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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

53 Van Natta ____ (2001)

In the Matter of the Compensation of
ROY O. WEAVER, Claimant
WCB Case No. 00-00728
ORDER ON REVIEW
Mitchell & Guinn, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's injury claim for a cervical disc herniation. On review, the issue is compensability.

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

The ALJ set aside SAIF's denial, finding that claimant had satisfied his burden of proving the compensability of a C5-6 disc injury under ORS 656.005(7)(a)(B). In so finding, the ALJ relied on medical evidence from a neurosurgeon, Dr. Bergquist, who performed surgery on claimant's disc condition, and an examining physician, Dr. Gritzka.

On review, SAIF contends that the ALJ misinterpreted Dr. Bergquist's opinion as supporting compensability of the "combined" condition, when, in actuality, it did not. Moreover, SAIF asserts that the ALJ incorrectly applied the legal standard of ORS 656.005(7)(a)(B). For the following reasons, we do not find SAIF's contentions persuasive.

With regard to the first contention, Dr. Bergquist did at one point agree in his deposition that preexisting degenerative joint disease was the major contributing cause of the need for treatment of the "combined" condition. (Ex. 18-9). However, Dr. Bergquist elsewhere opined that the disc herniation at C5-6 was the major contributing cause of the need for surgery and that claimant ruptured the disc at the time of his injury off-loading roofing material. (Ex. 18-8, 10). Thus, Dr. Bergquist's overall testimony can be construed as supporting the ALJ's finding that claimant sustained his burden of proof under ORS 656.005(7)(a)(B).

Nevertheless, having reviewed the medical evidence as a whole from Dr. Bergquist, we find that it is not a model of clarity. We note that Dr. Bergquist was very reluctant to offer an opinion on the causation issue due to a perceived conflict of interest. (Ex. 11). When he did so at his deposition, it was not entirely consistent. For this reason, we look to other medical evidence on the causation issue.

That evidence was provided by Dr. Gritzka, who concluded that the work injury was the major contributing cause of the combined condition, and another examining physician, Dr. Farris, who opined that there was no combined condition, but that, if there was, the preexisting degenerative condition was the major contributing cause of the combined condition. (Exs. 14, 17). As between those two physicians, we agree with the ALJ that Dr. Gritzka's opinion is the most persuasive, since, unlike Dr. Farris, he reviewed Dr. Bergquist's operative report and, further, provided a well-reasoned analysis of the causation issue. Thus, we conclude that a preponderance of the evidence establishes that claimant's work injury was the major factor in the need for treatment of the "combined" condition under ORS 656.005(7)(a)(B).

We now address SAIF's contention that the ALJ applied an incorrect legal standard under ORS 656.005(7)(a)(B). In this regard, the ALJ did at one point state that the herniation of the disc on September 23, 1999 was the major contributing cause of the need for treatment of the combined condition. SAIF is correct that, under the statute, an otherwise compensable *injury* must be the major factor in the need for treatment of the combined condition. *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309 (1997); *Gregory C. Noble*, 49 Van Natta 764, 767 (1997), *aff'd mem Liberty Northwest Insurance Corporation v. Noble*, 153 Or App 125 (1998). However, earlier in the order, the ALJ correctly recited that claimant must show that the injury was the major contributing cause of the need for treatment of the combined condition. (O&O page 5). Moreover, we interpret the ALJ's statement to mean that the otherwise compensable injury that resulted in the disc herniation was the major contributing cause of the need for treatment.

Accordingly, we conclude that the ALJ applied the correct legal standard under ORS 656.005(7)(a)(B) in determining the compensability issue. Therefore, 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 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 20, 2000 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by SAIF.

April 3, 2001 Cite as 53 Van Natta 500 (2001)

In the Matter of the Compensation of
MAUREEN L. GADOTTI, Claimant
WCB Case No. 00-05204
ORDER ON REVIEW
Schneider, et al, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Poland's order that affirmed an Order on Reconsideration that awarded claimant 3 percent (4.5 degrees) scheduled permanent disability for loss of use or function of the left forearm (wrist). On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ affirmed an Order on Reconsideration award of 3 percent scheduled permanent disability based on claimant's loss of left palmar flexion. On review, the insurer argues that the award should be reversed. We agree.

Claimant has an accepted bilateral carpal tunnel condition that resulted in a right carpal tunnel release. At the time of closure, claimant's treating physician, Dr. Donohoe, reported that claimant's permanent impairment had not been determined and that she had "mild chronic discomfort," but was able to work. (Ex. 2).

The medical arbiter, Dr. Sohlberg, examined claimant and reported that her complaints were mainly directed to her right hand. With regard to the left hand, Dr. Sohlberg diagnosed mild left carpal tunnel syndrome. Dr. Sohlberg noted loss of strength on the left side and loss of flexion, but noted that the flexion findings were '"normal" for her."' (Ex. 6-5). The arbiter reported that claimant's findings appeared to be valid, and that symptoms on the left side "continue to be mild and do not appear to be significantly restricting the patient's activities." (Ex. 6-3).

In a May 25, 2000 letter, Dr. Sohlberg submitted an addendum to the medical arbiter report and reported that claimant's strength loss on the left side "appeared to be due more to patient motivational factors rather than a valid loss of strength and, therefore, would not be ratable." He further reported that he "did not feel it was due to the accepted condition of left carpal tunnel syndrome." (Ex. 7).

OAR 436-035-0007(28) provides in 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 upon sound medical principles, explaining why the findings are invalid."

Here, it is unclear whether Dr. Sohlberg believed that claimant's findings were valid. Although he first reported that the findings were valid, he later explained that claimant's strength findings were not valid because of motivational factors and were not due to the accepted condition. (Ex. 7). Dr. Sohlberg's addendum, however, does not directly address the validity of claimant's left flexion findings.

Nevertheless, Dr. Sohlberg has noted that claimant's left flexion findings were "normal" for her. We have previously held that where the arbiter found that the claimant's impairment findings were valid but reported that the measurement were normal for the person, the arbiter had not related the claimant's findings to the compensable injury. *See Beverly B. Stigall*, 52 Van Natta 1892 (2000); *Rebecca S. Mundell*, 52 Van Natta 106 (2000) (medical arbiter's characterization of cervical range of motion as "normal for this individual" failed to relate decreased range of motion to the compensable injury).

Accordingly, consistent with our holdings in *Stigall* and *Mundell*, we conclude that Dr. Sohlberg has provided a written opinion, based upon sound medical principles, explaining why his findings should not be used. We therefore conclude that claimant is not entitled to an impairment value of 3 percent for loss of left flexion. We therefore reverse the ALJ's order.

ORDER

The ALJ's order dated December 28, 2000 is reversed in part and affirmed in part. The Order on Reconsideration award of 3 percent (4.5 degrees) scheduled permanent disability for loss of use or function of the left forearm (wrist) is reversed. The ALJ's "out-of-compensation" and insurer-paid attorney fee awards are also reversed. The remainder of the ALJ's order is affirmed.

April 3, 2001 Cite as 53 Van Natta 501 (2001)

In the Matter of the Compensation of
WAYNE D. SMITH, Claimant
WCB Case No. 99-05549
ORDER ON REVIEW
Mitchell & Guinn, Claimant Attorney
Cavanagh & Zipse, Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that upheld the insurer's denial of the neuroma condition in his right arm. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following change and supplementation. In the third paragraph on page 2, we change the first sentence to read: "Drs. Rosenbaum and Radecki reported that claimant did not have radial tunnel syndrome. (Ex. 26)."

We write only to address claimant's argument pertaining to ORS 656.273. Claimant contends that the opinions of Drs. Layman and Laidler establish that his neuroma is a worsened condition resulting from the April 1995 injury.

The ALJ's order stated that claimant was not pursuing the aggravation denial. At hearing, claimant's attorney agreed with the ALJ's statement that claimant was not pursuing an aggravation denial and was only pursuing the insurer's partial denial of a claim for a neuroma. (Tr. 1). Because the aggravation issue was not addressed at hearing, we decline to address it on review.[1] *See Stevenson v. Blue Cross*, 108 Or App 247 (1991).

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[1] In any event, we note that where, as here, the allegedly worsened condition (neuroma) at issue in the aggravation claim is not the accepted condition, then claimant must establish that it is a compensable condition. *See Carl F. Plumlee*, 52 Van Natta 185 (2000) (citing *Gloria T. Olson*, 47 Van Natta 2348 (1995)).

ORDER

The ALJ's order dated November 30, 2000 is affirmed.

April 4, 2001 Cite as 53 Van Natta 502 (2001)

In the Matter of the Compensation of
LISA L. DAULTON, Claimant
WCB Case No. 00-04044
ORDER ON RECONSIDERATION
Daniel M. Spencer, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

On February 16, 2001, the Board abated its January 30, 2001 order that upheld the SAIF Corporation's denials of claimant's current left knee condition. This action was taken to consider claimant's motion for reconsideration. Having received SAIF's response, we now proceed with our reconsideration.

On reconsideration, claimant argues that SAIF's denials are not supported by the medical evidence for several reasons. First, she contends that there is no evidence to support SAIF's assertion in its denials that the accepted injury was no longer the major contributing cause of her combined condition as of December 18, 1999. Second, she argues that there is no medical evidence that her work accident combined with "mucoid degeneration of the posterior horn of left medial meniscus, chondromalacia of the lateral tibial plateau of the left knee, grade III lesion of the lateral facet of the left patella and patellofemoral malalignment of the left knee." Further, claimant contends there is no evidence as to when the aforementioned conditions became the major contributing cause of her need for treatment. Finally, she argues that we erred by discounting Dr. Walther's opinion.

Claimant relies on Dr. Walther's opinion to establish compensability of her current left knee condition. In our previous order, we explained that we had persuasive reasons not to defer to the opinion of Dr. Walther. Among other things, we found that Dr. Walther did not explain several inconsistencies between her February 15, 2000 report and her agreement with Dr. Thompson's March 29, 1999 report. We determined that, because Dr. Walther did not explain the inconsistencies and her change of opinion, her opinion on causation was entitled to little weight. We also found that Dr. Walther's opinion was not persuasive because it was conclusory and lacked adequate explanation.

After considering claimant's arguments on reconsideration, we adhere to our previous conclusion that Dr. Walther's opinion is not persuasive and that the medical evidence is insufficient to establish that claimant's compensable injury is the major contributing cause of her need for medical treatment or disability of the current left knee condition.

Nevertheless, we supplement our previous order to address claimant's argument that there is no evidence to support SAIF's assertion in its denials that the accepted injury was no longer the major contributing cause of her combined condition as of December 18, 1999.

On May 19, 2000, SAIF issued a denial of claimant's "combined condition on and after December 18, 1999" on the basis that medical evidence indicated that on December 18, 1999, claimant's accepted injury was no longer the major contributing cause of her combined condition. (Ex. 26). In August 2000, SAIF issued another denial that stated, in part:

> "Medical information indicates that on December 18, 1999 your accepted injury is no longer the major contributing cause of your combined condition. Accordingly, SAIF hereby denies your combined condition on and after December 18, 1999." (Ex. 32).

On April 26, 2000, Dr. Thompson responded to SAIF's question as to when claimant's work incident ceased being the major contributing cause of her combined condition by stating: "One would expect that symptoms from such an injury would probably subside within six to eight weeks postoperative." (Ex. 23-2). Dr. Walther initially agreed with Dr. Thompson's report. (Ex. 27). Later, however, she changed her opinion and indicated she had not clearly recognized that Dr. Thompson had said the injury would no longer be the major contributing cause of the problem six to eight weeks after surgery. (Ex. 31).

As we explained in our previous order, because Dr. Walther did not explain the inconsistencies and her change of opinion, her opinion on causation is entitled to little weight. We adhere to that conclusion on review. On the other hand, we rely on Dr. Thompson's opinion to find that claimant's work injury was no longer the major contributing cause of her current left knee condition "six to eight weeks" after surgery. Claimant's left knee surgery was on November 23, 1999 (Ex. 11), and eight weeks after the surgery was January 18, 2000. Based on Dr. Thompson's opinion, we find that claimant's compensable injury was no longer the major contributing cause of her combined left knee condition on January 18, 2000.

Accordingly, we modify the ALJ's order as follows. SAIF's denials are reinstated and upheld insofar as they deny claimant's left knee condition after January 18, 2000. That portion of SAIF's denials that denied claimant's left knee condition before January 18, 2000 is set aside and the claim is remanded to SAIF for processing according to law.

Claimant's attorney is entitled to an assessed fee for services at hearing, on review and on reconsideration regarding the "pre-January 18, 2000" 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, on review and on reconsideration is $2,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's attorney's fee request 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 at hearing, on review or on reconsideration regarding the "post-January 18, 2000" compensability issue.

On reconsideration, as supplemented and modified herein, we adhere to and republish the Board's January 30, 2001 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

April 4, 2001 Cite as 53 Van Natta 503 (2001)

In the Matter of the Compensation of
CONRID J. PAXTON, Claimant
WCB Case Nos. 95-00537, 94-13809 & 94-10357
ORDER ON REMAND
Aller & Morrison, Claimant Attorney
William J. Blitz, Defense Attorney
James B. Northrop (Saif), Defense Attorney
Hornecker, Cowling, et al, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *RLC Industries v. Sun Studs, Inc.*, 172 Or App 233 (2001). The court has reversed our prior order, *Conrid J. Paxton*, 50 Van Natta 1709 (1998), that had found RLC responsible for claimant's occupational disease claim for a hearing loss condition. Concluding that RLC established that claimant's noise exposure while he was working for RLC could not have caused his hearing loss, the court held that we erred in assigning responsibility to RLC under the last injurious exposure rule. Determining that responsibility for claimant's hearing loss shifts to Woolley Enterprises/SAIF Corporation, the court has remanded.

In accordance with the court's mandate, we conclude that responsibility for claimant's hearing loss condition rests with Woolley/SAIF. Consequently, Woolley's/SAIF's denial is set aside and the claim is remanded to SAIF for processing pursuant to law. Woolley/SAIF is also responsible for the $2,800 attorney fee awarded by the ALJ's order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ADRIAN RODRIQUEZ, Claimant
WCB Case No. 00-05303
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Meyers, Bock, and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Johnson's order that: (1) found claimant was not entitled to an attorney fee under ORS 656.386(1); and (2) declined to assess a penalty or penalty-related attorney fee for SAIF's allegedly unreasonable failure to process his "new medical condition" claim within 90 days. On review, the issues are attorney fees and penalties.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the first paragraph on page 3, we change the second citation to "(Ex. 69)."

We replace the first paragraph on page 4 with the following:

On February 10, 2000, claimant's attorney wrote to SAIF, requesting that it amend its acceptance to include chronic pain syndrome and radiculopathy of the left side as new conditions, pursuant to ORS 656.262(7)(a). (Ex. 64). After the 90-day period had lapsed, SAIF issued a response to claimant on May 17, 2000. (Ex. 69). SAIF explained that it was unable to accept the additional conditions because they were not specific medical diagnoses; rather, they were symptoms of recognizable diagnoses. (*Id.*) SAIF asserted that it was not required to and would not formally accept the conditions. (*Id.*)

Claimant contends that he is entitled to an attorney fee under ORS 656.386(1)(b)(C) because SAIF "rescinded" a *de facto* denial and it "conceded" that the new medical conditions were compensable. To the contrary, SAIF's May 17, 2000 letter said that it would not accept chronic pain syndrome and radiculopathy of the left side as new medical conditions. (Ex. 69). Thus, although SAIF did not respond within 90 days to claimant's "new medical condition" claim, SAIF subsequently clarified that claimant's "symptoms" were encompassed within the prior acceptance. The ALJ's order noted that claimant had conceded that, based on the evidence in the record, SAIF correctly refused to formally accept the conditions of chronic pain syndrome and left-sided radiculopathy. As a result of SAIF's Mary 17, 2000 letter, claimant's "symptoms" have not been accepted as "new medical conditions." Under these circumstances, we conclude that SAIF did not rescind a denied claim and claimant's counsel is not entitled to an attorney fee under ORS 656.386(1).

On page 4, we replace the "Assessed Fee" section of the ALJ's order with the following:

Claimant argues that he is entitled to a penalty-related attorney fee for SAIF's allegedly unreasonable failure to process his new medical condition claim within 90 days. Claimant asserts, however, that there are no amounts due.

ORS 656.382(1) provides that, if a carrier "unreasonably resists the payment of compensation," it shall be liable for a reasonable attorney fee. However, even if a carrier does not timely accept a claim, there is no unreasonable resistance to payment of compensation if the carrier paid all compensation. *See SAIF v. Condon*, 119 Or App 194, *rev den* 317 Or 163 (1993); *Aetna Casualty Co. v. Jackson*, 108 Or App 253 (1991). Here, because there are no amounts due, claimant is not entitled to a penalty-related attorney fee under ORS 656.382(1).

ORDER

The ALJ's order dated November 17, 2000 is affirmed.

Board Member Biehl concurring in part and dissenting in part.

Although I agree with the majority that claimant is not entitled to a penalty or penalty-related attorney fee, the majority errs by concluding that claimant's attorney is not entitled to a fee under ORS 656.386. I respectfully dissent from that portion of the majority's order.

I agree with claimant that he is entitled to an assessed fee for prevailing on SAIF's *de facto* denial. ORS 656.386(1)(a) provides that in cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by an Administrative Law Judge, a reasonable attorney fee shall be allowed. ORS 656.386(1)(b)(C) explains that a "denied claim" includes a claim for a new medical condition under ORS 656.262(7)(a), which the insurer does not respond to within 90 days.

Here, claimant made a claim for new medical conditions pursuant to ORS 656.262(7)(a), but SAIF did not respond until after 90 days had lapsed. SAIF's inaction resulted in a *de facto* "denied claim." When SAIF finally responded, it conceded that the new conditions were compensable and were encompassed within the scope of its acceptance. I agree with claimant that SAIF's position had the effect of rescinding the *de facto* denial. Consequently, claimant is entitled to an assessed attorney fee. The majority errs by concluding otherwise.

In the Matter of the Compensation of
RONALD E. BEAMAN, Claimant
Own Motion No. 98-0414M
OWN MOTION ORDER OF ABATEMENT AND POSTPONEMENT OF ACTION
Black, Chapman, et al, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our March 23, 2001 Own Motion Order of Dismissal. In dismissing claimant's request for Board review of the SAIF Corporation's November 16, 2000 Notice of Closure, we interpreted claimant's announcement that the "Own Motion Notice of Closure is appropriate," as a withdrawal of his request for Board review. On reconsideration, claimant contends that his submission contained a typographical error and should have stated that the "Own Motion Notice of Closure is **inappropriate.**" In light of such circumstances, he clarifies that he was not withdrawing his request for review. In addition, claimant contends that "the claim should be processed pursuant to ORS 656.262 and 656.268."

Claimant has previously filed a hearing request, raising the following issues: failure to process "new conditions" claim; unreasonable resistance, penalties (pursuant to ORS 656.262) and attorney fees. (WCB Case No. 01-02329).

After considering claimant's submission, we find it appropriate to withdraw our prior order. Furthermore, under these circumstances we postpone action until pending litigation on related issues has been resolved. We request that the assigned Administrative Law Judge (ALJ), submit a copy of the hearing 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 Own Motion relief.

IT IS SO ORDERED.

In the Matter of the Compensation of
CARL L. CHARLES, Claimant
WCB Case No. 00-06382
ORDER ON RECONSIDERATION
Dale C. Johnson, Claimant Attorney
John M. Pitcher, Defense Attorney

The self-insured employer requests reconsideration of that portion of our March 12, 2001 Order on Review that directed it to calculate claimant's temporary disability benefit payments by first deducting 25 percent for previously overpaid compensation, then diverting an additional 25 percent from the remaining amount to the Department of Justice (DOJ) in partial satisfaction for claimant's support obligation. Specifically, the employer requests clarification of that portion of our order that directed it to "recalculate" claimant's temporary disability payment consistent with our order.

As discussed in our prior order, according to our interpretation of the statutory scheme, 25 percent of claimant's temporary disability benefits is subject to an offset for the employer's recovery of its overpayment. Thereafter, 25 percent of the remaining 75 percent balance is disbursable to the DOJ in partial satisfaction of the outstanding support order. Because the employer based its 25 percent "DOJ / support" disbursement on claimant's "pre-offset" benefits, a larger amount of the remaining balance was diverted to the DOJ under the employer's formula.

Thus, had the employer apportioned claimant's temporary disability compensation between him and the DOJ in the manner prescribed by our order, a smaller portion would have been disbursed to the DOJ, with a larger portion directed to claimant. In order to remedy this situation, the employer is directed to make an adjustment in its future claim processing actions.

Specifically, after calculating the amount that should have been alloted to the DOJ under the formula prescribed in our order, the employer shall compute the difference between that "prescribed" amount and the amount that was actually disbursed under the employer's formula. Once that difference is calculated, the employer shall adjust any future disbursement(s) between the DOJ and claimant until such time as the difference is eliminated. In other words, the future amount(s) disbursed by the employer to the DOJ shall be either eliminated or reduced until the aforementioned "difference" has been satisfied. Once the "difference" has been fully satisfied, the employer shall distribute future payments in the manner prescribed in our order so long as the outstanding support obligation exists.

Accordingly, our March 12, 2001 order is withdrawn. On reconsideration, as supplemented, our March 12, 2001 order is republished. 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
ROY M. DINNELL, JR., Claimant
WCB Case No. 00-04663
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of claimant's current right knee condition as procedurally improper. On review, the issues are propriety of the denial and compensability.[1] We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings," with the following supplementation.

By the time of the insurer's June 2000 current condition denial, claimant's compensable right knee injury had combined with his preexisting right knee degeneration and the injury was not the major contributing cause of the disability or need for treatment for the combined condition.

CONCLUSIONS OF LAW AND OPINION

Claimant injured his right knee at work on March 28, 1997. The employer accepted left and right knee strains and a torn right medial meniscus. (*See* Exs. 3, 5, 7, 11). Dr. Versteeg performed a right partial menisectomy on November 20, 1997. The claim was closed on July 28, 1997, reopened, and closed again on February 4, 1998.

Claimant returned to Dr. Versteeg in September 1999, with a diagnosis of right knee osteoarthritis. Dr. Versteeg provided conservative treatment.

Dr. Courogen examined claimant on April 17, 2000.

The insurer issued a current condition denial on June 9, 2000, on the ground that a preexisting condition (degenerative joint disease) was the major contributing cause of claimant's current need for treatment. (Ex. 20). Claimant requested a hearing.

The ALJ found that the insurer's acceptance of claimant's right knee strain and torn medial meniscus included acceptance of his underlying right knee degeneration. Reasoning that the insurer's denial of claimant's current right knee degenerative condition was therefore a denial of the previously accepted condition, the ALJ set the denial aside as procedurally improper. We reverse.

Claim acceptance encompasses only those conditions specifically and officially accepted in writing. *Johnson v. Spectra Physics*, 303 Or 49, 56 (1987). The scope of an acceptance is a question of fact. *See SAIF v. Tull*, 113 Or App 449, 454 (1992).

Here, the insurer specifically accepted claimant's right knee strain and torn right medial meniscus, nothing more. There is no evidence that these conditions were symptoms of another condition and no ambiguity on the face of the acceptance.[2] Consequently, the acceptance is limited, as written, to a right knee strain and torn meniscus and it does not preclude denial of a separate preexisting condition. *See Granner v. Fairview Center*, 147 Or App 406, 410 (1997) (acceptance of a particular condition does not necessarily include the cause of that condition); *Filbert M. Fimbres*, 52 Van Natta 772, 775 n. 2 (2000), *aff'd mem* 173 Or App 446 (2001) (same); *Phillip L. Shores*, 49 Van Natta 341,

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[1] The insurer also argues that the ALJ's attorney fee award was excessive. We do not reach this issue, because we uphold the insurer's denial and therefore claimant is not entitled to a fee.

[2] *See Kim D. Wood*, 48 Van Natta 482, 484, *aff'd mem* 144 Or App 496 (1996) (because there was a specific acceptance of a "left knee strain," it was not necessary to examine the contemporaneous medical evidence to determine what condition was accepted).

342 (1997) (where no evidence indicated that the claimant's right shoulder tendinitis was a symptom of his degeneration or disc herniation, carrier's denial of the spinal conditions not precluded by its acceptance of the tendinitis).[3]

It is undisputed that claimant had right knee degeneration that preexisted his 1997 work injury. (Exs. 2, 6, 9, 17-5; *see* Exs. 14, 16). However, no doctor attributed claimant's symptoms or need for treatment to that degeneration, or to a combined condition involving that degeneration, until long after the claim was accepted.

On the other hand, by early 2000, it is undisputed that claimant's preexisting right knee degeneration was at least the predominant cause of his ongoing right knee problems. (Ex. 18; *see* Ex. 17-6-7). Thus, the medical record reinforces our conclusion that the insurer accepted conditions medically separable from the preexisting degeneration,[4] but the injury combined *later* with that degeneration to cause claimant's ongoing need for treatment.[5]

In this regard, Dr. Versteeg opined that claimant's 1997 symptoms and need for surgery were work related, but his need for treatment "subsequent to that, ie in this year [2000] or subsequent years would be predominantly related to his arthritis[.]" (Ex. 18).[6]

Accordingly, based on Dr. Versteeg's 2000 opinion, we find that claimant's preexisting degeneration eventually combined with his 1997 injury to cause his need for treatment for his right knee. In addition, based on the same evidence, we further find that as of the insurer's June 2000 denial the preexisting condition was the major contributing cause of claimant's "current condition." *See Jerold D. Glover*, 51 Van Natta 169 (1999) (combined condition only compensable until injury was no longer the major contributing cause of ongoing problems); *Danny B. Conner, on remand* 48 Van Natta 1227 (1996) (same). Accordingly, because claimant's current condition is not compensable under ORS 656.005(7)(a)(B), we reverse the ALJ's order and reinstate the denial.

ORDER

The ALJ's order dated December 20, 2000 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[3] We also note that neither ORS 656.262(6) nor 656.262(7)(b) apply to this case because the acceptance did not include a preexisting condition. *Compare Janet R. Christensen*, 50 Van Natta 396, 400 (1998), *aff'd Freightliner v. Christensen*, 163 Or App 191 (1999) (where the preexisting conditions were included in the acceptance, there was no combined condition, and ORS 656.005(7)(a)(B), 656.262(6)(c), and 656.262(7)(b) did not apply).

[4] *See Gerry L. Schreiner*, 51 Van Natta 1998 (1999) ("if the carrier's acceptance is for a separate condition, the rule of *Piwowar* does not apply").

[5] We further note that claimant's 1998 post-surgery diagnoses included both post traumatic arthrosis and degenerative arthritis. (Exs. 14, 16). And, in January 1998, Dr. Versteeg opined, "Etiology of [claimant's] problem is partly related to the work injury and probably related to pre-existing wear and tear." (Ex. 14-1). Although we cannot say on this record exactly when claimant's right knee condition became a "combined condition," we find that it was a "combined condition," subject to ORS 656.005(7)(a)(B), by the time of the June 2000 current condition denial.

[6] Dr. Courogen provides the only expert evidence arguably contrary to Dr. Versteeg's causation opinion. Dr. Courogen opined that the compensable injury resolved "within a few days" and claimant's subsequent need for treatment was due solely to preexisting degeneration. (Ex. 17). Although Dr. Courogon's opinion differs from that of Dr. Versteeg's, the difference is not material to the issue before us, *i.e.*, whether claimant's condition was compensable as of the June 2000 current condition denial. In any event, we rely on Dr. Versteeg's analysis, considering his advantageous position as claimant's longtime treating physician and surgeon.

In the Matter of the Compensation of
GEORGE D. HILTON, Claimant
Own Motion No. 01-0073M
OWN MOTION ORDER ON RECONSIDERATION
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer requests reconsideration of our March 15, 2001 Own Motion Order in which we authorized the reopening of claimant's claim to provide temporary disability compensation beginning the date claimant is hospitalized for surgery. Specifically, the insurer contends claimant is not entitled to temporary disability benefits because he is receiving "Social Security Disability benefits" at the time of his current 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 compensation condition 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).

In our March 15, 2001 order, we found that claimant was in the work force at the time of his disability. We based our conclusion on claimant's submission of copies of his 2000 1099 Forms and a copy of his January 2001 paystub, which demonstrated that he worked for remuneration during that period of time. Therefore, we continue to find that claimant was performing work at the time of disability.[1] Because claimant has established that he worked, he is entitled to temporary disability to replace any lost wages, beginning the date of surgery. *See Robert D. Hyatt*, 48 Van Natta 2202 (1996) (the claimant was entitled to temporary partial disability when, although retired, the claimant established that he continued to work part-time).

On reconsideration, the insurer contends that claimant is receiving Social Security benefits, and thus, not entitled to temporary disability compensation. However, because we have concluded that claimant was working at the time of disability, we are not persuaded that the contention is pertinent to our inquiry.[2] In other words, we do not find that receipt of social security benefits determinative, because claimant has established that he was working at the time of disability, and thus, entitled to temporary disability benefits. *See Robert D. Hyatt*, 48 Van Natta at 2203.

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[1] In a January 25, 2001 chart note, Dr. Henderson recommended left knee surgery. 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, 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 January 25, 2001, when his condition worsened requiring surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270 (1990); *SAIF v. Blakely*, 160 Or App 242 (1999); *Paul M. Jordan*, 49 Van Natta 2094 (1997).

[2] In any event, notwithstanding our current findings, the receipt of Social Security benefits would not necessarily impact our decision. A claimant's eligibility for Social Security benefits indicates that he is disabled from work due to one or a number of medical conditions. On the one hand, receipt of Social Security benefits would establish that a claimant is disabled from work (it would be futile for the claimant to see work), *see Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989); on the other hand, the disability which makes seeking work futile may not be due to a compensable injury. *See Kenneth C. Felton*, 48 Van Natta 725 (1996); *Konnie Sprueill*, 45 Van Natta 541 (1993).

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our March 15, 2001 order in its entirety. 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
KATHY M. CLEARY, Claimant
WCB Case No. 99-07496
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorney
Hornecker, Cowling, et al, Defense Attorney

The self-insured employer requests reconsideration of that portion of our March 12, 2001 Order on Review that affirmed the Administrative Law Judge's (ALJ's) order that set aside the employer's denial of claimant's injury claim for a bilateral wrist condition.

Specifically, the employer contends that we erred in finding Dr Parvin's opinion persuasive. The employer argues that Dr. Parvin never identified one factor as the major contributing cause of claimant's bilateral carpal tunnel syndrome. The employer also contends that Dr. Parvin utilized an impermissible "precipitating cause" analysis. We disagree.

As we explained in our initial order, although Dr. Parvin initially identified several causal factors, eventually she implicated claimant's work injury as the major contributing cause of her current need for treatment for her carpal tunnel syndrome condition. (Ex. 38-2).

Moreover, we find that Dr. Parvin's opinion rests on more than just a "precipitating cause" analysis. Such an analysis, standing alone, is generally not persuasive. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 321 Or 416 (1995). Here, we acknowledge that Dr. Parvin reached her opinion based in part on the fact that claimant became symptomatic following her injury. (Ex. 38-2). However, Dr. Parvin also reasoned that the work injury had caused a cervical disc herniation, which in turn created a "double crush" phenomenon that combined with claimant's underlying risk factors and conditions to become the major contributing cause of claimant's need for treatment for her carpal tunnel syndrome. (*Id*). In an earlier report, Dr. Parvin had considered a myriad of different possible causes for claimant's condition, as we explained in our initial order. (Ex. 30-5). We find that Dr. Parvin has not relied solely on a precipitating cause analysis. We therefore continue to find Dr. Parvin's opinion persuasive.

Accordingly, we withdraw our March 12, 2001 order. On reconsideration, as supplemented herein, we adhere to and republish our March 12, 2001 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
CARL L. MULLINS, Claimant
WCB Case Nos. 00-04938 & 00-04937
ORDER ON REVIEW
Charles L. Lisle, Claimant Attorney
Atwood & Associates, Defense Attorney

Reviewed by Board Members Haynes, Bock, and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that upheld the self-insured employer's denials of his aggravation/new injury claim for a low back condition. On review, the issue is claim processing.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated November 21, 2000 is affirmed.

Board Member Phillips Polich dissenting.

The majority affirms without opinion the ALJ's determination that claimant failed to prove a compensable aggravation or "new injury" claim based on a February 2000 incident when he injured his low back jumping down from a stack of steel. However, I believe that claimant is entitled to "reopening" of his compensable November 1995 claim under ORS 656.005(7)(a)(A) and ORS 656.262(7)(c), based on the case authority cited by claimant. *See Douglas C. Abbott*, 50 Van Natta 1156 (1998). Therefore, I dissent.

In *Abbott*, the claimant sustained a compensable 1994 low back injury that resulted in two subsequent surgeries. The claimant later developed left leg symptoms that the carrier denied. Based in part on persuasive medical evidence that linked the left sided symptoms to scar tissue that developed from the prior compensable surgeries, we held that claimant proved that the left leg symptoms were a compensable consequential condition under ORS 656.005(7)(a)(A). Moreover, we held that the claimant was entitled to "reopening" of the claim under ORS 656.262(7)(c) for processing of the left leg symptoms. 50 Van Natta at 1159.

The facts of this case are very similar to those in *Abbott*. Claimant here suffered a compensable low back injury in November 1995. The low back condition eventually required surgery. After claim closure, claimant experienced the February 2000 incident, as a result of which he developed low back and left lower extremity complaints. Dr. Hubbard, the surgeon who treated claimant for the 1995 injury, opined that claimant's nerve root inflammation at the old surgery site was due to a "traction" injury resulting from the February 2000 incident. According to Dr. Hubbard's persuasive opinion, the scar tissue that had formed in the surgical site and a nerve root had become attached. When claimant jumped down from the stack of steel, the nerve root pulled against the attachment and caused irritation and inflammation.

Accordingly, as in *Abbott*, the medical evidence here also establishes that claimant's consequential symptoms are related to the scar tissue resulting from a prior compensable surgery. Just as it did in *Abbott*, the Board in this case should have concluded that claimant's current condition is a compensable consequential condition under ORS 656.005(7)(a)(A). However, the majority has declined to apply the *Abbott* analysis in this case. While the carrier has processed claimant's current medical treatment under the 1995 claim, the record does not disclose that it has properly processed the claim under ORS 656.262(7)(c). Because *Abbott* requires reopening of the claim under that statute and the record does not establish that the "reopening" has occurred, I would reverse the ALJ's decision and order the appropriate claim processing. Because the majority declines to do so, I respectfully dissent.

In the Matter of the Compensation of
TIMOTHY L. ROMERO, Claimant
WCB Case No. 00-02720
ORDER ON REVIEW
Heather Holt, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the insurer's denial of an L5-S1 disc herniation. 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 relied upon the opinions of Drs. Schilperoort, Farris, Staver and Young to conclude that claimant had not established compensability of an L5-S1 herniated disc. Claimant relies upon the opinions of his treating doctors, Dr. Hagie and Dr. Dunn, to argue that he established compensability.

This case presents a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967). There are four expert medical opinions in the record. The compensability issue depends largely on the interpretation by the physicians of a November 18, 1999 MRI and whether or not claimant has a disc herniation at L5-S1.[1]

The MRI was performed on November 18, 1999 by Dr. Gove. (Ex. 20). Dr. Gove reported that there was disc space narrowing at L5-S1 associated with a possible small confined posterolateral disc protrusion shown on saggital images. The MRI report stated that there were shallow annulus bulges at L3-4 and L4-5 and annulus bulge or small confined disc protrusion at L5-S1, eccentric to the left.

Dr. Hagie, claimant's attending physician, reviewed the MRI. Dr. Hagie stated that he went over the MRI "image by image and word by word." (Ex. 21). In Dr. Hagie's view, claimant had a herniated disc encroaching into the left lateral recess at L5-S1, which was consistent with claimant's symptoms. *Id.*

Dr. Hagie referred claimant to Dr. Dunn for a surgical consultation. Dr. Dunn review the MRI and stated: "His MRI shows clearly there is a herniated nucleus pulposus, far lateral, and intraforaminal at L5-S1 on the left." (Ex. 22).

In an December 29, 1999 chart note, Dr. Hagie stated, in part:

> "I spent a few minutes discussing with [claimant] the likelihood of his disk-injuring episode was probably the 1/25/99 lifting injury at work which caused him immediate back pain but no leg pain. By at least 3/11/99, the notes from Dr. Opel's office indicate [claimant] to be having leg pain. Unfortunately, at the time of this dictation I do not have the earlier part of the notes, and those are forthcoming. According to [claimant], he had back pain immediately, and it was on the order of a month before he began feeling leg pain. This is entirely consistent with a disk injury which would show up as negative for herniation and then slow increasing degenerative changes and further tearing of the disk, leading to a herniation as currently evidenced on the MRI of 11/18/99." (Ex. 24).

In a January 5, 2000 chart note, Dr. Hagie indicated that he reviewed MRIs from February and November 1999 and believed that there was a disk protrusion at L5-S1, left, partially occluding the left neural foramen. (Ex. 24-2).

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[1] We note that the record also contains an opinion from Dr. Schilperoort. Because Dr. Schilperoort never reviewed or commented on the November 18, 1999 MRI, we find his opinion unpersuasive because it is based on incomplete information.

Dr. Farris and Dr. Staver examined claimant on behalf of the insurer on March 4, 2000. These physicians opined that the November 18, 1999 MRI did not show any abnormality that would account for claimant's symptoms. They indicated that there was no evidence of significant herniation and no evidence of nerve root compression. Dr. Farris and Dr. Staver concluded that claimant had a personality disorder causing complaints out of proportion to the injury and the degenerative changes. The physicians concluded that the personality disorder was the major contributing cause of claimant's condition. (Ex. 25-7).

Dr. Hagie disagreed with portions of the report of Drs. Farris and Staver. In particular, Dr. Hagie disagreed with Dr. Farris' and Dr. Staver's opinion that there was no herniated disc at L5-S1. (Ex. 29).

Dr. Young, a diagnostic radiologist, reviewed claimant's MRI scans. After reviewing claimant's MRIs, Dr. Young opined that the January 25, 1999 injury probably combined with the preexisting degenerative disease at L4-5 and L5-S1 to cause claimant's disability and need for treatment. However, Dr. Young believed that the major contributing cause of the combined condition and the disability and need for treatment was the preexisting degenerative disease. (Ex. 30-4). Dr. Young stated that claimant's subjective complaints did not correlate with the objective findings noted on the MRI scans. Dr. Young concluded that claimant did not have objective evidence of radiculopathy or neurological compromise and the subjective symptoms he exhibited did not correlate well with the MRI studies.

Dr. Farris submitted an additional report on June 26, 2000. Dr. Farris indicated that claimant's examinations demonstrated a lack of credibility. Dr. Farris further indicated that the degenerative changes showed on the November 18, 1999 MRI did not explain claimant's low back complaints. Dr. Farris also opined that claimant was not a good surgical candidate because he did not have anything that needed to be removed surgically. (Ex. 32). In her deposition, Dr. Farris clarified that she did not attribute claimant's symptoms to his degenerative changes. She explained that she could not find a physical explanation for his symptoms. (Ex. 34-25, 26).

Dr. Dunn, in a October 10, 2000 report stated, in part:

> "I do definitively feel that his work injury of 1/25/99 was the major contributing cause to his current condition. I do not feel that his past history, his family history, or performance at IMEs has anything to do with the fact that he does clearly have a herniated nucleus pulposus at L5-S1, left, and it was related definitively to his work injury. It is possible that his previous injuries, which did have some left leg symptoms, but were only transient, may have been related to damage to his annulus. The injury on 1/25/99 when he was lifting railroad ties, obviously was of greater severity and persisted with severe leg pain.
>
> "The MRI taken on 2/2/99 did not show the findings that were evident in the MRI examination of 11/99. He had no interval injuries. The MRI was taken within one week of his injury and it is reasonable and probable that the injury extended the damage to his annulus and subsequently as his symptoms grew, the disc protrusion became more evident. I therefore feel that that particular injury on 1/25/99 was the major (51%) cause of his current condition and need for surgical intervention.
>
> "The issue of whether a radiologist, neurosurgeon, or orthopedist is more qualified than the other to read an MRI probably has to do with exposure. There are certain facilities where MRIs of the lumbar spine are read on a rather infrequent basis. My own personal experience is I read at least 10 MRIs of the spine daily and have been doing so ever since MRIs came into existence. Again, I do feel that Dr. Gove's reading is reasonable and accurate, although his description is not as detailed as it might have been." (Ex. 35-2).

After reviewing the medical evidence in this case, we are more persuaded by the opinions of the treating physicians, Dr. Hagie and Dr. Dunn. We find their opinions to be well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). In addition, we find no persuasive reason not to defer to the treating physicians in this case. *See Weiland v. SAIF*, 64 Or App 810 (1983) (In evaluating medical opinions, we generally defer to the treating physician absent persuasive

reasons to the contrary). In reaching our conclusions, we note that Drs. Farris and Staver only examined claimant on one occasion. Dr. Young, as a diagnostic radiologist, did not examine claimant. We are persuaded, based on this record, that the treating physicians, Dr. Hagie and Dr. Dunn, are in the best position to determine the nature and cause of claimant's condition.[2] Accordingly, we conclude that claimant has established compensability of his L5-S1 disc herniation pursuant to ORS 656.005(7)(a)(B).

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 $4,500, payable by the insurer. 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's services might go uncompensated.

ORDER

The ALJ's order dated November 10, 2000 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing in accordance with law. For services at hearing and on review, claimant's attorney is awarded $4,500, payable by the insurer.

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[2] We note that the insurer argues that the opinions of Drs. Dunn and Hagie are unpersuasive because they examined claimant months after the January 25, 1999 injury. After our review of the evidence, we are persuaded that Drs. Dunn and Hagie had complete and accurate information regarding claimant's injury and we are not persuaded that the delay between the injury and claimant's first treatment by Drs. Hagie and Dunn renders their opinions unpersuasive.

In the Matter of the Compensation of
DAVID R. LAMBIE, Claimant
Own Motion No. 01-0042M
OWN MOTION ORDER OF ABATEMENT
Vick & Conroyd, Claimant Attorney
Saif Legal Department, Defense Attorney

On March 20, 2001, we authorized the reopening of claimant's 1995 claim for the payment of temporary disability compensation. Since our order, we have received information from the Workers' Compensation Division, which raises the question whether this claim is subject to our Own Motion authority under ORS 656.278. (Copies of these materials are included with SAIF's and claimant's counsel's copies of this order.)

In order to further consider this matter, we withdraw our March 20, 2001 order. In addition, we implement the following briefing schedule. Claimant's opening brief, including any supporting documents, must be filed within 14 days from the date of this order. The SAIF Corporation's response, including any further supporting documents, must be filed within 14 days from the date of mailing of claimant's brief. Claimant's reply must be filed within 14 days from the date of mailing of SAIF's response. Thereafter, we will proceed with our review.

IT IS SO ORDERED.

In the Matter of the Compensation of
KYM A. PRATHER, Claimant
WCB Case No. C010035
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Hornecker, Cowling, et al, Defense Attorney

Reviewed by Board Member Biehl and Haynes.

On January 5, 2001, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, for payment of a stated sum, claimant, *pro se*, released rights to future workers' compensation benefits, except medical services, for the compensable injury. On February 6, 2001, the Board received a letter from claimant seeking to "suspend" the pending "CDA case." Having granted the parties an opportunity to state their positions on the suspension request, we now proceed with our review. For the following reasons, we approve the proposed disposition.

ORS 656.236(1) provides that a disposition shall be approved in a final order unless: (a) the Board finds the proposed disposition is unreasonable as a matter of law; (b) the Board finds the proposed disposition is the result of an intentional misrepresentation of material fact; or (c) within 30 days of submitting the disposition for approval, one of the parties requests the Board to disapprove the disposition. ORS 656.236(2) further provides that an order approving the disposition of a claim is not subject to review.

Therefore, in order to be considered, a request to withdraw the CDA must be received within 30 days of the receipt of the agreement. Here, the Board received the CDA on January 5, 2001. Thus, claimant had until Sunday, February 4, 2001, to request disapproval of the CDA. However, because the 30th day fell on a Sunday, the deadline for requesting disapproval was Monday, February 5, 2001. Because the request to withdraw the CDA was not received until February 6, 2001, claimant's request was untimely. Moreover, no contention is made, nor do we find, that the CDA on its face was either unreasonable as a matter of law or the result of an intentional misrepresentation of material fact. *See* ORS 656.236(1)(a), (b).

Inasmuch as no reason for disapproval was brought to our attention within 30 days of submitting the disposition for approval, and because the agreement was in compliance with all statutory and administrative prerequisites, 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.

IT IS SO ORDERED.

In the Matter of the Compensation of
DOUGLAS L. SHUMWAY, Claimant
Own Motion No. 99-0310M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Mitchell & Guinn, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

On November 2, 2000, we withdrew our November 2, 2000 Own Motion Order Reviewing Carrier Closure, that had affirmed the SAIF Corporation's August 4, 2000 Notice of Closure. We took this action to consider claimant's contention that the Board "lacks jurisdiction to close the newly accepted conditions." Having received SAIF's response, we proceed with our review.

In our prior order, we found that we had jurisdiction in our Own Motion capacity to review SAIF's Notice of Closure. We explained that, applying the reasoning in *Larry L. Ledin*, 52 Van Natta 680, 52 Van Natta 682 (2000), we had subject matter jurisdiction to issue our August 25, 1999 Own Motion Order that authorized reopening claimant's claim pursuant to ORS 656.278(1) and its closure pursuant to our Own Motion rules.[1]

In reviewing SAIF's closure, we noted that claimant made no argument regarding his medically stationary status at the time of closure nor did he argue that his medically stationary date was incorrect or that his temporary disability compensation was incorrectly calculated. Rather, claimant's argument was solely procedurally based, *i.e.*, he essentially argued that there were newly accepted conditions that should have been processed under ORS 656.262(7)(c) and 656.268, rather than under the Board's Own Motion jurisdiction pursuant to ORS 656.278. Inasmuch as we had concluded that we had subject matter jurisdiction to review SAIF's closure and claimant raised no substantive arguments, we affirmed SAIF's August 4, 2000 Own Motion Notice of Closure in its entirety.

On reconsideration, claimant continues to argue that the Board lacks jurisdiction to "close his newly accepted conditions." Nonetheless, as explained above, we have subject matter jurisdiction over the closure of a claim properly reopened under our Own Motion jurisdiction. Here, as in *Ledin*, claimant's argument is solely *procedurally* based, *i.e.* that his newly accepted conditions be processed under ORS 656.262(7)(c) and 656.268. However, as explained in our prior order, such a claim processing issue is a "matter concerning a claim" for which a claimant can request a hearing under ORS 656.283.[2] Therefore, because claimant has not raised any substantive arguments regarding SAIF's claim closure, we continue to affirm SAIF's August 4, 2000 Own Motion Notice of Closure.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our November 2, 2000 Own Motion Order Reviewing Carrier's Closure in its entirety. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

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[1] We also noted that the August 29, 1999 Own Motion Order was not appealed and became final by operation of law. *See* ORS 656.278(4).

[2] Claimant requested a hearing before the Hearings Division regarding the processing of his newly accepted conditions under ORS 656.262(7)(c) and 656.268. (WCB Case No. 00-06447). On December 18, 2000, Administrative Law Judge (ALJ) Kekauoha ordered that SAIF reopen claimant's 1971 claim and process his newly accepted medical conditions pursuant to ORS 656.262 and 656.268, including awards of any temporary disability and permanent disability benefits for the new conditions. SAIF appealed ALJ Kekauoha's order and in an order dated today, we have affirmed ALJ Kekauoha's order. Thus, in anticipation of an eventual "ORS 656.268" closure of the claim, we note that claimant is not entitled to duplicate compensation for any time period coinciding with temporary disability compensation awarded pursuant to SAIF's August 4, 2000 Own Motion Notice of Closure. *Larry L. Ledin*, 52 Van Natta 680, 52 Van Natta 682 (2000).

In the Matter of the Compensation of
DOUGLAS L. SHUMWAY, Claimant
WCB Case No. 00-06447
ORDER ON REVIEW
Mitchell & Guinn, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Kekauoha's order that directed it to process claimant's "new medical condition" claim for right ankle conditions under ORS 656.262 and ORS 656.268. On review, the issue is claim processing.

We adopt and affirm the ALJ's order. *See Dave A. Humphrey*, 52 Van Natta 2212 (2000); *Larry L. Ledin*, 52 Van Natta 682 (2000); *John R. Graham*, 51 Van Natta 1740 (1999).

Claimant's attorney is entitled to an assessed fee for services on review regarding the claim processing 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 concerning the claim processing issue is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the claim processing 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, 2000, is affirmed. For services on review regarding the claim processing issue, claimant's attorney is awarded $1,000, payable by SAIF.

In the Matter of the Compensation of
KIMBERLY K. BOLEN, Claimant
WCB Case No. 00-05026
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorney
Sheridan, et al, Defense Attorney

Reviewed by Board Members Haynes, Bock, and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that upheld the insurer's *de facto* denial of claimant's medical service claim regarding her left knee lax medial collateral ligament condition. On review, the issues are the effect of a prior Disputed Claim Settlement (DCS) and Claim Disposition Agreement (CDA) and, potentially, compensability.

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

At hearing, claimant argued, in part, that the DCS (which had upheld the insurer's prior current left knee condition denial) did not preclude compensability of her current left knee condition. (Tr. 2-5). Relying on *James M. Steele*, 51 Van Natta 1031 (1999), and *Judy A. Tuttle*, 45 Van Natta 165 (1993), the ALJ rejected that argument, finding that the DCS precluded compensability of claimant's current left knee condition because that condition remained the same as it was at the time of the DCS, although the diagnosis had changed.

On review, claimant does not contend that the ALJ erred in determining that the DCS precluded compensability of her current left knee condition. Instead, she argues that, notwithstanding the CDA and DCS, she may bring a claim for the left knee lax medial collateral ligament condition at any time as either a new medical condition claim under ORS 656.262(7)(a) or an omitted condition claim under ORS 656.262(6)(d). The insurer argues that, because claimant did not raise that issue at hearing, she may not raise it for the first time on review.

We agree with the insurer that claimant did not raise the issue of bringing a claim under ORS 656.262(6)(d) and/or (7)(a) at hearing. Claimant counters that she is presenting a new "legal theory" as opposed to a new issue; therefore, she is not precluded from raising it on review.

As a general rule, we do not consider issues that are raised for the first time on review. *See Stevenson v. Blue Cross*, 108 Or App 247, 252 (1991); *see also Fister v. South Hills Health Care*, 149 Or App 214 (1997) (absent adequate reason, Board should not deviate from its well-established practice of considering only those issues raised by the parties at hearing); *Jacqueline J. Griffin*, 51 Van Natta 1806 (1999) (Board found that prior stipulation precluded subsequent claim for a right ankle condition and declined to address issue of new medical condition under ORS 656.262(7)(a) because it was first raised on review). In this case, we find no reason to deviate from our general rule.

In addition, assuming without deciding that claimant is presenting a new "legal theory" rather than a new issue by relying on ORS 656.262(6)(d) and/or (7)(a) to make a new claim on review, we find that such a theory does not yet present a justiciable controversy. Both statutes require that claimant make a written request to the insurer and claimant has not made the required written request to the insurer under either ORS 656.262(6)(d) or (7)(a). *See Diane S. Hill*, 48 Van Natta 2351, 2352-53 (1996), *aff'd mem Hill v. Stuart Andersons*, 149 Or App 496 (1997).

Under these circumstances (where the insurer challenges the procedural validity of this "new claim"), even if claimant presents only a new theory on review, we find that that "theory" is not ripe for consideration. Consequently, we decline to consider the new medical condition/omitted condition issues raised by claimant for the first time on review.

ORDER

The ALJ's order dated November 9, 2000 is affirmed.

Board Member Phillips Polich dissenting.

I disagree with the majority's refusal to consider claimant's argument that, notwithstanding the CDA and DCS, she may bring a claim for the left knee lax medial collateral ligament condition at any time as either a new medical condition claim under ORS 656.262(7)(a) or an omitted condition claim under ORS 656.262(6)(d).

I agree with claimant that she is merely raising a new legal theory, not a new issue. Specifically, the issues raised at hearing relate to the compensability of claimant's left knee lax medial collateral ligament condition and whether she was precluded from litigating the compensability issue due to entering into a prior DCS. The theory under ORS 656.262(7)(a) and/or (6)(d) that claimant raises on review is a new legal theory as to why she is not precluded from litigating the compensability issue. The Board has held that alternative "legal theories," as opposed to new issues, can be considered for the first time on review if there is no prejudice to the adverse party. *See Daniel V. Covert*, 52 Van Natta 1635 (2000); *Martha E. Leyva*, 49 Van Natta 1177 (1997). The insurer does not argue that they have been prejudiced by raising this new theory and, in fact, addressed it in its respondent's brief.

The Board has *de novo* review and I say we should use it to decide this legal theory that claimant has put before us. Because the majority decides to avoid the issue, I respectfully dissent.

April 6, 2001 Cite as 53 Van Natta 519 (2001)

In the Matter of the Compensation of
WILLIAM A. SMEE, Claimant
Own Motion No. 01-0086M
OWN MOTION ORDER
Cole, Cary, et al, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted a request for temporary disability compensation for claimant's back condition. Claimant's aggravation rights have expired. SAIF opposes the reopening of the claim on the grounds that: (1) no surgery or hospitalization has been requested; and (2) surgery or hospitalization is not reasonable and necessary.

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.[1] 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.* 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] On March 15, 2001, the Board allowed claimant an opportunity to respond to SAIF's surgery contentions and requested his written response within 14 days. Having received no response, we have proceeded with our review.

In the Matter of the Compensation of
PATRICK LOOP, Claimant
WCB Case Nos. 00-05637, 00-03836, 00-01058, 00-01057 & 99-09862
ORDER ON REVIEW
Willner, Wren, Hill & Uren, Claimant Attorney
Miller, Nash, et al, Defense Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The alleged non-complying employer (NCE), Kid-A-Ride Amusement, requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) affirmed a Proposed and Final Order declaring noncompliance and assessing a civil penalty; (2) set aside the denials of claimant's head injury claim issued by Johnston and Culberson (JCI), the statutory processing agent for the alleged NCE; (3) upheld the denial of the head injury claim issued by Liberty Northwest on behalf of Polk County; and (4) awarded an assessed fee to be paid by JCI. The alleged NCE also requests that we award assessed attorney fees payable by either Liberty Northwest or the Department should we reverse the Proposed and Final Order declaring noncompliance. Finally, claimant moves to dismiss the request for review on the ground that it is moot in light of JCI's "post-hearing" acceptance of the head injury claim. On review, the issues are the status of the alleged NCE, compensability, attorney fees, and motion to dismiss.

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

Motion to Dismiss

Citing *SAIF Corporation v. Mize*, 129 Or App 636 (1994), claimant moves to dismiss the NCE's request for review as moot on the ground that JCI, the statutory claims processing agent for the alleged NCE, has issued an unqualified acceptance of the head injury claim.[1] Claimant asserts that the alleged NCE is bound by JCI's acceptance of the claim and can no longer contest compensability.

JCI and the Department oppose claimant's motion, arguing that the statutory claim processing agent's processing of the claim does not affect the NCE's right to challenge the compensability of the claim under ORS 656.054(1). They contend that *Mize* is distinguishable because it did not involve a noncomplying employer or such an employer's challenge to compensability under ORS 656.054(1).

We need not decide the issue of whether an NCE may be bound by the statutory processing agent's acceptance of a claim. The NCE has submitted a copy of JCI's December 14, 2000 letter to claimant advising him of acceptance of the claim. The letter is entitled "Initial Notice Of Claim Acceptance *Pending Appeal by Employer.*" (Emphasis added). Given that this letter indicates the acceptance was made pending the employer's appeal, we find that JCI's acceptance was not unqualified. Therefore, *Mize* is not applicable. *See Donna J. Calhoun*, 47 Van Natta 454 (1996). Accordingly, we deny claimant's motion.[2]

Order of Noncompliance

We adopt and affirm the ALJ's reasoning on this issue.

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[1] In *Mize*, the carrier accepted the claimant's claim by clear and unqualified notice of acceptance before it petitioned for review of a Board order that had set aside the carrier's claim denial. 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. 129 Or App at 640.

[2] Claimant argues, nevertheless, that, although JCI's acceptance of the claim would not resolve the controversy between the alleged NCE and the Department about who would pay claim costs, it does moot the compensability issue vis-a-vis claimant. We disagree. JCI's acceptance of the claim was conditioned on the outcome of the alleged NCE's appeal of the compensability. Should we determine that claimant did not sustain a compensable injury, claimant would not be entitled to receive workers' compensation benefits. Thus, there is a very real controversy as to claimant's entitlement to benefits in light of JCI's qualified acceptance of the claim pending the outcome of the alleged NCE's appeal of the compensability issue.

Applicability of ORS 656.029

We adopt and affirm the ALJ's reasoning on this issue.

Compensability

Turning to the compensability issue, claimant, an amusement ride operator for Kid-A-Ride, sustained a severe head injury when struck by a ride called the "Space Ball." This accident occurred while claimant was giving a coworker (Ridley) a ride. The ALJ determined that claimant's head injury was compensable, finding that he was a traveling employee who was injured in the performance of his job duties or at least while performing an activity that did not constitute a distinct departure from his employment and that was acquiesced in by the employer.

In making this finding, the ALJ rejected the NCE's contention, based on the testimony of another coworker (Tice), that claimant was injured during "horseplay." Specifically, Tice had testified that the ride, as a result of which claimant was injured, was given in retaliation for a fast ride that Ridley had given claimant a few minutes before that had made claimant dizzy. Tice also testified that claimant appeared disoriented from the ride Ridley had given him.

The ALJ discounted Tice's testimony because of earlier conflicting accounts from Tice regarding the purpose of the ride claimant was giving Ridley. The ALJ noted that Tice had originally stated that the injury had occurred while the workers were involved in "leveling" the ride itself, an activity that was a legitimate part of claimant's job duties.

On review, the NCE argues that Tice's accounts of the injury were essentially consistent and that it is claimant who provided incredible testimony regarding the purpose of his giving Ridley a ride in "Space Ball." Claimant testified that he was demonstrating the ride for a potential customer, but the NCE cites Tice's testimony that there were no customers in the area when the ride at issue was given and the fact that the fairgrounds were not open at the time of the accident. The NCE also points to other alleged inconsistencies or improbabilities in claimant's testimony in its attempt to show that claimant was engaged in a distinct departure from his employment activity when he was injured.

Having considered the NCE's arguments, we conclude that claimant's head injury is compensable. We reason as follows.

Claimant and the NCE agree that claimant was a traveling employee. The court has held that a person who has the status of a traveling employee is continuously within the course and scope of employment while traveling, except when it is shown that the person has "engaged in a distinct departure on a personal errand." *Savin Corp. v. McBride*, 134 Or App 321, 324 (1995); *Proctor v. SAIF*, 123 Or App 326, 330 (1993). The court has relied on the general rule governing the compensability of injuries to traveling employees, which is stated in 2 Larson, *Workers' Compensation Law*, section 25.01 (2000):

> "Employees whose work entails travel away from the employer's premises are held in the majority of jurisdictions to be within the course of their employment continuously during the trip, except when a distinct departure on a personal errand is shown. Thus, injuries arising out of the necessity of sleeping in hotels or eating in restaurants away from home are usually compensable." (Footnote omitted).

In determining whether a traveling employee's injury is compensable, we consider whether the activity that resulted in the injury was reasonably related to the employee's travel status. *McBride*, 134 Or App at 325; *Proctor v. SAIF*, 123 Or App at 330; *Slaughter v. SAIF*, 60 Or App 610, 616 (1982).

After reviewing Tice's and claimant's testimony regarding the circumstances of the injury, as well as the documentary evidence, there is reason to question claimant's account of the purpose behind giving Ridley a ride in "Space Ball." Nevertheless, even assuming that there was an element of retaliation in claimant's giving Ridley a ride in "Space Ball," we conclude, based on our review of the record, that the accident occurred during activity that occurred primarily for business reasons; *i.e.*, the "setting up" of "Space Ball." Therefore, we are not persuaded that the activity that caused claimant's

injury constitutes such a distinct departure from employment that claimant's head injury is not compensable.[3] Therefore, we find that claimant's injury was reasonably related to his travel status.

Accordingly, we conclude that the ALJ correctly determined that the claim is compensable. Thus, we affirm.

Attorney Fees

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). The NCE opposes, however, claimant's attorney's request for a $3,000 fee for services on review, arguing that it is excessive.

In deciding whether the requested fee is appropriate, we consider the factors in OAR 438-015-0010(4), which includes time devoted to the case, the complexity of the issues, the value of the interest involved, the skill of the attorneys, the nature of the proceedings, the benefits secured, and the risk that an attorney's efforts may go uncompensated. *See Schoch v. Leupold & Stevens*, 162 Or App 242 (1999) (Board must explain the reasons why the factors considered lead to the conclusion that a specific fee is reasonable).

Here, claimant only responded to the issue of the compensability of claimant's head injury claim, but did provide argument in support of his motion to dismiss the NCE's request for review, a motion we have denied. Claimant's attorney devoted 12.9 hours to the compensability issue on appeal and submitted a six and one-half page brief on the issue. The compensability issue concerned whether claimant's head injury arose out of and in the course of employment. As compared to typical compensability cases, the compensability issue here was of above average complexity. Because claimant's head injury has been found compensable, he is entitled to workers' compensation benefits, and the interest involved and the benefits secured for claimant are substantial (*i.e.*, medical bills exceed $60,000). The attorneys involved in this matter are skilled litigators with substantial experience in worker's compensation law. Finally, considering the conflicting testimony regarding the compensability issue, there was a risk that claimant's counsel's efforts might have gone uncompensated. No frivolous issues or defenses have been presented on review.

Consequently, 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 $2,500, payable by JCI. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by claimant's respondent's brief, his counsel's statement of services, and the NCE's objections), the complexity of the issue, and the value of the interest involved.[4]

ORDER

The ALJ's order dated November 15, 2000 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $2,500, to be paid by JCI, on behalf of the NCE.

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[3] Moreover, we are not persuaded that claimant violated any employer directives while giving Ridley the ride in "Space Ball." *See Proctor*, 326 Or App at 331. The employer's testimony indicates that, while operators were technically required to obtain employer permission before giving rides to each other, this often did not occur. (Trs. 40, 41, 137). Moreover, Tice indicated that there was really no company policy against operators giving each other rides. (Ex. 13-10). Given this evidence, we conclude that the employer acquiesced in the activity that resulted in claimant's injury.

[4] Because we have affirmed the ALJ's determination that Kid-A-Ride was a noncomplying employer, we reject its request that it be awarded attorney fees, to be paid by either Liberty Northwest or the Department.

In the Matter of the Compensation of
MARK W. VILES, Claimant
WCB Case Nos. 00-01536 & 00-00006
ORDER ON REVIEW
Kirkpatrick & Zeitz, Claimant Attorney
Walter D. Alley, Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Davis' order that upheld the statutory processing agent's (Johnson & Culberson Incorporated (JCI)) denial of his injury claim for a cervical spine condition. On review, the issue is compensability.

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

Claimant was involved in a rear-end automobile accident on July 7, 2000.[1] Claimant contends that as a result of that incident, he required cervical spine surgery.

The ALJ determined that the only medical opinion commenting on the cause of claimant's surgery was that of Dr. Rosenbaum, the attending surgeon. The ALJ reasoned that Dr. Rosenbaum's opinion was not persuasive because it was based on an incomplete history and an inaccurate understanding of claimant's preexisting medical condition. Consequently, the ALJ concluded that claimant had failed to establish that the auto accident was the major contributing cause of claimant's need for disability or need for treatment.

On review, claimant contends that the ALJ misread Dr. Rosenbaum's opinion and asserts that Dr. Rosenbaum's opinion persuasively established that the July 2000 auto accident was the major contributing cause of claimant's need for surgery. We disagree.

Claimant had a cervical condition that preexisted and combined with the effects of the July 2000 auto accident.[2] Therefore, in order to establish that his cervical condition is compensable, claimant must show that the auto accident was the major contributing cause of the disability or need for treatment of the combined condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, 106 (1997), *aff'd as modified on recon*, 149 Or App 309, 315 (1997), *rev den*, 326 Or 389 (1998). Because of claimant's preexisting condition and the possible alternative causes for his current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

To satisfy the "major contributing cause" standard, claimant must establish that the auto accident contributed more to his need for medical treatment or disability for the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's need for treatment of the combined condition and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

In responding to JCI's inquiry into the cause of claimant's condition, Dr. Rosenbaum stated:

> "It is a difficult assessment when an individual has a significant pre-existing cervical spinal stenosis and foramen stenosis as to the primary major contributing cause of his need for intervention. If claimant had any pre-existing symptoms referable to his neck or upper extremities, then it would have been my opinion that his need for treatment was based primarily on his congenital pre-existing condition. In the absence of any prior history, it appears the pathologic changes occurred with the moving vehicle accident superimposed on his pre-existing condition which required surgical intervention. The moving vehicle accident therefore became the primary contributing factor." (Ex. 34-3).

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[1] Because the ALJ determined that claimant's cervical condition was not compensable based on a failure to prove medical causation, the ALJ did not address JCI's contention that the auto accident was not within the course and scope of claimant's employment. Because we agree that claimant has failed to establish that injury from the auto accident was the major contributing cause of his cervical condition, we also do not address the course and scope issue.

[2] Dr. Rosenbaum described the preexisting condition as "cervical spinal stenosis with a very narrow canal as well as cervical spondylosis causing foramen narrowing." (Ex. 34-2).

Thus Dr. Rosenbaum was of the opinion that the major contributing cause of claimant's surgery was the July 2000 auto accident, unless it was shown that claimant had preexisting neck or upper extremity symptoms. However, if claimant did have preexisting neck or upper extremity symptoms, Dr. Rosenbaum would attribute the need for claimant's surgery to the preexisting condition instead of the auto accident.

Claimant sought medical treatment for neck pain and complaints of limited range of cervical motion on several occasions from July 28, 1997, through June 23, 1998.[3] (Exs. 4a; 5; 6; 7; 13-2; 15-1; 16a-2). Because these treatments for pain and limited range of cervical motion preceded the July 2000 auto accident, we are not persuaded that Dr. Rosenbaum's opinion supports a conclusion that the major contributing cause of claimant's need for surgery was the auto accident. ORS 656.005(7)(a)(B).

We acknowledge claimant's argument that Dr. Rosenbaum meant no symptoms immediately prior to the motor vehicle accident as opposed to no prior symptoms at any time. However, Dr. Rosenbaum's use of the word "any," immediately preceding "pre-existing symptoms" does not support claimant's argument. To the contrary, his use of the word "any," which is not otherwise limited, implies "any pre-existing symptoms at any time."

Moreover, even though Dr. Rosenbaum had diagnosed a preexisting stenosis, that fact alone does not establish that he was aware of claimant's prior treatment. To the contrary, his comments suggest that he was not aware of claimant's prior treatment. Consequently, we agree with the ALJ that claimant has failed to establish the compensability of his cervical condition.

ORDER

The ALJ's order dated January 3, 2001 is affirmed.

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[3] These complaints followed a July 1997 compensable injury with a different employer. (Ex. 8).

In the Matter of the Compensation of
MARGIE M. WEBB, Claimant
Own Motion No. 01-0107M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for a left forearm condition. Claimant's aggravation rights have expired. SAIF 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 claimant is actually hospitalized or undergoes outpatient surgery. *Id.*

On January 18, 2001, Dr. Perry, claimant's attending physician, recommended that claimant undergo an ulnar nerve decompression and possible transposition. Under such circumstances, we conclude that claimant's compensable injury has worsened requiring surgery. *See Howard L. Browne*, 49

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[1] SAIF notes that two surgical procedures are proposed. First, an ulnar nerve decompression and possible transposition, which it relates to claimant's 1990 left forearm claim. And second, an endoscopic carpal tunnel release at the left wrist, which it contends is not related to her 1990 left forearm claim. In light of such circumstances, we limit our current review to the undisputed ulnar nerve decompression and possible transposition.

Van Natta 485 (1997) (a claimant's multilevel back surgery, which included treatment for both compensable and noncompensable conditions satisfied the "surgery" requirement under ORS 656.278(1)(a) because a portion of the surgery was for an undisputed compensable condition).[2]

Accordingly, we authorize the reopening of claimant's 1990 injury claim for SAIF to provide temporary disability compensation beginning the date claimant is hospitalized for the ulnar nerve decompression. When claimant's condition related to the ulnar nerve decompression is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[2] This conclusion should not be interpreted as a decision, in any manner, regarding claimant's left wrist endoscopic carpal tunnel release and its relationship, if any, to claimant's 1990 left forearm claim.

In the Matter of the Compensation of
MARLEENE P. THOMPSON, Claimant
WCB Case No. 00-01556
ORDER ON REMAND
Nicholas M. Sencer, Claimant Attorney
Meyers, Radler, et al, Defense Attorney

This matter is before the Board on remand. Pursuant to the court's February 20, 2001 order, we have been directed to consider the parties' settlement.

The parties have submitted a "Stipulation and Order" that is designed to resolve all issues raised or raisable regarding this case, *i.e.*, temporary disability, penalties, and attorney fees. Specifically, the parties stipulate that the employer will pay claimant and her attorney a stated sum to resolve all issues related to non-payment of temporary disability awarded by the September 29, 1999 Order on Reconsideration. Finally, the parties agree that the settlement "resolves any and all issues, raised or raisable, with respect to issues in WCB No. 00-01556."

We approve the parties' agreement, thereby fully and finally resolving this dispute, in lieu of all prior orders.[1] Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] The agreement also provides for a carrier-paid attorney fee in addition to the sum payable to claimant. Entitlement to attorney fees in workers' compensation cases is governed by statute. Unless specifically authorized by statute, attorney fees cannot be awarded. *Forney v. Western States Plywood*, 297 Or 628 (1984). It is not clear from the agreement under what statute an assessed fee is authorized. However, because the parties' dispute does not involve a denied claim (ORS 656.386(1)), and because it does not concern a carrier's hearing request where we find that claimant's compensation has not been disallowed or reduced (ORS 656.382(2)), we interpret the agreement as providing an assessed fee under ORS 656.382(1) for unreasonable resistance to the payment of compensation. On that basis, we approve the attorney fee provided in the stipulation.

In the Matter of the Compensation of
MARGARET A. WEINSTEIN, Claimant
Own Motion No. 98-0266M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Starr & Vinson, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Claimant requests review of the SAIF Corporation's August 14, 2000 Notice of Closure which closed her claim with an award of temporary disability compensation from November 11, 1997 through August 1, 2000. SAIF declared claimant medically stationary as of August 1, 2000. Claimant contends that she was entitled to additional benefits as she was not medically stationary when her claim was closed.

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 the date of 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 August 14, 2000 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).

SAIF has submitted separate letters from Drs. Barrett and Deveney. Both of these physicians have treated claimant. Dr. Barrett concluded that claimant was medically stationary as of August 1, 2000. Dr. Deveney also concluded that claimant "meets the test for medically stationary as described in the Oregon Administrative Rules." These opinions are unrebutted.

Claimant contends that because of her "unique" type of injury and her extensive medical history she was not medically stationary at closure and will not become medically stationary "in the true sense, until she has a longer period of time without some type of curative treatment." In support of her contentions, claimant submitted copies of November 1999 - September 2000 chart notes from various treating physicians.

In particular, claimant relies on June 1 and July 20, 2000 chart notes, which outline problems that she had with her feeding tube and instructed her to follow-up with Dr. Deveney in thirty days. On August 25, 2000, claimant was hospitalized because of an obstruction in her feeding tube. During that visit, hand-maneuvering the tube cleared the obstruction and claimant was advised to resume her normal feeding and check with her treating physician.

Claimant also relies on Dr. Barrett's September 1, 2000 chart note. Dr. Barrett noted that he "felt [claimant] was medically stationary from her history." He further stated that claimant had not shown any sign of improvement. Dr. Barrett indicated that he "hoped" she would get better, but without knowing the cause of her current illness, there was no active treatment. He also reported that claimant continued treating with Dr. Deveney for her "eating situation" and with Dr. Webb for anxiety and depression.

Claimant also submitted a September 20, 2000 consultation report from Dr. Morris. Dr. Morris noted claimant's ongoing problems with her feeding tube and her psychological condition. He provided claimant with some pain management options. Dr. Morris opined that claimant needed behavioral management and a formal pain treatment program. He recommended a change in claimant's pain medications, as well as some anticonvulsant medication and physical therapy. Dr. Morris did not address claimant's "medically stationary" status at the time of closure nor did he indicate that any of the recommended treatment would materially improve claimant's compensable conditions.

Claimant's submissions support a conclusion that she continues to require medical treatment. Nonetheless, 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). Thus, although claimant may require further medical treatment, the record does not establish that this continuing medical treatment is designed to materially improve her compensable conditions.

Finally, Dr. Barrett's opinion that he "hoped" that claimant would get better is couched in terms of possibility rather than probability, which is not sufficient to establish that claimant's compensable condition would material improve. *Gormley v. SAIF*, 52 Or App 1055 (1981) (opinions in terms of medical possibility rather than medical probability are not persuasive).

Based on our review of the medical evidence, we find that claimant's compensable condition was medically stationary when her claim was closed. Therefore, we conclude that SAIF's closure was proper.

Accordingly, we affirm SAIF's August 14, 2000 Notice of Closure in its entirety.

IT IS SO ORDERED.

April 9, 2001 Cite as 53 Van Natta 527 (2001)

In the Matter of the Compensation of
WILLIAM M. BROWN, Claimant
WCB Case No. 00-02491
ORDER ON REVIEW
McGinty & Belcher, Claimant Attorney
Cummins, Goodman, et al, Defense Attorney

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Thye's order that: (1) set aside its denial of claimant's injury/occupational disease claim for bilateral carpal tunnel syndrome; and (2) awarded a $7,500 attorney fee. On review, the issues are compensability and attorney fees.

We adopt and affirm the ALJ's order.

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability issue.[1] 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 $3,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by claimant's respondent's brief and counsel's attorney fee affidavit), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 28, 2000 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $3,000, to be paid by the employer.

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[1] Claimant's attorney 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).

In the Matter of the Compensation of
WILLIAM L. ADAMS, Claimant
WCB Case No. 00-04405
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Nichols' order that: (1) awarded temporary disability benefits from May 10, 1999 through October 19, 1999; and (2) assessed a penalty under ORS 656.262(11)(a) for unreasonable refusal to pay compensation. On review, the issues are temporary disability benefits and penalties.

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

As a preliminary matter, we note that SAIF argues that the ALJ erred in awarding claimant's attorney an assessed fee under ORS 656.382(1). SAIF is mistaken. The ALJ did not award an assessed attorney fee. Instead, the ALJ awarded an "out-of-compensation" fee of 25 percent of the additional temporary disability benefits granted by her order, with the fee not to exceed $1,500 pursuant to OAR 438-015-0045. ORS 656.386(2). Under the circumstances of this case, the ALJ's "out-of-compensation" attorney fee award is appropriate.

In awarding the temporary disability benefits on this new medical condition claim, the ALJ relied on *John R. Graham*, 51 Van Natta 1740 (1999), and *Robert A. Rodgers*, 52 Van Natta 1243 (2000) (a carrier is obligated to provide interim compensation pending its acceptance or denial of a claimant's "new medical condition" claim, even though the claimant's 5-year "aggravation rights" had expired prior to the filing of his "new medical condition" claim). On review, SAIF makes several arguments contending that we should reverse our decision in *Graham*.

We rejected those same arguments from SAIF in *Dave A. Humphrey*, 52 Van Natta 2212 (2000), and continue to do so. We decline to revisit our decision in *Graham* and continue to rely on it as controlling precedent. *See Michael T. Bergmann*, 52 Van Natta 1931 (2000) (rejected arguments that *Graham* was wrongly decided and, after reexamining the text of ORS 656.262(7)(c), continued to adhere to our conclusion in *Graham* that "new medical condition" claims accepted after claim closure must be reopened under ORS 656.262(7)(c) for payment of benefits and processing to closure under ORS 656.268, even if aggravation rights have expired on initial claim); *see also Camilla S. Kosmoski*, 52 Van Natta 1573 (2000); *Robert A. Olson*, 52 Van Natta 1540 (2000); *Larry L. Ledin*, 52 Van Natta 682 (2000); *Craig J. Prince*, 52 Van Natta 108 (2000).

Noting that, at the time claimant requested SAIF to pay the above temporary disability benefits, *Rodgers* had been decided and required payment of interim compensation and likewise, temporary disability benefits on new medical condition claims, the ALJ found that SAIF had no legitimate doubt as to its liability and awarded a penalty under ORS 656.262(11)(a).[1]

On review, SAIF contends that such a penalty is unwarranted, given its challenge to the existing state of law. Specifically, SAIF argues that the standard for sanctions discussed in *Westfall v. Rust International*, 314 Or 533 (1992), should apply to penalties as well. Thus, SAIF argues, its argument for reversal of existing law provides a defense against an award of penalties. We disagree.

In *Westfall*, the Supreme Court defined "frivolous" in the context of the then current version of ORS 656.390, which authorized an award, including reasonable attorney fees to the opposing party, for a frivolous appeal of a workers' compensation claim. The Supreme Court held that "an appeal is 'frivolous' * * * if every argument on appeal is one that a reasonable lawyer would know is not well

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[1] ORS 656.262(11)(a) provides, in 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."

grounded in fact, or that a reasonable lawyer would know is not warranted either by existing law or by a reasonable argument for the extension, modification, or reversal of existing law." *Id.* at 559 (footnote omitted). Subsequently, the legislature enacted its own definition of frivolous for purposes of ORS 656.390.[2]

We find *Westfall* distinguishable. *Westfall* explicitly dealt with sanctions under *former* ORS 656.390 against an attorney who files an appeal determined to be frivolous, filed in bad faith, or for the purpose of harassment. In contrast, 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. *Brown v. Argonaut Insurance Company*, 93 Or App 588 (1988).

Thus, the standard for determining whether a penalty should be awarded for unreasonable resistance to the payment of compensation is different from the standard regarding sanctions against an attorney for a frivolous appeal of a workers' compensation claim. We find that the ALJ properly applied the correct standard. *Steven R. Azorr*, 52 Van Natta 2145 (2000).

Claimant's attorney is entitled to an assessed fee for services on review regarding the temporary disability 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 $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.

ORDER

The ALJ's order dated December 13, 2000 is affirmed. For services on review regarding the temporary disability issue, claimant's attorney is awarded an assessed fee of $1,200, payable by SAIF.

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[2] ORS 656.390(2) provides:

"As used in this section, 'frivolous' means that the matter is not supported by substantial evidence or the matter is initiated without reasonable prospect of prevailing."

In the Matter of the Compensation of
MICHAEL V. FIELD, Deceased, Claimant
WCB Case No. 95-01992
ORDER ON REVIEW
Kryger, et al., Claimant Attorney
Cummins, Goodman, et al., Defense Attorney

Reviewed by Board Members Haynes, Bock, and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that upheld the self-insured employer's denial of his occupational disease claim for small-cell carcinoma. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated July 25, 2000 is affirmed.

Board Member Phillips Polich dissenting.

Because I believe the ALJ erred in assessing the medical evidence in this complex asbestos exposure case, I respectfully dissent. Specifically, I do not find persuasive physicians supportive of the employer's theory of causation because they rely on statistical information that is not necessarily applicable to claimant specifically.

I begin by summarizing the three hypotheses into which the vast majority of medical opinion fits in regard to the relationship between asbestos exposure and lung cancer. Hypothesis one (H1) is that in order to have an increased risk of lung cancer from asbestos exposure, there must be a diagnosis of asbestosis (a fibrosis caused by asbestos in all cases). Hypothesis two (H2) states that a diagnosis of asbestosis is not necessary, but that there must be a significant threshold exposure to asbestos. Hypothesis three (H3) is that any level of asbestos exposure increases, at least incrementally, an individual's risk of developing lung cancer.

Drs. Churg, Barker, Kenyon and Kleinerman subscribe to H1. Because claimant was never diagnosed with asbestosis, in these doctors' opinions, his exposure to asbestos, no matter how great, would not be a contributing factor to his small-cell carcinoma. (Exs. 69-64, 74, 90; Tr. II-190). I do not find these opinions persuasive based on the analogy with which two physicians, Dr. Roggli and Dr. Hammar (who adhere to H2), agreed: Requiring a diagnosis of asbestosis to find an asbestos-related lung cancer is akin to requiring a diagnosis of emphysema before acknowledging a smoking-related lung cancer. (Ex. 94-38, Tr. II-86, 87).

Moreover, we have held in previous cases (most notably, carpal tunnel compensability cases) that opinions relying on generalized, statistical "risk factors" are unpersuasive. *See, e.g., Debra D. Osler*, 52 Van Natta 977 (2000); *Elizabeth Beairsto*, 47 Van Natta 750, 751 (1995). Yet, here, the ALJ relied on medical opinions that in turn rely on the statistical incidence of lung cancer with cigarette smoking. (*See, e.g.*, Tr. II-27).

Claimant was a relatively heavy smoker for at least twenty years of his life, although he quit altogether fifteen years before his death. (Ex. 5). Of course, most people are conscious of the fact that cigarettes can cause lung cancer. I also agree with the ALJ that the "CPS-II" (the Surgeon General's 1990 report) is the most reliable study regarding this correlation. (Ex. F). However, the number of people who smoke, or have smoked, cigarettes is enormous, while the number of those also exposed to significant amounts of asbestos is relatively small. In fact, the mortality tables due to cigarette smoking in the CPS-II study did not identify which, if any, of the deaths could have also been due to asbestos exposure. (*See* Tr. 218).

Most physicians in this record agree that asbestos is a primary carcinogen (cancer-causing agent), at least for some types of lung cancer. (Ex. 71, 94-37; Tr. II-89). Therefore, I would not necessarily find persuasive medical opinions relying on the CPS-II study, if the opinion does not also consider claimant's particular circumstances; *i.e.*, working with asbestos. The physicians utilizing these statistics include those who espouse H1, as well as Dr. Roggli, who believes in H2 but did not support compensability. (Tr. II-27).

Although Dr. Barnhart used statistical information as a basis for his opinion, he pinpointed risk factors specifically tailored to claimant's history of smoking and asbestos exposure. (Ex. 96-16). Importantly, Dr. Barnhart cautioned against applying statistics from the CPS-II study (which dealt solely with risks attributable to smokers alone) to situations where there is a history of both cigarette smoking and asbestos exposure. (Ex. 96-19).

I also note the medical evidence that, although the damage from cigarettes is "purged" from the lungs over time after cessation, the same is generally not true for asbestos fibers. (Exs. 94-47, 96-74). In other words, unlike smoking, the risk of developing lung cancer due to asbestos never diminishes as the exposure becomes more remote. (Ex. 96-4).

In my view, the more persuasive medical evidence comes from Dr. Hammar and Dr. Barnhart (the sole adherent to H3 in the record), who properly considered claimant's particular work exposure, the concentration of asbestos fibers found in claimant's lungs, and the remoteness of claimant's cigarette smoking, to conclude that exposure to asbestos was the major contributing cause of his small-cell carcinoma. (Exs. 71-2, 94-15). I would therefore reverse the ALJ's order and set aside the employer's denial.

For these reasons, I respectfully dissent.

In the Matter of the Compensation of
ROSIE J. GRANT, Claimant
WCB Case No. 00-05601
ORDER ON REVIEW
Ransom, et al, Claimant Attorney
Reinisch, et al, Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) increased claimant's unscheduled permanent disability award for a left shoulder condition from 14 percent (44.8 degrees), as awarded by an Order on Reconsideration, to 20 percent (64 degrees); and (2) awarded claimant 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of the left arm. On review, the issues are extent of scheduled and unscheduled permanent disability.

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

The ALJ increased claimant's unscheduled permanent disability award to 14 percent to account for loss of left shoulder range of motion as found by the medical arbiter, Dr. Takacs. The ALJ also awarded claimant a scheduled "chronic condition" award, to account for an inability to repetitively use the left arm, which Dr. Takacs related as a direct medical sequela of claimant's accepted left shoulder strain and left shoulder tendinitis conditions.

On review, the employer contends that claimant is not entitled to either a rating for loss of range of motion in her left shoulder or a scheduled "chronic condition" award for her left arm. First, the employer argues that the medical evidence does not prove that the loss of range of motion and chronic condition are related to the accepted condition, as opposed to the accepted injury. We disagree.

Pursuant to ORS 656.268(14), "[c]onditions that are direct medical sequelae to the original accepted condition shall be included in permanent disability of the claim unless they have been specifically denied." *See also* OAR 436-035-0005(5); OAR 436-035-0007(1). Here, Dr. Takacs has expressly characterized claimant's adhesive capsulitis condition as a direct medical sequela of the accepted condition. (Ex. 46-3).[1] The employer has not specifically denied adhesive capsulitis. Accordingly, we agree with the ALJ that the loss of range of motion in the left shoulder and inability to repetitively use the left arm attributable to the adhesive capsulitis condition must be rated. ORS 656.268(14). *See Barbara J. McGuire*, 53 Van Natta 104 (2001) (impairment findings rated where medical arbiter unequivocally attributed the claimant's loss of range of motion and inability to repetitively use the lumbar spine to the "accepted condition," despite diagnosing "chronic low back pain").

Similarly, we reject the employer's contention that impairment related to the adhesive capsulitis condition cannot be rated merely because the condition has not been accepted. The unrebutted medical evidence from Dr. Takacs proves that the adhesive capsulitis condition is a "direct medical sequela" of claimant's accepted left shoulder condition. As such, it was appropriately rated. ORS 656.268(14).

Moreover, we find no support in the statute or case law for the employer's assertion that "an accepted condition cannot cause another accepted condition" for the purposes of rating impairment. *See* OAR 436-035-0005(5) ("Direct medical sequela" means a *condition* which originates or stems from the compensable injury or disease that is clearly established medically.") (Emphasis added).[2]

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[1] We therefore disagree with the employer's contention that Dr. Takacs did not distinguish between the accidental injury and the accepted condition.

[2] For example, in *Linda K. O'Hallaran*, 52 Van Natta 1387 (2000), the Board stated (albeit in *dicta*) that the claimant's RSD and brachial plexus conditions would have been appropriately rated as "direct medical sequelae" of the claimant's accepted humerus fracture under ORS 656.268(14), notwithstanding the insurer's later agreement to accept those conditions. 52 Van Natta at 1388. *Cf. Leroy E. Augustus*, 51 Van Natta 339, 340 (1999) (no impairment value awarded for loss of grip strength where medical evidence did not establish that the loss of grip strength was a "direct medical sequela" of the claimant's accepted right elbow strain condition).

Finally, the employer contends that claimant is not "significantly" limited in her ability to repetitively use her left arm and thus is not entitled to a chronic condition award. We disagree. Although Dr. Takacs initially stated that she "anticipated" that claimant's limitations would "resolve" if treated, she later characterized claimant's chronic condition in her left arm as "permanent and related to the accepted condition." (Ex. 46-3). Under such circumstances, we are persuaded that claimant's left arm impairment findings satisfied the requirement for a scheduled "chronic condition" award under OAR 436-035-0010(5).

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 438-015-0100(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 issues, and the value of the interest involved.

ORDER

The ALJ's order dated January 9, 2001 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the self-insured employer.

April 10, 2001 Cite as 53 Van Natta 532 (2001)

In the Matter of the Compensation of
FRANKIE LAVERDURE, Claimant
WCB Case No. 00-05942
ORDER ON REVIEW
Schneider, et al, Claimant Attorney
VavRosky, et al, Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) found that claimant had withdrawn an issue of premature closure; and (2) affirmed an Order on Reconsideration that did not award additional temporary disability benefits. In its brief, the insurer requests sanctions for claimant's allegedly frivolous appeal. On review, the issues are premature closure, temporary disability and sanctions.

We adopt and affirm the ALJ's order with the following changes and supplementation.[1] On page 2, we change the first full paragraph to read: "On December 22, 1997, Dr. Satterfield found that claimant was medically stationary. (Ex. 25)." Also on page 2, we change the sixth and seventh full paragraphs to read:

> "A June 1, 1998 Order on Reconsideration reduced claimant's scheduled permanent disability award to 7 percent for loss of use or function of the right foot (ankle). (Ex. 37). The reconsideration order was affirmed by an ALJ's order and on Board review. (Exs. 38, 45)."

In the first full paragraph on page 4, we change the citation after the first sentence to: "*See, e.g., David L. Dylan*, 50 Van Natta 276, *on recon* 50 Van Natta 852 (1998)."

Premature Closure

Claimant challenges the ALJ's finding that she had withdrawn the issue of premature closure at hearing. She asserts that, although she withdrew the issue of extent of scheduled permanent disability, she did not withdraw the issue of premature closure. After reviewing the transcript (Tr. 1, 2), we agree with claimant and address the premature closure issue on review.

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[1] In light of our determination, we need not address the insurer's argument that claimant's request for additional temporary disability benefits is barred by claim preclusion.

We begin by summarizing the background of this case. Claimant compensably injured her right foot on December 1, 1996. The insurer accepted a disabling right foot contusion, sprain and covert fracture. (Ex. 5). On December 22, 1997, Dr. Satterfield reported that claimant was medically stationary. (Ex. 25). A January 14, 1998 Notice of Closure awarded 23 percent scheduled permanent disability for loss of use or function of the right foot, as well as temporary disability benefits. (Ex. 29). The Notice of Closure showed the medically stationary date as "December 23, 1997." (*Id.*) A June 1, 1998 Order on Reconsideration reduced claimant's scheduled permanent disability award to 7 percent for loss of use or function of the right foot (ankle). (Ex. 37). The medically stationary date was changed to "December 22, 1997." (Ex. 37-2). The reconsideration order was affirmed by an ALJ's order and on Board review. (Exs. 38, 45).

In the meantime, an authorized training program was approved to begin on January 19, 1998. (Exs. 31, 33). Claimant's training ended effective March 22, 1999. (Ex. 89).

In April 2000, the insurer issued an updated notice of acceptance at closure, listing the accepted conditions as right foot contusion, sprain and covert fracture. (Ex. 95). An April 10, 2000 Notice of Closure awarded temporary disability benefits from January 19, 1998 through March 22, 1999. (Ex. 97). The medically stationary date was December 23, 1997. (*Id.*) Claimant requested reconsideration. (Exs. 99, 100). A July 5, 2000 Order on Reconsideration amended the medically stationary date to December 22, 1997, but otherwise affirmed the April 10, 2000 Notice of Closure. (Ex. 103).

On review, claimant relies on ORS 656.268(9), which provides, in part:

> "If, after the 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 656.726, any permanent disability payments due under the 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 insurer or self-insured employer shall again close 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 closure shall include the duration of temporary total or temporary partial disability compensation." (Emphasis supplied).

Claimant asserts that ORS 656.268(9) provides that the insurer shall again close the claim *if* the worker is medically stationary. She contends that she was not medically stationary and was under active treatment when her training program terminated as of March 22, 1999. Claimant argues that she is entitled to additional temporary disability benefits beyond March 22, 1999.

An injured worker is medically stationary when "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). In determining whether a claim was prematurely closed, the issue is whether the claimant's condition was medically stationary on the date of closure, without considering subsequent changes in his or her condition. *Scheuning v. J.R. Simplot & Company*, 84 Or App 622, 625, *rev den* 303 Or 590 (1987); *Alvarez v. GAB Business Services*, 72 Or App 524, 527 (1985).

In *James L. Mack*, 50 Van Natta 338 (1998), 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 ORS 656.262(7)(c), which provides that if a condition is found compensable after claim closure, the carrier shall reopen the claim for processing regarding that condition.

Here, claimant contends that she was not medically stationary and was under active treatment when her training program terminated as of March 22, 1999. Claimant's accepted conditions were a right foot contusion, sprain and covert fracture. (Exs. 5, 95). For the following reasons, we find that the medical evidence is insufficient to establish that claimant's accepted conditions were not medically stationary when her training program was terminated as of March 22, 1999. To the contrary, it appears that claimant was being treated for other, unaccepted medical conditions during that period.

Claimant was treated primarily by Drs. Goldstein and Satterfield after March 1999. Dr. Goldstein reported in March 1999 that the majority of claimant's symptoms were from the right posterior tibial nerve at the scar, some symptoms along the anterior right ankle and some symptoms secondary to plantar fasciitis. (Ex. 46). On March 24, 1999, Dr. Goldstein explained that he was trying to differentiate between symptoms due to the right plantar fascia and those due to neuritis of the right posterior tibial nerve. (Ex. 48-1). He injected the posterior nerve and later injected the right plantar fascia. (Ex. 48-1, -2).

Claimant returned to Dr. Goldstein on April 28, 1999 and he reported that the majority of her symptoms were from right posterior tibial neuritis, but he could not rule out that there were also a minority of symptoms from right plantar fasciitis. (Ex. 55-2). In May 1999, Dr. Goldstein said that her symptoms were suggestive of posterior tibial neuritis rather than plantar fasciitis. (Ex. 58-1). He noted that her symptoms were "primarily, or entirely neurological[.]" (Ex. 58-2). In August 1999, he reported there was a high likelihood that claimant's neuritic pain was from scar entrapment of the posterior tibial nerve. (Ex. 75).

On April 5, 2000, Dr. Goldstein said he had treated claimant since September 1997 and explained that her diagnoses had been:

> "1. Neuritis, especially of the right posterior tibial nerve, complicated by surgery and a subsequent infection.
>
> "2. Plantar fasciitis of the right foot.
>
> "3. I believe there are some residual arthralgias at the right midfoot region." (Ex. 93).

He explained that nerve pain from the right posterior tibial nerve was the dominant symptom. (*Id.*) Dr. Goldstein said he had "no reason to believe that a treatment currently exists that would completely resolve her symptoms." (*Id.*)

Although Dr. Goldstein was treating claimant when her training program terminated as of March 22, 1999, his reports do not indicate that he was treating her accepted conditions; *i.e.*, a right foot contusion, sprain and covert fracture. To the contrary, he had been treating neuritis, plantar fasciitis and arthralgias. "Arthralgia" is defined as "pain in a joint." *Dorland's Illustrated Medical Dictionary* 140 (28th ed. 1994); *see SAIF v. Calder*, 157 Or App 224, 227 (1998) (Board may rely on medical dictionaries to define medical terms). There is no evidence in the record to establish that claimant's neuritis, plantar fasciitis or arthralgias were the same as the accepted right foot contusion, sprain and covert fracture. A determination of whether a claim has been prematurely closed (because the worker was not medically stationary) must focus only on those conditions that were accepted at the time of claim closure. *See James L. Mack*, 50 Van Natta at 339. We conclude that Dr. Goldstein's reports do not support claimant's assertion that the accepted conditions were not medically stationary when her training program terminated as of March 22, 1999.

Similarly, we find that Dr. Satterfield's reports after March 1999 are not sufficient to establish that she was treating claimant's accepted conditions. On April 14, 1999, Dr. Satterfield reported that claimant was doing "very poorly" and she noted that Dr. Goldstein had been giving claimant injections, but her foot pain was increasing. (Ex. 51-3). Dr. Satterfield said that "Goldstein is somewhat mystified as to what is going on with her foot[.]" (*Id.*) She also noted that claimant was very upset and depressed and was about to file bankruptcy. (*Id.*) Dr. Satterfield diagnosed: "Status post significant injury to her foot. Patient may be developing a complex regional pain syndrome." (*Id.*) She explained:

> "Patient is placed on temporary total disability times two months in order to give Dr. Goldstein adequate time to assess and work on her foot, in order to give her time to grieve and become less depressed." (*Id.*)

In June 1999, Dr. Satterfield reported that claimant's right foot exam was unchanged and she appeared mildly depressed. (Ex. 63). She diagnosed "[c]hronic pain from crushing injury to right foot." (*Id.*) She authorized time loss until July 16, 1999. (Ex. 64). In July 1999, Dr. Satterfield diagnosed "[w]orsening depression secondary to ongoing worker's compensation injury[.]" (Ex. 72). On August 4, 1999, she authorized modified work. (Ex. 74). Later that month, Dr. Satterfield diagnosed "[m]ajor depression secondary to foot injury." (Ex. 77). On February 18, 2000, Dr. Satterfield reported that claimant was stationary and was not going to get any better. (Ex. 90).

Although Dr. Satterfield treated claimant after March 1999, her reports do not indicate that she was treating claimant's accepted conditions; *i.e.*, a right foot contusion, sprain and covert fracture. Instead, Dr. Satterfield referred to a complex regional pain syndrome, chronic pain and depression, none of which are accepted conditions. As we discussed above, a determination of whether a claim has been prematurely closed must focus only on those conditions that were accepted. We find that Dr. Satterfield's reports do not support claimant's assertion that the accepted conditions were not medically stationary when her training program terminated as of March 22, 1999.

Dr. Satterfield referred claimant to Dr. Yerby, neurologist. In February 2000, Dr. Yerby diagnosed "[c]hronic right ankle pain and dysesthesia secondary to injury and surgery[.]" (Ex. 87-5). He noted that claimant was depressed and anxious and he said that certain findings suggested claimant may have "injudiciously used psychoactive substances." (Ex. 87-6). He recommended mental health treatment. (Ex. 88). "Dysesthesia" is defined as "distortion of any sense, particularly of that of touch[,]" and "an unpleasant abnormal sensation produced by normal stimuli." *Dorland's Illustrated Medical Dictionary* 515 (28th ed. 1994). Although Dr. Yerby diagnosed chronic right ankle pain and dysesthesia "secondary to injury and surgery[,]" we find that his report is insufficient to establish that those conditions are the same as the accepted right foot contusion, sprain and covert fracture. Moreover, his report is insufficient to establish that the accepted conditions were not medically stationary, particularly in light of the other diagnoses from Drs. Satterfield and Goldstein and Dr. Yerby's own recommendation for mental health treatment.

There is no other medical evidence that supports claimant's assertion that she was being treated for her accepted conditions when her training program terminated as of March 22, 1999. In September 1999, Drs. Schilperoort and Farris, who examined claimant on behalf of the insurer, found that claimant's foot contusion, sprain and covert fracture were resolved and they found no impairment due to the accepted conditions. (Ex. 80-6, -7).

In sum, with respect to claimant's accepted right foot contusion, sprain and covert fracture, we find no medical evidence to show that any further material improvement was reasonably expected from medical treatment, or the passage of time. The medically stationary status of claimant's non-accepted conditions is irrelevant to the premature closure determination.[2] *See, e.g., Raymond L. Harris*, 52 Van Natta 1357 (2000); *Vicky L. Woodard*, 52 Van Natta 796 (2000). On this record, we find that the preponderance of the medical evidence indicates that claimant's right foot contusion, sprain and covert fracture were medically stationary. Consequently, we affirm the July 5, 2000 Order on Reconsideration.

Sanctions

The insurer requests sanctions, alleging that claimant has frivolously requested review. The insurer contends that the appeal was filed with no prospect for prevailing.

ORS 656.390(1) provides that the Board may impose an appropriate sanction if the request for review was frivolous or was filed in bad faith or for the purpose of harassment. "Frivolous" means the matter is not supported by substantial evidence or is initiated without reasonable prospect of prevailing. ORS 656.390(2).

Here, claimant requested review, arguing, among other things, that the ALJ erred by finding that she had withdrawn the issue of premature closure. We agreed with claimant's assertion and we have addressed the premature closure issue on review. In addition, we find that claimant has presented colorable arguments on review that are sufficiently developed so as to create a reasonable prospect of prevailing on the merits. Although the arguments on review did not ultimately prevail, we do not agree that claimant's request for review was "frivolous." *See, e.g., Robert A. Rogers*, 53 Van Natta 209 (2001). Accordingly, we deny the insurer's request for sanctions.

ORDER

The ALJ's order dated November 30, 2000 is affirmed.

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[2] Claimant may choose to make a claim for the unaccepted conditions. *See* ORS 656.262(6)(d), (7)(a). Under ORS 656.262(7)(c), if a condition is found compensable after claim closure, the carrier is required to reopen the claim for processing regarding that condition.

In the Matter of the Compensation of
PATRICIA A. WALDO, Claimant
WCB Case No. 99-02591
ORDER ON REVIEW
Ransom, et al, Claimant Attorney
Meyers, et al, Defense Attorney

Reviewed by Board Members Haynes, Bock, and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Johnson's order that: (1) found claimant had made a claim for a left chest wall injury; and (2) awarded an "out-of-compensation" attorney fee. On review, the issues are claim processing and attorney fees. We reverse.

FINDINGS OF FACT

On October 21, 1998, claimant began working as a certified nurse's aide (CNA) at the employer's geriatric care center. On December 13, 1998, claimant had an onset of left-sided chest pain while working. (Tr. 24, Exs. 1, 2). That day, she presented to the emergency room where she was examined by Dr. Thompson, M.D., who filled out an 827 form. (Ex. 1). Dr. Thompson noted pain/tenderness on palpation, with no other physical findings. (Exs. 1, 2). He diagnosed "[l]eft anterior chest wall pain secondary to muscle strain or costochondral separation," and took claimant off work for one to two days, with instructions to see a physician if she did not improve. (Ex. 2). No further medical treatment was sought or provided for this left chest wall pain.

By letter dated January 21, 1999, the insurer's claim examiner notified claimant that he had received information that she may have had a work-related injury and requested that claimant complete an enclosed 801 form if her injury occurred at work. (Ex. 10). The claim examiner also stated that he had heard that claimant may wish to withdraw her claim. On January 25, 1999, claimant withdrew the claim by signing the following statement: "I, [claimant], wish to withdraw my claim made on 12-13-98." (*Id.*).

On January 29, 1999, the insurer formally denied claimant's claim relating to an alleged injury on December 13, 1998. (Ex. 13). The reason for the denial was that claimant had withdrawn her "claim filed on 12-13-98 by form 827." (Ex. 13-1). Claimant received that denial. (Ex. 13-3).

On or about March 31, 1999, claimant's attorney filed a request for hearing on the January 29, 1999 denial, raising the following issues: (1) the January 29, 1999 denial; (2) compensability of a complete claim denial; and (3) attorney fees. (Ex. 20A). This request for hearing was received by the Board on April 1, 1999.

At hearing, the parties stipulated that only by the request for hearing regarding the January 29, 1999 denial did claimant notify the employer that she felt the original December 13, 1998 claim remained viable. (Tr. 10, 13-14). Prior to filing this request for hearing, claimant did not reinstate the withdrawn December 13, 1998 claim, nor did she notify the employer or the insurer that she felt the withdrawn claim remained viable.

CONCLUSIONS OF LAW AND OPINION

At hearing, the insurer argued that claimant no longer had a viable claim because either: (1) claimant failed to timely request a hearing on the January 29, 1999 denial, which became final by operation of law; and/or (2) claimant withdrew her claim and never reinstated it. The ALJ found that the insurer's January 29, 1999 denial of claimant's withdrawn claim was null and void; therefore, the ALJ reasoned that claimant's failure to timely request a hearing on that denial did not preclude her from subsequently pursuing the claim.

It is not necessary to determine whether claimant "timely" requested a hearing on the January 29, 1999 denial of claimant's withdrawn claim because, even if claimant failed to request a hearing on that denial, such failure would not preclude her from later reasserting the claim. *See Richard J. James*, 52 Van Natta 1677 (2000) (a denial issued in response to a withdrawn claim is null and void, without legal effect, and invalid *ab initio*; therefore, failure to request a hearing on such a denial does not preclude a

claimant from subsequently reasserting the claim); *Troy M. Garner*, 48 Van Natta 1594-96 (1996) (where the claimant withdrew his claim before the 90-day claim 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).

The ALJ rejected the insurer's argument that claimant had no valid claim because she failed to reinstate the claim after explicitly withdrawing it. The ALJ found that claimant's March 31, 1999 hearing request satisfied ORS 656.265,[1] which provides the requirements of a notice of an accident from a worker. The ALJ further concluded that the 90-day processing period for that claim began upon the insurer's receipt of the request for hearing and, therefore, that period had expired by the date of the hearing.

Based on the following reasoning, we find that the March 31, 1999 hearing request, in and of itself, did not constitute a claim. In *Simmons v. Lane Mass Transit District*, 171 Or App 268 (2000), issued subsequent to the ALJ's order, the court explained what constitutes a "claim:"

> "Under ORS 656.005(6), a claim is '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.' Although the portion of the definition that refers to the employer's knowledge of the injury might suggest that the injury itself is the 'claim,' that suggestion is incorrect. The first part of the definition expressly requires a writing, and even when the employer knows of the injury, ORS 656.265 requires a written request, generally within 90 days, in order to perfect the claim. An injury that is a 'claim' under the statutory definition only because the employer has notice of it will become void in the absence of a written request made within the required time. *See McPhail v. Milwaukie Lumber Co.*, 165 Or App 596 * * * (2000). Thus, although an injury creates the basis for a claim, for the purposes of processing the 'claim' is the written request for compensation."

Here, there is no dispute that the insurer had notice of the December 13, 1998 injury. However, that is not sufficient to constitute a claim. As explained in *Simmons*: (1) notice of an injury in absence of a written request made within the required time is not sufficient to constitute a claim; and (2) for purposes of processing, the "claim" is the written request for compensation.

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[1] ORS 656.265 provides, in relevant part:

"(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. The employer shall acknowledge forthwith receipt of such notice.

"(2) The notice need not be in any particular form. However, it shall be in writing and shall apprise the employer when and where and how an injury has occurred to a worker. A report or statement secured from a worker, or from the doctor of the worker and signed by the worker, concerning an accident which may involve a compensable injury shall be considered notice from the worker and the employer shall forthwith furnish the worker a copy of any such report or statement.

"(3) Notice shall 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. If for any reason it is not possible to so notify the employer, notice may be given to the Director of the Department of Consumer and Business Services and referred to the insurer or self-insured employer.

"(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; or

"(b) The worker died within 180 days after the date of the accident.

"(5) The issue of failure to give notice must be raised at the first hearing on a claim for compensation in respect to the injury or death."

Claimant initially made a claim for a left chest wall injury through Dr. Thompson's December 13, 1998 827 form. (Exs. 1, 2). However, claimant explicitly withdrew that claim before issuance of the insurer's denial. Because claimant withdrew her initial claim, she may not rely on it to establish that she made a valid claim for the December 1998 injury. Thus, the issue is whether claimant subsequently made a valid "initial" claim for the December 13, 1998 injury by requesting a hearing on a null and void denial. We find the hearing request did not constitute a valid claim.

The March 1999 hearing request was directed to the Board's Hearings Division, with a copy to the insurer. It was entitled "Request for Hearing." Such circumstances do not suggest that claimant was making a written request for compensation to the insurer.

Moreover, the hearing request: (1) challenged the insurer's January 29, 1999 denial; (2) checked a box indicating "[c]ompensability - complete claim denial;" and (3) requested attorney fees. As explained above, however, the January 29, 1999 denial was null and void. In addition, the denial simply stated that claimant wished "to withdraw her claim filed on 12-13-98 by form 827." (Ex. 13-1). Claimant does not dispute that this is an accurate representation of what happened; *i.e.*, she had withdrawn her claim. The insurer stated no other substantive basis for the denial, although it stated that the denial was "not a waiver of other reasons for a claim denial." (*Id.*). Furthermore, there can be no "complete claim denial" until there is a claim.

Under such circumstances, the request for hearing does not constitute a written request for compensation. ORS 656.005(6). Therefore, we find that claimant failed to reinstate her claim after withdrawing it. Accordingly, there is no valid claim for a left chest injury before us.

ORDER

The ALJ's order dated April 21, 2000 is reversed. Claimant's requests for an order directing the insurer to process a left chest wall injury claim and awarding an attorney fee are denied.

Board Member Biehl concurring in part and dissenting in part.

I agree with the majority that it is not necessary to determine whether claimant "timely" requested a hearing on the January 29, 1999 denial of claimant's withdrawn claim because, even if claimant failed to request a hearing on that denial, such failure would not preclude her from later reinstating the claim. Thus, the question is whether claimant later reasserted her claim after withdrawing it. I would find that claimant's hearing request constituted reinstatement of her claim under the particular facts of this case. Because the majority finds otherwise, I respectfully dissent.

Here, claimant allegedly injured her left chest at work on December 13, 1998. There is no dispute that claimant initially filed a claim for that injury through Dr. Thompson's December 13, 1998 827 form. (Exs. 1, 13). Thus, at that time, the employer had written notice of the work injury claim. This notice satisfied the required elements under ORS 656.265; *i.e.*, it was in writing and apprised "the employer when and where and how an injury [had] occurred to a worker." ORS 656.265(2). Admittedly, claimant later withdrew that injury claim. (Ex. 10). However, by subsequently requesting a hearing and identifying the date of injury, I would find that claimant reinstated the left chest injury claim.

In this regard, the hearing request was in writing, communicated to the insurer, and provided the date of injury as December 13, 1998. The insurer already had received written notice of a December 13, 1998 work injury that resulted in medical treatment. (Ex. 1). Clearly, the hearing request that referenced that same date of injury represented reinstatement of claimant's left chest injury claim. It is disingenuous of the insurer to argue otherwise. More importantly, acceptance of such an argument puts form over substance.

I stress that my conclusion that a hearing request may constitute a proper work injury claim is limited to the facts before me. In other words, where a proper written claim for a work injury has been withdrawn, a hearing request identifying that work injury reinstates the work injury claim. Of course, that does not necessarily mean that the claim is compensable. However, claimant should be entitled to pursue a claim that the employer was clearly aware of.

In the Matter of the Compensation of
PATRICIA A. WALDO, Claimant
WCB Case No. 99-02904
ORDER ON REVIEW
Ransom, et al, Claimant Attorney
Meyers, et al, Defense Attorney

Reviewed by Board Members Biehl and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Johnson's order that set aside its denial of claimant's neck, back, and left hip injury claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following exception and supplementation. We do not adopt the last sentence of the first paragraph on page 8. We also do not adopt the fifth, ninth, eleventh, and sixteenth paragraphs of the ALJ's findings of fact which relate to a bifurcated case for which a separate Opinion and Order was issued. (WCB Case No. 99-02591).[1]

The insurer argues that claimant's history of prior back injuries was not properly considered by the ALJ. We disagree.

Claimant reported a back muscle strain type injury that occurred approximately ten years earlier and which did not result in any medical treatment. On August 26, 1998, about two months before starting with the employer, claimant was treated in the Emergency Room following two at-home incidents, which included falling down four stairs and landing on her right side. (Ex. D-1). Claimant was advised to follow-up with her treating physician if she did not improve within a week. (*Id.*) She missed no time from work and required no further treatment.

As the ALJ found, there is no evidence in the record that these prior injuries combined with claimant's current back injury condition. The only evidence regarding that matter is from Dr. Scheinberg, who examined claimant on behalf of the insurer. (Ex. 24). Dr. Scheinberg opined that, because there were no follow-up records from the August 1998 injury, he was unable to conclude that it was medically probable that the August 1998 injury had any relationship to claimant's symptoms on January 10, 1999, the date of the work injury at issue. (*Id.*)

The insurer also contends that claimant failed to meet her burden of proving a compensable injury by medical evidence supported by objective findings. ORS 656.005(7)(a) and (19). We disagree.

Dr. Arbeene acknowledged that he was aware that reduced ranges of motion constituted "objective findings" under Workers' Compensation Law. However, in his opinion, reduced ranges of motion caused by subjective response to pain did not constitute "objective findings." (Exs. 23, 29-8-10). Based on this reasoning, Dr. Arbeene did not consider that claimant's reduced ranges of motion represented "objective findings" because they were caused by her subjective response to pain. Nevertheless, he also opined that repeated examinations that exhibited loss of ranges of motion and reduced ranges of motion that remained over a period of six to seven months could represent objective findings. (Exs. 29-11, -15-16).

Here, claimant exhibited reduced ranges of motion over repeated examinations, including examinations by her current treating physician, Dr. Thomas, who began treating claimant about five months after the injury. (Exs. 6, 21A, 22A, 23C, 25). Moreover, as the ALJ found, Dr. Thomas found claimant's presentation reliable and opined her reduced ranges of motion represented objective findings of injury. (Ex. 22A).

In *SAIF v. Lewis*, 170 Or App 201 (2000), the court held that the requirement of "objective findings" is not satisfied if a medical expert "merely listens to a patient's description of his or her symptoms and, believing the patient and without any verification process, relies on that description to form a diagnosis." *Lewis*, 170 Or App at 203. The court stated, with regard to the definition of "objective findings" in ORS 656.005(19), that "[t]he statutory emphasis is on findings made by a medical expert on the basis of a verification process involving trained observation, examination, or testing that produces results -- either physical or *subjective responses* -- that are witnessed, measured, or can be reproduced." *Lewis*, 170 Or App at 212. (emphasis added)

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[1] We note that the insurer also requested review regarding WCB Case No. 99-02591 and, on today's date, we issued a separate Order on Review dealing with that case.

Here, we find that claimant's reproducible reduced ranges of motion constitute objective findings. Thus, claimant's claim is supported by objective findings consistent with the *Lewis* decision. *See also Timmy L. Flowers*, 52 Van Natta 2084 (2000) (reproducible tenderness verified on separate occasions by different examiners constitutes "objective findings" under ORS 656.005(19) consistent with the *Lewis* decision).

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 $1,200, 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 April 21, 2000 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,200, payable by the insurer.

April 11, 2001 Cite as 53 Van Natta 540 (2001)

In the Matter of the Compensation of
MARGARET J. CHRISTENSEN, Claimant
WCB Case Nos. 00-04545 & 00-02612
ORDER ON RECONSIDERATION
Westmoreland & Mundorff, Claimant Attorney
VavRosky, et al, Defense Attorney

On March 16, 2001, we withdrew our February 16, 2001 order that affirmed an Administrative Law Judge's (ALJ's) order that set aside the self-insured employer's partial denial of claimant's C3-4 instability condition. Asserting that claimant failed to establish the existence of a "combined condition" or its compensability, the employer seeks reconsideration of our order, the reversal of the ALJ's decision, and the reinstatement of its denial. Having received claimant's response to the employer's argument, we proceed with our reconsideration.

We begin with a summary of the relevant facts.

Claimant was 70 years old at the time of hearing. She worked as a crew person at the employer's fast food restaurant. On April 14, 1999, claimant slipped on water or oil in the grill area and fell. The employer accepted claimant's injury claim for a disabling "cervical strain."

On December 21, 1999, a Notice of Closure closed the claim, with a medically stationary date of December 7, 1999. Claimant requested reconsideration. An Order on Reconsideration rescinded the Notice of Closure on the grounds that the claim was prematurely closed.

On April 19, 2000, claimant wrote to the employer requesting acceptance of "cervical vertebral instability, C3-4." (Ex. 54). On May 31, 2000, the employer denied claimant's request for acceptance. (Ex. 55).

The employer requested a hearing regarding premature closure and claimant requested a hearing regarding the denial. The ALJ reinstated the Notice of Closure. In addition, the ALJ upheld the portion of the employer's partial denial concerning compensability of the C3-4 condition as an independent condition, but set aside the denial of the C3-4 condition as a preexisting condition that combined with claimant's cervical strain injury. The employer challenged only the latter portion of the ALJ's order. On review, we adopted and affirmed the ALJ's order.

The employer argues that the ALJ erred in evaluating claimant's C3-4 instability condition as a "combined condition" under ORS 656.005(7)(a)(B). Specifically, the employer contends that there is no evidence that any such condition combined with claimant's accepted cervical strain, or that any combined condition that claimant has is compensable. We disagree.

As we explained in our prior order, the persuasive medical evidence establishes that claimant's C3-4 instability preexisted her work injury[1] and combined with the injury to cause claimant's subsequent disability and need for treatment -- until the compensable strain resolved.[2] Because we also agree with the ALJ that the persuasive medical evidence establishes that claimant's compensable injury was the major contributing cause of her combined C3-4 condition until the strain resolved, we continue to adopt the ALJ's reasoning and conclusions on these issues. In addition, we offer the following supplementation.

The medical experts who reviewed claimant's films referred to her C3-4 condition[3] variously as "spondylolisthesis," "subluxation," and/or "instability." Because the experts used different terms to refer to the same vertebrae in the same films, and they used these terms interchangeably, we believe that the doctors described the same condition (a preexisting condition that initially combined with the work injury and later existed on its own). These references include: April 1999 films showing "spondylolisthesis of C3 on C4 of 2mm" (Ex. 5); an August 1999 MRI showing "Slight anterior subluxation C3 on 4 .... similar to the plain films dated April 1999." (Ex. 29); Dr. Nash's reference to "subluxation C3 on C4" and "cervical instability C3/4" (Ex. 40-5); and November 1999 films showing

> "2mm of anterolisthesis of C3 on 4, which increases with flexion, and becomes normally aligned with extension. Posterior elements remain normally aligned, and this variability may be related to physiologic translation." (Ex. 42).

In addition, in December 1999 and February 2000, Dr. Nash described "cervical vertebral instability, C3-4." (Exs. 45-2, 49-1-2). Then, after the new medical condition claim and the denial, Dr. Markham opined that claimant did not have "true instability" at C3-C4, but "there is subluxation, *i.e.* spondylolisthesis, but that is degenerative in nature and does not require fusion." (Ex. 56-2). Drs. Rosenbaum and Schilperoort agreed that claimant's strain was separable from her degenerative disc disease and she did not have "true instability" *at this point*. (Exs. 57, 58). Dr. Nash also agreed that claimant's instability was separate and distinct from her strain. (Ex. 59). We read these opinions as consistent and supportive of our conclusion that claimant's C3-4 condition changed from a combined condition (involving preexisting C3-4 degeneration-related instability/spondylolisthesis/subluxation and the work injury) to a separable, nonwork related degenerative condition (after the compensable injury resolved).

We find Dr. Schilperoort's analysis of causation particularly well-explained, consistent with the remainder of the record, and persuasive. Dr. Schilperoort described "spondylolisthesis C3 or C4, 2mm, due to degenerative facet disease." (Ex. 26-5). He opined that the preexisting degenerative changes combined with the injury and the *injury* was the major reason for claimant's need for treatment for her combined condition as of the July 30, 1999 examination. (Ex. 26-6-7; *see also* Ex. 18). Then, on

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[1] We do not rely on Dr. Nash's opinion that the work injury caused claimant's C3-4 instability or "changes," because it is persuasively rebutted by Dr. Markham's observation that a 1996 brain scan revealed "subluxations at C3-4 and C4-5 as far back as 1996." (*See* Exs. 49, 56-2). However, a preponderance of the remaining medical evidence supports our conclusion that claimant's compensable strain injury combined with her preexisting degenerative instability at C3-4 until the strain resolved. The same evidence supports our conclusion that the work injury was the major contributing cause of claimant's disability and need for treatment for the combined C3-4 condition until the strain resolved (and the noncompensable preexisting condition caused her ongoing problems thereafter). (*See* discussion *infra*).

[2] Moreover, as the ALJ explained, the employer's opening statement at hearing suggested that it was defending its partial denial of claimant's claim for a C3-4 condition on "major causation" grounds and it therefore understood at the outset that the statute applied to the claim. The employer began by acknowledging:

> "[O]f course this is a major-cause claim. The initial diagnostic studies confirmed moderate to advanced degenerative changes throughout the cervical spine." (Tr. 3).

The employer concluded its opening remarks by arguing that the work injury was not the major cause of claimant's current pain and need for treatment. (Tr. 7). Under these circumstances, we find that the employer correctly understood that ORS 656.005(7)(a)(B) applies to this claim, as explained herein.

[3] All of claimant's several, previously asymptomatic, cervical degenerative conditions preexisted her work injury. (*See* Ex. 26-5-7). The only one at issue is the C3-4 instability.

December 7, 1999, Dr. Schilperoort reiterated that the injury *had* combined with the preexisting condition, but the strain had resolved and claimant's then current condition was due to preexisting multilevel cervical spine degenerative changes. (Ex. 43-5). In June 2000, Dr. Schilperoort agreed that claimant's cervical strain was "separate and severable" from her degeneration, claimant did not have "true cervical instability at C3-4," and preexisting degenerative joint disease and disc disease were the major cause of claimant's *then current* need for treatment. (Ex. 57). We find Dr. Schilperoort's essentially unrebutted opinion persuasive and we rely on it. Accordingly, based on Dr. Schilperoort's opinion, we continue to agree with the ALJ's conclusions regarding the employer's partial denial of claimant's claim for C3-4 instability.

Claimant's attorney is entitled to an assessed fee for services on reconsideration. *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 reconsideration is $300, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case on reconsideration (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

Accordingly, on reconsideration, we republish our February 16, 2001 order as supplemented herein. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

April 12, 2001 Cite as 53 Van Natta 542 (2001)

In the Matter of the Compensation of
HOPE ROCCASALVA, Claimant
Own Motion No. 01-0007M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for a left wrist condition. Claimant's aggravation rights have expired.

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.*

On April 5, 2001, claimant underwent left wrist surgery. Thus, we are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, we authorize the reopening of the claim for SAIF to provide temporary disability compensation beginning the date claimant is hospitalized for the proposed surgery.[1] 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] Although SAIF agreed that claimant met the necessary criteria for reopening under the Board's Own Motion authority pursuant to ORS 656.278, it opposed reopening because surgery had not been formally scheduled. Since the submission of SAIF's Own Motion recommendation, claimant has not only scheduled, but has undergone the recommended surgery. Under such circumstances, SAIF's objection to the reopening of claimant's claim has been resolved.

In the Matter of the Compensation of
ELIZABETH J. WIMMER, Claimant
WCB Case No. 00-06569
ORDER ON REVIEW
Schneider, et al, Claimant Attorney
Bottini, et al, Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

The insurer requests review of Administrative Law Judge (ALJ) Hazelett's order that set aside its denials of claimant's injury claims for right shoulder adhesive capsulitis and impingement syndrome. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

Claimant, who managed the floral department at the employer, compensably injured her right forearm on September 25, 1999. The next day claimant reported pain into her shoulders. Dr. Andrews found good range of motion and no tenderness in the shoulders. (Ex. 2). The insurer accepted a disabling right arm contusion. (Exs. 6, 11).

Claimant continued to work, but had intermittent pain in her right shoulder with certain movements. On March 13, 2000, claimant sought medical treatment. Dr. Booker found a positive impingement sign in the right shoulder. He diagnosed rotator cuff tendinitis and adhesive capsulitis. (Exs. 7, 8). Claimant's condition failed to improve and her range of motion diminished. (Ex. 8).

On May 26, 2000, claimant was examined by Dr. Wilson. He interpreted an MRI as showing fluid in the acromial space and no significant arthritis. He injected claimant's shoulder. (Ex. 13). On July 10, 2000, claimant returned with complaints of chronic right shoulder pain. Dr. Wilson concluded that claimant had findings consistent with chronic impingement, for which claimant elected surgical treatment. (Ex. 13).

On July 12, 2000, Dr. Farris examined claimant for the insurer. X-rays revealed moderate degenerative arthritis of the acromioclavicular joint. Dr. Farris concluded that claimant had adhesive capsulitis and an impingement syndrome in the right shoulder. Dr. Farris concluded that it was unlikely that claimant sustained any injury of significance to her right shoulder as a result of the September 25, 1999 incident because Dr. Andrews determined that there were no physical findings in the shoulder and because claimant did not seek medical attention for her shoulder until about six months after the injury. (Ex. 14).

On August 3, 2000, the insurer denied adhesive capsulitis and impingement syndrome of the right shoulder. (Ex. 18). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Relying on Dr. Booker and Dr. Wilson, the ALJ concluded that claimant compensably injured her right shoulder. On review, the insurer contends that Dr. Booker offered no opinion on causation and that Dr. Wilson's opinion is insufficient to establish compensability. For the following reasons, we conclude that claimant has not carried her burden to prove compensability by either a major or material contributing cause standard.

It is claimant's burden to prove compensability by a preponderance of the evidence. ORS 656.266. Because of the length of time between the injury and treatment for the right shoulder condition, resolution of the cause of claimant's condition is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993). Moreover, because the question presented is a medical one, claimant's lay testimony is "probative but not dispositive." *See Moe v. Ceiling Systems*, 44 Or App 429, 433 (1980).

When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263 (1986).

Here, two physicians rendered causation opinions.[1] Dr. Farris examined claimant on behalf of the insurer. (Ex. 14). Dr. Farris noted that, when claimant presented to the emergency room the day after her injury, Dr. Andrews noted "some pain extending up into her shoulder." But because Dr. Andrews determined that there were no physical findings in the shoulder and because claimant did not seek medical attention for her shoulder until about six months after the injury, Dr. Farris concluded that there was no direct relationship between her current right shoulder condition and the September 1999 injury. Instead, Dr. Farris reasoned that her condition was probably adhesive capsulitis, which was not uncommon in claimant's age group without injury or unusual activity. Dr. Farris also noted that the MRI documented degenerative changes with some evidence of impingement syndrome, which he thought had probably preexisted the September 1999 injury. He stated that impingement syndrome generally resulted from repetitive overhead use of the upper extremity and did not result from a single traumatic incident. (Ex. 14).

Dr. Wilson did not concur with Dr. Farris' report. In explaining his nonconcurrence, Dr. Wilson stated that he agreed in a large part with Dr. Farris' information. Dr. Wilson stated that claimant's mechanism of injury was consistent with a rotator cuff tear, but, because there were no shoulder clinical findings or complaint, it was doubtful that she sustained a rotator cuff tear as the result of that injury. Dr. Wilson went on to say: "That is my primary difference in opinion related to this particular report, otherwise I agree with the basic findings." (Ex. 17).

Subsequently, Dr. Wilson provided a "check-the-box" response to a letter from claimant's attorney. In that letter, he indicated that it was his opinion that claimant suffered an injury to her right arm/shoulder in September 1999 that resulted in right shoulder impingement syndrome. Dr. Wilson also indicated that, because claimant had no prior injuries to her right shoulder, the 1999 fall was the major contributing cause of the onset of pain and need for treatment. (Ex. 19).

Here, Dr. Wilson's opinion is conclusory because he failed to explain the basis for his opinion. Although Dr. Wilson opined that the cause of claimant's right shoulder impingement syndrome was the 1999 on-the-job incident, his opinion was based solely on "but for" reasoning; *i.e.*, claimant did not have injuries to her right shoulder prior to the 1999 incident and experienced pain after the incident, therefore the incident was the cause of her impingement syndrome. (Ex. 19). Dr. Wilson did not explain the relationship of the impingement syndrome and the accepted right forearm condition, nor did he discuss the lack of physical findings in the shoulder the day after the injurious incident or the six month gap in seeking medical treatment for the right shoulder.

Finally, Dr. Wilson did not comment on Dr. Farris' opinion that claimant may have adhesive capsulitis due to her age and the natural degenerative process, or Dr. Farris' opinion that the impingement syndrome probably preexisted the 1999 injury. Because Dr. Wilson's opinion is devoid of reasoning and explanation, we find it unpersuasive. *See Moe v. Ceiling Systems, Inc.*, 44 Or App at 433. Consequently, we conclude that claimant has failed to prove that either her right shoulder adhesive capsulitis or her right shoulder impingement condition is compensable.

ORDER

The ALJ's order dated December 27, 2000 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[1] Although we agree with the ALJ that Dr. Booker treated claimant from March to May 1999, he did not provide a causation opinion.

In the Matter of the Compensation of
DELORES KINEY, Claimant
WCB Case No. 00-01515
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

The insurer requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS); and (2) assessed a penalty for its allegedly untimely denial. On review, the issues are compensability and penalties.

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

Note 1 on page two is corrected to indicate that the employer installed a computerized dialing system for full time marketers in about July 1998, not July 1999. (*See* Tr. 18).

The first full paragraph on page 5 is replaced with:

We do not find Dr. Schilperoort's opinion materially inconsistent.[1] However, we agree with the ALJ that it is unpersuasive because it is essentially general in nature and therefore inadequately explained. In this regard, we note that Dr. Schilperoort ascribed claimant's CTS in part to her status as a middle-aged Caucasian female and her "prior history of alcoholism" (13 years ago), without explaining how these factors were causative in claimant's case. (*See* Exs. 12A, 24-2-3).

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 $1,200 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. Claimant is not entitled to an attorney fee award for her counsel's services devoted to the penalty issue. *Saxton v. SAIF*, 80 Or App 631 (1986).

ORDER

The ALJ's order dated December 12, 2000 is affirmed. For services on review, claimant is awarded a $1,200 attorney fee, to be paid by the insurer.

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[1] *Cf.* Exs. 12A-6-7 and 24-3.

In the Matter of the Compensation of
JAMES K. ANDREWS, Claimant
WCB Case Nos. 99-06580 & 99-06579
ORDER ON REVIEW
Ransom, et al, Claimant Attorney
SAFECO Legal, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Mills' order that: (1) found that its April 19, 1999 denial solely pertained to claimant's aggravation claim for a left hand contusion; and (2) set aside its denial of claimant's occupational disease claim for a left thumb condition (osteoarthritis). On review, the issues are the scope of the insurer'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 insurer for a nondisabling left hand contusion. On January 19, 1999, claimant's treating physician filed a formal claim for aggravation. The employer responded by issuing an April 19, 1999 denial which read, in pertinent part:

> "[W]e received an injury 'aggravation' notice from Dr. Layman concerning your 9/19/96 industrial injury. The accepted condition of that injury was 'left hand contusion', and that remains the accepted condition.
>
> "Additional medical information we received indicates that there has not been a pathological worsening of the accepted contusion condition. Furthermore, the medical information indicates that the major contributing cause of your current need for treatment is due to an arthritic condition which predated the 9/19/96 industrial injury.
>
> "Therefore, [the insurer] * * * respectfully denies your claim for aggravation of the 9/16/96 industrial injury."

Claimant did not appeal this denial.

At hearing regarding claimant's hearing request concerning the insurer's denial of his occupational disease claim, the insurer took the position that the previous denial was a current condition denial and raised the issue of the preclusive effect of this denial. Claimant took the position that the denial was not a current condition denial and only encompassed claimant's aggravation claim.

The ALJ concluded that, although "the middle paragraph does indicate that the major cause of claimant's current need for treatment is arthritis which predated the 1996 injury," it "does not say anything specific about denying claimant's current need for treatment. It simply states that it denies the aggravation claim." The ALJ also concluded that any ambiguity would be construed against the drafter. After looking at the circumstances surrounding the issuance of the denial, the ALJ determined that, to the extent that the denial could be interpreted as a current condition denial, its applicability was limited to whether claimant's current condition was related to the 1996 injury and that it had no preclusive effect on claimant's occupational disease claim.

We acknowledge that the sentence "the medical information indicates that the major contributing cause of your current need for treatment is due to an arthritic condition which predated the 9/19/96 industrial injury" 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 insurer's April 19, 1999 denial clearly states that it was issued in response to "an injury 'aggravation' notice from Dr. Layman concerning your 9/16/96 industrial injury." 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 "medical information we received [that] indicates that there has not been a pathological worsening of the accepted contusion condition." Based on this reading of the denial as a whole, we conclude that it is limited to claimant's aggravation claim. Thus, claimant's failure to appeal the denial does not preclude him from litigating the occupational disease claim.

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 issues, and the value of the interest involved.

ORDER

The ALJ's order dated December 19, 2000 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500, to be paid by the insurer.

April 13, 2001 Cite as 53 Van Natta 547 (2001)

In the Matter of the Compensation of
ARTHUR C. COLLIER, Claimant
WCB Case No. 00-07231
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) affirmed an Order on Reconsideration that awarded claimant 19 percent (28.5 degrees) scheduled permanent disability benefits for loss of use or function of the right leg (knee); and (2) awarded claimant an insurer-paid attorney fee under ORS 656.382(2). On review, the issues are extent of 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 following supplementation and summary.

On November 4, 1999, claimant compensably injured his right knee. SAIF accepted the claim for a disabling medial meniscus tear of the right knee. (Exs. 10, 12, 22). On December 9, 1999, Dr. Pollard, attending physician, performed a partial meniscectomy of the posterior right meniscus. (Ex. 13). On February 28, 2000, Dr. Pollard performed a "closing examination" but did not include any impairment findings. (Ex. 17). Instead, Dr. Pollard requested that SAIF arrange an "independent medical evaluation" to determine claimant's medical stability and permanent impairment. (Ex. 17-2).

On March 28, 2000, Dr. Anderson, M.D., and Ms. Bottomley, O.T.R., performed that "independent medical evaluation." (Exs. 19, 20). Dr. Pollard concurred with their reports, which found claimant medically stationary as of March 28, 2000, and attributed claimant's residual impairment to his preexisting degenerative arthritis of the knee. (Exs. 19-3, 21).

On April 24, 2000, SAIF closed the claim with a Notice of Closure that declared claimant medically stationary as of March 28, 2000, awarded temporary disability compensation, and awarded five percent scheduled permanent disability. Claimant requested reconsideration and appointment of a medical arbiter.

On August 11, 2000, Dr. Tsang, M.D., performed a medical arbiter examination. (Ex. 25). Dr. Tsang noted that claimant's findings were due to the accepted condition. (Ex. 25-3).

On August 29, 2000, an Order on Reconsideration increased claimant's scheduled permanent disability award to 19 percent. (Ex. 26).

In 1984, claimant suffered a gunshot injury to the right groin that resulted in chronic thrombophlebitis in both lower extremities. (Exs. 20-2, 25-2). That condition did not result in any injury or disease to claimant's knees, including the contralateral (left) knee.

CONCLUSIONS OF LAW AND OPINION

Both the August 29, 2000 Order on Reconsideration and the ALJ relied on Dr. Tsang's medical arbiter's evaluation to rate claimant's scheduled permanent disability. In addition, both found that, pursuant to OAR 436-035-0007(23), a comparison of the contralateral (left) knee joint was not appropriate in rating the loss of range of motion in the right knee. SAIF appealed both the Order on Reconsideration and the ALJ's opinion. On review, SAIF argues that claimant's attending physician's (Dr. Pollard's) concurrence with examining physician Dr. Anderson's opinion establishes by a preponderance of the evidence that claimant's residual impairment is due to his preexisting degenerative right knee condition.

Extent of permanent disability benefits is limited to permanent impairment caused by accepted conditions or direct medical sequelae of accepted conditions. OAR 436-035-0007(1); *Bonnie J. Woolner*, 52 Van Natta 1579 (2000). Here, the accepted condition is a medial meniscus tear of the right knee.

Evaluation of a worker's disability is as of the date of issuance of the reconsideration order. ORS 656.283(7). For the purpose of rating permanent disability, only the opinions of claimant's attending physician at the time of claim closure, or any findings with which he or she concurred, and the medical arbiter's findings, if any, may be considered. *See* ORS 656.245(2)(b)(B), ORS 656.268(7); *Tektronix, Inc. v. Watson*, 132 Or App 483 (1995); *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994).

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(14). 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*, 125 Or App at 670.

Here, after reviewing the record, we agree with the ALJ that the medical arbiter has provided the most persuasive opinion regarding claimant's impairment. In this regard, in his closing examination, Dr. Pollard stated that claimant had some "permanent residual impairment from the loss of part of the medial meniscus and from the articular damage of the medial femoral condyle." (Ex. 17-1). Thus, Dr. Pollard opined that some impairment was due to the accepted medial meniscus tear condition. However, Dr. Pollard subsequently concurred with the opinion of Dr. Anderson that all of claimant's residuals were due to his preexisting degenerative arthritis of the knee. (Exs. 19-3, 21). Dr. Pollard does not explain this change of opinion. Therefore, we do not find his opinion persuasive. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of opinion renders physician's opinion unpersuasive). Thus, we do not find that the preponderance of the evidence establishes a different level of impairment than that determined by the medical arbiter.

In addition, although Dr. Tsang acknowledged that claimant had a degenerative condition, he found that claimant's impairment findings were due to the accepted condition. (Ex. 25). In addition, because the arbiter panel's August 14, 2000 exam was performed much closer in time to the August 29, 2000 Order on Reconsideration than Dr. Anderson's March 28, 2000 exam, we find that the medical arbiter panel's report is more persuasive. *See, e.g., Kelly J. Zanni*, 50 Van Natta 1188 (1998). Therefore, we rely on Dr. Tsang's opinion to establish claimant's impairment.

Dr. Tsang's opinion establishes that claimant had a partial loss of the right meniscus, which results in an impairment value of 5 percent. OAR 436-035-0230(5)(b). Dr. Tsang also found claimant significantly limited in the repetitive use of his right knee, which results in a chronic condition impairment value of 5 percent. OAR 436-035-0010(5)(b). Dr. Tsang measured claimant's extension as 10 degrees on the right knee and 0 degrees on the left. (Ex. 25-2). He measured flexion as 125 degrees on the right knee and 128 degrees on the left. (*Id.*).

The Order on Reconsideration found that claimant has chronic thrombophlebitis of both lower extremities. Based on that finding, the Order on Reconsideration found that a comparison of the contralateral *joints* under OAR 436-035-0007(23) would not be appropriate, reasoning that claimant has a documented history of injury or disease in the left *leg*. (Ex. 26-2). Therefore, the Order on Reconsideration applied OAR 436-035-0220(1) and (2) to determine the impairment values for flexion (9 percent) and extension (1 percent).

At hearing and on review, SAIF argues that the Order on Reconsideration incorrectly declined to apply OAR 436-035-0007(23) because the record does not establish that claimant has any history of injury or disease in his contralateral (left) knee *joint*, which is the body part to be compared under the facts of this case and the language of the rule in determining range of motion values. We agree.

OAR 436-035-0007(23) 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 or is ankylosed. The *strength* of an injured extremity, shoulder or hip shall be compared to and valued proportionately to the contralateral body part except when the contralateral body part has a history of injury or disease." (Emphasis added).

Dr. Tsang found that claimant had no laxity of the right knee and full strength of the lower extremities. (Ex. 25-2). Therefore, in this case, only the range of motion portion of the above rule may apply to rate impairment. In rating range of motion, OAR 436-035-0007(23) specifically requires that the injured *joint* be compared to the contralateral *joint* unless the contralateral *joint* has a history of injury or disease.

SAIF argues that there is no history of injury or disease in the *left* knee joint that would preclude application of OAR 436-035-0007(23). Claimant counters that "SAIF's own IME doctor took a history that claimant had received treatment for knee drainage of both knees in the past. (Ex. 3-2). Moreover, at the time of the examination, that physician noted that claimant had bilateral chondromalacia patella and pre-patella bursitis. (Ex. 3-8, 11)." Respondent's Brief, page 1. After reviewing the entire record, we disagree with claimant.

Exhibit 3 is a one page copy of a November 9, 1999 Form 827 from Dr. Pollard that refers to his chart note of that date. The November 9, 1999 chart note notes that claimant's *right* knee exam showed some "nursemaid's knee," which claimant stated was a chronic condition. (Ex. 5). That chart note also noted that claimant probably had a medial meniscus tear in the right knee and he had a history of "deep venous thromboses in the past." (*Id.*). Exhibit 11 is a copy of a December 2, 1999 chart note from Dr. Pollard that discusses claimant's upcoming arthroscopy, considering claimant's previous history of blood clots and Coumadin usage. Finally, although Dr. Pollard treated prepatella bursitis (which he also variously described as "nursemaid's knee" and "housemaid's knee") in claimant's *right* knee, he made no mention of any such condition in claimant's *left* knee, nor did he identify that condition as "bilateral." (Exs. 5, 6, 9, 11, 13, 14, 15, 16, 17).

Dr. Anderson, the examining physician, examined claimant and reviewed the medical records. (Ex. 19). Contrary to claimant's contention, Dr. Anderson did not mention any *bilateral* chondromalacia patella or prepatella bursitis conditions. Instead, when discussing claimant's prepatella bursitis condition, Dr. Anderson was referring to the *right* knee. (Ex. 19-1, -2). The only bilateral condition Dr. Anderson noted was "marked stasis dermatitis of both lower extremities with pitting edema." (Ex. 19-2). Dr. Anderson also noted that claimant had chronic thrombophlebitis, which Dr. Pollard described as present in both legs.

Ms. Bottomley, O.T.R., performed a physical capacity evaluation as part of Dr. Anderson's examination. (Ex. 20). Ms. Bottomley noted that claimant stated that his walking pace had been slow since 1984 when he had right hip surgery from a gunshot wound and there was some compromise of the venous system that resulted in discomfort that reduced his walking pace. (Ex. 20-3). Ms. Bottomley did not mention any history of *left* knee injury or disease.

We find nothing in the medical record that mentions any history of injury or disease to claimant's *left* knee. As SAIF notes, although claimant had preexisting thrombophlebitis affecting both *legs*, no physician stated that the thrombophlebitis affected the contralateral (left) knee *joint*. Claimant argues that we may draw a reasonable inference from the medical evidence and conclude that, since the chronic thrombophlebitis slowed claimant's walking pace, it "affects claimant's knee joints since the knee joints are used in walking."

In *Benz v. SAIF*, 170 Or App 22 (2000), the court held that, although the Board may draw reasonable inferences from the medical evidence, it is not free to reach its own medical conclusions in the absence of such evidence. *See also SAIF v. Calder*, 157 Or App 224, 227-28 (1998) ("[t]he Board is not an agency with specialized medical expertise entitled to take official notice of technical facts within its specialized knowledge"). Likewise, here, we are not free to reach a conclusion about whether claimant has a history of injury or disease affecting his left knee without medical evidence that persuasively establishes that fact.[1]

Based on the above reasoning, we find that the record does not establish a history of injury or disease to the contralateral (left) knee. Therefore, the loss of range of motion in the right knee is determined by comparison to and valued proportionately to the contralateral (left) knee. OAR 436-035-0007(23).

Claimant had extension of 10 degrees in the right knee and full extension of 0 degrees in the left knee, which results in a value for extension of 1.0 percent. OAR 436-035-0220(2). Claimant had flexion of 125 degrees in the right knee and 128 degrees in the left knee, which results in a value for flexion of 1.6 percent.[2] OAR 436-035-0007(23). The range of motion findings for the right knee are added for a total of 2.6 percent, which is rounded to 3 percent. OAR 436-035-0007(15). The impairment values are combined (5 percent for surgery, 5 percent for chronic condition impairment, and 3 percent for loss of range of motion) for a total impairment value of 13 percent. OAR 436-035-0007(18).

Finally, because SAIF's request for hearing and request for review have ultimately resulted in a reduction of claimant's compensation awarded by the reconsideration order, claimant's attorney is not entitled to an assessed fee for services at hearing or on review. ORS 656.382(2). It follows that the ALJ's attorney fee award pursuant to ORS 656.382(2) must be reversed.

ORDER

The ALJ's order dated December 15, 2000 is modified in part and reversed in part. In lieu of the ALJ's order, the Order on Reconsideration's award of scheduled permanent disability for loss of use or function of the right leg (knee) is reduced from 19 percent (28.5 degrees) to 13 percent (19.5 degrees). The Order on Reconsideration's "out-of-compensation" attorney fee is modified accordingly. The ALJ's attorney fee award pursuant to ORS 656.382(2) is reversed.

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[1] Claimant's invitation for us to infer that, because the chronic thrombophlebitis slowed claimant's walking pace, it "affects claimant's knee joints since the knee joints are used in walking" requires us to make a medical decision that we are not qualified to render. Although we may take administrative notice of the definition of medical terms, we may not go beyond such definitions to reach medical conclusions that are not supported by medical evidence in the record. *Calder*, 157 Or App at 227. In this regard, thrombophlebitis is defined as an "inflammation of a vein associated with thrombus formation." *Dorland's Illustrated Medical Dictionary*, Edition 28 (1994), page 1707. "Thrombus" is defined as "an aggregation of blood factors, primarily platelets and fibrin with entrapment of cellular elements, frequently causing vascular obstruction at the point of its formation." *Id.* at 1708. Without medical evidence, we are not qualified to draw the conclusion that an inflammatory process involving vein(s) of the left *leg* also results in injury or disease to the left *knee*.

[2] Pursuant to OAR 436-035-0007(23), flexion of the injured joint is determined as a proportion of the degrees of retained flexion of the contralateral joint. Here, that proportion is determined by the following equation (where "X" is the expected retained range of motion compared to the established norm of 150 degrees under OAR 436-035-0220(1)): 125/128 = X/150. In this case, X equals 146.49 degrees of retained flexion, which is rounded to 146 degrees and translates to a flexion value of 1.6 percent. OAR 436-035-0220(1).

In the Matter of the Compensation of
LONI M. GLAZE, Claimant
WCB Case No. 00-06321
ORDER ON REVIEW
Willner, et al, Claimant Attorney
Bottini, et al, Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the insurer's denial of her occupational disease claim for a bilateral carpal tunnel syndrome condition. In its respondent's brief, the insurer challenges the ALJ's evidentiary ruling admitting Exhibit 11A. On review, the issue is compensability.[1]

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

Claimant seeks to establish the compensability of her bilateral carpal tunnel syndrome condition, as an occupational disease. Therefore, she must prove that her work activities as a deli clerk were the major contributing cause of the bilateral carpal tunnel syndrome. ORS 656.802(2)(a). To satisfy the "major contributing cause" standard, claimant must establish that her work activities contributed more to the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983).

A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's disease and deciding which is the primary cause. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). Because of possible alternative causes for claimant's bilateral carpal tunnel syndrome condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

The only medical opinion in the record supporting the compensability of claimant's condition is the opinion of Dr. Jaczko, the attending physician. The ALJ determined that Dr. Jaczko's opinion was not persuasive. Consequently, the ALJ concluded that claimant had failed to establish the compensability of her bilateral carpal tunnel syndrome condition.

On review, claimant contends that Dr. Jaczko's opinion persuasively established that the major contributing cause of claimant's bilateral carpal tunnel syndrome was her work activities as a deli clerk. Consequently, claimant asserts she has met her burden to prove her condition is compensable.

When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). In evaluating medical opinions we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here we find persuasive reasons not to defer to the opinion of Dr. Jaczko.

Dr. Jaczko initially opined that he "could not state that it is definitely work related" (referring to the cause of claimant's carpal tunnel syndrome). (Ex. 10). Later, after reviewing the detailed description of claimant's work duties set forth in Exhibit 11A, Dr. Jaczko wrote:

> "There are various occupational factors that I believe contributed to [claimant's] carpal tunnel syndrome. Her work activities require repeated exertion of her wrists in a flexed or hyper-extended position, repetitive pressures at the base of her palms, and working with machines which induce vibration. To do her work activities, her hands are held in these fixed positions for prolonged periods of time. Because of the nature of these activities, the flexor and extensor tendons of the fingers become displaced, producing pressure and edema to both the tendons and the median nerve. This would result in median nerve compression and subsequent damage." (Ex. 12).

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[1] We need not address the insurer's challenge to the ALJ's evidentiary ruling because exclusion of Exhibit 11A from the record would not change the outcome of the compensability decision.

Although Exhibit 11A contains a detailed itemization and description of claimant's work tasks, there is nothing within that document that indicates the body mechanics claimant used to perform those tasks. In other words, it cannot be determined from Exhibit 11A that claimant performed her job duties with her wrists in flexed or hyper-extended positions exerting pressure at the base of her palms. Nor can it be determined from Exhibit 11A that claimant's job duties required her to hold her hands in fixed positions for prolonged periods of time. Therefore, we conclude that the description of claimant's job duties as set forth in Exhibit 11A does not adequately explain Dr. Jaczko's change of opinion regarding the cause of claimant's bilateral carpal tunnel syndrome condition. *Compare Kelso v. City of Salem*, 87 Or App 630 (1987) (physician's opinion found persuasive when accompanied by reasonable explanation for the physician's change of opinion).

Additionally we note that the record contains no other description, evaluation, or demonstration which establish the body mechanics claimant used to perform her job duties. Consequently, we find Dr. Jaczko's opinion unexplained, and as such, 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). Accordingly, we agree with the ALJ, that, based on this record, claimant has failed to establish the compensability of her bilateral carpal tunnel syndrome condition.

ORDER

The ALJ's order dated December 21, 2000 is affirmed.

April 13, 2001 Cite as 53 Van Natta 552 (2001)

In the Matter of the Compensation of
CHARLES W. BRACH, Claimant
WCB Case Nos. 99-05052 & 99-01454
ORDER ON REVIEW
Reinisch, et al, Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Black's order that: (1) upheld the insurer's denial of his new injury claim for right shoulder, right elbow and right knee conditions; and (2) upheld the insurer's denial of his "omitted medical condition" claim for a right knee condition. On review, the issue is compensability.

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

ORDER

The ALJ's order dated December 14, 2000 is affirmed.

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[1] Claimant protests the failure of the Board to include a transcript of closing arguments with the transcript of the hearing. However, the Board will not bear the cost of transcribing closing arguments. Instead, closing arguments are transcribed only at the request and cost of either party. *See Charles T. Brence*, 39 Van Natta 422 (1987).

In the Matter of the Compensation of
JAMES A. POELWIJK, Claimant
Own Motion No. 92-0427M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Swanson, Thomas & Coon, Claimant Attorney

Claimant requests review of the self-insured employer's February 4, 2000 Notice of Closure that closed his claim with an award of temporary disability compensation from August 17, 1992 through February 3, 2000. The employer declared claimant medically stationary as of February 3, 2000. 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 physicians recommended additional surgery for the compensable condition, his claim was prematurely closed. We affirm the employer's Notice of Closure.

FINDINGS OF FACT

On August 7, 1973, claimant sustained a compensable low back injury. Claimant's aggravation rights expired on February 21, 1979.

Over the years, claimant has undergone multiple surgeries related to his low back injury. On August 17, 1992, claimant underwent an L2-3 fusion. With that surgery, claimant had undergone fusion surgeries from L5-S1 through L2-3. On September 9, 1992, we issued an order reopening claimant's claim for the provision of temporary disability compensation.

On September 8, 1993, claimant underwent further surgery at the L2-3 disc level, including an anterior interbody fusion at L2-3 with a cage system and a posterior fusion at L2-3 with repair of pseudoarthrosis.

On August 11, 1996, the insurer closed the claim, declaring claimant medically stationary as of June 20, 1996.

On August 30, 1996, Dr. Flemming, claimant's treating orthopedic surgeon, opined that the closure of claimant's claim was premature, claimant was not medically stationary and needed further medical treatment of his back problem. Dr. Flemming felt that claimant was having L1 or L2 radicular pain and suspected that the cause was continued problems at the L1-2 level. He opined that claimant "may well need further surgical management." (August 30, 1996 chart note). He ordered an MRI and stated that claimant "more than likely will require surgical stabilization up into the thoracic spine in an attempt to final[ly] fix [claimant's] problem." (*Id.*).

Claimant appealed the August 11, 1996 closure, which we set aside as premature. In doing so, we relied on Dr. Flemming's August 30, 1996 opinion that claimant required further medical treatment for his back problem, which would likely consist of surgical stabilization up into the thoracic spine.

Claimant continued with conservative care. On March 17, 1998, claimant was examined by Dr. Rosenbaum, neurosurgeon, on behalf of the employer. Dr. Rosenbaum noted that, on October 20, 1997, Dr. Flemming had recommended a posterior fusion with instrumentation from T8 through L2 and an anterior interbody fusion at T12 through L2. (Rosenbaum March 17, 1998 report, page 3). Dr. Rosenbaum recommended against the proposed surgery, opining that claimant did not have neurologic involvement. He opined that claimant was medically stationary and no further treatment would improve his condition. He recommended a self-directed exercise program, anti-inflammatory medications, cessation of narcotic analgesics, and an attempt to return to work in the sedentary to light capacity with postural changes. (*Id.*, pages 5-6).

On April 20, 1998, Dr. Flemming disagreed with Dr. Rosenbaum, noting that claimant had tried Dr. Rosenbaum's approach without success. (Flemming April 20, 1998 report). Dr. Flemming opined that the proposed surgery (a fusion up to the "stable" mid/lower thoracic level (T8)) offered claimant a chance to help his pain and make him more functional. (*Id.*, page 2).

On April 30, 1998, Dr. Flemming stated that he understood the carrier was denying the need for further surgery. He noted that claimant requested help in managing his chronic pain syndrome. Dr. Flemming requested authorization for claimant to be evaluated and treated at the Oregon Health Sciences Pain Management Center. (OHSU Pain Center). On August 5, 1998, Dr. Flemming repeated this request, noting that the decision for further surgery had been denied, so claimant's remaining option was to attend a pain center.

On December 1, 1998, claimant began treating with Dr. Stacey, anesthesiologist, at OHSU Pain Center. Dr. Stacey began a program of long acting opiate medication, neuropathic pain medication, and physical therapy. Through 1999, trials of several different opiate and neuropathic medications were made in an attempt to find those that would provide the best relief with the fewest side effects.

On April 26, 1999, Dr. Flemming responded to an inquiry from the carrier regarding claimant's status. Dr. Flemming stated that the only surgical option for claimant was to extend his fusion up into the thoracic spine to stop the abnormal motion at the thoracolumbar junction. But claimant was not interested in proceeding with surgery at that time and the carrier had not been willing to authorize surgery of that magnitude. Dr. Flemming stated that, as far as he was concerned, claimant's condition was medically stationary since the carrier denied any surgical management of that condition. However, since claimant was undergoing pain management treatment, Dr. Flemming advised the carrier to contact the OHSU Pain Center as to the endpoint for that treatment.

In a May 12, 1999 chart note, Dr. Flemming noted that "[w]hether a more extensive fusion extending up into the thoracic spine would be beneficial or not, I cannot really tell and would not recommend at this time, until at least [claimant has] gone through the whole pain center therapy." Dr. Flemming also stated that claimant was not medically stationary until "he has at least finished [the OHSU Pain Center] evaluation and treatment."

In June and July 1999, claimant underwent two lumbar medial branch blocks from L2 to S1 at OHSU Pain Center. Based on positive results from those blocks, on July 30, 1999, claimant underwent bilateral medial nerve radiofrequency denervation at L2, L3, L4, and L5 at the OHSU Pain Center. On August 11, 1999, Dr. Flemming noted that those procedures helped, but claimant still had a fair amount of pain into the groin area, "pseudoradicular" pain in his legs, and mechanical back pain. (Flemming August 11, 1999 chart note).

On November 24, 1999, Dr. Stacey noted that claimant had made progress but had persistent pain that limited his function. Dr. Stacey recommended that claimant undergo a trial of neuraxial medications. If the trial was successful at controlling claimant's pain, Dr. Stacey proposed placement of an intrathecal morphine pump. Dr. Stacey noted that, if Dr. Nelson (OHSU Pain Center psychologist) agreed with the proposed treatment, they would proceed with the neuraxial trial.

On November 30, 1999, Dr. Nelson evaluated claimant to determine whether he was a suitable candidate for intrathecal pump implant. Dr. Nelson noted that claimant's pain level remained around 3-4 on a scale of 10 on his current medication of OxyContin. Dr. Nelson diagnosed adjustment disorder with anxiety and depression, pain disorder, and sleep disorder. Claimant was to return the next day to complete psychological testing. Dr. Nelson noted that claimant must complete all procedures before he could offer a recommendation. The record contains no further report from Dr. Nelson.

On December 17, 1999, Dr. Flemming examined claimant and noted that new x-rays showed significant instability at the L1-2 and T12-L1 levels. Dr. Flemming stated that he continued to feel that claimant was ultimately going to require some stabilization of the thoracolumbar junction. Dr. Flemming stated that he had no opinion as to whether the proposed morphine pump would be effective, but he ultimately thought that claimant's instability would become enough that he would still require stabilization sometime in the future.

On January 25, 2000, Dr. Flemming examined claimant and noted that claimant was having more pain into the groin and anterior upper thigh area, suggestive of an L2 radiculopathy. Flemming recommended an MRI scan of the upper lumbar and lower thoracic region. Dr. Flemming stated that claimant was ultimately going to need some form of stabilization extending his fusion up to the thoracic spine, but the carrier had been hesitant to authorize that, and claimant has wanted to try all other avenues prior to that.

On January 26, 2000, Dr. Stacey met with the claims adjuster to discuss claimant's condition. On February 3, 2000, Dr. Stacey agreed with a summary of that meeting. Specifically, Dr. Stacey agreed that the proposed medication pump was the "last resort" for claimant's pain control and was palliative in nature. Dr. Stacey did not think that surgery was a valid option for decreasing claimant's pain or improving his condition. As long as claimant continued to receive intrathecal medications, pump placement, and palliative physical therapy, Dr. Stacey considered claimant's condition to be medically stationary.

On February 4, 2000, the employer closed the claim, declaring claimant medically stationary as of February 3, 2000. Claimant requested Board review of that claim closure.

In a February 8, 2000 report, Dr. Stacey indicated that he had a "misunderstanding" regarding the February 3, 2000 report. Specifically, Dr. Stacey reported that claimant was not medically stationary until he recovered from the intrathecal morphine pump implant (at which time claimant's medical treatment would be "palliative in nature").

On April 20, 2000, Dr. Flemming recommended additional surgery to extend claimant's fusion into the thoracic spine, noting that claimant wanted to proceed with surgical management of his back pain. Dr. Flemming noted that flexion-extension x-rays showed significant wedging and instability at the L1-2 and T12-L1 levels. Based on this radiograph evidence, Dr. Flemming felt that claimant demonstrated an unstable motion segment of the spine. Dr. Flemming noted that claimant had attempted all forms of conservative management, including bracing, extensive therapy, and injections. Despite this, Dr. Flemming noted that claimant continued to have severe pain in his back radiating down into his groin area and legs with intermittent weakness in his legs. Dr. Flemming reported that the only way to insure a solid and stable thoracolumbar junction was to extend the fusion up into the mid-thoracic spine, with the ribs in the mid-thoracic region providing enough stability to the fusion to give claimant adequate stability in the thoracolumbar region. Although acknowledging that claimant's prior surgeries had not provided the best outcome primarily because the levels above the prior fusions eventually became unstable requiring further extension of the fusion, Dr. Flemming opined that extending the fusion to the mid-thoracic region would help claimant's current condition. As for the proposed morphine pump implant, Dr. Flemming opined that it was only a short-term solution.

The employer declined to authorize Dr. Flemming's request for additional surgery and Dr. Stacey's request for a morphine pump implant. On September 5, 2000, claimant requested Director's review.

On September 13, 2000, we issued an order postponing action on our review of the carrier's closure. We reasoned that, if the proposed surgery was found to be reasonable and necessary for claimant's compensable injury, the decision could affect our review of the employer's closure.

On November 28, 2000, at the request of the Director, claimant was examined by a panel of three physicians, an orthopedic surgeon, a neurosurgeon, and a psychologist. New flexion and extension x-rays of the thoracolumbar spine were taken and revealed no evidence of instability. (January 12, 2001 Administrative Order TX 01-008, pages 2-3). In addition, the orthopedic surgeon and neurosurgeon noted that claimant did not demonstrate objective clinical evidence of instability at the T12-L2 levels. (*Id.* at page 3). The panel recommended against both the proposed fusion and the trial morphine pump placement. (*Id.* at pages 3-4).

On January 12, 2001, the Medical Dispute Section issued an Administrative Order finding that neither the proposed fusion nor the proposed trial of a morphine pump placement were appropriate medical treatment for claimant's compensable condition. That order was not appealed and has become final by operation of law.[1] Therefore, it has been finally determined that the surgeries proposed by Drs. Flemming and Stacey are not reasonable and necessary for the compensable injury.

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).

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[1] As provided in our September 2000 Order Postponing Own Motion Action, once the Director's order issued, the parties were granted an opportunity to submit their written positions regarding the effect, if any, the Director's order had on claimant's request for review. Several months have passed since the Director's unappealed order was issued and there has been no response from either party. Under such circumstances, we have proceeded with our review.

The propriety of the closure turns on whether claimant was medically stationary at the time of the February 4, 2000 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). 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). 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).

Here, claimant contends that he was not medically stationary at the time the employer closed his claim. In support of this contention, claimant argues that Dr. Stacey proposed a morphine pump implant and Dr. Flemming proposed further back fusion surgery.

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 treatment for the claimant's compensable condition and that it would materially improve claimant's compensable condition. *Richard Uhing*, 48 Van Natta 465 (1996) (Board found claim closure premature where recommended surgery was pending at claim closure and there was no evidence that the claimant refused the surgery; rather, the claimant opted for other treatment prior to undergoing surgery); *Bill H. Davis*, 47 Van Natta 219 (1995). In contrast, when a claimant's medically stationary status is contingent upon the claimant undergoing a recommended surgery and that recommended surgery is determined not reasonable and necessary treatment for the compensable condition, the claim is not prematurely closed. *Dennis C. Gross*, 48 Van Natta 1125 (1996).

We find our decision in *Gross* is directly on point. In *Gross*, the claimant's aggravation rights had expired and his claim had been reopened under our Own Motion authority for surgical treatment of a compensable foot injury. Prior to claim closure, the claimant's treating pain center physician declared him medically stationary and his treating surgeon requested authorization to perform additional foot surgery. Relying on the pain center physician's opinion, the carrier closed the claim. The claimant requested review of that closure, contending, in part, that his claim was prematurely closed based on his treating surgeon's recommendation of additional foot surgery.

The carrier denied the reasonableness and necessity of the additional foot surgery and the claimant requested review of that decision. We postponed action on our review of the Own Motion closure pending the outcome of this review. Subsequently, the Director issued an order finding the proposed surgery was not reasonable and necessary treatment for the compensable injury. That order was not appealed and became final by operation of law.

In determining that the claim was not prematurely closed, we relied on the final determination that the proposed treatment was not reasonable and necessary. Specifically, we found that, "based on the inappropriateness of the proposed surgery and thus, the lack of evidence that the proposed surgery would materially improve [the] claimant's compensable condition, we are not persuaded that [the] claimant's medically stationary status was contingent upon undergoing that surgery." *Id.* at 1127.

The same reasoning applies here. Although formal requests for authorization for additional fusion surgery and the trial morphine pump placement were not made until after claim closure, those treatments had been proposed before claim closure. As the findings of fact show, Dr. Flemming had suggested extending the fusion of claimant's spine up into the mid-thoracic level as early as 1996. In fact, that proposed fusion surgery was the reason the employer's prior August 11, 1996 closure was set aside as premature. Over the years, Dr. Flemming and claimant fluctuated regarding whether to pursue additional fusion surgery. However, by December 1999 and January 2000, Dr. Flemming was again proposing additional fusion surgery. In addition, in his February 3, 2000 opinion, Dr. Stacey considered claimant's condition to be medically stationary, as long as claimant continued to receive intrathecal medications, pump placement, and palliative physical therapy.

Thus, we find that, at claim closure, the only treatments recommended were additional fusion surgery and a morphine pump implant. However, those treatments have conclusively been determined to be inappropriate treatment for the compensable condition. Therefore, they do not support claimant's

contention that his claim was prematurely closed. *Gross*, 48 Van Natta at 1127; *Lee R. Parker*, 51 Van Natta 786 (1999) (closure not premature where surgery proposed at closure subsequently found inappropriate treatment for compensable condition by unappealed Director's order and treating doctor found the claimant's condition would be medically stationary in absence of the proposed surgery).

The dissent contends that the appropriateness of proposed medical treatment is not a prerequisite to a medically stationary finding, noting that the Director's order did not decide the issue of the propriety of the employer's closure. While we agree that the Director's order did not decide the issue of the propriety of the employer's closure, we find that the Director's unappealed decision regarding the appropriateness of the proposed medical treatment is very relevant to the medically stationary issue before us.

Where appropriateness of proposed medical treatment is disputed and resolution of that dispute has determined that the proposed treatment is not reasonable and necessary, such a determination goes directly to the issue of medically stationary status, if the claimant is otherwise medically stationary. As explained above, the standard for determining whether a claimant is medically stationary is whether there is a *reasonable* expectation of further *material* improvement from medical treatment or the passage of time. ORS 656.005(17).

Here, there is no medical evidence that the passage of time is reasonably expected to materially improve claimant's compensable low back condition. In addition, the fact that the only proposed medical treatments have been determined to be inappropriate for the compensable condition goes to the *reasonableness* of any expectation of *material* improvement with those medical treatments. In other words, if a medical treatment is *not* reasonable and necessary, it follows that such treatment does not present any *reasonable* expectation of *material* improvement. Thus, such proposed treatment would not support a finding that a claimant is not medically stationary under the standard in ORS 656.005(17).[2] *Gross*, 48 Van Natta at 1127.

The dissent also contends that because the Director's order did not issue until January 12, 2001, it did not necessarily address claimant's condition at the time of closure. We find the Director's order relevant to claimant's condition at closure. In this regard, the Director's order specifically focused on the reasonableness and necessity of treatments that were proposed at the time of closure, as addressed above.

In summary, the proposed fusion surgery, as well as the morphine pump implant, have been found by an unappealed Director's order to be inappropriate treatment for claimant's compensable condition. Other than the inappropriate fusion surgery proposed, Dr. Flemming has not proposed any further treatment options that would reasonably be expected to materially improve claimant's compensable condition. Such circumstances support a conclusion that claimant's condition was medically stationary when his claim was closed in February 2000.

Additionally, as noted above, Dr. Stacey concluded that claimant was medically stationary on February 3, 2000, with the provision that claimant have interthecal medications, morphine pump placement, and "as needed" palliative physical therapy. On February 8, 2000, Dr. Stacey stated that it was premature to declare claimant medically stationary until he had recovered from the proposed morphine pump placement, at which time further care would be palliative and would include neuraxial

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[2] In *Thomas E. Suby*, 50 Van Natta 718 (1998) (*Suby I*), and *Thomas E. Suby*, 50 Van Natta 1088 (1998) (*Suby II*), we addressed the relationship between a Director's order that found a surgery not reasonable and necessary and the claimant's entitlement to temporary and permanent disability benefits related to that surgery. We found that the Director's final determination that the surgery in question was not reasonable and necessary broke the chain of causation between the accepted condition and any disability associated with that surgery. Thus, we found the claimant not entitled to any disability benefits related to the inappropriate surgery, whether those benefits were classified as procedural, substantive, temporary, or permanent.

Although the dissent relies on the dissent in *Suby* to support her position, we find that the majority opinion in the *Suby* decision controls. In other words, in addition to addressing the "reasonableness" of any expectation of "material" improvement, the Director's determination that the proposed medical treatments are not reasonable and necessary broke the chain of causation between the accepted condition and any disability associated with that treatment. It stands to reason that where the causal link has been broken, a proposed treatment that has been determined inappropriate would not support a finding that the claimant is not medically stationary. *See Tony D. Houck*, 52 Van Natta 1361 (2000).

medications, systemic medications, and physical therapy. However, as discussed above, the morphine pump implant has been conclusively determined inappropriate treatment for the compensable injury. Thus, that proposed treatment does not support a finding that claimant was not medically stationary at closure.

Moreover, 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, at claim closure, that further medical treatment would "materially improve" claimant's compensable condition. ORS 656.005(17); *Lois Brimblecom*, 48 Van Natta 2312 (1996). Here, Dr. Stacey's references to continued medication and "as-needed" physical therapy (which is primarily based on a proposed implant surgery which has been conclusively found to be inappropriate treatment) does not establish that further medical treatment has been recommended that would "materially improve" claimant's compensable condition.

In conclusion, we find that claimant's compensable condition was medically stationary when his claim was closed on February 4, 2000. Therefore, we conclude that the insurer's closure was proper.

Accordingly, we affirm the insurer's February 4, 2000 Notice of Closure in its entirety.

IT IS SO ORDERED.

Board Member Phillips Polich dissenting.

The majority finds that the claim was not prematurely closed, focusing on whether the proposed surgeries were reasonable and necessary for claimant's condition. However, the focus should not be on the "appropriateness" of a proposed treatment but rather on whether claimant was medically stationary at the time of closure. For this reason, I respectfully dissent.

The propriety of the carrier's closure turns on whether claimant was medically stationary at the time of the February 4, 2000 Notice of Closure. *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). A claim may not be closed unless the claimant's condition is medically stationary. *See* ORS 656.268(1); 656.278(1)(a); 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).

Here, the majority relies on the Director's findings regarding the proposed medical treatment for claimant's compensable condition. As noted above, the propriety of a closure turns on whether claimant was medically stationary at the time the carrier closed the claim and not on whether a proposed medical treatment is reasonable and necessary. In other words, the appropriateness of a proposed medical treatment is not a prerequisite to a medically stationary finding.

Although the majority references the Director's order which found that these two proposed treatments were "inappropriate," our primary task is to determine if claimant was medically stationary at the time of claim closure. Specifically, the Director's order recited the issue to be decided as "whether a T12-L2 fusion, and a trial of a neuraxial opioid medication and possible implantation of an intrathecal medication delivery system * * * are appropriate medical treatments for [claimant's] compensable condition." The Director's order therefore did not decide the specific issue before us; *i.e.*, the propriety of the carrier's closure order.

Board Members Hall and Biehl's dissent in *Thomas E. Suby*, 50 Van Natta 718 (1998), is analogous to this situation. *Suby* involved an issue of entitlement to temporary disability where the Director had found a particular medical procedure not reasonable and necessary, and is distinguishable on that basis. However, Members Hall and Biehl emphasized in their dissent in *Suby* that the Director's jurisdiction is limited to the appropriateness of the proposed surgery, and that "appropriateness of surgery" issue was not essential to the Board's determination on the issue of entitlement to temporary disability. 50 Van Natta at 725. Accordingly, Board Members Hall and Biehl would have found that principles of issue preclusion did not apply to the Board's determination regarding temporary disability. 50 Van Natta at 726. I agree with Members Hall and Biehl and would apply their reasoning to this case.

Even assuming the Director's order conclusively determines the issue of the "reasonableness" of the proposed treatments here, I would still find that there was a reasonable *expectation* of material improvement at the time of claim closure (February 4, 2000) based on the reports of Dr. Flemming and Stacey. ORS 656.005(17). If there is a reasonable expectation of improvement with surgery (or other medical treatment), the criteria for being declared medically stationary have not been met. *Richard Uhing*, 48 Van Natta 465, 466 (1996). Significantly, the Director's order did not issue until January 12, 2001, and thus does not necessarily address claimant's condition at the time of closure (February 4, 2000).

On this record, I would find that claimant's condition was not medically stationary as of February 4, 2000. In his February 8, 2000 report, Dr. Stacey retracted earlier comments regarding claimant's medically stationary status to indicate that claimant was not medically stationary until he recovered from an intrathecal morphine pump implant. In addition, on April 20, 2000, claimant's treating physician Dr. Flemming proposed a back surgery to extend claimant's fusion up through his thoracic spine. Dr. Flemming explained that the surgery is necessary to stabilize claimant's thoracolumbar region. Plainly, this is an extensive procedure designed to materially improve claimant's back condition. Based on Dr. Flemming's and Dr. Stacey's reports, I would find that claimant's condition had a reasonable expectation of improvement at the time of closure. I would therefore set aside the carrier's February 4, 2000 Notice of Closure.

For the above reasons, I respectfully dissent.

In the Matter of the Compensation of
ROBERT P. SALE, Claimant
WCB Case No. 99-02183
ORDER ON REVIEW
Walsh & Associates, Claimant Attorney
Reinisch, et al, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Martha Brown's order that set aside its denial of claimant's injury claim for a low back 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

Amended Denial

On February 4, 1999, the employer denied claimant's November 16, 1998 low back injury claim. (Ex. 17). That denial stated, in pertinent part,

> "Upon review of the available medical information in your file, it is our conclusion that your current condition and need for treatment, is a result of your pre-existing degenerative arthritis in your thoracic and lumbar spine. Therefore, [the claims administrator], on behalf of [the employer] must deny your current condition to include medical treatment, time loss and permanent partial disability." (Ex. 17).

At hearing, the employer orally amended its denial to include legal causation; *i.e.*, that claimant was not injured on November 16, 1998. (Tr. 1). The employer also asserted that the issue should be limited to the compensability of the injury claim, with the compensability of claimant's lumbar disc herniation conditions to be resolved through future claim processing if the denial were set aside. (Tr. 2). Claimant objected to the employer's assertion, contending that the employer's denial of a "current condition," had placed claimant's lumbar disc conditions at issue. (*Id.*)

The ALJ did not further address the parties' positions at the hearing. Instead, the hearing proceeded, and, following its completion, the record was eventually closed. Neither party sought clarification of the disputed issues nor objected to the closure of the record. The ALJ set aside the employer's denial, as amended at hearing. In reaching this conclusion, the ALJ expressly found claimant's lumbar disc conditions compensable as "combined conditions," based on the opinion of claimant's treating physician, Dr. Santiago. The ALJ also commented on the issues presented as follows:

> "At hearing, claimant requested that the employer be required to accept claimant's herniated discs at L2-3 and L3-4, while the employer contended that it is sufficient to order the acceptance of just the injury itself. I agree with claimant that the employer denied claimant's current condition, which includes the disc herniations. (Exs. 17, 21). As stated above, Dr. Santiago's report establishes that claimant's disc herniations and radiculopathy were caused in major part by the work injury. (Ex. 21-2). Nevertheless, I find that it is sufficient to set aside the denial, as amended at hearing. If claimant disagrees with the employer's processing of the claim, a hearing may be requested and penalties sought pursuant to ORS 656.262(11)(a)." -- O&O at 4, n3.

On review, the employer contends that the ALJ's order is ambiguous as to which conditions have been held compensable. Based on the ALJ's order, which includes an analysis of the compensability of the low back conditions as a "combined condition," we conclude that the compensability of claimant's low back strain and herniated disc conditions were both at issue and were actually litigated and decided. The ALJ's order is not ambiguous. Accordingly, we decline the employer's invitation to resolve an asserted ambiguity in the ALJ's order.

We also agree with the ALJ's characterization of the issue at hearing. The employer contends that it may amend its denial at hearing, citing *SAIF v. Ledin*, 149 Or App 94 (1997). However, here, the employer sought both to broaden and limit its written denial orally at hearing. The ALJ properly allowed an oral amendment to include a denial of legal causation, thus broadening the initial denial. However, the February 4, 1999 denial, by its terms, denied claimant's "current condition." (Ex. 17). The medical evidence in existence at the time of that denial diagnosed herniated discs at L2-3 and L3-4. (Exs. 12-2, 14-2). Therefore, we find that claimant's "current condition" referenced in the February 4, 1999 denial included the lumbar disc conditions.

Notwithstanding its oral amendment of its denial to include a denial of legal causation, the employer did not withdraw or rescind its February 4, 1999 denial. Although, pursuant to *Ledin*, the employer is permitted to amend its denial at hearing, extrinsic evidence as to the meaning of the initial denial is not permitted. *See Tattoo v. Barrett Business Services*, 118 Or App 349, 351-352 (1993); *James F. Shaughnessy*, 50 Van Natta 734 (1998).

In *Shaughnessy*, we held that the unambiguous terms of the carrier's initial denial encompassed a "current condition" denial. Therefore, we held that the carrier could not orally "limit" the express terms of its initial denial to include only a denial of the claimant's preexisting arthritis condition. 50 Van Natta at 737.

Here, the employer's February 4, 1999 denial of claimant's "current condition" encompassed claimant's lumbar disc conditions. Under such circumstances, and in the absence of a rescission of its prior denial, the employer did not limit the terms of the written denial in the guise of "amending" the denial. Finally, the employer did not claim surprise regarding the "combined condition" issue.[1] In those circumstances, we find that the issue was properly framed as including the compensability of claimant's lumbar disc conditions.

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[1] In any event, the remedy for any such claim of surprise would have been to request a continuance to further develop evidence. *See* OAR 438-006-0031, OAR 438-006-0036, OAR 438-006-0091(3); *Sandra L. Shumaker*, 51 Van Natta 1981, 1982 (1999), *on recon* 52 Van Natta 33 (2000); *John E. Noyer*, 46 Van Natta 395 (1994). The employer did not seek such a remedy. Moreover, a continuance would likely not have been warranted in these circumstances, where the claimant had already developed medical evidence supportive of his low back disc conditions as "combined conditions." (Ex. 21).

Compensability

We adopt and affirm the ALJ's order on the merits of the compensability issue, with the following supplementation. The ALJ found claimant's testimony that he was injured at work on November 16, 1998 credible based on demeanor. (O&O at 2, 3). We ordinarily defer to the ALJ's demeanor-based credibility findings. *International Paper v. McElroy*, 101 Or App 61 (1991); *Susan M. Backman*, 52 Van Natta 1910 (2000). Here, we do not find any reasons not to defer to the ALJ's credibility finding. In this regard, we note that claimant reported his injury to his supervisor the same day. (Tr. 7). Claimant also sought treatment the day of the injury with Dr. Benton, who took a history of an injury at work that day "lifting a light stanchion" and diagnosed a "LS strain." (Ex. 5).

As to medical causation, claimant needed to prove that his injury was the major contributing cause of his disability or need for treatment for his combined low back condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309 (1997). Dr. Santiago offered the only opinion on medical causation in the record, which is supportive of claimant's low back injury claim on the major contributing cause basis. (Ex. 21-3). Contrary to the employer's argument, Dr. Santiago expressly considered the effect of claimant's preexisting degenerative disk disease in reaching his opinion. (*Id.*)

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 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 issues, and the value of the interest involved.

ORDER

The ALJ's order dated December 18, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,250, payable by the self-insured employer.

April 16, 2001 Cite as 53 Van Natta 561 (2001)

In the Matter of the Compensation of
EDWARD W. PRICE, Claimant
WCB Case No. 99-07454
ORDER ON REVIEW
Roger Wallingford, Claimant Attorney
Jerry Keene, Defense Attorney

Reviewed by Board Members Meyers, Bock, and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that dismissed his hearing request as untimely filed. On review, the issue is timeliness.

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

The insurer issued a denial of claimant's claim on December 28, 1999. Claimant's former attorney had entered into settlement negotiations with the insurer's counsel. A disputed claim settlement (DCS) was drafted. The document stated that claimant was filing an appeal from the December 28, 1999 denial. Claimant declined to sign the DCS and the agreement was never approved. In early February 2000, claimant's former attorney withdrew from representation of claimant.

On February 22, 2000, still within the 60-day appeal period from the December 28, 1999 denial, claimant's new attorney wrote the insurer's counsel requesting the claim file and requesting that the insurer's attorney call him to discuss the case when he received the letter. The Board received claimant's March 8, 2000 request for hearing regarding the December 28, 1999 denial on March 10, 2000, more than 60 days, but fewer than 180 days, from the date of the denial.

A request for a hearing must be filed not later than the 60th day after the mailing of the denial to the claimant. ORS 656.319(1)(a). A hearing request that is filed after 60 days, but within 180 days of a denial, confers jurisdiction if the claimant establishes good cause for the late filing. ORS 656.319(1)(b).

Claimant has the burden of proving good cause. *Cogswell v. SAIF*, 74 Or App 234, 237 (1985). "Good cause" means "mistake, inadvertence, surprise or excusable neglect" as those terms are used in ORCP 71B(1). *Hempel v. SAIF*, 100 Or App 68, 70 (1990).

The ALJ found that reliance on a settlement agreement does not constitute good cause for an untimely filing where there was no indication that claimant was told by the insurer that his claim would be accepted. *See Michael D. Stanley*, 49 Van Natta 345 (1997). The ALJ further reasoned that the settlement was of a disputed and denied claim and the insurer gave claimant no reason to believe that the denial would be withdrawn. The ALJ also noted that, assuming that claimant's prior attorney was responsible for filing the hearing request, neglect by an attorney who is responsible for filing hearing requests is not excusable and does not constitute good cause for untimely filing. *See Sekermestrovich v. SAIF*, 280 Or 723, 727 (1977). Accordingly, the ALJ found that claimant had not established good cause for his untimely hearing request.

On review, claimant argues that the DCS misled him because it provided that claimant "hereby files an appeal from this denial." (Ex. 41-2). Claimant also argues that he was not represented after his first attorney withdrew on February 3, 2000. He asserts that the insurer's attorney misrepresented in the DCS that the denial was being appealed. Claimant also argues that his attorney sent the insurer's attorney a letter on February 22, 2000, within the 60-day period, requesting the claim file and asking the insurer's attorney to telephone him to discuss the case. Claimant argues that the insurer's counsel delayed responding to the letter until after the 60 day period had run.

Claimant asserts that *Voorhies v. Wood, Tatum, Moser*, 81 Or App 336 (1985), *rev den* 302 Or 342 (1986), is analogous and supports a conclusion that he has established "good cause." In *Voorhies*, "good cause" was established where a claims supervisor erroneously advised a claimant that mailing of a request for hearing on the 60th day would protect his rights. Prior to receiving this advice, the claimant intended to hand-carry his request for hearing to the Hearings Division on the 60th day. Thus, under the reasoning in *Voorhies*, reliance on a misleading statement of an insurer's representative can constitute good cause.

Here, however, there is no evidence that the insurer made any misleading statement to claimant about the claim. The insurer did not advise claimant that the denial would be withdrawn or that the claim would be accepted. To the contrary, the "denial appeal" statement in the DCS was merely a phrase contained in a proposed agreement during contract negotiations that never resulted in a formalized settlement. In addition, we do not agree with claimant that the insurer delayed responding to his attorney's February 22, 2000 request for the file. The parties stipulated that the insurer's counsel provided the file on March 3, 2000, the same day he received claimant's attorney's retainer agreement. Thus, we are not persuaded that the delay was the result of any intention by the insurer to allow the appeal period to run. We do not find *Voorhies* to be analogous to the present facts.

Based on this record, we agree with the ALJ that claimant has not established good cause for his untimely hearing request. Accordingly, we affirm the ALJ's dismissal.

ORDER

The ALJ's order dated October 26, 2000 is affirmed.

Board Chair Bock concurring.

I am in agreement with the majority opinion and write separately only to emphasize the point that claimant was represented by an attorney when the DCS was negotiated. The dissent takes the position that claimant was misled by the insurer's language in the DCS regarding the status of the denial.[1] First, as the majority opinion states, there is no evidence that the insurer made any misleading

[1] This case involved two denials. The first denial was initially mailed on September 2, 1999 and was remailed on September 14, 1999 to claimant's corrected address. (Exs. 27; 28). The September 1999 denial was a current condition denial and was timely appealed. The ALJ upheld the current condition denial and that portion of his order was not appealed. Claimant, through his then-attorney, made a new medical condition claim for right lower cervical facet syndrome, right rotator cuff tendinitis, and impingement with adhesive capsulitis, right cubital tunnel syndrome, and right radial tunnel syndrome. (Ex. 34). This claim was denied on December 28, 1999. It is this second denial that is the subject of this appeal. The denial was appealed by claimant's current attorney more than 60 days, but fewer than 180 days from the date of the denial. Thus, the hearing request confers jurisdiction only if good cause is shown for the late filing.

statement to claimant about the denial. Second, the fact remains that during the negotiation of the DCS claimant was represented by counsel. Claimant's counsel's job was to represent claimant and to clear up any misunderstanding or confusion that might have existed regarding the denial. Claimant's attorneys also undertook the task of protecting claimant's rights by timely appealing the denial when settlement negotiations were abandoned.

The dissenting opinion apparently discounts the fact that claimant was represented at the time of the negotiation of the DCS. Moreover, as the majority opinion already states, the language in the DCS does not mislead claimant into believing that the denial is withdrawn. By its very nature, the DCS settles a disputed (denied) claim in which the denial remains in effect. Because claimant was represented by an attorney at the time of the DCS, it was not incumbent upon the insurer to explain the DCS to claimant.[2]

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[2] In fact, the Code of Professional Responsibility would have prohibited an insurer's attorney from communicating with claimant regarding the denial or the DCS during the time he was represented. *See* DR 7-104 (communicating with a person represented by counsel). In addition, claimant's first attorney had an obligation under DR 2-110(A)(2) to "not withdraw from employment" until reasonable steps were taken "to avoid foreseeable prejudice" to the rights of the claimant. Clearly, this would include ensuring that an appeal was timely filed or advising claimant of what steps needed to be undertaken to avoid this unfortunate turn of events.

Board Member Phillips Polich dissenting.

I would conclude that the language of the DCS, providing that the denial was being appealed, misled claimant and constituted good cause for his late hearing request. In this regard, the language of the DCS gave claimant reason to believe the denial had been appealed. Good cause can be established through evidence that a claimant was misled by a carrier's representative. *See Voorhies v. Wood, Tatum, Moser*, 81 Or App 336 (1985), *rev den* 302 Or 342 (1986).

Because the DCS was prepared by the insurer, I believe that this case is analogous to those cases where an insurer's representative misleads the claimant regarding the status of a denial. On page 2, the DCS provides that "claimant hereby files an appeal" from the December 28, 1999 denial. This statement misled claimant into believing that the denial had been appealed and that his rights were protected. I would find this case distinguishable from *Michael D. Stanley*, 49 Van Natta 345 (1997), on the ground that in *Stanley*, the claimant believed that the case was settled and that he need not appeal the denial. Here, however, it was the statement in the DCS that had been prepared by the insurer that misled claimant. Thus, the present case is more analogous to the holding of *Voorhies* where a representative of the insurer has misled the claimant about the status of the denial.

The DCS in this case clearly stated that the denial was appealed. Thus, I would conclude that claimant has established good cause. Under such circumstances, I would find that claimant's untimely appeal amounted to "excusable neglect" and that claimant has established "good cause" for his failure to timely appeal the denial. For this reason, I respectfully dissent from the majority's opinion.

April 17, 2001 Cite as 53 Van Natta 563 (2001)

In the Matter of the Compensation of
JOSEPHINE A. GROFF, Claimant
WCB Case No. C002445
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Malagon, Moore, et al, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewed by Board Member Phillips Polich and Haynes.

The Board has 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 released certain rights to future workers' compensation benefits, except medical services, for the compensable injury.

The Board requested that the parties provide the original signature of claimant. *See* OAR 438-009-0025(1). On March 9, 2001, after receiving no response to its first letter, the Board sent another letter, reminding the parties that they had not responded to its prior letter and that, unless the prior deficiency was corrected within 21 days, the Board might disapprove the proposed CDA. *See* OAR 438-009-0020(4)(b).

On March 22, 2001, the Board received a letter from claimant's counsel, stating that counsel had "completely lost contact with [claimant]." Counsel further reported that "[w]e are unable to comply with your request of March 9, 2001."

Based on claimant's counsel's request, we conclude that the parties cannot amend the CDA as we previously requested. Under the circumstances, we find that the proposed disposition is unreasonable as a matter of law. *See* OAR 438-009-0020(4)(b). Accordingly, we disapprove the agreement.

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(5)(k).

IT IS SO ORDERED.

In the Matter of the Compensation of
MARCIA A. CLOMAN, Claimant
WCB Case No. 00-05406
ORDER ON REVIEW
Welch, et al, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Meyers and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that reduced her unscheduled permanent disability award for a left shoulder condition from 30 percent (96 degrees), as awarded by an Order on Reconsideration, to zero. On review, the issue is extent of unscheduled permanent disability.

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

Claimant compensably injured her left shoulder in April 1999. (Exs. 1; 5). In July 1999, the claim was accepted as a disabling "left shoulder adhesive capsulitis." (Ex. 15).

The claim was closed in February 2000 by Determination Order, which awarded no permanent partial disability (PPD). (Ex. 41). Claimant requested reconsideration, challenging, among other things, the medical impairment findings used to rate disability. (Ex. 42).

As a part of the reconsideration process, a medical arbiter's exam was performed by Dr. Ho. (Ex. 43). Relying on the medical arbiter's report, the Appellate Review Unit (ARU) issued an Order on Reconsideration awarding claimant 30 percent unscheduled permanent disability. (Ex. 44). The insurer requested a hearing challenging the Order on Reconsideration.

The ALJ determined that Drs. Walsh and Carlson (attending physicians) had ratified the evaluations of Drs. McNeill and Duff (insurer-arranged medical examiners). Consequently, the ALJ concluded that the preponderance of the medical evidence, as determined by the evaluations of Drs. McNeill and Duff, established that claimant's impairment was not attributable to the accepted condition. Accordingly, the ALJ reduced claimant's permanent disability award to zero.[1]

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[1] Because Drs. Walsh and Carlson, the attending physicians, concurred with the evaluations of Drs. McNeill and Duff, the evaluations of Drs. McNeill and Duff can be used to rate impairment. *Tektronix Inc., v. Watson*, 132 Or App 483, 486 (1995).

Claimant contends that Dr. Ho's medical arbiter report persuasively establishes that she has ratable impairment attributable to the accepted condition. Consequently, claimant argues that Dr. Ho's evaluation establishes her entitlement to a 30 percent unscheduled permanent disability award. We disagree.

Claimant's disability is determined as of the date of the Order on Reconsideration. ORS 656.283(7). Impairment is established by a preponderance of medical evidence based upon objective findings. ORS 656.726(3)(f)(B). 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(14) (WCD Admin Order No. 98-055). Where a preponderance establishes a different level of impairment, the impairment is established by the preponderance of evidence. (*Id.*)

Here, the medical arbiter, Dr. Ho, found that claimant had restricted ranges of motion in her left shoulder, noted that his findings were valid, and opined that the findings were attributable to the accepted condition. (Ex. 43). He further opined that as a result of the accepted condition, claimant's lifting was restricted to 15 pounds on an occasional basis. (Ex. 43). For reasons explained below, we are persuaded that the medical evidence establishes that Dr. Ho's evaluation should not be used to rate claimant's impairment.

In August 1999, attending physician Walsh indicated there was a question about "whether or not [claimant] has adhesive capsulitis or not." (Ex. 22-1). He recommended an arthrogram "to settle the issue." (Id.) The arthrogram was performed on September 28, 1999, and showed "no rotator cuff tear or evidence of adhesive capsulitis."[2] (Ex. 24). Two days later Dr. Walsh indicated that neither the MRI nor the arthrogram "evidence" either a rotator cuff tear or adhesive capsulitis. (Ex. 25).

On October 25, 1999, claimant was examined, at the insurer's request, by Dr. McNeill. As a part of that examination, Dr. McNeill reviewed the medical records, including the aforementioned MRI and arthrogram. (Ex. 26-4,5). As a result of his examination and the medical record review, Dr. McNeill opined that: (1) claimant did not have range of motion findings valid for the purpose of rating impairment; and (2) claimant had "left shoulder pain of undetermined etiology with non-anatomic sensory findings of the left hand" suggesting "a functional component and possibly even malingering." (Ex. 25-7,8). Claimant's attending physicians, Dr. Carlson and Dr. Walsh, concurred with Dr. McNeill. (Exs. 27; 28).

On December 21, 1999, claimant was examined, at the insurer's request, by Dr. Duff. After a review of the records and an examination, Dr. Duff diagnosed "chronic myofascial pain of left shoulder girdle with some nonanatomic sensory abnormalities of the left upper extremity, moderate functional overlay suspected." (Ex. 35-4). He also opined that "nothing by way of physical exam or diagnostic studies that have been accomplished is confirmatory of a specific pathology that would support these complaints." (Ex. 35-6). Claimant's attending physicians, Walsh and Carlson, concurred with Dr. Duff's evaluation. (Ex. 39, 40).

As a part of his medical arbiter's examination, Dr. Ho reviewed the above-listed medical records. (Ex. 43-1). Nonetheless, without any explanation, he opined that claimant's impairment was "because of adhesive capsulitis at the left shoulder." (Ex. 43-1). In light of the aforementioned medical records indicating that claimant has no evidence of adhesive capsulitis, we find Dr. Ho's unexplained opinion merely an unsupported conclusion, and as such, unpersuasive. *Moe v. Ceiling Systems, Inc.*, 44 Or App 429 (1980). Consequently, we agree with the ALJ that claimant's impairment is not attributable to the accepted condition.

ORDER

The ALJ's order dated June 30, 2000 is affirmed.

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[2] An athrogram interpretation by Drs. Pearson and Stoehr, radiologists. (Ex. 24).

In the Matter of the Compensation of
JEREMY J. HAWKINS, Claimant
WCB Case No. 00-02102
ORDER ON REVIEW
Christopher A. Slater, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Menashe's order that: (1) concluded that claimant's injury claim for myoclonus and dystonia conditions was not barred by claim preclusion; (2) set aside its denial of those conditions; and (3) awarded an attorney fee of $10,500 for services at hearing. On review, the issues are claim preclusion, compensability and attorney fees. We affirm.

FINDINGS OF FACT

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

On June 3, 1997, claimant suffered an electrocution injury while trimming trees for the employer. Claimant sought medical treatment and Dr. Cole filed a form 827 claim for electrical shock. On June 10, 1997, claimant sought treatment for discomfort in his left upper anterior chest. He was diagnosed with a left pectoral muscle strain. SAIF issued a June 19, 1997 denial of a circulatory system condition on the stated grounds that there was no diagnosable condition from his work exposure due to an electrical shock. Claimant did not appeal the denial and it became final by operation of law. (Exs. 1 thru 4).

On October 22, 1997, claimant sought treatment for abnormal movements of his head and neck that began about one month earlier, at the time of his marital breakup. (Exs. 5, 6). He was diagnosed with tics of unknown etiology and referred to a neurologist; there is no evidence that a neurologic evaluation was performed. (Ex. 5-6, -8). Claimant was treated for depression. (Exs. 7, 8, 9). In September 1997, he was diagnosed and treated for epileptic seizures. A June 10, 1997 EKG was normal. (Ex. 9-12).

Claimant changed medical providers. On January 21, 1999, Dr. Rozell diagnosed claimant's abnormal movement condition as idiopathic dystonia. (Ex. 10).

On May 25, 1999, claimant's abnormal head movements were evaluated by Dr. Hammarstad, neurologist and movement disorder specialist at Oregon Health Sciences University. Dr. Hammarstad diagnosed myoclonus related to his electrical injury at work. (Ex. 11A).

On January 7, 2000, claimant requested that SAIF accept dystonia and myoclonus as new conditions resulting from the 1997 accident. On January 13, 2000, SAIF responded that the original claim had been denied and not appealed, and that SAIF would not be accepting or denying the new medical conditions claim. Claimant requested a hearing. SAIF moved to dismiss the hearing, asserting that claimant was barred by claim preclusion from litigating the compensability of his new conditions.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's claim for myoclonus and dystonia was not barred by claim preclusion and that SAIF was equitably estopped from making such an argument. On review, SAIF challenges both of these conclusions. Alternatively, SAIF argues that claimant's claims are not compensable and, if they are, that the attorney fee awarded by the ALJ was excessive.

We begin by addressing the scope of SAIF's initial denial. Based on our reading of the denial letter as a whole, we conclude that the denial was of a circulatory system condition only. We base our interpretation on the first and second sentences of the denial, which state:

"You filed a claim for an alleged injury to your circulatory system which you believe occurred on or about June 3, 1997, while you were employed [at the employer]. We have examined the information obtained regarding this claim, and find that there is insufficient information that you have contracted any diagnosable condition from your work exposure [at the employer] due to an electrical shock on June 3, 1997."

This language specifically refers to a claim for, and denial of, a circulatory system condition. When the second sentence is read in the context of the denial letter as a whole, we find that SAIF's intent was to deny a circulatory system condition because claimant had not contracted any "diagnosable condition" as of the date of the denial. Although SAIF cites to extrinsic evidence to support a broader interpretation of its denial, it is bound by the express language of its denial. *See Tattoo v. Barrett Business Service*, 118 Or App 348, 351-52 (1993); *Gregg Muldrow*, 49 Van Natta 1866, 1867 (1997).

Moreover, to the extent that the June 19, 1997 denial letter could be interpreted to deny "any diagnosable condition" (aside from a circulatory system condition), we find that claimant did not seek treatment or make a claim for his current myoclonus or dystonia conditions prior to issuance of the denial. In contrast, the record shows that claimant first sought treatment for his current myoclonus/dystonia condition on September 12, 1997. (Ex. 9). The diagnosis of dystonia was not made until December 1998, and the diagnosis of myoclonus until May 25, 1999. (Exs. 10-1, 11A).

The doctrine of claim preclusion applies in workers' compensation cases when there is an opportunity to litigate an issue before a final determination and the party against whom the doctrine could be applied fails to litigate the issue. *Drews v. EBI Companies*, 310 Or 134, 140, 142 (1990). Claimant's January 2000 claims for myoclonus and dystonia were initial claims for compensation related to a June 3, 1997 injury, not "new medical condition" claims under ORS 656.262(7)(a) (or "omitted" conditions under ORS 656.262(6)(d)), as there was no accepted initial claim. *See Eugene J. Senger*, 52 Van Natta 1324 (2000); *compare Olive M. Bonham*, 51 Van Natta 1710 (1999) (ORS 656.262(7)(a), which allowed the claimant to "initiate a mew medical condition claim at any time" created an exception to claim preclusion); *Wallace M. Prince*, 52 Van Natta 45 (2000) (claim preclusion does not apply to claim under ORS 656.262(6)(d)). Nevertheless, SAIF's June 19, 1997 denial became final for the purposes of claim preclusion when claimant did not timely request a hearing. *See* ORS 656.319; *Popoff v. Newberrys*, 117 Or App 242, 244 (1992) (the claimant's failure to request a hearing on the denial barred her from asserting later claims for medical services for the same condition).

SAIF did not deny compensability of claimant's myoclonus or dystonia conditions in the June 19, 1997 denial. "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). However, "[a]lthough a claimant may be barred from presenting new evidence relating to the same condition, he may renew a request for medical services if his condition has changed and the request is supported by new facts that could not have been presented earlier." *Liberty Northwest Ins. Corp. v. Bird*, 99 Or App 560, 564 (1989), *rev den* 309 Or 645 (1990); *see also Liberty Northwest Ins. Corp. v. Rector*, 11 Or App 693 (1997) (claim was not precluded because the claimant's condition had changed).

Because claimant's current dystonia and myoclonus conditions arose after the 1997 denial, and were not the subject of the denial, this proceeding does not concern the same factual transaction. Consequently, claim preclusion does not apply. *See Drews v. EBI Companies*, 310 Or at 140.

Accordingly, we agree with the ALJ that claimant is not precluded by the June 19, 1997 denial from litigating the compensability of his current dystonia and myoclonus conditions.[1]

Compensability

We adopt and affirm the ALJ's opinion on this issue.

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[1] Because we have concluded that claimant's current nyoclonus condition claim was not barred by claim preclusion, we need not address SAIF's challenge to the ALJ's application of an equitable estoppel analysis to the denial.

Attorney Fees

The ALJ awarded a $10,500 assessed attorney fee to claimant's counsel for services at hearing for prevailing over the employer's denial of claimant's injury claim for a myoclonus condition. On review, SAIF contests the amount of the attorney fee, arguing that it is excessive and should be reduced to $4,500 to $5,000.

After *de novo* review of the attorney fee issue, and considering the specific contentions raised on review in light of the factors set forth in OAR 438-015-0010(4), we adopt and affirm the ALJ's reasoning and conclusions on this issue. *See Schoch v. Leupold & Stevens*, 162 Or App 242 (1999) (Board must explain the reasons why the factors considered lead to the conclusion that a specific fee is reasonable). In reaching this conclusion, we have particularly considered the time devoted to the issue, the complexity of the issue, the value of the interest involved, the nature of the proceedings (two hearings convened by the ALJ, one telephonic hearing, and written arguments on the preclusion issue), and the risk that claimant's counsel might go uncompensated.

In addition, claimant's attorney is entitled to an assessed fee for services on review relating to the preclusion and compensability issues. 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 these issues is $3,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief and claimant's attorney's fee request), the complexity of the issue, and the value of the interest involved. Claimant's attorney is not entitled to a fee for services related to the attorney fee issue.[2] *Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986).

ORDER

The ALJ's order dated January 9, 2000 is affirmed. For services on review, claimant's attorney is awarded $3,000, payable by the SAIF Corporation.

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[2] Claimant's attorney attested to spending a total of 14 hours, including 11.5 hours preparing his respondent's brief, and requested a fee of $4,200 for this work. However, the respondent's brief included several arguments regarding the attorney fee issue. As noted above, claimant's attorney is not entitled to a fee for services related to the attorney fee issue. Based on the above reasoning, we find that a reasonable attorney fee for services on review regarding the preclusion and compensability issues is $3,000.

In the Matter of the Compensation of
TIMOTHY TROUPE, Claimant
WCB Case No. 0001864
INTERIM ORDER OF DISMISSAL
Ernest M. Jenks, Claimant Attorney
Bostwick, et al, Defense Attorney

The claimant requested, and the self-insured employer cross-requested, review of Administrative Law Judge (ALJ) Thye's March 12, 2001 order. The employer has withdrawn its cross-request for review. Consequently, the employer's cross-request for review is dismissed.

However, inasmuch as the claimant has not withdrawn his request for review, we retain jurisdiction over this case. Consequently, this order shall be interim and eventually will be incorporated into a final appealable order. The briefing schedule will continue as previously implemented.

IT IS SO ORDERED.

In the Matter of the Compensation of
CINDA L. BARNES, Claimant
WCB Case No. 00-06737
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

The insurer requests review of Administrative Law Judge (ALJ) Mongrain's order that determined that claimant's bilateral foot claim was prematurely closed. On review, the issue is premature claim closure.

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

The ALJ determined that the claim was prematurely closed because claimant's foot condition was not medically stationary at the time of the April 24, 2000 claim closure and because there was not "sufficient information" to determine permanent impairment. *See* ORS 656.268(1)(a).

On review, the insurer contends that the ALJ mistakenly inferred from the attending physician's (Dr. Cronin's) chart notes that claimant was not medically stationary. The insurer argues that the record did not establish a reasonable expectation of material improvement in claimant's foot condition when the claim was closed. *See* ORS 656.005(17). Claimant disagrees with the insurer's contention, but responds that, even if the insurer is correct, the closure was still improper because there was insufficient information to close the claim. For the following reasons, we agree with claimant.

ORS 656.268(1)(a) provides that an insurer shall close the worker's claim, as prescribed by the Director, and determine the extent of the worker's permanent disability, provided the worker is not enrolled and actively engaged in training, when the worker has become medically stationary and there is "sufficient information" to determine permanent impairment. The Department has promulgated OAR 436-030-0020(3), (4) and (6), which defines "sufficient information" upon which to close a claim as including the information required by OAR 436-030-0015(2) and (4) and OAR 436-010-0280 and OAR 436-035-0001 *et seq*, the Disability Rating Standards.

In *Gloria Garibay*, 52 Van Natta 2252 (2000), we held that the carrier had "sufficient information" to determine permanent impairment when it closed a claim. Although a physician's closing report did not contain range of motion findings, we concluded in *Garibay* that, after reviewing the report as a whole, it provided sufficient information to determine permanent impairment. *See also Stephanie A. Dys-Dodson*, 53 Van Natta 207 (2001) (applying *Garibay*).

Here, claimant was not engaged in training at the time of claim closure. However, unlike *Garibay*, we find that there was not sufficient information to determine permanent impairment when the claim was closed.

On January 13, 2000, the last time claimant received treatment prior to claim closure, Dr. Cronin examined claimant's feet and noted that there was no tenderness over the right medial calcaneus and that claimant had mild to moderate tenderness over the left medial calcaneus. According to Dr. Cronin, the rest of the examination was unremarkable. (Ex. 17).

After the insurer received the January 13, 2000 chart note, it forwarded a series of questions concerning claimant's permanent impairment to Dr. Cronin. (Ex. 19). Dr. Cronin responded that most did not apply to the accepted plantar fasciitis condition, but that, of the three that did, two were confusing and unclear. (Ex. 21). Thus, Dr. Cronin was unable to respond to them. Without further clarifying the questions, the insurer closed the claim. (Ex. 24).

Having reviewed the relevant medical records, we are persuaded that there was not sufficient information to close the claim in light of Dr. Cronin's inability to fully respond to the insurer's request for information on permanent impairment.[1] Therefore, even if claimant's foot condition was medically

[1] It appears that the questions to which Dr. Cronin was unable to respond concerned the presence, if any, of a "chronic" condition and whether claimant had limitations on her ability to walk or stand for greater than two hours in an eight hour period. (Ex. 19-2). Both questions, therefore, concerned important aspects of rating claimant's permanent impairment.

stationary at the time of claim closure, the closure was not proper under ORS 656.268(1)(a), which requires that the claimant's condition be medically stationary *and* that there be "sufficient information" to determine permanent impairment. Accordingly, we conclude that the ALJ properly determined that the claim closure was premature.[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 regarding the premature claim closure issue 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 22, 2001, as amended on January 25, 2001, is affirmed. For services on review, claimant's attorney fee is awarded an assessed fee of $1,000, to be paid by the insurer.

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[2] The insurer, nevertheless, contends that the closure was administratively proper under OAR 436-030-0034, because the record contains no response to its March 28, 2000 letter to claimant. That letter advised claimant that, because she had not received medical treatment in excess of 30 days, she or her physician must respond to the letter within two weeks of the date of the letter or the insurer would assume that she had fully recovered without disability and actions would be taken to close the claim based on the failure to seek treatment. (Ex. 22). However, claimant's unrebutted affidavit adequately explains why she did not receive medical treatment during this period. (Ex. 26A). Accordingly, we conclude that claimant affirmatively established that her failure to seek treatment was attributable to reasons beyond her control. *See* ORS 656.268(1)(c). Thus, we conclude that the claim closure was not administratively proper.

In the Matter of the Compensation of
LINDA J. LUCAS, Claimant
WCB Case No. 00-06214
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order that: (1) found that the Hearings Division had jurisdiction over claimant's medical services claims; and (2) awarded an assessed attorney fee for services at hearing. On review, the issues are jurisdiction and attorney fees. We vacate.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, which we supplement and summarize as follows. We do not adopt the ALJ's ultimate findings of fact.

Claimant compensably injured her back, knees and wrist in August 1993. (Ex. 3). The insurer accepted "lumbar strain/mild strain left trapezius." (Ex. 9). Claimant also sought treatment for bilateral wrist complaints. The parties entered into a stipulation in which the insurer accepted "lumbar strain/mild strain left trapezius" and "left carpal tunnel syndrome and right wrist contusion." (Ex. 18). Claimant injured herself again in August 1994 while working for the same employer. (Exs. 1A, 13). The insurer accepted claimant's 1994 claim as "right ankle/knee strain, right sacrum and lower back strain." (Ex. 1B).

On August 28, 1996, Dr. Muller diagnosed fibromyalgia. (Ex. 32).

In 1997, pursuant to a Claim Disposition Agreement (CDA), claimant released all of her benefits, except medical services, for her 1993 claim. (Ex. 34).

In May 1997, Dr. Krohn diagnosed claimant with fibromyalgia. (Ex. 35).

On May 26, 2000, Dr. Muller diagnosed claimant's current condition as sciatica, fibromyalgia, and a rash. Dr. Muller prescribed a hot tub for the fibromyalgia. (Ex. 52). On June 12, 2000, the insurer advised claimant that the expense of a hot tub would not be reimbursed under OAR 436-010-0230(1) and (9). (Ex. 53). On the same date, Dr. Brown evaluated claimant's skin condition, which she diagnosed as neurodermatitis. (Ex. 54B).

On July 24, 2000, claimant was informed that a medical billing for a June 12, 2000 consultation would not be processed, as the "bill is for services which do not appear to be related to the claimed conditions." (Ex. 54). Claimant requested a hearing.

On October 2, 2000, the insurer requested review of the hot tub dispute before the Division's Medical Review Unit (MRU). In an accompanying letter, the insurer stated that the request for a hot tub was inappropriate under OAR 436-010-0230(1) and (9).[1] In that letter, the insurer also stated:

> "It would also appear that the major cause of the worker's need for treatment is related to the condition of fibromyalgia. This condition is not an accepted condition of this claim, as indicated by the NOA dated 10/25/1995 and Claim Disposition Agreement of 2/3/97. It is not determined that causation of the fibromyalgia is the accepted conditions. In addition, a recent MRI of the spine, indicates that [claimant] has developed a synovial cyst at the L4-5 level. This newly developed condition may also be contributing to her current need for treatment as well. Therefore, we do not feel that the purchase of a hot tub is warranted in that the accepted conditions may likely not be the major cause of the current need for treatment and/or the necessity of the use of a hot tub."

Claimant filed a supplemental request for hearing based on the insurer's letter.

The MRU issued a Defer Order deferring the Director's administrative review regarding the appropriateness of the hot tub until the dispute regarding the causal relationship was resolved. The order stated: "After compensability is resolved, the [ALJ] is requested to submit a copy of this order or settlement document to the director (Medical Review Unit). The director will then resume administrative review."

Prior to the hearing, the parties agreed that the issues would be submitted on the basis of the documentary record and written arguments.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted 1993 claim for "lumbar strain/mild strain left trapezius" and "left carpal tunnel syndrome and right wrist contusion" that was the subject of a 1997 CDA. She also has an open 1994 claim for "right ankle/knee strain, right sacrum and lower back strain."

In May 2000, claimant's attending physician, Dr. Muller, prescribed a hot tub for her fibromyalgia. The insurer advised claimant that the expense of a hot tub would not be reimbursed because the major cause of her need for treatment was related to the unaccepted condition of fibromyalgia.

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[1] OAR 436-010-0230(1) provides:

"Medical services provided to the injured worker shall not be more than the nature of the compensable injury or the process of recovery requires. Services which are unnecessary or inappropriate according to accepted professional standards are not reimbursable."

OAR 436-010-0230(9) provides:

"Articles including but not limited to beds, hot tubs, chairs, Jacuzzis, and gravity traction devices are not compensable unless a need is clearly justified by a report which establishes that the 'nature of the injury or the process of recovery requires' the item be furnished. The report must specifically set forth why the worker requires an item not usually considered necessary in the great majority of workers with similar impairments. Trips to spas, to resorts or retreats, whether prescribed or in association with a holistic medicine regimen, are not reimbursable unless special medical circumstances are shown to exist."

In June 2000, claimant sought treatment for neurodermatitis. The insurer declined to process the medical bill, as the "bill is for services which do not appear to be related to the claimed conditions." Claimant requested a hearing on each alleged "denial" of medical services. At hearing, the insurer argued that the ALJ lacked jurisdiction to decide the matter because claimant did not request formal acceptance of the "new medical conditions."

The ALJ determined that the Hearings Division had jurisdiction over the medical services disputes, despite claimant's failure to request formal acceptance of a "new medical condition " under ORS 656.262(7)(a). The ALJ reasoned that claimant's request for hearing had raised a matter concerning a claim, and that the Hearings Division had jurisdiction under ORS 656.283(1) and 656.704(3)(b)(A). The ALJ found that claimant's fibromyalgia and neurodermatitis condition were compensably related to her 1993 claim and set aside the insurer's denial of medical services for those conditions. The ALJ also awarded an assessed attorney fee of $1,750 for services with respect to the compensability issues.

On review, the insurer argues that the ALJ did not have jurisdiction to consider the compensability of claimant's unaccepted conditions absent either an express denial of those conditions or a formal written request that such new medical conditions be accepted, as provided by ORS 656.262(7)(a). The insurer also argues that the ALJ erred in awarding an attorney fee in a claim where all issues except medical services were fully disposed of by a CDA.[2]

We agree that the ALJ had the authority under ORS 656.704(3) and ORS 656.708 to determine compensability of the medical condition for which medical services are proposed. *See SAIF v. Roles*, 111 Or App 597 (1992) (subject matter jurisdiction depends solely upon whether a decision-making body has the authority to make an inquiry and exists when a statute authorizes that body to do something about the dispute; an ALJ's erroneous exercise of that authority did not deprive him of subject matter jurisdiction); *see also Vicki L. Mangum*, 52 Van Natta 1006 (2000) (Board has "jurisdiction" over "causation" portion of medical service dispute). Nevertheless, the insurer contends that compensability of those conditions could not be litigated before the ALJ due to the procedural defect regarding claim filing. We agree.

Although a CDA issued in relation to the 1993 claim, that CDA does not resolve the compensability for future conditions. *John L. Montgomery*, 52 Van Natta 1318, *on recon* 52 Van Natta 1687 (2000) (the claimant was not barred from arguing that his condition was compensably related to an earlier claim that was the subject of a CDA in order to establish a right to future medical services for a new medical condition). Moreover, because the record establishes that neither the fibromalgia nor neurodermatitis conditions were identified or diagnosed before the initial claims were accepted, those claims were "new medical condition" claims under ORS 656.262(7)(a). *See William B. Barrett*, 51 Van Natta 286, 287 (1999); *Mark A. Baker*, 50 Van Natta 2333, 2337 (1998). Specifically, claimant argues that her fibromyalgia and neurodermatitis were consequential conditions related to her 1993 injury claim. Thus, to the extent that claimant is asserting a "new medical condition" claim for a consequential condition, the Hearings Division would have jurisdiction over such a compensability dispute.

However, we find no evidence that claimant has made "new medical condition" claims for these conditions, and the insurer has raised a procedural challenge to the propriety of the compensability proceeding.

ORS 656.262(7)(a) sets forth very specific requirements for making a new medical condition claim.[3] A claimant is obligated to "clearly request formal written acceptance" of the claimed new

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[2] The insurer does not challenge the ALJ's finding of compensability on the merits.

[3] ORS 656.262(7)(a) provides:

"After claim acceptance, written notice of acceptance or denial of claims for aggravation or new medical conditions shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the insurer or self-insured employer receives written notice of such claims. New medical condition claims must clearly request formal written acceptance of the condition and 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. The worker must clearly request formal written acceptance of any new medical condition from the insurer or self-insured employer. * * * Notwithstanding any other provision in this chapter, the worker may initiate a new medical condition claim at any time."

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. Because claimant failed to satisfy the statutory requirements for asserting a new medical condition claim, any hearing request would be premature. *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) (a hearing request concerning an unaccepted condition was premature where a "new medical condition" claim had not been filed with the carrier prior to the filing of the hearing request and the carrier had challenged the propriety of the compensability proceeding).

Thus, in the absence of a clear, formal written request from claimant for the acceptance of her fibromyalgia and neurodermatitis conditions as new medical conditions, the insurer has no further processing obligations under ORS 656. 262(7)(c), and, considering the insurer's procedural challenge to the claim, the ALJ (and the Board) lack statutory authority under ORS 656.262(7)(a) to address the compensability of claimant's "new medical condition" claims.

In sum, although the Hearings Division and the Board have "jurisdiction" over the "causation" portion of the medical service dispute, that jurisdiction does not attach where the basis for the "claim" is an unclaimed, unaccepted, new medical condition and the carrier asserts that proceeding with litigation is procedurally invalid.[4]

Because we currently lack statutory authority to address the compensability issue, we need not address the insurer's attorney fee argument.

ORDER

The ALJ's order dated January 19, 2001 is vacated. Claimant's hearing requests are dismissed.

[4] Had the insurer not objected to the procedural validity of a "new medical condition" claim, we could have addressed the issue. *Hill*, 48 Van Natta at 2353 n.1.

In the Matter of the Compensation of
TRACEY A. BLAMIRES, Claimant
WCB Case Nos. 98-04194 & 98-02326
ORDER ON REMAND
Bottini, Bottini, et al, Claimant Attorney
Wallace, Klor, et al, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *Blamires v. Clean Pak Systems, Inc.*, 171 Or App 263 (2000). The court has reversed our prior orders, *Tracey A. Blamires*, 50 Van Natta 2275 (1998), that upheld the insurer's partial denials of claimant's "combined" condition. *Citing Croman Corp. v. Serrano*, 163 Or App 136 (1999), the court concluded that, under the wording of ORS 656.262(6)(c), the acceptance of a combined condition must precede the denial of a combined condition. Determining that we did not make any finding about whether the insurer's denial of a combined condition was preceded by an acceptance of a combined condition, the court has remanded for reconsideration.[1]

In our prior order, we consolidated claimant's two cases, WCB Case No. 98-02326 and WCB Case No. 98-04194 because we found that the issues were inextricably intertwined. On remand, we address each denial and case separately.

WCB Case No. 98-02326

Claimant was compensably injured in October 1997. Claimant's treating doctor, Dr. Brett, ordered an MRI that showed preexisting degenerative disc disease at L4-5 and L5-S1. On January 5, 1998, the insurer accepted claimant's claim as disabling cervical and lumbar strains.

[1] While conducting our reconsideration, we received claimant's request for supplemental briefing. Under such circumstances, and because we find the record and the parties' arguments sufficiently developed to resolve the disputed issues, we have proceeded with our reconsideration without entertaining supplemental briefing.

Thereafter, an insurer-arranged medical examiner reported that claimant's compensable lumbar injury combined with his preexisting degenerative condition to cause his disability and need for treatment. Following that report, on March 17, 1998, the insurer issued an updated notice of claim acceptance indicating that it had accepted cervical and lumbar strains. That same day, the insurer issued a "combined condition" denial. The insurer then closed the claim pursuant to a March 17, 1998 Notice of Closure.

Following a hearing concerning the insurer's March 17, 1998 partial denial, ALJ Tenenbaum issued an Opinion and Order that set aside the denial as procedurally improper. The insurer appealed and, on Board review, we reversed, finding that the insurer's preclosure denial was permissible because claimant's accepted injury combined with a preexisting condition to cause or prolong disability or a need for treatment on an open claim. Because claimant did not establish the compensability of his current conditions, we reinstated and upheld the insurer's denial.

Following claimant's appeal to the Court of Appeals, the court reversed and held that, under ORS 656.262(6)(c), the acceptance of a combined condition must precede the denial of a combined condition. Because our prior order made no finding about whether the insurer had accepted a combined condition, the court remanded.

On remand, after reviewing the record, we conclude that the insurer accepted only "cervical and lumbar" strains. (Ex. 20). In other words, there is no evidence that the insurer accepted claimant's "combined condition." Moreover, the insurer's denial was issued pursuant to ORS 656.262(6)(c) and (7)(b). Accordingly, pursuant to the court's holding, because there was no acceptance of a combined condition prior to the insurer's denial of claimant's combined condition under ORS 656.262(6)(c) and (7)(b), the denial was premature under *Croman Corp. v. Serrano*, 163 Or App at 141.

Because the insurer's March 17, 1998 denial was premature, it must be set aside. Therefore, on remand, we affirm the ALJ's order in WCB Case No. 98-02326.

WCB Case No. 98-04194

In the above-captioned case, the insurer issued a March 18, 1998 Notice of Closure. Thereafter, the ALJ's order in WCB Case No. 98-02326 issued, setting aside the insurer's "pre-closure" denial. On May 21, 1998, the Notice of Closure was rescinded by an Order on Reconsideration. On May 22, 1998, the insurer issued a second denial of claimant's "combined" condition. On May 26, 1998, the insurer accepted claimant's combined condition. On May 28, 1998, the claim was closed by Notice of Closure.

Claimant requested a hearing and contested the insurer's May 22, 1998 denial. At a hearing before ALJ Hoguet, claimant challenged the denial on both procedural and substantive grounds. The ALJ did not address the propriety of the denial, finding that claimant could not prevail on the merits of his claim. Claimant appealed to the Board.

On Board review, we found that the denial was procedurally valid and affirmed the ALJ's order upholding the insurer's denial. Claimant appealed and the court reversed and remanded to us to consider whether claimant's combined condition had been accepted prior to the denial.

On reconsideration, we find that there was no pre-denial acceptance of the combined condition prior to the insurer's second (May 22, 1998) denial.[2] Consistent with the insurer's first denial, the second denial was also issued pursuant to ORS 656.262(6)(c) and ORS 656.262(7)(b). Under the circumstances, we conclude that, because there was no acceptance of a combined condition prior to the second denial of claimant's combined condition under ORS 656.262(6)(c) and (7)(b), the denial was premature under *Croman Corp. v. Serrano*, 163 Or App at 141.

Consequently, we set aside the insurer's May 22, 1998 denial. On remand, we reverse the ALJ's order in WCB Case No. 98-04194. The insurer's denial is set aside and the claim is remanded to the insurer for further processing in accordance with law.

IT IS SO ORDERED.

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[2] Although the insurer accepted claimant's combined condition prior to claim closure, it nevertheless accepted such a condition after the denial.

In the Matter of the Compensation of
PENNY G. ELLIOTT, Claimant
WCB Case No. 00-02087
ORDER ON REVIEW
Kryger, et al, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Fitzwater's order that awarded claimant temporary total disability (TTD) benefits for the period from February 3, 2000 to April 3, 2000. On review, the issue is entitlement to TTD benefits. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following correction, supplementation, and summary. The ALJ's references to "Dr. Dutton" in the second paragraph of the findings of fact are changed as follows. The first reference should be to Dr. Ohling, and the second reference should be to Dr. McNabb. (Exs. 9, 11). The first sentence in the third paragraph of the findings of fact should begin with the date "January 20, 2000." (Exs. 16, 17).

On September 27, 1999, claimant injured her low back while working for the employer as an in-home care companion. SAIF accepted a lumbar strain. Shortly after her injury, claimant was released to modified work. (Exs. 2, 2A). Because modified work was not available with her employer, claimant did not return to work.

Subsequently, Dr. McNabb, M.D., became claimant's attending physician. After a period of total disability, Dr. McNabb released claimant to modified work and approved a modified job description for work at another employer (S&J Thrift Center [Thrift Center]) on January 26, 2000. (Ex. 18). SAIF notified claimant that she was to report for work at the Thrift Center on February 1, 2000. (Ex. 19).

Claimant worked at the Thrift Center on February 1, and February 2, 2000. Thereafter, she did not call in or report to work. Dr. McNabb continued to release claimant to this modified work. (Ex. 23).

On February 10, 2000, the employer notified claimant that she was considered a "voluntary quit" because she failed to conform to the employer's "no call - no show" policy. (Ex. 22).

On April 4, 2000, claimant began working for another employer. Claimant's light duty restrictions were continued until shortly before the hearing.

CONCLUSIONS OF LAW AND OPINION

The question at hearing and on review is whether the job at the Thrift Center qualifies as "modified employment" under ORS 656.268(4)[1] so as to permit SAIF to terminate TTD benefits. The

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[1] ORS 656.268(4) provides:

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

"(a) The worker returns to regular or modified employment;

"(b) The attending physician advises the worker and documents in writing that the worker is released to return to regular employment;

"(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; or

"(d) Any other event that causes temporary disability benefits to be lawfully suspended, withheld or terminated under ORS 656.262(4) or other provisions of this chapter."

ALJ interpreted the term "return" in this statute to mean that the worker "comes back" to the same place of employment. Thus, the ALJ concluded that ORS 656.268(4)(a) applies only when the worker returns to regular or modified employment *at the time of injury*. Under this reasoning, because the work at the Thrift Center was not claimant's regular or modified employment at the time of injury, the ALJ found that it did not qualify as a "return to * * * modified employment" under ORS 656.268(4)(a). Therefore, the ALJ found that SAIF's termination of TTD benefits was invalid and awarded TTD benefits for the period from February 3, 2000 through April 3, 2000.

On review, SAIF argues that claimant is not entitled to TTD benefits during this period because claimant returned to "modified employment" pursuant to ORS 656.268(4)(a) when she began modified employment at the Thrift Center. Thus, SAIF argues, it correctly terminated claimant's TTD benefits when she began this modified employment. Based on the following reasoning, we agree with SAIF's argument.

Subsequent to the ALJ's order, we decided *Ted Brenner, Jr.*, 53 Van Natta 257 (2001). In *Brenner*, the claimant was compensably injured while working as a truck driver for a welding supply company. During two separate periods when the claimant was only partially disabled, his attending physician released him for modified employment and the employer offered physician-approved modified work for employers other than his at-injury employer.[2] The claimant declined both offers. Based on ORS 656.268(4)(c), the carrier stopped paying TTD and began paying temporary partial disability (TPD) at the rate of zero during the periods that claimant declined physician-approved modified work. An ALJ affirmed this TPD rate and the claimant requested review.

On review, we analyzed the text and context of ORS 656.268(4)(c) and concluded that it did not necessarily require that claimant "return to modified work" for the employer at injury. In addition, we found that the cases relied on by the claimant, *Christine M. Mulder*, 50 Van Natta 521 (1998), and *Douglas B. Organ*, 49 Van Natta 198 (1997), did not require a different result.

In *Brenner*, the question was whether attending physician-approved modified work with another employer constituted a release to "return to modified employment" under ORS 656.268(4)(c) such that refusal of such employment would permit the termination of TTD benefits under that statute. Here, the question is slightly different in that claimant actually began the modified employment with another employer. Therefore, the question here is whether beginning such modified employment permits termination of TTD benefits under ORS 656.268(4)(a). However, this difference is without effect. The analysis of text and context of ORS 656.268(4)(c) applies equally to ORS 656.268(4)(a). Thus, based on our reasoning in *Brenner*, we find that the term "returns to * * * modified employment" in ORS 656.268(4)(a) does *not* require a return to modified employment with the at-injury employer.

Here, as did the claimant in *Brenner*, claimant argues that *Mulder* and *Organ* do not support a conclusion that "modified employment" includes employment with employers other than the employer at injury. As explained below, we continue to reject that argument.

In *Organ*, we found that the claimant's light duty position at a skills-center training site was not sufficiently related to the claimant's employment as a construction carpenter to constitute "modified employment." The specific issue the ALJ determined at hearing was whether the claimant's participation at the job skills center was "modified employment" within the meaning of *former* ORS 656.268(3)(c) (since renumbered to 656.268(4)(c)). The ALJ determined that it was not. The ALJ reasoned that, pursuant to ORS 656.005(30), claimant was not a "worker" at the skills center because he provided no services in exchange for the employer's remuneration. While acknowledging that a claimant generally would be considered at "work" if he or she was participating in an employer sponsored or paid training program, the ALJ refused to consider the skills-center program to be such a program because the training provided had nothing to do with the claimant's job and was at too basic a level to be considered "training." We agreed with the ALJ's reasoning. *Organ*, 49 Van Natta at 1999.

In contrast to *Organ*, where the record did not establish that the modified work significantly benefited the employer, in *Mulder*, we found that a light duty research position was of assistance to the employer's marketing of the bronze sculptures it produced. Thus, we concluded that the modified job in *Mulder* was legitimate. 50 Van Natta at 522.

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[2] One of these modified work offers was with S&J Thrift Center, the same alternative work site as in the present case.

As was true in *Mulder*, *Organ* is distinguishable from this case. In *Organ*, the claimant's alleged modified work consisted of a training program. In contrast, here, claimant's modified work at the Thrift Center was not part of a training program, but rather consisted of actual work as a customer service associate, which included greeting customers, testing electronic items, operating a cash register, and watching for shoplifters.[3] (Ex. 18, Tr. 65, 70-71). In addition, vocational evidence was admitted into evidence that indicated that the modified work offered claimant was legitimate employment. (Ex. 28-3-4, Tr. 87-88).

Moreover, like the employer in *Mulder*, and unlike the employer in *Organ*, which conceded that it received little, if any, benefit from the claimant's "work" in that case, the at-injury employer here received some benefit from claimant's modified employment in terms of increased community good will and the reduction of workers' compensation premiums. (Tr. 40, 44, 45). Furthermore, the employer testified that modified work, such as that begun by claimant in this case, assists the employer in getting the injured back to regular work, noting that it was costly to lose experienced workers and train new workers. (Tr. 40, 41, 42, 44).

Under these circumstances, we conclude that the modified work began by claimant at the alternative work site was appropriate "modified employment" pursuant to ORS 656.268(4)(a). Therefore, we affirm SAIF's termination of claimant's TTD benefits. ORS 656.268(4)(a).

ORDER

The ALJ's order is reversed in part and affirmed in part. That portion of the order that awarded temporary total disability benefits for the period from February 3, 2000 to April 3, 2000 is reversed. The ALJ's "out-of-compensation" attorney fee award is adjusted accordingly. The remainder of the order is affirmed.

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[3] Claimant's attorney conceded the assignment at the Thrift Center constituted work and was not a training program. (Tr. 65, 70-71).

Board Member Biehl specially concurring.

Although bound by the principles of *stare decisis*, I refer the parties to my dissent in *Ted Brenner, Jr.*, 53 Van Natta 257 (2001). In accordance with the reasoning in my dissent in *Brenner*, I would, on a clean slate, construe the term "return" in ORS 656.268(4) to mean that an injured worker must be returned to her employment *at injury* before ORS 656.268(4) applies to allow modification of temporary total disability benefits.

In addition, on a clean slate, I would find that the alternative "modified work" offered here was not a legitimate offer. In this regard, as in *Brenner*, the "modified employment" offered claimant provided no more than minimal benefit to the at-injury employer and provided claimant with no job skills relevant to her regular job. Under these circumstances, as addressed in my dissent in *Brenner*, I would find *Douglas B. Organ*, 49 Van Natta 198 (1997), controlling and conclude that the "modified employment" offered claimant did not constitute a legitimate offer. Thus, were it not for the Board's decision in *Brenner*, I would conclude that the terms of ORS 656.268(4) do not apply to the facts of this case and award claimant temporary total disability benefits for the period in question.

In the Matter of the Compensation of
MICHAEL L. SKIDMORE, Claimant
WCB Case No. 99-05861
ORDER ON REVIEW
Mitchell & Gunn, Claimant Attorney
Hitt, et al, Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that upheld the self-insured employer's denials of his claim for spondylolisthesis at L4-5 with articular defect. On review, the issue is compensability.

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

We write only to address claimant's argument pertaining to ORS 656.273. Claimant contends that the opinions of Drs. Gritzka and Zelaya establish that his spondylolisthesis is a worsened condition resulting from the November 1994 injury.

Although claimant filed an aggravation claim (Ex. 26), he did not pursue an aggravation claim at hearing and the ALJ did not address that issue. Instead, claimant's attorney framed the issue at hearing as compensability of spondylolisthesis at L4-5 with articular defect. (Tr. 1). Under these circumstances, it appears that claimant did not pursue an aggravation claim.

In any event, we are not persuaded by claimant's argument. ORS 656.273(1) provides that a worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition. *SAIF v. Walker*, 330 Or 102 (2000). In *Gloria T. Olson*, 47 Van Natta 2348, 2350 (1995), we held that ORS 656.273(1) requires proof of two specific elements in order to establish a worsened condition: (1) "actual worsening," and (2) a compensable condition. Both elements must be satisfied in order to establish a "worsened condition resulting from the original injury." *Id.* If the allegedly worsened condition is not a compensable condition, compensability must first be established under ORS 656.005(7). *Id.*

As a result of claimant's November 1994 injury, the employer accepted an acute articular sprain at L4-5. (Ex. 7). Thus, to prove an aggravation of his 1994 accepted condition, claimant must establish an actual worsening of the articular sprain at L4-5. The medical record, however, does not establish that the accepted articular sprain has worsened. Instead, we agree with the ALJ that claimant's current low back condition is diagnosed primarily as spondylolisthesis at L4-5, which is not an accepted condition. Therefore, in order to establish a worsened condition resulting from the original injury, claimant must first establish that the spondylolisthesis at L4-5 is compensable. For the reasons expressed by the ALJ, we conclude that the medical evidence is insufficient to establish compensability of claimant's spondylolisthesis at L4-5. Claimant has failed to establish an "actual worsening" of his accepted condition.

ORDER

The ALJ's order dated December 8, 2000 is affirmed.

In the Matter of the Compensation of
PETER VOORHIES, Claimant
Own Motion No. 97-0530M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Sheridan, Bronstein, et al, Defense Attorney

Claimant requested review of the insurer's September 13, 2000 Notice of Closure which closed his claim with an award of temporary disability compensation from January 7, 1997 through July 18, 2000. The insurer declared claimant medically stationary as of July 18, 2000. Claimant requested review of the closure as well as "the amounts paid and of the penalties for late payment." We affirm the Notice of Closure.

FINDINGS OF FACT

On January 23, 1982, claimant sustained multiple injuries to his left leg in a compensable motor vehicle accident. His aggravation rights on that claim expired on September 15, 1993.

On January 7, 1997, claimant underwent surgery for his left hip condition. The insurer voluntarily reopened the claim. On November 18, 1997, we authorized the reopening of claimant's claim to provide temporary disability benefits beginning January 7, 1997, the date of surgery.

On May 14, 1998, the insurer issued a Notice of Closure that closed the claim with an award of temporary disability compensation from January 7, 1997 through March 25, 1998. The insurer declared claimant medically stationary as of March 25, 1998. Claimant requested review of that closure. On October 15, 1998, we set aside the insurer's May 14, 1998 Notice of Closure and directed it to recommence payment of temporary disability benefits. *Peter Voorhies*, 50 Van Natta 2051 (1998).

On July 18, 2000, claimant attended an insurer-arranged medical examination (IME). The IME physician declared claimant's condition to be medically stationary as of that date.

On September 13, 2000, the insurer issued a Notice of Closure that closed the claim with an award of temporary disability compensation from January 7, 1997 through July 18, 2000. The insurer declared claimant medically stationary as of July 18, 2000. Claimant requested review of that closure.

CONCLUSIONS OF LAW

Premature 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 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 September 13, 2000 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).

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 issue 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 simply requests review of the insurer's September 13, 2000 Notice of Closure. We interpret claimant's request for review as a challenge to both the medically stationary determination and the temporary disability compensation award. The evidence in the record supports the conclusions that claimant was medically stationary at the time of closure and that temporary disability compensation was appropriately terminated.

On July 18, 2000, claimant was examined by Dr. Reese, the IME physician, who reported that claimant was medically stationary and "would not be expected to improve further from medical treatment or the passage of time in regards to the hip." On October 24, 2000, Dr. Winquist, claimant's attending physician, concurred with Dr. Reese's assessment. These opinions are unrebutted.

Based on the uncontroverted medical evidence, we find that claimant was medically stationary on September 13, 2000. Inasmuch as temporary disability was paid through July 18, 2000, the date claimant was declared medically stationary, we conclude that claimant is not entitled to additional temporary disability and that the insurer's claim closure was proper.

Calculation of Temporary Disability Benefits

Claimant also requested review of the amount of temporary disability compensation and penalties that were paid. The record indicates that claimant's temporary disability benefits were calculated using the "at-injury" wage plus increases made up to the present time. The record does not establish that the calculation of claimant's temporary disability benefits or the payment of any penalties was improper.[1]

Accordingly, the insurer's September 13, 2000 Notice of Closure is affirmed in its entirety.

IT IS SO ORDERED.

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[1] In his response to the insurer's submission, claimant contends that he had "found" a missing payment for the July 1997 period and he "believed" he was "short" two or three payments subsequently. Other than the assertions, he offers no documentation or corroboration. Instead, he contends that it is the insurer's burden to demonstrate that those payments had been made. Moreover, claimant argues that the insurer's submission of its payment ledgers are insufficient to meet that burden and that it should be required to submit copies of the cancelled checks. Contrary to claimant's contention, the insurer is not required to submit a particular type of evidence in defense of its actions. In this particular case, this insurer has presented copies of its payment ledgers. Based on that submission, this record supports a conclusion that the insurer paid claimant for the period he disputes. Furthermore, the record does not establish claimant's assertion that he was "short" two or three payments. In light of such circumstances, we are not persuaded that claimant is entitled to additional compensation for the period of time in question.

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In the Matter of the Compensation of
JON P. STANLEY, Claimant
WCB Case No. 00-06863
ORDER ON REVIEW
Schneider, et al, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that upheld the SAIF Corporation's denial of his injury claim for a right knee condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order of January 10, 2001 is affirmed.

Board Member Phillips Polich specially concurring.

I agree with the lead opinion that this case is not compensable. However, I believe it is not compensable for the following reason.

The only causation opinion in the record somewhat favorable to claimant is from Dr. Moeller, at one time the attending physician. Dr. Moeller opined that claimant's knee condition was a combination of preexisting degenerative joint disease and acute injury. (Ex. 22-1). Although Dr. Moeller believed claimant had a meniscal tear, the existence of such a tear was not confirmed by MRI. (*Id.*) Consequently, Dr. Moeller described the types of clinical findings (catching, locking, and recurrent effusions) that would be required to support a future clinical diagnosis of medial meniscus tear. (*Id.*)

Specifically, Dr. Moeller opined that if a meniscal tear is present, the major cause of the tear would be acute injury from the May 2000 work incident. (Ex. 22-2). The lack of additional explanation by Dr. Moeller, implies that if there is no meniscal tear present, the major cause of claimant's knee condition is the preexisting joint degeneration.

Because the record does not establish (through either diagnostic testing or clinical evaluation) that claimant suffered a medial meniscus tear, I conclude that there is insufficient medical evidence to support a conclusion that claimant's right knee condition is compensable.

In the Matter of the Compensation of
THOMAS W. DAVIS, Claimant
WCB Case No. 00-07531
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorney

Reviewed by Board Members Biehl and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) affirmed an Order on Reconsideration that awarded additional temporary disability, up to February 23, 2000 (claimant's medically stationary date); and (2) awarded a $3,500 attorney fee. On review, the issues are medically stationary, temporary disability and attorney fees.

We adopt and affirm the ALJ's order on the merits. *See Marvin Wood Products v. Callow*, 171 Or App 175 (2000) (although the insurer does not bear the "burden of proof," it does bear the burden of establishing error in the reconsideration process because it challenged the Order on Reconsideration).

In addition, we offer the following supplementation regarding the attorney fee issue.

The insurer argues that the ALJ's $3,500 attorney fee award was excessive, because claimant "had no burden of proof," the hearing took place in the town where claimant's counsel practices, no witnesses were called, and, although the record consists of 142 exhibits, claimant's counsel was familiar with them because of extensive prior litigation (for which services counsel was compensated).

Claimant responds that the ALJ's fee award was appropriate, considering the risk to claimant and the high value of the claim.

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), as applied 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 at the hearing were claimant's medically stationary date and entitlement to over 19 months of temporary disability compensation. The hearing lasted about an hour and consisted of closing arguments. The record consists of about 145 exhibits, including at least one letter from claimant's counsel to Dr. Dale that was important to the claim.

The case involved issues of average factual and legal complexity, considering the range of cases generally submitted to this forum. The claim's value and the benefits secured are above average, considering the amount of temporary disability compensation at stake (some 19 months, equal to approximately $25,000). 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 claimant's counsel's efforts might have gone uncompensated, particularly considering the employer's vigorous challenge.

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $3,500 is a reasonable attorney fee for services at the hearings level. 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.

Claimant's attorney is entitled to an assessed fee for services on review regarding the medically stationary and temporary disability issues. 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 those issues is $1,400, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's counsel's statement of services and claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. We note that claimant is not entitled to an attorney fee for services devoted to the attorney fee issue.

ORDER

The ALJ's order dated December 28, 2000 is affirmed. For services on review, claimant is awarded a $1,400 attorney fee, payable by the insurer.

April 24, 2001 Cite as 53 Van Natta 583 (2001)

In the Matter of the Compensation of
DELINDA S. FRENCH-DAVIS, Claimant
WCB Case No. 00-04541
ORDER ON RECONSIDERATION
Welch, et al, Claimant Attorney
Lundeen, et al, Defense Attorney

Claimant requests reconsideration of our March 29, 2001 Order on Review that vacated the Administrative Law Judge's (ALJ's) order and dismissed claimant's hearing request as untimely under ORS 656.319(6). In our order, we concluded that, under the particular circumstances of this case, the alleged inaction that triggered the running of the two-year period in ORS 656.319(6) occurred in December 1997, when the insurer issued its acceptance notice regarding a "post-closure" new condition, rather than when claimant specifically requested claim processing in October 1998 and April 2000.

Claimant contends that our conclusion was in error. She asserts that the triggering date should be either of the dates she requested the insurer to close the claim in October 1998 and April 2000 (which were both within two years of her hearing request), rather than the date of acceptance. According to claimant, to do otherwise allows a carrier to avoid its obligation of closing a claim without repercussions in circumstances where it is not appropriate to close a claim until two years after the date of formal acceptance.

While there may be circumstances in which the triggering date for the two-year period in ORS 656.319(6) may be a date other than the date of acceptance of a "post-closure" new condition, under the particular circumstances of *this* claim, we continue to find that the date of acceptance is the triggering date for purposes of determining the two-year period. As noted in our order, it was the insurer's obligation under ORS 656.262(7)(c) in December 1997 to "reopen" the claim for processing of the new condition accepted after claim closure. It was the insurer's inaction which began in December 1997 that ultimately led to claimant's processing requests in October 1998 and April 2000.

In conclusion, after further considering this matter, we remain persuaded that, under these particular circumstances, it was the insurer's inaction in December 1997 that triggered the two-year limitation period under ORS 656.319(6). Because the June 2000 hearing request regarding the insurer's claim processing was more than two years after the insurer's inaction, we continue to find that claimant's hearing request was untimely.

Accordingly, we withdraw our March 29, 2001 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
BRAULIO A. SANCHEZ, Claimant
WCB Case No. 99-07686
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Menashe's order that: (1) declined to award interim compensation benefits from April 26, 1999 through September 17, 1999; and (2) affirmed an Order on Reconsideration that awarded no permanent disability benefits. In addition, claimant argues that the May 24, 1999 Notice of Closure should be set aside as null and void. In its brief, the SAIF Corporation argues that the ALJ: (1) erred in not affirming its September 17, 1999 denial; and (2) erred in awarding an assessed attorney fee regarding the low back combined condition claim. On review, the issues are interim compensation, permanent disability, validity of a Notice of Closure, 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

Claimant was employed as a farm hand. On December 4, 1998, claimant was involved in a compensable motor vehicle accident. On December 14, 1998, claimant had back pain at work while handling lumber building a pole barn. On December 17, 1998, claimant first sought medical treatment with Dr. Johnson, chiropractor. (Ex. 1). On January 13, 1999, SAIF accepted a disabling lumbar strain. (Ex. 3). No degenerative conditions were diagnosed before this acceptance.

On January 25, 1999, Dr. Lawlor, M.D., began treating claimant's low back condition. (Ex. 4). At that time, Dr. Lawlor diagnosed probable lumbosacral strain and probable degenerative disc disease. This was the first mention in the medical record of any degenerative condition. Following testing that included x-rays and a CT scan, in addition to a lumbosacral strain, Dr. Lawlor diagnosed L5-S1 spondylolisthesis with bilateral L5 pars fracture, mild degenerative disc disease, and L5-S1 bilateral foraminal stenosis. (Ex. 9).

On May 24, 1999, SAIF issued an Updated Notice of Acceptance at Closure that listed the accepted condition as a lumbar strain. (Ex. 17). That same date, SAIF issued a Notice of Closure that awarded only temporary disability benefits. (Ex. 18).

Claimant requested reconsideration and appointment of a medical arbiter. Dr. Thomas, orthopedist, served as the medical arbiter. (Ex. 26). On September 2, 1999, an Order on Reconsideration affirmed the Notice of Closure in all respects. (Ex. 24).

By letter dated September 10, 1999, claimant's attorney requested that SAIF accept "L5 S1 stenosis, mild degenerative disc disease, bilateral pars defects" pursuant to ORS 656.262(6)(d). (Ex. 25). On September 17, 1999, SAIF issued a partial denial of those conditions. (Ex. 27).

Assessed Attorney Fee Regarding Combined Condition Claim

Claimant requested a hearing regarding SAIF's September 17, 1999 denial of L5-S1 stenosis, degenerative disc disease, and bilateral pars defects. (Ex. 27). At hearing, claimant affirmed that he was contesting SAIF's September 17, 1999 denial, which he contended was either a backup denial or "include[d] part of a combined condition that should have been accepted and processed[.]" (Tr. 1). SAIF did not object to claimant's statement of issues. (Tr. 2).

The ALJ found that, at hearing, claimant contended that the work injury combined with his preexisting conditions causing a compensable combined condition that SAIF failed to accept when it

issued its updated notice of acceptance. The ALJ noted that, although this issue was slightly different from the one framed by SAIF's denial and claimant's request for hearing, the parties without objection submitted the issue for decision. The ALJ concluded that, on the merits, claimant had established a compensable combined condition under ORS 656.005(7)(a)(B). The ALJ directed SAIF to accept a low back combined condition and process it as required by law. In addition, the ALJ awarded claimant's attorney an assessed fee of $1,500 for establishing a compensable condition.

On review, SAIF does not contest the ALJ's decision that claimant established a compensable combined low back condition claim on the merits. In any event, the record would not support such an argument. (Exs. 7, 9, 11, 13, 14, 30-5, 31, 33-6-7, 33-11, 33-16, 33-16-17). Instead, SAIF argues that the ALJ erred in awarding "an attorney fee for overturning an alleged denial of a combined condition." Specifically, SAIF argues that claimant first made an oral request for SAIF to accept a combined condition claim at hearing. SAIF contends that it had 90 days to accept or deny that claim. It also contends that it neither expressly denied the condition, nor did claimant put the request to accept the combined condition claim in writing, as required under ORS 656.262(7)(a). Therefore, SAIF argues, none of the requirements for an assessed attorney fee under ORS 656.386(1) was met and the ALJ erred in awarding such a fee.

Finally, SAIF submitted a copy of *Birrer v. Principal Financial Group*, 172 Or App 654 (2001), which issued after the briefing schedule was completed. SAIF contended that *Birrer* provided additional authority in support of its above arguments.

As a policy matter, unless authorized, we will not consider supplemental argument presented after completion of the briefing schedule. The parties may, however, bring to the Board's attention recent decisions issued after completion of the briefing schedule. *Betty L. Juneau*, 38 Van Natta 553 (1986), *aff'd mem* 85 Or App 219, *rev den* 303 Or 590 (1987). Here, the court's decision in *Birrer* was issued after completion of the briefing schedule. Therefore, SAIF acted properly in bringing the decision in *Birrer* to our attention with regard to the merits of the issue on review. Nevertheless, we find *Birrer* distinguishable.

In *Birrer*, the court reversed the Board's order in *Corinne L. Birrer*, 51 Van Natta 163, *on recon* 51 Van Natta 467 (1999), that had set aside a carrier's "pre-closure" denials of the claimant's current left wrist condition. Although the Board concluded that the carrier had not shown that the claimant had a combined condition, it also found that the claimant's current condition was not related to her accepted injury and determined that the denials were not impermissible "pre-closure" denials of an unaccepted "combined condition." The claimant appealed the Board's decision, arguing that the Board had gone beyond the express scope of the denials when it concluded that her current condition was not related to the accepted injury because the carrier's denials had expressly referred to the "combined condition" statute and had asserted that her accepted condition was no longer the major contributing cause of her disability.

The court agreed with the claimant's argument, as well as the claimant's contention that the Board had erroneously determined that the parties had implicitly agreed to try an issue outside the express terms of the denials. The court explained that "[a]n implicit *agreement* to try an issue outside the express terms of a denial requires the meeting of the minds of the parties on what issue is to be tried and their implicit consent to try that issue." 172 Or App at 660 (emphasis in original). The court concluded that the Board had not explained how the claimant's "failure to object" to a carrier's reliance on a particular case holding constituted an implicit agreement to try an issue outside the express terms of the denials. In addition, the court noted that the claimant did in fact object to the employer's attempt to raise the current condition argument in its oral argument before the ALJ. *Id.* at 661 fn 6.

Here, at hearing, claimant summarized the issues, in part, as including SAIF's September 17, 1999 denial, which he contended was a backup denial, or in the alternative, *included part of a combined condition that should have been accepted*. (Tr. 1) (emphasis added). When the ALJ asked SAIF's attorney if he had any comment on the issues, he responded that he had "[n]othing in addition." (Tr. 2). The parties proceeded to hearing on the issues as summarized by claimant.

On this record, we find that the parties implicitly agreed to try the issue of compensability of the combined low back condition outside the express terms of the denial. Unlike *Birrer*, where the attempt to modify the denial was objected to and there was no implicit agreement to try an issue outside the express terms of the denial, SAIF did not disagree with claimant's statement of the issues, which in

effect modified its denial to include a denial of the combined condition. In addition, SAIF did not contend at hearing, as it does on review, that claimant was raising a new condition claim for the combined condition for the first time at hearing and that it had 90 days to process that new claim. Moreover, SAIF did not request reconsideration of the ALJ's order that explained that the issue presented at hearing was different from that framed by the denial and the parties did not object to that change.

Under these circumstances, we find that there was a meeting of the minds of the parties on the issues to be tried and that SAIF implicitly agreed to try an issue outside the express terms of its denial. Thus, SAIF waived any potential procedural challenge based on the language of its denial. *See Thomas v. SAIF*, 64 Or App 193 (1983); *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). Accordingly, the issues litigated at hearing included the September 17, 1999 denial, which was modified to include compensability of the low back combined condition claim.

As summarized above, the ALJ found the low back combined condition claim compensable. Thus, the ALJ's $1,500 assessed fee award under ORS 656.386(1) was appropriate. SAIF does not contend that the fee was excessive. In any event, for the reasons explained by the ALJ, we find that $1,500 is a reasonable fee for services at hearing regarding the compensability of the low back combined condition.

Inasmuch as attorney fees are not compensation, claimant's counsel is not entitled to an attorney fee under ORS 656.382(2) for defending the attorney fee award. *See Saxton v. SAIF*, 80 Or App 631 (1986); *Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

September 17, 1999 Denial of L5-S1 Stenosis, Degenerative Disc Disease, and Bilateral Pars Defects

SAIF argues that the ALJ erred in not upholding its denial of claimant's claim for L5-S1 stenosis, degenerative disc disease, and bilateral pars defects conditions. (Ex. 27). As explained above, the issues at hearing included the September 17, 1999 denial, which was modified at hearing to *include* a low back combined condition claim. However, compensability of the remaining conditions expressly denied in the September 1999 denial also remained at issue and the parties proceeded to try those issues. Nevertheless, the ALJ only addressed compensability of the low back combined condition claim. Thus, compensability of the remaining denied conditions must be addressed.

Claimant has the burden of proving compensability of the L5-S1 stenosis, degenerative disc disease, and bilateral pars defects conditions. ORS 656.266. Under the circumstances of this case, we need not determine whether claimant's burden of proof is material or major contributing cause, because claimant failed to meet either standard on this record.

Dr. Lawlor first examined claimant on January 25, 1999, within two months of the date of injury, and remained his attending physician throughout his treatment. After testing, Dr. Lawlor diagnosed L5-S1 spondylolisthesis with bilateral L5 pars fracture, mild degenerative disc disease, and L5-S1 bilateral foraminal stenosis. Dr. Lawlor opined that these were underlying, preexisting conditions that combined with the compensable lumbar strain. On April 26, 1999, Dr. Lawlor listed claimant's bilateral pars defects and degenerative spine disease as non-work related. (Ex. 14). Dr. Lawlor opined that, by April 29, 1999, the compensable lumbar strain had resolved and any subsequent disability or need for treatment was due to the preexisting conditions. (Exs. 15, 33-6-7, -9).

Dr. Lawlor rendered no opinion that would support compensability of the preexisting conditions. Dr. Lawlor declined to approve a telephone conversation summary that summarized her opinion as indicating that the heavy work claimant did as a farm laborer was a contributing factor and accelerated the degenerative condition of claimant's back. (Ex. 28-2). Instead, Dr. Lawlor apparently wrote that "[t]he heavy work may have accelerated the degenerative condition but I have no way of knowing or proving this."[1] (*Id.*)

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[1] We assume that Dr. Lawlor wrote this statement, since the conversation summary letter was addressed to her. However, there is no signature indicating who wrote it. (Ex. 28). In any event, the statement does not support compensability of the preexisting conditions. *See Gormley v. SAIF*, 52 Or App 1055, 1060 (1981) (opinion in terms of medical possibility rather than medical probability is unpersuasive).

On November 18, 1999, Dr. Bergquist, neurologist, examined claimant on behalf of SAIF. (Ex. 30). He opined that claimant's L5-S1 spondylolisthesis, mild degenerative disc disease, and L5-S1 stenosis were preexisting conditions that were idiopathic in nature and not caused or worsened by the work injury. (Exs. 30-3-4). Dr. Bergquist opined that the compensable lumbar strain combined with claimant's preexisting conditions at the time of the work injury, but the strain would have resolved in two to three months and the major contributing cause of claimant's current need for treatment was the preexisting conditions. (Ex. 30-5). Dr. Lawlor concurred with Dr. Bergquist's opinion in its entirety. (Exs. 31, 33-10, -24).

There are no other medical opinions regarding the cause of the preexisting conditions. On this record, we find that claimant failed to establish compensability of the L5-S1 spondylolisthesis, mild degenerative disc disease, and L5-S1 stenosis conditions. Accordingly, that portion of SAIF's September 17, 1999 partial denial that denied those conditions is upheld. The ALJ's order is reversed insofar as it could be interpreted as setting aside SAIF's denial of the aforementioned conditions.

May 24, 1999 Notice of Closure

On review, claimant argues that SAIF's May 24, 1999 Notice of Closure is null and void because SAIF did not issue a denial under ORS 656.262(7)(b) before it closed the claim. SAIF counters that claimant did not raise this issue at hearing. Although claimant acknowledges that he did not raise this issue at hearing, he contends that he can raise "subject matter jurisdiction" at any time.

We generally do not consider issues that are not raised at hearing. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991). An exception is made for matters involving subject matter jurisdiction. *See Schlect v. SAIF*, 60 Or App 449 (1982) (subject matter jurisdiction may be raised at any time during the course of litigation). However, under the circumstances of this case, that fact does not further claimant's position.

Subject matter jurisdiction depends solely upon whether a decision-making body has the authority to make an inquiry. It exists when a statute authorizes that body to do something about the dispute. *SAIF v. Roles*, 111 Or App 597 (1992). Claimant does not explain how "subject matter jurisdiction" permits him to raise a procedural challenge to the Notice of Closure for the first time on Board review. In this case, the reconsideration process regarding the May 24, 1999 Notice of Closure had been completed. Thus, the ALJ had subject matter jurisdiction to consider the Notice of Closure, if such a challenge had been properly brought before him.[2] ORS 656.283(7). Because claimant did not raise the procedural challenge to the Notice of Closure at hearing, we will not consider that issue on review.

Interim Compensation

As noted above, SAIF accepted a claim for a disabling lumbar strain. Pursuant to work releases from Dr. Lawlor, SAIF paid temporary disability benefits on that claim. On April 26, 1999, Dr. Lawlor stated that the major contributing cause of claimant's ongoing symptoms was his preexisting, nonwork conditions and no longer the on-the-job injury of lumbar strain. (Ex. 26). SAIF terminated claimant's temporary disability benefits as of April 26, 1999. On September 10, 1999, claimant submitted a written request to SAIF to amend its Notice of Acceptance and accept L5-S1 stenosis, mild degenerative disc disease, and bilateral pars defects conditions. (Ex. 25). On September 17, 1999, SAIF denied those conditions. (Ex. 27). The ALJ found that claimant was not entitled to interim compensation related to claimant's request to accept new conditions because SAIF denied the claim within 14 days of the claim. We agree.

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[2] We note that the September 2, 1999 Order on Reconsideration lists the following issues as raised by claimant's attorney: (1) disagreement with impairment findings and request for a medical arbiter examination; (2) premature closure; (3) medically stationary date; (4) temporary disability benefits; and (5) rating of scheduled and unscheduled permanent disability benefits. (Ex. 24-1-2). Thus, it does not appear that claimant raised any procedural challenge to the Notice of Closure during the reconsideration process. Under ORS 656.283(7), 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. Similarly, ORS 656.268(8) provides that no hearing shall be held on any issue that was not raised and preserved before the department at reconsideration. Therefore, it is questionable whether claimant could have raised the procedural challenge for the first time at hearing; *i.e.*, if the issue was not raised on reconsideration, neither the ALJ nor the Board would have subject matter jurisdiction to hear the matter. *See Harrison S. Saputo*, 52 Van Natta 417 (2000). Nevertheless, we need not decide this issue because it was raised for the first time on review.

A worker is entitled to interim compensation if he has suffered a loss of earnings as a result of a work-related injury. *RSG Forest Products v. Jansen*, 127 Or App 247 (1994); *Robert W. Fagin*, 50 Van Natta 1680 (1998). "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. *Robert W. Fagin*, 50 Van Natta at 1681; *see also Rustee R. St. Jean*, 49 Van Natta 2161 (1997).

As the ALJ found, if the claim is denied within 14 days, no temporary disability is due. Therefore, no temporary disability is due based on claimant's September 10, 1999 request to accept additional conditions. Nevertheless, claimant argues that he is entitled to interim compensation for the period from April 26, 1999[3] to September 17, 1999, the date that SAIF denied claimant's request to amend its Notice of Acceptance.

As we understand claimant's argument, he contends that Dr. Lawlor's April 26, 1999 letter constituted a claim for the L5-S1 stenosis, mild degenerative disc disease, and bilateral pars defects conditions and interim compensation was due from the date of that claim until SAIF's September 17, 1999 denial. Claimant also contends that he did not have to first comply with ORS 656.262(6)(d)[4] in order to be entitled to interim compensation. Claimant relies on *Gustavo B. Barajas*, 51 Van Natta 613, *on recon* 51 Van Natta 732 (1999), *aff'd mem Nike, Inc. v. Barajas*, 166 Or App 237 (2000), in support of this argument. We disagree and find *Barajas* distinguishable.

Under the circumstances of this case, we need not address the issue of whether claimant must first comply with ORS 656.262(6)(d) because his argument fails at a more fundamental level. In *Barajas*, there was no dispute that the attending physician related the claimant's inability to work to a work-related condition, although that condition had not been accepted. Here, even if we accept Dr. Lawlor's April 26, 1999 chart note as a claim, Dr. Lawlor explicitly relates claimant's inability to work to the preexisting, nonwork-related conditions and *not* to the December 1998 work injury. (Exs. 14, 15-3, 16-1, 19-2, 33-5, 33-7). Therefore, claimant's medical records do not provide attending physician verification that he was entitled to interim compensation benefits after April 26, 1999 due to the December 1998 work injury. *See Teri L. Bernloehr*, 52 Van Natta 144 (2000).

Extent of Permanent Disability

As the ALJ found, extent of permanent disability benefits is limited to permanent impairment caused by accepted conditions or direct medical sequelea of accepted conditions. OAR 436-035-0007(1); *Bonnie J. Woolner*, 52 Van Natta 1579 (2000) (in rating permanent disability under the current statutory scheme, the focus is on accepted conditions at the time of claim closure and reconsideration); *Janet R. Christensen*, 50 Van Natta 1152 (1998) (evaluation of conditions ordered accepted after claim closure must

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[3] Claimant also states that "SAIF's obligation to begin paying interim compensation for the other conditions began on the day it issued the Notice of Closure since it must have had Dr. Lawlor's chart note that his lumbar strain was medically stationary." The Notice of Closure issued May 24, 1999, the same date as the Updated Notice of Acceptance that noted the accepted condition was a "lumbar strain." (Ex. 17).

[4] 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."

await the reopening and processing of the claim for that new condition); *James L. Mack*, 50 Van Natta 338, 339 (1998) (same); *Julio C. Garcia-Caro*, 50 Van Natta 160, 162-63 (1998) (the accepted condition determines what is included in rating permanent disability of a claim).

Here, the accepted condition at closure was a lumbar strain. As the ALJ found, neither Dr. Lawlor nor the medical arbiter related any permanent impairment to the lumbar strain condition. Citing *SAIF v. Belden*, 155 Or App 568 (1998), claimant argues that it is not appropriate to disallow impairment from his preexisting conditions because SAIF did not deny the preexisting conditions at closure. We disagree.

Belden is distinguishable. In *Belden*, the insurer accepted a combined condition but did not issue a denial of the combined condition before closing the claim. Consequently, the entire combined condition was properly rated.

Here, SAIF did not accept a combined condition. Therefore, SAIF was not required to issue a denial under ORS 656.262(7)(b) before arguing that claimant's impairment was due to a noncompensable condition. *See Kenneth R. Reed*, 49 Van Natta 2129 (1997); *Dorothy M. Harris*, 49 Van Natta 1348 (1997).

ORDER

The ALJ's order dated November 9, 2000 is affirmed in part and reversedin part. That portion of SAIF's September 17, 1999 partial denial that denied claimant's L5-S1 stenosis, degenerative disc disease, and bilateral pars defects conditions is reinstated and upheld. The remainder of the ALJ's order is affirmed.

April 20, 2001 Cite as 53 Van Natta 589 (2001)

In the Matter of the Compensation of
SHARMA JOHNSON, Claimant
WCB Case No. 99-03378
ORDER DENYING RECONSIDERATION
Hornecker, Cowling, et al, Defense Attorney

The self-insured employer requests reconsideration of our March 29, 2001 order that adopted and affirmed an Administrative Law Judge's (ALJ's) order that set aside the employer's denial of claimant's injury claim for a cervical strain. Specifically, the employer argues that we erred in finding the claim compensable because claimant and her daughter are not credible.

We conclude that the factual questions raised by the employer's request for reconsideration were adequately addressed by our prior order that adopted the ALJ's order. *See Jorge Pedraza*, 49 Van Natta 1019 (1997) (by adopting an ALJ's order, the Board order indicated that it found the ALJ's order sufficient for appellate review and the facts and conclusions in that order expressed the Board's opinion).

Accordingly, the request for reconsideration is denied. The parties' rights of appeal shall continue to run from the date of our March 29, 2001 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES M. FIRESTONE, JR., Claimant
WCB Case No. 96-04016
ORDER ON REMAND
Myrick, Seagraves, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *SAIF v. Firestone*, 172 Or App 388 (2001). The court has reversed our prior order, *James M. Firestone, Jr.*, 49 Van Natta 181 (1997), that affirmed the Administrative Law Judge's (ALJ's) order that awarded claimant temporary disability benefits from November 30, 1992 through February 4, 1993. In *Firestone*, 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 his entitlement to "substantive" temporary disability during the period in dispute. Citing *Fred Meyer, Inc. v. Bundy*, 159 Or App 44 (1999), *rev dismissed* 329 Or 503 (1999), the court has remanded for reconsideration.

The court in *Bundy* reversed our decision in *Kenneth P. Bundy*, 48 Van Natta 2501 (1996), that had held that the 14-day statutory limitation on "retroactive" temporary disability authorization from an attending physician 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 November 30, 1992 through February 4, 1993. The only reference to claimant's work status during this period is contained in a February 29, 1996 report from Dr. Sampson, claimant's treating physician, who stated that claimant was disabled from regular work for the period in dispute. (Ex. 14A). Because *former* ORS 656.262(4)(f) limited a retroactive award of temporary disability to 14 days, it follows that Dr. Sampson's February 29, 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 November 30, 1992 and February 4, 1993.

Accordingly, on reconsideration, the ALJ's "substantive" award of temporary disability from November 30, 1992 through February 4, 1993 (as granted by the ALJ's September 26, 1996 order) is reversed. The award of temporary disability in the March 29, 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.[1]

IT IS SO ORDERED.

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[1] Because claimant's award of temporary disability has ultimately been reduced as a result of SAIF's request for review, we also rescind the $1,000 attorney fee awarded in our prior order pursuant to ORS 656.382(2).

In the Matter of the Compensation of
FLOYD L. KEENEY, Claimant
WCB Case No. 00-05918
ORDER ON REVIEW
Doblie & Associates, Claimant Attorney
Hornecker, Cowling, et al, Defense Attorney

Reviewed by Board Members Meyers and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) declined to admit a medical report into evidence; and (2) upheld the self-insured employer's denial of his aggravation claim for bilateral carpal tunnel syndrome. On review, the issues are evidence and aggravation. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

Claimant argues that the ALJ erred by declining to admit Dr. Herring's October 24, 2000 report (proposed Exhibit 50) into evidence. He contends that there is "no basis in law" for not admitting the report. Claimant relies on Dr. Herring's report to establish his aggravation claim.

At the November 2, 2000 hearing, claimant submitted Dr. Herring's October 24, 2000 report. (Tr. 1-2). The employer objected to admission of that report on the grounds that it was not relevant to the issue currently being litigated; *i.e.*, the compensability of claimant's February 2000 aggravation claim. (Tr. 2-4). The employer also requested cross-examination of Dr. Herring, if the report was admitted in evidence. (Tr. 2). The ALJ sustained the employer's objection to admission of Exhibit 50 on the ground that it was not relevant to the issue currently litigated. (Tr. 8).

ORS 656.283(7) provides that an 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." The statute has been interpreted to give ALJ's broad discretion in admitting evidence. *See, e.g., Brown v. SAIF*, 51 Or App 389, 394 (1981). We review the ALJ's evidentiary ruling for abuse of discretion. *Rose M. LeMasters*, 46 Van Natta 1533 (1994), *aff'd mem LeMasters v. Tri-Met, Inc.*, 133 Or App 258 (1995).

On review, the employer argues that Dr. Herring's October 24, 2000 report is not relevant and, even if Dr. Herring's report is admitted, it is not persuasive. Alternatively, the employer argues that, if the Board finds that Dr. Herring's report should be admitted, it requests remand to the ALJ to allow cross-examination of Dr. Herring.

After reviewing Dr. Herring's October 24, 2000 report, we find that it is not necessary to decide whether the ALJ improperly declined to admit that exhibit because, even if that report is considered, claimant did not sustain his burden of proving an aggravation. *See, e.g., Sharon M. Battin*, 52 Van Natta 1340, *on recon* 52 Van Natta 1674 (2000) (admission of proposed exhibit was not reasonably likely to affect the outcome of the case).

Although Dr. Herring's October 24, 2000 report indicated that claimant's nerve conduction studies on that date showed abnormalities of both median nerves, he noted that "[c]linical correlation is required." (Proposed Exhibit 50). There is no such clinical correlation in this record. Furthermore, Dr. Herring provided no information as to whether claimant had sustained an "actual worsening" of his accepted bilateral carpal tunnel syndrome (CTS) in February 2000, when the aggravation claim was filed. In addition, Dr. Herring did not discuss the cause of the alleged worsening.[1] Under these circumstances, we conclude that the admission of proposed Exhibit 50 is not reasonably likely to affect the outcome of this case.

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[1] We note that claimant was previously diagnosed with chronic pain syndrome. (Ex. 40-6).

Aggravation

In February 1996, the employer accepted claimant's bilateral CTS. (Ex. 11). Claimant had left carpal tunnel surgery in January 1996 and right carpal tunnel surgery in February 1996. (Exs. 5, 9). A June 5, 1996 Notice of Closure awarded only temporary disability. (Ex. 15).

In August 1997, Dr. Bitter performed a second right carpal tunnel release. (Ex. 21). On August 26, 1997, the employer accepted an aggravation claim for right carpal tunnel syndrome. (Ex. 23). A December 11, 1997 Notice of Closure awarded only temporary disability. (Ex. 31).

The issue in this case pertains to the February 7, 2000 aggravation claim signed by Dr. Bitter. (Ex. 45). On June 13, 2000, the employer denied the aggravation claim on the basis that claimant's CTS had not objectively worsened. (Ex. 47).

To establish a compensable aggravation, claimant must establish an "actual worsening" of the compensable condition since the last award or arrangement of compensation. ORS 656.273(1). To prove an aggravation claim, a worker must present medical evidence of a worsening of the compensable condition itself, not merely a worsening of the symptoms related to the underlying condition. *SAIF v. Walker*, 330 Or 102, 110 (2000).

The ALJ concluded that claimant had not proved an aggravation of the accepted condition. For the following reasons, we agree that there is no persuasive medical evidence that establishes claimant's bilateral CTS condition has "actually worsened."

When Dr. Bitter signed an aggravation form on February 7, 2000, he did not authorize temporary disability and instead indicated that claimant was medically stationary. (Ex. 45). In Dr. Bitter's February 7, 2000 chart note, he diagnosed "[b]ilateral upper extremity pain of uncertain etiology." (Ex. 44). He noted that this problem had been previously evaluated "quite completely." (*Id.*) Although Dr. Bitter recommended another nerve conduction study, claimant was not interested in having one. (*Id.*)

In a later concurrence letter from the employer's attorney, Dr. Bitter agreed that he had not diagnosed a pathological worsening of claimant's condition, but merely considered his examination to be a progress report, rather than a true aggravation of the previously accepted condition. (Ex. 46). We conclude that Dr. Bitter's reports are insufficient to establish an aggravation.

Based on this record, there is no other medical evidence that establishes that claimant had an "actual worsening" of his bilateral CTS condition. To the contrary, Dr. Eckstein, psychologist, said that she was unable to determine the veracity of claimant's pain complaints. (Ex. 49-3).

In sum, we agree with the ALJ that the medical evidence is insufficient to establish an "actual worsening" of his bilateral CTS condition.

ORDER

The ALJ's order dated December 1, 2000 is affirmed.

In the Matter of the Compensation of
TRACEY A. BLAMIRES, Claimant
WCB Case Nos. 98-04194 & 98-02326
SECOND ORDER ON REMAND
Bottini, Bottini, et al, Claimant Attorney
Wallace, Klor & Mann, Defense Attorney

Claimant requests reconsideration of that portion of our April 19, 2001 Order on Remand that "reversed" an Administrative Law Judge's (ALJ's) order in WCB Case No. 98-04149 and remanded the claim to the insurer for processing. On reconsideration, claimant notes that, although the ALJ declined to address the procedural propriety of the May 22, 1998 denial, he did set aside the denial on substantive grounds. Claimant also notes that it was the insurer, rather than claimant, that appealed the ALJ's order to the Board.

We agree with claimant's contentions and correct our April 19, 2001 order. Consistent with these corrections, rather than reversing the ALJ's order, we affirm the ALJ's order in WCB Case No. 98-04149.

Accordingly, claimant's request for reconsideration is granted and our April 19, 2001 Order on Remand is withdrawn. On reconsideration, as supplemented and corrected herein, we republish our April 19, 2001 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

April 26, 2001 Cite as 53 Van Natta 593 (2001)

In the Matter of the Compensation of
BECKY J. McTAGGART, Claimant
WCB Case No. 98-01802
ORDER ON REMAND
Blake & Duckler, Claimant Attorney
Reinisch, et al, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *McTaggart v. Time Warner Cable*, 170 Or App 491 (2000). The court reversed our prior order that affirmed an Administrative Law Judge's (ALJ's) order that upheld the insurer's denial of claimant's injury claim. The ALJ had determined that claimant's injury from an unexplained fall did not arise from her employment as a customer service representative. The court has held that a truly unexplained fall in the course and scope of employment is compensable as a matter of law. Because we did not consider whether claimant's fall was truly unexplained, the court has reversed and remanded for reconsideration.

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 determined that claimant's fall occurred in the course and scope of her employment. However, because the fall was unexplained and it could not be linked to a risk connected with claimant's employment or a risk to which the work environment exposed claimant, the ALJ reasoned that the fall did not arise out of that employment. Further reasoning that claimant had satisfied only the "in the course of" element of the "unitary work connection test," with no evidence satisfying the "arising out of" element, the ALJ concluded that the claim failed. On review, we adopted and affirmed the ALJ's order. Claimant petitioned the court for judicial review of our order.

The court held that ORS 656.266, which provides that a claimant may not carry the burden of proving compensability merely by disproving other possible explanations of how the injury or disease occurred, did not affect the Supreme Court's essential holding in *Phil A Livesley Co. v. Russ*, 296 Or 25 (1983). In *Livesley*, a case involving an unexplained fall, the Court had held that an injury arises out of employment if it arises from a neutral risk of the employment.

Following *Livesley*, the *McTaggart* court reasoned that a truly unexplained fall that occurs in the course of employment arises out of the employment as a matter of law. Because we did not determine whether claimant adequately excluded idiopathic factors so that her fall was "truly unexplained," the court reversed our order and remanded for reconsideration. *McTaggart*, 170 Or App at 505.

Thus, the issue on remand is whether claimant adequately excluded idiopathic factors so that her fall was "truly unexplained." If so, her injuries are compensable as a matter of law. *Id.*

Neither claimant nor anyone else knows why claimant fell. (*See* Tr. 33). She may have "tripped," "slipped," or simply "lost her footing." (*See* Exs. 1, 2). In any event, there is no evidence

relating claimant's fall to idiopathic factors, such as illness or a nonwork related fainting spell. *Compare Damis v. Cotter & Company*, 89 Or App 219 (1988) (where the cause of the claimant's fall was known -- he fainted -- and idiopathic causes were not eliminated, the claimant failed to satisfy his burden of proof); *McAdams v. SAIF*, 66 Or App 415, *rev den* 296 Or 638 (1984) (same); *Bruce A. Drum*, 52 Van Natta 2005 (2000).

Under these circumstances, we conclude that claimant has adequately excluded idiopathic factors so that her fall was truly unexplained. Because claimant's injury occurred in the course and scope of her employment and her fall was truly unexplained, the claim is compensable.

Accordingly, on reconsideration, the ALJ's order dated June 19, 1998 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law.

IT IS SO ORDERED.

April 26, 2001 Cite as 53 Van Natta 594 (2001)

In the Matter of the Compensation of
GENE A. FRASIER, Claimant
WCB Case No. 00-03545
ORDER ON RECONSIDERATION
Robert J. Guarrasi, Claimant Attorney
Atwood & Associates, Defense Attorney

On March 29, 2001, we abated our March 2, 2001 order that affirmed the Administrative Law Judge's (ALJ's) order that declined to remand for appointment of a medical arbiter. We took this action to consider claimant's motion for reconsideration. Having received the self-insured employer's response, we proceed with our reconsideration.

Citing *Birrer v. Principal Financial Group*, 172 Or App 654 (2001), claimant contends that, when appointment of a medical arbiter is requested, such an appointment is mandatory. Thus, claimant asserts that we erroneously affirmed the ALJ's decision not to remand the claim for appointment of an arbiter. We disagree.

In *Birrer*, the court construed ORS 656.268(7)(a). That statute is not, however, at issue in this case. Thus, we conclude that *Birrer* is not controlling.

On reconsideration, as supplemented herein, we adhere to and republish our March 2, 2001 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
LLANCE A. PETERSON, Claimant
Own Motion No. 01-0123M
OWN MOTION ORDER
Carney, et al, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable asthma injury/occupational disease. Claimant's aggravation rights have expired. 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.*

From September 6, 2000 to September 10, 2000, claim was hospitalized for treatment due to a worsening of his compensable asthma condition.[1] Thus, we conclude that claimant's compensable condition worsened requiring inpatient 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).

For the purpose of determining whether claimant is in the work force under the Board's Own Motion jurisdiction,[2] the "date of disability" is the date he is hospitalized due to a worsening of his compensable condition. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). Thus, the relevant time period for which claimant must establish he was in the work force is the time prior to his September 6, 2000 hospitalization. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990); *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Paul M. Jordan*, 49 Van Natta 2094 (1997); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997).

Claimant submits Dr. Keppel's January 5, 2001 report in support of his contention that he could not work or seek work due to his compensable condition. Dr. Keppel agreed that claimant has "been continually unable to be regularly and gainfully employed due to his workers' compensation related conditions * * * and would it have been futile for [claimant] to seek work," since Dr. Keppel's February 16, 2000 report (when he opined that it would also have been futile for claimant to seek work). Thus, we conclude that claimant has persuasively established that he was unable to work at the time of his current worsening and that it would have been futile for him to seek work due to his compensable condition.

However, in order to satisfy the third *Dawkins* criterion, claimant must also establish, along with the "futility" standard, that he was willing to work. Failing to demonstrate a willingness to work, a claimant is not considered a member of the work force, and thus, is not entitled to temporary disability compensation. *See Stephen v. Oregon Shipyards*, 115 Or App 521 (1992); *Colin L. Spencer*, 53 Van Natta 144 (2001); *Marlene J. Andre*, 48 Van Natta 404 (1996).

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[1] Claimant was also hospitalized from October 3 through October 4, 2000 due to a worsening of his compensable hypertension condition.

[2] 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).

In response to SAIF's work force contentions, claimant's attorney states that claimant "has at all times remained willing to work and seek work but has been unable to do so because of his compensable conditions." In addition, claimant's attorney references a September 9, 1998 affidavit from claimant and states "[n]othing has changed." However, claimant's attorney's letter is not an affidavit from claimant attesting to his willingness to work. Further, his assertion that "nothing has changed" is insufficient evidence demonstrating claimant's willingness to work. We have previously found that a claimant's attorney's bare assertions are not sufficient to meet claimant's burden of proof. *Larry R. Ruecker*, 45 Van Natta 933, 934 (1993).

In addition, claimant's attorney references our March 17, 2000 Own Motion Order that found that claimant was in the work force during his October 11, 1999 hospitalization. In that order, we concluded that claimant remained in the work force based on Dr. Keppel's February 16, 2000 letter regarding "futility" and claimant's January 4, 2000 affidavit regarding his willingness to work. *Llance A. Peterson*, 52 Van Natta 433 (2000).

Although probative, our previous findings regarding the "willingness" issue concerning claimant's 2000 claim is not determinative. A prior finding does not irrevocably commit a claimant to a certain work force status for the purposes of workers' compensation benefits. Rather, claimant must show that he was in the work force at the time of his current worsening. *See Morris*, 103 Or App at 273; *Dean L. Watkins*, 45 Van Natta 1599 (1993).

Here, there is no contemporaneous affidavit from claimant regarding his recent work history prior to his current worsening and a statement as to whether he was willing to work if not for his work injury. Consequently, we find that claimant has failed to meet his burden of proof regarding the "willingness" standard of the third *Dawkins* criterion.

Accordingly, the record does not establish that claimant was in the work force at the time of the September 2000 worsening of his compensable condition. Therefore, claimant's request for temporary disability compensation is denied.

IT IS SO ORDERED.

April 26, 2001 Cite as 53 Van Natta 596 (2001)

In the Matter of the Compensation of
MARCIA A. CLOMAN, Claimant
WCB Case No. 00-05406
ORDER ON RECONSIDERATION
Welch, et al, Claimant Attorney
Lundeen, et al, Defense Attorney

The insurer requests reconsideration of our April 17, 2001 Order on Review. Specifically, the insurer notes that our order affirms an ALJ's order dated June 30, 2000, rather than the correct date of December 15, 2000.

On reconsideration, we agree that our April 17, 2001 order contains a typographical error. Consequently, the "ORDER" section of our April 17, 2001 Order on Review is corrected to read: "The ALJ's order dated December 15, 2000 is affirmed."

Accordingly, we withdraw our April 17, 2001 order. As supplemented and corrected herein, we republish our April 17, 2001 Order on Review. The parties' rights of appeal shall begin running from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
BONNIE PRICE, Claimant
Own Motion No. 00-0355M
SECOND OWN MOTION ORDER DENYING RECONSIDERATION
Welch, et al, Claimant Attorney

Claimant has submitted documentation which she contends demonstrate that she had undergone hospitalization and, thus, is entitled to temporary disability benefits related to her compensable left arm condition. We treat claimant's submission as a request for reconsideration of our prior orders that denied claimant's request for Own Motion relief.

Under 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. Claimant's request for reconsideration was received by the Board on February 15, 2001, more than 30 days after the issuance of our January 5, 2001 Own Motion Order on Reconsideration.[1] In addition, claimant provides no explanation that might provide "good cause" for her failure to request reconsideration within 30 days. Consequently, claimant's request for reconsideration is denied as untimely.

In any event, if we were to grant claimant's request for reconsideration, we would continue to find that the record fails to demonstrate that claimant's current condition required surgery or hospitalization. We base our conclusion on the following reasoning.

Claimant contends that in June and July 2000, she was hospitalized for "two separate procedures" because of a worsening of her compensable condition. In support of her contention, she submits a July 31, 2000 Statement of Services demonstrating medical services provided on July 7, 2000. In response, the employer submits July 7, 2000 reports, which show that claimant was admitted on a "short stay" to the hospital to obtain a Bier block injection for pain management.

Pursuant to ORS 656.278(1)(a), temporary disability benefits may be awarded only when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring overnight hospitalization. We have previously interpreted "surgery" to be an invasive procedure undertaken for a curative purpose and which is likely to temporarily disable the worker. *Fred E. Smith*, 42 Van Natta 1538 (1990). In addition, injections do not qualify as surgery or hospitalization. *Victor Schunk*, 50 Van Natta 2049 (1998); *Carol Knodel*, 45 Van Natta 426 (1993).

The record establishes that the Bier block injection was a "short-stay" procedure, that did not require overnight hospitalization. The procedure was performed to provide some left arm pain relief. Under such circumstances, this "non-curative" injection does not qualify as "surgery" within the meaning of ORS 656.278(1)(a). Moreover, because that treatment did not require an overnight stay in the hospital, we do not regard the procedure as "hospitalization" sufficient to justify claim reopening. *See Melvin L. Wall*, 51 Van Natta 23 (1999); *Daniel P. Moore*, 46 Van Natta 2490 (1994); *Fred E. Smith*, 42 Van Natta at 1538. Thus, the record fails to demonstrate that claimant has required or currently requires surgery or hospitalization.

Accordingly, claimant's request for reconsideration is denied. The issuance of this order neither "stays" our prior orders nor extends the time for seeking review. *International Paper Company v. Wright*, 80 Or App 444 (1986); *Fischer v. SAIF*, 76 Or App 656 (1985). However, should claimant's circumstances change, that is, should she require surgery and/or hospitalization for her compensable condition in the future, she may again request reopening of her claim.

IT IS SO ORDERED.

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[1] In her February 15, 2001 letter, claimant explains that the tardiness of her submission "was due to an incomplete address on the initial mailing of February 6, 2001." Even if mailed February 6, 2001, claimant's reconcideration request would still be untimely because it was mailed more than 30 days after our January 5, 2001 order.

In the Matter of the Compensation of
SUSAN R. TERZO, Claimant
WCB Case No. 00-00898
ORDER ON REVIEW (REMANDING)
Malagon, Moore, et al, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the insurer's denial of claimant's current right knee condition. Claimant has also submitted further medical evidence and requests that the matter be remanded for admission of that evidence. The insurer objects to claimant's request. On review, the issues are remand and compensability. We vacate and remand.

The ALJ upheld the insurer's denial of claimant's current right knee condition. Claimant has submitted further evidence and requests that the matter be remanded for admission of that evidence. The proffered evidence consists of a "post-hearing" July 17, 2000 operative report by Dr. Edelson, in which he states: "There was focal grade 2 to 3 changes in the central weight-bearing portion of the patella, acute-appearing in nature," and a "post-hearing" September 28, 2000 closing examination, in which he declares claimant's right knee condition medically stationary.

We may remand to the ALJ for the taking of further evidence if we determine that the record has been improperly, incompletely, or otherwise insufficiently developed. ORS 656.295(5). 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. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986).

Inasmuch as the proffered evidence relates to claimant's right knee condition, the evidence concerns disability. Moreover, since the surgery did not take place until after the June 14, 2000 hearing, the evidence submitted by claimant was not obtainable, with due diligence, at the time of the hearing. *See Wanda Kelley*, 47 Van Natta 146 (1995) (evidence derived from a "post-hearing" surgery not obtainable with due diligence).

Claimant contends that her accepted right knee twisting injury that combined with preexisting noncompensable prepatella chondromalacia of the right knee remains the major contributing cause of the disability or need for treatment of the combined condition. It is claimant's burden to prove the compensability of her current combined condition. ORS 656.266. If claimant's work injury, when weighed against her preexisting condition, remained the major cause of her disability or need for treatment for the combined condition, that condition is compensable. ORS 656.005(7)(a)(B).[1]

In upholding the insurer's denial of claimant's current right knee condition, the ALJ was not persuaded by Dr. Edelson's opinion that the October 28, 1999 injury remained the major contributing cause of claimant's current knee condition and need for medical treatment. Dr. Edelson reasoned that claimant had a significant change in her knee since her October 1999 injury. He opined that claimant's current condition, problems and limitations were not due to a preexisting knee condition, and that if mild degenerative change was present, it would have been a minor contributing factor and would have been significantly and materially worsened by her industrial accident.

The ALJ found the opinions of Dr. Vessely and Dr. Gripekoven more persuasive than that of Dr. Edelson because each concluded that claimant had preexisting degenerative changes in the right knee and that the preexisting, noncompensable degeneration had become the major contributing cause of her current condition and need for treatment. Because the proffered evidence concerns Dr. Edelson's "post-hearing" surgical findings of grade 2 to 3 changes in the central weight-bearing portion of the patella that appeared to be acute, claimant contends that the evidence is reasonably likely to affect the outcome of the case. If claimant is correct, there exists a compelling reason to remand.

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[1] 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."

While Dr. Edelson's opinion that claimant's injury remained the major contributing cause of claimant's current knee condition and need for medical treatment because she had had a significant change in her knee is not new, the opinion that actual physical findings indicate the damage in claimant's knee was acute is new. The proffered evidence fills in gaps in the medical record and tends to support Dr. Edelson's prior opinion that claimant had an acute injury that was the cause of the change in her knee. Accordingly, we find a compelling reason to remand. *See Parmer v. Plaid Pantry # 54*, 76 Or App 405 (1985); *Linda J. Williams*, 51 Van Natta 1528, 1529 (1999); *Patricia L. Serpa*, 47 Van Natta 2386, 2387 (1995).

The ALJ's order dated January 24, 2001 is vacated and this matter is remanded to ALJ Podnar to reopen the record for the admission of additional evidence regarding claimant's recent right knee surgery and the resulting findings regarding the cause of claimant's current right knee condition. The ALJ may proceed in any manner that will achieve substantial justice. ORS 656.283(7). The ALJ shall then issue a final appealable order.

IT IS SO ORDERED.

April 27, 2001 Cite as 53 Van Natta 599 (2001)

In the Matter of the Compensation of
MICHAEL J. McDERMITT, Claimant
WCB Case No. 00-05963
ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Claimant, *pro se*, requests reconsideration of our March 29, 2001 order that adopted and affirmed an Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's denial of claimant's claim for chronic neck and back pain with multiple segmental dysfunction and cervical radiculopathy.

Claimant seeks to revisit issues of fact litigated at a prior hearing, on March 26, 2000 (WCB # 99-09944). (*See* Exs. 30, 36). We lack authority to address these matters, because the prior litigation order is final. *See* ORS 656.295(8); 656.298(5). Therefore, the prior litigation finally established that claimant's condition was not compensable, as of the March 26, 2000 hearing. Consequently, to the extent that claimant relies on a challenge to the prior final order, his arguments do not aid his cause.[1]

On the merits of his current claim, claimant argues that the persuasive medical evidence supports a conclusion that his current cervical condition is due to his 1980 work injury and the contrary medical evidence is unpersuasive.

As we explained in our prior order (that adopted the ALJ's order), we do not find the opinions supporting the claim persuasive. We reached this conclusion in part because the contemporaneous medical record does not support claimant's contention that his cervical complaints continued since the 1980 injury. We also declined to rely on the opinions relating claimant's current condition to the 1980 injury because they did not address the naturally occurring cervical spondylosis and degenerative changes identified by the examining physicians. Because we continue to find the opinions relating claimant's current condition to the 1980 injury inadequately supported and insufficiently explained, we decline to rely on them.

Accordingly, we withdraw our March 29, 2001 order. On reconsideration, we republish our March 29, 2001 order as supplemented herein. 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 claimant is unrepresented. Because he is unrepresented, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in workers' compensation matters. He may contact the Workers' Compensation Ombudsman at (503) 378-3351 or 1-800-0927-1271 (V/TTY) (within the State of Oregon), or write to: Workers' Compensation Ombudsman, 350 Winter St. NE, Room 160, Salem, Or 97301-3878

In the Matter of the Compensation of
DARREL E. MADDOX, Claimant
WCB Case No. 00-05514
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Spangler's order that: (1) directed SAIF to issue a notice of classification regarding claimant's "post-closure accepted" bilateral plantar hyperkeratotic lesions (including reopening the claim); and (2) awarded a penalty-related attorney fee for SAIF's allegedly unreasonable resistance to the payment of compensation. On review, the issues are claims processing and penalty-related attorney fees.[1] We vacate in part, modify in part, reverse in part, and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact. We do not adopt the ALJ's Ultimate Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

We briefly summarize the procedural background of this case. Claimant compensably injured his left foot and right ankle on March 20, 1997. (Ex. 1). SAIF accepted "nondisplaced bimalleolar fracture, right ankle and nondisplaced calcaneal fracture intraarticular, left foot" as disabling injuries. (Ex. 5). A February 19, 1999 Notice of Closure awarded claimant 7 percent scheduled permanent disability for loss of use or function of his left foot. (Ex. 13).

A June 3, 1999 Order on Reconsideration increased his scheduled permanent disability award to 11 percent for loss of use or function of the left foot (ankle) and 12 percent for loss of use or function of the right foot (ankle). (Ex. 14). A June 14, 2000 Opinion and Order increased claimant's scheduled permanent disability award for his right ankle to 13 percent. (Ex. 31).

Claimant sought treatment from Dr. Malkin on June 30, 1999, complaining of painful calluses. (Ex. 15). In September 1999, Dr. Cornelius diagnosed bilateral plantar hyperkeratotic lesions. (Ex. 18).

Claimant's attorney requested SAIF's acceptance of claimant's bilateral plantar hyperkeratotic lesions as a sequela to his original claim. (Ex. 24). On April 12, 2000, SAIF accepted the bilateral plantar hyperkeratotic lesions as nondisabling injuries. (Ex. 27). SAIF did not advise claimant of his right to contest the nondisabling status.

On June 27, 2000, claimant asserted that the hyperkeratotic lesion condition was disabling. Claimant requested that SAIF submit the newly-accepted claim for closure. (Ex. 32). When SAIF did not issue a notice of classification or close the claim, claimant requested a hearing. The issues at hearing included whether SAIF had improperly failed to reopen and reclose claimant's claim and whether it had improperly classified a newly accepted condition as nondisabling.

The ALJ held that, under ORS 656.262(7)(c), SAIF was required to reopen and reclose claimant's claim so that his bilateral plantar hyperkeratotic lesions could be evaluated for temporary and/or permanent disability. In addition, the ALJ found that SAIF had not complied with *amended* ORS 656.277(1), which required it to review claimant's request and issue a notice of classification. The ALJ directed SAIF to issue a notice of classification that would give claimant an opportunity, if he wished, to request review of such notice by the Director of the Department of Consumer and Business Services.

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[1] We note that SAIF filed a motion to strike claimant's "respondent's brief," alleging that it was untimely. Claimant has filed a response, contending that his counsel's office erroneously believed that Monday, February 12, 2001 (the due date for his respondent's brief) was a federal holiday and, therefore, its office was closed. Because we have not received a brief from claimant, it is not necessary to address SAIF's motion. In any event, we further note that we generally do not consider a "calendaring" error to constitute "extraordinary circumstances" to warrant a waiver of the Board's rules. *See, e.g., Antonina Gnatiuk*, 50 Van Natta 976 (1998).

ORS 656.262(6)(b)(F) provides that the notice of acceptance shall "[b]e modified by the insurer or self-insured employer from time to time as medical or other information changes a previously issued notice of acceptance." ORS 656.262(6)(b) requires that the notice of acceptance shall, among other things:

> "(B) Advise the claimant whether the claim is considered disabling or nondisabling.
>
> "(C) Inform the claimant of the Expedited Claim Service and of the hearing and aggravation rights concerning nondisabling injuries, including the right to object to a decision that the injury of the claimant is nondisabling by requesting reclassification pursuant to ORS 656.277."

Here, SAIF modified its notice of acceptance on April 12, 2000, and informed claimant that it was accepting his bilateral plantar hyperkeratotic lesions as nondisabling injuries. (Ex. 27). The modified notice of acceptance did not inform claimant of the "hearing and aggravation rights concerning nondisabling injuries, including the right to object to a decision that the injury of the claimant is nondisabling[,]" as required by ORS 656.262(6)(b)(C).

Furthermore, there is no evidence that SAIF complied with *former* OAR 436-060-0045(1)(b) (WCD Admin. Order No. 97-065)[2] after it received notice of claimant's "pre-hearing" assertion that his claim should be classified as disabling.[3] (Ex. 32). *Former* OAR 436-060-0045(1) provides, in part:

> "When an insurer receives notice or knowledge that a nondisabling injury has become disabling, the insurer shall do one of the following:
>
> "* * * * *
>
> "(b) If the insurer disagrees that the claim is or originally was disabling, or is unable to decide whether the claim is disabling, the insurer shall submit an 'Insurer's Report', Form 440-1502, and 'Insurer Notice of Closure Summary or Request for Determination', Form 1503, to the department with copies of the Form 801 and Notice of Acceptance and all medical, vocational, and time loss records within 21 days from receipt of the notice or knowledge. The 1502 form shall indicate that the claim is nondisabling, and will state in the 'explanation' section that the claim is being reported pursuant to ORS 656.277 for department review of the nondisabling classification. A copy of the Form 1503 shall be sent to the worker and the worker's representative, explaining that the worker's assertion that the claim is disabling has been reported to the director for determination."

The record does not establish that SAIF complied with either ORS 656.262(6)(b)(C) or *former* OAR 436-060-0045(1)(b) when it modified its acceptance to include the new medical condition of bilateral plantar hyperkeratotic lesions. Therefore, in lieu of the ALJ's order, we direct SAIF to comply with those provisions.[4]

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[2] OAR 436-030-0003(3)(b) (WCD Admin. Order No. 00-061) provides that, for claims with dates of injury prior to October 23, 1999, the provisions of OAR 436-030-0045 in Administrative Order 97-065 shall apply until the industry is notified otherwise by the Director. Here, because SAIF's modified notice of acceptance referred to the date of injury as March 20, 1997, *former* OAR 436-030-0045 applies to this case.

[3] In *Johansen v. SAIF*, 158 Or App 672 (1998), *on recon* 160 Or App 579, *rev den* 329 Or 527 (1999), the court held that a "new medical condition" claim is distinct from the initial claim in several respects, including being entitled to its own classification as disabling or nondisabling. 158 Or App at 680, 681.

[4] Because we have determined that SAIF has not complied with the requirements for a notice of acceptance and claim classification, we need not address whether the claim must be reopened and reclosed or whether it was properly classified. Under these particular circumstances (where claimant expressly challenges the carrier's notice of acceptance and classification of the claim), those issues are currently premature, in that further claim processing actions and (potentially) appeals of those actions must occur until the matter is properly before the Hearings Division or this Board. Finally, in light of our disposition on this basis, it is likewise premature to address SAIF's arguments regarding the application of ORS 656.262(7)(c) and the necessity of closing a nondisabling new medical condition claim.

Penalty-related Attorney Fees

The ALJ found that SAIF's failure to issue a notice of classification and to reopen claimant's claim constituted an unreasonable resistance to the payment of compensation. The ALJ assessed a penalty-related attorney fee under ORS 656.382(1) for SAIF's unreasonable claims processing.

On review, SAIF argues that claimant is not entitled to a penalty-related attorney fee because there is no evidence that any compensation was due. We agree.

ORS 656.382(1) provides that, if a carrier "unreasonably resists the payment of compensation," it shall be liable for a reasonable attorney fee. However, there is no unreasonable resistance to payment of compensation if the carrier paid all compensation. *See SAIF v. Condon*, 119 Or App 194, *rev den* 317 Or 163 (1993); *Aetna Casualty Co. v. Jackson*, 108 Or App 253 (1991). Here, because there is no evidence of unpaid compensation related to the newly accepted bilateral hyperkeratotic lesion condition, claimant is not entitled to a penalty-related attorney fee under ORS 656.382(1). *See SAIF v. Wilson*, 95 Or App 748, 749 (1989).

ORDER

The ALJ's order dated December 15, 2000 is vacated in part, modified in part, reversed in part, and affirmed in part. The portion of the ALJ's order that directed SAIF to reopen the claim pursuant to ORS 656.262(7)(c) is vacated. In lieu of the ALJ's claim processing directives, SAIF is directed to issue a Modified Notice of Acceptance concerning the bilateral plantar hyperkeratotic lesions in accordance with ORS 656.262(6)(b)(C) and *former* OAR 436-060-0045(1)(b), and to issue a notice of classification pursuant to ORS 656.277. The ALJ's award of a $500 penalty-related attorney fee under ORS 656.382(1) is reversed. The ALJ's order is otherwise affirmed.

April 27, 2001 Cite as 53 Van Natta 602 (2001)

In the Matter of the Compensation of
PHILLIP W. BARTON, Claimant
WCB Case No. 00-03219
ORDER ON REVIEW
Hornecker, Cowling, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the self-insured employer's partial denial of claimant's bilateral hearing loss. The employer moves to strike claimant's reply brief as untimely filed. On review, the issues are motion to strike and compensability. We grant the motion to strike and affirm.

FINDINGS OF FACT

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

Claimant was born on April 17, 1948. He began working for the employer in 1972. Claimant filed a hearing loss claim on November 28, 1988, which was accepted and closed by an April 3, 1989 Determination Order that awarded 29.16 degrees scheduled permanent disability for his binaural hearing loss. (Ex. 12). This award was based on hearing tests conducted on or about February 23, 1989. Claimant continued to work and to use hearing protection.

On January 16, 1998, claimant requested new hearing aids and audiometric testing was performed. The tests revealed moderate to profound sensorineural hearing loss in the right ear and mild to severe sensorineural hearing loss in the left ear. (Ex. 14). Hearing aids were provided by the employer on March 31, 1998. (Ex. 15).

On August 17, 1999, claimant was seen for routine audiologic testing. The tests revealed that, since the 1998 tests, his hearing loss in the left ear was relatively stable, but had increased in the right ear. He also demonstrated an abnormal right tympanogram. Claimant was referred to Dr. Scott, otolaryngologist, to determine whether a hearing aid for the right ear would be of benefit.

Audiograms were performed on August 19, 1999 that showed a 92.5 percent hearing loss in the right ear and 33.7 percent hearing loss in the left ear. (Ex. 22).

Claimant was examined by Dr. Scott on September 1, 1999. (Ex. 23). Dr. Scott concluded that the etiology of claimant's hearing loss was unclear. (Ex. 23-2). On September 27, 1999, Dr. Scott noted that the audiogram performed on December 19, 1988 showed a 54 percent hearing loss in the right ear and a 26.5 percent hearing loss in the left ear. Dr. Scott opined that claimant's hearing loss in both ears was more than would be expected with presbycusis, but was unable to attribute the additional hearing loss in each ear to noise exposure at work. (Exs. 25, 26B).

On February 21, 2000, Dr. Ediger, audiologist, evaluated claimant's hearing loss. (Ex. 27).

Claimant filed a claim for the additional hearing loss since 1988, which was denied by the employer. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

The employer has moved to strike claimant's reply brief on the basis that it was not timely filed within 14 days of the mailing of its March 14, 2001 respondent's brief. The employer relies on our receipt of the brief as evidenced by our March 30, 2001 date stamp.

Claimant's reply brief was due on March 28, 2001. For purposes of appellant's briefs, "filing" is defined as "the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing." *See* OAR 438-005-0046(1)(c). Briefs filed with the Board are timely filed if mailed by "first class mail, postage prepaid." *See* OAR 438-05-046(1)(d). An attorney's certificate that a thing was deposited in the mail on a stated date is proof of mailing on that date. (*Id.*) If the thing is not received within the prescribed time and no certificate of mailing is furnished, it shall be presumed that the filing was untimely unless the filing party establishes that the filing was timely. (*Id.*).

Here, the cancelled envelope enclosing the reply brief sent to the Board indicates that it was deposited in the mail on March 29, 2001. Accordingly, under the applicable administrative rule, claimant's reply brief was untimely filed and we grant the employer's motion to strike.

Compensability

Claimant has an accepted claim for noise-related binaural hearing loss incurred through February 23, 1989.[1] The ALJ found that claimant failed to establish that his hearing loss incurred after that date was a compensable occupational disease. We agree.

Due to the passage of time since 1989 and the possible multiple causes of claimant's current hearing loss, we find that the causation issue in this case is a complex medical question that requires expert medical evidence. *Uris v. Compensation Department*, 247 Or 420, 424 (1967); *Barnett v. SAIF*, 122 Or App 279, 282 (1993). Dr. Scott, treating otolaryngologist, provided the only medical opinion arguably supporting compensability of claimant's hearing loss since 1989.

When Dr. Scott examined claimant on August 19, 1999, he opined that claimant's bilateral hearing loss was more than would be expected with presbycusis, but was unable to attribute the additional hearing loss in each ear to noise exposure at work. (Exs. 25, 26B). In a September 1, 1999 examination, he noted that claimant's right eardrum was scarred. He diagnosed right and left ear neurosensory hearing loss, "etiology unclear" and recommended an MRI to rule out lesions such as acoustic neuroma. (Ex. 23). On September 27, 1999, Dr. Scott noted that he was not sure whether claimant's hearing loss was related to noise exposure at work, but thought it a "possible contributing factor." (Ex. 25).

In a subsequent response to claimant's then-attorney, Dr. Scott concluded that claimant's additional hearing loss from 1988 to 1999 was secondary to noise exposure, although he admitted that it was difficult to say with certainty because claimant had been exposed to less noise and wore hearing protection during that period. (Ex. 26B). Finally, in a July 17, 2000 letter, Dr. Scott noted the causative factors in claimant's current hearing loss as the abnormal appearance of his ear drums, abnormal

[1] This was the last audiogram taken prior to the April 1989 claim closure.

tympanograms, evidence of hearing loss prior to 1972, the continuous use of hearing protection, and the abrupt decreased hearing in both ears from 1997 to the present. After eliminating current active ear disease as the cause of claimant's hearing loss, Dr. Scott concluded that it was medically probable that the increased hearing loss was due to noise exposure at work. (Ex. 31). In his opinion, however, Dr. Scott did not evaluate relative causation due to presbycusis, work-related noise exposure, and the other enumerated causes (aside from active ear disease).

Finally, on August 22, 2000, Dr. Scott opined that claimant's hearing loss was due to the noise exposure throughout his lifetime, particularly the exposure at work. (Ex. 31B). However, he offered no reasoned explanation for his opinion, other than his inability to determine another cause, although he again noted that he had previously thought that other pathologies other than work were causative factors. Moreover, the issue is not the cause of claimant's overall hearing loss, but only the portion that occurred from 1989 to the present. Because Dr. Scott did not evaluate the effect of the pre-1972 hearing loss in the right ear, presbycusis (particularly in light of Dr. Ediger's opinion that presbycusis comprised the majority of claimant's hearing loss), or the preexisting hearing loss, as is required under *Dietz v. Ramuda*, 130 Or App 297, 401 (1994), *rev dismissed* 320 Or 416 (1997), we agree with the ALJ that Dr. Scott's opinion is unpersuasive.[2]

ORDER

The ALJ's order dated November 13, 2000 is affirmed.

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[2] We note that claimant is unrepresented. Because he is unrepresented, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in such matters. He 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 97301-3878

In the Matter of the Compensation of
JEFF A. HICKEY, Claimant
WCB Case No. 99-08749
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Jerry Keene, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Johnson's order that: (1) upheld the self-insured employer's denial of his injury claim for a hernia condition; and (2) declined to assess a penalty for the employer'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.

The ALJ upheld the employer's denial under ORS 656.005(7)(a)(B), finding that claimant had failed to prove that his injury was the major contributing cause of the need for treatment of his indirect left inguinal hernia. On review, claimant contends that the ALJ should have applied a material contributing cause standard in determining compensability because the record does not establish the presence of a "preexisting condition." Claimant asserts that the only evidence of a preexisting condition is that he was predisposed to having a hernia because he is a male. According to claimant, such a "predisposition" cannot constitute a "preexisting condition" under ORS 656.005(24). For the following reasons, we do not find claimant's contentions persuasive.

Pursuant to ORS 656.005(24), a preexisting condition is:

> " * * * any injury, disease, congenital abnormality, personality disorder or similar condition that contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an initial claim for an injury or occupational disease, or that precedes a claim for worsening pursuant to ORS 656.273."

Here, Dr. Foster, claimant's surgeon, testified that it was medically probable that claimant has a preexisting congenital condition called "patent processus vaginalis" that predisposed claimant to a hernia. (Ex. 17-11). According to Dr. Foster, this condition occurs in about one percent of all infants that are born. (Ex. 17-7). Moreover, Dr. Foster testified that, while this occurs most commonly in males, it does occur in females. (Ex. 17-8).

Having reviewed Dr. Foster's medical opinion, we disagree with claimant's assertion that the mere fact of being male was the predisposing condition in this case. Instead, we find that the medical evidence establishes that claimant has a relatively rare congenital abnormality that predisposed him to disability or a need for treatment. Therefore, even assuming for the sake of argument that the sex of a claimant could never constitute a "preexisting condition" under ORS 656.005(24), we, nevertheless, conclude that the evidence in this case satisfies the statutory requirements for a "preexisting condition."

Thus, we conclude that the ALJ correctly applied the major contributing cause standard of ORS 656.005(7)(a)(B) because, for the reasons cited by the ALJ, the preexisting condition "combined" with claimant's injury to cause a need for treatment. In addition, we agree with the ALJ's reasoning that claimant failed to prove a compensable claim under that statute.

Turning to the penalty issue, claimant argues that the ALJ should have assessed a penalty for an untimely denial. Even if we assume that the employer's claim processing was unreasonable, the record does not establish that there was compensation due in the form of unpaid medical bills or temporary disability at the time of the delay period. *See Melody L. Rivers*, 48 Van Natta 2089 (1996) (a penalty may be assessed under ORS 656.262(11)(a) if there are amounts then due between the date when the acceptance or denial should have issued and the date of the denial). Thus, we decline to assess a penalty.

ORDER

The ALJ's order dated January 16, 2001 is affirmed.

April 27, 2001 Cite as 53 Van Natta 605 (2001)

In the Matter of the Compensation of
CHARLES W. HURLEY, Claimant
WCB Case No. 00-06769
ORDER ON REVIEW
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Johnson's order that affirmed an Order on Reconsideration that awarded no unscheduled permanent disability for claimant's left inguinal ligament strain and left inguinal hernia. Claimant has submitted a "post-hearing" medical report on review. We treat claimant's submission as a motion to remand to the ALJ for the taking of additional evidence. On review, the issues are remand and extent of unscheduled permanent disability.

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

Claimant has provided a "post-hearing" surgical report dated March 28, 2001 in support of his claim that he is entitled to additional permanent disability for left inguinal ligament strain and left inguinal hernia condition. Because this medical report was not presented as evidence at the hearing, we treat this submission as a request for remand for the admission of additional evidence. *Judy A. Britton*, 37 Van Natta 1262 (1985).

Our review is limited to the record developed by the ALJ. We may remand to the ALJ for the taking of additional evidence if we determine that the record as been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). In addition, to merit remand, it must clearly be shown that relevant, material evidence was not obtainable with due diligence at the time of the hearing. *Compton v. Weyerhaeuser Co.*, 301 Or 641 (1986).

Because this is an "extent" proceeding,[1] the ALJ is limited to the record developed at reconsideration before the Department. ORS 656.268(7)(h); ORS 656.283(7). Accordingly, because the medical report submitted by claimant was not in the reconsideration record, neither the ALJ nor the Board can consider it. *Douglas D. Power*, 52 Van Natta 107 (2000); *Brent Harper*, 51 Van Natta 1002 (1999).

Because the evidence would not be admissible at hearing, there is no compelling reason to remand this matter to the ALJ for further proceedings. The consideration of this document would not affect the outcome of this case. *Compton v. Weyerhaeuser*, 301 Or at 646; *Juana M. Lopez*, 52 Van Natta 1654 (2001). Consequently, we deny claimant's motion to remand.[2]

ORDER

The ALJ's order dated January 4, 2001 is affirmed.

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[1] Claimant informs us that his attending physician will be asking the SAIF Corporation to reopen his injury claim. We note that this claim processing issue is not before us at this time. *See* n.2, *ante*.

[2] It appears from claimant's arguments that he may not understand his rights and benefits under the Workers' Compensation Law. Since claimant is unrepresented, he may wish to contact the Workers' Compensation Ombudsman whose job is to assist injured workers regarding workers' compensation matters:

Workers' Compensation Ombudsman
Dept. of Consumer & Business Services
350 Winter Street NE
Salem, OR 97301
Telephone: 1-800-927-1271

In the Matter of the Compensation of
SALVADOR MACEDONIO, Claimant
WCB Case No. 00-06313
ORDER ON REVIEW
McGinty & Belcher, Claimant Attorney
Meyers, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Spangler's order that affirmed an Order on Reconsideration that awarded 39 percent (74.88 degrees) scheduled permanent disability loss of use or function of claimant's right wrist/forearm condition. On review, the issue is extent of scheduled permanent disability.

We adopt and affirm the ALJ's order, except for the next-to-last paragraph, with the following supplementation.

The ALJ stated that he could not consider Dr. Mayhall's medical arbiter's supplemental report because the Appellate Review Unit received it the day after the Order on Reconsideration issued and the supplemental report is therefore not part of the reconsideration record. We disagree, for two reasons.

First, the Order on Reconsideration is dated August 2, 2000. The relevant supplemental report bears a date stamp indicating that it was received that day. Moreover, the reconsideration order and the findings therein indicate that the Appellate Review Unit received and relied on Dr. Mayhall's supplemental report. (*See* Exs. 41A-1, 43-1-2, 43-7; *see also* Ex. 41-5). Under these circumstances, we conclude that the supplemental report was part of the reconsideration record.

Second, even if the report was not part of the reconsideration record, it would be admissible at hearing under ORS 656.268(6)(f). *See Mac A. Payne*, 49 Van Natta 31 (1997) (construing *former* ORS 656.268(6)(e)). Accordingly, we have considered Dr. Mayhall's supplemental report on review. Based in part on that report, we agree with the ALJ that the Order on Reconsideration correctly rated claimant's permanent impairment.

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 $500, 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 December 11, 2000 is affirmed. For services on review, claimant is awarded a $500 attorney fee, payable by the self-insured employer.

In the Matter of the Compensation of
GARY E. PUCKETT, Claimant
WCB Case No. 00-06965
ORDER ON REVIEW
Max Rae, Claimant Attorney
Julie Master (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Johnson's order that affirmed an Order on Reconsideration that did not award temporary disability benefits for the period beginning December 3, 1999. On review, the issue is temporary disability. We affirm.

FINDINGS OF FACT

Claimant worked as a roofer for 38 years. Over the years, he had low back and neck injuries, bilateral knee surgeries, and intermittent right wrist symptoms.

Claimant retired on January 1, 1999 and he has not worked since that date.

The SAIF Corporation accepted claimant's claim for right carpal tunnel syndrome and Dr. Wilson performed right carpal tunnel release surgery on November 23, 1999. SAIF paid temporary disability through December 2, 1999, the date that Dr. Wilson released claimant to work, "one handed use only." (Ex. 7A).

An April 26, 2000 Notice of Closure awarded no temporary or permanent disability benefits. An Order on Reconsideration awarded temporary disability compensation for the period from November 23, 1999 through December 2, 1999. Claimant requested a hearing, seeking additional temporary disability benefits for the period beginning December 3, 1999.

CONCLUSIONS OF LAW AND OPINION

The ALJ declined to award temporary disability benefits for periods after December 2, 1999, because he found no evidence that claimant's retirement was "meaningfully related to his injury."[1]

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[1] The ALJ also reasoned that claimant failed to carry his burden of proving entitlement to temporary disability after December 2, 1999, because the record does not indicate when any such disability period ended. We do not reach this question, because we find that claimant is not entitled to temporary disability in any event, as explained herein.

Claimant concedes that he was not entitled to temporary disability benefits on January 1, 1999, the date he retired. Rather, claimant contends that he is entitled to temporary disability benefits from December 3, 1999 forward as his January 1999 retirement was due in part to the compensable hand condition. The issue of whether claimant retired in January 1999 for reasons related to the injury is not relevant to the current dispute. Rather, the question presented is whether claimant was in the work force in December 1999, the time period for which claimant asserts entitlement to temporary disability benefits.

In order to be entitled to temporary disability compensation, claimant must have been in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). "[T]he critical time for determining whether a claimant has withdrawn from the work force is at the time of his disability." *Weyerhaeuser Co. v. Kepford*, 100 Or App 410, *rev den* 310 Or 71 (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).

As noted above, claimant must establish that he was in the work force at the time of his December 1999 disability. Claimant was not engaged in regular gainful employment in December 1999. Moreover, there is no evidence suggesting that claimant was willing to work or was seeking work. Finally, there is no medical evidence establishing that claimant's work-related injury would have made efforts to seek work futile. In fact, Dr. Wilson released claimant to modified work as of December 1, 1999. (Ex. 7A).

Under these circumstances, we conclude that claimant was not in workforce when he became disabled. *See Dawkins*, 308 Or at 258; *James F. Fowlkes*, 48 Van Natta 771 (1996) (claimant not entitled to temporary disability because he became disabled after he left the work force); *Patricia M. Demetrakos*, 44 Van Natta 707 (1992) (same). Accordingly, we agree with the ALJ that claimant has not established entitlement to temporary disability compensation for the period beginning December 3, 1999.

ORDER

The ALJ's order dated January 26, 2001 is affirmed.

April 27, 2001 Cite as 53 Van Natta 608 (2001)

In the Matter of the Compensation of
BONNIE J. ULRICH, Claimant
WCB Case No. 98-06744
ORDER ON RECONSIDERATION
Reinisch, et al, Defense Attorney

On April 10, 2001, we affirmed an Administrative Law Judge's (ALJ's) order that upheld the self-insured employer's denial of claimant's occupational disease claim for a left wrist condition. Claimant has resubmitted her March 19, 2001 letter, along with a copy of an article on carpal tunnel syndrome (which was otherwise not contained in the record). We treat claimant's submission as a request for reconsideration, as well as a motion for remand to the ALJ for the taking of additional evidence.

Our review must be based on the record certified to us. *See* ORS 656.295(5). Consequently, we treat claimant's request to present additional evidence on review as a motion to remand to the ALJ for the taking of additional evidence. *Tamara J. Fleshman*, 52 Van Natta 1918 (2000); *Judy A. Britton*, 37 Van Natta 1262 (1985).

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 clearly be shown that material 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).

Here, there is no evidence that the submitted article was unavailable with due diligence at the time of the hearing. *See Robert A. Wilson*, 52 Van Natta 2225 (2000); *Tamara J. Fleshman*, 52 Van Natta at 1918. Moreover, in light of the existing documentary and testimonial evidence already present in the record, consideration of this additional evidence would not likely affect the outcome. *See Compton v. Weyerhaeuser Co.*, 301 Or at 646. In other words, even if the article was considered, it would not change our decision that claimant's work activities were not the major contributing cause of her left wrist condition.

Under these circumstances, we conclude that the case has not been improperly, incompletely, or otherwise insufficiently developed. Consequently, it does not merit remand. ORS 656.295(5).

Accordingly, we withdraw our April 10, 2001 order. On reconsideration, as supplemented herein, we adhere to and republish our April 10, 2001 order.[1] 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 claimant is unrepresented. She may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers regarding workers' compensation matters. She may contact the Workers' Compensation Ombudsman at (503) 378-3351 or 1-800-927-1271 (V/TTY) (within the State of Oregon), or write to:

Workers' Compensation Ombudsman
Dept. of Consumer & Business Services
350 Winter Street NE
Salem OR 97301

In the Matter of the Compensation of
CHRISTOPHER W. YUNGE, Claimant
WCB Case No. 00-03542
ORDER ON REVIEW
Daniel Snyder, Claimant Attorney
Sheridan, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that upheld the insurer's denial of his injury claim for a cervical and thoracic condition. On review, the issue is compensability.

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

In the first paragraph of the findings of fact, we change the date in the first sentence to "January 31, 2000." In the second paragraph on page one, we replace the first sentence with the following: "Claimant testified that he did not realize he had been injured on January 31, 2000 until he experienced severe pain in the middle of the night and the next morning. (Tr. 32, 36, 67). The pain was at the base of his neck. (Tr. 36, 37)." In the third paragraph on page two, we change the citation in the second sentence to "ORS 656.266."

We delete the first full paragraph on page 3 and replace it with the following.

We find that this case presents a complex medical question due to the fact that it involves a delay in the onset of symptoms, as well as a delay in reporting the injury to the employer and in seeking medical attention. Under these circumstances, the causation issue must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 282 (1993). Claimant relies on the opinion of Dr. Takacs, his attending physician, to establish compensability of his cervical and thoracic condition.

For the following reasons, we agree with the ALJ that Dr. Takacs' opinion is not sufficient to establish compensability. Dr. Takacs examined claimant on February 4, 2000 and diagnosed "[s]ituational

agitation with cervical, upper thoracic and shoulder girdle strain, associated somatic dysfunction." (Ex. 83-1). Claimant indicated he had been injured on January 31, 2000 while doing some heavy lifting. (*Id.*) Dr. Takacs found that claimant had moderate cervical, upper thoracic and shoulder girdle somatic dysfunction and variable intensity of muscle spasm. (*Id.*) He noted that claimant had recently been fired and complained of sexual harassment at work. (*Id.*) Dr. Takacs said that claimant "displays emotional vicissitudes, concerns about his livelihood, child support, opportunity to work, etc." (*Id.*)

In a July 2000 "check-the-box" report from claimant's attorney, Dr. Takacs agreed that claimant had sustained a left cervical thoracic strain, related in major part to his work activities. (Ex. 94-2). Dr. Takacs agreed that his opinion was based upon a reasonable degree of medical probability. (*Id.*)

In a later concurrence letter from the insurer's attorney, however, Dr. Takacs agreed with the following:

> "With regard to the instant claim, you first saw [claimant] on February 4, 2000 with regard to cervical, upper thoracic and shoulder girdle complaints, as well as some apparent situational agitation. [Claimant] provided a history of feeling something pull in his neck and upper back while doing some heavy lifting on January 31, 2000 at work. He also was upset about some apparent work issues including a claim of sexual harassment, and his recent termination for failing a drug test.
>
> "During your examination, and during subsequent follow-up visits in February 2000, you found evidence of cervical, thoracic and shoulder girdle findings, which could be diagnosed as a strain, and which by history could have occurred at work. *Equally, your examination findings relative to [claimant's] cervical, thoracic and shoulder complaints could have come from a situational agitation over his failed drug test and subsequent termination and other work concerns. Summarizing, [claimant's] findings on examination were of variable intensity, and could have arisen from a work incident as described, or could have arisen from his situational agitation.*" (Ex. 95-1, -2; emphasis supplied).

In a deposition, Dr. Takacs adhered to the concurrence letter from the insurer. (Ex. 98-24). He explained that during the February 4, 2000 examination, claimant was upset on several counts and he felt that situational agitation was one of the most prominent features. (Ex. 98-21). Although Dr. Takacs found that claimant had muscle spasm, he said that other factors can contribute to tight muscles and can complicate the attempt to make an objective evaluation and diagnosis. (Ex. 98-10). In discussing "somatic dysfunction," Dr. Takacs explained that if a person is emotional or upset, they will have some tightness in their upper back and neck and shoulders. (Ex. 98-13). He said that a person can develop these types of objective findings due to a number of different causes, including stress, as well as injury. (Ex. 98-13, -14).

Dr. Takacs was asked about Dr. Baker's August 2, 2000 report, in which Dr. Baker said he did not believe claimant had a valid injury on January 31, 2000. (Ex. 98-25, *see* Ex. 96). Dr. Takacs commented that Dr. Baker's description appealed to him and he was inclined to look favorably on what he was trying to say. (Ex. 98-26).

In *Gormley v. SAIF*, 52 Or App 1055, 1060 (1981), the court found that the doctors' use of the words "could," "can," "it is reasonable to assume" and "we would like to assume" militated against a finding of medical causation in terms of probability. The court concluded that, because the claimant could not prove more than just the possibility of a causal connection, she failed to carry her burden of proof.

Here, Dr. Takacs adhered to the concurrence letter from the insurer, in which he agreed that "[e]qually, your examination findings relative to [claimant']s cervical, thoracic and shoulder complaints could have come from a situational agitation over his failed drug test and subsequent termination and other work concerns." (Ex. 95-1). Dr. Takacs agreed that claimant's examination findings "could have arisen from a work incident as described, or could have arisen from his situational agitation." (Ex. 95-2). We find that Dr. Takacs' opinion suggests only a possibility that claimant's cervical and thoracic condition was caused by a work injury. We conclude that Dr. Takacs' causation opinion is not sufficient to establish medical causation in terms of probability.[1]

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[1] We reach this conclusion whether the appropriate compensability standard is "major" or "material" contributing cause.

The remaining causation opinions do not support compensability. As mentioned above, Dr. Baker reconsidered and issued a second report indicating he did not believe claimant had a valid injury on January 31, 2000. (Ex. 96). Dr. Wicher, psychologist, opined that psychological factors played a major role in claimant's complaints. (Ex. 91-7). Consequently, we agree with the ALJ that claimant has failed to sustain his burden of proving a compensable cervical and thoracic condition.

ORDER

The ALJ's order dated December 26, 2000 is affirmed.

April 30, 2001 Cite as 53 Van Natta 611 (2001)

In the Matter of the Compensation of
WILLIAM M. TRUSTY, Claimant
Own Motion No. 01-0126M
OWN MOTION ORDER
Bischoff, Strooband & Ousey, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his right shoulder condition. SAIF agrees that claimant's current condition and need for surgery is causally related to his accepted condition and that it is responsible for claimant's current condition. However, SAIF 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).

SAIF contends that claimant was not in the work force at the time of the current disability because it has not received any documentation "that supports the worker was in the workforce at the time of disability." However, with its recommendation form, SAIF submitted a November 30, 2000 chart note from Dr. Galt, claimant's attending physician, which indicates that claimant was in the work force at the time of the current disability. Specifically, Dr. Galt noted that claimant was "working full time * * * both as a truck driver and more recently has a mechanic." Dr. Galt also reported that claimant was "limited as far as how much work he can do." *See John R. Kennedy*, 50 Van Natta 837 (1998) (the claimant was found to be in the work force at the time of his current disability based on work references incorporated in the medical record).

Additionally, SAIF submitted a copy of claimant's "Wage and Potential Benefit Report" which shows that claimant applied for and was granted unemployment benefits in January 2001. The receipt of unemployment benefits is *prima facie* evidence that claimant is willing to work and is making reasonable efforts to obtain employment. *See Carol L. Conaway*, 43 Van Natta 2267 (1991); *John T. Seiber*, 43 Van Natta 136 (1991).

Therefore, based on the record, we conclude that claimant was in the work force at the time of his current worsening. Accordingly, we authorize the reopening of claimant's claim for SAIF 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.

In the Matter of the Compensation of
BRIAN M. HAMILTON, Claimant
WCB Case No. 00-02842
ORDER ON REVIEW
Mitchell & Guinn, Claimant Attorney
Meyers, et al, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Otto's order that upheld the self-insured employer's denial of claimant's current right wrist condition. On review, the issue is compensability. We affirm, as modified below.

FINDINGS OF FACT

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

Claimant, a stock clerk, sustained a compensable right wrist injury on June 22, 1999. The employer accepted nondisabling "right wrist tendinitis." (Ex. 18). On September 15, 1999, Dr. Rabie reported that claimant's tendinitis condition had resolved and declared him medically stationary. (Ex. 17).

On October 19, 1999, claimant lifted an empty dinner plate at home and experienced right wrist pain. (Ex. 20). Dr. Rabie diagnosed de Quervain's tendinitis, which he characterized as a preexisting condition that dated back to his June 22, 1999 injury. Dr. Rabie found that the earlier condition had combined with the plate-lifting injury and opined that the major contributing cause of claimant's current combined condition was the new, off-the-job plate-lifting incident. (Exs. 21, 22). On November 10, 1999, Dr. Rabie declared that claimant's combined condition had resolved and that he was medically stationary without evidence of permanent impairment. (Ex. 23).

On March 2, 2000, the employer denied claimant's current right wrist condition claim on the basis that an intervening, off-the-job injury had become the major contributing cause of his current condition. (Ex. 26).

On April 10, 2000, claimant was examined by Dr. Carvalho. (Ex. 28).

On June 6, 2000, claimant was examined by Dr. Gritzka. (Ex. 28A).

On June 14, 2000, claimant was examined by Drs. Fuller and Radecki.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that the denial was a "back-up" denial of claimant's accepted tendinitis condition, but that it was properly issued based on "later obtained evidence." The ALJ reasoned that the evidence generated in support of the denial established that a preexisting bony abnormality was the major contributing cause of claimant's right wrist condition, and the only relevant change in the circumstances of the claim was the discovery of that preexisting condition. The ALJ further concluded that the employer had carried its burden to prove that claimant's preexisting condition was the major contributing cause of claimant's current right wrist condition.

We affirm, as supplemented and modified below. Our conclusion is based on the following reasoning.

On review, claimant contends that the ALJ properly found that the denial was a "back-up" denial of claimant's accepted right wrist condition, but argues that it should be set aside as procedurally invalid because it was based on the re-interpretation of the same x-rays the employer had in its possession prior to acceptance of the June 1999 claim. We conclude that the employer's March 2, 2000 denial was not a "back-up" denial, and, on the merits, conclude that claimant's current condition is not compensable. We reason as follows.

Our first inquiry is whether claimant's current condition was previously accepted. We conclude that it was not. The employer expressly accepted only right wrist tendonitis. Claimant's current condition involves a new, intervening injury that combined with his de Quervain's tendonitis and a preexisting radial boss that caused a nodular reaction in the abductor tendon.

Although the evidence from Drs. Fuller and Radecki supporting the employer's current condition denial could arguably be interpreted as being directed toward the compensability of the original June 22, 1999 right wrist injury,[1] the compensability of the original June 1999 injury is not at issue in this case, given that the employer has accepted that injury. Rather, the issue is the compensability of claimant's current condition arising from an October 19, 1999 injury that claimant incurred at home when he lifted a plate.[2] Because the accepted "right wrist tendinitis" condition is not the same condition as the denied combined condition, we reject claimant's assertion that the employer issued a "back-up" denial.[3] *See, e.g., Melvin E. Schneider, Jr.*, 47 Van Natta 1024 (1995) (a carrier's denial of a current condition is a "back-up" denial unless the denied condition is different from the accepted condition).

After reviewing the record *de novo*, we adopt the ALJ's opinion on the compensability issue, which begins at the last paragraph on page 4. We substitute the following for the last three sentences of his opinion on page 6: Consequently, claimant has failed to prove by a preponderance of the evidence that his June 1999 compensable injury is the major contributing cause of his need for medical treatment or disability of his current combined right wrist condition. *See* ORS 656.266; 656.005(7)(a)(B); *SAIF v. Nehl*, 149 Or App 309 (1997).

ORDER

The ALJ's order dated November 29, 2000 is affirmed, as modified above.

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[1] As noted by the ALJ, although Drs. Fuller and Radecki initially agreed with Dr. Rabie that the October 19, 1999 plate-lifting injury was the major cause of claimant's right wrist condition (Ex. 29-9), they later opined that the preexisting bony abnormality was the major contributing cause of claimant's de Quervain's tendonitis (Ex. 32).

[2] *See* reply brief at 2.

[3] Thus, we need not address whether the employer's denial was based on "later obtained evidence" under ORS 656.262(6)(a).

In the Matter of the Compensation of
MARGARET J. CHRISTENSEN, Claimant
WCB Case Nos. 00-04545 & 00-02612
ORDER OF ABATEMENT
Westmoreland & Mundorff, Claimant Attorney
VavRosky, et al, Defense Attorney

On April 11, 2001, we issued an Order on Reconsideration that republished our February 16, 2001 order that affirmed an Administrative Law Judge's (ALJ's) order that set aside the self-insured employer's partial denial of claimant's C3-4 instability condition. Announcing that the parties have settled their dispute, the employer seeks withdrawal of our order to await the submission of an executed settlement agreement for our consideration.

Based on the employer's representation, we withdraw our April 11, 2001 order. On receipt of the parties' proposed settlement, we will proceed with our consideration of their agreement. In the meantime, the parties are requested to keep us fully apprised of any future developments.

IT IS SO ORDERED.

In the Matter of the Compensation of
JEFFREY L. COEFIELD, Claimant
Own Motion No. 01-0110M
OWN MOTION ORDER
Martin L. Alvey, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his left knee condition. Claimant's aggravation rights have expired. SAIF opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force. Claimant requests assessment of a penalty, contending that SAIF's recommendation to deny reopening of his claim is unreasonable.[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.*

On March 9, 2001, Dr. Dales, claimant's attending physician, recommended surgery for claimant's left knee. On this record, 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).

The "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's Own Motion jurisdiction, is the date of the proposed surgery or the date of inpatient hospitalization for a worsened condition. *Fred Vioen*, 48 Van Natta 2110 (1996). The relevant time period for which claimant must establish he was in the work force is the time prior to March 9, 2001 when his condition worsened requiring surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270 (1990); *SAIF v. Blakely*, 160 Or App 242 (1999); *Paul M. Jordan*, 49 Van Natta 2094 (1997).

SAIF contends that claimant was not in the work force at the time of his current disability. Claimant contends that he is willing to work and would have sought work, but was unable to do so due to his compensable condition. In support of his contentions, claimant submitted copies of his 1999 and 2000 W-2 tax forms, an April 4, 2001 affidavit, and medical documents. We review the history of the claim, along with the additional documentation, to fully address both parties' contentions.

On May 3, 1999, we issued an Own Motion Order authorizing reopening of claimant's left knee condition for the provision of temporary disability compensation. A January 22, 2001 Notice of Closure closed the claim with an award of temporary total disability from April 29, 1999 through August 15, 1999, and from February 29, 2000 through January 8, 2001. SAIF declared claimant medically stationary as of January 8, 2001. That closure was not appealed.

On April 2, 2001, SAIF submitted its Own Motion Recommendation, recommending denying reopening because claimant failed to establish that he was in the work force at the time of the current worsening. With its recommendation, SAIF submitted a March 9, 2001 chart note demonstrating that claimant requires surgery.

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[1] Due to our resolution of the work force issue, we need not address the penalty issue. However, we note that, when a claim is under our Own Motion jurisdiction, no compensation is due until we issue an order authorizing reopening of the claim. Therefore, prior to such an order, there are no "amounts then due" upon which to base a penalty under ORS 656.262(11). *Debra D. Robinson*, 49 Van Natta 786 (1997); *John D. McCollum*, 44 Van Natta 2057 (1992); *Thomas L. Abel*, 44 Van Natta 1039, *on recon* 44 Van Natta 1189 (1992).

To begin, claimant's submission of his *1999 and 2000* W-2 tax forms demonstrates that he worked sometime in calendar years *1999 and 2000*. However, claimant's condition worsened in March of *2001*. In order to be considered in the work force at the time of his current disability, claimant must show that he was in the work force prior to his March *2001* worsening.

In his April 4, 2001 affidavit, claimant contends that he is willing work and would have either sought work or worked within his limitations had it not been for his first surgery and his current need for surgery. Based on claimant's affidavit, we find that he is willing to work.

However, in order to prove that he is a member of the work force, claimant must also satisfy either the "seeking work" factor of the second *Dawkins* criterion or the "futility" factor of the third *Dawkins* criterion. Based on the following, we find that claimant failed to satisfy either of those factors.

As noted above, the relevant time period to determine whether claimant was in the work force is at the time of disability. *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990). On this record, claimant's condition worsened requiring surgery on March 9, 2001, which is the date of disability. In his affidavit, claimant noted that when his claim was closed in January 2001, Dr. Rusch, one of his treating physicians, imposed permanent work limitations. Claimant also stated that he could not work due to the effects of the compensable injury and that, but for that condition, he would have sought work.

Whether it would be futile for claimant to seek work is not a subjective standard; rather it is an objective standard determined from the record as a whole, especially considering persuasive medical evidence regarding claimant's ability to work and/or seek work. *Jackson R. Shrum*, 51 Van Natta 1062 (1999) (Board denied request for Own Motion relief where the record lacked persuasive medical evidence establishing that the claimant was unable to work and/or seek work due to the compensable injury); *Janet F. Berhorst*, 50 Van Natta 1578 (1998) (same; Board cannot infer futility). In short, the question is whether the compensable injury made it futile for claimant to make reasonable efforts to seek work, not whether claimant reasonably believes it to be futile.

Here, no medical opinion supports claimant's current "futility" contentions, nor does the record demonstrate that it would have been futile for him to work or seek work at the time of the current worsening (March 2001). Although Dr. Rusch placed restrictions on claimant that might have prevented him from working in a job that exceeded those restrictions, the record lacks medical evidence that demonstrates that it would have been futile for him to seek work within those restrictions. *Henry Williams*, 53 Van Natta 2 (2001) (work force factor not established where treating physician placed restrictions on the claimant's ability to work, the claimant failed to establish that he sought work within those restrictions, and no physician released the claimant from work or opined that the claimant was unable to work due to the compensable injury).

In addition, although claimant contends in his affidavit that he is on a leave of absence from his employer and that he still remains employed, he submits no documentation to support this contention. Claimant also contends that nothing has changed regarding his work force situation since his claim was last in "open" status on January 22, 2001. We disagree.

The unappealed January 22, 2001 closure found claimant medically stationary as of January 8, 2001. Furthermore, as of January 8, 2001, Dr. Rusch placed work restrictions on claimant, but did not release him from work or opine that work would be futile due to the compensable injury. These circumstances represent a change in claimant's work force situation. *See Robert D. Peck*, 45 Van Natta 2202 (1993) (five to seven week period between prior claim closure/medically stationary date and worsening not so brief so as to relieve the claimant of burden of proving work force issue).

The dissent essentially argues that we may infer futility of a work search based on a short time period between claim closure/medically stationary status and a subsequent worsening. In *Berhorst*, we found that we were without the medical expertise to make an inference as to futility of a work search, especially where no physician rendered such an opinion or made any statement from which such an opinion could be drawn. 50 Van Natta at 1578.

Here, as addressed above, no medical opinion supports claimant's "futility" contentions. In fact, the only medical opinion addressing the matter refutes those contentions; *i.e.*, Dr. Rusch essentially

released claimant to modified work. Additionally, as we explained in *Peck*, the length of the time period within which to look for work may go to the reasonableness of a work search. 45 Van Natta at 2022. However, as in *Peck*, the time periods here are not so brief as to relieve claimant of his burden of proving that he remained in the work force.

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

Board Member Biehl dissenting.

On the facts of this case, I would find that claimant remained in the work force. In this regard, I agree with the dissenting opinion in *Robert D. Peck*, 45 Van Natta at 2203, which found that the brevity of a period of five to seven weeks between claim closure/medically stationary status and a subsequent worsening in itself established that the claimant remained in the work force at the time of worsening. Because the majority disagrees, I respectfully dissent.

Here, on May 3, 1999, the Board issued an order reopening claimant's claim for a worsening requiring surgery. There was no dispute that claimant was in the work force at the time of that reopening. In addition, by definition, claimant remained in the work force during the period that he was entitled to temporary disability benefits, although he was unable to work due to the compensable injury. *Dawkins*, 308 Or at 258.

On January 22, 2001, claimant's claim was closed with an award of temporary total disability from April 29, 1999 through August 15, 1999, and from February 29, 2000 through January 8, 2001. Claimant was declared medically stationary as of January 8, 2001. That closure was not appealed. Therefore, at the time claimant's claim was closed, he had been receiving temporary total disability benefits for over a year. In other words, claimant had been unable to work due to the compensable condition for more than a year at claim closure.

As of March 9, 2001, claimant's condition again worsened requiring surgery. Thus, less than nine weeks passed from claimant's medically stationary date to the date of worsening and less than seven weeks passed from the date of closure to the date of worsening. In addition, by virtue of the prior reopening, claimant remained in the work force through January 8, 2001, the date through which he received temporary disability benefits due to his compensable injury. The fact that claimant was unable to work for more than a year before that claim closure due to the compensable injury makes it reasonable to conclude that he remained in the work force during the brief period of less than seven to nine weeks before his condition again worsened requiring surgery.

It would be both inequitable and unreasonable to conclude that claimant had withdrawn from the work force in the short period of time between the time he became medically stationary and his claim was closed and the time his condition again worsened. Therefore, for the above reasons, I respectfully dissent and would find that claimant remained in the work force at the time of his current disability.

In the Matter of the Compensation of
MELINDA I. HALE, Claimant
WCB Case No. 00-05958
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorney
Thaddeus J. Hettle, Defense Attorney

Reviewed by Board Members Biehl and Meyers.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that affirmed an Order on Reconsideration that awarded 8 percent (12 degrees) for loss of use or function of the right forearm and 18 percent (27 degrees) for loss of use or function of the left forearm. On review, the issue is extent of scheduled permanent disability.

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

Claimant has a bilateral forearm condition that was accepted for bilateral carpal tunnel syndrome. (Ex. 55). Following bilateral surgical releases by Dr. Stanley, claimant developed cold intolerance in both hands. On March 8, 2000, the claim was closed by Notice of Closure without an award of permanent disability. (Ex. 53). Claimant requested reconsideration. (Ex. 63a).

As a part of the reconsideration process, a medical arbiter's exam was performed by Dr. Weller. (Exs. 65b; 68). Relying on the medical arbiter's evaluation, an Order on Reconsideration awarded 8 percent (12 degrees) for loss of use or function of the right forearm and 18 percent (27 degrees) for loss of use or function of the left forearm. (Ex. 70-4). The employer requested a hearing challenging the Order on Reconsideration.

The ALJ determined that the medical arbiter's evaluation persuasively established that claimant's cold intolerance was the result of a vascular problem that was a direct medical sequelae of the accepted bilateral carpal tunnel syndrome. The ALJ further determined that claimant's cold intolerance was permanent. Consequently, the ALJ concluded that the medical arbiter's evaluation should be used to rate claimant's impairment. Accordingly, the ALJ affirmed the Order on Reconsideration.

On review, the employer contends that: (1) claimant is not entitled to ratable impairment for her cold intolerance as that condition is not a "direct medical sequelae" of the bilateral carpal tunnel syndrome; and (2) claimant is not entitled to ratable impairment for her cold intolerance as that condition is not permanent. Where a carrier seeks reduction of a permanent disability award made by an Order on Reconsideration, the carrier has the burden of establishing error in the reconsideration process. *Marvin Wood Products v. Callow*, 171 Or App 175 (2000). As discussed below, we disagree with the employer's contentions.

Claimant's disability is determined as of the date of the Order on Reconsideration. ORS 656.283(7). Impairment is established by a preponderance of medical evidence based upon objective findings. ORS 656.726(3)(f)(B). 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(14) (WCD Admin Order No. 98-055). Where a preponderance of evidence establishes a different level of impairment, the impairment is established by the preponderance of evidence.[1] (*Id.*)

Here, Dr. Weller, the medical arbiter, reviewed claimant's medical records and performed a medical exam. As a result, Dr. Weller opined that claimant was "significantly limited in the ability to repetitively use bilateral hands due to the accepted condition of bilateral carpal tunnel syndrome." (Ex. 65b-4). She further stated that claimant's cold intolerance met "the criteria for class I vascular disease and probable Raynaud's phenomenon." (*Id.*) In explaining the relationship of the cold intolerance to the carpal tunnel syndrome, Dr. Weller stated: "It is my impression that it is related to an autonomic dysfunction and probable autonomic nerve injury related to the compressive median neuropathy." (*Id.*)

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[1] This preponderance of medical evidence must come from 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 find that Dr. Weller's analysis persuasively links claimant's cold intolerance to the accepted bilateral carpal tunnel condition. Consequently, we conclude that claimant's cold intolerance is a "direct medical sequelae" of her accepted bilateral carpal tunnel syndrome condition, and because it has not been specifically denied, it is to be rated in accordance with ORS 656.268(14).[2]

We acknowledge the employer's argument that claimant's cold intolerance is a consequential condition of the bilateral carpal tunnel syndrome rather than a "direct medical sequelae" of the accepted condition. Relying on OAR 436-035-0007(1), the employer asserts that if claimant's cold intolerance is a consequential condition, then that condition should not be rated as impairment. We disagree.

Although Dr. Nolan, an employer-arranged medical examiner, with whom Dr. Stanley (attending physician) concurred, described claimant's cold intolerance as an "annoying sequale" (*sic*) of the carpal tunnel releases, he did so in response to the employer's request to "outline all objective findings of impairment and delineate those which are specifically due to the carpal tunnel syndrome." (Ex. 48-5). Additionally, Dr. Weller specifically indicated that claimant's vascular impairment (cold intolerance) was "due to carpal tunnel syndrome." (Ex. 68). These medical opinions support a conclusion that claimant's cold intolerance is a medical sequelae of the accepted carpal tunnel syndrome condition.

The employer also argues that claimant's condition is not permanent and cannot support an award of permanent disability because Dr. Weller indicated it was possible that claimant's condition may recover over time. (Ex. 65b-4). First, we note that there was no contention that claimant's condition was not medically stationary at claim closure. By definition, a finding of medically stationary status means that no further material improvement would reasonably be expected from medical treatment or the passage of time.[3] See ORS 656.005(17). Second, although Dr. Weller indicated that claimant's condition may improve, she also indicated that: (1) improvement was not probable (she described improvement as "possible"); and (2) if there was no improvement within six months, the problem was permanent. (*Id.*) Under such circumstances, we are persuaded that claimant's cold intolerance is permanent. *See Jeffrey J. Hyson*, 50 Van Natta 684 (1998) (condition found permanent although physicians thought that it could gradually improve).

Based on the aforementioned reasoning, we find that claimant's cold intolerance is a permanent condition that is a "direct medical sequelae" of the accepted bilateral carpal tunnel syndrome condition. Furthermore, we conclude that Dr. Weller's persuasive evaluation should be used to rate claimant's impairment. Accordingly, we affirm the order of the ALJ.

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, to be paid 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 December 21, 2000 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the self-insured employer.

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[2] "Direct medical sequela" means a condition which originates or stems from the compensable injury or disease which contributes to the worker's overall disability or need for treatment and is the result of the original injury or disease. OAR 436-035-0005(5).

ORS 656.268(14) provides: "Conditions that are direct medical sequelae to the original accepted condition shall be included in rating permanent disability of the claim unless they have been specifically denied."

[3] Both Dr. Nolan and Dr. Dordevich, employer-arranged examiners, with whom the attending physician concurred, opined that claimant's condition was stationary. (Exs. 48-5; 49; 61-10; 62)

In the Matter of the Compensation of
JERRY D. RILETTE, Claimant
WCB Case No. 00-06435
ORDER ON REVIEW
Bottini, Bottini & Oswald, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a lymphatic condition (non-Hodgkin's lymphoma). On review, the issue is compensability.

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

Claimant is 50 years old and has worked as a fulltime firefighter since 1978. (Ex. 13). In March 2000, he was diagnosed with non-Hodgkin's lymphoma. (Exs. 10; 11; 12; and 18-1). Claimant seeks to establish the compensability of the non-Hodgkin's lymphoma as an occupational disease.

The ALJ determined that the medical opinion of Dr. Kolibaba (the attending physician) on which claimant relied to establish the compensability of his lymphatic condition was based on general scientific data rather than specific data personal to claimant. Consequently, the ALJ concluded that Dr. Kolibaba's opinion was not sufficient to carry claimant's burden of proof.

In order to establish the compensability of his lymphatic condition as an occupational disease, claimant must prove that his work activities were the major contributing cause of the non-Hodgkin's lymphoma. ORS 656.802(2)(a). To satisfy the "major contributing cause" standard, claimant must establish that his work activities contributed more to the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's disease and deciding which is the primary cause. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). Because of the possible alternative causes for his lymphatic condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

The record contains the opinions of three physicians regarding causation. The opinion of Dr. Kolibaba, the attending physician, favors compensability. The opinions of Drs. Pierce and Burton, insurer-arranged medical examiners, do not. When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). In evaluating medical opinions we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, for the reasons stated below, we find persuasive reasons not to defer to the opinion of Dr. Kolibaba.

According to Dr. Kolibaba, a specialist in hematology and oncology, the development of cancer is a multistep process (usually spanning a period of years), requiring the acquisition of multiple genetic alterations in a single cell. (Ex. 23-4). Most alterations of the DNA leading to cancer are acquired mutations resulting in a disturbance in the mechanisms that control cellular proliferation and survival. (*Id.*) Dr. Kolibaba also indicated that almost every form of human cancer can be reproduced in experimental animals by exposure to chemical carcinogens and that those animal studies have shown that repeated exposures to low concentrations of genotoxic carcinogens can produce tumors more effectively than fewer exposures to the same total dose. (*Id.*)

In explaining how medical science determines the cause of a particular cancer, Dr. Kolibaba explained:

> "Etiologic hypotheses are usually formed by correlating data derived from many lines of investigation. These data may include animal studies, clinical observations and basic laboratory investigations. At present, there is insufficient data to classify carcinogenic agents according to their mechanism of action. * * *

"Etiologic hypotheses are most often formulated on the basis of statistical associations between the cancer under consideration and personal characteristics of affected individuals. Analytic epidemiologic investigations are designed to explore whether an association exist between exposed and unexposed individuals, a relationship often expressed as relative risk." (Ex. 23-5).

While claimant was likely exposed to carcinogenic chemicals during his many years as a firefighter,[1] the record does not establish exposure to specific carcinogens or amounts thereof. Nonetheless, based on: (1) claimant's many years of service as a firefighter, some of which predated use of a self-contained breathing apparatus; (2) statistical epidemiologic studies indicating an occupational risk of firefighters for cancer, including an elevated risk for non-Hodgkin's lymphoma; and (3) the absence (in claimant) of any other known predisposition to the development of non-Hodgkin's lymphoma, Dr. Kolibaba opined that claimant's work was the cause of his cancer.[2] (Ex. 23-6, 7, 8).

Medical evidence grounded in statistical analysis is generally not persuasive because it is not sufficiently directed to the claimant's particular circumstances.[3] *See Yolanda Enriquez*, 50 Van Natta 1507 (1998); *Steven H. Newman*, 47 Van Natta 244, 246 (1995); *Catherine M. Grimes*, 46 Van Natta 1861, 1862 (1994). Here, we understand from Dr. Kolibaba's explanation that without statistical studies to establish associations of relative risks, an opinion regarding the medical cause of a specific cancer cannot be made. This understanding is further supported by the opinion of Dr. Pierce who stated: "[I]rrespective of epidemiologic data such as this, it would never be possible to determine if a given individual's exposure to an environmental toxin was the cause of their cancer given the uncertainty of the pathobiology of carcinogenesis." (Ex. 18-3).

Because the pathobiology of carcinogenesis is uncertain, we conclude that the analysis offered by Dr. Kolibaba establishes only a possibility that claimant's lymphatic condition was caused by his work as a firefighter. A possibility of a causal relationship is insufficient to meet claimant's burden of proof.[4] *Gormley v. SAIF*, 52 Or App 1055 (1981). Consequently, Dr. Kolibaba's opinion is not sufficient to establish that claimant's work activities were the major contributing cause of his lymphatic condition.[5]

ORDER

The ALJ's order dated December 22, 2000 is affirmed.

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[1] We note Dr. Pierce's opinion that there are no other exposures that could account for claimant's condition. (Ex. 19-1).

[2] Dr. Pierce also acknowledged that claimant has no known preexisting tendency to develop lymphoma. (Ex. 19-2).

[3] We acknowledge claimant's assertion that Dr. Kolibaba's opinion explains how the statistical analysis pertains to claimant in particular. However, we disagree with that assertion. Not only is Dr. Kolibaba unable to specifically identify a single carcinogenic substance to which claimant was exposed, but the studies upon which she relies do not establish that the participants of the studies had similar exposure histories as claimant or used a self-contained breathing apparatus in the same manner as did claimant. In short, it has not been established that claimant's experiences and exposures are similar to the firefighters in the sample group.

[4] We acknowledge claimant's argument that the medical evidence offered here is similar to the evidence offered by the claimant in *Johnson v. City of Roseburg*, 86 Or App 344 (1987). However, *Johnson* was a "firefighter presumption" case, in which the employer has the burden to prove by clear and convincing evidence that the claimant's condition was not employment related. ORS 656.802(4). This claim has not been litigated as a "firefighter presumption" case. Consequently, *Johnson* is distinguishable.

[5] As a result of our conclusion we need not address claimant's assertion that Dr. Burton's opinion is "seriously flawed."

Board Member Biehl dissenting.

I disagree with the majority's conclusion that claimant has failed to establish the compensability of his lymphatic condition. Specifically, I find no persuasive reason not to defer to the opinion of Dr. Kolibaba. *See Weiland v. SAIF*, 64 Or App 810 (1983). Therefore, I respectfully dissent.

The mere fact that Dr. Kolibaba's opinion relies on epidemiologic data as part of her opinion does not render her opinion unpersuasive as a matter of law. To the contrary, the Court has relied upon medical opinions grounded on empirical studies to establish the compensability of a medical condition.

> "In making a diagnosis the doctor draws upon the conclusions of medical science demonstrating that certain diseases can be traced to certain causes. These conclusions are not stated in absolutes; they are expressed in terms of probabilities. From the empirical study of many cases medical science can say that if certain symptoms are present there is a probability that certain disease is present. The probability is stronger in the identification of some diseases than it is in others, depending upon what has been learned about the causes for the particular disease. The diagnosis in a particular case involves the reasoning that since this probability has been established in cases in general the probability exists in the particular case being diagnosed. In the absence of evidence showing that the particular case in issue is distinguishable from cases in general it must be accepted that where medical science finds a probable causal relationship for the general group probable legal cause is established for the particular case being litigated." *Clayton v. State Compensation Department*, 253 Or 397, 403-04 (1969).

More recently (in discussing the admissibility of medical evidence dealing with toxic effects of silicone) the court noted that epidemiology is the field of public health and medicine that studies the incidence, distribution and etiology of disease in human populations. *Jennings v. Baxter Healthcare Corporation*, 331 Or 285, 305 n.9 (2000). The court further noted that three medical disciplines (clinical medicine, pathology, and biostatistics) have almost universal application in epidemiology. *Baxter Healthcare Corporation*, 331 Or at 305. The court then noted, by quoting Michael D. Green, *Expert witnesses and Sufficiency of Evidence in Toxic Substances Litigation: The Legacy of Agent Orange and Bendectin Litigation*, 86 Nw. U. L. Rev. 643, 658 (1992):

> "There plainly is a hierarchy to these different indirect forms of toxic effect evidence. Epidemiology is at the top, and structural similarity, in vitro testing, and case reports are at the bottom. Yet any one of these forms of evidence may have some utility in attempting to ascertain whether a causal connection exists." *Baxter Healthcare Corporation*, 331 Or at 306.

Here, there is no dispute that claimant was exposed to carcinogenic materials during his years of working as a firefighter. There is also no dispute that claimant has no known preexisting tendency to develop lymphoma. Based on that information, and epidemiology studies showing that firefighters have an elevated risk for non-Hodgkin's lymphomas, Dr. Kolibaba opined that claimant's work was the major contributing cause of his lymphatic condition. I find her opinion to be well reasoned, based on complete information, and sufficiently based on factors personal to claimant to be persuasive. Consequently, I conclude that claimant has established the compensability of his lymphatic condition.

Accordingly, I would reverse the ALJ's order.

In the Matter of the Compensation of
DAVID SUTHERLAND, Claimant
WCB Case No. 00-05509
ORDER ON REVIEW
Kryger, et al, Claimant Attorney
Craig A. Staples, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Myzak's order that set aside its denial of an occupational disease claim for a bilateral carpal tunnel syndrome condition. On review, the issue is compensability.

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

The ALJ, relying on the opinion of Dr. Dodds, the attending surgeon, concluded that claimant had established the compensability of the bilateral carpal tunnel syndrome condition.

On review, the employer contends that the opinion of Dr. Radecki, an employer-arranged examiner, persuasively established that claimant's work activities are not the major contributing cause of his bilateral carpal tunnel syndrome. Consequently, the employer asserts that claimant's bilateral condition is not compensable.

Claimant seeks to establish the compensability of his bilateral carpal tunnel syndrome condition as an occupational disease. Therefore, he must prove that his work activities are the major contributing cause of the disease. ORS 656.802(2)(a). To satisfy the "major contributing cause" standard, claimant must establish that her work activities contributed more to the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's disease and deciding which is the primary cause. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

Because of the possible alternative causes for his bilateral carpal tunnel syndrome condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967). Only Dr. Dodds and Dr. Radecki have expressed an opinion regarding the cause of claimant's bilateral wrist condition. Dr. Dodds' opinion supports compensability, while Dr. Radecki's opinion does not.

When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). In evaluating medical opinions, we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983).

Dr. Dodds explained that the numbness and tingling felt by individuals with carpal tunnel syndrome is actual compression of the median nerve due to pressure on the nerve the which causes difficulty with the microcirculation of blood flowing through the nerve. (Ex. 21-10, 11). According to Dr. Dodds, significant compression on the nerve will result in an hourglass deformation of the nerve in the area of the compression. (Ex. 21-10). Dr. Dodds noted such a deformity during surgery on claimant's right hand. (Ex. 20a-1).

Dr. Dodds indicated that the median nerve passes through the same three sided bony canal as the finger tendons. (Ex. 21-13). He further explained that overuse of the finger tendons can result in swelling of the synovial tissue of the involved tendons, thereby putting pressure on the median nerve. (*Id.*) Dr. Dodd noted such swelling of the flexor tenosynovium within the carpal canal during claimant's surgery; he noted no other abnormalities within the carpal canal. (Ex. 20a-1).

In reaching this conclusion that claimant's work activities were the major contributing cause of the bilateral carpal tunnel syndrome, Dr. Dodds considered: (1) his surgical findings of nerve compression and swelling of the synovial tissue of the flexor tendons; (2) claimant's work activities, which included repetitive forceful gripping, repetitive shoveling, and exposure to hand vibration while operating locomotive controls; (4) claimant's prior medical history of congestive heart failure and hypertension; and (5) claimant's weight, age, and prior alcohol use. (Exs. 20-1; 21-39). His opinion,

particularly based on his actual surgical observations, is entitled to great weight.[1] *Argonaut Ins. Co. v. Mageske*, 93 Or App 698, 701 (1988).

The employer contends, based on Dr. Radecki's comments, that an important factor in the onset of claimant's symptoms was that claimant stopped taking diuretics (prescribed for his heart problems), thereby allowing fluid to build up in the carpal tunnel, thus putting pressure on the median nerve. (Ex. 16-5). We note, however, that Dr. Dodds reported that claimant was not taking diuretics at the time of his surgery. (Ex. 21-35). Additionally, Dr. Dodds reported no such fluid build up in the carpal tunnel as part of his surgical observations. (Ex. 20a-1). The only abnormalities reported by Dr. Dodds were the observable compression of the median nerve and the swelling of the finger tendon tissue. (*Id.*) Because the employer's theory of fluid build-up in the carpal tunnel is inconsistent with Dr. Dodds' surgical observations, we are not persuaded by that argument.

The employer further asserts that Dr. Dodds misunderstood the nature of claimant's work. In particular, the employer argues that claimant's work was substantially less hand-intensive than Dr. Dodds believed. We disagree.

Claimant spent about 45 minutes per day removing netting from rail cars. (Tr. 19). He also was required to grip the net "hard," "like [he] was mad at it." (Tr. 16; 18). The process of rolling the nets required claimant to grip the nets hard to keep them from slipping out of his hands. (Tr. 19). Approximately half of claimant's work was spent operating a locomotive. (Tr. 46). During that time, his hands rested on the controls and were subject to vibration. (Tr. 15; 45-46). In addition, claimant also shoveled chips twice a day. (Tr. 20).

According to Dr. Dodds, claimant was mechanically at risk for injury because of: (1) heavy repetitive grasping of the netting; (2) the sustained grasp associated with shoveling; and (3) vibration associated with running the locomotive. (Ex. 21-21). Dr. Dodds' history is not inconsistent with claimant's description of his work activities. Consequently, we reject the employer's argument.

In contrast to Dr. Dodds, Dr. Radecki opined that the major contributing cause of the bilateral carpal tunnel syndrome was claimant's personal factors; *i.e.*, age, body mass index, and wrist ratio. (Ex. 16-8). We note, however, that at the time he rendered his opinion Dr. Radecki was unaware of Dr. Dodds' surgical findings concerning the hourglass deformity of the median nerve and swelling of the synovial tissue of the flexor tendons. Additionally, Dr. Radecki did not address claimant's exposure to vibration from the locomotive controls.[2] Consequently, because Dr. Radecki's opinion rests on incomplete information and because he has not considered the relative contributions of all the factors contributing to claimant's bilateral carpal tunnel syndrome, we do not find his opinion persuasive. *See Miller v. Granite Construction*, 28 Or App 473 (1977) (medical opinion based upon incomplete information is not persuasive); *Dietz v. Ramuda*, 130 Or App at 402.

In conclusion, we find Dr. Dodds' opinion to be more complete, and the more persuasive of the two medical opinions. Consequently, we conclude that claimant has established the compensability of his bilateral carpal tunnel syndrome 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 $1,500, to be paid 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 his counsel's uncontested attorney fee request), the complexity of the issue, and the value of the interest involved.

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[1] We acknowledge the employer's argument that Dr. Dodds' observation of median nerve compression is immaterial because the diagnosis of carpal tunnel was not disputed. We note , however, that in addition to observing median nerve compression, Dr. Dodds also observed swelling of the synovial tissue of the finger tendons, which he attributed to overuse. Consequently, Dr. Dodds' observations had a direct bearing on his opinion about causation. Accordingly, we reject the employer's argument.

[2] Dr. Dodds indicated that vibration exposure is "well documented as being provocative for nerve problems." (Ex. 21-21).

ORDER

The ALJ's order dated December 14, 2000 is affirmed. For services on review, claimant is awarded a $1,500 attorney fee, payable by the self-insured employer.

May 4, 2001 Cite as 53 Van Natta 624 (2001)

In the Matter of the Compensation of
JANIS C. DAVIS, Claimant
WCB Case No. 00-04695
ORDER ON REVIEW
Starr & Vinson, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that affirmed that portion of an amended Order on Reconsideration that found that her aggravation rights ran from April 30, 1997. On review, the issue is claim processing.

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

The ALJ affirmed the statement of claimant's aggravation rights in the Order on Reconsideration, citing to *Susan K. Clift*, 51 Van Natta 646 (1999). On review, claimant contends that she is entitled to a new set of aggravation rights, *i.e.*, five years from the notice of closure of her new medical condition claim. We disagree.

In *Susan K. Clift*, we held that a consequential condition claim is not entitled to a new set of aggravation rights. 51 Van Natta at 647. In other words, the aggravation rights are still established at the closure of the original claim. *Id.* Although *Clift* specifically involved a consequential condition claim, we expressly expanded our holding to encompass "new medical condition" claims as well. 51 Van Natta at 647 n3.[1] *See also* Board Chair Bock's concurrence, 51 Van Natta at 648.

We have continued to adhere to our holding in *Susan K. Clift*. *See Ronald A. Carnagey*, 53 Van Natta 374 (2001); *Leo R. Manley*, 52 Van Natta 573 n2 (2000). Accordingly, we agree with the ALJ that claimant's aggravation rights are determined by the closure of the original claim. ORS 656.273(4)(a). The Order on Reconsideration was properly affirmed.

ORDER

The ALJ's order dated December 14, 2000 is affirmed.

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[1] In doing so, we addressed *Johansen v. SAIF*, 158 Or App 672 (1999). We explained that we did not read the court's decision to suggest that, upon closure, a new medical condition/consequential condition claim is entitled to its own, independent aggravation rights period. 51 Van Natta at 647 n3.

VAN NATTA'S
WORKERS' COMPENSATION REPORTER
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UPDATE PAGES

ENCLOSED ARE *VAN NATTA'S* PAGES 625-688 WITH WORKERS' COMPENSATION BOARD ORDERS THROUGH MAY 17, 2001. THESE PAGES SHOULD BE INSERTED INTO YOUR CURRENT *VAN NATTA'S* BINDER, VOLUME 53, APRIL-JUNE 2001.

In the Matter of the Compensation of
CHERYL J. WILSON, Claimant
Own Motion No. 00-0277M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE

Claimant requests review of the self-insured employer's February 27, 2001 Notice of Closure which closed her claim with an award of temporary disability compensation from October 4, 2000 through October 22, 2000 and November 15, 2000 through December 10, 2000. The employer declared claimant medically stationary as of February 7, 2001.

On September 11, 2000, we authorized the reopening of claimant's claim to provide temporary disability compensation beginning the date claimant was hospitalized for the proposed surgery.

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).

Claimant does not contend that her medically stationary date is incorrect or that she was not medically stationary when the employer closed her claim. In any event, the record would not support such a contention.[1] Rather, claimant contends that she is entitled to temporary disability benefits for the time spent attending doctor and physical therapy appointments. In support of her contention, claimant submits a listing of dates and times she had to miss work to attend various appointments.

The Board is authorized to award temporary disability compensation to claimants whose compensable conditions have worsened requiring surgery or inpatient hospitalization. ORS 656.278(1)(a). This temporary disability compensation begins as of the date of actual surgery or hospitalization, which in this case is October 4, 2000. *Id.* Inasmuch as we are not authorized to award temporary disability compensation prior to the date of surgery, claimant is not entitled to additional temporary disability compensation for the time prior to October 4, 2000.

We next consider the time subsequent to claimant's October 4, 2000 surgery and before her condition became medically stationary. For claims in Own Motion status, temporary disability compensation shall be paid beginning the date the claimant is hospitalized for surgery or other treatment requiring hospitalization until claimant is declared medically stationary. ORS 656.278(2). However, a carrier may terminate temporary disability compensation if one of the following should occur: (1) the claim is closed pursuant to OAR 438-012-0055; (2) a claim disposition agreement 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(4)(a) through (c). OAR 438-012-0035(4).

ORS 656.268(4)(a) through (c) provides that payment of temporary total disability compensation shall continue until whichever of the following events first occurs: (a) the worker returns to regular or modified employment; (b) the attending physician advises the worker and documents in writing that the worker is released to return to regular employment; or (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.

Here, claimant was released to modified duty on October 18, 2000 and claimant returned to work for the employer in a modified capacity on October 23, 2000. She continued to work until November 15, 2000, when she underwent further surgery on her left wrist. The employer appropriately terminated temporary disability compensation when claimant returned to work on October 23, 2000 and reinstated temporary disability compensation when she underwent surgery on November 15, 2000. Claimant returned to work on December 11, 2000. The employer appropriately terminated timeloss when claimant returned to work on December 11, 2000.

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[1] In this regard, Dr. Butters, claimant's attending physician, provided the only medical evidence regarding claimant's medically stationary status. In a February 7, 2001 chart note, Dr. Butters noted that claimant was "stationary as of this time." He also gave her a full release to work. Dr. Butters' opinion is unrebutted.

Claimant's attendance on November 13, 2000, December 28, 2000 and February 7, 2001 at physical therapy and medical appointments did not trigger the employer's obligation to reinstate timeloss. We have previously found that to be entitled to temporary partial disability compensation under ORS 656.210(4),[2] claimant must miss four or more hours in one period, rather than for periods totaling four hours. *Alejandra R. Trevino*, 48 Van Natta 399 (1996).

Here, claimant indicates that she missed between one and two hours at each appointment she attended. Because the employer appropriately terminated timeloss and claimant's attendance at medical/physical therapy appointments were for one to two hours at a time, claimant is not entitled to the reinstatement of temporary disability compensation while attending those appointments.

Finally, claimant requests timeloss reimbursement for eight hours per day on the dates she underwent surgery, *i.e.* October 4, 2000 and November 15, 2000. The employer has submitted its payment ledger that demonstrates that temporary disability compensation was paid to her for those dates.

Based on the record, we affirm the employer's February 27, 2001 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[2] ORS 656.210(4) provides that:

"[w]hen an injured worker with an accepted disabling compensable injury is required to leave work for a period of four hours or more to receive medical consultation, examination or treatment with regard to the compensable injury, the worker shall receive temporary disability benefits calculated pursuant to ORS 656.212 for the period during which the worker is absent, until such time as the worker is determined to be medically stationary."

May 4, 2001 Cite as 53 Van Natta 626 (2001)

In the Matter of the Compensation of
BENNY H. RASH, Claimant
WCB Case No. TP-97009
THIRD PARTY ORDER ON REMAND
Preston, Bunnell, et al, Claimant Attorney
Lundeen, et al, Defense Attorney

This matter is before the Board on remand from the Supreme Court. *Rash v. McKinstry Company*, 331 Or 665 (2001). The Court has reversed the Court of Appeals' opinion, 160 Or App 131 (1999), that had affirmed our prior order, *Benny H. Rash*, 49 Van Natta 2124 (1997), that had held that the insurer was entitled to a share of the proceeds from claimant's third party settlement. The Court has determined that an insurer's lien against a claimant's third party recovery is a "matter[] * * * potentially arising out of claims within the meaning of ORS 656.236(1)(a)." Consequently, because the insurer's third party lien was not mentioned in the parties' Claim Disposition Agreement (CDA), the Court has concluded that the insurer's lien was "resolved," or extinguished by the CDA. Accordingly, the Supreme Court has remanded with instructions to dismiss the insurer's petition for third party relief.

In accordance with the Supreme Court's mandate, the insurer's petition for third party relief is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
AUSTIN P. YOUNG, JR., Claimant
WCB Case Nos. 00-06927 & 00-04382
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Julie Master (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Fitzwater's order that upheld the SAIF Corporation's denial of his claim for "painful chondromalacia right knee/patellofemoral joint." On review, the issue is compensability.

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

In upholding SAIF's denial, the ALJ found persuasive reasons not to give greater weight to the opinion of the attending physician, Dr. Walton, who opined in a November 2000 report that claimant's chondromalacia condition was related to a compensable March 22, 1999 claim that SAIF accepted as a right knee strain. The ALJ reasoned that Dr. Walton's opinion was not persuasive because he based his opinion on the absence of disability and impairment in claimant's right knee prior to the March 1999 injury, when claimant's testimony and medical records indicated claimant had right knee symptoms prior to the injury.[1] Concluding that Dr. Walton's opinion was based on an inaccurate history, the ALJ found that claimant did not sustain his burden of proving his chondromalacia condition was compensable.

On review, claimant contends that the basis on which the ALJ discounted Dr. Walton's opinion was faulty. Claimant asserts that, while he may have had transient pain after the incident in November 1998, the "law of the case" is that he had no disability or impairment as a result of that incident based on an October 1999 report from Dr. Walton that SAIF solicited prior to accepting the March 1999 injury. In that report, Dr. Walton opined that the November 1998 injury would not have been the cause of subsequent medical treatment and/or disability regarding the right knee. (Ex. 22). Claimant argues that mere pain and symptoms prior to the March 1999 injury do not equate to disability or impairment. Therefore, claimant contends that Dr. Walton's history that claimant had no impairment or disability prior to March 1999 was accurate.

Even assuming that claimant's contentions regarding the accuracy of Dr. Walton's history are correct, we, nevertheless, find persuasive reasons to discount Dr. Walton's opinion.

In his October 1999 report, Dr. Walton agreed that the March 1999 injury "was the cause of a simple right knee strain" and that "[s]ubsequent scans and examinations have ruled out other possible diagnoses and it is most likely that [claimant] had a simple right knee strain on March 22, 1999." (Ex. 22). Subsequently, however, in his November 15, 2000 report, Dr. Walton opined that the March 1999 injury caused claimant's chondromalacia. (Ex. 41-1). Dr. Walton gave no explanation for this apparent inconsistency between one report that stated that the March 1999 injury merely resulted in a knee strain and the subsequent report in which he attributed the chondromalacia condition to that injury.[2] For this reason, we find Dr. Walton's opinion unpersuasive and agree with the ALJ's decision to give it little weight. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of physician's opinion found unpersuasive).

ORDER

The ALJ's order dated January 11, 2001, as reconsidered on February 7, 2001, is affirmed.

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[1] On November 13, 1998, claimant experienced right knee symptoms after slipping and falling on the right knee while cleaning a shower room. Claimant, however, sought no treatment for this incident.

[2] Noting that, on April 23, 1999, Dr. Walton had diagnosed chondromalacia in connection with the March 1999 injury, claimant argues that Dr. Walton's current opinion is not inconsistent with his contemporaneous chart notes. (Ex. 8). However, considering Dr. Walton's October 1999 concurrence report, in which he agreed that the March 1999 injury only resulted a knee strain, we are persuaded that Dr. Walton's current opinion is inconsistent and, thus, deserving of little weight.

In the Matter of the Compensation of
PAULA L. BULLOCK, Claimant
WCB Case No. 00-04637
ORDER ON REVIEW
James W. Moller, Claimant Attorney
Steven T. Maher, Defense Attorney
Ernest M. Jenks, Attorny

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Hoguet's order that set aside its denial of claimant's left wrist contusion/sprain injury claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order, with the following supplementation to address the insurer's request for remand for the ALJ to evaluate credibility and assess the testimony of one witness, Ms. Luledjian.

We are not aware, and the insurer provides no authority in support, of the proposition that it is an abuse of discretion if an ALJ does not evaluate credibility. Furthermore, our review is *de novo* and, although we defer to the ALJ's demeanor-based credibility findings, the Board is equally qualified to make its 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).

Here, Exhibit 1E documents a conversation that Ms. Luledjian, claimant's coworker, recalled having with claimant approximately one month earlier. Ms. Luledjian recalled that claimant told her about an off work fall in early May after which, according to Ms. Luledjian, claimant reported having experienced a fat lip, sore neck and wrist, and various body bruises. However, Ms. Luledjian could not recall which wrist claimant said that she hurt. (Tr. 70). She recalled claimant wearing a wrist brace, but she was unsure which wrist it was worn on. Ms. Luledjian did recall that claimant was wearing a wrist brace "at or around the time of the claim that was filed at [the employer]." (Tr. 71) That statement supports claimant's testimony that she wore a left wrist brace every workday following her slip and fall.

In response to the question whether claimant continued to talk about her wrist problem during the week or two after the fall, Mr. Luledjian responded:

> "She had been talking about problems in her arms from-but she'd been doing that not all the time, but she'd mentioned it once or twice, but that was even before that incident." (Tr. 70-71).

This testimony is consistent with claimant's testimony and is also consistent with claimant's explanation that Ms. Luledjian was likely confused, because claimant had told her about her prior work-related fall in 1997, when she had injured her right wrist and neck. (Ex. A). The 1997 fall involved claimant's right wrist and ultimately resulted in right carpal tunnel surgery.

Claimant thought that Ms. Luledjian was likely confusing her discussion of her 1997 work-related fall with her discussion of the early May 2000 off-work fall. (Tr. 105-06). That conclusion is supported by Ms. Luledjian's testimony on cross-examination, when she remembered that claimant had discussed her carpal tunnel problems, but could not remember whether it involved one or both of her arms. (Tr. 73, 74).

The ALJ acknowledged that Ms. Luledjian testified at hearing. (O & O at 3). He nevertheless found that claimant experienced no left wrist/hand injuries prior to her May 18, 2000 work-related trip and fall. (*Id.* at 2). He explained that his findings of fact were based on his observation of all of the witnesses and his resulting conclusion that claimant's testimony was credible and reliable. In light of Ms. Luledjian's confusion and uncertainty, the ALJ was required to do no more.

After our *de novo* review of the record, we agree with the ALJ's conclusion. Claimant immediately reported her trip and fall to her coworkers and her supervisor. (Tr. 22, 31). There is no persuasive evidence that claimant injured her left wrist prior to the May 18, 2000 incident.

Consequently, we find no compelling reason to remand to the ALJ to determine Ms. Luledjian's credibility. *See* ORS 656.295(5); *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986) (in order to warrant remand, there must be a compelling reason established for doing so, including a reasonable likelihood that the evidence sought to be admitted on remand will affect the outcome of the hearing).

Claimant's attorney is entitled to an assessed fee under ORS 656.382(2) for services on Board review regarding the compensability issue. 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 $1,500, 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 8, 2001 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500, to be paid by the insurer.

May 7, 2001 Cite as 53 Van Natta 629 (2001)

In the Matter of the Compensation of
FRANKLIN D. BAUMAN, Claimant
WCB Case No. 00-07158
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Reinisch, et al, Defense Attorney

Reviewed by Board Members Haynes, Bock, and Phillips-Polich.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that reversed an Order on Reconsideration that reclassified claimant's claim as disabling. On review, the issue is claim classification.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated January 25, 2001 is affirmed.

Board Member Phillips Polich dissenting.

Claimant's 1998 injury claim is properly reclassified as disabling if there is a reasonable expectation that permanent disability will result from the injury (or temporary disability is "due and payable"). ORS 656.005(7)(c).

In this case, an Order on Reconsideration found a reasonable expectation of injury-related permanent disability, based on claimant's post-injury medical records that document ongoing injury-related problems, including reduced left shoulder range of motion. Absent any indication that to the contrary, I would find claimant's long-standing valid impairment sufficient to establish a reasonable expectation of permanent disability (such as lost range of motion), as the Board did in *Henry Parnell*, 52 Van Natta 1094 (2000) (where the claimant had valid, injury-related reduced range of motion, medical opinion as a whole supported a conclusion that there was a reasonable expectation that permanent disability would result from the injury).

Accordingly, I would find injury-related permanent disability likely on this record, the claim should be reclassified as disabling on that basis, and I must respectfully dissent from the majority's contrary decision.

In the Matter of the Compensation of
ERIC R. McKOWN, Claimant
Own Motion No. 01-0120M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Walsh & Associates, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's March 21, 2001 Notice of Closure which closed his claim with an award of temporary disability compensation from November 1, 2000 through March 9, 2001. SAIF declared claimant medically stationary as of March 9, 2001.[1]

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 claim closure turns on whether claimant was medically stationary at the time of the March 21, 2001 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).

Typically, there are only two issues to be raised when a claimant requests review of an insurer's claim closure. The most common issued raised is that the claimant was not medically stationary at claim closure. A second issue 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 simply "challenges the insurers [sic] decision to close his claim." We interpret claimant's request as a challenge to both the medically stationary determination and the temporary disability compensation award. 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.

In this instant case, there is no explicit statement that claimant was medically stationary at claim closure. Nonetheless, "magic words" are not necessary to establish a medically stationary date. *Liberty Northwest Ins. Corp. v. Cross*, 109 Or App 109 (1991), *rev den* 312 Or 676 (1992), as cited in *U-Haul of Oregon v. Burtis*, 120 Or App 353 (1993); *McClendon v. Nabisco Brands, Inc.*, 77 Or App 412, 417 (1986); *Henry Martin*, 43 Van Natta 2561, 2562 (1991).

On November 1, 2000, claimant underwent low back surgery. On February 6, 2001, Dr. Buza, claimant's attending surgeon, reported that he had completed his physical therapy treatment, had no leg pain and only back pain in the morning. Dr. Buza recommended that claimant seek other employment and noted that he needed to get a "closing exam."

Dr. Buza next examined claimant on March 9, 2001. At that examination, Dr. Buza reported that claimant had good range of motion and strength. noting that claimant had occasional low back pain, Dr. Buza released claimant to regular work. This opinion is unrebutted.

Dr. Buza does not use "magic words" and explicitly state that claimant was medically stationary. However, we find that his February 6 and March 9, 2001 chart notes, as a whole, establish that claimant was medically stationary and there was no reasonable expectation of material improvement with further treatment or the passage of time.

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[1] On November 15, 2000, we issued an Own Motion Order, which reopened claimant's 1993 claim for the provision of temporary disability compensation. (Own Motion Case No. 00-0318M). SAIF has issued its March 21, 2001 Notice of Closure for that claim.

Based on the uncontroverted medical evidence, we find that claimant's condition was medically stationary on the date his claim was closed and that the temporary disability awarded by the Notice of Closure was appropriate. Therefore, SAIF's closure was proper.

Accordingly, we affirm SAIF's March 21, 2001 Notice of Closure in its entirety.

IT IS SO ORDERED.

May 7, 2001 Cite as 53 Van Natta 631 (2001)

In the Matter of the Compensation of
KATIE J. ELMER, Claimant
WCB Case No. 00-03375
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorney
Scheminske, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Otto's order that set aside its denial of claimant's occupational disease claim for a bilateral hand dermatitis condition. The employer moves to strike portions of claimant's respondent's brief. On review, the issues are motion to strike, compensability and responsibility.

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

In its reply brief, the employer moves to strike parts of claimant's respondent's brief. Specifically, the employer contends that claimant makes improper inferences from a deposition of Dr. Storrs, treating dermatologist, and opinions of "IME physicians." The employer points out that none of those documents were admitted into the record. The employer also states that claimant did not offer Dr. Storrs' deposition into the record. However, we note that the ALJ sustained the employer's objection to claimant's submission of Dr. Storrs' deposition transcript that was taken post-hearing at the employer's request. None of the ALJ's evidentiary rulings were contested on review.

Our review is limited to the record developed at hearing. ORS 656.295(5). Because Dr. Storrs' deposition and the examining physicians' opinions were not admitted at hearing, we grant the employer's motion to strike those portions of claimant's brief that refer to such evidence.

We agree with the ALJ's analysis that actual causation was established against the employer. Therefore, the principles of the last injurious exposure rule relied on by the employer are not applicable. *See Richard A. Venner*, 53 Van Natta 352 (2001).

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),[1] the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 3, 2001 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500, payable by the employer.

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[1] Those portions of claimant's brief that have been stricken have not been considered.

In the Matter of the Compensation of
KAREN E. AFFOLTER, Claimant
WCB Case Nos. 00-04481 & 00-03750
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorney
Hornecker, Cowling, et al, Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Spangler's order that set aside its denial of claimant's "current" low back condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We affirm the ALJ's order, but base our decision on the following reasons.

Claimant compensably injured her low back when she fell carrying a tray of surgical instruments in October 1990. (Ex. 2). When conservative treatment failed to alleviate claimant's back problems, Dr. Burchiel performed a L5-S1 microdiskectomy with exploration of the left S1 nerve root. (Ex. 32-1). The surgery revealed residual scarring from a previous L5-S1 surgery and a disk "slightly bulging into the canal and into the root." (Ex 32-2). Following the surgery, Dr. Burchiel opined that the major contributor to the need for surgery was the October 1990 work incident. (Ex. 34).

The claim was initially closed by Determination Order in October 1993. (Ex. 94). Ultimately, after reconsideration and a subsequent hearing before a prior ALJ, claimant was awarded, among other things, 33 percent unscheduled permanent disability for the low back injury. (Ex. 112a).

By letter of April 7, 2000, claimant requested that the employer expand its previous acceptance to include: (1) L5-S1 herniated disc; (2) a combined condition consisting of L5-S1 herniated disc with degenerative disc disease resulting in chronic back pain; and (3) bilateral knee post-traumatic athrosis.[1] (Ex. 230a). On May 10, 2000, the employer denied the compensability of those conditions. (Ex. 235).

On June 22, 2000, claimant clarified that she was seeking acceptance of:

> "[A] combined condition consisting of a strain injury to the low back from the October 1990 compensable injury that combined with preexisting degenerative disc disease and with residuals from the prior L5-S1 surgery, resulting in a chronic back pain condition." (Ex. 240).

At the hearing, the parties agreed that the compensability of claimant's current low back condition as clarified by the June 22 letter was the only issue. (Tr. 2).

The ALJ, relying on the records and opinion of Dr. Brink, the attending physician, and Dr. Burchiel, the attending surgeon for claimant's 1991 L5-S1 surgery, determined that claimant had established the compensability of her current low back condition. Additionally, the ALJ concluded that the doctrine of issue preclusion prevented the employer from contesting the compensability of claimant's current low back condition.

On review, the employer contends that: (1) the doctrine of issue preclusion is not applicable; and (2) the opinion of Dr. Schilperoot persuasively establishes that claimant's current back condition is not compensable. Because we conclude on the merits that claimant has established the compensability of her current low back condition, we do not address the issue preclusion question.

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[1] The employer's February 2000 updated Notice of Acceptance listed the accepted conditions as "low back strain" and "bilateral knee injuries." (Ex. 225)

In order to establish that her current low back condition is compensable as a "combined condition," claimant must show that her 1990 work injury is the major contributing cause of her disability or need for treatment of the "combined condition." ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 149 Or App 309, 315 (1997), *rev den* 326 Or 389 (1998). To satisfy the "major contributing cause" standard, claimant must establish that her compensable injury contributes more to the "combined condition" than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983).

A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's "combined condition" and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). Because of the possible alternative causes for her low back condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263 (1986). In evaluating medical opinions, we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983).

Dr. Burchiel initially saw claimant on October 17, 1991, on referral from Dr. Klump. (Ex. 29). Dr. Burchiel noted that claimant had a "very discreet sciatic pain down the left leg" in addition to some vague back pain. (*Id.*) Following his examination of claimant and a review of her MRI scans, Dr. Burchiel opined that surgery would be reasonable. (*Id.*) He further opined that the need for surgery was either residual disc material or scar tissue, but that causation would not be clear without surgery. (*Id.*)

During the 1991 surgery, Dr. Burchiel found both scar tissue and residual disc material. (Ex. 32-2). He noted that the disc material bulged into the canal and into the nerve root. (*Id.*) Dr. Burchiel also noted that claimant had some bony stenosis, part of a degenerative process that predated the October 1990 accident. (Ex. 34). Ultimately, based upon his surgical observations, Dr. Burchiel opined:

> "I think that [claimant's] symptomatology, and the major contributor to her need for surgery on November 15, 1999, *was her 10/22/90 accident*. Thus, the correlation between the bony stenosis and the 10/22/90 accident is that the accident produced *an exacerbation of the pre-existing condition which was the major contributing need for her surgery on 11/15/91*." (emphasis in original) (Id.)

We interpret Dr. Burchiel's opinion to be that the 1990 work accident sufficiently damaged claimant's preexisting condition such that claimant needed surgery to alleviate the problem. Because Dr. Burchiel's opinion is based upon his actual surgical observations, his opinion is entitled to great weight. *Argonaut Ins. Co. v. Mageske*, 93 Or App 698, 701 (1988).

The employer contends that Dr. Burchiel's opinion is not persuasive because it is conclusory and based upon a "precipitating cause" analysis. We disagree.

First, we note that Dr. Burchiel's opinion reasonably correlates claimant's "very discreet sciatic pain down the left leg" with his surgical findings of disc material encroaching on a nerve root. Additionally, because he expressly noted the presence of preexisting scar tissue and the bony stenosis, and because he expressly indicated he could not determine causation until he had surgically viewed claimant's low back, we are persuaded that he necessarily evaluated the relative contributions of each of the preexisting conditions in rendering his overall opinion. Consequently, we find his opinion persuasive.[2]

Dr. Brink, who has been the attending physician since December 1993, concurred with Dr. Burchiel's assessment of causation. (Ex. 97-1; 243).

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[2] We acknowledge the employer's argument that Dr. Burchiel's opinion is dated and not probative of claimant's current condition. However, because his opinion reasonably explains the source of claimant's low back pain since the 1990 injury, and because the record does not contain a persuasive medical opinion to the contrary, we reject the employer's argument.

The employer asserts that Dr. Brink's chart note entries of February 28, 1998, and August 16, 2000 are inconsistent with his October 30, 2000 concurrence with Dr. Burchiel. We disagree.

In his February 1998 chart note, Dr. Brink merely noted that Dr. Schilperoort's opinion from the October 1997 examination recommended that claimant continue conservative treatment and not undergo an additional surgery. (Ex. 183-2). Nothing in that chart note is inconsistent with Dr. Brink's subsequent concurrence with Dr. Burchiel regarding the cause of claimant's back condition.

In his August 2000 chart note, Dr. Brink expressly indicated his disagreement with Dr. Schilperoort's May 2000 causation opinion and indicated that Dr. Burchiel would be in "the best position to make the decision as to the major contributing cause for [claimant's] back condition." (Ex. 242). Contrary to the employer's assertion, we find the August 16, 2000 chart note to be consistent with Dr. Brink's subsequent concurrence with Dr. Burchiel.

In contrast to the opinion of Dr. Burchiel is the opinion of Dr. Schilperoort, an employer-arranged medical examiner. Dr. Schilperoort first saw claimant in October 1997 to review the advisability of a proposed arthrodesis procedure (lumbar fusion).[3] (Ex. 181). His diagnosis (regarding claimant's back condition) was "low back pain." (Ex. 181-5). In advising that the proposed surgery was contraindicated, Dr. Schilperoort opined that the on-the-job injury was the "proximate cause of [claimant's] back pain."[4] (Ex. 181-6 & 7).

Dr. Schilperoort examined claimant again in May 2000. (Ex. 234). With regard to claimant's low back, he noted that constant pain was the primary problem. (Ex. 234-4). He stated that the 1990 work injury caused a lumbar strain and that that the work injury clearly combined with the preexisting conditions to cause symptomatic exacerbation of her prior degenerative condition and aggravation of the scar tissue. (Ex. 241-2 & 3). Ultimately, Dr. Schilperoort opined that the lumbar strain represented "little more than a speed bump" in the evolutionary post-surgical changes from claimant's 1988 laminectomy. (Ex. 241-4).

We are not persuaded by Dr. Schilperoort's opinion. First, we note that his most recent opinion is inconsistent with his opinion of October 1997. Moreover, Dr. Schilperoort offered no explanation for his change of opinion. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (physician's opinion found persuasive when accompanied by reasonable explanation for the physician's change of opinion). Consequently, we do not find his opinion to be well reasoned and based upon complete information. *See Somers v. SAIF*, 77 Or App 259, 263 (1986). Accordingly, we do not rely upon it.

In conclusion, we find the opinion of Dr. Burchiel, as supported by Dr. Brink, to be the most persuasive opinion in the record. Consequently, we agree with the ALJ that claimant has established the compensability of her current "combined" low back condition.[5]

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, to be paid 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 his counsel's uncontested attorney fee request), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 8, 2000. For services on review, claimant is awarded a $1,500 attorney fee, payable by the self-insured employer.

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[3] This examination was performed with Dr. Palla, another employer-arranged medical examiner. Dr. Palla did not participate in Dr. Schilerpoort's subsequent examination and opinion in May 2000.

[4] Claimant did not have the proposed arthrodesis procedure.

[5] In reaching this conclusion, we need not address and do not adopt that portion of the ALJ's decision that found that the employer had previously accepted a "combined" condition.

In the Matter of the Compensation of
INGER M. BARTELL, Claimant
WCB Case No. TP-01001
THIRD PARTY ORDER
Popick & Merkel, Claimant Attorney

Reviewed by Board Members Biehl and Haynes.

Johnston & Culberson, Inc. (JCI) has petitioned the Board for resolution of a dispute concerning the distribution of proceeds arising from a third party judgment. ORS 656.593(1). Specifically, JCI contends that: (1) it has never received a copy of the retainer agreement from claimant's attorney; (2) has not received clarification of claimant's cost bill; (3) its share of the proceeds submitted by claimant is insufficient; (4) claimant's attorney fees exceed the attorney fees authorized by OAR 438-015-0095; and (5) it is entitled to sanctions against claimant's attorney for failing to respond or cooperate. On the other hand, claimant asserts that JCI's claim is "frivolous" pursuant to ORS 656.390(2) and she requests $1,000 as an appropriate sanction.

For the reasons set forth below, we conclude that claimant is not entitled to an extraordinary attorney fee and she is not entitled to recover any additional costs. We deny both parties' request for sanctions.

FINDINGS OF FACT

Claimant was compensably injured on September 16, 1996 when she slipped and fell in a pool of water on the floor. She was initially diagnosed with a Colles' fracture of the left wrist and was later diagnosed with left carpal tunnel syndrome. A left carpal tunnel release was performed on May 24, 2000.

Claimant filed a third party action against a plumbing company, alleging negligence. An arbitration hearing was held on August 2, 2000. On September 8, 2000, the arbitrator found that claimant was entitled to $17,937.47, plus reasonable costs and disbursements. On September 19, 2000, an Arbitration Award and Money Judgment was filed, which awarded $17,937.47 plus costs of $1,617. There is no evidence that the arbitration award was appealed.

Claimant's counsel sent JCI a $7,413.71 check dated October 23, 2000 that said "workers' comp. lien in full." Claimant's counsel's itemized statement referred to attorney fees of $6,518.16 and other charges of $1,915.74.

On November 1, 2000, JCI wrote to claimant's attorney, acknowledging receipt of the $7,413.71 check. JCI asserted that it had not approved a settlement and it did not have a final figure for its workers' compensation lien. In addition, JCI said:

> "According to our file, we never received written documentation of representation. Records you had requested and itemized as an expense would have been provided for no charge with a retainer agreement. In addition, you listed expenses which were paid on the workers' compensation claim which includes mileage, arbiter and depositions. In addition what is a cost bill? Finally, your attorney fees exceed the statutory attorney fees according [to] OAR 438-015-0095.
>
> "Therefore, we are unable to accept your check as a final figure on our lien. We will notify you when we have our final lien. If you have any questions, please feel free to contact me."

JCI wrote to claimant's attorney on November 15, 2000, requesting a copy of the third party judgment.

On January 10, 2001, JCI again wrote to claimant's attorney and requested a copy of the third party judgment. Claimant's attorney responded to JCI's request on January 15, 2001, stating that he had advised repeatedly that this matter went to judgment after mandatory arbitration in Marion County Circuit Court. Claimant's attorney advised that JCI could obtain a copy of the judgment from the court.

On February 7, 2001, JCI petitioned the Board resolution of a dispute concerning the distribution of proceeds arising from a third party judgment. In an April 4, 2001 letter, JCI asserted that its actual claim costs to date are $14,094.83 and its anticipated future expenses are $50,345.09.

CONCLUSIONS OF LAW AND OPINION

Attorney Fees

ORS 656.578 provides that if a worker sustains a compensable injury due to the negligence or wrong of a third party, the worker or beneficiaries shall elect whether to recover damages from the third party. Under ORS 656.580(2), the paying agency has a lien against the cause of action, "which lien shall be preferred to all claims except the cost of recovering such damages." ORS 656.593(1) provides that the proceeds of any damages recovered from the third party by the worker or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds.

We first address JCI's contention that the attorney fees retained by claimant exceed the attorney fees authorized by OAR 438-015-0095. ORS 656.593(1)(a) provides that the total proceeds shall be distributed such that "[c]osts 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." OAR 438-015-0095 provides:

> "Unless otherwise ordered by the Board after a finding of extraordinary circumstances, an attorney fee not to exceed 33-1/3 percent of the gross recovery obtained by the plaintiff in an action maintained under the provisions of ORS 656.576 to 656.595 is authorized."

Here, claimant has not asserted that the third party case involved extraordinary circumstances. Moreover, claimant has not responded to JCI's specific assertion that the attorney fees specified in the itemized statement exceed the attorney fees authorized by OAR 438-015-0095. The Arbitration Award and Money Judgment awarded $17,937.47 plus costs of $1,617. Claimant's counsel's itemized statement referred to attorney fees of $6,518.16.

In some circumstances, we have authorized extraordinary attorney fees. *See, e.g., James D. Stevens*, 52 Van Natta 814 (2000) (approving an extraordinary attorney fee of 36-2/3 percent of the $433,369.15 judgment); *Ted Sowers*, 51 Van Natta 1223 (1999) (approving an attorney fee of 40 percent of the $257,955.24 adjusted verdict); *Victoria A. Brokenshire*, 50 Van Natta 1411 (1998) (approving a 45 percent share of a $729,967.76 judgment). In *Stevens*, the case involved complex issues and the claimant's law firm devoted 34 hours to investigation and research of federal and state loading dock regulations. The claimant's law firm took numerous witness statements and depositions. In addition, because of complex medical issues, the claimant's counsel hired an orthopedic surgeon to perform an independent medical examination. The paying agency did not object to the claimant's request for an attorney fee of 36-2/3 percent of the proceeds. We concluded that the case involved extraordinary circumstances and the claimant's counsel was entitled to an attorney fee in excess of one-third of the $433,369.15 third party judgment.

Similarly, in *Sowers*, extensive discovery was involved and the claimant's attorney conducted numerous depositions. The claimant's attorney consulted with three medical experts and hired an accident reconstruction expert. The jury trial lasted five days and the adjusted verdict was $257,955.24. The paying agency did not object to the claimant's request for an attorney fee of 40 percent of the proceeds. We concluded that the circumstances justified an extraordinary attorney fee.

Here, in contrast, claimant does not assert that the third party action involved extraordinary circumstances. Moreover, the paying agency challenges claimant's counsel's recovery of an attorney fee in excess of the Board's rule. Finally, our review of the record does not support a conclusion that the circumstances presented (as detailed) were "extraordinary."

OAR 438-015-0095 authorizes an attorney fee of 33-1/3 percent of the gross recovery obtained in a third party action "[u]nless otherwise ordered by the Board after a finding of extraordinary circumstances." The gross recovery in this case was $17,937.47 (excluding $1,617 in court-awarded costs) and 33-1/3 percent of $17,937.47 is $5,979.16. Claimant's counsel's itemized statement, however, refers to an attorney fee of $6,518.16, which exceeds 33-1/3 percent by $539. Because claimant has not asserted "extraordinary circumstances" and we find no evidence of "extraordinary circumstances," we agree with JCI that claimant is limited to attorney fees of 33-1/3 percent of $17,937.47, which is $5,979.16.

Costs

JCI disputes claimant's cost bill and argues that its share of the proceeds submitted by claimant is insufficient.

ORS 656.593(1)(a) provides that costs and attorney fees incurred in the third party action shall be initially paid from the third party recovery. Under OAR 438-015-0005(6), "costs" are defined as

> "money expended by an attorney for things and services reasonably necessary to pursue a matter on behalf of a party, but do not include fees paid to any attorney. Examples of costs referred to include, but are not limited to, costs of independent medical examinations, depositions, expert witness opinions, witness fees and mileage paid to execute a subpoena and costs associated with travel."

In previous cases, we have held that a claimant is entitled to reimbursement from the third party recovery for previously unreimbursed costs that are reasonably and necessarily incurred during litigation of the third party action. *E.g., Thomas Lund*, 41 Van Natta 1352, 1356 (1989). The claimant's reimbursable costs incurred during litigation of a third party action are not limited to court costs. *Id.* Here, the arbitration award and money judgment included $1,617 as costs. Claimant has not provided any explanation of those costs or otherwise identified what those costs entailed. In claimant's counsel's itemized statement to JCI, claimant referred to the judgment amount of $17,937.47 and a "cost bill" of $1,617, less the following items:

Attorney Fees	$6,518.16
Peregrine Corporation (Valley Records)	36.00
Smart Corp. (Dr. Becker's Records)	133.17
Roy Slack, M.D. (Records)	20.00
Arbitrator's Fee	725.00
Arbitration Exhibits	3.00
Inger Bartell Travel Expense	100.00
Depositions	166.05
Reimbursement to Todd McCann for Costs Previously Advanced	682.52
Postage, Xerox	50.00

Because claimant has provided no detail about the "costs" in the arbitration award, we cannot determine whether any of the costs in the arbitration award are the same as expenses listed in claimant's counsel's itemized statement. In other words, we are unable to determine which costs were recovered already in the third party action. Claimant is not entitled to be compensated twice for the same items. Furthermore, we are unable to determine whether the costs were "reasonably and necessarily incurred" in the course of the third party proceedings. Because claimant sought and recovered $1,617 as costs in the arbitration and has not provided any explanation as to any discrepancy between the arbitration costs and the itemized costs, we conclude that claimant has not established that any of the costs were unreimbursed costs that were reasonably and necessarily incurred during litigation of the third party action. *See Thomas Lund*, 41 Van Natta at 1356-57.

Distribution of Proceeds

As previously discussed, we have concluded that claimant's counsel is to receive a 33-1/3 share of the $17,937.47 third party recovery, which is $5,979.16. We further conclude that claimant has not established entitlement to any costs, in addition to the costs previously recovered in the arbitration award. Under these circumstances, the third party judgment shall be distributed consistent with the statutory formula of ORS 656.593(1) as follows:

Arbitration Award	$17,937.47	(total recovery)
less	$ 5,979.16	(less 1/3 attorney fee)
less	$ 0.00	(less reasonable and necessary litigation costs)

Remaining balance	$11,958.31	
less	$ 3,986.11	(less 1/3 statutory share to claimant)[1]

Remaining balance	$ 7,972.20	(remaining balance to JCI)

[1] We note that claimant's itemized statement indicates that she received a net remittance of $3,706.86.

JCI has asserted that its actual claim costs, as of April 4, 2001, are $14,094.83, and its anticipated future expenses are $50,345.09. Claimant has not disputed the amount of JCI's actual claim costs. Because JCI's actual claim costs exceed the remaining balance of proceeds from the third party judgment, we need not address the validity of JCI's lien for future expenses. Consequently, because JCI's $14,094.83 lien for actual claim costs exceeds the remaining $7,972.20 balance, JCI is entitled to the entire remaining balance ($7,972.20). Accordingly, claimant is directed to pay $7,972.20 to JCI as its statutory share of the third party judgment.[2]

Sanctions

JCI asserts that it is entitled to sanctions against claimant's attorney for failing to respond or cooperate in resolving this matter. On the other hand, claimant asserts that JCI's claim is "frivolous" and it requests sanctions of $1,000 under ORS 656.390(2).

ORS 656.390(1) provides:

> "Notwithstanding ORS 656.236, if either party requests a hearing before the Hearings Division, requests review of an Administrative Law Judge's decision before the Workers' Compensation Board, appeals for review of the claim to the Court of Appeals or to the Supreme Court, or files a motion for reconsideration of the decision of the Court of Appeals or the Supreme Court, and the Administrative Law Judge, board or court finds that the appeal or motion for reconsideration was frivolous or was filed in bad faith or for the purpose of harassment, the Administrative Law Judge, board or court may impose an appropriate sanction upon the attorney who filed the request for hearing, request for review, appeal or motion. 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."

This case does not involve a request for hearing before the Hearings Division or a request for review of an Administrative Law Judge's decision. Instead, this case involves the Board's authority under ORS 656.593 to resolve disputes involving third party judgments and settlements. Because this case involves a third party judgment, we have no statutory authority for awarding sanctions.

In any event, even if ORS 656.390 applies to this case, claimant is not entitled to sanctions against JCI. By its terms, ORS 656.390(1) only provides for sanctions against an attorney who files a frivolous request for review. Here, JCI's petition and response were filed by a senior claims examiner and there is no evidence that she is an attorney. Therefore, ORS 656.390(1) does not apply to claimant's motion for sanctions. *See James P. Lavin, Jr.*, 52 Van Natta 784 (2000). Moreover, the fact that JCI was successful in its petition indicates that it was not "frivolous." See ORS 656.390(2) ("frivolous" means that the matter is not supported by substantial evidence or is initiated without a reasonable prospect of prevailing).

In addition, we also find that claimant has presented a colorable argument on review that is sufficiently developed so as to create a reasonable prospect of prevailing on the merits. Under these circumstances, we also deny JCI's request for sanctions.

IT IS SO ORDERED.

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[2] We note that claimant's counsel has apparently already remitted $7,413.71 to JCI.

In the Matter of the Compensation of
JIMMY L. GRAZIER, Claimant
WCB Case No. 99-09893
ORDER ON REVIEW
Schneider, et al, Claimant Attorney
Jerry Keene, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Thye's order that: (1) denied claimant's motion to reopen the record for consolidation with another case arising from a claim that he had filed with the Department regarding the noncomplying status of Mr. Swain; (2) found that claimant was not a subject worker of Swain Construction, Inc.; and (3) upheld the SAIF Corporation's denial of claimant's neck injury claim. In addition, claimant submits a copy of a February 1, 2001 letter from the attorney representing Mr. Swain and Swain Construction, Inc., and moves that we remand this case for consolidation with WCB Case No. 00-08330, which is claimant's request for hearing regarding the subsequently issued Department's "nonsubjectivity determination" that held that Mr. Swain was not a noncomplying employer. In its brief, SAIF contends that the ALJ erred in finding that claimant provided timely notice of his neck injury claim. On review, the issues are the ALJ's consolidation ruling, remand, evidence, subjectivity, and timeliness of notice of injury.

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

Appropriateness of ALJ's Consolidation Ruling

At hearing, the parties stipulated that claimant was involved in a January 11, 1999 motor vehicle accident that resulted in injury. (Tr. 1). The ALJ recited the issues as framed by SAIF's contentions.[1] First, SAIF contended that, although it continued to insure Swain Construction, Inc., on January 11, 1999, that corporation was no longer in business at that time. Therefore, SAIF contended that claimant did not work for the corporation on the date of injury and was not a subject worker of the corporation. (*Id.*). Second, SAIF contended that claimant did not provide timely notice of the injury. (*Id.*). Claimant did not object to the ALJ's recitation of the issues and the parties proceeded to hearing regarding those issues. (Tr. 1-3).

On August 25, 2000, the ALJ issued an Opinion and Order finding that claimant failed to prove he was a subject worker of Swain Construction, Inc., and upholding SAIF's December 6, 1999 denial on that basis.

On September 22, 2000, claimant moved to abate and reconsider the Opinion and Order and requested that: (1) claimant be found a "subject worker" of Mr. Swain individually; and (2) the hearing matter be consolidated with a claim that claimant had filed with the Department contending that Mr. Swain was a noncomplying employer. The August 25, 2000 order was abated.

On November 14, 2000, the ALJ issued an Opinion and Order on Reconsideration. In that order, the ALJ deleted his comments in the earlier order regarding claimant's status as a subject worker of *Mr. Swain* at the time of injury. The ALJ noted that the issue at hearing concerning subjectivity was solely whether claimant was a subject worker of *Swain Construction, Inc.*, at the time of injury. The ALJ denied claimant's request for consolidation with the Department proceeding, reasoning that claimant did not request consolidation at the hearing, and the hearing was conducted without objection. With the deletion of the language concerning subjectivity of Mr. Swain, the ALJ found it unnecessary and inappropriate to consolidate the hearing with Department matters and republished his order, as modified with the above deletion.

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[1] The issues at hearing tracked the grounds listed in SAIF's December 6, 1999 denial: (1) at the time of injury claimant was not a subject worker of Swain Construction, Inc.; and (2) claimant did not give timely notice of injury to the employer. (Ex. 42).

Prior to the ALJ's Order on Reconsideration, on October 5, 2000, the Department issued a proposed and final order that found that claimant was not a subject worker of Mr. Swain.[2] The Department also found that Mr. Swain was not a subject employer at the time of injury. Subsequently, claimant requested a hearing before the Hearing Division regarding the Department's October 5, 2000 order. (WCB Case No. 00-08330). That hearing is currently pending.

ALJs are not bound by common law or statutory rules of evidence or by technical or formal rules of procedure. They 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 rulings for abuse of discretion. *James D. Brusseau, II*, 43 Van Natta 541 (1991).

At the time the ALJ issued the November 14, 2000 order on reconsideration, he apparently was not made aware of the Department's October 5, 2000 order or claimant's request for hearing regarding that order. We make this finding based on the ALJ's comments regarding claimant's request for consolidation with the "Department proceeding" and the lack of any mention of a hearing request regarding that proceeding. Order on Reconsideration, page 2.

In any event, we do not find that the ALJ abused his discretion in denying claimant's request for consolidation with those matters. As the ALJ explained, claimant did not request consolidation at hearing and the hearing was conducted on the issues presented without objection. Furthermore, OAR 438-006-0065(5) requires that a motion to consolidate be made at least seven days before the scheduled hearing. Claimant first requested consolidation in his request for reconsideration of the ALJ's Opinion and Order. Under these circumstances, we do not find that the ALJ abused his discretion in denying the motion for consolidation.

Motion to Remand and Evidence

With his request for review, claimant moved to remand this case to the Hearings Division for consolidation with WCB Case No. 00-08330. In the alternative, claimant requests that we postpone review of the present case pending issuance of an Opinion and Order in WCB Case No. 00-08330. SAIF opposes these requests, contending that the existence of an employment relationship (or lack of it) with Mr. Swain individually does not bear on whether claimant had an employment relationship with Swain Construction, Inc., the issue at hearing and on review in the present case. SAIF argues that these are two separate issues capable of separate analysis and determination. Moreover, citing ORS 656.740 and *Ferland v. McMurtry Video Productions*, 116 Or App 405 (1992), SAIF argues that the noncompliance proceedings against Mr. Swain individually are separate from proceedings in which "matters concerning a claim" are at issue, and reflect separate jurisdictional grants and appeal processes that bypass the Board and move directly to the Court of Appeals.

In addition, with his request for review, claimant submitted a copy of a February 1, 2001 letter from an attorney representing Mr. Swain and Swain Construction, Inc., in which the attorney alleged coverage against SAIF pursuant to ORS 656.740. SAIF objected to admission or consideration of that letter on review.

Our review is limited to the record created at hearing. We may remand to the ALJ for the taking of additional evidence if we determine that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or some other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986).

Claimant offers no showing of good cause or other compelling basis to remand for taking of this additional evidence. In any event, subsequent events render a decision on this evidentiary issue unnecessary.

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[2] We take these findings from a March 29, 2001 Order of Postponement and Joinder issued by another ALJ regarding WCB Case No. 00-08330. Claimant submitted a copy of that order on review. As a general rule, the Board may take administrative notice of a fact that is "[c]apable of accurate and ready determination by resort to sources whose accuracy cannot be reasonably questioned." ORS 40.065(2). In previous cases, we have taken administrative notice of agency orders involving the same claimant. *See, e.g., Janet R. Christensen*, 50 Van Natta 1152 (1998); *Brian M. Eggman*, 49 Van Natta 1835 (1997). We find that the March 29, 2001 order meets those criteria; therefore, we take administrative notice of it.

Subsequent to his request for review, claimant "renewed" his motion to remand this case. Attached to that "renewed" motion was a copy of a March 29, 2001 Order of Postponement and Joinder issued by another ALJ regarding WCB Case No. 00-08330. As noted above, we take administrative notice of that order, which discussed the above February 1, 2001 letter alleging coverage against SAIF and discussed a March 2001 conference call in which Mr. Swain individually alleged coverage against SAIF. Pursuant to ORS 656.740(3), the March 29, 2001 order joined SAIF in the matter pending in WCB Case No. 00-08330. Therefore, we find that SAIF has been joined in the proceeding in WCB Case No. 00-08330. Nevertheless, that fact does not further claimant's request for consolidation.

As a general rule, we will consolidate matters in which the issues are so inextricably intertwined that substantial justice and administrative efficiency dictate that the cases be reviewed together. However, such consolidations ordinarily pertain to separate cases pending Board review, not where, as here, one case is pending Board review and the other is pending hearing. *See, Tracey A. Blamires*, 50 Van Natta 2273, 50 Van Natta 2775 (1998); *Greg V. Tomlinson*, 47 Van Natta 1085 (1995), *aff'd mem* 139 Or App 512 (1996); *cf. Gaspar Lopez*, 48 Van Natta 1774 (1996) (case on Board review regarding procedural validity of carrier's closure remanded to ALJ for consolidation with pending hearing request regarding disabling status of that closed claim; Board found the matters inextricably intertwined, since procedural validity of carrier's closure depended on whether the claimant's claim was properly classified as nondisabling or disabling).

Here, we do not find that the above standard has been met. The issue in the present case was explicitly limited to whether claimant was a subject employee of Swain Construction, Inc., at the time of injury. Claimant argues that the issue in WCB Case No. 00-08330 is whether claimant was a subject employee of Mr. Swain, individually, and whether SAIF must extend coverage to Mr. Swain by virtue of the identity between Mr. Swain and Swain Construction, Inc. Those issues are distinct and separate. Thus, resolution of those issues is not interdependent. In other words, although the two cases arise out of the same general circumstances, they are not inextricably intertwined. Therefore, we do not find consolidation appropriate.[3]

For the same reasons, we deny claimant's request that we delay our review of the present case pending issuance of an Order and Opinion regarding WCB Case No. 00-08330.

Subjectivity

Claimant bears the burden of proving the existence of the employment relationship. *See Hix v. State Acc. Ins. Fund*, 34 Or App 819, 825 (1978). There are two fundamental elements which must be present to establish an employer-employee relationship: (1) a contract of hire[4] between the parties, either express or implied; and (2) a right of control. *Oremus v. Ore. Pub. Co.*, 11 Or App 444, 446 (1972), *rev den* (1973); *Audencia Montez*, 52 Van Natta 805 (2000).

Here, the question is whether there was an employer-employee relationship between claimant and Swain Construction, Inc., at the time of the January 11, 1999 injury. We agree with the ALJ's reasoning and conclusions that Swain Construction, Inc., was no longer doing business after mid-1998. As explained by the ALJ, a corporation is a legal entity separate from its shareholders, directors, and officers. *Willamette Nat. Lbr. Co. v. Cir. Ct., Mult. Co.*, 187 Or 591, 603 (1949). Because Swain Construction, Inc., was no longer doing business at the time of the injury, there could not be a contract of hire between the corporation and claimant at that time. Thus, for this reason as well as those provided by the ALJ, claimant failed to prove that he was working for Swain Construction, Inc., on the date of his injury. As discussed above, the issue of whether claimant was a subject worker of Mr. Swain individually is not before us.

ORDER

The ALJ's order dated August 25, 2000, as reconsidered on November 14, 2000, is affirmed.

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[3] Because we find consolidation inappropriate on the above grounds, we need not address SAIF's argument that consolidation is inappropriate on the basis of the separate jurisdictional grants and appeal processes regarding noncompliance proceedings under ORS 656.740.

[4] *See Rogers v. State Acc. Ins. Fund*, 289 Or 633, 641-642 (1980) ("The essence of the Workers' Compensation Act is that financial consequences flow from the existence of the employment relationship itself. Liability and compensability are predicated on employment.").

In the Matter of the Compensation of
CATHERINE F. HARDIN, Claimant
WCB Case No. 00-04945
ORDER ON REVIEW
Starr & Vinson, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Livesley's order that set aside its denials of claimant's injury/occupational disease claim for bilateral plantar fasciitis. Claimant cross-requests review, arguing that her claim is compensable as an injury. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant is a registered nurse who began working for the employer in March 1996. (Tr. 10). She was hired to work in the "float pool," which involved working in several areas in the hospital. (*Id.*)

In October 1999, claimant began noticing foot pain after she got home from work. (Tr. 11, 22; Exs. 1, 2A, 7). There was no specific trauma or injury that started her foot pain. (Tr. 22; Ex. 2). Claimant's pain progressed until February 2000, when she sought medical treatment. (Tr. 22). She testified that her foot pain seemed to be the worst when she worked in the emergency department and the short stay unit. (Tr. 12-13).

Dr. Wilson examined claimant on February 15, 2000. (Ex. 2). He explained that she had a four month history of progressively worsening bilateral heel pain, but she denied any specific trauma or injury. (*Id.*) He diagnosed bilateral calcaneal bone spurs and plantar fasciitis. (*Id.*) Dr. Wilson authorized modified work and claimant was treated with physical therapy, orthotics and medication. (Exs. 2, 3B, 3E, 4, 4A, 8). Claimant was also treated by Dr. Smith. (Ex. 3A).

On April 26, 2000, Dr. Peffley, podiatric physician, examined claimant on behalf of SAIF. (Ex. 7). He diagnosed acute plantar fasciitis, obesity, rear-foot varus, and forefoot varus with abnormal pronation and calcaneal plantar spurs. (Ex. 7-4). Dr. Peffley did not believe claimant's work was the primary cause of her condition. (Ex. 7-4, -6). Instead, he said that the major cause of claimant's discomfort was from the mild equinus, obesity, and the structural deformities and biomechanical dysfunction of her feet. (Ex. 7-6). Drs. Wilson and Smith concurred with Dr. Peffley's report. (Exs. 10, 11).

On May 12, 2000, SAIF denied claimant's bilateral foot claim on the grounds that her work was not the major contributing cause of her disease and the disease did not arise out of and in the course of her employment. (Ex. 9). On July 27, 2000, SAIF amended the denial to refer specifically to bilateral plantar fasciitis. (Ex. 13).

CONCLUSIONS OF LAW

The ALJ analyzed the claim as an injury, reasoning that claimant began having foot pain after a discrete period of four months of doing a single activity. The ALJ found there was no combination between claimant's foot condition and a preexisting condition and applied a material cause standard. The ALJ concluded that claimant established a compensable injury claim under ORS 656.005(7)(a).

SAIF argues that the ALJ erred in applying a material cause standard rather than the major contributing cause standard. SAIF contends that an occupational disease theory applies or, alternatively, ORS 656.005(7)(a)(B) applies. According to SAIF, there is no medical opinion that establishes that claimant's work activities were the major contributing cause of her bilateral plantar fasciitis condition.

We begin by determining the appropriate standard for analyzing compensability. An occupational disease stems from conditions that develop gradually over time. ORS 656.802; *Mathel v. Josephine County*, 319 Or 235, 240 (1994). By contrast, an injury is sudden, arises from an identifiable event, or has an onset traceable to a discrete period of time. *Id.*; *Active Transportation Co. v. Wylie*, 159 Or App 12, 15 (1999); *Valtinson v. SAIF*, 56 Or App 184, 188 (1982). The phrase "sudden in onset" refers to an injury occurring during a short, discrete period, rather than over a long period of time. *Valtinson*, 56 Or App at 188.

Claimant relies on *Donald Drake Co. v. Lundmark*, 63 Or App 261, 266 (1983), *rev den* 296 Or 350 (1984), to argue that an injury theory applies. Claimant asserts that she can point to a discrete period of time and to a particular activity that caused her disability.

In *Lundmark*, the court found that the claimant's back condition was properly analyzed as an injury. The court explained:

> "In *Valtinson* * * *, we construed the phrase 'sudden in onset' to mean occurring during a short, discrete period, rather than over a long period of time. Claimant's condition meets this aspect of the injury test in that his back trouble *coincided precisely* with the traumatic jolting of the faulty loader. Claimant thus points to an identifiable event that caused his disability. The fact that his pain grew progressively worse over his six-week employment with [the employer] does not make it 'gradual in onset.'" *Lundmark*, 63 Or App at 266 (emphasis in original).

Here, unlike *Lundmark*, there is no evidence of an "identifiable event" that caused claimant's disability. To the contrary, claimant agreed that there was no particular injury or event that started her foot pain. (Tr. 22). An injury report signed by claimant referred to the "date of injury" as "ongoing." (Ex. 2A). Similarly, Dr. Wilson recorded a four-month history of progressively worsening bilateral heel pain and noted that claimant "denies any specific trauma or injury." (Ex. 2). Dr. Peffley said claimant described her initial foot pain as "very vague[.]" (Ex. 7-1). Thus, the evidence indicates that claimant began noticing foot pain in October 1999 and her pain gradually progressed until February 2000, when she sought medical treatment.

Based on claimant's testimony and the medical reports, we find that the onset of claimant's foot pain was not sudden and did not arise from an identifiable event. Furthermore, claimant's foot pain occurred over a four-month period, rather than a short, discrete period. *Compare Lundmark*, 63 Or App at 266 (the claimant's back trouble coincided precisely with the jolting of a loader); *Ramona Andrews*, 48 Van Natta 1652 (1996) (the claimant's foot pain began after working three days in the employer's new facilities and increased within about two weeks so that she could hardly walk; claim was analyzed as an accidental injury). Under these circumstances, we find that claimant's foot symptoms related to an ongoing condition with a gradual onset and her bilateral plantar fasciitis condition is most appropriately analyzed as an occupational disease.

Under ORS 656.802(2)(a), claimant must establish that her employment conditions were the major contributing cause of her bilateral plantar fasciitis condition.

Claimant was treated by Drs. Wilson and Smith. On February 15, 2000, Dr. Wilson commented that claimant had a multifactorial condition and "walking at work may be part of the cause." (Ex. 2). However, he was "not convinced that this was a true Workers' Comp. claim." (*Id.*) In a March 21, 2000 letter responding to questions from SAIF, Dr. Wilson explained that plantar fasciitis can be caused by excessive repetitive stresses to the foot, obesity, overuse, inappropriate foot wear and structural instability, and could also be "idiopathic," *i.e.*, without cause. (Ex. 6). He found that claimant's obesity and bone spurs were preexisting/predisposing conditions. (*Id.*) SAIF asked Dr. Wilson what was the major contributing cause of claimant's condition and need for treatment. He responded:

> "Combination, overweight, bone spurs, walking and idiopathic causes. I am <u>not</u> convinced that this is a work injury or disease. She does walk at work, home, store, etc." (*Id.*; underline in original).

In a later letter from claimant's attorney, Dr. Wilson agreed that claimant's reassignment to the emergency room and short stay unit was "the cause" of her need for treatment and disability, but he did *not* agree that the work was "the major cause" of her plantar fasciitis and need for treatment. (Ex. 14-1, -2). We find that Dr. Wilson's opinion is not sufficient to establish that claimant's employment conditions were the major contributing cause of her bilateral plantar fasciitis.

Claimant was also treated by Dr. Smith. In response to questions from SAIF, Dr. Smith identified claimant's "overweight" as a preexisting/predisposing condition for her foot condition, but he said he could not attribute what percentage claimant's weight was as a contributing factor. (Ex. 5). Dr. Smith commented, however, that most of claimant's problems could be improved "with a better arch support and reduced weight." (*Id.*)

We find that the opinions of Drs. Wilson and Smith are not sufficient to establish compensability of claimant's occupational disease. Moreover, Drs. Wilson and Smith both concurred with the report from Dr. Peffley, who did not believe that claimant's work was the primary cause of her plantar fasciitis. (Exs. 7-4, -6; 10, 11). Although Dr. Peffley said that claimant's condition was "aggravated" by work, he concluded that the major cause of her discomfort was from the mild equinus, obesity, and her structural deformities and biomechanical dysfunction of her feet. (Ex. 7-4, -6). He explained that claimant had structural feet abnormalities related to a rear-foot varus and a forefoot varus deformity, and he noted that compensation for the two deformities led to instability of the forefoot. (Ex. 7-4).

In sum, we conclude that the medical evidence is not sufficient to establish that claimant's employment conditions were the major contributing cause of her bilateral plantar fasciitis.[1] We therefore reverse the ALJ's order.

ORDER

The ALJ's order dated January 10, 2001 is reversed. SAIF's denials of claimant's bilateral plantar fasciitis are reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[1] Even if an "injury" analysis applies to this claim, we agree with SAIF that the major contributing cause standard would apply, pursuant to ORS 656.005(7)(a)(B). The medical reports from Drs. Wilson, Smith and Peffley establish that claimant's work activities combined with preexisting foot conditions to cause her disability or need for medical treatment. (Exs. 5, 6, 7, 10, 11).

In the Matter of the Compensation of
DAVID A. STEINER, Claimant
WCB Case No. TP-98003
THIRD PARTY ORDER ON REMAND
Preston, Bunnell & Stone, Claimant Attorney
Steven Cotton (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *Steiner v. E.J. Bartells Co.*, 170 Or App 759 (2000). The court has reversed our prior order, *David A. Steiner*, 50 Van Natta 1078 (1998), that had directed claimant's counsel to reimburse the SAIF Corporation for its unpaid share of proceeds from claimant's third party judgment. Concluding that we do not possess the authority to order that claimant's attorney *personally* reimburse SAIF monies due it from the third party judgment proceeds, the court has remanded with instructions to rescind our June 1998 order.

In accordance with the court's mandate, we rescind our June 4, 1998 order that directed claimant's attorney to pay SAIF the sum of $1,759.46. Consistent with the court's decision, SAIF's petition for an order holding claimant's attorney personally liable for the unpaid portion of the third party judgment ($1,759.46) is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES E. HENDRIE, Claimant
WCB Case No. 00-06792
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorney
Garrett, Hemann, et al, Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that affirmed an Order on Reconsideration that awarded 13 percent (17.85 degrees) scheduled permanent disability for the loss of use and function of claimant's left foot (ankle), whereas a Notice of Closure awarded no permanent disability. On review, the issue is extent of scheduled permanent disability.

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

Both the August 16, 2000 Order on Reconsideration and the ALJ relied on Dr. Lowengart's medical arbiter's examination to rate claimant's scheduled permanent disability. The employer appealed both the Order on Reconsideration and the ALJ's order. On review, the employer argues that claimant's attending physician's (Dr. Weinman's) and Dr. Heyerman's opinions establish by a preponderance of the evidence that claimant had no residual impairment from his accepted left ankle sprain/strain.

Evaluation of a worker's disability is as of the date of the reconsideration order. ORS 656.283(7). For the purpose of rating permanent disability, only the opinions of claimant's attending physician at the time of claim closure or any findings with which he or she concurred, and the medical arbiter's findings, if any, may be considered. *See* ORS 656.245(2)(b)(B), ORS 656.268(7); *Tektronix, Inc. v. Watson*, 132 Or App 483 (1995); *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994).

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(14). This "preponderance of the evidence" must come from the findings of the attending physician or other physicians with which the attending physician concurs. *Koitzsch v. Liberty Northwest*, 125 Or App at 670. Claimant's attending physician at the time of claim closure was Dr. Weinman. (Ex. 13). Dr. Weinman did not concur with any of Dr. Heyerman's findings. Thus, contrary to the employer's argument, Dr. Heyerman's reports may not be considered in establishing claimant's impairment.

The employer also contends that we should give greater weight to Dr. Weinman's report because he was the treating physician. Although in evaluating medical opinions, 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 (1983), the record indicates that Dr. Weinman examined claimant on only one occasion before performing his closing examination. (Exs. 11, 14). Under these circumstances, we find that Dr. Weinman's opinion is not entitled to any particular deference as a treating physician.

In his April 3, 2000 closing examination, which took place after claimant had received physical therapy, Dr. Weinman measured and reported that both claimant's right and left ankle range of motion was normal. (Ex. 14-1). He also reported that, although most of the time claimant was asymptomatic in his left ankle, there were times when he had "15 minutes of pain." (*Id.*) He also reported that claimant had mild tenderness over the left ankle posterior tibialis tendon and that the left ankle was swollen in comparison to the right. (Ex. 14-2). Nevertheless, he also concluded that claimant's left ankle contusion and tibialis tendinitis had resolved. (*Id.*) Because Dr. Weinman's comments about claimant's pain, tenderness and swelling in the left ankle is inconsistent with his finding that claimant's left ankle condition had resolved, we do not find his report well reasoned or persuasive. *See Somers v. SAIF*, 77 Or App 259, 263 (1986).

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[1] We substitute the following for the last sentence in the ALJ's finding of fact (5) on page 2: "An Order on Reconsideration issued August 16, 2000 awarding 13 percent loss of the left foot (ankle)."

In contrast, at the time of the medical arbiter examination, claimant reported that he continued to have problems with his left ankle, such as ankle pain after walking more than two blocks, ankle stiffness, and intermittent pain. The medical arbiter found that claimant had restricted ranges of motion in his left ankle, noted that her findings were valid and opined that the findings of the right and left ankles, as compared to normal, were due to his age, and that the findings of the left ankle that were less than the right ankle were due to the accepted condition. (Ex. 20-2). The arbiter further opined that as a result of the work injury, claimant had significant limitation in his ability to use the left ankle for prolonged walking without the ability to sit. (*Id.*) These findings are more consistent not only with claimant's report of continuing left ankle problems, but also with Dr. Weinman's notations of left ankle tenderness and occasional pain. Consequently, we are not persuaded that Dr. Lowengart's range of motion measurements and finding of a significant limitation in his ability to use the left ankle for prolonged walking should not be used to rate claimant's impairment.

Finally, we note that the August 1, 2000 medical arbiter examination was performed much closer in time to the August 16, 2000 Order on Reconsideration than the April 3, 2000 examination by Dr. Weiman. *See, e.g., Kelly J. Zanni*, 50 Van Natta 1188 (1998) (a medical arbiter's report may be more probative when there is a significant time gap between the closing examination and the medical arbiter's examination). Consequently, under these circumstances, we conclude that the evidence supports a finding that claimant's impairment should be based upon the findings of Dr. Lowengart, the medical arbiter.

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 January 25, 2001 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500, to be paid by the self-insured employer.

May 8, 2001 Cite as 53 Van Natta 646 (2001)

In the Matter of the Compensation of
LEROY L. RICHMOND, Claimant
Own Motion No. 99-0409M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Saif Legal Department, Defense Attorney

Claimant requested review of the SAIF Corporation's February 28, 2001 Notice of Closure which closed his claim with an award of temporary disability compensation from August 3, 2000 through February 14, 2001.[1] SAIF declared claimant's condition medically stationary as of February 14, 2001.

In his request for review, claimant contends that his condition "seems to be worse then it was before surgery," and that his back has not returned to "normal." He requests reconsideration of his "entitlement for more compensation." We interpret such statements as a contention that claimant's condition was either not medically stationary at claim closure or that he is entitled to additional temporary disability.

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[1] Claimant's April 5, 1982 claim was accepted as a disabling claim and first closed on March 30, 1983. Thus, claimant's aggravation rights expired on March 30, 1988. ORS 656.273(4)(a). When claimant's condition worsened requiring surgery in October 1999, claimant's claim was under our Own Motion jurisdiction. ORS 656.278(1)(a). Consistent with our statutory authority, on November 24, 1999, we issued our Own Motion order authorizing the payment of temporary disability compensation and directing that when claimant was medically stationary, SAIF should close the claim pursuant to OAR 438-012-0055.

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's condition was medically stationary at the time of the February 28, 2001 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 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).

Typically, there are only two issues to be raised when a claimant requests review of a carrier's closure of his or her claim. The most common issue raised is that the claimant asserts that he or she was not medically stationary at claim closure. A second issue raised less often is that, although the claimant agrees that he or she was 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, seeking further compensation. We interpret claimant's request as a challenge to the "closure" of his claim and his timeloss award. The record supports the conclusion that claimant was medically stationary at the time of closure and temporary disability compensation was appropriately terminated.

In a February 14, 2001 doctor's report, Dr. Louie, claimant's attending physician, opined that claimant was medically stationary. Dr. Louie reported that claimant was "doing well status post a spinous process osteotomy at L4-5." He did not schedule claimant for a follow-up visit. This medical opinion is unrebutted.

Based on the uncontroverted medical evidence (*i.e.* the opinion of his attending physician), we find that claimant's condition was medically stationary on the date his claim was closed and that the temporary disability awarded by the Notice of Closure was appropriate.[2] Therefore, SAIF's closure was proper.

Accordingly, we affirm SAIF's February 28, 2001 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[2] It appears from claimant's request that he may have questions regarding his rights to benefits under the Workers' Compensation Law. Because claimant is unrepresented, he may wish to contact the Workers' Compensation Ombudsman, whose job it is to assist injured workers regarding workers' compensation matters:

Workers' Compensation Ombudsman
Dept. of Consumer & Business Services
350 Winter Street, NE
Salem OR 97301
Telephone: 1-800-927-1271

In the Matter of the Compensation of
JAVIER URZUA, Claimant
WCB Case No. 00-06160
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Meyers and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Davis' order that modified an Order on Reconsideration (which awarded no permanent disability) to award 15 percent (48 degrees) unscheduled permanent disability for claimant's left shoulder and low back injury. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the exception of the "Findings of Ultimate Facts."

CONCLUSIONS OF LAW AND OPINION

The ALJ awarded claimant 15 percent unscheduled permanent disability for a compensable low back and left shoulder injury. In so doing, the ALJ concluded that claimant had permanent impairment due to the compensable injury, despite the opinion of the attending physician, Dr. Hanley, that claimant had no permanent residuals from the injury (Ex. 4) and the conclusion of the medical arbiter, Dr. Dinneen, that the compensable injury was not the "medically probable cause of any abnormal findings in neither [sic] the shoulder nor the low back." (Ex. 14). Citing *SAIF v. Danboise*, 147 Or App 550 (1997), the ALJ, nevertheless, held that claimant's impairment should be rated using the arbiter's report.

On review, SAIF contends that *Danboise* does not apply and that the ALJ incorrectly inferred that the arbiter's impairment findings were due to the compensable injury. For the following reasons, we agree with SAIF's contentions.

Medical findings of impairment must be made by claimant's attending physician at the time of claim closure or the medical arbiter. ORS 656.245(2)(b)(B); ORS 656.268(7); *Lopez v. Agripac, Inc.*, 154 Or App 149, 155 (1998). Impairment findings from non-attending physicians may be considered only if the findings are ratified by the attending physician at the time of claim closure. *Koitzsch v. Liberty Northwest Insurance Corp.*, 125 Or App 666 (1994); *Adam J. Delfel*, 50 Van Natta 1041 (1998).

In this case, only the attending physician and the medical arbiter made impairment findings. The issue is whether the ALJ could properly infer that impairment findings were related to a compensable injury in the face of express statements by physicians that claimant had no impairment from the compensable injury. We conclude that the ALJ could not.

In *SAIF v. Alton*, 171 Or App 491, 499 (2000), the court discussed a claimant's burden of proof in the context of an extent of permanent disability case and explained that, in *SAIF v. Danboise*, 147 Or App 550, *rev den* 325 Or 438 (1997), it "concluded that the factfinder could infer causation from two 'facts' in combination: (1) a medical opinion expressly describing a claimant's permanent impairment as consistent with the compensable injury, and (2) the lack of any evidence that the impairment could be due to other possible causes."

Here, there is no medical opinion indicating that the impairment findings are consistent with the compensable injury. In fact, the record shows just the opposite. The medical opinions from Drs. Hanley and Dinneen are either that the impairment findings are not due to the work injury or that claimant has no injury-related impairment. Thus, we agree with SAIF that *Danboise* is not applicable and that it cannot be "inferred" that the impairment findings of the medical arbiter were due to the compensable injury.

This conclusion is in accordance with our recent decisions in this area. In *James A. Hanson*, 52 Van Natta 1671 (2000), we also distinguished *Danboise*. We noted that the medical arbiter panel did not describe the claimant's impairment as consistent with the accepted condition. We observed that, to the contrary, the arbiter panel suggested that the impairment was inconsistent with the accepted condition

and that the findings were not regarded as being "due to" the accepted condition. Under such circumstances, we held that *Danboise* did not apply. 52 Van Natta at 1672; *see also Jaime Santa Maria-Sanchez*, 53 Van Natta 74 (2001) (also distinguishing *Danboise*). The facts of this case are sufficiently similar to those in *Hanson*. Just as we did in *Hanson*, we find that *Danboise* does not apply.

In conclusion, we reverse the ALJ's award of unscheduled permanent disability. We affirm the Order on Reconsideration in its entirety.

ORDER

The ALJ's order dated January 10, 2001 is reversed. The Order on Reconsideration is affirmed. The ALJ's "out-of-compensation" attorney fee award is also reversed.

May 9, 2001 Cite as 53 Van Natta 649 (2001)

In the Matter of the Compensation of
LESLIE J. HARRIS, Claimant
WCB Case No. C010939
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Sather & Associates, Claimant Attorney
Neil W. Jones, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

On April 24, 2001, 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 his compensable injury. For the following reasons, we approve the proposed disposition.

The CDA provides that claimant has settled a third party action in the amount of $20,000. According to the agreement, the carrier has a lien in the amount of $39,731.83. In addition, the CDA provides that the carrier has reduced its lien in the amount of $32,943.71 and, thus, shall recover $6,788.12 of its third party lien.

We interpret the parties' CDA as follows. After deduction from the third party settlement of statutorily allowed costs and attorney fees (absent extraordinary circumstances, not more than 1/3 of the gross third party settlement, OAR 438-015-0095) and the worker's 33-1/3 percent statutory share of the balance of the settlement, the remaining balance of the recovery would be approximately $8,889; *i.e.*, $20,000 - $6,667 = $13,333 divided by 3 = $4,444; $13,333 - $4,444 = $8,889. *See* ORS 656.593(1)(a) and (b).

Because its lien is greater than $8,889, the carrier would statutorily be entitled to receive all of the remaining $8,889 balance after deduction of costs and attorney fees and claimant's statutory one-third share. *See* ORS 656.593(1)(c). By reducing its lien to $6,788.12, the carrier has allowed claimant to receive at least $2,100.88 more from the third party settlement than he would otherwise have recovered had the carrier not reduced its lien; *i.e.*, $8,889 - $6,788.12 = $2,100.88)

Under such circumstances, we find that the carrier's waiver of a portion of its otherwise recoverable third party lien provides valid consideration for the CDA. However, rather than the $32,943.71 suggested as consideration for the CDA, we find that the "otherwise recoverable" consideration is approximately $2,100.88. In any case, because we do not find such consideration to be unreasonable as a matter of law, the disposition is approved. *See* ORS 656.236(1)(a).

Based on the above interpretation, the agreement 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
GUADALUPE ARGUETA-PRADO, Claimant
WCB Case No. 00-04817
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's current low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

Claimant compensably injured her low back in March 1999. She complained of numbness in the left leg. Dr. Palmer diagnosed a lumbar strain with S1 radiculopathy. (Exs. 3, 4). The employer accepted a nondisabling low back strain. (Ex. 7). A July 22, 1999 MRI revealed an exophytic degenerative facet cyst at the L4-5 area that was probably putting pressure on the L4 nerve root. However, Dr. Palmer felt that her symptoms were more consistent with an S1 nerve root impingement. (Exs. 11, 12, 13). After Dr. Palmer aspirated the cyst, claimant obtained almost complete relief of her back pain and left leg symptoms. (Ex. 17).

After she returned to work, her back and left leg symptoms recurred. (Ex. 18). A trigger point injection resulted in no substantial improvement. (Exs. 20, 21, 22).

On January 3, 2000, claimant returned to Dr. Waring, who reported complaints in the left paraspinous area at the L2, 3 and 4 levels. (Ex. 23). On February 9, 2000, Dr. Palmer found ongoing, intermittent S1 radicular symptoms, which he suspected might be related to recurrence of the facet cyst. He requested authorization for another MRI. (Ex. 26).

On April 5, 2000, Dr. Gripekoven examined claimant at the employer's request. He concluded that claimant's low back strain had combined with the preexisting degenerative facet cyst, but that the cyst was now the major contributing cause of claimant's ongoing symptoms and need for treatment. He also declared claimant's soft tissue strain medically stationary. (Ex. 31). Dr. Palmer agreed with Dr. Gripekoven's report. (Ex. 34).

A May 4, 2000 MRI revealed a Tarlov's cyst[1] within the spinal canal at the S2 vertebral body, degenerative facet joint and ligament changes at L3-4 and L4-5 and a synovial facet cyst at L4-5. (Ex. 35). Dr. Palmer and Dr. Gehling reviewed the MRI films and concluded that there was a cyst at L4-5 without nerve impingement. They determined that claimant's ongoing back and leg symptoms were not related to the facet cyst and that there was no identifiable impingement of the left S1 nerve root. (Exs. 39, 40).

On May 11, 2000, the employer denied claimant's current condition. (Ex. 37).

On August 30, 2000, Dr. Thompson performed a records review for the employer. (Ex. 41). Dr. Gripekoven reviewed the additional medical records that were generated after his examination and concluded that the pathology in claimant's back appeared localized to the L4-5 facet with associated cysts, a preexisting degenerative process. (Ex. 42).

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[1] A Tarlov's cyst is a "perineural [surrounding a nerve] cyst found in the proximal radicles of the lower spinal cord; it is usually productive of symptoms." *Stedman's Electronic Medical Dictionary*, v.4.0, 1998.

CONCLUSIONS OF LAW AND OPINION

The ALJ, relying on Dr. Palmer's opinion, concluded that the compensable lumbar strain injury of March 1999 continued to be the major contributing cause of claimant's current low back condition, diagnosed as a chronic lumbar strain with left S1 radicular symptoms. The ALJ reasoned that Dr. Palmer originally considered claimant to have a lumbar strain with symptoms of S1 nerve involvement and, because the preexisting cyst condition produced no change in the strain condition, the strain remained the major contributing cause of claimant's complaints. The employer contends that claimant's accepted lumbar strain condition had resolved and was no longer the major contributing cause of claimant's current condition or need for treatment. For the following reasons, we agree with the employer.

Claimant's accepted condition is a nondisabling low back strain. Claimant was also treated for a degenerative facet cyst in 1999. All of the physicians who provided opinions regarding the cause of the degenerative cyst concluded that it was a preexisting degenerative condition. (Exs. 28, 31, 34, 41, 42). Dr. Gripekoven opined that the preexisting degenerative facet cyst combined with the work injury to cause or prolong the combined condition and need for treatment. Under such circumstances, to establish compensability of her current combined condition, claimant must prove that the March 1999 work injury remained the major contributing cause of the disability or need for treatment of the combined condition. *See* ORS 656.005(7)(a)(B).[2] A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's current condition and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

As of April 5, 2000, Dr. Gripekoven opined that claimant's compensable lumbar strain condition had resolved, and that claimant's ongoing complaints were due to the degenerative facet cyst condition. Dr. Palmer concurred in Dr. Gripekoven's assessment, and, as of May 22, 2000, indicated that the cyst was no longer contributing to claimant's symptoms. (Ex. 39). As of June 19, 2000, Dr. Palmer reported that claimant was medically stationary (no matter what condition was being considered), was not in need of surgery, and that there was no identifiable impingement of the left S1 nerve root. Consequently, Dr. Palmer does not support a conclusion that claimant's ongoing condition (chronic lumbar strain with left S1 radicular symptoms) remains compensable.

Finally, Dr. Thompson noted that claimant's imaging studies revealed not only the degenerative facet cyst at L4-5, but also significant facet degeneration at multiple levels in the lumbar spine. Dr. Thompson opined that these changes, both the degenerative facet cyst and the multiple levels of facet degeneration, were the major contributing cause of her current condition. Dr. Palmer has not acknowledged the potential impact of the multiple levels of facet degeneration on claimant's condition. Thus, even if we were to construe Dr. Palmer's opinion as favorable to claimant's position, we would not find it persuasive because of his failure to explain why these degenerative conditions are not involved in her ongoing symptoms, particularly in light of his opinion that claimant's ongoing complaints were not due to the cyst, but to some other unidentified process.

In sum, we conclude that the major contributing cause of claimant's current condition and need for treatment is no longer her accepted low back strain condition. Consequently, the employer's denial of claimant's current low back condition is upheld.

ORDER

The ALJ's order dated October 30, 2000 is reversed. The self-insured employer's denial of claimant's current low back condition is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[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."

In the Matter of the Compensation of
PATRICIA A. WALDO, Claimant
WCB Case Nos. 00-04879 & 00-04095
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorney
Meyers, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its denial of claimant's current low back condition; (2) awarded temporary disability compensation from April 21, 2000 to August 7, 2000; and (3) assessed a penalty for the insurer's allegedly unreasonable claim processing. On review, the issues are compensability, temporary disability, and penalties.[1] We reverse in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Facts," except for the "Ultimate Findings of Facts," with the following supplementation. By June 30, 2000, claimant's back condition involved a preexisting condition that combined with her compensable January 10, 1999 low back strain injury. (Exs. 16, 23-2, 38-4; *compare* Exs. 17, 52-1).

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant worked for the employer as a nurse's aide. She sustained a low back strain injury on or about January 10, 1999. The insurer denied claimant's initial injury claim and a prior ALJ set aside the denial. (Ex. 40). Thereafter, the insurer accepted a disabling lumbosacral strain that combined with L5-S1 degenerative disc disease with a midline protrusion. (Ex. 53).

On April 11, 2001, we affirmed the prior ALJ's order. *Patricia A. Waldo*, 53 Van Natta 539 (2001). Like the prior ALJ, we found that the injury was a material cause of claimant's condition. In reaching this conclusion, we relied on the treating doctors' opinions and claimant's history that her problems arose over two work shifts, with lifting and moving patients, including a specific lifting incident and hurrying after a fleeing patient.[2]

Meanwhile, on June 30, 2000, the insurer denied claimant's current low back condition on the ground that preexisting degeneration was the major cause of claimant's disability and need for treatment for her low back. (Ex. 55). Claimant requested a hearing.

The ALJ relied on Dr. Thomas' June 19, 2000 opinion that claimant's work injury was the major cause of her permanent work restrictions. (Ex. 52). Based on that opinion, the ALJ set aside the June 30, 2000 denial. We reach the opposite result, for the following reasons.

The medical evidence indicates that claimant's current back condition is a "combined condition," involving a preexisting condition and the compensable 1999 injury. Therefore, claimant is subject to the "major contributing cause" standard of proof under ORS 656.005(7)(a)(B) and she bears the burden of proving that her work injury contributes more to her current disability or need for treatment than do all other factors. *See* ORS 656.262(6)(c).[3] The statute requires evaluation of the relative contribution of different causes, including the precipitating cause, to determine which is the primary or major contributing cause. *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995). Because claimant's degenerative condition contributes to her current condition, causation is a complex medical question that requires expert evidence for its resolution. *See Uris v. Compensation Department*, 247 Or 420, 424-26 (1967).

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[1] As a preliminary matter, we note that the ALJ's order states that Exhibits 1 through 59 and 37A, 38A and 42A were all received into evidence. However, the parties understood that Exhibit 58 was not admitted because it was withdrawn at the outset of the hearing, (Tr. 5). We further note that Exhibit 58 is not included in the record.

[2] We also found that the prior ALJ properly considered claimant's prior back injuries.

[3] "Under ORS 656.262(6)(c), an insurer may now deny an accepted combined condition *at any point* if the "compensable injury ceases to be the major contributing cause of the combined * * * condition." *SAIF v. Belden*, 155 Or App 568, 574 (1998), *rev den* 328 Or 330 (1999) (emphasis in original).

Dr. Thomas, treating physician, provided the only medical evidence arguably supporting the claim. (Ex. 52). On June 16, 2000, Dr. Thomas opined that the January 10, 1999 work injury was the major cause of claimant's "lifting restrictions, " based on his understanding that she "did not have back pain" before the work injury. (*Id*). Dr. Thomas' history in this regard is inconsistent with the record.[4] Moreover, the doctor's reasoning is not persuasive because it appears to be based solely on the temporal relationship between claimant's work and her symptoms. *See Vicki F. Brown*, 51 Van Natta 1961 (1999) (treating doctor's opinion inadequately explained and unpersuasive because it was based on the temporal relationship between the claimant's work and her symptoms, without explaining why work contributed more than undisputed preexisting condition).

Finally, because Dr. Thomas did not evaluate the contribution of claimant's undisputed preexisting degeneration, we are not persuaded that his opinion supports a conclusion that the work incident contributed more to claimant's condition in June 2000 than all other causes combined. Under these circumstances, Dr. Thomas' opinion is insufficient to carry claimant's burden of proof. *See Jonna M. Moore*, 52 Van Natta 1984 (2000); *see also Dale L. Ilg*, 52 Van Natta 775, 777 (2000) (treating doctor's advantageous position not a substitute for causal analysis, particularly in a medically complicated case). Accordingly, absent adequately reasoned expert evidence establishing major causation, we reinstate the insurer's June 30, 2000 "current condition" denial. *See Roy M. Dinnell, Jr.*, 53 Van Natta 507 (2001) (combined condition only compensable until injury no longer the major contributing cause of ongoing problems); *Jerold D. Glover*, 51 Van Natta 169 (1999) (same).

Temporary Disability/Penalties

The ALJ awarded temporary disability compensation from April 21, 2000 (the date of the prior ALJ's order that set aside the insurer's denial of claimant's initial injury clam) through August 7, 2000 (the date of claim closure). The ALJ reasoned that the insurer was not entitled to terminate temporary disability benefits based on claimant's failure to begin work at the modified job it offered her on December 10, 1999. In this regard, the ALJ found that the job offer did not include a description of the physical tasks to be performed and therefore the offer did not strictly comply with the relevant statute and rule. Further reasoning that the insurer's failure to commence payment of temporary disability compensation on April 21, 2000 was unreasonable, the ALJ assessed a penalty.

We find that the modified job offer supported nonpayment of temporary *total* disability, but the insurer's nonpayment of temporary *partial* disability was unreasonable. We base this conclusion on the following reasoning.

ORS 656.325(5)(a) provides that an insurer may cease paying temporary total disability and begin paying temporary partial disability when an injured worker refuses wage-earning employment prior to claim determination, if the worker's attending physician agrees that the claimant can perform the duties of a particular job. OAR 436-060-0030(5) provides that ORS 656.325(5)(a) is to be administered as follows:

> "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:
>
> "(a) The attending physician has been notified by the employer or insurer of the physical tasks to be performed by the injured worker;
>
> "(b) The attending physician agrees the employment appears to be within the worker's capabilities; and
>
> "(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."

Here, the employer offered claimant modified work as an office clerk in December 1999. (Ex. 34). The employer's "Return to Work Form" indicated that the office clerk position was "Light Duty,"

[4] Claimant sought treatment for upper and lower back pain on August 26, 1998. (Exs. 1, 2).

including Sedentary Duty, and it involved: answering telephones, sorting mail and distributing it to appropriate departments, "clean-sorting files," stuffing envelopes, maintaining logs and records, passing out mail to patients and running Bingo games for them. (Ex. 35). Dr. Thomas, treating physician, reviewed the modified job description and approved it, stating, "This appears as a good job for [claimant]." (*Id*).

Based on the job description and Dr. Thomas' approval, we find that the employer's job offer included an accurate description of the physical requirements of the job and the attending physician found the job to be within claimant's capabilities. Because we also find that the employer otherwise complied with ORS 656.325(5)(a) and OAR 436-060-0030(5), we conclude that the insurer was authorized to calculate claimant's temporary disability benefits as if she performed the modified work that the employer offered, for the period beginning April 21, 2000, less wages received for work performed.[5] *See Glenda Jenson*, 50 Van Natta 1074 (1998).

Finally, on the penalty issue, we agree with the ALJ that the insurer's failure to pay temporary disability after April 21, 2000 was unreasonable, based on the following reasoning.

A penalty may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(11). The standard for determining unreasonable resistance to the payment of compensation is whether the insurer had a "legitimate doubt" as to its liability for payment of additional compensation. *Brown v. Argonaut Insurance Co.*, 93 Or App 588 (1988). The reasonableness of the carrier's refusal to pay temporary disability is judged in light of the circumstances existing at the time. *See Joseph M. Ardito*, 52 Van Natta 2174 (2000).

Here, as we have explained, when claimant failed to begin the approved modified job, the insurer was authorized to terminate temporary total disability. ORS 656.268(4)(c). However, the insurer had a continuing duty to process claimant's open claim. *See* OAR 436-060-0020(11); 436-060-0030; *see also* 436-0200(3). Moreover, because wages for the modified job would have been lower than wages for the job-at-injury, claimant was entitled to temporary partial disability for periods after the modified job offer, as provided under OAR 436-060-0030(5). We find the insurer's unexplained failure to compute claimant's temporary disability under the rule unreasonable. *See Salome Orenday*, 47 Van Natta 403 (1995). Consequently, we conclude that a penalty is appropriate on this basis.

ORDER

The ALJ's order dated August 31, 2000 is reversed in part and modified in part. That portion of the order that set aside the insurer's denial is reversed. The denial is reinstated and upheld. The ALJ's insurer-paid attorney fee award is reversed. In lieu of the ALJ's temporary total disability award, the insurer is directed to pay claimant temporary partial disability under OAR 436-060-0030(5) (less wages she received for the "post April 21, 2000" period). The ALJ's "out of compensation" attorney fee and penalty assessment are modified accordingly.

[5] We acknowledge that Dr. Thomas modified claimant's lifting restrictions in February 2000. (*See* Exs. 37, 43, 44). However, because the doctor did not withdraw his prior approval of the modified work (that the insurer offered claimant) and there is no indication that the job required lifting, the February 2000 restrictions do not affect our conclusion that the insurer was authorized to calculate claimant's temporary disability benefits as if she worked at the modified job.

In the Matter of the Compensation of
DELORES KINEY, Claimant
WCB Case No. 00-01515
ORDER OF ABATEMENT
Robert J. Guarrasi, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

The insurer requests abatement and reconsideration of our April 12, 2001 order that affirmed an Administrative Law Judge's (ALJ's) order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS) and assessed a penalty for its allegedly untimely denial.

The insurer contends that our order is insufficiently explained because it does not address alleged flaws in Dr. Butters' opinion supporting the claim. Specifically, the insurer argues that Dr. Butters' opinion is inadequate because it addresses only the cause of claimant's need for treatment, not the cause of her condition. The insurer also argues that the doctor's opinion is unpersuasive because it fails to analyze claimant's job duties, particularly the amount of time that claimant held a telephone at work with her wrist extended rather than flexed.

In order to further consider this matter, we withdraw our April 12, 2001 order. Claimant is granted an opportunity to respond. In order to be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

May 10, 2001 Cite as 53 Van Natta 655 (2001)

In the Matter of the Compensation of
THOMAS T. FRANK, Claimant
Own Motion No. 01-0082M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for a low back condition. Claimant's aggravation rights have expired. SAIF 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 claimant 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 for SAIF to provide temporary disability compensation beginning the date claimant is hospitalized for the proposed surgery. When claimant's condition is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[1] On March 27, 2001, the Board announced that it would await notification of the managed care organization (MCO) process. On May 7, 2001, SAIF reported that the MCO provider had precertified the proposed surgery as appropriate treatment for claimant's current condition. As a result, SAIF requested the issuance of an Own Motion Order reopening claimant's 1992 claim. In light of SAIF's announcement, we have proceeded with our review.

In the Matter of the Compensation of
DALE S. HALPIN, Claimant
WCB Case No. 00-06905
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorney
Jerry Keene, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) affirmed an Order on Reconsideration awarding 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of claimant's right arm; and (2) awarded a $2,400 assessed attorney fee under ORS 656.382(2). On review, the issues are extent of scheduled permanent disability and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," but not the ALJ's "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant is a flight attendant who compensably injured her right arm in July 1999.[1] In May 2000, the claim was closed without an award of permanent disability. (Ex. 96). Claimant requested reconsideration.

Dr. Kane performed a medical arbiter evaluation. (Ex. 97). Relying on Dr. Kane's evaluation, the Appellate Review Unit found impairment based on a "chronic condition" under OAR 436-035-0010(5). An Order on Reconsideration awarded 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of claimant's right arm. (Ex. 98). The employer requested a hearing challenging the permanent disability award.

The ALJ determined that Dr. Kane had opined that claimant was "significantly limited" in her ability to repetitively use her right elbow due to discomfort. The ALJ also determined that Dr. Rabie, the attending physician, had described claimant's epicondylitis condition as "chronic, insidious and unrelenting." Consequently, the ALJ concluded that the employer had failed to establish error in the reconsideration process. Accordingly, the ALJ affirmed the Order on Reconsideration.

On review, the employer contends that claimant does not have a chronic condition. In the alternative, the employer asserts that if claimant does have a chronic condition, such a condition is not attributable to the accepted epicondylitis.

We evaluate claimant's disability as of the date of the Order on Reconsideration. ORS 656.283(7). Impairment is established by a preponderance of medical evidence based upon objective findings. ORS 656.726(3)(f)(B). 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(14) (WCD Admin Order No. 98-055). Where a preponderance of the evidence establishes a different level of impairment, the impairment is established by the preponderance of evidence.[2] (*Id.*)

OAR 436-035-0010(5)(d) provides that a worker is entitled to a 5 percent scheduled chronic condition impairment value 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 the arm. We are not persuaded that the record supports a chronic condition impairment value.

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[1] The claim was accepted as a disabling right lateral epicondylitis. (Ex. 64). The updated Notice of Acceptance at Closure did not amend the accepted condition. (Ex. 95).

[2] This preponderance of medical evidence must come from 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).

Dr. Kane reported full range of motion of claimant's right elbow and wrist. (97-2). As a result of muscle strength and sensory testing, Dr. Kane diagnosed radial neuropathy in addition to epicondylitis. (Ex. 97-3). Although Dr. Kane opined that claimant was significantly limited in her ability to use her right elbow due to discomfort, he was unable to attribute the limitation to the epicondylitis as opposed to a "neuropathic process." (*Id.*) Such an opinion does not support a conclusion that claimant's limitation is due to the accepted epicondylitis condition.[3]

Dr. Rabie, claimant's attending physician, stated:

> "[T]his is a chronic, insidious, and unrelenting condition that takes several years to resolve. It has very poor predictability and her main goal therapeutically should be to control her symptoms rather that to cure her condition. * * * I have advised her that she may continue doing her current regular duties without any serious harm to her elbow. She will have intermittent symptoms from time to time but I am not sure that there is any therapeutic modality that could be given to her that has not been tried." (Ex. 91-1).

At the time Dr. Rabie wrote the above-referenced comment, he released claimant to her regular duties, and termed her condition "stationary without evidence of permanent impairment."[4] (*Id.*) Dr. Rabie's opinion does not support a conclusion that claimant is "significantly limited" in the use of her arm.

Consequently, we are not persuaded that claimant was significantly limited in her ability to repetitively use her right arm as a result of her accepted epicondylitis condition.[5] Accordingly, we reverse the ALJ's order and affirm the May 17, 2000 Notice of Closure.

ORDER

The ALJ's order dated December 6, 2000 is reversed. The May 17, 2000 Notice of Closure is affirmed. The ALJ's attorney fee award is also reversed.

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[3] Dr. Kane attributed the radial nerve problem to claimant's work. (Ex. 97-3). The record does not indicate whether claimant has requested acceptance of such a condition. Because the compensability of a radial nerve condition is not before us, we do not address that issue.

[4] Dr. Rabie noted that claimant was on a new route that was easier on her than what she had done in the past. (Ex. 91-1).

[5] As a result of our decision, the ALJ's attorney fee award is also reversed. Consequently, we need not address the employer's argument that the fee award was excessive.

In the Matter of the Compensation of
ROBERT P. SALE, Claimant
WCB Case No. 99-02183
ORDER OF ABATEMENT
Walsh & Associates, Claimant Attorney
Reinisch, et al, Defense Attorney

On April 13, 2001, we affirmed an Administrative Law Judge's (ALJ's) order that set aside the self-insured employer's denial of claimant's injury claim for a low back condition. Announcing that the parties have resolved their dispute, the employer seeks abatement of our order.

Based on the employer's representation, we withdraw our April 13, 2001 order. On receipt of the parties' executed settlement, we will proceed with our consideration of their agreement. In the meantime, the parties are requested to keep us apprised of any further developments.

IT IS SO ORDERED.

In the Matter of the Compensation of
KENNETH G. KROZSER, Claimant
WCB Case Nos. 00-06926 & 00-04361
ORDER ON REVIEW
Wallace, Klor, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Mills' order that: (1) upheld the insurer's denial of his injury claim for a left shoulder condition; and (2) upheld the insurer's denial of his occupational disease claim for a mental disorder. In his appellant's brief, claimant also asks for an opportunity to present additional testimony. We treat claimant's request as a motion for remand. In its respondent's brief, the insurer moves to strike the portion of claimant's appellant's brief that contains testimony not admitted at hearing. On review, the issues are motion to strike, compensability and remand.

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

Our review must be based on the record certified to us. *See* ORS 656.295(5). Consequently, we treat claimant's request to present additional testimony on review as a motion to remand to the ALJ for the taking of additional evidence. *Robert A. Wilson*, 52 Van Natta 2225 (2000); *Tamara J. Fleshman*, 52 Van Natta 1918 (2000); *Judy A. Britton*, 37 Van Natta 1262 (1985).

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 clearly be shown that material 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).

Here, there is no evidence that the testimony claimant would submit for the first time on review was unavailable with due diligence at the time of the hearing. *See Robert A. Wilson*, 52 Van Natta at 2225. Moreover, in light of the existing documentary and testimonial evidence already present in the record, we find that consideration of the additional evidence would not likely affect the outcome. *See Compton v. Weyerhaeuser*, 301 Or at 646. We therefore conclude that the case has not been improperly, incompletely or otherwise insufficiently developed. Accordingly, it does not merit remand. ORS 656.295(5).[1]

ORDER

The ALJ's order dated January 18, 2001 is affirmed.

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[1] In light of this disposition of claimant's offer to present additional testimony, we need not resolve the insurer's "Motion to Strike."

In the Matter of the Compensation of
ALLAN J. SCHLEGEL, Claimant
WCB Case No. 00-07491
ORDER ON REVIEW
Myrick, Seagraves, Claimant Attorney
Cummins, Goodman, et al, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that dismissed his request for hearing as untimely. On review, the issue is timeliness of the hearing request.

We adopt and affirm the ALJ's order with the following exception and supplementation. We do not adopt the first sentence in the third finding of fact.

In addition to serving as the City Attorney for the self-insured employer (the City of Grants Pass), Mr. Stapleton serves as the risk manager. (Tr. 54). In his capacity as risk manager, Mr. Stapleton has the authority to direct SAMIS (the employer's workers' compensation third-party administrator) to accept or deny claims. (Tr. 55). Except under unusual circumstances, SAMIS initially accepted or denied claims without input from Mr. Stapleton. (Tr. 55-6). Here, SAMIS denied claimant's claim and Mr. Stapleton learned about the denial after the fact. (Tr. 56). Mr. Stapleton testified that he would expect a denial under the circumstances of claimant's case, *i.e.*, where there was a positive reaction to a tuberculosis (TB) test but no confirmed TB disease. (Tr. 56-7).

Claimant worked as a police officer for the employer for 25 years. (Tr. 15). In March 2000, claimant tested positive following a TB screening test. On April 4, 2000, he filed a claim. (Ex. 4). On June 22, 2000, SAMIS denied the claim, contending it had received no medical evidence that claimant's condition occurred in the course and scope of his employment. (Ex. 6). Claimant acknowledged that the denial contained appeal rights that informed him that he had 60 days to appeal the denial. (Ex. 6, Tr. 19-20).

Claimant was curious as to why the claim was denied and went to see Mr. Stapleton, who was not in his office. Instead, claimant spoke with Ms. Lanning, a fire corporal with the City and the public safety coordinator, who does training on medical issues, including blood-borne pathogens. (Tr. 17, 58). Claimant asked Ms. Lanning what was going on, telling her that the "State's denying this." (Tr. 20). Ms. Lanning responded that she knew and had "talked to [Mr. Stapleton] about it, and [Mr. Stapleton] said not to worry, he would take care of it." (*Id.*). Based on that statement, claimant assumed that the City would see to it that the denial was withdrawn. (Tr. 20, 26). Although claimant acknowledged that Ms. Lanning's statement could have other possible meanings, those meanings did not occur to him. (Tr. 26).

Claimant did not clarify with Ms. Lanning or Mr. Stapleton as to whether his assumption regarding Ms. Lanning's statement was correct. (Tr. 24). Nor did he follow up on the status of the denial. (*Id.*).

Some time in September 2000, after the 60-day appeal period had expired, claimant became aware that the medical bills regarding his claim had not been paid. (Tr. 21). At that point, claimant discussed the matter with Mr. DeLonge, a Grants Pass firefighter who had also tested positive for TB and had filed a claim with the employer about the same time as claimant. (Tr. 21-22). Mr. DeLonge's understanding of Ms. Lanning's statement was that Mr. Stapleton wanted those employees who tested positive for TB to file a claim with the employer's private health insurance company and the employer would pay any costs not covered by the private insurance company. (Tr. 21).

On September 27, 2000, claimant obtained an attorney, who filed a hearing request on October 2, 2000. (Ex. 9).

Here, there is no dispute that claimant's request for hearing was filed more than 60 days, but less than 180 days, following the employer's denial. Therefore, under ORS 656.319(1)(b), claimant has the burden of proving "good cause" for the late filing of his request for hearing. *See Cogswell v. SAIF*, 74 Or App 234 (1985). In this context, good cause means "mistake, inadvertence, surprise or excusable neglect," as defined under ORCP 71B(1). *Hempel v. SAIF*, 100 Or App 68, 70 (1990). Lack of diligence does not constitute good cause. *Cogswell*, 74 Or App at 237. However, good cause can be established

through evidence that a claimant relied on the misleading statement of a carrier's representative. *See Voorhies v. Wood, Tatum, Moser*, 81 Or App 336, *rev den* 302 Or 342 (1986).

We have held in numerous cases that, where the carrier's employee did not inform a claimant that the claim would be accepted, the claimant's reliance on the carrier's statements did not constitute good cause for an untimely filing. *Carl Morrow*, 49 Van Natta 780 (1997); *Michael D. Stanley*, 49 Van Natta 345 (1997); *Altagrasia Lamm*, 46 Van Natta 252 (1994); *Joe Ann Aguilar*, 43 Van Natta 246 (1991); *Debra A. Smith*, 42 Van Natta 1531 (1990); *Diane T. Lindholm*, 42 Van Natta 447(1990).

For example, in *Morrow*, the employer had paid some medical bills on the claimant's claim before the claim was denied by the employer's insurer. After receiving the denial, the claimant called the employer's safety director, who told him to resubmit an unpaid medical bill to the insurer. After talking to the safety director, the claimant thought the bill was "going to be taken care of." 49 Van Natta at 780. However, the claimant was not told that the claim would be accepted or that the insurer's denial was rescinded. Nor was he told to disregard the denial. Under those circumstances, we found that the claimant had not established good cause for failing to timely appeal the denial.

Here, there is no evidence that Ms. Lanning told claimant that his claim would be accepted or that the denial would be withdrawn. Nor was he told to disregard the denial. Instead, claimant assumed that Ms. Lanning's statement that Mr. Stapleton said not to worry, he would "take care of it" meant that the denial would be withdrawn. However, claimant did nothing to confirm his assumption. We do not find that claimant's reliance on Ms. Lanning's statement constitutes good cause for the untimely filing.

In addition, claimant did not follow up on the status of the denial, which contained clear appeal rights. Under these circumstances, we find a lack of diligence on claimant's part. *Jeffery S. Sorn*, 53 Van Natta 237 (2001).

Accordingly, we agree with the ALJ that claimant did not meet his burden of proving good cause for the untimely hearing request.

ORDER

The ALJ's order dated January 25, 2001 is affirmed.

May 11, 2001 Cite as 53 Van Natta 660 (2001)

In the Matter of the Compensation of
VIRETT R. ENGLISH, Claimant
Own Motion No. 01-0033M
OWN MOTION ORDER

The self-insured employer has submitted a request for temporary disability compensation for claimant's low back condition. Claimant's aggravation rights have expired. The employer opposes the reopening of the claim on the grounds that: (1) no surgery or hospitalization has been requested; (2) claimant's current condition is not causally related to his accepted condition; (3) it is not responsible for the current condition; and (4) surgery or hospitalization is not reasonable and necessary.

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 currently requires surgery or hospitalization.[1] As a result, we are not authorized to grant claimant's request to reopen the claim.

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[1] In reaching this conclusion, we render no opinion as to whether claimant's current condition is causally related to his compensable injury. Rather, our decision is merely premised on the finding that, even if claimant's current condition is compensable, no surgery or hospitalization has been proposed. In the absence of surgery or hospitalization, we are without authority to award temporary disability benefits.

Accordingly, we deny the request for Own Motion relief. *Id.* Claimant's entitlement to medical expenses under ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

May 14, 2001 Cite as 53 Van Natta 661 (2001)

In the Matter of the Compensation of
MARY K. SULLIVAN, Claimant
WCB Case Nos. 00-04323 & 00-04321
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

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

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

Claimant fell at work on May 11, 1996, landing on her right elbow. (Tr. 9). The employer accepted her claim for right elbow strain, right elbow contusion and right medial epicondylitis. (Exs. 6, 9; Tr. 5). In December 1999, claimant developed a right ulnar nerve irritation. (Ex. 60, 62). The employer denied claimant's new medical condition claim for "ulnar neuropathy." (Ex. 71).

The ALJ set aside the employer's denial based on the opinion of claimant's treating physician, Dr. Casey. On review, the employer first contends that the ALJ erred in failing to evaluate the compensability of claimant's right ulnar nerve condition as a consequential condition. ORS 656.005(7)(a)(A). We disagree.

Conditions that arise directly, even if belatedly, from an industrial injury, are not "consequential conditions," and are subject to the material contributing standard. *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992). In *Gasperino*, the claimant compensably fell at work, suffering right wrist and shoulder strains, sacroiliac strain and cervical strain. The claimant then developed thoracic outlet syndrome (TOS) several months later. Based on the persuasive medical evidence, the Board had concluded that the claimant's TOS was directly and materially related to the fall at work, as opposed to the injuries sustained in that fall. 113 Or App at 413. The court affirmed the Board's order holding the claim for TOS compensable on a material contributing cause standard. 113 Or App at 414.

Here, the employer cites to Drs. Schilperoort and Maukonen's[1] opinions that claimant's ulnar nerve condition is related either to scarring and entrapment of the ulnar nerve arising from trauma to the elbow or to inflammation of the medial epicondyle. (*See* Exs. 66-7, 77-37). It argues that claimant's claim for the ulnar nerve is therefore necessarily viewed as a "consequence" of her compensable injury. However, in each instance, Dr. Schilperoort and Maukonen's opinions on this specific issue are couched in possibilities, not in terms of reasonable medical probability. (*Id.*); *Gormley v. SAIF*, 52 Or App 1055 (1981). Their opinions are therefore insufficient to establish that claimant's ulnar nerve condition should be evaluated as a "consequential condition."[2]

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[1] Dr. Maukonen examined claimant three times at the request of the employer. Dr. Schilperoort performed a records review at the request of the employer.

[2] On the other hand, if Dr. Maukonen and Schilperoort's suppositions about the relationship between the scarring caused by the elbow injury and the ulnar nerve condition are correct, their opinions would actually support compensability of the condition as a consequence of the compensable injury on a major contributing cause (indeed, the sole cause) basis. ORS 656.005(7)(a)(A).

Similarly, the employer cites to Dr. Casey's statement that the compensable elbow contusion condition "*could* lead to progressive problems with her ulnar nerve." (Ex. 60). (Emphasis added). That portion of Dr. Casey's opinion likewise is phrased in "possibility" language, and cannot alone establish a "consequential condition." Instead, we find persuasive Dr. Casey's opinion that claimant's "current problems with her ulnar nerve [are] related to her 1996 injury" and "[the ulnar nerve condition] is all part of the original problem." (Ex. 64). Dr. Casey's opinion thus establishes that claimant's right ulnar nerve condition is directly related to her work injury. Accordingly, we find that the major contributing cause standard in relation to consequential conditions does not apply. ORS 656.005(7)(a)(A).

In any event, for the following reasons, we find that claimant has satisfied her burden of proof, whether it be material or major contributing cause. Where the medical evidence is divided, we rely on those opinions that are well-reasoned and based on complete and accurate information. *Somers v. SAIF*, 77 Or App 259 (1986). In addition, absent persuasive reasons to the contrary, we generally rely on the opinion of claimant's treating physician. *Weiland v. SAIF*, 63 Or App 810 (1983).

The employer contends that Dr. Casey should not be accorded deference as claimant's treating physician, because he did not treat claimant soon after the 1996 injury. *See McIntyre v. Standard Utility Contractors*, 135 Or App 298 (1995). We agree that Dr. Casey is not entitled to deference as claimant's treating physician for that reason. Nevertheless, we agree with the ALJ that Dr. Casey's opinion is persuasive.

In this regard, we note that, although Dr. Casey did not treat claimant immediately after the 1996 injury, he has examined and treated claimant several times since 1997. (*See* Ex. 18). Dr. Casey is therefore in a superior position to comment on claimant's elbow condition.

We further find that Dr. Casey's opinion that claimant's ulnar nerve condition is (directly) related to the 1996 work injury supports claimant's claim on either a material or major contributing cause basis. (Ex. 64). Invocation of "magic words" is not necessary to meet a claimant's statutory burden of proof. *McClendon v. Nabisco Brands*, 77 Or App 412, 417 (1986); *Sharon L. Catterson*, 53 Van Natta 112, 113 (2001). Dr. Casey's opinion persuasively supports a conclusion that claimant's injury was the direct and sole cause of the ulnar nerve condition. (Ex. 64).

The employer argues that Dr. Casey's opinion is inconsistent and therefore unpersuasive. We disagree. On September 16, 1999, Dr. Casey commented that "I cannot state that [the ulnar nerve condition] is related to any particular work injury." (Ex. 54). However, after reviewing claimant's earlier chart notes from Dr. Balme (reflecting ulnar nerve symptoms), Dr. Casey arrived at his ultimate opinion on causation stated above. (Exs. 58, 64) ("I base her current problems with her ulnar nerve being related to her 1996 injury on our chart notes that go back to when Dr. Balme treated her in 1996.") In those circumstances, we find that Dr. Casey's change in opinion is explained, and therefore persuasive. *Kelso v. City of Salem*, 87 Or App 630 (1987) (a physician's change in opinion, if adequately explained, can still be persuasive).

The employer contends that the ALJ's reasons for discounting Dr. Maukonen's opinion were unwarranted. However, we agree with the ALJ that Dr. Maukonen's ultimate opinion was based on an occupational disease theory -- he does not offer an opinion on the relationship between claimant's work injury and her ulnar nerve condition. (See Ex. 70-2).

Finally, we agree with the ALJ that Dr. Schilperoort's opinion on causation is unpersuasive. In this regard, we specifically note that Dr. Schilperoort relies on an incorrect history of claimant's not injuring her elbow in a January 1997 fall. (Ex. 76-6, -7). We also agree with the ALJ that Dr. Schilperoort should have noted claimant's history of cigarette smoking. The record is replete with such a history; yet at deposition, Dr. Schilperoort stated that he would like to have known such information. (Exs. 29, 35. 45, 77-13).[3] We therefore find that Dr. Schilperoort's opinion, based solely on a records review, rests on an incorrect history and is unpersuasive.

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[3] We acknowledge the employer's argument that any defect in Dr. Schilperoort's understanding of claimant's smoking history was "cured" at deposition. Still, this omission raises questions regarding the accuracy and completeness of Dr. Schilperoort's report. Therefore, when compared with the opinion offered by Dr. Casey, we consider Dr. Schilperoort's opinion to be unpersuasive.

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 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 issues, and the value of the interest involved.

ORDER

The ALJ's order dated January 12, 2001 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the employer.

May 15, 2001 Cite as 53 Van Natta 663 (2001)

In the Matter of the Compensation of
JEFFREY R. GETCH, Claimant
WCB Case No. 00-07701
ORDER ON REVIEW
Brownstein, Rask, et al, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Peterson's order that dismissed his request for hearing. On review, the issue is the propriety of the ALJ's dismissal order.

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

The sole issue before us is whether claimant's hearing request regarding previously unpaid medical bills should have been dismissed.[1] Based on the following reasoning, we find the ALJ's dismissal order appropriate.

When a claimant signs a retainer agreement employing an attorney and authorizing that attorney to act on the claimant's behalf, a dismissal order issued in response to that attorney's withdrawal of the hearing request is appropriate. *Karen L. Johnson*, 52 Van Natta 1430 (2000); *Arlene F. Link*, 52 Van Natta 1032 (2000); *Gilberto Garcia-Ortega*, 48 Van Natta 2201 (1996). Here, the retainer agreement between claimant and his then-attorney authorized that attorney to act on claimant's behalf. Claimant does not assert that his attorney lacked authority to withdraw his hearing request.

Under these circumstances, although we note claimant's dissatisfaction with his former attorney's actions, we find no reason to alter the dismissal order. *See April F. Zamora*, 52 Van Natta 865 (2000), *Steve L. Paul*, 50 Van Natta 1987 (1998).[2]

ORDER

The ALJ's order dated January 8, 2001 is affirmed.

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[1] Claimant's attorney subsequently withdrew the hearing request when the medical bills were paid.

[2] We note that claimant is presently unrepresented. Because he is unrepresented, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in workers' compensation matters. Claimant may contact the Workers' Compensation Ombudsman at (503) 378-3351 or 1-800-927-1271 (V/TTY) (within the State of Oregon), or write to:

Workers' Compensation Ombudsman
Department of Business and Consumer Services
350 Winter Street NE, Room 160
Salem, OR 97301-3878

In the Matter of the Compensation of
CECIL A. GREEN, Deceased, Claimant
WCB Case No. 00-02435
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by the Board *en banc*.

The insurer requests review of Administrative Law Judge (ALJ) Poland's order that: (1) found that the deceased claimant's[1] head injury arose out of the course and scope of his employment; and (2) set aside the insurer's denial of the injury and death benefits. On review, the issues are course and scope of employment and compensability.

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

On January 25, 2000, claimant was performing his regular work for the employer, operating a vertical milling machine. During this activity, claimant sustained the beginning of a heart attack that caused him to pass out and fall. This fall was unwitnessed. Claimant could not remember the fall or the events leading to that incident.

As claimant fell, he struck the back of his head on a sharp object near his work station,[2] causing a large laceration as well as bleeding in his frontal and temporal lobes on the right, *i.e.*, a subdural hematoma, which required surgery the day of the injury. Because of this bleeding within claimant's brain, the treating physicians could not provide optimum treatment for claimant's heart attack. Moreover, this bleeding caused damage to claimant's brain and resulted in breathing problems that ultimately were the cause of claimant's death on March 3, 2000.

The ALJ found that claimant struck his head on a sharp object near his work station. The ALJ reasoned that claimant's fall was sufficient to invoke the "increased risk" doctrine adopted in *Marshall v. Bob Kimmel Trucking*, 109 Or App 101 (1991). The ALJ also relied on the "increased danger rule" as discussed in Professor Larson's treatise on workers' compensation law. The ALJ concluded that claimant's head injury arose out of and in the course of his employment.

On review, the insurer argues, among other things, that the "increased danger rule" is no longer viable. The insurer asserts that claimant experienced a heart attack, which was idiopathic[3] in nature, that caused him to lose consciousness and fall. The insurer contends that claimant's injuries sustained in the idiopathic fall are not compensable.

For the following reasons, we agree with the ALJ that claimant's head injury arose out of and in the course of employment.

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[1] We note that, although claimant originally filed a claim, he is now deceased, and his widow is pursuing a claim for survivor benefits.

[2] The insurer criticizes as purely speculative the ALJ's finding that claimant was standing on a 9 1/2 inch platform and hit a sharp object when he fell from that platform. Instead, the insurer argues, it was just as likely that claimant injured his head by falling while standing on the floor and striking his head on the concrete floor. Under such circumstances, the insurer argues, claimant's head injury would not be compensable. We need not determine whether claimant was standing on the 9 1/2 inch platform when he fell because we agree with the ALJ that Dr. Soldevilla, treating neurologist, persuasively establishes that claimant struck his head on a sharp object, causing the subdural hematoma. (Ex. 62). Thus, whether or not claimant was standing on a platform at the time of his fall, the sharp object against which claimant struck his head when he fell represented a risk in the work environment.

[3] In *McTaggart v. Time Warner Cable*, 170 Or App 491, 496 n7 (2000), the court explained that idiopathic reasons are those that are peculiar to the claimant, rather than arising out of the work situation. *See also Phil A. Livesley Co. v. Russ*, 296 Or 25, 27 n1 (1983) ("idiopathic" refers to an employee's preexisting physical weakness or disease that contributes to the accident).

While we agree that the Court has rejected the "increased risk doctrine," we disagree with the insurer's argument that the "increased danger rule" is no longer viable. In making this argument, the insurer appears to contend that risk created by the work environment may not be considered when the cause of a fall is idiopathic.

Some historical background is necessary to explain the fallacy of the insurer's contention. As explained by Larson, the "peculiar-risk doctrine" was part of the early evolution of American workers' compensation law. Under that doctrine, the claimant had to show that the source of the harm was in its nature peculiar to his occupation. Arthur Larson and Lex K. Larson, 1 *Larson's Workers' Compensation Law*, section 3.02 (2000). The "peculiar-risk doctrine" was replaced by the "increased-risk doctrine," by which "the distinctiveness of the employment risk can be contributed by the increased *quantity* of a risk that is *qualitatively* not peculiar to the employment." *Id.* at section 3.03 (emphasis in original).

However, the Oregon Supreme Court

> "specifically rejected 'the largely obsolete "peculiar-risk" and "increased-risk"' considerations' in assessing whether a worker's injury was linked to a risk connected with employment. Rather, a worker's injury is deemed to 'arise out of ' employment if the risk of the injury results from the nature of his or her work or when it originates from some risk to which the work environment exposes the worker." *Fred Meyer, Inc. v. Hayes*, 325 Or 592, 601 (1997) (quoting *Phil A. Livesley Co. v. Russ*, 296 Or at 31).

Thus, the Court has rejected the "increased-risk doctrine." That does not end the inquiry, however, because there is a difference between the "increased risk doctrine," which requires exposure to greater risk than that to which the general public is exposed in order to establish compensability of a claim, *see Hayes*, 325 Or at 601, and the "increased-danger rule," which Larson explains in relation to idiopathic falls as follows:

> "The basic rule, on which there is now general agreement, is that the effects of [an idiopathic] fall are compensable if the employment places the employee in a position increasing the dangerous effects of such a fall, such as on a height, near machinery or sharp corners, or in a moving vehicle. * * *
>
> "It should be stressed that the present question, although often discussed in the same breath with unexplained falls, is basically different, since unexplained-fall cases begin with a completely neutral origin of the mishap, while idiopathic fall cases begin with an origin which is admittedly personal and which therefore requires some affirmative employment contribution to offset the prima facie showing of personal origin." 1 *Larson's Workers' Compensation Law*, section 9.01(1) (footnotes omitted).

In *Marshall*, the claimant sustained injuries when he lost consciousness while driving a log truck. In finding the claim compensable, the court adopted the "increased danger rule," relying on Larson's statement that:

> "Awards are uniformly made when the employee's idiopathic loss of his faculties took place while he was in a moving vehicle * * * . It seems obvious that the obligations of their employment had put these employees in a position where the consequences of blacking out were markedly more dangerous than if they had not been so employed." *Marshall*, 109 Or App at 104, quoting *Larson* 3-356, section 12.112 (1990) [now at *Larson* section 9.01(2)].

Applying that principle, the court found that, whether the loss of consciousness was idiopathic or not, the risk of injury was increased by the fact that the claimant was driving a log truck for the benefit of his employer. *Id.*

The Supreme Court has not expressly or impliedly rejected the "increased danger rule" adopted in *Marshall*. As we explained in *Kim P. Kennedy*, 49 Van Natta 1534, 1535 fn1 (1997):

> "In *Fred Meyer, Inc. v. Hayes*, 325 Or 592 (1997), the Supreme Court recently stated that, in *Livesley*, the Court had specifically rejected the 'peculiar- risk' and 'increased-risk' considerations. However, it is readily apparent from the Court's discussion in *Hayes* that the concept rejected in *Livesley* was the 'largely obsolete' requirement that an injured

> worker establish a 'peculiar risk' or an 'increased risk' in order to prevail. The Court did not hold that the existence of a work-related increased risk would defeat compensability. Rather, the Court merely reiterated that 'a worker's injury is deemed to "arise out of" employment if the risk of injury results from the nature of his or her work or when it originates from some risk to which the work environment exposes the worker.' We conclude this statement of the law is entirely consistent with the Court of Appeals' reasoning in *Marshall* [*v. Bob Kimmel Trucking*]."[4]

Thus, the risk of the work environment may be considered in the context of an idiopathic fall. Accordingly, we agree with the ALJ's application of the "increased danger rule" under the facts of this case.

Moreover, even if the insurer is correct that the "increased danger rule" is no longer viable, we find that claimant's head injury arose out of and in the course of his employment, based on the following alternative analysis.

The insurer concedes that it is likely that claimant has satisfied the "in the course of" prong. The requirement that the injury occur "in the course of" the employment concerns the time, place, and circumstances of the injury. *Hayes*, 325 Or at 596. Here, claimant injured his head during his regular work hours while performing work-related duties. The injury occurred on the employer's premises. Consequently, the "course of employment" prong strongly favors compensability.

Claimant must also establish a causal connection between his head injury and a risk connected with employment. The injury arises out of employment if the risk of injury results from the nature of his or her work or when it originates from some risk to which the work environment exposes the worker. *Id.* at 601.

In *Redman Industries, Inc. v. Lang*, 326 Or 32, 36 (1997), the court said it had rejected the largely obsolete "peculiar risk" and "increased-risk" considerations in assessing whether a worker's injury was linked to a risk connected with employment. The court quoted with approval the risk analysis discussed in 1 *Larson's Workers' Compensation Law* section 7.00 at 3-14 (rebound ed. 1997). Id. The current version of Arthur Larson and Lex K. Larson, 1 *Larson's Workers' Compensation Law*, section 4 (2000) provides:

> "All risks causing injury to a claimant can be brought within three categories: risks distinctly associated with the employment, risks personal to the claimant, and 'neutral' risks--*i.e.*, risks having no particular employment or personal character. Harms from the first are universally compensable. Those from the second are universally noncompensable. It is within the third category that most controversy in modern compensation law occurs. The view that the injury should be deemed to arise out of employment if the conditions of employment put claimant in a position to be injured by the neutral risk is gaining increased acceptance.
>
> "*When employment and personal risks concur to produce injury, the injury arises out of the employment, since the employment need not be the primary cause, but need only contribute to the injury.*" (Emphasis supplied).

We must first categorize the nature of the risk of harm in this case. The insurer contends that, because claimant's fall was "idiopathic," he has failed to sustain his burden of proof.

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[4] Professor Larson describes the "increased danger rule" in the context of personal risks (such as an idiopathic fall) and neutral risks (such as being struck by lightening at work) as follows:

> "It should be stressed that this requirement of some employment contribution to the risk in idiopathic-fall injuries is a quite different matter from the requirement of increased risk in say, lightning cases. The idiopathic fall cases begin as personal-risk cases. There is, therefore, ample reason to assign the resulting loss to the employee personally. The lightning cases begin as neutral-risk cases. There is, therefore, no reason whatever to assign the resulting loss to the employee personally. To shift the loss in the idiopathic-fall cases to the employment, then, it is reasonable to require a showing of at least some substantial employment contribution to the harm. But in neutral risk cases, the question is not one of shifting the loss away from a prima facie assignment to the employee at all, since there has never been ground for any such assignment." 1 *Larson's Worker's Compensation Law* section 9.01(4)(b).

We understand the insurer to be arguing that claimant's risk in this case was personal to him and is therefore noncompensable. Larson indicates that risks personal to the claimant are "universally noncompensable." 1 *Larson's Workers' Compensation Law*, at section 4. In *SAIF v. Marin*, 139 Or App 518, 523-24, *rev den* 323 Or 535 (1996), the court explained that "personal risks," according to Larson, are risks of injury that arise from idiopathic conditions that the claimant may have, from personal confrontations, or from instrumentalities personal to the claimant. Larson describes risks personal to the claimant as:

> "At the other extreme are origins of harm so clearly personal that, even if they take effect while the employee is on the job, they could not possibly be attributed to the employment. If the time has come for the employee to die a natural death, or to expire from the effects of some disease or internal weakness of which he or she would as promptly expired whether the employee had been working or not, the fact that the demise takes place in an employment setting rather than at home does not, of course, make the death compensable. Or if the employee has a mortal personal enemy who has sworn to seek the employee out wherever he or she may be, and if this enemy happens to find and murder the employee while the latter is at work, the employment cannot be said to have had any causal relation to the death. The same is true if the employee, for reasons of his or her own, carries a bomb (as actually happened in one case), and if the bomb goes off during business hours." Arthur Larson and Lex K. Larson, 1 *Larson's Workers' Compensation Law*, section 4.02 (2000) (footnotes omitted).

On the other hand, Larson's discussion of risks distinctly associated with employment includes the following:

> "This group comprises all the obvious kinds of injury that one thinks of at once as industrial injury. All the things that can go wrong around a modern factory, mill, mine, transportation system, or construction project--machinery breaking, objects falling, explosives exploding, tractors tipping, fingers getting caught in gears, excavations caving in, and so on are clearly in this category[.] * * * As far as the 'arising' test is concerned, this group causes no trouble, since all these risks fall readily within the increased-risk test and are considered work-related in all jurisdictions." *Id.* at section 4.01.

Here, claimant is not arguing that the heart attack is compensable. Rather, he contends that his head injury is compensable. He argues that his fall was initiated by a syncopal event caused by cardiac and circulatory conditions. Claimant contends, however, that the employment risks that led to his head injury included the presence of a sharp object on which he hit his head.

We find that these circumstances do not clearly fit into either the purely "personal risk" or purely "employment risk" categories described by Larson. Rather, claimant's injury includes components of both types of risk. Claimant's fall was caused by the beginning of a heart attack, which caused him to lose consciousness while at his workstation. The syncopal episode and beginning of a heart attack were personal to claimant. On the other hand, as discussed above, we find that the head injury was caused by an employment risk; *i.e.*, the subdural hematoma was caused when claimant struck his head on a sharp object. We find that these circumstances qualify as a "mixed risk," which is described by Larson as follows:

> "Another troublesome problem is that of mixed risks, in which a personal cause and an employment cause combine to produce the harm. The most common example is that of a person with a weak heart who dies because of strain occasioned by the employment. In broadest theoretical outline, the rule is quite simple. The law does not weigh the relative importance of the two causes, nor does it look for primary and secondary causes; it merely inquires whether the employment was a contributing factor. If it was, the concurrence of the personal cause will not defeat compensability." *Id.* at section 4.04.

In this case, we find that claimant's employment was a contributing factor in his head injury because it was caused when he struck his head on a sharp object, causing the subdural hematoma.[5]

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[5] In relying on the "mixed risk" analysis in Larson's, we emphasize that this only applies to determine whether or not this injury arose out of claimant's employment. We are not using this analysis to determine the medical question as to the major contributing cause of claimant's death.

The fact that claimant's fall was initiated by a noncompensable syncopal episode at the beginning of a heart attack does not defeat compensability. Under these circumstances, claimant's head injury arose out of his employment because the risk of injury originated from a risk to which the work environment exposed him. *See Hayes*, 325 Or at 601.

In sum, we conclude that claimant has established that the head injury arose out of and in the course of his employment. Furthermore, we adopt and affirm the ALJ's reasoning and conclusion that the opinion of claimant's treating doctors establishes that claimant's head injury was the major contributing cause of his death.

Claimant's counsel 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 $2,000, to be paid 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 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 September 20, 2000 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $2,000, payable by the insurer.

May 15, 2001 Cite as 53 Van Natta 668 (2001)

In the Matter of the Compensation of
YVONNE R. HALL, Claimant
WCB Case No. 00-02232
ORDER ON REVIEW
John C. DeWenter, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Fitzwater's order that increased her scheduled permanent disability award for a left wrist condition from zero, as awarded by an Order on Reconsideration, to 1 percent (1.92 degrees) for loss of use or function of her left arm (wrist).[1] On review, the issue is extent of scheduled permanent disability.

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

Claimant had a 1996 work injury that resulted in an accepted disabling claim for left elbow lateral epicondylitis. (Ex. 4). The claim was closed in February 1997 by a Notice of Closure which awarded 5 percent scheduled permanent disability (9.6 degrees) for loss of use or function of left arm. (Ex. 10).

In June 1999, the claim was reopened for acceptance of "left intersectional syndrome tendinitis." (Ex. 26). The claim was subsequently closed in October 1999, without an additional award for permanent disability. (Ex. 34).

Following claimant's request for reconsideration, the Appellate Review Unit issued a February 2000, Order on Reconsideration that affirmed the October 1999, Notice of Closure. (Ex. 35). Claimant requested a hearing.

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[1] At hearing, claimant sought to increase the permanent disability award from zero to six percent. SAIF conceded that claimant was entitled to an award of 1 percent permanent disability. On review, the only issue is claimant's entitlement to an additional 5 percent impairment based on an alleged chronic condition.

The ALJ determined that the medical evidence did not establish that claimant had a chronic condition of her left forearm. Consequently, the ALJ declined to award claimant an additional 5 percent scheduled permanent disability under OAR 436-035-0010(5)(c).[2]

Claimant contends that Dr. Wuest's (attending physician) 1998 records establish that she is entitled to an impairment value for a chronic condition of her left wrist. We disagree.

Claimant's disability is determined as of the date of the Order on Reconsideration. ORS 656.283(7). Impairment is established by a preponderance of medical evidence based upon objective findings. ORS 656.726(3)(f)(B). 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). *See* 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).

Here, there was no medical arbiter. Nor were there impairment findings made at the time of closure by attending physician Wuest. There was, however, an evaluation by Dr. Mayhall, a SAIF-arranged examiner. (Ex. 30). Because Dr. Wuest concurred with Dr. Mayhall's evaluation (Ex. 31), Dr. Mayhall's examination may be used to rate impairment. *Watson*, 132 Or App at 486 (1995).

Dr. Mayhall opined that claimant's left intersectional tendinitis was stationary with no objective evidence of impairment. (Ex. 30-6). He further opined that claimant had: (1) no loss of motion associated with her left intersectional tendinitis; and (2) no permanent weakness due to left intersectional tendinitis. (Id.) Such an opinion does not support a conclusion that claimant has a chronic and permanent condition of her left wrist.

We acknowledge claimant's assertion that Dr. Wuest's April 1998 concurrence with a physical capacity evaluation indicating claimant should avoid repetitive pinching, gripping and squeezing, together with Dr. Wuest's own April 1998 recommendation that claimant find work that is not repetitive in nature, establish that claimant's left wrist condition is chronic. (Ex. 18; 19). However, to the extent that above-referenced records support such a conclusion, they are inconsistent with Dr. Wuest's September 1999 concurrence with Dr. Mayhall. Consequently, we do not find that Dr. Wuest's 1998 records persuasively establish that claimant is entitled to an impairment value for a chronic condition of the left wrist. Accordingly, we affirm the ALJ's order.

ORDER

The ALJ's order dated January 24, 2001 is affirmed.

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[2] OAR 436-035-0010(5)(c) entitles a worker to a 5 percent scheduled impairment value when a chronic and permanent medical condition significantly limits the worker's repetitive use of the forearm.

In the Matter of the Compensation of
LUIS G. MORENO, Claimant
WCB Case No. 98-03849
ORDER ON REMAND
Scott M. McNutt, Sr., Claimant Attorney
Lundeen, et al, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *Moreno v. Menlo Logistics, Inc.*, 171 Or App 675 (2000). The court has reversed our order, *Luis G. Moreno*, 51 Van Natta 1049 (1999), that reversed an Administrative Law Judge's (ALJ's) order setting aside the self-insured employer's denial of claimant's low back injury claim. The court reversed and remanded "for reconsideration in light of our conclusion that any inconsistency between [a medical report] and claimant's testimony does not justify the Board's disregard of the medical report for the purpose of determining medical causation of the low back strain." In accordance with the court's directive, we now proceed with our reconsideration.

FINDINGS OF FACT

Claimant worked for the employer as a truck driver. Late in the day on April 21, 1998, claimant was told to make a delivery. Claimant asked to take a lunch break before unloading his truck; his request was denied. Claimant then gave his two-week notice to quit his employment.

Upon arriving at his destination, claimant back up to the dock at an angle, leaving a gap on one side of about two feet. Claimant used a dock plate to cover the gap between the truck and the dock. After unloading the truck, claimant testified that he began picking up pieces of wood from broken pallets in the trailer, walking backwards toward the dock. According to claimant, his toe caught the handle on the dock plate, causing him to lose his balance; claimant testified that his right foot caught the lip of the trailer and his left leg went down in the space between the dock and the trailer. Claimant called the operations manager later that night and told him that he was injured while making a delivery.

On April 22, 1998, he sought treatment for neck and upper back pain, reporting that, the previous day, he slipped on a dock and fell between trailer and wall. (Ex. 1). Claimant was diagnosed with a cervical strain. (*Id.*) On April 27, 1998, claimant was again examined and reported that the neck pain improved but that he was continuing to have low back pain. (Ex. 3). The diagnosis was lumbar strain. (*Id.*)

Dr. Pierson examined claimant on April 29, 1998 and recorded that claimant "stepped backwards and fell in a space between the end of the truck and the dock plate," causing him to "split his legs, the right leg went down and the left was caught at the end of the truck." (Ex. 5-1). Dr. Pierson further stated that the "neck gradually improved, however, over the ensuing days he has developed pain in the low back and around the left hip area[.]" (*Id.*) Dr. Pierson diagnosed "strain of the cervical range" that was minor and improving, "low back strain", and "probable left hip strain." (*Id.* at 2). Dr. Pierson was deposed in October 1998. (Ex. 16).

The employer denied the low back injury claim and claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the claim was compensable after deciding that claimant had proved medical and legal causation. A majority of the Board reversed, first noting that the record contained only Dr. Pierson's diagnoses without an express opinion establishing causation. *Luis G. Moreno*, 51 Van Natta at 1049. We found that, whether or not the diagnoses could, by themselves, prove compensability, Dr. Pierson's chartnote was not sufficient to prove compensability. Specifically, we reasoned that, because Dr. Pierson's history that the onset of claimant's low back and left hip pain was a few days after the work incident and claimant testified that his symptoms all arose at the time of the accident, Dr. Pierson relied on an inaccurate history.

In reviewing our decision, the court first decided we appropriately addressed the issue of medical causation. The court then rejected claimant's contention that expert medical opinion was not necessary to prove compensability. 171 Or App at 679.

Finally, the court considered our finding that Dr. Pierson did not rely on an accurate history. The court found that we did "not adequately explain[] its rejection of Pierson's opinion" and that it did "not read Pierson's report to be that hip and low back symptoms had their *onset* a few days after the incident" because Dr. Pierson had noted that "symptoms arose 'over the ensuing days,' which means in the days following the injury." *Id.* at 680 (emphasis in original).

The court additionally did "not understand how the discrepancy is material to the question of medical causation" because it was "undisputed that in the days after his injury, claimant had pain in his low back." *Id.* In sum, the court concluded that we did "not adequately explain[] its rejection of Pierson's report based on an inconsistency with claimant's testimony that does not appear to be material to the question of medical causation of the low back strain" and, thus, remanded for "reconsideration in light of our conclusion that any inconsistency between Pierson's report and claimant's testimony does not justify the Board's disregard of the medical report for the purpose of determining medical causation of the low back strain." *Id.*

Claimant bears the burden of proving that the claimed April 21, 1998 injury was a material cause of her low back condition. ORS 656.005(7)(a); ORS 656.266. In particular, claimant must have expert medical evidence showing a causal relationship between the April 21, 1998 event and his low back conditions.[1]

The record contains the following evidence. As explained above, there are chartnotes from April 22 and 27, 1998. Dr. Pierson's April 29, 1998 examination generated a chartnote containing a history of the injury and diagnoses. Dr. Pierson then concurred with a report stating that claimant's range of motion findings were subjective; sensory findings did not constitute a "'real' diagnostic finding"; palpation did not reveal any muscle spasm; deep tendon reflexes were "non-diagnostic"; there was no bruising; and chartnotes from examinations on April 22 and April 27, 1998 showed "no objective medical findings." (Ex. 12).

Dr. Pierson was also deposed, where he reviewed the previous report. In particular, Dr. Pierson continued to indicate that claimant's range of motion was not an objective finding but that the diminished sensation in claimant's left leg and tenderness from palpation were objective findings. (Ex. 16-8, 16-9, 16-10).

As noted in our previous order, Dr. Pierson did not expressly address whether or not the April 21, 1998 work incident reported by claimant resulted in the diagnoses of cervical strain, low back strain, and probable left hip strain. Instead, Dr. Pierson's "opinion" consists of one chartnote containing the diagnoses and the concurring report and deposition addressing objective findings. Thus, we consider whether such evidence is sufficient to carry claimant's burden of proving medical causation.

As the court previously noted, we are not an "agency with specialized medical expertise entitled to take official notice of technical facts within [our] specialized knowledge." *SAIF v. Alton*, 171 Or App 491, 502 n.6 (2000) (quoting *SAIF v. Calder*, 157 Or App 224, 228 (1998)). Although we "may draw reasonable inferences from the medical evidence, [we are] not free to reach [our] own medical conclusions about causation in the absence of such evidence." *Benz v. SAIF*, 170 Or App 22, 26 (2000).

We find the court's decision in *Alton* instructive concerning our role in determining causation. Our order in that case found the claimant entitled to unscheduled permanent disability based on a medical arbiter report that provided impairment findings without expressly relating them to the compensable condition. The court found that, because the record contained significant medical evidence of contribution from noncompensalbe factors and there was no direct opinion that impairment was due to the compensable condition, we did not provide sufficient reasoning supporting our inference of causation from the medical arbiter's report. 171 Or App at 500-503.

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[1] The court based this portion of its decision on finding that "there was some inconsistency in the record as to the onset of claimant's symptoms" and that "the relation between the mechanism of injury and the diagnoses are [sic] not so obvious as to eliminate the necessity of expert opinion." 171 Or App at 679. We also note that the record contains evidence that claimant previously sought treatment for low back pain. (Tr. 27). *See Barnett v. SAIF*, 122 Or App 279, 283 (1993) (one factor for determining whether expert medical evidence is necessary is if the worker was previously free from disability of the kind involved).

Similarly, we recently reversed an ALJ's order setting aside the carrier's denial of the claimant's occupational disease claim. *Mona L. McPherson*, 53 Van Natta 307 (2001). There, the ALJ evaluated a medical report as establishing causation because, although attributing the occupational disease in major part to noncompensable factors, it found that employment was a contributing factor. After eliminating noncompensable factors, the ALJ concluded that work activity was the major contributing cause because it was the only remaining factor.

We found that, because the medical report had not found that employment was the major contributing cause, we could not substitute our own opinion by reaching the opposite conclusion. In other words, we concluded that the ALJ's inference was not supported by the medical evidence. 53 Van Natta at 308.

Here, we cannot reasonably infer from the limited evidence from Dr. Pierson that the claimed April 21, 1998 incident caused the diagnosed conditions. First, as indicated above, Dr. Pierson examined claimant one time and, thus, had very limited opportunity to become familiar with his condition. *See Laddie R. Tofell*, 53 Van Natta 251 (2001) (because treating physician saw the claimant one time, his opinion not entitled to deference). Furthermore, Dr. Pierson in no way explained how the incident caused the diagnoses or even indicated that the conditions were consistent with such an event. *See Moe v. Ceiling Systems, Inc.*, 44 Or App 429 (1980) (the claimant failed to meet his burden of proving causation where only medical opinion, although unrebutted, was unexplained).

In short, were we to conclude that claimant proved medical causation, we would be reaching our own conclusion in the absence of any in the record. Such a conclusion would essentially render this a "simple case," which is contrary to the court's express decision that the facts of this case require expert evidence concerning medical causation. For these reasons, we conclude that claimant failed to carry his burden of proving compensability.

Accordingly, on reconsideration, the ALJ's order dated January 8, 1999 is reversed. The self-insured employer's denial is reinstated and affirmed. The ALJ's attorney fee award is also reversed.

IT IS SO ORDERED.

May 15, 2001 Cite as 53 Van Natta 672 (2001)

In the Matter of the Compensation of
JESSICA R. PORTER, Claimant
WCB Case No. 00-04676
ORDER ON REVIEW
Mustafa T. Kasubhai, Claimant Attorney
Sather, et al, Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the insurer's denial of her occupational disease claim for bilateral carpal tunnel syndrome. 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 began working for the employer as a customer service technician in August 1998. She used a computer keyboard and mouse while talking to customers over the telephone. A new product was introduced in December 1998, which increased claimant's workload. (Tr. 64). In March 1999, claimant developed compensable bilateral hand, wrist and forearm pain. On May 27, 1999, the insurer's claim administrator accepted disabling bilateral overuse tendinitis of the wrists. (Ex. 9). Claimant's wrists and arms continued to be symptomatic with activity. (Exs. 12, 13). On August 25, 1999, Dr. Casey diagnosed possible early carpal tunnel syndrome after finding bilateral positive Phalen's signs and a right positive Tinel's. (Ex. 14). Nerve conduction studies were normal. (Ex. 16).

On September 16, 1999, claimant reported occasional waking up with aching hands and some aching pain with arm use. Her Tinel's test was negative. Dr. Casey opined that she had mild tendinitis and returned her to work.

On September 22, 1999, claimant returned to Dr. Casey complaining of increased forearm pain. Dr. Casey continued to think she had tendinitis, took her off work, and prescribed hard splints. (Ex. 18). On October 13, 1999, claimant reported that she was worse when she wore her splints and complained of continued forearm pain. Sensorimotor examination was normal. Dr. Casey prescribed physical therapy. (Ex. 20).

On November 9, 1999, Drs. Dinneen and Melson examined claimant for the insurer. Claimant reported continuous hand pain, increased by use of the hand or upper extremities and occasional radicular-type symptoms. Examination findings, including Phalen's and Tinel's tests, were negative. The doctors concluded that claimant was medically stationary, without any objective evidence of impairment. (Ex. 22).

On November 30, 1999, claimant reported aching pain in both arms to Dr. Casey. He told claimant that he did not think her condition was work related, noting that her condition had not improved from being off work. (Ex. 24). Dr. Casey concurred with Drs. Dineen and Melson's opinion. (Ex. 26).

On January 5, 2000, claimant returned to Dr. Casey. She continued to report bilateral hand and forearm pain with use. Dr. Casey was unable to document any objective findings from which he could make a diagnosis. (Ex. 27, 33).

The insurer issued a February 3, 2000 Notice of Closure that awarded no permanent disability. (Ex. 29). Claimant requested reconsideration.

Claimant returned to her regular work on or about February 17, 2000. On March 1, 2000, she sought treatment for pain from the tips of her fingers to her elbows bilaterally, left greater than right. She reported that her hands were colder than formerly, and that her hands shook. (Ex. 36). Dr. Casey noted tenderness in the midforearm and ordered an MRI, which reveal findings consistent with four MR criteria for carpal tunnel syndrome on the right wrist. (Ex. 39).

Claimant returned to regular duty on April 6, 2000. On April 12, 2000, she reported to Dr. Casey that her hand was swollen and had been worse with work. She reported that she got tingling and numbness that radiated up to her neck. Dr. Casey found a positive Phalen's and negative Tinel's. He suspected that claimant had mild carpal tunnel and took her off work. (Ex. 44). On April 14, 2000, claimant returned to Dr. Casey, complaining of hand pain. He found no evidence of carpal tunnel syndrome and concluded that she had tendinitis, but noted that it was difficult to assess whether it was related to work. (Ex. 46).

On April 25, 2000, Dr. Lowengart performed a medical arbiter examination. Claimant complained of chronic pain in her arms and wrists, with tightness in the forearm musculature and pain into the right shoulder. Claimant reported that she had been in a motor vehicle accident in which her neck was injured about a year and a half earlier. Claimant also reported that her symptoms had not improved despite physical therapy, time off, and work modifications. (Ex. 47-1). Dr. Lowengart found a negative Tinel's and marked tenderness in the forearm musculature. She diagnosed cervical segmental restrictions and muscular tightness contributing to radicular pain. Dr. Lowengart also thought that claimant had nerve irritation. (Ex. 47). After reviewing the MRI, however, Dr. Lowengart stated that a carpal tunnel syndrome diagnosis was established and the diagnosis of tendinitis was confirmed absent. Dr. Lowengart opined that claimant probably had a double crush on the nerve due to a combination of CTS and cervical nerve root irritation. (Ex. 48).

On May 3, 2000, Dr. Casey reported that being off work had made no difference to claimant's discomfort. He also thought that claimant showed symptoms of depression. (Ex. 49).

A May 11, 2000 Order on Reconsideration awarded no permanent disability. (Ex. 51).

On May 18, 2000, claimant's attorney formally requested that the insurer amend the acceptance to include bilateral carpal tunnel syndrome. (Ex. 52).

On June 20, 2000, Dr. Hartmann, neurologist, evaluated claimant for Dr. Casey. (Ex. 58).

On July 10, 2000, Dr. Young, a hand specialist, examined claimant for Dr. Casey. (Ex. 59).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that the existence of carpal tunnel syndrome had not been proved by a preponderance of the evidence and upheld the insurer's denial. We agree that claimant's bilateral carpal tunnel syndrome is not compensable, but reason as follows.

Claimant had an accepted claim for tendinitis that arose in March 1999. A diagnosis of bilateral carpal tunnel syndrome was entertained by Dr. Casey, claimant's treating physician, as early as August 1999. However, neither he nor Dr. Hartmann, a neurologist, were able definitively to establish that claimant had that condition prior to closure of the tendinitis claim. However, based on MRI evidence, Dr. Lowengart, orthopedist, opined that claimant had carpal tunnel syndrome, along with a neck condition that was causing radicular symptoms in her arms. Dr. Young, a hand specialist, also diagnosed claimant with carpal tunnel syndrome, as well as bilateral flexor and extensor tendinitis, right wrist ulnar nerve irritation, bilateral ulnar nerve neuritis at the elbows, myofascial forearm pain, and overuse syndrome. Thus, the medical record indicates that claimant has been diagnosed with carpal tunnel syndrome by two specialists.[1]

Accordingly, the causation issue (as opposed to the question of diagnosis) must be resolved. *Stewart E. Myers*, 41 Van Natta 1985 (1989). Because of multiple potential causal factors, this issue is of sufficient medical complexity to require expert medical opinion. *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 her alleged occupational disease is compensable. ORS 656.266.

Dr. Casey, who concluded that claimant's symptoms were not indicative of "typical carpal tunnel," opined that claimant's symptoms were probably not related to any activity or work condition. (Ex. 57). Dr. Hartmann did not offer an opinion on causation. (Ex. 58).

In contrast, Dr. Lowengart opined that carpal tunnel syndrome was established, based on the MRI, but concluded that claimant had a "double crush" on the nerve due to a combination of carpal tunnel syndrome and cervical nerve root irritation. (Ex. 48). Dr. Lowengart did not discuss the cause of the combined "double crush" condition, although she suggested that a lunate problem, which caused the carpal tunnel syndrome, "may be" due to chronic overuse and malpositioning. (Ex. 47-3). This suggestion is insufficient to establish compensability. *Billie W. Gale*, 52 Van Natta 192 (2000) (statement that carpal tunnel condition was presumably related to overuse did not satisfy requirement that medical opinions be expressed in terms of probability).

The only medical opinion arguably supporting causation is that of Dr. Young. However, for several reasons, we do not find it persuasive. First, it is based on his understanding that claimant's work activities consisted of "constant" typing. (Ex. 59-1; 61-9; -28, -29). However, he apparently was not aware that claimant's "constant" typing did not begin until December 1998. (Tr. 63-64). He also did not indicate that he was aware of how much time claimant spent off work or on light duty since the onset of her symptoms. (Tr. 23, 70-72, 74-75). Moreover, even though Dr. Young knew claimant was off work "a lot," he did not explain how, with so much time away from work or working at a reduced level, her returns to work led to degeneration of her tendinitis, which in turn resulted in her carpal tunnel syndrome. This analysis is important in light of the opinions of Drs. Dineen, Melson and Casey that claimant's compensable tendinitis condition had resolved by November 9, 1999, and Dr. Lowengart's opinion that claimant did not have tendinitis. In addition, Dr. Young did not offer a reasonable explanation why claimant's condition continued to worsen despite her lengthy absences from work and continued to worsen after May 2000, when she stopped work altogether. *Tina M. Valero*, 50 Van Natta 1475, 1477 (1998) (medical opinions are unpersuasive where they do not address the lack of improvement in claimant's symptoms despite an absence from work).

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[1] We note that the lack of a definitive diagnosis does not *per se* defeat the claim, *Tripp v. Ridge Runner Timber Services*, 89 Or App 355 (1988), nor is it a necessary predicate to compensability that the medical experts know the exact mechanism of the disease. *Robinson v. SAIF*, 78 Or App 581 (1986); *Candace M. Griffin*, 42 Van Natta 624 (1990).

Finally, Dr. Young did not distinguish or explain the relationship of each of claimant's diagnosed conditions to one another, to the carpal tunnel condition, or to claimant's work, nor did he discuss the contribution of the cervical nerve condition to claimant's symptom complex, as suggested by Dr. Lowengart. Consequently, we conclude that Dr. Young's opinion is insufficient to establish compensability. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995) (a determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's disease and deciding which is the primary cause); *Somers v. SAIF*, 77 Or App 259 (1986) (in evaluating the medical evidence concerning causation, we rely on those opinions which are both well-reasoned and based on accurate and complete information)

ORDER

The ALJ's order dated February 12, 2001 is affirmed.

May 15, 2001 Cite as 53 Van Natta 675 (2001)

In the Matter of the Compensation of
RAYMOND L. PRESNELL, Claimant
WCB Case No. 00-06493
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Howell's order that: (1) directed it to process claimant's "new medical condition" claim for left hip osteoarthritis under ORS 656.262 and 656.268; and (2) assessed a penalty for SAIF's allegedly unreasonable failure to pay compensation. On review, the issues are jurisdiction, claim processing, and penalties.

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

The ALJ assessed a 25 percent penalty based on SAIF's refusal to process claimant's new medical condition claim under ORS 656.262 and 656.268. SAIF argues that the ALJ's penalty assessment was in error because it is allowed to make a good faith argument that, despite our decisions in cases such as *Larry L. Ledin*, 52 Van Natta 682 (2000) and *John R. Graham*, 51 Van Natta 1740 (1999), ORS 656.278(1) is the sole basis for awarding additional benefits once a claimant's aggravation rights expire.[1]

We rejected a similar argument in *Steven R. Azorr*, 52 Van Natta 2145 (2000). Moreover, claimant request for processing of his new medical condition claim (and SAIF's refusal to do so) came after our decisions in *Ledin* and *Graham*. Under the circumstances, we find that SAIF did not have a legitimate doubt regarding its liability. *See International Paper Co. v. Huntley*, 106 Or App 107 (1991). Thus, we agree with the ALJ's decision to award a penalty. *Cf. Camilla S. Kosmoski*, 52 Van Natta 1573 (2000) (because *Ledin* issued after the carrier's claim processing actions, it had a legitimate doubt regarding its liability for processing a new condition claim).

Claimant's attorney is entitled to an assessed fee for services on review regading the claim processing issues. 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 issue (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] SAIF also argues that the standard for sanctions discussed in *Westfall v. Rust International*, 314 Or 533 (1992) should apply to penalties. We rejected that argument in *William L. Adams*, 53 Van Natta 528 (2001).

[2] 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 January 25, 2001 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000.

May 15, 2001 Cite as 53 Van Natta 676 (2001)

In the Matter of the Compensation of
GARY E. PUCKETT, Claimant
WCB Case No. 00-06965
ORDER ON RECONSIDERATION
Max Rae, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Claimant requests reconsideration of our April 27, 2001 order that affirmed an Administrative Law Judge's (ALJ's) order that affirmed an Order on Reconsideration that did not award temporary disability benefits for the period beginning December 3, 1999.

Claimant contends that he is entitled to temporary disability for periods from November 1999 into February 2000, because he retired in January 1999 due to physical disability. Thus, claimant essentially contends that he has not withdrawn from the workforce for purposes of temporary disability compensation, because his nonworking status is injury-related.

Claimant is correct that his January 1999 retirement does not necessarily foreclose temporary disability compensation for subsequent periods of disability, if his disability arose before he withdrew from the workforce or he reentered the workforce after retiring and then became disabled due to his compensable condition. However, claimant must have been in the workforce at the time of the disability claimed to be entitled to compensation for that disability. In other words, the critical time for determining whether a claimant has withdrawn from the work force is the date of disability. *See SAIF v. Blakely*, 160 Or App 242 (1999) (where the claimant sought temporary disability benefits for periods after surgery, she had to prove that she was "in the work force" at the time of the surgery); *Weyerhaeuser Co. v. Kepford*, 100 Or App 410, 414, *rev den* 310 Or 71 (1990). In this case, the date of disability claimed is December 3, 1999.[1]

We are not persuaded that claimant's work force status as of his January 1999 retirement is relevant to determining his work force status in December 1999.[2] Even if it is, the only evidence addressing claimant's January 1999 withdrawal from the workforce is Dr. Wilson's November 1999 recitation of claimant's history that he "had to quit [working] in January of 1999 due to his hand problems as well as his history of knee and other problems." (Ex. 6-1). Claimant's opinion regarding his physical condition is insufficient to establish that he was medically disabled when he retired.[3] *See Becky M. Stiles*, 48 Van Natta 439 (1996). Under these circumstances, we are not persuaded that claimant was disabled due to his compensable right carpal tunnel syndrome condition when he retired.

We reiterate that claimant could be entitled to temporary disability, despite his prior retirement, if he reentered the workforce before becoming disabled. *See Wausau Insurance Companies v. Morris*, 103

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[1] SAIF paid temporary disability from November 23, 1999, through December 2, 1999, the date Dr. Wilson released claimant to "one-handed" duty following surgery for claimant's compensable right carpal tunnel syndrome condition. An Order on Reconsideration found claimant entitled to that compensation, the ALJ affirmed the order, and we have affirmed the ALJ's order. The parties do not challenge that aspect of claimant's compensation.

[2] There is no evidence that claimant's work force status in December 1999 is the same as, or different from, his work force status when he retired in January 1999.

[3] We note that claimant concedes that he was not entitled to temporary disability compensation in January 1999 because time loss was not medically authorized.

Or App 270 (1990). However, there is no evidence to that effect in this case.[4] Therefore, we continue to conclude that claimant is not entitled to the claimed compensation. *See Ronald M. Davis*, 52 Van Natta 162 (2000); *James F. Fowlkes*, 48 Van Natta 771 (1996) (claimant not entitled to temporary disability because he became disabled after he left the work force); *Patricia M. Demetrakos*, 44 Van Natta 707 (1992) (same).

Accordingly, we withdraw our April 27, 2001 order. On reconsideration, we republish our April 27, 2001 order as supplemented herein. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[4] 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, no evidence satisfies any of the *Dawkins* "work force criteria."

May 16, 2001 Cite as 53 Van Natta 677 (2001)

In the Matter of the Compensation of
DUSTY M. PARKS, Claimant
WCB Case No. 00-07470
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order that found that the insurer was authorized to recover previously paid permanent disability benefits from claimant's current temporary disability benefits. On review, the issue is offset.

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

Claimant's claim for a disabling low back condition was closed by a May 1, 2000 Notice of Closure awarding 32 percent unscheduled permanent disability. (Ex. 42). The Notice of Closure was rescinded by a July 26, 2000 Order on Reconsideration. (Ex. 52-2). The Order on Reconsideration reopened claimant's claim and renewed the insurer's obligation to pay temporary disability, but also created an overpayment of $3,677 in permanent disability paid pursuant to the Notice of Closure. When the insurer began recovering the permanent disability from claimant's ongoing temporary disability, *see* ORS 656.268(13)(a), claimant requested a hearing.

The ALJ found that the insurer's "preclosure" unilateral offset of permanent disability against claimant's ongoing temporary disability benefits was proper, pursuant to ORS 656.268(13)(a). On review, claimant contends that ORS 656.268(13)(a) does not authorize the carrier to offset overpayments on an open claim; *i.e.* before closure. We disagree.

In *Adam J. Delfel*, 50 Van Natta 1041 (1998), and *Jerald J. Cooper*, 50 Van Natta 146, *on recon* 50 Van Natta 914 (1998), we held that a carrier may offset overpaid permanent disability without prior authorization under *former* ORS 656.268(15)(a) (renumbered ORS 656.268(13)(a)). Claimant acknowledges our decisions in *Delfel* and *Cooper*, but argues that those cases did not involve a carrier's ability to offset benefits on an open claim before closure.

However, the plain language of ORS 656.268(13)(a) suggests that the statute applies to open claims by specifically referencing a carrier's recovering overpayments from temporary disability. ORS 656.268(13)(a) provides:

> "An insurer or self-insured employer may offset any compensation payable to the worker to recover an overpayment from a claim with the same insurer or self-insured employer. *When overpayments are recovered from temporary disability* or permanent total disability benefits, the amount recovered from each payment shall not exceed 25 percent of the payment, without prior authorization from the worker." (Emphasis added).

Moreover, in *Carl L. Charles*, 53 Van Natta 289 (2001), a decision issued subsequent to the ALJ's order, although the current question was not specifically at issue on review, we affirmed that portion of an ALJ's order allowing a 25 percent offset (of overpaid permanent disability) against the claimant's temporary disability benefits. 53 Van Natta at 292. *See also* OAR 436-060-0170(2) ("[i]nsurers may recover an overpayment of benefits from any benefits currently due on any claim the worker has with that insurer.")

Claimant next contends that to allow offsets during an open claim would render meaningless the provisions of ORS 656.268(11).[1] Claimant argues that we should construe statutes so as to give meaning to all provisions, citing *SAIF v. Allen*, 320 Or 192 (1994). However, we find nothing in ORS 656.268(11) that is inconsistent with ORS 656.268(13)(a). ORS 656.268(11) does not specify that the time of issuance of a Notice of Closure is the *only* time at which a carrier may offset benefits.

Finally, claimant contends that, if the insurer is allowed to offset benefits prior to closure, there is no method through which to challenge such offset. However, as the ALJ noted, claimant need not wait until closure to contest the offset. Claimant has the right to request a hearing on any offset dispute, pursuant to ORS 656.283(1); *Adam J. Delfel*, 50 Van Natta at 1045.

Accordingly, we agree with the ALJ that the carrier is entitled to offset permanent disability against claimant's temporary disability payments prior to closure. ORS 656.268(13)(a).

ORDER

The ALJ's order dated March 1, 2001 is affirmed.

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[1] ORS 656.262(11) provides:

"Any notice of closure made under this section may include necessary adjustments in compensation paid or payable prior to the notice of closure, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against current or future permanent or temporary disability awards or payments and requiring the payment of temporary disability payments which were payable but not paid."

May 17, 2001 Cite as 53 Van Natta 678 (2001)

In the Matter of the Compensation of
CORINNE L. BIRRER, Claimant
WCB Case Nos. 98-01138, 98-01097 & 98-01095
ORDER ON REMAND (REMANDING)
Schneider, et al, Claimant Attorney
Sheridan, et al, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *Birrer v. Principal Financial Group*, 172 Or App 654 (2001). The court has reversed our prior orders, *Corinne L. Birrer*, 51 Van Natta 163, *on recon* 51 Van Natta 467 (1999), that: (1) upheld the self-insured employer's denials of claimant's left wrist condition; and (2) affirmed an Order on Reconsideration that did not award permanent disability for claimant's left wrist condition. The court concluded that we went beyond the express scope of the employer's denials in finding that claimant's current condition was not related to the accepted injury. In addition, the court determined that the record was insufficient for us to make a decision regarding the impairment of claimant's left wrist condition, and it remanded for reconsideration.

FINDINGS OF FACT

Claimant, age 45 at the time of hearing, has been working as a medical claims processor for the employer since May 1995. (Tr. 6-7). She has performed primarily data entry work since age 17. (Tr. 7). Claimant's work for the employer mainly involved keyboarding. (Tr. 6).

In January 1996, claimant filed a claim for a left wrist condition. (Ex. 1). The employer accepted a nondisabling left wrist strain. (Ex. 2). On August 7, 1996, Dr. Rabie reported that claimant's left wrist tendinitis had resolved and she was medically stationary without evidence of permanent impairment. (Ex. 3).

On August 8, 1996, claimant signed an "801" form for a right wrist condition, stating that her right wrist began hurting on July 17, 1996. (Ex. 4). Dr. Rabie examined claimant on August 8, 1996 and diagnosed right flexor and extensor wrist tendinitis. (Ex. 5). The employer initially accepted nondisabling right wrist tendinitis, which was later changed to disabling. (Exs. 6, 8).

Dr. Wright performed surgery on claimant's left wrist in late April 1997. (Ex. 10). His diagnosis was left intersection syndrome of the wrist. (*Id.*) Dr. Rabie felt that claimant's left wrist surgery was related to her open claim. (Ex. 12). Claimant was off work from January 2, 1997 until October 29, 1997. (Tr. 12).

In September 1997, claimant was examined by Dr. Nolan on behalf of the employer. (Ex. 13). He found no diagnosable condition in either of claimant's upper extremities. (Ex. 13-3). Dr. Nolan reported that claimant had a multitude of subjective complaints that outweighed any objective abnormalities. (*Id.*) He found no measurable impairment and he felt that claimant was medically stationary and could return to her regular work. (Ex. 13-4). Dr. Rabie agreed that claimant's right wrist was medically stationary without permanent impairment. (Ex. 15-2). A Notice of Closure for claimant's right wrist condition issued on October 29, 1997 that did not award any permanent disability. (Ex. 17).

Dr. Rabie signed a Notice of Claim for Aggravation of Occupational Injury or Disease in September 1997. (Ex. 14-1). His August 13, 1997 chart note indicated that claimant had right elbow problems. (Ex. 14-2).

Dr. Rabie indicated in December 1997 that claimant's left wrist condition was initially related, in major part, to her work activities. (Ex. 22-3). He said that the left wrist condition had not resolved after treatment, the passage of time and removal from keyboard activities. (*Id.*) Dr. Rabie felt that claimant's current left wrist conditions were no longer related to work. (*Id.*)

On January 28, 1998, the employer modified the acceptance to include disabling right wrist tendonitis and left wrist tendonitis/intersection syndrome. (Ex. 23). On the same date, the employer issued a denial of claimant's claim for benefits on the basis that her compensable injury was no longer the major contributing cause of the disability and need for treatment of her left wrist condition. (Ex. 24). The employer also issued a denial of claimant's right elbow condition. (Ex. 25-2).

The employer issued an updated notice of acceptance at closure on February 2, 1998, indicating it had accepted disabling right wrist tendonitis and left wrist tendonitis/intersection syndrome. (Ex. 27). A Notice of Closure issued the same day that did not award any permanent disability. (Ex. 28). On the same date, the employer issued a denial of the left wrist condition on the basis that claimant's compensable injury was no longer the major contributing cause of the disability and need for treatment of her left wrist condition. (Ex. 29).

Also on February 2, 1998, Dr. Nathan performed a medical arbiter examination. (Ex. 30). He noted that the accepted condition was right wrist tendinitis. (Ex. 30- 1). His examination was limited to both of claimant's upper extremities. (Ex. 30-2). He found no objective evidence of residuals from the right wrist tendinitis. (Ex. 30-4). He also noted that there were no objective findings with regard to the left intersection syndrome, but he said "this was not included in assessment for impairment." (*Id.*)

On February 20, 1998, the Department wrote to Dr. Nathan, informing him that claimant had an additional accepted condition; *i.e.*, left wrist tendonitis/intersection syndrome. (Ex. 31). The Department asked Dr. Nathan if the reported decreased ranges of motion for the left wrist were due to the accepted condition and whether claimant was "significantly limited in the ability to repetitively use the left hand, wrist/ forearm[.]" (*Id.*)

Dr. Nathan responded that his observations of claimant's left wrist were general in nature, since the left wrist condition had not been accepted at the time of his examination. (Ex. 33-1). He reported that his left wrist exam did not reveal the presence of any objective findings that he felt would be direct residuals from the intersection syndrome. (*Id.*) He noted that he had not specifically examined claimant to determine the source of the reduced range of motion in her left wrist. (*Id.*) Dr. Nathan did not believe there was any significant limitation in claimant's ability to use the left hand and wrist/forearm due to a diagnosed chronic and permanent condition arising out of the accepted condition. (*Id.*)

On February 23, 1998, an Order on Reconsideration issued, affirming the October 29, 1997 Notice of Closure, which pertained to the right wrist tendonitis claim. (Ex. 32). On March 5, 1998, an Order on Reconsideration issued, affirming the February 2, 1998 Notice of Closure, which pertained to the right wrist tendonitis and the left wrist tendonitis/intersection syndrome. (Ex. 34).

CONCLUSIONS OF LAW AND OPINION

Left Wrist Condition

The employer issued two denials of claimant's left wrist condition. On January 28, 1998, the employer denied claimant's left wrist condition, citing ORS 656.005(7)(a)(B) and asserting that her compensable injury no longer remained the major contributing cause of her disability and need for treatment. (Ex. 24). The employer issued a similar denial on February 2, 1998. (Ex. 29).

At hearing, the employer did not attempt to amend its denials of claimant's left wrist condition. In closing arguments, claimant argued that the employer's denials were procedurally improper because they were based on a combined condition under ORS 656.005(7)(a)(B), and no combined condition had been accepted. Claimant contended that the employer's "combined condition" denials could not be construed as "current condition" denials. On the other hand, the employer relied on *Charles L. Wallace*, 49 Van Natta 52, *on recon*, 49 Van Natta 472 (1997), *aff'd mem* 152 Or App 566 (1998), and *Zora A. Ransom*, 46 Van Natta 1287 (1994), to argue that preclosure denials are valid when the current need for treatment is no longer related to the accepted claim.

The ALJ concluded that the employer's denials were procedurally improper. The ALJ noted that the sole basis for the employer's denials was ORS 656.005(7)(a)(B), which applied to combined conditions. The ALJ reasoned that the employer could not deny claimant's left wrist condition pursuant to ORS 656.005(7)(a)(B) because her left wrist condition did not involve a preexisting condition or a combined condition.

On remand, we agree with the ALJ's reasoning. Although the employer relied on *Ransom* and *Wallace* in closing arguments, it made no attempt to amend its denial in order to rely on any basis other than ORS 656.005(7)(a)(B). *See SAIF v. Ledin*, 149 Or App 94 (1997) (a carrier may amend its denial at hearing). In *Tattoo v. Barrett Business Service*, 118 Or App 348, 351 (1993), the court held that a carrier is bound by the express language of its denial. Here, the employer relied on ORS 656.005(7)(a)(B) to deny claimant's left wrist condition on the ground that her compensable injury no longer remained the major contributing cause of her disability and need for treatment. (Exs. 24, 29). We proceed to analyze the denials under that theory.

The employer initially accepted a nondisabling left wrist strain in April 1996. (Ex. 2). Claimant continued to have left wrist problems and Dr. Wright performed surgery on April 29, 1997 for left intersection syndrome. (Ex. 10). The employer subsequently modified the acceptance to accept left wrist tendonitis/intersection syndrome. (Ex. 23).

The employer did not accept a "combined" condition. Furthermore, there is no evidence in the record that claimant had any preexisting conditions related to her left wrist or that any such conditions combined with her work activities. Under these circumstances, ORS 656.005(7)(a)(B) does not apply. In order for a carrier to have properly issued a preclosure denial under ORS 656.262(7)(b) or 656.262(6)(c), it must have accepted a combined condition. *Croman Corp. v. Serrano*, 163 Or App 136, 141 (1999); *see also Blamires v. CleanPak Systems, Inc.*, 171 Or App 263, 267, *on remand Tracey A. Blamires*, 53 Van Natta 573, *on recon* 53 Van Natta 592 (2000). Because the employer did not accept a combined condition, its denial pursuant to ORS 656.005(7)(a)(B) is procedurally improper. We agree with the ALJ's conclusion that the employer's denials of claimant's left wrist condition must be set aside.

Where a claimant finally prevails after remand from the Court of Appeals, the Board shall approve or allow a reasonable attorney fee for services before every prior forum. ORS 656.388(1). We first note that there is no challenge to the ALJ's award of $3,500 for claimant's attorney's services at hearing related to setting aside the employer's denials. Therefore, we republish that award.

In addition to the attorney fees previously awarded by the ALJ ($3,500), we award a reasonable carrier-paid attorney fee for claimant's counsel's services before the Board and the court. We determine the amount of attorney fees by applying the factors 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 an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

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 Board and court level is $5,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by 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's attorney did not provide any additional services on remand before the Board.

March 5, 1998 Order on Reconsideration

The ALJ found that Dr. Nathan's medical arbiter examination was insufficient regarding claimant's left wrist condition. The ALJ set aside the March 5, 1998 Order on Reconsideration and remanded the accepted left wrist component of the claim to the Department for completion of a full and complete medical arbiter examination.

On review, the employer argued that the ALJ erred in remanding the matter to the Department. The employer contended that the arbiter's examination was sufficient and the Order on Reconsideration should be affirmed.

Claimant's accepted condition is left wrist tendonitis/intersection syndrome. (Exs. 23, 27). At the time Dr. Nathan performed the arbiter examination on February 2, 1998, he was under the impression that the only accepted condition was right wrist tendinitis. (Ex. 30-1). He examined both upper extremities and found that claimant had reduced range of motion in her left wrist. (Ex. 30-2, -3). Dr. Nathan found no objective findings with regard to the left intersection syndrome, but he noted that "this was not included in assessment for impairment." (Ex. 30-4).

On February 20, 1998, the Department wrote to Dr. Nathan, informing him that claimant had an additional accepted condition; *i.e.*, left wrist tendonitis/intersection syndrome. (Ex. 31). The Department asked Dr. Nathan if the reported decreased ranges of motion for the left wrist were due to the accepted condition and whether claimant had a chronic left wrist condition. (*Id.*)

Dr. Nathan responded that his observations of claimant's left wrist were general in nature, since the left wrist condition had not been accepted at the time of his examination. (Ex. 33-1). Although his left wrist exam did not reveal the presence of any objective findings that he felt would be direct residuals from the intersection syndrome, he noted that he had not specifically examined claimant to determine the source of the reduced range of motion in her left wrist. (*Id.*)

ORS 656.268(7)(a) provides that, if the claimant's basis for objecting to a notice of closure is disagreement with the impairment used in rating disability, "the director shall refer the claim to a medical arbiter appointed by the director." Thus, a medical arbiter examination is mandatory.

The court explained that Dr. Nathan had emphasized that he had not examined claimant in order to determine the causation of her left wrist condition or its residual effects. 172 Or App at 662. He specifically did not express any opinion about the reasons for the reduced range of motion in her left wrist. Moreover, Dr. Nathan did not foreclose the possibility that the reduced range of motion was the result of claimant's tendinitis condition. The court concluded that claimant had not had a medical arbiter examination of her left wrist that ORS 656.268(7)(a) requires before her permanent disability is rated. *Id.*

In previous cases, we have held that, unless a medical arbiter's report is incomplete (as represented by the arbiter or the Department), a medical arbiter's supplemental or clarifying report is not admissible. *See, e.g., Jason O. Olson*, 47 Van Natta 2192 (1995); *see also Tinh Xuan Pham Auto v. Bourgo*, 143 Or App 73, 78 n.5 (1996). Here, Dr. Nathan's response to the Department's February 20, 1998 letter essentially acknowledged that his previous report was incomplete for purposes of rating claimant's left wrist condition. Under these circumstances, the case should be remanded for production of an additional medical arbiter's report.

Although we lack the authority to remand this claim to the Department for the appointment of a medical arbiter concerning claimant's left wrist condition, *see Pacheco-Gonzalez v. SAIF*, 123 Or App 312 (1993), we have adopted alternative remedies to provide for such an examination. *See, e.g., Gloria Garibay*, 52 Van Natta 2251 (2000); *Vicky L. Woodard*, 52 Van Natta 796 (2000). We find that the best remedy is to remand to the ALJ for deferral pending receipt of a medical arbiter's report pursuant to ORS 656.268(6)(f). The parties shall be responsible for contacting the Director to make arrangements for the appointment of a medical arbiter and preparation and submission of a medical arbiter's report. When the parties are ready to proceed to hearing, they shall contact the ALJ. Thereafter, the ALJ shall conduct further proceedings in any manner than achieves substantial justice.

Accordingly, on remand, as supplemented and modified herein, the ALJ's order dated September 4, 1998 is affirmed in part and vacated in part. That portion of the order that addressed the Order on Reconsideration is vacated. That portion of the case that pertains to the Order on Reconsideration issue is remanded to ALJ Hoguet for further proceedings consistent with this order. The remainder of the ALJ's order is affirmed. For services before the Board and court regarding the compensability issue, claimant's counsel is awarded $5,000, to be paid by the employer. This attorney fee award is in addition to the $3,500 granted by the ALJ's order.

IT IS SO ORDERED.

May 17, 2001 Cite as 53 Van Natta 682 (2001)

In the Matter of the Compensation of
VENITA A. GALLAGHER, Claimant
WCB Case Nos. 99-02177 & 98-07248
ORDER ON REMAND
Floyd H. Shebley, Claimant Attorney
Wallace, Klor & Mann, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's February 20, 2001 order, we have been directed to consider the parties' settlement. The parties have submitted a "Disputed Claim Settlement" that is designed to resolve all issues raised or raisable before the Board and the Hearings Division (WCB Case Nos. 00-00718, 00-00717). An Administrative Law Judge 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 "denials shall remain in effect and are hereby affirmed." The parties further agree that "claimant's Requests for Hearing and appeals shall be dismissed with prejudice."

We approve those portions of the parties' settlement that involve issues pending before the Board, thereby fully and finally resolving their dispute.[1] Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] The settlement does not include a list of medical service providers who shall receive reimbursement in accordance with ORS 656.313(4). *See* OAR 438-009-0010(2)(g). Instead, the parties stipulate that the employer's private health carrier has agreed to process any outstanding medical bills on file with the employer's workers' compensation carrier. We interpret such a stipulation as the parties' representation that there are no otherwise unreimbursed medical bills on the date the settlement terms were agreed on. (In reaching this conclusion, we have also considered the carrier's counsel's accompanying letter that explains that "all of claimant's medical bills would taken care of through [the employer's] group carrier.") Under such circumstances, a list of medical service providers is unnecessary and the settlement is approvable. *See Robert Wolford*, 46 Van Natta 522 (1994).

In the Matter of the Compensation of
DAVID L. TUCKER, Claimant
WCB Case No. 00-03927
SECOND ORDER OF DISMISSAL
Kenneth Russell (Saif), Defense Attorney

On February 16, 2001, we withdrew our January 19, 2001 Order of Dismissal. We took this action to consider claimant's assertion that "[c]opies [of his "request"] were sent to the parties involved." Having received the SAIF Corporation's response, we proceed with our reconsideration.

We begin with a review of pertinent events.

Claimant requested a hearing on May 22, 2000, raising a claim processing issue. A hearing was set for August 23, 2000. Claimant did not appear at the hearing.

On August 24, 2000, the ALJ issued an Order of Dismissal that dismissed claimant's request for hearing for failure to appear at hearing. Copies of the ALJ's order were mailed to claimant, the employer, the SAIF Corporation and SAIF's attorney. The order contained a statement explaining the parties' rights of appeal, including a notice that a request for review must be mailed to the Board within 30 days of the ALJ's order and that copies of the request for review must be mailed to the other parties within the 30-day appeal period. The ALJ also gave claimant 30 days from the date of his order to request abatement and reconsideration based on a showing of "good cause" that prevented his attendance at hearing.

On September 25, 2000, the Hearings Division received a letter from claimant. Addressing his letter to the ALJ, claimant sought "reconsideration of the Dismissal Order, 0003927 dated August 24, 2000." Claimant's letter did not indicate that copies were provided to SAIF, its insured, or its attorney.

On September 27, 2000, the ALJ wrote to claimant acknowledging that claimant had mailed a letter on September 22, 2000, requesting relief from the August 24, 2000 dismissal order. The ALJ advised claimant that he had not received the letter within 30 days of the dismissal order, the order had become final, and it remained "in effect."

On December 27, 2000, claimant wrote to the ALJ contesting the ALJ's conclusion that his request for reconsideration of the dismissal order was untimely. The ALJ forwarded claimant's letter to the Board and wrote to claimant reiterating that he could not reconsider his order, but the Board "may consider" the letter a timely appeal from the Order of Dismissal "because it was mailed within the 30 day period."

On January 19, 2001, we issued an order dismissing claimant's "request for review." Although we found claimant's "request" for review timely mailed to the Board, we reasoned that we lacked jurisdiction because notice of the request for review was not timely provided to the other parties within 30 days of the ALJ's August 24, 2000 order.[1]

Claimant requested reconsideration of our January 19, 2001 order, submitting a letter, asserting that "[c]opies [of his request] were sent to the parties involved." To further consider the matter, we withdrew our January 19, 2001 order and granted SAIF an opportunity to respond to claimant's submission. SAIF responded, conceding that it had timely received claimant's September 22, 2000 letter (on September 25, 2000, the first business day following the 30th day after the August 24, 2000 dismissal order). However, SAIF argues that we should dismiss claimant's "request for Board review" as "untimely" because it indicated that claimant sought reconsideration of the ALJ's dismissal order, not Board review of that order. We agree.

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 notice be received within the statutory period. *Argonaut Insurance Co. v. King*, 63 Or App 847, 852 (1983).

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[1] We noted that claimant's letter was addressed to the ALJ and expressly sought "reconsideration" of the ALJ's order. In light of such circumstances, we assumed (without expressly deciding) that claimant's letter constituted a request for Board review.

The request for review by the Board of an ALJ's order need only state that the party requests a review of the order. ORS 656.295(1). While no "magic words" are required for compliance, the statute contemplates a modicum of information sufficient to clearly identify a document as a party's request for Board review of an ALJ's order. *Gerardo V. Soto, Jr.*, 35 Van Natta 1801, 1803 (1983). Where a party has not expressly requested Board review, but their intention to do so is both clear and unmistakable, we have concluded that we have jurisdiction pursuant to ORS 656.295. *See Rochelle M. Gordon*, 40 Van Natta 1808 (1988).

In *Gordon*, the claimant mailed a letter to the Board some 21 days after an ALJ's dismissal order. In her letter, the claimant stated that she "had no intentions of stopping [her] case" and would "not stop this until [she got] a fair settlement." Inasmuch as the letter was received by the Board shortly after the ALJ's order and reflected the claimant's desire to continue the prosecution of her case, we held that it constituted a request for Board review.

The present case is distinguishable from *Gordon*. Here, as in *Gordon*, claimant's letter did not expressly request Board review. However, unlike *Gordon* (where the claimant mailed the letter to the Board), claimant's letter was specifically addressed to the ALJ and expressly requested "reconsideration of the Dismissal Order, 0003927."

Considering such circumstances, including claimant's express request for ALJ reconsideration, we interpret the September 25, 2000 letter to be a request for reconsideration of the ALJ's dismissal order. *See John W. Wharton*, 41 Van Natta 1673 (1989) (absent "clear and unmistakable" intention to request Board review, request addressed to ALJ treated as request for reconsideration of ALJ's order). Consequently, we hold that claimant did not request Board review of the ALJ's order. ORS 656.295(1).[2]

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[2] The dissent argues that, because claimant responded to the ALJ's "show cause" and dismissal order within 30 days of its issuance, the ALJ should have addressed claimant's offer to show cause. Moreover, because the ALJ did not do so, the dissent contends that "the matter is clearly within the Board's purview and discretion." The dissent cites no authority for its proposition and, instead, its position conflicts with the court's holding in *McCormac v. Cottage Crafts*, 113 Or App 173 (1992).

In *McCormac*, a claimant filed a motion to set aside an ALJ's dismissal order within 21 days of its issuance. The motion did not come to the ALJ's attention until the 34th day after the issuance of the order. On the 43rd day after the dismissal order, the ALJ issued a second order, holding that the dismissal order was final. When the claimant requested Board review, the Board dismissed the appeal as untimely under ORS 656.289(3). The claimant appealed to the court, contending that the Board retained jurisdiction to consider his appeal of the dismissal order because the ALJ's dismissal order was contingent on the passage of 30 days or the filing of a motion to set aside the dismissal (whichever came first). The *McCormac* court rejected the claimant's contention. Relying on ORS 656.289(3), the court held that the ALJ's dismissal order became final 30 days after its issuance. The court reasoned that, although the dismissal order invited the claimant to submit, within 30 days, documents establishing "good cause" for his failure to appear, the order was not and could not have been made contingent on the passage of 30 days. Furthermore, the court ruled that the filing of the claimant's motion did not and could not have effected a stay of the order because the 30-day appeal period began to run when the dismissal order was mailed and could not be extended.

The present case is controlled by *McCormac*. Because the 30-day statutory appeal period from the ALJ's dismissal order has expired without the timely filing of a request for Board review, claimant's response to the ALJ's "show cause" portion of the order (even if mailed within 30 days of the order) neither stays nor extends the running of the appeal period.

Finally, the dissent notes that our first order dismissed claimant's appeal on a lack of timely notice to SAIF, while this decision dismisses the appeal on a mischaracterization of claimant's intention. Our two decisions are entirely consistent. In issuing our first dismissal order, we expressly noted that we were assuming (without deciding) that claimant's letter constituted a request for Board review. The parties' response to our first order has eliminated our initial basis for dismissing this matter; *i.e.*, the record now supports a conclusion that SAIF was notified of claimant's letter within 30 days of the ALJ's dismissal order. Nonethless, the elimination of that ground for questioning our jurisdiction to review this matter merely brought the other ground (*i.e.*, whether claimant's letter constituted a "request for review") to the forefront. For the reasons expressed herein, we are unable to conclude that a letter addressed to the ALJ that expressly seeks "reconsideration of the Dismissal Order" constitutes a request for Board review of the ALJ's order.

Inasmuch as the ALJ's order has not been appealed, stayed, withdrawn, modified, or republished within 30 days of its issuance, it has become final by operation of law. ORS 656.289(3); *Farmers Insurance Group v. SAIF*, 301 Or 612, 619 (1986); *International Paper Co. v. Wright*, 80 Or App 444 (1986); *Fischer v. SAIF*, 76 Or App 656, 659 (1986).

Finally, we are mindful that claimant has apparently taken these actions 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. Yet, we are not free to relax a jurisdictional requirement, particularly in view of *Argonaut Insurance Co.*, 63 Or App at 852. *See Alfred F. Puglisi*, 39 Van Natta 310 (1987); *Julio P. Lopez*, 38 Van Natta 862 (1986). Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

Chair Bock specially concurring.

Were I writing on a "clean slate," I might conclude that claimant's letter to the ALJ seeking reconsideration of the ALJ's dismissal order would also be sufficient to constitute a request for Board review of the ALJ's dismissal order. Arguably a claimant who is unrepresented, such as the one in this case, cannot be expected to understand the implications of certain legal terms and may well be confused regarding the difference between a request for reconsideration and a request for review. However, the Board's prior holdings in *John W. Wharton*, 41 Van Natta 1673 (1989), *June M. Hejduk*, 41 Van Natta 887 (1989), and *Myron A. Schmidt*, 41 Van Natta 896 (1989), have conclusively ruled that letters expressly directed to an ALJ in response to the ALJ's dismissal order that seek reconsideration or similar action from the ALJ cannot be interpreted as a request for Board review of the ALJ's order. Because the present case falls squarely within the rulings reached by the *Wharton*, *Hejduk*, and *Schmidt* decisions, I am constrained by the doctrine of *stare decisis* to follow them. Consequently, I submit this concurring opinion.

Board Member Biehl dissenting.

The majority dismisses the *pro se* claimant's request for Board review, because it interprets claimant's timely letter expressing dissatisfaction with the ALJ's dismissal order as something less than an appeal from that order. The majority relies on the fact that the letter requested "reconsideration" of the ALJ's order and claimant addressed it to the ALJ. Although the majority recognizes claimant's *pro se* status, it reasons that it is "not free to relax a jurisdictional requirement" and therefore the majority leaves claimant with no opportunity to be heard on the ALJ's procedural ruling (or the merits of his claim). I disagree with the majority's reasoning and conclusions, for several reasons.

First, the legal issue is not determinative: The majority is correct that *timeliness* is jurisdictional. But claimant complied with the 30-day time limitation's for filing his objection to the ALJ's dismissal order. Therefore, timeliness is not the real issue in this case. What is at issue is whether the Board should allow a *pro se* claimant an opportunity to explain his failure to appear at hearing. Because claimant clearly responded to the ALJ's order within the jurisdictional time limitation (*i.e.*, before the order became final), the ALJ should have addressed his offer to show cause in the first instance. Because the ALJ did not do so, the matter is clearly within the Board's purview and discretion. *See* ORS 656.289(3).[1]

Second, the majority acknowledges that "magic words" are not necessary to request Board review and what matters is the party's intention. In this case, claimant timely responded to the ALJ's order that *dismissed* his request for hearing. The ALJ mistakenly ruled that claimant's response was untimely. Now the majority effectively upholds the ALJ's erroneous ruling, simply because it chooses to characterize claimant's dissatisfaction with the ALJ's dismissal as insufficient to place the matter before the Board.

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[1] Compare *McCormac v. Cottage Crafts*, 113 Or App 173 (1992) (Board lacked jurisdiction over the claimant's appeal from ALJ's dismissal order because request for review not filed within 30 days).

Our job is to review ALJ's orders, when a party raises a matter concerning a claim. Our first order addressing this matter dismissed claimant's request for hearing for failure to timely notify SAIF of his appeal. Now that SAIF has conceded that it in fact had timely notice of the appeal, the majority dismisses the appeal because *it* did not get timely notice. This is simply unreasonable. The Board had timely notice that claimant wished to be heard on the ALJ's show cause order. The Hearings Division and the Board are branches of the same agency, but today's decision holds the *pro se* claimant to a higher standard that it holds its own ALJ. This ruling is clearly unnecessary because the Board has discretion to do the right thing. This result is not compelled by *stare decisis* and it is inconsistent with substantial justice. Therefore, I respectfully dissent.

In the Matter of the Compensation of
ROGER S. PASKVAN, Claimant
Own Motion No. 00-0282M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Doblie & Associates, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests review of the insurer's January 26, 2001 Notice of Closure which closed his claim with an award of temporary disability compensation from October 5, 2000 through December 22, 2000. The insurer declared claimant medically stationary as of December 22, 2000.

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 claim closure turns on whether claimant was medically stationary at the time of the January 26, 2001 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).

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 issue raised less often, is that, although medically stationary at claim closure, the claimant asserts entitlement to additional temporary disability during the time the claim was open.

Here, claimant requests review of the insurer' January 26, 2001 Notice of Closure. We interpret claimant's request as a challenge to both the medically stationary determination and the temporary disability compensation award. 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.

On December 22, 2000, claimant attended a closing examination by Dr. Van Pett, claimant's attending physician. Dr. Van Pett reported that claimant had "recovered well and is currently pain free." Dr. Van Pett opined that claimant was medically stationary. This opinion is unrebutted.

Based on the uncontroverted medical evidence, we find that claimant was medically stationary on December 22, 2000. Inasmuch as temporary disability compensation was paid through December 22, 2000, we further 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 26, 2001 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
LLANCE A. PETERSON, Claimant
Own Motion No. 01-0123M
OWN MOTION ORDER ON RECONSIDERATION
Carney, et al, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our April 26, 2001 Own Motion Order which declined to reopen his 1986 industrial injury claim for the payment of temporary disability compensation because he failed to establish that he remained in the work force when his compensable condition worsened requiring surgery or hospitalization. With his request, claimant submits a May 3, 2001 affidavit in support of his request for benefits.

In declining to authorize the reopening of claimant's claim, we concluded that his attorney's representations regarding claimant's willingness to work were insufficient to satisfy the "willingness" standard of the third *Dawkins* criterion. *See Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989). Failing to demonstrate his willingness to work, claimant was not considered a member of the work force, and thus, was not entitled to temporary disability compensation. *See Arthur R. Morris*, 42 Van Natta 2820 (1990); *Stephen v. Oregon Shipyards*, 115 Or App 521 (1992); *Judith R. King*, 48 Van Natta 2303 (1996); *Marlene J. Andre*, 48 Van Natta 404 (1996).

On reconsideration, claimant submits a May 3, 2001 affidavit in support of his "willingness" contention. Claimant asserts that "[i]t is still my fervent desire to be able to return to an active position in the workforce and fully participate in earning a meaningful living." Claimant further attests that he has not retired from the work force, but has been unable to work due to his compensable condition. Based on *claimant's* sworn statement, we find that he is willing to seek employment.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning September 6, 2000, the date he was admitted to the hospital. 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. OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD WHEELER, Claimant
Own Motion No. 01-0070M
OWN MOTION ORDER

The insurer has submitted claimant's request for temporary disability compensation for his compensable cervical condition. Claimant's aggravation rights have expired. The insurer opposes authorization of temporary disability compensation, contending that: (1) it is unable to confirm whether the current condition is causally related to the accepted condition; (2) it is not responsible for claimant's current condition; and (3) surgery or hospitalization is not reasonable and necessary for the compensable injury.

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.*

The insurer contends that, because of claimant's failure to attend insurer-arranged medical examinations (IMEs), it is unable to determine: (1) whether claimant's current condition is causally related to the accepted injury; or (2) whether the recommended surgery is appropriate treatment for his compensable injury.[1]

Thus, the issues of whether claimant's current condition is related to his compensable 1994 injury and whether the recommended surgery is appropriate for his compensable 1994 injury remain unresolved at this time. Under such circumstances, we are not authorized to reopen claimant's 1994 injury claim for the payment of temporary disability benefits.[2] *See* ORS 656.278(1)(a). Should claimant's circumstances change, and the insurer accepts responsibility for claimant's current condition, he may again see Own Motion relief.[3]

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

IT IS SO ORDERED.

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[1] On April 13, 2001, the Board requested claimant's position regarding the insurer's compensability and surgery contentions. The Board requested that claimant's position be received within 14 days from the date of the letter. Inasmuch as the 14 day period has expired without receipt of any response from claimant, we have proceeded with our review.

[2] Our jurisdiction extends only to the authorization of temporary disability compensation under the specific circumstances set forth in ORS 656.278. We do not, in our Own Motion capacity, have jurisdiction to decide matters of compensability, responsibility or reasonableness and necessity of surgery or hospitalization (pre-1966 injuries excepted). Rather, jurisdiction over these disputes rests either with the Hearings Division or with the Director. *See* ORS 656.704; 656.245; 656.260; 656.327; *Gary L. Martin*, 48 Van Natta 1802 (1996). Thus, our decision should not be interpreted as a finding regarding the compensability of, or responsibility for, claimant's current condition or the propriety of the proposed surgery.

[3] Because claimant is unrepresented, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in such matters. Claimant may contact the Workers' Compensation Ombudsman, free of charge, at 1-800-927-1271, or write to:

WORKERS' COMPENSATION OMBUDSMAN
DEPT OF CONSUMER & BUSINESS SERVICES
350 WINTER ST NE
SALEM OR 97301

In the Matter of the Compensation of
CARMEN O. MACIAS, Claimant
WCB Case No. 99-02440
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorney
Lundeen, et al., Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Davis' order that awarded an attorney fee of $4,200 for prevailing on the insurer's denial of claimant's left shoulder claim. On review, the issue is attorney fees.

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

The attorney fee issue in this case involves two hearings. After the first hearing, the ALJ set aside the insurer's denial of claimant's cervical strain and awarded a $2,500 attorney fee. The ALJ upheld the insurer's denial of claimant's left shoulder claim.

Claimant requested Board review of that portion of the ALJ's order pertaining to the left shoulder condition. Claimant moved to remand the case for evaluation of new medical evidence involving her post-hearing surgery. After reviewing the proposed evidence, we found that such evidence was reasonably likely to affect the outcome and we remanded the case to the ALJ for consideration of the new evidence. *Carmen O. Macias*, 52 Van Natta 450 (2000).

A second hearing was held on September 18, 2000. The ALJ found the left shoulder condition compensable and initially awarded a $2,500 attorney fee. Claimant requested reconsideration, seeking an attorney fee of $5,000 for the left shoulder claim. Claimant's attorney submitted a statement of services and an affidavit of attorney fees. The statement of services requested a total fee of $7,500. The statement indicated that claimant's attorney had devoted 43 hours to both issues in the case, at an hourly rate of $150. The statement also included a legal assistant's time, estimated at 5.8 hours, at an hourly rate of $60, as well as 16 hours for interpreters, at an hourly rate of $30. On reconsideration, the ALJ awarded a $4,200 attorney fee for the left shoulder claim.

On review, the insurer argues that claimant's attorney's fee request improperly includes "non-attorney" costs. The insurer also argues that claimant's counsel's legal assistant's time is a cost, not an attorney fee. The insurer asserts that, at most, the left shoulder claim merits an attorney fee of $2,500.

Claimant responds that, even without considering the "costs" portions of the statement of services, the ALJ's attorney fee award was proper.

We disagree with the insurer that claimant's attorney's time traveling to and from both hearings should not be considered in assessing a reasonable attorney fee. An attorney's travel time to a hearing or deposition represents hours of legal services rendered on behalf of a party and that time is considered in awarding a reasonable attorney fee. *See, e.g., Rollin R. Bradford*, 50 Van Natta 33 (1998). However, costs of travel such as mileage expenses, lodging and meals are not reimbursable via an assessed fee. *Id.* Here, we find that claimant's attorney's travel time to and from both hearings is properly considered in determining a reasonable attorney fee.

On the other hand, we agree with the insurer that claimant's attorney's legal assistant's time should not be included in assessing the attorney fee. "Paralegal" time generally represents a cost incurred by an attorney in pursuing a matter on behalf of an attorney. *See* OAR 438-015-0005(6); *Patricia L. McVay*, 48 Van Natta 317, 318 n3 (1996). In previous cases, we have held that legal assistant time can only be considered if it represents hours devoted to "research and investigation" subject to supervision by an attorney. *See, e.g., Dale L. Haskins*, 52 Van Natta 1538 (2000); *Jamie J. Boldway*, 52 Van Natta 755 (2000).

Here, claimant's attorney's affidavit of attorney fees describes services for the legal assistant as: "request for hearing - letter to client, send exhibits 31 and 32, letter to Judge Davis, letter to client, request for review, request new medical condition acceptance letter, facsimile to claims adjuster, facsimile to Dr. Lawlor's office re: medical authorization and notes, facsimile to Dr. Lawlor's office re: records request, request for hearing, letter to Workers' Compensation Board, letter to client, and letter to Ken Marcus re: interpreting at hearing."

Claimant does not contend that the legal assistant services in this case involved research or investigation. Instead, it appears that the tasks attributed to the legal assistant in the affidavit are secretarial in nature. Because such secretarial services are not "research or investigation," we decline to consider the time spent by claimant's attorney's legal assistant in assessing a reasonable attorney fee. *See Jamie J. Boldway*, 52 Van Natta at 755.

We turn to an application 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. With regard to this attorney fee issue, the issue in dispute was compensability of claimant's left shoulder condition. Approximately 46 exhibits were admitted for both the cervical and left shoulder condition, five of which were submitted or generated by claimant's attorney. The nature of the proceedings was complex, involving two hearings, claimant's request for review, appellate briefs and interpreters. The first hearing lasted about 1 hour, with a transcript of 33 pages. At the first hearing, claimant and one witness testified. The second hearing lasted about 15 minutes, with a transcript of 6 pages. Claimant testified on her own behalf. No expert witnesses testified and there were no depositions.

The case involved issues of average legal complexity, but above average medical complexity, considering the range of cases generally submitted to this forum. The claim's value and the benefits secured are significant due to claimant's left shoulder surgery.[1] Claimant's attorney's statement of services and affidavit indicated that he devoted a total of 43 hours to the case. Claimant's attorney asserts that the majority of time was spent in securing benefits for the left shoulder condition. The parties' respective counsels are experienced workers' compensation attorneys who 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 claimant's counsel's efforts might have gone uncompensated, particularly considering the insurer's vigorous defense.

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we agree with the ALJ that $4,200 is a reasonable attorney fee for services at the hearings level (initially and on remand) and for the initial Board review. *See* ORS 656.388(1). In reaching this conclusion, we have particularly considered the time devoted to the left shoulder compensability issue (as represented by the record), the value of the interest involved, the nature of the proceeding (an initial hearing followed by an appeal and remand for additional evidence regarding claimant's post-hearing surgery), and the risk that claimant's counsel might go uncompensated. Claimant's attorney is not entitled to an attorney fee for services devoted to the attorney fee issue. *Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated October 17, 2000, as amended January 25, 2001, is affirmed.

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[1] Claimant's attorney asserts that claimant's medical bills are extensive.

In the Matter of the Compensation of
MARLINE D. MILLER, Claimant
WCB Case No. 99-10158
ORDER ON REVIEW
Cole, Cary, et al., Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Tenenbaum's order that declined to reopen the record for the submission of a "post Order on Reconsideration" deposition of the attending physician. On review, the issues are the ALJ's evidentiary ruling and, potentially, remand. We affirm.

FINDINGS OF FACT

Claimant has an accepted claim for right wrist and right index finger tendinitis and "bilateral lateral epicondylitis." (Ex. 3). On July 26, 1999, claimant's treating physician, Dr. Lin, performed a closing examination and reported that: (1) claimant's symptoms were "essentially resolved;" and (2) claimant had "normal range of motion" and "no residual deficits." (Ex. 5).

On August 20, 1999, SAIF issued a Notice of Closure awarding no permanent disability. (Ex. 5AA-1). Claimant requested reconsideration with a medical arbiter.

On December 8, 1999, Dr. Filarski performed a medical arbiter examination and found reduced elbow flexion bilaterally. (Ex. 6-2). However, Dr. Filarski diagnosed "resolved" tendinitis and epicondylitis. (*Id.*) Dr. Filarski further stated that "[t]he patient does not feel that there has been a change in her deficit of elbow extension through her symptomatic period, but that she has always had a mild degree of flexion contracture." (Ex. 6-3).

On December 20, 1999, the Appellate Unit requested a clarifying report from Dr. Filarski. (Ex. 7). That report was not received before the Order on Reconsideration issued on December 21, 1999. (Ex. 8). The Order on Reconsideration modified claimant's periods of temporary disability, but otherwise affirmed the Notice of Closure and awarded no permanent disability. (Ex. 8-3).

On December 29, 1999, Dr. Filarski authored a clarifying report, stating that "[d]ecreased elbow flexion and extension are NOT due to accepted condition. Medically probable [secondary to] preexisting acquired contracture; exact etiology undetermined." (Ex. 9) (Emphasis in original.)

Claimant requested a hearing challenging the Order on Reconsideration.

The ALJ declined to admit Dr. Filarski's clarifying report. The ALJ then relied on Dr. Filarski's initial evaluation (without the clarification) and awarded 7 percent scheduled permanent disability for the right arm (elbow) and 6 percent scheduled permanent disability for the left arm (elbow). SAIF requested Board review.

On review, we determined that Dr. Filarski's clarifying report was admissible pursuant to ORS 656.268(6)(f) and remanded the case to the ALJ for further proceedings.[1] *See Marline D. Miller*, 52 Van Natta 2069 (2000).

On remand, the ALJ admitted Dr. Filarski's clarifying report and affirmed the Order on Reconsideration. Following the ALJ's Opinion and Order on Remand, but before the order became final, claimant sought to reopen the record for the submission of the attending physician's (Dr. Lin) deposition, which had been taken in a companion case on October 27, 2000. On December 22, 2000, the ALJ abated her Opinion and Order on Remand.

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[1] ORS 656.268(6)(f) provides: "Any medical arbiter report may be received as evidence at a hearing even if the report is not prepared in time for use in the reconsideration proceeding."

On February 21, 2001, the ALJ declined to reopen the record for Dr. Lin's deposition, and republished her Opinion and Order on Remand, affirming the Order on Reconsideration. The ALJ reasoned that because Dr. Lin's deposition was in existence before the record closed and because claimant failed to respond to a November 30, 2000 letter advising that the record would close "within a week" that claimant had waived her right to seek reopening of the record.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that the ALJ erred in declining to reopen the record for the submission of Dr. Lin's deposition. Claimant acknowledges that the deposition was in existence when the record closed, but contends that there was no legal reason for her to seek admission of Dr. Lin's deposition before December 14, 2000.[2] Consequently, claimant argues that her request to reopen the record was timely and that she did not waive her right to seek reopening of the record by failing to do so "within a week" of November 30, 2000. We review the ALJ's ruling for abuse of discretion.[3]

Under OAR 438-007-0025, the ALJ may reopen the record and reconsider her decision based upon newly-discovered evidence where the motion to reconsider states the nature of the new evidence and explains why it could not have been reasonably discovered and produced at hearing. *Gary Nored*, 52 Van Natta 920, 921 (2000). Under the circumstances presented here, we are not inclined to find an abuse of discretion. However, we need not conclusively resolve that issue, because, for the reasons stated below, we conclude that admission of the evidence would not alter the outcome.

Claimant ultimately seeks a permanent disability award for the loss of range of motion of her elbows as reported by Dr. Filarski in his medical arbiter's evaluation. Claimant's disability is determined as of the date of the Order on Reconsideration. ORS 656.283(7). Impairment is established by a preponderance of medical evidence based upon objective findings. ORS 656.726(3)(f)(B). 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(14) (WCD Admin Order No. 98-055). Where a preponderance establishes a different level of impairment, the impairment is established by the preponderance of evidence. (*Id.*); *Javier H. Patino*, 52 Van Natta 2028 (2000).

In his medical arbiter evaluation, Dr. Filarski expressly opined that claimant's reduced elbow range of motion was due to "preexisting acquired contracture" and not due to the accepted epicondylitis condition. (Ex. 9). Consequently, claimant is not entitled to impairment for reduced elbow range of motion unless the preponderance of evidence establishes otherwise.

Here, the proffered exhibit (Dr. Lin's deposition) primarily discusses Dr. Lin's opinion regarding whether claimant suffers from fibrositis.[4] (Proposed Ex. 10-4). While the proffered exhibit indicates that Dr. Lin disagreed with Dr. Filarski over the diagnosis of "fibrositis" and the medical nature of that condition, it does not either expressly or impliedly indicate that claimant's loss of elbow range of motion is the result of the accepted epicondylitis condition as opposed to a "preexisting acquired contracture." Consequently, even if the proposed exhibit was admitted, the medical record would still be insufficient to establish claimant's entitlement to a permanent disability award for loss of elbow range of motion.

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[2] Claimant relies on *Koskela v. Willamette Industries, Inc.*, 331 Or 262 (2000), which was issued on December 14, 2000, as legal authority that she is entitled to submit Dr. Lin's deposition. Claimant's request to reopen the record was made on December 18, 2000.

[3] ORS 656.283(7) provides that an 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 an ALJ broad discretion on determinations concerning the admissibility of evidence. *See, e.g., Brown v. SAIF*, 51 Or App 389, 394 (1981). Consequently, 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).

[4] As a part of his medical arbiter evaluation, Dr. Filarski opined that claimant had "variable myofascial syptoms" (which he also termed "fibrositis") unrelated to the accepted condition. (Ex. 6-3,4).

Because we have concluded that even if the proposed exhibit was admitted, the medical record would still be insufficient to establish claimant's entitlement to a permanent disability award for loss of elbow range of motion, we conclude we need not conclusively resolve the propriety of the ALJ's procedural and evidentiary rulings.[5]

Accordingly, we affirm the ALJ's order.

ORDER

The ALJ's order dated February 14, 2001 is affirmed.

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[5] As previously noted, claimant cites *Koskela v. Willamette Industries, Inc.*, 331 Or 262 (2000), as legal authority that she is entitled to submit Dr. Lin's deposition. Because we have determined that admission of Dr. Lin's deposition will not change the outcome, we do not address whether *Koskela* applies under the circumstances presented here.

In the Matter of the Compensation of
MARGARET J. CHRISTENSEN, Claimant
WCB Case Nos. 00-04545 & 00-02612
SECOND ORDER ON RECONSIDERATION
Westmoreland & Mundorff, Claimant Attorney
VavRosky, MacColl, Olson, et al., Defense Attorney

On May 3, 2001, we withdrew our April 11, 2001 Order on Reconsideration that had republished our February 16, 2001 Order on Review that affirmed Administrative Law Judge (ALJ) Crumme's order that set aside the self-insured employer's partial denial of claimant's claim for a C3-4 instability condition. We took this action in response to the employer's announcement that the parties had settled their dispute.

The parties have submitted a proposed "Stipulation, Disputed Claim Settlement, and Order of Dismissal" that resolves the disputes currently pending before the Board, as well as the dispute pending before the Hearings Division in WCB Case No. 01-01962. The portion of the agreement that pertains to WCB Case No. 01-01962 has been approved by an ALJ.

Pursuant to the portion of the agreement that pertains to this case, the parties agree that "the employer's May 31, 2000 denial and the denial contained herein shall be affirmed." The parties further agree that the settlement disposes of all issues raised or raisable by claimant's hearing requests.

We approve the parties' settlement that involves issues pending before the Board in this case, thereby fully and finally resolving these disputes, in lieu of all prior orders. Accordingly, this matter is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
CARLOS NUNO, Claimant
WCB Case No. 99-09374
ORDER ON REVIEW
Willner, Wren, Hill & Uren, Claimant Attorney
Meyers, Radler, et al., Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Peterson'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.

Claimant, a warehouseman, suffered a compensable injury on February 10, 1997, when he fell from a loading dock onto his right side. (Ex. 1). The employer accepted claimant's claim for nondisabling right thigh bruise and right groin strain. (Ex. 7). Claimant returned to regular work within a few days. He had no ongoing symptoms a month after the injury. (Ex. 15A-3).

In June 1999, claimant sought treatment with Dr. Meeker for right hip and low back pain. (Ex. 8). Claimant was eventually referred for an MRI and then to neurosurgeon Dr. Soldevilla. Based on the MRI results, Dr. Soldevilla diagnosed an L4-5 disc herniation with extruded fragment. (Exs. 11, 12).

The ALJ upheld the employer's denial of claimant's new medical condition claim for a L4-5 disc herniation condition, finding that claimant had not met his burden of proof through the opinion of his treating physician, Dr. Soldevilla. On review, claimant contends that we should defer to Dr. Soldevilla because he was the only physician to take claimant's history directly in his native language of Spanish. We disagree.

Where the medical evidence is divided, we rely on those opinions that are well-reasoned and based on a complete and accurate history. *Somers v. SAIF*, 77 Or App 259, 263 (1986). Absent persuasive reasons to the contrary, we defer to the opinion of claimant's treating physician. *Weiland v. SAIF*, 63 Or App 810 (1983). Here, we find persuasive reasons not to defer to Dr. Soldevilla. We agree with the ALJ that Dr. Soldevilla's opinion rests on an inaccurate history of claimant's symptoms after the 1997 work injury, and is therefore unpersuasive.

Claimant contends that Dr. Soldevilla's history of ongoing back pain since the 1997 injury should be viewed as the most accurate, because he took the history in Spanish without the aid of an interpreter. However, the history taken by Dr. Soldevilla is not consistent with the remainder of the medical record, nor is it entirely consistent with claimant's testimony at hearing.

With the exception of Dr. Soldevilla, every other physician in the record took a history of claimant's back pain beginning in June 1999. (*See, e.g.*, Exs. 16, 31-2). In a September 28, 1999 statement, claimant provided a similar history of back pain commencing in June 1999, and of no back pain at the time of the 1997 injury. (Ex. 15A). Finally, at hearing, claimant testified initially that he first noticed back pain in November 1999, then testified that he experienced back pain "some weeks" after the 1997 injury. (Tr. 22, 23).

In short, Dr. Soldevilla's allegedly accurate history is not corroborated by any of the remaining portion of the record. In other words, we are not convinced that, in every instance, the history claimant was attempting to convey to physicians other than Dr. Soldevilla was altered by miscommunication created by interpretation.

In *Hector A. Martinez*, 51 Van Natta 1506 (1999), we declined to rely on a physician's opinion, even though he was the only physician to take claimant's history in his native language. 51 Van Natta at 1507. We reasoned that the physician's history, although consistent with the claimant's testimony (or at least more so than that of the other physicians) was not consistent with the remainder of the medical record. We therefore were not persuaded by the physician's history of the claimant's symptoms. *Id.*

This case is comparable to *Martinez*. In fact, here, Dr. Soldevilla's history is not even fully consistent with claimant's testimony, as opposed to the physician's history in *Martinez*. Accordingly, we find Dr. Soldevilla's opinion unpersuasive. Inasmuch as Dr. Soldevilla represents claimant's only supportive medical opinion, we agree with the ALJ that claimant has not met his burden of proving the compensability of his L4-5 disc condition.

ORDER

The ALJ's order dated December 26, 2000 is affirmed.

May 21, 2001 Cite as 53 Van Natta 695 (2001)

In the Matter of the Compensation of
DENNIS R. EMERY, Claimant
Own Motion No. 01-0158M
OWN MOTION ORDER

The insurer has submitted claimant's request for temporary disability compensation for a left knee condition. Claimant's aggravation rights have expired. The insurer 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 claimant 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 for the insurer to provide temporary disability compensation beginning the date claimant is hospitalized for the proposed surgery.[1] 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] On November 9, 2000, we issued an Own Motion Order authorizing the reopening of claimant's 1978 right knee injury claim (claim no. 4273179) for the provision of temporary disability compensation. (Own Motion Case No. 00-0337M). A review of the Department's records indicate that claimant's 1978 claim remains in open status (*i.e.*, claimant might still be receiving timeloss benefits as a result of that order). Claimant is not entitled to receive double compensation for the same time period. *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 left knee surgery under his 1974 claim during a period that he is receiving time loss for his 1978 right knee injury claim, the insurer may 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
DEENA GONZALEZ-FAWCETT, Claimant
WCB Case No. 00-04439
ORDER ON REVIEW
Mustafa T. Kasubhai, Claimant Attorney
Schwabe, Williamson & Wyatt, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

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 left foot plantar fasciitis. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings."

CONCLUSIONS OF LAW AND OPINION

Claimant worked as a sales clerk for the employer, beginning in June 1999. In October 1999, she experienced left foot pain and sought medical treatment. Dr. Leonard diagnosed plantar fasciitis, due primarily to claimant's work activities.

The issue is whether Dr. Leonard's opinion supporting the claim persuasively establishes that claimant's work activities were the major contributing cause of her condition. *See* ORS 656.802.

The ALJ declined to rely on Dr. Leonard's opinion, reasoning that the doctor had an inaccurate history about the nature and extent of claimant's work activities. We agree.

Dr. Leonard opined that repetitive walking or standing on a hard surface can cause plantar fasciitis and that claimant's walking and standing on a concrete floor at work was the major contributing cause of her condition. The doctor explained that he relied on claimant's history, her clinical examination, and her lack of prior foot problems in forming his opinion. (Ex. 15).

Dr. Leonard understood that claimant was on her feet "constantly" at work, 40 hours per week, except for two 10-20 minute breaks. (Ex. 15-1). As the ALJ noted, this amounts to an inaccurate history (because claimant could sit during her lunch hour). Dr. Leonard also understood that claimant stood and walked on a concrete floor at work, and the floor was "not padded." (Ex. 15-1). However, claimant testified that she stood on "a padding" when she stood at the cash register each work day. Therefore, Dr. Leonard's history that the floor claimant worked on was unpadded also amounts to an inaccurate history.

Claimant argues that Dr. Leonard's history was sufficiently accurate for his conclusions to be persuasive because claimant did work "long hours" on a "concrete floor," even if she sat down during her lunch hour and stood on a mat when she operated the cash register. The problem with that argument is it requires us to speculate that Dr. Leonard's opinion would have remained the same, based on a different history. Moreover, the experts dispute the amount of trauma (walking or standing on a hard surface) necessary to cause plantar fasciitis. Under these circumstances, we cannot say that the inaccuracies in Dr. Leonard's history are not material. *Compare Maria Gonzales*, 46 Van Natta 466, 467 (1994) (a medical opinion is not unpersuasive due to an incomplete history, unless the omitted facts "have some bearing on the relevant issue") Accordingly, on this record, we agree with the ALJ that Dr. Leonard's opinion is insufficient to carry claimant's burden of proof.

ORDER

The ALJ's order dated February 12, 2001 is affirmed.

In the Matter of the Compensation of
RICHARD YOREK, Claimant
Own Motion No. 99-0161M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE

Claimant requested review of the self-insured employer's February 14, 2001 Notice of Closure which closed his claim with an award of temporary disability compensation from May 12, 1999 through January 3, 2001. The employer declared claimant medically stationary as of January 3, 2001.

"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 the date of 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 14, 2001 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).

Typically, there are only two issues to be raised when a claimant requests review of a carrier's closure of his or her claim. The most common issue raised is that the claimant asserts that he or she was not medically stationary at claim closure. A second issue raised less often is that, although the claimant agrees that he or she was medically stationary at claim closure, the claimant asserts entitlement to additional temporary disability compensation during the time the claim was open.

Here, claimant contends that he is entitled to "timeloss" because he is "totally disabled." In addition, claimant submitted an April 5, 2001 request for authorization for revision surgery. Claimant contends that his need for further surgery demonstrates that he was not medically stationary when the insurer closed his claim. In addition, claimant contends that his condition has not changed since closure and that he has had "no relief from the pain at all any more."

The reports from Dr. Purtzer, claimant's attending physician, do not support claimant's contentions. In letters dated January 22 and 23, February 1 and 28 and March 1, 2001, Dr. Purtzer opined that claimant was medically stationary and that his condition would not improve with the passage of time or with further treatment.

In addition, Dr. Purtzer has explained claimant's need for revision surgery. Although describing the scar revision as medically necessary, Dr. Purtzer reported that the revision was a "minor procedure done as an outpatient." Dr. Purtzer further explained that the scar revision would not "change his medically stationary status." Dr. Purtzer's opinions are unrebutted.

Thus, based on the uncontroverted medical evidence (*i.e.*, the opinion of claimant's attending physician), we find that as of February 14, 2001, there was no reasonable expectation that claimant's condition would materially improve through further medical treatment or the passage of time. Consequently, claimant's condition was medically stationary on the date his claim was closed. Furthermore, based on Dr. Purtzer's opinion, claimant is not entitled to additional disability benefits beyond those granted by the Notice of Closure.

Accordingly, we affirm the employer's February 14, 2001 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
FRED L. YOUNGER, Claimant
WCB Case Nos. 00-01056 & 00-00591
ORDER ON REVIEW
Arthur P. Klosterman, Claimant Attorney
James B. Northrop (Saif), Defense Attorney
Mannix, et al., Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that: (1) upheld the denial of his aggravation claim for a low back condition issued by the SAIF Corporation on behalf of its insured, Colamette Construction Co.; (2) upheld SAIF/Colamette's denial of her current low back condition; and (3) upheld the denial of claimant's low back injury claim issued by SAIF on behalf of James John Construction Co. 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."

CONCLUSIONS OF LAW AND OPINION

Aggravation

We adopt and affirm the ALJ's reasoning and conclusions.

New Injury Claim

We adopt and affirm the ALJ's reasoning and conclusions.

Compensability of Current Condition

Claimant sustained a compensable low back injury on February 19, 1997, while employed by Colamette. That injury resulted in a discectomy at L4-5 and a laminectomy at L2-3 in July 1997. The claim was eventually closed in June 1998 by Notice of Closure that awarded 11 percent unscheduled permanent disability. An Order on Reconsideration increased the award to 13 percent.

In February 1999, SAIF denied an aggravation claim. A July 1999 Opinion and Order upheld that denial.

In September 1999, Dr. Grewe, a neurosurgeon, began treating claimant for complaints of severe low back and lower extremity pain. On October 4, 1999, claimant allegedly experienced a new injury while employed by James John Construction, a claim that SAIF denied on behalf of that insured on November 22, 1999. Claimant also filed an aggravation claim with Colamette with regard to the 1997 accepted low back claim. Meanwhile, Dr. Grewe performed surgery on December 1, 1999 to decompress claimant's spine from L3 to L5.

Claimant wrote SAIF and requested that additional conditions be accepted under the 1997 claim, consisting of the current low back condition, failed low back surgeries and multilevel disc disease. SAIF denied the claim on behalf of Colamette on February 2, 2000. SAIF also denied that claimant had experienced a compensable aggravation of the 1997 injury. Claimant requested a hearing from the denial.

In upholding SAIF/Colamette's denial, the ALJ determined that claimant's failed surgeries did not need to be specifically accepted because they were encompassed within the accepted conditions. With regard to the degenerative disease in claimant's lumbar spine, the ALJ upheld that part of the denial because there was insufficient medical evidence relating the degenerative condition to the accepted 1997 low back injury claim. Finally, the ALJ rejected claimant's contention that his current low

back condition and need for surgery in December 1999 was compensable as a consequential condition. The ALJ reasoned that the medical opinion of Dr. Grewe did not satisfy claimant's burden of proof because he failed to make a "quantitative comparison" between the two causal factors he identified in claimant's current condition: noncompensable degenerative changes in the lumbar spine and scarring from prior compensable surgeries.[1]

On review, claimant focuses on that portion of the ALJ's order that determined that claimant failed to prove a compensable consequential condition. Claimant asserts that Dr. Grewe adequately weighed the various causal factors in concluding that the surgeries undertaken for the compensable 1997 injury were the major contributing cause of claimant's current low back condition. Thus, claimant contends that Dr. Grewe's opinion satisfies his burden of proof. For the following reasons, we agree with claimant's contentions.

Claimant contends that his current low back condition developed as a consequence of his compensable low back injury and related surgeries. Claimant must, therefore, prove that his compensable injury is the major contributing cause of his consequential condition. ORS 656.005(7)(a)(A); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992).

The relation of claimant's current low back condition to his compensable low back injury is a complex medical question, resolution of which requires expert medical analysis. *Barnett v. SAIF*, 122 Or App 279, 283 (1993). Where the medical evidence is divided, we rely on those opinions which are well-reasoned and based on complete and accurate information. *Somers v. SAIF*, 77 Or App 259, 263 (1986).

Absent persuasive reasons to the contrary, we generally give greater weight to the opinion of claimant's treating physician. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find no persuasive reasons not to give greater weight the opinion of claimant's treating physician and surgeon, Dr. Grewe.

Dr. Grewe initially opined that, if claimant's earlier surgeries were approved workers' compensation related surgeries (which they were), then his December 1999 surgery was also related to the accepted claim. (Ex. 115B). Subsequently, Dr. Grewe noted that, at the December 1997 surgery, he observed that claimant had stenosis secondary to scar tissue and smaller component of degenerative changes. According to Dr. Grewe, claimant's surgery for stenosis was largely due to scar tissue from the prior surgery related to the compensable injury. Thus, according to Dr. Grewe, the December 1999 surgery was secondary to the accepted L4-5 disc herniation. (Ex. 131). Dr. Grewe emphasized that claimant had only "minimal" degenerative changes to his lumbar spine.

Dr. Grewe was then deposed. At his deposition, Dr. Grewe testified that the February 19, 1997 injury was the major contributing cause of claimant's current low back condition. (Ex.132-18). Dr. Grewe again attributed claimant's December 1999 surgery to scar tissue resulting from prior compensable surgeries. (Ex. 132-21). Dr. Grewe described his surgery as "following through on the same problem." (*Id.*)

Having reviewed Dr. Grewe's opinion, we find that it is well-reasoned and, hence, persuasive. In particular, we find that Dr. Grewe considered all potential causal factors, including claimant's degenerative changes in the lumbar spine, in opining that the major factor in claimant's current low back condition was the compensable 1997 injury and related, compensable surgeries that produced scar tissue and stenosis. *See SAIF v. Willcutt*, 160 Or App 568, 574 (1999) (holding that weighing of causal factors required by *Dietz v. Ramuda*, 130 Or App 574, *rev dismissed* 321 Or 416 (1995) applies to consequential conditions under ORS 656.005(7)(a)(A)). Especially important in our evaluation of the persuasiveness of Dr. Grewe's opinion is the fact that he performed the most recent surgery on claimant's lumbar spine and observed the scar tissue and the stenosis. *See Argonaut Insurance Company v. Mageske*, 93 Or App 698, 702 (1988). Moreover, Dr. Grewe could evaluate first hand the extent of the degenerative changes in claimant's spine. According to Dr. Grewe, those changes were "minimal."

The medical evidence contrary to Dr. Grewe's opinion is not more persuasive. Dr. Gripekoven performed a records review, on the basis of which he attributed claimant's current condition to multiple factors, such as total of all claimant's injuries, multiple surgical procedures, scar tissue and progressive degenerative changes. Significantly, Dr. Gripkoven could not identify the major contributing cause of claimant's current low back condition. (Ex. 127-3).

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[1] The ALJ also upheld the denials of claimant's aggravation claim and new injury claim. As previously noted, we adopt the ALJ's reasoning with regard to those issues.

Examining physicians Drs. Farris, Woodward and Murray, attributed claimant's current condition to degenerative changes that occurred over a prolonged period of time. (Exs. 109-13, 124-10). However, we do not find these opinions very persuasive given Dr. Grewe's description of claimant's degenerative changes (which was based on surgical observations) as "minimal."

In conclusion, we find that claimant has satisfied his burden of proving that the compensable injury is the major contributing cause of a consequential condition under ORS 656.005(7)(a)(A). Thus, we find that claimant's current low back condition is compensable under the 1997 claim.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding the compensability of claimant's current low back condition. 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 $3,500, payable by SAIF/Colamette. In reaching this conclusion, we have particularly considered the time devoted to the 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.

ORDER

The ALJ's order dated December 28, 2001 is reversed in part and affirmed in part. That portion of the ALJ's order that upheld SAIF/Colamette's denial of claimant's current low back condition is reversed. SAIF/Colamette's denial of claimant's current low back condition is set aside and the claim is remanded to SAIF for processing according to law. The remainder of the ALJ's order is affirmed. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,500, to be paid by SAIF/Colamette.

In the Matter of the Compensation of
PETER VOORHIES, Claimant
Own Motion No. 97-0530M
OWN MOTION ORDER OF ABATEMENT
Sheridan, Bronstein, et al., Defense Attorney

Claimant requests reconsideration of our April 19, 2001 Own Motion Order Reviewing Carrier Closure, that affirmed the insurer's September 13, 2000 Notice of Closure in its entirety. Claimant further requests that "the Board defer its reconsideration," until he has had an opportunity to review the self-insured employer's payment vouchers.

In light of such circumstances, we withdraw our April 19, 2001 order. The following briefing schedule shall be implemented. Claimant's opening brief must be filed 21 days from the date of this order. The insurer's response must be filed within 21 days from the date of mailing of claimant's brief. Claimant's reply must be filed within 14 days from the date of mailing of the insurer's response. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
TRACEY A. BLAMIRES, Claimant
WCB Case Nos. 98-04194 & 98-02326
THIRD ORDER ON REMAND
Bottini, Bottini & Oswald, Claimant Attorney
Wallace, Klor & Mann, Defense Attorney

The insurer has requested reconsideration of our April 24, 2001 Second Order on Remand. Our prior orders: (1) found that the insurer had not accepted claimant's "combined condition" prior to the issuance of its "pre-closure" denials under ORS 656.262(7)(b); and (2) affirmed the Administrative Law Judge's (ALJ's) order in WCB Case No. 98-04149 that set aside the insurer's denial on substantive grounds. Claimant has responded to the insurer's motion and requests sanctions, and/or penalties and attorney fees for the insurer's allegedly frivolous request for reconsideration.

In its request for reconsideration, the insurer contends that we "misunderstood the directive" from the Court of Appeals and that we addressed only the fact that there was no "express" denial. The insurer argues, however, that pursuant to *SAIF v. Tull,* 113 Or App 449 (1992), whether an acceptance occurs or not is an issue of fact. The insurer contends that the court's decision was not limited to whether the insurer had issued an "express" acceptance prior to its denial.[1]

First, we disagree with the insurer's characterization of our order. Our Order on Remand did not use the term "express" in addressing the issue of acceptance. Moreover, in our order, we specifically found "no evidence that the insurer accepted claimant's 'combined condition.'" Order on Remand, 53 Van Natta at 574.

We do agree that, under the *Tull* case, the acceptance issue is an issue of fact. On reconsideration, the insurer argues that it established an acceptance of claimant's combined condition based on its payment of timeloss and medical treatment and because an insurer-arranged medical exam (IME) found that claimant had a combined condition.

ORS 656.262(10) provides in pertinent part that, "[m]erely paying or providing compensation shall not be considered acceptance of a claim* * *." Accordingly, the insurer's payment of temporary disability benefits or medical bills is not sufficient to constitute an acceptance. We also do not consider a statement in an IME regarding claimant's condition and the lack of a denial to constitute an acceptance from an insurer of the condition. Consequently, under the *Tull* analysis, we continue to conclude that the record does not establish that the insurer accepted claimant's combined condition prior to the issuance of its denials under ORS 656.262(7)(b).

Finally, we do not agree with claimant that the insurer's motion for reconsideration is frivolous, was filed in bad faith or for the purposes of harassment. ORS 656.390. Consequently, we decline to impose sanctions.

Nevertheless, we conclude that claimant's counsel is entitled to an assessed attorney fee for his services on reconsideration devoted to responding to the insurer's motion. Inasmuch as we have not reduced claimant's compensation, we find that claimant is entitled to a fee under 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 reconsideration is $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the

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[1] Unless otherwise authorized by the Board, no additional briefs are considered. OAR 438-011-0020(2). In light of such circumstances, it is not unusual for parties on remand from the Court to seek Board authorization of a supplemental briefing schedule. The insurer apparently expected that we would request additional briefs from the parties on the issue of whether it had accepted the combined condition prior to denial. Although claimant made such a request that coincided with our first order on remand, we declined the request because we considered the record and the parties arguments to be sufficiently developed. Additionally, we note that the insurer neither requested supplemental briefing nor submitted any argument regarding the *Tull* issue in response to claimant's initial request for reconsideration. Had such an argument been submitted, we could have addressed the insurer's contentions at that time.

acceptance issue (as represented by claimant's response to the insurer's request for reconsideration), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services devoted to the sanctions and penalties/attorney fee issues.

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

IT IS SO ORDERED.

May 21, 2001 Cite as 53 Van Natta 702 (2001)

In the Matter of the Compensation of
BRIAN M. HAMILTON, Claimant
WCB Case No. 00-02842
ORDER ON RECONSIDERATION
Mitchell & Guinn, Claimant Attorney
Meyers, et al., Defense Attorney

Claimant requests reconsideration of our May 2, 2001 order that affirmed an Administrative Law Judge's (ALJ's) order that upheld the self-insured employer's denial of claimant's current right wrist condition.

Claimant contends that his current diagnosis of de Quervain's tendinitis is encompassed by the accepted right wrist tendinitis condition. For that reason, claimant requests that we reconsider his theory that the employer's denial was an improper "back-up" denial. We decline to do so for the following reasons.

As noted in our order, the employer expressly accepted right wrist tendonitis. Claimant's current condition is a "combined condition," not right wrist tendonitis. Specifically, the "combined condition" is a new, intervening injury that combined with claimant's tendonitis and a preexisting radial boss that caused a nodular reaction in the abductor tendon. Consequently, because the accepted "right wrist tendinitis" condition is not the same condition as the denied "combined condition," we continue to reject claimant's assertion that the employer issued a "back-up" denial.

Accordingly, we withdraw our May 2, 2001 order. On reconsideration, as supplemented herein, we adhere to and republish our May 2, 2001 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
JESUS J. FERRER, Claimant
WCB Case No. 00-05782
ORDER ON REVIEW
Craig A. Staples, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Crummé's order that: (1) declined to admit a letter into evidence; and (2) upheld the self-insured employer's denial of his current neck and upper back condition, including a herniated disc at C3-4. On review, the issues are evidence and compensability.

We adopt and affirm the ALJ's order, with the following supplementation regarding the evidentiary issue.

Claimant contends that the ALJ erred in not admitting a letter from Ms. Knutson dated October 26, 2000, which he submitted with his closing argument on November 28, 2000. Claimant argues that admission of the letter would establish that he did not at any time work for Meadow Lake Farms.

The issue at hearing was the compensability of claimant's current back and neck condition. The hearing was convened on October 25, 2000. At hearing, the ALJ continued the hearing for Dr. Bert's deposition and recorded closing arguments. (Tr. 31-32; 148-149). By letter dated October 26, 2000, the ALJ confirmed that the hearing was continued for the deposition testimony and closing arguments. The deposition was taken on November 14, 2000, but closing arguments were not recorded. (Ex. 46). Claimant faxed his closing argument to the ALJ and the employer on November 28, 2000 and included a copy of Ms. Knutson's letter. The record closed on December 15, 2000.

The employer objected to admission of the letter on the grounds that it was hearsay. The employer also requested cross-examination of Ms. Knutson, if the letter was admitted into evidence. The ALJ sustained the employer's objection on the basis that he had continued the hearing only for Dr. Bert's deposition.

ORS 656.283(7) provides that an 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." The statute has been interpreted to give ALJ's broad discretion in admitting evidence. *See, e.g., Brown v. SAIF*, 51 Or App 389, 394 (1981). We review the ALJ's evidentiary ruling for abuse of discretion. *Rose M. LeMasters*, 46 Van Natta 1533 (1994), *aff'd mem LeMasters v. Tri-Met, Inc.*, 133 Or App 258 (1995).

On review, the employer continues to object to admission of the letter on the grounds that it was hearsay and requests cross-examination of Ms. Knutson if the letter is admitted into evidence.

Ms. Knutson's letter goes to claimant's credibility. Claimant's credibility would be significant only if it affected the medical opinions on causation. However, after our *de novo* review of the record, we conclude that the medical opinions are insufficient to prove that claimant's work for the employer was the major contributing cause of his current neck and upper back conditions.[1]

Therefore, after reviewing Ms. Knutson's October 26, 2000 letter, we find that it is not necessary to decide whether the ALJ improperly declined to admit that exhibit because, even if that letter is considered, claimant did not sustain his burden of proving compensability of his current condition. *See,*

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[1] Dr. Bert, the only physician arguably supportive of compensability, concluded that claimant's work for the employer in 1990 was only "a" contributing cause of his current condition. (Ex. 46-14). This is insufficient to constitute persuasive medical evidence that employment conditions were the "major" contributing cause of claimant's current back and neck conditions, as required under ORS 656.802 or 656.005(7)(a)(A).

e.g., Sharon M. Battin, 52 Van Natta 1340, *on recon* 52 Van Natta 1674 (2000) (admission of proposed exhibit was not reasonably likely to affect the outcome of the case).[2]

ORDER

The ALJ's order dated January 16, 2001, as reconsidered February 15, 2001, is affirmed.

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[2] We note that claimant is unrepresented. Because he is unrepresented, he may wish to contact the Workers' Compensation Ombudsman, whose job it is to assist injured workers regarding workers' compensation matters:

Workers' Compensation Ombudsman
Dept. of Consumer & Business Services
350 Winter Street, NE
Salem, OR 97301
Telephone: 1-800-927-1271

In the Matter of the Compensation of
MICHAEL O. YORK, Claimant
Own Motion No. 01-0135M
ORDER POSTPONING ACTION ON OWN MOTION REQUEST
Cole, Cary, et al., Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant has requested review of the SAIF Corporation's February 23, 2001 Own Motion Notice of Closure. That closure resulted from our October 9, 2000 Own Motion Order that reopened the claim. Asserting that the condition for which Own Motion benefits was requested is a "new medical condition," claimant seeks specific acceptance of that condition and requests that SAIF reopen the claim under ORS 656.262(7)(c) for processing of that condition. SAIF has issued a denial of claimant's request for acceptance of a "new medical condition," on which claimant has filed a request for hearing. (WCB Case No. 01-03016).

In light of these circumstances, we defer action on the Own Motion matter pending the outcome of the litigation. We request that the assigned Administrative Law Judge (ALJ) submit a copy of the eventual order to the Board.[1] 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 approved agreement, we will take this matter under advisement.

IT IS SO ORDERED.

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[1] In submitting their respective positions to the assigned ALJ, the parties are requested to address the effect, if any, the following case holdings have on this dispute: *SAIF v. Ledin*, 174 Or App 61 (2001); *Douglas L. Shumway*, 53 Van Natta 516 (2001); *Steven R. Azorr*, 52 Van Natta 2148 (2000).

In the Matter of the Compensation of
JAY D. PERKINS, Claimant
WCB Case No. 00-05757
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorney
Hornecker, Cowling, et al, Defense Attorney

Reviewed by Board Members Haynes, Bock, and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the self-insured employer's partial denial of claimant's claim for medical services for his low back. On review, the issue is compensability.

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

Claimant acknowledges that he has longstanding low back degeneration. However, he contends that his degeneration is not *legally* a "preexisting condition" (that weighs against his claim), based on a prior ALJ's 1998 Opinion and Order and the employer's subsequent acceptance of claimant's "Right L5-S1 herniated disc." We disagree.[1]

At the 1998 hearing, claimant contended that his need for medical treatment was caused in major part by the accepted 1996 injury. (Ex. 100-1). The prior ALJ noted claimant's history of "multiple lumbar strains and degeneration" (in a footnote), but he relied on Dr. Purtzer's opinion relating claimant's condition to the injury and set aside the employer's denial of claimant's then current aggravation claim. (*See* Ex. 100-3-5). We adopted and affirmed the ALJ's order.

Thus, the prior litigation established that claimant's then current condition was compensable. It did not, however, determine that claimant's preexisting degeneration was compensable.[2] *See Ronald L. Merwin*, 51 Van Natta 1678, 1679 n.3 (1999) (where prior order addressed only causation of low back strain and held that injury was major cause of the strain, order did not establish that degenerative disc disease was a component of compensable condition).

We acknowledge that the compensable 1996 injury claim does include an L5-S1 herniated disc. The employer accepted that condition after the 1998 order.[3] (*See* Exs. 100, 102). However, because the acceptance was specific it was also limited, by its terms, to an L5-S1 herniated disc. Nothing about the acceptance or the 1998 order indicates that the acceptance included claimant's preexisting degeneration (at L5-S1, or elsewhere). *See Charles F. Klutsenbeker*, 52 Van Natta 2153, 2155 (2000) (where prior ALJ relied on medical evidence regarding disc condition to find disc condition compensable, the employer's acceptance resulting from ALJ's order was limited to disc condition and did not include degenerative condition).

Finally, the medical evidence establishes that claimant's 1996 injury and its residuals, including the compensable 1998 L5-S1 surgery, contribute to claimant's current need for treatment. The medical evidence also establishes that preexisting degeneration contributed to claimant's current need for treatment for his low back.[4] Dr. Purtzer provides the only expert evidence relating claimant's current need for treatment primarily to the 1996 injury and its residuals. However, Dr. Purtzer never explained why he discounted or ruled out claimant's undisputed preexisting degeneration in reaching his causation conclusion. Under these circumstances, we find Dr. Purtzer's opinion inadequately explained and we decline to rely on it. Accordingly, we agree with the ALJ that the claim fails. *See* ORS 656.245(1).

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[1] Claimant relies on *Silveira v. Larch Enterprises*, 133 Or App 297 (1997) and *Andrea E. Henwood*, 52 Van Natta 943 (2000), in support of his contention that the claim is compensable because all causes are work related. However, those cases do not apply because they involved occupational diseases and this is an injury claim. *See Jacalyn A. Mathews*, 52 Van Natta 1500 (2000).

[2] The order did not address the compensability of claimant's degeneration.

[3] However, we also note that claimant did not challenge the employer's prior denial (June 19, 1997) of claimant's lumbar spondylosis. (Ex. 75).

[4] For example, Dr. Purtzer acknowledged that the 1996 injury and 1998 surgery "accelerated" claimant's degeneration. (Ex. 122).

ORDER

The ALJ's order dated November 14, 2000 is affirmed.

Board Member Phillips Polich dissenting.

The majority upholds the employer's denial of claimant's claim for medical services for his low back, reasoning that Dr. Purtzer's opinion supporting the claim is not persuasive. I would reach an opposite result, based on the following reasoning.

This case is best understood in the context of its rather complicated medical and procedural history.

Claimant has had low back problems for many years, beginning with a low back strain in October 1993, while lifting weights. He had low back strains in June 1994 and September 1995. A claim for the latter strain was accepted and processed to closure in February 1996, with no award of permanent disability. A claim for a March 1996 low back strain was accepted in June 1996. In June 1997, the employer denied claimant's then current low back condition, then closed the claim with an award of one percent unscheduled permanent disability.

In 1998, claimant filed an aggravation claim that the employer denied. A prior ALJ set aside the aggravation denial, finding that claimant's then current need for surgery was caused in major part by the 1996 injury. The Board adopted and affirmed the ALJ's order. Thereafter, the employer accepted a claim for a "right L5-S1 herniated disc."

On June 21, 2000, the employer issued a partial denial of claimant's current claim for surgery at L4-5 and L5-S1, asserting that claimant's need for treatment was not related to the accepted 1996 claim.

Dr. Purtzer performed claimant's second surgery on September 7, 2000. Claimant requested a hearing.

Although I agree with the majority and the ALJ that the prior litigation is not determinative, I would find the claim compensable, nonetheless, based on the medical evidence. That evidences establishes (and it is undisputed) that claimant's recent need for surgery was due to a combination of the compensable 1996 injury, residuals of the 1998 L5-S1 surgery, a newer problem at L4-5, and degeneration.

Dr. Purtzer, treating surgeon, provides the medical evidence supporting the claim.[1] He explained that claimant's first surgery was done to repair disc injury caused by the 1996 compensable injury and the second surgery was done to address degeneration caused by the 1996 injury and the first surgery. (Ex. 122). Thus, in my view, Dr. Purtzer explained how claimant's current degenerative condition is primarily injury-related and the "area of concern" is L5-S1 (the site of the 1996 injury and prior surgery). (*Id.*) I would find Dr. Purtzer's opinion persuasive because it is well-reasoned and consistent with claimant's history. Accordingly, based on Dr. Purtzer's opinion, I would conclude that claimant has carried his burden of proof. *See* ORS 656.245(1). Under these circumstances, I must respectfully dissent.

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[1] I would not rely on Dr. Schilperoort's contrary opinion because it is based in part on a belief that claimant's 1998 surgery was due to noncompensable degeneration and that belief is contrary to the "law of the case" established by the prior litigation.

In the Matter of the Compensation of
MARK E. ST. MICHELL, SR., Claimant
WCB Case No. 00-08128
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that upheld the SAIF Corporation's denial of his injury claim for erectile dysfunction. On review, the issue is compensability.

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

Claimant argues that the ALJ erred by applying the major contributing standard under ORS 656.005(7)(a)(A) to his claim. He relies on Dr. Bashey's statement that the injury had a "direct causal relationship to his subsequent difficulties" and contends that a material cause standard applies.

ORS 656.005(7)(a)(A) provides that 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." The phrase "compensable as a consequence of a compensable injury" indicates that the major contributing cause standard applies only if the compensability determination depends on a showing that the injury or disease is a consequence of a compensable condition. *Robinson v. Nabisco, Inc.*, 331 Or 178, 185 (2000). In *Fred Meyer, Inc. v. Crompton*, 150 Or App 531, 536 (1997), the court explained that a consequential condition is "a separate condition that arises from the compensable injury, for example, when a worker suffers a compensable foot injury that results in an altered gait that, in turn, results in a back strain." On the other hand, if a condition arises directly from the work injury, the "material cause" standard applies. *Albany General Hospital v. Gasperino*, 113 Or App 411, 414 (1992).

On October 21, 1999, claimant was seriously injured and sustained a compensable left leg fracture and rib fractures. The first medical report referring to problems with erectile dysfunction was in Dr. Vela's March 29, 2000 chart note. (Ex. 17). Claimant was referred to Dr. Bashey, who first treated him on April 3, 2000, more than five months after the work injury. (Ex. 18). Dr. Bashey diagnosed erectile dysfunction and said he felt it was "very likely this is not completely an organic situation." (*Id.*) In a May 10, 2000 chart note, Dr. Bashey said that claimant had a history of erectile dysfunction that was "based on his long convalescence after his injury." (Ex. 22).

In a later report, Dr. Bashey concluded that claimant's injury had a "direct causal relationship" to his subsequent difficulties with erectile dysfunction. (Ex. 34-1). Nevertheless, as the ALJ noted, Dr. Bashey identified several physical factors (including immobility, pain, medication use and the task of convalescence), as well as psychological factors that caused claimant's erectile dysfunction. Moreover, Dr. Bashey's previous chart note said that claimant's dysfunction was based on his long convalescence after the injury. (Ex. 22).

We find that Dr. Bashey's reports indicate that claimant's dysfunction is a separate condition that developed secondarily as a consequence following the October 1999 injury. Despite Dr. Bashey's reference to a "direct causal relationship," we find that his reports, when read as a whole, indicate that claimant's dysfunction arose as a consequence after the injury, rather than directly from that traumatic event. We conclude that the ALJ properly applied the major contributing cause standard under ORS 656.005(7)(a)(A).

Next, claimant argues that, even if ORS 656.005(7)(a)(A) applies, Dr. Bashey's opinion is sufficient to establish compensability under a major contributing cause standard. We disagree.

A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's disability or need for treatment and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995); *see also SAIF v. Willcutt*, 160 Or App 568, 574 (1999) (applying the *Dietz* standard to consequential conditions).

Although work activities that precipitate a claimant's injury or disease may be the major contributing cause of the condition, that is not always the case. *Dietz*, 130 Or App at 401. The medical expert must take into account all contributing factors in order to determine their relative weight. *SAIF v. Strubel*, 161 Or App 516, 521 (1999).

In his initial chart note, Dr. Bashey said it was "very likely this [dysfunction] is not completely an organic situation." (Ex. 18). In his January 5, 2001 report, he explained that the etiology of erectile dysfunction is generally a mixture of physical and psychological factors. (Ex. 34-1). As explained earlier, the physical factors in claimant's case included immobility, pain, medication use and the "strenuous task of convalescence." (*Id.*) Dr. Bashey said, however, that the injury was not just physical. (*Id.*) He explained that when claimant tried to reinitiate sexual relations and had difficulty, that "created a great deal of anxiety, which further perpetuated the dysfunction." (*Id.*) In treating claimant, Dr. Bashey said he focused on solving the problem rather than identifying a specific causal factor. (Ex. 34-1, -2). He commented that "it is unhelpful to try and relegate weighted importance to each factor." (Ex. 34-1).

Our findings must be based on medical evidence in the record and the reasonable inferences that can be drawn from the medical evidence. *SAIF v. Calder*, 157 Or App 224, 227-28 (1998). In assessing major contributing cause, we must rely on evidence from medical experts and we cannot attempt to supply our own diagnosis. *SAIF v. Strubel*, 161 Or App 516, 520-21 (1999). In light of Dr. Bashey's comments that claimant's dysfunction was caused by psychological and physical factors, and the fact that he declined to assign particular weight to any of the factors, we are unable to determine on this record what Dr. Bashey's opinion would have been, had he evaluated the relative contribution of different causes of claimant's condition. Consequently, we agree with the ALJ that Dr. Bashey's opinion is not sufficient to establish that claimant's work injury was the major contributing cause of his erectile dysfunction.

There are no other medical opinions that support compensability. Dr. Elmgren, urologist, reviewed the medical records on behalf of SAIF. He found no evidence of a pelvic fracture or an injury to the nervous or vascular supply to affected area. (Ex. 29-1). He concluded that claimant's injury did not have an organic causal effect and he felt there may be some psychological dysfunction. (*Id.*) We agree with the ALJ that the medical evidence is insufficient to establish compensability.

ORDER

The ALJ's order dated January 31, 2001 is affirmed.

May 23, 2001 Cite as 53 Van Natta 708 (2001)

In the Matter of the Compensation of
JIMMY L. GRAZIER, Claimant
WCB Case No. 99-09893
ORDER OF ABATEMENT
Schneider, et al., Claimant Attorney
Jerry Keene, Defense Attorney

On May 8, 2001, we affirmed an Administrative Law Judge's (ALJ's) order that: (1) denied claimant's motion to reopen the record for consolidation with another case arising from a claim that he had filed with the Department regarding the noncomplying status of Mr. Swain; (2) found that claimant was not a subject worker of Swain Construction, Inc.; and (3) upheld the SAIF Corporation's denial of claimant's neck injury claim. Announcing that the parties have resolved their dispute, SAIF seeks abatement of our order to preserve our jurisdiction to consider their forthcoming settlement agreement.

Based on SAIF's representations, we withdraw our May 8, 2001 order. On receipt of the parties' proposed settlement, we will proceed with our review of their agreement. In the meantime, the parties are requested to keep us apprised of any future developments.

IT IS SO ORDERED.

In the Matter of the Compensation of
DALE A. COLLOM, Claimant
WCB Case No. 00-05360
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
Jerry Keene, Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

The self-insured employer requests review of Administrative Law Judge (ALJ) Howell's order that set aside its denial of claimant's occupational disease claim for a right carpal tunnel syndrome condition. On review, the issue is compensability.

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

The ALJ relied on the opinion of Dr. Jewell, a consulting hand surgeon, and concluded that claimant had established the compensability of his right carpal tunnel syndrome condition.

On review, the employer contends that Dr. Jewell's opinion is not persuasive. Additionally, the employer asserts that the opinion of Dr. Schilperoort, as supported by Dr. Wilson (the attending physician), persuasively established that claimant's work activities were not the type to cause carpal tunnel syndrome. Consequently, the employer argues that claimant has failed to establish the compensability of his carpal tunnel syndrome condition.

Claimant seeks to establish the compensability of his right carpal tunnel syndrome condition as an occupational disease. Therefore, he must prove that his work activities are the major contributing cause of the disease. ORS 656.802(2)(a). To satisfy the "major contributing cause" standard, claimant must establish that her work activities contributed more to the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's disease and deciding which is the primary cause. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

Because of the possible alternative causes for his bilateral carpal tunnel syndrome condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967). When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). In evaluating medical opinions, we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983).

All three doctors (Jewell, Schilperoort, and Wilson) agree that claimant has mild carpal tunnel syndrome.[1] (Ex. 46-5; 48; 51-2). Their opinions differ, however, as to the cause of claimant's condition. In particular, the differences in their opinions rests on their perceptions of the mechanics claimant used to perform his work duties. Consequently, before we can determine which medical opinion is persuasive, we first review how claimant performed his work duties.

Claimant worked as a materials handler for about a year and a half. (Tr. 4). One portion of that job consisted of unloading five pallets, each containing about 36 boxes. (Tr. 6). The boxes ranged in weight from 35 to 50 pounds. Each box had two bands, going in opposite directions, around the outside. (*Id.*) Claimant would unload from zero to three such loads per week. (*Id.*) To move a box, claimant would normally use two hands to grab one of the bands. (*Id.*) Claimant performed this maneuver with his "wrists bent down, so the fingers faced down," bending his fingers to grab the bands. (Tr. 7).

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[1] The employer contends that: (1) a portion of claimant's medical problem is due to a preexisting ulnar neuropathy; and (2) because Dr. Jewell was under the mistaken assumption that the ulnar nerve problem resolved in 1997, his opinion is not persuasive. We note, however, that Dr. Schilperoort found "no evidence of ulnar neuropathy" during his examination in June 2000. (Ex. 46-7). Additionally, we note that neither Dr. Schilperoort nor Dr. Wilson specifically attributed a portion of claimant's current problem to ulnar neuropathy. Consequently, even if we assume that Dr. Jewell was incorrect in his assumption that the ulnar neuropathy resolved in 1997, there is no medical opinion in this record that supports a conclusion that claimant's current medical problem is anything other than carpal tunnel syndrome.

Another portion of claimant's job consisted of pulling parts for the assembly line. (*Id.*) To perform this portion of the job, claimant would reach into a bin, mostly with his right hand, and bend his wrist and fingers to grasp an object. (Tr. 7-8). Approximately 50 percent of claimant's work was "pulling parts." (Tr. 8).

When claimant was not unloading pallets or "pulling parts" he was entering inventory data into a computer using a keyboard. (*Id.*) This job function was also performed with bent fingers. (*Id.*)

Claimant's credible testimony regarding how he performed his job duties was not challenged.[2] Consequently, we are persuaded that claimant's job duties involved repetitive-type hand and arm motions, in large part, with his wrists and fingers flexed. Having determined how claimant's job duties were performed, we now examine the varying medical opinions to determine, which doctor, if any, correctly understood the nature of claimant's work.

Of the three doctors rendering opinions on the cause of claimant's carpal tunnel condition, only Dr. Jewell understood that claimant performed his job duties with his fingers and wrists flexed.[3] (Ex. 51-3). Dr. Jewell explained that such activities place "a maximum strain on the medial nerve." (*Id.*) Consequently, Dr. Jewell opined that claimant's work activities were the major contributing cause his right carpal tunnel syndrome condition.[4] (Ex. 51-2).

Because Dr. Jewell's opinion is based upon an accurate understanding of how claimant performed his job functions, we find Dr. Jewell's opinion persuasive.[5] Consequently, we agree with the ALJ's conclusion that claimant has established the compensability of his right carpal tunnel syndrome 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, to be paid 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 January 12, 2001 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the self-insured employer.

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[2] The ALJ expressly found that claimant was credible. (O&O. 3).

[3] We realize that Dr Jewell did not actually examine claimant. However, because Dr. Jewell had an accurate understanding of claimant's work activities (Dr. Wilson did not), and because resolution of the causation involves expert analysis rather than expert external observations, we find persuasive reasons not to defer to the opinion of Dr. Wilson. *Allie v. SAIF*, 79 Or App 284 (1986); *Weiland v. SAIF*, 64 Or App 810 (1983).

[4] The employer contends that Dr. Jewell's opinion supports only a finding that claimant's work caused the need for treatment as opposed to the disease itself. Yet, as explained above, Dr. Jewell expressly identified claimant's work activities as the major cause of his right carpal tunnel syndrome condition. Although Dr. Jewell also referred to claimant's need for medical treatment, we are persuaded that Dr. Jewell related claimant's work activities to his occupational disease (carpal tunnel syndrome).

[5] The employer argues that Dr. Jewell's opinion is not sufficient to establish compensability because: (1) his opinion is expressed in possibilities, not probabilities; and (2) his opinion fails to consider other potential contributors to claimant's condition. However, Dr. Jewell expressly characterized his opinion in terms of "medical probability." (Ex. 51-3). Dr. Jewell also expressly considered potential causative factors prior to rendering his opinion. (*Id.*) Consequently, we reject the employer's argument.

In the Matter of the Compensation of
ROBERT A. DWYER, Claimant
WCB Case No. 00-06900
ORDER ON REVIEW
Swanson, Lathen, et al., Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that declined to authorize an offset of allegedly overpaid temporary disability compensation. Claimant cross-requests review of that portion of the order that affirmed an Order on Reconsideration that awarded 39 percent (125.8 degrees) unscheduled permanent disability for claimant's low back and bowel conditions. On review, the issues are extent of unscheduled permanent disability and offset. 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 and affirm the ALJ's "Conclusions of Law and Opinion" regarding this issue (through the first full paragraph on page 6).

Offset

The ALJ declined to authorize an offset of $1,694.48, the amount of an alleged 1993 overpayment under a prior claim. Considering the passage of time, the ALJ found the evidence insufficient to establish a current overpayment. We conclude that SAIF has established entitlement to offset the claimed $1,694.48 overpayment, based on the following reasoning.

An ALJ may authorize an offset for overpaid temporary disability benefits if the carrier establishes its entitlement to a particular amount of overpayment by a preponderance of the evidence. *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 248 (1988). Absent rebuttal evidence, entitlement to offset is established by evidence that: (1) shows how the payments of compensation were made; and (2) sets forth the method of calculating the claimed overpayment. *See Allen L. Frink*, 42 Van Natta 2666 (1990). Such evidence includes a carrier's audit letter stating that the claimant had been overpaid temporary disability for a certain time period and specifying the precise amount of the claimed overpayment. *See Ronald L. Tipton*, 48 Van Natta 2521 (1996); *Francis I. Bowman*, 45 Van Natta 500 (1993).

Here, SAIF's 1993 audit letter stated the precise amount of the claimed overpayment and detailed the time periods when claimant was overpaid temporary disability. (*See* Exs. 48, 29). Claimant has in no way rebutted the receipt of such compensation or the amount claimed as overpaid. Such circumstances warrant the approval of an offset. *See Jon S. O'Shane*, 49 Van Natta 1964 (1997).

ORDER

The ALJ's order dated January 31, 2001 is reversed in part and affirmed in part. That portion of the order that declined to authorize offset is reversed. The SAIF Corporation is authorized to offset a $1,694.48 overpayment against claimant's compensation in the manner prescribed by ORS 656.268(13)(a). The remainder of the order is affirmed.

In the Matter of the Compensation of
PAUL T. MILLIGAN, Claimant
WCB Case No. 00-09115
ORDER DENYING MOTION TO DISMISS
David L. Bussman, Defense Attorney

Claimant, *pro se*, has requested Board review of Administrative Law Judge (ALJ) Fulsher's April 11, 2001 Order of Dismissal on Reconsideration. Contending that its notice of claimant's request was untimely, the insurer has moved the Board for an order dismissing the request for review. The motion is denied.

FINDINGS OF FACT

The ALJ's order issued on April 11, 2001. On May 11, 2001, claimant's request for review of the ALJ's order was mailed to the Board. The request did not indicate whether a copy of the request had been mailed to the employer, the insurer, or their attorney.

On May 16, 2001, the insurer's counsel directed a letter to the Board, seeking dismissal of claimant's request for review. The insurer also forwarded to the Board a copy of the envelope postmarked May 11, 2001, in which its copy of claimant's request was contained.

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 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 notice be received within the statutory period. *Argonaut Insurance v. King*, 63 Or App 847, 852 (1983).

"Party" means a 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(20). In the absence of a showing of prejudice to a party, timely service of a request for review on the insurer's counsel is adequate compliance with ORS 656.295(2) and vests the Board with jurisdiction. *See Deborah J. Layton*, 46 Van Natta 436 (1994); *Allasandra O'Reilly*, 40 Van Natta 1180 (1988).

Here, the 30th day after the ALJ's April 11, 2001 order was May 11, 2001. Based on the insurer's counsel's submission of a copy of the envelope (carrying a postage date of May 11, 2001) which contained counsel's copy of claimant's request for review, we are persuaded that a copy of claimant's request for review was mailed to the insurer prior to expiration of the aforementioned 30-day period. *See Harold E. Smith*, 47 Van Natta 703 (1995). Inasmuch as no contention has been made that the employer or insurer has been prejudiced by apparently not receiving actual notice of claimant's request for review, we conclude that claimant's timely service on the insurer's counsel is adequate compliance with ORS 656.295(2).[1] Accordingly, the insurer's motion to dismiss is denied.

A hearing transcript has been ordered. On its receipt, copies will be distributed to the parties and a briefing schedule implemented. During the briefing schedule, the insurer may re-present its argument regarding claimant's submission of medical documents. Following completion of that briefing schedule, this case will be docketed for Board review.

IT IS SO ORDERED.

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[1] In reaching this conclusion, we emphasize that the insurer's counsel's *receipt* of a copy of claimant's appeal is not determinative; instead, the pivotal issue is when a copy of the request was *mailed* to the insurer's counsel. *E.g., Judy W. Louie*, 47 Van Natta 383 (1995).

In the Matter of the Compensation of
TOMMIE L. WALKER, Claimant
WCB Case No. 00-05007
ORDER ON REVIEW
Kryger, et al., Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order that upheld the SAIF Corporation's denial of his claim for traumatically induced degenerative arthritis of the left wrist. On review, the issue is compensability.

We adopt and affirm the ALJ's order, with the following correction and supplementation to address claimant's argument on review.[1]

We substitute the following for the third sentence in the second full paragraph on page 2: Dr. Vela reported that claimant could not recall a distinct injury to the left wrist; "however, he does remember falling from his chair at work some time ago, when he claims he sprained his left wrist." (Ex. 23-2). We substitute the following for the second sentence in the third paragraph: For the first time, claimant advised Dr. Gordin that he recalled an incident in which he fell from a chair at work onto his outstretched left hand.

Claimant contends on review that the cause of his left wrist degenerative condition was the fall from his chair at work. We find that claimant fell out of his chair at work on or about December 10, 1997, and that he may have used his left hand to catch himself. (Tr. 8, 9, 26). However, claimant testified that he did not have an onset of bad wrist pain immediately after that incident (Tr. 47), and he did not seek immediate medical attention. Instead, claimant did not seek treatment until December 16, 1997, when he complained to Dr. Barish of left elbow pain that was hurting in his wrist and up into his shoulder. Dr. Barish reported that there was no trauma that claimant was aware of, which supports Dr. Fuller's opinion that claimant did not suffer a traumatic injury to his left wrist in that incident sufficient to tear a ligament. Moreover, claimant admitted that he had some left hand symptoms prior to the December 1997 fall (*Id.*), which supports the opinions of Drs. Gordin, Anderson, Vela, Laycoe and Fuller that claimant had degenerative arthritis in his left wrist that preexisted the falling incident.

It is claimant's burden to prove by a preponderance of the evidence that his injury was the major contributing cause of his left wrist degenerative condition. ORS 656.266; ORS 656.005(7)(a)(B). After reviewing the record *de novo*, we agree with the ALJ that the only opinion that arguably supports compensability, that of Dr. Gordin, is insufficient to establish compensability of claimant's injury claim. *Somers v. SAIF*, 77 Or App 259, 263 (1986) (when there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information).

ORDER

The ALJ's order dated January 26, 2001 is affirmed.

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[1] Because it appears that claimant is presently unrepresented, he may wish to contact the Workers' Compensation Ombudsman, whose job it is to assist injured workers regarding workers' compensation matters:

Workers' Compensation Ombudsman
Dept. of Consumer & Business Services
350 Winter Street, NE
Salem, OR 97301
Telephone: 1-800-927-1271

In the Matter of the Compensation of
BARBARA MARTIN, Claimant
WCB Case No. 00-06489
ORDER ON REVIEW
Bottini, Bottini & Oswald, Claimant Attorney
Reinisch, MacKenzie, et al, Defense Attorney

Reviewed by Board Members Haynes, Bock, and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that upheld the insurer's denial of claimant's exposure to radioactive material. On review, the issue is compensability, and, if found compensable, penalties and attorney fees.

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

Claimant worked for the employer as a clean room technician. For about 6 to 8 months, she moved a nylon mesh bag in order to get to the materials she used to clean shelves. (Tr. 8). On January 10, 2000, while wearing ordinary gloves, claimant picked up the bag and carried it to the parts department where she removed a plastic beaker and nozzle, leaving the other items in the bag. (Tr. 9, 10). Later, an employee in the parts department informed claimant that there had been a radioactive element in the bag. (Tr. 11). Specifically, the bag contained an Alpha Clean II Ion Air Gun (a static eliminator gun) that held an ion cell containing the radioactive element Polonium 210 (NUCLECEL ion cell Model P-2021FR). (Exs. 1A, 3).

Concerned by this information, claimant brought this to the attention of the Site Manager. An investigation was conducted, which culminated in an hour-long meeting between claimant, the Site Manager, and representatives from the Safety section, including an occupational health nurse. An explanation regarding the operation of the static gun and reassurance that it was harmless was provided to claimant. (Exs. 3, 4-2). At the close of the meeting, claimant was asked if she would like to see a doctor. She said she would, and the employer set up and paid for an evaluation by Dr. Berney, an internal and occupational medicine specialist. (Exs. 1B, 3).

On January 21, 2000, Dr. Berney examined claimant. Dr. Berney reported that the ion cell had been analyzed at the employer's facility and did not emit any detectable radiation. (Ex. 1B). Dr. Berney reassured claimant that there was no evidence that the radioactive material could cause any adverse health effect. (*Id.*)

On March 1, 2000, claimant sought treatment for anxiety from Dr. Krause, who prescribed Paxil. (Ex. 3b). On April 3, 2000, claimant was treated by Dr. Silvestre for generalized anxiety, smoking and hormone replacement. (Ex. 4A).

On April 17, 2000, claimant was seen by Dr. Harris, Assistant Professor, Occupational Health Program, at Oregon Health Sciences University, concerning a possible radioactive exposure. Relying on a history that the ion cell had not been compromised, he concluded that there was extremely little risk to her future health, noting that only if the ion cell was broken or shattered would there be a potential for exposure to alpha particles. (Ex. 5a).

Claimant maintains that the facts in this case are similar to those in *K-Mart v. Evenson*, 167 Or App 46 (2000). In *Evenson*, the claimant worked as a store manager. The claimant had sores on her hands at that time. The claimant was exposed to bodily fluids when she assisted an HIV positive man in a wheelchair and she sought prophylactic treatment for HIV and hepatitis A. The court held that the claimant had sustained a compensable injury because the claimant had been exposed to life-threatening pathogens.

In *Evenson*, the court explained its holding in an earlier case, *Brown v. SAIF*, 79 Or App 205, *rev den* 303 Or 666 (1986). In Brown, the claimant had been exposed to asbestos for a two-week period. He later became concerned and sought medical advice. He was not diagnosed with asbestosis or any other condition, and no physician indicated that he needed or "required" medical treatment. The court stated:

> "[T]he decision in *Brown* merely stands for the proposition that '[t]he fact that one has *sought* medical services does not establish that one has a compensable injury.' (Citation omitted.) Instead, the statute requires that the injury *require* medical services. ORS 656.005(7)(a)." *Evenson*, 167 Or App at 51.

The court concluded in *Evenson* that the claimant's claim was compensable because the claimant had been exposed to pathogens and the physician believed that the exposure *required* testing and treatment.

We agree with the ALJ that the facts in this case are more analogous to those in *Brown* than to *Evenson*. In *Evenson*, fluid from an HIV-infected person seeped into the sores on the hands of the claimant. Moreover, at the urging of both an emergency room physician and the claimant's own treating physician, the claimant received diagnostic testing and prophylactic treatment for HIV and hepatitis A and B. In other words, the claimant was actually exposed to a harmful substance for which treatment was required.

Here, in contrast, the medical record and the scientific data established that the ion cell was intact and did not expose claimant to harmful radiation. No doctor recommended diagnostic testing or treatment. Rather, claimant was voluntarily offered medical evaluation for reassurance that she had not been exposed to harmful radiation. She voluntarily chose to accept the medical evaluation by Dr. Berney, an internal and occupational medical specialist, who reported that the ion cell had been analyzed at the employer's facility and did not emit any detectable radiation. Dr. Berney reassured claimant that there was no evidence that the radioactive material could cause any adverse health effect.

Here, as in *Brown*, the mere fact that claimant *sought* medical treatment does not establish that she sustained a compensable injury. Dr. Berney, as well as the doctors she consulted, told claimant that she was fine. No doctor advised her to seek future medical treatment, much less told her that she *required* medical treatment.

Consequently, in contrast to *Evenson*, because claimant did not *require* medical services, she has not established a compensable injury.

ORDER

The ALJ's order dated December 29, 2000 is affirmed.

Board Member Phillips Polich dissenting.

Because I believe that claimant's diagnostic medical services are compensable in this potential radioactive exposure case, I respectfully dissent.

I agree with claimant that *K-Mart v. Evenson*, 167 Or App 46 (2000), applies to make her claim for medical services compensable. In *Evenson*, the court affirmed our order finding compensable the claimant's exposure to an HIV-infected individual, which exposure eventually proved *not* to be causative of any actual illness or disease. 167 Or App at 52. The court reaffirmed the concept of compensable, diagnostic medical services by stating: "The medical services need not be directed toward the cure of any existing, identifiable disease; diagnostic or other medical services will suffice, (citing *Finch v. Stayton Canning Co.*, 93 Or App 168, 173 (1988))".

The court in *Evenson* also emphasized that the term "compensable injury," as defined in ORS 656.005(7)(a), uses the terms "requiring medical services or resulting in disability or death" in the disjunctive. In other words, a claimant need not suffer any actual disability as long as the injury or exposure requires medical services. 167 Or App at 49, 50.

I believe that the court's holding in *Evenson* can be read to modify and "loosen" its earlier holding in *Brown v. SAIF*, cited by the majority. Despite the majority's analogy to *Brown*, in *Evenson*, as here, the claimant's physicians eventually told the claimant that she was "fine" -- *i.e.*, "the test results [for HIV and Hepatitis A and B] so far have been negative." 167 Or App at 48.

I recognize that in *Evenson*, unlike here, an emergency room physician urged the claimant to come in for evaluation and prophylactic treatment. Still, I believe that claimant did not have to rely on the employer's lay opinion and assurances that the materials were not hazardous. The potential danger of such an exposure made an evaluation by a medical professional prudent. In fact, her employer offered and paid for claimant to be examined by a company doctor, Dr. Berney. (Ex. 3-2). I find it

inequitable for the carrier now to deny the necessity for claimant to obtain a second opinion from independent medical providers. The fact that the potentially radioactive material was eventually found not to be hazardous does not undermine the fact that claimant's seeking diagnostic medical treatment was entirely reasonable at the time.

Finally, I find it inequitable for the cost of claimant's medical treatment, the necessity of which originated from an on-the-job exposure, to be borne by claimant or her primary health care provider. This is the sort of medical treatment anticipated by the workers' compensation system and specifically articulated in the statute at 656.012(c): "An exclusive, statutory system of compensation will provide the best societal measure of those injuries that bear a sufficient relationship to employment to merit incorporation of their costs into the stream of commerce."

I believe that the medical treatment, and claimant's need for medical treatment, "bear a sufficient relationship to employment" to be found compensable.

Because I believe the majority fails to correctly apply the court's holding in *Evenson* to what I believe should be compensable diagnostic medical services, I respectfully dissent from that portion of the majority's order that affirms the ALJ's compensability determination.

May 25, 2001 Cite as 53 Van Natta 716 (2001)

In the Matter of the Compensation of
STEVEN D. JOHNSON, Claimant
WCB Case No. 00-09556
ORDER ON REVIEW
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Claimant, *pro se,* requests review of Administrative Law Judge (ALJ) Brazeau's order that dismissed his request for hearing on the ground that another ALJ's order had finally determined the issues raised in the present case. On review, the issue is propriety of the dismissal order.

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

ORDER

The ALJ's order dated March 6, 2001 is affirmed.[2]

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[1] We take administrative notice of ALJ Johnson's corrected order of February 21, 2001 and conclude that it does finally determine the compensability of claimant's macular degeneration condition, which was the subject of the request for hearing in this case. *See Glenn D. Oetken,* 52 Van Natta 2219 (2000) (the Board may take administrative notice of ALJ orders).

[2] We note that claimant is unrepresented. Because he is unrepresented, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in workers' compensation matters. He may contact the Workers' Compensation Ombudsman at (503) 378-3351 or 1-800-0927-1271 (V/TTY) (within the State of Oregon), or write to:

Workers' Compensation Ombudsman,
350 Winter St. NE, Room 160,
Salem, Or 97301-3878

In the Matter of the Compensation of
ROBERT E. MONTGOMERY, Claimant
Own Motion No. 66-0421M
INTERIM OWN MOTION ORDER REFERRING FOR CONSOLIDATED HEARING
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for medical services for his August 20, 1962 industrial injury. SAIF has recommended that we deny the provision of the requested medical services, contending that the "current condition is not related to the industrial injury." Because claimant's industrial injury occurred prior to 1966, the Board has jurisdiction to decide this compensability issue under ORS 656.278.

FINDINGS OF FACT

On August 20, 1962, claimant compensably injured his low back while working for SAIF's insured. As a result, he underwent a fusion at L5-S1. On August 11, 1970, claimant compensably reinjured his low back while working for a subsequent employer, who was also insured by SAIF. Since that time, claimant has had intermittent low back problems. There are no medical reports in the record prior to 1995.

In August 1995, claimant sought treatment for increasing leg and back pain. Dr. Bert, claimant's attending physician, diagnosed lumbar spondylosis and recommended an exercise program as well as medications. SAIF submitted an Own Motion recommendation to reopen claimant's 1962 claim for the provision of compensable medical services and to provide these medical services "until these services are no longer required."

On November 16, 1995, we issued an Own Motion Order, which reopened claimant's 1962 claim for the provision of compensable medical services. Our November 1995 order also provided that after those services were provided, SAIF shall close the claim pursuant to OAR 438-012-0055. The record does not demonstrate that the claim has been closed.

On August 30, 2000, Dr. Bert reported that, after the 1962 injury, resulting fusion, and the 1970 injury, claimant had slowly developed spinal stenosis. Dr. Bert opined that claimant's current spinal stenosis was a degenerative condition and while partially related to the fusion claimant underwent as a result of his 1962 work-related injury, it was primarily progressive and degenerative in nature. He stated that it was a combined condition. He also explained that persons with a lumbar fusion would have some progressive deterioration above or below the fusion with time and he thought that this was a factor in claimant's condition. However, he stated that it was impossible to "state the exact percentage contribution of the fusion to the degenerative spondylosis and spinal stenosis."

On December 11, 2000, Dr. Bert noted that claimant had rather severe stenosis and recommended decompression surgery at L1-L3. *See also* Dr. Bert's response dated January 31, 2001.

On December 22, 2000, SAIF submitted an Own Motion recommendation to deny reopening of claimant's 1962 claim for the provision of recommended medical services on the basis that his current condition was degenerative in nature and that his 1962 compensable injury was not the major contributing cause of his current need for treatment. In response, claimant argues that the 1962 compensable condition does not have to be the major contributing cause for his need for surgery, but rather it only has to bear a material relationship to his current need for treatment.

Claimant submitted two medical reports from Dr. Bert. On January 17, 2001, Dr. Bert responded to claimant's attorney's inquiries about the contribution of the 1962 and 1970 work injuries to claimant's current back condition. Dr. Bert stated that: (1) no degenerative disease existed prior to claimant's 1962 incident; (2) claimant's current level of degenerative disease is "extensive and severe"; (3) to a reasonable medical probability, the major contributing cause of the degenerative disease is claimant's "prior injury;" (4) aging was a considerable influence on claimant's degenerative disease; and (5) the 1962 work injury was not the major cause of a pathological worsening of any preexisting degenerative disease but was "the major cause for [claimant's] need for treatment at that time." Dr. Bert also agreed that: (1) the 1970 work injury was the major contributing cause of a pathological worsening of any preexisting degenerative disease in claimant's back; and (2) the 1970 injury was the "major contributing cause of the consequential combined condition and of the need for treatment."

On January 31, 2001, in response to further questions from claimant's attorney, Dr. Bert reiterated that he could not separate, "on a strict percentage basis," the amount of contribution the 1962 and 1970 work-related injuries had to claimant's current need for treatment, but that the degeneration over time was also a "significant factor" to his current need for surgery. Dr. Bert also agreed that the proposed surgery is "reasonable and necessary and related to [claimant's] 1962 injury."

On March 5, 2001, the Board requested additional information from SAIF regarding, in part, what conditions were accepted under the 1962 and 1970 claims. Claimant was provided the opportunity to respond. By letter dated March 21, 2001, SAIF responded that it had no description of the accepted conditions in the 1962 or 1970 claims. Claimant did not respond.

CONCLUSIONS OF LAW AND OPINION

Claimant sustained two work-related low back injuries, an injury in 1962 that resulted in a fusion at L5-S1, and a second injury in August 1970. Regarding the 1970 compensable injury, claimant has a lifetime right to medical benefits pursuant to ORS 656.245.[1] Thus, we do not have jurisdiction in our Own Motion authority over any medical service issue regarding the 1970 compensable injury.

On the other hand, because the compensable 1962 injury occurred before January 1, 1966, claimant does not have a lifetime right to medical benefits regarding that injury pursuant to ORS 656.245. *William A. Newell*, 35 Van Natta 629 (1983). Instead, we may exercise our Own Motion authority to authorize medical services for compensable injuries occurring before January 1, 1966. ORS 656.278(1)(b);[2] *Carl M. Price*, 46 Van Natta 514 (1994), *aff'd mem*, 132 Or App 376 (1995). No worsening of the pre-1966 injury is required for such authorization. *Gerald S. Gaage*, 42 Van Natta 2722 (1990); *Donald B. Karstetter*, 42 Van Natta 156 (1990).

Claimant has filed a claim with SAIF regarding the accepted August 11, 1970 back injury claim. SAIF denied that claim and claimant requested a hearing regarding that denial. WCB Case No. 01-03527.

Under these circumstances, we conclude that it would be in the best interest of the parties to consolidate this Own Motion matter with the pending litigation in WCB Case No. 01-03527. *Robert E. Morris*, 51 Van Natta 138 (1999).

At the scheduled hearing, the parties may present their arguments and any supporting evidence regarding whether claimant's current condition is compensable and, if so, whether SAIF is responsible under the 1962 or 1970 claim. The parties should also address the question of whether claimant's medical services claim for the current condition under the 1962 claim is subject to a material or major contribution cause standard. *See Beck v. James River Corp.*, 124 Or App 484, 487 (1993), *rev den* 318 Or 478 (1994); *Fred Meyer Inc. v. Crompton*, 150 Or App 531 (1997); *Edward T. Rothauge*, 52 Van Natta 648, 52 Van Natta 2016 (2000); *Ivan J. Cvarak*, 48 Van Natta 2367, 2368 fn2 (1996).

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[1] ORS 656.245(1)(a) provides, in relevant part:

"For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions caused in material part by the injury for such period as the nature of the injury or the process of the recovery requires * * *. In addition, for consequential and combined conditions described in ORS 656.005(7), the insurer or the self-insured employer shall cause to be provided only those medical services directed to medical conditions caused in major part by the injury."

[2] ORS 656.278(1)(b) provides:

"(1) Except as provided in subsection (6) of this section, the power and jurisdiction of the Workers' Compensation Board shall be continuing, and it may, upon its own motion, from time to time modify, change or terminate former findings, orders or awards if in its opinion such action is justified in those cases in which:

"* * * * *

"(b) The date of injury is earlier than January 1, 1966. In such cases, in addition to the payment of temporary disability compensation, the board may authorize payment of medical benefits."

At the conclusion of the hearing, the ALJ shall forward to the Board a separate, unappealable recommendation with respect to the Own Motion matter and a copy of the appealable order issued in WCB Case No. 01-03527. After issuance of the order, the parties should advise the Board of their respective positions regarding Own Motion relief.

IT IS SO ORDERED.

May 29, 2001 Cite as 53 Van Natta 719 (2001)

In the Matter of the Compensation of
DEBBIE ADAMS, Claimant
Own Motion No. 00-0204M
OWN MOTION ORDER OF DISMISSAL
Cole, Cary, et al, Claimant Attorney

On June 16, 2000, we referred claimant's request for temporary disability compensation for her low back condition to the Hearings Division. We took this action because litigation concerning the compensability of her current condition was pending before the Hearings Division. (WCB Case No. 00-04484).

On April 27, 2001, we approved the parties' Claim Disposition Agreement (CDA), in which claimant released all rights to "non-medical service" benefits (including Own Motion benefits under ORS 656.278) under this 1993 claim.[1] Inasmuch as the CDA resolves all pending Own Motion matters, we withdraw our June 16, 2000 order. Claimant's request for Own Motion relief is dismissed.

IT IS SO ORDERED.

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[1] We also note that on April 18, 2001, an Administrative Law Judge approved a "Disputed Claim Settlement," which resolved the parties' dispute concerning the compensability of claimant's current low back condition, which was pending before the Hearings Division. Pursuant to that settlement, claimant agreed that the self-insured employer's June 5, 2000 and November 13, 2000 denials would remain in full force and effect. In addition, claimant stipulated that his request for hearing "shall be dismissed with prejudice" and that the settlement resolved "all issues raised or raisable."

In light of the parties' settlement, the current condition for which claimant requests Own Motion relief remains in denied status. Consequently, even if claimant had not released her Own Motion rights through the CDA, we would still not be authorized to reopen claimant's 1993 injury claim with the employer as she is not entitled to temporary disability compensation.

In the Matter of the Compensation of
DANIEL B. PROUD, JR., Claimant
WCB Case No. 00-07133
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorney
Scheminske, et al, Defense Attorney

Reviewed by Board Members Biehl and Meyers.

The insurer requests review of Administrative Law Judge (ALJ) Black's order that: (1) declined to dismiss claimant's request for hearing for lack of jurisdiction; and (2) set aside the insurer's denial of claimant's request for surgery. In his respondent's brief, claimant seeks "administrative notice" of a "post-hearing" Notice of Closure and Order on Reconsideration. In its reply brief, the insurer challenges claimant's "administrative notice" request.[1] On review, the issues are administrative notice, jurisdiction and compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

We begin with a brief summary of the procedural posture of this case. Claimant sustained a compensable right knee injury on January 28, 1999. The insurer accepted the following disabling right knee conditions: Knee strain, anterior cruciate ligament (ACL) insufficiency, and lateral meniscus tear. (Exs. 1 through 5). On May 11, 1999, Dr. Zirschky reconstructed the ACL and repaired the lateral meniscus.

On April 4, 2000, the insurer partially denied claimant's ACL insufficiency condition. The denial also stated that the insurer continued to accept, among other conditions, claimant's knee strain and lateral meniscus tear. (Ex. 10). Claimant did not challenge the partial denial, which became final.

On May 1, 2000, claimant returned to Dr. Zirschky with complaints of right knee swelling and pain. (Ex. 12). Dr. Zirschky reviewed an MRI taken on May 4, 2000, and concluded that there were some changes in the posterior horn consistent with possible meniscus healing and noted areas that might indicate that pieces of the absorbable arrows used in the meniscal surgery were floating in the joint. (Ex. 14). On May 17, 2000, Dr. Zirschky requested authorization from the insurer for arthroscopic surgery to evaluate the loose bodies. This request was accompanied by copies of the recent chart note and MRI. (Ex. 14A).

The insurer made no response to the request for authorization. On September 20, 2000, claimant requested a hearing concerning the insurer's "de facto" denial of his claim for medical services related to the compensable knee injury; *i.e.*, its failure to respond to his request for surgery.

The insurer moved to dismiss the hearing for lack of jurisdiction. The insurer argued that the Hearings Division lacked jurisdiction to decide whether the medical services were compensable because its partial denial of claimant's torn ACL was not contested and became final by operation of law. Alternatively, citing *Earl F. Goodmanson*, 52 Van Natta 1347 (2000), the insurer argued that an express denial of the compensability of the contested medical service was required under ORS 656.704(3)(b)(C). Finally, the insurer asserted that claimant should have filed a request for administrative review of the medical services dispute with the Director, and, if an issue concerning a claim then arose, should then have requested the Director to transfer the case to the Hearings Division.

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[1] Because we conclude that the admission of the "post-hearing" Notice of Closure and Order on Reconsideration will not alter our ultimate decision, we need not address claimant's "administrative notice" request.

The ALJ concluded that the insurer's failure to respond to a request for authorization of medical services beyond the 90-day period for acceptance or denial of a claim resulted in a *de facto* denial of medical services for an accepted condition, which conferred jurisdiction on the Hearings Division under ORS 656.704(3)(b)(C). The ALJ also concluded that the holding in *Goodmanson* did not require an express denial under ORS 656.704. The ALJ denied the insurer's motion to dismiss for lack of jurisdiction and concluded that the medical evidence was sufficient to establish that claimant's need for surgery was caused in material part by the compensable January 28, 1999 meniscus tear.

On review, the insurer raises the same arguments; *viz.*, that claimant is precluded from relitigating compensability of the denied right knee condition, and that the Hearings Division has no jurisdiction because there was no express denial of compensability of the contested medical service.[2] We agree with the ALJ that the Hearings Division has jurisdiction over the dispute, but for the following reasons.

Insofar as the insurer is arguing that the Hearing Division's (and the Board's) jurisdiction over the medical services claim is limited to causation disputes, we agree. *See* ORS 656.704(3); *Vicki L. Mangum*, 52 Van Natta 1006 (2000). Thus, if the insurer conceded the causal relationship of claimant's medical services claim concerning his accepted condition, the Hearing's Division would be without jurisdiction over the medical services dispute; *i.e.*, there would be no causation dispute to resolve. ORS 656.704(3).

However, the insurer did not concede causation. Instead, it contended that claimant was precluded from relitigating compensability issues concerning the right knee. We have previously held that a preclusion argument is, in effect, an express denial. *See Michelle R. Wood*, 50 Van Natta 890 (1998); *John R. Syron*, 48 Van Natta 2091 (1996).

In *Wood*, the carrier at hearing argued that the claimant was precluded from relitigating compensability issues concerning her right shoulder. Although the carrier on review conceded that the conditions in question were part of the claimant's accepted condition and thus compensable, we concluded that the carrier's preclusion argument at hearing was an express assertion that the conditions in question were not compensable. Because the claimant prevailed over that denial, we held that she was entitled to an attorney fee under ORS 656.386(1).

Likewise, in *Syron*, the carrier contended that its notice of acceptance included the claimant's herniated disc. Alternatively, the carrier argued that the claimant was barred by claim preclusion from seeking modification of the notice of acceptance. We concluded that the carrier's claim preclusion argument at hearing constituted an express assertion that the disc condition was not compensable or otherwise did not give rise to an entitlement to compensation. We found that the requirements for an attorney fee under ORS 656.386(1) had been met.

We reach the same conclusion in this case. If successful, the insurer's preclusion argument would have prevented claimant from receiving medical services for his current right knee condition on the basis that it was not compensable. As in *Wood* and *Syron*, we conclude that claimant's medical services claim was expressly "denied" by the insurer.[3] Thus, the parties' dispute either required a

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[2] The insurer also asserts that the only statutory provisions regarding a *de facto* denial appear in ORS 656.262(6)(d) and (7)(a), which are inapplicable here. Because claimant requested medical services for an accepted condition, we agree that ORS 656.262(6)(d) (request for acceptance of an omitted medical condition) and ORS 656.262(7)(a) (request for acceptance of a new medical condition) are inapplicable in this case.

[3] The insurer contends that *Goodmanson* holds that an express denial of a claimant's request for medical services must be issued before jurisdiction attaches. Although we have concluded that the insurer in this case has expressly denied claimant's medical service request, we agree with the ALJ that *Goodmanson* does not hold that an express denial of a claimant's request for medical services is *required* before jurisdiction attaches.

In *Goodmanson*, the carrier issued a current condition denial after receiving medical services requests from the claimant's physicians. We concluded that ORS 656.382(1) and ORS 656.704(3)(b)(A) conferred jurisdiction over the dispute because the carrier had expressly denied the claimant's current condition on the basis of causation. Because the carrier had issued an express denial of the compensability of the claimant's current condition, we had no need to consider whether an express denial was required under the statute to confer jurisdiction.

determination of the compensability of a medical condition for which medical services were proposed or required a determination of whether a sufficient causal relationship existed between medical services and an accepted claim to establish compensability. Under such circumstances, we conclude that the Hearings Division has jurisdiction over this dispute. ORS 656.704(3)(b)(A) and (C).[4]

Causal Relationship

We adopt and affirm the ALJ's opinion on this issue.

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 issues, and the value of the interest involved.

ORDER

The ALJ's order dated January 18, 2001 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500, to be paid by the insurer.

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[4] ORS 656.704(3)(b) provides:

"The respective authority of the board and the director to resolve medical service disputes, other than disputes arising under ORS 656.260 [inapplicable here], shall be determined according to the following principles:

"(A) Any dispute that requires a determination of the compensability of the medical condition for which medical services are proposed is a matter concerning a claim.

"(B) Any dispute that requires a determination of whether medical services are excessive, inappropriate, ineffectual or in violation of the rules regarding the performance of medical services, or a determination of whether medical services for an accepted condition qualify as compensable medical services among those listed in ORS 656.245(1)(c), is not a matter concerning a claim.

"(C) Any dispute that requires a determination of whether a sufficient causal relationship exists between medical services and an accepted claim to establish compensability is a matter concerning a claim.

May 25, 2001 Cite as 53 Van Natta 722 (2001)

In the Matter of the Compensation of
BECKY J. McTAGGART, Claimant
WCB Case No. 98-01802
ORDER OF ABATEMENT
Holly Somers, Claimant Attorney
Reinisch, et al, Defense Attorney

On April 26, 2001, we issued an Order on Remand that reversed an Administrative Law Judge's (ALJ's) order that had upheld the insurer's denial of claimant's injury claim. Stating that the insurer's motion for reconsideration of the court's attorney fee award (which preceded our April 26, 2001 order) is currently pending, claimant seeks abatement of our order until the court resolves the insurer's motion.

Based on claimant's representation, we withdraw our April 26, 2001 order. In addition, to assist us in considering this matter, the following supplemental briefing schedule is implemented. The insurer's response must be filed within 21 days from the date of this order. Claimant's reply must be filed within 21 days from the date of mailing of the insurer's response. Thereafter, we will take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
DONICA J. FIELDS-ADDY, Claimant
WCB Case No. 00-05721
ORDER ON REVIEW
J. Michael Casey, Claimant Attorney
Jacqueline A. Weber, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that upheld the self-insured employer's denials of claimant's consequential condition and aggravation claims for low back conditions. On review, the issues are compensability and aggravation.

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

In October 1997, claimant compensably injured her low back when she fell descending a flight of stairs and fractured her coccyx. (Tr. 17; Ex. 1). In February 1998, the claim was initially accepted as a disabling "coccyx fracture." (Ex. 14). In May 1999, the acceptance was amended to include "sacroiliac strain (left)." (Ex. 45).

Following the May 1999 acceptance of sacroiliac strain, the claim was closed without an award of permanent disability. In September 1999, an Order on Reconsideration affirmed the May 1999 Notice of Closure.[1] (Ex. 49).

Following an increase in claimant's ongoing low back pain in March and April 2000, Dr. Satyanarayan, the attending physician, authorized time loss from May 1, 2000, through July 14, 2000. (Exs. 60; 62; 65; 71; 73). In June 2000, the employer denied claimant's aggravation claim. (Ex. 75).

In September 2000, claimant was seen by Dr. Tahir, a consulting neurosurgeon, who diagnosed claimant's current condition as "subtrochanteric bursitis on the left side." (Ex. 87-2). In December 2000, the employer denied the subtrochanteric bursitis as a consequential condition of the previously accepted coccyx fracture and sacroiliac strain. (Ex. 94).

The ALJ determined that claimant had failed to establish an actual worsening of her accepted coccyx fracture and sacroiliac strain. The ALJ also determined that claimant had failed to establish subtrochanteric bursitis as a consequential condition of the 1997 work injury. Consequently, the ALJ upheld both of the employer's denials.

Claimant contends that the opinion of Dr. Satyanarayan persuasively established that claimant's accepted conditions (coccyx fracture and sacroiliac strain) had worsened. In the alternative, claimant contends that Dr. Satyanarayan's opinion persuasively established that claimant's current condition (subtrochanteric bursitis) is a consequential condition of the accepted coccyx fracture and sacroiliac strain. We disagree with both of claimant's assertions.

In order to establish her subtrochanteric bursitis condition as a "consequential" condition of her compensable injury, claimant must prove that the compensable injury is the major contributing cause of the subtrochanteric bursitis condition. ORS 656.005(7)(a)(A); *Albany General Hospital v. Gasperino*, 113 Or App 411, 415 (1992). To satisfy the "major contributing cause" standard, claimant must establish that her work injury contributed more to the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983).

A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's disease and deciding which is the primary cause. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). Because of the possible alternative causes for her current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

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[1] Claimant requested a hearing challenging the Order on Reconsideration. In April 2000, a prior ALJ's order affirmed the September 1999 Order on Reconsideration. (Ex. 54). In August 2000, the Board affirmed the prior ALJ's order. (Ex. 81).

Dr. Tahir, the consulting neurosurgeon who initially diagnosed claimant's subtrochanteric bursitis condition, implied that claimant's weight was the cause of that condition.[2] (Ex. 87-2). Although Dr. Satyanarayan explained how claimant's accepted sacroiliac strain would result in an inflammation of the bursa in the trochanter region, he did not expressly opine that the major cause of claimant's subtrochanteric bursitis condition was her 1997 compensable injury.[3] Even if we assume that his explanation represents such an opinion, that opinion (in light of Dr. Tahir's opinion) would not be persuasive because Dr. Satyanarayan offers no evaluation of the relative contribution of claimant's weight in producing the subtrochanteric bursitis.[4] *Dietz*, 130 Or App at 402. Consequently, we conclude that, based on this record, claimant has failed to establish the compensability of her subtrochanteric bursitis condition as a consequence of her compensable sacroiliac strain injury.

To establish a compensable aggravation claim, claimant must prove an "actual worsening" of her compensable condition since the last arrangement of compensation. ORS 656.273(1). Evidence of a symptomatic worsening may prove an aggravation claim if, but only if, a physician concludes, based on objective findings (which may incorporate claimant's symptoms) that the underlying condition has worsened. *SAIF v. Walker*, 330 Or 102, 118-119 (2000); *Edward M. January*, 52 Van Natta 1363 (2000); *Norma L. Lamerson*, 52 Van Natta 1086 (2000).

Here, claimant relies on the opinion of Dr. Satyanarayan to establish a worsening of her compensable condition. Although Dr. Satyanarayan indicated that claimant's pain from the accepted sacroiliac strain had worsened, he was not able to opine that claimant's sacroiliac strain itself had worsened. (Ex. 55-26; 55-53; 55-54). Consequently, we are unable to conclude that Dr. Satyanarayan believed that claimant's symptomatic worsening represented an actual worsening of the underlying sacroiliac strain.[5] *January*, 52 Van Natta at 1363. Under such circumstances, we agree with the ALJ that claimant has failed to establish an actual worsening of her accepted condition.

ORDER

The ALJ's order dated February 12, 2001 is affirmed.

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[2] Dr. Tahir wrote: "Patient is advised further that she has not been suffering from any herniation of a disc or any sciatica. The only reason for the pain is the bursitis, * * *, but the problem is that she will have to lose some weight." (Ex. 87-2).

[3] Dr. Satyanarayan stated: "[W]hen the sacroiliac joint is sprained, the gluteal muscles, which are the muscles that support in that region, tend to set up on a cycle where it gets weaker, more disuse sets in. That, in turn, puts more stress on the tendon attachment to the trochanteric region, and the bursa gets inflamed because of the improper functioning of the whole muscle complex." (Ex. 55-38).

[4] In concluding that Dr. Satyanarayan's opinion is not persuasive, we have assumed that claimant has subtrochanteric bursitis. Consequently, we need not address claimant's challenge to the opinions of Drs. Jones and Pierson (that claimant does not have subtrochanteric bursitis).

[5] Because of this conclusion, we need not address claimant's challenge to the opinions of Drs. Jones and Pierson.

In the Matter of the Compensation of
JIM A. DOWELL, Claimant
WCB Case No. 00-04032
ORDER ON REVIEW
Westmoreland & Mundorff, Claimant Attorney
Atwood & Associates, Defense Attorney

Reviewed by Board Members Biehl and Meyers.

The insurer requests review of Administrative Law Judge (ALJ) Kekauoha's order that set aside its denial of claimant's claim for a current low back condition. On review, the issue is compensability.

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

The insurer argues that the opinion of Dr. Jenkins, treating surgeon, is not supported by objective findings. However, upon physical examination, Dr. Jenkins recorded objective findings, including "mild tenderness to palpation of [claimant's] spine, and his buttocks on the left side." He noted that claimant's range of motion was very limited "in all directions." (Ex. 14-2). These findings, including intermittent left buttock and leg pain, persisted following the work injury, until after claimant's surgery. (*See* Exs. 2, 3, 4, 7, 9, 11, 16, 17, 18, 47-14, 48-21).

Accordingly, on this record (and considering Dr. Jenkins' reasoning in context), we conclude that claimant's claim is established by medical evidence supported by objective findings as required by ORS 656.005(7)(a) and 656.005(19).

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 February 15, 2001 is affirmed. For services on review, claimant is awarded a $1,500 attorney fee, payable by the insurer.

In the Matter of the Compensation of
JAMES W. JORDAN, Claimant
Own Motion No. 00-0051M
OWN MOTION ORDER
Schneider, et al, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation requests authorization to suspend payment of claimant's temporary disability pursuant to OAR 438-012-0035(5) for failure to follow his doctor's instructions. Based on the following reasoning, we grant SAIF's request.

FINDINGS OF FACT

On March 14, 1986, claimant sustained compensable bilateral knee injuries. His aggravation rights regarding that claim expired on May 21, 1992. On February 18, 2000, we issued an Own Motion Order authorizing SAIF to reopen claimant's claim to provide temporary disability benefits beginning the date he underwent proposed surgery.

Claimant underwent a left knee anterior cruciate ligament (ACL) reconstruction on February 7, 2000, and a right knee ACL reconstruction on June 12, 2000. SAIF has paid temporary disability benefits from February 7, 2000.

On October 11, 2000, Dr. Edelson, claimant's treating physician, declared claimant's left knee medically stationary. He prescribed physical therapy for the right knee. Claimant was to attend eight physical therapy sessions between October 27, 2000 and November 27, 2000, representing about two visits per week. On October 27, 2000, claimant attended his initial appointment with Mr. Nelson, physical therapist, who indicated that there were no contraindications for treatment and that claimant's rehabilitation potential was "good." Claimant attended physical therapy sessions on November 2, November 3, and November 10, 2000.

On November 12, 2000, claimant underwent a left knee arthroscopy that was due to an acute infection caused by claimant's intravenous heroin use. (Dr. Tongue, M.D., November 12, 2000 operative report, Dr. Edelson's January 5, 2001 letter). That same date, claimant was referred to Dr. Morita, M.D., for medical evaluation and management of narcotic withdrawal. Dr. Morita provided a treatment plan for narcotic withdrawal that involved a tapering dose of methadone.

Claimant did not attend his scheduled November 28, 2000 physical therapy appointment. Claimant also failed to attend a scheduled December 19, 2000 appointment with Dr. Edelson.

By letter dated January 5, 2001, Dr. Edelson informed SAIF that claimant did not attend the December 19, 2000 appointment. Dr. Edelson stated that, if claimant did not return for an appointment, he would consider him medically stationary.

On January 5, 2001, SAIF notified claimant that it had rescheduled an appointment with Dr. Edelson on February 13, 2001, and that claimant was required to attend that appointment or face suspension of temporary disability benefits. Claimant attended the February 13 appointment.

In his February 13, 2001 chart note, Dr. Edelson noted that claimant was doing well with strengthening and range of motion until he was hospitalized for an "I & D of his left knee" and experienced a recurrence of bilateral knee discomfort. Dr. Edelson stated that claimant "has been unable to attend physical therapy consistently secondary to scheduling." He stated that claimant still needed to work on physical therapy for bilateral quadriceps weakness. Dr. Edelson reinstated physical therapy over the next four weeks.

On February 22, 2001, claimant returned to Mr. Nelson for physical therapy. Again, Mr. Nelson indicated that there were no contraindications for treatment and that claimant's rehabilitation potential was "good." Claimant was scheduled for two physical therapy sessions per week for four weeks. A physical therapy session was rescheduled from February 28, 2001 to March 1, 2001. Claimant did not attend the March 1, 2001 appointment.

On March 8, 2001, SAIF notified claimant that he had a scheduled appointment with Dr. Edelson on April 3, 2001, and that claimant was required to attend that appointment or face suspension of temporary disability benefits.

On March 15, 2001, SAIF requested that the Board suspend claimant's temporary disability benefits under OAR 438-012-0035(5) for failure to actively participate in treatment prescribed to promote recovery from the bilateral ACL reconstruction surgeries. This motion noted that claimant had failed to attend the December 19, 2000 appointment with Dr. Edelson and had failed to attend several physical therapy appointments. The motion was sent by certified mail to claimant and his attorney.

On March 20, 2001, claimant attended a physical therapy session with Mr. Nelson. Claimant reported that "he had to be out of town the last few weeks and has been unable to come to [physical therapy]." Claimant attended physical therapy on March 23, March 26, and April 2, 2001. In his April 2, 2001 note, Mr. Nelson noted that claimant had been seen for "6 visits"[1] and had a recent flare up to his right knee, with increased swelling and symptoms. Mr. Nelson advised claimant to follow up with Dr. Edelson to determine a continued treatment plan.

On April 3, 2001, claimant treated with Dr. Edelson, who stated that claimant had noted increased swelling and pain in the medial compartment of the right knee over the last two weeks. Dr. Edelson noted that "[p]hysical therapy has not helped, and because of discomfort, [claimant] stopped the therapy." After examination, Dr. Edelson noted that claimant's right knee was not medically stationary. He requested a MRI scan to rule out "meniscal tear vs osteochondral defect." He noted that, after the MRI was completed, claimant was to return and to discuss the findings and treatment options.

An MRI was performed on April 5, 2001. On April 10, 2001, claimant received physical therapy from Mr. Cruz, who noted that claimant reported that his doctor feels that he may require additional surgery and that he would undergo another MRI "next Tuesday."

CONCLUSIONS OF LAW AND OPINION

SAIF requests that we suspend claimant's temporary disability benefits pursuant to OAR 438-012-0035(5) for his failure to follow his doctor's instructions. If an own motion insurer believes that temporary disability compensation should be suspended for any reason, the insurer may make a written request for such suspension. *See* OAR 438-012-0035(5). The insurer shall not suspend compensation without prior written authorization by the Board. *Id.*

Here, the issue is whether we may authorize suspension of temporary disability benefits in an open Own Motion claim for claimant's failure to follow his treating doctor's instructions to attend a follow up medical appointment and physical therapy appointments. Our decision in *Glen A. Carr*, 52 Van Natta 1405 (2000), is instructive in resolving this issue.

In *Carr*, we held that, under OAR 438-012-0035(5), we may authorize suspension of payment of a claimant's temporary disability for failure to seek medical treatment. In reaching that conclusion, we found instructive ORS 656.012(2)(c), which states that an objective of the Workers' Compensation Law is "[t]o restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable." We found that requiring workers whose claims were reopened under ORS 656.278 to seek regular medical care promoted the legislative objective of restoring an injured worker physically and economically to a self-sufficient status as soon as possible and to the greatest extent practicable. ORS 656.012(2)(c). Therefore, although finding that neither ORS 656.278 nor the Board's Own Motion rules allowed *unilateral* termination of temporary disability benefits or *claim closure* for failure to seek medical treatment, we held that we were authorized under OAR 438-012-0035(5) to suspend temporary disability benefits for such failure under the appropriate circumstances.

In *Carr*, finding that the claimant had not sought medical treatment for over five months (without a reasonable explanation), we determined that suspension of temporary disability benefits was appropriate under OAR 438-012-0035(5). The present case presents a logical extension of the reasoning used in *Carr*. In other words, requiring workers whose claims have been reopened under ORS 656.278 to follow their treating doctors' instructions also promotes the legislative objective of restoring injured workers physically and economically to a self-sufficient status as soon as possible and to the greatest extent practicable. ORS 656.012(2)(c).

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[1] On the record submitted by the parties, we find evidence of only five visits during the second series of physical therapy treatments: February 22, March 20, March 23, March 26, and April 2, 2001. Thus, we find Mr. Nelson's comment regarding "6 visits" represents a clerical error.

In its March 15, 2001 request for suspension of benefits, SAIF requested that we suspend claimant's temporary disability benefits pursuant to OAR 438-012-0035(5) from December 19, 2000, the date he failed to attend an appointment with Dr. Edelson, until claimant "fully and actively participates in his own recovery," including attending all scheduled appointments with Dr. Edelson and all prescribed physical therapy sessions. In response, claimant counters that requiring him to attend every appointment and complete treatment within the time prescribed is punitive and deprives him of a right all other claimants have.

Pursuant to ORS 656.325(2),[2] a worker has a duty to participate in medical treatment that is reasonably essential to promote recovery, including participation in a program of physical rehabilitation. Furthermore, failure to abide by that duty can result in the suspension of compensation. Thus, suspending a worker's Own Motion benefits when that worker unjustifiably fails to follow treatment prescribed by his or her treating physician is consistent with the statutory scheme for workers whose "aggravation rights" have not expired; *i.e.*, workers whose claims are not within our Own Motion jurisdiction.

In addition, claimant was provided with the opportunity to respond to SAIF's request for suspension of benefits (and he availed himself of that opportunity) before we considered that suspension request. Thus, claimant received the appropriate procedural due process safeguards. *See Carr v. SAIF*, 65 Or App 110 (1983), *rev dismissed* 297 Or 83 (1984) (where the Workers' Compensation Department terminated the claimant's temporary disability benefits after being advised by carrier that the claimant failed to attend a scheduled medical examination, the claimant's right to continuing benefits was a property interest encompassed by the Fourteenth Amendment, and the claimant was entitled to notice and an opportunity to respond before the Department suspended his compensation pursuant to *former* ORS 656.325).

We turn to claimant's contention that his failure to attend the December 19, 2000 examination and the prescribed physical therapy sessions were justified. After considering the record, we do not find a valid, compelling reason that prevented claimant from following his treating physician's instructions.

Dr. Edelson prescribed physical therapy for claimant's right knee, directing him to attend eight physical therapy sessions between October 27, 2000 and November 27, 2000. Claimant attended four of those sessions. On November 12, 2000, claimant underwent a left knee arthroscopy due to an infection caused by intravenous heroin use. That same date, claimant was referred to Dr. Morita for medical evaluation and management of narcotic withdrawal.

According to the physical therapy log, claimant's next physical therapy appointment was scheduled for November 28, 2000, more than two weeks after the left knee arthroscopy. Claimant failed to attend that appointment. In addition, he failed to attend a December 19, 2000 appointment with Dr. Edelson.

Claimant argues that, due to the November 12, 2000 arthroscopy, he was "physically unavailable" to attend further physical therapy sessions. He gives no reason for failing to attend the December 19, 2000 appointment with Dr. Edelson. However, assuming that claimant contends that the November 12, 2000 arthroscopy also caused him to be unavailable to attend the December 19, 2000 appointment with Dr. Edelson, the evidence does not support such a contention.

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[2] ORS 656.325(2) provides:

"For any period of time during which any worker commits insanitary or injurious practices which tend to either imperil or retard recovery of the worker, or refuses to submit to such medical or surgical treatment as is reasonably essential to promote recovery, or fails to participate in a program of physical rehabilitation, the right of the worker to compensation shall be suspended with the consent of the director and no payment shall be made for such period. The period during which such worker would otherwise be entitled to compensation may be reduced with the consent of the director to such an extent as the disability has been increased by such refusal."

Because SAIF requests suspension of benefits as of December 19, 2000, the date claimant failed to attend a scheduled appointment with Dr. Edelson, we focus on claimant's conduct as of that date. The record contains no evidence that claimant underwent inpatient hospitalization as a result of the November 2000 arthroscopy or narcotic withdrawal treatment. Therefore, there is no evidence that hospitalization prevented claimant from attending the December 2000 appointment with Dr. Edelson. Moreover, when Dr. Edelson advised SAIF that claimant failed to attend the scheduled December 2000 appointment, he did not indicate that such failure was excused or caused by the November 2000 arthroscopy. Thus, there is no evidence to support claimant's contention that he was "physically unavailable" to attend the scheduled December 2000 appointment with Dr. Edelson.

After SAIF warned claimant that he could face suspension of benefits for failing to attend a rescheduled February 13, 2001 appointment with Dr. Edelson, claimant attended that appointment. Dr. Edelson prescribed additional physical therapy at that time. On February 22, 2001, claimant returned to physical therapy with Mr. Nelson, who indicated that there were no contraindications for treatment and that claimant's rehabilitation potential was "good." Claimant was scheduled for two physical therapy sessions per week for four weeks. Claimant failed to attend the second session that was rescheduled for March 1, 2001.

On March 15, 2001, SAIF requested that the Board suspend claimant's temporary disability benefits for failure to participate in prescribed treatment. On March 20, 2001, claimant attended a physical therapy session with Mr. Nelson. Claimant reported that "he had to be out of town the last few weeks and has been unable to come to [physical therapy]."

Claimant's statement that "he had to be out of town the last few weeks" does not provide a sufficient explanation for missing physical therapy treatment prescribed by his treating physician. *Compare Peter Voorhies*, 52 Van Natta 1483 (2000) (suspension of benefits denied where the Board found compelling reason for missing a scheduled insurer-arranged closing examination where the claimant explained that he had to be home at night with his ailing wife and flight schedules to the out-of-state examination would not allow his return home the night of the examination). In addition, there is no medical evidence that claimant was advised not to attend this second series of physical therapy sessions prescribed by Dr. Edelson. To the contrary, the physical therapist indicated that there were no contraindications for treatment and noted that claimant's rehabilitation potential was "good."

As of March 20, 2001, claimant began to again actively participate in prescribed medical treatment, including attending physical therapy sessions and appointments scheduled with Dr. Edelson. In an April 3, 2001 examination, Dr. Edelson found claimant's right knee was not medically stationary.

Claimant argues that suspension of benefits under the circumstances of his case is inappropriate because he is now complying with prescribed medical treatment. Due to his current compliance, claimant contends that his earlier conduct is not material to our decision. Claimant asserts that our holdings in *Carr* and *Voorhies* support his argument. Specifically, claimant notes that, in *Carr*, we: (1) authorized suspension of the claimant's temporary disability benefits effective the date of our order and continuing unless and until the claimant subsequently sought medical treatment and the medical treatment established that the condition was not medically stationary; and (2) provided that, should such events occur, the insurer was to reinstate payment of temporary total disability benefits the date of that medical treatment. Claimant contends that, because he is currently complying with prescribed treatment and is not medically stationary, *Carr* does not support suspension of benefits.

The issue in *Carr* was whether we were authorized to suspend temporary disability benefits for *failure to seek medical treatment*.[3] In *Carr*, the claimant had not seen his treating physician for several months at the time of our order, which explains the focus of our holding. Here, in contrast, the issue is whether we are authorized to suspend temporary disability benefits for *failure to follow prescribed medical treatment*. Based on the above reasoning, we have such authority under the appropriate circumstances.

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[3] In *Voorhies*, the issue was also different from the issue now before us. The issue in *Voorhies* was whether suspension of temporary disability benefits was appropriate under OAR 438-012-035(5) where the claimant failed to attend two insurer-arranged closing examinations. We found that the claimant provided compelling reasons for failing to attend the closing examinations and, therefore, suspension was not appropriate. Thus, the issue in *Voorhies* was not failure to seek medical treatment (as in *Carr*) or failure to follow prescribed medical treatment (as in the present case). Furthermore, as noted above, in contrast to the claimant in *Voorhies*, claimant in the present case failed to offer any compelling reasons for failing to follow prescribed medical treatment.

Furthermore, here, those circumstances have been met. In this regard, SAIF did not unilaterally terminate temporary disability benefits but, instead, complied with OAR 438-012-0035(5). In addition, prior to considering SAIF's suspension request, claimant was allowed the opportunity to respond (and he availed himself of that opportunity). *Carr v. SAIF*, 65 Or App at 124. As explained above, claimant failed to provide any compelling reason for failing to participate in the treatment prescribed by his treating physician.

As previously noted, SAIF requests that suspension of claimant's temporary disability benefits begin as of December 19, 2000, the date claimant failed to attend a scheduled appointment with his treating physician. Finding no valid, compelling reason for claimant's failure to attend that examination and to participate in the prescribed treatment, we authorize suspension of temporary disability benefits from December 19, 2000, to March 20, 2001, the date claimant began to actively participate in prescribed physical therapy treatment.

Because SAIF could not unilaterally terminate temporary disability benefits, the benefits for this period have already been paid to claimant. Therefore, we authorize SAIF to offset this overpayment against future temporary disability benefits pursuant to ORS 656.268(13)(a).[4] Temporary disability benefits are reinstated effective March 20, 2001, and are to continue until termination is allowed under law.

Furthermore, pursuant to the directive in our February 18, 2000 order, when claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[4] ORS 656.268(13)(a) provides:

"An insurer or self-insured employer may offset any compensation payable to the worker to recover an overpayment from a claim with the same insurer or self-insured employer. When overpayments are recovered from temporary disability or permanent total disability benefits, the amount recovered from each payment shall not exceed 25 percent of the payment without prior authorization from the worker."

In the Matter of the Compensation of
FRED F. LYDUM, Claimant
WCB Case No. 00-00527
ORDER ON REVIEW
Allison Tyler, Claimant Attorney
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Poland's order that set aside its denial of claimant's injury claim. On review, the issue is whether claimant's injury arose out of and in the course and scope of his employment.

We adopt and affirm the ALJ's order. *See Cecil A. Green*, 53 Van Natta 664 (2001)("increased danger" rule remains viable where cause of fall is idiopathic).

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 August 21, 2000 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the insurer.

VAN NATTA'S
WORKERS' COMPENSATION REPORTER
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UPDATE PAGES

ENCLOSED ARE *VAN NATTA'S* PAGES 731-756 WITH WORKERS' COMPENSATION BOARD ORDERS THROUGH JUNE 15, 2001. THESE PAGES SHOULD BE INSERTED INTO YOUR CURRENT *VAN NATTA'S* BINDER, VOLUME 53, APRIL-JUNE 2001.

In the Matter of the Compensation of
JAN L. COX, Claimant
WCB Case Nos. 00-07396 & 00-01752
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
VavRosky, et al., Defense Attorney

Reviewed by Board Members Biehl & Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that: (1) upheld Liberty Northwest Insurance Corporation's (Liberty's) denial of her current bilateral wrist and right elbow conditions; (2) upheld Constitution State Service Company's denial of claimant's occupational disease claim for bilateral hand, wrist, shoulder and neck conditions; and (3) declined to assess penalties against Liberty for allegedly unreasonable claim processing. On review, the issues are compensability, responsibility, and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact." We do not adopt the ALJ's "Findings of Ultimate Facts."

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld the denials of Liberty (on behalf of US Bancorp) and Constitution State Service Company (on behalf of Providence Health System), finding that claimant had not established the compensability of any of her current conditions. Accordingly, the ALJ did not address the responsibility issue.

Compensability - Right elbow and bilateral wrist conditions

On behalf of US Bank (the first employer), Liberty accepted and processed claimant's claims for right elbow and bilateral wrist tendinitis in 1993 and 1995. (Exs. 10, 39). Claimant began working for Providence in March 1999. In 1997, 1998 and 1999, claimant sought treatment for her neck and upper back, as well as her left wrist and left elbow. (Exs. 46, 56, 59, 82). Claimant filed a new claim for bilateral hand, wrists, neck and left shoulder conditions with Providence, which was denied by Constitution State on February 8, 2000. (Ex. 72).

When Liberty did not process certain medical bills, claimant requested a hearing from Liberty's *de facto* denial of the right elbow and bilateral wrist conditions. At hearing, Liberty challenged both the compensability of claimant's current condition and responsibility without further clarification. (Tr. 4). The ALJ interpreted Liberty's position as a denial of claimant's current condition (right elbow tendinitis and bilateral wrist tendinitis). (O&O at 7).

Based on our review of the medical evidence, claimant's current right elbow and bilateral wrist tendinitis conditions are the same conditions as the previously accepted conditions. *See Dale E. Holden*, 53 Van Natta 197 (2001); *Robert S. Wigget*, 49 Van Natta 1307 (1997).[1] Liberty's compensability denial of claimant's current right elbow and bilateral wrist tendinitis conditions therefore must be set aside.

In reaching this conclusion, we acknowledge Dr. Wong's and Dr. Greg Kirchem's opinions that claimant's current bilateral wrist conditions are related to her employment with Providence, rather than to her employment with US Bank. (Exs. 76-2, 82). However, those opinions are relevant to the issue of responsibility for these conditions. The opinions do not support a conclusion that claimant's current right elbow and bilateral wrist tendinitis conditions are different conditions from those previously accepted by Liberty.

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[1] Liberty did not accept a "combined condition." Thus, the provisions of ORS 656.262(6)(c) and ORS 656.262(7)(b) are not applicable. *See Blamires v. Clean Pak Systems*, 171 Or App 263 (2000). In addition, Liberty did not attempt to revoke its prior acceptance of the tendinitis conditions. Consequently, ORS 656.262(6)(a) is likewise not applicable.

Responsibility - Right elbow and bilateral wrist conditions

ORS 656.308(1) provides, in pertinent part:

"When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability related to the compensable conditions unless the worker sustains a new compensable injury involving the same condition."

ORS 656.308(1) applies only where there is an earlier accepted claim and a later injury involves the same condition as did the earlier accepted claim. *Sanford v. Balteau Standard/SAIF Corp.*, 140 Or App 177, 181 (1996); *SAIF v. Yokum*, 132 Or App 18 (1994). In this context, a "new injury involves the same condition as the earlier accepted injury when it has the earlier compensable injury within or as part of itself." *Multifoods Specialty Distribution v. McAtee*, 164 Or App 654, 662 (1999).

Under ORS 656.308(1), the first carrier remains responsible for the condition unless the medical evidence proves that the new exposure is the major contributing cause of the combined condition and pathological worsening of the disease. *Pedro L. Perera*, 52 Van Natta 2236 (2000); *Douglas L. Wilson*, 51 Van Natta 1473 (1999). There is no such proof in this record to shift responsibility to Providence. Instead, the medical evidence (from Drs. Campbell, Fechtel and Wong) establishes that claimant's work at Providence caused at most a symptomatic worsening of the tendinitis conditions. (*See* Exs. 70-4, 79-16, 80, 81).

Accordingly, Liberty remains responsible for claimant's bilateral wrist and right elbow tendinitis conditions. Therefore, we reverse that portion of the ALJ's order that upheld Liberty's denial insofar as it pertained to claimant's bilateral wrist and right elbow conditions.

Neck and Right Shoulder

We adopt and affirm the ALJ's order on the compensability of claimant's neck and right shoulder conditions as related to her employment exposure with Providence.[2]

Penalties

Claimant contends that she is entitled to a penalty for Liberty's allegedly unreasonable processing and unreasonable denial of her current claim for benefits related to her accepted right elbow and bilateral wrist conditions. ORS 656.262(11)(a). We agree.

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 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 light of all the available evidence. *Brown v. Argonaut Insurance Company*, 93 Or App 588 (1988).

Here, we find that, having previously accepted claimant's right elbow and bilateral wrist tendinitis conditions, Liberty had no legitimate doubt as to the continuing compensability of these conditions. Moreover, the record reflects that Liberty continued to refuse to pay medical benefits related to the accepted claims without basis in law, even after repeated requests. (*See* Exs. 77a, 78a). Accordingly, we reverse this portion of the ALJ's order and find that claimant is entitled to a penalty under ORS 656.262(11) based on any amounts payable as of the date of hearing as a result of this order, payable by Liberty in equal shares to claimant and her attorney.

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[2] Claimant did not claim these conditions in relation to US Bank/Liberty.

There are also references in the record to a *left* elbow epicondylitis condition. (*E.g.*; Ex. 76-1). However, as the ALJ noted, claimant has not made a specific claim for this condition, and the compensability of any left elbow condition is therefore not at issue with regard to any employer. (O&O at 7).

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding the compensability of the wrist and elbow conditions. 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 compensability of the right elbow and wrist conditions is $2,500, payable by Liberty. In reaching this conclusion, we have particularly considered the time devoted to the 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. We further note that claimant's attorney is not entitled to a fee for services related to the (noncompensable) neck and right shoulder conditions. Claimant's attorney is also awarded $1,000 for prevailing against Liberty's responsibility denial. ORS 656.308(2)(d).

ORDER

The ALJ's order dated January 29, 2001 is reversed in part and affirmed in part. Liberty's denial of claimant's current right elbow and bilateral wrist tendinitis conditions is set aside and the claim is remanded to Liberty for processing according to law. For services at hearing and on review regarding the compensability and responsibility issues relating to the right elbow and bilateral wrist conditions, claimant's attorney is awarded $3,500, payable by Liberty. Liberty is assessed a penalty equal to 25 percent of the compensation due as a result of this order, to be paid in equal shares to claimant and her counsel. The remainder of the ALJ's order is affirmed.

June 4, 2001 Cite as 53 Van Natta 733 (2001)

In the Matter of the Compensation of
JEFFERY L. COEFIELD, Claimant
Own Motion No. 01-0110M
OWN MOTION ORDER OF ABATEMENT
Martin L. Alvey, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our May 3, 2001 Own Motion Order, that declined to reopen his claim for the payment of temporary disability compensation.

In order to allow sufficient time to consider the motion, we abate our order. The SAIF Corporation is granted an opportunity to respond to the motion. To be considered, that response must be filed within 14 days of the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
KATIE J. ELMER, Claimant
WCB Case No. 00-03375
ORDER ON RECONSIDERATION
Ransom & Gilbertson, Claimant Attorney
Scheminske, et al, Defense Attorney

The insurer requests reconsideration of that portion of our May 7, 2001 order that adopted and affirmed, with supplementation, an Administrative Law Judge's (ALJ's) order that set aside its compensability and responsibility denial of claimant's occupational disease claim for a bilateral hand dermatitis condition. After reconsideration, we continue to adhere to our decision.

Dr. Storr, claimant's treating dermatologist, provided the only medical evidence regarding the cause of claimant's dermatitis condition. (Exs. 15, 20). At hearing and on review, the insurer's primary argument was that Dr. Storrs' causation opinion was unpersuasive because it was based on inaccurate and incomplete information. In the alternative, the insurer asserted an "empty chair" responsibility defense, pointing to Hospice of the Gorge (Hospice) as the appropriate employer to assume responsibility, if that employer had been joined.

The ALJ rejected both arguments. Specifically, the ALJ found that, contrary to the insurer's contentions, Dr. Storrs' causation opinion was persuasive because it was based on accurate and sufficiently complete information and no contrary medical evidence was offered. Regarding the responsibility issue, the ALJ found that the only evidence in the record established that the insured was the responsible employer.

After our "de novo" review, we adopted and affirmed the ALJ's order with supplementation. In our supplementation regarding the merits, we agreed with the ALJ's analysis that actual causation was established against the insured. Therefore, citing *Richard A. Venner*, 53 Van Natta 352 (2001), we found that the principles of the last injurious exposure rule were not applicable.

On reconsideration, the insurer argues that Dr. Storrs' opinion does not establish actual causation. Therefore, the insurer argues, under the last injurious exposure rule for assignment of responsibility, Hospice is responsible. In the alternative, the insurer argues that claimant's employment at Hospice was concurrent with her employment at the insured and, therefore, both employers could be responsible for the dermatitis condition.

We disagree with the insurer's underlying argument that Dr. Storrs' opinion does not establish actual causation against its insured. Dr. Storrs was aware of claimant's exposure to latex at her employment at Hospice and at the insured. Dr. Storrs opined that claimant's dermatitis condition was 100 percent work related. (Ex. 15-3). She also stated that claimant's latex exposure at the insured was the major contributing cause of the condition. Finally, she stated that claimant's "current reaction was caused by exposure to latex and the chemicals at [the insured]." (Ex. 20-2). Dr. Storrs' opinion was unqualified and unrebutted. We find that it establishes actual causation against the insured.

Where actual causation is established with respect to a specific employer, a carrier may assert the last injurious exposure rule of responsibility as a defense. *Willamette Industries, Inc. v. Titus*, 151 Or App 76, 79 (1997) (citation and footnote omitted); *see Spurlock v. International Paper Co.*, 89 Or App 461, 464-65 (1988) (same) (citing *Runft v. SAIF*, 303 Or 493, 501-2 (1987)); *Donna M. Johnston*, 51 Van Natta 1414 (1999); *Rick J. Pickrell*, 51 Van Natta 453 (1999). In *Safeco Ins. Co. v. Victoria*, 154 Or App 574, 577, *rev den* 327 Or 621 (1998), the court, citing *Titus*, explained that "[p]roof that the subsequent employment independently contributed to the current disability is required before the [last injurious exposure] rule of responsibility can be invoked defensively by the targeted employer."

Because of claimant's multiple work exposures, the causation issue presents a complex medical question requiring competent medical evidence. *Uris v. Compensation Department*, 247 Or 420 (1967). As addressed above, only Dr. Storrs provided an opinion regarding medical causation. Furthermore, for the reasons explained by the ALJ, we find Dr. Storrs' opinion persuasive. Therefore, on this record, there is no proof that subsequent employment independently contributed to the current disability. Accordingly, the last injurious exposure rule of responsibility cannot be invoked defensively by the insured.

Furthermore, because actual causation has been established against the insured, the judicially created rule of assignment of responsibility pertaining to concurrent employment is not applicable. *Eva R. Billings*, 45 Van Natta 2142 (1993).

Accordingly, we withdraw our May 7, 2001 order. On reconsideration, as supplemented herein, we adhere to and republish our May 7, 2001 order. The parties' right of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

June 5, 2001 Cite as 53 Van Natta 735 (2001)

In the Matter of the Compensation of
RINA MAURO, Claimant
Own Motion No. 01-0171M
OWN MOTION ORDER

The self-insured employer has submitted claimant's request for temporary disability compensation for a right wrist condition. Claimant's aggravation rights have expired. The employer 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 claimant is actually hospitalized or undergoes outpatient surgery. *Id.*

On March 22, 2001, Dr. Wuest, claimant's attending physician, recommended that claimant undergo a right carpal tunnel release. Under such circumstances, we conclude that claimant's compensable injury has worsened requiring surgery. *See Howard L. Browne*, 49 Van Natta 485 (1997) (a claimant's multilevel back surgery, which included treatment for both compensable and noncompensable conditions satisfied the "surgery" requirement under ORS 656.278(1)(a) because a portion of the surgery was for an undisputed compensable condition).[2]

Accordingly, we authorize the reopening of claimant's 1994 injury claim for the employer to provide temporary disability compensation beginning the date claimant undergoes the proposed right carpal tunnel release. When claimant's condition related to the right carpal tunnel release is medically stationary, the employer shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[1] The employer notes that two surgical procedures are proposed. First, a right carpal tunnel release, which it relates to claimant's 1994 right wrist claim. And second, a right long finger trigger release, which it contends is not related to her 1994 right wrist claim. In light of such circumstances, we limit our current review to the undisputed right carpal tunnel release.

[2] This conclusion should not be interpreted as a decision, in any manner, regarding claimant's right long finger trigger release and its relationship, if any, to claimant's 1994 right wrist claim.

In the Matter of the Compensation of
JESUS M. HERNANDEZ, Claimant
WCB Case No. 00-08090
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorney
Reinisch, et al., Defense Attorney

Reviewed by Board Members Meyers and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that upheld the insurer's partial denial of claimant's current low back/coccygeal condition. On review, the issue is compensability.

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

We do not adopt the last sentence of the first paragraph in the section entitled "Conclusions of Law and Opinion," or the last phrase of the third paragraph in the same section.[1]

In addition, we offer the following supplementation regarding the law we apply.

The medical evidence establishes that, as of the amended acceptance and subsequent partial denial, claimant's condition was a combined condition involving noncompensable preexisting low back degeneration and the accepted conditions, a lumbar strain and coccygeal contusion. (*See* Exs. 26, 35, 40). In other words, all three conditions merged to cause claimant's ongoing disability and need for treatment. *See Luckhurst v. Bank of America*, 167 Or App 11, 16 (2000) ("[i]n order for there to be a 'combined condition,' there must be two conditions that merge or exist harmoniously").

Accordingly, when medical evidence indicated that the compensable injury was no longer the major contributing cause of claimant's combined condition, the insurer was *required* to issue its denial on that basis before closing the claim. *See* ORS 656.262(7)(b); *SAIF v. Belden*, 155 Or App 568 (1998), *rev den* 328 Or 330 (1999). Finally, because we agree with the ALJ that the persuasive medical evidence establishes that claimant's preexisting condition was the major contributing cause of her disability and need for treatment for the combined condition as of the denial, we uphold the denial. *See* ORS 656.005(7)(a)(B); 656.262(6)(c); *Roy M. Dinnell, Jr.*, 53 Van Natta 507 (2001).

ORDER

The ALJ's order dated February 23, 2001 is affirmed.

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[1] Our conclusions do not depend on whether Dr. Ballard "physically examined" claimant.

In the Matter of the Compensation of
JOHN J. ANGELIS, Claimant
Own Motion No. 01-0047M
OWN MOTION ORDER
Doblie & Associates, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his low back condition. Claimant's aggravation rights have expired. SAIF opposes authorization for 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.*

On September 21, 2000, claimant underwent decompressive lumbar laminectomy at L3-4. 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" of 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 "date of disability" for the purpose of determining whether claimant is in the work force, under the Board's Own Motion jurisdiction, is the date he enters the hospital for the proposed surgery and/or inpatient hospitalization.[1] *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish he was in the work force is the time prior to September 21, 2000 surgery. *See generally Wausau Ins. v. Morris*, 103 Or App 270, 273 (1990); *Paul M. Jordan*, 49 Van Natta 2094 (1997); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997).

SAIF contends that claimant has not worked since 1998 when he left work due to a non-work related lumbar surgery and has been receiving monthly disability from a short-term disability policy. Claimant contends that, although he was not working at the time of his current worsening, he was willing to work and was seeking work within his limitations. Claimant submitted a December 14, 2000 statement and several progress reports from his vocational rehabilitation program in support of his contentions.

In his December 14, 2000 statement, claimant contends that at the time of the current worsening he was looking for work as a private investigator following completion of his vocational rehabilitation program. He further explained that when he was unable to return to his regular employment following an unrelated low back disability, he sought to retrain himself in a career that would fit his physical limitations. Since graduating from his vocational retraining program, he has been "proactively seeking employment in the [i]nvestigative and security fields." Based on claimant's unrebutted statement, we find that he was willing to seek employment.

Moreover, in order to prove that he is a member of the work force, claimant must also satisfy either the "seeking work" factor of the second *Dawkins* criterion or the "futility" factor of the third *Dawkins* criterion. Based on the following reasoning, we find that, at the time of his disability, claimant was willing to work and seeking work.

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[1] The Board in its Own Motion jurisdiction can only authorize temporary disability compensation at the time of surgery or hospitalization. *See* ORS 656.278(1)(a)

As noted above, the relevant time period to determine whether claimant was in the work force is at the time of disability. *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990). On this record, claimant's condition worsened requiring surgery on September 21, 2000, which is the date of disability.

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 this case, claimant's initial inability to work was due to an unrelated back disability. However, he entered and successfully completed a state sponsored vocational training program. Upon completion of the vocational program, as noted in the February 18, 2000 vocational rehabilitation progress report, claimant began "applying for jobs and making contacts for possible employment." In June 2000, when it became apparent that he was not going to be able to secure a position in the private sector, claimant, with assistance from the vocational rehabilitation program, made plans to become self-employed in the profession for which he was trained.

As noted in the August 23, 2000 vocational rehabilitation progress report, claimant completed course work that would aid him to begin his own business. He worked with a counselor on a business plan and an accountant to set up his business as a sole proprietor. Claimant also contacted various companies "to generate business."

On September 21, 2000, when he became disabled due to his 1993 work injury, claimant was planning and working on becoming self-employed. Self-employment may constitute regular gainful employment, and claimant need not prove a particular loss in wages to be entitled to temporary disability benefits. *Wes J. Sessums*, 52 Van Natta 823 (2000); *Carlos C. Santibanez*, 43 Van Natta 2685 (1991), *citing International Paper Co. v. Hubbard*, 109 Or App 452 (1991). Thus, we find that claimant was "seeking" work at the time of the current worsening.

In conclusion, based on our review of this record, we find that claimant was willing to work and was making a reasonable effort to find work at the time of his current worsening (September 21, 2000).

Accordingly, we authorize the reopening of claimant's claim for SAIF to provide temporary disability compensation beginning September 21, 2000, the date he was hospitalized for 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 $1,500, payable by SAIF directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

June 8, 2001 Cite as 53 Van Natta 738 (2001)

In the Matter of the Compensation of
VIRETT R. ENGLISH, Claimant
Own Motion No. 01-0033M
OWN MOTION ORDER OF ABATEMENT AND POSTPONEMENT OF ACTION

Claimant requests reconsideration of our May 11, 2001 Own Motion Order, that declined to reopen his claim for the payment of temporary disability compensation because the record did not establish that claimant currently required surgery or hospitalization. Furthermore, we noted that the self-insured employer opposed reopening on the grounds that claimant's current condition was not causally related to his accepted condition and that it was not responsible for claimant's current condition. With his request for reconsideration, claimant also requested a hearing regarding the compensability and responsibility issues.[1] (WCB Case No. 01-04394).

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[1] Because it is not apparent that claimant sent a copy of his requests to the employer, we are attaching a copy of the requests to the employer's copy of this Own Motion Order of Abatement and Postponement of Action. Pursuant to OAR 438-012-0016, a copy of any document in an Own Motion proceeding directed to the Board must be simultaneously mailed to all other parties. In the future, claimant is requested to copy the employer with any documentation or correspondence he submits to the Board.

Under such circumstances, we find it appropriate to withdraw our prior order and 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) 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. Thereafter, we will proceed with our review of claimant's request for Own Motion relief.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHARLES M. HANEY, Claimant
Own Motion No. 00-0339M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's request for temporary disability compensation for his right knee condition. Claimant's aggravation rights have expired. SAIF opposed reopening the claim on the ground that the recommended surgery was inappropriate treatment for claimant's compensable condition. SAIF requested Director's review of the requested medical treatment. (Medical Review Case No. 14049).

On March 29, 2001, the Director issued an Administrative Order (TX 01-217) which found that the proposed right knee arthroscopic surgery, as proposed by Dr. Hendrix, claimant's attending physician, was inappropriate medical treatment for claimant's compensable injury. That order has not been appealed.[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.s78(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 dispute regarding the reasonableness and necessity of claimant's proposed surgery has been resolved in a manner that finds the treatment to be inappropriate. ORS 656.327. In light of the Director's order, we are unable to find that claimant is entitled to temporary disability compensation. *See Dorothy Vanderzanden*, 48 Van Natta 1573 (1996).

Accordingly, claimant's request for Own Motion relief is denied.

IT IS SO ORDERED.

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[1] On May 9, 2000, the Board established a "briefing" schedule seeking claimant's position regarding the effect, if any, the Director's March 29, 2001 order had on claimant's request for Own Motion relief. Pursuant to the briefing schedule claimant's written position was due within 14 days from the date of the letter. SAIF's reply, if any, was due within 14 days from the date of mailing of claimant's submission. Inasmuch as the 14-day period has expired without receipt of any written response from claimant, we have proceeded with our review.

In the Matter of the Compensation of
WILLIAM H. McCORMICK, SR., Claimant
WCB Case Nos. 00-01706 & 99-05930
ORDER ON RECONSIDERATION
Preston, Bunnell & Stone, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

The parties have jointly requested reconsideration of our September 7, 2000 order that reversed an Administrative Law Judge's (ALJ's) order that found that claimant had timely filed a request for hearing on the employer's denial of claimant's low bank injury claim, and set aside the denial. The parties request that we address three ambiguities in our order.

Claimant filed a petition for judicial review of our decision on September 15, 2000. ORS 656.295(8). Because the 30-day period within which to withdraw and reconsider our order has expired, jurisdiction of this matter is currently with the court. ORS 656.295(8); ORS 656.298(1); *see Haskell Corporation v. Filippi*, 152 Or App 117 (1998).

Nevertheless, the parties ask that we exercise our authority to withdraw the appealed order in order to reconsider our decision in light of the ambiguities in our order. *SAIF v. Fisher*, 100 Or App 288 (1990); *see* ORS 183.482(6); ORAP 4.35. Specifically, the parties contend that we adopted a portion of the ALJ's findings of fact that is inconsistent with our decision that we need not resolve the question of whether claimant's hearing request was timely filed and that claimant had not established compensability. The parties also contend that our reference to a "September 11, 1995" work injury on page 2 of our order is unclear as to whether it was intended to reference claimant's 1999 injury or an August 18, 1995 injury. Finally, the parties note that, on page 4 of our order in the third paragraph, we refer to a *July* 1999 injury rather than a *June* 1999 injury.

Although we rarely exercise our authority to withdraw a prior order that is presently on appeal to the court, *see, e.g., Carole A. VanLanen*, 45 Van Natta 178 (1993), because the parties have jointly moved for reconsideration, and the court has given leave for the parties to do so in order to clarify the above ambiguities in our order,[1] we reconsider our September 7, 2000 order.

We address each contention in turn.

First, we agree that our adoption of the ALJ's findings of fact was inconsistent with our conclusions. We should have excluded the last paragraph of the ALJ's findings. Accordingly, in place of the sentence "We adopt the ALJ's findings of fact," we substitute the following: "We adopt the ALJ's findings of fact, with the exception of the last paragraph on page 4."

Second, we substitute the sentence in the second full paragraph on page 2 of our order referring to the "September 11, 1995" work injury with the following: "Claimant must prove by a preponderance of the persuasive medical evidence that his June 25, 1999 work injury is the major contributing cause of his need for medical treatment or disability of his L5-S1 herniated disc condition."

Finally, we substitute "June 1999" for "July 1999" in the third paragraph of page 4 of our order.[2]

Accordingly, on reconsideration, as corrected herein, we adhere to and republish our September 7, 2000 order.

IT IS SO ORDERED.

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[1] In a May 8, 2001 Order Denying Motion for Remand and Abatement, the court denied the parties' joint motion to remand to the Board with the instruction that it address three ambiguities, with leave to move the Board for reconsideration.

[2] We also substitute "August 18, 1995" for "December 18, 1995" in the first sentence of the last paragraph on page 2.

In the Matter of the Compensation of
BARBARA J. NELSON, Claimant
WCB Case No. 99-08732
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorney
Stephen E. Lawrence, Defense Attorney

Reviewed by Board Members Biehl, Bock, and Meyers.

The self-insured employer requests review of Administrative Law Judge (ALJ) Black's order that set aside its denial of claimant's medical services claim for a psychiatric condition. On review, the issue is compensability.

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

We agree with the ALJ that Dr. Sobotka had a substantial advantage in evaluating causation, based on his status as claimant's treating psychologist since 1993. Accordingly, considering Dr. Sobotka's firsthand exposure to and knowledge of claimant's condition, we give his opinion greater weight than that of Dr. Turco, examining psychiatrist. *See Givens v. SAIF*, 61 Or App 490 (1983). Because we find no persuasive reason to discount Dr. Sobotka's causation conclusion, we rely on it and conclude, as did the ALJ, that claimant's medical service claim for her current psychiatric condition is compensably causally related to her 1985 employment and her accepted major depression condition.[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 $2,000, 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 17, 2000 is affirmed. For services on review, claimant is awarded a $2,000 attorney fee, payable by the self-insured employer.

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[1] We would reach the same conclusion under the "major contributing cause" standard of proof, based on Dr. Sobotka's persuasive opinion. *See* ORS 656.245(1)(a); *Mohr v. Barrett Business Services*, 168 Or App 579 (2000). In reaching this conclusion, we acknowledge that a number of non-work-related factors may have contributed to claimant's current need for medical services. Nonetheless, after reviewing the record, we are persuaded that Dr. Sobotka's opinion that, whatever the specific diagnosis of claimant's current medical condition, the major contributing cause of her need for medical services is her 1985 employment and her accepted depression condition.

Board Member Meyers dissenting.

The majority relies on Dr. Sobotka's opinion supporting the claim, reasoning that he "had a substantial advantage in evaluating causation, based on his status as claimant's treating psychologist since 1993." What the majority fails to acknowledge, however, is that Dr. Sobotka first examined claimant *8 years* after the claimed work exposure. Considering this delay, Dr. Sobotka had no "advantage" and his opinion is entitled to no special deference. *See McIntyre v. Standard Utility Contractors, Inc.*, 135 Or App 298, 302 (1995) (a treating physician's opinion is less persuasive when the physician did not examine the claimant immediately following the injury); *Marshall v. Boise Cascade*, 82 Or App 130, 134 (1986) (same); *see also Dillon v. Whirlpool Corp.*, 172 Or App 484, 489 (2001) ("The Board properly may or may not give greater weight to the opinion of the treating physician, depending on the record in each case").

Moreover, it is undisputed that claimant's preexisting personality characteristics or traits contribute to her psychological problems and no reasoned opinion discounts this contribution.

In 1985, Dr. Martin noted that claimant has "many perfectionistic personality traits." (Ex. 4). In 1986, Dr. Schaffer found evidence of a moderate level of pathology in [claimant's] overall personality structure and he felt that claimant had "Mixed Personality with Compulsive, Paranoid, and Borderline Traits," though he did not make a "definitive Personality Disorder diagnosis." (Ex. 8-10). In 1989, Drs. Klecan and Glass felt that claimant's primary psychiatric problem was "Mixed personality disorder with obsessive-compulsive, passive-aggressive, passive-dependent, hypochondriacal dysthymic, and dysthymic features" and that her need for psychiatric treatment was "based on pre-existing characterologic difficulties." (Ex. 19-9, -11).

In 1986, Dr. Lieb, then-treating psychologist, stated, "[claimant] has continued to have symptoms consistent with a major depressive episode as well as personality traits which have impaired her capacity to return to work." (Ex. 15-1, emphasis added). Again, in 1989, Dr. Lieb agreed "that there are personality characteristics which have been complicating [claimant's] recovery." (Ex. 20-1). In 1990, Dr. Lieb opined, "In regards to [claimant's] personality disorder, I believe that the work-related injury did, in fact, worsen her personality disorder." (Ex. 27-1). In 1993, Dr. Lieb wrote to Dr. Sobotka, observing, "Initially in our work together we were able to examine [claimant's] unrealistic expectations, and she did have some insight to [sic] how she contributed to the nature of her condition." Dr. Lieb's diagnoses at the time included "Major Depression, Recurrent," "Agoraphobia with Panic Attacks," and "Mixed Personality Disorder with Dependent and Passive-Aggressive Traits." (Ex. 42-2-3).

Dr. Sobotka first examined claimant in 1993. He diagnosed "Post-traumatic Stress Disorder," "Major Depression, Recurrent," and "Obsessive Compulsive Disorder" (OCD). (Ex. 68-3). Regarding the latter diagnosis, Dr. Sobotka stated that he had administered the Yale-Brown Obsessive Compulsive Scale, "which indeed revealed the presence of this anxiety disorder to a 'moderate' degree. Certainly that was a condition which pre-existed [claimant's] on the job injury in 1985 * * * ."[1] (Ex. 68-2-3). The doctor views OCD as "a kind of biological trait or characteristic that [sic] upon which is superimposed the PTSD and major depression." (Ex.71-64).

Despite this persuasive evidence establishing the contribution and significance of claimant's preexisting personality disorder, neither Dr. Sobotka, nor Dr. Lieb before him, explained how or why he discounted claimant's undisputed contributory preexisting condition. Under these circumstances, the treating physicians' opinions are insufficient to prove the claim, the majority errs in relying on them, and I must respectfully dissent. *See Dietz v. Ramuda*, 130 Or App 397, *rev dismissed* 321 Or 416 (1995) (where standard of proof is "major contributing cause, evidence that does not weigh relative contributions of competing causes is insufficient to prove claim).

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[1] Dr. Sobotka later stated that claimant's OCD had not changed, except for intermittent worsening with stressors, since he began treating claimant in 1993. (Ex. 71-63-64).

In the Matter of the Compensation of
JOHNNY R. RICHEY, Claimant
WCB Case No. 99-02426
ORDER ON REMAND
Popick & Merkel, Claimant Attorney
Terrall & Terrall, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *Richey v. Barrett Business Services*, 173 Or App 29 (2001). The court has reversed our prior order, *Johnny R. Richey*, 52 Van Natta 461 (2000), that reversed an Administrative Law Judge's (ALJ's) order that had set aside the self-insured employer's denial of claimant's low back injury claim. Concluding that we applied the wrong legal standard in evaluating claimant's attending physician's opinion, the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the employer's denial of claimant's low back injury claim based on the opinion of claimant's treating physician, Dr. Grossman. Although claimant had preexisting low back degenerative disk disease, there was no medical evidence that this condition combined with the effects of his work injury. The ALJ concluded that claimant's work injury was a material contributing cause of his low back strain/sprain condition.

On review, we reversed. *Johnny R. Richey*, 52 Van Natta at 461. We concluded that claimant had not met his burden of proof through Dr. Grossman for several reasons. Among these reasons, we found that Dr. Grossman did not properly weigh the relative contribution of each cause; *i.e.*, claimant's degenerative disc disease and prior back injuries, citing to *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 321 Or 416 (1995).

The Court of Appeals reversed our order, finding that we had improperly applied *Dietz v. Ramuda* to a "material contributing cause" case. In that context, the court held, requiring medical experts to "weigh relative causes" is unnecessary. Accordingly, the court remanded for reconsideration. 173 Or App at 32. On remand, we withdraw our prior order and affirm the ALJ's order.

Where the issue represents a complex medical question, we must rely on expert medical opinion. *Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279 (1993). As we found in our initial order, we continue to find this case to be a complex medical question due to the delay in the onset of claimant's symptoms, the delay in reporting the injury to the employer, and claimant's multiple non-work-related prior back injuries. (Exs. AA, 8, 11, 17A, 26).

Claimant has the burden to prove that his work injury was a material contributing cause of his need for treatment or disability for his low back injury. ORS 656.266; ORS 656.005(7)(a); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992). The employer contends that claimant did not meet that burden through the opinion of Dr. Grossman. We disagree.

Dr. Grossman concluded that claimant's work injury was the major contributing cause of his back condition. (Ex. 42a-37). Dr. Grossman's opinion on causation is unrebutted. The employer contends, however, that Dr. Grossman's opinion is unpersuasive because he relies on an inaccurate and incomplete history.

Medical opinions that are based on inaccurate or incomplete information are unpersuasive. *Miller v. Granite Construction*, 28 Or App 473 (1977). Here, Dr. Grossman inaccurately assumed that claimant last injured his back five years prior to his work injury (as opposed to 13 months). (Ex., 24, 42A-22). Dr. Grossman also incorrectly believed that claimant did not injure his back in either of two prior motor vehicle accidents. (Ex. 26-1; Tr. 37, 67). However, the uncontroverted evidence is that claimant had no symptoms due to these prior back injuries just before his October 1998 work injury. (Tr. 36).

Furthermore, no physician found that claimant's prior injuries combined in any way with his work injury to produce his disability or need for treatment for his back condition. *See Patrick J. Kennedy*, 52 Van Natta 1390, 1391 (2000); *Michael D. Riordan*, 50 Van Natta 2375 (1998) (Board cannot infer that a prior injury or condition has combined with the effects of a work injury absent expert medical opinion establishing the combining). In those circumstances, we are not persuaded that Dr. Grossman's misunderstandings as to claimant's prior back injuries detract from his ultimate opinion on causation. *See Gale F. Farrester*, 53 Van Natta 176, *on recon*, 53 Van Natta 315 (2001) (the claimant's denial of some prior injuries was not material discrepancy in physician's history sufficient to detract from the physician's opinion on causation, where the claimant did not have a "preexisting condition" that contributed to his disability or need for treatment).

Moreover, although Dr. Grossman did not review claimant's other medical records prior to rendering his initial opinion, he was presented with these records at deposition. (Ex. 42A-23 to 30). Dr. Grossman explained that the additional records contained objective findings that confirmed and bolstered his initial opinion. (Ex. 42A-40).

Next, the employer challenges the ALJ's credibility finding in favor of claimant, contending that claimant was untruthful on his employment application and medical history forms, and that the record suggests "drug seeking" behavior as a motivation for filing the injury claim. We disagree. As the ALJ noted, despite claimant's acknowledged untruthfulness on the various claim forms, the medical record contains several objective findings of a low back injury. Moreover, the ALJ specifically noted claimant's credible, unrebutted testimony regarding the details of his work injury and onset of symptoms. We therefore find no reasons not to defer to the ALJ's credibility finding. *See Erck v. Brown Oldsmobile*, 311 Or 519 (1991).

Finally, the employer contends that Dr. Grossman failed to consider the opinions of Drs. Tesar, Geiger, Yarusso and Quarum to the effect that claimant magnified or embellished his symptoms. However, Dr. Grossman addressed that issue and, on the contrary, felt that claimant's presentation was straightforward. (Exs. 36G, 42A). In any event, the fact that claimant may have exaggerated his symptoms does not prove that he did not suffer an on-the-job injury. We particularly find this to be so in light of the ALJ's express credibility finding in favor of claimant. (O&O at 5); *see, e.g., Jorge Cruz-Lopez*, 52 Van Natta 1035 (2000) (Board affirmed ALJ's credibility finding that the claimant suffered an on-the-job injury notwithstanding evidence of exaggeration of symptoms in the medical record and on surveillance films). Accordingly, on remand, we affirm the ALJ's order setting aside the employer's denial.[1]

Where a claimant finally prevails after remand from the Court of Appeals, the Board shall approve or allow a reasonable attorney fee for services before every prior forum. ORS 656.388(1).

First, we note that there is no challenge to the ALJ's award of $5,000 for claimant's attorney's services at hearing related to setting aside the employer's denial. Therefore, we reinstate that award.

Next, 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 Board review and before the court is $5,000, payable by the self-insured employer. 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 attorney's uncontested attorney fee request on Board review), the complexity of the issues, the value of the interest involved, and the risk that claimant's attorney may go uncompensated.

Accordingly, on remand, the ALJ's order dated September 30, 1999 is affirmed. The ALJ's attorney fee award is reinstated. For services on review, and before the court, claimant's attorney is awarded $5,000, payable by the self-insured employer.

IT IS SO ORDERED.

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[1] On review to the Board, the employer did not specifically contest the ALJ's award of a penalty under ORS 656.262(11). Therefore, we also affirm that portion of the ALJ's order.

In the Matter of the Compensation of
ANDREW C. SHIPLEY, Claimant
WCB Case No. 00-09000
ORDER ON REVIEW
Schneider, et al, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the SAIF Corporation's denial of his L4-5 disc bulge 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 a low back strain from a December 6, 1999 work injury. He was subsequently diagnosed with a right-sided disc bulge. Claimant contended that the disc bulge was compensably related to the December 6, 1999 work injury. The ALJ concluded that claimant did not satisfy ORS 656.005(7)(a) because there was "no compensation due."

On review, claimant argues that the disc bulge condition does require treatment and he proved that it was caused by the December 6, 1999 injury. SAIF agrees with the ALJ that there is "no compensation due" for the condition and asserts that Dr. Berselli, who indicated that the work injury was the major cause of the disc bulge, provided a contradictory opinion.[1]

Dr. Berselli first indicated that claimant had a "central/right-sided disc protrusion at L4-5" that was "related to his December 6, 1999 work injury." (Ex. 35). Dr. Berselli further explained that the "complicating factor" was that claimant's "leg complaints have all been left sided" and thus did not "match" the right-sided disc protrusion. (*Id.*)

Claimant was then examined on behalf of SAIF by Dr. Reimer, neurologist, and Dr. Gripekoven, orthopedic surgeon. The panel found that claimant's initial symptoms following the injury were consistent with a "simple soft tissue muscular strain" rather than "any form of a discogenic event." (Ex. 36-7). The panel further stated that the bulge was primarily right-sided "which is also not in keeping with [claimant's] subjective symptomatology." (*Id.* at 9).

Dr. Berselli concurred with the panel's report. (Ex. 37). Dr. Berselli also agreed with a report from SAIF stating that the disc bulge was "an incidental finding because the right-sided disc bulge at L4-5 did not correlate with any of [claimant's] complaints or other objective findings" and "was not contributing to [claimant's] current disability or need for treatment." (*Id.*)

Finally, Dr. Berselli concurred with a report from claimant's attorney stating that the disc protrusion "was caused in major part by the described injury; and that even though the disc was caused by the injury, it is not a condition that requires surgical repair." (Ex. 41).

A compensable injury is an "accidental injury * * * arising out of and in the course of employment *requiring medical services* or resulting in disability * * *." ORS 656.005(7)(a) (Emphasis added). Even if there is a causal relationship between the compensable injury and the accidental injury, compensability is not proved if the compensable injury does not require medical services. *Marietta Z. Smith*, 51 Van Natta 491, 493 (1999).

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[1] SAIF also provides some argument that its acceptance reasonably apprised claimant of the compensable conditions in satisfaction of ORS 656.262(7)(a). As claimant notes, SAIF's acceptance was limited to a lumbar strain and it expressly denied compensability of the disc bulge condition. Thus, we find no basis for applying ORS 656.262(7)(a) in this case.

Here, both Dr. Berselli and the panel found that claimant's symptoms did not correlate with his disc bulge; as Dr. Berselli explained, the disc bulge was an "incidental finding." Thus, although Dr. Berselli thought that the disc bulge was caused by the December 6, 1999 work injury, the disc bulge did not require medical services. Thus, the disc bulge condition is not compensable. *See* ORS 656.005(7)(a); *Barbara Martin,* 53 Van Natta 714 (2001) (no compensable injury because the claimant did not require medical services).

ORDER

The ALJ's order dated March 7, 2001 is affirmed.

June 14, 2001 Cite as 53 Van Natta 746 (2001)

In the Matter of the Compensation of
STEVEN G. ZIMICK, Claimant
WCB Case No. 00-05638
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Reinisch, et al., Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

The insurer requests review of Administrative Law Judge (ALJ) Spangler's order that affirmed an Order On Reconsideration's award of temporary disability from November 2, 1999 through March 9, 2000. On review, the issue is temporary disability.

We adopt and affirm the ALJ's order with the following supplementation. To the ALJ's "Findings of Fact," we add the following:

> "The insurer issued a Notice of Closure on March 21, 2000, awarding temporary partial disability (TPD) from August 11, 1999 through August 19, 1999 and from August 23, 1999 through November 1, 1999. On July 10, 2000, an Order on Reconsideration awarded temporary disability beginning August 11, 1999 and ending September 28, 1999, and temporary disability beginning October 13, 1999 and ending March 9, 2000."

With respect to the merits of the case, the ALJ determined that claimant was entitled to temporary disability from November 2, 1999 through March 9, 2000. In so doing, the ALJ found that claimant's inability to work was due to his compensable August 1999 injury that the insurer accepted as lumbosacral strain combined with preexisting degenerative disc disease, spondylosis and spondylolisthesis. The ALJ rejected the insurer's argument that the insurer's March 14, 2000 retroactive denial of the "combined condition" as of November 1, 1999 rendered the proceeding on the temporary disability issue moot.[1] The ALJ reasoned that the issues of entitlement to temporary disability were not decided by the assertions of the insurer in a non-final denial.

On review, the insurer contends that, because it is allowed to issue a retroactive current condition denial, claimant is not entitled to temporary disability from November 1, 1999 forward until and if the denial is set aside. We reject that contention and agree with the ALJ that the insurer's non-final denial is not a bar to the determination of the temporary disability issue in this case. Until the denial is either upheld or becomes final, the assertions contained within it are not binding statements of law. Thus, the ALJ could determine claimant's entitlement to temporary disability during the disputed period based on an evaluation of the medical record. Moreover, we agree with the ALJ's reasoning that claimant's temporary disability was due to the compensable injury.

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[1] At the parties' request, the ALJ bifurcated the compensability issue from the temporary disability issue. Thus, the compensability issue raised by the insurer's denial was subject to separate proceedings. That proceeding currently remains pending before the Hearings Division.

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 March 2, 2001 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

June 15, 2001 Cite as 53 Van Natta 747 (2001)

In the Matter of the Compensation of
REGINALD CUFFEE, Claimant
WCB Case No. 99-06587
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorney
David L. Bussman, Defense Attorney

Reviewed by Board Members Meyers, Bock, and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's occupational disease claim for a mental disorder. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact with the following changes. At the end of the first paragraph on page 1, we add the following: "The employer subsequently retracted the information about claimant's drug test. (Tr. I-13, -89, -159, -160)." In the eighth paragraph on page 3, we change the first sentence to read: "On November 8, 1999, Dr. Glass, psychiatrist, examined claimant on behalf of the employer." We delete the last paragraph on page 3.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that Drs. Poole and Glass diagnosed claimant with an adjustment disorder, mixed anxiety and depressed mood. The ALJ relied on Dr. Poole's opinion that claimant's March 19, 1999 meeting with management and the discipline resulting from complaints of sexual harassment were the major contributing cause of claimant's mental disorder. The ALJ found that the employer's handling of claimant's discipline was unreasonable and that the manner in which claimant was disciplined had caused his mental disorder.

On review, relying on *Liberty Northwest Ins. Corp. v. Shotthafer*, 169 Or App 556 (2000), the employer argues that the ALJ failed to distinguish between excluded and non-excluded work-related factors under ORS 656.802(3)(b). The employer contends that, even assuming that its conduct in failing to provide claimant the details of his alleged misbehavior was unreasonable, the ALJ erred by failing to distinguish between the stress attributable to the non-disclosure of details and the stress resulting from the accusation of sexual harassment and the accompanying discipline.

Claimant contends that it is not necessary to categorize the factors stated in *Shotthafer* because the medical evidence was clear that the major contributor to his mental disorder was the employer's unreasonable discipline in March 1999 for his alleged sexual harassment. He argues that the March 19, 1999 discipline constituted 90 percent of the reason for his disability and need for treatment.

We disagree with the employer's contention in regard to distinguishing the various components of the disciplinary action. Nevertheless, we agree with the employer that its disciplinary action, as a whole, was reasonable.

To establish the compensability of a mental disorder, claimant must prove that employment conditions were the major contributing cause of the disorder. ORS 656.802(2)(a). Additionally, 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).

The ALJ found that this case turned on whether or not the employer's actions constituted "reasonable disciplinary, corrective or job performance evaluation actions by the employer" pursuant to ORS 656.802(3)(b). We address this issue first because we find it dispositive.

In *Shotthafer*, 169 Or App at 565, the court explained that the proper weighing process required by ORS 656.802(3)(b) consists of three steps. The first step is to place the various causal factors into three categories. The first category consists of causative work-related factors that are not excluded by ORS 656.802(3)(b). The second category are causative work-related factors that are excluded by the statute. The last category consists of causative factors that are not related to work. The next step in the weighing process is to

> "weigh the nonexcluded work-related factors against *both* the excluded work-related factors and the non-work-related factors. If the nonexcluded work-related factors outweigh all the other factors, the condition is considered work-related and the claim is *compensable*. However, if the combined weights of the excluded work-related factors and the non-work-related factors outweigh or are of equal weight to the nonexcluded work-related factors, the claim is *not compensable*." 169 Or App at 565-66 (emphasis in original).

We begin by summarizing claimant's testimony as to the main factors he believed contributed to his mental disorder and need for medical treatment in March 1999. Claimant began working for the employer in November 1997 as an outside sales representative. (Tr. I-5). His employment relationship was "at-will." (Ex. 1-1). Claimant experienced numerous incidents where supervisors did not respond to his business inquiries and he had difficulty obtaining cooperation from management. (Tr. I-14, -17, -18, -22, -27). He felt he was "grossly handicapped" because he had very little support from management in fulfilling the objectives he was hired to attain. (Tr. I-27).

Claimant testified that on a scale of one to ten, with one being minimal stress, his stress level in February 1999 was rated at "eight." (Tr. I-20, -21). He was feeling stressed enough in February 1999 that he contacted the employer's "EAP provider" for assistance in dealing with work stress. (Tr. I-28). He was given a name of a counselor and he scheduled an appointment. (*Id.*) According to claimant, because the counselor was mainly concerned about getting paid rather than helping him, he did not continue the appointment. (Tr. I-29).

Claimant testified that his next stressor was on March 19, 1999, when he was called into a meeting with Mr. Thuney, district sales manager and claimant's supervisor, and Ms. Larson, regional human resource manager. (Tr. I-30, -31). They gave him a letter, which provided:

> "It has come to our attention that during your sales call to Kelly on March 5, 1999[,] your behavior was unwelcome towards their customers. This type of conduct is not within [the employer's] expectations of professionalism. Effective immediately, you are not to call on this customer while employed by [the employer]. [Claimant], please be aware of the seriousness of this complaint and understand the emphasis we are putting on this for you to take immediate action in your behavior. Any future complaints will result in further disciplinary action up to and including termination.
>
> "On March 8, 1999, we received a complaint of sexual harassment against you. Harassment consists of conduct that unreasonably interferes with a working environment or creates an intimidating, hostile, or offensive environment. This behavior towards others is unwelcome and will not be tolerated as long as you are employed by [the employer]. Attached you will find a copy of our Harassment policy, as a reminder to you, as well as information regarding what constitutes sexual harassment.

> "It is the Company's policy to take immediate and appropriate disciplinary action to make you aware of the seriousness of this issue. Effective March 22, 1999 you will be placed on a 90-day performance review. Any future occurrences of this nature will result in disciplinary action including termination." (Ex. 6).

Claimant testified that he did not understand the nature of his alleged "unwelcome" behavior toward customers. (Tr. I-32). Claimant was shocked by the accusations. Claimant testified that, prior to the March 19, 1999 meeting, he had never been informed about any sexual harassment complaints. (Tr. I-34, -35, -37). Claimant said he was never given an opportunity to defend the allegations. (Tr. 37). He had to go through his records to find out who "Kelly" was and he found that the date of his alleged contact with that customer was off by a month. (Tr. I-33). Claimant was not told what behavior was subject to criticism. (*Id.*) He asked for further information at the meeting and was told that, per company policy, they did not have to divulge names or any elements of the allegations, but they had investigated the complaints and found sufficient evidence to warrant bringing this to his attention. (*Id.*)

On March 19, 1999 or shortly thereafter, claimant was also told that a coworker had complained about his behavior at a trade show. (Tr. I-41, -42). Claimant was told that a coworker alleged that claimant was asking women for dates and that he was not acting professionally. (Tr. I-42).

Claimant testified that, after the March 19, 1999 meeting, he was very angry about the accusations and his inability to defend or address his accusers. (Tr. I-57). On March 23, 1999, he sought treatment from Dr. Poole, psychologist. (Tr. I-59). Claimant testified that his "primary issue was to try and determine what behaviors they were alluding to so that when I did return to work that I could correct or at least be aware of what it was that I was doing so that it wouldn't be repeated." (Tr. I-60). He said he told Dr. Poole that part of his anxiety was due to the fact that he had been falsely accused of sexual harassment and placed on probation as a result. (Tr. I-84).

On March 31, 1999, claimant followed up with a written request to the employer for additional information concerning the sexual harassment accusations. (Tr. 33). Claimant wrote to Mr. Thuney and requested a detailed account of the alleged offending behaviors, a written account of the investigation and a copy of his personnel file. (Ex. 6G).

Claimant's request for additional information was denied. (Tr. 33). On April 5, 1999, Ms. Larson notified claimant that his request was denied in order to protect the employee's rights to privacy. (Ex. 8A). The letter stated, in part:

> "The circumstances described in my office by peers and customers, raised issues that behooved us to bring this sensitive issue to your attention. While conducting interviews, there were several occasions in which reference was made that you acted in a manner, with comments and gestures, that was not welcome to those around you. Therefore, we have asked you to be more conscientious in your daily routines and behavior. I would be more than happy to provide you with further training and information, upon your return, of what types of behavior constitute sexual harassment." (*Id.*)

The letter also informed claimant that he could review his personnel file under a supervisor's supervision and copy any documents. (*Id.*)

Claimant testified that he requested his personnel file for the second time shortly after he was terminated in August 1999. (Tr. I-54). At that time, he found out for the first time that a coworker had alleged that he had rubbed his genitals before he gave her a congratulatory "high-five." (Tr. I-52, -53, -54).

On April 28, 1999, claimant filed a complaint with the Bureau of Labor and Industries (BOLI), alleging, among other things, that he had been falsely accused of sexually harassing a coworker and put on a 90 day probation.[1] (Ex. 9DD).

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[1] Claimant testified that he filed two complaints with BOLI. (Tr. I-104). He withdrew the first complaint and the second complaint, which pertained to unlawful termination and retaliation, was pending at the time of hearing. (*Id.*)

Dr. Poole authorized time loss for claimant from March 24, 1999 until June 1, 1999. (Exs. 6D, 6H, 11B, 14A). Claimant was terminated on August 17, 1999, allegedly for "insubordination and unprofessional behavior." (Ex. 21).

Next, we address the employer's policy regarding harassment and the complaints that led to the March 19, 1999 meeting. The employer has a written policy prohibiting harassment, which provides, in part:

> "Any employee who has a complaint of harassment at work by anyone, including supervisors, co-workers, or visitors, should let the other individual know that his/her behavior is unwelcome. You should also report the problem to your immediate supervisor or the District Manager. If the complaint involves a manager, then the employee is encouraged to go to the District Manager or the Divisional or Regional Vice President having authority over the facility. All employees should be aware that the privacy of the charging party and the person accused of sexual harassment will be kept strictly confidential.
>
> "The Company will actively investigate any allegations of harassment, and if it is determined that harassment has occurred, the Company will take appropriate disciplinary action, depending on circumstances, up to and including termination of employment." (Ex. 1-3).

In March 1999, the employer had received several complaints concerning claimant's behavior, including a complaint from a customer. On March 5, 1999, a customer called to complain about how a sales representative had handled himself in front of his female customers. (Ex. 2). The customer requested that the sales representative not call on them again. (Ex. 6, Tr. I-101). Mr. Thuney, claimant's supervisor, had a phone conversation with the customer, who was a business owner. (Tr. I-124). Mr. Thuney said that the customer had complained that claimant "supposedly had inappropriately presented himself" and made the owner's ex-wife "feel uncomfortable." (Ex. I-117). Mr. Thuney testified that it was not possible that the customer was complaining about someone other than claimant. (Tr. I-128).

On March 8, 1999, Ms. Brown, one of claimant's coworkers, wrote a memo to Mr. Thuney, complaining that claimant had made several references to the way she looked and dressed that made her feel uncomfortable. (Ex. 3). In her memo, Ms. Brown said she did not believe her clothing would warrant such comments. (*Id.*) Ms. Brown did not feel comfortable around claimant and said it was embarrassing to have other coworkers comment on his behavior toward her. (*Id.*) Ms. Larson, the employer's regional human resource manager, discussed the complaint with Ms. Brown. (Tr. I-169).

On March 15, 1999, Ms. Larson prepared a memo about a complaint from Ms. Vogel, a coworker, who alleged that, before claimant gave her a "high-five" on one occasion, he "rubbed his genital area (excessively) such as to inadvertantly [*sic*] have [her] 'touch him.'" (Ex. 4). Ms. Vogel felt claimant's behavior was peculiar and unwarranted. (*Id.*) The memo also referred to a complaint from Ms. Coleman that she felt uncomfortable around claimant. (*Id.*) Ms. Larson testified that Ms. Coleman had complained that claimant's behavior was ongoing. (Tr. I-177). Ms. Larson also testified that Ms. McRoberts said she felt uncomfortable about things claimant said to her and looks he gave her. (Tr. I-185).

Also in March 1999, Ms. Larson recorded a complaint from Mr. Turner, a coworker, about claimant's behavior at a trade show. (Ex. 5). The complaint referred to claimant's embarrassing and unprofessional behavior and indicated claimant had flirted with women and asked them out. (*Id.*) Mr. Thuney testified that in March 1999, he learned from Mr. Turner about claimant's behavior at a recent trade show and based on what he heard, it was not acceptable behavior. (Tr. I-114).

Ms. Larson explained that the employer's policy is that if an employee makes a complaint and asks for confidentiality, they try to keep it confidential. (Tr. I-176). She is required to investigate complaints of any kind of discrimination or harassment. (Tr. I-176, -183). Ms. Larson said that the people who had complained about claimant had asked to remain confidential. (*Id.*)

Ms. Larson testified that, based on the complaints from coworkers and a customer, she was concerned about the employer's potential liability. (Tr. I-170). Mr. Thuney and Ms. Larson decided that probation was appropriate for claimant. (Tr. I-115). Ms. Larson described the March 19, 1999 meeting

with claimant and Mr. Thuney as a "counseling awareness session[.]" (Tr. I-170). Ms. Larson testified that she told claimant that the meeting was "not disciplinary," but they took the complaints seriously. (Tr. I-171).

Ms. Larson said they told claimant about the allegations during the March 19, 1999 meeting, but did not accuse him and they told him that if he wanted to speak his piece, they were open to it. (Tr. I-179). She said claimant was "quite quiet" and seemed "taken aback." (*Id.*) Mr. Thuney said claimant seemed "surprised" about the accusations of sexual harassment. (Tr. I-116). According to Ms. Larson, they "gave him enough specifics" that "he was acting in an unprofessional behavior in the workplace, and that had sexual connotations behind it." (Tr. I-180). She said she could not go much further without naming names. (*Id.*) Ms. Larson said that the protocol for an investigation includes an interview with the person who has been accused, which was part of their "counseling meeting" on March 19, 1999. (Tr. I-183). She agreed, however, that the March 19, 1999 meeting was the end of her investigation. (*Id.*)

At hearing, claimant explained that he understood sexual harassment was when you say, do or infer anything that another person perceives to be inappropriate, uncomfortable or threatening. (Tr. I-36). He testified that he had never sexually harassed anyone, male or female, during his employment with the employer. (Tr. I-97). He denied any inappropriate behavior with regard to the customer who had complained about him. (Tr. I-35, -36). Claimant testified about his behavior at the trade show and believed he had acted professionally. (Tr. I-41, -42, -43, -44, -45, -94, -95). Claimant emphatically denied Ms. Vogel's assertion that he had rubbed his genitals before giving her a "high five." (Tr. I-52, -53, -54, -95, II-18). Claimant acknowledged that he had complimented Ms. Brown about her clothes, but she had never indicated that it bothered her. (Tr. I-37, -38, -39). On review, claimant contends that Ms. Brown's "sexual talk" to claimant "negated" any sexual harassment on his part. (Tr. I-23, -24, -25, -40, -41, -49, -50).

In assessing causation, we must analyze the causal factors in three categories; *i.e.*, causative work-related factors that are not excluded by ORS 656.802(3)(b), causative work-related factors that are excluded by that statute and causative factors that are not related to work. *Shotthafer*, 169 Or App at 565-566.

ORS 656.802(3)(b) provides, in part, that employment conditions producing the mental disorder must be conditions other than "reasonable disciplinary, corrective or job performance evaluation actions by the employer[.]" The reasonableness of an employer's disciplinary actions must be decided on a case-by-case basis, taking into account the particular facts of the case. *Janice E. Ingersoll*, 48 Van Natta 100 (1996); *David B. Koepping*, 46 Van Natta 751 (1994).

In both *Ingersoll* and *Koepping*, we treated the employer's investigation and resulting disciplinary actions as one causal factor. *See Ingersoll*, 48 Van Natta at 101 (agreeing with the ALJ that the employer's disciplinary action was reasonable); *Koepping*, 46 Van Natta at 753 (concluding that the action taken by the employer did not constitute reasonable discipline). *Ingersoll*, in particular, is instructive, because the issue involved the reasonableness of the employer's accusations of sexual harassment against the claimant, its investigation, and resulting discipline, all of which were treated as one "disciplinary action." 48 Van Natta at 101.

Here, we conclude that the employer's disciplinary action as a whole should be treated as one causative factor, as opposed to several factors. That approach is consistent with the Board precedent cited above. *Shotthafer* does not require a different result. We therefore decline the employer's invitation to "parse" the disciplinary action into various causal factors.

Applying the aforementioned approach, we find that the disciplinary action as a whole was reasonable. Specifically, we find that the complaint from a customer about claimant's behavior and the customer's request that claimant not be allowed to return supported the employer's accusation of sexual harassment. We find further that the employer's March 19, 1999 accusation of sexual harassment was reasonable based on the several complaints it had received, both from customers and from claimant's coworkers.

The investigation stage of the disciplinary action was less reasonable. We acknowledge that the employer's "sexual harassment" policy requires an investigation to determine that harassment has occurred. (Ex. 1-3). Here, the employer's investigation did not involve claimant until the very end

stage; *i.e.*, the March 19, 1999 meeting. (Tr. I-183). However, we note that, at the March 19, 1999 meeting, claimant was given an opportunity to "speak his piece." (Tr. I-179). The employer's policy also mandates that "the privacy of the charging party" will be kept strictly confidential, which is in keeping with its refusal to identify claimant's accusers. (*Id.*) Finally, we find that the employer's placing claimant on a 90-day "performance review" was reasonable, in light of the multiple customer and coworker complaints and the seriousness of those complaints.

In sum, even if we assume that the employer did not conduct an entirely reasonable investigation, we still find that the disciplinary action as a whole was reasonable. In this regard, we do not necessarily accord equivalent weight to each stage of the disciplinary action but again, view the reasonableness of the action as a whole.

Because we find that the employer's disciplinary action was reasonable, it must be considered as an "excluded" work-related factor. ORS 656.802(3)(b); *Shotthafer*, 165 Or App at 565-566.

We turn to the medical evidence concerning causation. Because of the multiple possible causes of claimant's mental disorder, 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). There are two medical opinions on causation. Claimant relies primarily on the opinion of Dr. Poole, his treating psychologist, to establish compensability. He was also examined by Dr. Glass on behalf of the employer.

Dr. Poole first treated claimant on March 23, 1999, shortly after the March 19, 1999 meeting. (Exs. 6A, 6B). Dr. Poole eventually diagnosed adjustment disorder with mixed anxiety and depressed mood, and major depression. (Exs. 6C, 8D). Dr. Poole concluded that, as to his diagnosis of major depression, the "primary contributory factor to [claimant's] psychiatric illness at that time had been the work stress associated with sexual harassment charge leveled at him by his employer[.]" (Ex. 25-3). Similarly, he found that claimant's adjustment disorder was the "direct result of [claimant's] reaction to sexual harassment charges by his employer." (Ex. 25-4).

In sum, Dr. Poole's opinion was that the employer's disciplinary action caused claimant's mental disorder. However, because we have determined that the disciplinary action was reasonable (and thus, an "excluded" work-related factor), Dr. Poole's opinion does not support compensability. ORS 656.802(3)(b). In other words, Dr. Poole's opinion must be weighed on the side of "non-compensability." *Shotthafer*, 169 Or App at 565-566.

On November 8, 1999, Dr. Glass, psychiatrist, examined claimant on behalf of the employer. (Ex. 22). He found that, at that time, claimant did not have a psychiatric illness. (Ex. 22-12). Nevertheless, Dr. Glass stated that the diagnosis of adjustment disorder with mixed anxiety and depressed mood "could be considered related to his symptoms and leaving work" in March 1999. (*Id.*) He did not diagnose a personality disorder. Dr. Glass found that the accusation of sexual harassment and placement on probation "would appear to be the reason he contacted Dr. Swan, went off work and initiated counseling with Dr. Poole." (Ex. 22-13).

Accordingly, Dr. Glass' opinion, which relates claimant's condition to the employer's "reasonable" disciplinary action, must also be weighed on the "non-compensable" side of the Shotthafer scale. It follows that claimant's condition is not compensable.

ORDER

The ALJ's order dated October 5, 2000 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

Board Chair Bock concurring.

I agree with the result reached by the majority. I write separately only to address the dissent's contention that the employer did not conduct a reasonable investigation and that claimant was not afforded an opportunity to defend the allegations of sexual harassment.

In response to an allegation of sexual harassment in the workplace, an employer has certain legal obligations. The purpose of a proper investigation, which may result in discipinary action, surrounding accusations of sexual harassment is, in part, to shield the employer from potential civil liability. *See Hirras v. National Railroad Passenger Corporation d/b/a Amtrak,* 95 F3d 396 (5th Cir. 1996) (court found that employer took "prompt remedial action" as a matter of law sufficient to avoid liability under Title VII). This concern was reflected in the employer's approach to this investigation, as Ms. Larson confirmed. (Tr. I-170).

Given the multiple complaints from both customers and co-workers of claimant, the employer had no legitimate choice but to commence the investigation, as the dissent recognizes. In the face of such allegations, I also believe the employer was entirely reasonable in placing claimant on a 90-day performance review. In fact, in some instances, courts have found that an employer's discipline of an alleged sexual harasser was insufficient to avoid civil liability. *See, e.g., Ellison v. Brady,* 924 F2d 872 (9th Cir. 1991) (court found that the employer's failure to reprimand and/or put the harasser on probation was an insufficient response to avoid liability).

Finally, the dissent raises concerns over "due process" for claimant, which I do not dismiss lightly. However, in particular, I note that during the March 19, 1999 meeting claimant was afforded the opportunity to "speak his piece," but apparently never took advantage of that opportunity. (Tr. I-179). Likewise, although claimant was allowed to review and copy documents from his personnel file under supervision, he never followed up on this offer, although he twice demanded a copy. (Exs. 6G, 8A, Tr. I-54). In my view, it is not entirely accurate to state that the investigation was completed without claimant's involvement. Given these points, I am persuaded that claimant was given an opportunity to "defend himself." I believe, therefore, that the employer's disciplinary action as a whole was proper and reasonable.

Board Member Phillips Polich dissenting.

Because I agree with the ALJ that the employer's disciplinary action was unreasonable, I respectfully dissent. In particular, I would find that the employer's notice to claimant and its investigation of the complaints of sexual harassment were both unreasonable, making the disciplinary action, as a whole, unreasonable.

It is important to realize that the employer, by completing an investigation without the involvement of claimant, did *not* follow its own harassment policy. It is a fundamental tenet of our society that a person should be afforded some kind of notice and opportunity to defend accusations *before* any conclusions are drawn from those mere accusations. Here, that was not done. Instead, the employer acknowledged that the March 19, 1999 meeting, where claimant was first apprised of the accusations and immediately placed on a 90-day "performance review," represented the *end* of its investigation. (Tr. I-183). That approach does not afford claimant even the basic guarantees of procedural due process, and in my evaluation forces the conclusion that the employer's disciplinary action was unreasonable.

I agree with the majority that the mere accusation of sexual harassment by the employer may have been reasonable. The complaints against claimant were not isolated and could not have been realistically ignored by the employer. However, the employer then had an obligation, in accordance with its own policy, to actively investigate the allegations, which process necessarily should have included claimant.

When claimant was eventually apprised of the harassment allegations, the employer should have provided at least some details of the accusations. It could have done so without running afoul of its policy of protecting the identity of the accusers. I also find fault with the nature and terms of claimant's "performance review," which provided that claimant could be terminated within 90 days unless he conformed to some still unknown standard. Acknowledging, of course, that we work within a supposedly "no fault" workers' compensation system, I nevertheless believe these errors by the employer made its disciplinary action unreasonable when viewed as a whole.

In sum, like the ALJ, I would find the disciplinary action unreasonable for the above-stated reasons. I would then find claimant's claim compensable based on the opinions of Drs. Poole and Glass. Therefore, I respectfully dissent.

In the Matter of the Compensation of
DARWIN A. MONTGOMERY, Claimant
Own Motion No. 01-0143M
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 low back condition. Claimant's aggravation rights have expired. SAIF denied the compensability of claimant's current condition on which claimant has filed a request for hearing. (WCB Case No. 01-04087). In addition, SAIF recommends against reopening on the grounds that: (1) the carrier is not responsible for claimant's current condition; and (2) surgery or hospitalization is not reasonable and necessary for the compensable injury.

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) 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 approved agreement, we will take this matter under advisement.[1]

IT IS SO ORDERED.

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[1] SAIF is required to make a written recommendation to the Board within 90 days of receiving claimant's own motion request. OAR 438-012-0030. That recommendation must include the information specified in OAR 438-012-0030. The Own Motion recommendation submitted by SAIF does not include medical evidence regarding the surgery/hospitalization issue. SAIF is reminded, pending the resolution of the current litigation, that it must also file medical evidence addressing whether claimant requires surgery or other treatment requiring hospitalization.

In the Matter of the Compensation of
RICHARD YOREK, Claimant
Own Motion No. 99-0161M
OWN MOTION ORDER REVIEWING
CARRIER CLOSURE ON RECONSIDERATION

Claimant requests reconsideration of our May 22, 2001 Own Motion Order Reviewing Carrier Closure, in which we affirmed the self-insured employer's February 14, 2001 Notice of Closure. In his request, claimant contends that he "just came out of another surgery," and that his condition is "deteriorating," which demonstrates that he was not medically stationary at the time his claim was closed.

A claim may not be closed unless the claimant's condition is medically stationary. "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 the date of 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 14, 2001 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 his condition was not medically stationary at closure and that he continues to require medical treatment.[1] However, he does not offer any medical documentation, which would support a conclusion that his compensable condition was not medically stationary at the time his claim was closed on February 14, 2001. In this regard, we reiterate our previous finding that the medical opinion from Dr. Purtzer, claimant's treating physician, supported the conclusion that claimant was medically stationary at the time of closure.[2] Claimant does not offer any new medical evidence, which would persuade us to come to a contrary conclusion.

Based on the uncontroverted medical evidence, we find that claimant was medically stationary on the date his claim was closed. Therefore, we conclude that the employer's closure was proper.[3]

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[1] 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).

[2] As noted in our prior order, in letters dated January 22 and 23, February 1 and 28 and March 1, 2001, Dr. Purtzer opined that claimant was medically stationary and that his condition would not improve with the passage of time or with further treatment. Additionally, Dr. Purtzer explained that claimant's "surgery" was a scar revision procedure which would not "change his medically stationary status." Dr. Purtzer's opinions are unrebutted.

[3] Claimant requested a hearing "with the Board for reconsideration of [its] decision." The Board, in its Own Motion capacity, conducts its review of a parties' dispute through development of a written record. It may refer a matter for a fact-finding hearing when disputes are directly attributable to a witness' credibility or reliability, or when the factual record is insufficiently developed to permit the Board adequate and proper review. *See, e.g. Charles Tedrow*, 48 Van Natta 616 (1996). Here, the matter in dispute is not contingent upon an appraisal of a witness' credibility or reliability. In addition, as summarized above, the factual record is not incomplete. Consequently, we decline to refer this matter to a fact-finding hearing.

Finally, it appears from claimant's request that he is unclear as to his rights and benefits under the Workers' Compensation laws. Since claimant is unrepresented, he may wish to contact the Workers' Compensation Ombudsman, whose job it is to assist injured workers regarding workers' compensation matters:

Workers' Compensation Ombudsman
Dept. of Consumer & Business Services
350 Winter St NE
Salem, OR 97301
Telephone: 1-800-927-1271

Accordingly, we withdraw our May 22, 2001. On reconsideration, as supplemented herein, we adhere to and republish our May 22, 2001 order in its entirety. The parties' rights of appeal and reconsideration shall begin to run from the date of this order.

IT IS SO ORDERED.

June 15, 2001 Cite as 53 Van Natta 756 (2001)

In the Matter of the Compensation of
THEODORE EVANS, Claimant
WCB Case No. 98-08036
ORDER OF DISMISSAL
Welch, Bruun & Green, Claimant Attorney
Cummins, Goodman, et al, Defense Attorney

The self-insured employer requested review of Administrative Law Judge (ALJ) Otto's June 12, 2000 order that set aside its denial of claimant's mental disorder claim. The parties submitted a "Disputed Claim Settlement" (DCS) designed to resolve this matter, as well as issues pending in WCB Case No. 00-07416, a case pending before the Hearings Division. Those portions of the settlement that pertain to issues pending before the Hearings Division have received ALJ approval.

Pursuant to the settlement, claimant agrees that the "[e]mployer's compensability denial of October 5, 1998, shall be affirmed in its entirety, thereby nullifying the June 12, 2000, Opinion and Order." Moreover, claimant agrees that all issues raised or raisable are resolved in their entirety.

We approve the parties' settlement,[1] thereby fully and finally resolving this dispute, in lieu of the ALJ's order. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] The DCS was signed by an ALJ. Because the agreement, however, pertains to the resolution of a dispute pending Board review, the DCS requires Board approval. *See* OAR 438-009-0015(5). Our signatures on this order constitute approval of the parties' DCS.

VAN NATTA'S
WORKERS' COMPENSATION REPORTER
1017 Parkway Drive N.W.
Salem, Oregon 97304
Phone (503) 585-5173
Fax (503) 540-0114

UPDATE PAGES

ENCLOSED ARE *VAN NATTA'S* PAGES 757-832 WITH WORKERS' COMPENSATION BOARD ORDERS THROUGH JUNE 30, 2001. THESE PAGES SHOULD BE INSERTED INTO YOUR CURRENT *VAN NATTA'S* BINDER, VOLUME 53, APRIL-JUNE 2001.

In the Matter of the Compensation of
GAIL M. BUMALA, Claimant
WCB Case No. 99-02724
ORDER ON REVIEW
Welch, et al, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Phillips Polich & Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Martha Brown'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.

On page 2 of the ALJ's findings of fact, paragraph 4, the second and third sentences are amended to read: "The resident indicated that he should be coded as a 'full' code, which meant he wished to be resuscitated if anything occurred. However, claimant felt that inappropriate pressure was put on the resident by the staff to accept a DNR or 'do not resuscitate' code, although ultimately the staff acceded to the resident's wishes to be a full code."

On page 3 of the findings of fact in the second full paragraph, the third sentence is changed to read: "The toilet had been out of order for a few days and a common bathroom that the resident was supposed to use was observed to often be inaccessible because of equipment parked in front of the door." (Ex. PP-2).

The insurer argues that the ALJ erred in concluding that claimant was unable, because of conditions at the work place, to perform her job duties as a social worker at the employer's nursing home. We disagree.

In addition to claimant's advocacy role, her job description included promoting the residents' rights and dignity. Under such circumstances, we agree with the ALJ's conclusion that because of conditions in the care center, claimant was not able to carry out her job duties. In this regard, the ALJ noted that claimant identified serious problems with hygiene, equipment and basic care of the residents and brought them to the employer's attention, but was unable to obtain correction of the problems. The insurer's argument that claimant's job was limited to advocating on behalf of the residents for the correction of the problems with their care, but did not involve seeing that the corrections were actually carried out, is not persuasive. It is unclear why the employer would have an employee designated to advocate on behalf of the nursing home residents when it did not expect that the employee would follow up on the problems identified.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). Claimant's counsel has submitted a statement of services seeking an attorney fee of $7,400 on Board review. The insurer does not object to the hours expended by claimant's attorney, but objects to claimant's request on the basis that the "hourly rate" was excessive.

In deciding whether the requested fee is appropriate, we consider the factors in OAR 438-015-0010(4), which include the time devoted to the case, the complexity of the issues, the value of the interest involved, the skill of the attorneys, the nature of the proceedings, the benefits secured, and the risk that an attorney's efforts may go uncompensated. *See Schoch v. Leupold & Stevens*, 162 Or App 242 (1999) (Board must explain the reasons why the factors considered lead to the conclusion that a specific fee is reasonable).

Here, claimant's attorney devoted 38 hours to the compensability issue on appeal and submitted a 24 page brief on the issue. The compensability issue involved whether claimant's occupational disease claim for a mental condition was compensable. As compared to typical compensability cases, the compensability issue here was of above average complexity. Because claimant's condition has been found compensable, she is entitled to workers' compensation benefits. Thus, the interest involved and the benefits secured for claimant are significant. The attorneys involved in this matter are skilled and have substantial experience in workers' compensation law. Finally, considering the conflicting evidence regarding the compensability issue, there was a risk that claimant's counsel's efforts might have gone uncompensated. No frivolous issues or defenses have been presented on review.

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 $5,700, 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, claimant's counsel's statement of services, and the insurer's objections), the value of the interest involved, the complexity of the issue, the nature of the proceedings, and the risk that claimant's counsel's efforts might have gone uncompensated.

ORDER

The ALJ's order dated November 16, 2000 is affirmed. For services on Board review, claimant's attorney is awarded $5,700, payable by the insurer.

June 18, 2001 Cite as 53 Van Natta 758 (2001)

In the Matter of the Compensation of
KEITH A. KENDALL, Claimant
WCB Case No. 00-06285
ORDER ON REVIEW
Nicholas M. Sencer, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's claim for an L4-5 annular tear. On review, the issue is compensability.

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

The insurer argues that the ALJ erred in relying on Dr. Martinson's opinion to find claimant's L4-5 annular tear compensable for two reasons. First, the insurer notes that claimant's disc bulge at L4-5 is not compensable and argues that this affects the compensability of an annular tear at that level. Second, the insurer argues that Dr. Martinson admitted that if there was no muscle spasm following claimant's injury, the injury was not significant.

There is no evidence that the annular tear was caused by the L4-5 disc bulge. Rather, the persuasive medical evidence from Dr. Martinson establishes that the annular tear at the L4-5 level was directly caused by the compensable injury. Thus, we are not persuaded that the compensability of the L4-5 disc bulge affects the compensability of the annular tear.

Dr. Martinson indicated that if there was no muscle spasm following the injury, this could indicate that there was no annular tear. (Ex. 37-18). It is clear, however, that Dr. Martinson believed that the injury did cause an annular tear based on the mechanism of the injury and the fact that claimant's pain did not resolve. (Ex. 37-19). Under such circumstances, we agree with the ALJ that Dr. Martinson's opinion establishes compensability of an annular tear.

Claimant's counsel seeks an attorney fee of $2,100 for services on Board review, asserting that 14 hours were expended in preparing claimant's respondent's brief. The insurer objects to the amount of the requested fee and argues that the 23 page respondent's brief is unreasonably lengthy and that claimant's counsel on Board review did not try the case at the hearing level and therefore spent extra time reviewing the record. The insurer argues that the issues are not complex and no significant legal research was required.

In determining a reasonable attorney fee, we consider the factors in OAR 438-015-0010(4), which include the time devoted to the case, the complexity of the issues, the value of the interest involved, the skill of the attorneys, the nature of the proceedings, the benefits secured, and the risk that an attorney's efforts may go uncompensated. *See Schoch v. Leupold & Stevens*, 162 Or App 242 (1999) (Board must explain the reasons why the factors considered lead to the conclusion that a specific fee is reasonable).

Here, claimant's attorney devoted 14 hours to the compensability issue on appeal and submitted a 23 page brief on the issue. The compensability issue involved whether claimant's L4-5 annular tear was compensable. As compared to typical compensability cases, the compensability issue here was of average complexity. Because claimant's condition has been found compensable, he is entitled to workers' compensation benefits. Thus, the interest involved and the benefits secured for claimant are significant. The attorneys involved in this matter are skilled and have substantial experience in workers' compensation law. Finally, considering the conflicting evidence regarding the compensability issue, there was a risk that claimant's counsel's efforts might have gone uncompensated. No frivolous issues or defenses have been presented on review.

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 $2,100, 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, his counsel's statement, and the insurer's objections), the value of the interest involved and the risk that claimant's counsel's efforts might have gone uncompensated.

ORDER

The ALJ's order dated March 7, 2001 is affirmed. For services on Board review, claimant's attorney is awarded $2,100, payable by the insurer.

June 18, 2001 Cite as 53 Van Natta 759 (2001)

In the Matter of the Compensation of
FRED L. YOUNGER, Claimant
WCB Case Nos. 00-01056 & 00-00591
ORDER OF RECONSIDERATION
Arthur P. Klosterman, Claimant Attorney
James B. Northrop (Saif), Defense Attorney
Mannix, et al., Defense Attorney

The SAIF Corporation, on behalf of its insured, Colamette Construction Co., requests reconsideration of that portion of our May 22, 2001 Order on Review that set aside its denial of claimant's current low back condition. Noting that its denial had also included a denial of failed back surgeries at L5-S1, SAIF/Colamette specifically requests that we clarify our order to provide that its denial is set aside except to the extent that it denied responsibility for the failed surgeries at L5-S1.

Although we believe that our prior order was sufficiently clear as to the compensable condition, we perceive no harm in further clarifying our prior order. Accordingly, we modify our order to clarify that SAIF/Colamette's denial of February 2, 2000 is set aside only to the extent that it denied claimant's current low back condition. The denial is upheld in all other respects.

Accordingly, we withdraw our order. On reconsideration, as clarified 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
GENET ABATE, Claimant
WCB Case No. 00-05532
ORDER ON REVIEW
John M. Hoadley, Claimant Attorney
Meyers, et al., Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Thye's order that set aside its denial insofar as it pertains to claimant's L4-5 disc condition. On review, the issue is compensability.

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

In August 1999, claimant injured her low back in a lifting incident. (Ex. 1). In November 1999, the claim was accepted as a disabling "low back strain." (Ex. 44-1).

Sometime after the initial claim acceptance, claimant asked the insurer to expand its acceptance to include a disc herniation at L4-5. (Ex. 108). On November 30, 2000, the insurer denied that condition. (*Id.*) Claimant requested a hearing. At hearing, the parties agreed that the denial of the aforementioned L4-5 disc herniation included a claim for an L4-5 disc bulge. (Tr. 1).

The ALJ relied on the opinions of Drs. Larson, Nash, and O'Neill and determined that claimant had established the compensability of her L4-5 disc bulge/herniation.[1] Consequently, the ALJ set aside the insurer's denial of that condition.

To establish that her L4-5 disc condition is compensable, claimant must prove that her August 1999 lifting activity at work was a material contributing cause of the disability or need for treatment of the claimed condition.[2] *See* ORS 656.005(7)(a); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992). Because of possible alternative causes for claimant's condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). In evaluating medical opinions, we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983).

Drs. Larson, Nash, and O'Neill opined that claimant's work injury caused an intraforaminal disc bulge at L4-5.[3] (Exs. 110-1; 111-1; 112-1). The doctors expressly stated that their opinions were based on: (1) the strong temporal relationship between the work event and the onset of claimant's symptoms; (2) the absence of symptoms prior to the work event; and (3) the mechanism of claimant's injury.[4] (*Id.*)

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[1] Dr. Larson is the attending physician. Drs. Nash and O'Neill are consulting neurosurgeons.

[2] The ALJ determined that the material contributing cause standard applied to this claim. Because the medical evidence does not support a conclusion that claimant's work injury "combined" with any preexisting conditions, we use the material contributing cause standard on Board review.

[3] Dr. O'Neill advised that the terms "herniated disc" and "bulging disc" are synonymous. (Ex. 112-1). The insurer asserts that the terms "bulge," "protrusion," and "herniation" are distinct entities with different meanings and effects. We note that Drs. Hornick and Larson appear to recognize "bulge" and "protrusion" as separate conditions. (Exs. 32; 106-1). We also note that Dr. Quilici appears to recognize "bulge" and "herniation" as separate conditions. (Ex. 59). Nonetheless, no doctor in this record expressly disagrees with Dr. O'Neill's statement. Moreover, we note that the parties agreed that the insurer's denial of an L4-5 disc herniation included a claim for an L4-5 disc bulge. (Tr. 1). Consequently, we reject the insurer's assertion and, on this record, treat the term "herniated disc" as synonymous with "bulging disc."

[4] Both Drs. Nash and O'Neill opined that claimant's work injury was the major cause of claimant's L4-5 disc condition. (Exs. 110; 112).

Additionally, Dr. Larson opined that the intraforaminal disc bulge at L4-5 was different in size and location than other bulges present in claimant's spine. Thus Dr. Larson reasoned that the intraforaminal bulge was a separate condition caused by the August 1999 work incident.[5] (Ex. 111-2).

The insurer asserts that the opinions of Drs. Larson, Nash, and O'Neill are not persuasive because they are based solely on a temporal analysis. We disagree. In addition to the temporal relationship, all three doctors expressly considered the mechanism of injury and specifically noted that the mechanism of injury was consistent with claimant's condition. (Exs. 100-2; 111-1; 112-2). Additionally, Dr. Larson expressly considered the physical nature of the intraforaminal disc bulge. (Ex. 111-2). Consequently, we reject the insurer's argument. *See Lawrence L. Nicholson*, 51 Van Natta 1977 (1999) (the claimant met his burden of proof where the doctor's report was not based solely on a temporal relationship).

The insurer also contends that Dr. Larson's opinion as expressed in Exhibit 111, represents an unexplained changed of opinion of what he expressed in an earlier letter to the insurer's counsel. We disagree.

In a September 2000 letter to insurer's counsel, Dr. Larson stated: "At L4-5, there is either a disk protrusion or a left-sided intraforaminal bulge of the annulus. I cannot determine which from the MRI. It is not my opinion that that particular finding predates the injury of August 1999." (Ex. 106-2). In January 2001, as we have previously noted, Dr. Larson opined that claimant had a left intraforaminal bulge at L4-5. (Ex. 111-1). However, because the January 2001 opinion is based on both an MRI and a subsequent CT scan, we are not persuaded that the January 2001 opinion represents an unexplained change of opinion. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (physician's opinion found persuasive when accompanied by reasonable explanation for the physician's change of opinion). Nor are we persuaded that Dr. Larson's January 2001 opinion is inconsistent with his September 2000 opinion.[6] Rather, we consider Dr. Larson's later report to represent an evolution of his opinion based on further test findings.[7]

In conclusion, we find the opinions of Drs. Larson, Nash, and O'Neill persuasive.[8] Consequently, we agree with the ALJ that claimant has established the compensability of her L4-5 intraforaminal disc 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 $1,200, to be paid 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.

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[5] According to Dr. Larson, claimant also has other disc bulges at L3-4 and L4-5. He reasoned that, because those particular disc bulges are not prominent, cause no impingement, and are not uncommon in adults, those disc bulges preexisted the August 1999 work event. (Ex. 111-2).

[6] The insurer also argues that Dr. Larson's opinion is inconsistent because he uses the terms "herniation," "protrusion," and "bulge" interchangeably. Because Dr. O'Neill advised that the terms "herniated disc" and "bulging disc" are synonymous, we reject the insurer's argument. (Ex. 112-1).

[7] We note that in an earlier report, Dr. Larson stated: "[I]t is difficult to say when the disk problems actually developed." (Ex. 90). However, because this statement was rendered 9 months prior to his ultimate opinion and before the CT scan, we do not consider this statement an unexplained inconsistency rendering his overall opinion unpersuasive.

[8] We acknowledge the insurer's assertion that the opinions of Drs. Gripekoven, Williams, and Vessely (insurer-arranged examiners) are more persuasive that the opinions of Drs. Larson, Nash, and O'Neill. We note, however, that the opinions of Drs. Gripekoven, Williams, and Vessely are based on the major contributing cause analysis rather than a material contributing analysis. Because a material contributing cause standard applies to this claim, we do not find the opinions of Drs. Gripekoven, Williams, and Vessely probative.

ORDER

The ALJ's order dated February 20, 2001 is affirmed.[9] For services on review, claimant is awarded a $1,200 attorney fee, payable by the insurer.

[9] The insurer contends that claimant should not have been awarded an assessed fee at the hearing level, because the insurer's denial only expressly denied a "herniated disc" condition, not an "intraforaminal disc protrusion." In other words, the insurer contends that claimant did not perfect a claim for an "intraforaminal disc protrusion." Because the insurer agreed at hearing that its denial of a herniated disc also included a claim for disc bulge, and because (on this record) we treat the terms "herniated disc" and "bulging disc" as synonymous, we reject that argument. (Tr. 1; Ex. 112-1).

In the Matter of the Compensation of
ROGER S. PASKVAN, Claimant
Own Motion No. 00-0282M
OWN MOTION ORDER OF ABATEMENT
Doblie & Associates, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests reconsideration of our May 18, 2001 Own Motion Order, that affirmed the insurer's January 26, 2001 Notice of Closure.

In order to allow sufficient time to consider the motion, we abate our order and implement the following briefing schedule. Claimant has 21 days from the date of this order to submit material for reconsideration. The insurer's response to claimant's request, including any supporting documents, must be filed within 21 days from the date of mailing of claimant's submission. Claimant's reply, including any further supporting documents, must be filed within 14 days from the date of mailing of the insurer's response. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
DEBRA R. CAWRSE, Claimant
WCB Case Nos. 99-07754 & 99-07753
ORDER ON REVIEW
Scott M. McNutt, Jr., Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney
Jerry Keene, Defense Attorney

Reviewed by Board Members Biehl and Bock.

Commercial Compensation Insurance Company (CCI) requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) found that claimant was a subject worker at the time of her June 9, 1999 injury; (2) set aside CCI's compensability and responsibility denials of claimant's "new injury" claims for cervical strain, right shoulder strain, and L5-S1 conditions (herniated disc, degenerative disc disease, retrolisthesis, spondylolisthesis and bilateral sciatica); (3) upheld EBI Insurance Co.'s (EBI's) denials of the same conditions; and (4) assessed penalties for CCI's allegedly late denial. In her brief, claimant contends that she is entitled to interim compensation benefits from July 19, 1999 through December 22, 1999, and an assessment of penalties for unreasonable claim processing. On review, the issues are subjectivity, compensability, responsibility, interim compensation 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 two paragraphs on page 7. We summarize the pertinent facts as follows.

Claimant compensably injured her low back in August 1982 when EBI was on the risk. As a result of that injury, claimant underwent an L5-S1 laminotomy and diskectomy performed by Dr. Nash. In April 1987, the claim was closed by a Determination Order that awarded 30 percent unscheduled permanent disability for the low back and 5 percent scheduled permanent disability for each leg.

In July 1995, claimant's claim was reopened under the Board's Own Motion authority for an L5-S1 herniated disc. Dr. Calhoun performed a left L5-S1 hemilaminotomy and microdiscectomy for the recurrent disc. Dr. Calhoun declared claimant medically stationary in October 1996.

In March 1998, claimant sought physical therapy for pain in her low back, legs and right shoulder. After a brief period of treatment, she was much improved.

Claimant began working as a bookkeeper for CCI's insured in February 1999.[1] On June 9, 1999, the employer fired claimant shortly after she arrived at work. Claimant was instructed immediately to remove her belongings, which included her ergonomic chair, and leave the workplace. While lifting the chair, she felt the onset of pain in her low back and right buttock.

On June 14, 1999, claimant sought medical treatment for her low back, right shoulder and neck. (Ex. 66). An MRI was performed on June 23, 1999. (Exs. 68, 69). Dr. Calhoun diagnosed a lumbosacral strain. (Ex. 70).

On July 19, 1999, Dr. Miller, osteopath, examined claimant. He diagnosed a herniated disc and spondylolisthesis at L5-S1; sciatica, left greater than right; cervical strain; and shoulder strain. (Exs. 71, 73). He reported that the shoulder and cervical strains had resolved by August 6, 1999. (Exs. 73, 82).

On August 17, 1999, Dr. Gripekoven, orthopedic surgeon, examined claimant at CCI's request. (Exs. 86, 94). He diagnosed a lumbar strain, a dorsal strain, degenerative disc disease at L4-5 and L5-S1, and retrolisthesis at L5-S1. (Ex. 86).

On September 13, 1999, Dr. Nash, neurosurgeon, examined claimant. He opined that claimant had a recurrent disc at L5-S1 and clinical symptoms of lumbar instability at L5-S1. (Ex. 95).

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[1] Claimant began this job while working for a temporary agency; she became a regular employee of CCI's insured in May 1999.

On September 28, 1999, CCI accepted a nondisabling dorsal sprain. (Ex. 100).

By letters to CCI and EBI dated September 30, 1999, claimant formally requested acceptance of a herniated disc at L5-S1, sciatica, cervical strain, shoulder strain, degenerative disc disease at L4-5 and L5-S1, retrolisthesis at L5-S1, and spondylolisthesis at L5-S1. (Exs. 101, 102).

On November 12, 1999, Dr. Misko, neurosurgeon, evaluated claimant for Dr. Nash. Dr. Misko requested authorization for surgery to include an L5-S1 fusion. (Exs. 111, 113).

On November 29, 1999, Drs. Williams and Strum examined claimant at the request of EBI. (Ex. 112).

On December 10, 1999, EBI denied compensability and responsibility. (Ex. 115).

On the same date, Drs. Fuller and Williams examined claimant at the request of CCI. (Ex. 117).

On December 22, 1999, CCI denied compensability and responsibility for claimant's requested conditions. CCI also denied the claim on the basis that claimant was not in the course and scope of her employment and was not a subject worker at the time of the June 1999 incident. (Ex. 121).

Dr. Warnock, radiologist, reviewed studies from 1994, 1995 and 1999 at the request of CCI. (Ex. 132).

CONCLUSIONS OF LAW AND OPINION

Subjectivity

The ALJ concluded that claimant was a subject worker at the time of the June 9, 1999 incident. CCI contends that, under ORS 656.005(30), claimant was not a subject worker once she had been terminated.[2] Claimant argues that CCI may not argue that no work-related injurious event occurred on June 9, 1999 because it already accepted claimant's dorsal sprain claim that arose out of that event.

We agree with claimant that CCI may not contend that claimant was not a subject worker at the time of the June 9, 1999 injury because, by accepting claimant's June 9, 1999 dorsal strain injury claim, CCI necessarily agreed that a work-related injury occurred. *See Boise v. Katzenbach*, 104 Or App 732 (1990) (by accepting the claimant's injury claim, the employer necessarily agreed that a traumatic event had happened and could not subsequently challenge whether, in fact, an injury occurred (citing *Crumley v. Combustion Engineering*, 92 Or App 439, 443, *rev den* 307 Or 101 (1988)); *see also SAIF v. Mize*, 129 Or App 636 (1994) (carrier foreclosed from challenging compensability because it accepted the claimant's claim; carrier's petition dismissed as moot). Because the litigation in this case arises out of the same injurious event, and because claimant's dorsal sprain accepted by CCI remains an accepted condition, we conclude that CCI's subjectivity argument is moot.

Compensability

L5-S1 Conditions

Relying on the opinions of Dr. Miller and Dr. Misko, the ALJ determined that claimant's L5-S1 conditions were compensable. CCI contends that the medical evidence is insufficient to establish that the major contributing cause of the claimed conditions was the June 9, 1999 incident. We disagree.

Claimant has been diagnosed with a herniated disc, spondylolisthesis, retrolisthesis and degenerative disc disease at L5-S1, as well as bilateral sciatica. The medical evidence indicates that claimant's L5-S1 back condition is a "combined condition," involving claimant's prior surgeries, preexisting degenerative disease, preexisting spondylolisthesis and retrolisthesis, and the compensable 1999 injury. (Exs. 112; 114; 117; 120; 122-14, -15; 133-7, 8). Therefore, claimant is subject to the "major contributing cause" standard of proof under ORS 656.005(7)(a)(B) and she bears the burden of proving

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[2] The ALJ relied on *Donald N. Vatore-Buckout*, 49 Van Natta 93 (1997), to establish that claimant was a subject worker at the time of her injury. We agree with CCI that *Vatore-Buckout* does not establish that a person in claimant's position is a subject worker because that issue was not before us in that case. Furthermore, because we have concluded that CCI's subjectivity argument is moot, we need not address that issue in this case.

that her 1999 work injury contributed more to her disability or need for treatment than all other factors. The statute requires evaluation of the relative contribution of different causes, including the precipitating cause, to determine which is the major contributing cause. *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995). Because of the multiple potential causal factors, this issue is of sufficient medical complexity to require expert medical opinion for its resolution. *See Barnett v. SAIF*, 122 Or App 279, 282 (1993); *Uris v. Compensation Department*, 247 Or 420, 424-26 (1967).

The record contains a number of medical opinions regarding causation. The opinions of Dr. Miller, osteopath, claimant's current attending physician, and Dr. Misko, neurosurgeon, provided evidence supporting compensability.[3] The opinions of Drs. Fuller and Williams, who examined claimant for CCI, Dr. Calhoun, the neurosurgeon who performed claimant's 1995 disc surgery, and Dr. Gripekoven, orthopedic surgeon who also examined claimant for CCI, do not support compensability.[4]

Drs. Fuller and Williams examined claimant on December 10, 1999. They noted minimal settling of the posterior disc space at L5-S1, with a minimal retrolisthesis. They further noted that the bone modeling suggested that this had been present for many years and represented a stable construct. They also determined that neither the June 1999 MRI nor 1999 flexion/extension x-rays showed instability at L5-S1. They concluded that claimant had chronic mechanical back pain stemming from her two diskectomies that had combined with the lifting incident. The panel felt that no acute injury had occurred in 1999 because of claimant's psychological profile and because there were no acute objective symptoms. They concluded that the major contributing cause of claimant's current back pain was the 1995 herniated disc and the subsequent degeneration and that all pathology preexisted the 1999 injury. (Ex. 117).

Both Dr. Calhoun and Dr. Gripekoven, who examined claimant in June 1999 and August 1999 respectively, diagnosed claimant with a lumbar strain and preexisting degenerative disc disease. (Exs. 70, 86). Dr. Gripekoven opined that claimant's soft tissue sprain caused a symptomatic flare-up of her significant preexisting conditions, but that further evaluation and treatment of the preexisting conditions were not related to the June 1999 injury. (Ex. 86).

Dr. Miller, claimant's treating physician, initially concurred with Dr. Gripekoven's report, with the exception that he thought that claimant had a herniated disc and retrolisthesis. Dr. Miller noted at that time that the retrolisthesis had not existed prior to the June 1999 injury, although later, in his deposition, he agreed that claimant's two prior surgeries had contributed to the development of that condition. Dr. Miller opined that the retrolisthesis was the major cause of claimant's current symptoms and need for treatment, but, in contradistinction to his earlier concurrence with Dr. Gripekoven's position that further evaluation and treatment of the preexisting conditions would not be related to the June 1999 injury, Dr. Miller ultimately concluded that the June 1999 injury was the major contributing cause of claimant's retrolisthesis condition. Dr. Miller based his final opinion on a weighing of the preexisting surgeries, the mechanics of the injury, his palpation and measurement of claimant's L5-S1 displacement, and the fact that claimant had been relatively pain-free subsequent to the 1995 disc surgery. Under these circumstances, we find that Dr. Miller's change in opinion is explained, and therefore persuasive. *Kelso v. City of Salem*, 87 Or App 630 (1987) (physician's opinion found persuasive when accompanied by reasonable explanation for the physician's change of opinion).

Dr. Misko, neurosurgeon, examined claimant in November 1999. He opined that claimant had preexisting, degenerative spondylolisthesis that had been developing since the prior surgery, and a herniated disk. He opined that claimant ruptured her disc with the chair incident and that it was medically probable that the disc rupture worsened the preexisting spondylolisthesis. He explained that, if one tears the annulus and posterior ligament with a disk rupture, it can suddenly worsen the degree of spondylolisthesis. Dr. Misko concluded that the major contributing cause of claimant's current L5-S1 condition and need for treatment was the June 9, 1999 injury. Dr. Misko based his opinion on claimant's history, a comparison of the 1995 and 1999 MRIs, and his physical findings. (Exs. 120, 133).

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[3] Although Dr. Nash's opinion also arguably supports compensability, we do not find it persuasive because it is conclusory and unexplained.

[4] Drs. Strum and Williams, who examined claimant for EBI, also did not support compensability. As part of their opinion, they concluded that claimant's 1995 L5-S1 herniated disc surgery and subsequent degeneration was unrelated to her 1982 injury. EBI, however, accepted the 1995 L5-S1 herniated disc surgery as related to the 1982 injury. Because the law of the case is that the 1995 L5-S1 herniated disc is compensable to EBI, we do not find Drs. Strum and Williams' opinion to have much weight.

When there is a dispute between medical experts, more weight is given to those medical opinions that are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263 (1986). Here, Drs. Fuller and Williams opined that claimant did not have an acute injury after the June 1999 incident. However, they noted that they did not have available the medical reports from Ms. Irland, Dr. Russell or Dr. Calhoun regarding claimant's condition immediately after the 1999 injury, nor did they have any records from Dr. Nash. (Ex. 117-9). Drs. Fuller and Williams also thought that claimant did not have an acute injury because of her prior "psychological profile," evidence of which is not in the record. Consequently, we find the opinion of Drs. Fuller and Williams less persuasive than those of Dr. Miller and Dr. Misko. Finally, although Dr. Calhoun and Dr. Gripekoven concurred with the Fuller and Williams' opinion, neither Dr. Calhoun nor Dr. Gripekoven provided any discussion or explanation for their conclusions that claimant had suffered a lumbar strain. Consequently, we agree with the ALJ that the opinions of Dr. Miller and Dr. Misko are more persuasive than those of the other treating or examining physicians.[5]

Finally, CCI asserts that the diagnosis of spondylolisthesis is somewhat confusing and, if compensability is found, it should not be ordered to accept spondylolisthesis. CCI contends that either claimant does not have spondylolisthesis at all, or, citing ORS 656.262(7)(a), that it is encompassed by the more precise term of retrolisthesis. We find no evidence that CCI raised this issue at hearing. We generally 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). Consequently, we decline to address this issue for the first time on review.

Responsibility

The ALJ determined that the June 1999 injury pathologically worsened claimant's preexisting L5-S1 condition and that CCI is responsible. CCI argues that ORS 656.308(1), rather than the last injury rule, applies in this case to establish responsibility.

ORS 656.308(1) only applies where there is an earlier accepted claim and a later injury involves the same condition as did the earlier accepted claim. *Sanford v. Balteau Standard/SAIF Corp.*, 140 Or App 177, 181 (1996); *Smurfit Newsprint v. DeRosset*, 118 Or App 368, 371-72 (1993); *James A. Hoyt*, 52 Van Natta 346, 347 (2000). In this context, a "new injury involves the same condition as the earlier accepted injury when it has the earlier compensable injury within or as part of itself." *MultiFoods Specialty Distribution v. McAtee*, 164 Or App 654, 662 (1999); *Bobby Bradburry*, 52 Van Natta 1560, 1563 (2000). If ORS 656.308(1) applies, CCI is responsible for claimant's current low back condition only if the 1999 injury constitutes the major contributing cause of her disability or need for treatment for the current combined condition. *See SAIF v. Britton*, 145 Or App 288, 291-92 (1996); *Bradburry*, 52 Van Natta at 1563.

If, however, ORS 656.308(1) does not apply, then because the 1982 and 1999 injuries were "successive injuries" involving the same body part (*i.e.*, the low back), responsibility is determined under the "last injury rule." *Hoyt*, 52 Van Natta at 347; *see John J. Saint*, 46 Van Natta 2224, 2226 (1994). Larson's last injury rule provides:

> "The 'last injurious exposure' rule in successive injury cases places full liability upon the carrier covering the risk at the time of the most recent injury that bears a causal relation to the disability * * * [I]f the second incident contributes independently to the injury, the second insurer is solely liable, even if the injury would have been much less severe in the absence of the prior condition, and even if the prior injury contributed the major part to the final condition." *Hensel Phelps Const. v. Mirich*, 81 Or App 290, 293-94 (1986) (quoting *Smith v. Ed's Pancake House*, 27 Or App 361, 364- 65 (1976) (quoting 4 Larson, *Workmen's Compensation Law* sec. 95.12 (1976)); *Hoyt*, 52 Van Natta at 348 (footnote omitted)."

Here, as discussed above, Dr. Miller and Dr. Misko acknowledged that claimant's prior low back surgeries and degenerative conditions had combined with the June 1999 injury and both doctors opined that the major contributing cause for the current treatment and surgery was the June 1999 injury. Consequently, under either ORS 656.308(1) or "the last injury rule," responsibility for claimant's current low back condition rests with CCI.

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[5] Although Dr. Miller and Dr. Misko's opinions differ on whether claimant's current need for surgery is due to the herniated disc or the retrolisthesis at L5-S1, the lack of a definitive diagnosis is not dispositive on the issue of compensability. *See Tripp v. Ridge Runner Timber Services*, 89 Or App 355 (1988).

Cervical and Right Shoulder Strains

We adopt and affirm the ALJ's opinion on this issue, with the following supplementation to address CCI's arguments on review.

CCI contends that the opinions supporting the compensability of a cervical and shoulder strain by Dr. Nash and Dr. Miller are unreliable and that Dr. Gripekoven did not confirm that claimant had a cervical or shoulder strain. We disagree.

There is no evidence that claimant previously injured her neck or shoulder or that there were any preexisting conditions in claimant's cervical or shoulder areas. Thus, claimant can establish compensability of the strains in these areas under a material causation standard. ORS 656.005(7)(a); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992).

As discussed above, we have found the opinions of Dr. Miller and Dr. Misko more persuasive than those of the other physicians that provided causation reports. Moreover, when claimant initially sought treatment on June 14, 1999, Ms. Irland, CNM, found that her right shoulder was tender in the right rotator cuff. (Ex. 66). On July 19, 1999, Dr. Miller noted tenderness to palpation in the rhomboid and trapezius muscles into the neck. (Ex. 73). He diagnosed mild shoulder and cervical strains and, by August 6, 1999, declared that they had resolved. (Ex. 78). Dr. Miller opined that claimant's right shoulder and cervical strains were related to her June 6, 1999 injury.

On August 17, 1999, claimant reported to Dr. Gripekoven a snapping sensation behind the right shoulder and some spasm and tightness under the scapula with radiation into the neck. Dr. Gripekoven found that, by history, claimant had a "minor sprain of her dorsal spine" and noted that she had no history of a preexisting condition in the dorsal or cervical spine. After examining claimant's neck and shoulder, Dr. Gripekoven concluded that her right shoulder, cervical and dorsal problems related to the June 9, 1999 injury were medically stationary. (Ex. 86).

As noted by the ALJ, there is no medical evidence to contradict Dr. Miller's findings and conclusion that claimant suffered a cervical and right shoulder strain at the time of the June 9, 1999 injury. Moreover, Dr. Gripekoven's report affirms that claimant's neck and shoulder had been symptomatic. We accordingly agree with the ALJ that claimant's right shoulder and cervical strains are compensable, and are the responsibility of CCI.

Penalty for Allegedly Late Denial

The ALJ assessed a penalty for CCI's allegedly late denial. On review, CCI asserts that claimant is not entitled to a penalty because she has not proven when her letter seeking to have additional conditions added to the Notice of Acceptance was mailed or the date CCI received the letter. CCI reasons that, inasmuch as the 30-day time limit for responding to a request for acceptance of additional conditions under ORS 656.262(6)(d) runs "from receipt of the communication from the worker," claimant has not established an essential element of her claim for a penalty. We agree that no penalty is due, reasoning as follows.

First, we agree with the ALJ that ORS 656.262(6)(d) applies in this case with regard to claimant's request for acceptance of the additional conditions, as those conditions were in existence before the September 28, 1999 acceptance and claimant asked for acceptance of those conditions following the acceptance. *See Kimberly R. Rice*, 52 Van Natta 138 (2000) (because the claimant's condition was in existence before the updated notice of acceptance at closure and the claimant's attorney objected to the updated notice of acceptance, ORS 656.262(6)(d) applied).

ORS 656.262(6)(d) provides that 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. CCI argues that there is no proof when it received notice of the claim. Claimant contends that the presumptions in ORS 40.135(1)(p) and (q) are that a writing is truly dated and a letter duly directed and mailed was received in the regular course of the mail.

A letter dated September 30, 1999 from claimant's counsel to CCI requests acceptance of the additional medical conditions. While there is a presumption that a writing is truly dated and that a letter directed and mailed was received in the regular course of the mail, there is no presumption that a letter is mailed on the day it is dated or on the day it was written. *Madewell v. Salvation Army*, 49 Or App 713 (1980). This letter does not indicate when, or if, it was mailed to or received by CCI.[6] Because claimant has failed to establish when her letter was mailed (*e.g.*, certificate of service, postal receipt), she cannot take advantage of the presumption of receipt under ORS 40.135(1)(q). *See Edward J. Demille*, 47 Van Natta 91 (1995); *Carol M. Cote-Williams*, 44 Van Natta 367, 369 (1992). Consequently, the record does not establish when CCI received claimant's letter. Thus, we are unable to determine whether CCI's denial was untimely.

Because we cannot say when the 30-day statutory period for CCI to revise the notice or to make other written clarification in response to the letter commenced running, CCI's failure to respond until December 22, 1999 does not support a penalty for untimely processing. *See, e.g., George E. Sims*, 50 Van Natta 790 (1998); *Cameron D. Scott*, 44 Van Natta 1723, 1724 (1992). Accordingly, we reverse the ALJ's penalty assessment for CCI's allegedly late denial.

Interim Compensation and Penalties

Claimant filed a request for hearing regarding her entitlement to interim compensation and penalties. The ALJ concluded that claimant left work because she was fired. The ALJ also found that Dr. Miller authorized time loss on July 19, 1999, and that claimant was entitled to payment of compensation unless CCI's insured offered her modified employment. Because he ascertained that claimant was probably not paid interim compensation, the ALJ awarded a penalty based on the compensation due from July 19, 1999 to the date of the December 22, 1999 denial. The ALJ did not award interim compensation.

On review, claimant contends that temporary disability compensation is due from the date of the notice of disability until denial and a penalty is due for CCI's allegedly unreasonable claim processing. We agree.

Here, on July 19, 1999, Dr. Miller diagnosed claimant with a herniated disc, degenerative disc disease, spondylolisthesis, sciatica, a cervical strain and a shoulder strain due to her June 1999 work injury and placed her on modified work. (Exs. 71, 72, 73). This is sufficient to entitle claimant to interim compensation.[7]

Moreover, even if claimant was fired for disciplinary reasons (and not entitled to temporary disability benefits at that time), she would be entitled to temporary disability benefits as of the subsequent time loss authorization. *See Gray v. SAIF*, 70 Or App 313 (1984); *Lisa R. Angstadt*, 47 Van Natta 981 (1995) (where the claimant suffered diminished earning capacity after being terminated, she became entitled to interim compensation as of the date her diminished earning capacity began). Consequently, claimant would be entitled to temporary disability compensation from July 19, 1999 through December 22, 1999.

The ALJ assessed a penalty based on CCI's failure to pay the disputed interim compensation without further explanation. CCI knew, or should have known, that temporary disability was due based on Dr. Miller's authorization. Under these circumstances, we find that CCI's failure to pay interim compensation for the period from July 19, 1999 until December 22, 1999 was unreasonable. *See Joseph E. Bridwell, on recon*, 49 Van Natta 1452, 1453 (1997); *Lisa R. Angstadt*, 47 Van Natta at 983. Consequently, we agree with the ALJ that a penalty is appropriate.

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[6] Although there are two date stamps on the letter, they are illegible. *See* Exhibit 102.

[7] *See Gustavo B. Barajas*, 51 Van Natta 613, *on recon* 51 Van Natta 732 (1999), *aff'd mem Nike, Inc. v. Barajas*, 166 Or App 237 (2000) (to trigger a 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; the worker does not have to first comply with ORS 656.262(6)(d) in order to be entitled to interim compensation).

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 CCI. 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.[8]

Claimant's attorney is also entitled to an "out-of-compensation" fee for his services at hearing and on review regarding the interim compensation issue. ORS 656.386(2). Claimant's counsel is awarded an "out-of-compensation" fee equal to 25 percent of the increased compensation, if any, created by this order, not to exceed $5,000, to be paid by CCI directly to claimant's counsel. OAR 438-015-0055(1).

ORDER

The ALJ's order dated October 17, 2000 is affirmed in part and reversed in part. That portion of the order assessing a penalty against CCI for an allegedly late denial is reversed. That portion of the order that failed to award interim compensation is reversed and claimant is awarded interim compensation beginning July 19, 1999 through December 22, 1999. Claimant's attorney is awarded an "out-of-compensation" attorney fee equal to 25 percent of any additional temporary disability compensation created by this order, not to exceed $5,000, payable directly to claimant's counsel by CCI. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,500, to be paid by CCI.

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[8] Inasmuch as penalties are not compensation, claimant's counsel is not entitled to an attorney fee under ORS 656.382(2) for services devoted to the penalty issue. *See Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986).

June 19, 2001 Cite as 53 Van Natta 769 (2001)

In the Matter of the Compensation of
CHRIS A. CUPPY, Claimant
WCB Case No. 00-08285
ORDER ON REVIEW
Bradley P. Avakian, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewed by Board Members Haynes & Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Kekauoha's order that: (1) set aside its denial of claimant's injury claim for a left ankle or shin condition; and (2) awarded a $3,000 assessed attorney fee. On review, the issues are whether claimant's injury arose out of and in the course of employment, compensability, and attorney fees. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the employer's denial of claimant's left ankle/shin periostitis that allegedly occurred during a two-hour period while claimant was walking at work. In doing so, the ALJ reasoned that, because claimant's left shin/ankle pain arose during a short, discrete period, it should be analyzed as an injury claim. Moreover, because there was no evidence of a preexisting condition triggering the "combined condition" requirements in ORS 656.005(7)(a)(B), the ALJ applied a material contributing standard to the causation issue. The ALJ then determined that claimant satisfied his burden of proof under that standard, relying on the medical opinion of the attending physician, Dr. Ackerman, the only physician who addressed causation.

On review, the employer contends that claimant's injury did not arise out of claimant's employment because the only connection between claimant's condition and his work is that the pain allegedly arose at work. Alternatively, the employer asserts that the medical evidence from Dr. Ackerman is insufficient to establish medical causation.

Because we agree with the employer's alternative contention, we need not address the "course and scope" issue. We reason as follows.

At the outset, the employer does not contest the ALJ's application of a material contributing cause standard in determining the medical causation issue. Moreover, we agree with the ALJ's analysis in this regard. However, unlike the ALJ, we do not find Dr. Ackerman's opinion persuasive.

The employer's claims adjuster initially asked Dr. Ackerman whether it was medically probable that there was a causal relationship between claimant's left shin/ankle condition and his employment and, if so, whether the employment contributed 51 percent or greater. (Ex. 20). The employer also informed Dr. Ackerman that claimant played various sports off-the-job and rode motorcycles.

Dr. Ackerman replied that he was unable to say with medical probability of 51 percent or greater that claimant's injury was caused by work. Dr. Ackerman further stated that he just did not know the answer to that question. According to Dr. Ackerman, if claimant had admitted to playing sports one or two days prior to being seen in his clinic, then the cause was more likely related to sports. Dr. Ackerman noted that periostitis usually occurred in people who are not typically active and then go out and play sports. However, Dr. Ackerman also noted that he did not receive that history. (Ex. 21).

The only other evidence from Dr. Ackerman on the causation issue was a one sentence statement in response to an inquiry from claimant's attorney. Dr. Ackerman stated that "I believe that [claimant's] work injury was a material contributing cause of his need for treatment." (Ex. 24).

It is well-settled that even the uncontradicted medical opinion of a physician is not binding on the trier of fact. *See William K. Young*, 47 Van Natta 740, 744 (1995) (uncontradicted medical opinion found unpersuasive); *Edwin Bollinger*, 33 Van Natta 559 (1981) (uncontradicted medical opinion need not be followed). Here, we find that Dr. Ackerman's initial comments on the causation issue are ambiguous. Granted, Dr. Ackerman may have been only addressing a major contributing cause standard in his initial report. However, even if that were true, the one-sentence statement in the subsequent report contains no explanation of Dr. Ackerman's opinion. Given his statement in the previous report that claimant's condition usually arises in conjunction with sports activity, Dr. Ackerman's failure to provide any explanation for his conclusion that an alleged work injury was a material contributing cause of claimant's need for treatment renders that opinion unpersuasive.[1] *See Moe v. Ceiling Systems, Inc.*, 44 Or App 429, 433 (1980).

In summary, we are unable to conclude that claimant proved that an alleged work injury was materially related to his need for treatment for the left ankle/shin condition.[2] Thus, we disagree with the ALJ's decision setting aside the employer's denial. Therefore, we reverse.

ORDER

The ALJ's order dated February 28, 2001 is reversed. The employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[1] We note that claimant did not report any specific incident of injury at work, only that his left ankle/shin pain began while working. Indeed, claimant conceded that he could not explain how his pain began. (Tr. 4). In light of these circumstances, Dr. Ackerman's opinion is also unpersuasive in the absence of some explanation about how an alleged "injury" at work was causally related to the disputed left ankle/shin condition.

[2] In reaching this conclusion, we emphasize that we are not applying *Dietz v. Ramuda*, 130 Or App 397, *rev dismissed* 321 Or 416 (1995), to require Dr. Ackerman to have evaluated the relative contribution of each cause. *See Richey v. Barrett Business Services*, 173 Or App 29 (2001). Instead, we have only applied well-established case law requiring at least some explanation of a medical opinion. *Moe*, 44 Or App at 433.

In the Matter of the Compensation of
BARBARA A. HASSE, Claimant
WCB Case Nos. 00-06528 & 99-09130
ORDER ON REVIEW
Furniss, et al., Claimant Attorney
Reinisch, et al., Defense Attorney

Reviewed by Board Members Haynes and Phillips-Polich.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Mills' order that awarded a penalty-related attorney fee for its untimely acceptance of claimant's disabling lumbar strain injury. Claimant cross-requests review of that portion of the ALJ's order that upheld the insurer's partial denial of her current low back combined condition, L3-4 disc bulge, L3-4 canal stenosis, and L3-4 radiculopathy conditions. On review, the issues are compensability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following correction. The date of injury in the last paragraph of the ALJ's findings of fact should be April 22, 1999.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt and affirm the ALJ's reasoning and conclusions regarding the compensability issue.

Penalties

On April 29, 1999, claimant sustained a lumbar strain injury while working as a cashier for the employer. On May 3, 1999, claimant filed a claim for that injury. (Exs. 5, 8). On October 2, 1999, the insurer accepted the claim for a disabling lumbar strain. (Ex. 72).

The insurer did not accept or deny the claim within 90 days as required by ORS 656.262(6). The ALJ found the delay in accepting the lumbar strain claim unreasonable. Although the ALJ noted that there was no evidence of any amounts due, he awarded a $500 assessed attorney fee "because of unreasonable delay and resistance to the payment of compensation."

On review, the insurer argues that claimant is not entitled to a penalty-related attorney fee because there is no evidence that any compensation was due. We agree.

Under the facts of this case, despite the untimeliness of the insurer's acceptance, there is no basis for the assessment of either a penalty under ORS 656.262(11)(a) or an attorney fee under ORS 656.382(1). A penalty may be assessed under ORS 656.262(11)(a) if there were "amounts then due" between the date when the acceptance or denial should have issued and the date the acceptance or denial actually issued. *Melody L. Rivers*, 48 Van Natta 2089 (1996); *Jeffrey D. Dennis*, 43 Van Natta 857 (1991).

Here, claimant asserts that the insurer unreasonably delayed in not accepting the claim within 90 days, but there is no evidence of any "amounts then due." Because the record does not support a finding that there were amounts due at the time of the unreasonable delay, there is no basis for a penalty. *See Wacker Siltronic v. Satcher*, 103 Or App 513 (1990).

ORS 656.382(1) provides that, if a carrier "unreasonably resists the payment of compensation," it shall be liable for a reasonable attorney fee. However, even if a carrier does not timely accept a claim, there is no unreasonable resistance to payment of compensation if the carrier has paid all compensation. *See SAIF v. Condon*, 119 Or App 194, *rev den* 317 Or 163 (1993); *Ana M. Aguila*, 52 Van Natta 2038 (2000); *Mark A. Klouda*, 51 Van Natta 823 (1999); *see Lloyd A. Humpage*, 49 Van Natta 1784 (1996) (no entitlement to penalty or assessed fee under ORS 656.382(1) for untimely claims processing where no amounts due at time of unreasonable delay (citing *Condon*)). Here, there is no evidence of any unpaid compensation.

Claimant argues that *Janice A. Talevich*, 48 Van Natta 2318 (1996), cited by the ALJ, and *Betty V. West*, 46 Van Natta 1469 (1994), support the ALJ's penalty-related attorney fee award. We disagree.

Both *Talevich* and *West* are distinguishable. Both cases involve penalty-related attorney fee awards for discovery violations that occurred after issuance of denials that were subsequently set aside through litigation. Because the discovery violations occurred after the denials were issued, there were no "amounts then due" at the time of the discovery violations upon which to base penalties under ORS 656.262(11). Nevertheless, we found that, as a result of the subsequent litigation orders that set aside the denials, the discovery violations resulted in unreasonable resistance to payment of compensation. Therefore, we found that assessment of penalty-related attorney fees pursuant to ORS 656.382(1) was appropriate.

In contrast to *Talevich* and *West*, here, there is no evidence of any unreasonable resistance of payment of compensation. Consequently, we reverse the ALJ's "penalty-related" attorney fee of $500.

ORDER

The ALJ's February 23, 2001 order is reversed in part and affirmed in part. That portion of the ALJ's order that awarded penalty-related attorney fee is reversed. The remainder of the order is affirmed.

Board Member Phillips Polich concurring.

While I agree with the lead opinion's summary and application of the current state of the law regarding application of ORS 656.262(11) and 656.382(1) to the issue of untimely claim processing, I find myself compelled to make a few points by means of this concurrence.

Pursuant to ORS 656.262(6), the carrier is required to accept or deny a claim within 90 days after the employer has notice or knowledge of the claim. Thus, by statute, the carrier has a finite period within which to accept or deny a claim. Furthermore, an acceptance or denial is not a mere formality. Instead, it is a legal document that notifies the parties of the status of the claim at that point in time. In addition, it notifies claimant of his or her recourse if the claim is denied or the claimant disagrees with the conditions accepted or the disabling/nondisabling status assigned by the insurer. Other benefits also may flow from an acceptance, including eventual claim closure with rating of any permanent disability. Moreover, an untimely denial may result in problems for the claimant in gathering evidence to support his or her claim. In other words, more than simple payment of current medical bills and time loss is involved in processing a workers' compensation claim.

Nevertheless, a carrier can ignore the statutory scheme by failing to accept or deny a claim within 90 days and yet avoid any penalty by paying compensation due during its self-granted "extension" of the statutory claim processing period. Thus, as long as a carrier pays compensation due, the current state of the law provides no means for enforcement of the required 90-day processing period. In contrast, pursuant to ORS 656.265, an injured worker is held to strict reporting requirements, including definitive timelines, in reporting work injuries to the employer. An injured worker is not permitted to grant himself or herself an "extension" of the statutory timeline within which to report an injury. Likewise, a carrier should not be permitted to grant itself an "extension" of the statutory timeline within which to process a claim.

Given the statutory mandate requiring acceptance or denial of a claim within 90 days and the legal significance of such a document, a carrier's failure to comply with that mandate should result in some penalty. That said, I acknowledge that the current state of law does not provide for such a remedy.

In the Matter of the Compensation of
MICHAEL D. HULME, Claimant
WCB Case No. 00-05585
ORDER ON REVIEW (REMANDING)
Mustafa T. Kasubhai, Claimant Attorney
Terrall & Terrall, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that dismissed his request for hearing as untimely filed. Claimant requests remand for a determination of compensability. On review, the issues are timeliness of claimant's request for hearing and remand. We vacate the ALJ's order and remand.

FINDINGS OF FACT

Claimant signed an "801" form on February 29, 2000, alleging a work injury on January 6, 2000. (Ex. 1). The self-insured employer denied the claim on April 6, 2000, on the basis that claimant's injury did not arise out of and in the course of his employment. (Ex. 21).

By affidavit, claimant's counsel asserted that he had signed and completed a request for hearing form and a cover letter on April 17, 2000. (Ex. 26-1). He asserted that the request for hearing and cover letter were placed in a sealed envelope, which was properly addressed to the Workers' Compensation Board. (*Id.*) Claimant's counsel said that the sealed envelope containing the original request for hearing was deposited with the United States Postal Service in Eugene, Oregon on April 17, 2000 and was sent by first class mail, postage fully prepaid. (*Id.*) Claimant's counsel also mailed a copy of the request for hearing to the employer's processing agent. (*Id.*) On May 26, 2000, claimant's counsel received a notice of representation from the employer's attorney dated May 24, 2000 that acknowledged receipt of the request for hearing. (*Id.*)

The Board received claimant's request for hearing on July 26, 2000.

CONCLUSIONS OF LAW AND OPINION

At hearing, the employer argued that claimant's request for hearing was not timely filed pursuant to ORS 656.319. The ALJ found that the Board did not receive claimant's request for hearing until July 26, 2000, more than 60 days after the mailing of the employer's denial. The ALJ found that the request for hearing was mailed by first class mail, and the date on the U.S. Postal Service stamp was unreadable. The ALJ reasoned that, pursuant to OAR 438-005-0046(1)(c), the presumption is that the request for hearing was untimely filed. Because claimant did not prove that the Board received the request for hearing within 60 days of the April 6, 2000 denial date, *i.e.*, by June 5, 2000, the ALJ dismissed the hearing request as untimely filed.

Relying on *James R. Corum*, 52 Van Natta 984 (2000), claimant argues that he has rebutted the presumption of untimely filing. For the following reasons, we agree.

A request for a hearing must be filed not later than the 60th day after the mailing of the denial to the claimant. ORS 656.319(1)(a). A hearing request that is filed after 60 days, but within 180 days of a denial, confers jurisdiction if the claimant establishes good cause for the late filing. ORS 656.319(1)(b).

OAR 438-005-0046(1)(a) provides that "filing" means the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing. If filing of a request for hearing is accomplished by mailing, it shall be presumed that the request was mailed on the date shown on a receipt for registered or certified mail bearing the stamp of the United States Postal Service showing the date of mailing. OAR 438-005-0046(1)(c). 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. *Id.*

In *James R. Corum*, 52 Van Natta at 984, the insurer's request for review was received by the Board after expiration of the 30-day appeal period and, therefore, the insurer's request for review was presumed to be untimely. Nevertheless, the insurer argued that its request for review was timely mailed, based on affidavits by its attorney and the attorney's assistant. The insurer's attorney attested

that a signed original of the insurer's request for review was placed in an office "out box" for post office delivery on February 28, 2000, well before the 30-day appeal period ended. The attorney's assistant attested that she delivered the request for review to a U.S. Post Office and mailed it by certified mail, although she no longer had a receipt. We found that information was corroborated by the insurer's undisputed assertion that the claimant's counsel had received his copy of the request on or about March 1, 2000. Under those circumstances, we concluded that the insurer rebutted the presumption of untimely filing.

We reach a similar conclusion in this case. The Board received claimant's request for hearing more than 60 days after the employer's April 6, 2000 denial. Because the request for hearing was not mailed by registered or certified mail and it was actually received by the Board after the date for filing, it is presumed that the mailing was untimely unless claimant establishes that the mailing was timely. *See* OAR 438-005-0046(1)(c).

Here, claimant's counsel attested that he signed and completed a request for hearing form and a cover letter on April 17, 2000. (Ex. 26-1). He asserted that the request for hearing and cover letter were placed in a sealed envelope, which was properly addressed to the Workers' Compensation Board. (*Id.*) Further, claimant's counsel said the sealed envelope containing the request for hearing was deposited with the United States Postal Service in Eugene, Oregon on April 17, 2000 and sent by first class mail postage, fully prepaid.[1] (*Id.*) Claimant's counsel's assertions are corroborated by the notice of representation from the employer's attorney dated May 24, 2000, which acknowledged receipt of claimant's request for hearing.

Under these circumstances, we conclude that claimant has rebutted the presumption of untimely filing. *See James R. Corum*, 52 Van Natta at 985; *Randolph King*, 51 Van Natta 82 (1999) (presumption of untimely mailing rebutted by an affidavit from the claimant's counsel's legal assistant attesting that she timely mailed the request for review to the Board and parties); *Brian L. Schmitt*, 48 Van Natta 295 (1996) (the claimant rebutted the presumption under OAR 438-005-0046(1)(b) by showing that the carrier received a copy of the request for hearing before expiration of the appeal period and evidence showing the claimant's counsel's customary procedure of mailing the request to the Board, and a copy to opposing counsel, on the same date). Accordingly, the ALJ's March 7, 2001 order is vacated. Because we find that claimant's request for hearing was filed within 60 days after the mailing of the denial to the claimant, we need not address the employer's argument that claimant has not established good cause for untimely filing. *See* ORS 656.319(1)(b).

Claimant requests remand for a finding of compensability on the merits. We may remand to the ALJ if we find that the case has been "improperly, incompletely or otherwise insufficiently developed[.]" ORS 656.295(5). There must be a compelling reason for remand to the ALJ for the taking of additional evidence. *SAIF v. Avery*, 167 Or App 327, 333 (2000). Based on the finding that claimant's request for hearing was untimely filed, the ALJ found that he did not have jurisdiction to address the merits. Under these circumstances, the ALJ did not have an opportunity to make credibility findings or weigh the parties' arguments. Consequently, this matter is remanded to ALJ Brazeau for further proceedings consistent with this order. These proceedings may be conducted in any manner that the ALJ determines will achieve substantial justice. Thereafter, the ALJ shall issue a final, appealable order.

ORDER

The ALJ's order dated March 7, 2001 is vacated. This matter is remanded to ALJ Brazeau for further proceedings consistent with this order.

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[1] We note that the employer contends that claimant's attorney's affidavit merely sets forth his "belief" that the original request for hearing was mailed on April 17, 2000. We find that claimant's counsel's affidavit that the original request for hearing was deposited with the United States Postal Service in Eugene, Oregon on April 17, 2000 is sufficient to establish that the mailing for the request for hearing was timely.

In the Matter of the Compensation of
RUSSELL J. MEAD, Claimant
WCB Case No. 99-04641
ORDER ON REVIEW
Doblie & Associates, Claimant Attorney
Hornecker, Cowling, et al., Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers

Claimant requests review of that portion of Administrative Law Judge (ALJ) Black's order that determined that claimant had waived a personal appearance at hearing and barred him from testifying. On review, the issue is the propriety of the ALJ's evidentiary/procedural ruling.

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

Claimant requested a hearing from the self-insured employer's May 10, 1999 denial of an October 1998 low back injury claim. Claimant's counsel, but not claimant, attended a December 14, 1999 hearing regarding the denial. The ALJ granted the employer's motion to dismiss claimant's hearing request,[1] but, after claimant contacted the Hearings Division and his counsel to assert that transportation problems had prevented his appearance at the hearing, a telephone proceeding was later conducted to determine whether the hearing should be postponed.

In an interim order, the ALJ concluded that claimant was not entitled to postponement of the December 14, 1999 hearing and that the case should be decided based on the record as it stood on December 14, 1999. The ALJ determined that claimant had waived personal appearance and was barred from providing testimony or other evidence that could not have been presented at the December 14, 1999 hearing.

In his order addressing the merits of the compensability issue, the ALJ upheld the employer's denial. In so doing, the ALJ first determined that, based on the documentary record, claimant had proved legal causation (*i.e.*, that there was sufficient evidence of work exposure that could have caused a back injury). However, the ALJ concluded that claimant failed to prove medical causation.

On review, claimant's only contention is that the ALJ incorrectly denied him his right to testify. Thus, he argues that the case should be remanded to the Hearings Division for a new hearing. The employer responds that, because the ALJ had already concluded that claimant had proved legal causation, there is no reason to remand to the Hearings Division. We agree with the employer.

Claimant does not contest, and we agree with, the ALJ's determination that, because this case involves a complex issue of medical causation, expert medical evidence is necessary to resolve the compensability issue. *See Barnett v. SAIF*, 122 Or App 279 (1993). Therefore, at most, claimant's testimony could establish legal, but not medical, causation. However, the ALJ already determined that claimant had proved legal causation based on the documentary record.[2] Thus, we find no compelling reason to remand the case for inclusion of claimant's testimony, even assuming that the ALJ's evidentiary/procedural ruling barring such testimony was incorrect. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986) (in order to warrant remand, there must be a compelling reason established for doing so, including a reasonable likelihood that the evidence sought to be admitted on remand will affect the outcome of the hearing). Accordingly, we affirm.

ORDER

The ALJ's order dated February 16, 2001 is affirmed.

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[1] We note, however, that a claimant is not required to personally attend a hearing; therefore, an ALJ is not authorized to dismiss a hearing request for failure of a claimant to appear if claimant's counsel appears on his or her behalf. *See Williams v. SAIF*, 310 Or 320 (1990).

[2] The employer does not challenge this aspect of the ALJ's order.

In the Matter of the Compensation of
LESTER J. OCHOA, Claimant
WCB Case No. 00-07810
ORDER ON REVIEW
Scott M. McNutt, Sr., Claimant Attorney
Lundeen, et al., Defense Attorney

Reviewed by Board Members Phillips Polich, Bock, and Meyers.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order that set aside its partial denial of claimant's injury claim for a current C6-7 disc condition. On review, the issue is compensability.

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

The last sentence of the second full paragraph on page two is replaced with: "Drs. Marble and Rich concluded that claimant's overall problems were due primarily to idiopathic degenerative disc changes that occurred over the last 15 years. (*See* Ex. 32-7)."

We agree with the ALJ that the above examiners' opinion is not persuasive, because it is at least potentially inconsistent with the same doctors' finding that claimant's C6-7 disc pathology "changed but little" since it was "defined myelographically in 1985." (Ex. 32-5-6). And we find Dr. Bert's opinion supporting the claim persuasive, because it is consistent with claimant's clinical findings[1] and his history of cervical problems, beginning with the 1985 work injury and worsening progressively thereafter. (*See* Exs. 25, 33A, 36A, 38; *see also* Tr. 8, 10, 12, 16-18, 29-31).

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 $1,100, 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 February 23, 2001 is affirmed. For services on review, claimant is awarded a $1,100 attorney fee, payable by the insurer.

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[1] In this regard, we note that Dr. Whitney's 1985 observations support Bert's 2000 opinion that claimant's C6-7 disc is the primary source of his symptoms. (*See* Ex. 5-1, 7; see also Ex. 6). We find Drs. Marble and Rich similarly supportive: The examiners reported that claimant "complains of the chronic C6-C7 pattern of numbness in the right upper extremity" and the doctors diagnosed "Now remote history of industrial injury associated with a probable small right herniation of the C6-7 disc, which has been associated by ongoing complaints of pain and complaints of persistent C6-7 numbness on the right[.]" (Exs. 32-3, -5). Finally, we note the examiners' comment that claimant's June 2000 MRI "would be consistent with [claimant's] history of having a right sided C6-7 disc protrusion combined with an anterior bar that compromised the root in 1986." (Ex. 35-1).

Board Member Meyers dissenting.

The majority finds that claimant's C3-4, C5-6, and C7-T1 conditions are not compensable, but his C6-7 condition remains compensably related to his 1985 work injury. I would not find the C6-7 condition compensable, because the persuasive medical evidence establishes that it results from idiopathic degeneration - as do claimant's other upper back problems.

Drs. Marble and Rich distinguished claimant's 1985 C6-7 disc injury from his current C6-7 condition, noting that the injury was on the right and it caused right-sided symptoms, whereas claimant's symptoms in 2000 were new and primarily left-sided. The majority does not explain how claimant's condition in 2000 could be so different, yet still be due to an injury 15 years ago.

The majority discounts the examiners' opinion as inconsistent, because the doctors related claimant's C6-7 condition to idiopathic degeneration, despite finding that claimant's degeneration had "changed but little" since 1985. I disagree with the majority's reasoning, because nothing in the record supports characterizing the examiners' reasoning as inconsistent. On the contrary, there is no persuasive reason to question the examiners' reasoning: Claimant's degeneration has not changed much in 15 years, but his C6-7 condition is nonetheless due to degeneration.

I also disagree with the result in this case, because the claim is unmanageable. Multi-level surgery is recommended, yet the carrier is apparently only liable for part of the procedure. Because the well-reasoned medical evidence supports a conclusion that would make this difficult implementation unnecessary, I must respectfully dissent.

June 19, 2001 Cite as 53 Van Natta 777 (2001)

In the Matter of the Compensation of
GUY STURGEON, Claimant
WCB Case No. 00-00423
ORDER ON REVIEW
Welch, et al., Claimant Attorney
Sheridan, Bronstein, et al., Defense Attorney

Reviewed by Board Members Haynes 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 occupational disease claim for a mental disorder. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following exception and supplementation. We do not adopt the last paragraph on page 5 of the order or the last sentence of the first paragraph on page 6. We add the following supplementation.

The ALJ concluded that claimant had established compensability of his occupational disease claim for a mental condition and set aside the self-insured employer's denial of that condition. On Board review, the employer argues that: claimant is not credible; claimant did not tell the employer about his stress claim until after his hospitalization; Dr. Kohen possessed an inaccurate history; Dr. Kohen failed to consider claimant's prior bouts of depression; and claimant's condition is not compensable because it was caused by the employer's reasonable discipline.

The employer argues that claimant is not credible. To the extent that the employer's witnesses questioned the number of hours claimant worked, the record, including the employer's own documentation, suggests that employees in claimant's department (claimant and Ms. Thurley) worked excessive hours during the relevant time period. (Ex. 16B). In fact, the record establishes that claimant's department increased to four positions after he left work. (Tr. 188). Thus, we are not persuaded by the employer's arguments that claimant's hours were not excessive.

The employer also argues that claimant's testimony that he told some co-workers that he was stressed prior to leaving work is not supported by the record. Claimant believed that he told his co-workers that he had high blood pressure and was stressed. Claimant did not testify that he specifically told his co-workers on September 17, 1999 that he was filing a claim for stress or that he had been diagnosed with depression. The co-workers testified that other than high blood pressure, they did not know what was wrong with claimant when he left work on September 17, 1999. We do not find this discrepancy between the employer's witnesses' testimony and claimant's to be sufficient, without more, to establish that claimant's testimony was non-credible.

The employer argues that the medical evidence does not persuasively establish compensability because Dr. Kohen possessed an inaccurate history and failed to consider claimant's prior bouts of depression. Based on this record, we conclude that Dr. Kohen's history of claimant's work activities is accurate. Moreover, Dr. Kohen was aware of claimant's prior history of depression as well as a family history of depression and bipolar illness. (Ex. 55-6). In addition, Dr. Kohen opined that claimant's work exposure, rather than his preexisting factors, were the major cause of his condition. (Ex. 55-4). Under such circumstances, we are not persuaded by the employer's argument.

We likewise find the employer's argument that claimant's condition was caused by its reasonable discipline or termination unpersuasive. The record establishes that claimant was already disabled and off work prior to the employer's disciplinary action and termination of claimant. While the employer's institution of a work plan and its termination of claimant for failing to call in and report absences to a live person exacerbated claimant's condition, resulting in his hospitalization, claimant had already left work due to his mental condition prior to the discipline.[1] Thus, the employer's argument that claimant's condition is not compensable because it was caused by reasonable discipline is unpersuasive. We further note that the record reflects that the employer did not discipline claimant or notice any problems with claimant's work until after he became ill and left work. The record reflects that prior to becoming ill, claimant had no performance problems at work. In fact, prior to his illness, the record suggests that the employer was satisfied with claimant's work. (Tr. 235).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). Claimant's attorney has submitted a statement of services seeking a $4,500 attorney fee for 25 hours of work on Board review. The hours of work at the Board review level were performed by claimant's appellate attorney and the attorney who represented claimant at the hearing level. The employer has objected to the statement of services and argues that the hours expended on review by the two attorneys are excessive. The employer argues that the complexity of the case was average, and that although the record is large, it is not inordinately large. In response to the employer's objection, claimant asserts that having the attorney who appeared at hearing review the transcript took less time than if the appellate attorney had reviewed the transcript.

In determining a reasonable attorney fee, we apply the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. *See Schoch v. Leupold & Stevens*, 162 Or App 242 (1999) (Board must explain the reasons why the factors considered lead to the conclusion that a specific fee is reasonable). 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.

The issue is compensability of claimant's occupational disease claim for mental stress. The record is large and consists of 244 pages of transcript (the hearing took a day to complete) and 55 exhibits. Claimant submitted a 14 page respondent's brief.

The legal, medical, and factual issues, when compared to compensability disputes generally presented to this forum, are of above average complexity. The value of the claim and the benefits secured are significant. The parties' respective counsels presented their positions in a thorough and professional manner. No frivolous issues or defenses were presented. Finally, considering the conflicting medical opinions and the stringent standard for establishing compensability of occupational disease claims for mental illnesses, there was a significant risk that claimant's counsel's efforts might have gone uncompensated.

After considering claimant's counsel's statement of services, the employer's objection and claimant's response, and applying the factors set forth in OAR 438-015-0010(4), we conclude that $4,500 is a reasonable attorney fee under ORS 656.382(2) for services on Board review regarding the compensability issue. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue, the complexity of the issue, the value of the interest involved, the skill of the attorneys, the nature of the proceedings, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated October 11, 2000 is affirmed. For services on Board review, claimant's attorney is awarded $4,500, payable by the employer.

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[1] After claimant left work, the employer discovered problems with claimant's work and put him on a work plan when he returned to work. Claimant again left work after being put on the work plan, and was subsequently fired when he failed to call in every day and report his absence to a live person Because we find that claimant was ill prior to the employer's discipline and termination of claimant, we need not address whether that discipline was reasonable.

In the Matter of the Compensation of
JANET F. TILLITT, Claimant
WCB Case No. 99-08887
ORDER ON REVIEW
Sheridan, et al., Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

Claimant, *pro se*, requests review of that portion of Administrative Law Judge (ALJ) Davis' order that upheld the insurer's *de facto* denial of her injury claim for a L4-5 disc condition. Claimant has also submitted a document not entered into evidence at hearing. We treat claimant's submission as a motion to remand to the ALJ for the taking of additional evidence. On review, the issues are remand and compensability.

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

Claimant has provided a February 5, 2000 letter from the owner of a health club in support of her argument that she did not injure herself off-the-job. Because this letter was not presented as evidence at the hearing, we treat this submission as a request for remand for the admission of additional evidence. *Judy A. Britton*, 37 Van Natta 1262 (1985).

Our review is limited to the record developed by the ALJ. We may remand to the ALJ for the taking of additional evidence if we determine that the record as been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). In addition, to merit remand, it must clearly be shown that relevant, material evidence was not obtainable with due diligence at the time of the hearing and that it is likely to affect the outcome of the hearing. *Compton v. Weyerhaeuser Co.*, 301 Or 641 (1986).

Because the ALJ already determined that claimant did not injure herself at the health club, there is no compelling reason to remand this matter to the ALJ for further proceedings because the letter is not likely to affect the outcome of the hearing, even assuming the letter was not obtainable with due diligence prior to the hearing. *Compton v. Weyerhaeuser*, 301 Or at 646; *Juana M. Lopez*, 52 Van Natta 1654 (2001). Consequently, we deny claimant's motion to remand.

ORDER

The ALJ's order dated February 20, 2001 is affirmed.[1]

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[1] We note that claimant is unrepresented. Because she is unrepresented, she may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in workers' compensation matters. She may contact the Workers' Compensation Ombudsman at (503) 378-3351 or 1-800-0927-1271 (V/TTY) (within the State of Oregon), or write to:

Workers' Compensation Ombudsman
Dept. of Consumer & Business Services
350 Winter St. NE, Room 160
Salem OR 97301-3878

In the Matter of the Compensation of
PATRICK TROWBRIDGE, Claimant
WCB Case No. 00-07124
ORDER ON REVIEW
Kryger, et al., Claimant Attorney

Reviewed by Board Members Haynes, Bock, and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that affirmed an Order on Reconsideration that awarded 14 percent (18.9 degrees) scheduled permanent disability for loss of use or function of claimant's right foot (ankle). On review, the issue is extent of scheduled permanent disability.

We adopt and affirm the ALJ's order. *See Marjorie M. Short,* 52 Van Natta 324 (2000) (no impairment rating under OAR 436-035-0020(4)(a), where medical arbiter opined that the claimant "should be prevented" from standing or walking more than 2 hours out of 8 hours, not that she "cannot" do that).

ORDER

The ALJ's order dated February 20, 2001 is affirmed.

Board Member Phillips Polich dissenting.

The majority finds that claimant is not entitled to a permanent impairment rating for his inability to stand or walk more than 2 hours in an 8 hour period, despite the treating doctor's opinion imposing that restriction.

Claimant concedes that a medical arbiter is generally in as good a position as a treating physician to determine objectively measurable impairment, such as range of motion. However, claimant contends that a treating physician is in a much better position to subjectively evaluate the worker's ability to perform certain activities, where that ability is not simply measured, but depends instead on familiarity with the worker's condition.

Claimant's argument in this regard is persuasive and unrebutted. Here, Dr. Neuburg, treating physician, concurred with Dr. Young's "rating examination." And claimant's treating physician is certainly better informed regarding claimant's ability to stand and walk than the medical arbiter who examined claimant only once. Accordingly, I would rely on Dr. Neuberg's opinion that claimant should be restricted to 15 minutes of standing or walking per hour, and conclude that claimant is entitled to a an impairment rating under OAR 436-035-0020(4)(a) (for a total award of 27 percent scheduled permanent disability). Under these circumstances, I must respectfully dissent.

In the Matter of the Compensation of
ROBERT C. VICTORIA, Claimant
WCB Case No. 00-08331
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Meyers, Bock, and Phillips Polich.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Peterson's order that awarded 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of each of claimant's arms, whereas an Order on Reconsideration had awarded 4 percent (7.68 degrees) scheduled permanent disability for each arm. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," but not the "Ultimate Findings of Facts."

CONCLUSIONS OF LAW AND OPINION

The ALJ increased claimant's bilateral scheduled permanent disability award for his arms from 4 to 5 percent. In so doing, the ALJ concluded that, while claimant was not entitled to permanent impairment for loss of range of motion (as had been granted by the reconsideration order), he was entitled to a 5 percent scheduled "chronic" condition award for each of his arms.

On review, SAIF contends that claimant's permanent disability award should be reduced to zero because the medical evidence does not establish that he is significantly limited in repetitive use of the arms. For the following reasons, we agree with SAIF.

Under OAR 436-035-0010(5), a worker is entitled to a 5 percent scheduled chronic condition impairment value 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 a body part.

Dr. Van Allen, the medical arbiter, opined:

> "It is not clear whether this patient is significantly limited in his ability to repetitively use his upper extremities. Bilateral compression neuropathies of both median and ulnar nerves may indicated (*sic*) a propensity for nerve sensitivity to compression, and it *may* very well be that this gentleman would have a problem with repetitive use of his extremities as has been exhibited in the past. It would be my opinion that he *could* have *some limitation* because of the cubital tunnel and carpal tunnel, which has been appropriately treated surgically. This limitation would be due to the possibility of recurrent symptoms and fatigue but would be best determined with objective testing such as a PCE." (Ex. 10-2, 3; emphasis added).

Dr. Van Allen's opinion is not sufficient to establish a "significant" limitation on repetitive use because he never opined to a degree of medical probability that claimant had such a limitation. Dr. Van Allen stated that it was not clear that claimant was significantly limited in repetitive use of the arms. The most Dr. Van Allen could state was that claimant "may" or "could" have "some limitation." Such expressions of medical possibility are insufficient to prove a "significant" limitation in repetitive use. *See Gormley v. SAIF*, 52 Or App 1055 (1981); *Ted L. Golden*, 51 Van Natta 55, 56 (1999) ("could have" and "may have" indicate only possibility, not medical probability).

Moreover, to the degree that Dr. Van Allen believed that claimant needed a limitation, this was due to the possibility of recurrent symptoms and fatigue. It would, therefore, appear that Dr. Van Allen's restriction on repetitive use was intended to prevent a recurrence of symptoms. Such a restriction is inadequate to support a "chronic" condition award. *See Teena M. Headding*, 51 Van Natta 789, 790 (1999).

Finally, we have found that indications of "some limitation" are insufficient to meet the requirement of being "significantly limited in the repetitive use" of a body part under OAR 436-035-0010(5). *See Daralynn Nevett*, 52 Van Natta 1856 (2000); *Carl H. Kimble*, 52 Van Natta 1549 (2000); *Gregory P. Hublitz*, 52 Van Natta 673 (2000); *Lorraine F. Fortado*, 52 Van Natta 446 (2000).

Dr. Schader, the attending physician, provided the other medical opinion on the "chronic" condition issue. In his May 26, 2000 closing report, Dr. Schader noted that claimant reported difficulty with repetitive work of his upper extremities. However, because Dr. Schader did not state that he believed that claimant had a significant limitation on repetitive use, we find that claimant's subjective report is not sufficient to establish a chronic condition. *Cf. Charles D. Gode*, 53 Van Natta 139 (2001) (The claimant's report of headaches to physician insufficient to support award of impairment). The rest of Dr. Schader's report does not specifically address the repetitive-use issue. Dr. Schader, however, did state that any estimate of claimant's work tolerance would be pure conjecture on his part and that work tolerance would best be determined by a physical capacities evaluation. (Ex. 7). Having reviewed Dr. Schader's closing report, we conclude that, like the arbiter's, it does not prove entitlement to a "chronic" condition award.

Accordingly, we conclude that the ALJ improperly found that claimant was entitled to a bilateral arm award of 5 percent permanent disability for a "chronic" condition. Because claimant does not contest the ALJ's determination that he is not entitled to impairment for reduced range of motion, we reduce claimant's permanent disability award to zero.

ORDER

The ALJ's order dated February 8, 2001 is reversed. The October 26, 2000 Order on Reconsideration is modified to reduce claimant's scheduled permanent disability award to zero. The ALJ's attorney fee award is also reversed.

Board Member Phillips Polich dissenting.

The majority reduces claimant's award of scheduled permanent disability to zero, concluding that claimant is not entitled to a bilateral arm award of 5 percent permanent disability for a "chronic" condition. I disagree with that decision.

Dr. Schader, the attending physician, restricted claimant, a machinist, to only four hours of machine work a day. To qualify for a "chronic condition" award, claimant must be "significantly limited" in the repetitive use of his arms. *See* OAR 436-035-0010(5). Although the majority finds fault with Dr. Schader's opinion addressing the "chronic condition" issue, I agree with claimant that it only makes sense that a machinist who is limited to only four hours a day in the use of his arms has a "significant" limitation on repetitive use, thus entitling him to a bilateral "chronic condition" award.

The ALJ's decision, which the majority now reverses, was both legally and factually sound and should be affirmed. Because the majority concludes otherwise, I dissent.

In the Matter of the Compensation of
WILLIAM A. FRANKLIN, Claimant
WCB Case Nos. 99-08859, 99-08849, 99-05966, 99-05574, 99-03989 & 99-00636
ORDER DENYING MOTION TO DISMISS
Walsh & Associates, Claimant Attorney
Lundeen, et al., Defense Attorney
Meyers, Radler, et al., Defense Attorney
James Booth (Saif), Defense Attorney
Mannix, et al., Defense Attorney

Claimant requested review of Administrative Law Judge (ALJ) Johnson's order that: (1) upheld compensability and responsibility denials of claimant's pulmonary and respiratory conditions by Liberty Northwest Insurance Corporation (Liberty Northwest)/Multnomah Plywood Company (Multnomah) and by the SAIF Corporation/Custom Bilt Metals, Inc.; and (2) dismissed claimant's hearing requests

concerning SAIF/Multnomah; EBI Insurance Co.[1]/Multnomah; SAMIS, Inc./Multnomah; and Liberty Northwest/Market Transport Ltd. SAIF/Multnomah has moved for an order dismissing it as a party to this proceeding on the ground that the parties did not object to the dismissal of the request for hearing in its particular case while the cases were pending before the ALJ. The motion is denied.

FINDINGS OF FACT

Claimant filed hearing requests against EBI Insurance Co./Multnomah, the SAIF Corporation/Multnomah, SAMIS, Inc./Multnomah, Liberty Northwest Insurance Corporation/Multnomah, SAIF/Custom Bilt Metals, and Liberty Northwest/Market Transport Ltd., contesting the carriers' denials of his occupational disease claim for a pulmonary and respiratory condition. The hearing requests were consolidated.

At the hearing, without objection from any of the parties, claimant withdrew his hearing requests regarding EBI/Multnomah, SAIF/Multnomah, Liberty/Market Transport, and SAMIS/Multnomah. Those hearing requests were dismissed in the ALJ's March 23, 2001 order that also upheld the compensability/responsibility denials issued by the remaining carriers (Liberty Northwest/Multnomah and SAIF/Custom Bilt Metals).

Claimant timely requested Board review of the ALJ's order. The Board mailed letters to all parties to the proceeding acknowledging claimant's request for review. Thereafter, SAIF/Multnomah moved for its dismissal from this proceeding (noting that the other parties did not object to its motion).

CONCLUSIONS OF LAW AND OPINION

Although the ALJ's conclusions and opinions in consolidated cases may be separately stated, if the ALJ's decisions are contained in one final order, we retain jurisdiction to consider all matters contained therein. *Donald L. Melton*, 47 Van Natta 2290 (1998); *Riley E. Lott, Jr.*, 42 Van Natta 239 (1990); *William E. Wood*, 40 Van Natta 999 (1988). On the other hand, 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. *See Jerry R. Miller*, 44 Van Natta 1444 (1992).[2]

Here, the ALJ's dismissals, compensability, and responsibility determinations were contained in one final consolidated order. Inasmuch as that consolidated order has been appealed, we retain jurisdiction over that entire decision, and SAIF/Multnomah remains a party to this proceeding. *See Zurich Ins. Co. v. Diversified Risk Management*, 300 Or 47 (1985); *Mosley v. Sacred Heart Hospital*, 113 Or App 234 (1992); *Riley E. Lott*, 42 Van Natta at 240; *Rual E. Tigner*, 40 Van Natta 1789 (1988). However, considering the parties' lack of objection to claimant's withdrawal of his hearing requests regarding the aforementioned carriers, as well as the lack of objection to the motion for dismissal, as a practical matter, the participation in this case by the "dismissed" carriers will likely be nominal. *Lott*, 42 Van Natta at 240.

Accordingly, SAIF/Multnomah's motion to dismiss is denied. The briefing schedule will continue as previously implemented. On its completion, this case will be docketed for Board review.

IT IS SO ORDERED.

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[1] EBI is now known as Royal & SunAlliance.

[2] In *Shawn C. Mann*, 47 Van Natta 855 (1995), we noted that it was entirely appropriate for an ALJ to dismiss parties from a previously consolidated hearing by means of a dismissal order which was separate from the ALJ's Opinion and Order which would address the merits of the claimant's claims against the remaining carriers. Since the "dismissed" carriers would not be "parties" to the separate Opinion and Order, we reasoned that they likewise would not be "parties" on Board review of the appealed Opinion and Order. Here, in contrast to *Mann* and *Miller*, the dismissals of claimant's hearing requests were contained in the same order that addressed the merits of claimant's claims with the remaining carriers. Under such circumstances, all parties to the ALJ's order remain parties on Board review of that single, appealed order.

In the Matter of the Compensation of
SHANNON T. HOLDREN, Claimant
WCB Case No. 00-07387
ORDER ON REVIEW
Cole, Cary, et al., Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Howell's order that found that the SAIF Corporation was not required to pay permanent disability compensation between claimant's completion of an authorized training program (ATP) and issuance of a Notice of Closure that redetermined disability. On review, the issue is entitlement to permanent disability.

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

Claimant's claim was first closed by a November 12, 1998 Determination Order. An April 6, 1999 Order on Reconsideration awarded 44 percent unscheduled and 12 percent scheduled permanent disability. SAIF began monthly payments.

Between April 1999 and July 5, 2000, claimant completed an ATP. SAIF suspended its monthly payments during this period. On November 28, 2000, SAIF issued a Notice of Closure and, the next day, paid $3,894.18, the difference between the April 1999 Order on Reconsideration and November 2000 Notice of Closure.

Claimant alleges that he is entitled to the monthly payments under the Order on Reconsideration between the end of the ATP and Notice of Closure. Relying on *Gary S. Fox*, 52 Van Natta 425 (2000), the ALJ found that the Order on Reconsideration became unenforceable with the issuance of the Notice of Closure. Thus, the ALJ concluded that claimant was not entitled to the payments of permanent disability between the ATP and Notice of Closure. On review, claimant continues to argue that, because the permanent disability award was no longer suspended when claimant completed the ATP, he became entitled to those payments under the Order on Reconsideration before SAIF issued the Notice of Closure.

In *Fox*, we analyzed the text and context of ORS 656.268(9). That statute provides:

> "If, after the determination made or notice of closure issued pursuant to this section, the worker becomes enrolled and actively engaged in training * * *, 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 insurer or self-insured employer shall again close the claim pursuant to this section if the worker is medically stationary[.]"

In particular, we found that the "post-ATP" award replaced the "pre-ATP" award so that the claimant was not entitled to payment of the "pre-ATP" award. 52 Van Natta at 427. Furthermore, we noted that, if both awards were enforced, the claimant would be receiving compensation that was not "due to" the compensable injury and duplicative. *Id.* at 428.

In alleging entitlement to the first award, claimant essentially relies on OAR 436-060-0040(2), which directs the carrier to "stop temporary disability compensation payments and resume any award payments suspended pursuant to ORS 656.268(9) upon the worker's completion or ending of the training, unless the worker is not then medically stationary." The rule further provides, however, that "if the worker has returned to work, the insurer may reevaluate and close the claim without the issuance of a determination order by the Division."

Administrative rules must be consistent with an agency's statutory authority. An agency may not alter, enlarge or limit the terms of an applicable statute by rule. *E.g., Harrison v. Taylor Lumber & Treating, Inc.*, 111 Or App 325, 328 (1992). Thus, construing the rule in its entire context and consistently with the statute, we agree with the ALJ that it is not authority for enforcing the first award. That is, when the carrier reevaluates and closes the claim following completion of the ATP, the "pre-ATP" award is not enforceable.

Finally, we disagree with claimant's analogy to interim compensation, to which a claimant is entitled whether or not the claim is compensable. Unlike ORS 656.268(9), the applicable statute regarding interim compensation relies on the employer's notice or knowledge of the claim. *See* ORS 656.262(4)(a). Thus, based on the statute, a claim need not be compensable if other factors are satisfied. Because claimant's entitlement to permanent disability concerns a different statute, we find no analogy to interim compensation.

In sum, because we enforce the November 2000 Notice of Closure and not the April 1999 Order on Reconsideration, we find no additional entitlement to permanent disability.

ORDER

The ALJ's order dated February 23, 2001 is affirmed.

June 20, 2001 Cite as 53 Van Natta 785 (2001)

In the Matter of the Compensation of
RICKY G. PADUA, Claimant
Own Motion Nos. 01-0190M & 01-0154M
OWN MOTION ORDER
Vick & Conroyd, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reopening of his 1991 bilateral hernia claims with a self-insured employer, (presently administered by Pinnacle Risk Management Services ("Pinnacle") (Claim No. 199262363)) and the SAIF Corporation (Claim No. 7105129C) for the provision of temporary disability compensation.[1] Both carriers recommend 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 claimant 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 both claims to provide temporary disability compensation (in the "pro-rata" manner prescribed in the ALJ's November 1991 order) beginning the date claimant was hospitalized for the proposed surgery. When claimant is medically stationary, SAIF and Pinnacle shall close the claims pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[1] In 1991, claimant filed a claim for bilateral hernia condition against two employers, one self-insured and the other insured by SAIF. An unappealed November 1991 ALJ's order apportioned responsibility for claimant's bilateral hernia condition equally to both carriers. Pursuant to the November 8, 1991 order, the carriers pay temporary disability compensation benefits according to each employer's share based upon its wage rate's percentage of the total temporary disability compensation.

In the Matter of the Compensation of
MARK A. SNYDER, Claimant
WCB Case No. 00-07617
CORRECTED ORDER ON REVIEW
Welch, et al., Claimant Attorney
Jerry Keene, Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Mills' order that: (1) set aside its denial of claimant's current cervical and right shoulder conditions; and (2) awarded a $4,000 attorney fee under ORS 656.386(1). On review, the issues are compensability and attorney fees.

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

The ALJ set aside the employer's denial of claimant's current combined condition, including a C5-6 facet joint condition, based on the opinion of Dr. Long. On review, the employer first contends that the ALJ lacked jurisdiction to find the C5-6 facet joint condition compensable in the absence of an omitted or new medical condition claim. We disagree.

At hearing, both parties agreed with the following summary of the issues by the ALJ:

> "Issue-wise today, we have Exhibit 66.[1] It's a denial dated August 22, 2000. Basically, the claim was accepted the day before as a combined condition, and then the Denial denied claimant's current condition as a combined condition, major contributing-cause type Denial having to do with cervical and right-shoulder conditions specifically." (Tr. 1).

Initially, we note that the employer did not raise its so-called "jurisdictional" argument until closing argument, and again in a Motion for Reconsideration to the ALJ. We generally will not consider an issue raised for the first time during closing argument. *See Cindy M. Penturf*, 50 Van Natta 1718 (1998).

The employer contends that "jurisdiction" is never waived as an issue. Subject matter jurisdiction may be raised at any time during the course of litigation. *Schlecht v. SAIF*, 60 Or App 449 (1982). Subject matter jurisdiction depends solely upon whether a decision-making body has the authority to make an inquiry. It exists when a statute authorizes that body to do something about the dispute. *See SAIF v. Roles*, 111 Or App 597 (1992); *Braulio A. Sanchez*, 53 Van Natta 584, 587 (2001) (procedural challenge to a notice of closure held not to be an issue of "subject matter jurisdiction").

In *Linda J. Lucas*, 53 Van Natta 570, 573 (2001), we held that we lacked authority to address the compensability of a new medical condition in the absence of a claim for the condition, where the carrier objected at hearing to the procedural validity of the new medical condition claim. We stated that, although the Hearings Division and the Board had jurisdiction over the causation portion of the medical services dispute, "that jurisdiction does not attach where the basis for the 'claim' is an unclaimed, unaccepted new medical condition and the carrier asserts that proceeding with litigation is procedurally invalid." 53 Van Natta at 573. However, we specifically noted that we would have addressed the compensability issue had the carrier *not* objected to the procedural validity of the new medical condition claim. *Id.* at 573 n4.

Here, the ALJ framed the issue as the compensability of claimant's current combined condition. (Tr. 1). At the hearing, the employer did not object to the ALJ's description of the issue. Because the employer did not object to the procedural validity of the claim, and the parties proceeded to litigate the compensability issue, the employer waived any procedural challenge to the claim. Under such circumstances, it would be improper for the Board to decline to decide the issue now. *See Weyerhaeuser v. Bryant*, 102 Or App 432, 435 (1990); *Thomas v. SAIF*, 64 Or App 193 (1983). In other words, even if this particular issue is characterized as "jurisdictional," we still decline to address the issue, based on the employer's failure to raise a procedural challenge to the claim at hearing. *Linda J. Lucas*, 53 Van Natta at 573 n4.

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[1] The denial is actually Ex. 68.

Moreover, based on the parties' agreement at hearing to litigate the compensability of claimant's *current* condition, and given the state of the medical evidence at the time of hearing, which included several references to the C5-6 facet joint condition, the record supports a conclusion that the litigation of the compensability issue included the C5-6 facet joint condition. (Exs. 65, 73A-2); *see Cupertino A. Lopez*, 50 Van Natta 1452 (1998); *Dianne S. Hill*, 48 Van Natta 2351, 2356 (1996), *aff'd mem Hill v. Stuart Anderson's*, 149 Or App 496 (1997).

In *Lopez*, we held that the compensability of the claimant's left leg cyst condition was at issue even in the absence of a formal written request for acceptance of the condition. 50 Van Natta at 1453. In reaching that conclusion, we noted that the parties had agreed at hearing to litigate the compensability of the claimant's current condition, and that the employer failed to challenge the propriety of proceeding with litigation of the claimant's "current" cyst condition. *Id.*

Here, the employer also did not request a postponement or continuance as a remedy for any claim of "surprise." *See* OAR 438-006-0031, OAR 438-006-0081, OAR 438-006-0091. In these circumstances, the ALJ had authority to address the issue of the compensability of claimant's current condition, including his C5-6 facet joint condition. *See Linda J. Lucas*, 53 Van Natta at 573 n4.

In *Joseph R. Zwingraf*, 52 Van Natta 1299, 1300 (2000), we held that the claimant's medial meniscus condition was properly at issue, even in the absence of a new medical condition claim for the condition, where the carrier's "current condition" denial issued 11 days after the condition had been diagnosed. The employer contends that *Zwingraf* is distinguishable because here, at the earliest, claimant's C5-6 facet joint condition was diagnosed just four days prior to its August 22, 2000 "current condition" denial, and there is no evidence of receipt by the employer as of the date of the denial. (Exs. 65, 68).

However, even assuming, *arguendo*, that the employer was not aware of the C5-6 facet joint condition at the time of its denial, at hearing the employer agreed to litigate the compensability of claimant's "current combined condition." (Tr. 1). By the time of hearing, as previously noted, the medical evidence established the diagnosis of a C5-6 facet joint condition. (*See, e.g.*, Exs. 65, 73A-2). Consequently, the litigation of the denial of claimant's current combined condition encompassed the C5-6 facet joint condition.

Finally, the employer contends that the ALJ lacked authority to award an attorney fee pursuant to ORS 656.386(1) in the absence of a "claim" for the C5-6 facet joint condition. *See Stephenson v. Meyer*, 150 Or App 300, 304 (1997). However, we agree with the ALJ that the employer's "current condition" denial encompassed claimant's C5-6 facet joint condition, given the state of the medical evidence at the time of hearing, and the parties' agreement to litigate claimant's "current condition." (Ex. 68; Tr. 1).[2]

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 $2,250, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (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. Claimant is not entitled to an attorney fee for his counsel's services on review regarding the attorney fee issue. *See Dotson v. Bohemia*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated January 30, 2001 is affirmed. For services on review regarding the compensability issue, claimant's attorney is awarded $2,250, payable by the self-insured employer.

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[2] Contrary to the employer's argument, claimant need not have raised entitlement to a fee under ORS 656.386(1), as it was awardable as a "natural derivative" of overturning the denial. *Betty J. Martinez*, 50 Van Natta 2232 (1998).

In the Matter of the Compensation of
JOSE L. DURAN, Claimant
WCB Case Nos. 00-05791 & 98-02120
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
Lundeen, et al., Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Hoguet's order that: (1) declined to award additional temporary disability benefits after July 17, 1992; and (2) declined to assess a penalty for the insurer's allegedly unreasonable failure to process the claim. On review, the issues are temporary disability and penalties.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the second full paragraph of page 3, we change the last phrase in the last sentence to read: "labyrinthine-vestibular function." In the first line on page 9, we change the first date to "July 1998."

Temporary Disability

The ALJ awarded temporary disability benefits related to claimant's compensable inner ear conditions for the period February 24, 1992 to July 17, 1992, less any time loss/interim compensation already paid for that period. We adopt and affirm the ALJ's order and write to address claimant's argument that the ALJ's conclusion that his disability was primarily due to noncompensable perilymph fistulas is contrary to the "law of the case." Claimant contends that the Board determined in previous litigation that he had failed to prove the existence of perilymph fistulas and, since he does not have perilymph fistulas, they cannot be the cause of his disability from the inner ear disorders.

In prior litigation, it was determined that claimant's perilymph fistula condition was not compensable. A July 27, 1994 Opinion and Order upheld the insurer's denial of claimant's perilymph fistula, finding that claimant had not met his burden of proving that he suffered from a perilymph fistula caused by the August 1989 injury. (Ex. 41). In reaching that conclusion, the previous ALJ was not persuaded by Dr. Black's opinion that claimant had a perilymph fistula condition. (Ex. 41-4, -5). The June 27, 1994 Opinion and Order was affirmed by the Board, and is now final. (Ex. 43).

Although it was determined in previous litigation that claimant's perilymph fistula condition was not compensable, that is not the issue in this case. Instead, the issue is whether claimant is entitled to temporary disability benefits. The "law of the case" doctrine does not apply because there has not yet been a determination about claimant's temporary disability benefits for his compensable inner ear conditions. *See Blanchard v. Kaiser Foundation Health Plan*, 136 Or App 466, 470, *rev den* 322 Or 362 (1995) (explaining law of the case rule).[1]

The temporary disability issue involves the interpretation of Dr. Black's chart notes. On February 24, 1992, Dr. Black explained that claimant's underlying problem was the "PLF" (perilymph fistula), and he said that claimant must maintain "PLF" precautions. (*Id.*) The ALJ found, and we agree, that Dr. Black's February 24, 1992 chart note that said claimant was "totally disabled" (Ex. 22A) authorized time loss for the perilymph fistula condition. The fact that it was determined in prior litigation that Dr. Black's opinion that claimant had perilymph fistulas was not persuasive does not mean that *Dr. Black* no longer believed that claimant had perilymph fistulas. To the contrary, Dr. Black continued to believe that claimant had a perilymph fistula condition, well after the June 1994 litigation. (Ex. 53A). In January 2000, Dr. Black said that, when he had examined claimant in September 1997, he believed that claimant had active bilateral perilymph fistulas, and he continued to believe claimant's history strongly suggested a right perilymph fistula. (*Id.*) Under these circumstances, the ALJ's determination is not contrary to the "law of the case."

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[1] The court explained that the law of the case doctrine

"is a general principle of law and one well recognized in this state that when a ruling or decision has been once made in a particular case by an appellate court, while it may be overruled in other cases, it is binding and conclusive both upon the inferior court in any further steps or proceedings in the same litigation and upon the appellate court itself in any subsequent appeal or other proceeding for review." *Blanchard*, 136 Or App at 470 (internal quotations omitted).

In his reply brief, claimant argues that, based on "judicial estoppel," the insurer must be precluded from attempting to avoid the payment of temporary disability by alleging now that he does have a perilymph fistula and that condition caused Dr. Black to report that he was disabled. Again, the issue here is whether there is evidence of a time loss authorization for claimant's compensable inner ear conditions and, as discussed above, that determination requires us to interpret Dr. Black's chart notes and decide why he believed claimant was disabled. Because there has been no prior litigation regarding time loss authorization for claimant's compensable inner ear conditions, the insurer is not precluded from arguing about its interpretation of Dr. Black's reports.

Claimant also contends that the ALJ's finding that the February 24, 1992 time loss authorization was directed "primarily" at the perilymph fistula is not relevant. Claimant argues that if the perilymph fistulas do not exist, then the factors causing his disability must be caused, as least in material part, by the inner ear concussion syndrome and bilateral nystagmus. We disagree.

Claimant has two compensable inner ear conditions: bilateral inner ear concussion syndrome and bilateral robust direction fixed positional nystagmus. (Exs. 45, 46, 47). As discussed above, Dr. Black reported on February 24, 1992, that claimant's underlying problem was the "PLF" and claimant must maintain "PLF" precautions. (Ex. 22A). He explained that claimant was "totally disabled according to Social Security criteria 2.07, disturbances of labyrinthine-vestibular function." (*Id.*) In that report, Dr. Black referred to other conditions, including an inner ear concussion syndrome with a sensorineural hearing loss, secondary hydrops, peripheral vertigo and vestibular ataxia. (*Id.*) Nevertheless, in light of Dr. Black's comments on February 24, 1992 that claimant's underlying problem was the perilymph fistula, we agree with the ALJ that Black's time loss authorization is not reasonably interpreted as authorizing time loss for the compensable inner ear conditions after July 17, 1992, when the insurer denied the perilymph fistula.

Penalties

Although claimant raised a penalty issue at hearing based on the insurer's allegedly unreasonable failure to pay time loss, the ALJ did not address that issue. On review, claimant contends that he is entitled to a penalty for the insurer's failure to process this claim.[2] According to claimant, the insurer's failure to process the claim is documented as an "admission" by the insurer in a May 17, 2000 letter from the insurer to Dr. Langman, which stated, in part:

> "While [the insurer] did not, at the time of litigation, reopen the claim, based upon current case law, [the insurer] is now required to reopen the claim and process these two additional conditions to closure. That means that we have to go back and pay time loss *if there is any authorization for time loss* associated with these two conditions, and the conditions declared medically stationary before we can close the claim." (Ex. 53B-2; emphasis supplied).

Claimant argues that, despite the insurer's concession and "acknowledgement" of its obligations, temporary disability was never paid and the claim remains open.

The insurer responds that the letter to Dr. Langman acknowledged the procedure it was required to follow *if* authorization for time loss was established. The insurer continues to contend that there is no valid time loss authorization relating to claimant's accepted inner ear concussion syndrome and bilateral nystagmus.

ORS 656.262(11)(a) provides for a penalty if a carrier unreasonably delays or unreasonably refuses to pay compensation. 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.

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[2] In its respondent's brief, the insurer asserts that claimant's brief refers to written arguments that are not part of this record and the insurer moves to strike all portions of claimant's brief that refer to such arguments. In addition to the insurer's letter to Dr. Langman, claimant refers to the insurer's written arguments presented to the ALJ. The insurer's letter to Dr. Langman was admitted in evidence. (Ex. 53B). Moreover, although the parties' written arguments to the ALJ were not formally admitted as exhibits, they are part of the Hearings Division file and, as such, are part of the record on review. *See Lura F. Carter*, 51 Van Natta 1226 (1999). Consequently, we deny the insurer's motion to strike portions of claimant's brief.

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. *Brown v. Argonaut Insurance Company*, 93 Or App 588 (1988).

At hearing and on review, the insurer argued, among other things, that Dr. Black was not claimant's attending physician and there was no time loss authorization that required it to pay temporary disability benefits. Although we are not persuaded by the insurer's arguments, we find that the insurer had a legitimate doubt as to its duty to pay temporary disability benefits for claimant's accepted inner ear conditions, particularly since determination of this issue involved, among other things, the interpretation of Dr. Black's reports. Consequently, we conclude that a penalty for the insurer's failure to pay time loss is not warranted.

Although claimant refers to a penalty for the insurer's allegedly unreasonable "persistent" failure to process this claim, he does not explain what compensation the insurer allegedly delayed or refused to pay, other than the time loss for the compensable inner ear conditions.[3] There is no unreasonable resistance to payment of compensation if the carrier paid all compensation. *See SAIF v. Condon*, 119 Or App 194, *rev den* 317 Or 163 (1993); *Aetna Casualty Co. v. Jackson*, 108 Or App 253 (1991). We conclude that claimant is not entitled to a penalty for the insurer's allegedly unreasonable failure to process the claim.

ORDER

The ALJ's order dated December 19, 2000 is affirmed.

[3] Although the ALJ assessed a penalty for the insurer's unreasonable failure to timely pay an unscheduled permanent disability award, neither party challenges that penalty on review.

In the Matter of the Compensation of
LESLIE W. JANTZER, Claimant
Own Motion No. 01-0196M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for a right knee condition. Claimant's aggravation rights have expired. SAIF recommends that we authorize the payment of temporary disability compensation. SAIF further advises that claimant presently has another "reopened" Own Motion claim (Claim No. 4626831H) which has not been closed at this time.

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.*

We are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, we authorize the reopening of the claim for SAIF 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.

Finally, an injured worker is not entitled to receive any more than the statutory sum of benefits for a single period of temporary disability resulting from multiple disabling injuries. *See 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 any concurrent temporary disability compensation is due claimant as a result of this order, SAIF may petition the Workers' Compensation Division of the Department of Consumer and Business Services for a pro rata distribution of payments. OAR 436-060-0020(8) and (9); *Michael C. Johnstone*, 48 Van Natta 761 (1996); *William L. Halbrook*, 46 Van Natta 79 (1994).

IT IS SO ORDERED.

In the Matter of the Compensation of
MARGARET McGRAW, Claimant
WCB Case No. 00-06141
ORDER ON REVIEW
Welch, et al., Claimant Attorney
Lundeen, et al., Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that decreased claimant's scheduled permanent disability award for loss of use or function of the left leg (hip) from 30 percent (45 degrees) as awarded by an Order on Reconsideration to 17 percent (25.5 degrees). On review, the issue is extent of scheduled permanent disability.

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

On review, claimant argues that the opinion of the medical arbiter, Dr. Bald, M.D., should be relied on to rate her loss of range of motion. Although claimant acknowledges that Dr. Bald's methodology was not in accordance with the Director's rules in apportioning impairment due to the accepted condition, she contends that his findings were valid and, on that basis, should be used to rate her loss of range of motion. We disagree.

Claimant is only entitled to rating of permanent disability due to the compensable work injury. ORS 656.214(2);[1] OAR 436-035-0007(1).[2] As the ALJ found, Dr. Bald concluded that claimant's loss of range of motion in her left hip was due to a combination of the accepted left femoral neck fracture and preexisting degenerative osteoarthritis. Dr. Bald opined that claimant had a similar degree of osteoarthritis in her uninjured right hip and proposed comparison to the right hip to approximate the reduction in range of motion in the left hip resulting from the accepted condition. However, as the ALJ found, OAR 436-035-0007(23) provides that the contralateral joint shall not be used to calculate range of motion of the injured joint when, as here, the contralateral joint has a history of disease. Because Dr. Bald provided no other basis for eliminating the loss of range of motion in the left hip due to the preexisting degenerative condition, we agree with the ALJ that reliance on Dr. Bald's opinion to establish loss of range of motion impairment for the accepted condition is not appropriate.

Because Dr. Bald found the loss of range of motion measurements valid, claimant urges us simply to rely those measurements to rate her impairment, without any adjustment for the contribution of the preexisting osteoarthritis condition. Although Dr. Bald found his measurements valid, he also found them to be due to a combination of the accepted condition and a preexisting degenerative condition. To do as claimant urges would violate ORS 656.214(2) and OAR 436-035-0007(1) by awarding permanent disability for loss of use or function due to conditions other than the work injury.

ORDER

The ALJ's order dated December 6, 2000, as reconsidered on February 9, 2000, is affirmed.

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[1] ORS 656.214(2) provides, in relevant part: "When permanent partial disability results from an injury, the criteria for the rating of disability shall be the permanent loss of use or function of the injured member due to the industrial injury."

[2] OAR 436-035-0007(1) provides, in relevant part:

"a worker is entitled to a value under these rules only for those findings of impairment that are permanent and were caused by the accepted compensable condition, an accepted consequential condition and direct medical sequelea. Unrelated or noncompensable impairment findings shall be excluded and shall not be valued under these rules."

In the Matter of the Compensation of
TSEGAYE ADDISU, Claimant
WCB Case No. 00-07096
ORDER ON REVIEW
Gilroy Law Firm, Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Kekauoha's order that dismissed his request for hearing. On review, the issue is propriety of the ALJ's dismissal order.[1]

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

Claimant filed a request for hearing on September 8, 2000. A hearing was scheduled, then postponed at claimant's request to allow him time to retain an attorney. The hearing was reset for March 5, 2001 at 1:30 p.m. Neither claimant nor a representative appeared at that time.

The ALJ issued an "Order to Show Cause," granting claimant 15 days to show cause for his failure to appear at the scheduled hearing. When claimant did not respond, the ALJ dismissed the request for hearing. Claimant requested Board review.

Claimant argues that he should have been allowed to determine when the hearing would be held because he was in pain. He, therefore, asserts that the ALJ therefore improperly dismissed his request for hearing for failure to appear. We disagree.

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."

In this case, claimant did not respond to the ALJ's "show cause" order, thus failing to timely provide "extraordinary circumstances" that would justify postponement or continuance of the hearing. Claimant has now responded "post dismissal" regarding his failure to appear at the hearing.

However, our review must be based on the record certified to us. *See* ORS 656.295(5). Consequently, we treat claimant's response as a motion to remand to the ALJ for the taking of additional evidence. *Robert A. Wilson*, 52 Van Natta 2225 (2001); *Tamara J. Fleshman*, 52 Van Natta 1918 (2001); *Judy A. Britton*, 37 Van Natta 1262 (1985).

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 clearly be shown that material 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).

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[1] The self-insured employer moves to dismiss claimant's request for review, contending that claimant did not provide all parties with copies of his request for review within 30 days of the ALJ's order. *See Mosley v. Sacred Heart Hospital*, 113 Or App 234 (1992). However, the Board's letter acknowledging claimant's request for review was mailed to all parties on April 9, 2001, well within 30 days of the ALJ's March 23, 2001 order. Under these circumstances, we find it more probable than not that the employer received timely actual notice of the request for review. Thus, the employer's motion to dismiss is denied. *See Zurich Ins. Co. v. Diversified Risk Management*, 300 Or App 47, 51 (1985); *Donald N. Vatore-Buckout*, 49 Van Natta 93 (1997); *Grover Johnson*, 41 Van Natta 88 (1989).

Here, claimant gives no reason why he could not have provided his explanation for failure to attend the hearing in response to the "show cause" order. Moreover, even if claimant's explanation for failing to appear at the hearing was considered, it is not likely to affect the result of this case. In other words, claimant provides no explanation of why he could not attend the hearing, other than alleging general, uncorroborated pain complaints. Under these circumstances, we deny claimant's motion for remand. Moreover, considering claimant's failure to timely respond to the ALJ's "show cause" order, we further conclude that the ALJ properly dismissed claimant's request for hearing.[2] *See Michael L. Singleton*, 53 Van Natta 24 (2001).

ORDER

The ALJ's order dated March 23, 2001 is affirmed.

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[2] We note that claimant is presently unrepresented. Because he is unrepresented, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in workers' compensation matters. Claimant may contact the Workers' Compensation Ombudsman at (503) 378-3351 or 1-800-927-1271 (V/TTY) (within the State of Oregon), or write to:

Workers' Compensation Ombudsman
Dept. of Consumer & Business Services
350 Winter St NE, Room 160
Salem, OR 97301-3878

June 26, 2001 Cite as 53 Van Natta 793 (2001)

In the Matter of the Compensation of
BEVERLY BELL, Claimant
WCB Case Nos. 01-01486 & 00-07757
ORDER ON REVIEW
Scott M. McNutt, Sr., Claimant Attorney
Lundeen, et al., Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant request review of Administrative Law Judge (ALJ) Brazeau's order that upheld the insurer's denial of claimant's injury claim for a right shoulder (rotator cuff) condition. On review, the issue is compensability.

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

Claimant compensably injured her right shoulder and neck in 1991. (Exs. A; 2). The claim was initially accepted as a "right trapezius strain." (Ex. E). Following claim closure in October 1992, a prior ALJ determined that claimant was entitled to 36 percent unscheduled permanent disability and 7 percent scheduled permanent disability as a result of the 1991 work injury. (Ex. 2-5).

In 1993, claimant filed an occupational disease claim for additional problems with her right shoulder. (Ex. 3). That claim was accepted as right shoulder "impingement syndrome." (Ex. 8). In March 1994, Dr. Bert performed a resection of claimant's right distal clavicle and coracoacromial ligament. (Ex. 7). The 1993 claim was closed in May 1995, with claimant receiving a 23 percent unscheduled permanent disability award. (Ex. 9; 10).

An April 2000 MRI revealed a 1 cm, full thickness tear in claimant's right rotator cuff.[1] (Ex. 19). Eventually, claimant requested that the insurer amend its previous acceptances to include "rotator cuff tear." (Ex. 23). When the insurer declined to accept the rotator cuff tear, claimant requested a hearing.

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[1] MRI interpretation by Drs. Kates, Bert, and White. (Exs. 19; 20; 24-4).

The ALJ determined that the only medical opinion supporting the compensability of claimant's current right shoulder condition was the opinion of Dr. Bert, the attending physician. Finding Dr. Bert's opinion not persuasive, the ALJ concluded that claimant had failed to establish the compensability of the right rotator cuff tear.

Claimant asserts that her current right shoulder rotator cuff condition is compensably related to the 1991 injury and/or the 1993 occupational disease. Claimant does not dispute that the "major contributing cause" standard applies to her current shoulder condition. In order to satisfy the "major contributing cause" standard, claimant must establish that her work activities contributed more to the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's disease and deciding which is the primary cause. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

Because of the possible alternative causes for claimant's current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967). When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). In evaluating medical opinions, we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to the opinion of Dr. Bert.

Dr. Bert opined that the 1991 work injury was the major contributing cause of claimant's torn right rotator cuff. (Ex. 24-7). In rendering his opinion, Dr. Bert acknowledged that there was no tear present in claimant's rotator cuff at the time he performed surgery in 1994. (Ex. 24-4; 24-8). Nonetheless, based on his finding of inflammation in the rotator cuff during the 1994 surgery, Dr. Bert opined that the 1991 work injury started a progressive process that ultimately resulted in a complete tear of the rotator cuff by April 2000. (Ex. 24-9; 24-11).

During his deposition, Dr. Bert acknowledged that claimant's activities (both on and off the job) over the years contributed to produce the torn rotator cuff. (Ex. 24-12; 24-15). He also acknowledged that the torn rotator cuff could have occurred absent the 1991 work injury. However, Dr. Bert did not explain how he differentiated between a progressive process started by the 1991 work injury and the same type of process brought about entirely by claimant's activities over the years. Without such an explanation, his opinion is merely an unsupported conclusion, and as such, is not persuasive.[2] *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). Consequently, this record does not establish the compensability of her right rotator cuff condition.

ORDER

The ALJ's order dated March 20, 2001 is affirmed.

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[2] At best, Dr. Brett's opinion supports only a conclusion that the 1991 work injury precipitated claimant's rotator cuff tear. Such an opinion is insufficient to carry claimant's burden of proof. *See Elaine M. Baxter*, 51 Van Natta 1898 (1999).

In the Matter of the Compensation of
CAROL A. BRYANT, Claimant
WCB Case No. 99-00894
ORDER ON REMAND
Scott M. McNutt, Sr., Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *SAIF v. Bryant*, 173 Or App 402 (2001). The court has reversed our order, *Carol A. Bryant*, 51 Van Natta 1827 (1999), that reversed an Administrative Law Judge's (ALJ's) order upholding the SAIF Corporation's denial of claimant's current neck condition claim based on the opinions of treating surgeons Dr. Bert and Dr. Keiper. The court reversed and remanded after finding that our evaluation of Dr. Keiper's opinion did not meet the test for "substantial reason" and it could not decide if we would reach the same conclusion if we relied only on Dr. Bert's opinion. In accordance with the court's directive, we now proceed with our reconsideration.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for "cervical sprain" as a result of an injury occurring on May 24, 1998. On July 12, 1998, claimant again sought treatment, complaining of neck and hand symptoms. Claimant eventually was diagnosed with "cord compression" at C5-6 and underwent surgery.

The ALJ found that claimant did not carry her burden of proving compensability of her current neck condition. In a divided order, we reversed the ALJ's order, finding that the medical evidence showed that the May 1998 injury was the major contributing cause of claimant's need for treatment. *See* ORS 656.005(7)(a)(B). In particular, we relied on the opinions of Dr. Bert and Dr. Keiper, finding no reasons not to defer to their opinions. *See Weiland v. SAIF*, 64 Or App 810 (1983). With regard to Dr. Keiper's opinion, although acknowledging his indication that claimant's condition was "equally due to" her preexisting condition and the injury, considering "his entire report," we interpreted his opinion as showing that the compensable injury was the major contributing cause of claimant's need for treatment of her combined condition. 51 Van Natta at 1828.

The court found that our interpretation of Dr. Keiper's opinion "transformed a statement that the injury was an equal cause of the need for treatment into a statement that the injury was the major contributing cause of the need for treatment." 173 Or App 406-07. Specifically, the court found that our explanation for interpreting Dr. Keiper's opinion in such a manner did not meet the test for "substantial reason." *Id.* at 407. The court concluded that it could not decide whether "the Board would reach the same conclusion if it could rely only on Bert's opinion or whether the Board can provide a more complete explanation for its interpretation of Keiper's opinion" and reversed and remanded for reconsideration. *Id.* at 407-08. In reconsidering this case, we first again examine the medical record.

In September 1998, claimant saw Dr. Bert, who noted that claimant "basically had neck pain ever since" the May 1998 injury and diagnosed cervical disc syndrome. (Ex. 13).

Claimant also saw Dr. Sandell, orthopedic surgeon. Based on an MRI, Dr. Sandell found degenerative changes and a herniated disc at C5-6. (Ex. 17-2).

Dr. Keiper became claimant's treating neurosurgeon and diagnosed "C5-6 spondylitic degenerative changes with cord compression and early myelopathy." (Ex. 18-3).

Examining physicians Drs. Duff, orthopedic surgeon, and Morton, neurologist, found "severe pre-existing cervical spondylosis at multiple levels" that combined with the May 1998 injury. (Ex. 19-6). The panel also related the current neck condition in major part to the preexisting condition. (*Id.*)

Dr. Sandell responded to questions from claimant's attorney and indicated that claimant's preexisting condition at C5-6 combined with the injury. (Ex. 24-1). Dr. Sandell also wrote that "the injury brought on the symptoms" and was the "proverbial action that 'broke the camel's back.'" (*Id.* at 2).

Dr. Bert also found a combined condition and stated that the May 1998 injury "cause[d] a disc herniation at C5-6." (Ex. 26).

Finally, Dr. Keiper reported that the preexisting condition and injury combined. (Ex. 25-1). In explaining what was the major contributing cause, Dr. Keiper stated that the "injury caused [claimant] to become symptomatic" and "the major cause of the disability was obviously the injury of 5/24/98." (*Id.*) Dr. Keiper added that the "need for surgery was 50/50 in that this preexisting condition was compressing the spinal cord and therefore the spinal cord needed to be decompressed[.]" (*Id.* at 1-2).

In answering whether the injury caused any pathologic damage, Dr. Keiper stated that the injury "merely further exacerbated mild decompression." (*Id.* at 2). Finally, Dr. Keiper indicated that "[t]his condition is equally due to the preexisting condition and the acute injury." (*Id.*)[1]

After again reviewing the medical opinions, we agree with the ALJ that the record lacks sufficient persuasive medical evidence proving that the May 1998 injury is the major contributing cause of the need for treatment and disability of the combined condition. First, Dr. Keiper clearly found that the need for treatment was "50/50" and indicated that the injury precipitated the need for treatment and only caused claimant to become symptomatic. Although Dr. Keiper stated that the major contributing cause of claimant's *disability* was the May 1998 injury, the statement is conclusory by failing to explain why, when the injury was not the major contributing cause of the need for treatment, it was the major factor in causing claimant's disability.

Turning to Dr. Bert's opinion, it consists of the following: a "yes" response when asked whether the May 1998 injury was the major cause and, in response to the effect of the May 1998 injury to the neck, the statement that it "[c]ause[d] a disc herniation at C5-6." We find such an opinion entirely conclusory and lacking in explanation and, thus, not persuasive. Furthermore, it appears that, like Dr. Keiper, Dr. Bert was relying on a history that claimant's symptoms were unabated following the May 1998 injury. (Exs. 13, 18). Because the record elsewhere indicates that claimant had "no problems" after the injury until she sought treatment on July 12, 1998 (Ex. 8), we are not persuaded that either physician relied on an inaccurate history.

Finally, we note that, according to the record, Dr. Bert saw claimant twice and Dr. Keiper examined claimant one time before performing surgery. Given this limited contact, we find it unlikely that they were more familiar with claimant's condition than the examining panel.

In sum, based on our evaluation of the opinions of Drs. Bert and Keiper, as well as evidence that they did not rely on an accurate history and had limited contact with claimant, we conclude that neither physician's opinion is sufficient to carry claimant's burden of proof under ORS 656.005(7)(a)(B). Because the remaining opinion from Dr. Sandell also shows only that the May 1998 injury precipitated symptoms and the examining panel indicated that the preexisting condition was the major contributing cause of claimant's need for treatment and disability, we find those opinions also do not prove compensability. Thus, we conclude that claimant failed to prove compensability. *See* ORS 656.005(7)(a)(B).

Accordingly, on remand, as supplemented herein, the ALJ's order dated June 3, 1999 is affirmed.

IT IS SO ORDERED.

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[1] As noted by the court, it appears that this portion of Dr. Keiper's report is in response to the examining panel's conclusion that claimant's hand symptoms were not related to claimant's neck condition. According to Dr. Keiper, claimant's arm pain could be from two different causes, including a flexion/extension injury that caused cord compression or worsened preexisting cord compression. (Ex. 25-2).

In the Matter of the Compensation of
JAMI L. DEROBOAM, Claimant
WCB Case No. 00-02321
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the SAIF Corporation's denial of her aggravation claim. On review, the issue is aggravation.

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

The ALJ found Dr. Wells' opinion supporting compensability unpersuasive because the ALJ believed that claimant's worsening was attributable to claimant's subsequent work activity at a later employment. On this basis, the ALJ upheld SAIF's denial of claimant's aggravation claim. We agree with the ALJ that Dr. Wells' opinion is unpersuasive, but we base our conclusion on the following reasoning.

ORS 656.273(1) provides that a worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition. *SAIF v. Walker*, 330 Or 102 (2000). ORS 656.273(1) requires proof of two specific elements in order to establish a worsened condition: (1) "actual worsening," and (2) a compensable condition. *Gloria T. Olson*, 47 Van Natta 2348, 2350 (1995). Both elements must be satisfied in order to establish a "worsened condition resulting from the original injury." *Id.* If the allegedly worsened condition is not a compensable condition, compensability must first be established under ORS 656.005(7). *Id.*

Here, SAIF accepted right chest wall contusion and right-sided neck strain as a result of the 1996 injury. Dr. Wells, claimant's attending physician, diagnosed claimant's condition as regional fibromuscular pain. This condition has not been accepted; thus, compensability must be first be established prior to addressing the worsening issue.

With regard to causation, Dr. Wells could not identify another obvious inciting cause for claimant's current condition. (Ex. 68-2). On this basis, Dr. Wells attributed the regional fibromuscular pain to claimant's 1996 compensable injury.

Pursuant to ORS 656.266, compensability cannot be established merely by disproving other explanations of how the injury occurred. Here, Dr. Wells bases his conclusion solely on the fact that he cannot identify another inciting cause for the condition. Such an opinion is not persuasive. *See Bronco Cleaners v. Velazquez*, 141 Or App 295 (1996) (a claimant may not rely solely on exclusionary analysis to prove compensability). In addition, given the lapse in time between the 1996 injury and the diagnosis of claimant's current condition, we find Dr. Wells' causation opinion to be poorly explained and inadequately reasoned.

The only remaining opinion in the record that addresses the cause of claimant's current condition is from Dr. Woodward. Dr. Woodward's opinion does not support compensability. Under such circumstances, we conclude, based on this record, that claimant's current condition, diagnosed as regional fibromuscular pain, is not compensable. Accordingly, we agree with the ALJ's decision to uphold SAIF's aggravation denial.

ORDER

The ALJ's order dated January 12, 2001 is affirmed.

In the Matter of the Compensation of
ROBERT G. GLASSBURN, Claimant
WCB Case Nos. 00-01956 & 99-07817
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Scheminske, et al., Defense Attorney
Meyers, et al., Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) upheld Argonaut Insurance Company's (Argonaut) responsibility denial of his injury and occupational disease claims for a left shoulder condition; (2) dismissed claimant's injury claim for a left shoulder condition against Gallagher Bassett Insurance Services Corp. (Gallagher) as time-barred under ORS 656.265(4); (3) upheld Gallagher's denial of his occupational disease claim for the same left shoulder condition; and (4) declined to assess penalties against Gallagher for an allegedly unreasonable denial. On review, the issues are timeliness, compensability, responsibility, and penalties.

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

Claimant, an electrician, compensably injured his chest and left shoulder/arm on December 14, 1998, while working for Rosendin Electric, insured by Argonaut. Argonaut eventually accepted claimant's claim for chest contusion and left shoulder contusion. (Ex. 34). In March 1999, claimant began working for Sasco, insured by Gallagher. On June 21, 1999, claimant suffered another injury to his left shoulder. He did not report this injury to Sasco until his attorney made a claim with Sasco/Gallagher on October 7, 1999. (Ex. 46A).

On July 15, 1999, claimant sought treatment for his left shoulder with Dr. Edwards and Dr. Sedgewick. (Ex. 37, 38). Initially believing his shoulder problems were still related to his December 1998 injury, claimant filed two aggravation claims with Argonaut. (Exs. 42,44). Claimant was diagnosed with left shoulder impingement syndrome, and eventually underwent a decompression surgery with Dr. Sedgewick. (Ex. 49).

By letter dated September 17, 1999, Argonaut denied claimant's current condition on both compensability and responsibility grounds. (Ex. 46). Claimant requested a hearing from Argonaut's denial and from an alleged *de facto* denial by Gallagher.

At hearing, Argonaut withdrew its compensability denial, but continued to contest responsibility for claimant's left shoulder condition. (Tr. 2). Claimant amended his request for hearing to include the issue of penalties against Gallagher for an unreasonable resistance to compensation. (Tr. 27). Gallagher clarified that it contested both compensability and responsibility of any conditions filed against it. Gallagher also moved to dismiss claimant's claims as time-barred under ORS 656.265(4).

By Interim Order dated July 13, 2000, the ALJ dismissed claimant's injury claim against Gallagher for failure to provide timely notice pursuant to ORS 656.265.[1] The ALJ then upheld Argonaut's and Gallagher's denials, finding that claimant had not proved the compensability of his left shoulder condition against either employer. The ALJ therefore did not reach the issues of responsibility or penalties.

On review, claimant contends that the ALJ misconstrued ORS 656.265 in the context of a "responsibility" case. We disagree.

ORS 656.265 provides, in pertinent part:

> "(1) Notice of an accident resulting in injury or death shall be given immediately by the worker or dependent of the worker to the employer, but not later than 90 days after the accident. The employer shall acknowledge forthwith receipt of such notice. * * *

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[1] By the same Interim Order, the ALJ also found that claimant's occupational disease claim with Gallagher was timely. *See* ORS 656.807.

"* * * * *

"(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; * * *."

Here, claimant did not provide written notice of his June 21, 1999 injury with Sasco/Gallagher until his attorney's letter of October 7, 1999, more than 90 days later. (Ex. 46A). Claimant concedes that Sasco did not otherwise have knowledge of the injury within 90 days of the injury. (Tr. 57); *see* ORS 656.265(4)(a); *Jeffrey E. Henderson*, 50 Van Natta 2340, 2342 (1998) (employer must have had knowledge of an injury within 90 days of the accident for the claim not to be barred).

Notwithstanding this concession, claimant first contends that the 90 days contemplated in the statute was not tolled until July 15, 1999, his first date of medical treatment after the June 21, 1999 injury. (Ex. 37). Claimant cites to ORS 656.005(7)(a), the definition of "compensable injury."[2] Claimant contends that he did not suffer a "compensable injury" until the injury "require[d] medical services." ORS 656.005(7)(a). We disagree. The plain language of ORS 656.265 states that notice shall be given within 90 days "after the accident," not from the date of first medical treatment. ORS 656.265(1).

Claimant also relies on OAR 436-060-0010(2).[3] However, the rule provides only that, if an injury requires no medical treatment, no notice need be given *the insurer* (but that the employer shall maintain records of the injury). The rule also provides that the first date the employer learns that such an injury has required medical services shall be considered the date on which the employer received notice or knowledge of the injury for purposes of its processing obligations under ORS 656.262. *Id.* However, we find nothing in the rule extending a claimant's time within which to provide notice of an injury to the employer.

Next, claimant contends that the time limitations of ORS 656.265 should be modified in "responsibility cases" under ORS 656.308(1). We disagree. First, ORS 656.308(1) applies only to claims for a second injury involving the same condition as an earlier accepted claim. *SAIF v. Yokum*, 132 Or App 18 (1994); *Smurfit Newsprint v. DeRosset*, 118 Or App 363, 371 (1993). Here, Argonaut accepted a left shoulder and chest wall contusion. (Ex. 34). Claimant's current claim is for a left shoulder impingement syndrome and left shoulder rotator cuff tendinitis. ORS 656.308 therefore does not apply.

Moreover, although ORS 656.308(2)(a) allows claimants to file against other, potentially responsible insurers after the issuance of a responsibility denial, we find no support in the statute or in case law for the contention that it extends the time period for notice of a claim pursuant to ORS 656.265. Rather, ORS 656.265 unambiguously requires a notice of claim (in an injury context) to be filed within 90 days of the accident. ORS 656.265(1). Accordingly, we agree with the ALJ that claimant's injury claim against Gallagher Bassett is barred as untimely filed.

Finally, we adopt and affirm the ALJ's order in regard to the compensability of claimant's occupational disease claim against Gallagher and injury and occupational disease claims against

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[2] ORS 656.005(7)(a) provides, in pertinent part, "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[.]"

[3] OAR 436-060-0010(2) provides:

"If an injured worker requires no medical treatment or only first aid without medical services and is otherwise not entitled to compensation, no notice need be given the insurer. The employer shall maintain records showing the name of the worker, the date, the nature of the injury and treatment for one year. These records shall be open to inspection by the Director, or any party or its representative. If an employer subsequently learns that such an injury has resulted in medical services, disability or death, the date of that knowledge will be considered as the date on which the employer received notice or knowledge of the claim for the purposes of processing pursuant to ORS 656.262."

Argonaut.[4] Consequently, we do not reach the issue of responsibility and no penalty is assessable because no compensation was "then due." *See Wacker Siltronic v. Satcher*, 103 Or App 513 (1990).

ORDER

The ALJ's order dated January 8, 2001 is affirmed.

[4] In light of our disposition of the issues on these bases, we need not address Gallagher's contentions that claimant never perfected a claim with it for a left shoulder condition or that claimant did not raise his occupational disease theory until closing arguments.

In the Matter of the Compensation of
JULIE A. JOHNSON, Claimant
WCB Case No. 00-08466
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorney
Julie Master (Saif), Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Hoguet's order that set aside its denial of claimant's 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.

The ALJ set aside SAIF's denial based on the opinions of Drs. Gambee and Dietrich. On review, SAIF contends that claimant has not established that her claim is supported by objective findings related to an on-the-job injury. We disagree.

Claimant must establish by medical evidence supported by objective findings that her August 24, 2000 work injury is a material contributing cause of her disability or need for treatment for her low back strain condition.[1] ORS 656.005(7)(a); *SAIF v. Lewis*, 170 Or App 201 (2000) (requirement of objective findings not satisfied by reports of symptoms not presently verifiable by a physician); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992).

The ALJ expressly found claimant's and her spouse's testimony credible based on demeanor. We generally defer to an ALJ's demeanor-based credibility finding. *See Bush v. SAIF*, 68 Or App 230, 233 (1984); *James C. Hubbard*, 52 Van Natta 1286 (2000).

Here, we find no reasons not to defer to the ALJ's credibility finding in favor of claimant. In this regard, we find claimant's explanation of her delay in reporting and filing her injury claim (as well as her initial denial of a specific injury) persuasive. (*See* Exs. A, B). Claimant testified that, when she was first injured, she did not want to blemish her employer's compensation rating and increase its premium assessment, but eventually was forced to file a claim when her symptoms worsened. (Tr. 13-15). Claimant's testimony, as to her history of the lifting injury at work and as to the delay in filing, was corroborated by that of her husband, whose testimony the ALJ also found credible. (Tr. 25, 28). (O&O at 3).

Moreover, the opinions of Drs. Schilperoort and Woodward, who examined claimant on separate occasions at the request of SAIF, rest largely on claimant's credibility. In essence, both of these physicians stated that it was "possible" that claimant sustained a lumbar strain on August 24, 2000, but

[1] There is no evidence of a "preexisting condition" nor of a "combined condition" in the record. The parties do not contend otherwise.

that such an injury was supported only by claimant's history, and not supported by the contemporaneous medical record. (Exs. 3-5, 7-8). However, we have affirmed the ALJ's demeanor-based credibility finding in favor of claimant. Therefore, we do not find that Drs. Schilperoort or Woodward's opinions persuasively thwart a conclusion that a material contributing cause of claimant's disability or need for treatment for her low back condition is an August 24, 2000 work injury.

Dr. Dietrich, on the other hand, diagnosed a "work-related" low back strain, after taking a history of claimant's lifting a box of cleaning materials out of a trunk at work.[2] (Ex. 6). After taking the same history, Dr. Gambee diagnosed what "appeared to be a simple back strain."[3] (Ex. 2-2). Although these physicians did not specifically conclude that claimant's injury was a "material contributing cause" of her low back strain, it is well settled that "magic words" are not required to establish compensability. *McClendon v. Nabisco Brands, Inc.*, 77 Or App 412, 417 (1986); *Eric R. McKown*, 53 Van Natta 630 (2001). Moreover, these physicians did not attribute claimant's low back strain to any other, non-work causes.

SAIF argues that Drs. Dietrich and Gambee's opinions are "bare conclusions" that lack reasoning. SAIF contends that the opinions should therefore be discounted, citing *Moe v. Ceiling Systems*, 44 Or App 429, 433 (1980). We disagree. Drs. Dietrich and Gambee's opinions as supplemented by their chart notes, do not note any prior low back injuries or problems and accurately reflect claimant's history of an injury lifting cleaning materials at work. (Exs. 2-2, 6). Drs. Dietrich and Gambee do not merely "adopt claimant's opinion" that her back strain is work related, but rather reach this conclusion based on her history and on their respective examinations. Moreover, there is no "preexisting condition" or other, non-work-related cause that must be addressed.

Finally, although SAIF disputes that claimant's objective findings are related to an on-the-job injury, it concedes that the record otherwise contains objective findings supportive of claimant's claim. (Appellant's Brief at 2); ORS 656.005(7)(a); ORS 656.005(19). Accordingly, having found that claimant suffered a work-related low back injury, and based on the persuasive medical evidence from Drs. Dietrich and Gambee, we find that claimant's injury was a material contributing cause of her need for medical treatment or disability for her low back strain condition. 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 438-015-010(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 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 issues, and the value of the interest involved.

ORDER

The ALJ's order dated March 2, 2001 is affirmed. For services on review, claimant's attorney is awarded $1,250, payable by SAIF.

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[2] Contrary to SAIF's contention, we are not convinced that Dr. Dietrich "changed her opinion" without explanation because she initially diagnosed a possible disc fissure condition. (Ex. 3B). Rather, Dr. Dietrich never opined that either claimant's back strain or (unconfirmed) disc fissure conditions were not work related, and her ultimate diagnosis of a back strain was linked to the injury; *i.e.*, "work-related." (Ex. 6).

[3] We agree with SAIF that Dr. Gambee did not "refuse to agree" with Dr. Schilperoort, as claimant contends, but rather simply disabused SAIF of the notion that he was claimant's attending physician. (Ex. 5).

In the Matter of the Compensation of
BRIAN MOTTAZ, Claimant
WCB Case Nos. 00-06155 & 00-01848
ORDER ON REVIEW
Fontana & Takaro, Claimant Attorney
Cavanagh & Zipse, Defense Attorney

Reviewed by Board Members Biehl and Meyers.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Lipton's order that: (1) set aside its partial denial of claimant's injury claim for a right medial meniscus condition; and (2) awarded a $4,500 assessed attorney fee under ORS 656.386(1). In his respondent's brief, claimant contests that portion of the ALJ's order that found the insurer's denial procedurally valid. On review, the issues are the procedural propriety of the insurer's denial, compensability, and attorney fees.[1]

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

Claimant injured his right knee on November 26, 1999. (Ex. 2). On March 21, 2000, the insurer accepted the claim as a disabling "mild right knee ligament strain." (Ex. 22). On the same day, the insurer denied the compensability of claimant's right medial meniscus tear. (Ex. 20). Claimant requested a hearing asserting the compensability of his right medial meniscus condition.

The ALJ relied on the opinion of Dr. Hoppert, the attending physician, and concluded that claimant had established the compensability of his right medial meniscus condition.[2] The ALJ also awarded a $4,500 assessed attorney fee under ORS 656.386(1).

Here, the ultimate question to be resolved is the cause of claimant's right medial meniscus condition. Because of the possible alternative causes for claimant's medial meniscus condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

The record contains the opinions of two doctors regarding causation. One is from Dr. Hoppert, the attending physician, who opined that the major contributing cause of claimant's meniscal tear is the November 1999 work incident. The other opinion is from Dr. Schilperoort, an insurer-arranged examiner, who opined that claimant's meniscal tear is preexisting, and not in any way related to the November 1999 work incident.

When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). In evaluating medical opinions, we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983).

Dr. Hoppert opined that claimant may have had some preexisting degenerative changes in his knee prior to the November 1999 work incident, but the work incident caused a tear in the meniscus requiring claimant's need for surgery. (Ex. 27A). As explained by Dr. Hoppert, the work incident caused a preexisting unstable portion of claimant's meniscus to become caught in the joint line, pulling and tearing the meniscus. (Ex. 34-1). Dr. Hoppert based his opinion on: (1) a review of the MRI films;

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[1] Because we find "on the merits" that claimant's medial meniscus condition is compensable, we need not address the procedural propriety of the insurer's denial of that condition.

[2] The ALJ determined that claimant had established compensability under the "major contributing cause" standard. Because neither party challenges the applicability of the "major contributing cause" standard, we use the "major contributing cause" standard on Board review. Moreover, because we find that claimant has established the compensability of his medial meniscus condition under the "major contributing cause" standard, we necessarily find that he has also established compensability under the "material contributing cause" standard.

(2) claimant's age (31 years); (3) claimant's lack of prior knee problems; (4) the mechanism of injury; (5) his examination of claimant; and (6) his years of clinical experience. (Exs. 28; 34; 36). We find his opinion persuasive.[3]

Dr. Schilperoort agrees that claimant has a torn medial meniscus that is in need of surgical repair, but believes that the meniscal tear preexisted the November 1999 work incident and was not affected by it.[4] Dr. Schilperoort based his opinion on: (1) his examination of claimant; (2) his review of the MRI; (3) medical literature indicating that horizontal meniscal tears are usually degenerative; and (4) his personal experience as a physician.[5] (Exs. 19; 29; 33; 35).

Dr. Schilperoort's opinion appears to rest more heavily on the medical literature (studies showing that horizontal tears are usually degenerative) than any of the other previously enumerated factors. Consequently, we conclude that his opinion is grounded more in statistical analysis and less on factors personal to claimant than is the opinion of Dr. Hoppert. Accordingly, we find it less persuasive than Dr. Hoppert's opinion.[6] *See Yolanda Enriquez*, 50 Van Natta 1507 (1998) (medical evidence grounded in statistical analysis is generally not persuasive because it is not sufficiently directed to the claimant's particular circumstances); *Steven H. Newman*, 47 Van Natta 244, 246 (1995); *Catherine M. Grimes*, 46 Van Natta 1861, 1862 (1994).

In conclusion, we find Dr. Hoppert's opinion more persuasive than Dr. Schilperoort's opinion. Finding no persuasive reason to do otherwise, we defer to Dr. Hoppert's opinion and conclude that claimant has established the compensability of his right medial meniscus condition.

The insurer argues that the ALJ's $4,500 attorney fee award was excessive, because the hearing was short (1 hour 43 minutes) and the issues involved were simple and straightforward. Claimant responds that the ALJ's fee award was appropriate, considering the risk to claimant, the value of the claim, and the number of medical exhibits that claimant's counsel was required to obtain.

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), as applied 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 issue in dispute at the hearing was the compensability of claimant's right medial meniscus condition. The hearing lasted about an hour and 45 minutes not including closing arguments. The record consists of: (1) a 39-page transcript (that included five witnesses, four called by claimant); and (2) about 34 exhibits, including 4 letters from Dr. Hoppert, generated at claimant's counsel's request that were important to the resolution of the compensability issue.

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[3] The insurer argues that Dr. Hoppert's opinion is based solely on a temporal relationship between the November 1999 work incident and the onset of claimant's symptoms. Because Dr. Hoppert expressly considered other factors in addition to the temporal relationship, we reject the insurer's argument. *See Lawrence L. Nicholson*, 51 Van Natta 1977 (1999) (the claimant met his burden of proof where the doctor's report was not based solely on a temporal relationship).

The insurer also asserts that Dr. Hoppert's final opinion (as expressed in Exhibit 36) suggests that he does not know if claimant suffered a new injury or a worsening of a preexisting condition. We disagree. First, Exhibit 36 is a concurrence letter prepared by claimant's counsel to rebut the statements of Dr. Schilperoort regarding a "symptomatic worsening," as expressed in Exhibit 35. Next, prior to addressing the "symptomatic worsening" opinion of Dr. Schilperoort, Dr. Hoppert expressly stated that "in younger people like [claimant], it takes an injury to cause a meniscal tear including a horizontal tear." (Ex. 36-1). Consequently, we reject the insurer's assertion that Dr. Hoppert is unsure that the work injury caused claimant's meniscal tear.

[4] According to Dr. Schilperoort, the November 1999 work incident caused a mild ligament strain, but nothing more. (Ex. 19-4).

[5] Both doctors agree that claimant's meniscal tear is horizontal.

[6] The insurer contends that Dr. Hoppert's opinion is not persuasive because it is not consistent with a radiology opinion (by Dr. Tubbs) that the meniscal tear is degenerative. (Ex. 7). Dr. Hoppert explained that "the true diagnosis of degenerative vs. traumatic involves more than just an MRI reading, that is, involves history taking, physical examination, and clinical findings at the time of arthroscopy." (Ex. 34-2). Based on Dr. Hoppert's unrebutted explanation, we reject the insurer's assertion.

The case involved issues of average factual and legal complexity, considering the range of cases generally submitted to this forum. The claim's value and the benefits secured are above average, considering claimant's need for surgery. 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 claimant's counsel's efforts might have gone uncompensated, particularly considering the employer's vigorous challenge.

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. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record), 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.

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 that issue is $1,200, 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. Claimant is not entitled to an attorney fee for services devoted to the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated January 25, 2000 is affirmed. For services on review, claimant is awarded a $1,200 attorney fee, payable by the insurer.

In the Matter of the Compensation of
ROBERT A. SELLHEIM, Claimant
WCB Case No. 00-05533
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Bostwick, et al., Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that set aside its "pre-closure" denial of claimant's current low back condition. On review, the issues are the validity of the "pre-closure" denial and compensability. We affirm.

FINDINGS OF FACT

Claimant's November 1999 compensable injury was initially accepted as a disabling "lumbar back strain." (Ex. 20). In August 2000, following an evaluation by employer-arranged medical examiners, Drs. Tesar and Gardner, the employer modified its acceptance to "lumbar strain superimposed upon preexisting degenerative disc disease and spondylolisthesis." (Ex. 40).

Following its modified acceptance, the employer issued a "pre-closure" current condition denial, which stated in pertinent part:

> "Your claim has been accepted for lumbar strain superimposed upon pre-existing degenerative disc disease and spondylolisthesis. Review of medical information reveals that you are medically stationary for the accepted condition related to your 11/4/99 injury. Medical information indicates that your accepted condition is no longer the major contributing cause of your ongoing disability and need for medical treatment. Therefore, this claim denial is issued." (Ex. 43; 44).

Claimant requested a hearing challenging the employer's denial.

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that the accepted "lumbar strain superimposed upon pre-existing degenerative disc disease and spondylolisthesis" had not been accepted as a "combined" condition under the ORS 656.005(7)(a)(B). Consequently, relying on *Croman v. Serrano*, 163 Or App 136 (1999) (carrier must have accepted a "combined" condition in order to properly issue a "pre-closure" denial pursuant to ORS 656.262(7)(b) and ORS 656.262(6)(c)), the ALJ concluded that the employer's "pre-closure" current condition denial was procedurally improper. Accordingly, the ALJ set aside the denial.

The employer does not challenge the ALJ's determination that the current condition denial was based upon a "combined" condition. Rather, the employer contends that it accepted a "combined" condition, when it accepted "lumbar strain superimposed upon pre-existing degenerative disc disease and spondylolisthesis." Consequently, the employer contends that its denial was procedurally proper. Because we find, on the merits, that claimant's "current" condition is compensable, we need not address the procedural propriety of the employer's denial.

Neither party disputes that claimant's current low back condition is subject to ORS 656.005(7)(a)(B). Therefore, in order to establish the compensability of his current condition, claimant's compensable injury must be the major contributing cause of the disability or need for treatment of the combined condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101 (1997), *on recon* 149 Or App 309 (1997), *rev den* 326 Or 389 (1998).

To satisfy the "major contributing cause" standard, claimant must establish that his work incident of November 1999 contributed more to the disability or need for treatment of the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's disability or need for treatment of the combined condition and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397 (1994), rev dismissed 320 Or 416 (1995).

Because of the possible alternative causes for his current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967). When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). In evaluating medical opinions, we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983).

Here, Drs. Keenan and Thomas, attending physicians, opined that the major contributing cause of claimant's current disability and need for treatment was the November 1999 work injury. (Exs. 49; 51). In rendering their opinions the doctors expressly considered claimant's history, the mechanism of injury, and the relative contributions of claimant's preexisting degenerative disc disease and spondylolisthesis.[1] (*Id.*)

The employer asserts that because a portion of Dr. Thomas' opinion states that claimant's radicular findings may have developed sometime after the work injury, that Dr. Thomas' overall opinion regarding causation is based on possibilities rather than medical probabilities. We note, however, that those remarks by Dr. Thomas were in conjunction with a statement that, following an injury, it was not uncommon for a disc to "more fully bulge or herniate" with time. (Ex. 49-2). Consequently, we interpret Dr. Thomas' remarks as merely an indication that radicular findings do not necessarily appear immediately at the time of injury. Moreover, we note that Dr. Thomas' remarks are consistent with the contemporaneous medical record which indicates that claimant reported radicular pain eleven days after

[1] The employer asserts that Dr. Keenan's opinion rests on an incorrect history. Specifically, the employer argues that Dr. Keenan mistakenly believed that claimant had radicular pain into the left buttock and into the right buttock and thigh since the work incident. We note that claimant reported left buttock pain and right hip pain within eleven days of the work incident. (Ex. 8-1). We also note that, on December 8, 1999, claimant reported having had left buttock and leg pain in addition to intermittent right buttock and leg pain. (Ex. 13). Consequently, we do not find claimant's pain complaints (as recorded in the contemporaneous medical records) inconsistent with the history reported by Dr. Keenan.

the work injury. (Ex. 8-1). Accordingly, we reject the employer's argument that Dr. Thomas' opinion is not grounded in medical probabilities.[2]

In contrast to the opinions of Drs. Keenan and Thomas, both Drs. Tesar and Gardner opined that the major cause of claimant's current disability and need for treatment was his preexisting degenerative disc disease and spondylolisthesis. (Exs. 36; 50). Their opinions, however, are based largely on a belief that claimant had no radicular pain prior to January 2000. (Ex. 36-9). Because that belief is inconsistent with claimant's pain complaints as reported in the contemporaneous medical records, we conclude that the opinions of Drs. Tesar and Gardner rest on incomplete information. Consequently, their opinions are not persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977); *William R. Ferdig*, 50 Van Natta 442, 443 (1998).

Based upon our review of the medical record as a whole, we find no persuasive reason not to defer to the opinions of Dr. Keenan and Dr. Thomas. Consequently, we rely on their opinions and conclude that claimant has established the compensability of his current low back 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 $2,070, to be paid 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 his counsel's uncontested attorney fee request), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 4, 2001 is affirmed. For services on review, claimant is awarded a $2,070 attorney fee, payable by the self-insured employer.

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[2] The employer also contends that Dr. Thomas' overall opinion is inconsistent with his previous records, *i.e.*, his May 2, 2000 chart note and an 827 form. (Ex. 33, 34). Both of those documents list Dr. Thomas' diagnosis as spondylolisthesis with herniated disc; they do not mention a lumbar strain. We note, however, that at the time those documents were generated Dr. Thomas reported that he had x-rays and MRI films available for review, but he specifically reported he did not have Dr. Keenan's records. (Ex. 33-1). Additionally, we note that Dr. Thomas did have claimant's history of a November 14, 1999 lifting injury at work. Consequently, we are not persuaded that the aforementioned chart note and 827 form are inconsistent with Dr. Thomas' opinion that the major contributing cause of claimant's current disability and need for treatment was the November 1999 work injury. Accordingly, we reject this argument.

In the Matter of the Compensation of
SHAWN J. SEVERNS, Claimant
WCB Case No. 00-05354
ORDER ON REVIEW
Mustafa T. Kasubhai, Claimant Attorney
Hornecker, Cowling, et al., Defense Attorney

Reviewed by Board Members Phillips Polich, Bock, and Meyers.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order that upheld the insurer's denial of his occupational disease claim for a bilateral wrist condition. The insurer cross-requests review of that portion of the ALJ's order that set aside its denial of claimant's occupational disease claim for a low back condition. On review, the issue is compensability.

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

Carpal tunnel syndrome condition

The ALJ upheld the insurer's denial of claimant's claim for a bilateral carpal tunnel syndrome (CTS) condition based on the opinion of Drs. Denekas and Strum. On review, claimant contends that the ALJ misinterpreted Dr. Amstutz' opinion to defer to claimant's treating physician Dr. Casey on the issue of causation. We agree with claimant on that specific point, but nevertheless agree with the ALJ that the bilateral CTS condition is not compensable.

Where the medical evidence is divided, we rely on those medical opinions that are well-reasoned and based on complete and accurate information. *Somers v. SAIF*, 77 Or App 259 (1986). In addition, absent persuasive reasons not to do so, we rely on the opinion of claimant's treating physician. *Weiland v. SAIF*, 64 Or App 810 (1983).

On October 20, 2000 Dr. Amstutz, neurosurgeon, evaluated claimant in regard to his low back condition. (Ex. 16). On December 14, 2000, Dr. Amstutz concurred with an opinion summary prepared by claimant's counsel. (Ex. 17). In that report, Dr. Amstutz agreed with the statement that he would "otherwise defer to Dr. Casey's diagnosis and treatment of the CTS." (Ex. 17-3). Nevertheless, Dr. Amstutz also offered an opinion as to the causation of claimant's CTS condition. Dr. Amstutz reported that the frequent heavy gripping and pulling required in claimant's job would likely create the repetitive flexion and extension of the wrists that can cause the CTS condition. Dr. Amstutz concluded that claimant's work activities were more likely than not the major cause of his CTS. (Ex. 17-3).

We therefore agree with claimant that Dr. Amstutz did not defer to Dr. Casey on the issue of causation, but rather merely with regard to his diagnosis and treatment. However, we find that Dr. Amstutz' opinion in regard to the CTS condition is unpersuasive. In this regard, we note that Dr. Amstutz evaluated claimant specifically in relation to his low back condition. (Ex. 16). Although we do not agree with the insurer that Dr. Amstutz' opinion is "speculative" in nature, we find that his opinion is outweighed by the balance of the medical opinions in the record.

Dr. McKellar, who first diagnosed claimant's CTS condition, questioned the etiology of the condition. (Ex. 1-6). In other words, Dr. McKellar did not know the cause of claimant's CTS condition. However, Dr. McKellar later concurred with the opinions of Drs. Denekas and Strum, who examined claimant at the request of the insurer. (Ex. 14). Drs. Denekas and Strum did not diagnose a CTS condition, but opined that there was no evidence to suggest a causal relationship between claimant's hand complaints and his work activities. (Ex. 12-7).

Finally, claimant's treating physician, Dr. Casey, noted that *claimant* felt his CTS condition was related to work, but offered no medical opinion on the subject. (Ex. 3). In sum, we agree with the ALJ that the preponderance of the persuasive medical evidence does not establish the compensability of claimant's bilateral CTS condition.

Low back condition

The ALJ set aside the insurer's denial of claimant's low back condition based on the opinion of Dr. Amstutz. On review, the insurer contends that Dr. Amstutz' opinion relies on an impermissible "precipitating cause" analysis based on claimant's onset of symptoms, and is therefore unpersuasive. We disagree.

A "precipitating cause" analysis, standing alone, will generally not satisfy a claimant's burden of proving major contributing cause. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed*, 321 Or 416 (1995); *Steven M. Kenimer*, 53 Van Natta 6 (2001). However, here, we find that Dr. Amstutz' opinion was well-reasoned and based on a more extensive analysis.

Dr. Amstutz based his opinion that claimant's work activity was the major contributing cause of his low back condition in part on the fact that claimant did not have symptoms before the December 1999 work activity. (Ex. 16-4). However, Dr. Amstutz also noted that claimant's degenerative disk disease was confined to one level, and that the remaining levels were essentially disease free, indicating that claimant's herniated disc condition was traumatic in origin. (Ex. 17). The injured disc level, moreover, was not "desiccated," which also suggested to Dr. Amstutz a traumatically-induced condition. (Exs. 16-4, 17). Dr. Amstutz explained that, in his opinion, claimant's disc displacement was brought on by a "series of micotraumas" associated with claimant's bending and lifting at work. (Ex. 17).[1]

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[1] We also acknowledge the insurer's argument that Dr. Amstutz' opinion rests on speculation in regard to claimant's MRI findings. Dr. Amstutz stated that the MRI scan demonstrated an L5-S1 disc displacement that "could potentially compromise" the SI nerve roots. (Ex. 16-3). However, even assuming that particular statement is "speculative" in nature, we do not find that it is central to Dr. Amstutz' ultimate conclusions explained above.

We agree with the ALJ that Dr. Amstutz' opinion is the most well reasoned and persuasive. Therefore, we find that claimant's work activities were the major contributing cause of his low back condition. Accordingly, the insurer's denial of claimant's low back condition was properly set aside.

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability of the low back 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 $200, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's attorney's letter), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated February 6, 2001 is affirmed. For services on review regarding the compensability of the low back condition, claimant's attorney is awarded $200, payable by the insurer.

Board Member Meyers, concurring in part and dissenting in part.

I agree with the majority's decision to affirm the ALJ in regard to claimant's carpal tunnel condition. However, I would reverse the ALJ's order with regard to claimant's low back claim, and therefore respectfully dissent from that portion of the majority's order.

The medical record in this case reveals that claimant has the following preexisting conditions: lumbar spina bifida occulta and subluxation, decreased disc height at L5-S1, and degenerative disk disease (to varying degrees) at both L4-5 and L5-S1. (Exs. 1-2, 3, 8, 15). In particular, an MRI taken on May 19, 2000 revealed claimant's "premature disk degeneration with narrowing and desiccation at the L4-5 level." (Ex. 8). Based on these records, I am reluctant to accept Dr. Amstutz' opinion that claimant's degenerative condition was confined to one level.

Because the low back claim is one for an occupational disease, claimant must prove that his work activity is the major contributing cause of his low back condition. ORS 656.802(2)(a).[1] I do not believe that claimant met that burden on this record.

Dr. Amstutz stands alone in supporting the claim. In my view, the preponderance of medical evidence from Drs. Denekas, Strum, and McKellar outweighs Dr. Amstutz' opinion. Drs. Denekas and Strum diagnosed lumbar degenerative disk disease and found that "there is no medical evidence to support that [claimant's] work activities change[d] the progression of his degenerative disk disease." (Ex. 12-6). The examiners explained that claimant's "disc bulge" noted on MRI is a frequent finding in someone with degenerative disk disease. (*Id.*) They concluded that claimant's employment was not the major cause of claimant's degenerative disk disease or his need for treatment. (*Id.*) I find the opinion of Drs. Denekas and Strum well-reasoned and persuasive. Claimant's treating physician Dr. McKellar concurred with Drs. Denekas and Strum. (Ex. 14).

In contrast, Dr. Amstutz is not claimant's attending physician, but instead saw him only once, almost a year after the allegedly injurious work activity. (Ex. 16). His opinion relies largely on a temporal analysis and is unpersuasive, in my view. I would have reversed the ALJ and reinstated the insurer's denial of claimant's low back claim.

For these reasons, I respectfully dissent from that portion of the majority's order that affirms the ALJ's order setting aside the insurer's denial of claimant's low back claim.

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[1] That is, assuming that claimant need not meet an even higher burden of proving that his work activities are the major contributing cause of the combined (degenerative disk disease) condition and of a pathological worsening of the disease, pursuant to ORS 656.802(2)(b).

In the Matter of the Compensation of
LAWRENCE G. VANDAMME, Claimant
Own Motion No. 01-0067M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our May 10, 2001 Own Motion Order which declined to reopen his 1967 industrial injury claim for the payment of temporary disability compensation because he failed to establish that he remained in the work force when his compensable condition worsened requiring surgery or hospitalization. With his request, he submits a May 16, 2001 medical report from Dr. Butler, his attending physician.

In order to satisfy the third *Dawkins* criterion, claimant must first establish that he was willing to work. Failing to demonstrate his willingness to work, a claimant would not be considered a member of the work force, and thus, not entitled to temporary disability compensation. *See Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989); *Stephen v. Oregon Shipyards*, 115 Or App 521 (1992); *Judith R. King*, 48 Van Natta 2303 (1996).

As explained in our prior order, we were persuaded that claimant had demonstrated his willingness to work. On reconsideration, and based on the record before us, we continue to find that claimant was and is willing to work.[1]

However, claimant must also satisfy the "futility" standard of the third *Dawkins* criterion, in order to be found in the work force. In previously declining to authorize the reopening of claimant's claim, we concluded that Dr. Butler's March 6, 2001 "work release" related to claimant's ability to work from the time of his November 27, 2000 surgery and thereafter, which was not the "time of disability."[2]

On reconsideration, claimant submits a May 16, 2001 medical report from Dr. Butler. Dr. Butler opined that it "would have been futile for [claimant] to seek work *prior* to his November 27, 2000 surgery because of his work-related lower back injury dated Aug[ust] 9, 1967."

Based on Dr. Butler's unrebutted opinion, we are persuaded that, at the time of the current worsening, claimant was willing to seek employment but unable to do so because of his compensable condition. Consequently, claimant has satisfied the "futility" standard of the third *Dawkins* criterion.

Accordingly, we withdraw our May 10, 2001 order. On reconsideration, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning November 27, 2000, the date he underwent 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] Based on claimant's February 15, 2001 statement, we found that he was willing to seek employment. Specifically, claimant stated that" "I have always been willing to work and always will be. * * * I am not working but willing to work, and am not seeking work because of this work related injury has made such efforts futile."

[2] The "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's Own Motion jurisdiction, is the date he enters the hospital for the proposed surgery and/or inpatient hospitalization for a worsened condition. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish he was in the work force is the time *prior* to his November 27, 2000 surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990); *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Paul M. Jordan*, 49 Van Natta 2094 (1997); *Kenneth C. Felton*, 48 Van Natta 725 (1996).

In the Matter of the Compensation of
RICHARD C. VERRILL, Claimant
WCB Case No. 00-05019
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewed by Board Members Phillips Polich, Bock, and Meyers.

The self-insured employer requests review of Administrative Law Judge (ALJ) Menashe's order that awarded claimant additional temporary total disability. The employer also moves to strike claimant's respondent's brief. On review, the issues are the procedural motion and temporary disability. We deny the motion and affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Claimant's respondent's brief was due on March 20, 2001. On March 22, 2001, the Board received claimant's brief, which was accompanied by claimant's counsel's certificate of service stating that the brief was mailed to the employer's counsel on March 21, 2001. However, the envelope in which claimant's brief was contained carried a postmark date of March 20, 2001.

Asserting that claimant's brief was "untimely filed" the employer contends that is should not be considered. We disagree.

For purposes of appellate briefs, "filing" is defined as "the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing." *See* OAR 438-005-0046(1)(a). Unless mailed by registered or certified mail, a rebuttable presumption exists that an appellate brief received by the Board after the brief's due date is untimely filed. *See* OAR 438-005-046(1)(c).

Here, because claimant's brief was received after its due date, a rebuttable presumption exists that it was untimely filed. That presumption has been rebutted. In reaching this conclusion, we note that the envelope in which claimant's respondent's brief was mailed bears a postmark establishing March 20, 2001 as the actual date of mailing.[1] Consequently, claimant's respondent's brief was timely filed.[2] Accordingly, we deny the employer's motion to strike.

Temporary Disability

In January 2000, claimant compensably injured his left wrist using a sledge hammer. (Ex. 1). He eventually came under the care of Dr. Ash, a neurologist, who diagnosed tendonitis with irritation of the median nerve.[3] (Ex. 10-1).

On June 9, 2000, Dr. Ash authorized a light duty work release for a period of three weeks. (Ex. 27a). The term "light duty" was not explained or otherwise defined. (*Id.*)

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[1] In response to the employer's motion, claimant's counsel submitted an affidavit indicating that he had signed the certificate of mailing on March 20, 2000, but had inadvertently written the wrong date on the certificate. Claimant's counsel's affidavit is consistent with the postmark on the envelope in which claimant's respondent's brief was mailed.

[2] We further note that the attorney's certificate attached to claimant's respondent's brief indicates that a copy was mailed to the employer's counsel on March 21, 2001; *i.e.*, one day after the due date. Notwithstanding this allegedly untimely "service" of claimant's brief on the employer (OAR 438-005-0046(2)), the employer has been able to file its reply brief. Because the employer has not been aggrieved by this one-day delay in timely service, we decline to reject claimant's brief. *See Lisa A. Hiner*, 52 Van Natta 2203, n.1 (2000); *David F. Weich*, 39 Van Natta 468 (1987).

[3] In May 2000, the employer accepted "left wrist tendonitis." (Ex. 22).

On June 16, 2000, the employer sought Dr. Ash's approval of a temporary assignment for claimant as a "Light Duty Clerical Assistant." (Ex. 20). The job description supplied to Dr. Ash for approval enumerates the physical requirements of the clerical assistant position in terms of standing, sitting, lifting, reaching, kneeling, and carrying, but is silent regarding repetitive movements of the wrist. (Ex. 29). Dr. Ash approved the job description on June 16, 2000. On June 22, 2000, Dr. Ash modified claimant's work release to include "no repetitive wrist movements." (Ex. 29a).

On June 28, 2000, the employer mailed claimant a letter advising him that a temporary modified work, as approved by his doctor, was available and asking him to report to work at 8:30 a.m., on July 3, 2000. (Ex. 30). Claimant did not receive the letter; consequently he did not report to work on July 3, 2000. When the employer ceased temporary disability payments, claimant requested a hearing.

The ALJ determined that claimant had not received either actual or constructive knowledge of the employer's offer of modified work. Consequently, the ALJ concluded that the employer had not satisfied the provisions of ORS 656.268(4)(c) by providing a written offer of modified employment to the worker.[4] Accordingly, the employer was directed to resume the payment of temporary disability payments.

On review, the employer does not dispute the ALJ's determination that claimant failed to receive notice of the modified job offer. Rather, the employer asserts its offer of modified work was perfected on mailing; *i.e.*, claimant's knowledge of the offer is irrelevant. Consequently, the employer reasons that it was entitled to cease temporary disability payments when claimant failed to report for work on July 3, 1999, even though he had no knowledge that he was to report to work on that date.

When a claimant is released to modified duty, the applicable criteria for terminating temporary total disability compensation is found in ORS 656.268(4)(c), which states that a physician must advise the claimant and document in writing that he or she is released to "return to modified employment," that such employment is offered in writing to the claimant and that the claimant fails to begin such employment. The employer must strictly comply with the requirements set forth in ORS 656.268(4) in order to terminate a claimant's temporary disability benefits. *Eastman v. Georgia Pacific Corp.*, 79 Or App 610 (1986). Strict compliance includes following the sequence of events contemplated by ORS 656.268(4)(c). *See Anthony R. Holder*, 50 Van Natta 1760 (1998).

The facts here are similar to the facts in *James L. Bittle*, 52 Van Natta 2227 (2000). There, the claimant received the employer's modified job offer 5 days after he was scheduled to report to work. In concluding that the claimant had not "failed to begin" the modified job, we found it implicit under the terms of ORS 656.268(4), that in order for a claimant to "fail to begin" a modified job, the claimant must first be notified of the job before its starting date. *Bittle*, 52 Van Natta at 2228.

Here, claimant had no notice of the modified job before the date the modified job was scheduled to begin.[5] For the reasons stated in *Bittle*, we agree with the ALJ's conclusion that because not all the essential requirements of ORS 656.268(4) were met, claimant remains entitled to temporary total disability compensation.

Additionally, we note that Dr. Ash's June 22, 2000, work release with "no repetitive wrist movements" is essentially a retraction of his previous approval of the "clerical assistant" job. In these circumstances, we conclude that Dr. Ash has not "found the job to be within the workers' capabilities" as required by OAR 436-060-0030(5)(c). *See Joseph M. Ardito*, 52 Van Natta 2174 (2000). Consequently, even if claimant had received notice of the modified employment, he would still remain entitled to temporary total disability compensation.

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[4] The ALJ did not address whether the employer's job offer, if received by claimant, would have complied with the terms of OAR 436-060-0030(5)(c).

[5] We acknowledge the employer's argument that a subsequent letter on July 12, 2000, Exhibit 34, which claimant did receive, sufficiently notified him to report for modified work. We note however, that the letter did not advise claimant to report for modified work at a date other than July 3, 2000. (Ex. 34). Consequently, neither the July 12, 2000 letter nor the June 28, 2000 letter meet the essential requirements of ORS 656.268(4).

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, to be paid 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 20, 2000 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the self-insured employer.

Board Member Meyers concurring in part and dissenting in part.

I agree that claimant remained entitled to TTD benefits through 4:00 PM, July 17, 2000. However, for the reasons stated below, I find that claimant's entitlement to TTD benefits ended after that time. Because the majority finds otherwise, I respectfully dissent.

First, I note that claimant's doctor discussed a modified work release for a "non-manual position" with claimant in April 2000. (Ex. 18). Consequently, claimant should not have been surprised when the employer sought Dr. Ash's approval of such a position on June 16, 2000. (Ex. 28).

Additionally, I note that after claimant failed to report for modified work on July 3, 2000, the employer sent claimant another letter dated July 12, 2000. That letter contained the same information about the modified job offer as the employer's previous letter of June 28, 2000. (Ex. 34). In addition, the July 12, 2000 letter advised claimant to contact the employer no later than 4:00 p.m. on July 17, 2000 or his TTD payment would continue to be in jeopardy. (*Id.*) Under these circumstances, I find that the employer's July 12, 2000 letter meets the essential requirements of ORS 656.268(4).

Claimant acknowledged receiving the July 12, 2000 letter on July 13, 2000. Nevertheless, other than a request from claimant's counsel's office for a copy of the attending physician's return to work authorization, claimant made no attempt to contact the employer or otherwise report for work within the time provided in the July 12, 2000 letter. Because claimant had actual notice of the employer's modified job offer on July 13, 2000, and because he failed to report to the employer within the 4 day period provided, I conclude that claimant's entitlement to TTD benefits ceased at 4:00 PM, July 17, 2000.

In the Matter of the Compensation of
DAVID A. WOLVERTON, Claimant
WCB Case No. 00-05170
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's low back condition claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

On May 16, 2000, claimant filed a claim for a June 8, 1998 work injury. (Ex. 2). The ALJ found that claimant could not pursue this injury claim, but that he could litigate an occupational disease claim. Relying primarily on examining orthopedic surgeon, Dr. Linder, and to a lesser extent on the treating physicians, Dr. Pfeiffer, chiropractor, and Dr. Hyatt, M.D., the ALJ concluded that claimant proved compensability.

SAIF contends that, if the claim is analyzed as an accidental injury, claimant did not timely file it.[1] SAIF further argues that, if treated as a claim for occupational disease, the applicable statute is ORS 656.802(2)(b) and claimant did not persuasively show that work activities were the major contributing cause of the combined condition and pathological worsening of the disease. Claimant concedes that he did not sustain an accidental injury and asserts that the more persuasive medical evidence shows that the major contributing cause of his worsened condition after March 1998 was work activities.

Dr. Pfeiffer first reported a "correlation between mechanism of injury, x-ray findings, subjective symptoms, and exam findings[.]" (Ex. 3-40). According to Dr. Pfeiffer, the "torsional compressive blow to the lower spine and left hip on June 8, 1998[[2]] quite probably set the stage for recurrent and unresolved exacerbations of varying degrees" and "in itself would cause [claimant's] symptoms and resulting nerve deficit, but when superimposed upon a biomechanically 'stiffer' spine as evidenced by the radiographic findings of previous compressive injuries, causes the spine to behave more like a single long bone than a set of articulating structures." (*Id.*) Dr. Pfeiffer also stated that claimant's condition was "[g]reater than 50% from this 06-08-98 on-the-job injury and subsequent on-the-job exacerbations." (*Id.* at 41).

Dr. Pfeiffer subsequently indicated that the "work event of a torsional compressive blow disrupted [claimant's] spinal biomechanical function and his subsequent work activities caused a pathological worsening of his condition." (Ex. 20A-1). Dr. Pfeiffer found that the major contributing cause of the pathological worsening was claimant's "work activities following the accident[.]" (*Id.*)

Examining physicians Dr. Reimer, neurologist, and Dr. Fuller, orthopedic surgeon, diagnosed "[d]evelopmental/degenerative lumbar spondylosis, multiple levels, with degenerative discopathy at all lumbar levels, with the L5-S1 disc being the best maintained." (Ex. 20-4). The panel thought that claimant's condition was "the result of both developmental and idiopathic degenerative processes, superimposed upon the developmental disorder" and that this preexisting condition was the "major, if not sole, cause[.]" (*Id.* at 5).

Dr. Reimer later clarified that the imaging studies showed a "phenomenal amount of degenerative changes" and he characterized the condition as "dysplasia," which is an "abnormal development of the vertebral bodies and the bony structure of the spine" that could be "genetic or simply idiopathic." (Ex. 23-1). According to Dr. Reimer, this developmental disorder was preexisting and "leads to the various degenerative conditions, [including] spondylolisthesis, spur formation, and spondlylosis[.]" (*Id.*) Dr. Reimer attributed the major cause to the preexisting dysplasia and associated degenerative changes. (*Id.*)

Dr. Hyatt first saw claimant on June 13, 2000 at Dr. Pfeiffer's referral. Dr. Hyatt first indicated that "the major contributing cause of [claimant's] current low back condition and need for treatment relates to his overall work activities for the employer since 1989." (Ex. 22-1). Dr. Hyatt explained that claimant's heavy work activities "will accelerate the degenerative process in the spine." (*Id.*) Finally, Dr. Hyatt agreed with Dr. Pfeiffer that claimant's condition pathologically worsened. (*Id.* at 1-2).

Dr. Young performed a record review and reported that the lumbar radiograph "shows moderately advanced multilevel osteoarthritis, disc disease and facet arthritis which is superimposed on Scheuermann's disease or healed juvenile discogenic disease." (Ex. 24-2). Dr. Young explained that Scheuermann's disease is a "developmental abnormality which generally manifests itself clinically in early adolescence" and results in a higher incidence of degenerative disc disease in the thoracic and upper lumbar spine. (*Id.*) According to Dr. Young, the severity of claimant's degenerative disc disease indicated a lifetime process. (*Id.*) Dr. Young concluded that the work activities may have contributed in a minor way to the development of the degenerative disease but were not the major contributing cause of the combined condition. (*Id.* at 4).

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[1] There is no dispute that claimant did not timely give notice of the 1998 injury. A worker is required under ORS 656.265(1) and (2) to give written notice of an accident resulting in an injury within 90 days of the accident. Under ORS 656.265(4), the failure to give written notice bars a claim unless the notice is given within one year after the date of the accident and the employer had knowledge of the injury. Because there is no evidence that the employer had notice of the claim until claimant filed the Form 801 on May 16, 2000, more than a year after the accident, the injury claim is barred.

[2] Claimant first filed a claim for an injury on June 8, 1998. (Ex. 2). Claimant testified, however, that it more likely occurred in March or April 1998.

Dr. Linder diagnosed "[m]ultilevel degenerative disc disease * * * pre-existing but aggravated by the industrial injury of June 8, 1998." (Ex. 25-5). Dr. Linder thought that "historically" there was a "significant aggravation and exacerbation of the condition brought about by the industrial injury under review." (*Id.* at 6). In particular, Dr. Linder estimated the "pre-existing condition to constitute 49% of his problem and the injury 51%" on the basis that claimant had "no pre-existing problems whatsoever, there is potential for a significant spinal injury being thrown backwards on a concrete curb[.]" (*Id.*)

Dr. Linder then concurred with Dr. Young's report, adding that claimant's "condition appears to relate to a specific traumatic event, not his work in general." (Ex. 26A).

Dr. Hyatt then indicated that his review of the opinions of Drs. Young and Linder did not change his opinion that claimant's "low back condition was caused in major part from his overall work activities * * * and that his work activities since the March, 1998 accident are the major contributing cause of pathological worsening of his low back condition." (Ex. 28).

After reviewing Dr. Linder's report, Dr. Pfeiffer agreed that the March 1998 accident contributed to claimant's current condition but found that "the major contributing cause of a pathological worsening * * * is related to his work activities subsequent to the March 1998 incident." (Ex. 29-1). Dr. Pfeiffer also disagreed with Dr. Young that claimant showed evidence of Scheuermann's disease, noting that it most often occurred in the thoracic area and claimant's symptoms were in his lower lumbar region. (*Id.*) Dr. Pfeiffer also disagreed with Dr. Reimer's diagnosis of dysplasia, finding that such a condition could not be "proven on this record." (*Id.* at 2).

Dr. Linder attributed the major cause of claimant's condition to the 1998 accident. (Ex. 25-6). As previously noted, claimant's injury claim is time-barred. Consequently, Dr. Linder's opinion does not establish compensability.

The remaining opinions from Dr. Hyatt and Dr. Pfeiffer essentially show that claimant's preexisting condition pathologically worsened and work activities since the 1998 accident were the major contributing cause of the pathological worsening. (Exs. 28, 29).

If the occupational disease claim is based on the worsening of a preexisting disease or condition, 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, we find the opinions of Drs. Hyatt and Pfeiffer insufficient to meet this standard.

First, Dr. Pfeiffer initially indicated that the 1998 accident and subsequent exacerbations were most responsible for causing claimant's condition. (Ex. 3-40). His last opinion, however, implied that work activities were the major contributing cause of claimant's degenerative disease. (Ex. 29-2). Dr. Pfeiffer provided no explanation for this change of opinion.

Furthermore, both Dr. Pfeiffer and Dr. Hyatt provided little reasoning for attributing the "combined condition" to work activities. Dr. Hyatt's opinion was particularly conclusory, stating only that heavy work activities accelerate the degenerative process without explaining how claimant's work in particular caused his condition. Although Dr. Pfeiffer disagreed with Drs. Reimer and Young about the presence of developmental abnormalities, including dysplasia and Scheuermann's disease, Dr. Pfeiffer's only explanation was that such conditions could not be proven. This statement does little to undermine the opinions of Drs. Reimer and Young because both relied on imaging studies. In other words, Dr. Pfeiffer does not explain how those conditions could not be proven when, according to Drs. Reimer and Young, they are established by radiographic studies.

Similarly, neither Dr. Hyatt nor Dr. Pfeiffer respond to Dr. Young's point that the imaging studies show such severe degenerative changes that a lifetime would be required to produce them. Instead, as noted above, both physicians summarily attribute the degenerative process to work activities.

In sum, we find that the medical opinions of Drs. Hyatt and Pfeiffer are, at best, in equipoise with those of Drs. Reimer and Young. As such, claimant did not carry his burden of proving that work activities were the major contributing cause of the "combined condition" and pathological worsening of the preexisting condition. *See* ORS 656.802(2)(b).

ORDER

The ALJ's February 12, 2001 order is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

June 27, 2001 Cite as 53 Van Natta 815 (2001)

In the Matter of the Compensation of
RANDY M. PEDERSEN, Claimant
WCB Case No. 99-09968
ORDER ON REVIEW
Starr & Vinson, Claimant Attorney
Myrick Seagraves, Defense Attorney

Reviewed by Board Members Haynes, Bock, and Phillips Polich.

Johnston and Culberson, Inc. (JCI), the statutory processing agent for Hidden Hollow Ranch (HHH), a noncomplying employer, and HHH request review of Administrative Law Judge (ALJ) Stephen Brown's order that set aside JCI's denial of claimant's injury claim for multiple injuries. On review, the issues are course and scope of employment and compensability. We reverse.

FINDINGS OF FACT

Ms. Shelly operates HHH, a horse breeding business. (Tr. 63-64; Ex. 58). In December 1998, she owned about 20 horses. (Tr. 65). In late fall 1998, she placed an employment ad for assistance with the horses. (*Id.*) The advertisement specifically sought an employee who did not use alcohol or drugs. (*Id.*) Claimant applied for the job and Ms. Shelly interviewed him on November 4, 1998. (*Id.*) Ms. Shelly asked claimant whether he used drugs or alcohol and he denied the use of either substance. (Tr. 65-66).

Claimant sought methadone treatment on October 23, 1998. (Ex. 4). Claimant's treatment program reported that he had been treated for heroin addiction on numerous occasions and he had been addicted to opioids on and off for the past 30 years. (Exs. 4, 7). He started methadone treatment on November 11, 1998. (Ex. 8). Claimant did not inform Ms. Shelly that he was involved in a methadone program until sometime after December 2, 1998. (Tr. 78).

Ms. Shelly initially employed claimant on a trial basis, as a casual laborer. (Tr. 66). His job duties included feeding and watering the horses and cleaning the stalls. (Tr. 12). He was paid extra for handyman and repair work. (*Id.*) Ms. Shelly instructed claimant about the layout of the barn and how much to feed each horse. (Tr. 67). About 25 tons of hay had been delivered in late October 1998 and was stored in the loft of the barn. (Ex. 85). There is a 2-1/2 ft. by 4 ft. hay drop in the rear of the barn. (*Id.*) When claimant was hired, Ms. Shelly told him they were not using the back hay drop at all. (Tr. 67-68, 71, 93). Claimant was officially hired on December 1, 1998. (Tr. 82).

On the morning of December 2, 1998, claimant reported for methadone treatment. (Ex. 12; Tr. 14). The treatment program reported on that day that claimant was "still using occasionally[.]" (Ex. 12).

On the same day, claimant assisted Ms. Shelly installing feeding racks in the barn. (Tr. 15, 79). Ms. Shelly left between 4:00 and 4:30 pm to pick up her daughter and they stopped working on the feeders at that time. (Tr. 16, 96-97).

At some point after Ms. Shelly left, claimant went to the hayloft. He fell down the back hayloft and was seriously injured. There were no witnesses to the fall. Claimant was taken by ambulance for medical treatment. (Ex. 18). Claimant's blood and urine tests were positive for alcohol, opiates and benzodiazepine. (Ex. 19).

On December 3, 1999, Drs. Rich and Donahoo examined claimant on behalf of JCI. (Ex. 78). Dr. Jacobsen performed a records review on March 20, 2000. (Ex. 84).

JCI denied the claim on the basis that claimant's injuries were not compensably related to his employment, pursuant to ORS 656.005(7)(b)(C). (Ex. 81).

CONCLUSIONS OF LAW AND OPINION

At the hearing, JCI and HHH sought to expand the denial to include three other bases: (1) claimant's voluntary consumption of alcohol and drugs was not within the course and scope of employment and was specifically a violation of the job contract; (2) the claim was not compensable under ORS 656.005(7)(b)(B); and (3) claimant's injury was the product of his deliberate intention. (Tr. 2-3). The ALJ allowed JCI/HHH to amend the denial. (Tr. 4-5).

The ALJ found that claimant was not a reliable witness because he contradicted his own testimony and his testimony was inconsistent with the medical records. The ALJ found that claimant's injury arose out of and in the course of his employment. The ALJ concluded that, at the time of claimant's injury, he was impaired as a result of alcohol and methadone. Nevertheless, the ALJ determined that JCI/HHH failed to prove that claimant's alcohol consumption, to the exclusion of his legal consumption of methadone, was the major contributing cause of his work injury.

We first address claimant's argument that the ALJ erred in finding that he was not a reliable witness. 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 *de novo* review, we agree with the ALJ that claimant was not a reliable witness. Claimant testified that he had quite a bit of memory loss and sustained brain damage in the accident. (Tr. 13, 14). Based on claimant's inconsistent testimony and memory problems, we find that his testimony is not entitled to much weight.

On review, HHH argues, among other things, that claimant's injuries did not occur in the course and scope of his employment. HHH contends that, by consuming alcohol and violating the employer's work rule, claimant overstepped the boundaries of the ultimate work he was hired to perform.

ORS 656.005(7)(a) defines a compensable injury as one "arising out of and in the course of employment[.]" In *Andrews v. Tektronix, Inc.*, 323 Or 154, 166 (1996), the Court rejected the idea that an employee's violation of an employment rule rendered the worker's claim *per se* noncompensable. Instead, the question is whether the claimant was engaged in an activity that was within the boundaries of his or her ultimate work. *Id.* The "facts that an employer has instructed a worker to avoid certain work, and that the worker's injury occurred when he or she disregarded that instruction, are only two of many factors that must be considered in the over-all calculation of work-connectedness." *Id.* at 165. Among the "additional factors are the degree of connection between what the worker is authorized to do and is forbidden to do, the degree of judgment and latitude normally given the worker, workplace customs and practices, the relative risk to the worker when compared to the benefit to the employer, and the like." *Id.*

In this case, Ms. Shelly, the employer, placed an advertisement for a farm laborer that referred to no alcohol or drug use. (Tr. 65). When she interviewed claimant, she specifically asked him if he used alcohol or drugs and claimant denied the use of either substance. (Tr. 65-66). Claimant did not inform Ms. Shelly that he was involved in a methadone program until after the December 2, 1998 accident. (Tr. 78, 85). Ms. Shelly testified that she did not want employees using drugs or alcohol because her daughter and grandson lived with her and her horses were like an extended family and she was very concerned about their care. (Tr. 66). Ms. Shelly initially employed claimant as a casual laborer to observe how he was around the animals and to see how he interacted with her daughter and grandson. (Tr. 66).

On December 2, 1998, claimant sustained multiple serious injuries when he fell from the employer's back hay drop. There were no witnesses to the fall. Claimant did not know how he fell through the hole of the hayloft. (Tr. 50). He testified that he did not drink any alcohol before the injury and had not consumed any drugs that day other than prescribed methadone and high blood pressure medication. (Tr. 30-31). Nevertheless, claimant's blood alcohol level was measured at two different medical facilities on the evening of December 2, 1998, and the tests were positive for alcohol, opiates and benzodiazepine. (Ex. 19).

Thus, although the employer prohibited the use of drugs and alcohol and expressly informed claimant of that requirement at the time of hiring, claimant tested positive for both drugs and alcohol on the date of injury. Claimant violated the employer's work rule against the use of drugs and alcohol. Drinking alcohol was not a part of claimant's work. There is no evidence that the employer was aware of claimant's drinking and we find that no degree of judgment or latitude was involved in claimant's actions of drinking alcohol. We find no custom or practice of allowing consumption of alcoholic beverages.[1] In addition, the medical evidence from Dr. Jacobsen establishes that claimant's consumption of alcohol was causally related to his injury.

Furthermore, the preponderance of evidence indicates that claimant was not involved in any work activity at the time he was injured. Claimant testified that the procedure was to bring hay from the loft to the front of the barn and roll it into the pickup parked underneath the platform. (Tr. 19, 20; Ex. 2-3). Ms. Shelly instructed claimant to gradually expand the walkway down the center and work toward the back. (Tr. 71). Claimant agreed that he had been instructed to keep pulling bales away from the pathway and expand the pathway from the front first. (Tr. 53).

Ms. Shelly testified that the back hay drop was not used at all and she had instructed claimant not to put hay down the back hay drop. (Tr. 68, 71). She said it would have been "ridiculous" to take hay from the area around the back hay drop because the hay would have to be dragged almost the entire length of the barn. (Tr. 71-72). Ms. Shelly testified further that there was no work reason for claimant to have been in the vicinity of the back hay drop where he fell. (Tr. 76).

Claimant had no explanation of how he fell through the hole of the hayloft. (Tr. 50). He testified that he had never used the hole in the back part of the hayloft to drop any hay downstairs and he had no reason to use it. (Tr. 24, 45). He had not yet retrieved hay from the area by the back hay drop because he had not worked back that far. (Tr. 44, 54). Although claimant guessed that he had been pulling a hay bale out somewhere around the hole on December 2, 1998 (Tr. 55), Ms. Shelly testified that no hay had been dislodged or disturbed from that location after the accident. (Tr. 76). Thus, the preponderance of evidence demonstrates that, to the extent that claimant arguably may have been working around the back hay drop, that activity was contrary to the employer's specific instructions.

We find that claimant violated the employer's "no alcohol" rule and he also disregarded Ms. Shelly's instructions not to use the back hay drop. We conclude that claimant was injured while he was engaged in a prohibited activity that was outside the boundaries defining his ultimate work. This injury involved more than simply a prohibited method of accomplishing claimant's job. To the contrary, there was no work reason for claimant to be drinking alcohol or to be in the section of the barn by the back hay drop. In fact, Ms. Shelly testified that, after claimant's December 2, 1998 injury, no hay had been removed from that location. By violating both work rules, particularly the "no alcohol" rule, the risk of injury to claimant was great and there was no benefit to the employer. Under these circumstances, we conclude that claimant has failed to prove a sufficient work connection between his injury and employment.

Alternatively, even if we assume that claimant has established a prima facie case of compensability, we conclude that JCI/HHH have sustained their burden of proof under ORS 656.005(7)(b)(C). JCI/HHH must prove, by the preponderance of the evidence, that claimant's "consumption of alcoholic beverages or the unlawful consumption of any controlled substance" was the major contributing cause of the injury. The cause and effect of the use of alcohol or controlled substances is a medical question requiring expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967); *Erika W. Ortman*, 51 Van Natta 2012 (1999).

As discussed earlier, claimant's tests on the evening of the December 2, 1998 injury were positive for alcohol, opiates and benzodiazepine. (Ex. 19). The record indicates that claimant was a "long time heroin user[.]" (Ex. 8). On the morning of December 2, 1998, claimant was given methadone as part of his treatment program. (Ex. 12). The counselor noted that claimant was "still using occasionally" and wanted to raise his methadone level. (*Id.*)

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[1] We note that Ms. Shelly served claimant one glass of wine on Thanksgiving, but she did not offer him alcohol on any other occasion. (Tr. 90-91). We do not believe that serving one glass of wine on a holiday establishes a custom or practice of allowing alcoholic beverages, and it is not sufficient to establish that the employer "acquiesced" in claimant's use of alcohol.

Dr. Peterson treated claimant after the December 2, 1998 accident. He noted that claimant's blood alcohol was 65 mg/dl on the day of injury and he said the reason for the fall was "certainly debatable." (Ex. 71). Dr. Peterson believed that claimant's alcohol level would most likely have produced some degree of impairment that may have contributed to the fall. (*Id.*)

Drs. Rich and Donahoo examined claimant on behalf of JCI. They reported that the combination of alcohol, methadone and benzodiazepine made it much more likely to lose one's balance, trip and fall. (Ex. 78-6).

JCI and HHH rely on the opinion of Dr. Jacobsen to argue that claimant's injury is not compensable pursuant to ORS 656.005(7)(b)(C). Dr. Jacobsen has specialized in addiction medicine for the past 10 years. (Tr. 106). In March 2000, he reviewed claimant's records and reported that claimant's serum alcohol levels were "0.065 gm%" at 5:50 pm and "0.021 gm%" at 9:01 pm on December 2, 1998. (Ex. 84-5). When he corrected the levels to whole blood levels, the blood alcohol levels (BALs) were "0.056 gm%" at 5:50pm and "0.018 gm%" at 9:01 pm. (*Id.*) Based on the calculations, Dr. Jacobsen found that claimant's BAL at the time of the accident was about 0.06 to 0.07 gm%, which represented 3 to 3-1/2 unmetabolized standard drinks present in his body at the time of the accident. (Ex. 84-6). Dr. Jacobsen found that claimant had not completely absorbed all the alcohol, and his BAL was increasing at the time of his fall. (*Id.*)

Dr. Jacobsen concluded that, based on claimant's past medical and drug use history, as well as the blood and urine testing on December 2, 1998, claimant probably experienced a combination of additive brain depressant type impairments before his fall that would put him at very high risk to have an accident. (Ex. 84-7). Dr. Jacobsen did not believe there was good evidence that claimant was a regular heavy drinker or that he had developed significant alcohol tolerance. (Ex. 84-8). He said that, at a BAL of 0.06 to 0.07, alcohol impairment would include decreased attention, awareness, alertness and the beginning of impaired motor functions, including decreased balance, coordination and a slowed reaction time. (*Id.*) Dr. Jacobsen determined that claimant drank a significant amount of alcohol before his fall and the residual blood alcohol levels were sufficient to cause individual, as well as additive impairments. (*Id.*)

In addition, Dr. Jacobsen said that claimant's positive test for opioids on December 2, 1998 was from methadone and possibly other street narcotics. (Ex. 84-8). He explained that the use of any other type of brain depressant, *i.e.*, alcohol or tranquilizer in combination with methadone, will result in a greater level of impairment than with either substance alone. (*Id.*; Tr. 111). Dr. Jacobsen concluded that claimant's equivalent impairing effects from alcohol on December 2, 1998 would have been up to 50 percent higher than his blood alcohol level alone would indicate because of combining alcohol with methadone. (Ex. 84-8; Tr. 119). He felt that claimant's "effective BAL" was between 0.09 to 0.10 gm%. (Ex. 84-8; Tr. 119).

Dr. Jacobsen also explained that claimant had been prescribed high blood pressure medication, which can cause acute dizziness with loss of balance and fainting from a sudden drop in blood pressure. (Ex. 84-9). He said that high blood pressure medication should not be used with alcohol because, if combined, a person is more prone to a sudden decrease in blood pressure. (*Id.*; Tr. 112). Claimant testified that he had a regular routine for taking his blood pressure medication in the morning and evening. (Tr. 29). He acknowledged that, on the day of the accident, he had consumed the prescribed methadone and high blood pressure medication. (Tr. 30, 32). Dr. Jacobsen said that claimant's blood pressure medication combined with alcohol would have contributed to his impairment. (Tr. 124, 146).

Dr. Jacobsen concluded that at the time of the December 2, 1998 accident, claimant was significantly impaired from a combination of effects from alcohol and methadone. (Ex. 84-10). He believed that combined mental and physical impairments would have been significant, including decreased awareness, alertness and attention, with impaired coordination and decreased reaction time. (*Id.*) Dr. Jacobsen concluded that it was "medically probable that alcohol and possibly other substances was the major contributory cause of [claimant's] accident." (*Id.*)

Dr. Jacobsen testified at hearing. He agreed that, based on medical probability, claimant's alcohol impairment was the major contributing cause of the accident. (Tr. 119). He said that claimant's blood alcohol combined with methadone would have resulted in decreased attention, poor judgment, a

tendency for impulsive behavior, slowed reaction time, and difficulty with memory, problem solving and basic cognitive skills. (Tr. 119-120). Although Dr. Jacobsen indicated that claimant may have been able to pass a field sobriety test, he said that claimant would still have been significantly impaired in those fine level of brain depression impairments.[2] (Tr. 120).

Based on his experience, Dr. Jacobsen determined that it was reasonable and even conservative to state that claimant had a 50 percent increase in the total impairment from the alcohol level based on his methadone consumption. (Tr. 139, 141). He explained that both alcohol and methadone are brain depressants and affect alertness, awareness, coordination, speech, thought process and memory. (Tr. 139). Dr. Jacobsen said that claimant still would have had about half of the 7:30 am methadone dose still present in his body at the time of the accident. (Tr. 140).

Under ORS 656.005(7)(b)(C), a "compensable injury" does not include an "[i]njury the major contributing cause of which is demonstrated to be by a preponderance of the evidence the injured worker's consumption of alcoholic beverages[.]" Although Dr. Jacobsen discussed the "combined" impairment from alcohol and methadone, he also concluded that alcohol itself was the major contributing cause of claimant's injury. (Ex. 84-10, Tr. 119). When Dr. Jacobsen's report and testimony are read as a whole, we agree with JCI/HHH that his opinion persuasively establishes that claimant's consumption of alcohol was the major contributing cause of his December 2, 1998 injury.

Finally, we discuss claimant's arguments on review that: (1) the noncomplying employer (HHH) and the paying agent (JCI) may not rely on ORS 656.005(7)(b)(C) as a defense; and (2) the noncomplying employer's violation of safety codes, the Oregon Employer's Liability Act and the Oregon Safe Employment Act are the major cause of claimant's injury as a matter of law.

JCI contends that claimant did not raise an issue concerning the Oregon Safe Employment Act at hearing and, therefore, the Board should not address that issue. JCI argues that it has the right to deny the claim because it did not meet the statutory requirements for compensability.

After reviewing the transcripts, we find no evidence that claimant argued that HHH, as the non-complying employer, and JCI, as the paying agent, could not rely on ORS 656.005(7)(b)(C) as a defense. Furthermore, claimant did not raise arguments about the Oregon Employer's Liability Act (ORS 654.305) or the Oregon Safe Employment Act (ORS 654.001 to 654.295). Because there is no evidence that claimant raised those issues at hearing, we are not inclined to address them. For the first time in closing arguments, claimant argued that the employer had violated safety codes and that was the major cause of his injury. It is well-settled that an issue raised for the first time in closing arguments should not be considered. *See, e.g., Lawrence E. Millsap*, 47 Van Natta 2112 (1995). In any event, even if all these issues were properly before us, we would reject claimant's arguments for the following reasons.

Claimant argues that the fact that his employer was noncomplying does not permit it to use ORS 656.005(7)(b)(C) as a defense. Claimant relies on ORS 656.020(2) to contend that a noncomplying employer does not have a defense based on contributory fault of the injured worker.

ORS 656.020 provides, in part:

> "Actions for damages may be brought by an injured worker or the legal representative of the injured worker against any employer who has failed to comply with ORS 656.017 or is in default under ORS 656.560. Except for the provisions of ORS 656.578 to 656.593 and this section, such noncomplying employer is liable as the noncomplying employer would have been if this chapter had never been enacted. In such actions, it is no defense for the employer to show that:

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[2] We note that claimant argues that the evidence establishes that his blood alcohol level was below the level that would have established a violation for driving a motor vehicle under the influence, and he would have passed a police officer's field sobriety tests if he had been operating a motor vehicle. In previous cases, we have held that the degree of impairment is not the relevant inquiry. *See Janice Neuenschwander*, 49 Van Natta 1970, 1972 (1997); *Ronald Martin*, 47 Van Natta 473, 475 n3 (1995). Rather, the issue is whether claimant was impaired by his consumption of an alcoholic beverage and, if so, whether that impairment was the major contributing cause of the injury. *See id.*

"* * * * *

"(2) The negligence of the injured worker, other than a willful act committed for the purpose of sustaining the injury, contributed to the accident[.]"

JCI correctly points out that it is not asserting a defense barred by ORS 656.020(2). The case before us is *not* an action for damages. Instead, the issue in this case is whether claimant has established a compensable injury. The statutory language of ORS 656.005(7)(b)(C) provides no basis for distinguishing between a complying or noncomplying employer. We conclude that neither JCI nor HHH is barred from using ORS 656.005(7)(b)(C) as a defense.

Next, we address claimant's arguments that the noncomplying employer's violation of safety codes, the Oregon Employer's Liability Act and the Oregon Safe Employment Act are the major cause of his injury as a matter of law. According to claimant, the Board must consider the statutory standards of care and duties placed on the employer to provide claimant with a safe work place with the contribution, if any, of his consumption of alcohol or unlawful controlled substances, in order to determine the major cause of his injury.

In *Andrews v. Tektronix, Inc.*, 323 Or at 159-60, the Court explained:

"Fault is an idea that has no place in our workers' compensation scheme: Indeed, if our workers' compensation laws stand for anything, it is that fault is irrelevant in determining a worker's entitlement to compensation. *See, e.g., Ore-Ida Foods v. Indian Head Cattle Company*, 290 Or 909, 918, 627 P2d 469 (1981) (under Oregon Workers' Compensation Law, employer is liable for compensation '[w]hether the cause be the fault of the employer, the fault of the worker, the fault of a third person, or the fault of no one'); *McDonough v. National Hosp. Ass'n*, 134 Or 451, 460, 294 P. 351 (1930) (right to compensation 'is not dependent upon any negligence or wrongful act of the employer but is based wholly upon the fact of employment)."

In *Fred Meyer, Inc. v. Hayes*, 325 Or 592 (1997), the claimant was injured in the employer's parking lot when she was attacked by an unknown assailant. The Court noted:

"The issue whether claimant's injury is compensable under the Act is a different question from the issue whether employer was negligent in failing to provide adequate security for its employees. We do not address any negligence issue in this opinion." *Id.* at 595 n4.

In this case, as in *Hayes*, the issue is compensability, not whether or not the employer was negligent. In *Andrews*, the Court said that workers' compensation is a no-fault system that compensates a worker for injuries that arise out of and occur in the course of the worker's employment. The issue of alleged "fault" by the employer is not part of the analysis for workers' compensation purposes.[3] Instead, as the Court explained, an employee who is injured while engaged in a prohibited activity that is outside the boundaries defining his or her ultimate work cannot prevail on a claim that the injury is work connected. 323 Or at 163-64.

JCI correctly notes that there is no credible evidence that the employer's alleged safety violations were the major contributing cause of claimant's injury. To the contrary, Dr. Jacobsen considered the presence of the open hole and the surrounding circumstances, including the poor lighting, in rendering his opinion that claimant's impairment from alcohol was the major contributing cause of his injuries. (Tr. 126-28). Dr. Jacobsen was aware that the hole was completely open and unguarded and did not have railings, foot boards or toe boards. (Tr. 142). We find no expert evidence establishing that the employer's alleged safety violations were the major contributing cause of claimant's injury.

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[3] In *Smothers v. Gresham Transfer, Inc.*, 332 Or 83, 125 (2001), the Court continued to recognize the legislature's constitutional authority to substitute workers' compensation for the common-law negligence cause of action for work-related injuries.

In sum, for the reasons explained earlier, we find that claimant failed to prove a sufficient work connection between his injury and employment. In addition, even if claimant's injury occurred in the course and scope of his employment, JCI/HHH have sustained their burden of proving, by the preponderance of the evidence, that claimant's "consumption of alcoholic beverages" was the major contributing cause of the injury. Consequently, we reverse the ALJ's order.[4]

ORDER

The ALJ's order dated September 13, 2000 is reversed. JCI's denial of claimant's injury claim is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[4] In light of our conclusion, we need not address JCI/HHH's other arguments.

Board Member Phillips Polich dissenting.

I disagree with the majority's conclusion that claimant failed to establish a *prima facie* case of compensability. Additionally, I disagree with the majority's conclusion that the major contributing cause of claimant's injuries was his consumption of alcohol. In particular, as discussed below, I have significant concerns about the opinions expressed by Dr. Jacobsen as an "expert" witness. Consequently, I would affirm the ALJ's order finding claimant's injuries compensable.

I begin with the employer's alleged "no alcohol" rule.[1] The majority concluded that the employer had a policy requiring claimant to be a "clean and sober live in ranch hand" because the employer's daughter and grandson lived on the premises and because she considered her horses to be extended family.[2] Consequently, the majority determined that claimant's use of any alcohol or illicit drugs (during work hours or otherwise) was an overstepping of the boundaries defining his ultimate work. In other words, the majority concluded that claimant's violation of the employer's "no alcohol" policy constituted misconduct sufficient to take claimant's injuries outside the course and scope of employment. I disagree.

Assuming, without deciding that the employer had a "no alcohol" policy, I find *David Bottom*, 46 Van Natta 1485 (1994), controlling. There, the Board held that a worker's violation of an employer's drug and alcohol policy is not, by itself, a sufficient basis to conclude that a worker's injuries did not occur in the course and scope of employment. I conclude (as explained below) that here, as in *Bottom*, claimant was performing an activity defining his ultimate job responsibilities at the time of his injury; *i.e.*, throwing down hay from a loft. *See also Patterson v. SAIF*, 64 Or App 652 (1983). Consequently, I disagree with the majority's conclusion that claimant was engaged in a prohibited activity that was outside the boundaries of his ultimate work.

I now turn to the majority's conclusion that claimant had "no work reason" to be in the section of the loft by the back hay drop.

The barn loft from which claimant fell is 48 feet long and 32 feet wide. The front of the barn had an outdoor stairway with a landing and a full size door at the top leading into the loft. (Tr. 67; Exs. 2-3, 85). The hay stored in the barn consisted of 140 pound bales stacked about 8 feet high from the back of the loft to the front. The loft had, in fact, been overloaded such that a beam in the back right hand corner had begun to crack. (Tr. 70). The hay drop through which claimant fell was at the very back of the barn loft in the vicinity of the cracked beam at the end of the 18 to 24 inch aisle through the hay bales. (Tr. 85).

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[1] The employer acknowledged that she had served claimant wine on Thanksgiving. (Tr. 90-91). While that event may not establish that the employer "acquiesced" in claimant's use of alcohol, it is inconsistent with the existence of a "no alcohol" policy as well as the rationale for such a policy as explained by Ms. Shelly's testimony.

[2] The term "clean and sober ranch hand" comes from Appellant's Brief at page 14.

Claimant's duty at the time of his injury was to roll two or three hay bales out of the loft into a pickup that was parked under the outdoor landing in front of the barn. (Tr. 17-20). The employer testified that the only instructions she gave claimant at that point were to: (1) "not to put hay down the back hay drop"; and (2) "work down the center of the barn toward the back and remove the hay that way." (Tr. 70-71). The employer also testified that she was mainly concerned with removing the bulk of the hay off the overloaded right hand side of the loft. (*Id.*) Consequently, I conclude that claimant was injured while attempting to move hay bales out of the loft in accordance with the employer's instructions. Accordingly, I find that claimant established a *prima facie* case of compensability.

I now begin an analysis of the evidence from which the majority concludes that the major cause of claimant's injuries was the consumption of alcohol.

It is a longstanding principle of evidence that when a question is such that person of ordinary intelligence and experience is incapable of drawing correct conclusions from the facts in evidence without the assistance of someone who has special skill or knowledge on the subject, the opinion of an expert is desirable and competent evidence. ORS 40.410; *Fisher v. Oregon Short Line Ry. Co.*, 22 Or 533 (1892). However, a witness qualified to express an opinion on one subject may not be qualified to express an opinion on another subject, even if the subjects are related. *See State Dept. of Transportation v. Montgomery Ward Dev.*, 79 Or App 457, 465 (witness qualified as real estate appraiser not qualified to express opinion on probability of street being vacated), *rev den* 301 Or 667 (1986).

Here, JCI presented an alcohol defense based upon ORS 656.005(7)(b)(C). Such a defense requires JCI to prove not only that claimant was impaired by alcohol consumption at the time he was injured, but also prove that the impairment from the alcohol was the major contributing cause of his injuries.[3] While those two subjects (impairment from alcohol consumption and major cause of injury) may be related, they are not necessarily identical. Thus, an expert on alcohol impairment may not be qualified to evaluate the relative contributions of all factors combining to produce an injury.

Dr. Jacobsen is a medical doctor whose practice is limited to addiction medicine. (Tr. 106). As such, he is qualified to give an opinion on the effects of alcohol consumption (impairment). However, the record does not indicate that Dr. Jacobsen has any education, skill, knowledge, or training in the fields of accident reconstruction or human factors engineering. Thus, he may not be qualified, in each and every circumstance, to evaluate the relative contributions of all the various factors combining to produce an injury (accident).

Here, claimant was injured falling through a hole in the floor of a hay loft. The record establishes that the incident occurred after sundown and that the hayloft was poorly lit. The record also establishes that the hole through which claimant fell was unguarded (no railings, foot boards, or toe boards).[4] Consequently, I conclude that an "expert" offering an evaluation of the "major contributing cause" of claimant's injuries must possess a "scientific, technical or other specialized knowledge" not only of alcohol impairment, but also of accident reconstruction or human factors engineering.[5] Because Dr. Jacobsen has not demonstrated "knowledge, skill, experience, training or education" in either accident reconstruction or human factors engineering, I find, in these circumstances, that he is not qualified to give an opinion regarding the "major contributing cause" of claimant's injuries.

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[3] The "major contributing cause" is the cause that contributes more to claimant's injuries than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983).

[4] The lack of railings, foot boards, toe boards is a safety violation under the terms of OAR 437 section 1910.23(a)(3). While the violation of safety rules does not (as suggested by claimant) bar the employer of raising defense under ORS 656.005(7)(b)(C), the lack of the required safe guards is a factor that must be considered by the "expert" rendering an opinion as to the major contributing cause of claimant's accident.

[5] ORS 40.410 provides: "If scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness *qualified as a expert by knowledge, skill, expertise, training or education* may testify thereto in the form of an opinion or otherwise." (Emphasis added).

Even if I overlook Dr. Jacobsen's lack of expertise in the accident reconstruction field, I still do not find his opinion persuasive. Dr. Jacobsen's opinion regarding the degree of claimant's impairment rests largely on his estimate that claimant had a BAL equivalent of .09 to .10. During cross-examination Dr. Jacobsen indicated that the combining effect of brain depressants is very unpredictable. (Tr. 140). He further indicated he was not aware of any literature or scientific data to support his opinion that the Methadone in claimant's system would result in a 50 percent increase in the impairment effects of the alcohol claimant had consumed. (Tr. 141). In light of this testimony, I conclude that Dr. Jacobsen's opinion regarding claimant's overall impairment from alcohol is too speculative to be considered grounded on reasonable medical probability. Consequently, I do not find Dr. Jacobsen's opinion persuasive.[6] *See Somers v. SAIF*, 77 Or App 259, 262 (1986); *Gormley v. SAIF*, 52 Or App 1055, 1060 (1981).

Additionally, even though Dr. Jacobsen used magic words; *i.e.*, "major contributing cause" to express his opinion, I find that his opinion is actually based upon a "precipitating cause" or "but for" analysis. In his report of March 2000, Dr. Jacobsen stated:

> "Complicating the evaluation of this accident, claimant fell through a hay chute while working in a barn loft. It is not known how aware he was with the environment of the loft, whether or not there were any railings around the chute opening, or what other factors may have been contributory such low light conditions." (Ex. 84-10).

Nonetheless, without taking any steps to determine the nature and extent of the "other factors" he acknowledge contributed to claimant's injuries, Dr. Jacobsen opined "that it is medically probable that alcohol and possibly other substances was the major contributory cause of this accident." (*Id.*). In other words, if alcohol contributed at all, it is automatically the major cause according to Dr. Jacobsen. Thus, I conclude that Dr. Jacobsen's opinion is based upon a "but for" analysis, and accordingly I do not find it sufficient to establish JCI's burden of proof.[7] *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

For all of the above stated reason, I do not find that the employer has established that the major contributing cause of claimant's injuries was his consumption of alcohol. Accordingly, I would affirm the ALJ's order.

Finally, I write to express my concern that the Board continues to let the mere existence of alcohol impairment influence its separate determination of whether that impairment is the major contributing cause of an accident.

A successful defense under the terms of ORS 656.005(7)(b)(C) requires the carrier to prove both impairment and causation using the major contributing cause standard. Often, the Board appears to reason that impairment by itself equals causation, and thus does not require evidence establishing that the impairment contribute more to the accident than all other factors combined.[8] The end result is that the major contributing cause standard for employers under the terms of ORS 656.005(7)(b)(C) is less stringent than it is for claimant's under the terms of 656.005(7)(a)(A) or (B). Consequently, I dissent.

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[6] In reaching this conclusion I have assumed, without deciding, that Dr. Jacobsen's method of estimating the combined impairment effects of alcohol and Methadone satisfies the threshold requirements of scientific validity to be admissible. *See Jennings v. Baxter Healthcare Corp.*, 331 Or 285 (2000); *State v. O'Key*, 321 Or 285 (1995); *State v. Brown*, 297 Or 404 (1987). I do note however, that on this record, it is not clear that this portion of Dr. Jacobsen's analysis meets the scientific validity requirement set forth by the Supreme Court.

[7] Dr. Jacobsen also opined that claimant would have passed a field sobriety test administered by an experienced law enforcement officer. (Tr. 138). Thus, according to Dr. Jacobsen, claimant's impairment from alcohol consumption was not sufficient to legally effect his ability to drive a vehicle, but was sufficient to effect his ability to throw hay from a barn loft. Such an opinion is internally inconsistent and not persuasive.

[8] Former Board Member Hall expressed the same concern in both *Scott Fromm*, 47 Van Natta 1475, 1480 (1995) and *Carolyne D. Florea*, 47 Van Natta 2020, 2023 (1995). Board Member Biehl noted a similar problem in *Erika W. Ortman*, 51 Van Natta 2012, 2014 (1999).

In the Matter of the Compensation of
CHARLENE P. BRUMAGHIM, Claimant
WCB Case No. 00-06042
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Scheminske, et al., Defense Attorney

Reviewed by Board Members Meyers and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's occupational disease claim for her neck and upper back condition. On review, the issue is compensability.

We adopt and affirm the order of the ALJ, with the following supplementation.

On review, the employer contends that the ALJ erred in not addressing its arguments that claimant had a preexisting condition. The employer argues that its position was raised in closing argument and that because claimant did not object to any exhibits regarding a preexisting condition, the parties litigated the issue by agreement. We disagree.

In opening remarks, claimant stated that the issue was compensability and requested that the denial be overturned. (Tr. 1, 4). The written denial did not reference a preexisting condition as a basis for denying compensability. (Ex.18). Counsel for the employer agreed that the issue was one of compensability and stated that "our position is that based on Dr. Krause's initial examination has (sic) confirmed in Exhibit 22 when claimant went in for treatment, there were no objective findings." (Tr. 4).

In closing remarks, claimant stated that the case was primarily one of whether objective findings supported claimant's medical condition or diagnosis. (Closing Arguments 1). Counsel for the employer argued that there were no objective findings, but also contended that claimant had a preexisting condition. (Closing Arguments 10). Claimant's counsel objected to the preexisting condition "defense" being raised in closing arguments. (Closing Arguments 11).

After reviewing the record, we affirm the ALJ's decision to decline to consider the employer's arguments regarding a preexisting condition. First, we have consistently held that an issue raised for the first time in closing argument will not be considered. *See, e.g., Lawrence E. Millsap*, 47 Van Natta 2112 (1995). Moreover, based on the written denial and the parties' opening remarks, we are not persuaded that the issue or "defense" of a preexisting condition was litigated by agreement as the insurer contends. *See Birrer v. Principal Financial Group*, 172 Or App 654 (2001) (Board erred in determining that the parties had implicitly agreed to try an issue outside the express terms of the denial where there was no meeting of the minds on the issue to be tried and the parties had not implicitly consented to try that issue).

Rather, we agree with claimant that the issue to be litigated was whether objective findings existed to support the claim. In the Opinion and Order, the ALJ addressed this issue in addition to his reasoning regarding the persuasiveness of the medical opinions. (Opinion and Order, pgs. 3, 4). We agree with the ALJ's reasoning and conclusion and we therefore affirm the ALJ's order.

ORDER

The ALJ's order dated March 5, 2001 is affirmed.

In the Matter of the Compensation of
EARL F. FRAME, Claimant
Own Motion No. 01-0188M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Black, Chapman, et al., Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's April 12, 2001 Notice of Closure, which closed his claim with an award of temporary disability compensation from October 21, 2000 through February 8, 2001. SAIF declared claimant medically stationary as of February 8, 2001. We set aside the Notice of Closure as premature.[1]

A claim may not be closed unless the claimant's lung 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's condition was medically stationary at the time of the April 12, 2001 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).

Here, on March 19, 2001, prior to claim closure, Dr. Ordal, claimant's attending physician, opined that claimant was medically stationary as of February 8, 2001.[2] Following claim closure, in an April 20, 2001 medical report, Dr. Ordal opined that "[claimant] is not medically stationary from the standpoint of his asthma." Dr. Ordal explained that claimant was experiencing chronic "episodes" of bronchitis and bronchospasm. As a result, he had increased claimant's medication in an attempt to control his asthmatic condition. Dr. Ordal indicated at that time that it was "unclear" as to when claimant's condition would be medically stationary.

On June 5, 2001, in response to an inquiry from claimant's attorney, Dr. Ordal reported that claimant was not medically "from the standpoint of his asthma." As reported in his April 20, 2001 letter, Dr. Ordal indicated that claimant continued to experience recurring episodes of bronchitis and bronchospasms. He further noted that, when he examined claimant on February 8, 2001, he believed claimant's asthma condition was under control. However, given claimant's continued exacerbations of his asthma, Dr. Ordal opined that claimant was not medically stationary on February 8, 2001, as previously noted. Dr. Ordal's opinions are unrebutted.

Evidence that was not available at the time of closure may still be considered to the extent the evidence addresses the condition at the time of closure. *See Scheuning v. J.R. Simplot & Co.*, 84 Or App 622, 625 (1987). Here, Dr. Ordal retracted his earlier opinion that claimant was medically stationary on February 8, 2001 and noted that, due to continuing exacerbations, claimant's asthma condition was not stable and required further medical treatment. We consider Dr. Ordal's April and June 2001 medical reports to be sufficiently explained to overcome his initial March 19, 2001 opinion. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of physician's opinion found unpersuasive).

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[1] On December 11, 2000, we issued an Own Motion Order, which reopened claimant's 1980 claim for the provision of temporary disability compensation. (Own Motion Case No. 00-0366M). SAIF has issued its April 12, 2001 Notice of Closure for that claim.

[2] Dr. Ordal rendered this opinion by means of a "check-the-box" response to SAIF's inquiry regarding whether claimant's condition was medically stationary. In submitting its inquiry to Dr. Ordal, SAIF had also included the statutory definition of "medically stationary."

Based on Dr. Ordal's unrebutted opinions, we conclude that claimant's condition was not medically stationary on April 12, 2001 when SAIF closed his claim.

Accordingly, we set aside the April 12, 2001 Notice of Closure as premature. When appropriate, 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 $1,500, payable by SAIF directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

June 28, 2001 Cite as 53 Van Natta 826 (2001)

In the Matter of the Compensation of
DOROTHY GREEN, Claimant
WCB Case No. 99-09732
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorney
Cavanagh & Zipse, Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Crumme's order that set aside its denial of claimant's injury claim for a low back condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

On September 13, 1999, claimant helped one of the employer's owners clean out a storeroom. This work consisted of a day of bending and lifting, taking toner cartridges out of boxes, and lifting some filled boxes that weighed about 50 to 75 pounds. At about 3:30 p.m., claimant bent over to pick up another cartridge. She developed severe back pain and went home early. The next day, she told the owner that her back was still bothering her.

On September 16, 1999, claimant sought treatment, complaining of low back and abdominal pain, which she suspected was a kidney condition. The doctor found lumbosacral tenderness and prescribed pain and muscle relaxant medication.

On September 27, 1999, claimant was unloading a shipment at work, doing a lot of bending. She developed increased back and leg symptoms. On September 28, 1999, the doctor found tenderness to palpation and diminished ranges of motion in her low back. Claimant completed a workers' compensation claim form.

On November 11, 1999, the insurer denied claimant's claim for "mid/low back pain."

A November 15, 1999 MRI revealed the following at L5-S1: disc desiccation, an annular fissure, a protruded disc with slight mass effect on the left S1 nerve root, minimal canal stenosis, and retrolisthesis. There was no degeneration at the other lumbar levels.

On December 2, 1999, claimant was evaluated by Dr. Gallo, neurosurgeon, on referral from Dr. Douglas, claimant's then-attending physician. Dr. Gallo diagnosed internal disc disruption at L5-S1 with segmental instability that she attributed to claimant's lifting injury.

On January 19, 2000, Dr. Schilperoort examined claimant for the insurer. Dr. Schilperoort diagnosed L5-S1 internal disc derangement with disc bulge that he opined was preexisting and not causally related to the September 1999 episode at work.

On July 5, 2000, claimant was evaluated by Dr. Karasek on referral from claimant's new attending physician, Dr. Moshofsky. (Ex. 51B).

CONCLUSIONS OF LAW AND OPINION

Relying on the opinion of Dr. Gallo, the ALJ concluded that claimant had established the compensability of her low back injury claim. On review, the insurer contends that the ALJ erred in concluding that only Dr. Gallo addressed the causation issue, thereby misinterpreting or incorrectly evaluating Dr. Schilperoort's opinion. *See SAIF v. Grant*, 135 Or App 293, 297 (1995). The insurer further contends that Dr. Gallo's opinion is not persuasive because it is based only on a temporal relationship between claimant's work activity and the onset of symptoms. We disagree.

The medical evidence indicates that claimant's L5-S1 low back injury resulted in a "combined condition" that involved her preexisting degenerative condition and the 1999 injury.[1] Therefore, claimant is subject to the "major contributing cause" standard of proof under ORS 656.005(7)(a)(B) and she bears the burden of proving that her work injury contributes more to her disability or need for treatment than do all other factors. The statute requires evaluation of the relative contribution of different causes, including the precipitating cause, to determine which is the primary or major contributing cause. *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995). Because claimant's degenerative condition contributes to her low back condition, causation is a complex medical question that requires expert evidence for its resolution. *See Uris v. Compensation Department*, 247 Or 420, 424-26 (1967).

We first turn to Dr. Schilperoort's opinion. Dr. Schilperoort concluded that claimant's injury caused a symptomatic exacerbation of the preexisting pathology (i.e., a combined condition), as demonstrated by Dr. Wilson's initial finding of mild tenderness. (Ex. 47-5). Dr. Schilperoort also posited the possibility of a soft tissue strain incurred as a result of the injury. (Ex. 47-5, -6). But Dr. Schilperoort then stated that any soft tissue injury that may have occurred had cleared long ago. Accordingly, the doctor concluded that claimant's *current condition* was based on the L5-S1 pathology identified by the MRI scan. (Ex. 47-6). In other words, Dr. Schilperoort's opinion addresses the compensability of claimant's *current* low back condition, not the compensability of her condition at the outset.

Thus, the ALJ's evaluation of Dr. Schilperoort's opinion: "[H]e concludes that claimant's *future* need for treatment would be due to her preexisting pathology rather than her work activities," is correct. The ALJ then concluded that Dr. Schilperoort did not address whether the work activities had been the major cause of claimant's disability or need for treatment. In other words, the ALJ reasoned that Dr. Schilperoort's opinion did not assess the causation issue as of the date of claimant's disability or her need for treatment. After our *de novo* review of the record, we agree with the ALJ's analysis of Dr. Schilperoot's opinion. Thus, we do not consider the opinion to be persuasive.

We next turn to Dr. Gallo's opinion. As the ALJ recognized, Dr. Gallo had an accurate medical history that claimant's pre-injury low back symptoms had been extremely minor.[2] Moreover, the contemporary medical reports were consistent with claimant's testimony that she had never experienced the kind of back or leg pain prior to the September 1999 work incident that she did afterward, and with

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[1] We agree with the ALJ that claimant's claim should be analyzed as an injury rather than an occupational disease. Claimant pursued her claim under both injury and occupational disease theories. Because claimant's low back condition arose in a discrete period of time in relation to her bending and lifting activities on September 13, 1999, it should be analyzed as an injury rather than as an occupational disease. *See Active Transportation Co. v. Wylie*, 159 Or App 12, 15 (1999); *Valtinson v. SAIF*, 56 Or App 184, 188 (1982). Consequently, she must prove that her September 1999 injury is the major contributing cause of her disability or need for medical treatment of her combined condition. ORS 656.005(7)(a)(B). Because ORS 656.802, the occupational disease statute, is not applicable here, claimant is not required to establish a pathological worsening of her preexisting condition.

[2] Our *de novo* review of the record confirms that, while claimant had gone to doctors for minor back pain once or twice over the years, she did not seek treatment for back pain for several months prior to September 13, 1999. Thus, while we do not adopt the ALJ's opinion that the statement in Exhibit 16 that claimant had reported that she had been having lumbosacral pain for the last few months was erroneous, we do find that claimant's "report" is not supported in the medical record.

the employer's testimony that claimant had not complained of back pain prior to that incident. Dr. Gallo also based her opinion on the MRI, which showed no loss of disc height, which indicated a lack of significant low back degeneration prior to the injury. (Ex. 52-12, -13).

Thus, having reviewed Dr. Gallo's opinion as whole, and keeping in mind that "magic words" are not necessary to establish causation, we are persuaded that Dr. Gallo's opinion is sufficient to establish that claimant's September 12, 1999 injury was the major contributing cause of the disability and need for treatment of her combined condition. *See SAIF v. Strubel*, 161 Or App 516, 521-22 (1999); *Freightliner Corp. v. Arnold*, 142 Or App 98, 105 (1996). Thus, we conclude that Dr. Gallo's opinion satisfies the correct legal standard and is not based solely on a temporal relationship between claimant's injury and the onset of symptoms.

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 22, 2001 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,500.

In the Matter of the Compensation of
JESUS R. RAMIREZ, Claimant
WCB Case No. 00-08246
ORDER ON REVIEW
Adams, Day & Hill, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Johnson's order that affirmed an Order on Reconsideration that awarded 13 percent (41.6 degrees) unscheduled permanent disability for claimant's low back condition. On review, the issue is extent of unscheduled permanent disability.[1]

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

We do not find the medical arbiter's opinion concerning the validity of claimant's lumbar flexion findings unexplained, nor do we find the evidence on this issue "in equipoise."

However, we agree with the ALJ that claimant is not entitled to an impairment rating for lost lumbar flexion, based on the following reasoning.

We rely on the medical arbiter's opinion regarding claimant's lumbar flexion findings, because the preponderance of the medical evidence does not establish a different level of impairment.[2] The medical arbiter's report indicates that claimant failed the "straight leg raising validity test"[3] and the medical arbiter did not opine that claimant's lumbar flexion measurements were valid nonetheless. Under these circumstances, we conclude that claimant has not proven permanent impairment for lost lumbar flexion.

ORDER

The ALJ's order dated March 26, 2001 is affirmed.

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[1] We acknowledge the SAIF Corporation's motion to strike claimant's reference to a medical journal article. However, we need not address the motion, because consideration of the article would not affect the result: Claimant's lumbar flexion findings are invalid under the applicable rules, as explained herein.

[2] Dr. Malos, treating physician, concurred with a physical therapist's range of motion measurements. (Exs. 5, 6). Although the therapist's straight leg raising validity test did not "invalidate" claimant's lumbar flexion findings on that occasion, no preponderance of the medical evidence outweighs the arbiter's invalidity finding. *See* OAR 436-035-0007(14).

[3] Claimant concedes that the "straight leg raising" validity check is based on sound medical principles, but argues that it is insufficient, standing alone, to invalidate his flexion range of motion finding. We disagree. *See Jerrin L. Hickman*, 52 Van Natta 869, 870 (2000) ("The failed SLR test itself, as performed by the medical arbiters, establishes the invalidity of the lumbar flexion measurements."); *Beverly B. Stigall*, 52 Van Natta 1892, 1893 n. 1 (2000) (same); *see also Darcie A. Howard*, 53 Van Natta 133, 134 (2001) (where the medical arbiter panel found the straight leg raising test invalid, no valid lumbar flexion finding under OAR 436-035-0007(28)).

In the Matter of the Compensation of
CINDIE L. WELTCH, Claimant
WCB Case No. 00-00203
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Jerry Keene, Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's medial femoral condyle lesion in her left knee. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation.[1] On page 3, we replace the third paragraph with the following:

> "Dr. Frommlet, who examined claimant on October 7, 1999, did not agree with Dr. Farris' report because he felt his examination findings suggested a meniscus injury. (Ex. 37). On the other hand, Dr. Buuck indicated that he concurred with Dr. Farris' report, although he felt the MRI was positive for a degenerative tear. (Ex. 38)."

In the second full paragraph on page 6, we change the last sentence to refer to Dr. Farris, rather than Dr. Fuller.

On review, the insurer argues that this claim should be analyzed as an occupational disease and it asserts that the medical evidence is insufficient to establish compensability under that standard. Furthermore, the insurer contends that any accidental injury claim is barred as untimely.

Claimant responds that the insurer denied the claim as an injury and an occupational disease and she may rely on either theory. She argues that the Board should not address the insurer's timeliness defense because it was not raised in the insurer's denials, response to issues, or at hearing.

The insurer issued two denials. The insurer's December 21, 1999 letter denied the claim because claimant's work activities were not the major contributing cause of her current condition and need for medical care. (Ex. 36). The insurer amended its denial, asserting that there was insufficient evidence that claimant's left knee condition and need for treatment arose out of and in the course and scope of her employment. (Ex. 55).

The ALJ found that the insurer's denials were general and, in any event, claimant had not limited her claim to either an occupational disease or injury. The ALJ concluded, and we agree, that claimant was entitled to pursue her claim as either an injury or occupational disease. We find no evidence that the insurer raised an issue involving timeliness of the injury claim at hearing, nor did the ALJ address this particular issue. We decline to address this issue raised for the first time on review. *See Fister v. South Hills Health Care*, 149 Or App 214, 218-19 (1997); *Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991).

The insurer contends that the ALJ erred in finding claimant was credible. The ALJ found that, based upon claimant's demeanor and manner while testifying, she was a credible witness. The ALJ responded in detail to the insurer's specific arguments about credibility and explained why he did not find those arguments persuasive.

Although not statutorily required, the Board generally defers to the ALJ's credibility determination when it is based on the ALJ's opportunity to observe the witnesses. *See Erck v. Brown Oldsmobile*, 311 Or 519, 526 (1991). 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 *de novo* review, we agree with the ALJ's determination that claimant was a credible witness.[2]

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[1] We modify the ALJ's order to note that Exhibits 42 and 47 were withdrawn. (Tr. 2-3).

[2] In light of our conclusion, we need not address claimant's constitutional arguments about the ALJ's credibility findings, or the insurer's challenge that those arguments were raised for the first time on review.

Regarding the merits, we adopt and affirm the ALJ's conclusion that claimant's medial femoral condyle lesion is compensable. The ALJ concluded that claimant's history could support either an occupational disease or injury theory. The ALJ found that claimant was engaged in a number of activities during her employment that placed stress on her knees and she also had specific incidents where she bumped her knee and fell on her knee. The ALJ explained that claimant has sustained at least two falls that occurred in spring 1999, and she had not experienced any specific injuries to her knees off the job. Further, the ALJ found that claimant had knee pain after the two falls and she recalled knee pain when she lifted a table top at work.

Although we agree that claimant's history could support either an occupational disease or injury theory, we find that Dr. Buuck's opinion supports compensability under an injury theory. In light of claimant's preexisting left knee conditions, we apply the major contributing cause standard under ORS 656.005(7)(a)(B). For the following reasons, we are not persuaded by the insurer's argument that this claim should not be analyzed as an accidental injury because the medical record and claimant's testimony established that her condition developed gradually.

This case is complicated by the fact that Dr. Buuck diagnosed three conditions: medial meniscal tear, chondromalacia of the patella and a medial femoral condyle lesion, which he diagnosed as grade IV chondromalacia of the medial femoral condyle. (Ex. 43). On review, we address only compensability of the medial femoral condyle lesion.

In a deposition, Dr. Buuck said that claimant's chondromalacia of the patella was not her main complaint and the meniscus tear was probably not causing much of her symptoms. (Ex. 58-8, -10). Instead, claimant's real problem and primary need for treatment was the medial femoral condyle lesion. (Ex. 58-10, -25, -28). Dr. Buuck explained that the way a lesion like that would develop at claimant's age would probably be from twisting or a fall on the knee. (Ex. 58-10, -22, -35, -36). He testified that, because of the location and the discrete area, one fall probably caused the majority of damage. (Ex. 58-44). Dr. Buuck would expect a person to feel pain with such a fall, but not necessarily seek medical treatment. (Ex. 58-36, -41, -42). He explained that with an articular cartilage lesion,[3] if you smack right on a knee cap, it could take time for the cartilage to delaminate from the knee cap and from the femoral condyle and the person may not seek immediate medical attention. (Ex. 58-12). He said it was not unusual to develop articular cartilage lesions that would not necessarily cause someone to seek medical attention right away. (*Id.*)

Claimant testified that her knee pain arose gradually and there had been no recent direct trauma in October 1999 when she sought treatment from Dr. Frommlet. (Ex. 23, Tr. 40, 50-51). The ALJ found that claimant had sustained at least two falls in spring 1999, and she had knee pain following the two falls. Claimant also recalled knee pain at one point when she lifted up a table top at work. Based on Dr. Buuck's testimony that a fall causing an articular cartilage lesion would not necessarily cause someone to seek medical attention right away, we are not persuaded by the insurer's argument that the claim should not be analyzed as an injury. We note that Dr. Buuck diagnosed two other left knee conditions, chondromalacia of the patella and a medial meniscus tear, which he described as degenerative and at least mildly symptomatic.

Dr. Buuck concluded that, assuming there were no off-work falls, claimant's work was the major contributing cause of the medial femoral condyle lesion. (Ex. 58-21, -22, -23, -28, -29, -32). We agree with the ALJ that there is no evidence that claimant injured her knee anywhere other than at work.

Dr. Buuck did not believe the medial femoral condyle lesion was due to normal aging because the area was down to bare bone, which was unusual for claimant's age. (Ex. 58-15, -34). Also, the location was critical in that it was more medial than in the typical weight-bearing area of someone who has normal arthritis. (Ex. 58-15, -33, -34). In reaching his conclusions, Dr. Buuck relied on his observations during claimant's surgery. (Ex. 58-33, -34, -35).

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[3] Dr. Buuck's reference to an articular cartilage lesion means the medial femoral condyle lesion. (Ex. 58-8, -9).

We find that Dr. Buuck's opinion is persuasive because it is well-reasoned and based on an accurate history. Moreover, as claimant's treating surgeon, Dr. Buuck's opinion is entitled to deference. *See Argonaut Insurance Company v. Mageske*, 93 Or App 698, 702 (1988) (treating physician's opinion was given greater weight because of his first-hand exposure to and knowledge of the claimant's condition). We agree with the ALJ that claimant's disability and need for treatment for the medial femoral condyle lesion is related, in major part, to her 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 $1,900, 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 15, 2001 is affirmed. For services on review, claimant's attorney is awarded $1,900, payable by the insurer.

WORKERS' COMPENSATION CASES

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Cite as 332 Or 83 (2001) May 10, 2001

IN THE SUPREME COURT OF THE STATE OF OREGON

TERRY L. SMOTHERS, Petitioner on Review,
v.
GRESHAM TRANSFER, INC., an Oregon corporation, Respondent on Review.
(CC 9505-02969; CA A90805; SC S44512)

On review from the Court of Appeals.*

Argued and submitted November 8, 1999.

Michael A. Gilbertson, Ransom & Gilbertson, Portland, argued the cause and filed the briefs for petitioner on review.

Thomas W. Sondag, Lane Powell Spears Lubersky LLP, Portland, argued the cause and filed the brief for respondent on review.

Chess Trethewy, Garrett, Hemann, Robertson, Paulus, Jennings & Comstock, P.C., Salem, filed a brief on behalf of *amicus curiae* Associated Oregon Industries. With him on the brief was Paul J. Weddle.

Lawrence Baron, Portland, filed a brief on behalf of *amicus curiae* Oregon Trial Lawyers Association. With him on the brief was Daniel L. Keppler.

Kathryn H. Clarke, Portland, filed a brief on behalf of *amicus curiae* Oregon Trial Lawyers Association. With her on the brief were Maureen Leonard and Matthew Whitman.

David L. Runner, Salem, filed a brief on behalf of *amicus curiae* SAIF Corporation and Timber Products Company.

G. Kenneth Shiroishi, Dunn Carney Allen Higgins & Tongue, Portland, filed a brief on behalf of *amicus curiae* Oregon Association of Defense Counsel.

332 Or 84> Before Carson, Chief Justice, and Gillette, Durham, Kulongoski, Leeson, and Riggs Justices.**

LEESON, J.

The decision of the Court of Appeals is reversed. The judgment of the circuit court is reversed, and the case is remanded to the circuit court for further proceedings.

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* Appeal from Multnomah County Circuit Court, Henry Kantor, Judge. 149 Or App 49, 941 P2d 1065 (1997).

** Van Hoomissen, J., retired December 31, 2000, and did not participate in the decision of this case. De Muniz, J., did not participate in the consideration or decision of this case.

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332 Or 86> Plaintiff filed this negligence action against defendant, his employer, after an administrative law judge (ALJ) of the Workers' Compensation Board upheld the insurer's denial of plaintiff's workers' compensation claim. The ALJ found that plaintiff's exposure to sulfuric, hydrochloric, and hydrofluoric acid mist and fumes at work was not the "major contributing cause" of plaintiff's respiratory condition and other ailments and, therefore, that plaintiff had not suffered a "compensable injury" under the workers' compensation statutes. Nonetheless, plaintiff believed that he had suffered an injury at work. Accordingly, he brought this action against his employer for negligence. The trial court dismissed plaintiff's complaint for failure to state a claim, ORCP 21 A(8), reasoning that ORS 656.018 (1995) makes workers' compensation law the "exclusive remedy" for work-related injuries, whether or not a claim is compensable. The Court of Appeals affirmed. *Smothers v. Gresham Transfer, Inc.*, 149 Or App 49, 941 P2d 1065 (1997). This court allowed review to address plaintiff's contention that he has been denied a remedy for the injuries that he suffered at work, in violation of the remedy clause in Article I, section 10, of the Oregon Constitution. For the reasons that follow, we hold that, if a workers' compensation claim alleging an injury to a right that is protected by the remedy clause is denied for failure to prove that the work-related incident giving rise to the claim was the major contributing cause of the injury or condition for which the worker seeks compensation, then the exclusive remedy provisions of ORS 656.018 (1995) are unconstitutional under the remedy clause. Applying that holding to the facts of this case, we reverse the decision of the Court of Appeals and the judgment of the trial court and remand the case to the trial court for further proceedings.

I. BACKGROUND

A. *Facts*

Plaintiff's job as a lube technician for defendant's trucking company required him to work in a pit more than four feet deep in a mechanics' shop where trucks were serviced. A truck-washing area was located outside the shop. **<332 Or 86/87>** Defendant's employees cleaned the exteriors of trucks by spraying them with a chemical mixture of diluted sulfuric acid and small amounts of hydrochloric and hydrofluoric acids. When the doors to the shop were open, acid mist and fumes from the truck-washing area drifted into the shop and down into the pit where plaintiff worked. For many months, plaintiff experienced headaches, as well as itching, burning, and watering eyes.

In January 1993, plaintiff contracted an upper respiratory infection that developed into pneumonia. He was hospitalized for five days, and he was unable to work for a month. Plaintiff returned to work, but he suffered another episode of pneumonia in February 1993. In November 1993, his physician diagnosed him with bronchitis. In December 1993, plaintiff's coworkers found him so ill that he was lying on the lunchroom floor. He was sent home, where he was bedridden with bacterial bronchitis for most of the holiday season.

Plaintiff returned to work in January 1994, but his physician expressed concern about his slow rate of recovery. Plaintiff called in sick several times between March and mid-June 1994. In June 1994, claimant stopped working for defendant because of his illness.

Thereafter, plaintiff filed a workers' compensation claim for his lung condition. Defendant's insurer denied plaintiff's claim. At a hearing before an ALJ, the issue was whether plaintiff had a compensable occupational disease. See ORS 656.802(1)(a) (defining "occupational disease"). After the hearing, the ALJ upheld the insurer's denial, because plaintiff had failed to prove that his work exposure was the major contributing cause of his lung disorder. *See* ORS 656.802(2)(a) ("The worker must prove that employment conditions were the major contributing cause of the disease.").[1]

332 Or 88> B. *Legal Context for Plaintiff's Negligence Action*

In *Errand v. Cascade Steel Rolling Mills, Inc.*, 320 Or 509, 525, 888 P2d 544 (1995), this court held that the exclusive remedy provisions in ORS 656.018 (1993) did not preclude workers whose workers' compensation claims had been denied from bringing civil actions against their employers in an effort to recover damages for their work-related injuries. In this case, after the ALJ had upheld the denial of plaintiff's workers' compensation claim, plaintiff, relying on *Errand*, filed this action against defendant. His complaint alleged that defendant's negligence in subjecting him to the acid mist and fumes at work had caused permanent injury to his lungs; skin blisters, pain and swelling in the joints of his hands, elbows and knees; degeneration of his toenails, fingernails, and teeth; and other physical ailments.

Meanwhile, in response to this court's decision in *Errand*, the 1995 Legislature amended ORS 656.018 and added subsection (6) to provide that workers' compensation is the exclusive remedy for work-related injuries, even if a claim is not compensable. Or Laws 1995, ch 332, section 5. As amended, ORS 656.018 (1995) 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 * * *.
>
> "(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.

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[1] Thereafter, the Workers' Compensation Board affirmed the ALJ's opinion and order, and the Court of Appeals affirmed without opinion. *In the Matter of the Compensation of Smothers*, 145 Or App 482, 928 P2d 366 (1996).

"* * * * *

> 332 Or 89> "(6) *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.*"

(Emphasis added.)[2] Those amendments took effect on June 7, 1995, after plaintiff had filed his complaint, and they 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). Relying on the "exclusive remedy" provisions of ORS 656.018 (1995), defendant moved to dismiss plaintiff's complaint for failure to state a claim. The trial court granted that motion.

On appeal to the Court of Appeals, plaintiff argued that, although he could not prove that the acid fumes and mist that he had inhaled at work were the *major* contributing cause of his lung condition and other ailments, he nonetheless had been injured at work. Before the 1995 amendments to ORS 656.018, he noted, workers' compensation was the exclusive remedy for only *compensable* work-related injuries. The 1995 amendments to ORS 656.018 made workers' compensation the exclusive remedy for *all* work-related injuries, whether or not a claim is compensable. Those amendments, plaintiff argued, left him with no remedy for the injuries that he had suffered at work, in violation of the remedy clause of Article I, section 10, which guarantees every person a remedy by due course of law for injury to person, property, or reputation. The Court of Appeals rejected plaintiff's argument. *Smothers*, 149 Or App at 54.

332 Or 90> C. *Parties' Arguments*

Before this court, plaintiff repeats his contention that, under the mandate of the remedy clause of Article I, section 10, the legislature may not deprive a person of a remedy for an injury to person, property, or reputation that was recognized at common law, unless the legislature makes available an equivalent remedy. Defendant's response to plaintiff's constitutional argument is twofold. First, defendant contends that the legislature has plenary authority to define what constitutes a cognizable injury to person, property, or reputation. Second, defendant contends that the remedy clause does not limit the legislature's power to modify any common-law or statutory remedy.

In making their arguments, the parties and *amici curiae* assert that this court's remedy clause jurisprudence has not been consistent. This court has acknowledged as much. *See Neher v. Chartier*, 319 Or 417, 423, 879 P2d 156 (1994) (court's case law "has failed definitively to establish and consistently to apply any one theory regarding the protections afforded by" remedy clause); *Hale v. Port of Portland*, 308 Or 508, 529, 783 P2d 506 (1989) ("This court has written many individually tenable but inconsistent opinions about the remedy clause.") (Linde, J., concurring). Scholars likewise have observed that courts have not adopted a consistent remedy clause jurisprudence. *See, e.g.*, David Schuman, *The Right to a Remedy*, 65 Temp L Rev 1197, 1203 (1992) (courts have adopted a "daunting variety of remedy guarantee interpretations"); Jonathan M. Hoffman, *By the Course of the Law: The Origins of the Open Courts Clause of State Constitutions*, 74 Or L Rev 1279, 1282 (1995) (courts in "total disarray" over how to interpret remedy clauses).

As our subsequent discussion will show, the parties are correct that this court has not developed a consistent body of law interpreting the remedy clause of Article I, section 10. Moreover, despite its extensive remedy clause case law, this court previously has not analyzed that clause under the methodology prescribed in *Priest v. Pearce*, 314 Or 411, 415-16, 840 P2d 65 (1992), for interpreting an original provision of the Oregon Constitution. The purpose of that inquiry is "to understand the wording in the light of the way that **<332 Or 90/91>** wording would have been understood and used

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[2] The 1995 Legislature also amended the policy statement in ORS 656.012 to provide that the Workers' Compensation Act was intended

> "[t]o provide the *sole and exclusive* source and means by which subject workers, their beneficiaries and anyone otherwise entitled to receive benefits on account of injuries or diseases arising out of and in the course of employment shall seek and qualify for remedies for such conditions."

Or Laws 1995, ch 332, section 4 (emphasis added).

In 1997, the legislature renumbered ORS 656.018(6) as ORS 656.018(7). Or Laws 1997, ch 491, section 1.

by those who created the provision," *Vannatta v. Keisling*, 324 Or 514, 530, 931 P2d 770 (1997), and to "apply faithfully the principles embodied in the Oregon Constitution to modern circumstances as those circumstances arise," *State v. Rogers*, 330 Or 282, 297, 4 P3d 1261 (2000). Our analysis consists of an examination of the wording of the particular constitutional provision, the historical circumstances that led to its creation, and case law surrounding it. *Priest*, 314 Or at 415-16. We turn to an application of that methodology.[3]

II. REMEDY CLAUSE

A. *Text*

Article I of the Oregon Constitution is Oregon's Bill of Rights. 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."

Section 10 consists of one sentence that is made up of two independent clauses. Both clauses are phrased in mandatory terms. This court has held that the command "shall" in Article I, section 10, is a statement prescribing how government must conduct its functions. *Oregonian Publishing Co. v. O'Leary*, 303 Or 297, 301-02, 736 P2d 173 (1987).

The first clause of Article I, section 10, provides that "[n]o court shall be secret" and that justice "shall be administered, openly and without purchase, completely and without delay * * *." That clause prescribes how justice must be administered in Oregon by identifying both a prohibition (no court shall be secret) and a directive (justice must be administered openly, completely, and without purchase or delay).

332 Or 92> The second clause mandates that "every man shall have remedy by due course of law for injury done him in his person, property, or reputation." As applicable to modern circumstances, the phrase "every man" means every person. Unlike many provisions in bills of rights, which protect individual rights by prohibiting the legislature from enacting certain laws or prohibiting the government from taking certain actions, the second clause of section 10 protects rights respecting person, property, and reputation by mandating affirmatively that remedy by due course of law be available in the event of injury to those rights.

The key terms in the remedy clause are "remedy," "due course of law," and "injury." We examine the meaning of those terms.

The parties agree that the word "remedy" refers at least to a means for seeking redress for injury. Plaintiff describes a "remedy" as an "avenue to receive compensation for a loss," while defendant describes it as the "machinery of the law" that a party sets in motion to recover for a harm. Plaintiff contends that the word "remedy" also includes the redress for an injury, such as money damages, that a litigant obtains through a remedial process.

The Oregon Constitution, including Article I, section 10, was drafted in 1857 and adopted 1859. A mid-nineteenth century law dictionary defined "remedy" as "[t]he means employed to enforce a right or redress an injury." John Bouvier, *A Law Dictionary Adapted to the Constitution and Laws of the United States of America*, 340 (1839). A standard dictionary of the era defined "remedy" as:

> "1. That which cures a disease * * *. 2. That which counteracts an evil of any kind * * *. 3. That which cures uneasiness * * *. 4. That which repairs loss or disaster."

Noah Webster, *An American Dictionary of the English Language*, 934 (1851). Those definitions indicate that the word "remedy" refers both to a process through which a person may seek redress for injury and to what is required to restore a person who has been injured.

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[3] In *Neher v. Chartier*, 319 Or 417, 428 n 10, 879 P2d 156 (1994), which involved an interpretation of Article I, section 10, the court noted the methodology prescribed in *Priest*, 314 Or at 415-16 but stated that the parties had "not brought to the court's attention any historical circumstances that shed light on the meaning of Article I, section 10, of the Oregon Constitution, and the court is aware of none." Advocates since that time have provided some insight into the historical circumstances.

We turn to the phrase, "due course of law," which modifies the word "remedy" in Article I, section 10. Plaintiff <332 Or 92/93> contends that, when the drafters wrote the Oregon Constitution in 1857, "due course of law" referred to a common-law cause of action for an injury. Although plaintiff concedes that the legislature constitutionally may enact remedies that are substitutes for common-law remedies, he contends that the requirement in Article I, section 10, that remedy be by "due course of law" means that substitute remedies must be equivalent to common-law remedies. Defendant responds that "due course of law" means any remedial statute that provides a rational means for obtaining a principled decision under the controlling statutory framework. We explain later in this opinion how courts had interpreted the phrase "due course of law" in the years leading up to the drafting of the Oregon Constitution. At this stage of the inquiry, it suffices to note that the drafters of the Oregon Constitution did not explain what they meant by that phrase.

We turn to the word "injury." Plaintiff argues that, when the drafters wrote the Oregon Constitution in 1857, "injury" meant any wrong or damage done by or to another. Legal and standard dictionaries of the time support plaintiff's argument. A legal dictionary defined injury as "a wrong or tort." Bouvier, *A Law Dictionary* at 507. That dictionary further classified injuries as "public" or "private," and "absolute" or "relative." *Id.* Among "absolute" injuries were those affecting person, property, reputation, and liberty. *Id.* "Relative" injuries, by contrast, were, for example, those affecting the rights of husbands in relationship to their wives and parents in relationship to their children. *Id.* A standard dictionary defined "injury," in part, as

> "any wrong or damage done to a man's person, rights, reputation, or goods. That which impairs the soundness of the body or health, or which gives pain, is an injury."

Webster, *American Dictionary* at 606.

Defendant responds that the word "injury" in the remedy clause refers to a *legal* injury and that the legislature has plenary authority to determine whether an injury is legally cognizable. Defendant concedes that a legislative determination that a recognized injury no longer is legally cognizable effectively abolishes a previously recognized right, but contends that the only restriction that the remedy clause <332 Or 93/94> imposes on the legislature in that respect is that it cannot abolish a remedy and at the same time recognize the existence of the right. In other words, defendant contends, the drafters of the Oregon Constitution intended to permit the legislature to define what constitutes an injury respecting person, property, or reputation for which a remedy must be available by due course of law.

In summary: Although the text of the remedy clause states in mandatory terms that remedy by due course of law must be available for injury to person, property, or reputation, the clause does not define the terms "remedy," "due course of law," or "injury." Contemporaneous dictionaries provide some definitions, but no definitive picture of the scope or effect of the remedy clause emerges. For further insight into the drafters' intent in writing the remedy clause, we turn to an examination of the historical circumstances relating to that provision. *See Priest*, 314 Or at 416 (describing inquiry into historical circumstances as part of constitutional interpretation methodology).

B. *Historical Circumstances*

1. *Edward Coke's Second Institute*

The principle that the law makes available a remedy for injury to person, property, or reputation comes from the common law. The phrasing of remedy clauses that now appear in the Bill of Rights of the Oregon Constitution and 38 other states[4] traces to Edward Coke's commentary, first published in 1642, on the second sentence of Chapter 29 of the Magna Carta of 1225.

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[4] A list of the states whose bills of rights contain remedy clauses appears in David Schuman, *The Right to a Remedy*, 65 Temp L Rev, 1197, 1201 n 25 (1992).

The two sentences comprising Chapter 29 of the Magna Carta of 1225 had appeared as separate chapters, 39 and 40, in the original Magna Carta of 1215.[5] *See* A. E. Dick **<332 Or 94/95>** Howard, *Magna Carta: Text and Commentary*, 33-52 (1964) (reprinting complete text of Magna Carta 1215). A 1797 edition of Coke's *Second Institute* translated Chapter 29 of the Magna Carta of 1225 from the original Latin as follows:

> "No freeman shall be taken, or imprisoned, or be disseised of his freehold, or liberties, or free customs, or be outlawed, or exiled, or any otherwise destroyed; nor will we not pass upon him, nor condemn him, but by lawful judgment of his peers, or by the law of the land. We will sell to no man, we will not deny or defer to any man either justice or right."

Edward Coke, *The Second Part of the Institutes of the Laws of England*, 45 (1797). Coke's commentary on the Magna Carta viewed Chapter 29 as a "roote," out of which "many fruitfull branches of the law of England have sprung." *Id.* at 45. Coke identified nine such branches, and then he explained how each branch had been interpreted by parliament, by English legal writers, and by precedent. *Id.* at 46. In other words, Coke's commentary was not concerned with the meaning of Chapter 29 of the Magna Carta of 1225. Rather, Coke sought to explain how the common law had evolved *since* 1225 and to assert what Coke thought the law *ought* to be. Faith Thompson, *Magna Carta: Its Role in the Making of the English Constitution*, 1300-1629, 354-56 (1948). Coke used the Magna Carta of 1225, as he had used other ancient texts and reports, as a means to demonstrate how, in his view, the common law protected individuals by placing substantive restraints on both the Crown and Parliament, and by adjusting relations between private individuals. *See* Theodore F. T. Plucknett, *Bonham's Case and Judicial Review*, 40 Harv L Rev 30, 30-31 (1926-27) (discussing Coke's use of history to interpret English law).

332 Or 96> The dominant theme in Coke's commentary on the first sentence of Chapter 29 was his explanation that the law protected individuals' rights by prohibiting *official* acts depriving freemen of life, liberty, or property unless done according to "the law of the land" or by judgment of peers. Proceedings "by the law of the land" meant "by the common law, statute law, or custome of England," "by the due course, and process of law," or "by due process of the common law." Coke, *Second Institute* at 45-46, 50. With respect to deprivations by public officials, Coke contended that due process of law required indictment or presentment of good and lawful men by original writ of the common law, the opportunity to answer by due process of the common law, and presentment before justices "or thing of record." *Id.* at 50. Coke described at length the evolution and seventeenth-century meaning of the due process guarantees that had grown out of the first sentence of Chapter 29. *Id.* at 49-56; *see also* Charles Grove Haines, *The Revival of Natural Law Concepts*, 1006-07 (1930) (to Coke, due process conveyed principle that making and enforcement of laws must not be arbitrary or contrary to principles of natural or common law); Edward Corwin, *The "Higher Law" Background of American Constitutional Law*, 42 Harv L Rev 365, 393 (1929) (describing Coke's effort to establish common-law procedure as permanent restraint on power); Charles Grove Haines, *The American Doctrine of Judicial Supremacy*, 25-34 (1914) (describing Coke's conception of fundamental law binding both Crown and Parliament).

Coke declared that the second sentence of Chapter 29 had evolved into a different kind of guarantee in English law, viz., one involving the rights of subjects in their *private relations* with one another. The assurance that the king would not sell, deny, or defer justice or right had come to mean that

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[5] The only text of the Magna Carta that was available to Coke was the 1225 version. Faith Thompson, *Magna Carta: Its Role in the Making of the English Constitution, 1300-1629*, 5 (1948). However, Coke was aware that King John originally had issued the Magna Carta in 1215, *see* Coke, *Second Institute*, A *Proeme* at 4 (so stating). King John had done so in response to a list of grievances from his barons. Among other things, the barons contended that John, like his immediate predecessors, was using unscrupulous methods for raising money to support foreign wars that the barons did not support. Goldwin Smith, *Constitutional and Legal History of England*, 131 (1955). For example, the King had reorganized the royal courts, directing revenues from the sale of writs to the Crown, thereby undermining the baronial courts. A. E. Dick Howard, *Magna Carta: Text and Commentary*, 4 (1964).

The Magna Carta of 1215 was law for about only nine weeks, because King John persuaded the Pope to annul it. Theodore F. T. Plucknett, *A Concise History of the Common Law*, 23 (5th ed 1956). The document was reissued in 1216, 1217, and 1225, each time with many revisions. Smith, *Legal History of England* at 136. The reissue of the Magna Carta in 1225 by King Henry III marked the final form of the document. William McKechnie, *Magna Carta*, 183 (1905).

> "* * * *every subject of this realme, for injury done to him in bonis, terris, vel persona, by any other subject*, be he ecclesiastical, or temporall, free, or bond, man, or woman, old, or young, or be he outlawed, excommunicated, or any other without exception, *may take his remedy by the course of the law, and have justice, and right for the injury done to him,* **<332 Or 96/97>** *freely without sale, fully without any deniall, and speedily without delay.*"

Coke, *Second Institute* at 55. In other words, Coke asserted that the common law of England had come to guarantee every subject a legal remedy for injury to goods, lands, or person caused by any other subject. The purpose of the remedial branch of the common law was to discover "that which is tort, crooked, or wrong" and restore "right" or "justice." *Id.* at 56. Coke viewed the remedial branch of the law as the best birthright that English subjects had, because it protected their goods, lands, person, life, honor, and estimation from injury and wrong. *Id.* Coke praised the common law, because it guaranteed both justice ("justitiam") and the means to attain it ("rectum"). *Id.*

Coke's commentary on Chapter 29 of the Magna Carta of 1225 thus explained that the common law had evolved to protect individuals in two broad respects. The first was a shield against arbitrary government actions involving a person's life, liberty, or property. The second was a guarantee to every subject that a legal remedy was available for injury to goods, land, or person by any other subject of the realm. As noted, Coke viewed the remedial side of the law as "the best birthright the subject hath." *Id.* at 56.

Coke's *Second Institute* made its way to the American colonies through a variety of sources. Several lawyers had *The Institutes* in their libraries. A. E. Dick Howard, *The Road From Runnymede*, 122-24 (1968). In 1687, William Penn published *The Excellent Priviledge of Liberty & Property Being the Birth-Right of Free-Born Subjects of England*, the first commentary on the Magna Carta of 1225 to be published in the American colonies. Penn had copied his commentary verbatim from Henry Care's *English Liberties*, another commentary on the Magna Carta of 1225 that enjoyed immense popularity in England and in the colonies.[6] Howard, *Road From Runnymede* at 124. Care had paraphrased Coke when writing his commentary on the Magna Carta. *Id.* at 89-90. To Care, like Coke, the provisions of the **<332 Or 97/98>** Magna Carta of 1225 were not concessions that had been exacted from kings. Rather, the Magna Carta of 1225 affirmed the common law, which the English had claimed as their birthright. Henry Care, *English Liberties*, 6 (American ed 1721).

Care's commentary on the second sentence of Chapter 29 stated:

> "*We will sell to no Man, deny to no man, etc.* This is spoken in the Person of the King, who in Judgment of the Law, in all his Courts of Justice, is present. <u>And therefore every Subject of this Realm, for Injury done to him, in Person, Lands or Goods, by any other Subject, Ecclesiastical or Temporal, whatever he be, may take his Remedy by the Course of the Law, and have Justice and Right for the Injury done him, freely, without Sale; fully, without denial; and speedily without delay</u>; for Justice must have three Qualities, it must be *Libera*, free; for nothing is more odious than Justice set to sale; *Plena*, full, for justice ought not to limp, or be granted by piece-meal; And *Cleris*, speedy: *Quia Dilatio est quedam negatio*, Delay is a kind of denial: and when all these meet, it is both Justice and Right."

Care, *English Liberties* at 25-26 (italics in original; underscoring added).

2. *William Blackstone's Commentaries*

Blackstone's *Commentaries on the Laws of England*, the first volume of which was published in 1765, is another important source for understanding what the drafters of state constitutions intended when they included in declarations or bills of rights the guarantee of remedy by due course of law for injury to person, property, reputation and, in some instances, liberty. Blackstone's *Commentaries* updated Coke's accounts of the evolution of the common law. The *Commentaries* sold quickly in the American colonies and became one of the principal means of the colonists' information about the state of English law in general. Plucknett, *Concise History* at 287.

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[6] The first American edition of *English Liberties* appeared in the colonies in 1721.

Blackstone explained that the common law viewed Englishmen as having both absolute and relative rights. 1 William Blackstone, *Commentaries on the Laws of England* *123. Absolute rights are founded on immutable laws of **<332 Or 98/99>** nature and reason, and usually are called liberties. *Id.* at *123-24. Absolute rights exist in both a state of nature and in civil society, while relative rights, such as those that are based on the marital relationship, are rights that are defined solely by membership in civil society. *Id.* at *123. The principal aim of society is to protect individuals in their enjoyment of absolute rights. *Id.* at *124. The common law recognized three absolute rights: "the right of personal security [including reputation], the right of personal liberty, and the right of private property." *Id.* at *129.

Blackstone described an act that deprives a person of a right as a "wrong." 3 Blackstone, *Commentaries* *116. Wrongs can be public (crimes and misdemeanors) or private (civil injuries). *Id.* Blackstone explained that the remedial part of the law provides a method for recovering for deprivations of rights or for redressing wrongs, be they public or private. 1 Blackstone, *Commentaries* *54. Whenever the common law recognized a right or prohibited an injury, he wrote, it also gave a remedy by legal action initiated by filing the appropriate writ. 3 Blackstone, *Commentaries* *123.

Blackstone echoed Coke in stating that it would be "in vain" for the law to recognize rights, if it were not for the remedial part of the law that provides the methods for restoring those rights when they wrongfully are withheld or invaded. 1 Blackstone, *Commentaries* *56. To Blackstone, the guarantee of legal remedy for injury "is what we mean properly, when we speak of the protection of the law." Id. Hence, the maxim of English law, *Ubi jus, ibi remedium*: "for every right, there must be a remedy." James DeWitt Andrews, *American Law: A Commentary on the Jurisprudence, Constitution and laws of the United States*, 590 (2d ed 1908).

3. *English Rights in the American Colonies*

As early as 1606, royal charters granted colonists the rights of Englishmen.[7] The charters also gave the colonies **<332 Or 99/100>** the authority to legislate for themselves, so long as the laws that they enacted conformed to the English legal system. H. D. Hazeltine, *The Influence of Magna Carta on American Constitutional Development*, 17 Colum L Rev 1, 8 (1917). Because the colonists viewed themselves as English citizens, the common law of England, particularly as it had been summarized by writers like Coke, Care, Penn, and Blackstone, had a profound impact on the colonists' understandings of their rights and the authority of their legislatures, also known at the time as general courts. *See* Howard, *Road from Runnymede* at 119-25 (describing popularity of those writers in colonies); Julius Goebel, Jr., *Constitutional History and Law*, 38 Colum L Rev 555, 565 (1938) (describing colonists' faith in common-law rights).

In the eighteenth century, under the influence of writers like John Locke, James Harrington, and Algernon Sidney, colonists began to describe their ancient common-law rights as "natural rights." 1 F.N. Thorpe, *Constitutional History of the American People*, 1776-1850, 38 (1898); Kermit L. Hall, *The Magic Mirror: Law in American History*, 57-58 (1989). It became increasingly popular to refer to rights as "inalienable" and "God given" even though, historically, the rights could be traced to the Magna Carta or could be identified as basic to the common law. Goebel, *Constitutional History*, 38 Colum L Rev at 565. Couching debates about rights in natural law terms obscured the extent to which the colonists were relying on the common law in resisting parliamentary impositions. Hall, *The Magic Mirror* at 57-58. Despite the rhetoric of natural law, however, colonial leaders like John Adams understood that the common law was the source of "the unalienable, indefeasible rights of men, the honor and **<332 Or 100/101>** dignity of human nature, the grandeur and glory of the public, and the universal happiness of individuals * * *." Corwin, *The "Higher Law" Background of American Constitutional Law*, 42 Harv L Rev at 169 (quoting John Adams, Life and Works, 440 (1851)); *see also* H. D. Hazeltine, *The Influence of Magna*

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[7] For example, the first Virginia charter that King James I issued in 1606, part of which Coke had drafted on the King's behalf, guaranteed to the colonists all "Liberties, Franchises, and Immunities * * * as if they had been abiding and born, within this our Realm of *England*, or any other of our said Dominions." 1 Bernard Schwartz, *The Bill of Rights: A Documentary History*, 60 (1971) (setting out Virginia Charter; emphasis in original). The governors of proprietary colonies had made similar guarantees as part of their effort to recruit colonists. *See id.* at 68 (inhabitants of Maryland "[s]hall have and enjoy all such rights immunities priviledges and free customs within this Province as any naturall born subject of England hath or ought to have or enjoy in the realm of England by force or vertue of the common law or Statute Law of England").

The declarations in the royal charters that the colonists had the rights of Englishmen were a powerful factor in the spread of English constitutional principles and rights in the colonies. H. D. Hazeltine, *The Influence of Magna Carta on American Constitutional Development*, 17 Colum L Rev 1, 8 (1917).

Carta on American Constitutional Development, 17 Colum L Rev 1, 9 (1917) (common law also more important in Puritan colonies than even Puritans at time suspected). As the Revolution neared, colonial lawyers looked to the common law, as it then had evolved, as the source of their right to oppose Parliamentary measures such as the "Coercive Acts" of 1774. William Clarence Webster, *Comparative Study of the State Constitutions of the American Revolution, in 9 Annals of the American Academy of Political and Social Science*, 381 (R. P. Falker ed 1899).

History also had taught the American colonists that, notwithstanding the Magna Carta and the legal writings about common-law rights that had followed, their rights were not safe from the arbitrary exercise of government power unless they were embodied in positive law. Hazeltine, *The Influence of Magna Carta* at 39. Accordingly, in 1765, delegates from nine of the colonies met in New York and published a declaration of rights asserting their entitlement to all the common-law rights and liberties of English subjects. 2 James Kent, *Commentaries on American Law*, 5 (3d ed 1836). In the same vein, the first Continental Congress in 1774 adopted a Declaration of Rights asserting not only that the inhabitants of the English colonies in North America were entitled to life, liberty, and property by the immutable laws of nature, but also that they were entitled to the common law and statutory law of England and to all the immunities and privileges granted and confirmed by royal charters. The 1774 Declaration of Rights reflected the principle of English law that English subjects carried with them, as their birthright, the laws of England. *Id.*

Two years later, in 1776, the Declaration of Independence restated the colonists' right to continue to enjoy the ancient rights of the English constitution at the same time that it pleaded a legal case for political independence. Hall, *Magic Mirror* at 59. After the Revolution, all the states continued the operation of the common law within their borders. **<332 Or 101/102>** Webster, *Comparative Study* at 70.[8] Accordingly, courts continued to apply common-law remedies for injuries to absolute rights.

Shortly before the Revolution, the Continental Congress had recommended to the colonies that they establish independent governments. By the end of 1776, several of the colonies -- now states -- had adopted constitutions and had prefaced them with declarations or bills of rights that stated "in dogmatic form all of the seminal principles of the English constitutional system." C. Ellis Stevens, *Sources of the Constitution of the United States*, 34, 38 n 1 (1894).[9] After the Revolution, however, the function of declarations or bills of rights was to safeguard against arbitrary power of all kinds, not merely the Crown or Parliament. Willi Paul Adams, *The First American Constitutions*, 145 (1980).

Few of the original states formed constitutional conventions to draft their constitutions. Most states left the task to their legislatures, or general courts. Allan Nevins, *The American States During and After the Revolution: 1775-1789*, 137 (1924).[10] Not surprisingly, the drafters of the first state constitutions drew on their own colonial institutions and charters, which included the tenets of the common law as they understood them. Donald S. Lutz, *The Origins of American Constitutionalism*, 62 (1988); *see* Nevins, *The American States During and After the Revolution* at 1 ("Almost all of the **<332 Or 102/103>** early state constitutions descend directly from Colonial institutions."). There were few practical guides available to the drafters of state constitutions, apart from the existing royal and proprietary charters, the writings of Coke, Care, Penn, and Blackstone, and the philosophy of English revolutionists. Nevins, *The American States During and After the Revolution* at 126.

Declarations or bills of rights in state constitutions reflected the broad, deep foundations of English rights as those rights were understood at the time, but drafters restated their common-law rights

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[8] *See* Stevens, *Sources of the Constitution of the United States* at 34 ("[The American Revolution] was fought on the part of the colonists in defense of what they held to be their rights as men of the English blood."); *Report of the Committee Upon the Duty of Courts to Refuse to Execute Statutes in Contravention of the Fundamental Law*, 38 Report of New York State Bar Assoc, 230, 238 (1915) ("[T]he American Revolution was a lawyers' revolution to enforce Lord Coke's theory of the invalidity of Acts of Parliament in derogation of common right and of the rights of Englishmen.").

[9] New Jersey had adopted a constitution that did not contain a separate bill of rights. However, the New Jersey Constitution embedded many recognized liberties in the body of the document (e.g., trial by jury, right to counsel, free exercise of religion). 1 Schwartz, *The Bill of Rights* at 234 ff.

[10] Constitutions were drafted with amazing speed -- New Hampshire's in only a week; Delaware's, one of the few that was drafted by a convention, in less than a month. Nevins, *The American States During and After the Revolution* at 128, 138. There was no time for lengthy deliberation and debate about fundamental principles because, at the same time, the writers of those constitutions had to attend to pressing matters such as war, the economy, and statute-writing. *Id.* at 136.

as natural rights. Webster, *Comparative Study* at 384-85. The most significant legal provisions in the early bills of rights were taken from the Second Institute in an effort to give concrete content to the common-law rights of Englishmen. Roscoe Pound, *The Formative Era of American Law*, 98 (1938).[11]

Our historical inquiry to this point reveals that the common law had a powerful influence on the American colonists' understandings of their legal rights as private individuals in their relations with one another, as well as on their understandings of their rights and liberties in relation to government. Consistent with the writings of Blackstone and eighteenth century revolutionary writers, the colonists viewed some of their rights -- including those respecting person, property, reputation, and liberty -- as "absolute." The drafters of the first state constitutions sought to protect absolute rights by prefacing their constitutions with bills or declarations of rights that both prohibited official interference with some rights and mandated how the government was to protect other rights. In writing those bills or declarations of **<332 Or 103/104>** rights, the drafters looked to the common law, as it was described to them in sources that included Coke's *Second Institute*, to identify the rights that they sought to protect. Coke's commentary on the second sentence of Chapter 29 of the Magna Carta of 1225, describing the common-law guarantee of remedy by due course of law for injury to goods, land, or person, evidently provided the framework and phraseology for remedy clauses that first appeared in state declarations of rights beginning in 1776. John H. Bauman, *Remedies Provisions in State Constitutions and the Proper Role of the State Courts*, 26 Wake Forest L Rev 237, 243-44 (1991).

4. *Early Remedy Clauses*

The states of Maryland and Delaware were the first to place remedy clauses in their declarations of rights. Both states had been proprietary colonies before the Revolution and, as noted earlier, their governors had guaranteed to the residents of those colonies the rights of Englishmen. The remedy clauses of both states' constitutions echoed Coke's, Care's, and Penn's commentaries on the second sentence of Chapter 29 of the Magna Carta of 1225.[12]

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[11] The common law also had a significant impact on federal law. For example, the Northwest Ordinance of 1787, the first federal document to contain a bill of rights, contained six articles that Congress stated would extend and "fix forever" in the Northwest Territory fundamental principles of civil liberty. 1 Henry Steele Commager, *Documents of American History*, 130 (8th ed 1968). One of the guarantees was that "[t]he inhabitants of the said territory shall always be entitled to * * * judicial proceedings according to the course of the common law." *Id.* Another was that "[n]o man shall be deprived of his liberty or property, but by the judgment of his peers or the law of the land." *Id.* at 130-31. Both guarantees were intended to "bridle the new national government." Leonard W. Levy, *Original Intent and the Framers' Constitution*, 146 (1988); *see also* Hazeltine, *The Influence of Magna Carta*, 17 Colum L Rev at 31 (bills of rights in American constitutions "delimit" government powers).

[12] Section XVII of the Maryland Declaration of Rights of 1776 provided:

> "That every freeman, for any injury done him in his person or property, ought to have remedy, by the course of the law of the land, and ought to have justice and right freely without sale, fully without any denial, and speedily without delay, *according to the law of the land*."

1 Schwartz, *The Bill of Rights* at 281 (emphasis added). Section XXI provided that no free man should be deprived of life, liberty, or property except by the judgment of peers "or *by the law of the land*." *Id.* at 282 (emphasis added). The Maryland Declaration of Rights used the phrase "by the law of the land" in referring to remedy for both private injuries to person or property and to official actions depriving a person of life, liberty, or property.

Section 12 of the Delaware Declaration of Rights of 1776 also closely paraphrased commentaries on the second sentence of Chapter 29 of the Magna Carta of 1225:

> "That every freeman for every injury done him in his goods, lands or person, by any other person, ought to have remedy by the course of the law of the land and ought to have justice and right for the injury done to him freely without sale, fully without any denial, and speedily without delay, *according to the law of the land*." Schwartz, *The Bill of Rights* at 277-78 (emphasis added).

None of the remedy clauses adopted after 1776 used the phrase "by the law of the land." Instead, beginning with the Pennsylvania Constitution of 1790, the preferred phrasing was "due course of law" or "the due course of law." *See generally Sources and Documents of United States Constitutions* (William F. Swindler ed 1975) (quoting texts of remedy clauses in constitutions of Pennsylvania, Kentucky, Ohio, Mississippi, Connecticut, Massachusetts, Alabama, Texas, Tennessee, and the 1838 territorial constitution of Florida). *See* Charles Groves Haines, *The Revival of Natural Law Concepts*, 104 (1965) (phrase "by the law of the land" transformed into more popular form "due process of law").

332 Or 105> After 1776, the drafters of other state constitutions apparently looked to Maryland and Delaware, if not directly to Coke, Care, or Penn, in crafting their remedy clauses. *See* Howard, *Road From Runnymede* at 485-86 (Appendix O, listing state constitutions with remedy clauses derived from Coke or variants thereon).[13] Clauses guaranteeing remedy for injury to absolute common-law rights became more common after 1780, as constitution writers realized that unrestrained state legislative power was as much a threat to the security of individual rights as unrestrained parliamentary and royal power had been. *See* Gordon S. Wood, *The Creation of the American Republic 1776-1787*, 448-49 (1969) (by 1780s, growing awareness that legislative power is "essentially no different from magisterial power"); *see also* Haines, *American Doctrine* at 40-61 (describing theory of constitutions as fundamental laws unalterable by legislatures).

As noted, the drafters wrote the Oregon Constitution and its Bill of Rights in 1857. As part of our effort to understand the wording of Oregon's remedy clause in light of the way that wording would have been understood and used by those who wrote the provision, *Vannatta*, 324 Or at 530, and as a way of bridging the period from the immediate aftermath of the American Revolution to the middle of the nineteenth century, we turn to an examination of the historical evolution of the remedy clause in Indiana, whose constitution of 1851 was the primary source for the Oregon Constitution. Charles Henry Carey, ed., *The Oregon Constitution and Proceedings and Debates of the Constitutional Convention of 1857*, 28 (1926).

332 Or 106> 5. *Indiana Remedy Clause*

The territory of Indiana, which had been governed by the Northwest Ordinance of 1787, was admitted into the union in 1816. 1 Charles Kettleborough, *Constitution Making in Indiana*, 65 (1971). The Indiana Bill of Rights followed the model of other Midwestern states, such as Ohio and Kentucky.[14] William P. McLauchlan, *The Indiana State Constitution: A Reference Guide*, 3 (1996). Article I, section 11, of the Indiana Constitution of 1816, provided:

> "That all Courts shall be open, and every person, for an injury done him in his lands, goods, person, or reputation, shall have remedy by the due course of law; and right and justice administered without denial or delay."

That phrasing virtually was identical to Article X, section 13, of the Kentucky Constitution of 1799.

By the 1840s, there was considerable dissatisfaction in Indiana with the constitution of 1816, primarily because that constitution had not proved to be an adequate restraint on legislative power. 1 Kettleborough, *Constitution Making* at 186-87. Article III, section 25, of the 1816 constitution, had provided for annual sessions of the legislature, and the constitution had imposed few restraints on legislative powers. *Id.* at 95-96. Specific complaints in the 1840s were that the legislature was enacting too many laws and that too many of those laws were local and private in nature. *Id.* at 183, 186-87. Citizens of Indiana were not alone in distrusting legislative power. One of the notable features of all state constitutions that were drafted in the mid-nineteenth century was the mistrust of legislative power. Amasa M. Eaton, *Recent State Constitutions*, 6 Harv L Rev 109, 109 (1892); *see* Hall, *Magic Mirror* at 89 (populist and antigovernmental stirrings **<332 Or 106/107>** of late 1840s and 1850s "climaxed in an outburst of constitutional reform that diminished legislative power").

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[13] Maryland and Delaware both abandoned their original constitutions. Maryland, however, retained the wording of its remedy clause in its constitutions of 1851, 1864, and 1867. *See* 4 *Sources and Documents of United States Constitutions* at 394, 418, 449 (reproducing constitutions). Delaware, by contrast, expanded its remedy-clause guarantee to include "reputation" and "movable or immovable possessions" in its constitution of 1792, and provided that remedy would be by "the due course of law." *Id.* at 206. The text of the Delaware remedy clause has not changed since 1792. *See id.* at 206, 217, 237 (setting out Delaware constitutions).

[14] Article VIII, section 7, of the Ohio Constitution of 1802, provided:

> "That all courts shall be open, and every person, for an injury done him in his lands, goods, person or reputation, shall have remedy by the due course of law, and right and justice administered, without denial or delay."

Article X, section 13, of the Kentucky Constitution of 1799, provided:

> "That all courts shall be open, and every person for an injury done him in his lands, goods, person, or reputation, shall have remedy by the due course of law; and right and justice administered, without sale, denial or delay."

The Indiana Constitutional Convention of 1850 made fundamental changes to that state's original constitution, including limiting the legislature to biennial sessions (Article IV, section 9) and prohibiting the legislature from passing local or special laws (Article IV, section 22). 1 Kettelborough, *Constitution Making* at 314, 318-19. The convention also rewrote various provisions of Indiana's Bill of Rights to assure that the legislature would not invade the rights that were protected therein.

Article I, section 11, of the Indiana Constitution of 1816, was one of the provisions that the convention revised. Renumbered as Article I, section 12, of the Indiana Constitution of 1851, the convention rewrote it to provide:

> "All courts shall be open; and every man, for injury done to him in his person, property, or reputation, shall have remedy by due course of law. Justice shall be administered freely, and without purchase; completely, and without denial; speedily, and without delay."

1 Kettleborough, *Constitution Making* at 297-98. Unlike the one-sentence version in the 1816 constitution, the 1851 provision consisted of two sentences, each addressing different guarantees. The first sentence guaranteed both open courts and the right to remedy by due course of law for injury to person, property, or reputation. The second sentence prescribed how justice must be administered, and the delegates added requirements that had not been present in the 1816 constitution, including the requirement that justice be administered completely, as well as freely; without purchase; and speedily, without denial or delay.

The decisions to restructure Article I, section 12, to make the remedy clause an independent clause and to add the requirement that justice be administered completely are indications that the drafters of the Indiana Constitution of 1851 intended to secure more firmly than had been done in the 1816 constitution the common-law right to remedy for injury to absolute rights concerning person, property, and reputation. The evolution of the remedy clause in the Indiana **<332 Or 107/108>** Bill of Rights thus indicates that the commitment to protecting absolute common-law rights had strengthened, not waned, with the passage of time.

We have found no cases construing the Indiana remedy clause before the Oregon Constitution was adopted in 1857. However, legal commentaries and case law from other jurisdictions provide insight into the rights that remedy clauses were intended to protect and how the key terms "remedy," "due course of law," and "injury" were understood during that era. We turn to an examination of those sources.

6. *Commentaries and Case Law from Other Jurisdictions*

The commitment to natural rights was strong in the nineteenth century, just as it had been in the eighteenth century and before. New York Chancellor James Kent, for example, identified personal security (including reputation), personal liberty, and the right to acquire and enjoy property as absolute rights. 2 Kent, *Commentaries* at 1, 15. Kent described absolute rights as natural, inherent, and unalienable, *id.* at 1, and explained that the function of bills of rights is to guard absolute rights from attack in the ordinary course of public affairs, *id.* at 8. Similarly, the Ohio Supreme Court, in construing that state's remedy clause, referred to reputation as a "sacred right of every person," *Fisher v. Patterson*, 14 Ohio 418, 426 (1846), and the Mississippi Supreme Court, in a case involving that state's remedy clause, described liberty and property as fundamental, sacred rights. *Commercial Bank of Natchez v. Chambers et al.*, 16 Miss 9, 57 (1847).

It also was well established in the nineteenth century that, at a minimum, a "remedy" was a means for enforcing a legal right. In *Marbury v. Madison*, 5 US (1 Cranch) 137, 163, 2 L Ed 60 (1803), the United States Supreme Court held that the "very essence of civil liberty * * * consists in the right of every individual to claim the protection of the laws, whenever he receives an injury." That rule rested on Blackstone's assertion that "'it is a general and indisputable rule, that where there is a legal right, there is also a legal remedy by suit or action at law wherever that right is invaded,'" and that "'every right, when withheld, must have a remedy, and **<332 Or 108/109>** every injury its proper redress.'" *Id.* (quoting Blackstone's *Commentaries*).

Kentucky's highest court made a similar statement in *Davis v. Ballard*, 24 Ky (1 JJ Marsh) 563 (1829). The court explained that no one is secure in the enjoyment of life, liberty, or property unless the government provides an opportunity for redress if those rights are injured. *Id.* at 568. The court held that the remedy clause in Article X, section 13, of the Kentucky Constitution, imposes on "the functionaries of the government" the duty to assure the availability of a remedy for injury. *Id.*

Courts assumed that common-law remedies provided constitutionally adequate remedies for injuries to recognized rights. Nonetheless, they acknowledged legislative authority to alter remedies, so long as the alterations did not infringe on absolute, or vested, rights. *See Gooch v. Stephenson*, 13 Me 371, 376-77 (1836) (so stating). If legislatively enacted remedies did infringe on such rights, courts invalidated those remedies. Thus, in *Riggs, Peabody & Co. v. Martin*, 5 Ark 506, 508-09 (1844), the Arkansas Supreme Court declared unconstitutional a statute that prohibited a person from asserting rights to probate estates unless the person took an oath in open court stating that he had given the estate credit for all payments and offsets to which the estate was entitled. The court held that the legislature lacked authority to impose the open-court oath requirement:

> "The Legislature certainly does not possess the power to cut off all remedy on demands against the estate of deceased persons, or so to impair the right or clog its assertion as to render it inoperative or valueless." *Id.* at 508.

Courts in the nineteenth century also evaluated legislatively created remedies by examining whether they satisfied "due course of law," "due process of law," or "law of the land" requirements. As they had in Coke's time, those phrases continued to share an "identity of meaning" in the nineteenth century. Theodore Sedgwick, *A Treatise on the Rules Which Govern the Interpretation and Application of Statutory and Constitutional Law*, 534, 534 n (1857). State **<332 Or 109/110>** as well as federal courts viewed the phrases as imposing an "important limitation" on the exercise of legislative power. *Id.* at 534. For example, in *Townsend v. Townsend*, 7 Tenn (Peck) 1, 14 (1821), the Supreme Court of Tennessee stated that the remedy clause in Article XI, section 7, of the Tennessee Constitution, which guaranteed remedy by due course of law for injury to lands, goods, person, or reputation, imposed a "restriction * * * upon legislative and all other power." The legislature was not free to barter away constitutional rights, because they were "vested, unexchangeable, and unalienable." *Id.* at 12. In *Davis*, 24 Ky (1 JJ Marsh) at 571, the court held that the remedy clause in Article X, section 13, of the Kentucky Constitution, which guaranteed remedy by due course of law for injury to lands, goods, person, or reputation, was one of the constitutional provisions that imposed a duty on the judiciary to declare laws unconstitutional.

Courts also held that "law of the land" provisions in bills of rights imposed restraints on legislative power. In *Jones' Heirs v. Perry*, 18 Tenn (10 Yer) 59, 71 (1836), for example, the Tennessee Supreme Court explained:

> "The only means by which the legislature can be kept within the bounds of the constitution, in times of high political excitement, is to accustom its members to the restraints it imposes, and to check their assumption of an excess of power promptly whenever the case occurs."

See also Westervelt v. Gregg, 12 NY 202, 209 (1854) (due process of law does not mean any act legislature might think fit to pass "in the uncontrolled exercise of its power"); *Hoke v. Henderson*, 15 NC (4 Dev) 1, 12 (1833) *rev'd on other grounds Mial v. Ellington*, 134 NC 131, 46 SE 961 (1903) (phrase "law of the land" does not mean any act of general assembly).

Notwithstanding their duty to determine whether legislatively enacted remedies satisfied due course of law, due process of law, or law of the land requirements, courts approached their evaluative task with the presumption that the legislature had intended to provide a constitutionally adequate remedy for injury to protected rights. In *Schuylkill Navigation Company v. Loose*, 19 Pa 15, 18 (1852), for example, the Pennsylvania Supreme Court explained that the remedy clause in Article IX, section 11, of the Pennsylvania **<332 Or 110/111>** Constitution, had descended from the common-law guarantee that "'justice and right shall be denied * * * to no one.'" (quoting Magna Carta). Because the common law and the constitution guaranteed "right," or remedy, for injury, the court explained, it would evaluate remedial statutes that were substitutes for common-law remedies with a presumption that the legislature intended to provide remedies for injury that at least were equivalent to those that had been provided at common law. *Id.*

Finally, in our examination of historical sources providing insight into the meaning of the key terms in state constitutional remedy clauses, we turn to nineteenth century case law construing the word "injury." As they had in previous centuries, courts continued to view "injury" as any violation of a right or any wrong done to a right. In *Parker v. Griswold*, 17 Conn 288, 295 (1845), for example, the question

was whether the defendant had injured the plaintiff's land by diverting water away from a stream that ran through it. The defendant had argued that no injury had occurred merely because less water had come to the plaintiff's land. *Id.* at 295. The Connecticut Supreme Court rejected that argument, explaining:

> "An injury is a wrong; and for the redress of every wrong there is a remedy: *a wrong is a violation of one's right; and for the vindication of every right there is a remedy.* Want of right and want to remedy are justly said to be reciprocal. Where therefore there has been a violation of a right, the person injured is entitled to an action."

Id. at 303 (emphasis added). Courts also held that remedy clauses addressed "every possible injury which a man may sustain and which affects him in respect to his real or personal property, or in respect to his person or reputation * * *." *Townsend*, 7 Tenn (Peck) at 14; *see also Parker*, 17 Conn at 303 (for vindication of right that is injured or wronged, law supplies a remedy through some form of action).[15]

332 Or 112> In sum, when the Oregon Constitutional Convention convened in 1857, courts and commentators had provided considerable insight into the background and meaning of remedy clauses in state declarations or bills of rights. Those cases and commentaries revealed that the purpose of remedy clauses was to protect "absolute" common-law rights. For injuries to those rights, the remedial side of the common law had provided causes of action that were intended to restore right or justice. Remedy clauses mandated the continued availability of remedy for injury to absolute rights. The requirement that remedy be by due course or due process of law was intended as a limitation on the legislature's authority when it substituted statutory remedies for common-law remedies. It was the duty of courts to enforce those restraints in evaluating whether particular statutory remedies satisfied the requirement that remedy be by "due course of law." *See* 2 Kent, *Commentaries* at 13 n b (not every act of legislature reflects "law of the land"); Haines, *American Doctrine* at 63-121 (discussing state court decisions between 1778 and 1819 establishing practice of "judicial control of legislative acts"). With that background, we turn to the drafting and adoption of the remedy clause in Article I, section 10, of the Oregon Constitution.

332 Or 113> 7. *Oregon Constitutional Convention*

The Oregon Constitutional Convention convened on August 17, 1857, and elected territorial Justice Matthew Deady as its president. Carey, *The Oregon Constitution* at 27. Many of the delegates came from states that had undertaken constitutional reform in the late 1840s. David Alan Johnson, *Founding the Far West*, 142 (1992). Nineteen of the 60 delegates were lawyers. Charles H. Carey, *General History of Oregon*, 511 (3d ed 1971). Like their Indiana counterparts, the drafters of the Oregon Constitution were leery of legislative power. They limited the legislature to biennial sessions, Article IV, section 10, imposed a single-subject limitation on all acts, Article IV, section 20, prohibited the enactment of special or local laws, Article IV, section 23, and required a majority of all the members -- rather than a majority of a quorum -- to enact all laws, Article IV, section 25. *See* Carey, *The Oregon Constitution* at 390 (explaining reasons for wanting to restrain legislative power).

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[15] Contrary to one commentator's assertion, *Sharpless v. Mayor of Philadelphia*, 21 Pa 147 (1853), does not support a contrary view. *See* Hoffman, *Origins of the Open Courts Clause* at 1290 and n 65 (*Sharpless* authority for theory that remedy clauses in state constitutions merely intended to assure judicial independence). In *Sharpless*, the question was whether two Pennsylvania statutes authorizing the City of Philadelphia to issue bonds to raise revenue to subscribe to shares of stock in two railroad companies violated Article IX, section 9, of the Pennsylvania Constitution, which prohibited the state from taking private property without compensation. 21 Pa at 164. In seriatim opinions, the three justices of the Pennsylvania Supreme Court in the majority held that the revenue statute was within the legislature's power to tax.

In his opinion, Justice Black canvassed every provision of the Pennsylvania Constitution that might have had relevance to the scope of the legislature's taxing powers. *Id.* at 164-65. Regarding the remedy clause in Article IX, section 11, he wrote:

> "[Article IX, section 11,] was clearly intended to insure the constant and regular administration of justice between man and man. To say that it is violated by refusing a judicial remedy for bad legislation, would be straining it sadly. Certainly a contract, such as that which the defendants propose to make, however it may injure the plaintiffs, is not an injury for which they are entitled to redress if it be lawful to make it."

Id. at 166. Justice Black's observations, in dicta, about the remedy clause were that the clause played no role in resolving whether the legislature properly had exercised its taxing power because the remedy clause addressed only private injuries.

Early in the convention, lawyer-delegate Delazon Smith, who had studied other states' constitutions, proposed creating a committee on the bill of rights. *Id.* at 76, 100. Smith argued that a bill of rights was "a sort of textbook of weighty matters" that would command the respect of the people and the attention of the courts, and would limit the fractious spirit of the majority if it tried to infringe on the rights of the individual citizen. *Id.* at 102.

The delegates created a seven-member committee on the bill of rights headed by lawyer-delegate Layfayette Grover. *Id.* at 107. The committee submitted a proposed bill of rights less than a week later. *Id.* at 117. Many of the provisions were identical to the bill of rights of the Indiana Constitution of 1851. See W.C. Palmer, *The Sources of the Oregon Constitution*, 5 Or L Rev 200, 201-02 (1926) (comparing Oregon and Indiana bills of rights). The committee recommended the following wording for the provision that became Article I, section 10, of the Oregon Constitution:

> "No tribunal 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 **<332 Or 113/114>** of law for injury done him in his person, property, or reputation."

Carey, *The Oregon Constitution* at 120. In the final version, the convention substituted the word "court" for the word "tribunal." *Id.* at 327. The convention adopted the Bill of Rights on September 12, 1857. *Id.* at 343.

There is no record of the debates surrounding the changes that the committee on the Bill of Rights made to Article I, section 10. However, in the short time that the committee devoted to drafting the Bill of Rights for the Oregon Constitution, it rewrote Article I, section 12, of the Indiana Constitution of 1851, rather than merely adopting the Indiana provision verbatim. The committee reorganized the provision to express in one clause all the requirements relating to open courts and judicial administration. It expressed in a separate, independent clause the guarantee of remedy by due course of law for injury to person, property, or reputation. The decision to express in a separate, independent clause the guarantee of remedy by due course of law for injury to person, property, or reputation indicates that the drafters of the Oregon Constitution believed that the right to a remedy for injury to those rights needed to be stated clearly and unambiguously in the Oregon Bill of Rights.

Evidence of the scope of the drafters' intent when they wrote the remedy clause in section 10 of the Oregon Bill of Rights admittedly is sketchy. However, we find no indication that the drafters sought to depart from the historical purpose of remedy clauses, which was to mandate the availability of a remedy by due course of law for injury to absolute rights respecting person, property, and reputation. That the drafters of Article I, section 10, of the Oregon Constitution, rewrote and reorganized Article I, section 12, of the Indiana Constitution of 1851, rather than merely adopting that provision verbatim as they did several other provisions of the Indiana Bill of Rights, demonstrates that the drafters gave careful thought to the structure and wording of Article I, section 10. Their choice to express in one clause how justice is to be administered, and to reserve for a separate, independent clause the requirement of remedy by due course of law for injury to person, property, or reputation, indicates that the **<332 Or 114/115>** drafters regarded the remedy clause as providing substantive protection to those absolute common-law rights. Viewed in the context of the historical tradition that gave rise to remedy clauses in other state constitutions, and the mistrust of legislative power that pervaded the mid-nineteenth century, we conclude that the drafters of Article I, section 10, sought to give constitutional protection to absolute rights respecting person, property, and reputation as those rights were understood in 1857, and that the means for doing so was to mandate the availability of remedy by due course of law in the event of injury to those rights. That remedy must be by due course of law is a directive to courts, as the guardians of constitutional rights, to determine the constitutionality of legislatively created remedies respecting such rights.

Having examined the text of the remedy clause, and the historical circumstances leading to its adoption, we now turn to Oregon case law surrounding the provision. See Priest, 314 Or at 415-16 (prescribing sequence of analysis).

C. *Oregon Supreme Court Case Law*

This court's case law surrounding Article I, section 10, is extensive. We review that case law first by considering cases analyzing the rights that the remedy clause protects, then cases analyzing its key terms: remedy, due course of law, and injury.

1. *Rights Protected by the Remedy Clause*

This court has stated that the guarantee of remedy by due course of law for injury to person, property, or reputation "is one of the most sacred and essential of all the constitutional guaranties" and that "without it a free government cannot be maintained or individual liberty be preserved." *Gearin v. Marion County*, 110 Or 390, 396, 223 P 929 (1924). This court also has stated that the purpose of the remedy clause is to make the common-law maxim that there is no wrong without a remedy "a fixed and permanent rule of law in this state." *Platt v. Newberg et al.*, 104 Or 148, 153, 205 P 296 (1922). Those statements reflect this court's understanding that certain common-law rights are absolute rights that must be protected from infringement.

332 Or 116> Consistent with the foregoing observations, this court for many years held that the purpose of the remedy clause "is to save from legislative abolishment those jural rights which had become well established prior to the enactment of our Constitution." *See Stewart v. Houk et al*, 127 Or 589, 591, 271 P 998, *on reh'g* 272 P 893 (1928) (so stating and citing eight previous cases so holding). *Stewart* involved the constitutionality of a 1927 statute, which provided that "'[a]cceptance of a free ride as a guest in a motor vehicle shall be presumed to be a waiver of said guest of liability for accidental injury caused by [the] owner or driver of such motor vehicle.'" *Id.* at 591 (quoting statute). The court held that the statute violated the remedy clause. It reasoned:

> "[I]f the buttress erected by this constitutional provision for the safeguarding of long-established rights can be pierced by this piece of legislation, an entry will be effected through which may come other legislation in substitution for the safeguarded common-law rights. It is clear we possess no power to sanction the entry and the substitution."

Id. at 596. The holding in *Stewart* was consistent with previous cases in which the court had held that, under the remedy clause, "[v]ested rights are placed under constitutional protection, and cannot be destroyed by legislation." *Templeton v. Linn County*, 22 Or 313, 318, 29 P 795 (1892).

Soon after this court's decision in *Stewart*, the United States Supreme Court decided *Silver v. Silver*, 280 US 117, 50 S Ct 57, 74 L Ed 221 (1929). That decision presaged an alteration in the course of this court's Article I, section 10, jurisprudence. In *Silver*, the issue was whether the Connecticut guest-passenger statute, which barred a gratuitous guest from recovering for injuries caused by ordinary negligence in the operation of an automobile but not other modes of transportation, violated the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution.[16] *Id.* at 122. The Connecticut Supreme Court had held that the statute did not violate the Equal Protection **<332 Or 116/117>** Clause, *Silver v. Silver*, 108 Conn 371, 143 A 240 (1928), and the United States Supreme Court affirmed, *Silver*, 280 US at 122. The Supreme Court explained that the Equal Protection Clause "does not forbid the creation of new rights, or the abolition of old ones recognized by the common law, to attain a permissible legislative object." *Id.*

Thereafter, in 1935, in *Perozzi v. Ganiere*, 149 Or 330, 345, 40 P2d 1009 (1935), this court relied on Silver in upholding Oregon's 1929 guest passenger statute against a remedy clause challenge. That statute barred causes of action against drivers of motor vehicles by gratuitous guests who had been injured, unless the plaintiff could show that the accident was intentional or had been caused by gross negligence, intoxication, or reckless disregard for the rights of others. *Id.* at 331. The plaintiff in *Perozzi* relied on *Stewart* for the proposition that the 1929 statute, like its predecessor, deprived her of a remedy for the injury that she had suffered to her person when the car in which she was riding overturned as a result of the defendant's careless and negligent driving. *Id.* at 330-31. In rejecting the plaintiff's challenge, the court cited *Silver* for the proposition that the remedy clause in Article I, section 10, of the Oregon Constitution, does not prohibit the legislature from creating new rights or abolishing old rights recognized at common law.[17] *Id.* at 333.

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[16] The plaintiff in *Silver* did not challenge the validity of the Connecticut guest-passenger statute under that state's remedy clause. She limited her argument to the contention that the statute violated the Equal Protection Clause of the Fourteenth Amendment.

[17] The *Perozzi* court also rejected the plaintiff's contention that Article I, section 10, preserves all common-law remedies and that it is not within the province of the legislature to take away or limit remedies in any way. *Perozzi*, 149 Or at 345-47. We discuss that aspect of *Perozzi* later in this opinion.

The legislature repealed the guest passenger statute, ORS 30.110, in 1961. Or Laws 1961, ch 578, section 1.

As our analysis to this point makes clear, the *Perozzi* court erred in relying on the United States Supreme Court's analysis of the Equal Protection Clause in *Silver* for its interpretation of the rights protected by the Oregon remedy clause. The Equal Protection Clause and the remedy clause address distinctly different constitutional concerns. As this court correctly had held on many occasions before *Perozzi*, the purpose of the remedy clause in Article I, section 10, is to protect absolute common-law rights respecting person, property, and reputation by guaranteeing the availability of a remedy in the event of an injury. The purpose of the Equal **<332 Or 117/118>** Protection Clause, which was added to the United States Constitution after the Civil War, is to assure that all persons are treated equally by the law. Nonetheless, beginning with *Perozzi*, the United States Supreme Court's interpretation of the Equal Protection Clause of the Fourteenth Amendment in *Silver*, rather than the text, history, and this court's prior interpretations of the remedy clause, became the basis for this court asserting, in subsequent cases, that the legislature may abolish absolute common-law rights without violating Article I, section 10. As our review of subsequent cases will show, that error has had significant consequences.

In *Noonan v. City of Portland*, 161 Or 213, 249, 88 P2d 808 (1939), this court again relied on *Silver* in holding that Article I, section 10, "was not intended to give anyone a vested right in the law either statutory or common * * *." The court reiterated that point in *Josephs v. Burns & Bear*, 260 Or 493, 503, 491 P2d 203 (1971), again relying on *Silver*. Other remedy-clause cases examining the rights that are protected by Article I, section 10, likewise have relied on *Perozzi*, *Noonan*, and *Josephs*. *See, e.g., Holden v. Pioneer Broadcasting Co. et al*, 228 Or 405, 412-13, 365 P2d 845 (1961) (citing *Perozzi* and *Noonan* for proposition legislature may modify fault principle);[18] *Sealey v. Hicks*, 309 Or 387, 393-94, 788 P2d 435 (1990) (citing *Josephs* for proposition that legislature can determine what constitutes legally cognizable injury); *Hale v. Port of Portland*, 308 Or 508, 521, 783 P2d 506 (1989) (citing *Noonan* for proposition that Article I, section 10, not intended to give anyone vested right in law).

As we have explained, the history of the remedy clause indicates that its purpose is to protect absolute common-law rights respecting person, property, and reputation, as those rights existed when the Oregon Constitution was drafted in 1857. The means for protecting those rights is the mandate that remedy by due course of law be available in the **<332 Or 118/119>** event of injury. Until 1935, this court's case law was consistent with that historical purpose. In *Perozzi*, this court erroneously relied on the United States Supreme Court's interpretation of the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution in *Silver* to hold that Article I, section 10, does not forbid the legislature from abolishing absolute rights respecting person, property, or reputation that existed when the Oregon Constitution was adopted. Subsequent cases, relying on *Perozzi* and *Silver*, have repeated that error. We disavow this court's holdings, beginning with *Perozzi*, that the legislature can abolish or alter absolute rights respecting person, property, or reputation that existed when the Oregon Constitution was drafted without violating the remedy clause in Article I, section 10.

2. *Remedy*

For rights that are protected by Article I, section 10, this court consistently has held that the law must provide a means for seeking redress for injury. *See, e.g., Thomas v. Bowen*, 29 Or 258, 264, 45 P 768 (1896) (Article I, section 10, furnishes adequate remedy for any infringement of right to preservation of good name); *Batdorff v. Oregon City*, 53 Or 402, 408-9, 100 P 937 (1909) (city ordinance limiting recovery for injury to instances of gross negligence leaves "remediless" person injured by ordinary negligence in violation of Article I, section 10). The legislature lacks authority to deny a remedy for injury to absolute rights that existed when the Oregon Constitution was adopted in 1857. See *Mattson v. Astoria*, 39 Or 577, 580, 65 P 1066 (1901) (Article I, section 10, intended to preserve common-law right of action).

Although this court has held that the remedy clause preserves common-law rights of action, *id.*, it never has held that the remedy clause prohibits the legislature from changing a common-law remedy or form of procedure, attaching conditions precedent to invoking the remedy, or perhaps even abolishing old remedies and substituting new remedies. *Id.* That is, the court never has held that the remedy clause freezes in place common-law remedies. However, just as the legislature cannot deny a

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[18] The *Holden* court acknowledged that, in upholding a statute that eliminated the right of a defamed person to recover general damages for inadvertent libel by certain news media when a retraction was made, it was adopting a minority view. 228 Or at 410.

remedy entirely for injury to constitutionally protected common-law rights, *id.*, neither can it substitute an "emasculated remedy" that is incapable of <332 Or 119/120> restoring the right that has been injured, *West v. Jaloff*, 113 Or 184, 195, 232 P 642 (1925).[19]

3. *Due Course of Law*

For many years, this court viewed the phrase, "due course of law," as a guarantee of "due process of law," like that contained in the Fourteenth Amendment to the United States Constitution. In *Hough v. Porter*, 51 Or 318, 449, 98 P 1083 (1909), for example, the court identified Article I, section 10, as authority for the proposition that, "under the fundamental law of our land[,] all persons are entitled by due process of law to protection in their property rights, and to a speedy hearing of any controversy in respect thereto." In *Perozzi*, 149 Or at 350, the court again asserted that Article I, section 10, "is a 'due process of law' clause." Consistent with that view, this court held that the procedural requirements of Article I, section 10, are applicable to criminal proceedings, *see State v. Bouse*, 199 Or 676, 686, 264 P2d 800 (1953) (Article I, section 10, like Fourteenth Amendment, demands fair and impartial trial); to habeas corpus proceedings, *see Penrod/Brown v. Cupp*, 283 Or 21, 26, 581 P2d 934 (1978) ("Where the deprivation involves a constitutionally protected right, either Oregon's Article I, Section 10, or the federal fourteenth amendment obliges the state to provide some remedy in due course, or due process, of law."); and to prison discipline proceedings, *see Bonney v. OSP*, 270 Or 79, 91-2, 526 P2d 1020 (1974) ("in the inmate hearing context we choose to interpret Oregon's constitutional due process provision as <332 Or 120/121> mandating no greater rights than does the Fourteenth Amendment"). During the period that the court viewed the guarantee of "due course of law" as equivalent to "due process of law in the Fourteenth Amendment," it followed substantially federal court interpretations of the Fourteenth Amendment. *See School Dist. No. 12 v. Wasco County*, 270 Or 622, 632, 529 P2d 386 (1974) (so stating).

Justice Linde's concurrence in *Davidson v. Rogers*, 281 Or 219, 222-23, 574 P2d 624 (1978), set the stage for a different approach. He wrote:

> "The guarantee in article I, section 10, of a 'remedy by due course of law for injury done [one] in his person, property, or reputation' is part of a section dealing with the administration of justice. It is a plaintiffs' clause, addressed to securing the right to set the machinery of the law in motion to recover for harm already done to one of the stated kinds of interest, a guarantee that dates by way of the original state constitutions of 1776 back to King John's promise in Magna Carta chapter 40: 'To no one will We sell, to no one will We deny or delay, right or justice.' It is concerned with securing a remedy from those who administer the law, through courts or otherwise."

(Brackets in original; footnote omitted.) In 1982, in *Cole v. Dept. of Rev.*, 294 Or 188, 191, 655 P2d 171 (1982), this court adopted Justice Linde's view that the guarantee of remedy by due course of law is not equivalent to the guarantee of due process of law of the Fourteenth Amendment. Unlike the Due Process Clause in the Fourteenth Amendment, which evaluates the adequacy of the processes provided before government deprives a person of life, liberty or property, the remedy clause guarantees remedy by due course of law for injuries to person, property, or reputation that already have occurred. *Id.*; *see also State v. Wagner*, 305 Or 115, 145-56, 752 P2d 1136 (1988) (Article I, section 10, not equivalent to Fourteenth Amendment Due Process Clause); *State v. Hart*, 299 Or 128, 140, 699 P2d 1113 (1985) (same).

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[19] Recently, this court has suggested that, in addition to being a means for seeking redress for injury, the word "remedy" also refers to the amount of damages that a person is entitled to recover for an injury. In *Hale*, for example, the court held that, under Article I, section 10, the legislature may limit the size of an award that can be recovered for an injury, so long as "the remedy is a substantial one." 308 Or at 523. *See also Greist v. Phillips*, 322 Or 281, 290, 906 P2d 789 (1995) (legislature entitled to amend amount of damages available in statutory wrongful death action without running afoul of Article I, section 10, "as long as the plaintiff is not left without a substantial remedy"); *Neher*, 319 Or at 426 (Article I, section 10, not violated so long as injured party has substantial remedy).

As we have explained, the only question in this case is whether the legislature has deprived plaintiff of a *means* for seeking redress for the injury that he alleges that he suffered at work. Accordingly, it is beyond the scope of this opinion to address issues relating to the adequacy of the amount of damages that may be available under a legislatively substituted process for a common-law cause of action for injury to one of the rights that is protected by the remedy clause.

Our historical inquiry in this case supports this court's holding in *Cole* that the remedy clause of Article I, section 10, is not a due process clause in the sense that due process is used in the Fourteenth Amendment to the United States Constitution. Nonetheless, the mandate in Article I, **<332 Or 121/122>** section 10, that remedy be by due course of law for injury to person, property, or reputation, expresses a limitation on the exercise of legislative power. It is the duty of courts to evaluate the constitutionality of legislative enactments regarding the availability of remedies for injuries to rights that are protected by the remedy clause.

4. *Injury*

Judge Matthew Deady, who had served as the president of the Oregon Constitutional Convention in 1857, provided the first judicial explanation of the meaning of the term "injury" in the remedy clause:

> "[T]he remedy guarantied by [Article I, section 10,] is not intended for the redress of any novel, indefinite, or remote injury that was not then regarded as within the pale of legal redress. But whatever injury the law, as it then stood, took cognizance of and furnished a remedy for, every man shall continue to have a remedy for by due course of law. * * * If [a] then known and accustomed remedy can be taken away in the face of this constitutional provision, what other may not? Can the legislature, in some spasm of novel opinion, take away every man's remedy for slander, assault and battery, or the recovery of a debt?"

Eastman v. County of Clackamas, 32 F 24, 32 (D Or 1887). The word "then" appears to refer to the time when the drafters wrote the Oregon Constitution. Thus, according to Judge Deady, if there was a common-law cause of action for injury to person, property, or reputation in 1857, then the remedy clause mandates the continued availability of remedy for that injury. *Id.*

This court adopted Judge Deady's view of injury in *Theiler v. Tillamook County*, 75 Or 214, 217, 146 P 828 (1915). Earlier, this court had cited with approval decisions from other jurisdictions holding that "injury" means wrongs or harms to rights that are recognized by the common law, that is, for which common-law causes of action existed. *Mattson*, 39 Or at 580 (citing *McClain v. Williams*, 10 SD 332, 73 NW 72 (1897), and *Reining v. City of Buffalo*, 102 NY 308, **<332 Or 122/123>** 6 NE 792 (1886)). *See Stewart*, 127 Or at 592 (quoting *Mattson* for proposition that injury means wrongs for which remedy must be available); *see also Cole*, 294 Or at 191 (procedural requirement that one pay assessed taxes before suing to have them refunded not type of injury contemplated by Article I, section 10).

In 1990, in *Sealey*, this court held that the legislature has authority to determine what constitutes a legally cognizable injury. 309 Or at 394. The *Sealey* court relied on *Josephs*, which in turn had relied on *Noonan* and *Silver*, for the proposition that the remedy clause does not give anyone a vested right in the law, either statutory or common. *See Josephs*, 260 Or at 503 (so stating). If it were true that the legislature had authority to declare what rights are protected by the remedy clause, then it would follow that the legislature also had plenary authority to define what constitutes a legally cognizable injury to those rights. However, as we have explained above, the remedy clause protects absolute common-law rights respecting person, property, and reputation that existed when the drafters wrote the constitution. If the legislature constitutionally cannot abolish or alter those rights directly, then it cannot abolish them indirectly by defining narrowly what constitutes an injury to those rights. We disavow the holding in *Sealey* that the legislature constitutionally is authorized to define what constitutes an injury to absolute rights respecting person, property, and reputation that are protected by Article I, section 10.

D. *Summary*

Having analyzed the remedy clause in the manner prescribed by *Priest* for interpreting an original provision of the Oregon Constitution, 314 Or at 415-16, we reach the following conclusions. As one of the provisions of the Oregon Bill of Rights, the remedy clause of Article I, section 10, protects rights respecting person, property, and reputation that, in 1857, the common law regarded as "absolute," that is, that derive from nature or reason rather than solely from membership in civil society. By the seventeenth century, the remedial side of the common law had developed to protect those rights in the event of injury by any other subject of the English realm. The function of common-law causes of action **<332 Or 123/124>** was to restore "justice" or "right" following injury. "Injury" at common law meant any harm or wrong to absolute rights for which a cause of action existed.

Drafters of remedy clauses in state constitutions sought to protect absolute common-law rights by mandating that a remedy always would be available for injury to those rights. The drafters of the Oregon remedy clause identified absolute rights respecting person, property, and reputation as meriting constitutional protection under the remedy clause. As to those rights, the remedy clause provides, in mandatory terms, that remedy by due course of law shall be available to every person in the event of injury. The word "remedy" refers both to a remedial process for seeking redress for injury and to what is required to restore a right that has been injured. Injury, in turn, is a wrong or harm for which a cause of action existed when the drafters wrote the Oregon Constitution in 1857. A common-law cause of action is a constitutionally adequate remedy for seeking redress for injury to protected rights. However, the remedy clause does not freeze in place common-law causes of action that existed when the drafters wrote the Oregon Constitution in 1857. The legislature may abolish a common-law cause of action, so long as it provides a substitute remedial process in the event of injury to the absolute rights that the remedy clause protects. At a minimum, to be remedy by due course of law, the statutory remedy must be available for the same wrongs or harms for which the common-law cause of action existed in 1857. That is, if the common law provided a cause of action for an injury to one of the rights that the remedy clause protects, then a legislatively substituted remedial process must be available for that injury.

It follows from the foregoing that, in analyzing a claim under the remedy clause, the first question is whether the plaintiff has alleged an injury to one of the absolute rights that Article I, section 10 protects. Stated differently, when the drafters wrote the Oregon Constitution in 1857, did the common law of Oregon recognize a cause of action for the alleged injury? If the answer to that question is yes, and if the legislature has abolished the common-law cause of action for injury to rights that are protected by the remedy clause, then the second question is whether it has provided a constitutionally adequate substitute remedy for the common-law cause of action for that injury.

332 Or 125> E. *Analysis of This Case*

In light of the foregoing principles for analyzing claims under Article I, section 10, we turn to the specific issue to be decided in this case. At the outset, we emphasize that the issue is a narrow one. Plaintiff does not challenge the constitutionality of the workers' compensation system as a whole. Neither does he contend that the "exclusive remedy" provisions of ORS 656.018 (1995) *per se* are unconstitutional. Thus, unlike the plaintiff in *Evanhoff v. State Industrial Acc. Com.*, 78 Or 503, 154 P 106 (1915), plaintiff here does not assert that substituting the workers' compensation remedial process for the common-law cause of action by an employee against an employer for negligence violates Article I, section 10.[20] Moreover, and as context for the discussion that follows, we note that, since *Evanhoff* in 1915, this court implicitly has recognized the legislature's constitutional authority to substitute workers' compensation for the common-law negligence cause of action for work-related injuries. *See, e.g., Atkinson v. Fairview Dairy Farms*, 190 Or 1, 13, 222 P2d 732 (1950) ("The Workmen's Compensation Act has been held on a number of occasions to be constitutional."). Nothing in this case challenges those precepts. The constitutionality of the overall workers' compensation statutory program is not in question.

The narrow issue in this case is whether the exclusive remedy provisions of ORS 656.018 (1995) are unconstitutional under the remedy clause to the extent that there now is a category of workers who have been injured at work but receive no compensation benefits, because they cannot prove that the work-related incident was the *major* contributing cause of their injury or disease. From the perspective of the workers' compensation system, such workers are deemed to have suffered no injury and therefore are not entitled to compensation benefits. At common law, by contrast, injury was understood to be any wrong or harm to person, rights, **<332 Or 125/126>** reputation, or property. *See Kinney v. SIAC*, 245 Or 543, 548-49, 423 P2d 186 (1967) (explaining common-law definition of injury as "any wrong or harm," and noting same definition of personal injury under then-existing workers' compensation law).

We turn to the facts of this case. Plaintiff contends that he was injured at work, that is, that he suffered a harm to his person in the form of severe and progressive respiratory problems, as well as

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[20] The court in *Evanhoff* rejected the plaintiff's Article I, section 10, challenge on the ground that the workers' compensation scheme was voluntary, not compulsory. 78 Or at 517-19. In 1965, the legislature made workers' compensation insurance compulsory. Or Laws 1965, ch 285, section 5. With certain exceptions, the legislature also made workers' compensation the exclusive remedy for work-related injuries. Or Laws 1965, ch 285, section 6(2).

other physical ailments, after he inhaled sulfuric, hydrochloric, and hydrofluoric acid mist and fumes while working in the pit in defendant's shop. Before his exposure, plaintiff had not experienced any of his symptoms. Because plaintiff was unable to prove that his work exposure was the major contributing cause of his disabling lung condition, however, he did not have a compensable injury under present workers' compensation law. Moreover, as we have explained, under ORS 656.018 (1995), workers' compensation purports to be the exclusive remedy for work-related injuries, whether or not a claim is a compensable claim. Thus, under present workers' compensation law, plaintiff was left with no means for seeking redress for the injuries that he alleges that he suffered at work and for which a common-law cause of action would have been available before the advent of the workers' compensation system.

After the ALJ had denied plaintiff's workers' compensation claim, plaintiff filed this negligence action. Defendant moved to dismiss for failure to state a claim. ORCP 21 A(8). Although defendant did not dispute that plaintiff might have suffered an injury at work, it argued that plaintiff had not suffered a compensable injury, as that term presently is defined in workers' compensation law, *see* ORS 656.802(2)(a) (to be compensable, claimant must prove work-related exposure was major contributing cause of occupational disease), and that ORS 656.018 (1995) makes workers' compensation the exclusive remedy for work-related injuries, whether or not a claim is compensable. In response to defendant's motion to dismiss, plaintiff argued, among other things, that the exclusive remedy provisions of ORS 656.018 (1995) violated the remedy clause of Article I, section 10. Plaintiff contended that the remedy clause guarantees the availability of a process for seeking redress for injuries that were recognized at **<332 Or 126/127>** common law and that ORS 656.018 (1995) impermissibly eliminated the existence of a remedy for the injuries that he believes he suffered at work. The trial court granted defendant's motion to dismiss for failure to state a claim.

In affirming the trial court, the Court of Appeals reasoned that, under *Sealey*, the legislature has plenary authority to define what constitutes a "legally cognizable" injury. *Smothers*, 149 Or App at 54. Earlier in this opinion, we have explained why we now disavow that holding in *Sealey*. Under the remedy clause, if a cause of action existed for an injury to an absolute right respecting person, property, or reputation when the drafters wrote the Oregon Constitution, then either that cause of action or a legislatively created substitute process that provides a constitutionally adequate remedy for that injury must be available to every person.

The Court of Appeals also relied on *Kilminster v. Day Management Corp.*, 323 Or 618, 919 P2d 474 (1996), in holding that plaintiff in this case had no "right" that would support the argument that he had been deprived of a remedy. *Smothers*, 149 Or App at 55. In *Kilminster*, a worker died when he fell from a radio tower that his employer had ordered him to climb without providing adequate fall-protection equipment. *Id.* at 621. The decedent's parents brought an action for wrongful death under ORS 30.020(1). That statute gives a plaintiff a right to bring a wrongful death action only "'if the decedent might have maintained an action, had the decedent lived.'" *Id.* at 626 (quoting statute). In other words, ORS 30.020(1) gives a plaintiff only a derivative right. *Id.* If the decedent in *Kilminster* had lived, then the "exclusive remedy" provisions of ORS 656.018 would have barred him from pursuing a common-law action against his employer. *Id.*

The plaintiffs in *Kilminster* argued that the "exclusive remedy" bar deprived them of their right to pursue a claim for the wrongful death of their son. *Id.* at 625. This court rejected that argument. It reasoned:

> "Because the legislature has chosen not to provide decedent's parents with a wrongful death action based on a theory of negligence, *and because Oregon has no common law* **<332 Or 127/128>** *action for wrongful death* [citations omitted], they have suffered no legally cognizable injury to their person, property, or reputation."

Id. at 627 (emphasis added).

Unlike the plaintiffs in *Kilminster*, plaintiff's right to remedy for injury in this case does not derive from a statute. Rather, plaintiff's right is grounded in the common law of negligence. Although Oregon has no common-law action for wrongful death, it does have a common-law action for negligence. The Court of Appeals erred in relying on *Kilminster* to affirm the trial court's dismissal of plaintiff's complaint in this case.

Having explained why the Court of Appeals' reliance on *Sealey* and *Kilminster* do not dispose of plaintiff's constitutional challenge in this case, we turn to an application of the methodology discussed earlier in this opinion for analyzing claims under the remedy clause. The first question is whether plaintiff has alleged an injury to one of the rights for which the remedy clause mandates that a remedy be available by due course of law. Plaintiff's complaint alleges that he suffered permanent injury to his lungs and that he suffers other physical ailments, because defendant negligently permitted mist and fumes from sulfuric, hydrochloric, and hydrofluoric acid to drift into the shop area and pit where plaintiff worked, was aware that exposure to them could cause harm to plaintiff, failed to provide plaintiff with proper safety instructions or protection from the chemicals, and failed to warn plaintiff that he would be exposed to the chemicals. To answer the first question, we must decide whether, when the drafters wrote the Oregon Constitution, the common-law of Oregon would have recognized an action for negligence under the circumstances of this case. We conclude that it would.

The territorial law of Oregon of June 27, 1844, provided, in part:

> "[T]he Common Law of England and principles of equity, not modified by the statutes of Iowa or of this government, not incompatible with its principles, shall constitute a part of the law of this land."

332 Or 129> Laws of Oregon 1843-49, Act of June 27, 1844, Art III, section 1, p 100 (1853). Article XVIII, section 7, of the Oregon Constitution, re-adopted territorial laws.[21] This court has held that, in their reference to the common law, the drafters of the Oregon Constitution "must have had reference to that law as it existed, modified and amended by the English statutes passed prior to the Revolution." *Peery v. Fletcher*, 93 Or 43, 53, 182 P 143 (1919).

It is undisputed that, at the time of the American Revolution, the common law recognized a cause of action for negligence. See J. H. Baker, *An Introduction to English Legal History*, 346-48 (2d ed 1979) (describing evolution of negligence tort). This court's case law is replete with cases involving that tort.

Our next, more specific, inquiry is whether at common law in Oregon in 1857, an employee would have had a cause of action against an employer for failure to provide a safe workplace and failure to warn of dangerous working conditions to which the employee would be exposed. That is, and unlike most other exercises in constitutional construction, the substantive content of the constitutional right can be established only by identifying the content of the common law in 1857. Although no Oregon cases addressed the common-law rights of employees to bring such negligence actions against their employers in the years immediately surrounding the creation of the Oregon Constitution, the content of the common law in 1857 may be divined from a wide range of sources. Cases from other jurisdictions, as well as Oregon cases decided within a relatively short period after 1857, are instructive.

In *Hough v. Texas and Pacific R.R. Co.*, 100 US 213, 25 L Ed 612 (1879), the United States Supreme Court addressed the duty that an employer owed to an employee and whether the negligence of a fellow servant relieved the employer of liability for injuries to the employee. The Court held that it was "firmly established" in American jurisprudence that employers, or masters, are obligated "not to **<332 Or 129/130>** expose the servant, when conducting the master's business, to perils or hazards against which he may be guarded by proper diligence on the part of the master." *Id.* at 217. The Court surveyed treatises, cases from state courts, and several English and Scottish cases from the mid-nineteenth century to demonstrate that the principle was well established. *Id.* at 219-24. Moreover, the Court noted, employees could not be presumed to assume the risk of dangers at work that they had no reason to believe they would encounter. *Id.* at 217.

In 1883, in a different negligence action brought by an employee against his employer, the Kansas Supreme Court explained:

> "In all cases, at common law, a master assumes the duty toward his servant of exercising reasonable care and diligence to provide the servant with a reasonably safe place at which to work, with reasonably safe machinery, tools and implements to work with, with reasonably safe materials to work upon, and with suitable and competent fellow-servants to work with him * * *."

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[21] Article XVIII, section 7, provides: "All laws in force in the Territory of Oregon when this Constitution takes effect, and consistent therewith, shall continue in force until altered, or repealed."

A.T. & S.F. Rld Co. v. Moore, 29 Kan 632, 644 (1883). Only when the master himself had performed the duty imposed by the common law to provide a worker with a reasonably safe place to work, the court reasoned, did the fellow-servant or assumption-of-the-risk rules shield the employer from liability for negligence. *Id.* at 644-45; *see also Wilson v. Willimantic Linen Co.*, 50 Conn 433, 440-41 (1883) (same).

This court's first opportunity to address the question of an employer's common-law liability to an employee for negligence was in 1888. In *Anderson v. Bennett*, 16 Or 515, 19 P 765 (1888), the plaintiff, a laborer who had been hired to help construct a tunnel for the Northern Pacific Railroad Company, was blinded when his supervisor negligently ordered him to drill a hole in some rock and the drilling caused an explosion. *Id.* at 516-17. The plaintiff's employer sought to avoid liability on the grounds that the plaintiff had assumed the risk and that a master was not liable for injuries caused by the negligence of a fellow servant. *Id.* at 520. This court rejected both arguments, drawing on common-law rules that had developed in other jurisdictions:

> **332 Or 131>** "It is the duty which the master owes to every servant to provide a reasonably safe place in which to work, and although he is not an insurer he is bound on the same principle by the law to exercise due and proper care in this regard, as he is in hiring competent servants, or in supplying reasonably safe machinery or other instrumentalities for the use of his servants.
>
> "This is regarded as a personal or absolute obligation. And if the discharge of this obligation is intrusted to a servant, such servant is the representative of the master, and any negligence on his part is the negligence of the master.
>
> "The servant has a right to rely on the master's performance of this duty, and his omission to take due care in this respect, whereby injury results to his servant, will be included among the risks he assumes, and for which he is liable; and while he is not an insurer of their safety, he is not at liberty to neglect all care; he must use due and reasonable care, according to the exigencies of the undertaking. The obligation not to expose the servant to perils which by proper diligence may be guarded against becomes more important, and the degree of diligence and care to be exercised in its performance the greater in proportion to the dangers which may be encountered."

Id. at 528. This court held that an employer, and the employer's representatives, have a duty "to use reasonable care and diligence and [to] make reasonable provision for the servant's safety," and that failure to do so subjected the employer to liability. *Id.* at 532.

Although *Anderson* was decided some 30 years after the drafters wrote the Oregon Constitution, nothing in the court's opinion in that case suggested that the holding was novel or that the decision marked a departure from any previous decisions or jurisprudence on the subject. We conclude that, in 1857, the common law of Oregon would have recognized that a worker had a cause of action for negligence against his employer for failing to provide a safe workplace and failing to warn of the dangerous conditions to which the worker would be exposed at work.

The next question is whether there is a remedial process available to plaintiff for seeking redress for the injuries that he alleges that he suffered to his lungs and other **<332 Or 131/132>** parts of his body when he was exposed to acid mist and fumes at work. As we have explained, when the drafters wrote the Oregon Constitution, plaintiff would have had a negligence cause of action against his employer for his alleged injuries. However, in 1913, the Oregon Legislature adopted the "Workmen's Compensation Act," which subsequently was referred to the people by petition under Article IV, section 1, of the Oregon Constitution. *See Salem Hospital v. Olcott*, 67 Or 448, 449-50, 136 P 341 (1913) (explaining adoption of Workmen's Compensation Act). Section 12 of the act provided, in part:

> "Every workman subject to this Act * * * who, * * * while so employed sustains personal injury by accident arising out of and in the course of his employment and resulting in his disability * * * shall be entitled to receive from the Industrial Accident Fund hereby created the sum or sums hereinafter specified and the right to receive such sum or sums shall be in lieu of all claims against his employer on account of such injury or death except as hereinafter specifically provided * * *."

Or Laws 1913, ch 112, setion 12. Many years later, this court explained that the workers' compensation system had been adopted "to require industry to carry the burden of personal injuries sustained by its employees in their work," *Newell v. Taylor*, 212 Or 522, 527, 321 P2d 294 (1958), and that it was so well established that no citation was required for the proposition "that the act is remedial in character and should be liberally construed to promote the beneficial results intended." *Id.* at 527-28.

Earlier, this court had observed that the twofold purposes of workers' compensation statutes were to afford protection to workers in the form of compensation for work-related injuries and to protect employers from expensive litigation. *See Bigby v. Pelican Bay Lbr. Co.*, 173 Or 682, 692, 147 P2d 199 (1944) (so stating). The Workmen's Compensation Act achieved those purposes by providing compensation to injured workers in lieu of the common-law remedy, and by making workers' compensation the exclusive remedy for work-related injuries, unless provided otherwise by statute. *Atkinson*, 190 Or at 13. In keeping with the purposes of the act, this court long has held that an award of compensation is **<332 Or 132/133>** the full and complete measure of a worker's recovery for work-related injuries, including all consequences of the injury, such as aggravation. *See Kowcun v. Bybee*, 182 Or 271, 295, 186 P2d 790 (1947) (so stating).

When the workers' compensation program was adopted, and for almost 70 years thereafter, the statutory scheme provided that a work-related injury was a "compensable injury" if the worker could show, as a plaintiff had been required to show at common law, that the work-related incident was a contributing cause of the injury. *See Kehoe v. Ind. Accident Com.*, 214 Or 629, 637, 332 P2d 91 (1958) ("[T]he law does not weigh the relative importance of the several causes that bring about the injury -- it is sufficient if the accident occurring through employment is a contributing cause of the result."). Moreover, this court held that the word "injury" in the workers' compensation statutes was to be given "broad and liberal construction in view of the remedial and humanitarian purposes of the [Workers'] Compensation Law." *Kinney*, 245 Or at 549.

Under current workers' compensation law, an occupational disease generally is considered to be an injury. ORS 656.804. However, as we have explained, workers' compensation law now provides that occupational diseases and some injuries are "compensable" injuries only if the worker can prove that the work-related incident was the major contributing cause of the disease or injury. *See* ORS 656.802(2)(a); ORS 656.005(7)(a) (identifying circumstances in which "major contributing cause" standard applies).[22] The major contributing cause standard means a cause, or combination of causes, that contributes more to the injury for which the worker seeks compensation than all other causes combined, or most of the cause. *See McGarrah v. SAIF*, 296 Or 145, 166, **<332 Or 133/134>** 675 P2d 159 (1983) (if at-work conditions, compared to nonemployment exposure, are major contributing cause of disease or disorder, then claimant eligible for compensation). The major contributing cause standard did not exist at common law. Thus, for those workers' compensation claims that are subject to the major contributing cause standard, workers' compensation law does not provide compensation for a work-related incident that was only a contributing cause of the workers's injury. Therefore, workers' compensation law no longer provides a remedy for some wrongs or harms occurring in the workplace for which a common-law negligence cause of action had existed when the drafters wrote the Oregon Constitution in 1857. Nevertheless, under ORS 656.018 (1995), workers' compensation law purports to be the exclusive remedy for work-related injuries, whether or not a claim is compensable.

In *Errand*, this court examined the legislature's intent when it enacted the "exclusive remedy" provisions of ORS 656.018 (1993). The court concluded that the legislature had not intended to prevent a worker whose workers' compensation claim had been denied for failure to meet the major contributing cause standard from pursuing civil negligence claims against the employer in the effort to receive at least

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[22] This court first used the "major contributing cause" standard for establishing the compensability of occupational disease claims in *Dethlefs v. Hyster Co.*, 295 Or 298, 310, 667 P2d 487 (1983). The Court of Appeals previously had done so in *SAIF v. Gygi*, 55 Or App 570, 574, 639 P2d 665 (1982). Thereafter, the legislature codified the "major contributing cause" standard in ORS 656.802(2)(a) and ORS 656.005(7)(a). Or Laws 1990, ch 2, sections 3, 43 (Spec Sess). Thus, to the extent that the exclusive remedy provisions of ORS 656.018 (1995) are infirm constitutionally in situations in which the worker must meet the "major contributing cause" standard of proof for a claim to be compensable, we acknowledge the appellate courts' inadvertent contribution to the problem that we now are addressing in this case.

some damages for work-related injuries. *Errand*, 320 Or at 525. Because this court decided *Errand* based on its analysis of the legislature's intent when it enacted ORS 656.018 (1993), the court did not reach the argument that the exclusive remedy provisions of the statute violated the remedy clause. *See id.* at 525 n 6 (so stating).

As we have explained, in response to *Errand*, the 1995 Legislature amended ORS 656.018 to make workers' compensation the "exclusive remedy" for work-related injuries, whether or not a claim is compensable. That is, the legislature made clear that, in enacting the 1995 amendments, it *did* intend what this court had assumed it had *not* intended in *Errand*. The question of the constitutionality of the exclusive remedy provisions in ORS 656.018 that the court was not required to address in *Errand* therefore is presented squarely in this case.

332 Or 135> Based on our analysis of the remedy clause of Article I, section 10, we conclude that determining whether the exclusive remedy provisions of ORS 656.018 (1995) violate that clause involves a case-by-case analysis. The first inquiry is whether a workers' compensation claim alleges an injury to an "absolute" common-law right that the remedy clause protects. If it does, and the claim is accepted and the worker receives the benefits provided by the workers' compensation statutes, then the worker cannot complain that he or she has been deprived of a remedial process for seeking redress for injury to a right that the remedy clause protects. Neither can the worker complain that he or she has been deprived of a remedial process if a compensation claim is denied because the worker is unable to prove that the work-related incident was a contributing cause of the alleged injury, which is what a plaintiff would have had to prove in a common-law cause of action for negligence. However, if a workers' compensation claim for an alleged injury to a right that is protected by the remedy clause is denied because the worker has failed to prove that the work-related incident was the major, rather than merely a contributing, cause of the injury, then the exclusive remedy provisions of ORS 656.018 (1995) are unconstitutional under the remedy clause, because they leave the worker with no process through which to seek redress for an injury for which a cause of action existed at common law.

In this case, as noted, plaintiff alleges that he suffered injuries to his lungs and other ailments when he was exposed to sulfuric, hydrochloric, and hydrofluoric acid mist and fumes at work. As we have explained, for those injuries, he would have had a common-law cause of action when the drafters wrote the Oregon Constitution in 1857. However, plaintiff followed the procedures prescribed by Oregon statutes and first filed a workers' compensation claim. The ALJ held that plaintiff had not suffered a compensable injury because, although the work exposure might have contributed to his injuries, plaintiff could not prove that the work exposure was the major contributing cause of his injuries.

As we have explained, plaintiff believed that he had suffered *an* injury at work, albeit not a *compensable* injury as defined under present workers' compensation law. Therefore, **<332 Or 135/136>** after his workers' compensation claim was denied, plaintiff filed this action to seek redress for his injuries. For the reasons that we have explained, the remedy clause mandates that a remedy be available to all persons -- including workers -- for injuries to "absolute" common-law rights for which a cause of action existed when the drafters wrote the Oregon Constitution in 1857. Having alleged an injury of the kind that the remedy clause protects, and having demonstrated that there was no remedial process available under present workers' compensation laws, plaintiff should have been allowed to proceed with his negligence action. The Court of Appeals erred in affirming the trial court's dismissal of plaintiff's complaint on the ground that the exclusive remedy provisions of ORS 656.018 (1995) barred his claim.

The decision of the Court of Appeals is reversed. The judgment of the circuit court is reversed, and the case is remanded to that court for further proceedings.

Cite as 173 Or App 717 (2001) March 21, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

E. MAX WOODBURY II, Respondent,

v.

CH2M HILL, INC., a Florida corporation, Appellant.

(9706-04494; CA A103037)

Appeal from Circuit Court, Multnomah County.

Michael H. Marcus, Judge.

Argued and submitted August 7, 2000.

M. Elizabeth Duncan argued the cause for appellant. With her on the briefs were Greene & Markley, P.C.

James S. Coon argued the cause for respondent. With him on the brief were Raymond F. Thomas, Douglas A. Swanson, and Swanson, Thomas & Coon.

Robert E. Babcock filed a brief amicus curiae for Continental Casualty Company, Inc.

Before Landau, Presiding Judge, and Linder and Brewer, Judges.

LANDAU, P. J.

Reversed and remanded for entry of judgment in favor of defendant.

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173 Or App 173> Plaintiff was injured while working for a subcontractor on a construction site. He initiated this action against defendant, the general contractor CH2M Hill, Inc., for violation of the Employer Liability Act (ELA), ORS 654.305 *et seq.*, and for negligence. The jury returned a verdict for plaintiff on both claims, and defendant appeals. Among other things, defendant assigns error to the trial court's denial of motions for directed verdict on the ELA and negligence claims. According to defendant, the evidence is legally insufficient to support a claim against the general contractor. We agree and reverse and remand for entry of judgment in favor of defendant.

We state the facts in the light most favorable to plaintiff, who prevailed at trial. *Cole v. Ford Motor Co.*, 136 Or App 45, 49, 900 P2d 1059 (1995). Reynolds Metal Company (Reynolds) hired defendant to conduct an environmental remediation investigation at a Reynolds plant in Troutdale, Oregon. Defendant, in turn, hired several subcontractors to perform certain work at the site. Stratus Corporation (Stratus) was one of those subcontractors.

Stratus was owned and operated by Scott Flaherty. It had no full-time employees and fulfilled its own employment needs by hiring temporary employees. One such "temporary" employee was plaintiff, who had worked exclusively for Stratus for over a year when he was hired to work on the Reynolds job.

Defendant and Stratus executed a contract, which included the following terms:

"ARTICLE 2. OBLIGATIONS OF SUBCONTRACTOR

"A. Independent Contractor

"SUBCONTRACTOR will perform all Work under this AGREEMENT as an independent Contractor and will not be considered as an agent of CH2M HILL or CLIENT, nor will SUBCONTRACTOR's lower-tier subcontractors or employees be agents of CH2M HILL or CLIENT.

173 Or App 174> "* * * * *

"J. Safety

"SUBCONTRACTOR will be solely and completely responsible for conditions of the jobsite, including safety of all persons (including employees) and property during performance of the Work. This requirement will apply continuously and not be limited to normal working hours. Safety provisions will conform to * * * applicable federal, state, county and local laws, ordinances, codes, and any regulations that may be detailed in other parts of this SUBCONTRACT, including applicable site-specific health and safety plans. Where any of these are in conflict, the more stringent requirement will be followed. * * *

"* * * * *

"ARTICLE 3. OBLIGATIONS OF CH2M HILL

"* * * * *

"C. Duties and Responsibilities of CH2M HILL

"CH2M HILL reserves the right, but not the obligation, to inspect or otherwise evaluate the Work during the various stages to observe the progress and quality of the Work and to determine, in general, if the Work is proceeding in accordance with the intent of this AGREEMENT. CH2M HILL will not be required to make comprehensive or continuous inspections to check quality or quantity of the Work. Visits and observations made by CH2M HILL will not relieve SUBCONTRACTOR of its obligation to conduct comprehensive inspections of the Work, to furnish materials, to perform acceptable Work, and to provide adequate safety precautions in conformance with this AGREEMENT.

"D. Limitations of CH2M HILL'S Responsibilities

"CH2M HILL will not be responsible for SUBCONTRACTOR's means, methods, techniques, sequences or procedures of the Work, or the safety precautions including compliance with the programs incident thereto. CH2M HILL will not be responsible for SUBCONTRACTOR's failure to perform the Work in accordance with this AGREEMENT.

"CH2M HILL will not be responsible for the acts or omissions of SUBCONTRACTOR, or any lower-tier subcontractors, or any of its or their agents or employees or any **<173 Or App 174/175>** other persons at the site or otherwise performing any of the Work." (Uppercase and boldface in original.)

Defendant hired Stratus, among other things, to construct a "vehicle decontamination pad" at the Reynolds site. This required Stratus to install a means of processing liquid waste from the decontamination pad. Defendant told Stratus to install a water pipe from the pad to a clarifier tank to accomplish the task. Defendant further told Stratus where to locate the pipe and what kind of materials to use. All of the Stratus work was performed by Flaherty and plaintiff.

Most of the pipe was installed underground. In order to reach the clarifier tank, however, the last few feet of pipe had to be installed over a sunken stairway and corridor that ran approximately ten feet below ground level. Flaherty discussed with Griffin, one of defendant's employees, how to suspend the pipe over the stairway and corridor. They decided to construct a platform made of four-by-four and two-by-four boards and plywood. Later, Griffin recalled that the idea to construct the platform was Flaherty's. Flaherty could not remember how the decision was arrived at. Both agreed, however, that, once they decided to build the platform, the details of how to construct it were left to Flaherty. Plaintiff and Flaherty then built the platform without input from or oversight by any of defendant's employees.

When the remediation work was complete, Stratus was required to dismantle the platform supporting the pipe to the clarifier tank. Because Flaherty was occupied with other work, plaintiff attempted to dismantle the platform by himself. No employee of defendant's assisted. Nor did any employee of defendant's provide instructions, offer advice, or provide oversight. While dismantling the platform, plaintiff wore no fall-protection harness. In the course of attempting to move one of the boards from the platform, he lost his balance and was seriously injured when he fell onto the subsurface corridor.

Plaintiff brought two claims against defendant. First, he asserted that defendant violated the ELA. According to plaintiff, defendant at least indirectly employed him **<173 Or App 175/176>** and, as his employer, failed to comply with various safety regulations applicable to employers at construction sites. In particular, plaintiff complained that defendant had failed to require the installation of guardrails on the platform and to provide plaintiff with training concerning the hazards of working in areas where there may be fall hazards. Second, plaintiff asserted that defendant was negligent in failing "to provide proper training and supervision for the disassembly of the platform."

At trial, defendant moved for a directed verdict on both claims. The trial court denied the motion and sent the case to the jury, which returned a verdict for plaintiff, awarding substantial economic and noneconomic damages.

On appeal, defendant first assigns error to the denial of the motion for a directed verdict as to the ELA claim. Defendant argued that it was not liable as a matter of law, because it was not plaintiff's employer, either direct or indirect. Plaintiff concedes that defendant was not his direct employer, but insists that it was his indirect employer because it either retained the right to control or actually did control his work. Defendant replies that, under the express terms of the contract with Stratus, defendant did not have the right to control plaintiff's work and that, in fact, it exercised no control over the disassembly of the platform. We agree with defendant.

In reviewing a denial of a directed verdict motion, we examine the record in the light most favorable to the plaintiff to determine if there is any evidence to support the verdict. *Cole,* 136 Or App at 49.

The ELA imposes a heightened standard of care on employers and others who are in charge of work involving "risk or danger." *Miller v. Georgia Pacific,* 294 Or 750, 753, 662 P2d 718 (1983). ORS 654.305 provides:

> "Generally, all owners, contractors or subcontractors and other persons having charge of, or responsibility for, any work involving a risk or danger to the employees or the public shall use every device, care and precaution that is practicable to use for the protection and safety of life and limb, limited only by the necessity for preserving the efficiency of the structure, machine or other apparatus or **<173 Or App 176/177>** device, and without regard to the additional cost of suitable material or safety appliance and devices."

Because of its broad language, the ELA has been read to apply not only to direct employers but also to "indirect" employers. *Wilson v. P.G.E. Company,* 252 Or 385, 390-92, 448 P2d 562 (1968); *Brown v. Boise-Cascade Corp.,* 150 Or App 391, 396, 946 P2d 324 (1997), *rev den* 327 Or 317 (1998). "Indirect" employer liability is triggered if any of three conditions is satisfied: (1) plaintiff's direct employer and defendant are engaged in a "common enterprise"; (2) defendant retained the right to control the manner or method in which the risk-producing activity was performed; or (3) defendant actually controlled the manner or method in which the risk-producing activity was performed. *Brown,* 150 Or App at 396.

In this case, plaintiff concedes that defendant and Stratus were not engaged in a common enterprise. He argues that defendant nevertheless is an indirect employer because it either retained the right to control or actually controlled the manner or method in which the risk-producing activity was performed.

We begin with the question whether plaintiff offered any evidence that established the requisites for liability under the retained-control test. Under that test, there may be liability under the ELA if the defendant "retain[ed] a right to control * * * the manner or method in which the risk-producing activity [was] performed." *Miller,* 294 Or at 754. The fact that defendant retained some control over some aspects of plaintiff's work will not suffice; the retained right of control must concern the "manner or method in which the risk-producing activity [was] performed." *Id.*

Two recent decisions from this court illustrate the point. In *Brown,* the plaintiff was injured when he fell from a Boise Cascade Corporation paper mill that he was painting. He asserted an ELA claim against Boise Cascade, based on the company's failure to provide guardrails or other fall-protection devices. According to the plaintiff, Boise Cascade was an indirect employer under, among other criteria, the retained-control test, because his work order specified that his work was to be completed in accordance with the directions of a Boise Cascade representative. We held that the **<173 Or App 177/178>** work order was insufficient to create liability under the ELA, because it was issued pursuant to a contractor services agreement that expressly provided that the plaintiff was hired as an independent contractor and that the company had no power to control the manner of his work except as necessary to permit it to inspect the work to ensure compliance with specifications. *Brown,* 150 Or App at 398. Moreover, we held, the work order itself merely "pertained solely to the scope" of the plaintiff's work, not the "manner or method" of his performance. *Id.* (emphasis omitted). That is to say, Boise Cascade retained the right to tell the plaintiff *where* to paint, but not *how* to paint. *Id.*

Similarly--and even more directly to the point--in *George v. Meyers*, 169 Or App 472, 10 P3d 265 (2000), the defendant general contractor hired a subcontractor to frame a house. The plaintiff was one of the subcontractor's employees. The plaintiff completed the framing of three walls on the third floor of the house, but was unable to complete the fourth wall until a large bundle of two-by-four boards could be moved. As he attempted to move the boards, the plaintiff slipped and fell backwards off the third floor. The plaintiff brought an action against the general contractor under the ELA. The trial court dismissed the claim, and we affirmed. On appeal, the plaintiff argued that the trial court erred, because the general contractor had retained control over his work. We disagreed, holding that

> "there is no evidence that defendant retained control over the method and manner of [the subcontractor's] performance and, particularly, the 'risk-producing activity' of moving the bundle of lumber. Rather, all evidence is to the contrary--*i.e.*, defendant's retained control pertained solely to the *scope* of the work, *viz.*, whether defendant's performance comported with the architectural design."

Id. at 477 (citation omitted).

In this case, the "risk-producing activity" was the disassembly of the platform. There is no evidence that defendant retained control over that activity. Indeed, all the evidence is to the contrary. As in *Brown*, the agreement between defendant and Stratus clearly identifies Stratus as an independent contractor and further provides that Stratus "will be **<173 Or App 178/179>** solely and completely responsible for conditions of the jobsite, *including safety of all persons (including employees)* and property during performance of the Work." (Emphasis added.) Defendant expressly disclaimed any responsibility for Stratus's "means, methods, techniques, sequences or procedures of the Work, *or the safety precautions* including compliance with the programs incident thereto." (Emphasis added.)

Moreover, as in both *Brown* and *George*, the authority that defendant did retain in this case concerned the *scope* of Stratus's work only:

> "CH2M HILL reserves the right, but not the obligation, to inspect or otherwise evaluate the Work during the various stages to observe the progress and quality of the Work and to determine, in general, if the Work is proceeding in accordance with the intent of this AGREEMENT. * * * Visits and observations made by CH2M HILL will not relieve SUBCONTRACTOR of its obligation to conduct comprehensive inspections of the Work, to furnish materials, to perform acceptable Work, and to provide adequate safety precautions * * * ."

In other words, defendant may have retained the authority to tell Stratus to disassemble the platform and may even have retained the authority to inspect the work, but it did not retain the authority to tell Stratus how to do the work.

Plaintiff insists that, for three reasons, the evidence is sufficient to raise at least a jury question as to the scope of the authority that defendant retained. We find none of those arguments persuasive.

Plaintiff first insists that the "risk-producing activity" must be more broadly interpreted to include all of Stratus's work for defendant, or at least the "work over the stairwell," and not just the specific activity that caused plaintiff's injuries.[1] In support of that contention, plaintiff quotes selected portions of the Supreme Court's decisions in *Thomas* **<173 Or App 179/180>** *v. Foglio*, 225 Or 540, 358 P2d 1066 (1961), and *Sacher v. Bohemia*, 302 Or 477, 731 P2d 434 (1987), in which the court imposed liability on indirect employers who were more generally involved with the plaintiffs' work.

Neither case, however, involved the retained-control test; rather, both were resolved under the "common enterprise" test. Moreover, although *Thomas* and *Sacher* at some points generally referred to common enterprise liability in broader terms, in both cases, those broader formulations are followed by narrowing qualifications that plaintiff ignores.

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[1] Actually, it is difficult to pin down precisely what plaintiff believes to be the proper scope of the risk-producing activity. At various points in his briefing, he suggests that the proper focus is the decision to "run the two-inch pipe above the stairwell," or more generally "working over the stairwell," or even more generally "working at height."

In *Thomas*, for example, the court began by commenting that the ELA had been construed liberally to cover situations in which the defendant cooperated in accomplishing work in which both the defendant and the plaintiff's employer were interested. 225 Or at 546-47. But then, the court stated that

> "this participation must be more than a common interest in an economic benefit which might accrue from the accomplishment of the task; the defendant or his employee and plaintiff's employer *must actively join in a physical way in carrying on the particular work which produces the injury*." *Id.* at 547 (emphasis added; citations omitted).

Sacher likewise began with a summary of prior holdings liberally construing the provisions of the ELA. 302 Or at 485-86. It then spelled out the elements of common enterprise liability in the following specific terms:

> "Thus, the 'common enterprise' test requires, first, that two employers (the plaintiff's actual employer and a third-party defendant employer) participate in a project of which the defendant employer's operations are an 'integral' or 'component' part, *Thomas;* second, the work must involve a risk or danger to the 'employe[e]s or the public,' ORS 654.305; third, the plaintiff must be an 'employee' of the defendant employer * * *; and fourth, *the defendant employer must have charge of or responsibility for the activity or instrumentality that causes the plaintiff's injury*[.]" *Id.* at 486-87 (emphasis supplied; footnote omitted).

173 Or App 181> Our recent cases follow suit. *Brown*, for example, examined the prior case law--including *Sacher*--and concluded that common enterprise liability may be imposed only if there is evidence that the defendant exercised control "over the activity or instrumentality that causes the injury." 150 Or App at 396 (quoting *Sacher*, 302 Or at 485).

Finally--and most important--plaintiff's broad reading of the "risk-producing activity" cannot be reconciled with our decision in *George*, which *is* a retained-control case. In *George*, we held that what precipitated the accident was the plaintiff's attempt to move boards to another location to permit him to complete the framing of the third story of the house where he had been working. Thus, the risk-producing activity was the discrete activity of moving the boards, not more generally of framing the house. 169 Or App at 477. So also in this case, what precipitated plaintiff's accident was his attempt to move boards to facilitate the disassembly of the platform. It was not more generally the construction of the platform or the "work over the stairwell."

Plaintiff next insists that the conduct of the parties is sufficient to support a finding that defendant had a right to control the risk-producing activity. Specifically, plaintiff points to evidence that defendant exercised daily control over other aspects of Stratus's work, such as where to dig a hole for a vault associated with the decontamination pad, where to run the pipeline from the pad to the tank, what material to use to backfill the ditch where the pipe was located, at what angle the pipe should be installed, and what sealant should be used to connect it with the tank.

To begin with, resort to evidence of the conduct of the parties when there is an unambiguous contract detailing the rights and responsibilities is inappropriate. As the court explained in *Wilson*,

> "[w]here the provisions of the contract are undisputed and the question is whether the right to control retained thereunder by the [defendant] over the work is sufficient to bring him within the purview of the ELA, the question is one of law for the court."

173 Or App 182> 252 Or at 395. In this case, the contract between defendant and Stratus plainly--and repeatedly--places responsibility for the details of the work and, in particular, for compliance with safety regulations on Stratus. Plaintiff insists that the agreement could be read as preserving defendant's authority to control those matters. Yet plaintiff fails to identify any particular provision that is reasonably susceptible to that construction. Aside from that, in relying on such extrinsic evidence, plaintiff assumes that the scope of the "risk-producing activity" is properly defined to include all of Stratus's work, not just the disassembly of the platform. That assumption, as we have stated, is incorrect as a matter of law. We conclude that there is no evidence of liability under the retained-control test.

Whether or not defendant retained control, defendant nevertheless may be liable under the ELA if there is evidence that it actually exercised control over the manner and method in which the risk-producing activity was performed. *Wilson*, 252 Or at 397; *Brown*, 150 Or App at 398-99. As we have noted, the "risk-producing activity" in this case was the disassembly of the platform. As to that activity,

there is a complete absence of evidence of control on the part of defendant. Plaintiff does not argue to the contrary. His sole argument is that the "risk-producing activity" should be more broadly construed. Again, as we have held, that is incorrect as a matter of law.

There being no basis for concluding that defendant was an indirect employer under the ELA, we conclude that the trial court erred in denying defendant's motion for a directed verdict on plaintiff's ELA claim.

Defendant next assigns error to the trial court's denial of a directed verdict motion on plaintiff's negligence claim. The complaint includes several specifications of negligence, the gravamen of which is that "defendant failed to provide proper training and supervision for the disassembly of the platform." Defendant contends that, because the undisputed evidence shows that it had nothing to do with the disassembly of the platform, it cannot be held liable in negligence as a matter of law. Plaintiff's response is:

> **173 Or App 183>** "The connection between training and supervision and the work methods of those who are to be trained and supervised is plain: One provides training and supervision in order to cause workers to perform their work safely. The evidence was uncontradicted that defendant failed to provide plaintiff, or its own supervisory workers, with any fall protection training or supervision."

Once again, we review the evidence in the record in the light most favorable to plaintiff to determine whether there is any evidence to support the verdict. *Cole*, 136 Or App at 49. In evaluating that evidence we are informed by our decision in *Fortney v. Crawford Door Sales Corp.*, 97 Or App 276, 775 P2d 910 (1989). In that case, the defendant hired a general contractor to supply overhead rolling steel doors at a warehouse site. The plaintiff was an employee of the contractor. When the plaintiff encountered difficulties in installing a door, the contractor called the defendant for assistance. The defendant sent Svir, one of its employees, to assist. While Svir watched from some 15 feet away, the plaintiff scaled a ladder to attempt to work on the door. The plaintiff fell from the ladder and suffered injury. He sued the defendant for negligence and for violations of the ELA. The trial court entered a directed verdict on both claims, and we affirmed. Concerning the negligence claim, we explained:

> "[D]efendant and Svir had no responsibility for the safety of the equipment or for plaintiff's job safety. * * *
>
> "Plaintiff relies on *Fazzolari v. Portland School Dist. No. 1J*, 303 Or 1, 734 P2d 1326 (1987), and argues that he was not required to establish a duty on defendant's part in order to reach the jury. Defendant argues that plaintiff's theory necessarily presupposes the 'special relationship' of employer and employe[e], 'where "duty" is still a factor not altered by the holding in *Fazzolari*.' *See Budd v. American Savings & Loan*, 89 Or App 609, 750 P2d 513 (1988). Defendant also contends that plaintiff 'would impose liability for a falling ladder where the defendant did not own it, did not use it and did not touch it.' We agree with defendant's implicit suggestion that, although *Fazzolari* has changed the role of duty in negligence law, it has not eliminated the rule that a defendant must have some responsible involvement with an event in order to be found negligent for its occurrence. *See Fuhrer v. Gearhart By The Sea, Inc.*, 306 Or **<173 Or App 183/184>** 434, 760 P2d 874 (1988). No involvement was established here." *Id.* at 280 (emphasis in original).

In this case, as in *Fortney*, defendant had no responsibility for the safety of plaintiff's equipment or for plaintiff's safety. Nor did defendant have any involvement in the disassembly of the platform. Plaintiff's argument that the evidence is uncontradicted that defendant failed to provide any training concerning the proper disassembly of the platform is beside the point; indeed, it simply assumes the very matter in issue, that is, that defendant had the responsibility for doing so in the first place. As we have noted, the evidence is uncontradicted that defendant did not. It necessarily follows that plaintiff's negligence claim must fail and that the trial court erred in denying the motion for a directed verdict on that claim.

Defendant advances a number of other assignments of error, but, because of our disposition of the first two, we need not address them.

Reversed and remanded for entry of judgment in favor of defendant.

Cite as 173 Or App 254 (2001) March 28, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Helen F. Iles, Claimant.

HELEN F. ILES, Petitioner,
v.
FRED MEYER, INC., Respondent.
(WCB 98-09479; CA A108026)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 22, 2000.
Dennis O'Malley argued the cause and filed the brief for petitioner.
Tracy J. White argued the cause for respondent. With her on the brief were Deborah L. Sather and Sather, Byerly & Holloway.
Before Haselton, Presiding Judge, and Deits,* Chief Judge, and Wollheim, Judge.
WOLLHEIM, J.
Reversed and remanded for reconsideration.

*Deits, C. J., *vice* De Muniz, J., resigned.

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173 Or App 256> In this workers' compensation case, claimant seeks review of a Workers' Compensation Board's (Board) order that affirmed a denial of her workers' compensation claim. Claimant argues that the Board's order is insufficient as a matter of law because (1) it concluded that claimant's wrist injury was noncompensable due to a lack of objective findings without acknowledging evidence of edema contained in the medical record, and (2) it rejected without discussion other objective findings supported by the medical evidence. We reverse and remand for reconsideration.

The material facts are not disputed. Since 1971, claimant has worked for Fred Meyer, Inc. (employer). On July 1, 1998, while working in the shoe department, claimant was assisting a customer when she entered employer's stockroom to retrieve the customer's shoe selections. The shoes in the stockroom were kept on large metal racks approximately eight feet tall. Some of those racks were attached to the walls, while others were on rails and were moveable. The moveable racks would "jam" on occasion and additional force was necessary to move them. Claimant grabbed one of the moveable racks with her right hand. The rack jammed and claimant exerted additional force. As claimant did that, she heard a pop in her right wrist and felt a shooting pain up her right arm. Claimant took an over-the-counter pain reliever and completed her shift. The following day she again completed her normal work shift but experienced pain and swelling in her right wrist.

On July 8, 1998, claimant filed a workers' compensation claim, alleging that she sustained a work-related injury to her wrist on July 1, 1998. On July 13, 1998, claimant saw Dr. Pribnow for her wrist pain. Pribnow diagnosed right wrist pain with nonanatomic findings and released claimant to modified work with no repetitive use of the right wrist. Soon thereafter, claimant started physical therapy sessions. Later that month, claimant again saw Pribnow and he diagnosed a right wrist sprain/strain by history. On August 28, 1998, claimant saw Dr. Corrigan, on referral by Pribnow, who similarly diagnosed a right wrist strain by history.

173 Or App 257> Employer denied the claim due to a lack of objective findings. The administrative law judge (ALJ) agreed with employer and concluded that "the record does not contain sufficient evidence of 'objective findings' related to the July 1, 1998 work incident." The ALJ affirmed employer's denial.

Claimant appealed to the Board. On appeal, claimant asserted, among other things, that her claim was supported by "objective findings" and specifically referred to evidence of mild edema contained in a chart note that the ALJ ignored. The Board affirmed and adopted the ALJ's decision, stating "we agree with the ALJ's reasoning that the injury claim was not supported by 'objective findings.'"

Claimant then sought judicial review, assigning as error the Board's failure to consider evidence in the record regarding the existence of objective findings. Specifically, claimant argues that the Board erred because it failed to acknowledge Pribnow's chart note that claimant had mild edema[1] following the work incident. That chart note, claimant contends, establishes "objective findings" to support compensability. Because the Board failed to address the chart note, claimant argues that we should remand the case to the Board. Claimant also argues that the Board failed to explain adequately its rejection of Pribnow's observation and measurement of claimant's reduced grip strength as an objective finding. We agree with both of claimant's contentions.

"A 'compensable injury' is an accidental injury * * * arising out of and in the course of employment requiring medical services or resulting in disability or death[.]" ORS 656.005(7)(a). For an accidental injury to be compensable, it must be "established by medical evidence supported by objective findings[.]" *Id.* "Objective findings" are defined by ORS 656.005(19) as

> "'[o]bjective 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 **<173 Or App 257/258>** findings' does not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable."

See also SAIF v. Lewis, 170 Or App 201, 12 P3d 498 (2000).

Claimant argued to the Board that the medical evidence of edema was an objective finding. Rather than address that issue, the Board simply adopted the ALJ's opinion and order without addressing the evidence of edema contained in the chart note. Similarly, the Board failed to explain why Pribnow's observation and measurement of claimant's reduced grip strength was not an objective finding. The Board did not explain why the ALJ's opinion was sufficient with regard to those issues.

Our role is to review the Board's order for substantial evidence. ORS 183.482(8). Here, the Board did not "provide a 'sufficient explanation to allow a reviewing court to examine the agency's action.'" *SAIF v. January*, 166 Or App 620, 626, 998 P2d 1286 (2000), *quoting Schoch v. Leupold & Stevens*, 325 Or 112, 118, 934 P2d 410 (1997). We reverse and remand to the Board to consider whether the chart note containing evidence of edema and reduced grip strength constitute objective findings. If so, the Board needs to consider the compensability of this claim.

Reversed and remanded for reconsideration.

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[1] Edema is defined as, "[a]n accumulation of an excessive amount of watery fluid in cells, tissues, or serous cavities." *Stedman's Medical Dictionary*, 544 (26th ed 1995).

Cite as 173 Or App 282 (2001) March 28, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Kathleen A. Climer, Claimant.

WAL-MART STORES, INC., Petitioner,
v.
KATHLEEN CLIMER and KINNEY SHOE COMPANY, Respondents.
(98-00453, 98-09140; CA A108391)

Judicial Review from the Workers' Compensation Board.
On respondents' petition for attorney fees filed November 20, 2000.
Daniel J. Sato for the petition.
Delbert J. Brenneman and Hoffman, Hart & Wagner *contra.*
Before Brewer, Presiding Judge, and Armstrong and Kistler, Judges.
BREWER, P. J.
Petition for attorney fees allowed in amount of $6,747.

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173 Or App 284> Claimant, the prevailing party in *Climer v. Wal-Mart Stores, Inc.*, 171 Or App 77, 14 P3d 648 (2000), petitions for an award of attorney fees. The issue for decision is whether claimant is entitled to an award of attorney fees on review in this court under ORS 656.382(2).[1] For the reasons explained below, we overrule employer Wal-Mart Stores, Inc.'s objections to the petition and award claimant attorney fees in the sum of $6,747.

In 1992, claimant suffered right hip and low back strains when she fell off a ladder while working for Kinney Shoe Corporation (Kinney). Kinney's workers' compensation insurer accepted claimant's claim for that injury. Claimant later was employed by Wal-Mart, where her work involved fast-paced walking, running, and extensive hours on her feet. During her employment with Wal-Mart, claimant's pain increased and she was diagnosed with degenerative disk disease at L4-5 and L5-S1, which required surgery. Both Kinney and Wal-Mart denied responsibility for claimant's current claim for medical services, and neither employer accepted the claim as compensable.

An ALJ determined that the onset of claimant's current condition occurred while she was working for Wal-Mart and that Kinney was not responsible. The ALJ ordered Wal-Mart to pay the claim and awarded claimant $4,000 in attorney fees. Wal-Mart appealed the decision to the Workers' Compensation Board (Board), which affirmed the ALJ's decision. The Board determined that claimant's current condition arose while she was working at Wal-Mart. The Board also found that there was no evidence that Kinney had **<173 Or App 284/285>** accepted claimant's degenerative disc disease as a compensable condition. Alternatively, the Board found that, even if the condition was caused by the injury that occurred while she was employed at Kinney, claimant's work at Wal-Mart contributed to the worsening of her condition, thus shifting responsibility for the condition to Wal-Mart. The Board ordered Wal-Mart to pay $1,000 in attorney fees under ORS 656.382(2) for the appeal to the Board. Wal-Mart then sought review of the merits of the Board's order in this court.

Wal-Mart assigned two errors to the Board's order. First, Wal-Mart argued that the Board erred in not applying ORS 656.308(1) to this case. That statute provides, in part:

> "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."

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[1] ORS 656.382(2) provides:

"If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the Administrative Law Judge [ALJ], board or court 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 an amount to be set by the [ALJ], board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal."

Wal-Mart urged this court to reconsider its opinion in *SAIF v. Yokum*, 132 Or App 18, 887 P2d 380 (1994), which held that ORS 656.308(1) applies only when a previous employer has accepted a claim for the current injury. Second, Wal-Mart argued that the Board erred in concluding that claimant's injury occurred while she was employed by Wal-Mart. According to Wal-Mart, the injury actually occurred years earlier while claimant was working for Kinney. Citing *Yokum*, we issued a per curiam decision affirming the Board's order. *Climer*, 171 Or App at 77.

The decisive issue is whether ORS 656.382(2) requires that an employer must directly challenge the compensability of an injury or condition on review in order to be liable for the claimant's attorney fees in this court. Claimant contends that she is entitled to attorney fees under ORS 656.382(2) because Wal-Mart sought review of her claim in this court and her compensation was not disallowed or reduced. Wal-Mart argues that the statute applies only when an employer directly challenges the claimant's right to compensation. Wal-Mart contends that claimant is not entitled to attorney fees on review because Wal-Mart did not challenge the compensability of claimant's degenerative disc disease on review.

173 Or App 286> Wal-Mart's current position before this court is contrary to its arguments on the merits of its appeal. On the merits, Wal-Mart argued that *Yokum* was incorrectly decided. In *Yokum*, we rejected a subsequent employer's argument that responsibility for a current injury remained with the claimant's former employer under ORS 656.308(1) because the former employer had never accepted the current injury. 132 Or App at 23. By arguing that *Yokum* was incorrectly decided, as opposed to arguing that *Yokum* did not govern this case, Wal-Mart implicitly conceded that Kinney had not accepted claimant's current disc disease. As further confirmation of that point, on review Wal-Mart did not challenge the Board's finding that Kinney had never accepted claimant's disc disease.

We agree with Wal-Mart that more than mere responsibility must be at issue on review for ORS 656.382(2) to apply. *See, e.g., Ray Schulten's Ford v. Vijan*, 105 Or App 294, 804 P2d 1196 (1991) (holding that claimant was not entitled to attorney fees under ORS 656.382(2) when the only issue in the case was responsibility and compensation would not be affected by the decision). However, by seeking review of the Board's decision, Wal-Mart necessarily placed claimant's entitlement to compensation for her current claim for medical services at issue.

Our decision in *SAIF v. Bates*, 94 Or App 666, 767 P2d 87 (1989), is instructive. In *Bates*, we held that the claimant was entitled to attorney fees under ORS 656.382(2) for an employer's appeal to the Board. On appeal, the employer sought to shift responsibility for the claim to another employer. We held that the Board erred in denying attorney fees, even though the appealing employer had not denied compensability, because the employer to whom it had attempted to shift responsibility denied compensability.

This case differs from *Bates* in two inconsequential respects. First, claimant seeks attorney fees on review to this court, rather than at the Board level. That difference is immaterial because ORS 656.382(2) applies to both levels of review. Second, unlike in *Bates*, Kinney has not formally denied the compensability of claimant's current claim for medical services. However, neither has Kinney accepted that **<173 Or App 286/287>** claim. Had we reversed and remanded the Board's order, claimant's entitlement to compensation could have become an issue between Kinney and claimant, even though on appeal Wal-Mart did not argue, in particular, that the claim was not compensable. *See Dennis Uniform Manufacturing v. Teresi*, 115 Or App 248, 837 P2d 984 (1992), *on recons* 119 Or App 447, 851 P2d 620 (1993) (holding that compensability was necessarily at issue on appeal to the Board, even though the parties did not raise compensability on appeal, because compensability was an issue before the referee, and the Board has de novo review). Therefore, claimant's right to compensation was placed at risk and she was justified in actively participating on review in order to protect that right. Because we did not disallow or reduce claimant's compensation, claimant is entitled to attorney fees under ORS 656.382(2).[2]

Petition for attorney fees allowed in amount of $6,747.

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[2] We reject without discussion Wal-Mart's assertion that the amount of attorney fees sought by claimant is excessive.

Cite as 173 Or App 599 (2001) April 25, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Fred L. Dobbs, Claimant, Deceased.

SAIF CORPORATION and JERRY & JEAN TRUCKING, INC., Petitioners - Cross-Respondents,
v.
PATRICIA DOBBS, successor in interest for Fred L. Dobbs, deceased, Respondent - Cross-Petitioner, and SAIF CORPORATION/SHERMAN BROTHERS, LIBERTY NORTHWEST INSURANCE CORPORATION/SHERMAN BROTHERS, and INDUSTRIAL INDEMNITY/KWIK KAFE OF OREGON, Respondents.
97-09540, 97-09535, 97-07489 & 97-02870; A104744

Judicial Review from Workers' Compensation Board.

On respondent Industrial Indemnity's motion to modify allowance of costs filed February 16, 2001; respondent - cross-petitioner's petition for reconsideration filed February 22, 2001; respondent SAIF/J&J Trucking's response filed March 1, 2001. Opinion filed February 14, 2001, 172 Or App 446, 19 P3d 932.

John E. Snarskis for motion to modify allowance of costs for Industrial Indemnity.

Jenny Ogawa and Kevin L. Mannix, P.C., contra.

Thomas Cary for petition.

Before Haselton, Presiding Judge, and Deits, Chief Judge, and Wollheim, Judge.

WOLLHEIM, J.

Petition for reconsideration allowed; opinion adhered to. Industrial Indemnity's motion to modify award of costs allowed.

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173 Or App 602> Claimant has filed a petition for reconsideration of our decision in *SAIF v. Dobbs*, 172 Or App 446, 19 P3d 932 (2001). The Workers' Compensation Board had upheld the compensability denial of SAIF and Sherman Brothers (SAIF/Sherman) for claimant's current low back condition and assigned responsibility for claimant's condition to claimant's earlier employer, SAIF and Jerry & Jean Trucking, Inc. (SAIF/J&J). We affirmed that order. We allow reconsideration for the purpose of addressing claimant's concern that our decision "suggest[s] the logical impossibility" that a condition can be noncompensable as to one employer but compensable as to another. In claimant's view, a condition is either compensable as to all employers and responsibility should be assigned to one or the condition is not compensable and no employer is responsible. SAIF/J&J concurs in claimant's view that we have left the case in an odd posture by upholding SAIF/Sherman's denial while at the same time assigning responsibility for the claim to SAIF/J&J. Although we acknowledge that that disposition is atypical, in these circumstances it is correct.

As we held in our original opinion, substantial evidence supports the Board's finding that SAIF/Sherman originally accepted only a claim for a lumbar strain. In processing claimant's claim for lumbar strain, SAIF/Sherman determined that the compensable strain had combined with claimant's preexisting degenerative condition that had previously been accepted by SAIF/J&J and then determined that the accepted strain was no longer the major contributing cause of claimant's "combined condition." It therefore denied the compensability of claimant's current condition. The Board upheld the denial, determining that claimant had failed to show a compensable combination of the SAIF/Sherman strain and the preexisting condition. In fact, the Board found no evidence that claimant continued to suffer from a strain. Claimant asserts that the Board could not, on the one hand, uphold the compensability of the claim as to SAIF/J&J and on the other, uphold SAIF/Sherman's compensability denial. What makes SAIF/Sherman's concurrent denial of compensability **<173 Or App 602/603>** possible, however, is the fact that the denial related only to the "combined condition" of the lumbar strain and the preexisting degenerative condition. As the Board said:

> "SAIF/Sherman denied compensability of claimant's current low back condition on the basis that his *lumbar strain had ceased to be the major cause of the treatment and disability of the combined condition.*" (Emphasis added.)

In light of its finding that claimant no longer suffered from a lumbar strain, the Board correctly upheld SAIF/Sherman's denial of a current condition consisting of a combination of the compensable strain and the preexisting condition. The Board further found that claimant's current condition was the same condition accepted by SAIF/J&J, the degeneration of the lumbar spine and spinal stenosis, that the SAIF/Sherman claim had involved a different condition, and that SAIF/J&J therefore remained responsible for claimant's condition under ORS 656.308(1). The Board's findings are supported by substantial evidence. We therefore adhere to our affirmance of the Board's order.

As a prevailing party on the petition, respondent Industrial Indemnity has filed a motion seeking payment of its costs by petitioner SAIF/J&J. We grant the motion.

Petition for reconsideration allowed; opinion adhered to. Industrial Indemnity's motion to modify award of costs allowed.

Cite as 173 Or App 402 (2001) April 4, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Carol Bryant, Claimant.

SAIF CORPORATION and HERITAGE PLACE, Petitioners,

v.

CAROL A. BRYANT, Respondent.

(99-00894; CA A108495)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 20, 2000.
Jerome P. Larkin argued the cause and filed the brief for petitioners.
Scott Michael McNutt, Jr., argued the cause and filed the brief for respondent.
Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.
KISTLER, J.
Reversed and remanded for reconsideration.

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173 Or App 404> The Workers' Compensation Board found that claimant's workplace injury was the major contributing cause of the need for treatment of her combined condition. Employer petitions for review of the Board's order. We reverse and remand.

Claimant worked as a care giver at an assisted living facility. On May 24, 1998, a patient at the facility grabbed claimant from behind by her hair, pulled her neck back, and dragged her down a hallway. On July 1, 1998, employer accepted a cervical sprain as a nondisabling condition. On July 12, 1998, claimant went to the emergency room because she had been experiencing tingling and swelling in her hands for three days. The emergency room doctor diagnosed claimant with acute exacerbation of cervical radiculopathy.

Claimant was referred to Dr. Bert, who diagnosed her with probable cervical disc syndrome and arranged for a cervical spine MRI. The MRI revealed a straightening of the cervical spine and degenerative hypertrophic changes at the C4-5, C5-6, and C6-7 levels. Dr. Keiper also examined claimant. He diagnosed her with spondylitic degenerative changes with cord compression and early myelopathy at C5-6. Keiper, a neurosurgeon, recommended surgery to correct claimant's condition.

Shortly after Keiper's diagnosis, Dr. Duff and Dr. Morton examined claimant at employer's request. According to Duff and Morton, the symptoms claimant was presently experiencing in her hands might not have any causal relationship with her workplace injury. Alternatively, they reasoned that, even if there were some relationship, claimant's workplace injury had combined with her preexisting spondylosis and her spondylosis was "the major contributing cause of [her] current neck symptomaltology[.]"

Employer denied that claimant's combined condition was compensable. It reasoned that her workplace injury had combined with her preexisting condition and had ceased to be "the major contributing cause of [her] combined condition and the disability and need for treatment resulting therefrom."

173 Or App 405> On February 1, 1999, Keiper performed surgery to relieve the compression on claimant's spinal cord.[1] He explained in a letter to claimant's counsel that the workplace injury had combined with claimant's preexisting spondylosis to cause the pain in her hands. Keiper concluded:

> "[T]he major cause of [claimant's] disability was obviously the injury of 5/24/98. The need for surgery was 50/50 in that this preexisting condition was compressing the spinal cord and therefore the spinal cord needed to be decompressed to prevent further injury and to alleviate the symptoms in her hands. It was a combined cause."

Later in the letter, Keiper repeated that "[t]his condition is equally due to the preexisting condition and the acute injury." He also noted Duff and Morton's opinion that the present pain in claimant's arms could be unrelated to the combined condition. Keiper disagreed with that opinion and explained that the "flexion/extension injury" that claimant had suffered at work either caused or worsened the pain in her arms.

After reviewing Keiper's surgery report, Bert answered "yes" when asked whether the workplace injury was the "major cause of current disability and medical treatment including surgery[.]" He explained that the injury had "cause[d] a disc herniation at C5-6," a conclusion that did not find any express support in Keiper's surgical report.

A divided Board found that the injury was the major contributing cause of claimant's need for treatment. Relying on Bert and Keiper's opinions, the majority reasoned:

> "Unlike the ALJ, we do not find Dr. Bert's diagnosis of a herniated disc to be a reason for discounting his opinion because we find that it is consistent with the pathological findings in [claimant's] neck. Furthermore, although Dr. Keiper said that claimant's condition was 'equally due to' her preexisting condition and the injury, he also further explained that the 'flexion/extension injury' either caused **<173 Or App 405/406>** claimant's pain or worsened the preexisting condition. Thus, viewing his entire report, we consider Dr. Keiper's opinion as showing that the compensable injury is the major contributing cause of claimant's need for treatment of her combined condition."

On review, employer argues that Keiper's opinion is legally insufficient to show that claimant's workplace injury was the major contributing cause of her need for treatment. It also challenges the Board's reliance on Bert's report. Employer does not argue that Bert's report is legally insufficient. Rather, it argues that, in light of what it perceives as Bert's misdiagnosis of a herniated disc, Bert's opinion does not provide substantial evidence to support the Board's opinion.

The parties do not dispute that claimant suffers from a combined condition. *See* ORS 656.005(7)(a)(B).[2] Their dispute centers initially on whether the Board properly relied on Keiper's opinion to find that claimant's workplace injury was the major contributing cause of the need for treatment of the combined condition. We explained in *SAIF v. Nehl*, 148 Or App 101, 106, 939 P2d 96, *on recons*, 149 Or App 309, 942 P2d 859 (1997), *rev den* 326 Or 389 (1998), that a workplace injury may be the major contributing cause of the need for treatment of a combined condition but not the major contributing cause of the disability of the combined condition. In this case, Keiper stated that the workplace injury was the major contributing cause of the disability of the combined condition but only a 50-50 cause of the need for surgery.

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[1] Keiper explained:

"[Claimant] underwent an anterior cervical discectomy and fusion at C5-6 because of compression of her spinal cord. The diagnosis is cervical spondylosis, central cord syndrome, and early myelopathy. The generator pain was the C5-6 disc."

[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."

The issue in this case arises because the Board found that Keiper's opinion showed that the workplace injury was major contributing cause of the need for treatment. The Board thus transformed a statement that the injury was an equal cause of the need for treatment into a statement that the injury was the major contributing cause of the need for **<173 Or App 406/407>** treatment. We do not doubt that the Board has the authority to interpret what an ambiguous medical report means, *see SAIF v. Strubel*, 161 Or App 516, 522, 984 P2d 903 (1999), and it may be that the Board could satisfactorily explain why it interpreted Keiper's report the way it did. However, the Board's present explanation of its interpretation does not meet the test of substantial reason. *See Furnish v. Montavilla Lumber Co.*, 124 Or App 622, 863 P2d 524 (1993).

As an initial matter, the Board never explains why Keiper's statement that the "need for surgery was 50/50" is an ambiguous statement that the Board may interpret. Beyond that, the Board offered two explanations for its interpretation of Keiper's statement. It explained initially that "although Dr. Keiper said that claimant's condition was 'equally due to' her preexisting condition and the injury, he also further explained that the 'flexion/extension injury' either caused claimant's pain or worsened the preexisting condition." The fact, however, that Keiper found that the injury either caused claimant's pain or worsened her condition does not necessarily mean that the injury was the major contributing cause of the need for treatment. Indeed, it appears that the portion of Keiper's statement on which the Board relied addressed a separate issue.[3] The Board also explained that "viewing [Keiper's] entire report," his opinion showed that the injury was the major contributing cause of the need for treatment. The Board, however, never explained why the other portions of Keiper's opinion caused it to conclude that the quoted portion of Keiper's report means something other than what it appears to say. Neither explanation that the Board provided satisfies the test of substantial reason.

In finding that claimant's combined condition was compensable, the Board also relied on Bert's opinion. We do not know, however, whether the Board would reach the same **<173 Or App 407/408>** conclusion if it could rely only on Bert's opinion or whether the Board can provide a more complete explanation for its interpretation of Keiper's opinion. We accordingly reverse and remand for reconsideration. *See Skochenko v. Weyerhaeuser Co.*, 118 Or App 241, 245, 846 P2d 1212 (1993) (reversing and remanding where the Board's misinterpretation of some of the medical evidence may have influenced its ultimate conclusion); *Asten-Hill Co. v. Armstrong*, 100 Or App 559, 563, 787 P2d 890 (1990) (same).[4]

Reversed and remanded for reconsideration.

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[3] The Board's discussion of Keiper's opinion, although not completely clear, suggests that it is relying on paragraph seven of Keiper's letter. That portion of Keiper's opinion appears to be addressed to the question raised in Duff and Morton's analysis of whether there was any causal connection between the workplace injury and the pain in claimant's arms. It does not appear to be addressed to the question whether the workplace injury was the major contributing cause of the need for treatment.

[4] Employer argues that the Board gave too much weight to Bert's opinion. As noted above, we do not know whether the Board will provide a sufficient explanation on remand for relying on Keiper's opinion, nor do we know whether the Board would reach the same conclusion if it could rely only on Bert's opinion. It would be premature to decide how much weight Bert's opinion will bear until we know how much weight the Board chooses to place on it.

Cite as 174 Or App 61 (2001) May 2, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Larry L. Ledin, Claimant.

SAIF CORPORATION and LEO CARIGNAN, Petitioners,
v.
LARRY L. LEDIN, Respondent.
99-03403; CA A110298

Judicial review from Workers' Compensation Board.
Argued and submitted April 6, 2001.
Julene Marian Quinn argued the cause and filed the brief for petitioners.
Gordon Gannicott argued the cause for respondent. With him on the brief was Hollander, Lebenbaum & Gannicott.
Before Edmonds, Presiding Judge, and Kistler and Schuman, Judges.
PER CURIAM
Affirmed.

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174 Or App 62> SAIF seeks review of a decision of the Workers' Compensation Board that required it to reopen claimant's claim to process a new medical condition rather than treating that new condition as a claim within the Board's own motion jurisdiction. In *Johansen v. SAIF*, 158 Or App 672, 976 P2d 84, *on recons* 160 Or App 579, 987 P2d 524, *rev den* 329 Or 528 (1999), we held that under ORS 656.262(7)(a) a claim for a new medical condition is subject to the processing requirements of ORS 656.262(4)(a). The statute expressly provides that a claimant may bring such a new medical condition claim at any time, without regard to any other provision of the Workers' Compensation Law. It is not relevant to a new medical condition claim that the claimant's aggravation rights have expired or that the Board might exercise its own motion jurisdiction.

SAIF argues that ORS 656.262(7)(c), which provides in part that, "[i]f a condition is found compensable after claim closure, the insurer * * * shall reopen the claim for processing regarding that condition," refers only to conditions that existed at the time of the original claim closure, which necessarily excludes a claim for a new medical condition. That interpretation is inconsistent with our holding in *Johansen*. When read in light of ORS 656.262(7)(a) as construed in *Johansen*, the statute requires an insurer to reopen a closed claim to process a claim for a new medical condition.

Affirmed.

Cite as 174 Or App 114 (2001) May 9, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Paul E. Clark, Claimant.

PAUL E. CLARK, Petitioner,
v.
GRINNELL FIRE PROTECTION, Respondent.
99-02738; A110410

Judicial Review from Workers' Compensation Board.
Argued and submitted April 18, 2001.
Kevin Keaney argued the cause and filed the brief for petitioner.
Jerald P. Keene argued the cause and filed the brief for respondent.
Before Landau, Presiding Judge, and Brewer and Schuman, Judges.
LANDAU, P. J.
Affirmed.

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174 Or App 116> Claimant seeks review of an order of the Workers' Compensation Board (Board) upholding employer's denial of his claim on the ground that it is not compensable. We affirm.

The Board found the following facts. Claimant installed fire control sprinkler systems for employer. While installing sprinkler systems at Benson High School, claimant obtained permission from the school janitor to use some of the school's tools, including saws used to cut blocking for use in ceilings during the installation process. Employer did not know that claimant was using Benson High School's equipment.

Claimant took a lunch break in the school shop. He noticed that one of the table saws had a dado blade on it. A "dado" blade is a type of saw blade that is typically used in cabinet making and is designed to cut channels of various widths in wood. Claimant had never used a dado blade before, but he thought that one might be useful for a cabinet-making project that he had started at home. He decided to test the dado blade, and, if it seemed to do the job that he needed, he would ask the janitor for permission to bring in his cabinets from home and work on them in the shop.

After he finished his lunch, but before returning to his work activities, claimant took a block of wood and attempted to make an experimental cut with the dado blade. In the process, he severely injured his left hand. He sought medical treatment and filed a claim with employer, which employer denied.

At the hearing, the principal issue was whether claimant's injury arose out of and in the course of his employment. Claimant argued that his claim was controlled by our opinion in *Freightliner Corporation v. Arnold*, 142 Or App 98, 919 P2d 1192 (1996), in which the claimant was injured while using his employer's equipment on a personal errand of a type typically performed on the job with the employer's permission. Employer argued that the case is distinguishable because, among other things, the employer in this case did not know about, much less authorize, claimant's use of a client's equipment for a personal errand. The administrative **<174 Or App 116/117>** law judge (ALJ) upheld employer's denial, concluding that the claim did not meet the unitary work connection requirements of *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 867 P2d 1373 (1994). The ALJ concluded that our decision in Arnold was distinguishable:

> "This injury occurred on a job site, but not on the employer's premises. The injury was caused by equipment belonging to a client, not to the employer or, for that matter, any other contractor at the job site. The employer had no control over the equipment nor did it specifically authorize its use. Even if it can be said that the employer probably should have known that its employees would occasionally use the equipment of other trades during the course of their employment, there is no suggestion from the record that the employer could or should have known that its employees would use tools belonging to a client for an activity that bore no relationship to any task necessary to completing the job.

> "As was true in *Arnold*, claimant's activity at the time of the injury was purely personal, however, unlike in *Arnold*, claimant [in this case] was using a tool that was not necessary to perform his work. There is no evidence in this case that there was a practice of allowing employees to engage in personal projects. And, of course, there was no specific acquiescence in the particular task that claimant engaged in this case, whereas there was in *Arnold*. In addition, claimant was at the end of his unpaid lunch break and essentially on his own time when the injury occurred."

The Board adopted the ALJ's opinion.

On review, claimant argues that the Board erred, because this case is indistinguishable from *Arnold*. According to claimant, both *Arnold* and this case involve injuries that occurred during a personal errand. Moreover, he argues, although employer in this case did not expressly sanction the use of a client's equipment on the job, it had to know that claimant would do so, because employer failed to provide him with all the necessary equipment--such as saws--to perform his work.

Claimant reads *Arnold* too broadly. As the Board correctly explained, although the claimant in *Arnold* was injured on a personal errand, the injury occurred by means of the use of the employer's equipment, during work hours, in **<174 Or App 117/118>** accordance with an employer policy permitting employees to use work equipment for personal errands. In this case, claimant used Benson High School's equipment, not employer's. Moreover, he used the equipment on his own time, without the knowledge of employer, much less in accordance with an employer policy permitting such activity. We conclude that the Board did not err in concluding that claimant's injury neither arose out of nor occurred in the course of employment.

Affirmed.

Cite as 174 Or App 275 (2001) May 9, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Dorothy E. Toy, Claimant.

HEWLETT-PACKARD CO., Petitioner,
v.
DOROTHY E. TOY, Respondent.
99-01934 and 98-09995; A108244

Judicial Review from Workers' Compensation Board.
Argued and submitted October 9, 2000.
Thomas W. Sondag argued the cause for petitioner. With him on the brief were Scott P. Monfils, Lane Powell Spears Lubersky and Hitt Hiller & Monfils.
Robert D. Carlson argued the cause for respondent. With him on the brief were James C. Egan and Kryger, Alexander, Egan & Elmer.
Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.
KISTLER, J.
Affirmed.

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174 Or App 277> The Workers' Compensation Board (the Board) set aside employer's denial of claimant's occupational disease claim. Employer seeks review, arguing that the medical opinion on which the Board relied is not supported by objective findings. We affirm.

In June 1994, claimant began working as a process operator in employer's microchip fabrication facility. She worked 12-hour shifts for three to four days per week with a team of process operators. Each team spent two weeks at one of five workstations and then rotated to the next workstation. Although her duties varied, claimant's job at each workstation required repetitive head and neck movements. On August 8, 1995, after her fourth consecutive 12-hour workday on the scanning electron microscope, claimant experienced stiffness and pain in her neck and sought medical treatment. She filed a workers' compensation claim, which employer accepted as a disabling cervical strain injury.

Claimant returned to a modified work environment with a somewhat reduced hourly workload[1] and abbreviated workstation rotation. Although she was permanently taken off the scanning electron microscope, she continued to experience severe neck pain. On January 26, 1998, employer closed the claim without an award of permanent disability.

After her claim was closed, claimant sought additional medical treatment. She also filed a new claim for an occupational disease, which employer denied on October 26, 1998. Employer explained that, if the claim were compensable, it would be compensable only as an aggravation of the earlier injury. Claimant filed an aggravation claim, which employer denied on February 9, 1999.

Claimant sought a hearing on both the occupational disease and aggravation claims. The administrative law judge (ALJ) found that "there is not a preponderance of medical evidence that the accepted strain condition has actually, **<174 Or App 277/278>** pathologically worsened," *see* ORS 656.273(1), and upheld the denial of the aggravation claim.

The ALJ ruled that employer erred in denying the occupational disease claim. Relying on Dr. Rung, claimant's treating physician, the ALJ found that claimant had a "significant preexisting condition" and "that repetitive movements of the cervical spine on top of the probable preexisting degenerative changes would likely pathologically worsen the preexisting condition * * * ."[2] Based on Rung's report, the ALJ also found that "the major contributing cause of claimant's neck and shoulder

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[1] She returned for six-hour days and had worked her way up to ten-hour days by November 1996.

[2] If an occupational disease claim is based on a worsening of a preexisting condition, the claimant must prove that work activities were the major contributing cause of either the onset or pathological worsening of the disease. ORS 656.802(2).

condition * * * was claimant's work activity for * * * employer." The ALJ set aside employer's October 26, 1998, denial of the occupational disease claim and directed employer to accept that claim. Employer sought review before the Board, which adopted the ALJ's opinion and order, with a minor modification, and affirmed.

On judicial review, employer argues that the Board erred in relying on Rung's opinion because it is not supported by objective findings. *See* ORS 656.802(2)(d).[3] As claimant points out, however, Rung's chart notes document, over a six-month period, that her physical examination of claimant revealed tenderness with myofascial trigger points primarily in the left upper trapezius and tenderness in the cervical paraspinous musculature. Rung's notes track the degree and location of the pain over that period and rule out other possible causes for it. In her next to last chart note, Rung also found diminished range of motion of claimant's cervical spine.

174 Or App 279> We recently explained that objective findings are "findings made by a medical expert on the basis of a verification process involving trained observation, examination, or testing that produces results--either physical or subjective responses--that are witnessed, measured, or can be reproduced." *SAIF v. Lewis*, 170 Or App 201, 212, 12 P3d 498 (2000), *rev allowed* 331 Or 692 (2001). Employer never explains why the Board could not find that the results of Rung's physical examinations of claimant constituted "objective findings" within the meaning of the statute. Rung's chart notes reveal that not only were her findings reproducible but that she in fact reproduced similar findings over a six-month period. Moreover, Rung's measurement of claimant's diminished range of motion is a statutorily enumerated "objective finding." *See* ORS 656.005(19). Rung's opinion is supported by objective findings within the meaning of ORS 656.802(2)(d) and ORS 656.005(19).[4]

Affirmed.

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[3] ORS 656.802(2)(d) provides:

"Existence of an occupational disease or worsening of a preexisting disease must be *established by medical evidence supported by objective findings*." (Emphasis supplied.)

In defining "objective findings," ORS 656.005(19) provides:

"'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."

[4] Employer appears to argue in its brief that Rung's report is deficient because the report does not explain how the objective findings that Rung made support the conclusion that she reached. In essence, employer seeks to impose a "substantial reason" requirement on physicians' opinions. Employer never explains where it finds that requirement in the statute. In any event, that objection was not raised below, and "[a]n argument that is not raised to the Board is deemed waived." *Roy v. McCormack Pacific Co.*, 171 Or App 526, 532, 17 P3d 550 (2000); *accord Oregon Lox Co. v. Nichols*, 151 Or App 531, 949 P2d 741 (1997).

Cite as 174 Or App 531 (2001) June 6, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Marvin E. Lewis, Claimant.

MARVIN E. LEWIS, Petitioner - Cross-respondent,
v.
CIGNA INSURANCE CO. and ACTIVE TRANSPORTATION CO., Respondents - Cross-petitioners.
97-05360, 97-05050 and 97-00071; A106117

Judicial Review from Workers' Compensation Board.
Argued and submitted January 7, 2000.
Linda C. Love argued the cause for petitioner - cross-respondent. With her on the briefs was Craine & Love.
Vera Langer argued the cause for respondents - cross-petitioners. With her on the brief was Scheminske & Lyons.
Before Edmonds, Presiding Judge, and Kistler and Schuman, Judges.*
SCHUMAN, J.
Affirmed on petition; on cross-petition, reversed and remanded with instructions to vacate ALJ and Board orders and reinstate June 20, 1997 denials of petitioner's claims.

* Schuman, J., *vice* Armstrong, J.

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174 Or App 533> Claimant seeks review of the part of a Workers' Compensation Board (Board) order affirming denial of his claim due to his noncooperation with the insurer, Cigna. Cigna cross-petitions from the part of the Board's order denying its motion to dismiss due to claimant's failure timely to request an expedited noncooperation hearing. We reverse on Cigna's cross-petition; the Board should have granted the motion to dismiss. We therefore need not and do not address claimant's petition for review.

ORS 656.262(14) requires injured workers "to cooperate * * * in the investigation of claims for compensation." If the Director of the Department of Consumer and Business Services (DCBS) finds that the worker has unreasonably failed to cooperate, the worker's interim compensation is suspended and the worker receives a warning that, unless the worker complies with the cooperation requirement within 30 days, the suspension of compensation may become a permanent denial. ORS 656.262(15). If the worker continues to refuse to cooperate and the employer or insurer denies the claim for that reason, the worker cannot receive a hearing on the merits of the underlying compensation claim "*unless the worker first requests and establishes at an expedited hearing* * * * that the worker fully and completely cooperated with the investigation, that the worker failed to cooperate for reasons beyond the worker's control or that the investigative demands were unreasonable." *Id.* (emphasis added). The worker, in other words, must either cooperate or satisfactorily explain non-cooperation, before his or her claim can be processed, and, in order to avoid delaying that claim process, the cooperation issue must be resolved in an expedited manner. The dispositive issue in this case is whether the language in ORS 652.262(15) italicized above means that, if the worker fails to make a timely, affirmative request for an expedited hearing on the noncooperation denial, the worker can receive no further hearing on his or her claim. We agree with Cigna that it does, that claimant did not make the required request, and that Cigna therefore lawfully denied his claims.

174 Or App 534> In 1997, claimant filed two workers' compensation claims against employer, one for degenerative disc disease in his low back and one for aggravation of an earlier compensable injury sustained in 1992. Cigna arranged two compelled medical exams (CMEs), as permitted by ORS 656.325(1)(a), but claimant refused to attend either, disputing Cigna's authority to order them when he had already had a CME on an earlier claim. At a subsequent deposition, claimant's attorney instructed claimant not to answer questions regarding his failure to attend the scheduled CMEs and ended the deposition. As a result, Cigna requested a suspension of benefits based on claimant's alleged failure to cooperate with the CMEs and at the deposition.

On May 20, 1997, the Compliance Section of DCBS notified claimant that his benefits on both claims would be suspended in five days for "noncooperation," pursuant to ORS 656.262(15), unless he either documented the reasonableness of his alleged failure to cooperate or notified the insurer that he was willing to cooperate. Also pursuant to ORS 656.262(15), DCBS notified claimant that, if he did not cooperate within 30 days of the May 20 notice, Cigna was authorized to deny the claims. On June 6, DCBS issued orders suspending benefits on both claims. The orders again notified claimant that his claims would be denied if he did not cooperate as requested. He did not do so and on June 30 Cigna issued denials on both claims based on claimant's failure to attend the CMEs and his alleged failure to cooperate at the deposition.

Claimant requested a hearing on those denials by filling out the Board's standard hearing request form that provides claimants with a checklist to identify the reasons for the requested hearing. Claimant did not check the box for "worker noncooperation" or otherwise expressly indicate on that form that he was requesting an expedited hearing on the noncooperation denials.[1] Pursuant to that request, the Board **<174 Or App 534/535>** scheduled a hearing that ultimately occurred on February 12, 1998.

At that hearing before an Administrative Law Judge (ALJ), Cigna moved for dismissal, arguing that claimant had not timely requested an expedited hearing on the noncooperation denials and thus, under ORS 656.262(15), was not entitled to any further hearings on the merits of his claims. Cigna also argued in the alternative that claimant had, in fact, failed to cooperate. Skipping over the expedited hearing request motion, the ALJ set aside the suspension orders and the "noncooperation" denials because claimant's failure to attend the CMEs did not amount to noncooperation under the relevant statute.

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[1] Claimant's completed checklist provides:

"A hearing is requested for the reason(s) checked below:

"[x] A DENIAL **12/13/96; 6/18/97; 6/6/97; 5/20/97; and 6/20/97**

"[x] B Compensability - complete claim denial

"[x] X Partial denial after a claim acceptance

"[ ] Z challenge to notice of acceptance ORS 656.262

"[ ] V Worker noncooperation ORS 656.262(15)

"[x] K Aggravation ORS 656.273

"[x] L Responsibility ORS 656.307

"[ ] M NONCOMPLYING EMPLOYER ORDER ORS 656.740

"[ ] TTD/TPD

"[x] D Procedural entitlement

"* * * * *

["x] Q OTHER (Explain and cite ORS) **ORS 656.262 (11, 14 & 15) et. al. WMC Dept. Order(s) of 5/20/97, 6/6/97 & 6/18/97, ORS 656.262 et al, OAR 436-060-0135 * * ***

"[x] P DIRECTOR'S ORDER **dated 6/6/97, 6/18/97 & 5/20/97[.]**"

(Items in bold provided by claimant.)

On review by the Workers' Compensation Board (Board), Cigna again moved to dismiss, arguing again that neither the ALJ nor the Board had jurisdiction over the noncooperation denial because claimant had not timely requested an expedited hearing. The Board denied the motion to dismiss and, on the merits of the noncooperation claim itself, reversed the ALJ and reinstated the noncooperation denials. Claimant sought review of the Board's reinstatement of the noncooperation denials, and Cigna cross-petitioned for review of the denial of its motion to dismiss.

In denying that motion, the Board relied on its decision in *SAIF v. Dubose*, 50 Van Natta 1631, *on recons* 50 Van **<174 Or App 535/536>** Natta 1822 (1998). Some time after the Board's denial, however, we reversed that decision. *SAIF v. Dubose*, 166 Or App 642, 999 P2d 529 (2000), *rev allowed* 331 Or 692 (2001). Accordingly, our decision in *Dubose* controls our decision here.

Two aspects of *Dubose* are relevant to our disposition. First, we held that, under ORS 656.262(15), "the procedure for setting aside a noncooperation denial is an expedited hearing." *Id.* at 646. Without an expedited hearing, neither the ALJ nor the Board is authorized to set aside a noncooperation denial under ORS 656.262(15). *Id.* at 650. Second, we held that "the statute plainly places a burden on the worker to make an effective request for the necessary hearing." *Id.* at 647. As we explained, that burden is easily met by checking the appropriate box on the hearing request form:

> "[T]he Board provides a standardized form for requesting a hearing. On that form, the worker first indicates that the hearing is for a claim denial. The form then requires the worker, in a simple check-the-box-that-applies format, to identify the reason for the denial. Included is a box for indicating a denial based on 'Worker noncooperation,' followed by citation to the relevant statute, ORS 656.262(15). A worker who accurately fills out that form satisfies the statutory requirement to request an expedited hearing for a noncooperation denial. The Board's administrative obligation, both under the statute and pursuant to its rules, is then to provide that hearing.
>
> "* * * Nothing in the way claimant filled out the form, or in her accompanying cover letter, would have alerted the Board that the matter should be placed on the expedited hearings docket. Claimant therefore did not do what she needed to do to trigger an expedited hearing." *Id.* at 647-48.

Here, as in *Dubose*, the hearing on the noncooperation denials did not take place on an expedited basis, as ORS 656.262(15) requires. Rather, the hearing on the merits of the denials was held in February 1998, approximately eight months after the denials and a year after the relevant claims were initiated. And, as in *Dubose*, claimant did not meet his burden of making an effective request for an expedited hearing. Although he promptly submitted a hearing request on the noncooperation denials, claimant did not check the box **<174 Or App 536/537>** labeled "worker noncooperation ORS 656.262(15)." Nor did he in any other way indicate on the form that the denials for which he sought a hearing were based on allegations of noncooperation. Claimant did check the box on the form labeled "OTHER" and, in the space for an explanation cited, *inter alia*, ORS 656.262(15). However, that citation was embedded in a string of citations to other statutes and rules that deal with issues unrelated to noncooperation denials. Moreover, section 15 itself deals with a number of actions other than denials. Claimant's bare reference to ORS 656.252(15) was therefore insufficient to "alert[] the Board that the matter should be placed on the expedited hearings docket." *Dubose*, 166 Or App at 648.[2]

Thus, the ALJ and the Board lacked authority under ORS 656.262(15) to consider claimant's challenge to the June 20, 1997 noncooperation denials, and Cigna was entitled to have those denials upheld. *Dubose*, 166 Or App at 648.

Affirmed on petition; on cross-petition, reversed and remanded with instructions to vacate ALJ and Board orders and reinstate June 20, 1997 denials of petitioner's claims.

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[2] After claimant's benefits had been suspended, but *before* his claims had been denied, he unsuccessfully requested an expedited hearing *on the suspension*. After the *denial*, on July 9, 1997, he moved for reconsideration of his unsuccessful request for an expedited hearing on the suspension. That motion does not suffice as an "effective request" for an expedited hearing *on the denial*. The motion for reconsideration made no mention of the June 20 denials and thus did not suffice to alert the Board that those denials provided a basis for hearing the case on an expedited basis.

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* Appealed to Courts as of May 31, 2001