17, 1997, Dr. Arbeene, orthopedic surgeon, and Dr. Brooks, neurologist, examined claimant at SAIF's request.

On July 29, 1997, Dr. Kitchell, orthopedic surgeon, examined claimant on referral from Dr. Schroeder.

CONCLUSIONS OF LAW AND OPINION

We affirm the ALJ's ultimate conclusion that claimant has not established a compensable occupational disease claim, but we do so based on the following alternative rationale.

Claimant has the burden of proving that her work activity for the employer is the major contributing cause of the onset or worsening of her current conditions. ORS 656.266 and 656.802(2)(a). Given the contrary causation opinions of the medical experts and claimant's preexisting history of ongoing symptoms and treatment, we conclude that the causation issue in this case involves complex medical issues that must be resolved by expert medical opinion. *Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993). In evaluating expert medical opinion, we rely on those that are both well-reasoned and based on an accurate and complete history. *Somers v. SAIF*, 77

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[1] The "second evidentiary session" referenced in the introductory paragraph of the ALJ's order occurred on October 7, 1998, not June 7, 1998.

Or App 259, 263 (1986). Absent persuasive reasons to do otherwise, we generally give deference to the opinion of a treating physician who has had the opportunity to evaluate a claimant over time. *See Weiland v. SAIF*, 64 Or App 810 (1983).

Claimant contends that the requisite major causal relationship is established by the opinions of Dr. Schroeder, the current treating chiropractor, and Dr. Kitchel, an orthopedic surgeon who evaluated claimant on referral from Dr. Schroeder. Dr. Kitchel opined that, assuming claimant's history was correct, her current problem was "a work related injury." (Ex. 61A). Dr. Schroeder opined that claimant's fibromyalgia, thoracic myofibrositis, bilateral hip joint arthritis and lumbar and lumbosacral osteoarthritis were aggravations of the preexisting work related injury; that the inflammatory process of the left sacral/gluteal tissues was a new injury and worsened condition compounded by the original injury; and that claimant had new wrist and elbow pain that she had not previously complained of that was most likely due to carpal tunnel. (Exs. 50, 51, 59, 62, 65).

SAIF's denial is based on the contrary medical opinion of Drs. Arbeene and Brooks, who examined claimant for SAIF. These doctors reasoned that claimant has had the same complaints on a regular basis since the 1986 injury, and that her work activity with the employer did not pathologically worsen her preexisting condition. (Exs. 60, 63, 64).[2]

We find persuasive reasons not to defer to the opinions of Drs. Schroeder and Kitchel. In so doing, we do not adopt the ALJ's rationale that Dr. Schroeder's opinion is not objective and is based on an inaccurate history of no prior wrist/hand symptoms and work activity requiring prolonged bending. Nor do we accept the opinion of Drs. Arbeene and Brooks that all of claimant's current conditions preexisted his work activity for the employer.[3] Nevertheless, Drs. Schroeder and Kitchel have not opined that claimant's work for the employer was the *major* cause of the onset or worsening of her occupational diseases, as distinct from a material or a precipitating cause. *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev den* 321 Or 416 (1995). Nor do these doctors address the relative contribution of claimant's preexisting conditions. *Id.* Furthermore, as noted by the ALJ, Dr. Schroeder inaccurately assumed that claimant worked six to twelve hours each day, usually five to six days per week. (Exs. 49A-1, 50, 50A, 53-2, 55-5, 65-1). We also agree with the ALJ's rationale that Dr. Schroeder is entitled to less deference because he did not treat claimant during the six-year period following her 1986 injury. Finally, we are unable to determine whether the causative "work related injury" identified by Dr. Kitchel is the 1986 injury or claimant's work activity for the employer.

For these reasons, we conclude that the record does not satisfy claimant's burden of proving that her work activity for the employer was the major contributing cause of the onset or worsening of her occupational diseases.[4] Consequently, we affirm the ALJ's ultimate decision that claimant has not established a compensable occupational disease claim.

ORDER

The ALJ's order dated January 15, 1999 is affirmed.

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[2] Dr. Kitchel concurred in the opinion of Drs. Arbeene and Brooks.

[3] The ALJ reasoned that there was no claim for claimant's wrist and elbow complaints because these conditions were not treated. We, instead, conclude that claimant filed a claim for her wrists and elbows, but that these conditions are not compensable because the record does not establish the requisite major causal relationship to claimant's work activity.

[4] Claimant's brief on review includes a description of her specific work activity and then focuses on alleged inaccuracies and misrepresentations in SAIF's closing argument at hearing, including: an incorrect exhibit citation and diagnosis; SAIF's reliance on claimant's functional overlay and prior psychological diagnoses and treatment; SAIF's argument that Dr. Schroeder's opinion is entitled to less weight because he is a chiropractor; SAIF's assertion that claimant was not willing to return to work; SAIF's assumption that claimant did not give Dr. Kitchel a history of her 1986 injury; SAIF's assertion that claimant took a ten minute break every fifteen minutes; and SAIF's incorrect characterization of Dr. Russo as claimant's treating physician. Claimant also contends that the employer did not try to find her suitable lighter work and fired her because she filed a workers' compensation claim. Even if we accepted claimant's position on each of these issues, the record would not establish a compensable occupational disease claim for the reasons explained above. Consequently, we decline to discuss the assertions in claimant's brief in any greater detail.

In the Matter of the Compensation of
PATRICK T. DAGGETT, Claimant
Own Motion No. 99-0193M
OWN MOTION ORDER
Carney, et al, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer has submitted a request for temporary disability compensation for claimant's compensable right knee condition. Claimant's aggravation rights expired on September 13, 1995.

The insurer recommends that we authorize the payment of temporary disability compensation under claimant's 1989 claim. Claimant has also filed an "occupational disease" claim for his right knee condition with the same employer/same insurer. (Claim No. 604578385). He has requested a hearing from the "occupational disease" carrier's responsibility denial. (WCB Case No. 99-04067). In addition, claimant has requested the issuance of a ".307" order.

Relying on *Leslie D. Marcum*, 50 Van Natta 2242 (1998), the parties agree that claimant's claim should be reopened under ORS 656.278. In *Marcum*, we authorized reopening of a claimant's own motion claim when the same insurer did not oppose reopening under ORS 656.278 but contested its responsibility for the claimant's "new injury" claim. In *Marcum*, we noted that, where there are available "administrative" remedies we generally postpone own motion action until exhaustion of those administrative procedures. OAR 438-012-0050. For example, when responsibility for a claimant's condition is the only issue which is contested, the matter is generally referred to the Department for a designation of a paying agent pursuant to ORS 656.307. *James D. Ortner*, 49 Van Natta 257 (1997); OAR 438-012-0032(3).

Here, although responsibility is being contested under the "occupational disease" claim, the insurer has accepted responsibility in the 1989 own motion claim. Additionally, the language of ORS 656.307(1)(a) and OAR 436-060-0180 indicates that the statute and rule apply when there is a responsibility issue involving "more than one insurer" or "two or more employers." By its terms, therefore, ORS 656.307 does not apply to a dispute involving only one insurer of one employer. Because this case does not involve a responsibility dispute among two or more employers and/or insurers, it does not fall within the parameters of the statute. *See James M. Van Natta*, 50 Van Natta 2104 (1998). Thus, claimant is unable to avail himself of the administrative remedies allowed under that statute and OAR 436-060-0180.

Here, as previously explained, the insurer is not contesting the compensability and/or responsibility of claimant's current right knee condition as it relates to the 1989 own motion claim. Additionally, the insurer acknowledges that surgery is appropriate for the compensable condition. In fact, the insurer recommends that we authorize reopening of claimant's own motion claim. Thus, there are no issues in the own motion claim for which claimant would need to avail himself of "administrative remedies."

Under these particular circumstances, and consistent with the *Marcum* rationale, we decline to postpone action on the own motion claim pending resolution of claimant's litigation of a responsibility issue regarding his current condition under an "occupational disease" claim. Consequently, we proceed with our review.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

We are persuaded that claimant's current condition (for which the insurer has accepted responsibility under the 1989 claim) constitutes a worsening of his 1989 compensable injury that requires surgery.[1] Accordingly, we authorize the reopening of claimant's claim to provide temporary total

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[1] This conclusion is based on the presumption that the insurer, under the 1989 claim, will ultimately be held responsible for claimant's condition. In the event that the insurer is ultimately found responsible for claimant's current condition under his "occupational disease" claim, the insurer and/or claimant may request reconsideration of this decision under OAR 438-012-0065(3) at that time. *See Marcum*, 51 Van Natta at 2242.

disability compensation beginning the date claimant is hospitalized for the proposed surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHAEL D. DEMAGALSKI, Claimant
Own Motion No. 99-0181M
OWN MOTION ORDER
Rex Q. Smith, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer has submitted a request for temporary disability compensation for claimant's compensable right wrist condition. Claimant's aggravation rights expired on December 11, 1990. The insurer opposes authorization of temporary disability compensation, contending that claimant was not in the work force at the time of his disability.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work *and* is seeking work; or (3) not working but willing to work, *and* is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

The insurer contends that claimant was not in the workforce at the time of his current disability because it has not received written evidence regarding claimant's work force status. Claimant contends that he qualifies for temporary disability compensation because, subsequent to his February 1999 from incarceration, he did handywork on rentals and other odd jobs. Claimant has the burden of proof on this issue and must provide persuasive evidence that he was in the work force during the relevant period of time. *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990).

In a May 25, 1999 affidavit, claimant stated that, since February 1999, "to cover the rent, I did handywork (painting, yard work, minor repairs, etc.) on rental [property]." Claimant attested that he also performed "odd jobs for other people from time to time. All of this work was done for cash, and there are no records." Finally, claimant reports that he has attempted to do a job search through Adult and Family Services.

The burden of establishing entitlement to compensation rests with claimant. ORS 656.266. We have previously found that room and board, with or without pay, can equal wages, and thus, qualifies as "wages" under ORS 656.005(29). *See George L. Peachy*, 48 Van Natta 2115 (1996); *Orvel L. Chaney*, 48 Van Natta 612 (1996).

Claimant asserts that, since February 1999, he was doing handywork and other odd jobs. This assertion is unchallenged.

Under such circumstances, the record establishes that, since February 1999, claimant has been exchanging work for room and board, as well as attempting to seek employment using the services of the Adult and Family Services Unit.[1] Consequently, we conclude that claimant was in the work force at the time of his disability.

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[1] Claimant would not be entitled to temporary disability compensation while incarcerated. ORS 656.160. Nonetheless, claimant's uncontested affidavit establishes that he reentered the work force following his February 1999 release and remained there at the time of his current disability. *SAIF v. Stephen*, 308 Or 41 (1990); *Howard L. Browne*, 49 Van Natta 864 (1997).

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning the date he was hospitalized for surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,500, payable by the insurer directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

June 28, 1999 Cite as 51 Van Natta 1044 (1999)

In the Matter of the Compensation of
MARGARET L. EVANS, Claimant
WCB Case No. 98-07413
ORDER ON REVIEW
Westmoreland & Mundorff, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's current cervical condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for C5-6 herniated nucleus pulposus condition. In March 1994, claimant underwent neck surgery by Dr. Wayson. After claim closure, in August 1995, claimant and the employer entered into a claim disposition agreement (CDA), providing that claimant would give up all benefits, except medical services, in exchange for a sum of money.

In January 1997, claimant returned to Dr. Wayson, who proposed a second surgery. Eventually, claimant filed a claim for C5-6 foraminal stenosis as a result of the compensable herniated disc. The employer denied the claim.

The ALJ set aside the denial after finding that claimant carried her burden of proof with Dr. Wayson's opinion. The employer challenges the order, first asserting that the applicable statute in this case is ORS 656.005(7)(a)(A) rather than 656.005(7)(a)(B). The employer also contends that Dr. Wayson's opinion is not sufficiently persuasive to prove compensability.

Examining orthopedic surgeon, Dr. Coletti, reported that the proposed surgical "plan is apparently directed at treating the cervical spondylosis" rather than the "herniated C5-6 disc." (Ex. 49-6). Dr. Coletti also characterized the cervical spondylosis as an "underlying degenerative condition." (*Id.* at 8).

Dr. Rosenbloom, internal medicine specialist, reported that the MRI "reveals failure of fusion, and the stenosis * * * is probably secondary to scarring from the initial procedure. Therefore, the proposed procedure is directly related to the accepted C5-C6 herniated disc." (Ex. 51).

Dr. Wayson then reported that the MRI scan "suggested a failure of the fusion at C5-6, and there was significant scar build up posteriorly to the disc space." (Ex. 52-1). The report further stated that a subsequent CT scan "shows significant foraminal stenosis" at C5-6 and C6-7 and the "fusion appeared to be solid[.]" (*Id.*) According to Dr. Wayson, claimant "has continued to have significant motion at the area of C5-6 and C6-7 * * * subsequent to surgery," resulting in "further deterioration and narrowing of the foramen[.]" (*Id.* at 2). Dr. Wayson continued: "Pathophysiologically, what has gone on is that with scarring and progressive calcification secondary to the degeneration at that level, in part related to the injury and part [sic] related to the subsequent surgery, has led to progressive compromise of the nerve root foramen." (*Id.*)

Dr. Wayson then reported that "the original industrial injury and subsequent need for surgery at C5-6 and C6-7 and the subsequent degeneration that was exacerbated and caused by that original injury and surgery is the major cause for the current need for medical services." (Ex. 53).

After Dr. Wayson performed the second surgery in April 1998, he provided a final report stating that, although claimant had "evidence of degenerative cervical disc disease," her need for surgery "is directly related to her previous need for surgery and the failure of the initial surgery to result in a firm fusion at C5-6." (Ex. 63-2).

Examining orthopedic surgeon, Dr. Farris, also provided a report. Dr. Farris found that claimant had cervical spondylosis that preexisted the original May 1992 injury. (Ex. 61-1). Dr. Farris also reported that the "herniated nucleus pulposus at C5-C6 is clearly not the major contributing cause of [claimant's] foraminal stenosis." (*Id.*)

Absent persuasive reasons to the contrary, we generally defer to the treating physician's opinion. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we agree with the ALJ that Dr. Wayson provided the most persuasive opinion. First, he has treated claimant over a long period, performing both neck surgeries. Thus, he is in the best position to be familiar with claimant's neck condition, as opposed to Drs. Coletti and Farris, who saw claimant one time.[1]

Furthermore, we find that Dr. Wayson provided a thorough and well-reasoned report. Although acknowledging preexisting degenerative changes, Dr. Wayson clearly attributes claimant's current neck condition to the original injury and the first surgery.[2] Dr. Farris, on the other hand, does not expressly indicate what caused claimant's current neck condition and Dr. Coletti does not address any effect on claimant's condition from the first surgery. Thus, having found that Dr. Wayson's opinion is most persuasive, we defer to it in determining compensability.

Finally, we agree with the ALJ that claimant carried her burden of proof under ORS 656.005(7)(a)(B). Specifically, claimant showed that the major contributing cause of her "combined condition" (consisting of preexisting degenerative changes and the accepted condition, including the effects of the first surgery) was the compensable condition. We disagree with the employer that ORS 656.005(7)(a)(A) should apply because claimant entered into a CDA. Rather, if consistent with the medical evidence, we apply ORS 656.005(7)(a)(B) in deciding the compensability of conditions whether or not those conditions are subject to a CDA. *E.g., Charles V. Burkhart*, 50 Van Natta 375 (1998). Based on the medical evidence in this case, we apply ORS 656.005(7)(a)(B).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated February 10, 1999 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,500, to be paid by the self-insured employer.

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[1] We agree with the employer, however, that Dr. Rosenbloom's opinion is not persuasive. The record does not reveal his relationship to claimant and we consider his opinion is be conclusory.

[2] As the employer notes, Dr. Wayson reported that the MRI indicated a failure and the CT showed a firm fusion with regard to the first surgery. We disagree, however, that Dr. Wayson's opinion is inconsistent in this regard. After noting these differences, Dr. Wayson explained that claimant continued to have "significant motion" at the areas of the surgery and then, after performing the surgery, reported that the first surgery failed to result in a firm fusion. Other than explaining the CT scan, Dr. Wayson never stated that he considered claimant as having a firm fusion. Based on this evidence, we conclude that Dr. Wayson was consistent in finding that the first surgery resulted in a failed fusion.

In the Matter of the Compensation of
JAMES M. EVANS, Claimant
Own Motion No. 99-0152M
OWN MOTION ORDER
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer has submitted a request for temporary disability compensation for claimant's compensable stomach muscle condition. Claimant's aggravation rights expired on April 15, 1999. The insurer opposes authorization of temporary disability compensation, contending that claimant was not in the work force at the time of his disability.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work *and* is seeking work; or (3) not working but willing to work, *and* is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

Claimant contends that he qualifies for temporary disability compensation because, subsequent to his May 1998 release from incarceration, he has performed odd jobs for his landlord in return for rent. Specifically, he has "rak[ed] saw dust, [rode] lawn mower[s] and pick[ed] up litter."

In response, the insurer contends that claimant's unsupported assertions are insufficient to establish his work force status. In addition, reporting that claimant was in jail until just prior to his condition worsening requiring surgery, the insurer contends that he was not in the work force at time of his disability.

The burden of establishing entitlement to compensation rests with claimant. ORS 656.266. We have previously found that room and board, with or without pay, can equal wages, and thus, qualifies as "wages" under ORS 656.005(29). *See George L. Peachy*, 48 Van Natta 2115 (1996); *Orvel L. Chaney*, 48 Van Natta 612 (1996).

Here, claimant's general statement that he was "doing odd jobs for my land lord for rent" is disputed. In response to the insurer's challenge, claimant provides no corroborating evidence supporting his statement that, since May 1998, he was doing odd jobs for his landlord and that he has been self-employed. In the absence of corroborating evidence, we do not find claimant's challenged general assertions sufficient to establish that he was in the work force at the time of his disability. *See Dawkins*, 308 Or at 258; *Dustin L. Crompton*, 50 Van Natta 92 (1998).[1]

Accordingly, claimant's request for temporary disability compensation is denied. *See id.* We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

Claimant's entitlement to medical expenses pursuant to ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

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[1] Subsequent to our earlier decision in *Crompton*, the claimant submitted an additional affidavit regarding his work in exchange for room and board as well as his job search that went unchallenged by the self-insured employer. Because the statement contained in the second affidavit went unchallenged, we found that the record established that the claimant was in the work force at the time of his disability. *Dustin L. Crompton*, 50 Van Natta 431 (1998). Here, in contrast to *Crompton*, claimant has not provided corroborating evidence in response to the insurer's challenge to his previous statements regarding his work activities.

In the Matter of the Compensation of
PATRICIA A. HOLDER, Claimant
Own Motion No. 98-0277M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Greg Noble, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's December 21, 1998 Notice of Closure which closed her claim with an award of temporary disability compensation from July 10, 1998 through December 11, 1998. SAIF declared claimant medically stationary as of December 11, 1998. Claimant seeks additional benefits, contending that she was not medically stationary when her claim was closed.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981).

The propriety of the closure turns on whether claimant was medically stationary at the time of the December 21, 1998 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980).

On December 11, 1998, Dr. O'Neill, claimant's attending surgeon, opined that claimant was "stationary at present." Reporting that he last examined claimant on October 1, 1998, Dr. O'Neill concluded that there was no further surgery recommended and there was no other treatment he could offer to improve her condition. Expecting that claimant would not have "clinical improvement in the near future," Dr. O'Neill recommended that claimant be enrolled in a progressive rehabilitation program.

Claimant has submitted two medical reports authored by her attending physician, Dr. Kenyon. In a January 6, 1999 chart note, Dr. Kenyon reported that claimant had returned to part-time work but, with the rehabilitation program, she continued to improve. Dr. Kenyon found material improvement in claimant's condition in that she was working more hours and was in less pain. He expected that with the continued treatment she would improve sufficiently to return to full duty.

Dr. Kenyon also disagreed with Dr. O'Neill that claimant was medically stationary. Reasoning that claimant had shown material improvement since her October 1998 examination with Dr. O'Neill, Dr. Kenyon observed that claimant was steadily increasing her work hours and her subjective complaints had improved. Under such circumstances, Dr. Kenyon expected claimant to continue to "make further improvements over the next several months and therefore should not be considered medically stationary."

Dr. Kenyon disagreed with Dr. O'Neill's opinion that claimant was medically stationary in December 1998 (which was rendered without an examination since October 1998) and opined that claimant's condition had materially improved since that examination. Dr. Kenyon's January 6 and 12, 1999 opinions were based on a medical examination conducted on January 6, 1999, just two weeks after SAIF closed the claim. Inasmuch as the record does not suggest that claimant's condition changed between the December 1998 claim closure and Dr. Kenyon's January 1999 examination, we conclude that Dr. Kenyon's January 6 and 12, 1999 opinions address claimant's condition at claim closure. *See Scheuning v. J.R. Simplot & Co.*, 84 Or App at 622, 625 (1987). (Evidence that was not available at the time of closure may be considered to the extent the evidence addresses the condition at the time of closure).

We generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). In this case, we find no persuasive reason not to defer to the opinion of Dr. Kenyon, claimant's long time treating physician. We do not find Dr. O'Neill's opinion persuasive in that it was rendered two months after claimant's last examination and at a time that Dr. O'Neill was not actively treating her. In contrast, Dr. Kenyon has been treating claimant before and after her condition worsened requiring surgery and had examined her prior to and subsequent to claim closure, Under such circumstances, we find Dr. Kenyon's opinion to be more persuasive.

Dr. Kenyon's reports establish that there was a reasonable expectation at the time of the December 1998 claim closure that claimant's low back condition would continue to materially improve with further treatment and the passage of time. Therefore, we find that claimant's compensable back condition was not medically stationary on December 21, 1998, the date of claim closure.

Accordingly, we set aside the Notice of Closure as premature. When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-012-0055.

Finally, claimant's attorney is entitled to a reasonable attorney fee, payable out of the increased compensation awarded by this order. However, we cannot approve such a fee unless claimant's attorney files a current retainer agreement. *See* OAR 438-015-0010(1). Because no retainer agreement has been received to date, an attorney fee shall not be approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
MABLE I. GALUSHA, Claimant
Own Motion No. 99-0029M
OWN MOTION ORDER ON RECONSIDERATION
Burt, Swanson, et al, Claimant Attorneys

On April 14, 1999, we withdrew our March 26, 1999 Own Motion Order, which declined to reopen her 1974 claim for the payment of temporary disability compensation. We took this action to consider claimant's contention that she was in the work force at the time of her current disability. After completing our reconsideration, we withdraw our prior order and replace it with the following order.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery.

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

Here, the employer contended that claimant's failure to provide proof of earnings demonstrated that she was not in the work force. In response to the employer's contention, claimant submitted a March 19, 1999 affidavit asserting that she has worked on and off, part-time, for her present employer, since March 1993. Responding to claimant's submission and reporting that it was in receipt of employment verification, the employer now agrees that claimant was in the work force at the time of her current worsening.

Inasmuch as the parties agree that claimant was in the work force at the time of her current worsening and in lieu of our March 10, 1999 order, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning April 8, 1999, the date she underwent surgery. When claimant is medically stationary, the employer shall close the claim pursuant to OAR 438-012-0055.

Finally, claimant's attorney is entitled to a reasonable attorney fee, payable out of the increased compensation awarded by this order. However, we cannot approve such a fee unless claimant's attorney files a current retainer agreement. *See* OAR 438-015-0010(1). Because no retainer agreement has been received to date, an attorney fee shall not be approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
LUIS G. MORENO, Claimant
WCB Case No. 98-03849
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock, and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Podnar's order that set aside its denial of claimant's low back injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" except for the finding that claimant informed his dispatcher about an injury on April 21, 1998. Instead, we find that claimant telephoned the operations manager the night of April 21, 1998, and told him that he was injured while making a delivery. (Tr. 70).

CONCLUSIONS OF LAW AND OPINION

Claimant worked as truck driver, making deliveries for the employer. Late in the day on April 21, 1998, claimant was told to make a delivery. Claimant asked to take a lunch break before loading his truck; his request was not granted. Claimant then gave his two-week notice of intent to quit employment.

Upon arriving at his destination, claimant backed up to the dock at an angle, leaving a gap on one side of about two feet. Claimant then used a dock plate to cover the gap between the truck and dock. After unloading his truck, claimant testified that he began picking up pieces of wood from broken pallets in the trailer; as he worked from the front of the trailer towards the dock, claimant's toe caught the handle on the dock plate, making him lose his balance. Claimant's right foot then caught on the lip of the trailer and his left leg went down in the space between the dock and the trailer.

Claimant sought treatment the next day and was eventually diagnosed with cervical strain, lumbar strain and probable left hip strain.

The ALJ decided that claimant proved legal and medical causation and, thus, established compensability. *See* ORS 656.005(7)(a). The employer challenges the ALJ's order, asserting that claimant's account of the event was inconsistent and he is not credible.

When claimant initially sought treatment on April 22, 1998, he reported left neck and upper back pain. (Ex. 1). On the Form 827, completed on the same day, claimant wrote that the "back of my neck left side and lower back hurts[.]" (Ex. 2).

On April 27, 1998, claimant again sought treatment for complaints of lumbar and left hip pain. (Ex. 3). When claimant saw Dr. Pierson on April 29, 1998, Dr. Pierson recorded that, "over the ensuing days [after the accident] he has developed pain in the low back and around the left hip area with numbness in the anterior left thigh." (Ex. 5-1). Dr. Pierson diagnosed cervical strain, low back strain, and probable left hip strain. (*Id.* at 2).

Claimant then provided a statement to the employer's investigator. According to this statement, claimant felt some left hip pain immediately after the incident and then, in the morning, "I was really stiff and throughout the night it was really hurting a lot, giving me really shocking pains on it." (Ex. 9C-8). At hearing, claimant testified that, after falling, he "mainly" experienced left hip soreness, along with some neck pain, which lasted three to four days. (Tr. 14).

We first note that, although Dr. Pierson was contacted by the employer's attorney and deposed by counsel for claimant and the employer, there is no express opinion from Dr. Pierson addressing causation. Instead, Dr. Pierson was asked, and responded to, questions concerning objective findings. (Exs. 12, 13). Apparently, claimant is relying on Dr. Pierson's diagnoses of cervical strain, lumbar strain, and left hip strain as evidence that he sustained such conditions as a result of the work incident.

Whether or not diagnoses, by themselves, can establish medical causation, we do not find Dr. Pierson's chart note containing the diagnoses sufficient to prove compensability. In this regard, Dr. Pierson relied on a history that the onset of claimant's low back and left hip pain was a few days *after* the work incident; as claimant's statement and testimony shows, his symptoms, and in particular the left hip pain, arose at the same time as the fall. Because Dr. Pierson did not rely on an accurate history, we do not find his chartnote establishes causation.

In the absence of medical causation, we further conclude that, whether or not claimant was credible concerning the work incident itself, claimant failed to carry his burden of proving compensability. *See* ORS 656.005(7)(a).

ORDER

The ALJ's order dated January 8, 1999 is reversed. The employer's denial is reinstated and upheld. The ALJ's attorney fee award also is reversed.

Board Member Phillips Polich dissenting.

I disagree with the majority's analysis and conclusion concerning this case. Because I would affirm the ALJ's order, I respectfully dissent.

In deciding that claimant did not prove compensability, the majority finds "an absence of medical causation." I note that, in litigating this case, medical causation was not asserted as a defense to the claim. At hearing, the employer's counsel agreed that the issue was "strictly compensability," further stating that the employer was "attacking his credibility, number one, and number two, no objective medical evidence of any injury." (Tr. 6). The employer's attorney continued this defense on review, stating that the "issue is whether claimant sustained a compensable injury as he alleged" and arguing that claimant's "testimony is contradictory and therefore not persuasive."

Because the employer did not assert "an absence of medical causation" defense, I do not agree with the majority's approach basing its conclusion on this factor. It is my belief that because this was not raised by the employer at hearing, that the employer conceded, in essence stipulated, that medical causation was not at issue. This is supported by how the issues were framed and presented to the ALJ. (Tr. 6).

Addressing the employer's arguments, I would affirm the ALJ's conclusion that "claimant experienced an injury as described." That is, I find claimant's testimony concerning the injury is credible; as the ALJ stated, although claimant may have demonstrated a faulty memory when asked about prior claims and an old felony conviction, claimant's consistent and prompt reporting of the injury shows that his testimony was truthful. Thus, I agree with the ALJ that claimant satisfied legal causation.

The employer's other major argument--that the medical evidence was not supported by objective findings--also should be rejected. According to Dr. Pierson, claimant exhibited mildly limited range of motion, diminished sensation in the thigh, and tenderness. Such findings are sufficient to satisfy the statute. *See* ORS 656.005(19).

Therefore, addressing only the arguments raised by the employer's counsel, I would find that claimant satisfied his burden of proof. I would not come to a different conclusion even if I went beyond those arguments and focused on medical causation. The emergency room physician submitted a Form 827 with supporting chartnotes indicating that claimant sustained a work-related injury. Although Dr. Pierson did not provide an opinion containing "magic words," in the absence of any alternative cause of claimant's injury, I find his records support a compensability finding.

Finally, I disagree with the majority that Dr. Pierson based his opinion on an inaccurate history. The majority does not distinguish between claimant's report of *pain* versus *numbness*. What appears to be significant is that claimant's numbness developed subsequent to the injury. Claimant testified only to the onset of pain and does not say anything about numbness.

In sum, I would affirm the ALJ's order and adopt his finding that claimant's testimony was credible and, based on that testimony, the record establishes the compensability of claimant's low back condition. Because the majority concludes differently, I dissent.

In the Matter of the Compensation of
PENNY I. NEWTON, Claimant
WCB Case No. 98-07237
ORDER ON REVIEW
Westmoreland & Mundorff, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes, Bock, and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that upheld the self-insured employer's denial of her claim for a right shoulder injury. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated February 1, 1999 is affirmed.

Board Member Phillips Polich dissenting.

The majority adopts and affirms the ALJ's order that found claimant was not a credible witness and concluded that she did not prove her right shoulder injury claim. I disagree with both findings and respectfully dissent.

At hearing, claimant admitted that she had lied in her statement to the employer's investigator about her working activities and the lack of prior claims. Claimant said she had used bad judgment and explained that she was afraid the information regarding the injury would be given to her new employer and would jeopardize her new job. The employer's "impeachment" evidence only showed what claimant had already admitted.

The question in this case is whether or not claimant sustained a right shoulder injury at work. Claimant's testimony regarding the occurrence of the injury is consistent with the history provided to the physicians. Moreover, when claimant sought emergency room treatment, Dr, Oksenholt reported that she had a bruise on the right inner arm, which was consistent with the mechanism of injury. Additionally, claimant reported the injury to her employer at the time the injury occurred. The portion of the "801" form completed by the employer indicates that the injury occurred during the course and scope of employment. (Ex. 2).

Although the ALJ did not find claimant to be credible, he made no express credibility findings based upon claimant's demeanor. When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. *Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987). After reviewing the record, I am not persuaded that claimant's credibility has been impeached. I believe that claimant has proven she suffered a right shoulder injury on or about July 4, 1998. The medical opinions are consistent with a work-related injury. Based on the record as a whole, I would set aside the self-insured employer's denial.

In the Matter of the Compensation of
BARBARA OPPLIGER, Claimant
WCB Case No. 96-00387
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Livesley's order that set aside its partial denial of claimant's claim for a consequential right knee osteoarthritis condition. In its brief, SAIF contends that the ALJ should have admitted Exhibits 37 and 38, the Order on Review and the appellate judgment for the prior right knee claim. On review, the issues are evidence, issue preclusion and compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, which we summarize and supplement as follows.

On February 2, 1989, claimant fractured her left ankle. She made a claim, which SAIF accepted as a disabling left ankle fracture. Claimant underwent four ankle surgeries prior to an October 1992 left ankle arthrodesis. Subsequently, claimant was diagnosed with greater trochanteric bursitis in the right leg, secondary to altered gait. On July 9, 1993, SAIF accepted right greater trochanteric bursitis. An August 4, 1993 Notice of Closure reclosed the claim and awarded an additional 31 percent scheduled permanent disability for the loss of use and function of the left ankle, for a total of 47 percent.

On May 10, 1994, claimant sought treatment for progressive onset of right knee pain. Dr. Jones, orthopedic surgeon, diagnosed a right patellofemoral or possible medial compartment condition for which he performed a partial medial meniscectomy in October 1994. In addition to a torn medial meniscus, Dr. Jones's postoperative diagnoses included Grade II chondromalacia retropatellar surface and Grade III-Grade IV changes in the medial compartment.

On November 18, 1994, SAIF denied claimant's right knee claim on the basis that the torn medial meniscus was unrelated to the accepted left ankle fracture. On February 24, 1995, a hearing was held before a prior ALJ on the issues of compensability and "de facto" denied medical services (WCB Case No. 94-14622). At hearing, SAIF agreed to pay for the medical services. The hearing record remained open for Dr. Jones's deposition.

Meanwhile, on April 12, 1995, claimant returned to Dr. Jones. He diagnosed medial compartmental disease (osteoarthritis) and referred claimant to Dr. Mohler for evaluation for a possible high tibial osteotomy. On June 1, 1995, Mohler scheduled claimant for total knee replacement. On September 27, 1995, SAIF denied osteoarthritis, medial compartment of the right knee, on the basis that her February 1989 injury was not the major contributing cause of the new condition. On October 23, 1995, claimant requested a hearing.[1]

Dr. Jones's deposition was taken on October 5, 1995.

The prior ALJ's January 8, 1996 Opinion and Order determined that claimant's 1989 left ankle injury was not the major contributing cause of the pathological worsening of her preexisting right knee condition. (Ex. 28A). We take administrative notice[2] of the following: The prior ALJ's order was affirmed by a June 26, 1996 Order on Review, which was affirmed by the Court of Appeals. *Oppliger v. SAIF*, 147 Or App 241 (1997).

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[1] Claimant's request for consolidation with the prior hearing was denied by the prior ALJ.

[2] We may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot be readily questioned." *Rodney J. Thurman*, 44 Van Natta 1572 (1992).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that the prior ALJ's January 1996 Opinion and Order did not bar litigation of the current right knee claim because there was no prior opportunity to litigate the question presented in this case, namely whether claimant's current osteoarthritis condition is compensable. On review, SAIF contends that compensability of claimant's right knee condition had previously been litigated in the prior case; thus, issue preclusion bars relitigation of the right knee condition.

The doctrine of issue preclusion bars litigation of an issue if that issue was actually litigated and determined in a setting where the determination of the issue was essential to the final decision on the merits. *See North Clackamas School Dist. v. White*, 305 Or 48, 53 (1988) (if a claim is litigated to final judgment, the decision on a particular issue or determinative fact is conclusive in a later or different action between the same parties if the determination was essential to the judgment). Under the circumstances of this case, we agree with SAIF that issue preclusion bars claimant's claim for her worsened osteoarthritis condition.

We begin with an examination of the issues decided as a result of the first hearing. With respect to the issue of compensability of claimant's combined consequential right knee condition, the prior ALJ not only concluded that her condition was not compensable, but went on to state:

> "Although the record proves that [claimant's] altered gait from her 1989 compensable left ankle injury was the major cause of her symptoms, disability and need for treatment relating to her right knee condition, the record does not prove that her left ankle injury was the major cause of the pathology of her right knee condition."

The Board adopted and affirmed the ALJ's opinion and order with supplementation:

> "Claimant contends that the medical evidence establishes that she has "patellofemoral compression syndrome," osteoarthritis and degenerative change of the right knee which are caused, in major part, by the compensable injury. After reviewing the medical evidence, we are not persuaded that claimant's right knee condition, *however diagnosed*, is compensable.
>
> "* * * * *
>
> "Although Dr. Jones has opined that the left ankle condition was the major cause of the symptoms of the preexisting right knee condition, we are not persuaded that the left ankle injury was the major contributing cause of *the consequential right knee condition itself*, as required by ORS 656.005(7)(a)(A)." (Emphasis added).

Claimant appealed the Board's decision to the Court of Appeals, which affirmed. Meanwhile, SAIF had issued a partial denial of claimant's "osteoarthritis" condition. Claimant requested a hearing on the partial denial and further alleged that her condition had worsened. The ALJ set aside the partial denial.

We conclude that the issues raised by claimant's present right knee claim are not significantly different from those previously litigated. The prior ALJ found that claimant's then existing right knee condition was not caused in major part by her initial compensable injury. That determination was affirmed by the Board and the court. Moreover, the medical evidence does not distinguish claimant's current right knee condition from the right knee condition that she had asserted before the prior ALJ. Because the prior ALJ's determination that claimant's preexisting, degenerative right knee condition, however diagnosed, had not been pathologically worsened as a result of her compensable left ankle injury, the underlying causation issues are essentially identical. Therefore, the compensability of claimant's right knee condition has already been determined.

ORDER

The ALJ's order dated January 15, 1999 is reversed. The SAIF Corporation's denial of claimant's consequential right knee condition is reinstated and upheld in its entirety. The ALJ's attorney fee award is reversed.

In the Matter of the Compensation of
RICHARD YOREK, Claimant
Own Motion No. 99-0161M
OWN MOTION ORDER

The self-insured employer has submitted a request for temporary disability compensation for claimant's compensable low back condition. Claimant's aggravation rights expired on November 30, 1994. The employer opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work *and* is seeking work; or (3) not working but willing to work, *and* is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[1] is the date he enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). Here, the relevant time period for which claimant must establish he was in the work force is the time prior to February 23, 1999 when his condition worsened requiring that surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997).

The employer contends that claimant was not in the work force at the time of the current disability. In response, claimant submits a May 12, 1999 notarized statement that "I have continuously tried to return to the work force but as my back got worse so did my pain * * * I do wish I had the ability to work and play like I used to but I do not."

We are not persuaded by claimant's signed statement that he was and is willing to work. We base this conclusion on the following reasoning.

Claimant was awarded permanent total disability in 1989. A 1990 Referee's order rescinded claimant's "permanently and totally disabled" (PTD) status and awarded claimant 65 percent unscheduled permanent disability. In doing so, the Referee found that claimant could return to sedentary work. In June 1991, we affirmed that order. *Richard R. Yorek*, 43 Van Natta 1401 (1991) (found claimant able to perform sedentary work both physically and vocationally).

The record indicates that claimant has not worked since 1984. Claimant reports the following efforts regarding the work force issue. He asserts that he did not return to work because he was attending "welding class" as well as welding school. When he completed his training, claimant contends his doctors informed him he could not work as a welder because of the "deterioration of my back." It is unclear, from claimant's submission, what dates he attended his welding training classes.

Following his welding training, claimant contends that, at one point, he returned to work at his son's RV detailing shop. He further asserts that he was unable to continue working because the "fusions in my back broke and since then I have not been physically able to return to work." Again, it is unclear when this "work period" took place. However, provided he did return to work at one time over the years, there is no evidence of a recent work search in the record. Therefore, claimant's lack of reasonable efforts to obtain employment, albeit not determinative, indicates a lack of willingness to work. *See Fendrich v Curry County*, 110 Or App 409 (1991).

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[1] The Board in its own motion jurisdiction can only authorize temporary disability from the time of surgery or hospitalization. *See* ORS 656.278(1)(a).

Claimant also alleges that, although willing to work, he has been unable to work since that time because of the compensable injury. Thus, claimant contends that his work injury has made any work search futile. Until the Referee's 1990 order, claimant was classified as permanently and totally disabled. *See Dawkins*, 308 Or at 258. However, such a conclusion does not establish that following the Referee's 1990 order, claimant was willing to work even if he was rendered incapable of working due to the compensable injury during that time. *See SAIF v. Blakely*, 160 Or App at 246-47; *Fendrich v. Curry County*, 110 Or App at 413.

Finally, given the context of his contention that he is currently unable to work because of the compensable injury, there is no medical evidence in the record which would persuade us that claimant has been unable to work since the 1990 Referee and 1991 Board orders removed his PTD status and found him capable of sedentary work. Further, the medical documentation contained in the record fails to establish that claimant was unable to work at the time of disability and that it would have been futile for him to seek work due to his compensable condition. In other words, claimant does not provide medical documentation supporting the contentions made in his notarized statement.

Given the lack of evidence that he was either seeking work or unable to work at the time of disability, we find that claimant was not willing to work at any time since he last worked in 1984, despite his statement to the contrary. *See Wausau Insurance Companies v. Morris*, 103 Or App 273 (1990); *Dawkins*, 308 Or at 258.

Accordingly, claimant's request for temporary disability compensation is denied. *See id.* We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

Claimant's entitlement to medical expenses pursuant to ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
BRIAN E. BRINK, Claimant
WCB Case No. 97-09950
ORDER ON REVIEW
Heather Holt, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by the Board *en banc*.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of claimant's occupational disease claim for exposure to tuberculosis. On review, the issue is compensability.

We adopt and affirm the ALJ's opinion, which we supplement as follows to address the employer's arguments on review.

The issues presented in this case involve the presumption created for the benefit of firefighters in Oregon's occupational disease law, ORS 656.802(4). Relying on *Wright v. SAIF*, 289 Or 323 (1980), and *Johnson v. The City of Roseburg*, 86 Or App 344 (1987), the ALJ concluded that claimant had proved a compensable occupational disease. On review, the employer asserts that claimant failed to prove a prima facie case that would shift the burden of proof to the employer. Specifically, the employer contends that claimant has failed to establish that his condition "resulted from his employment as a firefighter," and that he failed to establish that he suffers from a disease that has resulted in "death, disability or impairment of health." We disagree with both contentions for the following reasons.

The employer contends that the ALJ's reliance on *Wright* and *Johnson* was inappropriate because the statutes applied in those cases have since been amended to add the phrase "and resulting from their employment as firefighters." Therefore, the employer reasons that the legislature must have intended to add another factor that a firefighter-claimant must prove in order to establish a prima facie case.

The employer misreads *former* ORS 656.802, which provides in pertinent part:

"(1) As used in ORS 656.802 to 656.824, 'occupational disease' means:

" * * * * *

"(b) Death, disability or impairment of health of firemen of any political division who have completed five or more years of employment as firemen, caused by any disease of the lungs or respiratory tract, hypertension or cardiovascular-renal disease, *and resulting from their employment as firemen.*

"(2) Any condition or impairment of health arising under paragraph (b) of subsection (1) of this section *shall be presumed to result from a fireman's employment.* (Emphasis added).

ORS 656.802(4) provides in pertinent part:

"Death, disability or impairment of health of firefighters of any political division who have completed five or more years of employment as firefighters, caused by any disease of the lungs or respiratory tract, hypertension or cardiovascular-renal disease, and *resulting from their employment as firefighters* is an 'occupational disease.' Any condition or impairment of health arising under this subsection *shall be presumed to result from a firefighter's employment.*" (Emphasis added).

The phrase "and resulting from their employment as firefighters" has been a part of the statute and has been retained (with the exception of substituting the word "firefighters" for "firemen) in the first sentence of ORS 656.802(4), which defines an occupational disease for purposes of triggering the "firefighters presumption," just as *former* ORS 656.802(1)(b) does. Similarly, the second sentence of ORS 656.802(4), like section (2) of the former statute, sets forth the "firefighters presumption" itself. Therefore, based on a comparison of the text and context of each statute, we conclude that the legislature has not amended the statute to require a worker to prove an additional element to establish a prima facie case under the "firefighters presumption." *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610 (1993). Finally, were we to interpret ORS 656.802(4) as suggested by the employer, the "firefighters presumption" would become meaningless. Accordingly, the ALJ's application of *Wright* and *Johnson* was not error.

As for the employer's second objection, the ALJ relied on medical evidence to establish that tuberculosis is a lung disease caused by microbacteria transmitted from an infected person, that ninety percent of the time it is found in the respiratory tract, and that it is not idiopathic. (Ex. 21, 22-8, -9). Claimant tested positive for exposure to the disease. As a result of the positive test, claimant was immediately treated with daily doses of Isoniazid for six months. Because claimant tested positive for the exposure to the disease (which included physical symptoms), which required an extensive course of treatment to prevent active tuberculosis, we agree with the ALJ that claimant experienced "impairment of health" caused by a "disease of the lungs or respiratory tract."

Here, there is no question that claimant established the basic facts that give rise to the statutory presumption. ORS 656.802(4) directs that "[d]enial of a claim for any condition or impairment * * * must be on the basis of clear and convincing medical evidence that the cause of the condition or impairment is unrelated to the firefighter's employment." Thus, the remaining question is whether the employer can rebut the presumption by clear and convincing opposing medical evidence.

Dr. Frank, treating physician, opined that, within reasonable medical probability, claimant's exposure to tuberculosis resulted from claimant's employment with the fire department. Dr. Frank based his conclusion on a comparison of the hours claimant worked at the fire department with the hours he worked for an ambulance service. There is no contrary evidence. Consequently, the employer has not carried its burden to rebut the presumption.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated February 24, 1999 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
TOMMY L. BROWN, Claimant
WCB Case No. 98-03270
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Podnar's order that set aside its denial of claimant's injury claim for a hernia condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation.[1]

We agree with the ALJ that this case is most appropriately analyzed as an injury, rather than an occupational disease. The insurer argues that the ALJ erred by applying a material cause standard and it contends that ORS 656.005(7)(a)(B) applies. We need not decide which causation standard is applicable because, in any event, the persuasive medical evidence establishes that claimant's industrial injury is the major contributing cause of his subsequent need for treatment and disability.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). Although claimant's attorney has requested an assessed fee of $2,000, he did not submit a statement of services showing the time devoted to the case on review. Claimant's respondent's brief is 13 pages in length. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,700, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review concerning the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated February 3, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,700, payable by the insurer.

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[1] We note that Exhibit 31A, rather than Exhibit 30A, was admitted in evidence.

In the Matter of the Compensation of
CATHLEEN M. GERLACH, Claimant
WCB Case Nos. 98-08018 & 98-05430
ORDER ON REVIEW
Cedric R. Brown, Claimant Attorney
Sather Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes, Bock, and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that upheld the self-insured employer's denial of her occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated January 29, 1999 is affirmed.

Board Member Phillips Polich dissenting.

I disagree with the majority's analysis for the following reasons. First, I do not agree that claimant has a preexisting condition as defined in ORS 656.005(24). While it is true that both the treating physician and examining physician make a presumptive diagnosis of carpal tunnel syndrome based solely on the symptoms reported by claimant during employment with a prior employer, this "presumptive diagnosis" does not rise to the level of a preexisting condition as contemplated by the statute.

Second, even assuming that this "presumptive diagnosis" rises to the level of a preexisting condition, I would still find that claimant has met her burden of proof. In this regard, the basis for the ALJ's conclusion that a preexisting condition exists was claimant's reporting of symptoms to the physicians. If those symptoms are sufficient to establish a preexisting condition, then those symptoms must be the disease, which has presumptively and concurrently been diagnosed as carpal tunnel syndrome.

I believe that the medical evidence is sufficient to establish compensability.

Dr. Adams states:

> "It is apparent to me that in her history the working conditions at [employer] which were much more intensive and her symptoms were much worse than anything she had while employed at the [previous employer], therefore, it is my primary feeling that the need for care for her current medical condition of carpal tunnel syndrome is the result directly and most prominently due to the employment at [employer] as a cashier. This type of work, specifically cashiering, is well-known in the medical literature to be directly related to development of carpal tunnel syndrome on many an individual because of the repetitive gripping and bending of the wrist at checking." (Ex. 22).

Dr. Nolan makes similar statements:

> "More than likely, her job as a checker, being relatively strenuous, is causing increased swelling in her hands which then precipitates carpal tunnel symptomatology. However, this work would not be considered the major cause of this problem since she had similar symptomatology a few years ago."

* * *

"From a treatment standpoint, probably the most pragmatic suggestion I would make is a job change, which this woman has every intention of pursuing on her own. With the cessation of relatively hand intensive work, I would predict that her symptoms may abate and in fact the carpal tunnel may disappear if she can effect a job change to a less manually intensive occupation." (Ex. 14-3).[1]

Both doctors determine that the symptoms claimant had before and now are carpal tunnel syndrome. Both doctors state that it is claimant's work activities which have worsened her symptoms diagnosed as carpal tunnel. Because the symptoms, presumptively diagnosed as carpal tunnel, have now worsened, I would infer that the symptoms are the disease. Therefore, claimant has met her burden of proof under ORS 656.802(2)(b).

ORS 656.802(2)(c) specifically states that "occupational diseases shall be subject to all of the same limitations and exclusions as accidental injuries under ORS 656.005(7)." The parties agree that the evidence in this case meets the requirements set forth in ORS 656.005(7)(a). Where the parties disagree is whether claimant has a preexisting condition and, if so, whether she has established a pathological worsening of her underlying condition.

The parties agree that the major contributing cause of claimant's need for treatment is her current work activities. The only reason that claimant's treatment is not compensable is because her medical condition is characterized as an occupational "disease" versus an industrial "injury." This outcome is contrary to the basic principles of the workers' compensation system. If this is an accurate application of the law, then responsibility is being shifted to the private sector for medical treatment that is directly attributable to work activities assigned by an employer. Claimant's claim for medical treatment, which the parties agree is caused by her work activities, should not fail because of an artificial distinction between language utilized in the injury and disease statutes. For these reasons, I respectfully dissent.

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[1] Dr. Nolan does ultimately conclude that the major contributing cause of claimant's carpal tunnel is idiopathic. That conclusion, however, is not supported by the "Assessment" portion of his report. Since Dr. Adams had only Dr. Nolan's report, (Ex. 14), and not the accompanying letter sent by the insurer, (Ex. 13), his concurrence in Exhibit 18 can only be to those portions that stand alone, including the "Assessment" section. The answers to the insurer's letter by Dr. Nolan in his report are meaningless without the letter to which he was responding.

June 30, 1999 Cite as 51 Van Natta 1059 (1999)

In the Matter of the Compensation of
RIGMOR WALTER, Deceased, Claimant
WCB Case No. C9-01445
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

On June 11, 1999, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

A CDA shall not be approved if, within 30 days of submitting the disposition to us, the worker, insurer or self-insured employer requests that we disapprove the disposition. ORS 656.236(1)(c).

Here, the CDA was submitted to us on June 11, 1999. The statutory 30th day following the submission is July 13, 1999. The SAIF Corporation filed its request for disapproval of the CDA on June 21, 1999. Accordingly, we disapprove the CDA. *Id.*

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-060-0150(4)(i) and (6)(e).

IT IS SO ORDERED.

June 29, 1999 Cite as 51 Van Natta 1060 (1999)

In the Matter of the Compensation of
EDWARD A. SPRAGUE, Claimant
WCB Case No. 97-09753
ORDER OF DISMISSAL
Pamela A. Schultz, Claimant Attorney
Wallace, Klor & Mann, Defense Attorneys

Claimant requested review of Administrative Law Judge (ALJ) Tenenbaum's order that set aside the self-insured employer's amended denial insofar as it pertained to claimant's lower and upper hernias. The parties have submitted a proposed "Disputed Claim Settlement" that is intended to resolve all issues pending review, as well as all issues raised or raisable between the parties that were pending before the Hearings Division in WCB Case No. 98-07362. An ALJ has approved those portions of the settlement that pertain to issues pending before the Hearings Division.

Pursuant to the settlement, the parties agree that the employer's denials "shall be construed consistent with [their] agreement and shall remain in effect and are hereby affirmed." The agreement further provides that claimant's "Request for Hearing shall be dismissed with prejudice."

We have approved that portion of the parties' settlement that pertains to issues pending Board review, thereby fully and finally resolving their dispute, in lieu of the ALJ's order.[1] Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] A provision in the parties' settlement states that a portion of claimant's share of the proceeds shall be provided to several "non-workers' compensation" insurance providers in satisfaction of their liens for health insurance and disability benefits. Inasmuch as the parties' compensability dispute is being resolved by means of a Disputed Claim Settlement (DCS), only medical service providers may be directly reimbursed from the settlement proceeds. ORS 656.313(4)(c). (Health insurance providers may be directly reimbursed by the workers' compensation carrier when "the services are determined to be compensable." ORS 656.313(4)(b).) Nonetheless, because proceeds from a DCS are not considered "compensation," a claimant's assignment of all or a portion of his share of the proceeds is not prohibited by ORS 656.234. *Robert D. Surina*, 40 Van Natta 1855 (1988); *Theodule Lejeune, Jr.*, 40 Van Natta 493 (1988).

Here, we do not interpret the aforementioned settlement provision to represent that a non-workers' compensation insurance carrier will receive reimbursement *directly* from the workers' compensation carrier. Rather, in granting our approval of the settlement, we have interpreted the settlement as stating that claimant has assigned a portion of his share of the settlement proceeds to the non-workers' compensation carrier. Pursuant to *Lejeune* and its progeny, such an assignment is not contrary to ORS 656.234. Finally, because the entities listed as receiving portions of the settlement proceeds are limited to non-workers' compensation carriers and attorneys, we interpret the agreement as effectively providing that no outstanding medical bills from medical service providers were in the self-insured employer's possession on the date the settlement terms were agreed on. In light of such circumstances, the proposed settlement is approvable. OAR 438-009-0010(2)(g); *Robert E. Wolford*, 46 Van Natta 522 (1994).

In the Matter of the Compensation of
JAMES E. TEMPLETON, Claimant
WCB Case No. 98-06720
ORDER ON RECONSIDERATION
Welch, Bruun & Green, Claimant Attorneys
Moscato & Hallock, Defense Attorneys

The insurer requests reconsideration of that portion of our June 16, 1999 Order on Review that set aside its denial of claimant's "new medical condition" claim for a thoracic strain. In doing so, we determined that a prior Administrative Law Judge's (ALJ's) Order of Dismissal did not preclude claimant's current "new medical condition" claim for a thoracic strain.

In our prior order, we noted that claimant's former attorney had filed a hearing request alleging a "de facto" denial after he had written the insurer on October 23, 1995 requesting acceptance of claimant's cervical complaints (among other conditions). The prior ALJ, however, dismissed the hearing request with prejudice after claimant's former attorney withdrew the request for hearing. In our first order, we held that claimant's current "new medical condition" claim was not precluded by the dismissal order because claimant had not filed a new medical condition claim for a thoracic strain before that order.

The insurer now requests that we reconsider our holding, asserting that claimant's former attorney did file a "new medical condition claim" for a thoracic strain in the October 23, 1995 letter. For the following reasons, we decline to depart from the reasoning in our prior order.

To make a "new medical condition" claim pursuant to ORS 656.262(7)(a), claimant must clearly request formal written acceptance of the condition. *See Eston Jones*, 50 Van Natta 1407, *on recon* 50 Van Natta 1582 (1998); *Diane S. Hill*, 48 Van Natta 2351, 2352-53 (1996), *aff'd mem Hill v. Stuart Andersons*, 149 Or App 496 (1997). Here, the October 23, 1995 letter to the insurer stated:

> "Additionally, according to the medical records, and conversations with my client [the] Notice of Acceptance has not accepted all of the conditions suffered by [claimant] in his accident. There is no mention of his left wrist injury, his neck or shoulder complaints, or his headaches, all of which were mentioned in the medical reports***." (Ex. 10).

Because the October 23, 1995 letter does not request acceptance of, let alone mention, a thoracic strain, we continue to conclude that claimant did not file a "new medical condition" claim for a thoracic strain prior to the 1996 dismissal order. Under such circumstances, claimant could not have litigated a claim for a thoracic strain when his prior request for hearing was dismissed. Therefore, we adhere to our conclusion that the 1996 dismissal order does not preclude the current "new medical condition claim" for a thoracic strain.

The insurer contends, however, that the October 23, 1995 letter incorporated the diagnosis of thoracic strain contained in an August 21, 1995 medical report when the letter used the phrase "the medical reports." Therefore, the insurer argues that October 23, 1995 letter constituted a "new medical condition claim" for a thoracic strain. We disagree.

As previously noted, ORS 656.262(7)(a) requires that a claimant "clearly request formal written acceptance of the [new medical] condition." The insurer's "incorporation" argument notwithstanding, we cannot say that there was a "clear request" for formal written acceptance of a thoracic strain condition in the October 23, 1995 letter. *Eston Jones*, 50 Van Natta at 1582 n.1. Thus, we find that the statutory requirements of ORS 656.262(7)(a) were not satisfied with respect to the alleged thoracic condition.

Accordingly, we withdraw our June 16, 1999 order. On reconsideration, as supplemented herein, we adhere to and republish our June 16, 1999 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JACKSON R. SHRUM, Claimant
Own Motion No. 98-0482M
OWN MOTION ORDER
Welch, Bruun, et al, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer submitted a request for temporary disability compensation for claimant's compensable left elbow condition. Claimant's aggravation rights expired on December 4, 1997. The insurer denied the compensability of claimant's current left radial tunnel syndrome condition. In addition, the insurer opposed reopening on the grounds that: (1) the insurer was not responsible for claimant's current condition; (2) surgery or hospitalization was not reasonable and necessary for the compensable injury; and (3) claimant was not in the work force at the time of disability. Claimant requested a hearing with the Hearings Division. (WCB Case No. 99-00087).

On February 24, 1999, we consolidated this own motion matter with the pending hearing. If the Administrative Law Judge (ALJ) found claimant's current condition causally related to the accepted injury, we requested that the ALJ make findings of fact and conclusions of law regarding whether claimant was in the work force at the time his condition worsened.

On April 19, 1999, Administrative Law Judge (ALJ) Otto issued an Opinion and Order which set aside the insurer's denial. In doing so, ALJ Otto found that claimant's left radial tunnel syndrome condition was causally related to the February 10, 1992 compensable injury. The ALJ's order has not been appealed.

Finding that claimant was not in the work force at the time his condition worsened, ALJ Otto recommended that claimant be denied entitlement to temporary disability benefits pursuant to ORS 656.278(1)(a).

Under ORS 656.278(1)(a), we may exercise our own motion authority to reopen a claim for additional temporary disability compensation when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization.

On August 28, 1998, Dr. Layman, claimant's attending surgeon, recommended that claimant undergo a radial tunnel release. Thus, we conclude that claimant's compensable injury has worsened requiring surgery.

However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work *and* is seeking work; or (3) not working but willing to work, *and* is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989); *SAIF v. Blakely*, 160 Or App at 244.

In his own motion recommendation, ALJ Otto found that claimant had not worked or looked for work since he was terminated from his employer in May 1996 for reasons unrelated to his industrial injury. The ALJ concluded, that although it was claimant's belief that he was unable to do work, the medical evidence demonstrated that claimant was capable of working and failed to seek work. Having found that claimant was not in the work force when his condition worsened requiring surgery, ALJ Otto recommended that claimant's request for temporary disability benefits be denied.

In response to ALJ Otto's Own Motion Recommendation, claimant's attorney asserts that it would have been futile for him to seek work due to his "total inability to engage in substantial gainful employment."[1] The record does not support this contention.

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[1] A claimant's attorney's assertion that it would have been futile for a claimant to seek work due to his compensable condition does not suffice as evidence supporting claimant's contentions. *See Earl J. Prettyman*, 46 Van Natta 1137 (1994). Nonetheless, for purposes of this decision, we have assumed (for the sake of argument) that such an assertion is probative evidence regarding claimant's futility to seek work.

On August 28, 1998, Dr. Layman released claimant to modified work. Prior to that release, Dr. Long, claimant's attending physician, noted that claimant was limited only by occasional light lifting with the left extremity. Thus, the record lacks persuasive medical evidence establishing that claimant was unable to work and/or seek work due to his compensable condition. In light of such circumstances, claimant is not entitled to temporary disability benefits.

Accordingly, claimant's request for temporary disability compensation is denied. *See id.*

IT IS SO ORDERED.

In the Matter of the Compensation of
JACQUELINE ECKERT, Claimant
WCB Case Nos. 98-02924 & 97-03181
ORDER ON REVIEW
Greg Noble, Claimant Attorney
Miller, Nash, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that found her low back injury claim with the self-insured employer was time-barred under ORS 656.265(4). On review, the issue is timeliness of the claim and, in the event the claim was timely, compensability.

We adopt and affirm the ALJ's order with the following supplementation.

Claimant contends that her low back injury arose from a specific incident, when she transferred sheets from the washer to the drier.[1] Therefore, ORS 656.265[2] is the applicable limitations statute, and the employer must have had knowledge of the injury within 90 days after the alleged injury date. *Jeffery E. Henderson*, 50 Van Natta 2340, 2342 (1998).

In *Argonaut Insurance v. Mock*, 95 Or App 1 (1989), the court discussed what constitutes "knowledge of the injury" for purposes of ORS 656.265(4)(a):

> "'[K]nowledge of the injury' must be sufficient reasonably to meet the purposes of prompt notice of an industrial accident or injury. If an employer is aware that a worker has an injury without having any knowledge of how it occurred in relation to the employment, there is no reason for the employer to investigate or to meet its responsibilities under the Workers' Compensation Act. Actual knowledge by the employer need not include detailed elements of the occurrence necessary to determine coverage under the act. However, knowledge of the injury should include enough facts as to lead a reasonable employer to conclude that workers' compensation liability is a possibility and that further investigation is appropriate." *Id.* at 5.

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[1] When symptoms occur over a discrete, identifiable period of time, are unexpected and due to a specific activity or event, the condition is properly analyzed as an injury. *See, e.g., James v. SAIF*, 290 Or 343 (1981); *Valtinson v. SAIF*, 56 Or App 184 (1982).

[2] ORS 656.265 provides, in pertinent part, as follows:

"(1) Notice of an accident resulting in an injury or death shall be given immediately by the worker or a dependent of the worker to the employer, but not later than 90 days after the accident. * * *

"* * * * *

"(4) Failure to give notice as required by this section bars a claim under this chapter unless the notice is given within one year after the date of the accident and:

"(a) The employer had knowledge of the injury or death[.]"

After reviewing the record, we are not persuaded that claimant provided the employer with enough facts regarding her alleged low back injury within 90 days to conclude that workers' compensation liability was a possibility.[3] Therefore, even though claimant gave notice of the claim within one year, her claim is nevertheless time-barred under ORS 656.265 because she did not give notice of the accident within 90 days.

ORDER

The ALJ's order dated December 21, 1998 is affirmed.

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[3] As discussed by the ALJ, claimant reported to Dr. Knox on March 13, 1996 that she had experienced some low back discomfort after working for one week, including "doing laundry," among other tasks. He reported "new onset of low back pain due to on-the-job factors." However, claimant did not report a specific injury to Dr. Knox that occurred as a result of doing laundry. (Exs. 85, 87). Moreover, claimant's report to Ms. Allen is equally vague: Claimant reported "some difficulty with her lower back hurting." (Ex. 86A-2). Finally, on May 2, 1996, claimant reported to Dr. Rung that "on awakening after her first week of work, on a weekend morning she had severe low back pain and was almost unable to get out of bed." Claimant did not report a specific injury to Dr. Rung. Given the lack of specificity in her reports to her doctors, we would not infer that any report she may have made to her employer would have constituted the requisite "knowledge of the injury" under the statute.

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Cite as 159 Or App 350 (1999) March 24, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Consuelo Trujillo, Claimant.

CONSUELO TRUJILLO, Petitioner,
v.
PACIFIC SAFETY SUPPLY and SAIF CORPORATION, Respondents.
(WCB 96-10056; CA A99410)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 13, 1998.
Max Rae argued the cause and filed the brief for petitioner.
David Runner argued the cause and filed the brief for respondents.
Before Landau, Presiding Judge, and Deits, Chief Judge, and Wollheim, Judges.
WOLLHEIM, J.
Affirmed in part, reversed in part and remanded for reconsideration.

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159 Or App 352> Claimant seeks review of an order of the Workers' Compensation Board that awarded him 21 percent unscheduled permanent disability. Claimant makes two assignments of error. First, he argues that the procedure set forth in ORS 656.283(7) violates his right to due process under the Fourteen Amendment to the United States Constitution by not allowing him to testify at the hearing. This argument was addressed and rejected in *Koskela v. Willamette Industries*, 159 Or App 229, ___ P2d ____ (1999). Second, he argues that the Board's findings regarding his base functional capacity are not consistent. We affirm on the first assignment of error, and reverse and remand on the second.

Claimant injured his neck, shoulders and chest pulling a piece of plywood. Claimant's physician diagnosed cervical, thoracic, right scapula and right trapezius strains. After claimant became medically stationary, SAIF issued a notice of closure, awarding claimant 16 percent unscheduled disability. The worksheet attached to the notice indicated that claimant's base functional capacity (BFC) was light and that his residual functional capacity (RFC) was also light.[1] Claimant requested reconsideration and the reconsideration order affirmed the closure order.

The Board made inconsistent statements regarding claimant's BFC. The Board stated that claimant's BFC was both medium and light.[2] Both statements cannot be correct. SAIF concedes error but argues that the error is harmless. We do not agree. If claimant's BFC is medium, he would be entitled to additional permanent disability. If claimant's BFC **<159 Or App 352/353>** is light, claimant would not be entitled to additional permanent disability. Accordingly, remand to the Board is necessary to determine claimant's correct BFC.

Affirmed in part, reversed in part and remanded for reconsideration.

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[1] OAR 436-035-0310(3)(a) defines BFC as "an individual's demonstrated physical capacity before the injury or disease." OAR 436-035-0310(3)(b) defines RFC as "an individual's remaining ability to perform work-related activities despite medically determinable impairment resulting from the accepted compensable condition."

[2] OAR 436-035-0310(3)(h) provides that medium level work "means the worker can occasionally lift 50 pounds and can lift or carry objects weighing up to 25 pounds frequently." OAR 436-035-0310(3)(f) provides that light level work "means the worker has the ability to occasionally lift 20 pounds and can frequently lift or carry objects weighing up to 10 pounds."

Cite as 159 Or App 413 (1999) March 31, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Robert W. Coburn, Claimant.

SAIF CORPORATION and G. I. JOES, INC., Petitioners - Cross-Respondents,
v.
ROBERT W. COBURN, Respondent - Cross-Petitioner, and DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, Respondent - Cross-Respondent.
(WCB No. 96-10496; CA A99711)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 9, 1998.
David L. Runner argued the cause and filed the briefs for petitioners - cross-respondents.
Robert Pardington argued the cause for respondent - cross-petitioner. With him on the brief was Pozzi Wilson Atchison LLP.
No appearance for respondent - cross-respondent.
Before De Muniz, Presiding Judge, and Haselton and Linder, Judges.
LINDER, J.
On petition, order of Workers' Compensation Board reversed and remanded for reinstatement of order of administrative law judge; on cross-petition, remanded to Board for an award of attorney fees.

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159 Or App 415> Employer seeks review of an order of the Workers' Compensation Board (Board) reversing an order of the administrative law judge (ALJ) and holding that, after claim closure and claimant's subsequent completion of an authorized training program (ATP), employer was not entitled to redetermine the extent of claimant's unscheduled permanent disability because the original award had become final. We agree with employer that the Board erred in holding that there could be no redetermination of the extent of claimant's disability. We conclude, however, that employer is not entitled to an offset of amounts previously paid. On the petition, we reverse and remand the Board's order for reinstatement of the order of the ALJ.

Claimant has filed a cross-petition, asserting that the Board erred in failing to award attorney fees to claimant for prevailing on SAIF's assertion that it is entitled to an offset. We agree with claimant that the Board should have awarded attorney fees to claimant. On the cross-petition, we remand the case to the Board for an award of attorney fees to claimant, for the reasons explained in *Bowman v. Esam, Inc.*, 145 Or App 46, 928 P2d 359 (1996).

Claimant suffered a compensable injury to his back in 1993. SAIF accepted the claim and ultimately closed it by a notice of closure in January 1995, with an award of 42 percent unscheduled permanent partial disability. Claimant did not request reconsideration of the notice of closure, and it therefore became final by operation of law 60 days after its issuance. ORS 656.268(4)(e).[1] SAIF paid the award in a lump sum.

159 Or App 416> Claimant subsequently entered an ATP and completed the program in April 1996. In June 1996, the Department of Consumer and Business Services (DCBS) reconsidered the claim pursuant to ORS 656.268(9) and reduced claimant's award of permanent disability from 42 percent to 19 percent. Subsequently, SAIF wrote a letter to claimant explaining that the payment that claimant had received on the original award would be deducted from the amount stated in the determination order and that, accordingly, no benefits were due. The letter further noted that claimant had received an "overpayment" of $10,449.01.

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[1] ORS 656.268(4)(e) provides:

"If a worker objects to the notice of closure, the worker first must request reconsideration by the department under this section. The request for reconsideration must be made within 60 days of the date of the notice of closure."

The statute has been renumbered and amended since the events in this case, but the changes do not alter the substance of the statute as it relates to this case. In this opinion, we refer to the current version of the statute.

Claimant requested a hearing, contending that DCBS was precluded from reducing claimant's award of 42 percent permanent partial disability to 19 percent, because the original award had become final. The ALJ rejected the contention, concluding that DCBS was authorized under ORS 656.268(9) to reduce the award. The ALJ determined, however, that SAIF would not be entitled to an offset of the alleged overpayment:

> "[T]he fact that the insurer can reevaluate and reduce the earlier permanent disability award does not mean that the insurer can recoup the difference. Where, as here, the earlier award is final by operation of law, the insurer cannot offset that award against the subsequent reduction."

We assume that in seeking authorization to "recoup the difference," SAIF was seeking authorization to offset the alleged overpayment portion of the original award against any future benefits that might be awarded but was not seeking to recover from claimant the amount overpaid.

This case potentially poses three legal questions: (1) If a worker begins an ATP after a claim has been closed by notice of closure and after the award has come due and has been paid, is the employer authorized to reevaluate and to reduce the extent of the claimant's permanent disability upon completion of the ATP? (2) If so, and if the reevaluation process results in a reduction of the original rating, is the amount that was previously paid pursuant to the original award in excess of the award on reevaluation an "overpayment" of compensation? (3) If the amount is an overpayment, may it be offset against future awards?

159 Or App 417> The Board answered the first question in the negative, holding that, once the original award has become final, it may not be reevaluated. Accordingly, the Board never reached the remaining two questions. We conclude that, pursuant to ORS 656.268(9), there *must* be a reevaluation of the worker's extent of disability upon completion of an ATP, even if the original award has become final. We further conclude, for the reasons explained here, that an amount previously paid on a final unappealed award in excess of the award on reevaluation is not an "overpayment," and accordingly, may not be offset against future awards.[2]

ORS 656.268(9) provides, in pertinent part:

> "If, after the determination made or notice of closure issued pursuant to this section, the worker becomes enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and ORS 656.726, *any permanent disability payments due under the determination or closure shall be suspended, and the worker shall receive temporary disability compensation while the worker is enrolled and actively engaged in the training. When the worker ceases to be enrolled and actively engaged in the training, the Department of Consumer and Business Services shall redetermine the claim pursuant to this section if the worker is medically stationary or if the worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005(7). The redetermination shall include the amount and duration of temporary total or temporary partial disability compensation. Permanent disability compensation shall be redetermined for unscheduled disability only.* If the worker has returned to work or the worker's attending physician has released the worker to return to regular or modified employment, the insurer or self-insured employer may redetermine and close the claim under the same conditions as the issuance of a determination order by the Department of Consumer and Business Services. The redetermination or notice of closure is appealed in the same manner as are other determination orders or notices of closure under this section." (Emphasis added.)

159 Or App 418> Subsection (9) sets the procedural requirements for claims processing in the event that the worker becomes enrolled in an ATP after claim closure. The statute prescribes that (1) at the time of enrollment *any permanent disability payments due under the determination or notice of closure shall be suspended* and (2) upon completion of or withdrawal from the program, DCBS *shall redetermine the claim if the worker*

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[2] We note that, contrary to SAIF's suggestion, claimant does not contend that SAIF must again pay the amount awarded on reevaluation.

is medically stationary. The redetermination must include the amount and duration of temporary total or temporary partial disability compensation. Permanent disability compensation is to be redetermined for unscheduled disability only. Here, claimant's original award included an award for unscheduled permanent partial disability. However, at the time claimant enrolled in the ATP, no payments were due on that award, because SAIF had paid the full amount in a lump sum.

The Board apparently reasoned that, because all benefits had been paid and there would be no suspension of benefits pending claimant's participation in the ATP, there could be no reevaluation of disability on his completion of the program. That is an incorrect reading of the statute. Although the requirement for reevaluation is described in the statute following the requirement for suspension of payment of benefits, the statute does not condition the reevaluation of the claim on the existence of unpaid and suspended benefits. As we said in *SAIF v. Sweeney*, 115 Or App 506, 511, 839 P2d 254 (1992), *on recons* 121 Or App 142, 854 P2d 487 (1993):

> "In providing for reevaluation [after participation in an ATP] the legislature apparently recognized that the extent of a claimant's disability may change as a result of participation in a vocational rehabilitation program."

The reevaluation provides for the opportunity to reduce or to increase the original determination to accommodate that change. *Sweeney*, 115 Or App at 511. We conclude that ORS 656.268(9) requires redetermination in all cases upon completion of an ATP, not just those in which benefits were not yet due or remained due on the original determination order. The statute does not exclude from reevaluation cases in which the original determination order or notice of closure has become final. The Board erred in holding that, because **<159 Or App 418/419>** the original award had become final and had been paid, it could not be reevaluated pursuant to ORS 656.268(9).

In light of the fact that the extent of claimant's disability must be redetermined following his participation in the ATP, we consider whether a reduction in that award creates an overpayment of compensation that may be offset by employer against future awards of compensation. There is no statutory definition of "overpayment." The pertinent statutory and administrative provisions imply the obvious: that an overpayment occurs when an amount is paid in excess of the compensation to which the worker is entitled. *See Fazzolari v. United Beer Distributors*, 91 Or App 592, 595, 757 P2d 857, *on recons* 93 Or App 103, 761 P2d 6 (1988).

We conclude, as did the ALJ, that there was no overpayment here.[3] Employer does not challenge the correctness of the original award. At the time of that award, claimant was disabled to the extent described in the notice of closure, and the benefits awarded were due and payable. SAIF correctly paid claimant benefits for his disability, as it existed at that time. When the extent of claimant's disability was reevaluated after his completion of the ATP, it was determined that his earning capacity had increased and his permanent disability had diminished. That does not alter the correctness of the original award at the time SAIF made the lump sum payment. Because the award was correct when it was made, the payment of the award did not result in an overpayment. Accordingly, we conclude that there can be no offset of the amount paid in excess of the amount awarded on reevaluation.

As we held in *Bowman*, 145 Or App at 50, for successfully prevailing on employer's assertion before the Board that it had made an overpayment and was therefore entitled **<159 Or App 419/420>** to an offset, claimant is entitled to an assessed attorney fee under ORS 656.382(2).

On petition, order of Workers' Compensation Board reversed and remanded for reinstatement of order of administrative law judge; on cross-petition, remanded to Board for an award of attorney fees.

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[3] Because we conclude that there is no overpayment under the circumstances presented here, we do not reach the third question that this case potentially presented--*i.e.*, whether an overpayment made during an earlier period or on an earlier claim may be offset against future awards involving the same insurer. We note only that since our decisions in *Forney v. Western States Plywood*, 66 Or App 155, 672 P2d 1376 (1983) and *Travis v. Liberty Mut. Ins.*, 79 Or App 126, 717 P2d 1269 (1986), the legislature enacted ORS 656.268(15)(a) and the Workers' Compensation Division promulgated OAR 436-060-0179(2), both of which appear to bear on the question.

Cite as 159 Or App 435 (1999) April 7, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Betty L. Kneeland, Claimant.

SILVERTON THRIFTWAY and GROCERS INSURANCE, Petitioners,
v.
BETTY L. KNEELAND, Respondent.
(97-04934; A101591)

Judicial Review from Workers' Compensation Board.
Argued and submitted on November 20, 1998.
Karen O'Kasey argued the cause for petitioners. With her on the brief were Jean Ohman Back, and Schwabe, Williamson & Wyatt, P.C.
Michael D. Callahan argued the cause for respondent. With him on the brief was Callahan & Stevens.
Before Edmonds, Presiding Judge, and Deits, Chief Judge,* and Armstrong, Judge.
EDMONDS, P. J.
Reversed and remanded for reconsideration.

*Deits, C. J., *vice* Warren, P. J., retired.

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159 Or App 437> Insurer and claimant's employer seek judicial review of an order of the Workers' Compensation Board (Board) affirming the administrative law judge's (ALJ's) order that found claimant's conditions to be compensable. We reverse and remand for reconsideration.

We state the facts as found by the ALJ and adopted by the Board. Claimant was injured in a non-work related motor vehicle accident in 1988. By early 1990, her physical problems resulting from the accident had resolved. On March 22, 1995, claimant was working in a retail grocery store and injured her lower back while performing her duties. Insurer accepted a claim for a disabling lumbosacral strain on behalf of employer. Claimant was declared medically stationary on June 17, 1996, and insurer closed the claim on July 15, 1996. As a result, claimant received an award of unscheduled permanent partial disability. At claimant's request, the Appellate Review Unit of the Department of Consumer and Business Services reconsidered the claim closure and, in its November 1996 order, reduced the previously awarded unscheduled award to zero.

Subsequently, in a February 1997 letter, claimant requested that insurer accept

"as additional component[s] of the claim the following:

"1. Pain condition associated with [claimant's] accepted physical condition;

"2. Right gluteal with piriformis syndrome;

"3. Chronic pain syndrome;

"4. Depression; and

"5. Degenerative disc disease in the lumbar spine."

Insurer denied the claim, and claimant requested a hearing.

After the hearing, the ALJ upheld the denial of the claim as it pertained to the degenerative disc disease because claimant had withdrawn her claim with regard to that condition. The ALJ overturned the denial as it pertained to the remaining conditions. The ALJ accepted the opinions of **<159 Or App 437/438>** Dr. Roxanne Donovan and Dr. Kate Morris that the March 22, 1995, injury was the major contributing cause of the denied conditions and discounted the opinions of the independent medical examiners. In concluding that the denied conditions were compensable, the ALJ reasoned:

> "I am not persuaded that the effects of the lumbosacral strain (the accepted condition) resolved by 1996 and 1997. Pain symptoms of the lumbar area have persisted since March 22, 1995. Claimant and her husband are credible witnesses. However, if the lumbosacral strain resolved, the 1996 and 1997 lumbar and leg symptoms appear to be the product of the right gluteal/sacroiliac strain (with possible piriformis syndrome) or depression. The post-March 22, 1995, mental state (depression and anxiety), as noted by the ALJ, is a compensable condition. I note, medical arbiter Peterson, if her reported opinions are accepted, opined that the March 22, 1995, industrial accident was the triggering event of the pain syndrome and that the later 1996 pain symptoms (those experienced by claimant between March 22, 1995, and October 23, 1996, when medical arbiter Peterson examined claimant) were maintained by (caused by) depression.
>
> "The diagnosis of a chronic pain syndrome is sufficient to support a compensable claim if the symptom complex is attributable to a work related injury. A specific medical diagnosis is not required. *Boeing Aircraft Co. v. Roy*, 112 Or App 10[, 827 P2d 915] (1992) *citing, Tripp v. Ridge Runner Timber Services*, 89 Or App 355[, 749 P2d 586] (1988); *Karen M. Partridge*, 39 Van Natta 137 (1987)."

Insurer and employer appealed to the Board and argued that the denied conditions were not compensable because they were not supported by objective findings as required by ORS 656.005(7) and (19) and that the cases cited by the ALJ were decided before the legislature amended ORS 656.005(19) in 1995.[1] The Board identified the issue as compensability of the denied conditions and adopted and affirmed the ALJ's order without explanation.

159 Or App 439> Insurer and employer then sought judicial review by this court, assigning as error that the Board found the denied conditions compensable without determining whether there were objective findings to support them as required by ORS 656.005(7) and (19). At oral argument, counsel for insurer and employer asserted that, because the Board failed to find that objective findings that are consistent with the applicable statutory standard existed, its order is inadequate for judicial review. We agree.

To be adequate for judicial review, we must be able to discern "what the Board found as fact and why it believes that its findings led to the conclusions that it reached. That requires a reasoned opinion based on explicit findings of fact." *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 752 P2d 312 (1988) (footnote omitted). The Board can adopt an order of an ALJ that contains those components. *Campos v. Hood River Care Center*, 104 Or App 261, 264, 799 P2d 1152 (1990). In this case, the ALJ's order that the Board adopted did not address the issue of objective findings to support the denied conditions. Even though insurer and employer argued to the Board that the denied conditions were not compensable because there were no objective findings sufficient to satisfy the requirements of ORS 656.005(7) and (19), the Board made no explicit factual findings of its own regarding the existence of objective findings and did not explain why, if at all, the ALJ's opinion was sufficient with regard to that issue. Thus, the Board's order is inadequate for review.

Reversed and remanded for reconsideration.

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[1] ORS 656.005 provides, in part:

"(7)(a) A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings * * *[.]

"* * * * *

"(19) 'Objective findings' in support of medical evidence are verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength and palpable muscle spasm. 'Objective findings' does not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable."

Cite as 159 Or App 440 (1999) April 7, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Lynn M. Brown, Claimant.

SAIF CORPORATION and GARY'S MARKET, Petitioners,
v.
LYNN M. BROWN, Respondent.

(96-05732; CA A98806)

Judicial review from Workers' Compensation Board.
Argued and submitted on November 12, 1998.
David L. Runner argued the cause and filed the brief for Petitioners.
Greg Noble argued the cause and filed the brief for respondent.
Before Edmonds, Presiding Judge, and Deits, Chief Judge,* and Armstrong, Judge.
EDMONDS, P. J.
Reversed and remanded for reconsideration.

*Deits, C. J., *vice* Warren, P. J., retired.

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159 Or App 442> SAIF Corporation and claimant's employer seek judicial review of an order of the Workers' Compensation Board (Board) that reversed the administrative law judge's (ALJ's) order upholding SAIF's denial of claimant's mental disorder claim. We reverse and remand for reconsideration.

We state the facts as found by the ALJ and adopted by the Board. In December 1995, claimant, a convenience store clerk, was compensably injured when a man punched her in the face as a second man attempted to shoplift beer from the store. She received treatment at a hospital and returned to work approximately one week later. In January 1996, SAIF accepted claimant's claim for a laceration and contusion of her left cheek. In March 1996, claimant indicated to Dr. Ronald Schwerzler, her physician, that although she had continued to work, she was experiencing fear, anxiety and depression when she had to work alone. Schwerzler referred her to Dr. Steven Malone, a psychologist, and took her off work. Malone diagnosed post traumatic stress disorder (PTSD). In April 1996, Dr. Eugene Klecan, a psychiatrist, conducted an independent medical examination (IME) of claimant on behalf of SAIF. Klecan concluded that claimant did not have PTSD. In May 1996, SAIF issued a letter that denied the PTSD. SAIF took the position that the December injury was not the major contributing cause of the PTSD. In July, SAIF amended the denial based on the additional rationale that there were no objective findings of PTSD. Claimant requested a hearing. At the hearing, claimant testified that she had incurred gambling debts and had gone through a bankruptcy during 1995 and that she and her husband had separated briefly that fall but subsequently had reunited.

The ALJ framed the issues as "whether claimant [had] a diagnosed mental disorder, and whether there is clear and convincing evidence to support the claim." After indicating that the medical evidence regarding whether claimant had PTSD was in conflict, the ALJ found that Klecan's opinion was the most persuasive for several reasons, including that he had listened to claimant's testimony at the hearing regarding the off-work stressors. The ALJ discounted **<159 Or App 442/443>** Malone's diagnosis, finding that there was no evidence that he was aware of claimant's off-work stressors or that he weighed those factors in arriving at his conclusion. The ALJ affirmed SAIF's denial, concluding:

> "Therefore, in light of the fact that Dr. Klecan opined that claimant did not have a diagnosable mental disorder, claimant has not proven one of the statutory elements required to prove a compensable psychological disorder. ORS 656.802(3)(c). Additionally, because the medical evidence which would arguably support claimant's case is not persuasive, I am unable to find that claimant has proven her case by clear and convincing evidence."

Thereafter, claimant appealed to the Board. In her brief to the Board, claimant argued that she had satisfied the four requirements of ORS 656.802(3) and had established that her PTSD was caused by her employment.[1] In its brief to <159 Or App 443/444> the Board, SAIF contended that "[t]he ALJ correctly determined that claimant failed to satisfy her burden of proving that she suffered from [PTSD] that resulted in major part from a work incident * * *." Specifically, SAIF asserted that the more persuasive evidence established that claimant does not have a generally recognized psychological disorder as required by ORS 656.802(3)(c). Additionally, SAIF contended that, because the treating physicians had failed to address the off-work stressors, their opinions were insufficient to satisfy claimant's burden of proving by clear and convincing evidence that any mental disorder arose out of and in the course of employment. *See* ORS 656.802(3)(d).

In its ruling on appeal, the Board agreed with claimant's contention "that a preponderance of the medical evidence establishes the diagnosis of PTSD resulting from the assault." After acknowledging that for a mental disorder to be compensable, a claimant must satisfy the requirements of ORS 656.802(2)(a) and (3)(a)-(d), the Board identified the primary issue as whether "as a result of the work-related assault, claimant developed a generally recognized mental or emotional disorder." It then found that "there [were] no persuasive reasons not to defer to the opinion[s] of the attending physicians that claimant developed PTSD after being assaulted at work." The Board discounted the fact that Malone was unaware of the off-work stressors, because it found that they had resolved or improved before the assault. In conclusion, the Board stated:

> "[W]e find that claimant satisfied her burden of proving that she suffered a compensable mental disorder (PTSD) as a result of a work-related assault on December 14, 1995. Since, there is no dispute that claimant's psychological claim satisfies the other statutory criteria in ORS 656.802(3), we reverse the ALJ's decision upholding SAIF's denial."

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[1] ORS 656.802 provides, in part:

"(1)(a) As used in this chapter, 'occupational disease' means any disease or infection arising out of and in the course of employment caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death, including:

"* * * * *

"(B) Any mental disorder, whether sudden or gradual in onset, which requires medical services or results in physical or mental disability or death.

"* * * * *

"(2)(a) The worker must prove that employment conditions were the major contributing cause of the disease.

"* * * * *

"(3) Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter unless the worker establishes all of the following:

"(a) The employment conditions producing the mental disorder exist in a real and objective sense.

"(b) The employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment or employment decisions attendant upon ordinary business or financial cycles.

"(c) There is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community.

"(d) There is clear and convincing evidence that the mental disorder arose out of and in the course of employment."

On review, SAIF and employer argue that the medical opinions of the treating physicians are based on incomplete information regarding the cause of claimant's disorder and that the Board rendered its own "medical opinion" when it concluded that the off-work stressors had resolved or improved before the assault occurred. Thus, they conclude that the opinions are insufficient as a matter of law to satisfy **<159 Or App 444/445>** claimant's burden of proving by clear and convincing evidence that the assault was the major contributing cause of her PTSD.[2] Also, they contend:

> "To prove the compensability of such a disorder, claimant must satisfy each of the elements of ORS 656.802(3). Among these elements is the requirement that claimant prove by 'clear and convincing evidence that the mental disorder arose out of and in the course of employment.' ORS 656.802(3)(d).
>
> "A condition arises out of employment under ORS 656.802 only if the claimant proves that employment conditions were the major contributing cause of the condition. ORS 656.802(1)(a), (2)(a); *Dethlefs v. Hyster Co.*, 295 Or 298, 309-10, 667 P2d 487 (1983). Accordingly, to satisfy paragraph (d) of ORS 656.802(3), claimant was required to prove by clear and convincing evidence that employment conditions were the major contributing cause of her condition." (Footnotes omitted.)

Before we can address SAIF's and employer's arguments, we must be able to ascertain the basis of the Board's ruling. In other words, for an order to be adequate for judicial review, we must be able to discern what the Board found as fact and why its findings led to its conclusions. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 752 P2d 312 (1988). SAIF's "bottom-line" argument is that the medical evidence does not satisfy claimant's burden of proof under ORS 656.802(3)(d). Although SAIF raised that issue in its brief to the Board, we are unable to determine from the Board's order whether it considered or decided that issue. The Board agreed with claimant that she had established by a "preponderance" of the medical evidence that PTSD had resulted from the assault. The Board also indicated that there was no "dispute" regarding the other requirements of ORS 656.802(3). In fact, there is a dispute. SAIF expressly raised the issue of whether claimant's proof of causation was clear and convincing under section 3(d). In light of the Board's opinion, we cannot determine whether the Board considered only the diagnosis of PTSD to be in dispute and issued its **<159 Or App 445/446>** order on that ground alone or whether it also considered the issue of whether claimant satisfied her burden under ORS 656.802(3)(d). Thus, the Board's order is inadequate for review.[3]

Reversed and remanded for reconsideration.

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[2] We understand the statutory term "clear and convincing" to mean that "the truth of the facts asserted must be highly probable." *Riley Hill General Contractor v. Tandy Corp.*, 303 Or 390, 407, 737 P2d 595 (1987).

[3] Because of our disposition of this case, we do not consider the substantive merits of SAIF's and employer's arguments or what effect ORS 656.802(3)(d) has on the major contributing cause standard of ORS 656.802(2)(a).

Cite as 159 Or App 464 (1999) April 7, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Bryan M. Fitzsimmons, Claimant.

SAIF CORPORATION and ISLAND CITY STEEL, Petitioners,
v.
BRYAN M. FITZSIMMONS, Respondent.
(96-08824; CA A101755)

Judicial Review from Workers' Compensation Board.
Argued and submitted on November 30, 1998.
David L. Runner argued the cause and filed the brief for petitioners.
R. Adian Martin argued the cause and filed the brief for respondent.
Before Edmonds, Presiding Judge, and Deits, Chief Judge,* and Armstrong, Judges.
EDMONDS, P. J.
Affirmed.

* Deits, C. J., *vice* Warren, J., retired.

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159 Or App 466> Insurer and employer seek review of a Workers' Compensation Board order in which the Board increased claimant's rate of temporary disability compensation. We review for errors of law, ORS 656.298(7), and affirm.

Claimant injured his elbow and filed a workers' compensation claim with his employer. After an initial denial, insurer accepted the claim and paid claimant temporary disability compensation based on a 52-week average wage of $247.67. Thereafter, insurer issued a notice of closure, and claimant requested reconsideration on several issues but did not specifically raise the issue of the *rate* of compensation. After the request for reconsideration, insurer sent an explanation of its calculations to claimant. The Department of Consumer and Business Services (Department) affirmed the insurer's notice of closure in all respects.

Claimant requested a hearing and raised the issue of the compensation rate for the first time. The administrative law judge (ALJ) concluded that claimant's failure to raise the issue of the compensation rate on reconsideration precluded him from raising it at the hearing under ORS 656.283(7). On review, the Board disagreed and then concluded that insurer had improperly calculated the rate of temporary disability under the version of OAR 436-60-025(5)(a) in effect at the time of claimant's injury.

Insurer first assigns error to the Board's conclusion that claimant was not precluded from raising the rate issue at hearing. Insurer argues that the payment of compensation at a particular rate was sufficient to put claimant on notice and that, because the issue was not raised on reconsideration, claimant is precluded under 656.283(7) from raising the issue at hearing.[1] Claimant asserts that the reconsideration process is not a bar to issues that are not manifest in the notice of closure and that the notice did not specify the compensation rate.

159 Or App 467> ORS 656.283(7) provides, in relevant part:

> "Evidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, and issues that were not raised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself."

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[1] Insurer does not argue that claimant received sufficient information to raise the rate issue while reconsideration was pending before the department and before the notice of closure was affirmed.

Claimant argues that the facts in this case are not distinguishable from those in *Venetucci v. Metro*, 155 Or App 559, 964 P2d 1090 (1998). In that case, the claimant requested a hearing after receiving a letter from the insurer notifying her that compensation had been overpaid. Even though the issue of overpayment was not raised on reconsideration, we held that it could be litigated at hearing because the objection was not to an issue raised at closure. Instead, the objection was to an issue raised in the letter, and the rate of compensation had not been manifest in the notice of closure. *Venetucci*, 155 Or App at 564. Therefore, the claimant in *Venetucci* was not precluded by ORS 656.283(7) from objecting at hearing to the rate of compensation.

Here, neither the rate nor the method of calculation was specified in the notice of closure. The notice informed claimant of the number of days of total disability and the total amount of temporary disability paid before closure. Although insurer argues that the facts in this case can be distinguished from the facts in *Venetucci*, we are not persuaded that those distinctions make any difference. As in *Venetucci*, the notice of closure did not make the rate of compensation manifest. Accordingly, the Board did not err when it held that claimant was not precluded by ORS 656.283(7) from raising the issue of the *rate* of compensation at hearing.

The next issue is whether the Board's interpretation of OAR 436-60-025(5)(a) (WCD Order 94-055), as applied to the facts in this case, is correct. That rule provides, in part:

> "(5) The rate of compensation for workers regularly employed, but paid on other than a daily or weekly basis, or employed with unscheduled, irregular or no earnings shall be computed on the wages determined by this rule. * * *
>
> "(a) For workers employed on call, paid hourly, paid by piece work or with varying hours, shifts or wages, insurers **<159 Or App 467/468>** shall use the worker's average weekly earnings with the employer at injury for the 52 weeks prior to the date of injury. For workers employed less than 52 weeks or where *extended gaps* exist and where there has been no change in the amount or method of the wage earning agreement, insurers shall use the actual weeks of employment with the employer at injury up to the previous 52 weeks. Where there has been a change in the amount or method of the wage earning agreement during the previous 52-week period, insurers shall use only the actual weeks of employment under the wage earning agreement at time of injury. For workers employed less than four weeks, insurers shall use the intent of the most recent wage earning agreement as confirmed by the employer and the worker." (Emphasis added.)

The facts are not in dispute. Claimant's injury occurred on September 2, 1995. He worked during all of the 52 weeks before his injury with the exception of 15 weeks between December 6, 1994 to April 1, 1995 due to a "regular, seasonal layoff." Claimant's wages totaled $12,879 for the 52-week period before his injury. Insurer determined his compensation rate by dividing the total by 52 and arriving at an average weekly wage of $247.67. The Board concluded that under the rule, the 15-week layoff constituted an "extended gap" and that the 15 weeks had to be excluded from the calculation. As a result, the Board divided the total wages by 37 weeks to arrive at an average weekly wage of $348.08.

Whether insurer or the Board's calculation is correct turns on the meaning of "extended gap" and the purpose of the rule. Insurer views the rule as providing for an average wage loss. The Board interprets the rule to approximate the worker's wage at the time of injury. In interpreting an administrative rule, our task is to determine the meaning of the words used, giving effect to the intent of the enacting body. *Abu-Adas v. Employment Dept.*, 325 Or 480, 485, 940 P2d 1219 (1997). We begin with the text and context of the rule. Context includes "other provisions of the same rule, other related rules, the statute pursuant to which the rule was created, and other related statutes." *Abu-Adas*, 325 Or at 485.

159 Or App 469> The first sentence of OAR 436-60-025(5)(a) contemplates that an hourly worker's wages be calculated by averaging weekly earnings for the 52 weeks before the injury. The second sentence creates two exceptions to that rule: (1) if the worker was employed for less than 52 weeks, or (2) if "extended gaps" in employment occurred, then the insurer is obligated to calculate an average wage by using the "actual weeks of employment * * * at injury." If the worker's hourly wage has changed during the applicable period, the third sentence requires an insurer to use only the weeks at the most recent wage "at the time of injury." Finally, the last sentence provides for using the intent of

the "most recent wage earning agreement" to arrive at an hourly wage for a worker employed less than four weeks. While the text of the rule does not define "extended gap," it consistently provides for methods to calculate the wage at the time of injury when less than a 52-week work period is applicable.[2]

The above purpose of the rule is consistent with the legislature's mandate. OAR 436-60-025(5)(a) was promulgated pursuant to ORS 656.210, which provides:

> "(1) When the total disability is only temporary, the worker shall receive during the period of that total disability compensation equal to 66-2/3 percent of wages, but not more than 100 percent of the average weekly wage nor less than the amount of 90 percent of wages a week or the amount of $50 a week, whichever amount is lesser. * * *
>
> "(2)(a) For the purpose of this section, the weekly wage of workers shall be ascertained by multiplying the daily wage the worker was receiving by the number of days per week that the worker was regularly employed.
>
> "(b) For the purpose of this section:
>
> **159 Or App 470>** "(A) *The benefits of a worker who incurs an injury shall be based on the wage of the worker at the time of injury.*
>
> "* * * * *
>
> "(c) *As used in this subsection, 'regularly employed' means actual employment or availability for such employment. For workers not regularly employed and for workers with no remuneration or whose remuneration is not based solely upon daily or weekly wages, the Director of the Department of Consumer and Business Services, by rule, may prescribe methods for establishing the worker's weekly wage.*" (Emphasis added.)

The statute's focus is on the wage at the time of injury. *See Hadley v. Cody Hindman Logging*, 144 Or App 157, 161, 925 P2d 158 (1996) (holding that "ORS 656.210(2)(b)(A) contains a clear expression of a legislative policy to pay injured workers benefits based on the wage of the worker at the time of injury"). The rule is aimed at proving a method of "approximating the wage amount at the time of injury," *id.* at 160, when there is less than a 52-week work period involved. The term "extended gap" in the rule need not correlate to an exact number of days nor to a list of narrow, specific circumstances. Rather, it can have an elastic meaning as long as the application of the term accomplishes what the legislature intended. We hold that the Board's application of the "extended gap" exception to the circumstances of this case falls within the ambit of the rule's purpose to provide claimant with a benefit based on his wage at the time of his injury.

Affirmed.

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[2] We note that insurer acknowledges in its brief on review that it has been unable to find any legislative or administrative history that is helpful in construing "extended gap." The Board has also stated that it could not find guidance in the rule adoption documents. *Ken T. Dyer*, 49 Van Natta 2086, 2087 (1997). At oral argument, insurer suggested that the Director of the Department of Consumer and Business Services had submitted a brief to the Board that provided guidance. See Workers' Compensation Division's Brief on Remand, *Earin J. Hadley*, 49 Van Natta 1101 (1997) (WCB No. 95-01763). Upon review, we conclude that the Attorney General's "argument" on behalf of the Director in that brief does not aid the interpretation of the rule.

Cite as 159 Or App 604 (1999) April 14, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Nadine D. Shook, Claimant.

NADINE D. SHOOK, Petitioner,
v.
PACIFIC COMMUNITIES HOSPITAL and SAIF CORPORATION, Respondents.
(WCB No. AF-97028; CA A101848)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 21, 1999.
Christine I. Jensen argued the cause for petitioner. With her on the brief was Malagon, Moore & Jensen.
David L. Runner argued the cause and filed the brief for respondents.
Before De Muniz, Presiding Judge, and Haselton and Linder, Judges.
HASELTON, J.
Affirmed.

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159 Or App 606> Claimant seeks review of the Workers' Compensation Board's denial of "out-of-compensation" attorney fees pursuant to ORS 656.386(2).[1] She contends that her attorney's services in noncontested case proceedings before the Director of the Department of Consumer and Business Services (DCBS) resulted in an "increase in the claimant's compensation" in that the Director approved claimant's back surgery, which, in turn, yielded an automatic award of permanent partial disability benefits. OAR 436-035-0350(2). We conclude that ORS 656.385(5) and ORS 656.388(1) precluded the Board from awarding fees and, thus, affirm.

Claimant suffered a compensable back injury in February 1996. Her treating physician requested authorization for back surgery. In September 1996, the insurer, SAIF Corporation, requested that the Director of DCBS review the matter, contending that the surgery was not reasonable or necessary. ORS 656.327(1)(a). On March 3, 1997, the Medical Review Unit (MRU) issued an order determining that SAIF was not required to pay for the proposed surgery. Claimant requested review of that determination, and a hearing was set for June 2, 1997. However, before the hearing occurred, claimant underwent the proposed surgery. Following that surgery, which included a lumbar microdiscectomy, the matter was remanded to the MRU to reassess its determination in the light of surgical and postsurgical information.

Ultimately on October 12, 1997, following the MRU's review and determination that the surgery had resolved claimant's symptoms, the Director issued an order concluding that the surgery "was appropriate * * * and SAIF was liable for that procedure." As a result of the Director's order, claimant was entitled to an automatic award of nine percent permanent partial disability benefits pursuant to **<159 Or App 606/607>** OAR 436-035-0350.[2] The Director's final order did not award claimant attorney fees.

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[1] ORS 656.386(2) provides: "In all other cases [cases not governed by subsection (1)], attorney fees shall be paid from the increase in the claimant's compensation, if any, except as otherwise expressly provided in this chapter."

[2] OAR 436-035-0350 provides, in part:

"(2) For purposes of this section, the cervical, thoracic, and lumbosacral regions are considered separate body parts. Values determined within one body part are first added, then the total impairment value is obtained by combining the different body part values. The following values are for surgical procedures performed on the spine.

	% Impairment		
"1st Surgical Procedure involving one disc and/or up to 2 vertebrae	Cervical	Thoracic	Lumbosacral
	8%	4%	9%"

In November 1997, claimant's attorney filed a request for hearing with the Workers' Compensation Hearings Division, asserting an entitlement to fees under ORS 656.383(2). That request described counsel's considerable efforts in "establishing claimant's right to surgery" and requested approval of a 25 percent attorney fee out of claimant's permanent partial disability award "that is directly due to the surgery."

The ALJ denied fees. The Board affirmed that denial, concluding that, because "the compensation [was] not awarded or approved by the Hearings Division or the Board, neither the ALJ nor the Board has the authority to approve an out-of-compensation attorney fee."

On review, claimant reiterates that her attorney is entitled to out-of-compensation fees pursuant to ORS 656.386(2) because her counsel's efforts before the Director yielded an "increase in compensation" in that the Director's approval of the surgery resulted in the automatic award of permanent partial disability benefits. SAIF does not dispute claimant's factual premise that her attorney's efforts may have contributed to her receipt of increased compensation. SAIF contends, however, that that premise is legally immaterial because ORS 656.385(5) and ORS 656.388(1) preclude the Board from awarding fees in these circumstances.

159 Or App 608> ORS 656.385 provides, in part:

> "(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 in a contested case order by 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, after a contested case hearing request by the claimant, where an attorney is instrumental in obtaining a settlement of the dispute prior to a decision by the director, the director may require the insurer or self-insured employer to pay a reasonable attorney fee to the claimant or claimant's attorney.
>
> "* * * * *
>
> "(5) Notwithstanding any other provision in ORS 656.382 or 656.386, an Administrative Law Judge or the Workers' Compensation Board may not award penalties or attorney fees for matters arising under the review jurisdiction of the Director."

ORS 656.388(1) provides, in part:

> "No attorney fees shall be approved or allowed for representation of the claimant before the managed care organization or Director of the Department of Consumer and Business Services except for representation at the contested case hearing."

SAIF contends that those statutes, in combination, express and effectuate two overarching legislative policies. First, attorneys who represent claimants in medical services matters are to be compensated *only* for those services that are rendered in the context of contested case proceedings. Second, only the Director can award fees for services rendered "in matters arising under the review jurisdiction of the Director." SAIF further argues that those policies either individually, or together, bar an award of fees under ORS 656.386(2). *See* ORS 656.385(5) ("Notwithstanding any other provision in * * * ORS 656.386 * * *."). Claimant counters that ORS 656.385(5) is inapposite because the basis for her alleged entitlement to fees is "the future permanent [partial] disability benefits flowing from the surgery the Director ordered, not for the surgery itself"--and the former, claimant **<159 Or App 608/609>** asserts, is not a "matter[] arising under the review jurisdiction of the Director."

Claimant's position is not without practical appeal. It is likely that counsel's efforts did, in fact, contribute to claimant's ultimate receipt of permanent partial disability compensation. But, as a legal matter, claimant's position cannot be squared with the statutes: The representation occurred solely before the Director, not the Hearings Division; the services were not rendered in the context of a contested case proceeding; and the subject of the representation, the appropriateness and necessity of the back surgery, was a matter uniquely within the Director's review jurisdiction. The entitlement to permanent partial disability benefits was never litigated before the Director (as, indeed, it could not have been) but, instead, flowed automatically, as a matter of law, from the operation of OAR 436-035-0350. In those circumstances, ORS 656.385(5) and ORS 656.388(1) preempted and precluded the Board from awarding "out-of-compensation" fees.

Affirmed.

Cite as 159 Or App 663 (1999) April 14, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Barbara Johnson, Claimant.

BARBARA JOHNSON, Petitioner,
v.
EASTERN OREGON STATE COLLEGE and SAIF CORPORATION, Respondents.
(WCB Nos. 95-07224, 95-05888; CA A98381)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 22, 1998.

Dale C. Johnson argued the cause for petitioner. With him on the brief was Malagon, Moore, Johnson & Jensen.

David L. Runner, Special Assistant Attorney General, argued the cause for respondents. With him on the brief were Hardy Myers, Attorney General, and Michael D. Reynolds, Solicitor General.

Before Landau, Presiding Judge, and Deits, Chief Judge, and Wollheim, * Judge.

PER CURIAM

Affirmed.

* Wollheim, J., *vice* Riggs, P. J., resigned.

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159 Or App 664> Claimant seeks review of an order of the Workers' Compensation Board reversing an Administrative Law Judge's (ALJ) order awarding claimant permanent total disability for her work-related condition. She assigns error to the Board's holding that the ALJ erred in considering vocational expert testimony and claimant's testimony regarding her motivation to seek work on the ground that the evidence had not been offered in the reconsideration proceeding before the Department of Consumer and Business Services (DCBS). ORS 656.283(7).

Claimant's first contention, that the procedure set forth in ORS 656.283(7) violates her right to due process under the Fourteenth Amendment of the United States Constitution, has been addressed and rejected in *Koskela v. Willamette Industries, Inc.*, 159 Or App 229, ___ P2d ___ (1999). Claimant failed to preserve her second assignment of error before the Board that *retroactive* application of ORS 656.283(7) violated her federal constitutional right to due process. Accordingly, we do not address it.

Affirmed.

Cite as 160 Or App 1 (1999) April 21, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

ROBERT D. GRAHAM, Appellant,
v.
BRIX MARITIME CO., a Delaware corporation doing business as FOSS MARITIME CO., Respondent,
and FOSS MARITIME CO., Defendant.
(9508-05510; CA A95063)

Appeal from Circuit Court, Multnomah County.
Ellen F. Rosenblum, Judge.
Argued and submitted May 20, 1998.
Robert K. Udziela argued the cause for appellant. With him on the briefs was Pozzi Wilson Atchison.
Jay W. Beattie argued the cause for respondent. With him on the brief was Thomas E. McDermott and Lindsay, Hart, Neil & Weigler, LLP.
Before Edmonds, Presiding Judge, and Deits, Chief Judge, and Armstrong, Judge.
DEITS, C. J.
Affirmed.

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160 Or App 3> Plaintiff was injured while working as a deckhand on the tugboat *Lewiston*, which is owned and operated by defendant Brix Maritime Co. He brought this action under the Jones Act, 46 USC section 688, stating claims based on negligence and unseaworthiness. Defendant interposed an affirmative defense of contributory negligence. In response to a special verdict form, the jury found for defendant on the allegations of both of plaintiff's claims and, therefore, did not reach the affirmative defense in connection with either. Plaintiff appeals and makes four assignments of error. We find that only his first and last assignments merit discussion. We affirm.

Plaintiff contends in his first assignment that the trial court erred by excluding portions of the deposition of one of the boat's captains, Stu Richard, that plaintiff sought to introduce as substantive evidence. ORS 45.250 provides, in relevant part:

> "(1) At the trial or upon the hearing of a motion or an interlocutory proceeding, any part or all of a deposition, so far as admissible under the rules of evidence, may be used against any party who was present or represented at the taking of the deposition or who had due notice thereof, in accordance with any of the following provisions of this subsection:
>
> "* * * * *
>
> "(b) The deposition of a party, or of anyone who at the time of taking the deposition was an officer, director or managing agent of a public or private corporation, partnership or association which is a party, may be used by an adverse party for any purpose.
>
> "(2) At the trial or upon the hearing of a motion or an interlocutory proceeding, any part or all of a deposition, so far as admissible under the rules of evidence, may be used against any party for any purpose, if the party was present or represented at the taking of the deposition or had due notice thereof, and if the court finds that:
>
> "* * * * *
>
> 160 Or App 4> "(c) The party offering the deposition has been unable to procure the attendance of the witness by subpoena[.]"

Plaintiff contends that Richard, as a captain of the boat, was a "managing agent" of defendant, within the meaning of ORS 45.250(1)(b). Alternatively, he argues that, because Richard lives in Washington state, is frequently away at sea, and was apparently away during part of the trial, his

attendance could not be procured by subpoena for purposes of ORS 45.250(2)(c).[1] We conclude that plaintiff did not establish that the deposition evidence was admissible on either basis.

Plaintiff relies on *Rich v. Tite-Knot Pine Mill*, 245 Or 185, 421 P2d 370 (1966), as support for his "managing agent" theory. The court held in that case that the deposition of the defendant's mill superintendent was admissible under ORS 45.250(1)(b), and explained:

> "Defendant was a corporation and in so far as the evidence discloses had no plant or activity other than the one with which we are concerned. The superintendent was in charge of both the day and the night shifts." *Rich* at 201.

Richard's role in defendant's operations here was not comparably prominent. Defendant is a foreign corporation. Its business operations in Oregon were not limited to the single boat on which plaintiff served. Moreover, Richard did not have complete preeminence even on that boat. The *Lewiston* was operated as a double-crewed tugboat, with two captains and two deckhands, respectively, working alternating shifts.

Black's Law Dictionary 59 (5th ed 1979), defines "managing agent" as:

> "A person who is invested with general power, involving the exercise of judgment and discretion, as distinguished from an ordinary agent or employee, who acts in an inferior capacity, and under the direction and control of superior authority, both in regard to the extent of the work and the manner of executing the same. One who has exclusive supervision and control of some department of a corporation's business, the management of which requires of such **<160 Or App 4/5>** person the exercise of independent judgment and discretion, and the exercise of such authority that it may be fairly said that service of summons upon him will result in notice to the corporation."

Because ORS 45.250(1)(b) relates to corporations and other business associations, the second sentence of *Black's* definition comes closer than the first to capturing the legislature's probable intended meaning. *See Steele v. Employment Department*, 143 Or App 105, 113, 923 P2d 1252 (1996), *aff'd* 328 Or 292, ___ P2d ___ (1999). Moreover, the statute makes "managing agents" the only corporate personnel to whom it applies other than the corporation's general officers and directors. The import is that "managing agent" refers to a person who enjoys substantial rank and authority. We do not understand the term to encompass an employee like Richard whose status was shown to be nothing more than outranking one other employee and possessing some level of authority over one small corporate operation. We conclude that Richard was not a "managing agent" of defendant, within the meaning of ORS 45.250(1)(b), and that the deposition was not admissible by reason of that provision.

Similarly, we conclude that the trial court did not err in ruling that the evidence was not made admissible by ORS 45.250(2)(c), on the theory that plaintiff was unable to procure Richard's attendance by subpoena. Plaintiff relies on the Supreme Court's decision in *Hansen v. Abrasive Engineering and Manufacturing*, 317 Or 378, 856 P2d 625 (1993), and explains his understanding of that case, as follows:

> "[O]nce a party establishes that the witness resides out of state, there is no further inquiry required regarding the party's reasonableness in attempting to procure the witness for trial. If the witness lives out of state, the witness is unavailable under ORS 45.250(2)(c), and the deposition testimony is admissible."

We do not agree with plaintiff's understanding of *Hansen*. The question there, as stated by the court, was

> "whether ORS 45.250(2), which refers only to unavailability to service of a subpoena, limits the requirement of OEC 804(1)(e) that a proponent also must demonstrate that some 'other reasonable means' in addition to issuance of a **<160 Or App 5/6>** subpoena were employed to secure the witness." 317 Or at 390.

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[1] The parties appear to agree that Richard was not *in fact* served with a subpoena.

The court concluded that the "other reasonable means" requirement of OEC 804 is inapplicable when deposition evidence qualifies for admission under ORS 45.250(2)(c), but it did not hold that the "unavailability to service of a subpoena" requirement of the statute itself is not a prerequisite to the admission of the evidence, nor did it hold that a witness who lives out of state is *per se* unamenable to service of a subpoena.[2]

Notwithstanding his out-of-state residence and absences at sea, Richard was in Oregon on a regular basis in connection with his work for defendant. Moreover, there was evidence that a trial date had been set and that a subpoena could have been served on him on the day of the deposition itself.[3] The trial court could and did find that Richard's attendance could have been secured by subpoena. Therefore, the deposition evidence was not admissible under ORS 45.250(2)(c). We reject plaintiff's first assignment of error.

In his last assignment, plaintiff asserts that the court erred by refusing to give the following requested instruction:

> "I instruct you that, as a seaman, plaintiff's duty was to do his work as he was directed. He was not obligated to protest against any method of operation which he had been instructed to follow or to devise a safer method, nor was he obligated to call for additional or different equipment."

The requested instruction was derived from federal case law dealing with the defense of contributory negligence in actions under the Jones Act and other federal statutes that, for purposes of the analysis here, are analogous. *E.g.*, **<160 Or App 6/7>** *Fashauer v. New Jersey Transit Rail Operations*, 57 F3d 1269, 1276-80 (3rd Cir 1995); *Merchant v. Ruhle*, 740 F2d 86, 88 (1st Cir 1984). Under those cases and on its face, the instruction is pertinent only to defendant's contributory negligence/comparative fault affirmative defense. However, the jury found that defendant was not negligent and that the vessel was not unseaworthy as alleged by plaintiff. Therefore, it did not reach the question of plaintiff's alleged negligence or fault in connection with either theory of liability. Consequently, the refusal to give the instruction, if error, was harmless.

Affirmed.

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[2] Nor did we so suggest in our opinion in *Hansen*, 112 Or App 586, 831 P2d 693 (1992), *rev'd in part on other grounds*, 317 Or 378, 856 P2d 625 (1993), on which plaintiff also appears to rely. Our reasoning and holding on the issue in question were in general accord with those later reached by the Supreme Court. We noted, in particular, that "the witnesses here were out of state *and unavailable to process*." 112 Or App at 594 (emphasis added).

[3] The trial was set over to a later date. However, that does not alter the capability of the fact to support the trial court's finding that Richard *could* have been served.

Cite as 160 Or App 55 (1999) April 21, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Phyllis M. Hays, Claimant.

PHYLLIS M. HAYS, Petitioner,
v.
TILLAMOOK COUNTY GENERAL HOSPITAL and GAB ROBINS NORTH AMERICAN, INC.,
Respondents.
(WCB 95-13427; CA A102275)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 15, 1998.
Kevin Keaney argued the cause for petitioner. With him on the brief was Willner Keaney Mata & U'ren, LLP.
Nancy J. Meserow argued the cause and filed the brief for respondents.
Before Edmonds, Presiding Judge, and Armstrong and Kistler,* Judges.
KISTLER, J.
Affirmed.

*Kistler, J., *vice* Warren, P.J., retired.

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160 Or App 57> The Workers' Compensation Board reduced the amount of attorney fees the administrative law judge (ALJ) awarded claimant. On review, claimant argues that the Board should not have decided whether the ALJ's fee award was excessive because employer failed to make a timely objection to her fee request. We affirm.

Employer denied claimant's request for workers' compensation because it concluded that her claims were not compensable. After a hearing before the ALJ, the parties submitted written closing arguments. In her closing argument, claimant primarily addressed compensability. She also "request[ed] a reasonable attorney fee based upon the statement of services Claimant's counsel will file when appropriate." In its response, employer did not object to claimant's request for a reasonable attorney fee if the ALJ found her claims were compensable. In rebuttal, claimant stated for the first time that she was asking for "an extraordinary assessed attorney fee" of $28,250. She explained that her attorney fee request was based in part on an hourly rate of $250. No further arguments were submitted to the ALJ. The ALJ found that the claim was compensable. The ALJ also awarded claimant the full amount of the attorney fees she requested, noting that her fee request was "uncontested."

Employer sought review of the ALJ's order. Before the Board, employer argued, among other things, that even if the claim were compensable, the ALJ's fee award was excessive. After considering the parties' arguments, the Board upheld the ALJ's determination that the claim was compensable. It agreed that claimant was entitled to an award of attorney fees but found that the fee the ALJ had awarded was too high. Specifically, the Board found that an hourly rate of $175 rather than $250 was appropriate. It accordingly reduced the fee award to $19,775.

Claimant petitioned for reconsideration. She argued for the first time that the question whether the fee award was excessive was not properly before the Board because employer had failed to object to her fee request before the **<160 Or App 57/58>** ALJ. On reconsideration, the Board explained that, as a matter of statute, it has "*de novo* review authority and may reverse or modify the ALJ's order or make any disposition of the case [it] deem[s] appropriate." The Board recognized that even though it had statutory authority to reach unpreserved issues, it had "consistently refused to consider issues raised for the first time on Board review." The issue, as the Board framed it, was whether a request for or an objection to attorney fees under ORS 656.386(1) should be an exception to that general rule. The Board concluded that it should, reasoning:

> "This case is distinguishable from *Fister* [*v. South Hills Health Care*, 149 Or App 214, 942 P2d 833 (1997)]. While the issue in Fister was the admissibility of evidence, the issue in the instant case is entitlement to an attorney fee under ORS 656.386(1). We have previously held that a represented claimant's entitlement to assessed attorney fees under

> ORS 656.386(1) is the 'natural derivative' of a determination that the claimant prevailed over a denied claim. For this reason, we have not required that a represented claimant 'preserve' entitlement to attorney fees as a separate issue at a hearing concerning the compensability of a denied claim. If a represented claimant prevails over a denial at hearing, we have held that his entitlement to an assessed attorney fee for his counsel's efforts at hearing is an automatic result of the compensability determination.
>
> "Because a represented claimant is not required to 'preserve' the issue of attorney fees at a hearing concerning a compensability determination, we have treated the issue of attorney fees (for prevailing over a denied claim) as an exception to our general practice of considering only issues raised by the parties at hearing. *See Wray A. Renfro*, 49 Van Natta at 1752 n 2. For this reason, we likewise treat the 'excessive fee' defense as an exception to our general practice as well. That is, if a represented claimant prevails over a denied claim at hearing, and submits a statement of services and/or attorney fee petition for services at hearing, the carrier need not 'preserve' at the hearing its defense that the fee amount requested was excessive. Rather, we conclude that the carrier may raise its 'excessive fee' defense for the first time on Board review of the ALJ's fee award."

(Some citations omitted.) The Board accordingly denied claimant's petition for reconsideration.

160 Or App 59> On review, claimant argues that the Board should not have reached the question whether the ALJ's fee award was excessive.[1] She does not argue that either a statute or a rule limits the Board's ability to reach an unpreserved issue.[2] Rather, she claims that the Board's decision in this case impermissibly departs from its earlier decisions. Starting from the proposition that the Board has consistently declined to reach unpreserved issues, she argues that its decision to do so here is contrary to this court's decision in *Fister* as well as the Board's own decisions.

Claimant's argument raises two related but separate issues. She argues initially that our decision in *Fister* precludes the Board from considering any issue that was not presented to the ALJ. Claimant reads *Fister* too broadly. In *Fister*, this court recognized that "[t]he Board's own precedent establishes the rule that it will consider only issues raised by the parties at the hearing." 149 Or App at 218. The court also recognized that the Board is bound to follow its own precedent unless it "set[s] forth an adequate reason for deviating from that well-established practice." *Id.* at 218-19. *Fister* thus requires that once the Board has announced a policy in the course of issuing a decision, it must follow that policy in future decisions. *Fister* leaves open, however, the possibility that the Board, much like a court, may recognize exceptions to its precedent, distinguish them, or even reverse them as long as it "set[s] forth an adequate reason" for doing so. *See also* ORS 183.482(8)(b)(B).[3] To the extent claimant **<160 Or App 59/60>** views *Fister* as an absolute bar to the Board's order here, she misperceives what *Fister* says.

Claimant argues alternatively that the Board erred in relying on its decision in *Wray A. Renfro*, 49 Van Natta 1751 (1997), to resolve her petition for reconsideration. In claimant's view, the Board's decision in *Renfro* and its decision here are inconsistent with its earlier decision in *James D. Lollar*, 47 Van Natta 740, *on recons* 47 Van Natta 878 (1995). The difficulty with claimant's argument is its premise: As the Board has explained them, its decisions in *Lollar* and *Renfro* are consistent.

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[1] Claimant does not argue that if the Board properly considered the employer's objection, it erred in reducing the fee award. Similarly, employer has not cross-petitioned for review of the Board's order holding that the claim was compensable.

[2] The ALJ relied on OAR 438-006-0045 for the proposition that the insurer had 10 days in which to file an objection to claimant's request for attorney fees. That rule applies generally to pre-hearing and post-hearing motions, not specifically to requests for assessed attorney fees. The Board apparently did not find the rule applicable to this situation, and claimant has not argued in this court that the rule applies.

[3] The court's reasoning in *Fister* is consistent with ORS 183.482(8)(b)(B), which sets out the standard of review when a litigant claims that the Board's order is inconsistent with its earlier decisions. *See* ORS 656.298(7) (making ORS 183.482(7) and (8) applicable to judicial review of Board orders); *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988) (same). ORS 183.482(8)(b)(B) provides that the court "shall remand the order to the agency if it finds the agency's exercise of discretion to be * * * [i]nconsistent with * * * an officially stated agency position, or a prior agency practice, if the inconsistency is not explained by the agency[.]" As in *Fister*, the standard of review set out in ORS 183.482(8)(b)(B) requires consistency with "an officially stated agency position" *unless* the agency explains the reasons for its new course.

In *Lollar*, SAIF had denied responsibility for the claimant's condition, and the claimant's actions resulted in SAIF's rescission of its denial before the hearing. In deciding whether the claimant was entitled to attorney fees under ORS 656.386(1), the Board explained that the issue turned on whether SAIF's denial of responsibility had also raised an issue of compensability. 47 Van Natta at 740. If it had, the claimant was entitled to fees. If it had not, the claimant was not entitled to fees. The Board initially concluded that SAIF's denial of responsibility had "raise[d] issues of compensability" and that the claimant was thus entitled to fees. *Id.*

On reconsideration, the Board observed that the "claimant's attorney [had] agreed without objection that the only issue at hearing was responsibility." 47 Van Natta at 878. Moreover, the claimant had not contended before the ALJ that "SAIF's denial raised compensability issues [nor had] he sought an attorney fee for obtaining rescission of a compensability denial prior to hearing." *Id.* As the parties had framed the issue before the ALJ, the issue was not one for which the claimant could recover fees under ORS 656.386(1). Given that procedural posture, the Board held that the claimant could not change positions and argue for the first time before the Board that the issue was one for which, if the claimant prevailed, he would be entitled to fees under ORS 656.386(1).

160 Or App 61> Two years later, the Board faced a different issue in *Renfro*. In that case, the claimant sought an award of assessed attorney fees under ORS 656.386(2). There was no question that the issue litigated before the ALJ was one that would entitle the claimant to assessed attorney fees if he prevailed. The only question was whether the claimant should have requested attorney fees sooner than he did. *See* 49 Van Natta at 1751. In resolving that question, the Board reasoned that a claimant's entitlement to an assessed fee under ORS 656.386(1) is a "natural derivative" of a compensability determination. *Id.* If the ALJ holds that a denied claim is compensable, it follows that the claimant is entitled to recover a reasonable assessed attorney fee. The same is true under ORS 656.386(2) if the ALJ declines to reduce a claimant's award of compensation. The Board explained that where an assessed fee is a natural derivative of the issue raised at the hearing, the claimant need not seek attorney's fees before the ALJ. *Id.* It is sufficient if the claimant raises the fee request before the Board. *Id.*

The distinction between *Lollar* and *Renfro*, as the Board explained it, turns on the nature of the issue a claimant raises at the hearing. The Board reasoned in *Renfro*:

> "In reaching this conclusion, we distinguish *James D. Lollar.* There, the claimant obtained rescission of the compensability portion of the carrier's denial. We concluded, however, that the claimant was not entitled to an attorney fee award pursuant to ORS 656.386(1) where he did not seek attorney fees pursuant to that statute until after the hearing. We noted that the parties had characterized the denial as a responsibility denial, and that there was no contention at hearing that the denial raised compensability issues or that the claimant was entitled to a '386(1)' attorney fee. 47 Van Natta at 879.
>
> "Unlike *Lollar*, where, in the context of a responsibility denial, the claimant sought an attorney fee pursuant to ORS 656.386(1) after the hearing based on an allegation that the denial raised a compensability issue, claimant in this case did not raise a new issue as a basis for his request for an assessed fee under ORS 656.382(2). Under these circumstances, we do not find *Lollar* to be controlling."

Renfro, 49 Van Natta at 1751.

160 Or App 62> Given the distinction the Board drew in *Renfro*, we cannot say that its decision in *Renfro* is inconsistent with its decision in *Lollar*. Similarly, we cannot say that the Board's decision in this case is inconsistent with *Lollar*. In this case, claimant successfully contested employer's denial of compensability. Under the Board's decision in *Renfro*, her entitlement to an assessed attorney fee under ORS 656.386(1) was a "natural derivative" of the issue before the ALJ, and she was not required to assert her right to attorney fees before the ALJ in order to recover them. Following *Renfro*, the Board reasonably extended the rationale in that decision to employer's objection to her fee request.

Affirmed.

Cite as 160 Or App 77 (1999) April 21, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Stanley M. Shaw, Deceased, Claimant.

MICHELLE SHAW, Beneficiary of the Estate of Stanley M. Shaw, Deceased, Petitioner,
v.
STEINFELDS PRODUCTS, INC., and LIBERTY NORTHWEST INSURANCE COMPANY, Respondents.
(97-08533; CA A102622)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 26, 1999.
Susan L. Frank argued the cause and filed the brief for petitioner.
Alexander D. Libmann argued the cause and filed the brief for respondents.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
WARREN, S. J.*
Reversed and remanded for reconsideration.

* Retired March 1, 1999.

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160 Or App 79> Claimant, an injured worker's surviving spouse, seeks review of an order of the Workers' Compensation Board holding that she is not entitled to benefits for the worker's permanent partial disability because the worker died of unrelated causes before becoming medically stationary and at the time of death did not suffer from any "irreversible impairment findings." We hold that the Board's order is based on an administrative rule that is inconsistent with ORS 656.218, and we accordingly reverse the Board and remand for reconsideration.

The worker shattered the bones of his right foot and broke his left foot when he fell off a ladder while working for employer as a mustard maker. Employer's insurer accepted a claim for bilateral heel fractures. The worker eventually returned to regular work but experienced increased foot pain when he had to apply the brakes of his car. His doctor took him off work for ten days and then released him for light duty work. While at home, and before his injuries had become medically stationary, the worker died of heart disease. A medical arbiter determined that, if the worker had lived, he would have suffered permanent disability from loss of range of motion and loss of use of his right ankle and that he would have been unable to walk or stand more than two hours in an eight hour period.

A determination order awarded claimant benefits for time loss only and no permanent disability. Claimant sought reconsideration. Relying on a department administrative rule, OAR 436-035-0007(23)(b)(A), the appellate reviewer determined that, because the worker had died of unrelated causes before his injury had become medically stationary, claimant was entitled to benefits only for "irreversible impairment findings." Concluding that the record did not demonstrate such impairment, the reviewer upheld the determination order.[1]

160 Or App 80> The department's ruling was upheld at each level of review. The Board, in affirming the administrative law judge's order, also relied on OAR 436-035-0007(23)(b)(A), which provides, in part:

> "(23) If the worker dies due to causes unrelated to the accepted conditions of the claim, the following applies:
>
> " * * * * *
>
> "(b) *When all compensable conditions are not medically stationary pursuant to OAR 436-030-0035 at the time of death,* the following applies:

---

[1] In its order on reconsideration, the department's appellate reviewer noted that she had considered "leg shortening" as a potentially applicable irreversible finding but had eliminated it, because the medical arbiters had indicated that no leg shortening was expected.

> "(A) Only those impairment findings that are irreversible and are addressed by these rules shall be rated[.]
>
> * * * * * *
>
> "(d) For purposes of this section 'irreversible findings' are defined in subsection (2)(d) of this rule." (Emphasis added.)

OAR 436-035-0007(2)(d) lists 30 irreversible findings of impairment, including knee angulation, length discrepancy, meniscectomy, patellectomy, joint replacements, amputations, fused joints, and loss of opposition. The listed conditions are those that were in existence before the worker's death and for which fixed impairment ratings are set forth in the director's rules.

Citing *Shubert v. Blue Chips*, 151 Or App 710, 951 P2d 172 (1997), the Board said that it may not substitute its judgment for the judgment of the director concerning standards for evaluating disability and held that, when a worker dies of causes unrelated to the accepted conditions and all compensable conditions are not medically stationary, the director's rules allow rating only of "irreversible findings." The Board held that, if the director's rules do not provide for a rating in a particular circumstance, no rating is available for the condition. The Board upheld the director's determination that OAR 436-035-0007(23)(b)(A) and (d) allow ratings only for irreversible findings listed in OAR 436-035-0007(2)(d) and that the second rule lists all possible irreversible findings and does not merely provide a list of examples of irreversible conditions. In its order, the Board noted that it had considered joint fusion as a potentially **<160 Or App 80/81>** applicable "irreversible finding" but had determined that such a finding was not supported by the record. The Board held that "[i]nasmuch as claimant has failed to prove a measurable impairment under OAR 436-035-0007(2)(d), he is not entitled to a rating for his heel condition."

Claimant contends that, if it is construed to provide for benefits only for the listed impairments, OAR 436-035-0007(23)(b)(A) is inconsistent with ORS 656.218, which requires an award of benefits to the beneficiaries of a deceased worker *as if the worker had survived*. She asserts, in the alternative, that OAR 436-035-0007(2)(d) lists examples of what must be considered as "irreversible findings" but does not preclude consideration of other permanent conditions. Because we agree with claimant that the department's rules and the Board's interpretation of them are inconsistent with ORS 656.218, we remanded the case for reconsideration.

Before 1973, ORS 656.218(1) provided:

> "In case of the death of a workman *receiving* monthly payments on account of permanent partial disability, such payments shall continue for the period during which the workman, if surviving, would have been entitled thereto." (Emphasis added.)

Interpreting the statutory language, the Supreme Court held in *Fertig v. Compensation Department*, 254 Or 136, 455 P2d 180, 458 P2d 444 (1969), that a beneficiary's right to benefits for permanent partial disability does not accrue unless the worker was *receiving* benefits at the time of death, which, the court held, "presupposes that an order awarding the workman such benefits already had been made." 254 Or at 139. In 1973, the legislature amended ORS 656.218, which it now provides, in part:

> "(1) In case of the death of a worker *entitled* to compensation, *whether eligibility therefor or the amount thereof have been determined*, payments shall be made for the period during which the worker, if surviving, would have been entitled thereto.
>
> "(2) If the worker's death occurs prior to issuance of a notice of closure or making of a determination under ORS **<160 Or App 81/82>** 656.268, the insurer or the self-insured employer shall proceed under ORS 656.268 and determine compensation for permanent partial disability, if any." (Emphasis added.)

As amended, subsection (1) provides that, even if the worker's eligibility for benefits for permanent disability has not been determined as of the date of death, the worker's beneficiaries are entitled to compensation for the period during which the worker, *if surviving*, would have been entitled to them. Under subsection (2), permanent disability benefits to which the worker would have been entitled are to be calculated pursuant to ORS 656.268.

ORS 656.268 does not itself refer to the processing of a claim when the worker has died of unrelated causes before closure; however, ORS 656.268(4) discusses the closure of a claim by the insurer or self-insured employer:

> "(a) When the worker's condition resulting from an accepted disabling injury has become medically stationary, and the worker has returned to work or the worker's attending physician releases the worker to return to regular or modified employment, or when the worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005(7), the claim may be closed by the insurer or self-insured employer * * * .
>
> "(b) Findings by the insurer or self-insured employer regarding the extent of the worker's disability in closure of the claim shall be pursuant to the standards prescribed by the Department of Consumer and Business Services."

Subparagraph (4)(a) requires that before closure "the worker's condition resulting from an accepted disabling injury has become medically stationary." Necessarily, when a worker dies before becoming medically stationary, the requirement of subparagraph (4)(a) cannot be satisfied. Nonetheless, pursuant to ORS 656.218, benefits are to be *determined* and paid to the worker's beneficiaries pursuant to ORS 656.268 as if *the worker had survived*. Furthermore, under ORS 656.268(4)(b), the insurer's or self-insured employer's findings regarding disability must be pursuant to the standards prescribed by the department. Accordingly, the Board correctly referred to the department's rules in **<160 Or App 82/83>** determining claimant's benefits. However, we conclude that the department's rule with regard to determining benefits for workers who die of unrelated causes before becoming medically stationary is inconsistent with ORS 656.218.

ORS 656.218(1) clearly states that in the case of a worker *entitled* to compensation, "payments shall be made for the period during which the worker, if surviving, would have been entitled thereto." In *Mayes v. Boise Cascade Corp.*, 46 Or App 333, 611 P2d 681 (1980), *rev den* 289 Or 373, we noted that, under ORS 656.218(1), the beneficiaries of a deceased worker entitled to compensation for permanent partial disability may receive payments for the period during which the worker, if surviving, would have been entitled to them. 46 Or App at 344. Employer's response is that, pursuant to the department's administrative rule, a worker who dies of unrelated causes before becoming medically stationary simply is not *entitled* to benefits for permanent disability other than for irreversible impairments. The reasoning is circular. We read the statute to establish that both the payment *and calculation* of benefits are to be made as if the worker had survived. Thus, under the statute, the surviving beneficiary's "entitlement" is the same as the worker's would have been had the worker survived. The department's administrative rule establishes a more limited entitlement to benefits for workers who die of unrelated causes before becoming medically stationary.

The medical arbiters determined that, had he survived, the worker would have experienced permanent loss of range of motion and loss of use of his right ankle. For that disability, he would have been entitled to compensation. The department's administrative rule eliminated that impairment from consideration by limiting benefits to "irreversible findings." The rule is inconsistent with ORS 656.218, because it does not encompass the full benefits to which the worker would have been entitled had the worker survived. Accordingly, we remand the case to the Board for reconsideration of claimant's entitlement to benefits under ORS 656.218.

Reversed and remanded for reconsideration.

Cite as 160 Or App 91 (1999) April 28, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

JENNIFER MACCRONE, Appellant - Cross-Respondent,
v.
EDWARDS CENTER, INC., an active Oregon non-profit corporation, Respondent - Cross-Appellant.
(9509-06509; CA A95658)

En banc
Appeal from Circuit Court, Multnomah County.
Ellen F. Rosenblum, Judge.
Argued and submitted September 28, 1998; resubmitted en banc March 3, 1999.
Gregory Kafoury and Mark McDougal argued the cause and filed the briefs for appellant - cross-respondent.
I. Franklin Hunsaker argued the cause for respondent - cross-appellant. With him on the briefs was Bullivant, Houser, Bailey, Pendergrass & Hoffman.
Before Deits, Chief Judge, and Edmonds, De Muniz, Landau, Haselton,
Armstrong, Linder, Wollheim, Kistler, and Brewer, Judges.
EDMONDS, J.
On appeal, reversed and remanded with instructions to reinstate jury's verdict; on cross-appeal, affirmed.
Deits, C. J., dissenting.

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160 Or App 93> Plaintiff was awarded judgment against defendant[1] for intentional infliction of emotional distress and appeals the trial court's remittitur of the jury's punitive damage award. Defendant cross-appeals and assigns error to: (1) the trial court's denial of a directed verdict on the issue of liability; (2) the trial court's refusal to instruct the jury that defendant was not liable for the consequences of a third-party's attack on plaintiff; (3) the trial court's denial of defendant's motion for a directed verdict on the issue of punitive damages; and (4) the denial of several other post-trial motions. We reverse on plaintiff's appeal and remand with instructions to reinstate the jury's punitive damage award and affirm on defendant's cross-appeal.

We state the facts in the light most favorable to plaintiff. *See Brown v. J.C. Penney Co.*, 297 Or 695, 705, 688 P2d 811 (1984). After moving to Portland, plaintiff obtained a position as a caregiver at a residential facility for the developmentally disabled that defendant operated. The position required that plaintiff stay overnight with the facility's clients. She had had prior experience working with the developmentally disabled. Before she began work, defendant provided plaintiff with 18 hours of training, which included 10 hours of classroom instruction. According to plaintiff, her training included reading and signing various documents and being informed about blood-borne pathogens and the dispensing of medication. In addition, she observed the operation of the residential home to which she had been assigned to work. She also spoke to the facility's manager about each of the five clients who lived at the home. According to plaintiff, **<160 Or App 93/94>** the manager indicated that one client, Michelle, merely liked to act tough. No one told her that Michelle was prone to having violent outbursts.

When plaintiff arrived for her first day of work on May 12, 1994, she believed that the manager would remain at the facility until she dispensed medication to the clients after dinner. However, the manager told plaintiff that he was involved with the Special Olympics and had to make a trip to California the next day. He assured plaintiff that everything would be fine, gave plaintiff his home and cellular telephone numbers and instructed her to call if anything happened.

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[1] In *Wheeler v. Marathon Printing, Inc.*, 157 Or App 290, ___ P2d ___ (1998), the issue on appeal was Marathon's direct liability for the intentional infliction of emotional distress one employee caused another rather than its vicarious liability. In this case, the jury was instructed:

> "An employer is liable for the acts or omissions of its employees. Doug Taylor [the manager] was the employee of the defendant, the Edwards Center, Incorporated. So, any fault of Doug Taylor is the fault of the defendant, Edwards Center, Inc."

Defendant did not except to this instruction. Thus, this case was tried on a vicarious liability theory, and at issue is whether the manager's conduct is tortious and defendant's vicarious liability for that conduct.

Later in the day, plaintiff was confronted with a dispute between Michelle and another client, Lori. Michelle was dissatisfied with plaintiff's resolution of the conflict and punched Lori. According to plaintiff, Lori "flopped like a rag doll" onto the couch, and Michelle continued to assault her. Plaintiff pleaded with Michelle to stop punching Lori, but she refused. She then tried unsuccessfully to restrain Michelle. At that point, Michelle grabbed plaintiff, shook her, threw her to the ground and then climbed on top of her. When plaintiff tried to push Michelle off, Michelle grabbed plaintiff's hands and forced them across plaintiff's throat. Michelle alternated between squeezing plaintiff's wrists until her hands turned blue from lack of circulation and leaning on plaintiff's wrists, which cut off her air supply. Plaintiff tried to be passive and to reason with Michelle. Plaintiff indicated that she "had to sort of balance the two because [she] would start running out of air, and [she] would [have to] sort of save enough air that [she] could ask [Michelle] to let go of [her] neck." After 10 to 15 minutes, another client, Brian, asked Michelle if she wanted to watch a television show. According to plaintiff, Michelle laughed, released plaintiff's wrists, helped plaintiff stand up and indicated that she wanted to be friends with plaintiff.

Plaintiff immediately telephoned the manager and spoke with him for approximately 10 to 15 minutes. She testified that she had difficulty breathing during the call because she was crying. Eventually, she was able to explain to the manager that Michelle had tried to strangle her. After plaintiff requested that the manager return to the facility, he <160 Or App 94/95> inquired as to whether Michelle was hurting anyone at that time and whether plaintiff's behavior had caused the outburst. He indicated that it would be better for plaintiff to remain there alone because he thought that his return to the facility would reinforce Michelle's behavior. He also told plaintiff that Michelle had engaged in those sorts of outbursts in the past and that it was unlikely that there would be another problem that night. Ultimately, he refused to come to the facility, despite plaintiff's plea.

When the manager refused to come to the facility, plaintiff telephoned her husband. After they conversed, plaintiff agreed to call him every 30 minutes. Plaintiff made dinner for the clients, dispensed their medication and allowed Lori and Brian to remain with her in the office. Michelle and the two other clients went to bed. Later, while plaintiff was on the phone with her husband, Michelle appeared in the doorway to the office. She blocked the entrance and indicated that she was "just watching" plaintiff. Plaintiff shut and locked the door in Michelle's face. Again, she called the manager and insisted on leaving the facility. Eventually, the manager instructed plaintiff to call the on-call coordinator to obtain approval for him to return to the facility, and plaintiff left.

On cross-examination, when asked whether the manager intended to cause her emotional distress, plaintiff stated:

> "I don't see how he could have avoided intending me to be upset. He knew how upset I was. I communicated that very clearly to him. He was well aware of my situation and he chose not to come. I have a hard time believing that he did not intend for me to suffer more. He certainly knew that I would.
>
> "* * * * *
>
> "He knew that I would suffer because [Michelle] had tried to strangle me and kill me and then he knew that I would suffer because he knew that she had a really long history of attacking people before, that this was commonplace for her. I have a hard time believing that he didn't know that it was likely."

160 Or App 96> Plaintiff did not return to work after the events of May 12, 1994.

Thereafter, plaintiff began experiencing panic attacks, developed phobias, was easily startled and became overly vigilant for danger. Her psychologist diagnosed her as having post-traumatic stress disorder, which he defined as "a very complex reaction to an identified traumatic event," such as a sudden event involving physical injury or in which the person perceives that he or she is going to die. According to the psychologist, individuals with post-traumatic stress disorder experience nightmares and flashbacks and relive the event that caused the disorder. He indicated that such individuals suffer from an overwhelming anxiety that causes them to "shut down" and "avoid things they normally enjoy because there's no pleasure." According to the psychologist, these individuals often experience a "shattering of assumptions" including the individuals' thoughts about themselves, the world, other people and the concept of fairness. He testified that individuals with post-traumatic stress disorder avoid situations that remind them of the traumatic event, and, if they accidentally encounter a similar

situation, they respond with panic attacks or tremendous fear. He also testified that individuals with post-traumatic stress disorder "remain vulnerable and find it [easier] to get anxious or develop new fears." He concluded that there is a measure of permanence in plaintiff's condition and that, in his opinion, if the manager had supported plaintiff by coming to the facility in response to the first call, the post-traumatic stress disorder would not have developed.

Eventually, plaintiff filed a complaint against defendant for intentional infliction of emotional distress. The complaint alleges:

> "The above statements by the house manager which blamed plaintiff for the violent incident, minimized the continuing threat which she faced, and indicated that plaintiff was incompetent in her performance of their duties, all coupled with the house manager's refusal to come to her aid when he knew that she was hysterical and in reasonable fear for her life, were actions beyond the limits of social toleration and were made for the deliberate purpose of inflicting great distress, fear, guilt, and feelings of incompetence **<160 Or App 96/97>** in the plaintiff, and they did in fact cause plaintiff severe emotional distress. As a result thereof, plaintiff has developed post traumatic stress disorder, resulting in physical injury and illness, and has been and is plagued with feelings of fear, incompetence, inferiority, and helplessness, and will permanently suffer from such conditions and feelings, all to her non-economic damage in the amount of $500,000."

Plaintiff also sought $2,000,000 in punitive damages.

Defendant moved for a directed verdict on the grounds that plaintiff had not proven the requisite intent to inflict emotional distress and that the manager's conduct did not rise to the level of an extraordinary transgression of the bounds of socially tolerable conduct. Defendant also moved for a directed verdict on the ground that plaintiff was not entitled to recover punitive damages as a matter of law. The trial court denied the motions. A jury found in favor of plaintiff and awarded her noneconomic damages of $275,000 and punitive damages of $1,250,000. Defendant then moved for a judgment notwithstanding the verdict, a new trial and to have the punitive damage award set aside. The trial court reduced the punitive damage award to $1,000,000 but denied the other motions.

Because defendant's assignments of error on cross-appeal could be dispositive, we begin by reviewing them. First, defendant assigns error to the trial court's denial of its motion for a directed verdict on the ground that plaintiff failed to prove that it acted with the requisite intent and that its conduct was an extraordinary transgression of the bounds of socially tolerable conduct. Ordinarily, to prevail on a claim for intentional infliction of emotional distress (IIED), a plaintiff must prove that:

> "'(1) the defendant intended to inflict severe emotional distress on the plaintiff, (2) the defendant's acts were the cause of the plaintiff's severe emotional distress, and (3) the defendant's acts constituted an extraordinary transgression of the bounds of socially tolerable conduct.'" *McGanty v. Staudenraus*, 321 Or 532, 543, 901 P2d 841 (1995) (quoting *Sheets v. Knight*, 308 Or 220, 236, 779 P2d 1000 (1989)).

160 Or App 98> In general, the element of intent exists "'*where the actor desires to inflict severe emotional distress, and also where he knows that such distress is certain, or substantially certain, to result from his conduct.*'" *McGanty*, 321 Or at 550 (quoting Restatement (Second) of Torts section 46 comment i (1965)) (emphasis in original).

Defendant contends that this case differs from the ordinary IIED case because ORS 656.018 and ORS 656.156[2] require that plaintiff must prove that defendant, as plaintiff's employer, had the deliberate intent to injure her in order to **<160 Or App 98/99>** avoid the exclusivity provision of the Workers' Compensation Law and that proof of negligence, gross negligence, recklessness or conscious

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[2] Currently, ORS 656.018 provides, in part:

"(1)(a) The liability of every employer who satisfies the duty required by ORS 656.017(1) is exclusive and in place of all other liability arising out of injuries, diseases, symptom complexes or similar conditions arising out of and in the course of employment that are sustained by subject workers, the workers' beneficiaries and anyone otherwise entitled to recover

indifference is insufficient to meet that requirement.[3] Defendant asserts that there is no evidence that its manager acted with the requisite intent. Plaintiff counters that the jury was entitled to infer from the circumstances surrounding the manager's refusal to come to the facility that he acted with the deliberate intent of causing her emotional injury.

We turn then to the evidence in light of the parties' arguments and the applicable law. "Because plaintiff ha[s] a verdict, we cannot set it aside unless we can affirmatively say that there is no evidence from which the jury could have found the facts necessary to establish the elements of plaintiff's cause of action." *Brown*, 297 Or at 705. The jury could have found that the manager knew that plaintiff was distressed when she called him immediately after Michelle had attempted to strangle her and that, despite her request that he return to the facility, he chose to leave her alone with her attacker. Based on that evidence, a jury reasonably could infer that the manager wished to inflict more emotional distress on plaintiff, knowing that she was suffering severe emotional distress because of the attack. Such an inference suffices to meet the requisite intent under ORS 656.018 and ORS 656.156.[4]

> damages from the employer on account of such conditions or claims resulting therefrom, specifically including claims for contribution or indemnity asserted by third persons from whom damages are sought on account of such conditions, except as specifically provided otherwise in this chapter.
>
> "* * * * *
>
> "(2) The rights given to a subject worker and the beneficiaries of the subject worker under this chapter for injuries, diseases, symptom complexes or similar conditions arising out of and in the course of employment are in lieu of any remedies they might otherwise have for such injuries, diseases, symptom complexes or similar conditions against the worker's employer under ORS 654.305 to 654.335 or other laws, common law or statute, except to the extent the worker is expressly given the right under this chapter to bring suit against the employer of the worker for an injury, disease, symptom complex or similar condition.
>
> "* * * * *
>
> "(7) The exclusive remedy provisions and limitation on liability provisions of this chapter apply to all injuries and to diseases, symptom complexes or similar conditions of subject workers arising out of and in the course of employment whether or not they are determined to be compensable under this chapter."

In 1995, the legislature amended the language of ORS 656.018(1)(a) and (2) and added what is now ORS 656.018(7). These amendments apply to "all claims or causes of action existing or arising on or after the effective date of this Act, regardless of the date of injury or the date a claim is presented." Or Laws 1995, ch 332, section 66(1). The 1997 amendments did not affect the substance of the quoted language.

ORS 656.156(2) currently provides, in part:

> "If injury or death results to a worker from the deliberate intention of the employer of the worker to produce such injury or death, the worker * * * may take under this chapter, and also have cause for action against the employer, as if such statutes had not been passed, for damages over the amount payable under those statutes."

[3] To demonstrate "deliberate intent" under ORS 656.156(2), the employee must prove that: (1) the employer's act was deliberate or, in other words, that the employer had an opportunity to weigh the consequences and chose among courses of action, *Lusk v. Monaco Motor Homes, Inc.*, 97 Or App 182, 188, 775 P2d 891 (1989), and (2) the employer specifically intended to injure the employee or one similarly situated, *id.*; *Kilminster v. Day Management Corp.*, 323 Or 618, 631, 919 P2d 474 (1996). In *Davis v. United States Employers Council, Inc.*, 147 Or App 164, 176, 934 P2d 1142, *rev den* 325 Or 368 (1997), we described the statute as requiring proof that the employer acted or did not act because it 'wished to injure' the employee or someone similarly situated."

[4] The dissent would hold that a reasonable fact finder could not infer that Taylor's refusal to come to plaintiff's aid was motivated by an intention to subject her to additional emotional distress and potential physical distress inflicted by Michelle, and accordingly, it would vacate the jury's verdict by directing a verdict in favor of defendant. In support of its position, the dissent draws inferences and relies on evidence favorable to defendant, contrary to the applicable legal rule in determining whether a party is entitled to a directed verdict as a matter of law. The jury in this case was entitled to draw any inference "from facts which reason dictates." *Judson v. Bee Hive Auto Service Co.*, 136 Or 1, 10, 294 P 588, 297 P 1050 (1931). An undeclared intention of an actor is hardly susceptible to direct evidence. Juries necessarily discern an actor's intent by the actor's conduct and expressions in the midst of the prevailing circumstances. In the light of plaintiff's communications to Taylor and her unobjected-to testimony characterizing Taylor's refusal as intended to make her "suffer more," the jury had before it evidence of Taylor's mind set regarding plaintiff's dilemma. From that evidence, it could have drawn a number of different inferences as to his intention. The fact that it chose the inference that it did rather than the inference that the dissent proposes does not make the jury's choice unreasonable or the denial of the motion for directed verdict error.

160 Or App 100> Plaintiff must also prove that defendant's conduct constituted an extraordinary transgression of the bounds of socially tolerable conduct. *McGanty*, 321 Or at 543. Whether defendant's conduct rises to that level of severity is initially a question of law, viewing the evidence in the light most favorable to plaintiff. The inquiry is whether defendant's conduct constitutes "extraordinary conduct which a reasonable jury could find beyond the farthest reaches of socially tolerable behavior." *Hall v. The May Dept. Stores*, 292 Or 131, 137, 637 P2d 126 (1981). *Accord Tenold v. Weyerhaeuser Co.*, 127 Or App 511, 517, 873 P2d 413 (1994), *rev dismissed* 321 Or 561 (1995). "Conduct that is merely 'rude, boorish, tyrannical, churlish and mean' does not satisfy that standard[.]" *Watte v. Edgar Maeyens, Jr., M.D., P.C.*, 112 Or App 234, 239, 828 P2d 479, *rev den* 314 Or 176 (1992) (quoting *Patton v. J.C. Penney Co.*, 301 Or 117, 124, 719 P2d 854 (1986)). A court may consider the existence of special relationships between the parties in determining the issue. *Rockhill v. Pollard*, 259 Or 54, 60, 485 P2d 28 (1971). *See McGanty*, 321 Or at 545 (reasoning that the special relationship discussion in *Rockhill* applies only to the conduct element of the tort). An employee and employer relationship is such a relationship. *Hall*, 292 Or at 138.

As we have said, the evidence supports the inference that defendant, knowing that plaintiff had been exposed to physical danger, declined to come to her assistance, intending that she be placed in further danger. In the context of an employer-employee relationship where the employer has the ability to extricate the employee from a dangerous situation in which it has placed her, we hold that that kind of conduct is so extraordinary that a jury reasonably could find it to be beyond the furthest reaches of the bounds of socially tolerable conduct. We conclude that the trial court did not err in denying the motion for a directed verdict on the grounds that **<160 Or App 100/101>** plaintiff failed to prove the requisite intent and that defendant's conduct was not socially intolerable.[5]

Second, defendant contends that the trial court committed prejudicial error when it refused to give the following requested instruction to the jury:

> "In the course of her complaint, plaintiff describes two separate sets of traumatic occurrences that took place on May 12, 1994. First she alleges that Miche[l]le * * * assaulted and battered her by choking her to the point of unconsciousness and that late that evening, Miche[l]le * * * stood over her staring at her and trying to intimidate her.
>
> "Second, she alleges that the house manager, Doug Taylor, on two separate occasions that evening refused to come to her and refused to relieve her, telling her that she was responsible for the assault by Michel[l]e.
>
> "I instruct you that Edwards Center is not liable for the consequences of assault or the attempted intimidation by Michel[l]e * * *. It can only be held liable for the conduct of Doug Taylor. It is your duty as jurors to separate the consequences of the conduct of the two individuals and to determine whether the conduct of Doug Taylor was intended to cause and, in fact, did cause plaintiff sever[e] emotional distress as I have defined that term for you [in the] course of these instructions.
>
> "If you find either that Doug Taylor did not intend to cause plaintiff to suffer severe emotional distress or that plaintiff did not suffer severe emotional distress as a result of Doug Taylor's conduct, then your verdict will be for defendant."

Defendant argues that the instruction was necessary to prevent the jury from awarding damages based on Michelle's assault on plaintiff. In determining whether the **<160 Or App 101/102>** instruction was necessary, we examine the other instructions that the trial court gave to the jury. The trial court instructed the jury as to the elements of the tort and gave the following instruction on causation:

> "In order to be a cause of damage an act or omission must be a substantial factor in producing the damage. A substantial factor is an important or material factor and not one that is insignificant.

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[5] The dissent asserts that defendant's conduct was insufficient to support an intentional infliction of emotional distress claim as a matter of law because "[plaintiff] accepted and was performing a job that, subjectively or objectively, had dangerous aspects." 160 Or App 114. There are many jobs involving interactions with human beings in which there are inherently dangerous aspects. The extent to which plaintiff assumed the risk that she would be without aid to deal with Michelle's behavior was an issue of fact for the jury to decide based on conflicting evidence about plaintiff's job description and what she was told about Michelle's propensities.

> "Many factors or things may operate either independently or together to cause damage. In such a case each may be the cause of the damage, even though the others would have been sufficient of themselves to cause the same damage.
>
> "You need not find that the conduct of the defendant was the only cause of the damage."

In addition, the trial court's instructions with regard to damages included the statement that "[i]n deciding the amount of any such damages, you must determine each of the items of damages that I'm going to mention to you in a moment; provided, you find the damages to have been sustained by her as a result of the defendant's fault."

"It is not error for a trial court to refuse to give a requested instruction if the instruction given by the court, although not in the form requested, adequately covers the subject of the requested instruction." *State v. Tucker*, 315 Or 321, 332, 845 P2d 904 (1993). We hold that the trial court's instructions regarding the elements of the tort, causation and damages covered the same subject matter as defendant's requested instruction. When viewed as a whole, the instructions told the jury that the defendant could be liable only if its conduct was a substantial factor in causing the emotional distress and that damages could be awarded only if they were sustained as a result of defendant's conduct. Those instructions adequately separated the damages caused by the manager's conduct from those caused by Michelle's conduct. Thus, the trial court did not err in refusing to give the instruction that defendant requested because its other instructions covered the same subject.

160 Or App 103> Defendant's next assignment of error is that, "[t]he award of punitive damages should be set aside or at least further reduced because Defendant's conduct, even if tortious, was not extraordinary, arbitrary, aggravated, aggressive, malicious or unconscionable." In its argument, defendant makes three points: (1) "Defendant's conduct did not rise to the degree of reprehensibility to justify an award of punitive damages"; (2) "the jury had insufficient evidence upon which it could rationally base an award of punitive damages"; and (3) "[t]he punitive damage[] award should at least be further reduced because it is excessive."[6]

During the trial, defendant moved for a directed verdict as to punitive damages on the ground that punitive damages could not be recovered for oral communications. After trial, defendant moved for a judgment notwithstanding the verdict and a new trial. Defendant also moved to set aside the jury's punitive damage award. Defendant presented two issues to the trial court in that motion. The first issue was whether the punitive damage award should be set aside because defendant's conduct was not sufficiently aggravated and because the jury had insufficient evidence on which it rationally could base the award. The second issue was whether the punitive damage award should be set aside because "it is unconstitutionally standardless, excessive and disproportionate in violation of the Due Process Clause of the Fourteenth Amendment of the Constitution of the United States."

In its order, the trial court ruled:

> "The court grants defendant's motion to reduce the punitive damage award and hereby reduces the punitive damage award to one million dollars. All other motions relating to the award of punitive damages as well as Motions for Judgment Notwithstanding the Verdict and New Trial are denied."

160 Or App 104> Thus, the trial court appeared to treat each issue presented in defendant's motion to set aside the punitive damage award as a separate motion.

In his motion for a directed verdict on the issue of punitive damages before the matter was submitted to the jury, defendant did not argue to the trial court that its conduct was not sufficiently aggravated nor that there was insufficient evidence to support an award. As we stated in *Gardner v. First Escrow Corp.*, 72 Or App 715, 727-28, 696 P2d 1172, *rev den* 299 Or 314 (1985):

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[6] ORS 18.537 currently addresses the standards for awarding and reviewing punitive damage awards. That statute applies to actions commenced on or after September 9, 1995. Or Laws 1995, ch 688, section 5. Because this action was commenced on September 8, 1995, ORS 18.537 does not apply.

> "A motion for a directed verdict must be made before the moving party may move for a judgment notwithstanding the verdict. ORCP 63A; *Stark v. Henneman*, 250 Or 34, 36, 440 P2d 364 (1968). The grounds asserted in the motion for judgment notwithstanding the verdict must previously have been raised in a motion for a directed verdict and in a manner that specifically brings the issue to the trial court's attention."

Accordingly, the first two points of defendant's assignment of error regarding the sufficiency of the evidence for an award of punitive damages are not cognizable on appeal. Moreover, the denial of defendant's motion for a new trial suffers from the same deficiency.

Finally, we turn to defendant's motion to set aside the punitive damage award on the ground that it was constitutionally excessive. The motion challenges the amount of a punitive damage award rather than its propriety. Such a motion cannot be required to be made during trial because the jury has not yet made its award. We hold that defendant's post-trial motion that challenged the jury's punitive damage award on the ground that it was constitutionally excessive is properly before us. Although the trial court granted defendant's motion in part and reduced the award, defendant contends on appeal that the award should be further reduced because it is excessive. The issue of whether the jury's award is excessive is the same issue that plaintiff raises on appeal. We turn then to plaintiff's appeal.

Plaintiff assigns error to the trial court's reduction of the punitive damage award from $1,250,000 to $1,000,000. **<160 Or App 104/105>** She specifically contends that the trial court erred by reducing the jury's award based on its knowledge of other punitive damage awards. Before we can address the merits of the issue, we must identify our standard of review.

Defendant contends that we should apply an abuse of discretion standard. We rejected defendant's contention in *Stranahan v. Fred Meyer, Inc.*, 153 Or App 442, 467 n 21, 958 P2d 854, *rev allowed* 328 Or 115 (1998), when we said:

> "Defendant suggests that this court adopt an abuse of discretion standard of review as to whether a trial court properly reduced a punitive damages award. That standard of review does not comport with the Oregon Supreme Court's approach to this issue in *Oberg*: 'We are in as good a position as would be the trial court to apply a legal standard to the evidence in the record.' *Oberg*, 320 Or at 552."

Plaintiff contends that we should apply the legal standard in *Oberg v. Honda Motor Co.*, 320 Or 544, 551, 888 P2d 8 (1995), *cert den* 517 US 1219 (1996), when reviewing the trial court's reduction of the punitive damage award. In *Oberg*, the Oregon Supreme Court stated that

> "post-verdict judicial review of a jury's award of punitive damages is as follows: Was the award of punitive damages within the range that a rational juror would be entitled to award in the light of the record as a whole? The range that a rational juror is entitled to award depends, in turn, on the statutory and common law factors that the jury is instructed and permitted to consider when awarding punitive damages for a given claim." 320 Or at 551.

The purpose of the standard announced by the Oregon Supreme Court in Oberg was to provide judicial review of punitive damage awards in order to assure that they are not excessive in violation of the Due Process Clause of the federal constitution. *Blume v. Fred Meyer, Inc.*, 155 Or App 102, 110-11, 963 P2d 700 (1998). After this standard was announced, the United States Supreme Court, in *BMW of North America, Inc. v. Gore*, 517 US 559, 116 S Ct 1589, 134 L Ed 2d 809 (1996), described three guideposts to identify constitutionally excessive awards. We described the *BMW* analysis in *Parrott v. Carr Chevrolet, Inc.*, 156 Or App 257, 275, 965 P2d 440 (1998), *rev allowed* 328 Or 418 (1999):

> **160 Or App 106>** "Under BMW, the starting point for examination of a punitive damage award is identification of the state's interests that a punitive award is designed to serve. Underlying the inquiry are elementary notions of fairness: that persons must receive fair notice of the conduct that will subject them to punishment and also of the severity of the penalty the state may impose. The United States Supreme Court articulated three 'guideposts' to assist in evaluating whether the award exceeds constitutional limits: (1) the degree of reprehensibility of the defendant's conduct; (2) the disparity between the harm or potential harm suffered and the punitive damage award; and (3) the difference between the award and the civil or criminal penalties authorized or imposed in comparable cases. Although those guideposts are not exclusive, other considerations

must be grounded in clear legal principles or historical or community-based standards." (Citations omitted.)

In *Blume*, we held that BMW altered the limited role of the reviewing court under the *Oberg* standard and reasoned that:

> "a reviewing court's determination of whether the punitive damage award is unconstitutionally excessive is not dependent on instructions to the jury or on the jury's considerations. Under *BMW*, although the reviewing court accepts the facts and inferences as the jury found them, evaluating whether a punitive damage award is excessive requires examination of, but not deference to, the jury's award." 155 Or App at 113 (footnote omitted).

Thus, when a party assigns error in this court to a trial court's reduction of a jury's punitive damage award, we will make an independent assessment of the jury's award to determine whether it is constitutionally excessive in violation of due process under the *BMW* guideposts without regard to the trial court's reasoning.

First, we examine the reprehensibility of defendant's conduct, which may be the most important factor and which focuses our attention on whether the punitive award reflects the enormity of defendant's conduct. *BMW*, 517 US at 575. As the Court indicated in *BMW*, "[t]hree aggravating factors associated with particularly reprehensible conduct are (1) whether defendant's conduct was violent or threatened violence; (2) whether defendant acted with trickery or **<160 Or App 106/107>** deceit as opposed to mere negligence; and (3) whether defendant has engaged in repeated instances of misconduct." *Parrott*, 156 Or App at 276.

Here, the manager's conduct toward plaintiff was not an affirmative act of violence or threatened violence toward plaintiff. However, as a result of his refusal to return to the facility after Michelle attempted to strangle her, plaintiff remained alone at the facility where there was a danger that Michelle would physically harm her. In addition, the evidence supports the inference that the manager acted with a specific intent or a wish to injure plaintiff. Such conduct is certainly more reprehensible than mere negligent conduct. The final factor involving repeated misconduct is not present here because there is no evidence that defendant intentionally inflicted severe emotional distress on other employees. However, in light of the egregious nature of the manager's conduct which caused plaintiff to remain with her attacker and to be subject to a continuous threat of physical violence, the degree of reprehensibility is significant.

Second, we examine the disparity between the harm suffered or the potential harm and the punitive damage award. The Supreme Court has indicated that:

> "[w]e need not, and indeed we cannot, draw a mathematical bright line between the constitutionally acceptable and the constitutionally unacceptable that would fit every case. We can say, however, that general concerns of reasonableness * * * properly enter into the constitutional calculus." *Pacific Mut. Life Ins. Co. v. Haslip*, 499 US 1, 18, 111 S Ct 1032, 113 L Ed 2d 1 (1991).

Although in *Haslip* the Supreme Court concluded that a ratio of punitive damages to actual harm that was more than 4 to 1 "may be close to the line" of constitutional impropriety, 499 US at 23, the Court in *BMW* noted that:

> "low awards of compensatory damages may properly support a higher ratio than high compensatory awards, if, for example, a particularly egregious act has resulted in only a small amount of economic damages. A higher ratio may also be justified in cases in which the injury is hard to detect or the monetary value of noneconomic harm might have been difficult to determine." 517 US at 582.

160 Or App 108> Here, plaintiff's psychologist opined during his testimony that, if the manager had responded to plaintiff's call for help by taking her seriously and had validated her fear by providing support, she would not have developed the post-traumatic stress disorder. The evidence indicates that plaintiff suffers from panic attacks and phobias, is easily startled and is inappropriately fearful of danger. Her psychologist testified that individuals with post-traumatic stress disorder remain vulnerable and that there is "some measure of permanenc[e]" in plaintiff's condition. Thus, the ability of plaintiff to enjoy a productive and contented life has been significantly impaired as a result of defendant's conduct. The jury awarded plaintiff $275,000 in noneconomic damages and punitive damages of $1,250,000. The

ratio between the punitive award and the award of noneconomic damages is approximately 4.5 to 1. In light of plaintiff's psychological condition and the fact that noneconomic damages for a post-traumatic stress disorder may have been difficult to calculate, the disparity between the award of compensatory damage harm and the award of punitive damages is reasonable in our view.

Finally, we examine the difference between the punitive damage award and the civil or criminal penalties that could be authorized or imposed for comparable conduct. In *BMW*, the Supreme Court indicated that considerable deference should be given to legislative sanctions for the conduct in issue. 517 US at 583. In this case, the parties do not cite to specific, comparable, legislative civil or criminal sanctions that the court should consider. However, the Workers' Compensation Law and the criminal penalties for menacing and harassment provide some insight into the grievousness of the manager's conduct. Additionally, we are mindful that the state's interest in allowing punitive damages is to punish willful, wanton or malicious wrongdoers and to deter the wrongdoers and others similarly situated from further engaging in such conduct. *Friendship Auto v. Bank of Willamette Valley*, 300 Or 522, 532, 716 P2d 715 (1986).

ORS 656.156 places employers on notice that, if they act with the deliberate intent to cause an employee severe emotional distress, they could be subject to a tort claim for intentional infliction of emotional distress in which a jury could award punitive damages. The gravamen of the crimes **<160 Or App 108/109>** of menacing, ORS 163.190,[7] and harassment, ORS 166.065,[8] are also analogous to the manager's conduct when it is considered as a manifestation of an intent to make plaintiff fearful. Menacing, a Class A misdemeanor, is currently punishable by imprisonment up to a maximum of one year, ORS 161.615(1), and a maximum fine of $5,000, ORS 161.635(1)(a). Harassment, a Class B misdemeanor, is currently punishable by imprisonment up to six months, ORS 161.615(2), and a maximum fine of $2,000, ORS 161.635(1)(b). As we reasoned in *Blume*, "[a]ssuming that an incarcerative sanction may fairly be viewed as some notice of a possibly severe punitive damage for a corporate defendant in a somewhat analogous civil action," 155 Or App at 118, the possibility of incarceration demonstrates the seriousness of the manager's conduct.

The Court in *BMW* also examined under this guidepost whether a lesser penalty would have the effect of deterring future misconduct. 517 US at 584. The *BMW* court ultimately concluded that the defendant's conduct, which was analogous to a violation of the state's deceptive trade practices statutes, was not sufficiently egregious to justify a punitive damage award of $2,000,000 when the only injury suffered by the plaintiff was an economic one, reflected by compensatory damages of $4,000. 517 US at 565, 584-85. In *Blume*, the plaintiff had been stopped in the defendant's store and her bag had been searched pursuant to the defendant's policy to randomly check customers for receipts. 155 Or App at 104-05. We upheld a punitive damage award of $450,000 when compensatory damages were assessed at $25,000. *Id.* While we noted in that case that the random application of the defendant's policy could have resulted in innocent people being accused of theft, we also indicated that the defendant's egregious conduct caused an injury that went beyond mere economic harm and instead interfered with plaintiff's right of **<160 Or App 109/110>** personal freedom. *Id.* at 114, 119. In this case, as in *Blume*, the manager's refusal to return to the facility with the deliberate intent of causing her emotional distress is conduct that caused more than mere economic loss. Plaintiff has suffered an additional injury, permanent damage to her mental health. The appropriateness of a penalty to deter conduct that causes injury to personal health may reasonably include an amount of money that is commensurate not only with the nature of the conduct but also with the relationship of the parties. In the light of the facts of this case, we are unable to say that a lesser penalty would deter future misconduct.

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[7] ORS 163.190(1) provides that "[a] person commits the crime of menacing if by word or conduct the person intentionally attempts to place another person in fear of imminent serious physical injury."

[8] ORS 166.065 provides, in part:

"(1) A person commits the crime of harassment if the person intentionally:

"(a) Harasses or annoys another person by:

"(A) Subjecting such other person to offensive physical contact[.]"

We have independently examined the jury's award in light of the *BMW* guideposts that necessarily establish permissible awards. So long as the jury's award does not cross the line between permissible and excessive awards, it is not subject to reduction by the trial court. For the reasons stated above, we hold that the jury's punitive damage award was not excessive. Accordingly, we reverse the trial court's reduction of the punitive damage award and remand with instructions to reinstate the jury's verdict.

On appeal, reversed and remanded with instructions to reinstate jury's verdict; on cross-appeal, affirmed.

DEITS, C. J., dissenting.

As the majority correctly describes, the tort of intentional infliction of emotional distress (IIED) requires proof of the elements that the "defendant intended to inflict severe emotional distress on the plaintiff" and that the defendant's act giving rise to the distress constituted "extraordinary conduct which a reasonable jury could find beyond the farthest reaches of socially tolerable behavior." The Supreme Court has emphasized that the intent element and the "extraordinary conduct" elements are separate and distinct and that both must be present in order for the tort to be found. *See Madani v. Kendall Ford, Inc.*, 312 Or 198, 818 P2d 930 (1991). In my view, plaintiff's proof here did not support a finding of either element, and I would hold that the trial court erred by denying defendant's motion for a directed verdict.

160 Or App 111> Reduced to essentials, the majority reaches its contrary conclusion in both regards on the theory that the two necessary findings can be inferred from the fact that defendant's manager, Taylor, did not return to the care facility pursuant to plaintiff's request when she made the first of her telephone calls to him after Michelle's aggressive outburst. The majority reasons that intent to inflict emotional distress could be found at the end of a chain of inferences, all based on that telephone conversation, that Taylor knew plaintiff was upset, that he nevertheless "chose to leave heralone with her attacker" and, hence, that he "wished to inflict more emotional distress on plaintiff, knowing that she was suffering severe emotional distress because of the attack." 160 Or App at 99. Similarly, the majority relies on the inference to which it considers the first phone call can give rise in reaching its conclusion that the nature of Taylor's act could be found to exceed the farthest reaches of socially tolerable behavior. The majority explains:

> "As we have said, the evidence supports the inference that defendant, knowing that plaintiff had been exposed to physical danger, declined to come to her assistance, intending that she be placed in further danger. In the context of an employer-employee relationship where the employer has the ability to extricate the employee from a dangerous situation in which it has placed her, we hold that that kind of conduct is so extraordinary that a jury reasonably could find it to be beyond the furtherest reaches of the bounds of socially tolerable conduct." 160 Or App at 100.

I disagree with the majority in both connections. I do not think that a reasonable factfinder could infer that Taylor's failure to send assistance to plaintiff in response to her first phone call can lead to a finding that he intended to inflict severe emotional distress on her. Plaintiff was performing the job that she had been hired for, had been trained for and had agreed to do. She had had 10 hours of classroom training and spent two additional four-hour training sessions at the home, during which she observed the facility and was given some information about the residents. She had been forewarned--although perhaps not sufficiently--about Michelle's "tough" disposition. Unfortunately, the predictable happened on her first night of work for defendant, and she **<160 Or App 111/112>** called for help. Taylor spoke with her, asking where Michelle was and if she posed a threat to anyone at that time. After receiving assurances from plaintiff that Michelle was not harming anyone, Taylor gave plaintiff affirmative reasons why his return to the facility at that time was not a good idea in terms of patient care and offered reassurances to plaintiff about the unlikelihood that Michelle's attack would continue or be repeated.

His prediction, arguably, was wrong. Further, it is quite inferable that he was aware that plaintiff was upset. He may have been negligent in his assessment of the situation and in not going to the facility himself or arranging in some other way to relieve plaintiff. However, the remaining links in the inferential chain from that point to a permissible finding of an intent to inflict emotional distress are simply not there.

Plaintiff was not in the position of a bystander, like a visitor to the facility who arrived at the wrong time and fell in harm's way. She had accepted employment as the nighttime attendant at the facility and was performing that job at the time that Michelle attacked and at the time that plaintiff called Taylor. There is no question that plaintiff was upset at the time of the call. However, there is also no question that the cause of her distress was an event that was very much within the contemplation of her employment. Taylor was clearly not the cause--let alone the intentional one--of the emotional distress that plaintiff was experiencing at the time she called him.

The majority's theory is that, because he did not send relief, it could be inferred that Taylor intentionally caused the *further* distress that plaintiff suffered after the first telephone call. The problem with that theory is that it converts what was, at worst, a negligent management decision into an intentional tort aimed at causing the continuation or worsening of an already existing circumstance that an arguably more opportune decision might have brought to a stop. There was absolutely no evidence, independent of the fact that he did not provide or send held to plaintiff in dealing with Michelle and her job, that Taylor intended to cause her **<160 Or App 112/113>** any harm whatever. In my view, the flow of permissible inferences from the fact on which plaintiff and the majority rely does not go beyond negligence. Moreover, that view is reinforced by the fact that Taylor *did* provide the relief that plaintiff wanted in response to her later call. For the foregoing reasons, I conclude that plaintiff failed in her proof of the intent element of IIED.

Even clearer, however, is that the conduct on Taylor's part that plaintiff alleged and proved, as a matter of law, was not of a kind that a trier of fact could reasonably find to be "beyond the farthest reaches of socially tolerable behavior." As noted above, the "intent" and the "conduct" elements of IIED are distinct from one another, and the Supreme Court has treated the distinction as a rigid one. To illustrate, the plaintiff in *Madani* alleged that he was fired from his employment because he refused a supervisor's order to pull down his pants and expose himself in a public place and that the termination, in turn, resulted in severe emotional distress. The plaintiff did not allege that the supervisor's order, independently of the discharge, was a cause of his distress. The Supreme Court held that the allegations failed to state a claim for IIED. It explained that, although the employer's motive or reason for the firing may have been relevant to the intent element of the tort, it was not relevant to whether the act that allegedly brought about the distress, *i.e.*, the firing itself, "extraordinarily transgressed the bounds of socially tolerable conduct." *Id* at 204. The court continued:

> "[T]he act itself must be intolerable. The mere act of firing an employee, even if wrongfully motivated, does not transgress the bounds of socially tolerable behavior." *Id.*

The majority concludes that Taylor's conduct was susceptible to a finding of transgressing the farthest reaches of socially tolerable behavior, because he knew that plaintiff had been exposed to danger; he declined to come to her assistance, *intending* that she be placed in further danger; and that it is beyond the outer reaches of the tolerable for an employer with "the ability to extricate [an] employee from a dangerous situation in which it has placed her" to fail to do so. It is unclear whether, notwithstanding the Supreme Court's distinction between the two, the majority's analysis **<160 Or App 113/114>** blurs the line between the "intent" and the "conduct" elements.

Be that as it may, however, I do not agree with the majority's reasoning or its conclusion that the latter element could be found here. Defendant did not unilaterally place plaintiff in a dangerous situation; she accepted and was performing a job that, subjectively or objectively, had dangerous aspects. The majority's reasoning might be more persuasive, for example, in a situation where a defective wall collapses on an employee at the workplace and the employer is heedless of the employee's cries for assistance in extricating himself from the rubble. In this situation, however, any danger was inherent in the job itself. Plaintiff, a novice on the job, thought from the inception of Michelle's onslaught that relief or help was urgently needed. Rightly or wrongly, the manager of the center disagreed and left plaintiff to continue to perform her job without assistance, as he thought she could, and as she had agreed to do. Again, Taylor's decision may have been negligent. However, it surely was not an act that fell beyond the outside reaches of humanly acceptable behavior.

The rule that the majority would establish is operationally untenable. Under it, any employer could be found by a jury to have acted outside the bounds of social toleration if the employer failed or decided not to provide job reassignments or relief from duties in response to an employee's communication of a perceived danger in or related to the performance of the employee's job. Indeed, under the majority's analysis, an employee could have a viable claim for IIED against the employer for not relieving the employee of a putatively onerous job responsibility, under circumstances where the employee would not necessarily even be entitled to unemployment compensation benefits if the employee refused to perform. *See, e.g., Pintok v. Employment Division*, 32 Or App 273, 573 P2d 773 (1978).[1]

160 Or App 115> In my view, when all is said and done, the majority gives too little regard to whether this case should have gone to the jury and too much to what the jury could have found once the case was submitted to it under instructions that presupposed that a viable claim for liability was before it. However, the decisive question before us is whether the case should have been taken from the jury on the ground that the facts here were such that, as a matter of law, plaintiff had no viable claim that defendant's actions ran afoul of either the "intent" or the "conduct" element of the tort. The majority acknowledges that the tenability of the claim, at least as to the latter element, "is initially a question of law." 160 Or App at 100. The case should not have gone beyond that initial question, either in the trial court or here.

It follows from what I have said that I would also hold that defendant did not have the requisite intent to come within ORS 656.156, and that the claim is therefore barred by the exclusive remedy provision of the Workers' Compensation Law, in addition to failing on its merits. Whether the action would be barred under ORS 656.156 and ORS 656.018 if it were tenable as a tort claim is a question I need not reach. *But see Davis v. United States Employers Council, Inc.*, 147 Or App 164, 934 P2d 1142, *rev den* 325 Or 368 (1997).

It also follows, *ipso facto*, from the holding that I would reach that the punitive damages award should be vacated in its entirety.

For the foregoing reasons I disagree with the majority's disposition of both the appeal and the cross-appeal, and I respectfully dissent.

Landau, Linder, and Kistler, JJ., join in this opinion.

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[1] I expressly note that my observation here is not directed at whether plaintiff would be entitled to such benefits if she sought them. Rather, my comments are directed at a general possibility that could arise in light of the rule for intentional tort liability that the majority develops here and in light of ORS chapter 657 as it has been applied to different facts.

Cite as 160 Or App 116 (1999) April 28, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Mir Iliaifar, Claimant.

MIR ILIAIFAR, Petitioner,
v.
SAIF CORPORATION and DON RASMUSSEN CO., Respondents.
(WCB 96-05052; CA A98271)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 27, 1998.
Rex Q. Smith argued the cause and filed the briefs for petitioner.
Steven R. Cotton argued the cause and filed the brief for respondent.
Before Edmonds, Presiding Judge, and Deits, Chief Judge, and Armstrong, Judge.
EDMONDS, P. J.
Reversed and remanded for reconsideration.
Deits, C. J., dissenting.

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160 Or App 118> Claimant seeks review of a Workers' Compensation Board (Board) order upholding insurer's denial of his claim. We review for errors of law, ORS 656.298(7) and 183.482(8), and remand.

Claimant sold used cars for employer. He injured his back at the car lot and was released from work by his physician. After several days and two telephone conversations with his supervisor, claimant complied with the supervisor's request to deliver his physician's authorization to be off work to employer. Claimant left his Beaverton residence in a car provided to him by his employer and headed to downtown Portland to the car lot where he worked. On his way, claimant stopped at his credit union, and, shortly after leaving its parking lot, he was injured in a car accident. It is the injury resulting from the car accident that is the basis of his claim.

Employer's insurer denied the claim, contending that claimant was not injured in the course and scope of employment. Claimant requested a hearing before the hearings division, and the administrative law judge ruled in favor of claimant. On appeal, the Board ruled that claimant's injury did not occur within the course and scope of his employment and made the following findings:

> "Claimant, age 35 at the time of hearing, works as a car salesman for the employer. In connection with his employment, the employer furnished claimant with a 'demonstrator' vehicle, which he was to use primarily for transport to and from work.
>
> "Claimant compensably injured his back at work on December 12, 1995. On Friday, December 22, 1995, claimant's treating doctor released him from work for the following week. The next day, claimant telephoned his supervisor and reported that he was released from work. The supervisor requested a copy of the off-work authorization, which claimant understood he was to personally deliver to the employer. Claimant advised his supervisor that he would deliver the off-work slip as soon as he could.
>
> "On December 28, 1995, claimant again spoke with his supervisor by telephone. The supervisor again requested **<160 Or App 118/119>** the off-work slip and claimant advised he would deliver it the next day. On the afternoon of December 29, 1995, claimant left his home in Beaverton in his demonstrator car to deliver the off-work slip to his place of employment on Martin Luther King, Jr. Blvd. in Portland. On his way to the employer's premises, claimant stopped to do some banking at a downtown bank. After leaving the bank and while on his way to the employer's premises, claimant's vehicle was rear-ended. The rear-end collision resulted in claimant's herniated disc at L4-5."

The Board's findings are supported by substantial evidence in the record.[1] We take those findings and determine whether the Board drew the correct legal conclusions from them.

The Board determined that claimant's injury did not occur "in the course of employment." It explained:

> "Here, we find it significant that claimant was not actually traveling to perform any 'work' on the day of his injury. Although he was going to the employer's premises at the time of his injury, he had been released from work because of his prior back injury. Therefore, neither the 'going and coming' rule nor the 'special errand' exception are directly applicable."

As to the "special errand" exception to the "going and coming" rule, it reasoned:

> "Although the employer directed claimant to drop off a copy of his off-work slip, claimant's actions were not in furtherance of the employer's business (the sale of automobiles), nor was claimant acting on the employer's behalf at the time of his injury. Claimant made the trip primarily for his own benefit, to secure his entitlement to continued temporary disability benefits in connection with his prior injury claim. In addition, although claimant used his demonstrator vehicle to make the delivery, the employer did not have any right to control the time, manner of travel, or route to **<160 Or App 119/120>** be taken on claimant's trip. Indeed, the record establishes that, regardless of whether or not claimant was actually required to personally deliver the off-work slip, he made the delivery when it was convenient for him to do so. * * * Finally we find nothing about claimant's mid-afternoon trip to the employer's premises on December 29, 1995 which resulted in a substantially increased risk over his usual trips to and from work. Under these circumstances, we conclude the 'special errand' exception does not apply, even by analogy." (Footnotes omitted.)

On review, claimant argues: (1) that his actions on the day of his injury were in furtherance of employer's business; (2) that the personal delivery of the "off-work" authorization was an act in the course of his employment; (3) that employer had the right to control the time, manner of travel or route of claimant's trip; and (4) that the "special errand" exception to the "coming and going" rule applies.

In *Fred Meyer, Inc. v. Hayes*, 325 Or 592, 596-97, 943 P2d 197 (1997), the Supreme Court summarized:

> "For an injury to be compensable under the workers' compensation law, it must 'aris[e] out of' and occur 'in the course of employment.' ORS 656.005(7)(a). The 'arise out of' prong of the compensability test requires that a causal link exist between the worker's injury and his or her employment. *Krushwitz v. McDonald's Restaurants*, 323 Or 520, 525-26, 919 P2d 465 (1996); *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366, 867 P2d 1373 (1994). The requirement that the injury occur 'in the course of' the employment concerns the time, place, and circumstances of the injury. *Krushwitz*, 323 Or at 526; *Norpac*, 318 Or at 366.
>
> "This court views the two prongs as two parts of a single 'work-connection' inquiry, that is, whether the relationship between the injury and the employment is sufficient that the injury should be compensable. *Krushwitz*, 323 Or at 526; *Norpac*, 318 Or at 366. *See* ORS 656.012(1)(c) (Legislative Assembly finds that 'those injuries that bear a sufficient relationship to employment * * * merit incorporation of their costs into the stream of commerce'). Both prongs of the work-connection test must be satisfied to some degree;

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[1] Claimant apparently understands the Board to have made an additional finding of fact that "Claimant made the trip primarily for his own benefit, to secure his entitlement to continued temporary disability benefits in connection with his prior injury claim." He argues that there is no substantial evidence to support that finding. After reviewing the Board's order of review, order on reconsideration and second order on reconsideration, we understand the above statement to be a legal conclusion relating to whether claimant fell within the "special errand" exception of the "coming and going" rule.

neither is dispositive. *Krushwitz*, 323 Or at 531; *Norpac*, 318 Or at 366. The work-connection test may be satisfied if the factors supporting one prong of the statutory test are **<160 Or App 120/121>** minimal while the factors supporting the other prong are many. *Krushwitz*, 323 Or at 531, (citing *Phil A. Livesley Co. v. Russ*, 296 Or 25, 28, 672 P2d 337 (1983)). Both prongs serve as analytical tools for determining whether, in the light of the policy for which that determination is to be made, the causal connection between the injury and the employment is sufficient to warrant compensation. *Andrews v. Tektronix, Inc.*, 323 Or 154, 161-62, 915 P2d 972 (1996).

"Ordinarily, an injury sustained while a worker is going to or coming from work is not considered to have occurred 'in the course of' employment and, therefore, is not compensable. *Krushwitz*, 323 Or at 526 (citing *Cope v. West American Ins. Co.*, 309 Or 232, 237, 785 P2d 1050 (1990)); *Norpac*, 318 Or at 366. That general rule is called the 'going and coming' rule. The reason for the 'going and coming' rule is that the relationship of employer and worker ordinarily is suspended from the time the worker leaves work to go home until he or she resumes work because, while going to or coming from work, the worker is rendering no service for the employer. *Krushwitz*, 323 Or at 526-27 (citing *Heide/Parker v. T.C.I. Incorporated*, 264 Or 535, 540, 506 P2d 486 (1973))." (Footnotes omitted.)

In addition, the *Hayes* court quoted favorably from our statement in *Allen v. SAIF*, 29 Or App 631, 633-34, 564 P2d 1086, *rev den* 280 Or 1 (1977):

"The statutory phrase 'arising out of and in the course of employment' must be applied in each case so as to best effectuate the socio-economic purpose of the Workers' Compensation Act: the financial protection of the worker and his/her family from poverty due to injury incurred in production, regardless of fault, as an inherent cost of the product to the consumer. Various concepts have arisen from attempts to rationalize that purpose, *e.g.*, the going and coming rule, special errands,[2] lunch hour cases, dual purpose trips, impedimenta of employment, horseplay, *etc.* Each is helpful for conceptualization and indexing, but there is no formula for decision. Rather, in each case, every pertinent factor must be considered as a part of the whole. **<160 Or App 121/122>** It is the basic purpose of the Act which gives weight to particular facts and direction to the analysis of whether an injury arises out of and in the course of employment." (Citations omitted.)

We disagree with the Board that claimant's actions did not occur in the course of claimant's employment. For many years, Oregon has recognized that injuries are work related that occur in the performance of duties even though the claimant is off the employer's premises and performing duties that are not directly connected with the profit-making function of the employer's business or that are not considered within the claimant's typical job duties. *See, e.g., King v. Ind. Acc. Com.*, 211 Or 40, 309 P2d 159, 315 P2d 148, 318 P2d 272 (1957); *Reynolds v. State Ind. Acc. Com.*, 141 Or 197, 16 P2d 1105 (1932). In this case, claimant's uncontradicted testimony is that employer required the "off-work" authorization to be delivered to his supervisor "to make sure we are in the condition we are." Employer's written employee policy pertaining to on-the-job injury time losses requires "[a]n employee * * * to report to their manager on a weekly basis by reporting in the first day of their scheduled work week," and provides that the failure to report "could lead to disciplinary action." Employer can hardly argue that the delivery of the authorization was not for its benefit when its policies and reported requests required claimant to perform that act.

In light of the Board's finding under the circumstances that "the employer directed claimant to drop off a copy of his off-work slip," the requirement that the injury occur in the course of his employment is satisfied. The fact that claimant stopped to do some banking on the way does not affect the analysis. *See Savin Corp. v. McBride*, 134 Or App 321, 325-26, 894 P2d 1261 (1995) (holding that, although the claimant's stop at a bank was a personal errand, it was not so unrelated to her work as a

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[2] The "special errand" rule is an exception to the rule that injuries that occur while coming to and going from work are not compensable and applies when the employee was in the process of performing a special task or mission. *Philpott v. State Ind. Acc. Com.*, 234 Or 37, 41, 379 P2d 1010 (1963).

traveling employee so as to constitute a substantial departure from her work duties). Moreover, the "going and coming" exception to work connectedness is inapplicable to this case because of employer's specific direction. By directing claimant to deliver the "off-work" authorization to the car lot at a time when he was injured and unable to work, employer assumed the risk that claimant would be injured in an activity that was other than the travel **<160 Or App 122/123>** involved in going to work on an ordinary work day. Because of the same circumstances, claimant's injury also arose out of the course of his employment. The Board erred when it concluded that claimant's injury was not compensable.

The dissent's criticism appears to be two-fold. First, it complains that we do not analyze this case under the "coming and going" and "special errand" rules. Second, it argues that we have embarked on our own fact-finding mission contrary to the Board's findings. It points to the Board's assertion that claimant made the trip primarily for his own benefit. It says, "[a]n example of the majority's disagreement with the Board's findings of fact involves the Board's explicit finding that claimant's activities were not in furtherance of employer's business." 160 Or App at 127.

This case does not fit neatly under either the "coming and going rule" or the "special errand" exception to that rule. Claimant was not injured on the way to or from work at the car lot during a regularly scheduled workday. He was off work because of his work-related injury and was specifically directed by employer to bring the authorization to it. In that sense, he was "working" when he drove into the city to deliver the authorization. In contrast, the "special errand" exception to the "coming and going" rule generally applies when the claimant performs a special service for the employer while going to or coming from work. *Philpott*, 234 Or at 41. Rather than to apply a lock-step approach based on prior case law involving the two rules, we believe that *Hayes* instructs us to view the two-prong work-connection inquiry under all the circumstances to determine whether in light of the policy of the Workers' Compensation Law, the causal connection between the injury and the employment suffices to warrant compensation. In this case, the controlling fact resulting from the application of the *Hayes* formulation is that employer directed claimant to make the trip to downtown Portland at a time when he was off work.

As to the dissent's second criticism, it fails to read our opinion or the Board's opinion correctly. As we said previously, "[w]e take [the Board's findings] and determine whether the Board drew the correct legal conclusions from them." 160 Or App at 119. The appropriate legal, as opposed **<160 Or App 123/124>** to factual, inquiries are whether claimant's injury arose out of and in the course of employment. The Board's "finding" that claimant made the trip primarily for his own benefit to secure his entitlement to benefits is not a "finding of fact" but rather a conclusion of law drawn from the fact that employer directed claimant to bring the authorization to employer. The operative fact (that employer directed claimant to act) is uncontested. The benefits of delivering the authorization to the employer are derived from the legal implications of claimant's compliance and the injury that he suffered as a result. What weight his compliance is given is part of the calculus in determining whether claimant's injury occurred in the course of his employment.

Reversed and remanded for reconsideration.

DEITS, C. J., dissenting.

The Board concluded in this case that claimant's injury did not occur "in the course of" his employment and, therefore, that his injury was not compensable. The majority concludes that claimant's injury did occur "in the course of" his employment and, consequently, reverses the Board. In my opinion, the majority reaches that result by misapplying applicable case law. I believe that the Board correctly analyzed and decided this case. Accordingly, I dissent.

The Board begins its opinion by correctly articulating the applicable law. It explains that an injury is compensable if it "arises out of" and occurs "in the course of" the worker's employment. *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 867 P2d 1373 (1994). As the Board points out, these two prongs are part of a "work connection" inquiry to determine whether the relationship between the injury and the employment is sufficient to conclude that the injury is compensable. Both the "arising out of" and the "in the course of" prongs must be satisfied to some degree. *Krushwitz v. McDonald's Restaurants*, 323 Or 520, 919 P2d 465 (1996).

The Board then goes on to explain that, generally, an injury that occurs while a worker is going to or coming from work is not considered to have occurred "in the course of" employment and is not compensable. That general rule is called the "going and coming" rule. As the Board notes, the **<160 Or App 124/125>** reason for the "going and coming" rule is that the relationship of employer and worker ordinarily is suspended from the time that the worker leaves work to go home until he or she resumes work. *Id.* at 527.

The Board then recognizes that the courts have determined that there are some exceptional circumstances that involve a worker traveling to and from work that may be considered to be "in the course of" a worker's employment. The Board notes that one exception of significance here is the "special errand" rule. Under that exception, an injury may be compensable even if incurred while off the employer's premises traveling to and from work, if the employee is "acting in the furtherance of the employer's business at the time of the injury" or if the employer had "a right to control the employee's travel in some respect." *Id.* at 528.

In applying the above legal principles, the Board first concludes that, because claimant was not actually traveling to perform any "work" on the day of his injury, neither the "going and coming" rule nor the "special errand" exception is applicable to this case.[1] The Board explains that that conclusion alone should end the work-connection inquiry and would support the conclusion that claimant's injury was not compensable. However, the Board goes on to hold that, even assuming that the "going and coming" rule and the "special errand" exception apply directly or by analogy to circumstances where the employee is not traveling to the employer's premises to "work," but for an employment-related purpose, the requirements of the special errand rule are not met here and, accordingly, the injury is not in the course of claimant's employment and is therefore, not compensable.

The majority begins its analysis of this case by correctly explaining the two prongs of the work connection test discussed above. It is after that, however, that, in my view, the majority goes astray. Despite the fact that there is a well established legal framework for analyzing the compensability of injuries that occur while a worker is traveling to and from the workplace, namely the "going and coming rule" and the **<160 Or App 125/126>** "special errand" exception to that rule, and despite the fact that this framework was the basis of the Board's decision and the focus of claimant's arguments, the majority does not appear to deem it necessary to address those concepts. Rather, the majority quotes language from the Supreme Court's decision in *Fred Meyer v. Hayes*, 325 Or 592, 942 P2d 197 (1997), explaining the work-connection test first set forth in the Supreme Court's 1994 *Norpac* decision. The majority then refers to language from a 1977 decision of this court, *Allen v. SAIF*, 29 Or App 631, 564 P2d 1086, *rev den* 280 Or 1 (1977), for the proposition that all of the concepts such as the "going and coming" rule and the "special errand" rule are "helpful for conceptualization and indexing, but there is no formula for decision." Pursuant to the language from *Allen*, the majority then proceeds to analyze this case without considering the "going and coming" rule.

In my opinion, the case law does not support the proposition that the legal framework developed to analyze cases involving workers traveling to and from the workplace need not be addressed at all. The only support that the majority relies on for the approach that it takes is the language from our decision in *Allen*, noted above. The majority states that this language was "quoted favorably" by the Supreme Court in *Fred Meyer*. 160 Or App at 121. However, the reference in *Fred Meyer* to the language in *Allen* simply cannot be read as an abandonment of the existing legal framework for analyzing the compensability of injuries that occur while an employee is traveling to and from the workplace. As discussed above, the premise underlying the general rule, that injuries incurred while a worker is traveling to and from work are not compensable, is that the relationship of employer and employee is suspended from the time that the worker leaves work until the time that the worker resumes work. The exceptions to that rule have been specifically and narrowly defined. *Krushwitz*, 323 Or App 529. It makes no sense to conclude that the carefully defined limits applied when reviewing the compensability of injuries that occur while a worker is traveling to and from his or her place of employment are abandoned if the worker is not traveling there to work, but to carry out some other employment-related purpose.

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[1] The Board concluded that there was no evidence that travel was part of his employment, and claimant does not argue otherwise.

160 Or App 127> I am not sure that I fully understand the basis of the majority's decision here. Although the majority apparently does not believe it necessary to consider the "going and coming" rule and its exceptions, and does not directly address them, the points on which the majority relies to reach the conclusion that the Board was wrong appear to involve elements of the "special errand" exception to the "going and coming" rule. The majority appears to accept the Board's findings and agrees that the Board's findings were supported by substantial evidence. It explains that its disagreement with the Board is that, in its view, the Board's findings do not lead to the legal conclusion that claimant was injured in the course of his employment. Inexplicably, however, in reaching that conclusion, the majority seems to quarrel with the Board's findings of fact.

An example of the majority's disagreement with the Board's findings of fact involves the Board's explicit finding that claimant's activities were not in furtherance of employer's business. The Board found:

> "Although the employer directed claimant to drop off a copy of his off-work slip, claimant's actions were not in furtherance of the employer's business (the sale of automobiles), nor was claimant acting on the employer's behalf at the time of his injury. Claimant made the trip primarily for his own benefit, to secure his entitlement to continued temporary disability benefits in connection with this prior injury claim." (Footnote omitted.)

Claimant moved for reconsideration of the Board's decision, arguing that he was acting in furtherance of the employer's business and, therefore, came within the "special errand" rule, because he was injured while driving a demonstrator vehicle and because the employer had an interest in seeing him in person to determine his condition. In rejecting those arguments, the Board explained:

> "In our prior order, we expressly concluded that these facts did not render claimant's injury *per se* compensable. We explained that claimant was not acting in furtherance of the employer's *business* (the sale of automobiles) nor was he acting on the employer's behalf at the time he was injured. We found that claimant made the trip primarily for his own benefit; *i.e.*, to secure his entitlement to continued **<160 Or App 127/128>** temporary disability benefits. We also noted that claimant was not under the employer's control at the time of his injury. Although claimant was driving a 'demonstrator' vehicle furnished by the employer, claimant had been released from work and the employer did not control the time, manner of travel, or route to be taken on this particular trip to the employer's premises." (Emphasis in original; footnote omitted.)

Claimant filed a second motion for reconsideration of the Board's order on that point, and the Board again rejected his argument, explaining:

> "We conclude that even if claimant's trip to the employer's premises did not affect his entitlement to temporary disability and even assuming the employer had an interest in having injured workers personally deliver documentation of their medical status, claimant's trip did not fall within the 'special errand' exception (even by analogy) because claimant was not acting in furtherance of the *employer's business* at the time of the injury." (Emphasis in original.)

The majority rejects those findings, concluding that they involve a question of law and, therefore, in its view, it is entitled to substitute its judgment on the question. The majority states:

> "Employer's written employee policy pertaining to on-the-job injury time losses requires 'an employee * * * to report to their manager on a weekly basis by reporting in the first day of their scheduled work week,' and provides that the failure to report 'could lead to disciplinary action.' Employer can hardly argue that the delivery of the authorization was not for its benefit when its policies and reported requests required claimant to perform that act." 160 Or App at 122.

In my opinion, the question of whether claimant's activities were in furtherance of employer's business involves a question of fact. The Board found that these activities were not in furtherance of

employer's business and that finding is supported by substantial evidence. Accordingly, I would hold that the Board's legal conclusion that these activities did not <160 Or App 128/129> come within the "special errand" exception and, consequently, were not "in the course of" claimant's employment is correct.

The second point that the majority relies on to support its legal conclusion that claimant's injuries were compensable is the fact that the employer directed the claimant to drop off a copy of his off-work slip. The majority concludes that the employer's direction creates a sufficient work connection to support the conclusion that claimant's injury was compensable. In reaching this conclusion, however, I believe that the majority again uses the wrong legal framework. Under the applicable case law, the inquiry as to the significance of whether this activity was directed by the employer should be analyzed in the context of the "special errand" exception to the "going and coming" rule. These rules were specifically designed to analyze circumstances where an injury occurs while the worker is traveling to the place of employment. Again, as noted above, it makes no sense to conclude that if a worker is not traveling to the employer's place of business to work, but to carry out a work-related purpose, less stringent standards should apply in determining if the injury is compensable. *Krushwitz*, 323 Or at 528.

The Board made explicit findings on this point. It found:

> "In addition, although claimant used his demonstrator vehicle to make the delivery, the employer did not have any right to control the time, manner of travel, or route to be taken on claimant's trip. Indeed, the record establishes that, regardless of whether or not claimant was actually required to personally deliver the off-work slip, he made the delivery when it was convenient for him to do so. Finally, we find nothing about claimant's mid-afternoon trip to the employer's premises on December 29, 1995 which resulted in substantially increased risk over his usual trips to and from work. Under these circumstances, we conclude that the 'special errand' exception does not apply, even by analogy." (Footnote omitted; citation omitted.)

The Board's findings are supported by substantial evidence. In view of these findings of fact and applying the correct legal framework, I would hold that the Board did not err in concluding that claimant's activities did not come within the <160 Or App 129/130> "special errand" rule and, consequently, were not "in the course of" his employment.

For all of the above reasons, I would affirm the Board's decision and, accordingly, I respectfully dissent.

Cite as 160 Or App 131 (1999) April 28, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Benny H. Rash, Claimant.

BENNY H. RASH, Petitioner,
v.
MCKINSTRY COMPANY and LIBERTY NORTHWEST INSURANCE CORPORATION, Respondents.
(TP-97009; CA A100576)

Judicial review from Workers' Compensation Board.
Argued and submitted on October 16, 1998.
Robert K. Udziela argued the cause for petitioner. With him on the brief were Gregory A. Bunnell, and Pozzi, Wilson & Atchison.
Alexander D. Libmann argued the cause and filed the brief for respondents.
Before Edmonds, Presiding Judge, and Deits, Chief Judge,* and Armstrong, Judge.
EDMONDS, P. J.
Affirmed.
Armstrong, J., dissenting.

*Deits, C. J., *vice* Warren, P. J., retired.

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160 Or App 133> Claimant seeks review of a Workers' Compensation Board (Board) order ruling that insurer's lien rights, pursuant to ORS 656.580 and 656.593, on claimant's third-party settlement proceeds were not resolved by the parties' Claim Disposition Agreement (CDA). We review for errors of law, ORS 656.298(7) and 183.482(8), and affirm.

On June 16, 1994, claimant injured his neck and back while in the course and scope of his employment. Employer's insurer accepted the neck and back injuries as work-related and provided benefits to claimant. In July 1996, after claimant began a tort action against a third party involved in the cause of the injuries, insurer and claimant entered into a CDA. The CDA did not specifically preserve insurer's lien rights against any recovery that claimant might receive in the tort action. After claimant settled with the third party for $400,000, insurer sought to recover $124,716.73 from the proceeds, the amount that it had paid on claimant's claim.

The Board, concluded that in the absence of an express waiver in the CDA of the insurer's lien rights under ORS 656.580[1] and 656.593,[2] insurer had a statutory **<160 Or App 133/134>** right to

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[1] ORS 656.580 provides:

"(1) The worker or beneficiaries of the worker, as the case may be, shall be paid the benefits provided by this chapter in the same manner and to the same extent as if no right of action existed against the employer or third party, until damages are recovered from such employer or third party.

"(2) The paying agency [which pursuant to ORS 656.576 includes the insurer] has a lien against the cause of action as provided by ORS 656.591 or 656.593, which lien shall be preferred to all claims except the cost of recovering such damages."

[2] ORS 656.593 provides, in part:

"(1) If the worker or the beneficiaries of the worker elect to recover damages from the employer or third person, notice of such election shall be given the paying agency by personal service or by registered or certified mail. * * * The proceeds of any damages recovered from an employer or third person by the worker or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds as set forth in this section. * * * The total proceeds shall be distributed as follows:

"(a) Costs and attorney fees incurred shall be paid, such attorney fees in no event to exceed the advisory schedule of fees established by the Workers' Compensation Board for such actions.

recover what it had paid on behalf of claimant. Claimant's sole assignment of error is that the Board erred in holding that, "in the absence of an express waiver in the CDA of the [insurer's] lien rights under ORS 656.580 and 656.593, the parties' CDA does not deprive the [insurer] of its statutory right to recover from the third party proceeds." Claimant argues that an amendment made to ORS 656.236(1)(a) by Oregon Laws 1995, chapter 332, section 24, requires an insurer expressly to reserve its lien rights in a CDA. Insurer argues that the only rights released in the CDA belonged to claimant and that the amendment did not affect its statutory lien rights.

In interpreting a statute, our task is to discern the intent of the legislature. We look first to the text and context of the statute to ascertain its meaning. ORS 656.236(1)(a) provides, in part:

> "The parties to a claim, by agreement, may make such disposition of any or all matters regarding a claim, except for medical services, as the parties consider reasonable, **<160 Or App 134/135>** subject to such terms and conditions as the Workers' Compensation Board may prescribe. *For the purposes of this section, 'matters regarding a claim' includes the disposition of a beneficiary's independent claim for compensation under this chapter. Unless otherwise specified, a disposition resolves all matters and all rights to compensation, attorney fees and penalties potentially arising out of claims, except medical services, regardless of the conditions stated in the agreement.* Any such disposition shall be filed for approval with the board. If the worker is not represented by an attorney, the worker may, at the worker's request, personally appear before the board. Submission of a disposition shall stay all other proceedings and payment obligations, except for medical services, on that claim." (Emphasis indicates language added by Oregon Laws 1995, chapter 332, section 24.)

Claimant focuses on the language "all matters and all rights to compensation" in the statute to support his argument. Insurer counters that its third-party lien is not related to claimant's right to receive compensation, and that, therefore, plaintiff's lien rights are not governed by ORS 656.236(1)(a).

ORS 656.005(8) defines compensation for purposes of the Workers' Compensation Statutes as including "all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to this chapter." The phrase "all rights to compensation" in ORS 656.236(1)(a) by definition relates only to claimant's rights. It is less clear whether the words "all matters" in ORS 656.236(1)(a) refer to rights other than those relating to claimant's compensation or are intended to encompass only the rights of claimants. The "doctrine of the last antecedent" provides:

> "Referential and qualifying words and phrases, where no contrary intention appears, refer solely to the last antecedent. The last antecedent is 'the last word, phrase, or clause that can be made an antecedent without impairing the meaning of the sentence.'" *State v. Webb*, 324 Or 380, 386, 927 P2d 79 (1996) (quoting Norman J. Singer, 2A *Sutherland Statutory Construction* section 47, 33, at 270 (5th ed 1992)).

"(b) The worker or the beneficiaries of the worker shall receive at least 33-1/3 percent of the balance of such recovery.

"(c) The paying agency shall be paid and retain the balance of the recovery, but only to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under this chapter. Such other costs include expenditures of the Department of Consumer and Business Services from the Consumer and Business Services Fund, the Self-Insured Employer Adjustment Reserve and the Workers' Benefit Fund in reimbursement of the costs of the paying agency. Such other costs also include assessments for the Workers' Benefit Fund, and include any compensation which may become payable under ORS 656.273 or 656.278.

"(d) The balance of the recovery shall be paid to the worker or the beneficiaries of the worker forthwith. Any conflict as to the amount of the balance which may be retained by the paying agency shall be resolved by the board.

"* * * * *

"(3) A claimant may settle any third party case with the approval of the paying agency, in which event the paying agency is authorized to accept such a share of the proceeds as may be just and proper and the worker or the beneficiaries of the worker shall receive the amount to which the worker would be entitled for a recovery under subsections (1) and (2) of this section. Any conflict as to what may be a just and proper distribution shall be resolved by the board."

If the doctrine is applied to ORS 656.236(1)(a), "to compensation" would only qualify "all rights" and not "all matters." However, the context of ORS 656.236(1)(a) leads us to a **<160 Or App 135/136>** different conclusion, *i.e.*, that the legislature intended that the "matters" released in a CDA, unless otherwise specified, are claimant's, not insurer's.

ORS 656.576 to ORS 656.596 govern the interaction between the workers' compensation system and recovery against third parties and noncomplying employers. Throughout those statutes, a distinction is made between damages recovered from third parties and benefits received by an injured worker under the workers' compensation system. In ORS 656.593, the legislature uses the term "proceeds" in describing the monies recovered from a third-party tortfeasor. In contrast, the legislature uses the terms "compensation" and "benefits" when it refers to the expenditures made by the insurer that are recoverable from third party proceeds. ORS 656.593(1)(c) and, (2). Similarly, the legislature uses the terms "release of the claim" or "claim release" in providing that a worker may elect to release the insurer from liability for purposes of workers' compensation. ORS 656.593(6) and (7). It uses "cause of action" or "right of action" in referring to the ability of a claimant to seek recovery from a third party. ORS 656.580, 656.587, 656.591(1). Nowhere in ORS 656.236 do the terms "action" or "proceeds" appear. Rather, the terms "claim"[3] and "compensation" are used in the sentences proceeding the language in dispute and in the language itself. In context, it appears that "all matters and all rights to compensation" refers to benefits and claims of *claimants* and not to the lien rights of insurers.

Whatever ambiguity is left is resolved by the legislative history. It does not contain anything that indicates that the legislature contemplated that third party actions be presumptively included in a CDA. Instead, the legislative history reveals that the legislature's concern was that the rights involving a *claim* or *compensation* would be presumptively resolved.[4] To the extent that the language of the statute is redundant, that fact does not change the legislature's focus on claimant's rights and its silence about insurer lien **<160 Or App 136/137>** rights. Therefore, we hold that the Board did not err in finding that insurer did not release its rights to a lien on third-party proceeds through the CDA because plaintiff failed to expressly preserve those rights in the agreement.

Affirmed.

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[3] ORS 656.005(6) defines claim as "a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge."

[4] *See* Tape recording, Senate and House Labor Committees, SB 369, January 30, 1995, Tape 16, Side A (statement of Representative Kevin Mannix); Senate Labor & Gov't Operations Committee, SB 369, February 17, 1995, Ex F (committee staff summary); tape recording, Senate Labor & Gov't Operations Committee, SB 369, March 6, 1995, Tape 45, Side A (statement of Representative Kevin Mannix); House Labor Committee, SB 369, March 6, 1995, Ex A (committee summary); tape recording, House Labor Committee, SB 369, March 13, 1995, Tape 57, Side A (statement of Glen Lasken, member of the Oregon State Bar Workers' Compensation Section).

ARMSTRONG, J., dissenting.

The majority concludes that an insurer entering into a claim disposition agreement under ORS 656.236(1)(a) does not need to include in the agreement a reservation of its lien rights in order to enforce those rights in the event that the claimant later recovers damages from a third-party tortfeasor. Because I believe that that conclusion is contrary to the express language of the statute, I respectfully dissent.

When asked to construe a statute, our task is to discern the intent of the legislature. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993). The text of the statute is the best evidence of the legislature's intent, and it is only if the text, in context, is ambiguous that we go beyond it. *Id.* at 610-11. The statutory text at issue here is:

> "Unless otherwise specified, a [claim] disposition [agreement] resolves *all matters* and all rights to compensation, attorney fees and penalties *potentially arising out of claims*, except medical services, regardless of the conditions stated in the agreement." ORS 656.236(1)(a) (emphasis added).

The majority concludes that "all matters" doesn't really mean *all* matters but, rather, means only those matters pertaining to a claimant's right to compensation. It reaches that conclusion by examining other provisions of the Workers' Compensation Law and by looking to the legislative history of the amendment creating the provision at issue. In doing so, the majority ignores the plain, unambiguous text of the statute itself. I am at a loss to see how the phrase "all matters," given its plain, natural and ordinary meaning, PGE, 317 Or at 611, could be read to mean anything other **<160 Or App 137/138>** than *all* matters. By concluding otherwise, the majority has effectively erased that phrase from the statute. If, as the majority holds, the legislature intended "all matters" to mean only those matters that involve a claimant's rights to compensation, then it did not need to refer in the statute to "all rights to compensation, attorney fees and penalties." Under the majority's interpretation of the statute, the phrases "all matters" and "all rights to compensation, attorney fees and penalties" are redundant of each other. Of course, that interpretation runs afoul of the direction to us in ORS 174.010 to construe statutes, if possible, in such a way as to give effect to all of their provisions.

The majority seeks to avoid that problem by focusing on other statutes that address third-party recovery and the release of claims. It discusses the difference in meaning between the words "benefits" and "proceeds" and between the phrases "release of claim" and "cause of action." It then concludes that, because the terms "proceeds" and "action" do not appear in ORS 656.236, the provision can apply only to benefits and claims of claimants. I fail to understand the majority's logic. It is true that related statues provide context for the interpretation of statutory language. However, it is unremarkable that words found in statutes specifically addressed to third-party recovery do not appear in a statute that is addressed to claim settlement rather than third-party recovery. Hence, the differences in phrasing between ORS 656.236 and the statutes on third-party recovery provide an insufficient basis to conclude that the legislature did not intend the phrase "all matters" to include an insurer's lien.

Indeed, the only linguistically defensible interpretation of the statutory language is that the phrases "all matters" and "all rights to compensation, attorney fees and penalties" are independent of each other and are each qualified by the phrase "potentially arising out of claims." In other words, the legislature intended that "all matters" be read as matters *other than* rights to compensation, attorney fees or penalties. A disposition agreement, therefore, would resolve a claimant's rights to compensation, attorney fees and penalties *and* would resolve any other matter that might arise out of a claim. A claimant's right to compensation necessarily will arise out of a claim, but an insurer's lien is not a part of **<160 Or App 138/139>** every claim. By adding the reference to other matters that *might* arise from a claim, the legislature has recognized that, in some circumstances, there may be issues other than compensation that would need to be resolved. Rather than attempt to specify the universe of matters that could arise, the legislature chose only to specify those matters that always or frequently arise and bundled the rest into the phrase "all matters." There is no other way to read that text and, therefore, there is no need to look elsewhere for meaning.[1]

That understanding of the statute also happens to make sense. Insurer acknowledged that claim disposition agreements can, and do, address the disposition of an insurer's lien rights arising from a claim. It is not surprising that they would. A claimant settling a workers compensation claim often would want to resolve the extent to which he or she would be required to repay the insurer the money received from it on the claim. Given that, the statute provides that the disposition agreement does resolve all matters between the claimant and the insurer, including the obligation of the claimant to repay the insurer if the claimant recovers money from a third party for the work-related injury, unless the parties provide otherwise. It thus requires the parties to decide which of their rights and obligations arising from a claim, other than the claimant's right to medical benefits, survives the settlement, thereby avoiding later disputes over that issue. The majority errs in concluding otherwise.

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[1] Even though I conclude that there is no need to resort to legislative history to interpret ORS 656.236(1)(a), I note that there is nothing in that history to indicate that the legislature intended *only* to affect the rights of claimants. The fact that the discussion was focused on the resolution of claimants' rights does not mean that, when the legislature adopted the language that it did, the legislature meant the provision to apply only to claimants. And, even if that were the intent of the legislature, the express language that it adopted goes beyond that intent. *See Deluxe Cabinet Works v. Messmer*, 140 Or App 548, 554, 915 P2d 1053, *rev den* 324 Or 305 (1996) ("whatever the legislative history shows, the fact remains that the language of the statute cannot reasonably be read to accomplish what employer suggests, and we may not rewrite that language so that it more closely tracks with the legislature's unenacted intentions").

Cite as 160 Or App 242 (1999) April 28, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Bobbi J. Blakely, Claimant.

SAIF CORPORATION and DOUGLAS COUNTY SCHOOL DISTRICT #19, Petitioners,
v.
BOBBI J. BLAKELY, Respondent.
(WCB 97-0529M; CA A101506)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 5, 1999.
Julene M. Quinn argued the cause and filed the briefs for petitioners.
Martin J. McKeown argued the cause and filed the brief for respondent.
Before De Muniz, Presiding Judge, and Haselton and Linder, Judges.
HASELTON, J.
Reversed and remanded for reconsideration.

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160 Or App 244> Petitioners, an employer and its insurer, seek review of an "own motion" order of the Workers' Compensation Board, ORS 656.278, awarding claimant temporary disability benefits. ORS 656.210. They assert that the Board's determination that claimant was willing to work, which is a prerequisite to the receipt of such benefits, was not supported by the evidence on which the Board relied. We agree and, consequently, reverse and remand for reconsideration.

Claimant sought temporary disability compensation benefits, pursuant to the Board's own motion authority,[1] as a result of arthroscopic knee surgery in November 1997. To be entitled to such benefits, claimant had to prove that she was "in the work force" at the time of that surgery. *See Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258, 778 P2d 497 (1989); *Weyerhaeuser Co. v. Kepford*, 100 Or App 410, 414, 786 P2d 745, *rev den* 310 Or 71 (1990). A claimant is deemed to be "in the work force" if:

> "a. The claimant is engaged in regular gainful employment; or "b. The claimant, although not employed at the time, is willing to work and is making reasonable efforts to obtain employment; or
>
> "c. The claimant is willing to work, although not employed at the time and not making reasonable efforts to obtain employment because of a work-related injury, where such efforts would be futile." *Dawkins*, 308 Or at 258 (citations and footnotes omitted).

The circumstances in this case are somewhat confused by the fact that in November *1996*, a year before the surgery involved here, claimant had also undergone arthroscopic knee surgery and had, ultimately, recovered own motion temporary disability benefits with respect to that surgery. In that instance, the Board had concluded that claimant was in the work force at the time of the disability because she had been engaged in regular gainful employment up to the time of the surgery. Claimant's treating physician, Dr. **<160 Or App 244/245>** Mohler, rendered an opinion on March 26, 1997, that claimant was medically stationary following the November 1996 surgery, and that claim closed.

Immediately before the November 1997 surgery, claimant requested time loss benefits with respect to that surgery, and the insurer, SAIF Corporation, opposed that request, asserting that "no proof has been provided to show [claimant] is in the work force." The Board evaluated that request under *Dawkins*'s third category--willingness to work but not seeking employment because the work-related injury renders such efforts futile--and initially denied benefits for want of proof. On reconsideration, the Board reiterated that denial, reasoning that, although certain medical evidence demonstrated claimant's physical *inability* to work, there is no evidence of claimant's *willingness* to work as of the time of the November 1997 surgery.

Claimant then sought reconsideration for a second time, based on her submission of additional evidence consisting of a December 17, 1997, cover letter and statement by Dr. Mohler in which he stated

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[1] Claimant's aggravation rights had expired in July 1984.

that claimant "has had severe right knee pain since her [prior] arthroscopic knee surgery on 11/19/96 and in my opinion could not be part of the work force during that time."[2] From that statement, the Board majority concluded:

> "Furthermore, Dr. Mohler's opinion establishes that claimant remained unable to work due to the compensable injury after that November 19, 1996 surgery. Thus, there was essentially no change in claimant's work status from the time of the November 19, 1996 surgery until the November 21, 1997 surgery. Because there was no change in claimant's work status, we find that she remained in the work force by virtue of our prior findings regarding the work force issue. Consequently, at the time of the November 21, 1997 surgery, claimant met the third criterion of Dawkins - she was not employed, but she was willing to work and was not seeking work because a work-related injury had made such efforts futile."

160 Or App 246> One Board member dissented:

> "[A]lthough willingness to work ultimately may be a subjective factor, claimant still has the burden of proving that factor, as well as the other elements of the work force issue. Here, given the fact that claimant has proved that, due to the compensable injury, any reasonable work search would have been futile, proof of willingness to work could include a sworn affidavit from claimant regarding her willingness to work if not for her work injury. * * *
>
> "[C]laimant has submitted no evidence regarding her willingness to work during the relevant time regarding her current own motion claim, *i.e.*, her November 1997 surgery."

On review, SAIF invokes the Board dissent's analysis. Although SAIF asserts that the Board "failed to apply the correct legal standard" in determining whether claimant was in the work force, the substance of SAIF's complaint is that the evidence on which the Board purported to rely does not support its conclusion. Specifically, although the Board did, in fact, explicitly apply the *Dawkins* analysis and expressly determined that "at the time of the November 21, 1997 surgery, claimant * * * was willing to work," the only evidence on which the Board relied[3]--Mohler's December 19, 1997, letter--does not support that conclusion.

SAIF is correct. Nothing in Mohler's December 19, 1997, statement, as described and quoted by the Board, touches on claimant's *willingness* to work. That statement refers only to claimant's physical ability to work, and not to her willingness to work, on the date of surgery. It may be that claimant's physical inability to work would have rendered any efforts to obtain employment futile. However, *Dawkins* is explicit that such futility is distinct from willingness to **<160 Or App 246/247>** work--that is, that proof of the former does not, without more, establish the latter--and the Board did not purport to hold otherwise. Thus, the Board's determination of willingness to work was unsupported by the evidence on which it relied. Because that unsupported determination was essential to the Board's ultimate conclusion that claimant was "in the work force" and, thus, eligible for temporary disability benefits at the time of the November 1997 surgery, we reverse and remand for the Board to reconsider the "willingness to work" issue. *See Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205-06, 752 P2d 312 (1988).

Reversed and remanded for reconsideration.

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[2] For undisclosed reasons, the actual text of Mohler's letter and statement are not in the record. We quote the Board's quotation of that letter, which neither party disputes.

[3] As the Board correctly noted in its initial opinion, representations by claimant's counsel that claimant was willing to work did not "meet claimant's burden of proving the willingness to work element of the work force issue."

On review, claimant notes that, in March 1997, certain of her medical records were sent to vocational rehabilitation, and she asserts that that transmittal implies participation in rehabilitation after the 1996 surgery, which, in turn, could imply willingness to work before, and at the time of, the 1997 surgery. There is, however, no evidence in the record that claimant actually participated in rehabilitation, much less of the extent of any such participation. In all events, the Board did not purport to rely on the transmittal of the medical records as evidence of willingness to work.

Cite as 160 Or App 254 (1999) April 28, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Joni M. Varah, Claimant.

SAIF CORPORATION and FAIRVIEW TRAINING CENTER, Petitioners,
v.
JONI M. VARAH, Respondent.
(WCB 97-06270; CA A103050)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 21, 1999.
Steve Cotton, Special Assistant Attorney General, argued the cause for petitioners. With him on the brief were Hardy Myers, Attorney General, and Michael D. Reynolds, Solicitor General.
Dale C. Johnson filed the brief for respondent.
Before De Muniz, Presiding Judge, and Haselton and Linder, Judges.
HASELTON, J.
Reversed and remanded.

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160 Or App 256> Petitioners, an employer and its insurer, seek reversal of an order of the Workers' Compensation Board that awarded claimant assessed attorney fees pursuant to ORS 656.386(1)(a) and (c). They contend that the Board erred in concluding that the original notice of acceptance of claimant's claim was, in fact, a denial and that the insurer's subsequent modification of that notice constituted a "rescission of the denial." ORS 656.386(1)(a). We reverse and remand.

In April 1997, claimant, who was employed as a habilitive training technician, suffered a compensable injury while lifting a client. Claimant subsequently filed a Report of Occupational Injury or Disease and received medical treatment for what was ultimately diagnosed as "[t]horacolumbar muscular back strain relating to lifting activities * * * resolved stationary without impairment." On July 14, 1997, the insurer, SAIF Corporation, issued a Notice of Acceptance, accepting a "thoracolumbar muscular back strain, *resolved*." (Emphasis added.) On August 5, 1997, claimant filed a request for hearing, describing the issue as "Improper prospective denial (see Notice of Claim Acceptance dated 7/14/97 alleging that accepted claim is resolved)." On August 27, 1997, before any hearing, SAIF issued a Modified Notice of Acceptance, accepting a "thoracolumbar muscular back strain"--*i.e.*, the modified notice deleted the term "resolved."[1]

Claimant then sought an assessed attorney fee pursuant to ORS 656.386(1), which provides, in part:

> "* * *In such cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge, a reasonable attorney fee shall be allowed.
>
> "(b) For purposes of this section, a 'denied claim' is:
>
> "(A) A claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is **<160 Or App 256/257>** not compensable or otherwise does not give rise to an entitlement to any compensation;
>
> "* * * * *

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[1] The parties stipulated that all compensation was paid--that is, the use of "resolved" in the original Notice of Acceptance did not result in any staying or nonpayment of compensation.

> "(c) A denied claim shall not be presumed or implied from an insurer's or self-insured employer's failure to pay compensation for a previously accepted injury or condition in timely fashion. Attorney fees provided for in this subsection shall be paid by the insurer or self-insured employer."[2]

Claimant contended that, because of SAIF's use of the term "resolved" in the original notice of acceptance, that notice was, in fact, a denial and not an acceptance and that SAIF's deletion of "resolved" in the modified notice effected a "rescission of the denial prior to a decision by the Administrative Law Judge." ORS 656.386(1)(a).

The administrative law judge rejected that argument, reasoning that, even if SAIF's use of "resolved" "impl[ied] that future responsibility might be denied," such an "implication" was insufficient to trigger ORS 656.386(1)(a). An en banc majority of the Workers' Compensation Board disagreed and concluded that claimant was entitled to an assessed fee. The essence of the Board's holding, which invoked *Galbraith v. L.A. Pottsratz Construction*, 152 Or App 790, 955 P2d 319 (1998), was that, although "SAIF did not literally state that claimant was entitled to no relief * * * its acceptance of a 'resolved' condition * * * constitutes a denial of further benefits under the claim." The Board majority observed:

> "Because it is well settled that the term 'resolved' carries with it the connotation of a denial of future claims for benefits, its inclusion in an 'acceptance' essentially represents a notice to the injured worker discouraging him/her from seeking further benefits for their 'resolved' condition. To find that the removal of the word 'resolved' from a carrier's acceptance does not warrant an attorney fee under ORS 656.386(1) for finally prevailing over a 'denied claim' would also mean that there are no consequences for the carrier's **<160 Or App 257/258>** acceptance of a 'resolved' condition. * * * [A]cceptance of a 'resolved' condition carries the implication that claimant is no longer entitled to relief for her compensable condition."

Two members of the Board dissented:

> "In light of the legislature's requirement [in the 1995 amendments to ORS 656.386(1)] that a 'denied claim' involve a refusal to pay compensation on the 'express ground' that an injury or condition is not compensable or otherwise does not give rise to an entitlement to any compensation, it seems clear that the concept of an implied denial of future benefits * * * did not survive the 1995 legislative amendments."

On review, SAIF relies primarily on the Board dissent's reasoning, contending that the inclusion of "resolved" in the original notice of acceptance did not give rise to a "denied claim" within the meaning of ORS 656.386(1). We agree.

In *Stephenson v. Meyer*, 150 Or App 300, 945 P2d 1114 (1997), we held that, before a claimant can recover an assessed fee under ORS 656.386(1), three conditions must be met:

> "(1) [T]here is a request for compensation; (2) the request for compensation is denied; and (3) the claimant prevails finally against the refusal to pay compensation as requested." 150 Or App at 304.

Under the statute, there is no "denied claim" unless the employer "refuses to pay on the express ground that the injury or condition * * * is not compensable." ORS 656.386(1).

Here, there was no *express* refusal to pay compensation. At most, the use of "resolved" in the original notice of acceptance *implied* that SAIF might refuse to pay future benefits for claimant's condition. The Board majority acknowledged as much: "[A]cceptance of a 'resolved' condition carries *the*

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[2] The quoted language was, for the most part, originally enacted as part of the 1995 amendments to ORS 656.386. Or Laws 1995, ch 332, section 43. In 1997, the legislature modified the structure and numbering of subsections within ORS 656.386(1) but did not alter the substance of the quoted provision. Or Laws 1997, ch 605, section 3.

implication that claimant is no longer entitled to relief for her compensable condition."[3] (Emphasis added.) Such an **<160 Or App 258/259>** "implication" is not "express" and, thus, does not trigger the statutory entitlement to an assessed fee.

Galbraith, on which the Board majority relied, is materially factually distinguishable. There, in responding to the claimant's hearing request, SAIF stated, "The claimant is entitled to no relief." In concluding that the claimant was entitled to attorney fees, we emphasized that language and concluded, "We are at a loss to understand how SAIF's statement can be understood as anything *but* an express denial of the claim" for purposes of ORS 656.386(1). 152 Or App at 793-94 (emphasis in original). Thus, *Galbraith* turned on an explicit denial. In this case, "resolved" connotated, at most, an implicit denial of future benefits.

The Board erred in awarding claimant attorney fees under ORS 656.386(1).[4]

Reversed and remanded.

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[3] Indeed, the Board majority relied substantially on Board precedent that held that the term "resolved" implied that the carrier was no longer responsible for the future benefits for claimant's condition. *Gary L. Best*, 46 Van Natta 1694 (1994). That authority antedated the 1995 amendments to ORS 656.386(1), including the statutory definition of "denied claim," which is central to our analysis.

[4] Our disposition obviates any need to address petitioners' other assignment of error, which asserts that the Board, in awarding fees, failed to comply with the dictates of *Schoch v. Leupold & Stevens*, 325 Or 112, 934 P2d 410 (1997).

Cite as 160 Or App 338 (1999) May 12, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Judy J. Gornick, Claimant.

JUDY J. GORNICK, Petitioner,
v.
J. FRANK SCHMIDT & SON, SAIF CORPORATION, and DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, Respondents.
(96-01924; CA A101382)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 5, 1998.

Robert Pardington argued the cause for petitioner. With him on the brief was Pozzi Wilson Atchison LLP.

Steve Cotton argued the cause and filed the brief for respondents J. Frank Schmidt & Son and SAIF Corporation.

Philip Schradle, Assistant Attorney General, waived appearance for respondent Department of Consumer and Business Services.

Before Landau, Presiding Judge, and Wollheim, Judge, and Warden, Senior Judge.

LANDAU, P. J.

Affirmed.

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160 Or App 340> Claimant suffered a compensable injury to her back in 1988 and was awarded permanent total disability benefits. In 1995, the Department of Consumer and Business Services determined that she was able to perform part-time sedentary or light work and issued an order concluding that she was no longer entitled to permanent total disability benefits. Claimant requested a hearing, and an administrative law judge (ALJ) affirmed the order, finding that she could perform a number of jobs suitable to her skills from three to four hours each day. Claimant appealed to the Workers' Compensation Board (Board), which adopted and affirmed the ALJ's order. Claimant now seeks judicial review of the Board's order, arguing that, because part-time work is not regular work, she is entitled to continue receiving permanent total disability benefits. We affirm.

ORS 656.206(1)(a) defines permanent total disability as:

> "[T]he loss * * * of use or function of any * * * portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation."

The statute does not define "regularly." The term "regular" ordinarily refers to "returning, recurring, or received at stated, fixed or uniform intervals[.]" *Webster's Third New Int'l Dictionary*, 1913 (unabridged ed 1993).

Consistent with that ordinary meaning, we have construed the term, as used in ORS 656.206, to refer to work that occurs at fixed or uniform intervals, whether full or part time. For example, in *Georgia-Pacific Corp. v. Perry*, 92 Or App 56, 57, 757 P2d 437, *rev den* 307 Or 77 (1988), we held:

> "The expert conducted tests, evaluated claimant's ability and testified that, considering claimant's age, limited experience and abilities, vocational rehabilitation was inappropriate and would not have returned claimant to 'gainful full-time employment.' The expert was mistaken that claimant must be able to return to *full-time* employment. If he is able to do regular part-time work, he is not permanently and totally disabled."

160 Or App 341> (Emphasis in original.) *See also Tee v. Albertson's, Inc.*, 107 Or App 638, 640, 813 P2d 574 (1991), *rev'd on other grounds* 314 Or 633, 842 P2d 374 (1992) ("It is well settled that the ability of a claimant to perform regular part-time work precludes an award for permanent total disability."); *Pournelle v. SAIF*, 70 Or App 56, 60, 687 P2d 1134 (1984) ("The ability to work on a permanent part-time basis is sufficient to avoid a finding of permanent total disability.").

Claimant nevertheless argues that, in some other of our cases, we have held that "regular" employment means only "'full-time,' eight hours per day, 40 hours per week" employment. She cites *Lankford v. Commodore Corporation*, 92 Or App 622, 759 P2d 329 (1988); *Wiley v. SAIF*, 77 Or App 486, 713 P2d 677, *rev den* 301 Or 77 (1986); *Allen v. Fireman's Fund Ins. Co.*, 71 Or App 40, 691 P2d 137 (1984); and *Munger v. SAIF*, 63 Or App 234, 662 P2d 808 (1983). In each of those cases, however, the claimant suffered an injury that restricted him or her to working irregular hours at best.

In *Lankford*, the only work that the claimant was capable of performing either was not available at all or was available only "on occasion." 92 Or App 625. We held that such work did not qualify as "regular" within the meaning of the statute. *Id.* We did not hold that--nor did we even address whether--only full-time employment qualifies as "regular."

In *Wiley*, the claimant suffered an injury that allowed him to work, if at all, only while lying in a recliner. We held that the fact that his employer was willing to accommodate him and provide a job he could perform from a recliner did not mean that he was regularly employable in an open job market and therefore found that he was entitled to permanent total disability benefits. 77 Or App at 491.

In *Allen*, the uncontradicted testimony was that the claimant could work "only intermittently and unpredictably." 71 Or App at 45. We held that such intermittent and unpredictable work did not qualify as "regular" employment. *Id.* at 46.

In *Munger*, the claimant had an injury that required that he be catheterized. The catheter had to be sterilized **<160 Or App 341/342>** three to four times a day, a process that consumed 15 minutes each time it was done. We held that he was entitled to permanent total disability benefits because the vocational expert could not find any job that would permit him to do this. *Munger*, 63 Or App at 237-38. There was no evidence in *Munger* that the claimant could find even a part-time job that would accommodate his needs.

We conclude that the Board correctly determined that, because claimant was capable of performing regular, part-time work, she is not entitled to permanent total disability benefits.

Affirmed.

Cite as 160 Or App 383 (1999) May 12, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

SAIF CORPORATION and K.F. JACOBSEN & COMPANY, INC., Petitioners,
v.
JOHN REID and DEPARTMENT OF CONSUMER AND BUSINESS SERVICES and CAREMARK COMP., Respondents.
(WCB H96-148, H96-149; CA A97497)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 28, 1998.
Julene Quinn argued the cause for petitioners. On the brief was Michael O. Whitty.
John M. Oswald argued the cause for respondent John B. Reid. With him on the brief was Bottini, Bottini & Oswald, P.C.
Denise Fjordbeck, Assistant Attorney General, argued the cause for respondent Department of Consumer & Business Services. On the brief were Hardy Myers, Attorney General, Michael D. Reynolds, Solicitor General, and Erika L. Hadlock, Assistant Attorney General.
Jerald P. Keene waived appearance for respondent Caremark Comp.
Before Landau, Presiding Judge, and Wollheim, Judge, and Rossman, Senior Judge.
WOLLHEIM, J.
Affirmed.

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160 Or App 385> SAIF seeks review of a final order on reconsideration from the Department of Consumer and Business Services (DCBS). DCBS held that SAIF was required to pay for psychological services that claimant received outside a certified managed care organization (MCO) during the time SAIF *de facto* denied the psychological condition claim. We review for errors of law, ORS 183.482(8)(a) and 656.298(6), and affirm.

The facts are not disputed. Claimant sustained an injury in January 1992 when he fell approximately 40 feet. SAIF accepted various physical conditions in March 1992. SAIF knew, as early as May 1993, that claimant was making a claim for a psychological condition, but SAIF did not accept claimant's psychological condition until October 1995. SAIF enrolled claimant in an MCO and claimant received medical services for his accepted *physical* conditions from the MCO. However, for the *psychological* condition that SAIF had neither accepted nor denied, claimant received treatment outside the MCO. After SAIF accepted the psychological condition, it refused to pay for the prior psychological services because they were provided outside the MCO. Relying on ORS 656.245(4)(b)(D), DCBS concluded that SAIF was required to pay for the disputed medical services. SAIF argues that the statute only applies to initial claims and aggravation claims. We disagree and affirm.

When an insurer contracts with a certified MCO, the insurer can require an injured worker to receive all compensable medical treatment from the MCO. ORS 656.245(4)(a). For "initial or aggravation claims" an insurer can require an injured worker to immediately receive all medical treatment from the MCO. ORS 656.245(4)(b)(A). However, if the insurer gives notice to the worker that all treatment must be received from the MCO, then the insurer must guarantee that all reasonable and necessary medical treatment will be paid even if the claim is subsequently denied. If the claim is denied, the worker may receive medical treatment outside the MCO until the denial is reversed. On reversal, the insurer is responsible for payment of medical services **<160 Or App 385/386>** received outside the MCO for the time the claim was denied. ORS 656.245(4)(b)(D).

SAIF argues that ORS 656.245(4)(b)(D) does not apply here because claimant's psychological condition claim was neither an "initial" claim nor an "aggravation" claim. DCBS interpreted ORS 656.245(4)(b)(D) to include claims for new medical conditions like the one at issue here. We review to determine whether DCBS's interpretation was correct.

ORS 656.003 provides that, "Except where the context otherwise requires, the definitions given in this chapter govern its construction." A claim is defined as "a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject

employer has notice or knowledge." ORS 656.005(6). We have held that "claim" is an inexact statutory term that can mean something different from the definition contained in ORS 656.005(6). *Altamirano v. Woodburn Nursery, Inc.*, 133 Or App 16, 21, 889 P2d 1305 (1995). The issue in *Altamirano* was whether a *claim* under ORS 656.005(12)(b)(B) (1993)[1] carried the same meaning as the ORS 656.005(6) definition. We determined that if the definition of a claim in ORS 656.005(6) was applied to under ORS 656.005(12)(B)(b) (1993), the time limit for chiropractic treatment would be illusory. Accordingly, we held that the legislature did not intend for the statutory definition to apply to the word "claim" in ORS 656.005(12)(b)(B) (1993). *Id.* at 22-23.

We recently discussed the meaning of the term "claim" in *Johansen v. SAIF*, 158 Or App 672, ___ P2d ___(1999). There, the issue was whether an insurer was required to pay interim compensation on a new medical condition claim under ORS 656.262(7). We held that "[a] new medical condition (1) arises after acceptance of an initial claim, (2) is related to an initial claim, and (3) involves a condition other than the condition initially accepted." *Id.* at 679. We identified three different types of claims: (1) initial claims; (2) new medical condition claims; and (3) aggravation claims.[2] *Id.* at **<160 Or App 386/387>** 679-80. We recognized that a new medical condition claim was one that related to the initial accepted claim. We noted, however, that a new medical condition claim is distinct from an aggravation claim because different requirements existed for each.[3] Ultimately, we held that a new medical condition claim requires processing under ORS 656.262 because "a new medical condition claim, although distinct from an initial claim or an aggravation claim, is nonetheless a claim." *Id.* at 680.

With this understanding in mind, we turn to the text of ORS 656.245. An insurer is required to provide "medical services for such conditions caused in material part by the compensable injury for such period as the nature of the injury or the process of the recovery requires * * *." ORS 656.245(1)(a). The duty to provide these medical services continues for the life of the worker. ORS 656.245(1)(b). Generally, an injured worker may choose to treat with any physician. ORS 656.245(2)(a). Again, an insurer that has contracted with an MCO may require an injured worker to receive medical treatment for the accepted claim solely from the MCO medical providers. ORS 656.245(4)(a). The dispute here concerns ORS 656.245(4), which provides, in part:

> "(b)(A) For *initial or aggravation claims* filed after June 7, 1995, the insurer or self-insured employer may require an injured worker, on a case by case basis, immediately to receive medical services from the managed care organization.
>
> "(B) If the insurer or self-insured employer gives notice that the worker is required to receive treatment from the managed care organization, the insurer or self-insured employer must guarantee that any reasonable and necessary services so received * * * will be paid as provided in ORS 656.248, even if the claim is denied * * *.
>
> "(C) If the insurer or self-insured employer does not give notice that the worker is required to receive treatment **<160 Or App 387/388>** from the managed care organization, the insurer or self-insured employer is under no obligation to pay for services received by the worker unless the claim is later accepted.
>
> "(D) If the *claim* is denied, the worker may receive medical services after the date of the denial from sources other than the managed care organization until the denial is reserved. Reasonable and necessary medical services received from sources other than the managed care organization after the date of *claim* denial must be paid as provided in ORS 656.248 by the insurer or self-insured employer if the *claim* is finally determined to be compensable." (Emphasis added.)

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[1] ORS 656.005(12)(b)(B) (1993) provided that a chiropractor can be the attending physician on the *claim* for a period of 30 days or 12 visits.

[2] There may be other claims as well, such as an own motion claim, ORS 656.278, or a claim for a condition that was omitted from the notice of acceptance, ORS 656.262(6)(d).

[3] For example, a new medical condition claim can be made at any time while an aggravation claim must be made within five years from the first closure of the claim. Additionally, to establish an aggravation claim the injured worker must establish an actual worsening of the compensable condition. There is no similar requirement for a new medical condition claim.

SAIF argues that ORS 656.245(4)(b)(D) does not apply here because subsection (4)(b) only applies to "initial or aggravation claims" and claimant's claim is neither. However, in subsection (4)(b)(D), the legislature did not similarly limit its language. Subsection (4)(b)(D) refers simply to "the claim," not the "initial or aggravation claim." The legislature's "use of a term in one section and not in another section of the same statute indicates a purposeful omission." *PGE v. Bureau of Labor and Industries*, 317 Or 606, 611, 859 P2d 1143 (1993). *See also Dale v. Electrical Board*, 109 Or App 613, 616, 820 P2d 868 (1991) ("When the legislature uses different language in similar statutory provisions, it is presumed to have intended different meanings").

Taken to its analytical inevitability, SAIF's position means that claimant would only be required to treat with the MCO for either "initial or aggravation claims." Since the psychological claim here is neither an initial nor an aggravation claim, claimant would never be required to treat with the MCO for his psychological condition. We do not believe the legislature intended such a result, because it would render the requirement to treat with a MCO illusory for certain types of claims. Rather, we believe that the legislature intended ORS 656.245(4) to apply to all types of claims, including new medical condition claims or claims seeking acceptance of a condition omitted from the notice of acceptance. This approach is consistent with our decision in *Johansen*, where we held that a new medical condition claim under ORS 656.262(7)(a) must be treated like any other claim. 158 Or App 680. We therefore conclude that the **<160 Or App 388/389>** term "claim" in ORS 656.245(4)(a)(D) applies to any type of claim and not just to initial or aggravation claims.

SAIF's final assignment of error is that even if ORS 656.245(4)(b)(D) applies, it still should not be required to pay for claimant's psychological treatment because DCBS failed to apply OAR 436-010-0230(3)(a), which provides:

> "Ancillary services including, but not limited to, physical therapy or occupational therapy by a medical service provider other than the attending physician shall not be reimbursed unless carried out under a written plan prescribed prior to the commencement of treatment and approved by the attending physician within seven days of the beginning of treatment."

SAIF argues that (1) claimant's psychological treatment qualifies as an ancillary service and (2) no treatment plan was filed prior to claimant beginning psychological treatment.

DCBS rejected SAIF's argument:

> "As discussed above, when a worker's claim is denied, either with a full claim denial or partial denial, the worker is not within the workers' compensation system for that portion of the claim. It is not until the claim, or claim for a specific condition, is accepted that the worker is within the workers' compensation system and subject to the workers' compensation laws. Therefore, the ancillary treatment rule would not apply until the denied condition was accepted."

We are bound by DCBS's interpretation of its own rule unless that interpretation is "inconsistent with the wording of the rule itself, or the rule's context, or with any other source of law." *Don't Waste Oregon Com. v. Energy Facility Siting*, 320 Or 132, 142, 881 P2d 119 (1994). For example, we affirmed DCBS's interpretation of its rule concerning reimbursing an injured worker for travel expenses because we concluded that DCBS's interpretation was plausible. *Safeway Stores, Inc. v. Cornell*, 148 Or App 107, 111, 939 P2d 99 (1997). We likewise hold that DCBS' interpretation of OAR 436-010-0230(3)(a) is plausible.

Affirmed.

Cite as 160 Or App 489 (1999) May 19, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Diane H. Kurcin, Claimant.

SAIF CORPORATION and OREGON HEALTH SCIENCES UNIVERSITY, Petitioners,
v.
DIANE H. KURCIN, Respondent.
(96-03838; CA A98272)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 17, 1998.
Julene M. Quinn argued the cause for petitioners. On the brief was Michael O. Whitty.
Edward J. Harri argued the cause for respondent. With him on the brief was Martin L. Alvey.
Before Landau, Presiding Judge, and Deits, Chief Judge,* and Wollheim, Judge.
LANDAU, P. J.
Reversed and remanded for reconsideration.
Wollheim, J., dissenting.

*Deits, C. J., *vice* Riggs, J., resigned.

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160 Or App 491> Employer seeks review of an order of the Workers' Compensation Board (Board) reversing employer's denial of the compensability of claimant's claim. Employer contends that the Board erred in granting claimant a continuance of the hearing without requiring claimant to show due diligence and the necessity of the continuance. We agree with employer and reverse and remand for reconsideration.

The relevant facts are not in dispute. Claimant filed a claim for a herniated disc, which employer denied. Claimant requested a hearing. Well before the hearing, employer notified claimant that its medical expert would testify and employer provided claimant with a copy of the expert's complete medical report. On the day of the hearing, claimant requested a continuance to prepare rebuttal testimony to the testimony of employer's expert. Claimant cited a single ground for the continuance, namely, that, as the party with the burden of proof, she was entitled to present the last evidence:

> "Your honor, we have one more matter to take up prior to testimony, and that is if Dr. Gambee, in fact, testifies today, I would like the record left open to have a transcript submitted to the attending physician, Dr. Calhoun, for him to review and comment on. That is pursuant to Administrative Rule 438-007-[0]023, which states the party bearing the burden of proof has the right to present the last evidence. And, in this case, I will not have the opportunity to present the last evidence because Dr. Gambee will be the last evidence regarding compensability. So, based upon that rule on the fundamental fairness of Workers' Compensation, we ask to have Dr. Calhoun comment on Dr. Gambee's testimony."

Employer objected on the ground that it had informed claimant of its intention to call its expert four weeks before the hearing. Employer argued that it was incumbent upon claimant to explain why she could not have requested the continuance earlier. Claimant's only response was that:

> "It may well be that after I hear Dr. Gambee testify that I don't need to exercise that right. I, at least, want to have the opportunity."

160 Or App 492> Claimant offered no explanation why the advance copy of the expert's medical report did not afford her a reasonable opportunity to prepare her for cross-examination or rebuttal.

The administrative law judge (ALJ) agreed with claimant. He stated as the reason for permitting claimant a continuance the rule that claimant "has the last opportunity to rebut." According to the ALJ, claimants always are entitled to a continuance to rebut, because "if [s]he hasn't heard the testimony, [s]he can't rebut it." The ALJ did not specifically find that claimant had acted with due diligence. When pressed by employer on the point, the ALJ at one point stated that he did not know whether claimant had exercised due diligence and at another point stated that he was not finding that claimant was *not*

diligent. Nor did the ALJ address why, in view of the disclosure of employer's expert's medical report in advance of the hearing, a continuance was necessary to afford claimant a reasonable opportunity to prepare rebuttal.

The Board affirmed on the ground that the ALJ had made a finding of due diligence and necessity and that he had not abused his discretion in doing so. It is that ruling that employer challenges. According to employer, applicable administrative rules require a showing of due diligence and a demonstration that a continuance is necessary to afford a reasonable opportunity to prepare rebuttal evidence. In this case, employer contends, claimant made no such showing. Claimant argues that such a showing is not required. She argues that, as the party bearing the burden of proof, she always has the right to present rebuttal:

> "Given that the party carrying the burden of proof has the opportunity for the last presentation of the evidence, pursuant to the administrative rule, requesting the right to rebut represented due diligence. OAR 438-007-0023."

According to claimant, merely requesting the continuance entitled her to the continuance.

Whether to grant a continuance is a matter committed to the discretion of the Board. That discretion, however, is not without limit. In reviewing the Board's decision, therefore, we apply the following standard:

> **160 Or App 493>** "We will reverse the Board's decision to grant claimant's request for a continuance if the Board acted outside the range of discretion delegated to it by law or if it acted inconsistently with its own rules, because those rules are as binding on the agency as if the legislature itself had enacted them."

Georgia-Pacific Corp. v. Kight, 126 Or App 244, 246, 868 P2d 36 (1994).

OAR 438-006-0091 provides that "[c]ontinuances are disfavored." It further provides that "[u]pon a showing of due diligence" a claimant may obtain a continuance

> "if necessary to afford reasonable opportunity for the party bearing the burden of proof to obtain and present final rebuttal evidence or for any party to respond to an issue raised for the first time at a hearing."

OAR 438-006-0091(3).

By the terms of the applicable rules, to obtain a continuance, a claimant must establish "due diligence" and the necessity of the continuance "to afford a reasonable opportunity * * * [to] present final rebuttal evidence." *Id.* In this case, claimant made no such showing. Her contention was that she did not need to make the showing, because, as the party bearing the burden of proof, she always has the right to put in the proverbial last word. Claimant's argument, of course, is a *non sequitur*. It simply does not follow that, because one has the right to rebut, one also has the right to a continuance.

Claimant and the dissent contend that she could not have shown necessity at the hearing, because she had not yet heard the expert's testimony. The argument fails to account for the fact that employer, in accordance with applicable Board rules, disclosed both the identity of the expert and the full text of the medical report before the hearing.

Claimant and the dissent insist--for the first time on review--that the continuance was necessary, because there was a risk that the expert would change his testimony. That, however, is a risk in any case. The rules, moreover, contemplate just that problem. If a claimant reasonably is surprised by a change in an expert's testimony, then the claimant will have little difficulty establishing his or her need for a **<160 Or App 493/494>** continuance at that time. OAR 438-006-0091(3) expressly provides for a continuance to respond to an issue raised for the first time at a hearing.

The dissent suggests that the continuance also was justified by considerations of substantial justice, including in particular, the financial hardship involved in requiring claimants to bring expensive experts to hearing. No one in this case, however, has suggested that claimant suffered a financial hardship, that financial hardship was the basis for the continuance request, or that the ALJ relied on financial hardship as a basis for the continuance. Considerations of financial hardship, therefore, are beside the point. The ALJ's decision must be reviewed on the basis of the decision that he made, not on the basis of a decision that he might have made.

Moreover, no one has argued that claimants always must bring an expensive expert to hearing, or that claimant in this case was required to do so. As we have explained, the rules are designed to avoid just that problem. They require employers to provide advance notice of their expert testimony. The point of those rules is to enable claimants to evaluate in advance of the hearing whether they will be required to retain an expert for rebuttal purposes. If the testimony at hearing turns out to be different from what the employers advertised, the rules make clear that claimants then will have grounds for a continuance to prepare appropriate rebuttal. There is no danger of requiring claimants to incur unreasonable expenses. The dissent's complaint thus amounts to the pummeling of a straw man.

We conclude that claimant made no showing of diligence or necessity, which OAR 438-006-0091(3) requires as a predicate to obtaining a continuance. The Board therefore erred in upholding the ALJ's decision to allow the continuance.

Reversed and remanded for reconsideration.

WOLLHEIM, J., dissenting.

The essence of the dispute in this case is whether a showing of "due diligence" required claimant to pay for and require the attendance of an expert witness at hearing. Although the majority's opinion does not explicitly state that **<160 Or App 494/495>** requirement, its decision accepts the rationale underlying such a conclusion, and I write to elucidate the errors in that rationale.

I add to the facts as stated by the majority only that claimant sought a continuance to allow her treating physician, Dr. Calhoun, to prepare a *written report* in rebuttal to live testimony by SAIF's expert, Dr. Gambee, and that SAIF had the opportunity to cross-examine Calhoun at its own expense, if it so desired. SAIF argues that to rebut SAIF's expert required the treating neurosurgeon to sit through the hearing to determine if the neurosurgeon's rebuttal testimony was necessary.

SAIF arrives at that conclusion by selectively construing two rules together. The first rule is OAR 438-006-0091, which states that "[c]ontinuances are disfavored" but nevertheless commits to the administrative law judge's (ALJ) discretion the ability to grant a continuance. OAR 438-006-0091(3) provides:

> "Upon a showing of due diligence if necessary to afford reasonable opportunity for the party bearing the burden of proof to obtain and present final rebuttal evidence or for any party to respond to an issue raised for the first time at a hearing[.]"

The second rule is OAR 438-007-0016, which requires parties to disclose prior to hearing the identity of expert witnesses to be called at hearing. SAIF argues that allowing claimant to continue the hearing for expert rebuttal evidence without fulfilling that notice requirement obviates the policy that the parties "shall be prepared to present all of their evidence at the scheduled hearing." OAR 438-006-0091. Thus, according to SAIF, claimant did not establish due diligence.

That argument is incorrect. Nothing in the workers' compensation statutes or administrative rules requires coupling the rules in that manner. Instead, OAR 438-007-0016 permits the ALJ, "in his or her discretion, [to] allow the testimony of expert witnesses not disclosed as required by this rule," taking into consideration the reasons for, and any prejudice caused by, the failure to provide notice. The notice **<160 Or App 495/496>** requirement therefore is not rigid but rather admits flexibility in order to effect "substantial justice," which is the "overriding principle" of the claim adjudication proceedings. OAR 438-005-0035. Substantial justice allows an ALJ to deviate from "common law or statutory rules of evidence [as well as] * * * technical or formal rules of procedure" in conducting hearings. ORS 656.283(7). Furthermore, OAR 438-005-0035 *requires* the ALJ or Board to consider "the relative financial hardship of the parties" in determining whether continuance of a hearing is warranted.[1] The touchstone of due diligence is substantial justice and not whether claimant gave timely notice of her expert's appearance at hearing.

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[1] It should be noted that when the injured worker brings an expert to hearing the injured worker pays the expert. When the self-insured employer or insurer demands cross-examination of the injured worker's expert, it must pay the cost of the expert's cross-examination.

I believe the majority's analysis is selective. Without any discussion, the majority explains that claimant's mere request of her right under OAR 438-007-0023[2] to present rebuttal evidence does not *show* due diligence. The issue of the necessity of a continuance to prepare rebuttal evidence, OAR 438-006-0091(3), appears more important to the majority than due diligence. That significance reveals the underlying motive driving the majority's analysis. The majority finds that claimant did not establish that a continuance was necessary to prepare the rebuttal evidence because claimant had Gambee's report in advance of hearing. Further, claimant could have had her expert prepare any rebuttal testimony from Gambee's report. The majority is primarily focused on the fact that claimant did not obtain the presence of her treating physician at hearing rather than on the ALJ's considerations of "substantial justice" in determining whether a continuance was, in his discretion, warranted.

I believe that the ALJ correctly concluded that claimant established a need for the continuance. I think it is within the ALJ's purview to consider that, because SAIF called Gambee to testify rather than rely on his written report, it indicated that Gambee's testimony would differ **<160 Or App 496/497>** from his written opinion. This was a battle between two *expert* witnesses on a complex issue of medical causation. The ALJ could have concluded that, if Gambee's testimony would have been different from his report, then time was needed for claimant's expert to rebut and respond to Gambee's testimony. Therefore, the ALJ properly determined that substantial justice necessitated a continuance to prepare rebuttal expert evidence.[3]

The Board correctly noted the ALJ's conclusion that claimant had shown due diligence in her request for a continuance. While the majority relies on the fact that the ALJ expressly failed to articulate a finding of due diligence, the ALJ implicitly found that claimant exercised due diligence in concluding that the continuance was warranted.[4] The failure to expressly articulate a finding of due diligence is not fatal because we review whether, as a matter of law, the facts would support findings consistent with the ALJ's ultimate conclusion. In deciding whether a continuance was warranted, the ALJ was required to look at the financial burden on the claimant. OAR 438-005-0035. The ALJ found substantial justice weighed in favor of the continuance due, in part, to the financial burden on claimant to require the presence of her neurosurgeon at hearing.[5] Thus, due diligence did not require the presence of the expert witness at hearing.

The ALJ had additional factors by which to weigh whether claimant's request was diligent. First, SAIF knew its expert would likely add evidence to that contained in his report. SAIF also knew that claimant, as the party with the burden of proof, had the right to present the first and last evidence. Thus, SAIF could have reasonably expected that claimant would want to present rebuttal evidence and would need time to do so, given the expert nature of the evidence. Second, claimant requested the continuance at the beginning **<160 Or App 497/498>** of the hearing, giving SAIF notice of the continuance. Importantly, claimant requested an opportunity to submit written rebuttal testimony. That is consistent with OAR 438-007-0005, which favors written testimony over live testimony. Finally, SAIF was free to cross-examine Calhoun, if it desired to do so. This is simply not a situation where SAIF was denied fundamental fairness by claimant's request for a continuance.

Given the financial hardship on claimant to require the presence of her expert witness at hearing, the timing of the continuance request, the nature and form of both experts' evidence, the lack of surprise or likely prejudice to SAIF from the request, and the strong policy allowing the party with the burden of proof to present the last evidence, I conclude, as a matter of law, that claimant's request showed due diligence. Further, the ALJ did not abuse his discretion in concluding that the continuance was warranted to achieve substantial justice.

I dissent.

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[2] OAR 438-007-0023 provides that "[t]he party bearing the burden of proof on an issue in a hearing has the right of first and last presentation of evidence and argument on the issue."

[3] Support for that conclusion can be found in the ALJ's statement that "[claimant] has the last opportunity to rebut, and it seems to me if [claimant] hasn't heard the testimony, [she] can't rebut it. I'm going to hold the record open * * *."

[4] Neither SAIF nor the majority disputes the fact that the question of whether claimant was duly diligent was expressly raised for the ALJ's consideration in determining whether the continuance was warranted.

[5] The ALJ explained that "[i]t would be ludicrous to bring somebody in here to rebut something that he doesn't even know what it is."

Cite as 160 Or App 548 (1999) May 19, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jerry E. Bishop, Claimant.

JERRY E. BISHOP, Petitioner - Cross-Respondent,
v.
OBEC CONSULTING ENGINEERS and EMPLOYERS INSURANCE OF WAUSAU, Respondents - Cross-Petitioners.
(WCB 94-14311; CA A99634)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 15, 1998.
David C. Force argued the cause and filed the briefs for petitioner - cross-respondent.
Abigail V. Marshall argued the cause and filed the briefs for respondents - cross-petitioners.
Before De Muniz, Presiding Judge, and Haselton and Linder, Judges.
HASELTON, J.
Reversed and remanded on petition; affirmed on cross-petition.

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160 Or App 550> Claimant petitions for review from a final order of the Workers' Compensation Board that determined that claimant was entitled to interim compensation,[1] ORS 656.262(2), from May 1, 1992, the date that claimant notified employer of his medically verified inability to work, through December 15, 1993, the date that claimant received "actual knowledge" that insurer had denied his claim. Claimant contends that where, as here, the Board determines that the insurer never "furnished to the claimant" written notice of the denial, ORS 656.262(6)(a), the claimant's actual knowledge of the purported denial is immaterial to, and does not excuse, that failure. Consequently, claimant asserts that he was entitled to interim compensation through June 20, 1995. Insurer cross-petitions for review, asserting that its obligation to pay interim compensation ended on October 19, 1992, when it mailed a notice of denial to an attorney whom it erroneously believed represented claimant. We agree with claimant that he is entitled to interim compensation through June 20, 1995, and, consequently, reverse and remand.

The material facts are undisputed: Claimant was a partner in a consulting engineering firm. Sometime in the late 1980s, an ownership struggle began, which resulted in claimant's eventual ouster. By mid-1992, claimant was no longer involved in the firm and had retained counsel to resolve issues involving his ownership interest and other matters concerning the firm.

On April 30, 1992, an attorney representing claimant, Cohen, an associate at the Gildea & Facaros law firm, wrote to the employer's attorney to give notice that claimant was suffering from a mental disorder that allegedly arose out of his employment. The parties ultimately stipulated that employer and its insurer had knowledge of that claim by no later than May 1, 1992.

160 Or App 551> In the fall of 1992, Cohen took a leave of absence and, apparently, requested that another attorney, Warshafsky, monitor claimant's workers' compensation file in Cohen's absence. Warshafsky was not an associate or partner of the Gildea firm. He did, however, share office space with the firm and was sometimes associated with the firm on specific cases. Neither Warshafsky nor the Gildea law firm ever executed a valid retainer agreement authorizing representation of claimant on the workers' compensation matter.

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[1] The term "interim compensation" does not appear in ORS 656.262. The origin of that term appears to be *Jones v. Emanuel Hospital*, 280 Or 147, 151, 570 P2d 70 (1977), where, in discussing ORS 656.262, the court observed:

> "Subsection (2), construed together with subsections (4) and (5) requires the employer to pay what may for convenience be called interim compensation payments until the employer denies the claim."

In October 1992, Warshafsky and counsel for the insurer had a telephone conversation regarding the mental condition claim. On October 16, insurer's counsel, apparently--but erroneously--believing that Warshafsky represented claimant, sent a letter to Warshafsky, enclosing an original notice of denial of claimant's mental condition claim, as well as a copy of that denial. Insurer did not send a copy of the letter or of the denial to claimant. Rather, in his letter, which was dated October 16, insurer's counsel explained:

> "Accompanying this letter is the original and your copy of my client's denial of [claimant's] workers' compensation claim. I am sending it to you rather than to [claimant's] home because I felt that best under the circumstances. If he wishes to pursue the claim, [claimant] must request a hearing."

Claimant was unaware of that letter and of the denial until December 15, 1993. He discovered the letter and denial only after he demanded, and received, his file from the Gildea firm. Notwithstanding his knowledge of the purported denial, claimant did nothing until November 1994, when he retained his present counsel. At that time, claimant filed a request for hearing, alleging *de facto* denial and entitlement to interim compensation. Claimant did not request a hearing on the compensability of his mental condition or otherwise assert that his condition was compensable.

In deciding claimant's entitlement to interim compensation, the administrative law judge initially determined that insurer's denial of the claim was constructively served on claimant because insurer sent the denial to an attorney, Warshafsky, who the ALJ concluded "represented" claimant. Consequently, the ALJ determined that insurer's **<160 Or App 551/552>** denial was effective to terminate interim compensation as of October 19, 1993. Claimant sought Board review.

The Board ultimately vacated the ALJ's order and remanded for reconsideration, for reasons that are immaterial to our review. On remand, the ALJ allowed the admission of newly discovered evidence regarding the relationship between Warshafsky and claimant and, particularly, whether Warshafsky did, in fact, represent claimant. Based on that new evidence, the ALJ determined that Warshafsky did not represent claimant and that insurer's October 19, 1993, denial was ineffective to terminate entitlement to interim compensation, because the mailing was not reasonably calculated to apprise claimant of the denial. See ORS 656.262(6)(a), (9); OAR 438-005-0065; ORCP 7(D)(1). Consequently, the ALJ awarded claimant interim compensation from May 1, 1992 to June 20, 1995, and allowed claimant's attorney an out-of-compensation fee award. ORS 656.262(11). Insurer sought Board review.

The Board adopted the findings of the ALJ but reduced claimant's award of interim compensation to extend only through December 15, 1993. The Board agreed with the ALJ that the October 19, 1992, denial did not terminate insurer's obligation to pay interim compensation. In so holding, the Board stated:

> "[i]nasmuch as it is undisputed that the denial *was not furnished to claimant,* himself, when it was issued, we find that * * * the October 19, 1992 denial did not terminate the insurer's obligation to pay interim compensation on the date the denial was issued." (Emphasis added.)

The Board specifically rejected insurer's argument that mailing the notice to Warshafsky was "reasonably calculated to apprise" claimant of the denial:

> "Under the circumstances of this claim, where the denial was apparently sent by ordinary mail to an attorney who not only never represented claimant, but also never discussed claimant's legal business with him, we are not persuaded that the insurer's method of service was reasonably calculated to apprise claimant of the denial."

160 Or App 553> The Board did, however, modify the ALJ's award. In particular, the Board concluded that, because claimant had "actual knowledge" of the denial on or about December 15, 1993, his entitlement to interim compensation ended on that date--and not on June 20, 1995, as under the ALJ's order. Consequently, the Board reduced claimant's interim compensation award and, concomitantly, modified the out-of-compensation attorney fee award. On claimant's petition for

reconsideration, the Board amplified its explanation of why, in its view, claimant's "actual knowledge" of the purported denial was sufficient to terminate the entitlement to interim compensation:

> "In our original order, we terminated interim compensation on December 15, 1993 because we found that claimant 'received actual knowledge' of the denial on that date. In *Jones v. Emanuel Hospital*, 280 Or 147, 152[, 570 P2d 70] (1977) the Court held that a worker cannot appeal until he or she 'receives the notice of denial.' Thus, under Jones, the focus is on actual receipt of the denial by a claimant.
>
> "In this case, claimant stipulated that he actually received the denial on or about December 15, 1993 after he obtained his legal file from the Gildea law firm. Thus, applying the *objective* standard of *Jones*, we find that claimant received the notice of denial on December 15, 1993. We, therefore, reiterate our prior holding that claimant's right to interim compensation ceased on that date." (Emphasis in original.)

The parties' positions in petitioning and cross-petitioning for review mirror their positions before the Board: Claimant asserts that his entitlement to interim compensation did not terminate upon his "actual knowledge" of the denial in December 1993, but, instead, continued through June 20, 1995. Insurer contends that claimant's interim compensation ended on October 19, 1992, with its mailing of the denial to Warshafsky.

For the sake of analytic coherence, we first address insurer's arguments on cross-petition. ORS 656.262 provides, in part:

> "(1) Processing of claims and providing compensation for a worker shall be the responsibility of the insurer or self-insured employer. * * *
>
> **160 Or App 554>** "* * * * *
>
> "(6)(a) Written notice of * * * *denial* of the claim *shall be furnished to the claimant by the insurer* * * * within 90 days after the employer had notice or knowledge of the claim. * * *."[2]
>
> "* * * * *
>
> "(9) If an insurer * * * denies a claim for compensation, *written notice of such denial,* stating the reason for the denial, and informing the worker of the Expedited Claim Service and of hearing rights under ORS 656.283, *shall be given to the claimant.* A copy of the notice of denial shall be mailed to the director and to the employer by the insurer. The worker may request a hearing pursuant to ORS 656.319." (Emphasis added.)

OAR 438-005-0065, which governs the manner of furnishing notice of denial, provides:

> "Notice of denial or other notice from which statutory time runs against a claimant shall be in writing and shall be delivered by registered or certified mail with return receipt requested or by personal service meeting the requirements for service of a summons."

In this case, the Board construed, and equated, the phrase "personal service meeting the requirements for service of a summons" in OAR 438-005-0065 with the requirements of ORCP 7 D, which governs service of process in civil cases. ORCP 7 D provides, in part:

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[2] *Former* ORS 656.262(6) was amended in 1995 and renumbered as ORS 656.262(6)(a) (1995). That amendment was fully retroactive and did not lengthen or shorten the procedural time limitations with regard to any action on the claim taken prior to the effective date of the amendments. *See* Or Laws 1995, ch 332, section 66(6), *compiled after* ORS 656.202.

> "D(1) Summons shall be served, either within or without this state, in any manner reasonably calculated, under all the circumstances, to apprise the defendant of the existence and pendency of the action and to afford a reasonable opportunity to appear and defend. Summons may be served in a manner specified in this rule or by any other rule or statute on the defendant or upon an agent authorized by appointment or law to accept service of summons for the defendant. Service may be made, subject to the restrictions **<160 Or App 554/555>** and requirements of this rule, by the following methods: personal service of summons upon defendant or an agent of defendant authorized to receive process; substituted service by leaving a copy of summons and complaint at a person's dwelling house or usual place of abode; office service by leaving with a person who is apparently in charge of an office; service by mail; or, service by publication."

Insurer does not challenge the validity of OAR 438-005-0065 or contest the correctness of the Board's construction of that rule by reference to ORCP 7. Rather, insurer contends that the mailing to Warshafsky was sufficient under ORCP 7 D(1)--and, thus, under OAR 438-005-0065--because it was "reasonably calculated to apprise" claimant of the denial. *See generally Baker v. Foy*, 310 Or 221, 228-29, 797 P2d 349 (1990) (describing two-step inquiry for determining whether, under ORCP 7, process was properly served).

We disagree. "Service" on an attorney who is not representing a party is not "reasonably calculated to apprise" that party of a matter--here, the denial. In this case, it is undisputed that Warshafsky did not, in fact, represent claimant. Warshafsky testified that at no time did he represent claimant with respect to the workers' compensation claim, and Warshafsky never gave insurer written notice that he was representing claimant. *See generally* ORS 656.331 (providing for written notice of representation). Accordingly, the Board correctly concluded that the October 19, 1992, mailing to Warshafsky did not provide notice of denial to claimant and, thus, did not terminate entitlement to interim compensation. We thus affirm on the cross-petition.

We turn to claimant's petition, which asserts that the Board erred in determining that his "actual knowledge" of the purported denial terminated his entitlement to interim compensation. As noted, see 160 Or App at 553, the Board's holding in that regard was based on its reading of *Jones v. Emanuel Hospital*.

We disagree with the Board's conclusion for two reasons. First, *Jones* does not support the Board's reading. Second, a claimant's actual knowledge of a notice of denial does **<160 Or App 555/556>** not vitiate noncompliance with the explicit requirements of ORS 656.262(6)(a), (9) and OAR 438-005-0065.

In *Jones*, the employer failed to timely accept or deny a claim for compensation and failed to pay any interim compensation. Ultimately, after six months, the employer sent written notice of denial to the claimant. Notwithstanding its failure to provide timely notice of denial, the employer contended that it was not obligated to pay interim compensation because the claimant's injury was not, in fact, compensable. In rejecting that argument, the Supreme Court reasoned:

> "ORS 656.262 gives the employer two choices: deny the claim or make interim payments. To interpret the word 'compensation' as the employer would have us do would give the employer a third choice: to delay acceptance or denial of the claim while making no interim payments. This third choice would delay the worker's appeal from an adverse decision since the worker cannot appeal until he or she receives the notice of denial. * * * We decline to adopt such an interpretation of the statute and hold that the word 'compensation' includes interim compensation." *Jones*, 280 Or at 151-52 (emphasis added).

In this case, the Board apparently understood *Jones's* reference to "receiv[ing] the notice of denial" to encompass actual notice of the denial by whatever means--that is, that a claimant's actual knowledge of a denial is sufficient to terminate entitlement to interim compensation regardless of the employer's or insurer's failure to comply with the explicit requirements for providing written denial to the claimant. *Jones* does not say that. Nothing in *Jones* even suggests that actual notice can "cure" a failure to furnish notice of denial in the prescribed manner. Indeed, in *Jones* itself the employer *did* give the claimant written notice of the denial--albeit belatedly.

Conversely, the Board's acceptance of the sufficiency of "actual knowledge" cannot be squared with OAR 438-005-0065. That rule provides that the notice of denial is effective only when delivered "by registered or certified mail" or "by personal service meeting the requirements for service of a <160 Or App 556/557> summons." Neither occurred here. Nor can some broad-ranging notion of "actual knowledge" be bootstrapped into OAR 438-005-0065 by reference to ORCP 7 and its caselaw.[3] Indeed, decisions applying ORCP 7 in the civil context have uniformly held that actual notice does not cure substantative deficiencies in the method of service. *See, e.g., Jordan v. Wiser*, 302 Or 50, 726 P2d 365 (1986)[4]; *Murphy v. Price*, 131 Or App 693, 699, 886 P2d 1047 (1994), *rev den* 321 Or 137 (1995) (right to receive adequate service of summons as defined by ORCP 7 and its case law is a "substantial right" for purposes of ORCP 12 B; actual notice is insufficient to excuse noncompliance with ORCP 7). *See generally Abbotts v. Bacon*, 133 Or App 315, 891 P2d 1321 (1995) ("There is no question that defendant actually received the complaint and summons in a timely fashion and was not prejudiced by the deficiencies in service. But Oregon's arcane rules governing service of process make no allowance for actual notice and, thus, compel such technically correct, but practically absurd, results.").

We thus conclude that the Board erred in determining that claimant's actual knowledge of the denial terminated his entitlement to interim compensation as of December 15, 1993. Accordingly, claimant was entitled to interim compensation through June 20, 1995, as well as to out-of-compensation attorney fees corresponding to that award.

Reversed and remanded on petition; affirmed on cross-petition.

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[3] As noted, the Board referred to ORCP 7 D(1) in determining the sufficiency, under OAR 438-005-0065, of the October 19, 1993, letter to Warshafsky.

[4] We and the Supreme Court have consistently held that actual notice is insufficient, notwithstanding ORCP 7 G, which provides, in part:

> "Failure to comply with provisions of this rule relating to the form of summons, issuance of summons, and the person who may serve summons shall not affect the validity of service of summons or the existence of jurisdiction over the person, if the court determines that defendant received actual notice of the substance and pendency of the action.

Jordan v. Wiser is exemplary. There, the plaintiff attempted to effect substituted service by leaving certified copies of a summons and complaint with the defendant's mother. Because the defendant did not reside with his mother, the substituted service was ineffective. The plaintiff argued, nevertheless, that, because the mother subsequently informed defendant of the pendency of the action, the defendant's actual notice obviated the deficient substituted service. In rejecting that argument, the Supreme Court observed:

> "Plaintiff argues that the first sentence of ORCP 7G. excuses the fact that Jones was a party and therefore disqualified from serving the summons under ORCP 7E. Plaintiff misses the point. ORCP 7G. only excuses the failure to comply with ORCP 7E., but it does not furnish authorization to serve the summons where none existed nor excuse the lack of such authorization to serve the summons.
>
> "* * * * *
>
> "Plaintiff cannot make a silk purse out of a sow's ear nor can she bootstrap Jones' volunteer delivery of summons into authorized service." *Jordan*, 302 Or at 58, 60 (footnotes omitted).

Cite as 160 Or App 568 (1999) May 19, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Clyde E. Willcutt, Claimant.

SAIF CORPORATION and THE BOEING CO., Petitioners,
v.
CLYDE E. WILLCUTT, Respondent.
(Agency No. 96-05370; CA A97345)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 6, 1998.
David L. Runner argued the cause and filed the brief for petitioners.
Richard C. Pearce argued the cause and filed the brief for respondent.
Before Edmonds, Presiding Judge, and Deits, Chief Judge,* and Armstrong, Judges.
ARMSTRONG, J.
Affirmed.

*Deits, C.J., *vice*, Warren, P.J., retired.

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160 Or App 570> SAIF petitions for judicial review of a Workers' Compensation Board decision that found that the condition for which claimant had sought treatment was a compensable consequence of a 1974 work-related back injury. We review for errors of law and substantial evidence and affirm. ORS 183.482(8)(a), (c).

Claimant first injured his back in 1974 when, while working as a machinist for the Boeing Company in Portland, he fell against a workbench. As a result of that injury, claimant was awarded permanent total disability in May 1977. Since the injury, claimant has complained of chronic back pain. Attempts to alleviate the pain have included multiple back surgeries, physical therapy, and the prescription of narcotic analgesics.

At some time in the late 1980s, claimant began receiving intramuscular injections of Demerol and Phenergen to help relieve his pain symptoms. In October 1994, claimant suffered nerve damage as a result of one of the injections. The nerve damage caused numbness and weakness in his right leg, which continued to plague him long after the injection. A consequence of that damage was that claimant often would not know if he had properly placed his right foot when taking a step. In February 1996, claimant was walking on his driveway when he fell and hit his head and shoulder. He attributed the fall to the right leg numbness and weakness. Immediately after the fall, claimant developed severe neck pain on his right side and right upper extremity pain.

Claimant's family physician, Dr. James, examined claimant on February 13, 1996. An x-ray taken at that time revealed what James described as "an unusual appearance of the cervical spine with straightening except between C5-6 where he has a definite angulated area and narrowed disc space. Suspect he may have had a ruptured disc." James arranged for claimant to undergo a cervical MRI, which was performed on February 16, 1996. The MRI revealed "disc space narrowing at C4-5, C5-6 and C6-7, with associated degenerative spondylosis and osseous foraminal stenosis on the right at C4-5 and to a lesser degree at C5-6." In other **<160 Or App 570/571>** words, the MRI disclosed that claimant suffered from a degenerative condition that, among other things, had caused bone spurs to form and narrow the central passage in the spine through which the spinal cord passed. The MRI did not reveal any evidence of a herniated disc. James referred claimant to Dr. Grewe, who had treated claimant in the past for lower back pain.

Grewe examined claimant on February 26, 1996. His records of the examination include the following impressions:

> "1. Acute cervical nerve root compression C4-5 and C5-6, right, secondary to a fall, which was secondary to his right leg giving way during the first part of February, 1996.
>
> "2. Pre-existing spondylosis changes C4-5, C5-6 and C6-7."

Grewe then stated that he would request authorization for an anterior discectomy and interbody fusion, along with nerve root decompression, if claimant's symptoms did not abate. On March 25, 1996, Grewe operated on claimant, removing an acute herniated disc at C5-6 and C4-5 on the right. Grewe also removed osteophytes at the C5-6 and C4-5 levels.

On May 20, 1996, SAIF denied claimant's request for treatment and disability related to the surgery, stating that claimant's 1974 compensable injury was

> "not the major contributing cause of your cervical nerve root compression, acute C4-5, C5-6 and osteophyte formation associated with spondylosis changes principally at C5-6 and to a lesser extent C4-5."

Claimant requested a hearing before an Administrative Law Judge (ALJ), who issued an opinion and order in the case in October 1996. In that order, the ALJ made the following findings:

> "(1) Claimant's cervical condition resulted from a fall in February 1996. Dr. Grewe described the mechanism of injury as a wrenching of the cervical spine. * * * Immediately after the fall claimant experienced new and severe symptoms on the right side of the neck with radiating pain down the right arm. * * * Dr. Grewe diagnosed acute nerve compression at C4-5 and C5-6. * * * At surgery, he noted acute disc herniations at C4-5 and C5-6.
>
> **160 Or App 572>** "(2) The fall was a direct consequence of right leg numbness and right ankle weakness. Claimant credibly testified his right ankle gave way causing him to fall. There is no evidence [that] the fall was due to any other causal factor."

The ALJ went on to find that claimant's right leg numbness and weakness was a direct result of the treatment of the earlier compensable low back injury:

> "(3) The right leg numbness and weakness was a direct result of treatment of the low back injury claim. This treatment took the form of an October 15, 1994 injection of medication for chronic pain associated with the low back. Nothing in the file shows the treatment was not necessary and reasonable. Moreover, the file is persuasive [that] the accepted low back injury was the material contributing cause of the need for treatment. The record persuasively shows [that] the right leg weakness resulted from sciatic nerve damage which resulted from giving the injection."

Based on those findings, the ALJ ordered SAIF to accept the claim.

SAIF requested review by the Board, which adopted and affirmed the ALJ's order. The Board found Grewe's opinion about the cause of claimant's injury to be persuasive. It explicitly rejected the opinion of SAIF's medical expert, Dr. Rosenbaum, who had examined claimant at SAIF's request. After examining claimant and reviewing claimant's medical records, Rosenbaum had concluded that the 1974 compensable injury was not the major contributing cause of the condition for which claimant had sought treatment. In response to a question from SAIF about whether the preexisting degenerative spondylosis could be distinguished from a cervical condition attributable to claimant's fall, Rosenbaum had replied:

> "The patient does not have evidence of acute pathology. He has evidence of degenerative osteoarthritis. A soft disk component was not present. If a soft disk component was present, one would potentially presume that it was a more recent abnormality. In essence, his pre-existing cervical condition cannot be directly distinguished from his cervical condition potentially created by the fall of February of 1996."

160 Or App 573> Finally, the Board did not consider it problematic that Grewe had not identified the fall as the major contributing cause of claimant's cervical pain symptoms:

> "Despite the absence of 'magic words' * * * Dr. Grewe's opinion satisfies claimant's burden of proof in this case. Prior to and during surgery, Dr. Grewe noted the presence of preexisting degenerative changes at C4-5 and 5-6. *Nevertheless, Dr. Grewe attributed claimant's condition to 'acute' herniations at C4-5 and 5-6.* Viewing Dr. Grewe's opinion as a whole, we conclude that the October 1994 treatment for the compensable low back condition (that injured claimant's sciatic nerve causing [right] leg numbness/weakness) was the major contributing cause of claimant's cervical condition." (Emphasis added.)

SAIF makes two assignments of error. First, SAIF contends that the Board misinterpreted and, therefore, misapplied ORS 656.005(7)(a)(A) when it determined that the fall was the major contributing cause of claimant's cervical pain symptoms. Second, SAIF argues that the numbness and weakness in claimant's leg that resulted from the treatment of claimant's low back injury and that led to claimant's fall was not a compensable consequence of claimant's low back injury.

SAIF acknowledges that it cannot prevail on its second assignment of error under our current case law. *See Barrett Business Services v. Hames*, 130 Or App 190, 881 P2d 816, *rev den* 320 Or 492 (1994). SAIF presents the assignment, nevertheless, in anticipation of favorable rulings from the Supreme Court on cases pending before it. We reject the second assignment without further discussion and turn to the first.

Under ORS 656.005(7)(a)(A), a condition is not compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition.[1] In *Dietz v. Ramuda*, 130 Or App <160 Or App 573/574> 397, 882 P2d 618, *rev dismissed* 321 Or 416 (1995), we interpreted a similar statute, ORS 656.005(7)(a)(B),[2] to require the determining body to evaluate the relative contribution of the causes of an injury or disease to decide which is the *primary* cause. *Id.* at 401. Although in *Dietz* we were interpreting ORS 656.005(7)(a)(B), which applies to situations in which a work-related injury combines with a preexisting condition, the same reasoning applies to consequential conditions under ORS 656.005(7)(a)(A).

SAIF made two arguments below about the causal relationship between the treatment of claimant's back pain and his cervical condition. First, it argued that there was insufficient evidence to establish that the back treatment had caused claimant to fall and, hence, to suffer the herniated cervical disc. Second, it argued that, even if the back treatment had caused the herniated disc, there was insufficient evidence to establish that the herniated disc was the major contributing cause of claimant's cervical condition. In SAIF's view, the herniated disc had combined with the preexisting degenerative changes in claimant's cervical spine to cause claimant's condition and there was insufficient medical evidence to establish that the herniated disc was the primary cause of that condition.

On review to us, SAIF has abandoned its argument about the cause of the fall, accepting, for these purposes, that the back treatment caused the herniated disc. That means that SAIF's challenge to the compensability of claimant's cervical condition depends on the proposition that the herniated disc combined with the degenerative changes to claimant's cervical spine to cause the condition, because only then would the Board be required to do what SAIF claims that the evidence is insufficient to permit it to do, which is to weigh the relative contribution to the condition of the herniated disc and the degenerative changes.

160 Or App 575> The ALJ found, however, and the Board accepted her finding, that "the record is not persuasive [that] the preexisting degenerative spondylosis was a causal factor in [claimant's cervical] symptoms or the need for surgery." The Board restated that point in its order supplementing the ALJ's opinion:

> "Prior to and during surgery, Dr. Grewe noted the presence of preexisting degenerative changes at C4-5 and 5-6. Nevertheless, Dr. Grewe attributed claimant's condition to 'acute' herniations at C4-5 and 5-6."

Taken together, those statements indicate that the Board found that the herniated disc did not combine with the degenerative changes to cause the cervical condition for which claimant sought treatment. We conclude that there is substantial evidence to support that finding. In light of that finding, the Board did not need to weigh the herniated disc against the degenerative changes to determine which was the primary cause of claimant's cervical condition. Consequently, the Board did not err in concluding that the back treatment and resulting disc herniation was the major contributing cause of the condition.

Affirmed.

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[1] ORS 656.005(7)(a)(A) provides:

"No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition."

[2] ORS 656.005(7)(a)(B) provides:

"If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition."

Cite as 160 Or App 576 (1999) May 19, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Joe M. Mann, Claimant.

LABOR READY, INC., Petitioner,
v.
JOE M. MANN, Respondent.
(WCB 96-01194; CA A100900)

Judicial Review from Workers' Compensation Board.

On petitioner's petition for reconsideration filed March 17, 1999. Opinion filed March 3, 1999. 158 Or App 666, ___ P2d ___.

Patrick D. Gilroy for petition.

Before De Muniz, Presiding Judge, and Haselton and Linder, Judges.

LINDER, J.

Petition for reconsideration allowed; opinion modified; reversed and remanded for an award of interim compensation due from the date employer received claimant's attorney's letter of September 26, 1996.

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160 Or App 578> Employer has filed a petition for reconsideration of our opinion in this case. *Labor Ready, Inc. v. Mann*, 158 Or App 666, ___ P2d ___ (1999). We allow reconsideration to modify our opinion as follows: (1) The sentence at the end of the first paragraph of page 1 of the slip opinion is corrected to delete the language that is bracketed and to add the language that is underlined: "Accordingly, we reverse the Board in part and remand the case for an award of interim compensation [beginning the 14th day after] *due from the date* employer received the September 26, 1996 letter." (2) At page two of the slip opinion, the sentence beginning at line 11 is corrected to delete the language that is bracketed and to add the language that is underlined: "*At the time of the hearing*, employer [has] *had* neither accepted nor denied the compensability of claimant's headache and vestibular disorders and [has not paid] *did not pay* interim compensation pending its decision to accept or deny the newly diagnosed conditions."

Petition for reconsideration allowed; opinion modified; reversed and remanded for an award of interim compensation due from the date employer received claimant's attorney's letter of September 26, 1996.

Cite as 160 Or App 579 (1999) May 19, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Paul D. Johansen, Claimant.

PAUL D. JOHANSEN, Petitioner,
v.
SAIF CORPORATION and PATTERSON PLUMBING, Respondents.
(WCB 96-05209; CA A100445)

Judicial Review from Workers' Compensation Board.
On respondents' petition for reconsideration filed March 17, 1999; on petitioner's response filed March 29, 1999. Opinion filed March 3, 1999. 158 Or App 672, ___ P2d ___.
David L. Runner for petition.
Edward J. Hill and Carney, Buckley, Kasameyer & Hays contra.
Before De Muniz, Presiding Judge, and Haselton and Linder, Judges.
LINDER, J.
Reconsideration allowed; opinion adhered to.

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160 Or App 581> SAIF Corporation has filed a petition for reconsideration of our opinion in *Johansen v. SAIF*, 158 Or App 672, ___ P2d ___ (1999), contending that we erred in determining that claimant is entitled to benefits for temporary total disability (TTD) for a new medical condition. We write only to address SAIF's assertion that we committed a "technical error" in remanding the case for an award of TTD benefits rather than for a *determination* of whether claimant is entitled to TTD benefits. SAIF contends that claimant's entitlement to benefits for temporary disability has never been determined.

The record shows that at the hearing SAIF raised legal and factual challenges to claimant's entitlement to benefits. The administrative law judge (ALJ) found as a factual matter that claimant's physician had authorized benefits for time loss and that claimant was disabled. Before the Workers' Compensation Board, SAIF made legal challenges to claimant's entitlement to benefits but did not challenge the ALJ's findings of authorization or disability. The Board adopted the ALJ's findings, including its findings regarding authorization of time loss and disability, and agreed with SAIF's legal assertion that claimant was not entitled to benefits. But the Board also said, "We are not holding that claimant may not obtain reclassification or that his claim was not disabling." In its brief on judicial review, SAIF made no argument with regard to the factual issue of disability or authorization. We consider those arguments to be waived.

Reconsideration allowed; opinion adhered to.

Cite as 160 Or App 596 (1999) May 19, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Frank D. Bacon, Claimant.

SAIF CORPORATION and S.R. SMITH, INC., Petitioners,
v.
FRANK D. BACON, Respondent.
(98-01053; CA A103417)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 17, 1999.
Steve Cotton argued the cause and filed the brief for petitioners.
Jeffrey D. Munns argued the cause for respondent. On the brief were James T. Guinn and Mitchell & Associates, PC.
Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.
KISTLER, J.
Affirmed.

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160 Or App 598> SAIF argues on review that the Workers' Compensation Board erred in awarding claimant $3,000 in fees for his attorney's work at hearing and before the Board. SAIF does not challenge the reasonableness of the fee the Board awarded. It argues instead that the Board should have provided a more comprehensive explanation of its fee decision. We affirm.

SAIF sought a hearing before an administrative law judge (ALJ) to challenge the amount of permanent partial disability that the appellate review unit had awarded claimant. The ALJ upheld the appellate review unit's award of permanent partial disability and also concluded that claimant was entitled to an assessed attorney fee of $2,000. Claimant had not submitted a statement of services describing the number of hours his attorney had spent on the case or the reasonable value of his attorney's services. Rather, the ALJ relied on the record of the hearing and the nature of the issues addressed at the hearing to determine the amount of time and the value of the services that an attorney reasonably would have expended.

After the ALJ issued her order, neither claimant nor SAIF asked the ALJ to reconsider the decision. SAIF, for example, did not submit any affidavits or other evidence on reconsideration to show that the fee the ALJ had awarded was too high. Conversely, claimant did not submit any evidence to show that the ALJ's award did not reflect the hours his attorney had in fact worked or the value of his attorney's services.

SAIF requested Board review of the ALJ's order. Before the Board, SAIF argued primarily that claimant's disability was not as great as the appellate review unit and the ALJ had found. It also challenged the ALJ's fee award. A number of threads ran through SAIF's fee argument before the Board. It argued that "[t]here is no evidence in this case from claimant's counsel concerning the time spent by counsel that justifies the award of $2000." It added that the fee was excessive "because there is no explanation as to how the ALJ arrived at the figure." Finally, it observed that "[c]laimant **<160 Or App 598/599>** should be required to provide the amount of time spent on the case, in order to meet the requirements of OAR 438-015-0010(4)."

The Board disagreed and affirmed the ALJ's fee award. The Board reasoned:

> "The record contains no statement of services documenting the time claimant's attorney spent on the case. The transcript is 4 pages long and the hearing lasted 15 minutes. No witnesses testified. The record contains approximately 18 exhibits, one of which was submitted by claimant's attorney.
>
> "The issue at hearing was limited to the extent of claimant's permanent disability arising from a compensable neck injury which involved a herniated disc at C5-6 and required

> cervical fusion surgery. SAIF requested the hearing on the Order on Reconsideration and sought reduction of claimant's permanent disability award. Based on other disputed extent of permanent disability claims presented for resolution to this forum, we find that the extent issue was of average complexity. The value of the interest and the benefit secured for claimant were significant in that the ALJ affirmed the Order on Reconsideration which awarded claimant 27 percent unscheduled permanent disability for the cervical injury (whereas SAIF's Notice of Closure had awarded 8 percent unscheduled permanent disability). Claimant's attorney skillfully conducted the litigation. No frivolous issues or defenses were raised. In addition, given the divided medical evidence and SAIF's challenge to claimant's permanent disability award, there was a significant risk that claimant's counsel might go uncompensated.
>
> "After our review of the record and application of the factors [set out in OAR 438-015-0010(4)], we agree with the ALJ that the time and effort expended by claimant's counsel and the complexity of the case justify a fee of $2,000. Consequently, we affirm the ALJ's attorney fee award."

The Board also awarded claimant's attorney $1,000 for defending the ALJ's order before the Board. The Board explained: "In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue and the value of the interest involved." The Board's assessment of a reasonable fee was not based on a statement of services **<160 Or App 599/600>** that claimant filed with it. After the Board issued its order, neither claimant nor SAIF objected to the $1,000 fee that the Board awarded claimant. Neither provided the Board with any argument or facts to show that its assessed fee was either too low or too high.

As SAIF frames the issue before us, the question is whether the Board provided a sufficient explanation of its findings. SAIF begins from the proposition that OAR 438-015-0010(4) sets out eight factors for the ALJ and the Board to consider in determining the amount of a reasonable attorney fee. It follows, SAIF reasons, that in *every* case in which fees are warranted, the Board must make findings on each of those eight factors and explain how those findings support the amount of the fee it awards. In SAIF's view, the Board's rule and the Supreme Court's decision in *Schoch v. Leupold & Stevens*, 325 Or 112, 934 P2d 410 (1997), require that much.

Before turning to the issue SAIF raises on review, we note what is not at issue in this case. SAIF does not argue on review that the Board had no basis for awarding claimant attorney fees because claimant had not submitted a statement of services to either the ALJ or the Board.[1] Rather, SAIF's argument assumes that the ALJ or the Board legitimately may infer the amount of time that the attorney reasonably expended on the case and the reasonable value of his or her services from the extent of the proceedings and the nature of the issues litigated before the agency. SAIF also has not argued on review that the fees the ALJ and the Board awarded in this case are unreasonable. Finally, SAIF did not submit any documentation to either the ALJ or the Board to show that those fees were too high. Accordingly, the issue on review is not whether the Board's order was sufficient to resolve a specific objection to the agency's fee award. *Compare Schoch*, 325 Or at 118-20 (addressing that issue). Rather, the issue, as SAIF frames it in its brief, is whether the Board's explanation is sufficient in the absence of any specific objection to the fee award.

160 Or App 601> On that point, SAIF argues that, even if it raised no objection to the reasonableness of the fees the ALJ and the Board awarded, the Board still had an obligation to make factual findings on each of the eight factors listed in its rule, to set out the weight it gave each of those eight factors, and to explain how those factors led to the result it reached. SAIF identifies three potential sources for the obligation it perceives: (1) the Board's rule; (2) the need for special findings to facilitate judicial review; and (3) an agency's obligation to explain its reasoning. We examine each of those sources in turn.

The Board's rule provides: "In any case where an Administrative Law Judge or the Board is required to determine a reasonable attorney fee, the following factors shall be considered." OAR 438-

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[1] SAIF made that argument before the Board, but it does not pursue it in its brief on review.

015-0010(4).[2] The rule then lists eight factors. By its terms, the Board's rule only requires that the agency "consider" the eight factors. It does not, in and of itself, require the Board to make factual findings, draw conclusions from those findings, or explain how those conclusions lead to the fee the Board awards. It may be that either the need to facilitate appellate review or general administrative law principles require the Board to make factual findings and explain the conclusions it draws from them. *See Schoch*, 325 Or at 118. The Board's rule, however, does not unilaterally impose that obligation on the Board. At least, the Board has not interpreted its rule that way.

160 Or App 602> SAIF relies alternatively on the need for "special findings to support or explain the order under review." *See McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or 84, 95, 957 P2d 1200, *on recons* 327 Or 185, 957 P2d 1200 (1998). In *McCarthy*, the Supreme Court explained that special findings on attorney fees may be necessary to permit meaningful appellate review. 327 Or at 96.[3] The court accordingly remanded the fee award in that case for further explanation. The court was careful to make clear, however, that the need for special findings does not exist in the abstract. Rather, a court only has to make findings on the factors that are relevant to its attorney fee decision. 327 Or at 188.[4] Moreover, the court explained that, "[a]s a consequence of the court's role in resolving the parties' disputed claims regarding attorney fees, the objections of a party who resists a petition for attorney fees play an important role in framing any issues that are relevant to the court's decision to award or deny attorney fees." 327 Or at 189. The court accordingly concluded, "[n]o party will be heard to complain of the absence of a finding by the court on an issue that the party did not raise in a petition, objection, or reply under [the applicable rules]." *Id.*

The need for findings as a prerequisite for appellate review arises only if there is something to review. As *McCarthy* makes clear, if there is no substantive objection to the fee award, there is nothing to review. SAIF argues, however, that an objection before the Board would have been premature. It reasons:

> "SAIF does not contend that $3,000 is an excessive fee for services at hearing and before the board. Such an argument would be premature. The board has not yet made findings of fact or drawn conclusions from those facts that would allow the parties to discuss whether the fee is reasonable. Only when the board follows the procedures required by its own administrative rule will the parties be able to argue whether an attorney fee is reasonable."

160 Or App 603> SAIF's argument puts the cart before the horse. An agency's findings and conclusions are intended to resolve the parties' objections, not give rise to them. If either claimant or SAIF believed that the ALJ's or the Board's fee award was too low or too high, they needed to raise that objection before either the ALJ or the Board. *Cf. Hays v. Tillamook County General Hospital*, 160 Or App 55, ___ P2d ___ (1999) (discussing when objections to the amount of fee awards may be raised).[5] We note that

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[2] OAR 438-015-0010(4) provides:

"In any case where an Administrative Law Judge or the Board is required to determine a reasonable attorney fee, the following factors shall be considered:

"(a) The time devoted to the case;

"(b) The complexity of the issue(s) involved;

"(c) The value of the interest involved;

"(d) The skill of the attorneys;

"(e) The nature of the proceedings;

"(f) The benefit secured for the represented party;

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

"(h) The assertion of frivolous issues or defenses."

[3] The obligation the court identified in *McCarthy* applies equally to courts and agencies.

[4] SAIF's claim that the Board has to make findings on all eight factors listed in its rule regardless of whether they have any relevance to its decision is inconsistent with the court's reasoning in *McCarthy*.

former ORS 656.388(2) (1989) provided that if an attorney and the board could not agree on the amount of the fee, a written statement of services would be submitted to the circuit court to determine "in a summary manner" the amount of the fee. That subsection was repealed in 1990. See Or Laws 1990, ch 2, section 30.[5]

The final question is whether the Board had an obligation under general administrative law principles to provide more specific findings of fact and reasoning than it did. *See Drew v. PSRB*, 322 Or 491, 500, 909 P2d 1211 (1996). The court explained in Drew that "in addition to the statutory requirement that findings be supported by substantial evidence, agencies also are required to demonstrate in their opinions the *reasoning* that leads the agency from the *facts* it has found to the *conclusions* that it draws from those facts." *Id.* at 499-500 (emphasis in original). That administrative requirement stems both from the need to facilitate meaningful appellate review and the need to ensure that the agency acts consistently. *Id.* (quoting *Williams v. SAIF*, 310 Or 320, 329, 797 P2d 1036 (1990) (Unis, J., concurring) (explaining the reasons for the requirement)).

The Supreme Court applied that principle in *Schoch*. In that case, the Board had awarded the claimant an attorney fee of $3,000. 325 Or at 116. The claimant requested reconsideration and submitted an affidavit showing that his attorney had devoted 47.5 hours of time to the case and offering evidence that the value of his attorney's services were $175 an hour. *See id.* & n 6. After considering the claimant's <160 Or App 603/604> request for reconsideration, the Board "adhered to the reasoning and conclusions of its [earlier] order without further explanation." *Id.* at 116.

"[N]oting the discrepancy between the amount of the attorney fee that claimant sought and the amount that the Board awarded," the court concluded that the Board's explanation was insufficient. *Id.* at 118-20. The court reasoned that it was unclear whether the Board had thought that the claimant's attorney had spent too many hours on the case, whether it thought that the hourly rate was too high, or whether the Board had discounted the claimant's fee request because of fees earned in a parallel administrative proceeding. *Id.* The court explained: "In sum, we conclude that the Board's order does not contain a sufficient explanation to permit an appellate court to review the Board's exercise of discretion in setting a reasonable attorney fee." *Id.* at 120.

The reasoning in *Schoch* makes clear that its holding is driven in large part by the need for meaningful appellate review. When, however, neither the claimant nor the employer objects to the reasonableness of the fee award, the need to ensure meaningful appellate review is absent. *See McCarthy*, 327 Or at 189. Although general administrative law principles still require the Board to explain the basis for its fee award, the need for specificity diminishes in the absence of any substantive objection to the fee award itself. Moreover, when, as in this case, neither the claimant nor the employer submits any evidence of either the hours that were reasonably expended or the value of an attorney's services, we cannot say that the agency erred in not going into greater detail than it did here. We emphasize that if SAIF or claimant had submitted specific evidence challenging either the ALJ's or the Board's fee award, as the claimant did in *Schoch*, the Board's explanation would have to comply with the standard in *Schoch*. In this case, however, SAIF has converted whatever specific objection it might have had to the Board's fee award into an abstract claim that detailed findings and an elaborate explanation are always required. We conclude that neither the Board's rule nor the Oregon cases impose that abstract obligation on the Board.

Affirmed.

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[5] By not requiring the party seeking fees to submit a statement of services as a prerequisite for receiving them, the Board has effectively shifted the burden to the party opposing the fee request to file specific objections if it believes that the amount of the fee awarded is excessive. At least before this court, however, SAIF has not challenged that practice. SAIF has not explained why the Board's practice is inconsistent with either its rule or its governing statute, *see* Or Laws 1990, ch 2, section 30 (deleting statutory requirement that a party submit a written statement of services in support of its fee claim), and we do not have the benefit of the Board's explanation of its practice before us. We accordingly leave that issue for another day when it has been squarely presented and briefed.

Cite as 161 Or App 49 (1999) June 2, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Gerrardo Alcantar-Baca, Claimant.

GERRARDO ALCANTAR-BACA, Petitioner,
v.
LIBERTY NORTHWEST INSURANCE CORPORATION and RINCON REFORESTATION,
Respondents.
(WCB 97-02281; CA A100987)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 15, 1998.
Edward J. Harri argued the cause for petitioner. With him on the brief were Randy Elmer and Emmons, Kropp, Kryger, Alexander, Egan and Elmer, P.C.
Alexander D. Libman argued the cause and filed the brief for respondents.
Before De Muniz, Presiding Judge, and Haselton and Linder, Judges.
HASELTON, J.
Affirmed.

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161 Or App 51> Claimant seeks review of an order of the Workers' Compensation Board that determined that, because his request for reclassification of an injury from nondisabling to disabling was made more than one year after the date of his injury, that request is time-barred under ORS 656.277(1) and must, instead, be processed as an aggravation claim under ORS 656.277(2). We agree with the Board's ultimate conclusion that ORS 656.277(2) requires claimant's request for reclassification to be made as an aggravation claim. Accordingly, we affirm.

Claimant injured his right ankle on May 10, 1995, while working for employer as a tree planter. He reported the incident to employer immediately but did not file a claim or seek medical treatment until April 1996, 11 months after the injury. On June 14, 1996, more than a year after the injury occurred, employer's insurer accepted the claim as a "nondisabling" right ankle sprain.[1] On August 22, 1996, 15 months after the injury, claimant wrote a letter to insurer requesting reclassification of his claim from nondisabling to disabling pursuant to ORS 656.277(1).[2]

ORS 656.277 provides, in part:

> "(1) If *within one year after the injury,* the worker claims a nondisabling injury originally was or has become disabling, the insurer or self-insured employer, upon receiving notice or knowledge of such a claim, shall report the claim to the Director of the Department of Consumer **<161 Or App 51/52>** and Business Services for determination pursuant to ORS 656.268.
>
> "(2) A claim that a nondisabling injury originally was or has become disabling, if made *more than one year after the date of injury,* shall be made pursuant to ORS 656.273 as a claim for aggravation." (Emphasis added.)

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[1] The Oregon Workers' Compensation statute defines a "nondisabling compensable injury" as "any injury which requires medical services only," ORS 656.005(7)(d), and a "disabling compensable injury" as "an injury which entitles the worker to compensation for disability and death." ORS 656.005(7)(c). A notice of acceptance of a claim must "advise the claimant whether the claim is considered disabling or nondisabling." ORS 656.262(6)(b)(B).

[2] The primary substantive effect of the classification of a claim relates to the extent of a claimant's statutory aggravation rights. *See* ORS 656.273(4). A claimant whose claim is classified as "disabling" is entitled to statutory aggravation rights for a period of five years *from the date of the first determination order or notice of closure.* ORS 656.273(4)(a). A claimant whose claim is in "nondisabling status" for a year or more after the date of injury is entitled to aggravation rights running five years *from the date of the original injury.* ORS 652.273(4)(b).

Based on ORS 656.277(2), the Director of the Department of Consumer and Business Services (DCBS) issued a Proposed and Final Order on April 16, 1997, dismissing claimant's request for reclassification because it was made more than one year after the date of injury. The Director concluded:

> "In this case, the claimant did not request reclassification of the right ankle sprain within one year from the date of injury. To do so was an impossibility since the insurer did not find the ankle sprain compensable until well after a year from the date of injury. Therefore, based upon the limiting language of ORS 656.277, the director does not have jurisdiction to consider the merits. However, the claimant is not without a remedy. Since the claimant was precluded, through no fault of his own, from requesting reclassification of the right ankle sprain within one year from the date of injury, the claimant may find a remedy at the Board."

Claimant then requested a hearing before the Hearings Division. In July 1997, the administrative law judge issued an opinion and order, that concluded that "because claimant had lost wages within one year of the date of the injury of this accepted claim, his accepted right ankle sprain should be reclassified from nondisabling to disabling." In so holding, the ALJ reasoned that, under *DeGrauw v. Columbia Knit, Inc.*, 118 Or App 277, 846 P2d 1214, *rev den* 316 Or 527 (1993), the Hearings Division had jurisdiction to consider claimant's request for reclassification notwithstanding that it was made more than one year after the date of injury. Insurer sought review, and the Board reversed, holding that "because claimant requested reclassification more than one year after the date of injury, his request is barred under ORS 656.277(1) and he is required to prove a valid aggravation claim under ORS 656.277(2)." Claimant seeks review of the Board's order, again relying on *DeGrauw*, and we review for errors of law. ORS 183.482(7).

161 Or App 53> Whether claimant's request for reclassification of his claim from nondisabling to disabling may be made to the Director under ORS 656.277(1) or must be made as an aggravation claim under ORS 656.277(2) is a matter of statutory construction. Our task in interpreting a statute is to discern the intent of the legislature. ORS 174.020; *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993).

We begin with the text of ORS 656.277. Subsection (1) explicitly provides that requests for reclassification can be made to the Director only if the claim is made "within one year after the injury * * *." Subsection (2) provides that "[a] claim that a nondisabling injury originally was or has become disabling, if made more than one year after the date of injury, shall be made pursuant to ORS 656.273 as a claim for aggravation." The statutory text thus admits to only one construction: Within one year of the date of injury, claims for reclassification are determined by the Director of DCBS; more than one year after the date of injury, such claims must be processed as aggravation claims. Here, it is undisputed that claimant's request for reclassification was made 15 months after the date of the injury. Given the plain language of ORS 656.277(2), the Board correctly concluded that, "because claimant requested reclassification more than one year after the date of injury, his request is barred under ORS 656.277(1) and he is required to prove a valid aggravation claim under ORS 656.277(2)."

Nevertheless, claimant argues that, under *DeGrauw*, he is entitled to request reclassification of his claim under ORS 656.277(1). In order to properly understand the reasoning of the Board, as well as the parties' positions, we begin by reviewing our decision in *DeGrauw*.

In *DeGrauw*, the claimant first sought medical treatment for back problems in August 1989[3] and filed a workers' compensation claim against her employer in September 1989. In February 1990, the insurer accepted the claim as a **<161 Or App 53/54>** "disabling" lumbosacral strain. In September 1990, more than a year after the date of injury, the insurer issued a second notice of acceptance, this time designating the claim as "nondisabling." Believing that a request for reclassification by the Director would have been untimely, the claimant requested a hearing challenging the insurer's reclassification of her claim. The Board determined that the insurer was not precluded from reclassifying the claim from disabling to nondisabling but noted that, by doing so more than one year after the date of injury, the

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[3] In *DeGrauw*, given the nature of the claimant's condition, the date of injury was August 1989, the date she first sought medical treatment. *See Papen v. Willamina Lumber Co.*, 123 Or App 249, 254, 859 P2d 1166 (1993), *rev den* 319 Or 81 (1994) ("The date of injury in an occupational disease case is either the date of disability or the date when medical treatment is first sought.").

insurer made it impossible for the claimant to request reclassification by the Director within one year of her injury, as provided by ORS 656.262(6)(c) and ORS 656.277(1).[4] For that reason, the Board concluded that the claimant was not subject to the one-year time limit for challenging the reclassification with the Department of Insurance and Finance (DIF) (DCBS's predecessor) under ORS 656.277(1), and that DIF--not the Board--had jurisdiction over the claimant's request for reclassification.

On judicial review, we reversed the Board's order because we agreed with the claimant that the insurer's reclassification of her claim more than one year after the date of injury--while not expressly prohibited by statute--violated the spirit of the statutory scheme:

> "As contemplated by ORS 656.262(6) and ORS 656.268, a claimant is entitled to reconsideration by DIF of the employer's decision to reclassify the claim as nondisabling. If the claim is reclassified more than one year from the date of the injury, the claimant is precluded, through no fault of her own, from seeking reconsideration by DIF. *We conclude* **<161 Or App 54/55>** *that, if an employer chooses to reclassify a claim from disabling to nondisabling, it must do so within sufficient time to permit the claimant to challenge the reclassification within one year from the date of the injury.* If, as here, it does not act within one year, then it must process the claim to closure. The notice of closure of determination order can then be reconsidered by DIF pursuant to ORS 656.268(4)(e) or (5)." *DeGrauw*, 118 Or App at 281 (emphasis added).

Having so concluded, we reversed and remanded with instructions to order the employer to process the claim as initially classified, *i.e.*, as "disabling."

Applying *DeGrauw* to this case, the Board concluded:

> "[U]nlike in *DeGrauw*, claimant did not file an injury claim until eleven months after his injury. The insurer had 90 days in which to accept the claim as either disabling or nondisabling. ORS 656.262(6)(a). The insurer's timely acceptance of claimant's claim as nondisabling issued more than one year after claimant's injury. Thus, claimant's request for reclassification more than one year after the date of injury was primarily the consequence of his own late filing, and not because he was prevented from timely requesting reclassification from the Department due to inactions of the carrier.
>
> "Accordingly, because claimant requested reclassification more than one year after the date of injury, his request is barred under ORS 656.277(1) and he is required to prove a valid aggravation claim under ORS 656.277(2)."

On review, claimant argues that the Board erred in barring claimant's request for reclassification under ORS 656.277(1) because the reasoning in *DeGrauw* applies in the "initial" classification context and entitles claimant to request reclassification under ORS 656.277(1). Specifically, claimant asserts that he cannot be considered "at fault" for filing a claim 11 months after the injury occurred because ORS 656.265 explicitly provides claimants with a full year from the date of injury to file a claim.[5] Claimant

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[4] Both ORS 656.262(6) and ORS 656.277(1) refer to the claimant's right to object to classification of an injury as nondisabling by requesting a determination by DCBS pursuant to ORS 656.268. See ORS 656.277(1) (providing that a request for reclassification made within one year of the date of injury shall be made to DCBS for determination *pursuant to ORS 656.268*); ORS 656.262(6)(b)(C) (providing that a notice of claim acceptance must inform claimants of their "right to object to a decision that the injury of the claimant is nondisabling by requesting a determination thereon *pursuant to ORS 656.268* within one year of the date of injury.").

The relevant provision of ORS 656.268 provides, in part:

"(11) Upon receipt of a request made pursuant to ORS 656.262, this section or ORS 656.277, the Department of Consumer and Business Services shall determine whether the claim is disabling or nondisabling."

[5] ORS 656.265(4) provides:

"Failure to give notice as required by this section bars a claim under this chapter unless the notice is given within one year after the date of the accident and:

"(a) The employer had knowledge of the injury or death; or

"(b) The worker died within 180 days after the date of the accident."

cites **<161 Or App 55/56>** *DeGrauw* as support for his argument that, because his failure to request reclassification within one year after injury was "through no fault of his own," he "should be able to challenge the classification by requesting a hearing."[6] We disagree for two reasons.

First, both claimant and the Board interpret *DeGrauw* to create an equitable exception to the express one-year time limit of ORS 656.277; we disagree with that interpretation. *DeGrauw* did not create an exception to the unambiguous requirement in ORS 656.277(2) that "[a] claim that a nondisabling injury originally was or has become disabling, *if made more than one year after the date of injury*, shall be made * * * as a claim for aggravation." (Emphasis added.) Rather, in *DeGrauw* we addressed the limited issue of whether--in the absence of an express statutory time limit on an employer's ability to reclassify a claim--an employer could initially accept a claim *within* one year of the date of injury, and then later reclassify it *after* the one-year period had passed. We concluded that, where the initial classification was issued in time for the claimant to request reclassification within a year after the injury, it would be "contrary to the statutory scheme" to permit an employer to later reclassify a claim such that the claimant is unable to request reclassification within a year from the date of injury under ORS 656.277(1). *DeGrauw*, 118 Or App at 281. Accordingly, we held that "if an employer chooses to reclassify a claim from disabling to nondisabling, it must do so within sufficient time to permit the claimant to challenge the reclassification within one year from the date of the injury." *Id.* In so concluding, we implicitly rejected the notion that claimants are ever excused from the one-year time limit for requesting reclassification under ORS 656.227(1)--even when the claimant's **<161 Or App 56/57>** untimeliness was not his fault. Thus, DeGrauw does not stand for the proposition that a claimant may request reclassification under ORS 656.277(1) more than one year after the date of injury.

Second, we disagree with both claimant's and the Board's view that *DeGrauw's* reasoning applies in the context of initial claim classification. Claimant asserts that, under *DeGrauw*, insurer had an "obligation to process the claim with sufficient diligence to permit claimant to challenge the classification of the claim should he be dissatisfied." While that is an accurate statement of *DeGrauw's* holding in the reclassification context, we decline to extend our holding beyond those circumstances. Application of *DeGrauw's* reasoning in the initial classification context would yield the untenable result of requiring employers to initially classify all claims "within sufficient time to permit the claimant to challenge the []classification within one year from the date of the injury." *DeGrauw*, 118 Or App at 281. Such a requirement cannot be squared with the statutory scheme, which--unlike in the reclassification context in *DeGrauw*--expressly provides a time line for initial claim classification: A claimant has up to one year after the date of injury to file a claim, ORS 656.265(4), and an employer has 90 days to accept or deny a claim. ORS 656.262(6)(a). Under that time line, even if both claimant and employer act within the periods specified by statute, the employer's acceptance and initial classification might issue more than one year after the date of the injury. Thus, requiring employers to initially classify all claims within one year from the date of injury does not comport with the statutory scheme.

We conclude that *DeGrauw's* reasoning applies only to the reclassification context at issue there and cannot be extended to excuse claimant from complying with ORS 656.277(2)'s requirement that "a claim that a nondisabling injury originally was or has become disabling, if made more than one year after the date of injury shall be made pursuant to ORS 656.273 as a claim for aggravation." Our conclusion that *DeGrauw* does not save claimant's request under ORS 656.277(1) does not, however, end our inquiry.

161 Or App 58> Claimant next argues that he should be permitted to challenge the initial classification of his claim as nondisabling under ORS 656.277(1) because--despite the plain language of the statute--logic prohibits requiring him to frame his challenge as a "claim for aggravation" as required by ORS 656.277(2). Claimant points to the fact that, in order to successfully prove an aggravation claim under ORS 656.273, an injured worker is required to prove a "worsened condition." ORS 656.273(1). Claimant asserts that, if an injured worker's condition is disabling from the outset--but is initially classified as "nondisabling" more than a year after the date of injury--the worker's request for reclassification in the form of an aggravation claim will necessarily fail because it would be impossible

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[6] Although we understand claimant to argue that he should be entitled to challenge insurer's classification under ORS 656.277(1), his references to his right to request a "hearing" under that provision are somewhat confusing. ORS 656.277(1) provides for an administrative review of the insurer's claim classification by DCBS, not a hearing. *See* ORS 656.268(11). In all events, if claimant is, in fact, arguing that he is entitled to a hearing under ORS 656.283, that argument fails. *See* 161 Or App at 58 n 7 herein; *Shaw v. Paccar Wagner Mining*, 161 Or App 60, ___ P2d ___ (1999).

for the worker to show the requisite "worsening." That is, if the claimant's condition was originally disabling and remains disabling, it may be impossible to demonstrate a "worsening" because the condition has *always* been disabling. In claimant's view, in order to provide meaningful review, a claimant must be permitted to challenge the initial classification under ORS 656.277(1) even where the request is made more than one year after the date of injury. Claimant's understanding of the practical operation of the statutes is correct; in the scenario just described, the statutes dictate an entirely unworkable result. Nevertheless, his arguments fail for the reasons that follow.

Claimant's approach, however practical and sensible, cannot be reconciled with the explicit mandatory language of ORS 656.277(2): "A claim that a nondisabling injury *originally was* or has become disabling, if made more than one year after the date of injury, *shall be made* * * * as a claim for aggravation." (Emphasis added.) The phrase "originally was" unambiguously states that even claims that an injury "originally was" disabling--*i.e.*, claims challenging initial classification--must be processed as aggravation claims when made more than one year after the date of injury.[7] We **<161 Or App 58/59>** readily acknowledge that, as claimant points out, that construction of ORS 656.277(2) both deprives the phrase "originally was" of any practical effect and deprives certain claimants of meaningful review of the initial classification of their claim. However, the text of the statutes and our principles of statutory construction unambiguously compel that result. See PGE, 317 Or at 611.[8]

No matter how implausible its application may be in certain circumstances, ORS 656.277 is unambiguous. We are not free to rewrite ORS 656.277 to allow claimant the opportunity to challenge the initial classification of his claim under ORS 656.277(1) more than one year after the date of injury, because to do so would entail either adding or omitting statutory language. *See* ORS 174.010. Amendment, if appropriate, lies with the legislature.[9]

The Board did not err in holding that claimant's challenge to the initial classification of his claim must be processed as an aggravation claim under ORS 656.277(2).

Affirmed.

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[7] For that reason, the Board's reasoning in *Donald R. Dodgin*, 45 Van Natta 1642 (1993), was erroneous. In *Dodgin*, the Board concluded:

> "[T]he statutory scheme provides that a claimant has a right to object to a nondisabling classification. We conclude, therefore, that the claimant should have a meaningful opportunity to exercise that right.
>
> "For these reasons, we reject SAIF's contention that a claimant must make his reclassification request as an aggravation claim. An aggravation is established by proof that a claimant has a worsened condition * * *. ORS 656.273(1); *Smith v. SAIF*, 302 Or 396,399 (1986). It would be virtually impossible for a claimant whose injury was, in fact, disabling from the outset to establish a change in condition. Thus, if his claim was classified as nondisabling more than a year after the date of injury, the claimant would be effectively denied an opportunity to object to the classification. Such a result is not consistent with the statutory scheme.
>
> "Rather, we believe that, inasmuch as an objection to a nondisabling classification is a matter 'concerning a claim,' ORS 656.283(1) allows claimant the opportunity to make that objection. That is, claimant may object to an initial claim classification by requesting a hearing, as he did in this case."

Although we fully appreciate the concerns underlying the Board's reasoning in *Dodgin*, its holding cannot be squared with the language of ORS 656.277(2). We note, moreover, that, following the Board's decision in *Dodgin* in 1993, the legislature amended ORS 656.277(2) to include the phrase "originally was." Or Laws 1995, ch 332, section 32. Thus, while the Board's holding that ORS 656.277(2) (1993) did not apply to challenges to initial claim classifications was somewhat plausible with respect to the 1993 version of the statute, it cannot apply to the current statute's clear language that "a claim that an injury * * * originally was disabling shall be made * * * as a claim for aggravation." ORS 656.277(2).

[8] *Cf. State v. Young*, 161 Or App 32, ___ P2d ___ (1999) (Haselton, J., concurring).

[9] We note that the legislative history of the 1995 amendment to ORS 656.277, which inserted the phrase "originally was," characterizes that amendment as "*Housekeeping only*." Staff Measure Summary, Senate Committee on Labor and Government Operations, Senate Bill 369, March 6, 1995, setion 32 (emphasis added).

Cite as 161 Or App 60 (1999) June 2, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of John B. Shaw, Claimant.

JOHN B. SHAW, Petitioner,
v.
PACCAR WAGNER MINING, Respondent.
(WCB 96-0277M; CA A100807)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 15, 1998.
Linda C. Love argued the cause and filed the brief for petitioner.
David Johnstone argued the cause for respondent. With him on the brief was VavRosky, MacColl, Olson, Busch & Pfeifer, P.C.
Before De Muniz, Presiding Judge, and Haselton and Linder, Judges.
HASELTON, J.
Reversed and remanded for reconsideration in light of *Alcantar-Baca v. Liberty Northwest Ins. Corp.*, 161 Or App 49, ___ P2d ___ (1999).

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161 Or App 62> Claimant seeks review of a Workers' Compensation Board order that (1) denied his request for reclassification of his claim from "nondisabling" to "disabling"; and (2) held that, pursuant to ORS 656.273(4)(b), claimant's aggravation rights expire five years after the date of his injury. We conclude that the Board erred in considering claimant's request for reclassification as a "matter concerning a claim" under ORS 656.283. *See Alcantar-Baca v. Liberty Northwest Ins. Corp.*, 161 Or App 49, ___ P2d ___ (1999). Accordingly, we reverse and remand for the Board to reconsider in the light of *Alcantar-Baca*.

Claimant worked for Wagner Mining (now known as PACCAR Wagner Mining) for 26 years, predominantly as a "press brake" operator on a 600-ton capacity press. On January 11, 1988, claimant filed a claim for a neck-arm-shoulder occupational disease, listing the date of the onset of the occupational disease as November 24, 1987. Claimant did not miss work at that time but did seek medical treatment. Employer, who was self-insured at that time, initially deferred the claim but shortly thereafter provided benefits for the medical treatment claimant received in connection with his neck pain. Employer did not send claimant a formal notice of acceptance of his claim at that time.

On December 13, 1994, claimant underwent surgery on his neck. He sought workers' compensation coverage for the surgery under three separate claims he had filed during the course of his employment with Wagner Mining, including the November 1987 claim for neck-arm-shoulder pain. Employer denied responsibility for claimant's surgery expenses on all three claims, and claimant requested a hearing before an administrative law judge. On review, the ALJ found that employer's insurer had accepted claimant's November 1987 neck-arm-shoulder claim in 1988; that claimant's upper vertebrate fracture and related problems were accepted as part of the 1987 occupational disease claim; and that claimant had not sustained either a new compensable injury or a new occupational disease involving his neck since that time. Based on those findings, the ALJ determined **<161 Or App 62/63>** that "current responsibility for claimant's occupational disease processes continues with [employer's insurer at the time of the November 1987 injury]." On review, the Board affirmed that order. Following the Board's determination that employer was responsible for claimant's neck condition under the 1987 claim, employer issued a formal notice of acceptance of the 1987 claim in November 1996--nine years after the "date of injury."[1] Pursuant to ORS 656.262(6), the acceptance advised claimant that the claim was accepted as "nondisabling."[2]

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[1] *See Papen v. Willamina Lumber Co.*, 123 Or App 249, 254, 859 P2d 1166 (1993), *rev den* 319 Or 81 (1994) ("The date of injury in an occupational disease case is either the date of disability or the date when medical treatment is first sought.").

[2] The Oregon workers' compensation statute defines a "nondisabling compensable injury" as "any injury which requires medical services only," ORS 656.005(7)(d), and a "disabling compensable injury" as "an injury which entitles the worker to compensation for disability and death." ORS 656.005(7)(c). A notice of acceptance of a claim must "advise the claimant whether the claim is considered disabling or nondisabling." ORS 656.262(6)(b)(B).

After receiving the formal notice of acceptance of his claim, claimant requested a hearing on the ground that his claim should be reclassified as disabling because his injury was disabling at the time of the formal acceptance--*i.e.*, regardless of whether the injury was disabling in 1987, it was disabling by December 1996.[3] The timing and procedure for requesting reclassification of a claim from nondisabling to disabling is provided in ORS 656.277:

> "(1) If *within one year after the injury*, the worker claims a nondisabling injury originally was or has become disabling, the insurer or self-insured employer, upon receiving notice or knowledge of such a claim, shall report the claim to the Director of the Department of Consumer and Business Services for determination pursuant to ORS 656.268.
>
> "(2) A claim that a nondisabling injury originally was or has become disabling, if made *more than one year after* **<161 Or App 63/64>** *the date of injury*, shall be made pursuant to ORS 656.273 as a claim for aggravation." (Emphasis added.)

After a hearing, the ALJ issued an opinion and order holding that, even though claimant's request for reclassification was made more than one year after the date of injury, it need not be processed as an aggravation claim pursuant to ORS 656.277(2). Citing *DeGrauw v. Columbia Knit, Inc.*, 118 Or App 277, 846 P2d 1214, *rev den* 316 Or 527 (1993), and *Donald R. Dodgin*, 45 Van Natta 1642 (1993), the ALJ determined that claimant was entitled to challenge the initial classification of his claim before the Hearings Division under ORS 656.283[4] because it was not claimant's fault that he could not challenge the classification of his claim until employer issued the formal acceptance six years after the injury, and it would therefore be unfair to require claimant to comply with ORS 656.277(2). However, the ALJ concluded, claimant failed to prove that his claim was misclassified because he did not show that his injury was "disabling" within one year of the date of the original injury.

At the hearing, claimant also asked for a determination that, because his injury was not in "nondisabling status" for a year or more after the date of injury, his aggravation rights run five years from the date of first closure of the claim pursuant to ORS 656.273(4)(a). The ALJ disagreed and held that, because claimant's injury was in "nondisabling status" for a year or more after the date of injury, claimant's aggravation rights under ORS 656.273(4)(b) expired five years after the date of the injury.

Claimant requested review, and the Board adopted and affirmed the ALJ's opinion. Claimant now seeks review of the Board's order, challenging both aspects.

We do not address the particulars of claimant's arguments because those arguments--and employer's responses--proceed from the premise that the Board correctly considered, and analyzed, claimant's request for **<161 Or App 64/65>** reclassification as a "matter concerning a claim" under ORS 656.283(1), and not as a "claim for aggravation" pursuant to ORS 656.277(2). That premise is incorrect. *See Alcantar-Baca*, 161 Or App at 58 n 7.

As we explain in *Alcantar-Baca*, *DeGrauw* "does not stand for the proposition that a claimant may request reclassification under ORS 656.277(1) more than one year after the date of injury." *Id.* at 57. Similarly, given the explicit language of ORS 656.277(2), a request for reclassification made more than one year after the date of injury *must* be made "pursuant to ORS 656.273 as a claim for aggravation." That language admits to no exceptions--"equitable" or otherwise. Consequently, the Board's holding in *Dodgin* that such a request can be considered under ORS 656.283 is erroneous. *Id.* at 58 n 7.

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[3] The primary substantive effect of the classification of a claim relates to the extent of a claimant's statutory aggravation rights. *See* ORS 656.273(4). A claimant whose claim is classified as "disabling" is entitled to statutory aggravation rights for a period of five years *from the date of the first determination order or notice of closure*. ORS 656.273(4)(a). A claimant whose claim is in "nondisabling status" for a year or more after the date of injury is entitled to aggravation rights running five years *from the date of the original injury*. ORS 652.273(4)(b).

[4] ORS 656.283 provides, in part:

> "(1) * * * [A]ny party * * * may at any time request a hearing on any matter concerning a claim, except matters for which a procedure for resolving the dispute is provided in another statute * * *."

Claimant's request for reclassification must, thus, be "made pursuant to ORS 656.273 as a claim for aggravation." ORS 656.277(2). Accordingly, we reverse and remand for reconsideration.

Reversed and remanded for reconsideration in light of *Alcantar-Baca v. Liberty Northwest Ins. Corp.*, 161 Or App 49, ___ P2d ___ (1999).

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