VAN NATTA'S
WORKERS' COMPENSATION REPORTER

VOLUME 53

(Pages 1-498)

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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.

JANUARY-MARCH 2001

Van Natta's Workers' Compensation Reporter is published quarterly by the editors, Robert Coe and Merrily McCabe. A one-year subscription costs $300 for the four quarterly volumes; a bi-monthly update service is available for an additional cost of $180. All subscription, billing, editorial and similar correspondence should be addressed to: The Editors, *Van Natta's Workers' Compensation Reporter*, 1017 Parkway Drive NW, Salem, Oregon 97304. Phone (503) 585-5173; fax (503) 540-0114. All requests for permission to make any otherwise infringing use of all or any part of this publication, including photocopying and copying for use with electronic media, should be addressed to the editors.

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CITE AS

53 Van Natta ____ (2001)

VAN NATTA'S
WORKERS' COMPENSATION REPORTER
1017 Parkway Drive N.W.
Salem, Oregon 97304
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UPDATE PAGES

ENCLOSED ARE *VAN NATTA'S* PAGES 1-74, WITH BOARD ORDERS TO JANUARY 22, 2001. THESE PAGES ARE THE FIRST INSTALLMENT OF BOARD ORDERS FOR THE FIRST QUARTER (JANUARY-MARCH) OF VOLUME 53 (2001).

LATER PAGES SHOULD BE INSERTED INTO THIS BINDER.

YOU MAY DISCARD THIS PAGE AT YOUR OWN CONVENIENCE.

Oregon Workers' Compensation Board
Attn.: Roger Pearson
2601 25th St. S.E.
Salem, OR 97302

In the Matter of the Compensation of
JAMES E. CLEMONS, Claimant
WCB Case No. 97-00968
ORDER ON REMAND
Flaxel & Nylander, Claimant Attorney
Hornecker, Cowling, et al, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *Roseburg Forest Products v. Clemons*, 169 Or App 231 (2000). The court has reversed our prior order, *James E. Clemons*, 50 Van Natta 267 (1998), that affirmed an Administrative Law Judge's (ALJ's) order that awarded claimant 4 percent (5.4 degrees) scheduled permanent disability for loss of use or function of the left foot and 9 percent (28.8 degrees) unscheduled permanent disability for a low back condition.

The parties have now submitted a "Stipulation and Order of Dismissal," designed to resolve all issues raised or raisable with regard to the pending claim. Specifically, the parties stipulate that the employer shall reinstate claimant's award of 10 percent unscheduled permanent disability and that claimant's award of 4 percent scheduled permanent disability for the left foot shall be affirmed. The parties also agree that the employer shall pay claimant's counsel an assessed fee of $2,200. Finally, the parties stipulate that the request for review "shall be dismissed with prejudice as to all issues raised or raisable therein."

After reviewing this agreement, we perceive no impediment to our approving the parties' agreement, which fully and finally resolves this dispute, in lieu of all prior orders. However, we take this opportunity to address the effect of a recent court decision on our authority to approve settlements of this nature.

In *Simmons v. Lane Mass Transit District*, 171 Or App 268 (2000), the court reversed a Board order that had declined to set aside as invalid a previously approved stipulation (in which the carrier had accepted the claimant's aggravation claim for a disputed condition and its denial of the claimant's "new injury" claim for the same condition was upheld). Asserting that resolution of the carrier's denial of the claimant's "new injury" claim could only be achieved by means of a disputed claim settlement (DCS) under ORS 656.289(4), the claimant contended that the stipulation was invalid because the agreement had not complied with the statutory or administrative requirements for a DCS.

The court agreed with the claimant's contention. Reasoning that the claimant's "new injury" claim was distinct from his aggravation claim, the court determined that the stipulation had, in effect, attempted to dispose of a denied claim. Relying on ORS 656.289(4), OAR 438-009-0001(2), and OAR 438-009-0010(2), the court concluded that a DCS was required to achieve the disposition of the denied claim. Because the stipulation did not meet the statutory and rule requirement for the resolution of the denied claim, the court held that the stipulation should not have been upheld. 171 Or App at 277.

In making its decision, the court extensively reviewed the various mechanisms for settling all or part of a workers' compensation claim. The court noted that, because a CDA is proper only when the parties intend to resolve all aspects of a claim other than medical benefits, and because a DCS is proper only when the issue is the resolution of a claim denial and may be limited to situations in which the parties intend the claim to remain denied, neither is suitable for many of the other issues that could arise during the course of a claim. Accordingly, the court acknowledged that the Board's rules provide for a third category of settlement, a "settlement stipulation," which OAR 438-009-0001(3) defines as:

> "a written agreement, or an oral agreement if made on the oral record of a hearing and approved in writing by a [sic] Administrative Law Judge, in which any matter contested between the parties, other than matters resolvable in a claim disposition agreement or disputed claim settlement, are [sic] resolved by agreement of the parties."

The court further observed that the statutory authority for a settlement stipulation is not entirely clear, but that such a stipulation does not appear to fall within the terms of ORS 656.289(4). However, the court noted that ORS 656.236(1), unlike the rules governing a CDA, does not expressly limit the authority to settle to agreements that resolve an entire claim, although it may contemplate that that will ordinarily be the result of a settlement. According to the court, that statute is probably sufficient to authorize a settlement stipulation. Another possibility the court considered was that such a stipulation is

an exercise of the inherent authority of a quasi-judicial body to approve a settlement of issues before it. The court noted, however, that possibility may run afoul of ORS 656.236(8).[1] 171 Or App at 273 n. 3.

Having considered the court's discussion of the various forms of settlement, we do not interpret *Simmons* as precluding our approval of the stipulation in this case or of settlement stipulations in general. The stipulation in *Simmons* was invalid because it attempted to dispose of a denied claim. Specifically, in *Simmons*, the denial of a "new injury" claim was upheld in a settlement stipulation. In contrast, the stipulation in this case does not uphold a denial, but rather resolves a dispute concerning the extent of permanent disability in an accepted claim by reinstating claimant's award of unscheduled permanent disability and affirming claimant's scheduled permanent disability award. Accordingly, we conclude that *Simmons* is distinguishable on its facts.

Moreover, while we acknowledge the court's concerns regarding the potential conflict between settlement stipulations and ORS 656.236(8), typically, settlement stipulations award compensation, assess penalties and attorney fees, or withdraw appeals or requests for hearing. They do not "release" benefits. Thus, our authority to approve such settlement stipulations does not conflict with ORS 656.236(8), which pertains to the "release" of rights under ORS Chapter 656.[2]

Accordingly, because the settlement stipulation in this case does not dispose of a denied claim and is otherwise in accordance with the Board's administrative rules, we approve the parties' settlement, thereby fully and finally resolving the parties' dispute, in lieu of all prior orders. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] ORS 656.236(8) provides that "[n]o release by a worker or beneficiary of any rights under this chapter is valid, except pursuant to a claim disposition agreement under this section or a release pursuant to ORS 656.593."

[2] As previously noted, the *Simmons* court stated that "a CDA is proper only when the parties intend to resolve all aspects of a claim other than medical services. 271 Or App at 273. Although most CDAs involve a full release of all "non-medical service" benefits, some, however, do not. The CDA statute, ORS 656.236(1)(a), states that "*[u]nless otherwise specified*, a disposition resolves all matters and rights to compensation, attorney fees and penalties potentially arising out of claims, except medical services, regardless of the conditions stated in the agreement." (emphasis added). While the *Simmons* court suggests that a CDA is only proper when the parties intend to resolve all aspects of the claim, we have approved, and will continue to approve, CDAs that partially release benefits in light of the "unless otherwise specified" language in ORS 656.236(1)(a).

In the Matter of the Compensation of
HENRY WILLIAMS, Claimant
WCB Case No. 00-0300M
OWN MOTION ORDER ON RECONSIDERATION

Claimant requested reconsideration of our November 7, 2000 Own Motion Order in which we declined to reopen his 1979 claim for the payment of temporary disability benefits on the ground that he failed to prove he was in the work force at the time of disability.

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

It is undisputed that claimant's compensable 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 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 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); *Arthur R. Morris*, 42 Van Natta 2820 (1990).

In our prior order we were not persuaded that claimant had demonstrated his willingness to work. We based our conclusion on claimant's failure to submit persuasive evidence regarding whether he was willing to work. On reconsideration, and based on the record before us, we are now persuaded that claimant has demonstrated his willingness to work.

With his request, claimant asserts that he was "willing to work but unable to work due to [his] injury to his right knee." He submits copies of his 1996 W-2 form and his Social Security earnings records through 1998 which he contends demonstrates that he was working until 1998 when he left work due to a worsening to his compensable knee condition. In conclusion, claimant states that he is willing to work but not working or seeking work due to his work-related injury. Based on claimant's assertions, we are persuaded that he was willing to work at the time of the current worsening.

However, claimant must also satisfy the "futility" standard of the third *Dawkins* criterion, in order to be found in the work force. In our prior order, we found that Dr. Finkel's, claimant's attending physician, July 25, 2000 medical report as well as claimants July 18, 2000 affidavit *may* have demonstrated claimant's physical inability to work.

In his July 18, 2000 affidavit and his recent submission, claimant attested that he has not been able to work due to a worsening of his compensable injury. However, whether it would be futile for claimant to seek work is not a subjective test viewed through the eyes of claimant; it is an objective test determined from the record as a whole, especially considering persuasive medical evidence regarding claimant's ability to work and/or seek work. *Jackson R. Scrum*, 51 Van Natta 1062 (1999). In short, the question is whether the work injury made it futile for claimant to make reasonable efforts to seek work, not whether claimant reasonably believes it to be futile.

In his July 25, 2000 medical report, Dr. Finkel stated that claimant "remains disabled from any type of employment which would require bending, stooping, lifting or walking on the leg for any period of time." We are not persuaded by Dr. Finkel's statement that claimant was unable to work and/or seek work. Rather, Dr. Finkel's statement simply indicates that claimant's work ability has limitations (*i.e.* no bending, stooping, lifting or walking on his leg for any period of time). There is no evidence that claimant attempted to look for work within these limitations.

Additionally, no physician released claimant from work or opined that claimant was unable to work due to the work injury. Dr. Finkel did not opine that claimant was unable to work due to the work injury. Rather, he opined that claimant could not work in any type of employment that would exceed his limitations. Therefore, on this record, we continue to conclude that claimant has not demonstrated that he was in the work force at the time of disability.[1]

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our November 7, 2000 order in it entirety. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

---

[1] It appears from claimant's request that he may not understand his rights under the Workers' Compensation Act. Inasmuch as claimant 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
GREG HARSHA, Claimant
WCB Case No. 00-0216M
OWN MOTION ORDER
Nicholas M. Sencer, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

By Own Motion Order dated August 15, 2000, as reconsidered on September 14, 2000, we authorized the reopening of claimant's March 20, 1985 low back injury claim to provide temporary total disability benefits beginning March 17, 2000, the date claimant was hospitalized for surgery. The insurer requests that we authorize it to "offset" claimants short- and long-term disability payments against his temporary total disability benefits. Based on the following reasoning, we deny the insurer's request.

The insurer contends that claimant received short-term disability benefits between February 1, 2000 and May 15, 2000, and began receiving monthly long-term disability benefits as of June 6, 2000. Citing *Wells v. Pete Walker's Auto Body*, 86 Or App 739, *rev den* 304 Or 406 (1987), the insurer argues that these disability benefits should be considered wage replacement benefits and it should be permitted to offset these benefits against the temporary disability benefits awarded by our prior orders. The insurer requests that we issue an order authorizing such an offset.

ORS 656.262(1) provides that the processing of claims and providing compensation for a worker shall be the responsibility of the insurer or self-insured employer. Likewise, OAR 438-012-0020(1) provides that Own Motion claims shall be processed by the insurer. ORS 656.210 and 656.212 provide the statutory basis for temporary total and temporary partial disability benefits. The Workers' Compensation Division (WCD) provides rules for implementing these statutes, including calculation of temporary total and temporary partial disability benefits. *See* OAR 436-060-0020, 436-060-0025, 436-060-0030. Finally, temporary disability benefits authorized under the Board's Own Motion jurisdiction are calculated and paid pursuant to these WCD rules and the Boards Own Motion rules. OAR 438-012-0035; *Daniel D. Lathrop*, 49 Van Natta 2023 (1997) (in the interest of administrative efficiency, we apply WCD rules in determining the rates of TTD and TPD regarding Own Motion claims); *Thomas L. Abel*, 45 Van Natta 1768 (1993).

Thus, it is the insurer's responsibility, in the first instance, to process claimant's claim, which includes calculating and paying temporary disability benefits. By requesting "authorization" to offset short- and long-term disability benefits against temporary disability benefits, the insurer is essentially requesting that we issue an advisory opinion. The issue of the appropriateness of such an offset is not ripe for adjudication unless and until the insurer makes such an offset and claimant contests it by requesting our review of the insurer's actions. We decline to issue what, in effect, would be an advisory opinion. *See Jerald J. Cooper*, 50 Van Natta 146 (1998) (Board declines to address whether doctrine of "issue preclusion" would bar future litigation regarding the insurer's entitlement to an offset); *Scott C. Clark*, 47 Van Natta 133 (1995) (Board declines to issue advisory opinion); *Jimmie D. Jordan*, 43 Van Natta 1161 (1991) (Board declines to issue advisory opinions on matters of potential dispute).

In any event, the insurer is, in effect, seeking permission to recalculate claimant's temporary total disability as temporary partial disability under ORS 656.212 and OAR 436-060-0030. However, those provisions apply only when the temporary disability is or becomes partial. Here, there is no evidence that claimant's disability has become partial. In addition, pursuant to OAR 436-060-0030(10), "'post-injury wages' are wages the worker could have earned by accepting a job offer, or actual wages earned, whichever is greater, and any unemployment, sick or vacation leave payments received."

Finally, the insurer's reliance on *Wells* is misplaced. In *Wells*, the claimant was released to modified work and began receiving unemployment benefits when he was unable to find modified work. The carrier offset those unemployment benefits against the claimant's temporary disability benefits. The claimant requested a hearing, contending that the unemployment benefits should not have been offset. Ultimately, the court affirmed our decision that offset was appropriate under such circumstances and held that "[w]hen a worker is receiving unemployment benefits by representing an ability to work, those benefits may be treated as receipt of post-injury wages." 86 Or App at 247. The court also explicitly stated that it made no comment about whether private insurance benefits should be treated differently from statutory unemployment benefits, since that issue was not before the court. 86 Or App at 247 n3.

Several factors distinguish *Wells* from the present case. First, in *Wells*, the carrier did not request an advisory opinion prior to offsetting unemployment benefits. Second, the claimant had been released to modified work and, by representing that he was able to work by seeking unemployment benefits, the court reasoned that the claimant demonstrated that his disability was no longer total. Finally, the court explicitly stated that it made no holding regarding treatment of private insurance benefits. Thus, *Wells* does not support the insurer's position.

In summary, because it is premature to address an issue that has not become ripe for adjudication, we decline to issue an advisory opinion regarding the insurer's request for authorization to offset private disability insurance benefits against claimant's temporary disability benefits. In the event that the insurer recalculates claimant's temporary disability benefits and should claimant challenge that recalculation by seeking our review, we will then consider the matter.

Accordingly, the insurer's current request is denied.

IT IS SO ORDERED.

January 5, 2001 Cite as 53 Van Natta 5 (2001)

In the Matter of the Compensation of
JIM E. HUNT, Claimant
WCB Case Nos. 98-08443, 98-07975, 98-06120 & 97-09473
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) set aside its denial of claimant's right shoulder adhesive capsulitis condition; and (2) set aside its denial of claimant's aggravation claim for a right shoulder condition. Claimant cross-requests review of that portion of the ALJ's order that upheld the self-insured employer's denial of his claim for C7 radiculopathy. On review, the issues are compensability and aggravation.

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

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to the aggravation and compensability issue (adhesive capsulitis), we find that a reasonable fee for claimant's attorney's services on review regarding this case $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 March 8, 1999 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500, to be paid by the self-insured employer.

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[1] The employer also raises a procedural challenge to claimant's aggravation claim arising from the October 1995 injury, asserting that, because claimant failed to perfect his 1997 aggravation claim, it was procedurally invalid. Because employer denied claimant's aggravation claim on the merits and did not raise any procedural challenges at hearing, we decline to consider the issue for the first time on review. *See, e.g., Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991); *Kenneth L. Devi*, 49 Van Natta 108 (1997).

In the Matter of the Compensation of
STEVEN M. KENIMER, Claimant
WCB Case No. 99-01862
ORDER ON REVIEW
Charles Robinowitz, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

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

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

As the ALJ found, all three physicians who rendered causation opinions found that claimant's work activities on October 8, 1998 combined with his preexisting right knee degenerative joint disease. Thus, claimant must show 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." ORS 656.005(7)(a)(B).

To satisfy the "major contributing cause" standard, claimant must establish that his work incident of October 1998 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 all potential 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). The fact that a work event precipitated the symptoms or need for treatment of a condition does not necessarily mean that the work incident was the major contributing cause of the condition or its need for treatment. *Id.* at 401; *see also Robinson v. SAIF*, 147 Or App 157, 162 (1997).

Dr. Hayes, treating orthopedist, examined claimant twice and opined that claimant had a medial meniscus tear as a result of a particular incident while squatting at work in October 1998. Dr. Hayes based his opinion that this work incident was the major contributing cause of claimant's need for treatment on the temporal relationship between the work incident and the swelling/pain for which claimant sought treatment. (Exs. 12A, 12B, 12C, 14-11-13). Although Dr. Hayes acknowledged that claimant's preexisting bowleggedness and degenerative changes in the medial compartment of claimant's right knee predisposed him to problems, he stated that he was treating claimants acute, painful knee, not the degenerative condition or bowleggedness. (Ex. 14-11-12). Dr. Hayes concluded that claimant sought treatment because he had one event that was painful and made his knee swell up. (Ex. 14-13).

We do not find that Dr. Hayes evaluated the relative contribution of all potential causes of claimant's disability or need for treatment of the combined condition, as required under *Dietz*. Although claimant had extensive degenerative changes in nearly all of his medial meniscus, Dr. Hayes failed to weigh this. Instead, it appears that Dr. Hayes simply relied on a precipitating cause, or a "but for" analysis, which, without the required *Dietz* analysis, is not sufficient to establish the work injury as the major contributing cause of the need for treatment or disability of the combined condition. *Georgia Barklow*, 49 Van Natta 1261 (1997); *Alec E. Snyder*, 47 Van Natta 838 (1995) (persuasive medical opinion must weigh the relative contribution of different causes; "but for" analysis not well reasoned).

ORDER

The ALJ's order dated August 3, 2000 is affirmed.

In the Matter of the Compensation of
RODNEY SULLIVAN, Claimant
Own Motion No. 96-0269M
OWN MOTION ORDER
Julene M. Quinn (Saif), Defense Attorney

In an August 1, 2000 Own Motion Order Reviewing Carrier Closure and November 2, 2000 Order on Reconsideration, we set aside the SAIF Corporation's January 26, 2000 Notice of Closure and remanded the claim to SAIF for further processing in accordance with law. *Rodney Sullivan*, 52 Van Natta 1964 (2000). Claimant now requests enforcement of our August 1 and November 2, 2000 orders (in addition to penalties), contending that SAIF unreasonably failed to pay benefits as directed by our orders.

In response, SAIF relies on ORS 656.268(4)(d), which states that temporary disability compensation may be terminated upon the occurrence of any other event that causes temporary disability benefits to be lawfully suspended, withheld or terminated under ORS 656.262(4). SAIF contends that it has not paid claimants temporary disability benefits because it has not received any medical documentation (from an attending physician) authorizing said benefits.

Temporary disability compensation shall be paid on an open Own Motion claim until one of the following events occurs: (1) the claim is closed pursuant to OAR 438-012-0055; (2) a claim disposition agreement (CDA) is submitted to the Board pursuant to ORS 656.236(1); or (3) termination of such benefits is authorized by the terms of ORS 656.268(4)(a) through (c). *See* OAR 438-012-0035(4).

Unlike benefits payable under ORS 656.268, temporary disability benefits payable under ORS 656.278 arise by means of voluntary reopening by the carrier or Board authorization. *See* OAR 438-012-0035(1). Board authority to award temporary disability benefits under ORS 656.278 is not contingent on an attending physician's time loss authorization. *Terri A. Briggs*, 52 Van Natta 1009 (2000); *Jeffrey T. Knudson*, 48 Van Natta 1708 (1986). In *Knudson*, we reasoned that, because an attending physician's time loss authorization is not required for commencement of temporary disability benefits pursuant to ORS 656.278, the lack of such authorization is not a basis for the withholding or termination of such benefits.

Here, our August 1, 2000 and November 2, 2000 orders set aside SAIF's Notice of Closure, which necessarily reinstated SAIF's obligation as set forth in our June 11, 1996 Own Motion Order that had reopened the claim for the payment of temporary disability compensation until such benefits could be terminated under OAR 438-012-0035 and the claim closed under OAR 438-012-0055. Based on the *Knudson* and *Briggs* rationale, the absence of an attending physician time loss authorization does not constitute a ground to delay payment of claimant's temporary disability benefits under OAR 438-012-0035(1). Consequently, claimant is entitled to temporary disability benefits beginning January 7, 2000, the date SAIF effectively stopped paying such benefits.

SAIF argues that the holding in *Edward Hines Lumber Co. v. Kephart*, 81 Or App 43 (1986) is controlling and that our holdings in *Knudson* and *Briggs* fail to consider the clear authority of *Kephart*. We disagree.

In *Kephart*, the court reversed our Own Motion Order, which had awarded the claimant permanent total disability. In reaching its conclusion, the court rejected a carrier's contention that the Board's Own Motion award of permanent total disability benefits had been unconstitutional. In doing so, the *Kephart* court observed that the rules and standards contained in statutes covering disability awards are not abrogated by ORS 656.278. It further noted that the Board's Own Motion jurisdiction provide the mechanism for adjustments (on a discretionary basis). In other words, the court reasoned that the other provisions of the Workers' Compensation Act provide rules and standards to guide the Board in conducting its Own Motion review under ORS 656.278.

Notwithstanding its rejection of the carrier's constitutional argument, the court agreed with the carrier that the Boards Own Motion Order was erroneous. The court reasoned that the Board had acted in contravention of its own rules, when it did not allow the carrier 20 days within which to respond to the claimant's request for Own Motion relief pursuant to *former* OAR 438-12-005(c). Consequently, the court remanded for reconsideration.

SAIF argues that, in *Kephart*, the court interpreted ORS 656.278 to be subject to the rules and standards contained in the statutes covering awards for temporary and permanent disability. Consistent with the *Kephart* principle, the Board does utilize most claim processing standards and rules contained in the statutes when it reviews issues such as the timely payment of temporary disability compensation (*Christopher L. Camara*, 50 Van Natta 355 (1998)), the calculation of temporary total and temporary partial disability compensation (*Ed Gibson*, 50 Van Natta 832 (1998)), and premature claim closure (*Edward D. Riggs*, 52 Van Natta 93 (2000)). However, the issue here is whether the carrier can lawfully withhold or terminate temporary disability compensation pursuant to *ORS 656.278* or our Own Motion rules. As explained in *Knudson*, the *initiation/triggering* of temporary disability compensation under *ORS 656.278* is *not* contingent on an attending physician's authorization of time loss. Therefore, the *termination* of such benefits is likewise not dependent on the absence of time loss authorizations.

Here, as explained above, the absence of an attending physicians authorized temporary disability compensation is not a ground for terminating benefits under OAR 438-012-0055. Consequently, the *Knudson* rationale is not contrary to our administrative rule and, as such, is consistent with the *Kephart* holding.

We turn to claimant's request for the assessment of a penalty. Under ORS 656.262(11)(a), if the carrier unreasonably delays or unreasonably refuses to pay compensation, it shall be liable for an additional amount of up to 25 percent of the amounts then due. In determining whether a delay or refusal to pay compensation is unreasonable, the question is whether the carrier had a legitimate doubt as to its liability at the time of the denial. *Brown v. Argonaut Insurance Company*, 93 Or App 588, 591 (1988).

Here, SAIF's failure to reinstate claimant's temporary disability in response to our prior orders setting aside its Notice of Closure was contrary to the holdings set forth in *Knudson* and its progeny. Nonetheless, none of those previous decisions had addressed the question of whether the *Knudson* rationale was consistent with the court's *Kephart* decision. That question had not been considered until today's decision.

Under such circumstances, we find that SAIF had a legitimate doubt as to its obligation to reinstate claimant's temporary disability compensation. Thus, no penalty shall be assessed to SAIF.

Accordingly, SAIF is directed to recommence temporary disability compensation beginning January 7, 2000, the date it terminated compensation, and continuing until SAIF can lawfully terminate such benefits under OAR 438-012-0035 and close the claim under OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
MATTHEW P. LIGATICH, Claimant
WCB Case No. 00-01879
ORDER ON REVIEW
G. Joseph Gorciak III, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) upheld the insurer's denials of claimant's low back disc conditions and his current low back condition; (2) declined to award penalties and attorney fees for the insurer's allegedly untimely claim processing; and (3) declined to award an attorney fee based on the insurer's modified "pre-hearing" acceptance. On review, the issues are compensability, penalties and attorney fees.

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

We do not adopt the second sentence of the next-to-last paragraph on page 5 and we express no opinion regarding the timeliness of the insurer's claim processing. Nonetheless, there is no basis for a penalty or "penalty-related" attorney fee, because there is no evidence of amounts due or resistance to the payment of compensation. *See Willard R. Allen*, 52 Van Natta 818 (2000).

ORDER

The ALJ's order dated September 7, 2000 is affirmed.

January 5, 2001 Cite as 53 Van Natta 9 (2001)

In the Matter of the Compensation of
ELEANOR NAGAI, Claimant
WCB Case No. 98-07355
ORDER ON RECONSIDERATION
Parker, Bush & Lane, Claimant Attorney
Meyers, Radler, et al, Defense Attorney

Claimant requests reconsideration of our October 31, 2000 Order on Review in which we reversed an Administrative Law Judge's order that had set aside the self-insured employer's denial of claimant's occupational disease claim for a mental disorder. Specifically, we found that there was insufficient persuasive medical evidence to establish that claimant suffered from a diagnosed mental or emotional disorder that is generally recognized in the medical or psychological community.

On November 24, 2000, we withdrew our October 31, 2000 order and allowed the employer an opportunity to respond. Having received the employer's response, we proceed with our reconsideration.

In her request for reconsideration, claimant contends that we failed to make adequate findings of fact on which to base our conclusion that Dr. Klecan's opinion was more persuasive that that of Dr. Lange. Specifically, claimant contends that Dr. Klecan's opinion is not persuasive because he relied on an inaccurate history regarding work force reductions and his belief that claimant was treated the same as other workers. Having reviewed the record *de novo*, we conclude that Dr. Klecan had a sufficiently accurate understanding of the work environment, claimant's work performance, and the employer's disciplinary actions. More importantly, we are persuaded that Dr. Klecan adequately considered the significance of claimant's psychological symptoms (or relative lack thereof) in concluding that those symptoms were insufficient to demonstrate the presence of a "mental disorder."

Finally, to establish the compensability of a mental disorder, claimant must prove, among other things, that there is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community. ORS 656.802(3)(c). Because claimant has failed to prove the existence of a mental or emotional disorder, claimant has failed to establish the compensability of her mental disorder claim. *See Dana Lauzon*, 43 Van Natta 841 (1991) (if the claimant fails to establish any one of these statutory elements, the occupational disease claim for a stress-related mental disorder fails).

Finally, because we have previously considered claimant's arguments regarding reasonable corrective or job performance evaluations and the ALJ's credibility findings, we adhere to our prior order.

Therefore, on reconsideration, as supplemented herein, we republish our October 31, 2000 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
VICTOR J. CERVANTES, Claimant
WCB Case No. 99-07541
ORDER ON RECONSIDERATION
Ransom & Gilbertson, Claimant Attorney
Terrall & Terrall, Defense Attorney

Claimant requests reconsideration of our December 11, 2000 Order on Review that affirmed that portion of the Administrative Law Judge's (ALJ's) order that declined to assess a penalty for the self-insured employer's allegedly unreasonable refusal to pay procedural temporary disability (TTD). In our order, we agreed with the ALJ that claimant was not entitled to any further temporary disability than that awarded by a November 18, 1999 Notice of Closure and affirmed by a January 31, 2000 Order on Reconsideration that had become final. *See, e.g., Charles Marsing,* 52 Van Natta 2218 (2000) (a final Notice of Closure precludes "pre-closure" temporary disability for the same condition); *Michael J. Drake,* 45 Van Natta 1117 (1995) (when the claim has been subsequently closed following a request for hearing regarding a procedural temporary disability issue, the appropriate method for resolution of an issue regarding the resumption of temporary disability is by means of review of the closure notice/order). Because there were no "amounts then due" on which to base a penalty, we affirmed the ALJ's order.

In his request for reconsideration, claimant concedes that no additional temporary disability is due because the Order on Reconsideration has become final. Nevertheless, he contends that he is entitled to a penalty on the temporary disability amounts that should have been paid, *i.e.,* "amounts then due" while the claim was open. Claimant cites *Roger C. Atchley, Jr.,* 48 Van Natta 1065 (1996), *Jose Garza,* 47 Van Natta 1643, 1645 (1995), and *Pascual Zaragoza,* 45 Van Natta 1219, 1223 (1993), in support of his contention that a penalty may be assessed despite the limitation placed on awarding a procedural overpayment by awarding temporary disability benefits beyond the medically stationary date.[1]

Here, the issue claimant raised before the ALJ was entitlement to additional procedural temporary disability and related penalties on a claim that had been closed and for which an Order on Reconsideration had issued prior to hearing. Claimant did not appeal the Order on Reconsideration or raise the issue of substantive entitlement to temporary disability at hearing. Unlike the procedural posture in this case, *Zaragosa* arose from an appeal of an Order on Reconsideration.

Also unlike the procedural framework in this case, in *Garza* the claim was open at the time the hearing was held on entitlement to additional procedural temporary disability. In that case, the ALJ found that the insurer's unilateral termination of temporary disability benefits was improper and awarded a penalty based on the additional time loss due until claim closure. A few days prior to the issuance of the ALJ's order, the claim was closed by a Determination Order that awarded temporary disability for the period prior to the unilateral termination of benefits and one additional day of benefits.

The ALJ in *Garza* issued a reconsideration order which admitted the Determination Order and found that, pursuant to *Lebanon Plywood v. Seiber,* 113 Or App 651 (1992), the claimant was not entitled to a procedural overpayment of temporary disability.

On review in *Garza,* the claimant argued that the Board should reinstate the ALJ's initial order, contending that he was entitled to a procedural award of temporary disability from the date of the unilateral termination of temporary disability until claim closure. The Board disagreed, noting that the proper method to challenge the insurer's award of substantive temporary disability was through a direct appeal of the Determination Order. The Board concluded that the effect of the ALJ's order was no award of procedural temporary disability. The Board nevertheless agreed that the claimant was entitled to a penalty, but found that it was to be based on the temporary disability due from the date of the insurer's improper termination of temporary disability to the date of the hearing on that matter.

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[1] Likewise, in *Atchley,* the request for hearing arose from a Determination Order. Although the ALJ assessed a penalty, the sole issue raised on review and before the Court of Appeals was entitlement to substantive temporary disability; no penalty issue had been raised on review. *See Atchley,* 48 Van Natta at 1065; *see also Atchley v. GTE Metal Erectors,* 149 Or App 581 (1997) (finding that, because the claimant was substantively entitled to temporary disability benefits under former OAR 436-060-040(3), *Lebanon Plywood v. Seiber* was inapplicable.

Here, in contrast to *Garza*, there is no basis for a penalty because claimant has conceded that he is not entitled to any additional temporary disability benefits, either procedural or substantive, because he failed to timely challenge the January 31, 2000 Order on Reconsideration. Thus, because claimant has conceded that no additional compensation is due, there were no "amounts then due" at hearing or otherwise on which to base a penalty.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our December 11, 2000 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

January 8, 2001 Cite as 53 Van Natta 11 (2001)

In the Matter of the Compensation of
JOSE L. DIAZ, Claimant
WCB Case Nos. 99-08830, 99-02351, 98-08163 & 98-07698
ORDER ON REVIEW
McGinty & Belcher, Claimant Attorney
Wallace, Klor & Mann, Defense Attorney
Meyers, Radler, et al, Defense Attorney
Jerald Keene, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Travelers Insurance Company, on behalf of Western Staff Services/Western Temporary Services (Travelers/Western), requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that: (1) set aside its responsibility denial of claimant's occupational disease claim for a bilateral Carpal Tunnel Syndrome (CTS) condition; (2) upheld Travelers Insurance Company's responsibility denial for the same condition, made on behalf of Guerdon Homes/American Homestar Corporation (Travelers/Guerdon); and (3) upheld the self-insured employer's (Redman Industries') *de facto* responsibility denial for the same condition. On review, the issue is responsibility.

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

In addition to Exhibits 9 through 16, Exhibits AA, A through I, 1 through 8, 4A, 4AA, 4B, 4C, 4D, 5A, 6A, 6B, and 7A were admitted into the hearing record. (June 22, 1999 transcript, pages 1-2).

Applying the last injurious exposure rule (LIER), the ALJ assigned responsibility for claimant's bilateral CTS to Travelers/Western. On review, Travelers/Western does not dispute that it is initially responsible for claimant's condition under LIER.[1] Instead, Travelers/Western asserts that responsibility should shift forward to Travelers/Guerdon, contending that claimant's CTS pathologically worsened during his employment there. Like the ALJ, we reject this argument.

As the initially responsible carrier, Travelers/Western can transfer liability to a subsequent carrier by establishing that the subsequent employment actually contributed to a worsening of the condition. *Oregon Boiler Works v. Lott*, 115 Or App 70, 74 (1992). However, in order to shift responsibility to a subsequent carrier, the injured worker must suffer a worsening of the condition; a mere increase in symptoms is not sufficient. *Reynolds Metals v. Rogers*, 157 Or App 147 (1998); *Timm v. Maley*, 134 Or App 245, 249 (1995); *Oregon Boiler Works*, 115 Or App at 74.

Only Dr. Wilson, claimant's treating orthopedist, offers an opinion regarding responsibility. Dr. Wilson unequivocally opined that claimant's work activities were the major contributing cause of his bilateral CTS. (Exs. 4A, 8-9, -22, -24). He stated that he first examined claimant on October 24, 1997

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[1] As the ALJ found, because claimant did not have any time loss before seeking medical treatment, the date of first medical treatment (October 24, 1997) is determinative for assigning initial responsibility for this claim. *Timm v. Maley*, 125 Or App 396, 401 (1993), *rev den* 319 Or 81 (1994). Claimant was working for Travelers/Western on that date.

(claimant was working at Travelers/Western at that time) and that claimant had the same examination when Wilson examined him in April 1998 (claimant was working at Travelers/Guerdon at that time). (*Id.*). Dr. Wilson also agreed with a May 20, 1999 conversation summary prepared by Travelers/Guerdon's attorney, stating that claimant had bilateral CTS before beginning work at Guerdon and the work at Guerdon did not materially worsen the preexisting CTS condition or independently contribute to the cause of it. (Ex. 7). In addition, Dr. Wilson agreed with a June 1, 1999 letter from claimant's attorney, stating that claimant's work activity prior to October 24, 1997, caused, or could have caused, claimant's bilateral CTS, adding a comment that that work activity "was probably the major contributing cause (the most likely cause)." (Ex. 7A-2).

Finally, Dr. Wilson was deposed. (Ex. 8). In support of its position that claimant's bilateral CTS worsened during his work at Travelers/Geurdon, Travelers/Western points to isolated statements Dr. Wilson made during his deposition. However, reading his deposition as a whole, we do not find that it supports Travelers/Western's position. In this regard, Dr. Wilson repeatedly stated that he continued to adhere to his opinions as stated in Exhibits 7 and 7A, i.e., that the work at Travelers/Guerdon did not materially worsen the bilateral CTS or contribute to the cause of it and claimant's work activity prior to October 24, 1997 was the major contributing cause of his bilateral CTS. (Ex. 8-15, -18, -24, -28).

When questioned about the contribution of claimant's work at Travelers/Guerdon, Dr. Wilson stated that the type of work claimant was doing at all three employers over longer periods of time would produce CTS, so it was "assumptive - it's an additive in that regard, so there was a very small contribution [during work at Travelers/Guerdon]." (Ex. 8-26). However, Dr. Wilson explained that the question was whether there was any true pathological worsening of the condition, to which he responded there was not, although there may have been some increase in symptoms. (*Id.*). Nevertheless, as explained above, an increase in symptoms is not sufficient to shift responsibility. *See Industrial Indemnity Co. v. Weaver*, 81 Or App 493, 497 (1986) (concluding that where the claimant's physician determined that the employment had worsened the symptoms, but not the underlying condition, the Board did not err in finding that the employment had not caused a worsening of condition).

In addition, Dr. Wilson opined that, without a second nerve conduction test he could not determine whether there had been any pathological worsening since the initial test in April 1998. (Ex. 8-28). He also stated that, although it was possible to determine whether there was a pathological worsening based on examination of a patient, he could not make such a determination in claimant's case because he had not examined claimant in over a year. (Ex. 8-32, -34).

On this record, we are not persuaded that claimant's bilateral CTS worsened during his subsequent employment at Travelers/Guerdon. Therefore, responsibility remains with Travelers/Western.

Because both compensability and responsibility were decided by the ALJ, and by virtue of the Board's *de novo* review authority, compensability remained at risk on review as well. *See Dennis Uniform Manufacturing v. Teresi*, 115 Or App 248, 252-53 (1992), *mod on recon*, 119 Or App 447 (1993); *Dilworth v. Weyerhaeuser Co.*, 95 Or App 85 (1989). Consequently, claimant's counsel is entitled to an assessed attorney fee for services on Board review regarding the potential compensability issue, payable by Travelers/Western. *See International Paper Co. v. Riggs*, 114 Or App 203 (1992); *Cigna Insurance Companies v. Crawford & Company*, 104 Or App 329 (1990); *Burton I. Thompson*, 48 Van Natta 866 (1996).

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by Travelers/Western. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's counsel's uncontested statement of services and claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated August 7, 2000 is affirmed. For services on review, claimant's counsel is awarded a fee of $1,500, payable by Travelers/Western.

In the Matter of the Compensation of
ROBERT R. MASTERSON, Claimant
WCB Case Nos. 99-05253 & 99-02250
ORDER ON REVIEW
Allison Tyler, Claimant Attorney
Meyers, Radler, et al, Defense Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

Liberty Northwest Insurance Corporation, on behalf of Pacific Stainless Products (Pacific), requests review of those portions of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) set aside its denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome (CTS) condition; and (2) upheld its denial, on behalf of Kalberer Hotel Supply, of the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the procedural history and pertinent facts.

Claimant worked in the sheet metal industry for about 20 years. On May 13, 1985, he sought treatment for right arm symptoms. Dr. Ash diagnosed right CTS "without evidence of conduction block," noting "significantly slowed" sensory conduction through the carpal tunnel" on the right. (Ex. 1). Dr. Ash prescribed "Easprin, to take 1 t.i.d., and have asked him to wear a splint at night." Dr. Ash also recommended a surgical release if claimant did not experience relief within a week. (*Id*). Claimant did not seek treatment for upper extremity symptoms again until 1997.

Claimant worked for Pacific for about 9 years beginning in December 1988 and ending March 30, 1997. After a three-week interval between jobs, he worked for Kalberer for about 2 1/2 years (beginning April 21, 1997). Claimant's work for both employers involved hand intensive activities fabricating and installing restaurant equipment.

In 1995 or 1996, claimant began having bilateral hand symptoms, worse on the right. (Ex. 2). He sought treatment on February 6, 1997 and filed a claim. (Exs. 2, 3, 5). Pacific accepted a "right wrist strain." Dr. Farris performed a right carpal tunnel release on January 7, 1999 (and an unrelated right clavicle resection) and a left carpal tunnel release on January 28, 1999.

On January 22, 1999, Liberty denied responsibility for claimant's CTS on Pacific's behalf. On June 22, 1999, Liberty denied responsibility for claimant's right CTS on Kalberer's behalf. (Ex. 18A). Claimant requested a hearing.

A hearing was held on September 22, 1999. After some discussion, claimant asked Pacific to accept his bilateral CTS as a condition "omitted" from its acceptance. (Tr. 21, see Tr. 43). The parties agreed that compensability was not denied and the issue to be litigated was responsibility for claimant's bilateral CTS.[1]

The ALJ set aside Pacific's denial of claimant's claim for bilateral CTS as an "omitted condition," reasoning that Pacific "should have" accepted claimant's CTS when it accepted a "right wrist strain." That portion of the ALJ's order is not challenged on review, except insofar as the parties dispute how the scope of Pacific's acceptance impacts applicable responsibility law.

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[1] After the hearing, the following events occurred: (1) claimant wrote to Pacific, requesting acceptance of his bilateral CTS as an "omitted condition" (on September 28, 1999); (2) an order issued under ORS 656.307 (on October 27, 1999); and (3) Pacific denied responsibility for claimant's bilateral CTS (on October 28, 1999).

On the responsibility issue, the ALJ did "not resort to the last injurious exposure rule," but concluded that Pacific was responsible, based on evidence that claimant's employment with Pacific was the major cause of his bilateral CTS.

Pacific argues that the ALJ erred in applying "major cause" analysis, rather than the last injurious exposure rule, to determine responsibility because there was no accepted CTS claim at the time of hearing. We agree, but we conclude that Pacific is responsible nonetheless, based on the following reasoning.

The parties agree that claimant's CTS is work related and the only issue is responsibility. In addition, there is medical evidence relating claimant's condition to his work generally. (Exs. 12-7, 15, 16). Thus, because compensability is not disputed and claimant's work for both Kalberer and Pacific was capable of contributing to his CTS, defensive use of the last injurious exposure rule (as a rule of responsibility) is invoked here. *See Safeco Ins. Co. v. Victoria*, 154 Or App 574, *rev den* 327 Or 621 (1998) (where the only dispute was responsibility, only the last injurious exposure "rule of assignment" was relevant); *Douglas R. Barnes*, 52 Van Natta 2097 (2000) (same).

We acknowledge Kalberer's and claimant's arguments (and the ALJ's implicit finding) that Pacific accepted claimant's right CTS when it accepted a right wrist strain. However, we disagree that the acceptance included anything other than a strain--regardless of the contemporaneous medical evidence. *See Kim D. Wood*, 48 Van Natta 482, 484, *aff'd mem*, 1344 Or App 496 (1996) (because there is a specific acceptance, we need not look to the contemporaneous medical records to determine what condition was accepted). Moreover, the likelihood that claimant did not have a wrist strain at the time of the acceptance neither changes the condition accepted nor does it make Pacific liable for conditions other than those specifically accepted in writing. *Id.*

We reiterate that Pacific's acceptance was specifically limited to a "right wrist strain." It did not accept CTS or symptoms of CTS. Accordingly, because there is no accepted CTS condition, responsibility for that condition is determined under the last injurious exposure "rule of assignment." *See SAIF v. Yokum*, 132 Or App 18 (1994) (ORS 656.308(1) does not apply to initial claim determinations).

As the Court explained in *Boise Cascade Corp. v. Starbuck*, 296 Or 238, 241 (1984): "In an occupational disease context, the rule is this: If a worker establishes that disability was caused by disease resulting from causal conditions at two or more places of employment, the last employment providing potentially causal conditions is deemed to have caused the disease." The onset of disability is the "triggering date" for determining which employment is the last potentially causal employment. *Bracke v. Baza'r*, 293 Or 239, 248 (1982). Where a claimant seeks or receives medical treatment for the compensable condition before experiencing time loss due that condition, it is appropriate to designate a triggering date based on either the seeking or receiving of medical treatment, whichever occurs first. *Agricomp Ins. v. Tapp*, 169 Or App 208, 213 (2000).

Once initial responsibility is assigned under the rule, the initially responsible carrier can transfer liability to a subsequent carrier by establishing that the subsequent employment actually contributed to a worsening of the condition. *Reynolds Metals v. Rogers*, 157 Or App 147, 153 (1998) (citing *Starbuck*, 296 Or at 243).

In this case, claimant first sought treatment for left CTS symptoms on February 6, 1997, while working for Pacific. (Ex. 2). Therefore, responsibility for claimant's left CTS is initially and presumptively assigned with Pacific.

The "date of disability" for claimant's right CTS is more difficult to discern, because claimant did seek treatment for what may have been right CTS in 1985, almost 10 years before the onset of his current problems. (Ex. 1). However, we are not persuaded that claimant's 1985 doctor visit accurately identifies the point when claimant's CTS became disabling because claimant was apparently not actually disabled due to his CTS until over 10 years later. *See Tapp*, 169 Or App at 212 ("[T]he objective in designating a triggering date is to identify a point when a condition generally becomes a disability."). However, we need not decide whether claimant's right CTS "disability date" was in 1985 or 1997, because the result would be the same in either event. In other words, even if claimant's disability date was in 1985, responsibility would shift to Pacific, because the medical evidence establishes that

claimant's work for Pacific caused or worsened his right CTS condition. (See Exs. 12-7, 17A, 17B-8, 21-6).[2] *See Donna R. Goodrich*, 52 Van Natta 2089, 2091 (2000) (unnecessary to specifically identify "triggering" disability date where the medical evidence establishes that subsequent work activities contributed to worsening of underlying condition).[3] Accordingly, even if claimant's right CTS existed before he worked for Pacific, the Pacific employment contributed to cause or worsen the condition. Therefore, even if the non-joined carrier was initially responsible for claimant's right CTS, responsibility would shift to Pacific. *Id.*

We further find that responsibility for claimant's bilateral condition does not shift from Pacific to Kalberer's, because the persuasive medical evidence does not establish that claimant's subsequent employment with Kalberer contributed to his CTS. Although Dr. Reimer summarily opined that it did, and Drs. Farris and Wolfe concurred, these opinions are not persuasive because they offer no reasoning to support their conclusions. (Exs. 13, 15, 16). Moreover, Dr. Long thoroughly reviewed claimant's history, noting that claimant's CTS was "progressive through early 1997, and relatively stable from March 1997 through January of 1999[.]" (Ex. 21-6). Considering claimant's history, Dr. Long found no convincing evidence that claimant's work for Kalberer caused his current condition. (*Id*). We rely on Dr. Long's opinion, because we find it better-reasoned than the conclusory opinions. Accordingly, based on Dr. Long's opinion, we conclude that claimant's work for Kalberer's did not contribute to his condition and responsibility does not shift from Pacific to Kalberer's.

Finally, because there is no evidence that prior employment was the sole cause of claimant's condition or that claimant's work for Pacific could not cause it, we agree with the ALJ that Pacific is responsible for claimant's bilateral CTS.

Claimant's counsel is awarded an attorney fee for services on review. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,635, payable by Pacific. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and claimant's counsel's statement of services), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated June 5, 2000 is affirmed. For services on Board review, claimant is awarded a $1,635 attorney fee, to be paid by Liberty Northwest Insurance Corporation, on behalf of Pacific Stainless Products.

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[2] We note that, in April 1997, Dr. Wolfe described Dr. Ash's 1985 diagnosis as "EMG normal right carpal tunnel syndrome." (Ex. 4, *see* Ex. 1). Claimant's next electrodiagnostic studies, in 1999, were abnormal, supporting his bilateral CTS diagnosis. (Exs. 11, 12).

[3] *Compare Pamela M. Christman*, 52 Van Natta 122 (2000) (where disability date occurred with non-joined carrier and medical evidence did not establish that later employment contributed to condition, neither joined carrier held responsible); *see also Kristin Montgomery*, 47 Van Natta 961 (1995) (responsibility may not be assigned to non-joined carrier).

In the Matter of the Compensation of
COLIN L. SPENCER, Claimant
Own Motion No. 00-0078M
OWN MOTION ORDER ON RECONSIDERATION
Cole, Cary, et al, Claimant Attorney
Hettle & Martin, Defense Attorney

We have previously abated our prior Own Motion Order, which declined to reopen claimant's 1991 industrial injury claim for the payment of temporary disability compensation because he failed to establish that he remained in the work force when his condition worsened requiring surgery or hospitalization. Having received the parties' responses, we proceed with our review.

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

It is undisputed that claimant's compensation condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work *and* is seeking work; or (3) not working but willing to work, *and* is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

The "date of disability" for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[1] is the date he enters the hospital for the proposed surgery 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 May 13, 1999 hospitalization when his condition worsened requiring that hospitalization. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; *SAIF v. Blakely*, 160 Or App 242 (1999); *Paul M. Jordan*, 49 Van Natta 2094 (1997); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997); *Michael C. Batori*, 49 Van Natta 535 (1997); *Kenneth C. Felton*, 48 Van Natta 725 (1996).

The insurer contends that claimant was not in the work force at the time of the current disability. In response, claimant submits an affidavit, stating that "[f]rom January 1, 1999 to May 13, 1999, I was not in the work force due to my on-the-job injury; however, I was willing to look for gainful employment." The remainder of the record does not support claimant's statement.

Claimant has not returned to work since he re-injured his back and underwent surgery in 1994. Following that surgery, his attending physician opined that claimant could not return to his construction job and referred him to be counseled into job placement or re-training.

On September 9, 1994, claimant was found eligible to receive return-to-work assistance. By November 1994, he received his first "Possible to End Return-to-Work Assistance" letter because he failed to cooperate in developing a return-to-work plan.

In December 1994, claimant was found medically stationary with limitations.

In January 1995, a return-to-work plan was developed, with a beginning date of January 3, 1995. On January 13, 1995, claimant received his second warning letter regarding the possible termination of his vocational assistance program for failure to attend the training. Finally, on February 1, 1995, claimant's return-to-work assistance was terminated because he failed to attend classes for a variety of transportation and personal issues.

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[1] The Board in its Own Motion jurisdiction can only authorize temporary disability from the time of surgery or hospitalization. *See* ORS 656.278(1)(a).

In February 1999, claimant sought treatment with Dr. Van Winkle. Dr. Van Winkle referred him to Dr. Hacker, who diagnosed a recurrent lumbar disc hernia and recommended surgery. Claimant underwent the recommended surgery on May 13, 1999.

On August 31, 1999, the insurer taped an interview with claimant. During his taped interview, claimant acknowledged that: (1) he had been homeless for sometime; (2) he was not currently employed and had not worked since the 1994 surgery; (3) after the surgery, the doctor released him to work, but he did not return to work because of persistent pain; (4) he started a re-training program that he did not want to participate in at that time because of a separation and divorce, however the vocational counselor said that he would have to "use it or lose it;" (5) he drew some unemployment, but has been surviving mainly on "food stamps, food baskets and friends; and (6) he has not work for the last four years because "basically my back * * * it hasn't allowed me to work."

The medical record does not support claimant's contention that he was unable to work since 1994 because of the compensable injury. Moreover, the record does not establish claimant's willingness to work. In other words, there is no evidence that, when claimant was released to modified work in 1994, he either worked or looked for work. By his own statement, claimant has not worked or looked for work since 1994. Claimant's lack of reasonable efforts to obtain employment, albeit not determinative, indicates a lack of willingness to work. *See Fendrich v. Curry County*, 110 Or App 409 (1991). Finally, given the fact that claimant was enrolled in a return-to-work plan but failed to attend the training and was terminated, we are not persuaded that claimant was willing to work at any time since he last worked in 1994, despite his statement to the contrary. Therefore, we conclude that claimant has failed to prove that he was willing to work and was in the work force at the time his compensable condition worsened.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our March 15, 2000 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

January 9, 2001 Cite as 53 Van Natta 17 (2001)

In the Matter of the Compensation of
KARLANN E. GREENWOOD, Claimant
WCB Case No. C003118
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Malagon, et al, Claimant Attorney
Scheminske, et al, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

On December 22, 2000, 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 released rights to future workers' compensation benefits, except medical services, for the compensable injury. For the following reasons, we approve the proposed disposition.

The first page of the proposed CDA provides that the total amount due claimant is $7,125 and the total due claimant's attorney is $2,375. This would equal a total consideration of $9,500. However, the total consideration recited on the third page of the CDA is "$9,400" instead of $9,500. Finally, on page 3 of the agreement (numbers 9 and 10), it is recited that claimant will receive $7,125 and that claimant's attorney will receive an attorney fee in the amount of $2,375. These sums total $9,500.

Considering the document as a whole, we are persuaded that the reference on the third page of the CDA to a total consideration of $9,400 is a typographical error. Accordingly, we interpret the agreement as providing for a total consideration of $9,500, with $2,375 payable as an attorney fee.[1]

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[1] We note that an attorney fee of $2,375 from total CDA proceeds of $9,500 is consistent with OAR 438-015-0052(1).

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved.

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

IT IS SO ORDERED.

January 8, 2001 Cite as 53 Van Natta 18 (2001)

In the Matter of the Compensation of
DANNY L. DANIELS, Claimant
WCB Case Nos. 99-08751 & 99-08750
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Julie Masters (Saif), Defense Attorney
Scheminske, et al, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) upheld the SAIF Corporation's denial, on behalf of Robben & Sons Heating, Inc. (SAIF/Robben), of claimant's aggravation claim for a neck condition; (2) upheld SAIF/Robben's denial of a "new medical condition" claim for degenerative disc disease and disc protrusions and/or herniation at C5-6 and C6-7; and (3) upheld SAIF's compensability and responsibility denial, on behalf of Heating Specialist, Inc. (SAIF/Heating), of claimant's "new injury" claim for a neck condition. On review, the issues are compensability and responsibility.

We adopt and affirm the ALJ's order with the following change and supplementation. After the second paragraph on page 3, we add the following:

> "On April 17, 2000, SAIF/Robben denied claimant's "new medical condition" claim for degenerative disc disease and disc protrusions and/or herniation at C5-6 and C6-7. (Ex. 31A)."

In the second paragraph on page 4, we change the last portion of the sentence to refer to an "actual worsening" rather than a "pathological worsening."

The ALJ found that claimant had failed to perfect his aggravation claim against SAIF/Robben and, in any event, the medical evidence was insufficient to establish an aggravation claim. The ALJ analyzed claimant's 1999 injury claim and concluded that claimant had failed to establish that his 1999 work activity was the major cause of his need for treatment or disability. The ALJ found no medical evidence to establish that claimant's 1999 work activity was the major cause of a pathological worsening of the 1994 injury or that it caused a separate and distinct injury in its own right.

On review, we write to address claimant's argument in his reply brief that, at a minimum, SAIF/Robben remains responsible for the "acute and chronic cervical strain" it accepted after his 1994 injury. (Claimant's reply br. at 3).

As a result of claimant's October 1994 injury, SAIF/Robben accepted a right shoulder contusion and acute cervical strain. (Exs. 2, 14). Claimant was declared medically stationary on January 16, 1996 and Dr. Talley found no permanent impairment. (Exs. 16, 17).

In January 1996, claimant began working for Heating Specialist, Inc. (Tr. 18). In July 1999, claimant experienced a "flare-up" in neck pain and sought treatment from Dr. Sayson, who ordered a cervical MRI that showed a small disc protrusion at C5-6. (Tr. 8, 14; Ex. 19).

On October 21, 1999, claimant was tightening a pipe at work when he experienced severe neck pain and was unable to use his right arm. (Tr. 9, 10). He was treated by Drs. Sayson and Silver.

Although claimant argues on review that SAIF/Robben remains responsible for an acute cervical strain, there is no medical evidence that establishes that his current condition is related to a cervical strain. Dr. Silver diagnosed "[c]hronic right upper extremity pain of unknown etiology" and cervical disc degeneration at C6-7. (Ex. 22-3). He said that "[d]etailed study to date has not revealed a cause of the continuing symptomatology." (*Id.*) Dr. Silver did not diagnose claimant with a cervical strain.

In November 1999, Dr. Sayson diagnosed "[h]x of cervicalgia - since OTJ injury 1994" and "cervical disc degeneration - C5-6 HNP on MRI 7/16/99[.]" (Ex. 25). He had a similar diagnosis in December 1999 and early January 2000, except that he referred instead to a mild C6-7 HNP. (Exs. 25A, 25B). Dr. Sayson did not explain his diagnosis of "cervicalgia,"[1] nor did he state whether or not that condition was related to the accepted cervical strain.

Dr. Bergquist could not make a specific diagnosis on the basis of reasonable medical probability. (Ex. 26-5). He explained that claimant's cervical strain was a soft tissue injury "which would have resolved and would not be expected to have *any* recrudescence or exacerbation." (Ex. 26-6; emphasis in original). He found no objective and pathological findings related to the October 1994 injury and he concluded that there was no indication that the 1994 claim contributed to the current condition. (*Id.*)

Drs. Gardner and Woodward did not know the cause of claimant's neck pain, but they suggested that it was related in part to the C6-7 disc protrusion. (Ex. 30-9).

Thus, none of the medical opinions indicate that claimant's current condition is related to an acute cervical strain. Furthermore, we agree with the ALJ that the medical evidence is insufficient to establish that claimant sustained a compensable aggravation or a new injury/new medical condition related to the October 1999 work incident.

ORDER

The ALJ's order dated September 29, 2000 is affirmed.

[1] We note that neither Dorland's *Illustrated Medical Dictionary* (28th ed. 1994) nor Stedman's *Electronic Medical Dictionary* (1998), includes a definition of "cervicalgia."

In the Matter of the Compensation of
EUDOCIA HERNANDEZ, Claimant
WCB Case No. 99-08078
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Lundeen, et al, Defense Attorney

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

Claimant requests review of that portion of Administrative Law Judge (ALJ) Herman's order that upheld the insurer's "de facto" denial of left transitional vertebra with impingement of the L5-S1 nerve root, left lateral disc herniation at L4-5, and chronic fracture of the transverse process at S1. The insurer cross-requests review of that portion of the ALJ's order that set aside its "back-up" denial of a left sacral fracture. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation regarding the "back-up" denial issue.

The ALJ concluded that prior to acceptance, x-rays showed an area in claimant's sacrum that was difficult to interpret and could represent a fracture or some other anomaly. The insurer ultimately accepted a fracture. Subsequently, other studies (MRI and CT scans) were done and later physicians rendered opinions regarding the correct diagnosis of the sacral area. At hearing, the insurer issued an oral "back-up" denial of the fracture and argued that later obtained medical evidence established that there was no fracture.

Under ORS 656.262(6)(a), if a carrier accepts a claim in good faith and "later obtains evidence" that the claim is not compensable or the carrier is not responsible, it may revoke its acceptance of a claim and issue a denial as long as the denial is issued no later than two years after the date of the initial acceptance. If the worker requests a hearing on the "back-up" denial, the carrier has the burden of proving by a preponderance of the evidence that the claim is not compensable or that it is not responsible for the claim. The requirement of "later obtained evidence" in ORS 656.262(6)(a) refers to new material, *i.e.*, something other than the evidence that the carrier had at the time of the claim acceptance. *CNA Ins. Co. v. Magnuson*, 119 Or App 282, 286 (1993). But a reevaluation of known evidence, for whatever reason, does not constitute "later obtained evidence" under the statute. *Id.*

Here, the insurer essentially argues on review that a reevaluation by a physician (rather than the insurer) of previous medical information constitutes "later obtained evidence" for purposes of ORS 656.262(6)(a). We disagree. *See Renato H. Morales*, 51 Van Natta 1753 (1999) (medical opinions that rely upon a reinterpretation of the same information available to the insurer when it issued its acceptance, does not amount to "later obtained evidence"). Accordingly, we agree with the ALJ that the "back-up" denial was not valid.

ORDER

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

Board Member Phillips Polich dissenting.

The majority adopts the ALJ's decision to uphold the insurer's "de facto" denial of claimant's new medical condition claims. I disagree with the ALJ's (and majority's) reliance on Dr. Young, a radiologist, who does not treat patients and who has never examined claimant. I would, instead, rely on claimant's treating physicians, Dr. Cindrich and Dr. Breland, whose opinions are supported by examining physician, Dr. Gritzka, to find claimant's new medical condition claims compensable.

The medical evidence from Drs. Cindrich, Breland and Gritzka establishes compensability of a transverse process fracture, a left L4-5 disc herniation and an impingement of the L5-S1 nerve root. In Exhibit 45, Dr. Cindrich causally relates a linear fracture and nerve root impingement to the compensable injury. Likewise, in Exhibit 46A, Dr. Breland relates the transverse process fracture and L4-5 disc herniation to the compensable injury on a more probable than not basis. In Exhibit 47, Dr. Breland opines that the major contributing cause of the transverse process fracture, the L4-5 herniated disc and the nerve root impingement is the September 1998 injury at work. The opinions of Drs. Cindrich and Breland are supported by Dr. Gritzka, who opined that the September 1998 injury is the major contributing cause of claimant's current condition.[1] Based on this evidence, I would find that claimant has established compensability of the new medical conditions.

In summary, because I would rely on the treating physicians, as supported by Dr. Gritzka, I would set aside the denial of claimant's new medical conditions. For this reason, I respectfully dissent from the majority's opinion that adopts the ALJ's decision.

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[1] In reaching their conclusions, Drs. Cindrich, Breland and Gritzka reviewed claimant's x-rays and other imaging studies. (Exs. 40; 46A-1; 52-8,9).

In the Matter of the Compensation of
FRIEDA M. NEVIN, Claimant
WCB Case No. 00-03909
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorney
Reinisch, et al, Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

The insurer requests review of Administrative Law Judge (ALJ) Marshall's order that set aside an Order on Reconsideration as premature. On review, the issue is premature closure, and, alternatively, extent of unscheduled permanent disability.

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

The ALJ found that claimant's low back strain condition was not medically stationary, based on the opinion of the treating physician, Dr. Weller. The ALJ therefore set aside the insurer's Notice of Closure (as affirmed by an Order on Reconsideration) as premature.

At the time of claim closure, claimant's claim was accepted for a lumbar strain condition.[1] (Ex. 44). In order to establish that her claim was prematurely closed, claimant must prove by a preponderance of the evidence that this condition was not medically stationary as of March 13, 2000, the date of claim closure. (Ex. 64). *Berliner v. Weyerhaeuser Co.*, 54 Or App 624, 628 (1981); *Eugene I. Bisceglia*, 52 Van Natta 404 (2000). "Medically stationary" means that no further material improvement would reasonably be expected from further medical treatment, or the passage of time. ORS 656.005(17).

Whether or not claimant is medically stationary is primarily a medical question. *Harmon v. SAIF*, 54 Or App 121 (1981). Absent persuasive reasons to the contrary, we defer to the opinion of claimant's treating physician. *Weiland v. SAIF*, 64 Or App 810 (1983). We agree with the ALJ that there are no reasons not to defer to the opinion of claimant's treating physician, Dr. Weller.

Dr. Weller concluded that claimant was not medically stationary with regard to her compensable lumbar strain condition. (Exs. 49, 64B). As claimant's treating physician since October 1999, Dr. Weller had the opportunity to compare claimant's condition over time, in contrast to Drs. Woodward and Schilperoort, who each examined claimant once. (Exs. 42, 62).

On review, the insurer specifically contends that claimant's ongoing need for treatment is not related to her accepted condition. *See Vicky L. Woodward*, 52 Van Natta 796, 798 (2000); *James L. Mack*, 50 Van Natta 338 (1998) (the only conditions that may be considered in determining medically stationary status are those that have been accepted at the time of claim closure). We disagree.

Dr. Woodward, who examined claimant at the request of the insurer on November 22, 1999, concluded that claimant was medically stationary with regard to her accepted low back condition. (Ex. 42-8). Dr. Woodward further stated that claimant's then-current symptoms were not due to her injury, but rather to a preexisting spondylosis condition. (*Id.*) However, Dr. Weller declined to concur with Dr. Woodward's conclusion in regard to claimant's medically stationary status and specifically rebutted Dr. Woodward's opinion that claimant's ongoing symptoms were not due to the injury because her symptoms were worsening. (Ex. 49).

Moreover, in a later report, Dr. Weller acknowledged the presence of claimant's low back degenerative disk disease, but felt that it was "of fairly mild degree" and was "not contributing significantly to the patient's symptoms." (Ex. 64B-1). Dr. Weller further stated that "I do not feel that [claimant] is medically stable with regards to her work related low back condition, which I have diagnosed as lumbosacral strain and persistent low back pain." (*Id.*) In these circumstances, we rely on Dr. Weller's persuasive opinion and find that claimant was not medically stationary at claim closure with regard to her accepted condition.

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[1] A knee strain condition, also accepted, is not at issue here.

Finally, the insurer contends that the mere fact that claimant continued to seek treatment for her low back condition does not necessarily indicate that she was not medically stationary, citing *Maarefi v. SAIF*, 69 Or App 527, 531 (1984). We disagree. The persuasive medical evidence indicates that claimant's low back condition was continuing to improve through physical therapy at the time of claim closure. For instance, through physical and aquatic therapy, claimant was experiencing gains in lumbar flexion and extension. (*See, e.g.* Ex. 50). It was not until April 17, 2000 that Dr. Weller remarked that claimant was thought to have "reached a plateau in her response to treatment [physical therapy]." (Ex. 64C). Accordingly, we agree with the ALJ that claimant's improvement through continued medical treatment is supportive of Dr. Weller's opinion that claimant was not medically stationary at the time of claim closure.

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 issues, and the value of the interest involved.

ORDER

The ALJ's order dated October 11, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the insurer.

January 9, 2001 Cite as 53 Van Natta 22 (2001)

In the Matter of the Compensation of
MAURICE K. SIMMONS, Claimant
WCB Case No. 99-08184
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Terrall & Terrall, Defense Attorney

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Davis' order that set aside its denials of claimant's occupational disease claim insofar as the denials pertain to an iliolumbar strain. 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. Haber, the attending physician, determined that claimant had established the compensability of an iliolumbar strain as an occupational disease. The employer contends that claimant's back condition is the result of a gradual worsening of a preexisting problem secondary to a prior 1992 ankle injury and leg length discrepancy, unrelated to claimant's present employment. (Appellant's Brief, p. 6).

Because claimant seeks to establish the compensability of his low back condition as an occupational disease, he must prove that his work activities are the major contributing cause of the disease itself (iliolumbar strain). ORS 656.802(2)(a); *Tammy L. Foster*, 52 Van Natta 178 (2000). If the occupational disease claim is based on the worsening of a preexisting disease or a "combined" condition pursuant to ORS 656.005(7), claimant must prove that his work activities were the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(b). To satisfy the "major contributing cause" standard, claimant must prove 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. *Stacy v. Corrections Div.*, 131 Or App 610, 614 (1994); *see 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).

Claimant acknowledges that, as a result of a prior 1992 injury, one of his legs is shorter than the other. However, claimant contends that this condition is separate from and has not combined with the iliolumbar strain condition. Based on our review of the medical evidence (particularly the persuasive opinion offered by Dr. Haber), we agree with claimant.

The record contains opinions from two physicians regarding the nature of claimant's iliolumbar strain condition. One is from Dr. Haber, the attending physician. The other is from Dr. Neumann, an employer-arranged medical examiner. Both doctors agree that claimant has, among other conditions, an iliolumbar strain, which is caused, to some extent, by claimant's work activities for this employer. However, while Dr. Haber concluded that claimant's work was the major contributing cause of the iliolumbar strain, Dr. Neumann concluded that claimant's work was the precipitating cause, but not the major cause, of the iliolumbar strain. (Ex. 65-2; 66-5).

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 no persuasive reasons not to defer to the opinion of Dr. Haber.

Dr. Haber's opinion is based on his examinations of claimant, claimant's history, and claimant's recovery following an injection into the iliolumbar ligament.[1] In explaining his reasoning that claimant's work was the major contributing cause of the iliolumbar strain, Dr. Haber indicated he would expect different findings (more unilateral) if the strain was prominently related to claimant's leg length discrepancy. (Ex. 66-22). We find his opinion well-reasoned and persuasive.

Dr. Neumann initially opined that claimant's work was the major contributing cause of claimant's low back condition. (Ex. 64-5). In rendering that opinion he specifically noted claimant had no contributing preexisting conditions. (*Id.*). Later, after a conversation with employer's counsel, Dr. Neumann indicated that claimant's work was the precipitating cause of the iliolumbar sprain, but not the major contributing cause of that condition.[2] (Ex. 65-2).

Part of Dr. Neumann's change of opinion appears to be based upon a July 1998 flareup in claimant's back pain coincident with his receipt of a new heel lift. (*Id.*). Because Dr. Neumann does not explain how this flareup in pain alters his previous opinion that claimant's preexisting leg length discrepancy did not contribute to the iliolumbar sprain, we find his opinion unpersuasive. *Blakely v. SAIF*, 89 Or App 653, 656, *rev den* 305 Or 972 (1988) (physician's opinion lacked persuasive force because it was unexplained).

In conclusion, we are persuaded that claimant's iliolumbar strain condition is separate from his preexisting shortened leg condition. Furthermore, we agree with the ALJ that claimant's work activities were the major contributing cause of has his iliolumbar strain condition. Consequently, the occupational disease claim is compensable for that 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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[1] We acknowledge the employer's argument that Dr. Haber's opinion rests on an incorrect history, *i.e.* that Dr. Haber was not aware of claimant's waxing and waning back pain dating from about November 1997. We note, however, that Dr. Haber had reviewed the chart note of Deborah Rogers, ANP, indicating claimant reported pain "on and off" since November 1997, and recorded such a history in his own chart note of December 12, 1998. (Ex. 13-2; 16-1). Consequently, we are not persuaded that Dr. Haber's opinion rests on an incorrect history.

[2] Prior to his conversation with employer's counsel, Dr. Neumann thought the precipitating cause was necessarily the major cause. (Ex. 65-1).

ORDER

The ALJ's order dated July 31, 2000 is affirmed. For services on review, claimant is awarded a $1,200 attorney fee, payable by the self-insured employer.

January 9, 2001 Cite as 53 Van Natta 24 (2001)

In the Matter of the Compensation of
MICHAEL L. SINGLETON, Claimant
WCB Case Nos. 00-04895 & 99-09809
ORDER ON REVIEW
Lundeen, et al, Defense Attorney
Hoffman, et al, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant, *pro se,* requests review of Administrative Law Judge (ALJ) Lipton's order that dismissed his request for hearing for failure to appear. On review, the issue is propriety of the ALJ's order.

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

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 and he did not contend that extraordinary circumstances justified postponement or continuance of the hearing. Under these circumstances, we conclude that the ALJ properly dismissed claimant's request for hearing.[1] *See Tobin E. Weymiller,* 50 Van Natta 2184 (1998).

ORDER

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

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[1] 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
350 Winter St NE, Room 160
Salem, OR 97301-3878

In the Matter of the Compensation of
JAVIER M. CHAVEZ, Claimant
WCB Case No. 00-00138
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that affirmed an Order on Reconsideration award of 13 percent (19.5 degrees) scheduled permanent disability for loss of use or function of his right hand. On review, the issue is extent of scheduled permanent disability.

We adopt and affirm the ALJ's order with the following changes and supplementation.[1] In the first paragraph of the "Opinion" on page 2, we change the first citation to "ORS 656.214(2)." In the second paragraph of the "Opinion" on page 2, we change the first three citations to "OAR 436-035-0050, 436-035-0075" and "OAR 436-035-0007(22)(b)."

Claimant argues that he is entitled to an additional scheduled permanent disability award for loss of muscle strength in his right hand. Claimant relies on the closing measurements taken by Ms. Saunders, that were "signed off on" by Dr. Jewell, claimant's attending physician. For the following reasons, we are not persuaded by claimant's argument.

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).

Claimant's attending physician at closure was Dr. Jewell. Claimant relies on the closing measurements taken by Ms. Saunders. On June 22, 1999, Ms. Saunders, who is apparently an occupational therapist, wrote to Dr. Jewell regarding claimant's June 14, 1999 closing examination. (Ex. 13). Ms. Saunders explained that claimant's "grip strength was approximately 50% of his left side." (Ex. 13-1). She referred to claimant's right grip strength as "47 pp" and his left grip strength as "96 pp." (*Id.*)

On June 29, 1999, Dr. Jewell wrote to the insurer and said he was enclosing a final wrist and hand evaluation. (Ex. 15). He stated that claimant had "what appears to be 5/5 strength and normal two-point discrimination." (*Id.*)

We find no evidence that Dr. Jewell "ratified" Ms. Saunders' June 1999 report. Even if we assume that Dr. Jewell's June 29, 1999 reference to the "final wrist and hand evaluation" was for Ms. Saunders' report, his letter expressly stated that claimant had "what appeared to be 5/5 strength[.]" (Ex. 15). Dr. Jewell's June 29, 1999 letter is inconsistent with Ms. Saunders' statement that claimant's "grip strength was approximately 50% of his left side." (Ex. 13-1). Furthermore, Ms. Saunders' report is not persuasive because she did not report claimant's loss of strength under the appropriate grading system as required by OAR 436-035-0007(19).[2] *See, e.g., Rosemary Peterson*, 52 Van Natta 1552 (where disability was not reported in the manner required by the standards, the findings did not establish entitlement to an award for loss of strength), *corrected* 52 Van Natta 1622 (2000).

We conclude that Dr. Jewell's opinion does not establish that claimant is entitled to an additional scheduled permanent disability award for loss of muscle strength in his right hand. There are no other medical opinions to support claimant's argument. We therefore affirm the ALJ's order.

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[1] We modify the ALJ's order to indicate that Exhibits 1 through 20 were admitted in evidence.

[2] OAR 436-035-0007(19) provides, in part: "To determine impairment due to loss of strength, the 0 to 5 international grading system and 0 to 5 method as noted in the **AMA Guides to the Evaluation of Permanent Impairment, 3rd Ed. Revised, 1990** shall be used." (Bold in original).

ORDER

The ALJ's order dated September 28, 2000 is affirmed.

January 10, 2001 Cite as 53 Van Natta 26 (2001)

In the Matter of the Compensation of
BRUCE W. BURROUGHS, Claimant
WCB Case No. 99-06219
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Terrall & Terrall, Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's occupational disease claim for a bilateral thumb 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. Coe's opinion is entitled to deference because he had an opportunity to treat claimant at least 12 times over an eight month period. *See Weiland v. SAIF*, 64 Or App 810 (1983). Dr. Coe considered claimant's age, his possible genetic predisposition and his work and off-work activities in assessing causation. Thus, he properly weighed the potential causative factors and found that claimant's repetitive work activities were the major contributing cause of the combined bilateral thumb condition and pathological worsening of the disease. (Exs. 25, 29, 30-34, -35, -39, -40, -44, -45). *See Dietz v. Ramuda*, 130 Or App 397, 402 (1994) (the relative contribution of each cause, including the precipitating cause, must be evaluated to establish major causation), *rev dismissed* 321 Or 416 (1995). We agree with the ALJ that Dr. Coe's opinion is persuasive because it is complete and well-reasoned.

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 $2,418, 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, which included claimant's counsel's uncontested statement regarding the hours devoted to the case), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated May 2, 2000 is affirmed. For services on review, claimant's attorney is awarded $2,418, payable by the self-insured employer.

In the Matter of the Compensation of
SCOTT D. DORRY, Claimant
WCB Case Nos. 00-03773 & 99-06251
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Claimant requests reconsideration of our December 14, 2000 Order on Review that affirmed the Administrative Law Judge's (ALJ's) order that declined to remand claimant's claim to the Department for promulgation of a temporary rule and affirmed an Order on Reconsideration that awarded no additional permanent disability beyond that which claimant had previously been awarded.

Specifically, claimant contends that our order is not consistent with the Supreme Court's decision in *Shubert v. Blue Chips*, 330 Or 554 (2000). Claimant asserts that *Shubert* holds that "the Department cannot promulgate a rule that contemplates impairment and award zero permanent disability for that impairment."

Initially, we note that in *Shubert*, the Board had found that the claimant had suffered impairment as a result of the surgical repair of his compensable shoulder condition, and that the claimant's disability was not addressed by the standards. 330 Or at 557. The Board therefore remanded to the Department for the promulgation of a temporary rule. *Id.* On remand, the Department adopted a temporary rule, but found that "the impairment value for these procedures shall be a value of zero." 330 Or at 557-558. The Supreme Court held that such a temporary rule, which did not address the claimant's personal circumstances, was "unresponsive as a matter of law" and contrary to ORS 656.726(4)(f)(C). 330 Or at 561. The Court specifically stated that "[I]f the Director *finds that a worker suffers from an impairment that results in disability and that that disability is not addressed by existing standards*, then the Director must promulgate a rule that addresses the worker's particular impairment." 330 Or at 560-561. (Emphasis added)

Here, unlike *Shubert*, the Appellate Unit found that claimant's "disability" related to his facial nerve condition *was* addressed by the existing standards, and therefore did not promulgate a temporary rule. (Ex. 30-3). We and the ALJ have affirmed the Appellate Unit's finding in that regard. On that basis, *Shubert* is distinguishable.

Moreover, here, claimant's (partial) dysfunction and motor loss of his right facial nerve is not an "impairment" entitled to a positive value under the applicable administrative rule. OAR 436-035-0390(6) contemplates an impairment value for the "complete" motor loss on either side of the face. Therefore, as the Appellate Unit found, claimant's "disability" (dysfunction and motor loss) related to the right facial nerve is addressed by the existing standards, but does not meet the threshold for an impairment rating under the standards. Under such circumstances, remand for a temporary rule is not appropriate. *Shubert*, 330 Or at 560 ("If the Director concludes that the condition at issue is not an impairment (or, at least, not one that is entitled to a positive impairment rating), then the condition is not a disability and no temporary rule is required by ORS 656.726(4)(f)(C).")

Accordingly, we withdraw our December 14, 2000 order. On reconsideration, as supplemented herein, we adhere to and republish our December 14, 2000 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
THOMAS J. GREENWOOD, Claimant
WCB Case No. 00-04416
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Meyers and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Fulsher's order that upheld the SAIF Corporation's denial of a left low back injury claim. Claimant also moves for remand for admission of a medical report that he received from SAIF after the hearing. On review, the issues are remand and compensability.

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

Our review is limited to the record developed at hearing. ORS 656.295(5). We may only remand to the ALJ should we find that the hearings record has been "improperly, incompletely or otherwise insufficiently developed." *Id.* Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

SAIF objects to claimant's request for remand, arguing that the medical report in question would not likely affect the outcome of the case because the opinion in that report continues to rely on an inaccurate history. Based on the following reasoning, we agree.

In this case, the ALJ found that claimant did not meet his burden of proving a compensable low back injury claim primarily because the medical opinions supporting compensability were based on incomplete and/or inaccurate histories. Regarding the opinion of Dr. Johns, claimant's treating chiropractor, the ALJ found that Dr. Johns was apparently unaware that claimant had recurrent exacerbations of back pain and was treated for low back pain in November 1999, prior to the March 2000 work incident. In addition, the ALJ found that Dr. Johns had an incorrect understanding of claimant's work duties, believing that claimant "sits all day." Because Dr. Johns' history was based on incomplete information, the ALJ did not find his opinion persuasive.

Regarding his request for remand, claimant submits a June 6, 2000 report from Dr. Johns that he received from SAIF on October 11, 2000, after the hearing record closed and the ALJ's order issued. In this report, Dr. Johns explained his disagreement with a May 1, 2000 report from Dr. Woodward, M.D., who examined claimant on behalf of SAIF. In reaching his opinion that claimant's work was the major contributing cause of his low back injury, Dr. Johns continued to rely on a history that claimant had not required any formal medical treatment to his lower back since the time of a lumbar laminectomy 16 years earlier.

As the ALJ found, however, that is not a correct history. Because Dr. Johns continues to rely on an inaccurate history in rendering his causation opinion, his June 6, 2000 report would likely not affect the outcome of this case. Thus, we find no compelling reason to remand to the ALJ for additional proceedings. Accordingly, claimant's motion is denied.

ORDER

The ALJ's order dated October 4, 2000 is affirmed.

In the Matter of the Compensation of
JUNE M. COCHRAN, Claimant
WCB Case No. 00-05085
ORDER ON REVIEW (REMANDING)
Meyers, Radler, et al, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Mills' order that dismissed her request for hearing for failure to appear at hearing. On review, the issue is the propriety of the ALJ's order. We remand.

FINDINGS OF FACT

Claimant filed a request for hearing on June 6, 2000. Neither claimant nor an attorney representing her was present when the hearing convened as scheduled on October 5, 2000. The self-insured employer moved to dismiss claimant's hearing request based on her failure to appear.

On October 13, 2000, the ALJ issued an Order of Dismissal, based on claimant's failure to appear or otherwise prosecute her request for hearing. However, the ALJ gave claimant 30 days from the date of his order to request reconsideration and to show good cause for her failure to appear at the scheduled hearing.

On November 7, 2000, the Board received a letter from claimant. Claimant stated that she had attempted to change the date of hearing by telephone, due to rescheduling of a medical appointment. Claimant also stated that she missed the hearing because of her busy schedule.

CONCLUSIONS OF LAW AND OPINION

An ALJ shall dismiss a request for hearing if claimant or her attorney fails to attend a scheduled hearing unless extraordinary circumstances justify a postponement or continuance of the hearing. OAR 438-006-0071(2). The ALJ, however, must consider a motion for postponement even if submitted after the ALJ issues an order of dismissal. *E.g., Olga G. Semeniuk*, 46 Van Natta 152 (1994). In those cases where the ALJ does not have the opportunity to rule on the motion to postpone, the Board remands the case to the ALJ for consideration of the motion. *Id.* The exception is when the motion to postpone contains no explanation concerning the claimant's failure to appear; in the absence of such discussion, we have found no compelling reason to remand. *E.g., James C. Crook, Sr.*, 49 Van Natta 65 (1997).

Here, in her letter, claimant explains her failure to appear as being due to a rescheduled medical appointment and her busy schedule. Therefore, we find that claimant's letter following the Order of Dismissal constitutes a motion for postponement. In addition, because the ALJ did not have the opportunity to rule on the motion to postpone, the case should be remanded for the ALJ to decide if there are "extraordinary circumstances" preventing dismissal.[1] We emphasize that our order does not address the substance of claimant's allegations and it is up to the ALJ to evaluate the grounds of the motion.

Accordingly, the ALJ's October 13, 2000 order is vacated. This matter is remanded to ALJ Mills to determine whether to postpone claimant's hearing request. The ALJ shall proceed in any manner that will achieve substantial justice. If the ALJ grants the motion to postpone, the case will proceed to a

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[1] We note that the ALJ's order that both dismissed the hearing request and gave claimant an opportunity to request abatement and reconsideration was appropriate here, where claimant did not appear at a scheduled hearing and no communication regarding the non-appearance was received. Nevertheless, to avoid confusion and conflict with the 30-day appeal period, the "show cause" period might have been reduced to a period less than 30 days. *See Teresa Marion*, 50 Van Natta 1165, 1166 n.1 (1998); *Brent Harper*, 50 Van Natta 499, 500 n.2 (1998).

hearing on the merits at an appropriate time as determined by the ALJ. If the ALJ does not grant the motion to postpone, the ALJ shall dismiss the request for hearing.[2]

IT IS SO ORDERED.

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[2] Inasmuch as claimant is presently unrepresented, she may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in such matters. She may contact the Workers' Compensation Ombudsman at (503) 378-3351 or 1-800-927-1271, 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
LARRY T. WOLTER, Claimant
Own Motion No. 00-0027M
OWN MOTION ORDER
Dennis O'Malley, Claimant Attorney

The self-insured employer submitted claimant's request for temporary disability compensation for his current low back condition. Claimant's aggravation rights expired on June 13, 1996. The employer denied the compensability of claimant's current condition on which claimant has filed a request for hearing with the Hearings Division. (WCB Case No. 00-02242).

On March 27, 2000, the Board postponed action on the Own Motion request pending the resolution of the litigation before the Hearings Division. However, pursuant to an approved December 6, 2000 Claim Disposition Agreement (CDA), claimant has fully released his rights to all "non-medical service" workers' compensation benefits (including temporary disability and Own Motion benefits).

As a result of the CDA, claimant is no longer entitled to any temporary disability benefits related to his November 10, 1987 injury claim. *See* ORS 656.236(1); *Jack F. Stewart*, 51 Van Natta 22 (1999); *Jeffrey B. Trevitts*, 46 Van Natta 1767 (1994); *aff'd Trevitts v. Hoffman-Marmolejo*, 138 Or App 455 (1996). In light of such circumstances, claimant's request for Own Motion relief has been rendered moot.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
MOISES HERNANDEZ, Claimant
WCB Case No. 00-03941
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorney
Reinisch, et al, Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Mongrain's order that set aside its denial of claimant's injury claim for an L5-S1 intervertebral disc displacement, L5-S1 lumbar spondylolisthesis and bilateral L5-S1 radiculopathy. On review, the issue is compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the first paragraph of the findings of fact on page 1, we replace the last sentence with the following:

> "Dr. McClure performed claimant's hernia surgery on February 8, 2000. (Ex. 21). His postoperative diagnosis was an incarcerated umbilical hernia with a left inguinal hernia. (*Id.*)
>
> "After the hernia surgery, claimant continued to complain of pain in his right inguinal region. (Ex. 22). Dr. Fridinger noted that claimant had pain back into his right buttock and the pain 'really hasn't changed any since the very beginning.' (*Id.*) Dr. Fridinger also reported that claimant had intermittent tingling and weakness in his right leg. (*Id.*)"

CONCLUSIONS OF LAW AND OPINION

We adopt and affirm the portion of the ALJ's order that set aside the insurer's denial of claimant's L5-S1 intervertebral disc displacement, and bilateral L5-S1 radiculopathy.

For the following reasons, however, we reverse that portion of the ALJ's order that set aside the insurer's denial of claimant's L5-S1 lumbar spondylolisthesis.

The insurer issued a partial denial of claimant's L5-S1 bilateral lumbar intervertebral disc displacement, L5-S1 lumbar spondylolisthesis and bilateral L5-S1 radiculopathy. (Ex. 39). At hearing, claimant's attorney said claimant was not claiming that the work injury caused the L5-S1 spondylolisthesis, so that was not at issue. (Tr. 3). He explained that the issues were compensability of the L5-S1 herniation/disc displacement and bilateral radiculopathy. (*Id.*) In closing arguments, the ALJ explained that the issues were L5-S1 herniation or herniated disc/disc displacement and bilateral radiculopathy. (Closing arguments at 14).

On review, both parties agree that the ALJ's order should be altered to reflect that the L5-S1 spondylolisthesis is not an accepted condition. We therefore reverse the ALJ's order to the extent that the insurer's denial of claimant's L5-S1 spondylolisthesis was set aside. Instead, that portion of the insurer's denial is reinstated and upheld.

Claimant's attorney is entitled to an assessed fee for services on review concerning the L5-S1 intervertebral disc displacement and bilateral L5-S1 radiculopathy. 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 conditions is $1,800, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated October 2, 2000 is affirmed in part and reversed in part. That portion of the ALJ's order that set aside the insurer's denial of claimant's L5-S1 spondylolisthesis is reversed. The insurer's denial of that condition is reinstated and upheld. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded $1,800, payable by the insurer.

January 10, 2001 Cite as 53 Van Natta 32 (2001)

In the Matter of the Compensation of
WILLIAM E. LEWIS, Claimant
WCB Case No. 00-04633
ORDER ON REVIEW
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that upheld the SAIF Corporation's denial of claimant's occupational disease/injury claim for a low back condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

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

Board Member Phillips Polich specially concurring.

I agree with the conclusion that claimant has failed to carry his burden to prove that his low back condition is compensable. I write separately to emphasize that claimant failed to meet his burden of proof to establish his claim under an occupational disease theory because Dr. Fohrman opined that claimant's work activity caused a temporary symptomatic worsening of his preexisting condition rather than a pathological worsening of his preexisting condition, as is required under ORS 656.802(2)(b).

In the Matter of the Compensation of
TRUDIE L. PFAFF, Claimant
WCB Case No. 00-01023
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of claimant's left groin injury claim. On review, the issue is compensability.

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

In setting aside SAIF's denial, the ALJ analyzed the claim as one for an accidental injury involving a "combined condition" under ORS 656.005(7)(a)(B). Relying on the opinion of attending physician Dr. Lebow, the ALJ determined that claimant had satisfied her burden of proving that an incident at work on October 8, 1999 when claimant was carrying a heavy mail tote upstairs was the major contributing cause of the need for treatment of the "combined condition."

On review, SAIF contends that Dr. LeBow's opinion is insufficient to carry claimant's burden of proof, as it is no more than a precipitating cause analysis. We disagree.

After *de novo* review of this record, we agree with the ALJ that, because the medical evidence establishes that an otherwise compensable injury combined with claimant's preexisting left inguinal hernia surgery, the appropriate framework for determining the compensability of the October 1999 injury is the "combined condition" standard in ORS 656.005(7)(a)(B). Accordingly, claimant must prove that the stepping incident was the major contributing cause of the disability or 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).

A medical opinion that only identifies the work injury as a precipitating cause of the condition or need for treatment is not sufficient to establish the work injury as the major contributing cause. *Nehl*, 149 Or App at 313; *Robinson v. SAIF*, 147 Or App 157 (1997). However, we must evaluate Dr. Lebow's opinion in the context in which it was rendered in order to determine its sufficiency. *SAIF v. Strubel*, 161 Or App 516 (1999).

Initially, Dr. Lebow stated that "historically" the lifting incident appeared to be the cause of claimant's complaints. (Ex. 17). He also stated that "in the normal state of affairs there would most likely be no way this (the lifting incident) would have caused problems without the prior hernia and repair." (*Id.*) Subsequently, Dr. Lebow indicated that the "lifting incident" at work was the major contributing cause of the need for treatment of claimant's combined condition. (Ex. 19). Dr. Lebow explained that all of claimant's symptoms had occurred since the lifting incident and that, based on the length of time that claimant was without symptoms following the March 1999 surgery, that the (noncompensable) hernia repair surgery had been a success. (*Id.*) Finally, Dr. Lebow stated that the July 2000 surgical findings confirmed his earlier opinions, and that it was the *dislodgement* of the mesh plug (that had been placed during the March 1999 surgery) that had caused claimant's medical problem. (Ex. 20).

In other words, Dr. Lebow established that claimant's March 1999 hernia repair surgery with placement of a mesh plug and floor had been successful because claimant had been asymptomatic for several months prior to the October 1999 work incident. Dr. Lebow also established that the mesh plug had been dislodged as a result of the lifting incident. Finally, Dr. Lebow stated that he had weighed all the potential causes of claimant's need for treatment after October 8, 1999 and thereafter.

Under the circumstances, we agree with the ALJ that claimant has met her burden to prove that her October 1999 lifting incident was the major cause of her need for medical treatment for her

combined left groin condition. *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 work injury was not only the precipitating cause but was also the primary cause of the claimant's need for treatment for his combined 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 $2,000, 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 September 22, 2000 is affirmed. For services on review, claimant's attorney is awarded a fee of $2,000, to be paid by the SAIF Corporation.

January 11, 2001 Cite as 53 Van Natta 34 (2001)

In the Matter of the Compensation of
HEDI M. HOESING, Claimant
WCB Case No. C003154
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Kryger, et al, Claimant Attorney
Sather, et al, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

On December 28, 2000 the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

A claim disposition agreement shall not be approved if, within 30 days of submitting the disposition to us, the worker, insurer or self-insured employer requests that we disapprove the disposition. ORS 656.236(1)(a)(C).

Here, the disposition was submitted to us on December 28, 2000. The statutory 30th day following the submission is January 29, 2001. The insurer's attorney filed a request for disapproval of the disposition on January 4, 2001. Because the insurer (through its attorney) has requested disapproval within the 30-day period, we disapprove the disposition. *Id.*

Inasmuch as the proposed disposition has been disapproved, the insurer 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
LYLE L. POPE, Claimant
WCB Case No. 99-05769
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) set aside its denial of claimant's right index finger injury claim; and (2) awarded claimant's counsel an assessed attorney fee of $1,000. On review, the issues are coverage and attorney fees.

We adopt and affirm the order of the ALJ, with the following supplementation.

At hearing, the parties agreed that the issue was whether the insurer covered claimant's employer for workers' compensation purposes at the time of claimant's injury. On review, the insurer argues that its coverage responsibility had been terminated and it did not insure the employer at the time claimant was injured.

The ALJ found that the statute, ORS 656.423, requires that the employer provide written notice to the insurer; however, the ALJ concluded that there was no evidence that such notice had been provided and therefore, the guaranty contract provided by the insurer had not been properly cancelled. On review, the insurer contends that, pursuant to *Jose S. Sandoval-Perez*, 48 Van Natta 395 (1996), the knowledge of the employer is legally attributable to the insurer. Consequently, the insurer argues that it is not dispositive that the employer in this case did not provide notice to the insurer of its cancellation.

We do not find *Sandoval-Perez* to be on point. In *Sandoval-Perez*, the issue was the propriety of a "back-up" denial. The statutes at issue in this case, ORS 656.247 and ORS 656.423, were not discussed. Moreover, the statutes also require that notice of cancellation be provided to the Director, yet there is no evidence of compliance with the statutes on this additional basis. Consequently, even assuming that the notice from the employer could be considered as "knowledge legally attributable" to the insurer sufficient to satisfy the statute, the fact that the Director was not provided with notice supports the ALJ's conclusion that there was no effective cancellation of the insurer's guaranty contract. Accordingly, at the time claimant was injured, the insurer's contract was in effect and the insurer is responsible for claimant's injury claim.[1]

ORDER

The ALJ's order dated September 18, 2000 is affirmed.

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[1] We note that no attorney fee has been awarded for claimant's counsel's services on review, in light of the fact that claimant's counsel has taken the position that the sole issue is responsibility and his total fee is limited to $1,000, pursuant to ORS 656.308(2)(d). Accordingly, because the ALJ has awarded the maximum permitted under the statute, we do not award a fee on review.

In the Matter of the Compensation of
KARL J. WOLF, Claimant
WCB Case No. 99-08766
ORDER ON REVIEW
Doblie & Associates, Claimant Attorney
Reinisch, et al, Defense Attorney

Reviewed by Board Members Biehl and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Mills' order that: (1) set aside its denial of claimant's occupational disease claim for an L5-S1 herniated disc; and (2) awarded a fee of $4,000 for claimant's counsel's services at hearing. On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

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

Claimant, a software engineer, performs a sedentary job, sitting in an office chair at a desk in a cubicle. In April 1999, claimant's usual chair was switched for a different chair that was broken in two ways: (1) it had a ten-degree forward tilt that claimant could not return to a more ergonomic reverse tilt; and (2) the height adjustment was broken, so that it continually sunk to its lowest height. In order to prevent the sinking, claimant locked the chair at its highest position, which was too high for him. The chair, which was at an unergonomic tilt and too high, was immediately uncomfortable for claimant. Claimant continued to work eight hour days sitting in the chair through the first week or so of April.

On Saturday, April 9, 1999, claimant awoke with left hip and buttocks pain. On April 12, 1999, claimant sought medical treatment. He was diagnosed with a low back strain.

Claimant continued to work, using the bad chair, and continued to treat for low back pain. By the first of May, claimant connected the chair to his low back pain and complained to his employer about the chair.

Claimant developed radicular complaints, so Dr. Gonzalez ordered an MRI, which revealed a left-sided L5-S1 herniated disc. Claimant filed a claim.

In June 1999, claimant began treating with Dr. Breitenstein, chiropractor, who has provided the majority of claimant's care and who has treated claimant on a number of occasions.

Claimant's condition was also evaluated for surgery by Dr. Rohrer, neurosurgeon. Because claimant's condition improved, Dr. Rohrer agreed that ongoing conservative care was appropriate.

On January 12, 2000, Dr. Scheinberg performed a records review.

CONCLUSIONS OF LAW AND OPINION

Applying ORS 656.802(2)(a), the ALJ concluded that claimant's occupational disease claim for his herniated disc was compensable. On review, the insurer first contends that the appropriate standard for establishing compensability is ORS 656.802(2)(b). Claimant agrees.

ORS 656.802(2)(b) provides: "If the occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005(7), the worker must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease." *See Ron L. Merwin*, 49 Van Natta 1801 (1997).

The insurer also asserts that, because Dr. Breitenstein is a chiropractor, he does not possess the level of expertise of medical doctors to persuasively evaluate complex causation issues. For the reasons stated by the ALJ, we agree that there are no persuasive reasons not to defer to Dr. Breitenstein's opinion. *See Weiland v. SAIF*, 64 Or App 810, 814 (1983). That is, Dr. Breitenstein is the treating physician, his opinion is based on an accurate history and is well-reasoned; thus, it is persuasive. *See Somers v. SAIF*, 77 Or App 259, 263 (1986).

Here, Dr. Breitenstein articulated the various factors under consideration as possible causes of claimant's condition: a mild preexisting degenerative disc condition, and accumulated compressive loads resulting from sitting in a forward-tilted position for extended periods. Dr. Breitenstein explained that one would not expect the mild degeneration to result in a herniation to the degree found in claimant. He also discussed the effect of sitting in the non-ergonomic chair. He explained that normal sitting puts compressive loads on the back that are greater than standing. These loads are increased several times in a non-ergonomically positioned chair.

Dr. Breitenstein then explained the progression of the pathology in claimant's back as a two-step process. First, the compressive loads caused strain to the muscles and ligaments. Then, with the muscles and ligaments unable to provide compensatory support, along with the continued postural stress, the preexisting degenerative disc began to swell, causing a tear within the weakened annular fibers, followed by eventual herniation of the disc. (Ex. 35).

Dr. Breitenstein's persuasive opinion is sufficient to establish that employment conditions, namely the continued postural stress of sitting 8 hours a day in the non-ergonomic chair, were the major contributing cause of the combined condition and pathological worsening of the disease.[1]

The insurer next contends that the ALJ's attorney fee award of $4,000 was excessive. After review of this record and consideration of the factors set forth in OAR 438-015-0010(4), we adopt and affirm the ALJ's reasoning and conclusion that a $4,000 attorney fee award was reasonable for claimant's counsel's services at hearing for prevailing over the insurer's denial.

Finally, claimant's counsel is entitled to an insurer-paid attorney 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), we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $2,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's counsel's statement of services, claimant's respondent's brief, and after considering the insurer's objection), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for services devoted to the attorney fee issue. *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated June 9, 2000 is affirmed. For services on review regarding the compensability issue, claimant's counsel is awarded a $2,000 attorney fee, payable by the insurer.

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[1] For the same reasons as expressed by the ALJ, we do not find the opinions of Dr. Rohrer or Dr. Scheinberg persuasive, and adopt the ALJ's discussion regarding their reports.

January 12, 2001 Cite as 53 Van Natta 37 (2001)

In the Matter of the Compensation of
MARTY C. HAYTER, Claimant
WCB Case No. 00-03501
ORDER ON REVIEW
Todd Hammond (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that dismissed his request for hearing. On review, the issue is propriety of the ALJ's dismissal order.

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

Pursuant to claimant's hearing request, a hearing was scheduled for August 9, 2000. The day before the hearing, the case was reported as settled and the hearing was cancelled. After more than 60 days passed without receipt of settlement documents, the ALJ issued an October 10, 2000 Order to Show Cause, giving claimant 15 days to show cause why the case should not be dismissed as abandoned or for unjustified delay.

Fifteen days passed without a response to the ALJ's order. The ALJ then issued an Order of Dismissal on October 30, 2000.

On November 9, 2000, claimant filed a letter, requesting Board review of the ALJ's order. In his letter, claimant stated that he "[did] not agree with this dismissal order. I need time to seek legal counsel." The Board has also received another letter from claimant repeating his intention to seek legal counsel and his belief that he was treated unfairly (specifically, that he did not receive reimbursement for lost time and medical expenses for attending a July 2000 medical arbiter examination).

The issue here is whether the ALJ properly dismissed claimant's hearing request. Thus, claimant's substantive arguments regarding the processing of his claim are not before us at this time. Turning to the procedural issue of the ALJ's dismissal order, we find that the ALJ properly dismissed hearing request in light of claimant's failure to respond to the ALJ's show-cause order within 15 days. Moreover, claimant's letters provide no explanation for his failure to respond. Under such circumstances, we affirm the ALJ's dismissal order because claimant engaged in conduct that resulted in an unjustified delay in the hearing of more than 60 days.[1] *See* OAR 438-006-0071(1).[2]

ORDER

The ALJ's order dated October 30, 2000 is affirmed.[3]

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[1] We have interpreted a claimant's "post-dismissal order" correspondence after a hearing request has been dismissed for failure to appear as a motion for postponement of the scheduled hearing. In those cases, where the ALJ did not have an opportunity to rule on the motion, we have remanded to the ALJ for consideration of the motion. *See Randy L. Nott*, 48 Van Natta 1 (1996); *Olga G. Semeniuk*, 46 Van Natta 152 (1994).

Here, the ALJ issued an Order to Show Cause requiring claimant to respond within 15 days. Unlike other cases where we have remanded to ALJs to rule on a "post-dismissal order" request for postponement, claimant has not offered any explanation for his failure to respond to the ALJ's show-cause order within the allotted 15-day period. Under these circumstances, we find no compelling reason to remand to the ALJ for further proceedings. *See Glen A. Harbison*, 50 Van Natta 2157 (1998).

[2] OAR 438-006-0071(1) provides: "A request for hearing may be dismissed if an Administrative Law Judge finds that the party that requested the hearing has abandoned the request for hearing or has engaged in conduct that has resulted in an unjustified delay in the hearing of more than 60 days."

[3] 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. He 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
350 WINTER ST NE, ROOM 160
SALEM OR 97301-3878

In the Matter of the Compensation of
SCOTT A. GRIGGS, Claimant
WCB Case No. 99-09923
ORDER ON REIVEW
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) Stephen Brown's order that dismissed his request for hearing. On review, the issue is dismissal.

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

We replace the ALJ's Finding (7) with the following.

Dr. Benton agreed with the following statement from claimant's attorney:

"It was your opinion that based on the history you recorded in your August 6, 1999 chart note that the major cause (51% or more) of the tendinitis was the work injury in June 1999. You also considered the fact that [claimant] is a bow hunter and was lifting weights of 20 or 30 pounds as part of a conditioning program when you made your diagnosis and are still of the opinion that the work injury is the major cause of [claimant's] tendinitis." (Ex. 15).

ORDER

The ALJ's order dated July 20, 2000 is affirmed.

Board Member Phillips Polich dissenting.

I disagree with the majority's conclusion that claimant had not established good cause for his failure to timely request a hearing. Instead, I would reverse the ALJ's order and find that claimant is entitled to a hearing on the merits of his claim.

Claimant testified that after receiving the denial he called both the insurer and the Workers' Compensation Ombudsman in order to find out what he needed to do to get his claim accepted. (Tr. 9). Claimant's testimony is corroborated by the Ombudsman's office phone log which indicates that claimant contacted the Ombudsman's office on September 21, 1999. (Ex. 12A). Following his conversation with the Ombudsman's office, claimant testified that on either October 14th or 15th, he mailed a request for hearing contesting the insurer's denial. (Tr. 10). On December 8, 1999, claimant again called the Ombudsman's office because he had not received any information regarding his request for hearing. (Tr. 11). Claimant's testimony was again corroborated by the Ombudsman's office phone logs which indicate that claimant called on December 8, 1999. (Ex. 12B). The phone logs also support claimant's testimony that he had requested a hearing on October 14, 1999, but had not received any confirmation. (Id.).

Based on the above, I would find that claimant had established good cause for his failure to timely request a hearing. Claimant was not represented by counsel at the time he was attempting to appeal the insurer's denial. His testimony regarding his actions is corroborated by the Ombudsman's office phone logs. (Exs. 12A, 12B). Unlike the majority, I do not believe that a chart note referencing weight-lifting activities is sufficient to cast doubt on claimant's credibility with regard to appealing the insurer's denial. As noted earlier, claimant's testimony concerning his actions is supported by his phone calls to the Ombudsman's office.

On this record, I believe that claimant has established good cause for his failure to timely request a hearing. Because the majority concludes otherwise, I respectfully dissent.

In the Matter of the Compensation of
LARRY T. OLSON, Claimant
WCB Case No. 00-04232
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that upheld the insurer's denial of his 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.

After claimant filed a claim for low back pain in March 2000, the insurer arranged an evaluation by Drs. Courogen and Brooks, who attributed claimant's low back symptoms in major part to preexisting degenerative disc disease. (Ex. 9). Dr. Bert, the attending physician, concurred with the report without reservation. (Ex. 11).

The insurer then denied the claim and claimant requested a hearing. In a "post-denial" report to claimant's attorney, Dr. Bert opined that claimant's work activity was the major contributing cause of a worsening of the degenerative disc disease and stated that he agreed with Dr. Courogen's history and diagnosis of degenerative disc disease. (Ex. 14).

In upholding the insurer's denial, the ALJ determined that the opinion of Dr. Bert was no more persuasive than that of examining physicians, Drs. Courogen and Brooks. The ALJ reasoned that Dr. Bert did not explain why he had changed his opinion regarding the cause of claimant's low back condition or provide any explanation in support of his "altered" opinion.

On review, claimant disagrees with the ALJ's determination and contends that the Courogen/Brooks report did not address the occupational disease aspect of the claim. Thus, claimant asserts that Dr. Bert's final report does not represent a change of opinion, but rather only a clarification of his opinion. We disagree.

Drs. Courogen and Brooks were asked to address whether claimant sustained a work-related injury or occupational disease. They responded that they had no consistent history of a work-related injury or specific event, but that the persistence of claimant's symptoms in the absence of "occupational activity" for three months was evidence against "occupational activity" as a major factor in the genesis of his back pain. (Ex. 9-6). In light of this response, we are persuaded that the panel considered not just the possibility of an occupational injury as the cause of claimant's low back condition, but also claimant's work activities in general as part of an occupational disease.

Thus, we conclude that Dr. Bert, through his unqualified concurrence with the Courogen/Brooks report, did at one point agree that claimant's overall work activity was not the major contributing cause of his low back condition. In light of this, his subsequent opinion attributing claimant's low back condition in major part to his work activity conflicts with his prior concurrence opinion.

Moreover, we also agree with the ALJ's reasoning that Dr. Bert's final opinion is not persuasive because it offers little or no explanation for his causation opinion. *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). For example, if, as Dr. Bert contends, claimant's work activity is the major factor in his low back condition, Dr. Bert does not explain why claimant's condition did not significantly improve with three months off work. Thus, for these reasons, we conclude that Dr. Bert's opinion is not persuasive.

In summary, we find that the ALJ properly upheld the insurer's denial. Accordingly, we affirm.

ORDER

The ALJ's order dated September 22, 2000 is affirmed.

In the Matter of the Compensation of
EILEEN CAVITT, Claimant
WCB Case No. 00-00246
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorney
Meyers, Radler, et al, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Hoguet's order that set aside its denial of claimant's occupational disease claim for a right shoulder condition. On review, the issue is compensability.

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

The ALJ relied upon the medical opinion of Dr. Chestnutt (attending physician), and determined that claimant had established the compensability of her right shoulder condition as an occupational disease.

On review, the employer argues that because of the sudden onset of claimant's symptoms, the right shoulder condition is an injury, not an occupational disease.[1] We disagree.

The distinction between occupational diseases and accidental injuries is usually drawn along the lines that occupational diseases are gradual rather than sudden in onset. *Fuls v. SAIF*, 321 Or 151 (1995); *Mathel v. Josephine County*, 319 Or 235, 240 (1994); *James v. SAIF*, 290 Or 343, 348 (1981); *Weyerhaeuser v. Woda*, 166 Or App 73, 79-80 (2000).

Here, claimant performed repetitive activities for this employer for a period of five years before she began to experience pain on November 13, 1998. (Tr. 7; 39; 40). She had no preexisting conditions. (Tr. 38; 39). Claimant continued to work for about one year after the 1998 incident, during which time her shoulder problems worsened, eventually requiring surgery. Such a history suggests a condition that is gradual in onset.

Dr. Chestnutt opined that claimant's right shoulder condition was the result of cumulative trauma of impingement of the rotator cuff caused by claimant's work activities which required use of the right arm in positions above shoulder height. (Ex. 11-3). Consequently, based upon claimant's work history and Dr. Chestnutt's explanation of the mechanics involved in producing claimant's problems, we conclude that claimant's right shoulder condition is an occupational disease, and not an accidental injury.[2] Accordingly, we affirm the ALJ's order.

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 10, 2000 is affirmed. Claimant's attorney is awarded an assessed fee of $1,000, to be paid by the self-insured employer.

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[1] The employer alleges that claimant did not give notice of an accident resulting in injury within 90 days of the onset of her arm pain as required by ORS 656.265(1), and that therefore, the claim is time barred pursuant to ORS 656.265(4). (Ex. 8). Because we have found that the condition is an occupational disease, however, we need not address this issue.

[2] According to Dr. Chestnutt, claimant's right shoulder condition is caused by a series of traumatic occurrences as the result of her work. ORS 656.802(1)(a)(C) specifically defines "[a]ny series of traumatic events or occurrences which requires medical services or results in physical disability or death," as an occupational disease. As a result, such a condition is considered an "occupational disease" regardless of the suddenness of its onset. *Fuls*, 321 Or at 158; *Woda*, 166 Or App at 82. Consequently, even if claimant's right shoulder condition had a sudden onset, it nonetheless, must be analyzed as an occupational disease. *See Fuls v. SAIF*, 321 Or 158; *see Woda*, 166 Or App at 82.

Board Member Haynes specially concurring.

I agree with the conclusion that this claim is based on an occupational disease and not an injury. I also agree that claimant has established the compensability of her right shoulder condition. However, I do not adopt the ALJ's rationale for discounting the opinions of Dr. Button and Dr. Anderson (employer-arranged medical reviewers).

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). In reviewing the medical record, I find no persuasive reason to deviate from this general practice. Consequently, I agree that claimant's right shoulder condition is compensable as an occupational disease.

In the Matter of the Compensation of
JAMES M. DAVIS, Claimant
WCB Case No. 99-08694
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorney
Hornecker, Cowling, et al, Defense Attorney
James W. Moller, Defense Attorney

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that set aside its partial denial of claimant's injury claim for an L5-S1 disc condition. In its brief, the employer requests remand to submit additional documents. On review, the issues are remand and compensability. We deny the employer's motion for remand and reverse.

FINDINGS OF FACT

Claimant, age 22, began working for the employer in August 1998. (Ex. 5). His work as a dryer grader involved pulling and feeding plywood. (Tr. 10, 11). Claimant testified that his low back started hurting on December 20, 1998, when he was feeding the wood into the dryer. (Tr. 11, 12).

Claimant sought treatment from Dr. Russo on December 22, 1998. (Ex. 2, Tr. 25). Dr. Russo reported that claimant had low back pain and "has no specific injury that he can recall." (Ex. 2). He reported that claimant "feels his injury happened at work when he was pulling some wood approximately two days ago." (*Id.*) Dr. Russo diagnosed a low back strain and recommended light duty. (*Id.*)

On January 2, 1999, Dr. Russo reported that claimant still had some low back pain, but denied any radicular pain. (Ex. 4-1). Dr. Russo did not anticipate any long-term problem or disability. (*Id.*)

On January 12, 1999, Dr. Russo reported:

> "[Claimant] states he is getting better, still having some soreness on exertion of lumbar spine. At this time [claimant] denies lower extremity pain, denies any radicular complaints. He feels he can return to his regular job at this time. He feels stable, approximately 80% improved." (Ex. 4-3).

Dr. Russo diagnosed "[l]ow back strain resolving." (*Id.*) He estimated claimant would be stationary in two to four weeks. (*Id.*) When claimant did not return for follow-up treatment, Dr. Russo assumed that he was medically stationary. (Ex. 6).

The employer accepted a nondisabling acute lumbosacral strain. (Ex. 7).

Claimant testified that he continued to have back pain. (Tr. 21). There is no evidence of medical treatment between January 12, 1999 and July 20, 1999. Claimant sought chiropractic treatment from Dr. Combe from July 1999 through October 1999. (Exs. 14, 22).

On August 17, 1999, claimant was treated by Dr. Stoddard. (Ex. 8). His chart notes said "low back pain - not sure if hurt by injury x 6 mos." (*Id.*) Dr. Stoddard's notes said "radiates * * * some." (*Id.*) He recommended back exercises and medication. (*Id.*) A lumbar spine x-ray was essentially normal. (Ex. 9).

Claimant was treated by Dr. Collins on August 31, 1999. (Ex. 10). Claimant complained of continued back pain from a December 1998 injury. (*Id.*) Dr. Collins referred to pain into the right buttock and "buttock pain x 2 mos." (*Id.*) He noted "minimal objective findings." (*Id.*)

Claimant returned to Dr. Russo on September 13, 1999. (Ex. 11). Dr. Russo reported that claimant had periods without pain and then the pain would flare up again with minor activity, such as coughing or twisting. (*Id.*) Claimant denied any radicular-type complaints, other than some occasional pain into his left buttock. He diagnosed low back pain and possibly slight sciatica. (*Id.*)

A September 13, 1999 MRI showed a central disc herniation at L5-S1 of "uncertain clinical significance." (Ex. 12).

Dr. Russo's October 8, 1999 chart note said that claimant denied any specific radicular complaints, although he had some low back pain into his buttocks. (Ex. 17). Claimant was referred to Dr. Stephen Goodwin. In November 1999, Dr. Russo said he did not have any further treatment to offer claimant. (Ex. 24).

On October 22, 1999, the employer issued a partial denial of claimant's low back radicular complaints. (Ex. 20).

Dr. Stephen Goodwin examined claimant on October 28, 1999 and referred to a history of low back pain since the December 1998 injury. (Ex. 23-2). He reported that claimant had a normal neurologic exam, but "an abnormal MRI appearance." (Ex. 23-1). He diagnosed an "[a]pparent discal injury[,]" but did not recommend surgery. (Exs. 23-3).

On November 30, 1999, Dr. Allen Goodwin diagnosed "[l]ikely discogenic pain judging from the MRI coupled with the patient's history." (Ex. 28-2). He recommended an epidural steroid injuection and a possible discogram. (*Id.*)

Claimant was examined by Dr. Lewis on December 15, 1999. (Ex. 30A-1). He felt that claimant's work injury had damaged his L5-S1 disc with a small central disc herniation. (*Id.*) He recommended a discogram. (Ex. 30A-2).

On January 12, 2000, Drs. Bald and Farris examined claimant on behalf of the employer. (Ex. 33).

CONCLUSIONS OF LAW AND OPINION

Remand

The employer requests remand to submit four documents: (1) a July 25, 2000 report from Drs. Farris and Bald regarding claimant's low back condition; (2) Dr. Bald's September 14, 2000 concurrence letter from the employer's attorney; (3) January 12, 2000 examination notes from Drs. Bald/Farris; and (4) July 25, 2000 examination notes from Drs. Bald/Farris.

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). A compelling reason exists when the new evidence (1) concerns disability; (2) was not obtainable at the time of the hearing; and (3) is reasonably likely to affect the outcome of the case. *Id.; Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986).

We find that the documents submitted by the employer concern claimant's disability. However, the employer provides no reason why the January 12, 2000 examination notes from Drs. Bald/Farris were not obtainable at the February 3, 2000 hearing. We deny the employer's request to remand for admission of the January 12, 2000 examination notes.

The remaining items, *i.e.*, the July 25, 2000 report from Drs. Farris and Bald, Dr. Bald's September 14, 2000 concurrence letter and the July 25, 2000 examination notes from Drs. Bald/Farris were not "available" at the time of the February 3, 2000 hearing. Nevertheless, although evidence not generated until after the hearing is "unavailable," it may still have been "obtainable" at the time of hearing. *Compton*, 301 Or at 648-49.

For the following reasons, we find that the employer's proferred evidence is cumulative. In March 1999, the employer accepted an acute lumbosacral strain resulting from a December 20, 1998 injury. (Ex. 7). On January 12, 2000, Drs. Bald and Farris examined claimant on behalf of the employer. They reported the following history:

> "About a week prior to December 20, 1998, [claimant] was temporarily shifted to working with boards that were eight feet long and 54 inches wide. He had no symptoms at work. He recalled awakening on December 21 with low back pain to the extent that he could hardly move." (Ex. 33-2).

Thus, the evidence submitted at hearing from Drs. Bald and Farris indicated that claimant did not have symptoms at work and that he woke up with low back pain.

The employer seeks remand to admit a July 25, 2000 report from Drs. Farris and Bald regarding claimant's low back condition, which stated that "[a]bout four to five months after beginning the work he awoke one morning with back pain." (Proposed Ex. 36-2). Similarly, the employer seeks remand regarding Dr. Bald's September 14, 2000 concurrence letter from the employer's attorney, which stated, in part:

> "The history you and Dr. Farris recorded in your January 12, 2000 report came from Mr. Davis. He told you on January 12, 2000, that he did not experience back symptoms at work and awoke on December 21, 1998, with low back pain. The history you and Dr. Farris recorded in your July 25, 2000 report came from Mr. Davis. He told you on July 25, 2000 that he awoke one morning with back pain. He did not mention an inciting event at work during either examination." (Proposed Ex. 37-1).

The employer also seeks remand for admission of the July 25, 2000 examination notes from Drs. Bald/Farris and the employer's questions provided to them. (Proposed Ex. 39).

We conclude that the substantive matters discussed in the July 25, 2000 report from Drs. Farris and Bald, Dr. Bald's September 14, 2000 concurrence letter from the employer's attorney, and the July 25, 2000 examination notes from Dr. Bald/Farris are cumulative because they are essentially a reiteration of the January 12, 2000 report from Drs. Bald/Farris. As we noted above, the January 12, 2000 report from Drs. Bald and Farris, which was admitted at hearing, indicated that claimant did not have pain at work and woke up with low back pain. (Ex. 33-2). Moreover, because the evidence is cumulative, we conclude that it is not reasonably likely to affect the outcome of this case. Therefore, we deny the employer's motion for remand.

Compensability

At hearing, the parties clarified that the issue was compensability of claimant's L5-S1 disc herniation. (Tr. 6). The ALJ found that, because there were persuasive reasons to discount the opinions of Drs. Farris, Bald and Russo regarding preexisting and combined conditions, the standard of proof was material contributing cause. The ALJ relied upon Dr. Lewis' opinion and found that claimant's L5-S1 disc condition was caused by the December 1998 work injury.

The employer argues that claimant is not credible and Dr. Lewis' opinion is not persuasive. Further, the employer contends that the major contributing cause standard applies to this case, either as a combined or consequential condition under an injury theory, or as an occupational disease.

Because of the number of possible causes of claimant's L5-S1 disc herniation, this case presents a complex medical question that depends on expert medical analysis for its resolution. *See Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279 (1993).

For the following reasons, even if we assume that claimant is credible and that he need only establish that his injury was a material cause of his L5-S1 disc condition, we conclude that he has not sustained his burden of proving medical causation.

Claimant relies on the opinions of Drs. Lewis, Combe, Stephen Goodwin and Allen Goodwin to argue that his ongoing back problems are caused by his L5-S1 disc pathology. For the reasons that follow, we are not persuaded that the medical evidence is sufficient to establish that claimant's L5-S1 disc herniation is causing his current back pain, and furthermore, we find that the medical evidence is insufficient to establish that the L5-S1 disc herniation is related to the December 1998 work injury.

Dr. Seibel interpreted claimant's September 13, 1999 lumbar MRI as showing a central disc herniation at L5-S1 of "uncertain clinical significance." (Ex. 12). In contrast, Dr. Lewis felt that the L5-S1 disc was causing claimant's pain and said he could document it with a provocative discogram, which he expected would show an abnormal structure. (Ex. 30A-2). In a later report, Dr. Lewis explained:

> "I felt and still feel that further investigation of that [L5-S1] disc with a discogram is appropriate to see if it is his pain generator, and this would truly define whether it was merely coincidental, unrelated, or was or is the cause of his discomfort." (Ex. 35-1).

Although Dr. Lewis initially said that claimant's L5-S1 was causing his pain, his later report indicated that he was unsure whether the disc was actually causing claimant's discomfort, and he felt claimant needed additional testing to determine if the disc was the pain generator. We are not persuaded by Dr. Lewis' opinion because it indicates only a possibility that claimant's current symptoms are caused by the L5-S1 disc. *See Gormley v. SAIF*, 52 Or App 1055, 1060 (1981) (opinions in terms of medical possibility rather than medical probability are not persuasive).

We reach the same conclusion concerning the opinions of Drs. Stephen and Allen Goodwin. In October 1999, Dr. Stephen Goodwin reported that claimant had a normal neurologic exam, but an "abnormal MRI appearance." (Ex. 23-1). He "suspect[ed]" that claimant had "discal pain." (*Id.*) He diagnosed an "[a]pparent discal injury[,]" but did not recommend surgery. (Ex. 23-3). Similarly, Dr. Allen Goodwin said that claimant had "[l]ikely discogenic pain" based on the MRI and his history. (Ex. 28-2). He recommended an epidural steroid injection and a discogram for further evaluation for possible internal disc disruption. (*Id.*) We find that the opinions of Drs. Stephen and Allen Goodwin suggest only a possibility that claimant's L5-S1 disc is causing claimant's current symptoms. *See Gormley v. SAIF*, 52 Or App at 1060.

Claimant also relies on the opinion of Dr. Combe, chiropractor. Dr. Combe opined that the basis of developing radicular complaints from a lumbar strain condition was the "edema and inflammation of facets and soft tissue and *possible* aggravation of the disc causing irritation and compression of the right nerve." (Ex. 27; emphasis supplied). We find that Dr. Combe's opinion about a "possible" aggravation of the disc is not sufficient to establish, by a medical probability, that claimant's current symptoms are caused by the L5-S1 disc herniation.

In any event, however, even if we assume that claimant has established that his current low back symptoms are related to the L5-S1 disc herniation, we find that the medical evidence is insufficient to establish that his L5-S1 disc herniation was caused by his December 20, 1998 work injury.

We are most persuaded by the opinion of Dr. Russo, who treated claimant before the December 1998 injury, after that injury and again in September 1999. He was, therefore, in an advantageous position in which to determine causation of claimant's current need for treatment. *See Kienow's Food Stores v. Lyster*, 79 Or App 416, 421 (1986) (greater weight accorded to physicians who observed the claimant's condition before and after the critical event).

Dr. Russo's chart notes after the December 1998 injury did not refer to radicular pain. (Ex. 4-1, -3). By January 12, 1999, claimant was released to regular duty and Dr. Russo said that claimant felt "approximately 80% improved." (Ex. 4-3). Dr. Russo estimated claimant would be stationary in two to four weeks. (*Id.*) In a later report, Dr. Russo agreed that claimant did not have any objective or subjective radicular complaints in December 1998 and January 1999 to indicate a herniated disc. (Ex. 19). Furthermore, he agreed that the acute strain injury was not the major or a material cause of the L5-S1 herniated disc. (*Id.*) We find that Dr. Russo has provided the most persuasive opinion because he had an accurate understanding of claimant's history and because he had an opportunity to examine claimant over an extended period.

Claimant relies instead on the opinion of Dr. Lewis. 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). Here, however, because Dr. Lewis examined claimant on only one occasion, almost one year after the December 1998 injury, his opinion is not entitled to any particular deference. *See McIntyre v. Standard Utility Contractors*, 135 Or App 298, 302 (1995) (treating physician's opinion was less persuasive when the physician did not examine the claimant immediately following the injury).

Dr. Lewis reported that claimant had injured his back pulling plywood in December 1998.[1] (Ex. 30A-1). He noted that claimant had no past history of back problems. (*Id.*) Dr. Lewis referred to claimant's "persistent pain" and indicated that he eventually had to stop working because of the pain. (*Id.*) He felt that claimant's work injury damaged his L5-S1 disc with a small central disc herniation and this "tripped a cascade of events in the disc structure which causes the disc to desiccate and have a degenerative appearance on x-ray." (*Id.*)

There is no evidence that Dr. Lewis had reviewed the medical records to determine what treatment and symptoms claimant had after the December 20, 1998 injury. A February 14, 2000 letter from claimant's attorney to Dr. Lewis indicated only that a February 1, 2000 report from Dr. Farris had been forwarded to Dr. Lewis. (Exs. 34, 35A). The February 1, 2000 report from Dr. Farris, however, did not include a discussion of Dr. Russo's medical records after the December 1998 injury, which showed that, by January 12, 1999, claimant felt "approximately 80% improved" and Dr. Russo estimated claimant would be stationary in two to four weeks. (Ex. 4-3).

Likewise, there is no evidence that Dr. Lewis was aware of Dr. Russo's statement that claimant did not have any objective or subjective radicular complaints in December 1998 and January 1999 to indicate a herniated disc. (Ex. 19). There is no evidence that Dr. Lewis was aware that claimant did not seek any medical treatment between January 12, 1999 and July 20, 1999, nor is there any evidence that Dr. Lewis was aware that claimant's medical records did not refer to any radicular pain until August 17, 1999, almost eight months after the work injury. On August 17, 1999, Dr. Stoddard's chart note indicated "radiates * * * some." (Ex. 8). Dr. Collins's August 31, 1999 chart note referred to pain into right buttock and "buttock pain x 2 mos" (Ex. 10), which would indicate that claimant first had buttock pain in June 1999, six months after the work injury.

We find that Dr. Lewis did not adequately explain his opinion that claimant injured his disc on December 20, 1998. Even if we assume that claimant's current symptoms are caused by the L5-S1 disc herniation, we are not persuaded that Dr. Lewis had a complete and accurate history of claimant's low back symptoms and treatment after the December 20, 1998 work injury. Consequently, we conclude that his opinion on causation is entitled to little weight and is not sufficient to establish that claimant's L5-S1 disc herniation is related to the December 1998 injury. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) (medical opinions that are not based on a complete and accurate history are not persuasive).

Similarly, we are not persuaded that Dr. Combe had a complete and accurate history of claimant's symptoms and treatment after the December 1998 injury and we find that his opinion is entitled to little weight.

The medical report on causation from Drs. Farris and Bald does not support compensability of claimant's L5-S1 disc herniation. They did not believe claimant's L5-S1 disc was responsible for his pain complaints and they did not believe he had discogenic pain. (Ex. 33-7, -8). Instead, they found that claimant's pain complaints were consistent with a musculoskeletal lumbosacral strain. (Ex. 33-8).

In sum, we conclude that the medical evidence is insufficient to establish compensability of claimant's L5-S1 disc condition under a material or major contributing cause standard. We therefore reverse the ALJ's order.

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[1] Although Dr. Lewis referred to the injury as "December 20, 1999" early in his report, he subsequently referred to the "December 1998" injury. (Ex. 30A-1).

ORDER

The ALJ's order dated June 19, 2000 is reversed in part and affirmed in part. The self-insured employer's denial of claimant's L5-S1 disc herniation is reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

January 17, 2001 Cite as 53 Van Natta 47 (2001)

In the Matter of the Compensation of
RANDY L. FRETWELL, Claimant
WCB Case No. 00-03771
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Fitzwater's order that awarded 12 percent (38.4 degrees) unscheduled permanent disability for claimant's low back injury. On review, the issue is extent of unscheduled permanent disability.

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

The ALJ found that claimant was entitled to 12 percent unscheduled permanent disability for his compensable low back injury, accepted by SAIF as a lumbosacral strain.[1] In doing so, the ALJ determined that the impairment findings of the attending physician, Dr. Fechtel, were more persuasive than those of the medical arbiter, Dr. Filarski.

On review, SAIF contends that the ALJ incorrectly evaluated the permanent disability issue. It asserts that only the medical arbiter, Dr. Filarski, addressed claimant's level of impairment due to the accepted condition and that, "[e]ven if there were no medical arbiter report in this case, claimant would still not be entitled to a PPD award, because Dr. Fechtel's opinions do not attribute impairment to the accepted condition, as required by law." (Appellant's brief p. 4).

SAIF's assertions notwithstanding, it found Dr. Fechtel's opinion to be a sufficient basis for awarding permanent disability in its Notice of Closure. Moreover, we agree with the ALJ's reasoning that Dr. Fechtel provided the most thorough, complete and well-reasoned evaluation of claimant's injury-related impairment. *See Kenneth W. Matlack,* 46 Van Natta 1631 (1994). Thus, we conclude that the ALJ correctly relied on that report in awarding unscheduled permanent disability. Accordingly, we affirm.

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

ORDER

The ALJ's order dated October 13, 2000 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by SAIF.

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[1] SAIF had originally awarded 12 percent unscheduled permanent disability in a December 22, 1999 Notice of Closure. Claimant requested reconsideration, which resulted in an Order on Reconsideration that reduced the unscheduled permanent disability award to zero.

In the Matter of the Compensation of
JUDITH LYNNE, Claimant
WCB Case No. 00-01212
ORDER ON REVIEW
Willner, Wren, Hill & Uren, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the insurer's denial of her injury claim for a lumbosacral sprain/strain, bilateral foot pain, cervical strain, and left hand and arm pain. In her brief, claimant requests remand because of alleged procedural errors. On review, the issues are remand and compensability. We deny claimant's motion for remand and affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes and supplementation. On page 1, we replace the second paragraph of the findings of fact with the following:

> "On November 29, 1999, claimant sought emergency treatment, complaining of pain in her feet, legs and left arm. (Ex. 82). On December 7, 1999, she sought treatment from Dr. Engstrom, who had been treating her since 1996. Dr. Engstrom reported that claimant had been working for the employer one week when she developed symptoms in both feet and her legs and left arm. (Ex. 87). He noted that claimant had a 'long history of multiple musculoskeletal-type complaints which have been difficult to sort out.' (*Id.*) His assessment was '[m]ultiple complaints' and he was 'unable to find any type of explanation for this.' (*Id.*) In an '827' form signed by claimant on November 29, 1999, Dr. Engstrom noted: 'I am not convinced this is work related.' (Ex. 86)."

In the first full paragraph on page 2, we change the citations at the end of the paragraph to "(Exs. 85, 89, 90)." In the second full paragraph on page 2, we replace the third sentence with the following:

> "They found that claimant had degenerative disc disease at multiple levels and chronic cervical and lumbar pain related to numerous motor vehicle accidents and previous work-related injuries. (Ex. 96-6, -7). Drs. Arbeene and Morton found no objective evidence to support any specific diagnosis related to claimant's work activities at the employer. (*Id.*)"

CONCLUSIONS OF LAW AND OPINION

Remand

Although claimant represented herself at hearing, she is represented by an attorney on review. Claimant argues that the claim should be remanded for additional proceedings under ORS 656.295(5) because "grievous" procedural errors have essentially deprived her of a full and fair opportunity to have her claim heard on an adequately developed record. She contends that the ALJ failed to "encourage" representation by counsel pursuant to OAR 438-006-0100(1),[1] and failed to establish a known waiver of the right to counsel. She also argues that the ALJ misstated the issues and claimant's burden with respect to those issues.

Our review is limited to the record developed at hearing. ORS 656.295(5). We may remand to the ALJ if we find that the case has been improperly, incompletely, or otherwise insufficiently developed. *Id.*

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[1] OAR 438-006-0100(1) provides, in part: "The Board encourages injured workers also to be represented in formal hearings."

The denial at issue is the insurer's February 3, 2000 responsibility and compensability denial of claimant's claim for lumbosacral sprain/strain, bilateral foot pain, cervical strain, left hand and arm pain and high blood pressure.[2] (Ex. 98). The insurer's denial stated, in part:

> "You may be represented by an attorney of your choice at no cost to you for attorney fees. If you have questions you may call the benefits section toll free in Oregon 1-800-452-0288 or in Salem or from outside Oregon at (503) 947-7585." (Ex. 98-2, -3).

Claimant, *pro se*, requested a hearing. A hearing was scheduled for May 8, 2000. The hearings file indicates claimant was sent a hearing notice and a Notice of Rights and Procedures in Contested Workers' Compensation cases, as well as a letter that stated, in part:

> "Since our hearings are like civil non-jury trials, you are strongly urged to retain an attorney who is knowledgeable in workers' compensation law. If the case goes to hearing, the employer and its insurer will be represented by an attorney. If you wish to have your case reviewed by an attorney, you should contact one as soon as possible. You can locate an attorney who practices in the area of workers' compensation law through the telephone directory classified ads, or from the Oregon State Bar referral service." (Underline in original).

The letter also provided information about the Oregon State Bar referral service and explained the general attorney fee arrangement.

The hearings file indicates that claimant was initially represented by an attorney on February 28, 2000, but that attorney withdrew from the case on March 14, 2000. Similarly, claimant was represented by a second attorney on March 16, 2000, but that attorney withdrew from the case on March 22, 2000. Claimant was then represented by a third attorney, but that attorney withdrew from the case on May 3, 2000. On May 4, 2000, the hearing was postponed because claimant needed a new attorney. The hearing was rescheduled and held on August 16, 2000.

At hearing, the ALJ said that claimant planned to represent herself. (Tr. 1). The ALJ explained that he had provided claimant with a copy of ORS 183.413(2), Notice of Rights and Procedures in Workers' Compensation Hearings, and claimant advised that she had read that notice. (*Id.*) Claimant indicated that she had an understanding of the procedures and acknowledged that she had been in a previous workers' compensation proceeding. (Tr. 1, 2). Claimant agreed that she had been provided with a copy of the exhibits and she did not object to admitting them in evidence. (Ex. 2). The ALJ explained that the issue to be litigated was the insurer's February 3, 2000 denial of her December 1, 1999 claim for benefits. (Tr. 2, 3). The ALJ further explained claimant's burden of proof. (Tr. 3, 4). Claimant provided an opening statement and testified on her own behalf. The transcript indicates that there were closing arguments, although they were not transcribed.

The record establishes that claimant was properly advised of her rights pursuant to ORS 183.413(2). That statute provides, in part:

> "Prior to the commencement of a contested case hearing before any agency including those agencies identified in ORS 183.315, the agency shall inform each party to the hearing of the following matters:
>
> "(a) If a party is not represented by an attorney, a general description of the hearing procedure including the order of presentation of evidence, what kinds of evidence are admissible, whether objections may be made to the introduction of evidence and what kind of objections may be made and an explanation of the burdens of proof or burdens of going forward with the evidence."

We find that claimant had an adequate opportunity to obtain counsel prior to the rescheduled August 16, 2000 hearing. Claimant had been represented by three attorneys, all of whom withdrew from the case. After the third attorney withdrew from the case, the hearing originally scheduled for May 8, 2000 was postponed to allow claimant to obtain another attorney. We find further that claimant was adequately advised of her rights pursuant to ORS 183.413(2) at the August 16, 2000 hearing. *Compare Charles W. Brach*, 52 Van Natta 1084 (2000) (because there was no evidence that the claimant was made aware of his rights under ORS 183.413 and he was not permitted to testify, remand was

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[2] At hearing, claimant withdrew her claim for high blood pressure.

appropriate). We also find that the ALJ adequately explained claimant's burden of proof. For the foregoing reasons, we deny claimant's request for remand.

Compensability

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

Claimant argues that the opinion of Dr. Verzosa establishes that her November 1999 work injury was the major contributing cause of her disability and need for treatment.

In evaluating expert medical opinion, we rely on those that are both well-reasoned and based on an accurate and complete history. *Somers v. SAIF*, 77 Or App 259, 263 (1986). Absent persuasive reasons to do otherwise, we generally give deference to the opinion of a treating physician who has had the opportunity to evaluate a claimant over time. *See Weiland v. SAIF*, 64 Or App 810 (1983).

Here, we are most persuaded by the opinion of Dr. Engstrom, who has been treating claimant at least since 1996, and treated her before and after her November 1999 work exposure. On December 7, 1999, Dr. Engstrom reported that claimant had been working at the employer for one week when she developed symptoms in both feet and her legs and left arm. (Ex. 87). He noted that claimant had a "long history of multiple musculoskeletal-type complaints which have been difficult to sort out." (*Id.*) His assessment was:

> "Multiple complaints. I am unable to find any type of explanation for this. I think her feet started because she was standing on them and she hasn't done a lot of work or standing in a long time. I told her she can go back to work. I put some restrictions on her." (*Id.*)

In an "827" form signed by claimant on November 29, 1999, Dr. Engstrom noted: "I am not convinced this is work related." (Ex. 86)."

Dr. Engstrom subsequently concurred with a report from Drs. Arbeene and Morton, who found that claimant did not sustain any injuries while working for the employer in November 1999. (Exs. 96, 101). Drs. Arbeene and Morton found that claimant had degenerative disc disease at multiple levels and chronic cervical and lumbar pain related to numerous motor vehicle accidents and previous work-related injuries. (Ex. 96-6, -7). Drs. Arbeene and Morton found no objective evidence to support any specific diagnosis related to claimant's work activities. (*Id.*)

We find that Dr. Engstrom's opinion is persuasive because it is well-reasoned and based on a complete and accurate history. Dr. Engstrom's opinion, however, does not support compensability of claimant's condition under either a major contributing cause or material cause standard.

Although claimant relies on Dr. Verzosa's opinion, we do not find his opinion persuasive. Unlike Dr. Engstrom, Dr. Verzosa did not examine claimant until January 4, 2000, more than a month after claimant's November 1999 work exposure. Dr. Verzosa felt that claimant had a low back sprain/strain from repetitive lifting and bending at work and an "associated inflammation of a probable pre-existing degenerative disc, which was asymptomatic prior to her work" at the employer. (Ex. 94-4). He said that claimant's preexisting conditions and injuries had "resolved." (*Id.*) Dr. Verzosa believed that claimant had a "valid injury and her present condition and need for treatment is from her work injury." (Ex. 103).

We acknowledge that no incantation of "magic words" or statutory language is required to establish the compensability of a claim, provided the opinion otherwise meets the appropriate legal standard. *See SAIF v. Strubel*, 161 Or App 516, 521-22 (1999); *Freightliner Corp. v. Arnold*, 142 Or App 98, 105 (1996). Here, however, we are not persuaded that Dr. Verzosa had an accurate and complete history of claimant's preexisting injuries and conditions. Moreover, he did not adequately discuss the extent of claimant's preexisting cervical and lumbar degenerative conditions. Under these circumstances, we find that Dr. Verzosa's conclusory opinion is not sufficient to establish compensability. We therefore affirm the ALJ's order.

ORDER

The ALJ's order dated September 7, 2000 is affirmed.

In the Matter of the Compensation of
ROBIN A. ROHRBACKER, Claimant
WCB Case No. 99-08758
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorney
Hornecker, Cowling, et al, Defense Attorney

Reviewed by Board Members Haynes, Bock, and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Mongrain's order that set aside its denial of claimant's current neck and left shoulder conditions. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. On page 2, we change the seventh full paragraph to read:

> "On July 19, 1999, Dr. Goodwin examined claimant for her left neck and shoulder pain. (Ex. 26). He found a 'strong suggestion' of a C6 painful radiculopathy. (Ex. 26-4). He felt there was a great likelihood of a discogenic source of pain, which he did not believe would show up on usual imaging studies. (*Id.*) Dr. Goodwin recommended diagnostic injections. (Ex. 26-6)."

We change the first full paragraph on page 3 to read:

> "On September 30, 1999, the insurer reclassified the claim as disabling. (Ex. 32)."

We do not adopt the ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured her left shoulder and neck on September 17, 1998. The insurer accepted a nondisabling left C5-6 disc herniation and left trapezius strain, which was later reclassified as disabling. (Exs. 24, 32).

Claimant continued to have neck and left shoulder pain. On October 15, 1999, the insurer issued a denial of claimant's current need for medical treatment and disability on the basis that the accepted condition was no longer the major contributing cause of the "accepted combined condition of C56 disc herniation and left trapezius strain." (Ex. 37-1).

The insurer amended its denial on January 24, 2000. The insurer's denial stated, in part:

> "You have an accepted workers' compensation claim for disability and a need for medical treatment arising from a September 17, 1998, left trapezius strain in combination with pre-existing cervical disc changes. Medical evidence now indicates that the preexisting degenerative changes, variously identified as disc disease, cervical spondylosis and foraminal stenosis, are now the major contributor to the current disability and need for treatment.
>
> "As such, we deny compensability of your current condition, continuing disability and need for treatment. Alternatively, if your current condition remains compensable to any extent, we specifically deny compensability of any cervical disc disease, spondylosis and stenosis conditions beyond the scope of the specific claim acceptance, issue this precautionary partial denial in order to clarify the scope of the accepted claim, in which case claim closure will be pursued on the accepted portions of the claim." (Ex. 40-1).

The ALJ found that the insurer's amended denial "misrepresented" the accepted condition as a left trapezius strain in combination with preexisting cervical disc changes. The ALJ reasoned that the insurer had accepted a C5-6 disc injury and he found that claimant's current symptoms were consistent

with a disc injury. Although the ALJ noted the medical evidence was uncertain as to what was contributing to claimant's current condition, he concluded that the accepted C5-6 herniated disc and left trapezius strain were the major contributing cause of her continued disability and need for treatment.[1]

The insurer argues that it accepted a "combination claim involving a strain along with pre-existing spinal changes and similar symptoms." (Appellant's brief at p. 4). The insurer contends that the ALJ erred by not applying ORS 656.262(6)(c). The insurer argues that, because claimant did not raise any issues about the scope of acceptance of the procedural basis of the denial at hearing, the Board should not address those issues.

On the other hand, claimant argues that the insurer did not accept a "combined condition" and, therefore, ORS 656.262(6)(c) does not apply. Relying on *Croman Corp. v. Serrano*, 163 Or App 136 (1999), claimant contends that the Board may address this issue, since the insurer asserted in opening statement that this is a "combination claim."

At hearing, claimant's attorney said that claimant was appealing two denials, exhibits 37 and 40, that "appear to be current condition denials." (Tr. 2). The insurer's attorney responded:

> "Just briefly, Exhibit 37 is the initial denial, and the claims examiner issued what I'll call a clarifying or supplemental denial, marked as Exhibit 40. I believe the statute is 656.262(7). We're contending that this is a combination claim, that the preexisting conditions are now the major contributor to the current need for treatment." (*Id.*)

An ALJ's scope of review is limited to the issues raised by the parties. *See, e.g., Saedeh K. Bashi*, 46 Van Natta 2253 (1994). We find no evidence that claimant challenged the procedural validity of the insurer's denial at hearing. Moreover, claimant did not argue that the holding in *Serrano* applied to the insurer's denial.

We generally do not consider issues that are not raised at hearing. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991). Moreover, we have previously declined to consider a challenge to the procedural validity of a preclosure denial based on Serrano that is raised for the first time on review. *See, e.g., Juventino Vaquera*, 52 Van Natta 1945 (2000); *Earl W. Rookhuizen*, 52 Van Natta 1831 (2000); *Leroy W. Steece*, 52 Van Natta 482 (2000). We reach the same conclusion in this case and decline to address the procedural validity of the insurer's denial.

The insurer argues that claimant's accepted strain is not the major contributing cause of her current condition. For the following reasons, we agree with the insurer.

Dr. McMahon began treating claimant on September 18, 1998, a day after her work injury. (Ex. 1). He initially diagnosed a "[c]ervical strain with radiculopathy, R/O HNP, R/O DDD." (*Id.*) One week later, he also diagnosed left trapezius myofascitis.[2] (Ex. 5-1). After finding that claimant's cervical MRI was essentially "normal," Dr. McMahon diagnosed a cervical strain with radiculopathy and left cervical myofascitis. (Ex. 5-4). He referred claimant to Dr. Louie, neurosurgeon. After additional tests, Dr. Louie ultimately diagnosed claimant with myofascial neck pain. (Exs. 17, 19).

Claimant continued to treat with Dr. McMahon. In May 1999, Dr. McMahon added a diagnosis of left shoulder strain. (Ex. 21). In June 1999, he also diagnosed mixed-type cephalgia. (Ex. 22A). In August 1999, he included a diagnosis of bilateral trapezius myofascitis. (Ex. 28A).

In October 1999, Dr. McMahon wrote to the insurer and said that several possible etiologies had been suggested, but he could "only feel confident in stating that this does not appear to be related to a simple strain of the muscles[.]" (Ex. 39).

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[1] The ALJ also upheld the insurer's denial of the separate conditions of cervical disc disease (other than the accepted C5-6 herniated disc), cervical spondylosis and foraminal stenosis. Neither party challenges that portion of the ALJ's order on review.

[2] In a deposition, Dr. McMahon explained that myofascitis refers to the inflammatory condition of the muscle. (Ex. 48-8).

In a January 18, 2000 chart note, Dr. McMahon summarized a conversation with claimant's attorney. (Ex. 39A-2). Dr. McMahon felt that claimant's current condition was related to her work because she did not have any symptoms before this condition began with her work. (*Id.*) He also explained that claimant's myofascial pain was "partially the cause, but otherwise the cause is still being determined and the objective findings were not correlating with the subjective and physical examination findings with the patient." (*Id.*)

In November 1999, Dr. McMahon changed his diagnoses to cervical strain with radiculopathy "R/O HNP" and "[c]ervical DDD with radiculopathy." (Ex. 39AA-1).

In a March 2000 concurrence letter from the insurer's attorney, Dr. McMahon agreed with the following:

> "[Claimant] had an acute, soft tissue injury on or about 9/17/98 which combined with pre-existing cervical disc and spine changes to cause pain and the need for medical treatment. The exact nature of that 1998 acute injury is still undetermined. All of those factors continue to be contributing in some way to her current complaints. Drs. Williams and Goodwin are reaching alternative possible conclusions regarding [claimant's] current condition. You do not agree with Dr. Williams' IME report entirely, but this is a complex case where there appears to be a reasonable dispute between the specialists. In the face of uncertainty, your position is to support continued diagnostic efforts." (Ex. 43).

In March 2000, Dr. McMahon referred claimant to Dr. Ross, neurosurgeon, who performed additional tests and concluded that the "only possible diagnosis now would be foraminal stenosis[,]" although he thought it was possible claimant had thoracic outlet syndrome. (Ex. 46). An April 18, 2000 cervical MRI showed "[v]ery mild posterior disk bulge at the C4/5 and C5/6 levels but otherwise unremarkable MR of the cervical spine with no significant change since 10/19/98." (Ex. 46A). Dr. McMahon's April 26, 2000 chart note again diagnosed cervical strain with radiculopathy "R/O HNP" and "[c]ervical DDD with radiculopathy." (Ex. 47).

In a deposition, Dr. McMahon said that he was treating claimant for reproducible pain emanating from her neck involving her left upper extremity, which he believed was related to the September 1998 work activity. (Ex. 48-6). He felt that myofascitis was a secondary part of her diagnosis. (Ex. 48-9). Dr. McMahon said that claimant's current diagnosis was related to some form of neuropathy that was causing secondary muscle pain and inflammation. (*Id.*) He explained that the neuropathy meant that there was something that was irritating a nerve and causing reproducible pain and secondary muscle inflammation. (*Id.*) He felt that the cause of the irritation was the September 1998 work activity. (Ex. 48-10). Dr. McMahon's understanding of Dr. Ross' report was that there was some nerve root impingement by the foraminal opening that could not be fully evaluated by radiology. (Ex. 48-11, -12).

Dr. McMahon testified that he would defer to claimant's specialists for a specific diagnosis, including Dr. Ross. (Ex. 48-12). When he was asked to explain the nature of claimant's current condition, Dr. McMahon responded:

> "To put that more specifically I would say that as I have continued the diagnoses that I know of and not made any conjectures, and so initially the diagnosis of the strain was made and continues to be made not as the ultimate final diagnosis, but as the only thing that's specifically known that has not been constituted in x-rays or other objective testing." (Ex. 48-13).

Dr. McMahon said that the April 2000 MRI did not completely rule out the possibility of discogenic causes. (Ex. 48-14). He deferred to Dr. Ross' comment that the only possible diagnosis now was the foraminal stenosis. (Ex. 48-14). Dr. McMahon agreed that was just a possibility. (Ex. 48-16). He said there was no objective evidence to rule out foraminal stenosis. (*Id.*) He felt that claimant had more symptoms than just a muscular etiology of her pain. (Ex. 48-15, -16).

In summary, Dr. McMahon acknowledged that the nature of claimant's 1998 injury was still undetermined. (Exs. 43, 48). As the previous reports demonstrate, Dr. McMahon has changed his diagnosis on several occasions. He appeared confident, however, that claimant's condition was *not*

related to a simple muscle strain. (Ex. 39). He said that her symptoms were more than a muscular etiology and he thought she had some form of neuropathy that was causing the muscle pain and inflammation. (Ex. 48-9, -15, -16). Furthermore, he testified that the specific diagnosis of strain and/or myofascitis was not a long-term diagnosis. (Ex. 48-9). We find that Dr. McMahon's opinion does not support a conclusion that claimant's current condition is related, in major part, to a left trapezius strain. Dr. McMahon said that he deferred to claimant's specialists for a specific diagnosis, including Dr. Ross. (Ex. 48-12). Dr. Ross, however, has merely stated that the "only possible diagnosis" was foraminal stenosis (Ex. 46), which was not an accepted condition.

In light of the equivocal nature of Dr. McMahon's opinion, we find that it is not sufficient to establish that claimant's current condition is related, in major part, to the September 1998 compensable injury. We acknowledge that a specific diagnosis is not required to establish compensability; instead, the issue is whether claimant's condition is work-related, whatever the diagnosis. *See Boeing Aircraft Co. v. Roy*, 112 Or App 10, 15 (1992); *Tripp v. Ridge Runner Timber Services*, 89 Or App 355 (1988). Nevertheless, we find that Dr. McMahon's varying and apparently inconsistent diagnoses do not support a finding that claimant's need for treatment or disability for her current condition is related, in major part, to either her accepted left trapezius strain or C5-6 disc herniation.

Moreover, we are not persuaded that Dr. McMahon was basing his opinion on an accurate history of the onset of claimant's symptoms. When he first examined claimant on September 18, 1998, one day after the work injury, Dr. McMahon said that claimant's neck and arm had been bothering for the past two months. (Ex. 1). In a January 18, 2000 chart note, however, Dr. McMahon said that he felt claimant's current condition was related to her work because she "had not had any symptoms prior to this condition beginning with her work." (Ex. 39A-2). Because Dr. McMahon's chart note is inconsistent with his own medical reports, his conclusion is not based on an accurate history and is therefore entitled to little weight. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) (medical opinions that are not based on a complete and accurate history are not persuasive).

There are no other medical reports that establish that claimant's current condition is related, in major part, to the September 1998 compensable injury. Dr. Peterson found that claimant had left neck, shoulder and arm pain "of uncertain origin." (Ex. 22-2). Although Dr. Louie diagnosed myofascial neck pain, he found that claimant was medically stationary on April 26, 1999. (Exs. 17, 19, 20). Dr. Ross concluded that the only possible diagnosis was foraminal stenosis and did not discuss whether it was related to the September 1998 work injury. (Ex. 46). Although Dr. Goodwin felt that there was a likelihood of a discogenic source of pain, he recommended diagnostic injections, which apparently have not been performed. (Ex. 26). Drs. Woodward and Williams concluded that claimant's current condition was related to her preexisting conditions of foraminal stenosis and cervical spondylosis. (Exs. 29, 34-2, 41, 42). Dr. Williams opined that a strain would not need treatment for more than 90 days from the date of onset. (Exs. 34-2, 42-14, -15).

Based on the foregoing medical reports, we conclude that claimant's compensable injury is not the major contributing cause of her need for treatment or disability for her current left shoulder and neck condition. Consequently, we reverse the portion of the ALJ's order that set aside the insurer's denial of her current condition.

ORDER

The ALJ's order dated July 20, 2000 is reversed in part and affirmed in part. The insurer's denial of the current condition is reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

Board Member Biehl dissenting.

I disagree with the majority's decision not to address the important issue regarding the procedural validity of the insurer's denial. Because I believe that the "current condition" portions of the insurer's denial constitute impermissible preclosure denials, they should be set aside as procedurally invalid. For the following reasons, I respectfully dissent.

The ALJ correctly found that the insurer's amended denial on January 24, 2000 "misrepresented" the accepted condition as a left trapezius strain in combination with preexisting cervical disc changes. I agree with claimant that the insurer did not accept a "combined condition" and, therefore, ORS 656.262(6)(c) does not apply.

In *Dibrito v. SAIF*, 319 Or 244, 248 (1994), the court explained that the Board's first task is to determine which provisions of the Workers' Compensation Law are applicable. In this case, we must determine whether ORS 656.262(6)(c) applies.

In *Croman Corp. v. Serrano*, 163 Or App 136 (1999), the court addressed a Board order that set aside a denial as an impermissible preclosure denial of medical treatment. The employer had accepted a cervical contusion and left shoulder, cervical/back strain. After claim acceptance, the employer contended that the claimant's need for ongoing medical treatment was not related to the accepted injury and it issued a preclosure denial under ORS 656.262(7)(b). The court concluded that in order for an employer to have properly issued a preclosure denial under ORS 656.262(6)(c) and ORS 656.262(7)(b), the employer must have accepted a combined condition. *Id.* at 140; *see also Blamires v. Clean Pak Systems, Inc.*, 171 Or App 263 (2000). Because the employer had not accepted a combined condition, the court agreed that ORS 656.262(7)(b) did not apply. The court affirmed the Board's decision to set aside the employer's denial as an impermissible preclosure denial. *Id.* at 141-42. The court noted that if the employer believed that the accepted conditions were resolved and that the claimant was no longer in need of medical treatment for those conditions, it could have closed the claim. *Id.*

In this case, there is no evidence that the insurer closed the claim before issuing its October 15, 1999 and January 24, 2000 denials of claimant's current condition. Therefore, it issued a "preclosure denial." Based on *Serrano* and *Blamires*, in order for the insurer to have properly issued a preclosure denial under ORS 656.262(6)(c), it must have first accepted a combined condition. The insurer did not do so. Rather, it accepted a left C5-6 disc herniation and left trapezius strain.

Under these circumstances, the "current condition" portions of the insurer's denials constitute impermissible preclosure denials of medical treatment for an accepted condition, unless the insurer's denials pertain to a condition that is separate or severable from the accepted condition. For example, in *Zora A. Ransom*, 46 Van Natta 1287 (1994), we held that a preclosure denial was proper where the medical evidence "unequivocally" indicated that the claimant's current condition was not related to the accepted condition. *See also Connie L. Birrer*, 51 Van Natta 163, *on recon* 51 Van Natta 467 (1999) (medical evidence established that the claimant's current left wrist condition was not related to the accepted condition).

Here, unlike *Ransom*, the medical evidence does not "unequivocally" indicate that claimant's current left shoulder and neck condition are not related to her accepted C5-6 disc herniation and left trapezius strain. In other words, the medical evidence is not sufficient to establish that claimant's current condition is separate or severable from the accepted condition.

Claimant's treating physician, Dr. McMahon, has been treating her for neck and left shoulder symptoms since the September 17, 1998 work incident. He explained that he had been treating her for reproducible pain emanating from her neck involving her left upper extremity, which he believed was related to the September 1998 work activity. (Ex. 48-6). He said that claimant's April 2000 MRI did not completely rule out the possibility of discogenic causes. (Ex. 48-14).

Dr. Goodwin found there was a "great likelihood" of a discogenic source of pain, at the C5-6 level or so, based on claimant's symptoms at the time of the work incident, her examination findings and continued symptoms. (Ex. 26-4). He felt that the discogenic injury would not likely show up on the usual imaging studies and would instead require specialized investigative techniques. (*Id.*) He recommended a multidisciplinary approach, including diagnostic and therapeutic injections, which have apparently not been performed. (Ex. 26-5, -6). Thus, Dr. Goodwin's opinion indicates that claimant's current condition could be related to a C5-6 disc problem.

Although some of the physicians opined that claimant's current symptoms were related to cervical spondylosis or foraminal stenosis, those reports are not sufficient to establish that claimant's current condition is "unequivocally" separate or severable from the accepted conditions. After additional testing, Dr. Ross merely concluded that the "only possible diagnosis now would be foraminal stenosis[.]" (Ex. 46). Dr. Ross' opinion, however, is couched in terms of possibility rather than probability, which is not persuasive. *See Gormley v. SAIF*, 52 Or App 1055, 1060 (1981).

Similarly, although Drs. Woodward and Williams diagnosed cervical spondylosis and foraminal stenosis, Dr. Woodward agreed that claimant had only minimal evidence of those conditions. (Ex. 41-15). When Dr. Woodward was asked what was causing claimant's pain, he responded:

> "That's a difficult question to answer. She had some signs of cervical spondylosis, a general condition of the neck which is sometimes at least associated with neck pain. She has some tenderness in the neck muscles, which just may have been an element, pain coming from these muscles." (Ex. 41-16).

Dr. Woodward said he did not determine any cause for the pain coming from her neck muscles. (*Id.*) Dr. Woodward's opinion is not persuasive because it suggests only the possibility that claimant's current condition is related to cervical spondylosis or foraminal stenosis. *See Gormley*, 52 Or App at 1060.

Dr. Williams opined that claimant's current need for treatment and disability was "directly related to pre-existing conditions such as foraminal stenosis and cervical spondylosis." (Ex. 34-2). Even if I assume that those conditions preexisted the September 17, 1998 injury, Dr. Williams' opinion is not sufficient to establish that those conditions are the major contributing cause of claimant's current condition. Claimant's October 19, 1998 cervical MRI was "[e]ssentially normal" and showed minimal posterior disc bulging at C4-5 and C5-6. (Ex. 6). A December 1998 CT scan showed "[m]inimal cervical spondylosis" and the cervical myelogram was "[n]ormal." (Exs. 13, 14).

In a deposition, Dr. Williams testified that the degenerative changes on claimant's October 1998 MRI were "normal" for her age and her December 1998 CT scan was not unusual for a person her age. (Ex. 42-8, -10). He was uncertain if the posterior bony ridges at C3-4, C4-5 and C5-6 reduced claimant's cervical range of motion. (Ex. 42-12). When he was asked if cervical spondylosis, in and of itself, causes pain, Dr.Williams responded that it was a "very gray area and that's a very troublesome area." (Ex. 42-24 to -26). Dr. Williams' report is not sufficient to establish that claimant's current condition is caused, in major part, by cervical spondylosis and foraminal stenosis.

The remaining medical reports do not support a conclusion that claimant's current condition is separate or severable from her accepted conditions. Dr. Peterson found that claimant had left neck, shoulder and arm pain "of uncertain origin." (Ex. 22-2). Dr. Hagie examined claimant on one occasion in August 1999 and said it was his "suspicion" that there was a facet syndrome more than a cervical disc etiology to her pain and he recommended diagnostic injections. (Ex. 27-3). Dr. Louie concluded that claimant had "myofascial" neck pain. (Exs. 17, 19).

In sum, the medical evidence is not sufficient to establish that claimant's current condition is separate or severable from the accepted condition. *Compare Connie L. Birrer*, 51 Van Natta at 163, 51 Van Natta at 467; *Zora A. Ransom*, 46 Van Natta at 1287. Consequently, I believe that the "current condition" portions of the insurer's denials constitute impermissible preclosure denials of medical treatment for an accepted condition and I would set aside that portion of the insurer's denial as procedurally invalid.

In the Matter of the Compensation of
BRIAN C. LEMBACH, Claimant
WCB Case No. 0006716
ORDER OF DISMISSAL
Daniel Spencer, Claimant Attorney
Meyers, et al, Defense Attorney

Claimant requested a hearing, raising issues of temporary disability rate, procedural entitlement to temporary disability from July 31, 2000 to the present, penalties and attorney fees. The parties have now submitted a "Disputed Claim Settlement" designed to resolve all issues raised or raisable between them.[1]

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[1] Although described as a "Disputed Claim Settlement," it is apparent that compensability of a claim is not at issue. *See* OAR 438-009-0010. Therefore, the settlement agreement is interpreted as a "settlement stipulation." Because the settlement is in accordance with the Board's rules pertaining to such settlements, the parties' agreement may be approved. *See* OAR 438-009-0001(3); *James E. Clemons*, 53 Van Natta 1 (2001) (reaffirming the Board's authority to approve "settlement stipulations" in light of *Simmons v. Lane Mass Transit District*, 171 Or App 268 (2000).

Pursuant to this settlement, claimant withdraws his request for hearing. Further, the parties agree that "claimant's request for hearing shall be dismissed with prejudice."

The parties' settlement is approved, thereby fully and finally resolving this dispute. Accordingly, the request for hearing is dismissed with prejudice.

IT IS SO ORDERED.

January 17, 2001 Cite as 53 Van Natta 57 (2001)

In the Matter of the Compensation of
BUZZ VSETECKA, Claimant
WCB Case No. 00-02916
ORDER ON REVIEW
J. Michael Casey, Claimant Attorney
Meyers, Radler, et al, Defense Attorney

Reviewed by Board Members Haynes, Bock, and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Herman's order that: (1) found that claimant's right wrist injury claim was timely filed; and (2) set aside the employer's denial of the claim. On review, the issues are the timeliness of the claim filing and compensability. 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 right wrist injury claim, finding that claimant, a warehouseman, filed a timely claim for an injury that allegedly occurred on April 30, 1998, when he was struck on the wrist by a 50-pound box of apples. The ALJ then determined that claimant proved medical and legal causation and, therefore, that he sustained a work-related injury in the course and scope of his employment.[1]

In concluding that claimant had filed a timely injury claim, the ALJ found that a preponderance of evidence showed that claimant gave written notice of injury within 90 days of its occurrence as required by ORS 656.265(1).[2] Specifically, the ALJ determined that three entries claimant made in a first-aid logbook within 90 days of the alleged injury satisfied the requirement of ORS 656.265(2) that written notice "shall apprise the employer when and where and how an injury has occurred to a worker."

On review, the employer contends that the entries in the employer's first-aid logbook are insufficient to satisfy the notice requirements of ORS 656.265(2), because they did not apprise the employer of "when and where and how an injury occurred to a worker." Inasmuch as these entries are the only possible written notice of an injury within one year of the alleged date of injury, the employer asserts that the ALJ incorrectly found that claimant filed a timely injury claim. For the following reasons, we find the employer's contentions persuasive.

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[1] Given our resolution of the timeliness issue, we do not address the merits of the compensability issue.

[2] ORS 656.265(1) requires that the worker notify the employer of an accident resulting in an injury within 90 days of the accident. ORS 656.265(2) requires that the notice be in writing and "shall apprise the employer when and where and how" the worker's injury occurred. In addition, ORS 656.265(4) provides as follows:

"Failure to give notice as required by this section bars a claim under this chapter unless the notice is given within one year after the date of the accident and

"(a) The employer had knowledge of the injury or death."

As previously noted, 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. That written notice must apprise the employer of "when and where and how" the injury occurred. 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. Claimant has the burden to prove by a preponderance of the evidence that the employer received some form of written notice of the claim within one year of the accident. *James J. Lascari*, 51 Van Natta 965, 966 (1999). In *Allied Systems Co. v. Nelson*, 158 Or App 639, 644 (1999), the court held that the written notice requirement of ORS 656.265 may be satisfied by a written report from claimant or claimant's doctor concerning the accident.

Here, in the event of an injury, it was the employer's policy that an injured worker notify his or her supervisor within 24 hours of an injury and make an annotation in a first-aid logbook. After being struck by the box of apples, claimant testified that he immediately notified a supervisor, although he could not remember the particular individual to whom he reported the incident. (Tr. 19). Claimant then made an entry in a first-aid log book. It consisted of a date ("4/30/98"), the words "pain in right wrist" and "Buzz V." (Ex. 2B). Claimant made two additional entries dated May 8, 1998 and May 29, 1998 that contained similar information. (Ex. 3). During this time, no medical treatment was sought and no formal claim was filed.

Claimant did not seek treatment for the right wrist condition until January 17, 2000, when he consulted Dr. Lisook, to whom he reported the April 30, 1998 injury and who signed a form 827. That same day, claimant also filled out an employee incident form, as well as a form 801, giving April 30, 1998 as the date of injury.

The employer denied the claim on March 27, 2000, on the basis of untimely claim filing and insufficient evidence of causation. Claimant requested a hearing that resulted in the ALJ setting aside the denial, as noted above.

The ALJ reasoned that claimant had satisfied the statutory requirement for written notice of when, where and how the injury occurred by meeting the parameters the employer had set for reporting work injuries. Specifically, the ALJ noted that an employer representative, Mr. Faddis, had testified that the purpose of the first-aid logbook was to document work injuries and that claimant had provided the information requested. Thus, the ALJ determined that it was a reasonable inference that claimant had injured himself at work on April 30, 1998. Although claimant had not mentioned the "falling box" incident in the logbook, the ALJ noted claimant's and Mr. Faddis' testimony that a detailed explanation was not required. Under these circumstances, the ALJ concluded that the employer had sufficient written notice of the alleged injury.

The employer challenges the ALJ's reasoning that satisfaction of the employer's reporting procedures necessarily met the statutory requirements for written notice of an injury. We agree with the employer and reverse.

Claimant's initial entry in the logbook was dated April 30, 1998. This was the date of the alleged injury. Thus, the "when" requirement of ORS 656.265(2) was satisfied. Moreover, while claimant did not explicitly indicate in any entry that the injury occurred at work, the fact that the logbook was located at work could support a conclusion that, in a general sense, the "where" requirement of the statute was satisfied.

Nonetheless, even if we were to construe that requirement in claimant's favor, the fact remains that none of the entries contain any explanation of "how" the injury occurred. All that is contained in the three logbook entries are the statements: "Right Wrist Pain," "pain in right wrist" and "Right Wrist Pain Again." (Exs. 2B, 3). No explanation is offered regarding "how" the alleged injury happened. While claimant's notations in the logbook are similar to those of other workers and appeared to satisfy the employer's reporting procedures, claimant's written reports of injury did not satisfy the precise requirements of ORS 656.265(2) that written notice apprise the employer of when and where and how the injury occurred. *James J. Lascari*, 51 Van Natta at 966.

Because the record does not contain any other writing that could conceivably constitute written notice within a year of the alleged date of injury, we find that claimant's claim was untimely filed. ORS 656.265(4). Accordingly, we reverse the ALJ's order and dismiss the request for hearing.

ORDER

The ALJ's order dated August 22, 2000 is reversed. The ALJ's attorney fee award is reversed. The employer's denial is reinstated. Claimant's hearing request is dismissed.

Board Chair Bock concurring.

I agree that claimant failed to provide sufficient written notice within one year of the date of injury. Thus, claimant did not file a timely claim for his right wrist injury. However, I write separately to express my concern about this employer's reporting procedures.

From my review of the record, it appears that claimant did, in fact, comply with the employer's procedures for reporting an alleged injury. Yet, that compliance was still not satisfactory to file a timely claim. If the employer was going to insist on technical compliance with the statute, it should have made it much clearer to employees just what information was required in order to provide adequate written notice of an injury. Moreover, if, as Mr. Faddis testified, the first-aid logs were used as a method for giving written notice of a claim, they should be checked far more often than this employer apparently does. While it is not our place to advise claimant regarding potential claims outside the workers' compensation arena, this would seem an appropriate instance for investigating the possibility of an employment law violation.

Board Member Biehl dissenting.

The majority reverses the ALJ's order that found that claimant gave timely written notice of his right wrist injury and dismisses claimant's hearing request. Because I believe the ALJ properly determined that claimant gave timely written notice of injury, I respectfully dissent.

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. That written notice must apprise the employer of "when and where and how" the injury occurred.

Here, even the majority concedes that claimant's logbook entries probably satisfy the "when and where" requirements of the statute. The difficulty in this case concerns the "how" requirement. Unlike the majority, I would not insist on hypertechnical compliance with the statute. The Court of Appeals has held that the employer's knowledge of an injury need only include enough facts to lead a reasonable employer to conclude that workers' compensation liability is a possibility and that further investigation is appropriate. *See Allied Systems Co. v. Nelson*, 158 Or App 639, 646 (1999).

In this case, claimant immediately informed his foreman of the injury and documented the injury in the employer's logbook. Claimant fully complied with the employer's reporting procedures. Indeed, the employer's representative, Mr. Faddis, testified that injured workers were not required to give detailed explanations in the logbook and that it was reasonable to conclude that there was a reasonable possibility of a workers' compensation claim based on claimant's logbook entries.

Under these circumstances, I believe that the employer had sufficient written notice of an injury. Claimant did everything the employer required of him. I believe that is unreasonable for the employer to now defend the claim based on insufficient compliance with the statute when claimant fully satisfied its reporting procedures.

Accordingly, I agree with the ALJ's determination that claimant provided the employer with sufficient written notice of the injury within 90 days of the alleged injury as required ORS 656.265(1). Therefore, I would hold that the claim was timely filed. Because the majority concludes otherwise, I dissent.

In the Matter of the Compensation of
COLLEEN H. CARROLL, Claimant
WCB Case Nos. 99-07947 & 99-02099
ORDER ON REVIEW
Lundeen, et al, Defense Attorney
Sheridan, Bronstein, et al, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant, *pro se*,[1] requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) upheld Reliance Insurance Company's compensability and responsibility denials of claimant's current condition; (2) upheld Reliance's "back-up" denial of claimant's foot condition; and (3) upheld Wausau Insurance Company's compensability and responsibility denials of claimant's current condition. In her appellant's brief, claimant contends that the ALJ erred by excluding two medical reports at hearing. Claimant further contends that her shoes should be admitted into evidence to show patterns of wear. We treat claimant's contention as a motion for remand. On review, the issues are remand, evidence, compensability and, potentially responsibility. We deny the motion for remand and affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Remand

On review, claimant argues that she should be permitted to submit pairs of her shoes in order to demonstrate that her wear patterns are normal. We treat claimant's request as a motion to remand. *See 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 be clearly shown that material evidence was not obtainable with due diligence at the time of hearing. *Compton v. Weyerhaeuser Co.*, 301 Or 641 (1986).

Here, claimant has provided no reason why the evidence she seeks to have admitted was not submitted at hearing and there has been no contention that the evidence was not available. Accordingly, remand is not appropriate, and claimant's motion to remand must be denied.

Evidence

At hearing, the ALJ excluded two medical reports offered by claimant (one from Dr. Chestnutt and one from Dr. Lamy) on the grounds that there was lack of due diligence in not providing the reports until the date of hearing and that admission of such evidence would be prejudicial to the other parties. On review, claimant argues that the ALJ erred in excluding the evidence.

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 the admission of evidence. *See, e.g., Brown v. SAIF*, 51 Or App 389, 394 (1981). We review the ALJ's evidentiary ruling for abuse of discretion. *Sandra L. Dehart*, 46 Van Natta 244 (1994).

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[1] We note that claimant is presently 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 1-800-927-1271 (V/TTY09within the State of Oregon), or write to:

Workers' Compensation Ombudsman
350 Winter St NE, Room 160
Salem, OR 97301-3878

The record establishes that claimant was aware of the aforementioned medical reports in May 2000, but the reports were not provided until the date of hearing in September 2000. We agree with the ALJ that claimant did not establish good cause for the untimely disclosure and that the employers were materially prejudiced by the late disclosure. OAR 438-007-0018(4). Accordingly, we do not find that it was an abuse of discretion for the ALJ to exclude the two medical reports.

Back-up denial/compensability/responsibility

We adopt and affirm the ALJ's "Conclusion" on the compensability and responsibility issues.

ORDER

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

January 19, 2001 Cite as 53 Van Natta 61 (2001)

In the Matter of the Compensation of
LELAND W. HUTCHINSON, Claimant
WCB Case Nos. 00-05995 & 99-09596
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Poland's order that: (1) set aside its denial of claimant's cervical disc lesion condition; (2) awarded temporary disability benefits (interim compensation) from December 6, 1999 through January 7, 2000; and (3) vacated an Order on Reconsideration that rated claimant's permanent disability. Claimant cross-requests review of those portions of the ALJ's order that: (1) upheld the insurer's denial of claimant's lumbar condition; and (2) found that claimant's accepted back and neck claims had not been prematurely closed. Alternatively, claimant contends that he is entitled to awards of scheduled and unscheduled permanent disability. On review, the issues are compensability, temporary disability, premature closure, and alternatively, extent of scheduled and unscheduled permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

WCB Case No. 00-05995

We adopt the ALJ's Conclusions of Law and Opinion with respect to the issues of compensability and interim compensation. We add the following supplementation.

On review, the insurer argues that the ALJ erred in relying on Exhibit 14 to support a conclusion that Dr. Long was claimant's new attending physician. The insurer notes that Exhibit 14 involves another worker represented by claimant's counsel and was submitted in order to establish that Dr. Long was aware of the procedure for obtaining authority in order to carry out further testing.

We agree that Exhibit 14 does not pertain to claimant. Nevertheless, for the remaining reasons stated by the ALJ, we agree that Dr. Long was claimant's attending physician. *See Debbie I. Jensen*, 48 Van Natta 1235 (1996).

WCB Case No. 99-09596

The ALJ found that claimant had not established that his accepted claim was prematurely closed. Therefore, the ALJ affirmed the Order on Reconsideration on the issue of premature closure. We agree

with the ALJ's Conclusions of Law and Opinion regarding the issue of premature closure, and we adopt the ALJ's reasoning on that issue.

Although the ALJ found that claimant's accepted claim had not been prematurely closed, the ALJ concluded that, in light of the fact that the insurer's denial of claimant's cervical disk lesions had been set aside it was not appropriate to rate claimant's permanent disability. The ALJ reasoned that it was not possible to segregate the permanent impairment related to the previously accepted conditions from the impairment related to the newly compensable cervical lesions. Accordingly, the ALJ vacated the Order on Reconsideration to the extent that it rated claimant's permanent disability.

On review, both claimant and the insurer contend that, if the accepted claim is not found to have been prematurely closed, it is proper to rate claimant's permanent disability for the accepted conditions. We agree.

In *William J. Barabash,* 50 Van Natta 1561 (1998), we held that evaluation of the claimant's newly compensable ulnar neuropathy and cervical strain conditions must await the reopening and processing of those claims as neither of the conditions was an accepted condition at the time of claim closure. Nevertheless, we reasoned that it was proper to rate claimant's extent of disability based on the *accepted* conditions at claim closure. 50 Van Natta at 1566.

Here, a June 28, 1999 Notice of Closure awarded claimant 8 percent unscheduled permanent disability for his low back condition. (Ex. 29). Claimant requested reconsideration and a medical arbiter, Dr. Smith, was appointed. Dr. Smith found that claimant was medically stationary and his report regarding claimant's impairment was directed specifically toward claimant's accepted conditions. (Exs. 43, 44). Accordingly, we disagree with the ALJ's conclusion that the Order on Reconsideration should be vacated, and we proceed to address claimant's extent of permanent disability with regard to the accepted conditions.

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).

After reviewing the record, we find that Dr. Smith, the medical arbiter, has provided the most thorough, complete, and well-reasoned evaluation of claimant's injury-related impairment. Claimant concedes that his treating doctor did not measure his impairment near the time of closure and, therefore, claimant relies on an exam performed by a medical examiner and concurred in by treating doctor in February 1999. (Exs. 20, 21).

After considering the impairment findings relied on by claimant and the medical arbiter's exam, we find that the arbiter's exam is the most persuasive. First, we note that a significant time gap exists between the time claimant was examined in February 1999 and the October 1999 arbiter exam. *See, e.g., Kelly J. Zanni,* 50 Van Natta 1188 (1998) (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).

Moreover, we note that the closing examination performed in February 1999 declined to specify whether there was permanent impairment due to the compensable injury. Dr. Williams reported that, without documentation of claimant's lower extremity function in the years prior to the injury, he was unable to determine if there was permanent impairment. (Ex. 20-8). Finally, Dr. Williams found that claimant had inconsistent range of motion measurements which would invalidate lumbar range of motion findings. (Ex. 20-10). Claimant's treating doctor at the time, Dr. Parsons, concurred with Dr. Williams' report in its entirety. (Ex. 21).

Accordingly, we conclude that the Order on Reconsideration properly relied on the opinion of the medical arbiter, Dr. Smith. (Ex. 46). Dr. Smith considered claimant's preexisting condition and found that there was no impairment due to the accepted conditions. Dr. Smith also found that

claimant's spinal ranges of motion test results were not valid. Finally, Dr. Smith found no limited or partial loss of ability to repetitively use any body part or area as a result of the accepted conditions.[1] (Exs. 43, 44).

Based on Dr. Smith's report, we conclude that claimant has failed to establish that he has permanent impairment due to the accepted conditions. ORS 656.214(2); ORS 656.726(3)(f)(A). Under the circumstances, we conclude that claimant has failed to establish an entitlement to an award of either scheduled or unscheduled permanent disability. Therefore, we affirm the Order on Reconsideration that reduced claimant's permanent disability award to zero.

Claimant's counsel is entitled to an assessed attorney fee for services on review in defending against the insurer's request for review on the issues of compensability of the cervical condition and temporary disability benefits. 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 counsel's services on review is $1,200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the compensability (cervical) and temporary disability issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. We note that no fee has been awarded for claimant's counsel's services on review devoted to the issues of compensability of the lumbar condition, premature closure, and extent of permanent disability.

ORDER

The ALJ's order dated September 22, 2000 is affirmed in part and reversed in part. That portion of the ALJ's order that vacated the November 15, 1999 Order on Reconsideration is reversed. The Order on Reconsideration is reinstated and affirmed in its entirety. The remainder of the ALJ's order is affirmed. Claimant's counsel is awarded an assessed attorney fee of $1,200 for services on review, to be paid by the insurer.

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[1] Claimant's objection to the medical arbiter exam is based on contentions made under an "offer of proof" at the time of hearing. The ALJ declined to rely on claimant's testimony regarding the issues pertaining to the Order on Reconsideration. We adopt the ALJ's reasoning concerning claimant's testimony on those issues. Moreover, as the insurer notes, claimant was aware of the proper procedure on reconsideration as he submitted an affidavit to support his position at the time of that proceeding. However, there was no evidence submitted by claimant regarding his allegations that the medical arbiter exam was incomplete or improper, until the time of hearing.

In the Matter of the Compensation of
JENNY L. BOYDSTON, Claimant
WCB Case No. 97-03081
ORDER ON REMAND (REMANDING)
Darris K. Rowell, Claimant Attorney
Lundeen, et al, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *Boydston v. Liberty Northwest Insurance Corporation*, 166 Or App 336 (2000). The court has reversed our prior order, *Jenny L. Boydston*, 50 Van Natta 691 (1998), that affirmed an Administrative Law Judge's (ALJ's) order that dismissed claimant's hearing request from a Second Order on Reconsideration. Reasoning that no hearing request had been filed within thirty days of the first Order on Reconsideration or within thirty days of the expiration of the "18-working day" period under *former* ORS 656.268(6)(b), we determined that claimant's hearing request was untimely filed. Concluding that the Department of Consumer Business Services (DCBS) was authorized to withdraw and abate its first Order on Reconsideration and to issue a second Order on Reconsideration, the court held that we erred in dismissing claimant's timely hearing request from the second order. Consequently, the court has reversed and remanded.

As a result of the ALJ's dismissal order, no hearing was convened. In light of such circumstances, we conclude that it is appropriate to remand this matter to the ALJ. *See* ORS 656.295(5).

Accordingly, the ALJ's order is vacated and this matter is remanded to ALJ Howell for further proceedings consistent with the court's decision and to this order. Those proceedings may be conducted in any manner that the ALJ deems satisfies substantial justice. Following those proceedings, the ALJ shall issue a final appealable order.

IT IS SO ORDERED.

January 19, 2001 Cite as 53 Van Natta 64 (2001)

In the Matter of the Compensation of
DAVID L. TUCKER, Claimant
WCB Case No. 00-03927
ORDER OF DISMISSAL
Kenneth Russell (Saif), Defense Attorney

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Mills' order that dismissed his request for hearing for failing to appear at the scheduled hearing. On review, the issue is dismissal. We dismiss.

FINDINGS OF FACT

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 Board received a letter from claimant. Addressing his letter to the ALJ, claimant sought "reconsideration of the Dismissal Order, 0003927 dated August 24, 2000." Claimant stated that he was unable to attend the scheduled hearing because a Municipal Court trial on August 24, 2000 had taken most of his time and attention. Claimant's letter did not indicate that copies were provided to SAIF, its insured, or its attorney.

Because the 30-day period for reconsidering his decision had expired, the ALJ referred claimant's letter to the Board. On January 5, 2000, the Board's administrative staff mailed its computer-generated letter to all parties acknowledging its receipt of a request for review. SAIF's receipt of this acknowledgement letter constitutes SAIF's and its insured's first notice of claimant's request for Board review.

CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. *See* ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2).

Compliance with ORS 656.295 requires that statutory notice of the request be mailed or actual notice be received within the statutory period. *Argonaut Insurance Co. v. King*, 63 Or App 847, 852 (1983). The failure to timely file and serve all parties with a request for Board review requires dismissal, *Mosley v. Sacred Heart Hospital*, 113 Or App 234, 237 (1992), except that a non-served party's actual notice of the appeal within the 30-day period will save the appeal. *See Zurich Ins. Co. v. Diversified Risk Management*, 300 Or App 47, 51 (1985); *Argonaut Insurance Co. v. King*, 63 Or App at 853.

Here, the 30th day after the ALJ's August 24, 2000 order was September 23, 2000, a Saturday. Inasmuch as claimant's "request for review"[1] was received by the Board on September 25, 2000 (the following Monday), it was timely filed.[2] *See* ORS 656.289(3); 656.295(2); OAR 438-005-0046(1)(b).

However, the record fails to establish that the other parties to the proceeding before the ALJ were provided with a copy, or received actual knowledge, of claimant's request for review within the statutory 30-day period.[3] Instead, it appears that the other parties' first notice occurred when SAIF received a copy of the Board's January 5, 2001 letter acknowledging claimant's request for review. Under such circumstances, notice of claimant's appeal was untimely. *Stella T. Ybarra*, 52 Van Natta 1252 (2000).

Consequently, we conclude that notice of claimant's "request for Board review" was not provided to the other parties within 30 days after the ALJ's August 24, 2000 order.[4] Therefore, we lack jurisdiction to review the ALJ's order, which has become final by operation of law. *See* ORS 656.289(3); 656.295(2).

Finally, we are mindful that claimant has requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. However, instructions for requesting review were clearly stated in the ALJ's order. Moreover, we are not free to relax a jurisdictional requirement. *Alfred F. Puglisi*, 39 Van Natta 310 (1987); *Julio P. Lopez*, 38 Van Natta 862 (1986). Accordingly, the "request for Board review" is dismissed.

IT IS SO ORDERED.

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[1] For purposes of this order, we have assumed (without conclusively deciding) that claimant's letter constituted a request for review of the ALJ's order. However, because the letter was addressed to the ALJ and expressly sought "reconsideration" of the ALJ's Dismissal Order, it is unlikely that this assumption would be our ultimate conclusion. *See John W. Wharton*, 41 Van Natta 1673 (1989).

[2] We have previously held that, when the last day of the 30-day appeal period falls on a Saturday or a legal holiday, including Sunday, the appeal period runs until the end of the next day that is not a Saturday or legal holiday. *E.g., James D. Hill*, 49 Van Natta 308 (1997); *Anita L. Clifton*, 43 Van Natta 1921 (1991); *Sharon D. Stephens*, 40 Van Natta 105 (1988). *See also* ORS 174.120; ORCP 10A. Inasmuch as the 30th day in this case fell on a Saturday and the following day (Sunday) was a legal holiday, *see* ORS 187.010(1)(a), claimant's appeal period ran until the end of Monday, September 25, 2000.

[3] Claimant's letter to the Board, which was enclosed in an envelope postmarked September 22, 2000, did not indicate that copies had been provided to the other parties to the proceeding.

[4] In the event that claimant can establish that he provided notice of his "request for Board review" to the other parties to the proceeding within 30 days after the ALJ's August 24, 2000 order, he may submit written information for our consideration. However, we must receive such written information in sufficient time to permit us to reconsider this matter. Because our authority to reconsider this order expires within 30 days after the date of this order, claimant must file his submission as soon as possible.

In the Matter of the Compensation of
BRENT W. COLLIER, Claimant
WCB Case Nos. 99-09423 & 99-05396
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorney
Atwood & Associates, Defense Attorney
Meyers, Radler, et al, Defense Attorney
Lundeen, et al, Defense Attorney

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

Claimant requests review of those portions of Administrative Law Judge (ALJ) Poland's order that: (1) dismissed (as untimely filed) claimant's hearing request from Liberty Northwest Insurance Corporation's (Liberty's) responsibility denial of claimant's occupational disease claim for binaural hearing loss on behalf of its insured, the City of Milwaukie (Liberty/Milwaukie); (2) upheld Liberty's responsibility denial of claimant's occupational disease claim for the same condition on behalf of its insured, the City of Troutdale (Liberty/Troutdale); and (3) upheld Liberty's responsibility denial of claimant's occupational disease claim for the same condition on behalf of its insured, the City of Oregon City (Liberty/Oregon City). On review, the issues are timeliness of claimant's request for hearing and responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following supplementation and summary.

From 1971 to 1999, claimant was employed in police work. From late October 1972 to mid-September 1988, claimant worked as a police officer for Oregon City. From mid-September 1988 to mid-June 1994, claimant worked as the Chief of Police for the City of Troutdale. From mid-June 1994 until he retired from police work in 1999, claimant worked as the Chief of Police for the City of Milwaukie.

During all three jobs, claimant was required to qualify quarterly on the firing range, which involved firing .38 and .45 caliber handguns, a shotgun, and during his employment with Milwaukie, an MP5 machine gun. Claimant fired approximately 150 rounds during each quarterly qualification. Prior to the mid- 1980's claimant did not wear hearing protection during these quarterly qualifications. In the mid-1980's, claimant begin wearing earplugs and earmuff-type hearing protection during these qualifications. Claimant was exposed to more noise in his early days as a police officer than during the years he served as Chief of Police for Troutdale and Milwaukie.

Claimant first noticed his hearing loss in the late 1970's or early 1980's, at which time a doctor evaluated him. Claimant does not remember the name of this doctor or the exact date of this exam; therefore, no medical records regarding this exam are in the record. (Tr. 5). Following this exam, claimant was shown his audiogram, and was told that he had permanent hearing loss and needed to protect his hearing.

Claimant did not become disabled due to his hearing loss. On December 1, 1998, claimant filed an occupational disease claim for his binaural hearing loss with Liberty/Milwaukie. (Ex. 1). On January 27, 1999, Dr. Hodgson, otolaryngologist, examined claimant on behalf of Liberty/Milwaukie. (Ex. 2). This examination included an audiogram, which is the only audiogram in the record. (Tr. 5).

On February 22, 1999, Liberty/Milwaukie denied compensability of and responsibility for claimant's claim. (Ex. 5). The day after receiving this denial, claimant called and spoke with Ms. Hiles, the claims examiner who issued the denial. Claimant did not file a request for hearing from this denial until July 8, 1999.

On March 2, 1999, and August 20, 1999, claimant filed claims for his hearing loss with Liberty/Oregon City and Liberty/Troutdale, respectively. Both insurers denied the claims. Claimant timely filed hearing requests from those denials.

On November 9, 1999, Dr. Brown, otolaryngologist, examined claimant on behalf of Liberty. (Ex. 5). It is not clear whether this exam was on behalf of Liberty/Oregon City or Liberty/Troutdale.

At hearing, both Liberty/Oregon City and Liberty/Troutdale clarified their denials as constituting both responsibility and compensability denials.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's hearing loss was compensable. That finding is not disputed on review.

Regarding the responsibility issue, the ALJ declined to apportion claimant's hearing loss among the three employers. Instead, the ALJ found that responsibility should be assigned to Liberty/Milwaukie. However, since claimant failed to timely request a hearing from Liberty/Milwaukie's denial, the ALJ found that the Hearings Division had no jurisdiction to assign responsibility to Liberty/Milwaukie. Therefore, the ALJ concluded that claimant failed to prevail against any denial of his binaural hearing loss claim. Based on the following reasoning, we affirm the ALJ's ultimate decision that the responsibility denials should be upheld.

Timeliness of Hearing Request on Liberty/Milwaukie's Denial

We adopt and affirm the ALJ's reasoning and conclusions that claimant failed to establish good cause for his failure to timely request a hearing on Liberty/Milwaukie's denial of his occupational disease claim for binaural hearing loss. Therefore, Liberty/Milwaukie's denial is final by operation of law.

Responsibility

Apportionment

At hearing and on review, claimant argues that assignment of responsibility for his hearing loss claim should be apportioned among the three employers. Although the January 27, 1999 audiogram is the first audiogram in the record, claimant contends that Dr. Hodgson's estimation of contribution to claimant's hearing loss among the three employers should be used to apportion responsibility.[1] In support of this argument, claimant relies on *James River Corp. v. Green*, 164 Or App 649 (1999), *Papen v. Willamina Lumber Co.*, 123 Or App 249, *rev den* 31 Or 81 (1994), and *Nomeland v. City of Portland*, 106 Or App 77 (1991). The ALJ found that it would be inappropriate to apportion responsibility because there were no pre-employment audiograms that would allow the hearing loss attributable to each employment to be determined. Although we find that apportionment to assign initial responsibility is not appropriate, we do so based on the following reasoning.

The cases relied on by claimant do not support apportionment of initial responsibility among successive employers because those cases did not address that issue. Instead, they addressed the issue of extent of scheduled permanent disability for hearing loss claims for which compensability/responsibility had already been determined.

In *Nomeland*, the claimant suffered a compensable hearing loss while working for the employer, and the parties stipulated that the claimant had a significant hearing loss before his employment, as established by an audiogram. The sole issue was how to treat the claimant's documented, preemployment hearing loss in calculating his extent of disability. 106 Or App at 79. The court disagreed with the claimant's contention that the entire hearing loss, including any preexisting disability, should be considered when calculating benefits due to loss of hearing. Instead, the court concluded that the claimant's preexisting hearing loss, as determined by a preemployment audiogram, should be offset from the claimant's total hearing loss in determining the benefits to which he was entitled. *Id.* at 82.

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[1] When pressed for an allocation of hearing loss among the three employers, Dr. Hodgson stated that claimant's binaural hearing loss was probably 60 to 75 percent due to his work at Oregon City, 10 to 15 percent due to his work at Troutdale, with the remainder due to his work at Milwaukie. (Exs. 16-15-16). However, Dr. Hodgson acknowledged that, without any prior audiograms for comparison, he could not assign a definite exposure period because one time on the firing range could cause hearing loss, his allocation was based on statistical results rather than any objective testing concerning claimant, and it was difficult to say whether the 1999 audiogram had changed from the audiogram in the 1970's, since that earlier audiogram was not available. (Exs. 2-3, 16-12, -18, -22).

In reaching that conclusion, the court held that the applicable administrative rule[2] was consistent with ORS 656.214(2), which required that the loss be "due to the industrial injury." *Id.* at 80. The court also rejected the claimant's argument that offsetting his preexisting hearing loss would conflict with the general principle that, in cases of successive, incremental injuries, liability for the entire disability is assigned to the last employer under the last injurious exposure rule (LIER). The court explained that LIER applies to successive employment-related disabilities, stating that the rule "is not applied, in the context of partial disability, to hold an employer responsible for a non-work-related disability that pre-existed the injury." *Id.* at 81 (citation omitted). The court further explained:

> "We have held that, when injuries are so distinct that it is possible to segregate them in terms of causation, responsibility for the injuries can and will be apportioned between or among the employers. *Cascade Corporation v. Rose*, 92 Or App 663 (1988). Similarly, when it is possible, as here, to segregate a claimant's disability that preexisted his employment from that caused by the employment, the employer is responsible only for the disability caused by the employment." *Id.*

In *Papen*, the claimant had been exposed to noise while working at successive lumber mills, and the current employer had accepted the hearing loss claim. At closure, the permanent disability award offset the claimant's hearing loss as measured by an audiogram performed before the claimant began working for the current employer. The issue was whether the claimant's preexisting hearing loss could be offset against his present hearing loss in determining his permanent disability award. 123 Or App at 252. Applying ORS 656.214, *former* OAR 436-35-250,[3] and *Nomeland*, the court concluded that the offset was appropriate under the facts of the case. *Id.* at 252-53.

The *Papen* court also rejected the claimant's argument that, under LIER, the employer was responsible for his aggregate condition. *Id.* at 253. In this regard, the court held that substantial evidence supported the Board's finding that the claimant had failed to prove that his hearing loss prior to the time he began employment with the current employer was caused or worsened by his work exposure. The court held that, because LIER is not applied to hold an employer responsible for a non-work-related disability that preexisted the injury, the Board did not err in concluding that the employer was only responsible for that measured loss of hearing that occurred during the claimant's employment with the current employer. *Id.*

In *Green*, the issue again was extent of scheduled permanent disability for a hearing loss claim. 164 Or App at 651; *see also Kenneth L. Green*, 50 Van Natta 132 (1998). There, claimant had worked 27 years for the same mill where he was exposed to high levels of noise. *Id.* at 651. Crown Zellerbach owned the mill until 1976, when the James River Corporation (James River) purchased it. Within 180 days preceding the change in ownership, the claimant had an audiogram that measured his hearing loss. It was not disputed that the claimant's hearing loss in excess of age-related hearing loss was related to

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[2] In *Nomeland*, the applicable rule wasformer OAR 436-30-360(2), which provided: "Compensation for work-related hearing loss, whether diagnosed as an occupational disease or acoustic trauma, will be offset by pre-existing hearing loss if previously compensated, presbycusis, or if supporting evidence such as base-line or pre-exposure audiograms are provided." This rule is currently found at OAR 436-035-0250(2), which provides:

> "Compensation may be given only for loss of normal hearing which results from an on-the-job injury or exposure. Unless the conditions have combined pursuant to OAR 436-035-0007(4), hearing loss which existed before this injury or exposure will be offset against hearing loss in the claim, if adequately documented by a baseline audiogram obtained within 180 days of assignment to a high noise environment." WCD Admin. Order 98-055 (eff. July 1, 1998).

[3] The version of OAR 436-35-250 in effect at the pertinent time in *Papen* read:

> "(2) Compensation may be given only for loss of normal hearing which results from an on-the-job injury or exposure. The following will be offset against hearing loss in the claim:
>
> (a) Hearing loss which existed before this injury or exposure, if adequately documented by pre-employment audiogram."

See footnote 1 above for the language of the current rule, now at OAR 436-035-0250.

his 27 years of employment at the mill and that the major contributing cause of that hearing loss was his employment with Crown Zellerbach. *Id.* Pursuant to an ORS 656.307 order, James River was held responsible and ultimately issued a notice of closure that awarded the claimant disability for his hearing loss, less the loss attributable to the claimant's work for Crown Zellerbach before 1976. The claimant challenged James River's notice of closure, and the Board ultimately determined that James River should pay the claimant disability for his entire ratable hearing loss. The court reversed. *Id.*

In *Green*, the parties agreed that OAR 436-035-0250 applied. The court stated that its case law, specifically *Nomeland* and *Papen*, "generally supports the concept of apportionment of responsibility between employers in hearing loss cases." *Id.* at 652. The court also recognized that *Nomeland* and *Papen* "can be read to suggest that when the entire hearing loss is employment related, the last injurious exposure rule might be applicable to assign responsibility for the entire hearing loss to the most recent employer, although the loss occurred through successive employments." *Id.* (citations omitted). However, the court held that that discussion was dictum,, noting that "it is followed in *Nomeland* by the dispositive language providing that, 'when injuries are so distinct that it is possible to segregate them in terms of causation, responsibility for the injuries can and will be apportioned between or among the employers.'" *Id.* at 652-53 (citations omitted).

The *Green* court concluded that such an analysis was particularly apt in the context of a claim for hearing loss when the loss attributable to successive employments could be determined by audiograms. *Id.* at 653. The court also held that OAR 436-035-0250 achieved apportionment in a manner consistent with its cases, as well as the requirement of ORS 656.214(2) that a worker receive benefits for permanent partial disability "due to" the work injury. Importantly, the court noted that the claimant did not challenge the rule. Therefore, the court reversed and remanded the case to the Board for reconsideration and apportionment of responsibility pursuant to OAR 436-035-0250. *Id.; see Kenneth L. Green*, 52 Van Natta 343 (2000) (on remand, the Board reduced the claimant's scheduled permanent disability award to the ratable hearing loss during his employment with James River).

Here, in arguing that initial responsibility should be apportioned among the three insurers/employer, claimant primarily relies on language in *Green*. We acknowledge that some language in *Green* can be broadly read as pertaining to assignment of initial responsibility. Such a reading is not accurate, however, because the sole issue before the court in *Green* was extent of scheduled disability, not assignment of initial responsibility. Moreover, as summarized above, the statute and rules the court interpreted in reaching its conclusions in *Nomeland, Papen,* and *Green* address extent of scheduled disability. *See* ORS 656.214(2); *former* OAR 436-30-360(2); *former* OAR 436-35-250; OAR 436-035-0250; *see also Louis C. Thomas,* 48 Van Natta 2519 (1996) (Board held that OAR 436-035-0250 related only to determining permanent disability and did not apply to determine initial compensability/responsibility of a hearing loss condition; instead, Board applied LIER to determine compensability/responsibility). Thus, *Nomeland, Papen,* and *Green* do not support claimant's position that initial responsibility for his hearing loss claim should be apportioned among the three employers.

In addition, the Court has long disapproved of apportionment as a means of assigning initial responsibility in favor of applying LIER for responsibility assignment. *Bracke v. Baza'r, Inc.*, 293 Or 239, 245 (1982); *Boise Cascade Corp. v. Starbuck,* 296 Or 238 (1984); *see also UAC/KPTV v. Hacke,* 101 Or App 598, *rev den* 310 Or 393 (1990) (Oregon law does not provide for apportionment of responsibility according to causation); *Billy D. Davidson,* 45 Van Natta 825 (1993) (Board declined to assign responsibility for a hearing loss claim based on apportionment of hearing loss during different periods of coverage; instead, Board applied LIER to assign responsibility). The Supreme Court recognized the arbitrariness of such an approach, but reasoned that such arbitrariness was mitigated in the long run as responsibility is spread proportionately among employers by operation of the law of averages. *Bracke v. Baza'r,* 293 Or at 249-50. Furthermore, there is no indication that the *Green* court intended to overrule this longstanding policy favoring LIER, especially since that issue was not before the *Green* court.

Finally, *Cascade Corporation v. Rose,* 92 Or App 663 (1988), cited in *Green* and relied on by claimant, does not support claimant's position regarding apportionment of his hearing loss claim. The claimant in *Rose* sustained a compensable knee injury in 1982, followed by a second knee injury in 1984 while working for another insured. Because the two injuries were distinct, the court found that they could be segregated for purposes of allocating responsibility. *Id.* at 667.

Here, however, claimant did not have separate injuries involving separate conditions. Rather, he has sustained progressive hearing loss over a period of many years while working for different employers. While claimant lost a portion of hearing while working for each employer, his hearing loss arose from ongoing exposure to noise at work. Thus, *Rose* is distinguishable and does not control. *Compare Timothy O. Fetterhoff*, 41 Van Natta 1935 (1989) (applied *Rose* analysis to allocate responsibility where the claimant suffered from two separate and distinct low back conditions).

Instead, we find *Dean M. Hunsaker*, 45 Van Natta 851 (1993), *aff'd Medford Corp. v. SAIF*, 128 Or App 119, *rev den* 320 Or 109 (1994), controlling. In *Hunsaker*, we found that the analysis in *Rose* did not apply to allocate responsibility between two carriers where a hearing loss condition did not involve two separate conditions but was, instead, a progressive loss resulting from years of ongoing noise exposure at work. Under such circumstances, we found that LIER applied to determine responsibility. *Id.* at 852.

The court affirmed on appeal. 128 Or App at 119. On appeal, the carrier assigned responsibility (Medco) argued that, because the claimant's hearing loss from each period of employment could be precisely quantified by audiograms, the claimant actually had two disabilities, responsibility for which could be allocated between the two separate carriers. Although finding Medco's argument superficially appealing, the court rejected it because it overlooked the fact that although it was possible to measure the contribution that each period of employment made to the claimant's hearing loss, the claimant had but one hearing loss. *Id.* at 122. The court explained that "Oregon law does not apportion liability among several employers or insurers for a single condition." *Id.* The court held that, under LIER, Medco was assigned full responsibility for the claim based on the last period of employment that contributed to the claimant's hearing loss. *Id.*

Accordingly, based on the above reasoning, we do not find it appropriate to assign initial responsibility by apportioning claimant's hearing loss among the three employers. Instead, on this record, initial assignment of responsibility is made under LIER.

Responsibility Under LIER[4]

Dr. Brown opined that claimant's occupational exposure was the major contributing cause of his hearing loss. (Exs. 12, 14). He also stated that it was likely that most of this hearing loss occurred in the 1970's and 1980's because claimant had been diligent about protecting his hearing since then, although no amount of hearing protection can be complete. (Ex. 12-4). Dr. Brown also stated that, even using two types of hearing protection (earplugs and earmuff-type) claimant sustained a substantial amount of noise exposure during the quarterly firearms qualifications. (Ex. 14-1).

Dr. Hodgson also opined that claimant's occupational exposure was the major contributing cause of his hearing loss. (Exs. 2-2, 11, 15, 16). Dr. Hodgson opined that the major contributing cause of claimant's hearing loss was the earlier noise exposure while working for Oregon City, noting that hearing loss was greatest in the first 10 to 15 years of exposure, with the majority of hearing loss occurring before 1994. (Ex. 16-14). However, Dr. Hodgson also opined that claimant's later employment with Troutdale and Milwaukie also contributed to a pathological worsening of his hearing loss. (Ex. 11-1). In his deposition, Hodgson explained the physical process of damage to hearing caused by gunfire, even when using two types of noise protection, which would not reduce the decibel level to a safe level. (Exs. 16-8-9, 16-10-11).

On this record, we find that the medical opinions establish that, although the majority of claimant's hearing loss was caused by noise exposure at Liberty/Oregon City, noise exposure at Liberty/Troutdale and Liberty/Milwaukie also contributed to claimant's hearing loss.

Claimant argues that he did not elect to rely on LIER as a rule of proof and, instead, proved "actual causation" against Oregon City by establishing that noise exposure at Liberty/Oregon City is the major contributing of his hearing loss. Therefore, claimant argues, because he did not elect to rely on

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[4] We note that, because there is no previously accepted claim for claimant's hearing loss condition, ORS 656.308(1) does not apply to determine responsibility. *SAIF v. Yokum*, 132 Or App 18, 23 (1994). Therefore, responsibility is determined under LIER.

LIER as a rule of proof, Liberty/Oregon City cannot rely on LIER to shift responsibility to a later employer. Liberty/Oregon City responds that claimant confuses the rule of proof aspect of LIER with the assignment of responsibility aspect of the rule. We agree with Liberty/Oregon City.

> "[I]t is well established that [a carrier] * * * may assert the rule of responsibility as a defense even when a claimant has chosen to prove actual causation." *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 explained the applicability of this defense. The court noted that the last injurious exposure rule is both a rule of proof and a rule of assignment of responsibility. In *Victoria*, there was no dispute that the claim was work related and the only dispute was responsibility. Therefore, the court found that only the latter aspect of the rule was relevant. *Id.* The court rejected the claimant's assertion that the rule should be applied only to cases where it was impossible to determine which employment was the major contributing cause of a claimant's compensable injury. The court found that that assertion as "not apposite here because it employs a principle of the last injurious exposure rule when it is used as a rule of proof." *Id.* Finally, quoting *Titus*, 151 Or App at 82, the court stated 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." *Id.*

Here, as in *Victoria*, there is no dispute that the claim is work related and the only dispute is responsibility. Therefore, only the rule of assignment of responsibility portion of the last injurious exposure rule is relevant. In addition, here, the medical opinions attribute claimant's binaural hearing loss to noise exposures occurring at all three employers. That is sufficient to invoke defensive use of the last injurious exposure rule as a rule of responsibility. *Safeco Ins. Co. v. Victoria*, 154 Or App at 577-78. Consequently, we turn to the responsibility assignment portion of the last injurious exposure rule to resolve the responsibility dispute. *Douglas R. Barnes*, 52 Van Natta 2097 (2000).

Under LIER, initial or presumptive responsibility for a condition is assigned to the last period of employment where conditions could have caused claimant's disability. *Bracke v. Baza'r*, 293 Or at 248-49. The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. *Id.* at 248. Where a claimant seeks or receives medical treatment for the compensable condition before experiencing time loss due that condition, it is appropriate to designate a triggering date based on either the seeking or receiving of medical treatment, whichever occurs first. *Agricomp Ins. v. Tapp*, 169 Or App 208, 213 (2000); *see Reynolds Metals v. Rogers*, 157 Or App 147, 153 (1998) (the date of the first medical treatment is the triggering date that dictates which period of employment is assigned initial responsibility for the treatment).

Here, claimant testified that he first sought treatment for hearing loss in the late 1970's or early 1980's. (Tr. 23). At that time, claimant worked for Oregon City. Although he could not recall the name or the specialty of the person performing the examination and audiogram, he recalled that the tests were similar to the ones he underwent recently. (Tr. 35). He also recalled that the examination occurred at a medical facility, not a retail store selling hearing aids. (Tr. 37). Following this exam, he was told that he had permanent hearing loss and should protect his hearing from further damage. (Tr. 23, 36). No formal treatment was provided, and he was not told he needed hearing aids. (Tr. 35-36). Claimant next had his hearing examined by Dr. Hodgson on January 27, 1999, after he filed an occupational disease claim with Liberty/Milwaukie. (Ex. 2).

Claimant argues that, under *Tapp*, responsibility is assigned to Liberty/Oregon City because he first sought treatment while Liberty/Oregon City was on the risk. However, the inquiry does not end there.

Even assuming that claimant first sought treatment for his hearing loss while Liberty/Oregon City was on the risk and, thus, presumptive responsibility is assigned to Liberty/Oregon City, under the responsibility assignment portion of LIER, Liberty/Oregon City may shift responsibility to a later carrier. In order to shift responsibility to a later carrier, the later employment conditions must "contribute to the

cause of, aggravate, or exacerbate the underlying disease." *Bracke v. Baza'r*, 293 Or at 250; *Oregon Boiler Works v. Lott*, 115 Or App 70, 74 (1992) (later employment conditions actually contribute to a worsening of the condition). A claimant must suffer more than a mere increase in symptoms. *Timm v. Maley*, 134 Or App 245, 249 (1995); *see Bracke*, 293 Or at 250 ("[a] recurrence of symptoms which does not affect the extent of a continuing underlying disease does not shift liability for the disabling disease to a subsequent employer").

Based on Dr. Hodgson's explanation of the mechanics of hearing loss caused by gun fire, and his opinion that additional hearing loss was caused by gun fire exposure during claimant's employment at Troutdale and Milwaukie, we find that claimant's employment at Troutdale and Milwaukie contributed to the cause of claimant's hearing loss. Under these circumstances, claimant's work at Milwaukie constituted the last injurious exposure causing claimant's hearing loss. However, as noted above, because claimant failed to timely request a hearing on Liberty/Milwaukie's denial, that denial is final by operation of law. Therefore, responsibility may not be assigned to Liberty/Milwaukie.[5]

We reach the same result if we find that claimant first sought medical treatment while employed at Liberty/Milwaukie's insured. Under such circumstances, we would ordinarily assign presumptive responsibility for claimant's condition to Liberty/Milwaukie. In the usual situation, Liberty/Milwaukie could attempt to shift responsibility to an earlier carrier. As noted above, however, claimant did not timely request a hearing from Liberty/Milwaukie's denial. Consequently, Liberty/Milwaukie cannot be held responsible for claimant's hearing loss condition.

Nevertheless, claimant can attempt to shift responsibility to an earlier carrier by proving either: (1) that it was impossible for conditions at Milwaukie to have caused the hearing loss condition or (2) that the hearing loss condition was caused solely by conditions at one or more previous employments. *See Roseburg Forest Products v. Long*, 325 Or 305, 313 (1997); *Reynolds Metals v. Rogers*, 157 Or App at 153. Based on this record, which establishes that noise exposure at all three employments contributed to claimant's hearing loss, claimant failed to shift responsibility to an earlier carrier.

Accordingly, claimant has failed to establish responsibility against Liberty/Oregon City, Liberty/Troutdale or Liberty/Milwaukie.

ORDER

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

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[5] In reaching this conclusion, we find instructive those cases where the claimants chose not to join a carrier and that carrier is ultimately determined to be presumptively responsible for the claimants' conditions under LIER. *See, e.g., Pamela M. Christman*, 52 Van Natta 122 (2000); *Kristin Montgomery*, 47 Van Natta 961 (1995). In those cases, because the claimants chose not to pursue responsibility against the "presumptively responsible" carrier, we found that that carrier could not be held responsible for the claimants' condition. Also instructive are those cases holding that a claimant may settle his rights to benefits with one carrier and, in so doing, accept the possibility that he will not receive compensation from the remaining carriers. *See E.C.D, Inc. v. Snider*, 105 Or App 416 (1991); *Jack Spinks*, 43 Van Natta 1181, 43 VaN Natta 1350 (1991), *aff'd mem Spinks v. Mosley and Sons*, 112 Or App 66, *rev den* 313 Or 627 (1992) (finding that claimant was not entitled to further compensation against the responsible carrier since he had settled his claim with that carrier by entering into a Disputed Claim Settlement (DCS). The same reasoning applies here. By failing to timely request a hearing on Liberty/Milwaukie's denial, claimant essentially chose not to pursue responsibility against Liberty/Milwaukie. Because that denial is final, Liberty/Milwaukie cannot be held responsible for claimant's hearing loss condition.

Board Member Phillips Polich dissenting.

The majority finds that claimant failed to establish good cause for his failure to timely request a hearing on Liberty/Milwaukie's denial of his occupational disease claim for binaural heari loss. I disagree.

It is undisputed that claimant requested a hearing from Liberty/Milwaukie's denial more than 60 days and less than 180 days after the mailing of the denial. Consequently, the hearing request confers jurisdiction only if claimant had "good cause" for the late filing. ORS 656.319(1); *Tracie L. Salustro*, 52 Van Natta 1420 (2000). Mistake, inadvertence, surprise or excusable neglect, as those terms are used in ORCP 71B(1), constitute "good cause." *Hempel v. SAIF*, 100 Or App 68, 70 (1990); *Anderson v. Publishers Paper Co.*, 78 Or App 513, 517, *rev den* 301 Or 666 (1986). In addition, good cause can be established through evidence that a claimant was mislead by a carrier's representative. *See Voorhies v. Wood, Tatum, Moser*, 81 Or App 336 (1985), *rev den* 302 Or 342 (1986). Based on the following reasoning, I would find that claimant has met his burden of proving good cause for the late filing.

Here, claimant was misled by the Liberty/Milwaukie's representative. In this regard, Liberty/Milwaukie's denial states that employment at the City of Milwaukie was not the major contributing cause of claimant's binaural hearing loss. Given this language, claimant could not possibly be expected to know that responsibility could serve as a defense to a compensable hearing loss claim. Furthermore, claimant called Liberty/Milwaukie's representative in an attempt to resolve his confusion regarding the language of this denial and was not advised to request a hearing on that denial. Instead, he was only advised to file a claim against the earlier employers. On this record, I would find that claimant acted with reasonable diligence in attempting to resolve his confusion. *Compare Debra A. Gould*, 47 Van Natta 1072 (1995) (confusion regarding the contents of a denial does not, without reasonable diligence, constitute good cause).

Therefore, claimant has established good cause for his untimely hearing request and his occupational disease claim against Liberty/Milwaukie remains viable. Because the majority finds otherwise, I respectfully dissent.

In the Matter of the Compensation of
JAIME SANTAMARIA-SANCHEZ, Claimant
WCB Case No. 00-04030
ORDER ON REVIEW
Roger Wallingford, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that affirmed an Order on Reconsideration that awarded no unscheduled permanent disability for a back condition. On review, the issue is extent of unscheduled permanent disability.

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

ORDER

The ALJ's order dated October 27, 2000 is affirmed.

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[1] Claimant contends on review that the medical evidence is sufficient to establish that claimant is entitled to a permanent impairment rating under *SAIF v. Danboise*, 147 Or App 550, *rev den* 325 Or 328 (1997). We disagree.

The court discussed *Danboise* in *SAIF v. Alton*, 171 Or App 491 (2000). The court noted that, in rating impairment in *Danboise*, the medical evidence expressly described the impainment as "consistent with" the compensable injury, and that nothing in the record disclosed any other possible source for the impairment. Here, unlike in *Danboise*, the medical arbiter expressly stated that claimant's reduced ROM "[we]re not medically probably due to the reported [work] incident to a measurable degree." (Ex. 28-3). Moreover, Dr. Kane, claimant's treating physician, diagnosed claimant with somatic dysfunction in the thoracolumbar spine. Although Dr. Kane indicated that the somatic dysfunction was partly related to the accepted work claim, he also opined that "a portion, perhaps even the majority, is preexisting relative to [claimant's] industrial injury." (Ex. 19). Accordingly, based on this medical evidence, we conclude that the ALJ correctly found that claimant's reduced ROM was unrelated to the accepted injury and, as such, not ratable under the standards.

In the Matter of the Compensation of
JOHN F. HILLIARD, Claimant
Own Motion No. 01-0010M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's low back condition. Claimant's aggravation rights have expired. SAIF opposes authorization of temporary disability compensation on the grounds that: (1) it is unknown whether claimant's compensable condition requires surgery or inpatient hospitalization; (2) it is unknown whether surgery or hospitalization is reasonable and necessary for claimant's compensable condition; and (3) 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.*

In order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

We need not resolve the questions of whether claimant's current condition requires surgery/hospitalization or whether any treatment is reasonable and necessary. We reach this judgment because, even if the answer to those questions was "yes," the record would still not authorize us to award benefits. This conclusion is based on the following reasoning.

SAIF contends that claimant was not in the work force at the time of the current disability. Claimant has not responded to SAIF's contention. Claimant has the burden of proof on this issue and must provide evidence, such as copies of paycheck stubs, income tax forms, unemployment compensation records, a list of employers where claimant looked for work and dates of contact, a letter from the prospective employer, or a letter from a doctor stating that a work search would be futile because of claimant's compensable condition for the period in question.

Lacking such evidence, we are unable to conclude that claimant was in the work force at the time of disability. Accordingly, claimant's request for temporary disability compensation is denied. *See id.* We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
THOMAS M. THORSON, Deceased, Claimant
WCB Case No. 99-07930
ORDER ON RECONSIDERATION
Arthur P. Klosterman, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

On December 27, 2000, we abated our November 20, 2000 order that vacated the Administrative Law Judge's (ALJ's) order that: (1) excluded Exhibit 13 (an accident reconstruction report); and (2) upheld the SAIF Corporation's denial of claimant's claim (as the widow of the deceased worker) for survivor's benefits. Concluding that it was an abuse of discretion for the ALJ to have excluded the exhibit, we remanded to the ALJ for further proceedings. Following issuance of our November 20, 2000 order, SAIF sought reconsideration, asserting that we misunderstood the basis for the ALJ's evidentiary ruling. We abated our order to further consider SAIF's position. Having received claimant's response, we proceed with our reconsideration.

In our Order on Review, we found that the ALJ excluded Exhibit 13, which was an accident reconstruction report submitted by claimant, on the ground that the report did not fall under the exception set forth in ORS 656.310(2). We noted that the statute provided that the contents of *medical* reports presented by a claimant shall constitute *prima facie* evidence as to matters contained therein, provided that the *doctor* rendering the report consents to submit to cross-examination. ORS 656.310(2). Because the accident reconstruction report was not a medical report from a physician, we concluded that the statute did not apply. Furthermore, because the report was timely disclosed pursuant to the Board's rules, we held that it was an abuse of discretion for the ALJ to have excluded the report at hearing.

On reconsideration, SAIF argues that, although the ALJ did not use the term "hearsay," that was the basis for his exclusion of Exhibit 13. SAIF contends that because there was no timely notice of claimant's expert witness (the author of Exhibit 13), the exhibit was properly excluded on the ground that it was hearsay.

We do not agree with SAIF's interpretation of the basis for the objection and the ruling that followed the objection. At hearing, counsel for SAIF objected to the report on the ground that:

> "the rules do not provide for reports of reconstruction experts" and "[the rules] were provided for reports of medical and vocational experts only, and that's why you provide notice of your expert, who's going to testify in order to provide the other side adequate opportunity to prepare." (Tr. 7).

Accordingly, we conclude that SAIF objected to the report on the ground that it was not a medical report and that there was no timely notice of the expert witness. In response to the objection, the ALJ recited the statute and ruled that the expert would not be permitted to testify as he was not "under the protection of .310." The ALJ further stated: "I don't think he can do the report. It doesn't fit under .310." (Tr. 8). Finally, the ALJ stated that claimant had not "provided notice of expert witness" and he was going to sustain SAIF's objection. *Id.*

Based on SAIF's objection and the ALJ's ruling, we conclude that the ALJ agreed that the expert witness could not *testify* because timely notice had not been provided. However, as we explained in our prior order, claimant did not seek the *testimony* of the author of the accident reconstruction report. Rather, he sought the *admission* of the *report*.

As we reasoned in our prior order, the ALJ's sole reason for excluding the accident reconstruction report was that the report was not a medical report as provided for in ORS 656.310(2). Again, because that statute pertains to medical reports, and the exhibit at issue here is not a medical report, we do not find that it provides a basis for exclusion at hearing. Therefore, because the document was timely disclosed, we continue to conclude that the ALJ abused his discretion by excluding the exhibit on the ground that it did not fall under the provisions of ORS 656.310(2).[1]

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[1] In reaching this conclusion, we emphasize that our decision is limited to the question of whether it was an abuse of discretion for the ALJ to have excluded the proposed exhibit based on ORS 656.310(2). Had the ALJ's evidentiary ruling been based on other grounds (for example, that the report was "hearsay" and/or designed to avoid the "expert witness/notice" requirements of OAR 438-007-0016), our analysis and decision may well have been different.

Accordingly, on reconsideration, as supplemented herein, we republish our November 30, 2000 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

January 23, 2001 Cite as 53 Van Natta 77 (2001)

In the Matter of the Compensation of
CHRISTOPHER J. WEHREN, Claimant
WCB Case Nos. 00-01180 & 99-01486
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorney
Cummins, Goodman, et al, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

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 cervical condition. On review, the issue is compensability.

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

The ALJ set aside the employer's denial of a "myofascial pain syndrome" as related to claimant's compensable 1992 cervical injury based on the opinion of claimant's treating physician, Dr. Grant. On review, the employer first contends that the ALJ erred in according Dr. Grant deference as claimant's "treating physician. Although we do not defer to Dr. Grant's opinion as claimant's "treating physician," we find that Dr. Grant's opinion is the most persuasive on alternate bases.

Because claimant contends that his myofascial pain syndrome is a result of his compensable 1992 cervical strain condition, we agree with the ALJ that the major contributing cause standard relating to "consequential condition" claims applies. ORS 656.005(7)(a)(A); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992).

Due to the presence of several intervening injuries, the relationship of claimant's myofascial pain syndrome to his 1992 injury is a complex medical question. *Uris v. Compensation Dept.*, 247 Or 420 (1967). As such, resolution of the causation issue must be resolved with expert medical opinion. *Barnett v. SAIF*, 122 Or App 279 (1993). Where the medical evidence is divided, we rely on those medical opinions that are well-reasoned and rely on complete and accurate information. *Somers v. SAIF*, 77 Or App 259, 263 (1986).

Moreover, absent persuasive reasons to the contrary, we generally rely on the opinion of claimant's treating physician. *Weiland v. SAIF*, 64 Or App 810 (1983). However, we have declined to defer to a treating physician who has not examined the claimant soon after the injury. *Steve E. Powonka*, 52 Van Natta 272 (2000). Here, Dr. Grant examined claimant only once, on May 27, 1999, several years after claimant's November 2, 1992 compensable injury. (Ex. 116). In those circumstances, we decline to defer to Dr. Grant as claimant's treating physician.

Nevertheless, we find Dr. Grant's opinion the most persuasive because it relies on a complete and accurate history and because it is the most well-reasoned in the record. Dr. Grant relied on a complete medical history, including records documenting claimant's 1993 suicide attempt, when he attempted to hang himself by the neck. (Exs. 125, 130). Dr. Grant authored a lengthy and well-reasoned report as to the validity of the myofascial pain syndrome diagnosis, supported by several pieces of medical literature. (Ex. 130). Dr. Grant also provided a well-reasoned explanation of the "vicious cycle" of the syndrome, beginning with an "acute injury" or a "chronic overuse type of injury." (Ex. 125).

Contrary to the employer's assertion, Dr. Grant did not state that *all* myofascial pain syndromes are limited to "three to five years." Rather, he stated that the condition may "extend essentially indefinitely." (Ex. 125-2). Moreover, claimant's myofascial pain syndrome was not diagnosed until May 27, 1999, shortly before the filing of this "consequential condition" claim. (Ex. 116).

The employer next contends that Dr. Grant never explicitly stated that claimant's injury was the major contributing cause of his myofascial pain syndrome condition. We disagree.

In an "opinion summary" letter prepared for Dr. Grant, claimant's counsel stated that "[B]ased on the history contained in your report of May 27, 1999, you felt the original work injury in 1992 was the major cause of [claimant's] post traumatic myofascial pain syndrome in his neck." (Ex. 124-1). Claimant's counsel's letter then asked specifically whether reviewing additional medical reports from 1993 (regarding claimant's suicide attempt of that year) altered this opinion on causation. (*Id.*) Instead of signing this report, however, Dr. Grant wrote a separate letter that stated "Reviewing the medical report regarding Mr. Wehren's attempted suicide, does not change my conclusions and previous opinion regarding his chronic myofascial and shoulder pain problems." (Ex. 125-1).

Although Dr. Grant did not restate this opinion on causation in his own words, we are persuaded that he agreed with that portion of claimant's attorney's letter from the context of Dr. Grant's response letter. *See McClendon v. Nabisco Brands*, 77 Or App 412 (1986) ("magic words" are not required to meet a statutory burden of proof). This opinion on "major contributing cause" is also consistent with Dr. Grant's May 27, 1999 report, wherein he diagnosed a "posttraumatic" myofascial pain syndrome, which began following claimant's 1992 compensable injury. (Ex. 116).

In contrast, we find Dr. Thompson's opinion unpersuasive because his opinion is internally inconsistent and because it is contrary to the law of the case. Dr. Thompson examined claimant once at the request of the employer in 1995. (Ex. 84). Initially we note that Dr. Thompson is at the disadvantage of not having examined claimant since 1995. In addition, although Dr. Thompson originally diagnosed claimant's neck condition "starting back in 1992" as "chronic cervical thoracic strain," within the same report he diagnosed claimant's neck condition in 1992 as "acute idiopathic torticollis." (Ex. 120-1, -2). Moreover, as the ALJ noted, Dr. Thompson's diagnosis of claimant's condition as a result of the 1992 injury as "idiopathic torticollis" is contrary to the accepted condition, cervical strain. (Ex. 17). His opinion is therefore unpersuasive. *Kuhn v. SAIF*, 73 Or App 768 (1985).

Dr. Woodward also examined claimant at the request of the employer. (Ex. 114). Dr. Woodward concluded that claimant's "present symptoms" were not attributable to his work activities in 1992 and 1993. (Ex. 114-10). However, Dr. Woodward's opinion was based at least in part on the inaccurate assumption that claimant had "neck problems" prior to 1992. (Ex. 114-10). Although Dr. Woodward disputed Dr. Grant's diagnosis of a "myofascial pain syndrome," Dr. Grant persuasively rebutted Dr. Woodward's criticism of the diagnosis in general and specifically with regard to claimant. (Exs. 127, 130). For this reason, we find Dr. Grant's opinion more persuasive than that of Dr. Woodward.

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 August 31, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the self-insured employer.

In the Matter of the Compensation of
BERTHA J. AVILA, Claimant
WCB Case No. 00-01823
ORDER ON REVIEW
Mustafa T. Kasubhai, Claimant Attorney
Reinisch, et al, Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the self-insured employer's denial of claimant's low back injury claim. On review, the issue is compensability.

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

Claimant argues that medical causation was the only issue at hearing and the ALJ should not have addressed legal causation. We do not find that the compensability issue was limited to medical causation.[1] Moreover, we would reach the same result even if medical causation was the only issue raised at hearing, based on the following reasoning.

Dr. Amstutz provides the only expert evidence addressing causation. He opined that the claimant's prior back injury and surgery were the major causes of her "underlying difficulty with her spine," (Ex. 27-32; *see* Ex. 15-2), but the December 1999 work incident was the cause of her recent need for treatment. (Exs. 26-2; see Ex. 27-32). The latter portion of the doctor's opinion was based in part on the understanding that claimant had no "significant" problems with her low back since her 1978 low back injury and subsequent surgery. (Ex. 25; *see* Exs. 6-1, 13-1, 27-32). However, the record indicates that claimant sought treatment for at least 4 days of low back pain in September 1999, three months before the claimed December 11, 1999 work incident.[2] (*See* Ex. 1). Thus, Dr. Amstutz's belief that claimant was "doing well clinically," before the December 1999 onset of symptoms amounts to an inaccurate history. Accordingly, because the medical evidence supporting the claim is based on an inaccurate history, we decline to rely on it and we agree with the ALJ that claimant has not carried her burden of proof.

ORDER

The ALJ's order dated October 10, 2000 is affirmed.

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[1] At the outset of the hearing, claimant's counsel stated that the "issue is *essentially* medical causation * * * whether the condition or need for treatment is in major part caused by the work incident to which [claimant] will be testifying." (2Tr. 1, emphasis added).

[2] We acknowledge claimant's testimony that her September 1999 low back pain was due to a kidney infection. However, there is no medical evidence addressing the etiology of these symptoms and lay testimony is insufficient to establish causation in a medically complex case such as this.

In the Matter of the Compensation of
MARK W. DURBIN, Claimant
WCB Case No. 00-01072
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorney
Craig A. Staples, Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) set aside its denial of claimant's occupational disease claim for a right carpal tunnel syndrome (CTS) condition; and (2) awarded a $4,750 attorney fee. On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

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

Claimant requested a hearing regarding the employer's January 19, 1999 denial of claimant's claim for a right CTS condition. The issue was compensability.

The hearing lasted 45 minutes and the transcript is 26 pages long. Claimant was the only witness who testified.

The record consists of 24 exhibits, with at least 7 submitted by claimant, including two "concurrence letters" signed by claimant's treating physician and generated by claimant. The insurer requested the deposition of Dr. Lundsgaard, treating physician. The deposition lasted about 30 minutes.

Claimant requested an attorney fee of $6,000 for about 25 hours of legal services, based in part on an hourly rate of $250 per hour.

CONCLUSIONS OF LAW AND OPINION

We adopt the ALJ's "Discussion of Findings" and "Ultimate Findings of Fact and Conclusions of Law," with the following supplementation regarding the attorney fee issue.

The ALJ awarded a $4,750 attorney fee for claimant's counsel's services at the hearing level, considering the rule-based factors discussed below, especially the time claimant's attorney devoted to the matter, the benefit obtained by claimant, and the risk that claimant's counsel would go uncompensated. The ALJ noted that claimant's counsel spent over 25 hours on the case and faced a relatively significant risk of going uncompensated. On the other hand, the ALJ found that the benefit from prevailing was rather limited, because claimant's mild CTS improved with conservative treatment (without the need for surgery).

On review, the employer argues that the ALJ's attorney fee award should be substantially reduced, contending that the value of claimant's counsel's services was significantly less than that in other cases where the Board awarded lower fees.

We review the attorney fee issue *de novo*, considering the specific contentions raised on review, in light of the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that any attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Here, the issue at the hearing was the compensability of claimant's right CTS condition. Claimant's counsel provided about 25 hours of legal services at the hearing level. The hearing's length was 45 minutes, resulting in 26 pages of transcript. Twenty-four exhibits were admitted, 7 submitted by claimant. Two "claimant-generated" medical reports were of significant probative value in establishing the compensability of his claim. One physician was deposed "pre-hearing."

The case involved issues of average legal complexity and above average medical complexity, considering the range of cases generally submitted to this forum. The claim's value and the benefits secured are average. Claimant's attorney devoted a significant amount of time to the case.[1] 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 defense.[2]

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $4,750 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 and evaluating claimant's counsel's submission in light of the insurer's objection), the value of the interest involved, the nature of the proceeding (a brief hearing, followed by a deposition), and the risk that claimant's counsel might go uncompensated.

Claimant's attorney requests a fee of $2,500 for about 14 hours of legal services on review under ORS 656.382(2). The employer objects to the amount claimant requests, contending that $1,000 would be more appropriate.

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 employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief, claimant's counsel's fee request, and the employer's objection thereto), the complexity of the issue, and the value of the interest involved. Finally, we note that claimant is not entitled to an attorney fee for services expended on Board review that were related to the attorney fee issues and about one-third of his brief is devoted to that issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated September 20, 2000 is affirmed. For services on review, claimant is awarded a $1,500 attorney fee, to be paid by the self-insured employer.

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[1] Claimant's counsel devoted a significant number of hours skillfully advocating claimant's claim in the face of a vigorous defense. Nonetheless, the amount of time expended in litigating a claim is but one of many factors to be considered in determining a reasonable attorney fee award under OAR 438-015-0010(4).

[2] *See Schoch v. Leupold & Stevens*, 144 Or App 259 (1996) (The risk in a particular case that an attorney's efforts may go uncompensated is a factor to be considered in setting a reasonable attorney fee under OAR 438-015-0010(4)). Nevertheless, we do not apply a contingency factor or "multiplier" in a strict mathematical sense. *E.g., Lois J. Schoch*, 49 Van Natta 788, 790, n 1 (1997). Rather, in accordance with OAR 438-015-0010(4)(g), in arriving at our determination of a reasonable attorney fee award, we have taken into consideration the risk (particularly in light of the nature of the proceedings, and the employer's vigorous defense) that claimant's attorney's efforts might have gone uncompensated for the services rendered in this case.

In the Matter of the Compensation of
DANNY G. EADES, Claimant
WCB Case Nos. 00-04743, 00-04146 & 00-01844
ORDER ON REVIEW
J. Michael Casey, Claimant Attorney
Lundeen, et al, Defense Attorney
Gilroy Law Firm, Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

Crawford & Company, (Crawford) requests review of Administrative Law Judge (ALJ) Poland's order that: (1) set aside its denial of claimant's occupational disease claim for a left rotator cuff tear; and (2) upheld Liberty Northwest's denial of claimant's claim for the same condition. On review, the issues are timeliness, compensability and responsibility.

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

Crawford argues that claimant's claim should have been analyzed as a claim for an industrial injury and that claimant's injury claim is untimely. Whether the claim should be analyzed as an injury or a disease is a close question. Some evidence supports a gradual onset of the left shoulder condition over years, months and weeks while other evidence suggests a specific incident that occurred in August 1999. After reviewing the entirety of this evidence, we conclude that the preponderance of the evidence supports a conclusion that claimant's left shoulder problems were gradual in onset and involved an ongoing condition of the body that is correctly analyzed as an occupational disease claim.

In this regard, the record reflects that claimant had years of chronic, low grade pain in the left shoulder. (Ex. 43-1). Although claimant testified that he noticed a pull in his left shoulder in August 1999, he also indicated that the condition developed over several weeks. (Tr. 30). Given claimant's history of an ongoing left shoulder condition that worsened gradually in August 1999, we conclude that the ALJ correctly analyzed the claim as an occupational disease rather than an industrial injury.

Crawford also argues that the ALJ erred in finding that Dr. Brenneke's opinion supported a conclusion that claimant's condition was pathologically worsened by his work activities in August 1999. We disagree with Crawford. Dr. Brenneke acknowledged that claimant had a preexisting condition that contributed to his left rotator cuff tear. However, Dr. Brenneke also indicated that either the rotator cuff pathology was a small tear that was accentuated or was a partial tear that became a full tear. (Ex. 44). Thus, based on this evidence, we agree with the ALJ's conclusion that Dr. Brenneke's opinion supports a conclusion that claimant's underlying condition worsened as well as his symptoms. Under such circumstances, we agree with the ALJ that claimant established a compensable occupational disease claim for which Crawford is responsible.

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 issues, and the value of the interest involved.

ORDER

The ALJ's order dated September 26, 2000 is affirmed. For services on Board review, claimant's attorney is awarded $1,200, payable by Crawford.

In the Matter of the Compensation of
GERALD MELTON, SR., Claimant
WCB Case No. 00-03762
ORDER ON REVIEW
Coughlin, Leuenberger, & Moon, Claimant Attorney
David L. Bussman, Defense Attorney
Craig A. Staples, Defense Attorney

Reviewed by Board Members Meyers and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the insurer's denial of his claim for a right shoulder rotator cuff tendinitis and impingement condition. On review, the issue is compensability.

We adopt and affirm the order of the ALJ, with the following supplementation.

On review, claimant argues that the ALJ erred in addressing compensability only under an "injury" theory. Claimant contends that the ALJ should have also considered whether the right shoulder claim was compensable as an occupational disease. The insurer argues, however, that the issue of occupational disease was not properly raised by claimant at hearing.

We need not address whether occupational disease was properly raised at hearing because we find that claimant cannot meet his burden of proof under either theory. Claimant relies on the opinion of Dr. Sandefur to establish compensability. However, while Dr. Sandefur reported that repetitive work activities over a number of years were the major contributing cause of claimant's condition, he also acknowledged that claimant had a degenerative condition in his right shoulder. Dr. Sandefur further noted that claimant's long term use of a steroid prescription could have potentially weakened the rotator cuff tendons. (Ex. 58).

We agree with the ALJ's conclusion that claimant has a preexisting shoulder condition. Accordingly, claimant must prove that his employment conditions are the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(b). Furthermore, the fact that work activities are the immediate or precipitating cause of a claimant's condition does not necessarily mean that the work activities are the major contributing cause of the condition. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995). Instead, determination of the major contributing cause involves evaluating the relative contribution of different causes of claimant's need for treatment of the combined condition and deciding which is the primary cause. *Id.*

Here, Dr. Sandefur has not provided any reasons for his conclusion that claimant's work activity, as opposed to his preexisting condition or his use of prescription steroids, is the major cause of his combined condition. Moreover, Dr. Sandefur stated that he believed that work activities were the major contributing cause because the activities "aggravated the shoulder to the point where he has had to undergo medical treatment." (Ex. 58).

Dr. Sandefur's conclusion that claimant's work "aggravated" his shoulder condition is not sufficient to establish a pathological worsening of the condition. Moreover, Dr. Sandefur's opinion appears to be based on a "precipitating cause" analysis. Finally, Dr. Sandefur has not provided an explanation of his opinion or any evaluation of the relative contribution of the preexisting condition, the steroid use, and the work activities. Therefore, we do not find that his opinion is persuasive. *See Denise N. Brown*, 51 Van Natta 836 (1999) (persuasive medical opinion must weigh the relative contribution of different causes; "but for" analysis not well reasoned).

Accordingly, we conclude that, under either an "injury" or an "occupational disease" analysis, claimant has not met his burden of proof. We therefore affirm the ALJ's order.

ORDER

The ALJ's order dated September 20, 2000 is affirmed.

In the Matter of the Compensation of
CANDACE Y. MITCHELL, Claimant
WCB Case No. 98-07156
ORDER ON REVIEW
Jerry Keene, Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Poland's order that found that claimant's claims for current low back and psychological conditions are precluded. Along with her brief, claimant submits additional evidence, which we treat as a motion for remand. On review, the issues are remand and *res judicata*.

We adopt and affirm the ALJ's order with the following supplementation to address the remand issue.

Enclosed with claimant's brief are two documents which were apparently generated after the hearing. These documents are a September 21, 2000 letter from Dr. Anderson and a September 28, 2000 report by Dr. Welling. Because our review is limited to the record developed before the ALJ, we treat claimant's submission as a motion for remand the case to the ALJ. *See Judy A. Britton*, 37 Van Natta 1262 (1985). We remand only if the record is improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Specifically, to merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

The documents claimant submits on review do not indicate that her conditions changed since the prior unappealed denials. Therefore, we conclude that admission of the proposed evidence would not affect the outcome of the case. Accordingly, there is no compelling reason to remand the case to the ALJ and we deny the motion to remand.[1]

ORDER

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

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[1] It appears from claimant's arguments, that she is unclear about to her rights under the Workers' Compensation system. Because claimant is unrepresented, she may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in such matters. She 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

Board Member Phillips-Polich concurring.

Claimant contends that her low back condition worsened in 1998, based on an MRI revealing a disc fragment impinging on a nerve root, Dr. Welling's reports and surgical notes, and her "100%" pre-surgery disability. She argues that her medical records from 1997 until the 1998 surgery prove that she was in severe pain and unable to walk without assistance before her surgery. On this basis, claimant urges us to find that her claim is not precluded because her back condition worsened since the 1996 denial.

Because of the passage of time since the 1990 work injury, the nature of claimant's current condition is a "medically complex" issue. Therefore, claimant's severe symptoms and firm belief that her condition worsened is not sufficient to establish a changed condition, absent expert evidence to that effect.

I acknowledge claimant's frustration with her long-standing back pain and her reasonable assertion that her claim should have been classified as "disabling." Unfortunately, we are legally precluded from addressing the merits of the current claim, because the 1996 denial became final and there is no medical evidence establishing that claimant's current condition differs from her condition at the time of the denial.

January 24, 2001 Cite as 53 Van Natta 85 (2001)

In the Matter of the Compensation of
MELINDA SKUBINNA-PULLINS, Claimant
WCB Case No. C010002
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Mustafa T. Kasubhai, Claimant Attorney
Reinisch, et al, Defense Attorney

Reviewed by Board Members Bock and Phillips Polich.

On January 3, 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 her compensable injury. We approve the proposed disposition.

On page 3 (numbers 1 and 2), the CDA provides: "The parties agree that the right carpal tunnel syndrome is medically stationary and resolved without impairment."

We have held that it is impermissible for a CDA to accomplish claim processing functions, such as determining whether a claimant is medically stationary or awarding permanent partial disability, because it is not one of the objectives to be resolved with such an agreement. *E.g., Kenneth R. Free*, 47 Van Natta 1537 (1995); *Debbie K. Ziebert*, 44 Van Natta 51 (1992). Furthermore, the language, "resolved without impairment" could reasonably be interpreted to limit claimant's right to medical services under ORS 656.245. *See Marilyn London*, 43 Van Natta 1689 (1991).

Here, however, we do not interpret the present CDA as impermissibly attempting claim processing functions. Instead, because the CDA expressly provides that the claim has "never been closed" and that "no permanent disability benefits have been awarded on the claim," we interpret the agreement merely as stating that the parties believe that claimant's condition is medically stationary. Additionally, because the CDA (on page 3, lines 16 - 18) specifically provides that claimant retains her right to medical services for the right carpal tunnel syndrome, we do not consider the "resolved" language as limiting claimant's right to medical services.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DIANA L. FORDYCE, Claimant
WCB Case No. 00-02713
ORDER ON REVIEW
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that upheld the SAIF Corporation's denials of claimant's injury claims for low back, cervical and thoracic conditions. On review, the issue is compensability.

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

The ALJ upheld SAIF's denial of claimant's claim for an L3-4 disc herniation condition based on the opinions of Drs. Seres, Dinneen and Dinekas. In reaching that conclusion, the ALJ found that claimant had not proved that her compensable injury was the major contributing cause of her L3-4 disc herniation condition. The ALJ also upheld SAIF's denial of claimant's claim for cervical and thoracic strains based on the opinion of Dr. Seres.

On review, claimant contends that the ALJ erred in failing to evaluate claimant's L3-4 disc herniation claim as a "combined condition." ORS 656.005(7)(a)(B). SAIF agrees that the ALJ applied the incorrect standard, but contends that claimant still did not meet her burden of proof. We find that, even under the correct "combined condition" standard, claimant has failed to meet her burden of proof.

Claimant has an accepted low back strain condition as a result of a fall at work on October 24, 1999. (Ex. 32). Claimant also has preexisting spondylosis (degenerative changes) at L3-4. (Exs. 14, 19, 22, 24). The persuasive medical evidence indicates, and claimant acknowledges, that her preexisting low back condition combined with the effects of her compensable injury to cause her disability or need for treatment for her L3-4 disc herniation. (*See, e.g.* Ex. 52). Therefore, under the "combined condition" statute, claimant must prove that her October 24, 1999 injury was the major contributing cause of her disability or need for treatment for her combined L3-4 disc herniation condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 301, *on recon*, 149 Or App 309 (1997).

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, 263 (1986). Absent persuasive reasons to the contrary, we generally rely on the opinion of claimant's treating physician. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to claimant's treating physician, Dr. Newby.

Initially, we note that the medical evidence is divided as to whether claimant has a clinically significant herniated disc. Dr. Newby diagnosed a herniated disc at L3-4 based on an MRI scan. (Ex. 27). However, Dr. Dinneen, who examined claimant at the request of SAIF, reasoned that there was no objective evidence of an L3-4 disc rupture because claimant did not experience symptoms of motor loss or significant reflex loss. (Ex. 37). Dr. Seres, who also examined claimant at the request of SAIF, stated that any L3-4 herniated disc was not "clinically verifiable" because claimant did not have immediate symptoms in an "L4 distribution." (Ex. 61).

Nevertheless, even assuming claimant has an L3-4 disc herniation, the persuasive medical evidence does not establish that her compensable injury is the major contributing cause of the disability or need for treatment for the combined condition. ORS 656.005(7)(a)(B).

When determining major contributing cause in a "combined condition" context, a persuasive medical opinion must evaluate the relative contribution of different causes of claimant's need for treatment for the combined condition and decide which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397, 401-402 (1994), *rev dismissed* 320 Or 416 (1995). Here, Dr. Newby acknowledged some contributory role from claimant's preexisting psychological condition to her need for treatment, but did not weigh or analyze its relative contribution. (Ex. 57). In those circumstances, we agree with the ALJ that Dr. Newby's opinion is unpersuasive.

Dr. Koller, a consulting physician, stated that claimant's compensable injury was the major contributing cause of her need for treatment for her L3-4 disc herniation and resulting nerve root impingement. (Ex. 63). The ALJ rejected Dr. Koller's opinion, in part, because he phrased his opinion in terms of the major contributing cause of claimant's need for treatment, which the ALJ stated "is not the issue herein." (O&O at 8). As Dr. Koller's opinion coincides with our framing of the legal standard above, we do not reject Dr. Koller's opinion on that basis.

However, Dr. Koller's opinion on major contributing cause rests solely on a temporal, or "precipitating cause" analysis. Dr. Koller's opinion regarding the L3-4 disc condition "is based on [claimant's] reported history of the incident and symptom onset." (Ex. 63-1). An opinion based solely on a "precipitating cause" analysis will not generally satisfy a claimant's burden of proving major contributing cause. *Dietz v. Ramuda*, 130 Or App at 401-402. Accordingly, we find Dr. Koller's opinion unpersuasive on that basis.

Dr. Maloney authored an ambiguous opinion on causation which also does not satisfy claimant's burden of proof. Dr. Maloney agreed with the statement that "To the extent that the extruded disc fragment is causing [claimant's] symptoms, it is your opinion that the degenerative changes combined with the October 24 chair incident with soft tissue strain to cause in major part the need for treatment." (Ex. 60-1). We cannot determine from this statement whether Dr. Maloney implicated claimant's compensable injury, as opposed to the "degenerative changes," as the major contributing cause of her need for treatment. Therefore, Dr. Maloney's opinion is unpersuasive.

Because we have found the medical opinions that support the compensability of claimant's low back condition to be unpersuasive, it follows that claimant's low back herniated disc claim is not compensable.

Finally, we adopt and affirm the ALJ's order on the issue of the compensability of claimant's cervical and thoracic strain conditions.

ORDER

The ALJ's order dated October 19, 2000 is affirmed.

January 24, 2001 Cite as 53 Van Natta 87 (2001)

In the Matter of the Compensation of
ADA THIEMS, Claimant
WCB Case No. C010061
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
McGinty & Belcher, Claimant Attorney
VavRosky, et al, Defense Attorney

Reviewed by Board Member Bock and Phillips Polich.

On January 10, 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 released rights to future workers' compensation benefits, except medical services, for the compensable injury. For the following reasons, we approve the proposed disposition.

The first page of the proposed CDA provides that the total amount due claimant is $5,240 and the total due claimant's attorney is $1,750. This would equal a total consideration of $6,990. However, the total consideration recited on the third page of the CDA is "$7,000," from which claimant's attorney receives a fee of $1,750.

Considering the document as a whole, we are persuaded that the reference on the summary page of the CDA to a total due claimant of $5,240 is a typographical error. Accordingly, we interpret the agreement as providing for a total consideration of $7,000, with $5,250 to claimant and $1,750 payable as an attorney fee.[1]

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[1] We note that an attorney fee of $1,750 from total CDA proceeds of $7,000 is consistent with OAR 438-015-0052(1).

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved.

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

IT IS SO ORDERED.

January 25, 2001 Cite as 53 Van Natta 88 (2001)

In the Matter of the Compensation of
CAROL R. HOUSTON, Claimant
WCB Case No. 99-09877
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorney
Jerald Keene, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

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

We adopt and affirm the ALJ's order with the following supplementation to address the employer's contentions on review.

The employer argues that Dr. Ludwig-Cohen's opinion is unpersuasive because she did not explain the delay between claimant's injury and the date claimant sought treatment. Dr. Ludwig-Cohen was aware that the incident occurred on July 9, 1999, and that claimant sought treatment on September 10, 1999. Dr. Ludwig-Cohen diagnosed a "left SI sprain" and stated that the correlation between the onset of trauma and the findings on examination led her to believe that the condition was a direct result of the July 9, 1999 slipping incident. There is no evidence of an intervening injury or incident and no contrary medical evidence. Based on Dr. Ludwig-Cohen's unrebutted opinion that causally relates the sprain to the incident, we are not persuaded that the delay in treatment affects the persuasiveness of her opinion.

The employer also cites *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 321 Or 416 (1995), and argues that Dr. Ludwig-Cohen's opinion is unpersuasive because it did not evaluate the relative contribution of claimant's arthritis to the sprain. The evidence does not establish, however, that the arthritis or any other condition combined with the compensable injury. Thus, there is no evidence that any preexisting condition contributed to the condition. Under such circumstances, the "major contributing cause" standard is not applicable. Accordingly, we are not persuaded by the employer's argument.

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 employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and her attorney's statement of services), the value of the interest involved and the complexity of the issue.

ORDER

The ALJ's order dated September 28, 2000 is affirmed. For services on Board review, claimant's attorney is awarded $1,200, payable by the employer.

In the Matter of the Compensation of
VICTOR R. O'NEILL, Claimant
Own Motion No. 96-0411M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE

Claimant requests review of the insurer's July 19, 2000 Notice of Closure which closed his claim with an award of temporary disability compensation from September 6, 1996 through July 10, 2000. The insurer declared claimant medically stationary as of July 10, 2000. We set aside the Notice of Closure as premature.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981).

The propriety of the closure turns on whether claimant was medically stationary at the time of the July 19, 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). We generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983).

Claimant asserts that he was not medically stationary at the time of closure because he required further medical treatment for his compensable right knee and foot conditions. We agree.

It is well established that the term "medically stationary" does not mean that there is no longer a need for continuing medical care. *Maarefi v. SAIF*, 69 Or App 527, 531 (1984). Rather, there must be a reasonable expectation that further or ongoing medical treatment would "materially improve" claimant's compensable right knee and foot conditions at claim closure. *Lois Brimblecom*, 48 Van Natta 2312 (1996).

Here, prior to claim closure, Dr. Beaman opined that claimant was medically stationary as of July 10, 2000.[1] Following claim closure, in a September 4, 2000 response to an inquiry from claimant's attorney, Dr. Beaman opined that claimant "should have continued therapy before making him medically stationary with respect to his condition. This includes back and hip problems as well as foot amputation." Reporting that claimant should return in a one to two month period, Dr. Beaman concluded that he would then "consider restating his medically stationary status."

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, we find that Dr. Beaman's September 4, 2000 letter addresses claimant's condition at the time of closure. In making this conclusion, we note that although Dr. Beaman wrote the letter to claimant's counsel on September 4, 2000, he based this opinion on his last examination of claimant on August 10, 2000, less than a month after the July 19, 2000 Notice of Closure. *See Edward D. Riggs*, 52 Van Natta 93 (2000) (physician's opinion found to address the claimant's condition at closure where it was written two weeks after carrier closure and there was no evidence that the claimant's condition had changed in that interval). In his August 10, 2000 chart note, Dr. Beaman also recommended physical therapy, because claimant was "advancing his ability" with his prosthesis on his right foot.

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[1] Dr. Beaman rendered this opinion by means of a "check-the-box" response to the insurer's inquiry regarding whether claimant's condition was medically stationary. In submitting its inquiry to Dr. Beaman, the insurer had also included the statutory definition of medically stationary.

Moreover, although the September 4, 2000 letter contradicts Dr. Beaman's earlier "check-the-box" response to the insurer, his change of opinion is not unexplained. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (A physician's change in opinion, if adequately explained, can still be persuasive). Specifically, Dr. Beaman stated that claimant required continued physical therapy before he would "make him" medically stationary. Dr. Beaman had explained in an earlier chart note that, through physical therapy, claimant was advancing his ability with his prosthesis. We are persuaded by these statements that at the time of claim closure there was a reasonable expectation of further material improvement through continued medical treatment. ORS 656.005(17).

Accordingly, we set aside the insurer's July 19, 2000 Notice of Closure as premature. When appropriate, the insurer shall close the claim pursuant to OAR 438-012-0055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,500, payable by the insurer directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

In the Matter of the Compensation of
ED LONG, Claimant
WCB Case No. 98-02853
ORDER ON REMAND
Gloria D. Schmidt, Claimant Attorney
Jerald Keene, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *Long v. Argonaut Insurance Co.*, 169 Or App 625 (2000). The court has reversed our prior order, *Ed Long*, 51 Van Natta 748 (1999), that had held that claimant's request for reconsideration of a Notice of Closure was untimely filed. Specifically, the court held that we had erred in determining that the insurer's failure to mail claimant's attorney a copy of the Notice of Closure neither invalidated the notice nor stopped the running of the 60-day appeal period from the notice. Reasoning that the Director's rules clearly contemplate sending copies of closure notices to *all* those listed before a notice may be considered "mailed," the court concluded that the closure notice had never become effective because the insurer had not sent a copy to claimant's attorney. Accordingly, the court has remanded.

Our prior order had reversed the Administrative Law Judge's (ALJ's) order that had set aside both the Notice of Closure and the Director's Order Denying Reconsideration. Reasoning that the Notice of Closure was invalid (because a copy had not been mailed to claimant's counsel), the ALJ had concluded that the claim remained open and directed the insurer to process the claim to closure when appropriate.

Based on the court's decision, we conclude that the court has agreed with the ALJ's conclusion. Consequently, on remand, we affirm the ALJ's order.

Accordingly, the ALJ's order dated October 9, 1998 is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
ANTOINETTE PERCISO, Claimant
WCB Case No. 00-04539
ORDER ON REVIEW
Schneider, et al, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Podnar's order that awarded 17 percent (54.4 degrees) unscheduled permanent disability for claimant's left shoulder injury, whereas an Order on Reconsideration had awarded no permanent disability. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the exception of the finding that claimant has 17 percent loss of earning capacity. We also supplement the ALJ's findings to include the following: a consulting physician, Dr. Corrigan, opined that work restrictions placed by Dr. Feldstein, the attending physician, were "appropriate and prudent particularly in view of the risk for reinjury here." (Ex. 37-4). In addition, Dr. Corrigan stated that he was not convinced that claimant had any "significant true structural or objective functional deficit in the left shoulder." *Id.* Finally, Dr. Feldstein opined that claimant has no permanent impairment. (Exs. 39, 41).

CONCLUSIONS OF LAW AND OPINION

In awarding claimant 17 percent unscheduled permanent disability for her compensable left shoulder injury, the ALJ determined that claimant had permanent impairment consisting of a "chronic condition" in the left shoulder. In making this determination, the ALJ interpreted the medical opinions of both the attending physician, Dr. Feldstein, and the medical arbiter, Dr. Ho, as supporting a finding that claimant had a restricted ability to repetitively use the left shoulder.

On review, SAIF contends that the ALJ's unscheduled permanent disability award should be reversed because the medical evidence does not establish the presence of a "chronic" left shoulder condition that renders claimant unable to repetitively use the left shoulder. Specifically, in determining whether claimant has a "chronic condition," SAIF asserts that we should rely on Dr. Corrigan's report of his examination, with which Dr. Feldstein concurred. SAIF argues that it is more persuasive than Dr. Ho's arbiter's report and constitutes a preponderance of evidence establishing that claimant does not have "chronic condition" impairment. Moreover, SAIF contends that, even if we relied on Dr. Ho's report, it does not satisfy the requirement of OAR 436-035-0320(5) that claimant be *unable* to repetitively use her left shoulder due to a chronic and permanent medical condition.[1]

With the exception of a medical arbiter, impairment findings can be made only by the attending physician at the time of claim closure or other physicians with whom the attending physician concurs. *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670 (1994).[2] OAR 436-035-0007(14) provides in material part that "[o]n 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. Where a preponderance establishes a different level of impairment, the impairment is established by the preponderance of evidence." In addition, we rely on the most thorough, complete and well-reasoned evaluation of claimant's injury-related impairment. *Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

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[1] In light of our resolution of the permanent disability issue, we need not address this contention.

[2] Given this precedent, we consider Dr. Corrigan's report because Dr. Feldstein concurred with it. (Ex. 38).

After reviewing the record, we find that a preponderance of the medical opinion establishes a different level of impairment than that reported by Dr. Ho, the medical arbiter. Specifically, we find that Dr. Ho's opinion is not persuasive because his report does not adequately explain his conclusion that claimant has a "limited and partial loss" of ability to repetitively use the left shoulder. (Ex. 56-1). Moreover, Dr. Ho's report contains no medical history and consists mainly of a recitation of impairment findings.

In contrast, Dr. Corrigan's report contains an extensive discussion of claimant's medical history, as well as a detailed and comprehensive physical examination. (Ex. 37). Based on that examination, Dr. Corrigan stated that "he was not convinced" that claimant had a significant structural or objective functional deficit in the left shoulder. In addition, Dr. Corrigan opined that Dr. Feldstein's restrictions (consisting of weight lifting restrictions and no overhead work) were appropriate in view of the risk of reinjury. (Ex. 37-4). We have previously held that a restriction on repetitive use to prevent reinjury or an increase in symptoms does not constitute persuasive evidence of a chronic condition impairment. *See Gorden L. Atkins*, 52 Van Natta 284 (2000); *Rena L. Rose*, 49 Van Natta 2007 (1997); *Maria E. Jimenez-Menera*, 48 Van Natta 2139 (1996). Applying that standard, we do not find that Dr. Corrigan's report establishes that claimant has a "chronic condition" restricting repetitive use of the left shoulder.

Moreover, even if we assumed that the limitations imposed by Dr. Feldstein were not designed to prevent reinjury or an increase in symptoms, we would still conclude that claimant is not entitled to an award of unscheduled permanent disability. Dr. Corrigan was not persuaded that claimant had an objective functional deficit in the left shoulder, and Dr. Feldstein opined that claimant did not have permanent left shoulder impairment. Having considered these reports, we are not persuaded that claimant has permanent left shoulder impairment. Without such impairment, claimant is not entitled to an award of unscheduled permanent disability. *See German C. Ronquillo*, 49 Van Natta 129, 132 (1997).

Accordingly, we find that claimant is not entitled to an award of unscheduled permanent disability. Thus, we reverse the ALJ's award.

ORDER

The ALJ's order dated October 12, 2000 is reversed. In lieu of the ALJ's award, the Order on Reconsideration is reinstated and affirmed in its entirety. The ALJ's "out-of-compensation" attorney fee is also reversed.

January 25, 2001 Cite as 53 Van Natta 92 (2001)

In the Matter of the Compensation of
HAROLD G. MANGUM, Claimant
WCB Case No. 00-03579
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) directed it to reopen and process claimant's new medical condition claim pursuant to ORS 656.262(7)(c) and 656.268; (2) awarded claimant a penalty for an allegedly unreasonable resistance to the payment of compensation; and (3) awarded an assessed attorney fee. On review, the issues are claims processing, penalties and attorney fees.

We adopt and affirm the order of the ALJ. *See Dennis D. Hall*, 52 Van Natta 1993 (2000); *Olive M. Bonham*, 51 Van Natta 1710 (1999).

Claimant's attorney is entitled to an assessed attorney fee for services on review concerning the claims 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 is $1,200, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by that portion of claimant's respondent's brief), the complexity of the issue and the value of the interest involved.

ORDER

The ALJ's October 16, 2000 order, as reconsidered November 6, 2000, is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,200, to be paid by the SAIF Corporation.

January 25, 2001 Cite as 53 Van Natta 93 (2001)

In the Matter of the Compensation of
TERRY A. PETRIE, Claimant
Own Motion No. 00-0364M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted a request for temporary disability compensation for claimant's left knee condition. Claimant's aggravation rights have expired. SAIF issued a denial of compensability of claimant's current condition. In addition, SAIF opposes the reopening of the claim on the grounds that: (1) surgery or hospitalization is not reasonable and necessary; and (2) claimant is not in 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 27, 2000, Dr. Buehler, claimant's attending physician, recommended surgery for claimant's left knee condition. SAIF contends that the recommended surgery is inappropriate treatment for his compensable condition. In addition, SAIF contends that claimant's submission of "generic receipts" does not demonstrate that claimant was in the work force at the time of the current disability.[1]

The issue of whether the proposed surgery is reasonable and necessary treatment for claimant's left knee condition remains unresolved at this time. Under such circumstances, we are not authorized to reopen claimant's 1976 injury claim for the payment of temporary disability benefits.[2] *See* ORS 656.278(1)(a).

Accordingly, we deny the request for own motion relief. *Id.*

IT IS SO ORDERED.

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[1] On December 15, 2000, the Board requested claimant's position regarding SAIF's surgery and work force contentions. The Board requested that claimant's position be received within 21 days from the date of the letter. Inasmuch as the 21-day period has expired without receipt of any written 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 authority, 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 pursuant to ORS 656.283 to 656.295 or with the Director under ORS 656.245, 656.260 or 656.327. *See Gary L. Martin*, 48 Van Natta 1802 (1996).

In the Matter of the Compensation of
BEVERLY J. RICE, Claimant
Own Motion No. 00-0266M
OWN MOTION ORDER DENYING RECONSIDERATION
Saif Legal Department, Defense Attorney

On August 29, 2000, we authorized the reopening of claimant's 1986 injury claim with the SAIF Corporation for the payment of temporary disability compensation beginning the date claimant is hospitalized for the proposed surgery. Announcing that claimant has decided to postpone her proposed surgery, SAIF requests that we "rescind" our August 29, 2000 order or, in the alternative, advise it how it "might proceed with placing this claim back in the closed status." We treat this request as a request for reconsideration of our prior order. For the following reasons, we deny that request.

Pursuant to OAR 438-012-0065(2), a reconsideration request must be filed within 30 days after the mailing date of the order, or within 60 days after the mailing date if there was good cause for the failure to file within 30 days. The standard for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized by ORCP 71B(1) and *former* ORS 18.160. *Anderson v. Publishers Paper Co.*, 78 Or App 513, 517, *rev den* 301 Or 666; *see also Brown v. EBI Companies*, 289 Or 455 (1980). Lack of due diligence does not constitute good cause. *Cogswell v. SAIF*, 74 Or App 234, 237 (1985). However, OAR 438-012-0065(3) also provides that "[n]otwithstanding section (2) of this rule, in extraordinary circumstances the Board may, on its own motion, reconsider any prior Board order." *See Larry P. Karr*, 48 Van Natta 2182 (1996); *Jay A. Yowell*, 42 Van Natta 1120 (1990).

In *Charles Kurnick*, 46 Van Natta 2501 (1994), we declined to grant reconsideration where the claimant had not undergone surgery or the required hospitalization following the issuance of a Board's Own Motion order authorizing reopening of the claim. In *Kurnick*, we reasoned that, because surgery or hospitalization is a prerequisite for authorization for reopening, it followed that an Own Motion order may not authorize the payment of temporary disability benefits until that surgery or hospitalization occurs. ORS 656.278(1)(a). Thus, an Own Motion order that authorizes reopening of a claim for the payment of temporary disability compensation is, essentially, a "contingent" order. If surgery or hospitalization subsequently occurs, then the prerequisite is met and no further Own Motion order is necessary. If, on the other hand, surgery or hospitalization does not occur, then the claim would not be reopened under our Own Motion order as the necessary prerequisite would not have been met.

In *Kurnick*, because the claimant had not undergone surgery, the prerequisite had not yet occurred and the order remained a "contingent" order. Under such circumstances, we held in *Kurnick* that there were no extraordinary circumstances that would justify reconsideration.

Here, as in *Kurnick*, the statutory prerequisite for the payment of temporary disability has not occurred in that claimant has not undergone the proposed surgery. Therefore, the August 29, 2000 Own Motion Order remains a "contingent" order, because the necessary prerequisite for reopening the claim for Own Motion relief has not yet occurred. Inasmuch as the order remains contingent, there are no extraordinary circumstances that would justify reconsideration. *Kurnick*, 46 Van Natta at 2502.

Accordingly, SAIF's request for reconsideration of our August 29, 2000 Own Motion Order is denied.[1]

IT IS SO ORDERED.

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[1] Based on the foregoing reasoning, SAIF's requests to "rescind" our prior order or to "return the claim to closed status" are denied.

In the Matter of the Compensation of
PEGGY L. STAMP, Claimant
Own Motion No. 99-0276M
OWN MOTION ORDER
Stebbins & Coffey, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer requests authorization to suspend payment of claimant's temporary disability compensation pursuant to OAR 438-012-0035(5). The request is denied.

FINDINGS OF FACT

Claimant was originally injured on January 9, 1992. On July 22, 1999, the Board issued an Own Motion Order that authorized reopening of this claim for the payment of temporary disability compensation. On January 18, 2000, claimant underwent arthroscopic surgery with Dr. Freudenberg. On July 25, 2000, Dr. Freudenberg requested authorization for a second surgery, a "Mumford procedure" on claimant's right shoulder. That surgery has yet to be performed.

By letter dated December 12, 2000, the insurer requested suspension of temporary disability compensation awarded for this claim, contending that claimant had not sought further treatment since November 13, 2000. On December 27, 2000, claimant's attorney represented that claimant had last sought treatment on December 15, 2000, and was still undecided as to whether to pursue further surgery.

CONCLUSIONS OF LAW AND OPINION

Pursuant to OAR 438-012-0035(5), the insurer may make a written request for suspension of temporary disability compensation. *See Robert E. Anderson*, 52 Van Natta 151 (2000) (Own Motion carrier may not unilaterally terminate temporary disability benefits). Based on the following reasoning, we conclude that suspension is not warranted.

We are authorized to suspend payment of temporary disability based on a claimant's failure to seek medical treatment. OAR 438-012-0035(5); *see Glen A. Carr*, 52 Van Natta 1405 (2000). Requiring workers whose claims have been reopened under ORS 656.278 to seek regular medical care promotes 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. *Id*; ORS 656.012(2)(c).

Here, the insurer has not provided sufficient evidence that claimant has failed to seek regular medical care. The insurer contended in its letter of December 12, 2000 that claimant had not sought medical care since November 13, 2000.[1] However, on December 27, 2000, claimant's attorney advised that claimant had sought treatment on December 15, 2000 (although the Board does not have the corresponding chart note), and may still require another shoulder surgery. In these circumstances, we are not persuaded that the record supports a conclusion that claimant has unreasonably delayed treatment or surgery. *Cf. Glen A. Carr*, 52 Van Natta at 1409 (carrier's request for suspension of benefits granted where the claimant had not sought medical treatment for more than five months and had not provided an explanation for his failure to seek treatment).

Accordingly, the insurer's request for suspension of temporary disability benefits is denied.[2]

IT IS SO ORDERED.

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[1] The insurer also contended that it has no current "time loss" authorization. However, we have held that the 14-day limit on "retroactive" authorization of temporary disability compensation in former ORS 656.262(4)(f) is not applicable in an Own Motion context. *See Rodney Sullivan*, 53 Van Natta 7 (2001); *Jeffrey T. Knudson*, 48 Van Natta 1708 (1998).

[2] In addition, although not required by rule, we note that the insurer had not provided any warning notice to claimant of its intent to request suspension of benefits. Such a warning would promote the efficient processing of claims without the involvement of the Board.

In the Matter of the Compensation of
GUADALUPE CHAVEZ, Claimant
WCB Case No. 00-02611
ORDER ON REVIEW
Max Rae, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Meyers and Phillip Polich.

Claimant requests review of Administrative Law Judge (ALJ) Johnson's order that: (1) declined to direct the SAIF Corporation to pay temporary partial disability (TPD) benefits at the temporary total disability (TTD) rate from November 16, 1998 through March 19, 1999; and (2) declined to assess a penalty for SAIF's allegedly unreasonable failure to timely pay those benefits. On review, the issues are TPD benefits and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We begin with a brief summary of the relevant facts. Claimant compensably injured her right elbow on September 2, 1998. On September 30, 1998, claimant was released to modified work that her attending physician had approved and remained released to modified work through March 19, 1999. She was paid at the same rate of pay and worked the same hours as her regular work. (Exs. 3, 14). She began the modified employment and worked until November 16, 1998, when she voluntarily quit. Thereafter, claimant earned no wages and SAIF paid no temporary disability benefits.

On March 19, 1999, claimant was declared medically stationary. An August 26, 1999 Order on Reconsideration noted:

> "In accordance with OAR 436-030-0036(1), only the beginning and ending dates of 'authorized' temporary disability for this open period of the claim are shown in this Order. Computation for temporary disability compensation, including temporary total disability, and the three-day wait, shall otherwise be a function of claims administration under OAR 436-060. After review, we find the temporary disability authorized by the attending physician should be from 9/2/98 through 3/19/99, less time worked, pursuant to OAR 436-030-0036(1)." (Ex. 37-2).

The Order on Reconsideration was not appealed and became final.

On August 27, 1999, SAIF wrote to claimant requesting that she report any earnings or unemployment benefits she received for the period from September 2, 1998 to March 19, 1999. (Exs. 38, 39, 40). On September 29, 1999, claimant reported that she had received no earnings or unemployment benefits during this period. (Ex. 41). SAIF paid no additional benefits after November 16, 1998.

On April 5, 2000, claimant requested a hearing, raising the issue of the rate of temporary disability. Prior to hearing, the parties agreed to stipulated facts and also stipulated that the matter could be resolved based upon the exhibits, stipulated facts, and written closing argument.

The ALJ found that, based on the analysis and conclusion in *Jerilyn J. Hendrickson*, 49 Van Natta 1208 (1997), although SAIF was obligated to pay temporary disability pursuant to the Order on Reconsideration, the rate of payment was zero. The ALJ also rejected claimant's argument that ORS 656.212 requires that claimant receive payment of TPD at her full TTD rate, finding that her argument ignored ORS 656.325(5)(a), OAR 436-060-0030(8) and Board precedent. Finally, the ALJ concluded that, because claimant's loss of wages was due to her quitting her modified job, her loss of wages was not due to the compensable injury. *See Dawes v. Summers*, 118 Or App 15 (1993) (temporary disability benefits are to replace wages lost because of a compensable injury); *Noffsinger v. Yoncalla Timber Products*, 88 Or App 118 (1987), *rev den* 305 Or 102 (1988). Consequently, because claimant left work for reasons unrelated to her injury, the ALJ concluded that no temporary disability compensation was "due."

On review, claimant and SAIF both agree that claimant was, at least theoretically, entitled to TPD after November 16, 1998. Claimant continues to contend that she is entitled to payment of the TPD benefits at the TTD rate and that SAIF is not permitted to offset theoretical wages that she did not earn in the period after she voluntarily quit the modified employment. SAIF argues that claimant was not entitled to the resumption of full TTD benefits. For the following reasons, we agree with SAIF's argument.

We begin with a discussion of the governing statutes and rules. OAR 436-060-0030(8)[1] specifies those circumstances in which TPD shall be paid at the full TTD rate. However, that rule specifically excepts from payment at the full TTD rate a worker who quits while performing modified work. The rule provides that such a worker "shall be considered the same as the worker refusing modified wage earning employment pursuant to ORS 656.325(5)(a)."

ORS 656.325(5)(a)[2] provides that when a worker refuses wage earning employment, the insurer shall cease making payments pursuant to ORS 656.210 (the TTD statute) and shall commence making payments of such amounts as are due pursuant to ORS 656.212 (the TPD statute).

ORS 656.210(2)(b)(A) provides that TTD benefits for injuries are based on the worker's at-injury wage. ORS 656.212(2)[3] provides, in turn, that when the disability is or becomes partial, the payment of TTD pursuant to ORS 656.210 shall cease and the worker "shall receive that proportion of the payments provided for temporary total disability which the loss of wages bears to the wage used to calculate temporary total disability pursuant to ORS 656.210." In other words, TPD is calculated based on a comparison of a claimant's loss of wages, if any, at modified employment to the wage used to calculate TTD, *i.e.*, a claimant's at-injury wages. Thus, if a claimant's wages at modified work are the same as his wages at the time of injury, the calculation of the claimant's TPD equals zero. *See Audrey L. McDaniel*, 50 Van Natta 1423, 1424 (1998).

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[1] OAR 436-060-0030(8) provides:

"Temporary partial disability shall be paid at the full temporary total disability rate as of the date a modified job no longer exists or the job offer is withdrawn by the employer. This includes, but is not limited to, termination of temporary employment, layoff or plant closure. A worker who has been released to and doing modified work at the same wage as at the time of injury from the onset of the claim shall be included in this section. For the purpose of this rule, when a worker who has been doing modified work quits the job or the employer terminates the worker for violation of work rules or other disciplinary reasons it is not a withdrawal of a job offer by the employer, but shall be considered the same as the worker refusing wage earning employment pursuant to ORS 656 .325(5)(a). This section does not apply to those situations described in sections (5), (6) & (7) of this rule."

[2] ORS 656.325(5)(a) provides:

"(5) Notwithstanding ORS 656.268:

"(a) An insurer or self-insured employer shall cease making payments pursuant to ORS 656.210 and shall commence making payment of such amounts as are due pursuant to ORS 656.212 when an injured worker refuses wage earning employment prior to claim determination and the worker's attending physician, after being notified by the employer of the specific duties to be performed by the injured worker, agrees that the injured worker is capable of performing the employment offered."

[3] ORS 656.212 (2) provides:

"When the disability is or becomes partial only and is temporary in character:

"* * * * *

"(2) The payment of temporary total disability pursuant to ORS 656.210 shall cease and the worker shall receive that proportion of the payments provided for temporary total disability which the loss of wages bears to the wage used to calculate temporary total disability pursuant to ORS 656.210."

Claimant argues that the inquiry ends with the calculation provided in ORS 656.212(2). In other words, claimant argues that because she had no wages after she quit the modified job on November 16, 1998, she is entitled to TPD benefits paid at the full TTD rate from November 16, 1998 through March 19, 1999. However, claimant's argument ignores ORS 656.325(5)(a) and OAR 436-060-0030(8).

In addition, subsequent to the ALJ's order, the court rejected that same argument. *Madrigal v. J. Frank Schmidt & Son*, 172 Or App 1 (2001). In *Madrigal*, the claimant was released to modified work and failed to report to a modified job that paid the same wage as the claimant's at-injury wage and was scheduled to begin on January 29, 1996. Subsequently, the claimant's claim was closed. The claimant ultimately appealed the closure to the Board and we determined that the claimant was, at least theoretically, entitled to receive TPD benefits until he was released to regular work on May 18, 1996. We also found that the TPD rate would be zero if the claimant was to receive his regular wage or more for performing the modified work. Our decision was not appealed. Subsequently, the employer calculated the claimant's TPD benefits for the period from January 30, 1996, through May 17, 1996, to be zero. The claimant ultimately requested a hearing and Board review. Both levels of review found that the proper TPD rate was zero.

The claimant in *Madrigal* appealed the TPD rate issue to the court, arguing that ORS 656.212(2) required the payment of TPD benefits at the full TTD rate regardless of a refusal to begin modified work. The court rejected that argument and, instead, concluded that ORS 656.212(2) requires payment of temporary disability benefits only for wages lost due to the compensable injury, not due to the worker refusing to accept modified work. In reaching this conclusion, the court examined the text and context of ORS 656.212 and found that the term "the loss of wages" used in ORS 656.212(2) refers to the loss of wages due to the compensable injury.

In addition, the court found that the claimant's construction of ORS 656.212(2) could not be reconciled with a worker's general obligation to mitigate his or her losses. ORS 656.325(2). The court noted that, under ORS 656.325(5), when a worker receiving TTD benefits refuses modified employment for which he or she is qualified, the worker is no longer entitled to those benefits. The court also noted that ORS 656.268(3)(c) similarly provides that TTD benefits must cease if, after being released to modified work, a worker refuses to accept an offer of such work. The court concluded that the claimant's contention that, under ORS 656.212(2), a partially disabled worker may receive TTD benefits merely by refusing to take a valid offer of modified work was at odds with a worker's duty to minimize his or her damages. Therefore, the court concluded that the claimant's TPD benefits were correctly calculated to be zero.

The same reasoning applies here. Claimant was earning her at-injury wage while performing the modified job approved by her attending physician. Therefore, her TPD rate was zero. Her loss of wages after voluntarily quitting the modified job was not due to the compensable injury. Instead, it was due to her action in voluntarily quitting the modified job. There is no evidence that the employer withdrew the modified job or that claimant's attending physician withdrew his approval of that job. Claimant does not argue otherwise. Therefore, after claimant voluntarily quit the modified job, she lost no wages due to the work injury and her TPD rate remained zero.

In other words, when a worker quits modified employment, and therefore will not be receiving any wages from that modified employment, the insurer shall nevertheless cease TTD benefits and pay TPD benefits. Moreover, if the modified work paid the at-injury wage, the worker's loss of wages is not due to the compensable injury, but is due to his or her voluntarily quitting the modified employment. Under such circumstances, the TPD rate would be zero. *Madrigal*, 172 Or App at 7.

This interpretation gives effect to both ORS 656.325(5)(a) and 656.212(2). To decide otherwise would render ORS 656.325(5)(a) meaningless and ineffective, rewarding an injured worker for refusing or quitting a modified job, and would be contrary to OAR 436-060-0030(8), which specifically excepts workers who quit modified work or who are terminated for violation of work rules or other disciplinary reasons from the resumption of TTD benefits. *See Alfredo R. Hernandez*, 51 Van Natta 71, 74 (1999) (harmonizing apparent conflict between ORS 656.325(5)(c) and ORS 656.212(2) to give effect to both; insurer authorized to cease TTD payments and commence TPD payments when attending physician approved a modified job for illegal alien claimant); *Gerardo Alanis*, 51 Van Natta 271, 274 (1999) (calculation of TPD under ORS 656.212(2) in light of ORS 656.325(5)(c) did not require actual lost wages from modified employment in order to prorate the claimant's earnings).

Accordingly, we conclude that, although SAIF is obligated to pay the temporary disability benefits ordered by the August 26, 1999 Order on Reconsideration, those benefits consist of TPD only, and the rate of this TPD is zero.

In sum, we agree with the ALJ that SAIF properly determined that claimant was not entitled to resumption of full TTD benefits after claimant quit her modified job. Therefore, claimant is not entitled to full TTD benefits from November 16,1998 through March 19, 1999.[4] Because claimant is not entitled to the requested compensation, there is no basis for a penalty.

ORDER

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

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[4] We do not interpret claimant's arguments at hearing or on review as a request for additional temporary partial disability benefits.

January 26, 2001 Cite as 53 Van Natta 99 (2001)

In the Matter of the Compensation of
LYLE L. POPE, Claimant
WCB Case No. 99-05769
ORDER OF ABATEMENT
Thomas J. Dzieman, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorney

On January 11, 2001, we affirmed an Administrative Law Judge's (ALJ's) order that set aside the insurer's denial of claimant's right index finger injury claim and awarded an insurer-paid attorney fee. Asserting that our order neglected to address several of its arguments regarding the question of whether it provided coverage for claimant's employer at the time of claimant's injury, the insurer seeks reconsideration of our decision.

In order to further consider this matter, we withdraw our January 11, 2001 order. In addition, we implement the following supplemental briefing schedule. Claimant's supplemental response must be filed within 14 days from the date of this order. The insurer's supplemental reply must be filed within 14 days from the date of mailing of claimant's response. Thereafter, we will take this matter under advisement.

In submitting their respective positions, the parties are requested to address the effect, if any, of the following points and authorities: ORS 656.423; ORS 656.427; OAR 436-050-0100; *Wausau v. Walker*, 155 Or App 231 (1998); and *D Maintenance Co. v. Mischke*, 84 Or App 218 (1987).

IT IS SO ORDERED.

In the Matter of the Compensation of
TIMOTHY D. GAINES, Claimant
WCB Case Nos. 99-00211 & 98-05837
ORDER ON REVIEW
Hornecker, Cowling, et al, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the self-insured employer's denials of claimant's injury claim for hearing loss, hyperacusis, tinnitus, inner ear, right shoulder and right arm conditions. Claimant moves to have the ALJ disqualified for "misconduct." Claimant also requests that the Board "retranscribe" the April 26, 2000 hearing tapes due to alleged irregularities. In addition, claimant has included several documents and audio tapes with his appellate briefs. We treat such submissions and requests as motions for remand to the Hearings Division for the taking of additional evidence and "correction" of the record. *See* ORS 656.295(5). With its respondent's brief, the employer moves to strike claimant's documents submitted on review.

On review, the issues are motion to strike, remand and compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Remand

We treat claimant's attached documents (medical records, sworn statements, letters and telephone records) and audio tapes, as well as his request to "correct" the hearing transcript, as requests to remand for the admission of additional evidence. *Judy A. Britton*, 37 Van Natta 1262 (1985). Our review is limited to the record developed at hearing. We may remand to the Hearings Division for the taking of additional evidence if we determine that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). To merit remand for consideration of additional evidence, it must be clearly 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).

The proceedings in this matter were originally convened on October 19, 1998. The hearing was continued several times, among other reasons, for claimant to gather additional medical evidence, and for additional depositions. Given that procedural posture, we are not convinced that the additional evidence in terms of medical reports (although at least some of the reports were "unavailable" at the time of hearing) and the sworn statements from claimant's neighbors, were "unobtainable" at hearing with due diligence. *See Compton*, 301 Or at 648-649; *Anita Charpentier*, 52 Van Natta 2200, 2201 (2000). Moreover, we are not persuaded that consideration of these materials is reasonably likely to affect the outcome of the case.

Claimant has also attached several miscellaneous letters and subpoenaed telephone records to his briefs. However, these documents are not relevant to the issues at hearing, *i.e.* compensability of the aforementioned conditions. Thus, their admission into the record is not reasonably likely to affect the outcome of this case. Accordingly, we decline to remand for their admission.

We reach the same conclusion regarding the "audio tape" evidence offered by claimant. These audio tapes (and claimant's transcription of these tapes) concern conversations between claimant and a court reporter at his hearing. Claimant contends that these tapes provide evidence of "tampering" with the hearing transcript tapes by the employer or the employer's attorney.

Neither the record nor claimant's submissions support his contention that the hearing transcript was "doctored" by either the employer, the employer's attorney, or the court reporter. Instead, claimant's contentions rest on speculation rather than on any direct evidence of improper handling of the hearing transcript or transcript tapes. In any event, the few minor, specifically identified typographical errors in the hearing transcript have already been corrected through correspondence with the court reporter.[1]

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[1] Accordingly, we decline claimant's request to "retranscribe" the hearing tapes.

Under such circumstances, we find that the minor discrepancies in the audio tape transcriptions of the hearing testimony would not be reasonably likely to affect the outcome of the compensability issues. Accordingly, we deny claimant's motion to remand.[2]

Motion to Disqualify ALJ

Claimant has moved for "disqualification" of the ALJ based on a perceived bias and incorrect rulings in favor of the employer. Initially, we note that claimant's motion is untimely. If claimant believed that the ALJ was biased in favor of the employer, it was incumbent on him to have objected at the hearing and to have requested a change of ALJ. *See* OAR 438-006-0095(2). In effect, claimant's current challenge is a motion for a change of ALJ. Such a request made for the first time on review is neither timely nor in accordance with the applicable administrative rule. *Allen B. Ehr*, 52 Van Natta 2209 (2000); *Philip G. Michael*, 46 Van Natta 519 (1994); *Virginia L. Baker*, 44 Van Natta 217 (1992).

In any event, even assuming claimant's objection to the ALJ was timely filed, we are statutorily authorized to make our own appraisal of the documentary and testimonial evidence (irrespective of the ALJ's order). *Sueyen A. Yang*, 48 Van Natta 1626 (1998). In other words, we are authorized to review this record without consideration of the ALJ's findings and conclusions. Therefore, there is no compelling reason to return this case to the Hearings Division for a new hearing before a new ALJ. Accordingly, we deny claimant's motion.

Compensability

We adopt and affirm the ALJ's order on the compensability issue, with the following supplementation.

The ALJ upheld the employer's denials of claimant's hearing loss, hyperacusis, tinnitus, inner ear, right shoulder and right arm conditions based on the opinions of Drs. Brown, Ediger and Schilperoort.[3]

Regarding the hearing loss condition, we agree with the ALJ that the medical evidence uniformly indicates that claimant's hearing loss condition is at least normal for his age. (Exs. 25-5, 49, 97, 99, 100). Accordingly, claimant has no work-related hearing *loss* for which he can seek compensation.

The ALJ upheld the employer's denial of his claim for various inner ear conditions (inner ear concussion syndrome and endolymphatic hydrops) based on a lack of objective findings of these conditions. ORS 656.005(19). Although Dr. Grimm diagnosed "inner ear concussion syndrome," this term is not a valid diagnosis that has otologic meaning, according to Dr. Brown. (Ex. 96-18). In any event, even assuming "inner ear concussion syndrome" is a valid medical diagnosis, there are no objective findings supporting the existence of such a condition. In addition, the persuasive medical evidence from Drs. Brown and Ediger fails to demonstrate either the requisite objective findings supportive of, or the symptoms correlating with, an endolymphatic hydrops condition. (*See* Exs. 96-14, 99-2).

Finally, there is no persuasive medical evidence that claimant's right shoulder capsulitis and "sensory loss in the C2 right dermatome" conditions resulted from either his motor vehicle accident work injury or his compensable "post-traumatic headaches." Drs. Schilperoort and Williams, who examined claimant at the request of the employer, concluded that claimant had an adhesive capsulitis condition that was long-standing and unrelated to the motor vehicle accident. (Ex. 93-7). Dr. Schilperoort further stated the uncontradicted opinion that claimant's motor vehicle accident injury was not sufficient to cause an injury to the C2 disc space. (Ex. 98-2).

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[2] In light of our decision not to remand for the admission of additional evidence, we need not address the employer's "motion to strike."

[3] In addition, the ALJ found claimant not to be a "reliable witness." We need not address the ALJ's credibility finding, as we determine that claimant has not satisfied his burden of proving the compensability of his various conditions with persuasive medical evidence.

ORDER

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

January 26, 2001 Cite as 53 Van Natta 102 (2001)

In the Matter of the Compensation of
GREGORY R. HUGHES, Claimant
WCB Case No. 00-04103
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
Cavanagh & Zipse, Defense Attorney

Reviewed by Board Members Meyers and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the insurer's denial of claimant's injury/occupational disease claim for a left knee condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation to address claimant's argument on review.

The ALJ concluded that claimant failed to establish compensability under an occupational disease theory. On review, claimant contends that his claim should be analyzed an an injury, not an occupational disease. Claimant relies on the opinion of Dr. Walton.

For the following reasons, Dr. Walton's opinion is not sufficient to establish compensability. On March 17, 2000, Dr. Walton provided a letter to claimant's attorney that indicated that claimant's condition, post-traumatic arthritis of the left knee, was caused in major part by claimant's 1991 football injury and that his work activities were not the major contributing cause of his knee condition or his pathology. He also opined that the primary cause for treatment was the 1991 injury. (Ex. 18). On April 12, 2000, Dr. Walton agreed that a discrete period of work of several weeks in October 1999 was the major contributing cause of claimant's need for medical treatment of his left knee condition. (Ex. 21). Because Dr. Walton provided no explanation for his apparent change of opinion, his opinion is not persuasive. *Compare Kelso v. City of Salem*, 87 Or App 630 (1987) (medical opinion that provided a reasonable explanation for the change of opinion was persuasive).

In addition, we find that Dr. Walton's opinion on causation does not support an injury theory. Dr. Walton's concurrence letter from claimant's attorney said that claimant's left knee problems occurred over a period of several weeks in October 1999 when he climbed ladders and performed heavy lifting with climbing and walking on pitched roofs. Dr. Walton agreed that that period of work was the major contributing cause of claimant's need for treatment of his left knee condition. However, Dr. Walton's concurrence letter did not attribute the onset of claimant's left knee condition to a specific event. Rather, he attributed his need for treatment for that condition to several weeks of work activities.

An injury is sudden, arises from an identifiable event, or has an onset traceable to a discrete period of time. *Active Transportation Co. v. Wylie*, 159 Or App 12, 15 (1999); *Valtinson v. SAIF*, 56 Or App 184, 188 (1982). In contrast, an occupational disease stems from conditions that develop gradually over time. ORS 656.802; *Mathel v. Josephine County*, 319 Or 235, 240 (1994). Dr. Walton's opinion on causation indicates that claimant's left knee symptoms developed gradually over several weeks. Based on Dr. Walton's understanding, the onset of claimant's symptoms did not correspond to a specific "event." *Compare Donald Drake Co. v. Lundmark*, 63 Or App 261, 266 (1983) (the claimant's back trouble was unexpected and coincided precisely with jolting of the faulty loader; the fact that the claimant's back pain grew worse over his six-week employment did not make it "gradual in onset"), *rev den* 296 Or 350 (1984). Consequently, Dr. Walton's opinion is not sufficient to establish causation under an injury theory.

ORDER

The ALJ's order dated September 22, 2000 is affirmed.

In the Matter of the Compensation of
STARLENE E. HERNDON, Claimant
WCB Case No. 00-01717
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the SAIF Corporation's denial of her injury/occupational disease claim for bilateral wrist, left arm and neck conditions. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," including the "Ultimate Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

On November 23, 1999, claimant filed a claim for injury to multiple body parts, including the wrists, left arm and neck, that allegedly occurred on November 12, 1999, while employed by Bi-Mor. Claimant had previously sustained a compensable injury in 1996 while working for a different employer (Microtrains). That claim had produced similar complaints, except that the 1999 incident allegedly produced a left lateral epicondylitis condition that had not previously existed.

On January 11, 2000, SAIF denied the November 12, 1999 claim on the ground that the alleged incident was not a material or major cause of claimant's disability or need for treatment. Claimant requested a hearing.

The ALJ found that, prior to her employment at Bi-Mor, claimant had a compensable myofascial neck, shoulder, periscapular and upper extremity condition that was "flared up" by the work-related event on November 12, 1999, but that the work event was not the major or a material contributing cause of the myofascial condition or claimant's left lateral epicondylitis condition. Moreover, the ALJ determined that claimant's general work activity for Bi-Mor was not the major contributing cause of a pathological worsening of her preexisting condition or the major contributing cause of lateral epicondylitis. Thus, the ALJ found that claimant had not proved her November 1999 claim was compensable as either an industrial injury or an occupational disease.

On review, claimant focuses on a portion of the ALJ's analysis that applied ORS 656.308, which, according to the ALJ, allowed SAIF to "point a finger" at claimant's preexisting myofascial condition even though it had not issued a responsibility denial. Claimant asserts that the ALJ erred in engaging in a responsibility analysis because SAIF did not raise a responsibility issue until closing argument. Citing numerous cases in which we have held it impermissible to raise a "new issue" during closing arguments, *e.g.*, *Cindy M. Penturf*, 50 Van Natta 1718 (1998), claimant argues that the ALJ's analysis that SAIF could contend that responsibility could lie elsewhere was incorrect. In its respondent's brief, SAIF agrees that it is improper to raise a responsibility issue for the first time during closing arguments.

Having reviewed the record, we find that claimant is correct that a responsibility issue was not raised prior to closing argument.[1] Therefore, the ALJ was not authorized to engage in a responsibility analysis. However, SAIF and claimant were the only parties to the dispute. SAIF did not contend in its denial that claimant's current myofascial condition is not "compensable" because the condition was related to the 1996 Microtrains injury. Rather, in denying claimant's current condition, SAIF asserted that the alleged November 1999 injury was not a material or the major contributing cause of claimant's disability and need for treatment.

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[1] Closing arguments were unrecorded. Responsibility was not raised as an issue in the "pre-testimony" discussions at the hearing. (Tr. 4).

In other words, rather than conceding compensability of the claim and attempting to shift responsibility to the prior employer, SAIF was availing itself of its statutory right to deny the claim under ORS 656.262(6) and require claimant to establish the compensability of his current condition and need for treatment and/or disability. This was permissible. *See David E. Stutzman*, 50 Van Natta 776, *on recon* 50 Van Natta 889 (1998) (holding that, where the carrier and the claimant were the only parties to the dispute and there was no attempt to shift responsibility to a prior carrier, the issue was compensability, rather than responsibility).[2]

For the reasons cited by the ALJ, we agree that claimant failed to prove a new injury or occupational disease relative to her preexisting myofascial condition or an occupational disease or injury relative to her lateral epicondylitis condition.[3] Claimant contends, however, that the ALJ incorrectly determined that her myofascial condition was "preexisting" because there is no evidence that it preexisted the date she sought treatment for her compensable 1996 claim.

Pursuant to ORS 656.005(24), a condition is "preexisting" if it "contributes or predisposes a worker to disability or need for treatment and * * * precedes the onset of an initial claim for an injury or occupational disease * * * .]" *See also SAIF v. Cessnun*, 161 Or App 367 (1999). The "initial claim" in this case is not, as claimant contends, the 1996 injury, but rather is the claim filed as a result of the November 1999 incident at Bi-Mor. Specifically, claimant is attempting to establish that a separate and distinct injury or occupational disease occurred in November 1999. Because this is an "initial claim for an injury or occupational disease," and because the myofascial condition preceded the onset of the initial claim for injury or occupational disease in November 1999, the myofascial condition qualifies as a "preexisting condition" under ORS 656.005(24). The ALJ did not err in treating it as such.

ORDER

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

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[2] We recognize that, unlike the carrier in *Stutzman*, SAIF in this case may have attempted to shift responsibility (albeit in an impermissible manner) to the 1996 injury. However, because SAIF's "post-hearing" attempt was impermissible, and considering that SAIF's denial was of compensability only, we find that *Stutzman* is applicable.

[3] Moreover, even if the ALJ correctly determined that ORS 656.308(1) applied, we would still find that SAIF is not responsible for claimant's bilateral wrist, left arm and neck conditions. That is, we agree with the ALJ that the medical evidence does not establish that the alleged November 12, 1999 injury was the major contributing cause of claimant's need for treatment for the disputed conditions or that claimant's work activity at Bi-Mor was the major contributing cause of a pathological worsening of a preexisting myofascial condition or the major contributing cause of the lateral epicondylitis condition.

In the Matter of the Compensation of
BARBARA J. McGUIRE, Claimant
WCB Case Nos. 00-04322 & 00-02303
ORDER ON REVIEW
Charles Robinowitz, Claimant Attorney
Scheminske, et al, Defense Attorney

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) declined to reduce claimant's temporary disability award, as granted by an Order on Reconsideration; and (2) affirmed an Order of Reconsideration award of 13 percent (41.6 degrees) unscheduled permanent disability for a low back injury. On review, the issues are temporary disability and unscheduled permanent disability.

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

Unscheduled Permanent Disability

The ALJ relied on Dr. Berselli's medical arbiter's report to conclude that claimant's chronic low back pain was a direct medical sequela of the accepted "right low back contusion." Consequently, the

ALJ concluded that claimant's impairment, as measured by Dr. Berselli, should be used to determine the extent of claimant's unscheduled permanent disability pursuant to ORS 656.268(14).[1]

The employer contends that the only accepted condition is "right low back contusion," and that the condition diagnosed by Dr. Berselli ("chronic low back pain") is not a direct medical sequela of the accepted condition. Consequently, the employer reasons that because it has not accepted "chronic low back pain" that "condition" may not be used in rating claimant's unscheduled permanent disability. We disagree.

Claimant was struck in the low back by an open door of a moving vehicle. (Ex. 5; 6-1; 10-1). The speed of the vehicle at impact was approximately 15 to 20 miles per hour. (Ex. 10-1). As a result of the impact, claimant experienced pain in her right ribs, right hip, and low back. (Ex. 6-1). She was hospitalized for two days. (*Id.*). Despite conservative care, claimant continues to experience pain.[2] Claimant has no psychiatric or personality disorders. (Ex. 14-4).

Dr. Berselli diagnosed "chronic low back pain with the possibility of right-sided lumbar nerve root pressure." (Ex. 34). He found claimant had valid restricted ranges of motion for lumbar extension and lumbar lateral flexion (right and left), and specifically attributed his findings to the "accepted condition." (Ex. 30; 34). Additionally, Dr. Berselli determined that claimant "has a partial loss of ability to repetitively use the lumbar spinal area due to the diagnosed chronic and permanent medical condition which arose out of the accepted condition." (Ex. 34).

Because the medical arbiter unequivocally related his impairment findings to the "accepted condition," we conclude that the medical arbiter's impairment findings are ratable either directly to the compensable injury under ORS 656.214 or, indirectly, as "medical sequalae" of the accepted condition under ORS 656.268(14). Consequently, we agree with the ALJ's conclusion to affirm the Order on Reconsideration's award of unscheduled permanent disability.

Temporary Disability

The ALJ determined that claimant's attending physician, Dr. Datena, did not release claimant to regular duty work prior to claimant becoming medically stationary on January 3, 2000.[3] Consequently, the ALJ concluded that the evidence failed to establish that claimant's entitlement to temporary disability (beginning August 5, 1999, and ending January 3, 2000, as awarded by the Order on Reconsideration) should be reduced.

The employer contends that claimant's entitlement to temporary disability should terminate on December 9, 1999. In support of its position, employer relies on an alleged return to work authorization authored by Dr. Gavlick, who it asserts was claimant's attending physician. Additionally, the employer argues that the ALJ incorrectly assigned it with the burden to prove that claimant's temporary disability should be reduced. We disagree with the employer's contentions.

The employer requested a hearing regarding the Order on Reconsideration, contesting (among other issues) claimant's temporary disability award. Under such circumstances, the employer has the burden of establishing error in the reconsideration process. *Marvin Wood Products v. Callow*, 171 Or App 175 (2000); *Daniel B. Covert*, 52 Van Natta 1635 (2000). In other words, the employer must persuasively establish, from the reconsideration record, that the Department's award of temporary disability is in error. *Callow*, 171 Or App at 183.

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[1] 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. Here, the employer has not denied "chronic low back pain."

[2] Drs. Vessely and Garnder (employer-arranged medical examiners) diagnosed "ongoing chronic pain in the right paralumbar area radiating into the right buttock." (Ex. 15-5).

[3] ORS 656.268(4) provides: "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."

Temporary total disability benefits shall continue until the worker returns to regular work or the attending physician advises the worker and documents in writing that the worker is released to return to regular work. ORS 656.268(4)(a) and (b). The record does not support such a finding. To the contrary, the record does not establish that Dr. Gavlick was the attending physician.[4] Moreover, the record does not persuasively establish when, if ever, Dr. Datena ceased to be the attending physician or that his time loss authorizations ceased prior to claimant's condition becoming medically stationary on January 3, 2000.

Based on this record, we are not persuaded that claimant's award of temporary disability should be reduced. Consequently, we agree with the ALJ's conclusion to affirm the Order on Reconsideration's award of temporary disability. Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,100, 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 issues, and the value of the interest involved.

ORDER

The ALJ's order dated October 6, 2000 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the self-insured employer.

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[4] Initially, 44 exhibits had been submitted. However,by stipulation the parties limited the record to Exhibits 3 through 21, 29, 30, 33 through 35, and 38. (Tr. 2).

In the Matter of the Compensation of
SUSAN M. SHOTTHAFER, Claimant
WCB Case No. 98-01697
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. *Liberty Northwest Ins. Corp. v. Shotthafer*, 169 Or App 556 (2000). The court has reversed our order, *Susan M. Shotthafer*, 51 Van Natta 43 (1999), that affirmed an Administrative Law Judge's (ALJ's) order setting aside the insurer's denial of claimant's mental disorder claim for depression. The court reversed and remanded "to determine the reasonableness of the January 1997 letter and to reweigh the various causative factors to determine the major contributing cause of claimant's mental disorder." In accordance with the court's directive, we now proceed with our reconsideration.

FINDINGS OF FACT

We republish the "Findings of Fact" in our Order on Review and provide the following summary.

Claimant worked as a high school teacher; the position was probationary for the first three years, which meant that claimant was subject to a more rigorous evaluation process and her contract could be terminated more easily than that of a permanent teacher. Claimant was assigned to a "portable" classroom that was separate from the main high school building.

In January 1997, after claimant taught for one semester, Principal Powell wrote to claimant expressing his concern about declining enrollment in both of her Spanish classes. The letter asked claimant to give "serious thought" in making the "classes more attractive to students," adding that, "if we lose the students we lose the classes and the program and therefore the position." The letter encouraged claimant "to consider grades and praise more in line with what [the students] are used to receiving."

In March 1997, claimant received her first performance evaluation. Although noting some areas that needed improvement, Powell recommended continuation of claimant's employment. Shortly thereafter, Superintendent Paul Prevenas notified claimant of the renewal of her probationary teacher contract for the following school year. Claimant accepted the renewal.

During the summer of 1997, Powell wrote to claimant, telling her that he had received a letter, several telephone calls, and personal visits from parents complaining about her Spanish classes. The letter outlined Powell's concerns about claimant's teaching and stated that he would recommend that the Board withhold a salary step increment. Prevenas later told claimant that, because her performance evaluation was not substandard, the school district could not withhold a salary increment. Prevenas further informed claimant, however, that he had directed Powell to commence an evaluation process at the beginning of the school year.

After the school year began, claimant submitted performance goals to Powell. More parents and students complained to Powell about claimant's Spanish classes. In October 1997, Powell formally observed claimant's class and then sent claimant a "Notification of Performance Deficiency." About the same time, claimant began psychological counseling and then began treating with a psychiatrist. In late November 1997, claimant's treating osteopath removed claimant from her job and claimant filed a claim.

In December 1997, Powell completed a formal evaluation and then a "Plan of Assistance." In February 1998, Prevenas notified claimant of the school board's decision not to renew her contract.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had proved all the factors necessary for a compensable mental stress claim and, therefore, she carried her burden of proof. Our Order on Review affirmed, first finding that one of the principal causes of claimant's mental condition was criticism from her students and their parents, and that the events experienced by claimant were not "generally inherent." *Susan M. Shotthafer*, 51 Van Natta at 47.

Our first order further found that another primary factor in causing claimant's mental condition was the actions by Powell and Prevenas in responding to criticism from parents and students. In particular, we considered whether particular actions constituted "reasonable disciplinary, corrective or job performance evaluation actions by the employer" under ORS 656.802(3)(b). We first found that the January 1997 letter did not come under the statute. We also decided that Powell's recommendation to withhold a salary step increment qualified as a disciplinary action but was unreasonable. Consequently, we included both events in determining the major contributing cause of claimant's mental disorder. *Id.*

With regard to the January 1997 letter, the court found that it was "a corrective action" and, thus, determined that we erred in deciding otherwise. 169 Or App at 564. The court further concluded that, because our order did not assign specific weight to the various causative factors when we determined that compensable work-related employment conditions were the major contributing cause of claimant's mental stress, it could not decide whether this error affected our ultimate conclusion. Consequently, the court remanded "to determine the reasonableness of the January 1997 letter and to reweigh the various causative factors to determine the major contributing cause of claimant's mental disorder." *Id.*

The court additionally considered, however, whether we erred as a matter of law with our statement concerning the test under ORS 656.802(3)(b). The court found that, although the statement of law was unclear, we engaged in the proper weighing process. The court then described that process for purposes of clarity. *Id.* at 565-66.

The court then considered whether we erred in considering two off-work incidents in concluding that claimant was threatened and intimidated. The court decided that substantial evidence supported our conclusion that the two events were work related. *Id.* at 566.

Similarly, the court found that substantial evidence supported our decision that "claimant was subjected to work-related factors that are not 'generally inherent in every working situation.'" *Id.* at 566-67. In sum, the court determined that we did not err in concluding that "claimant was intimidated and threatened at work." Finally, the court found no error concerning the insurer's assertion that we "relied on claimant's own list of stressors, without differentiating between the compensable stressors and noncompensable stressors, in reaching the conclusion that the medical opinions uniformly showed that employment was the major contributing cause of claimant's stress." *Id.* at 567.

We turn to the January 1997 letter. As the court found, the letter constitutes corrective action under ORS 656.802(3)(b). We further find it to be reasonable. The facts show that Powell wrote the letter following claimant's first semester teaching at the high school. The letter noted that enrollment in claimant's Spanish classes had dropped and, in an effort to prevent the program from ending, gave suggestions for retaining students. (Ex. 5). Given claimant's probationary status and dropping enrollment, we find that Powell's letter was a reasonable corrective action regarding claimant's performance and the continuation of her position. Thus, this factor is excluded in determining causation.

As the court clarified, the weighing process required by ORS 656.802(3)(b) consists of three steps. The first step is to put potentially causal factors in three categories. The first category includes causative work-related factors that are not excluded by the statute. The second category are causative work-related factors that are excluded by ORS 656.802(3)(b). The last category consists of causative factors that are not related to work.

Here, because we have found the January 1997 letter to be a reasonable corrective action, it is excluded by the statute. We continue to adhere, however, to those portions of our initial order finding that criticism from students and parents, including the two off-work incidents,[1] personal confrontations by angry parents, letters from parents criticizing claimant's grading system, information from Powell about his meetings with numerous parents and students complaining about claimant's classes, a warning that a group of parents planned to confront claimant at school, being "booed" at a school assembly, and the "egging" of the portable classroom, come under the first category of causative work-related factors that are not excluded by ORS 656.802(3)(b). We also continue to adhere to our prior conclusion that Powell's recommendation to withhold a salary step increment was an unreasonable disciplinary action and, thus, that factor is not excluded. We find no causative factors falling under the nonwork-related third category.

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).

In weighing the excluded January 1997 letter against the remaining factors, we find that the included causative work-related factors outweigh the January 1997 letter. In this regard, we rely on the medical evidence attributing claimant's mental stress to these factors. This evidence shows that the January 1997 letter was a very small part of the conditions causing claimant's mental stress. Therefore, claimant carried her burden of proving that causative work-related factors not excluded by ORS 656.802(3)(b) were the major contributing cause of her mental disorder.

Finally, because the court found that substantial evidence supported our decision that the employment conditions causing claimant's condition was not "generally inherent," we continue to adhere to that portion of our initial order. Thus, we conclude that claimant proved compensability.

Where, such as in this case, 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 $8,000 for services at hearing and our award of $2,000 for services on review. Thus, we republish those awards.

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[1] As noted by the court, claimant's tires were slashed on one occasion and several youths were seen at night in front of her home. As explained above, the court found substantial evidence supporting our finding that such events were work-related and, thus, properly considered in determining causation.

Claimant's attorney submitted a statement of services asking for $7,184 for services before the court. In support, counsel asserted that he devoted 33 hours and that the case is more complex than the average. Claimant's attorney also applies a multiplier of 40 percent.

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.

We have repeatedly said, however, that we do not apply a contingency factor or "multiplier" in a strict mathematical sense. *See, e.g., Lois J. Schoch*, 49 Van Natta 788, 790, n.1 (1997). Instead, we consider the risk that claimant's counsel may go uncompensated in conjunction with the other relevant factors of OAR 438-015-0010(4) in determining a reasonable attorney fee award. *See John M. Morley*, 50 Van Natta 1598 (1998).

Considering those factors, we agree with claimant's attorney that the complexity of the issue, the value of the interest involved, and the benefit secured for claimant were high in this case. Based on the insurer's vigorous defense and the numerous statutory requirements for establishing a compensable mental stress claim, there also was a risk that claimant's attorney's efforts could go uncompensated. There was no assertion of frivolous issues or defenses.

Based on these factors, we conclude that a fee of $5,500 is reasonable for claimant's services before the court. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's statement of services), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney could go uncompensated.

Accordingly, on reconsideration, we republish and adhere to our Order on Review, as modified by this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
AUDREY J. BIGELOW, Claimant
Own Motion No. 99-0391M
OWN MOTION ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorney
Saif Legal Department, Defense Attorney

On July 27, 2000, we withdrew our July 18, 2000 Own Motion Order, in which we had found that, in light of the Medical Review Unit's (MRU) order (which had found that a proposed surgery was not reasonable and necessary medical treatment), claimant was not entitled to temporary disability compensation. We took this action because claimant had appealed the MRU order and requested a contested case hearing.

In a January 8, 2001 Final Order, the Administrator affirmed the Administrative Law Judge's (ALJ's) Proposed and Final Contested Case Hearing Order and the MRU's order. The Final Order has not been appealed. In light of such circumstances, we proceed with our reconsideration.

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 dispute regarding the reasonableness and necessity of claimant's proposed surgery has been resolved. ORS 656.327. Because it has been determined that the SAIF Corporation is not responsible for claimant's proposed medical treatment, we continue to find that claimant is not entitled to temporary disability compensation for surgery which has been determined inappropriate for claimant's compensable condition.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our July 18, 2000 order in its entirety. The parties' rights of appeal shall run from the date of this order.[1]

IT IS SO ORDERED.

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[1] It appears from claimant's submission that she may be unclear as to her rights under the Workers' Compensation laws. Inasmuch as claimant is unrepresented, she may wish to consult with the Workers' Compensation Ombudsman, whose job it is to assist injured workers in such matters. She 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
JERRY BOLIN, Claimant
Own Motion No. 00-0296M
OWN MOTION ORDER
Patrick K. Mackin, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for his 1992 claim. Claimant's aggravation rights have expired. The insurer opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force.

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

Claimant underwent low back surgery on April 19, 2000. Thus, 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,[1] 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 April 19, 2000 surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990); *SAIF v. Blakely*, 160 Or App 242 (1999); *Paul M. Jordan*, 49 Van Natta 2094 (1997).

The insurer contends that claimant was not in the work force at the time of his current disability. 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. In support of his contention, claimant submitted: (1) copies of his 1999 W-2 forms; (2) a copy of his 1999 tax return; (3) a January 12, 2001 affidavit; and (4) several medical reports from his treating physicians.

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[1] The Board in its Own Motion jurisdiction can only authorize temporary disability from the time of surgery or hospitalization. *See* ORS 656.278(1)(a).

In his January 2001 affidavit, claimant asserts that he has been "at all times willing to work and have sought work." Claimant's 1999 W-2 forms and tax return demonstrate that claimant was working sometime in 1999, just a few months prior to his April 2000 worsening. Based on claimant's unrebutted affidavit and the fact that he had been working in the year prior to his current worsening, we find that claimant was 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 reasoning, we find that, at the time of his disability, claimant was willing to work and seeking work.

Claimant submitted medical reports from Drs. Maloney, Grossman and Alder. On January 17, 2001, Drs. Maloney and Grossman agreed that, prior to his April 2000 surgery claimant was unable to work due to his compensable condition. Dr. Alder, claimant's attending surgeon, noted in his pre-surgery report that claimant was working as a "home builder and does heavy work." Dr. Alder also noted that claimant's low back condition had worsened to the extent that he required surgery on an urgent basis.

In his January 2001 affidavit, claimant outlines his work search efforts. He contends that he: (1) made phone calls to prospective employers; (2) looked in the newspaper for "basic labor jobs;" (3) signed up with a temporary employment agency "but was unable to obtain any positions; and (4) performed some maintenance work for his landlord and discussed future projects. Claimant submitted a January 16, 2001 affidavit from his landlord, which supports his contention that he performed some maintenance work and discussed further projects. Claimant's other work search contentions are unchallenged by the insurer. Thus, despite Drs. Maloney's and Grossman's opinions that claimant was unable to work prior to his April 2000 surgery, claimant continued to seek work.

On this record, we conclude that claimant has established that he was willing to work and was making a reasonable effort to find work at the time of his current worsening. Consequently, we are persuaded that he was in the work force at the time of his disability.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning April 19, 2000, the date he was hospitalized for surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,500, payable by the insurer directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

In the Matter of the Compensation of
SHARON L. CATTERSON, Claimant
WCB Case No. 00-01900
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
VavRosky, et al, Defense Attorney

Reviewed by Board Members Haynes, Bock and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the self-insured employer's denials of her current low back condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated October 18, 2000 is affirmed.

Board Member Phillips Polich dissenting.

Without supplementation, the majority affirms the ALJ's order that upholds the employer's denials of claimant's occupational disease claim for her current low back condition. In so doing, the majority approves the ALJ's reasoning that the medical opinion of an attending physician, Dr. Belza, was not sufficient to establish the compensability of the occupational disease claim. Because I disagree with the majority's evaluation of the medical evidence, I respectfully dissent.

To begin, it is necessary to briefly set forth the background of the claim. Claimant, a hospital nurse, filed a claim for a low back injury occurring on July 21, 1997, when lifting patients. Dr. Kendrick, a consulting physician, diagnosed a "sprain type injury" on August 29, 1997.

The employer denied the injury claim on October 30, 1997. Claimant did not request a hearing from the denial.

Claimant returned to regular work, but later sought care from her primary-care physician, Dr. Fitzpatrick, on January 28, 2000, for low back pain. Dr. Fitzpatrick diagnosed progressive low back pain in the last two months with known degenerative joint disease. (Ex. 14-1).

On February 9, Dr. Belza saw claimant on referral from Dr. Fitzpatrick. Dr. Belza diagnosed mechanical instability of the lumbar spine. (Ex. 16A-2).

Claimant filed a workers' compensation claim for her low back condition on February 15, 2000, citing ongoing low back pain for 3 years. On February 23, 2000, the employer denied the claim on the ground that the prior denial in October 1997 barred the new claim. (Ex. 21). Claimant requested a hearing from this denial, as well as a later denial on April 4, 2000, which denied an occupational disease claim for claimant's current low back condition and/or mechanical instability. (Ex. 23).

In the meantime, Dr. Belza continued to provide claimant's primary care for her low back condition. On May 5, 2000, Dr. Belza diagnosed lumbar disc disease. (Ex. 25 A).

As previously noted, the ALJ upheld the employer's denials. In upholding the denials, the ALJ first reasoned that the unappealed denial from October 1997 precluded claimant from asserting the compensability of the 1997 low back injury claim. The ALJ then concluded that, in order to establish a compensable occupational disease claim for her current low back condition, claimant had to prove, consistent with ORS 656.802(2)(b), that her low back condition was due to work activity subsequent to July 1997.

I do not disagree with this portion of the ALJ's order. I do, however, take issue with the rest of his analysis, wherein he concluded that claimant failed to sustain her burden of proving a compensable occupational disease.

The ALJ reasoned that claimant had to prove that her work activity was the major contributing cause of a pathological worsening of the preexisting low back condition. The ALJ concluded that claimant failed to do so. Specifically, the ALJ determined that Dr. Belza's causation opinion was conclusory in comparison to that of an examining physician, Dr. Schilperoort. Because I disagree with the ALJ's evaluation of the relative persuasiveness of the medical evidence, I cannot accept the result in this case.

Because of the possible alternative causes for claimant's current 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).

In this case, Dr. Belza is entitled to the deference generally accorded an attending physician since he became primarily responsible for claimant's treatment. *See* ORS 656.005(12)(b). Moreover, use of "magic words" or statutory language is not required where the record as a whole satisfies claimant's burden of proof. *See McClendon v. Nabisco Brands, Inc.*, 77 Or App 412 (1986). Here, the record as a whole does satisfy claimant's burden of proof.

Dr. Belza treated claimant on numerous occasions and opined on May 23, 2000, that claimant's work activities over the previous 2 years (consisting of lifting, turning, stooping and bending over patients) accelerated and increased the instability in her lumbar spine. (Ex. 26A-1). According to Dr. Belza, this work activity was the major contributing cause of a pathological worsening of mechanical instability resulting from claimant's preexisting low back condition. *Id.* Because Dr. Belza's opinion is well-reasoned and based on a complete and accurate history, the majority should have deferred to it.

Granted, Dr. Belza made some comments in other reports that linked claimant's current low back condition to the prior 1997 injury. (See Ex. 27). However, in his deposition, Dr. Belza testified that he was not treating claimant for a lumbosacral strain. (Ex. 28-5). Inasmuch as the 1997 injury only involved a sprain, Dr. Belza's testimony makes it clear that claimant's current low back symptoms involve a different condition. Read in its entirety, Dr. Belza's opinion supports a finding of a compensable occupational disease claim based on "post-1997 injury" work activity.

Claimant's testimony supports this conclusion and Dr. Belza's opinion. Claimant testified that her current low back pain differs from that which experienced in association with the 1997 injury. (Tr. 15, 16, 17). Based on this testimony, it is abundantly clear that claimant's current low back condition is very different from what she previously experienced and indicates to me that her current work activity has caused her back condition to worsen substantially between 1997 and 2000.

Claimant's testimony is also significant with respect to the nature of her work activities. It establishes that claimant's work duties involved heavy physical labor, requiring her to lift elderly patients, pull them up in bed and turn them on their sides. (Tr. 7). The patients lifted ranged from 79 to 300 pounds. (Tr. 8).

Dr. Schilperoort, whose opinion represents the sole medical evidence opposing Dr. Belza's, erroneously believed that claimant did not perform heavy lifting. (Ex. 26-7). This incorrect history renders Dr. Schilperoort's opinion unpersuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977). In light of this, Dr. Schilperoot's opinion is insufficient to overcome the weight generally accorded an attending physician's opinion.

In conclusion, claimant proved by a preponderance of the medical evidence that she sustained a compensable occupational disease based on her "post-injury" work activities from 1997 to 2000. Because the majority by adopting the ALJ's order reaches an opposite conclusion, one not supported by this record, I respectfully dissent.

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

Reviewed by Board Members Phillips Polich and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Howell's order that set aside its denials of claimant's current left knee condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. We replace the last paragraph on page 2 with the following:

On May 3, 2000, claimant's attorney requested that SAIF amend the notice of acceptance to include claimant's "current knee condition diagnosed as tearing of the anteromedial joint structures, medial capsular soft tissue injury, chondral defect to the lateral aspect of her patella." (Ex. 24).

On May 19, 2000, SAIF issued a "Notice of Modified Acceptance and Denial." (Ex. 26). SAIF amended its acceptance to include a symptomatic synovial plica of the left knee. (*Id.*) SAIF also stated that beginning on or after October 21, 1999, claimant's "injury and/or accepted condition(s) have combined with one of more preexisting conditions including: 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." (*Id.*)

SAIF also 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. (*Id.*) In August 2000, SAIF issued another denial, stating that claimant's current condition was no longer compensable. (Ex. 32).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's accepted injury was the major contributing cause of her ongoing left knee condition. In reaching this conclusion, the ALJ relied on Dr. Walther's opinion.

On review, SAIF contends that claimant's current combined left knee condition is not compensable. For the following reasons, we agree with SAIF.

We begin by summarizing the procedural posture of this case. Claimant compensably injured her left knee on October 21, 1999. Drs. Skaggs and Walther diagnosed a left knee medial meniscus tear. (Ex. 3, 4, 6). A left knee MRI on November 4, 1999 was interpreted as showing a small tear of the posterior horn of the medial meniscus. (Ex. 9).

SAIF initially accepted a disabling left knee strain. (Ex. 10).

On November 23, 1999, Dr. Walther performed surgery on claimant's left knee. (Ex. 11). She found that claimant's medial meniscus was intact. (*Id.*) Although her preoperative diagnosis had been a left knee medial meniscus tear, Dr. Walther's postoperative diagnoses were: left knee suprapatellar plica, scar anterior medial compartment, patellar malalignment and traumatic lateral plateau lesion. (Ex. 11-1).

On May 3, 2000, claimant's attorney requested that SAIF amend the notice of acceptance to include claimant's "current knee condition diagnosed as tearing of the anteromedial joint structures, medial capsular soft tissue injury, chondral defect to the lateral aspect of her patella." (Ex. 24).

On May 19, 2000, SAIF issued a "Notice of Modified Acceptance and Denial." (Ex. 26). The letter stated that claimant's "current condition" was no longer compensable for the following reason(s):

> "Your claim was originally accepted for left knee strain. By this notice, SAIF Corporation also accepts symptomatic synovial plica of the left knee. Information in your claim file also indicates that beginning on or after October 21, 1999 your injury and/or accepted condition(s) have combined with one of more preexisting conditions including: 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. Accordingly, SAIF hereby accepts a combined condition beginning on October 21, 1999. This document becomes part of and is incorporated into your original Notice of Acceptance." (*Id.*)

SAIF also 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. (*Id.*) In August 2000, SAIF issued another denial, stating that claimant's current condition was no longer compensable. (Ex. 32).

Thus, SAIF initially accepted a left knee strain (Ex. 10) and, on May 19, 2000, SAIF modified its acceptance to include symptomatic synovial plica of the left knee. (Ex. 26). The May 19, 2000 acceptance indicated that, beginning on or after October 21, 1999, claimant's "injury and/or accepted condition(s)" combined with one of more preexisting conditions including: 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. (*Id.*) Based on the language of SAIF's May 19, 2000 letter, we find that SAIF accepted a left knee strain and a symptomatic synovial plica of the left knee and that both accepted conditions combined with the aforementioned preexisting conditions.

ORS 656.005(7)(a)(B) provides that 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 or need for treatment of the combined condition. Furthermore, ORS 656.262(6)(c) provides that a carrier's acceptance of a combined condition shall not preclude the carrier from later denying the combined condition "if the otherwise compensable injury ceases to be the major contributing cause" of the combined condition.

Claimant relies on Dr. Walther's opinion to establish compensability of her current left knee condition. In evaluating the medical evidence concerning causation, we rely on those opinions that are both well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). In addition, we generally defer to the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). For the following reasons, however, we find persuasive reasons not to defer to the opinion of Dr. Walthers.

As discussed above, Dr. Walther was claimant's treating surgeon. After the November 23, 1999 surgery, Dr. Walther's postoperative diagnoses were: left knee suprapatellar plica, scar anterior medial compartment, patellar malalignment and traumatic lateral plateau lesion. (Ex. 11-1). She performed a left knee arthroscopy, excision of plica and excision of scar anterior medial compartment, and a lateral release. (*Id.*)

On February 15, 2000, Dr. Walther wrote to SAIF regarding her opinion of Dr. Schilperoort's January 11, 2000 report.[1] (Ex. 14). Dr. Walther said that the MRI finding of a medial meniscus tear was a false positive finding. (Ex. 14-1). She explained:

> "Instead, [claimant] had suffered a tearing of the anteromedial joint structures which resulted in a large scar ball. It was this scar tissue which had been the cause of her medial pain; this had mimicked a medial meniscus tear - which was a false positive finding on the MRI." (*Id.*)

Dr. Walther explained claimant's additional injuries:

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[1] Dr. Schilperoort found that claimant's work injury had caused a left knee sprain, which was now resolved. (Ex. 12A-3, -4). He also diagnosed preexisting patellofemoral malalignment and grade III patellofemoral chondromalacia, which were not causally related to the work injury. (*Id.*)

"In addition to the medial capsular/soft tissue injury, [claimant] suffered an injury to the lateral aspect of her knee. This resulted in a large fissure in the articular surface of the lateral tibial plateau. This lesion was extensive, but unamenable to arthroscopic repair. Also, [claimant] had a chondral defect on the lateral aspect of her patella. Likewise, this was a result of her injury. However, in regards to her patellar injury, [claimant] was predisposed to injury given her tight lateral patellar retinaculum. On her initial examination she was found to have decreased passive the [sic] patellar tilt. [Claimant's] passive patellar tilt was zero (0) degrees, with normal being positive 10 to 15 degrees. This predisposed her to a patellar injury. However, the intraoperative finding of a chondral lesion of the lateral tibial plateau (not to confused with chondromalacia) in combination with a chondral lesion of the undersurface of the patella, requiring a lateral release and debridement, was primarily caused by her accident." (Ex. 14-1, -2).

Dr. Walther felt that claimant had injured both the medial and lateral aspects of her knee. (Ex. 14-2).

On May 30, 2000, Dr. Walther concurred with the "diagnosis(es), findings, tests, medically stationary date, work release and opinions and discussion" in Dr. Thompson's March 29 and April 26, 2000 reports. (Ex. 27). In his March 29, 2000 report, Dr. Thompson diagnosed the following conditions:

"1. Patellofemoral dysplasia with lateral displacement of the patella (patellofemoral malalignment) preexisting and unrelated to the industrial injury.

"2. Probable medial synovial plica, right knee.

"3. Mucoid degeneration, posterior horn of the medial meniscus, right knee.

"4. Probable medial collateral ligament strain, right knee." (Ex. 20-4).[2]

Dr. Thompson felt that claimant's medial side pain and tenderness were related to the work incident. (Ex. 20-5). He said claimant apparently had a medial collateral ligament strain and possibly an injury to the medial synovial plica. (*Id.*) He explained, however, that claimant's preexisting patellofemoral malalignment and patellofemoral dysplasia were *not* related to the industrial injury, nor were those conditions the major factor in her need for surgery. (Ex. 20-5, -7). He found it implausible that the "scar ball" that was described as contiguous with the plica could have developed in one month between the injury and the surgery. (Ex. 20-5). Dr. Thompson found no relationship "whatsoever" between the injury and chondromalacia of the lateral tibial plateau or the grade III lesion of the lateral facet of the patella. (*Id.*) Dr. Thompson did not believe any of the findings in the lateral joint were related to the work injury because Dr. Walther did not report any clinical findings in that area when she first examined claimant. (Ex. 20-6). He concluded that claimant's ongoing symptoms were referable to the treatment for the preexisting patellar malalignment. (Ex. 20-7).

In a clarification letter on April 26, 2000, Dr. Thompson said he did not understand Dr. Walther's reference to a "scar ball" and he said it was not possible to indicate the etiology of that condition. (Ex. 23). SAIF asked when the October 21, 1999 incident ceased being the major contributing cause and Dr. Thompson responded that claimant's symptoms probably subsided within six to eight weeks after surgery. (Ex. 23-1, -2). Dr. Thompson reiterated that claimant's ongoing symptoms were referable to the patellar malalignment. (Ex. 23-2).

Although Dr. Walther initially concurred with Dr. Thompson's reports, she agreed with the following letter from claimant's attorney on July 31, 2000:

"The IME on March 29, 2000 believed the major contributing cause of the combined condition was the work incident. You agree. However, you do not agree with the addendum report of April 26, 2000 that the major contributing cause of [claimant's] problem became the preexisting condition. Consistent with your opinion, more specifically your letter of February 15, 2000 to Ms. Peralta [at SAIF], you believe the major contributing cause of [claimant's] combined condition is the work incident.

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[2] Although Dr. Thompson referred to three of the diagnoses as related to the "right" knee, he reported that claimant had injured her left knee in the work incident. When Dr. Walther concurred with Dr. Thompson's reports, she did not comment on his apparent error.

"At the time of your concurrence, you did not clearly recognize the fact Dr. Thompson stated the injury would no longer be the major contributing cause of the problem six to eight weeks after surgery. Such a statement is inconsistent with your opinion which you have held all along that the major contributing cause of [claimant's] combined condition would be the work injury versus the pre-existing conditions." (Ex. 31-1).

According to claimant, Dr. Walther adequately explained her change of opinion in the July 31, 2000 concurrence letter. Claimant also relies on Dr. Walther's February 15, 2000 report to establish compensability.

Although Dr. Walther's July 31, 2000 concurrence letter clarified that she did not agree with Dr. Thompson's April 26, 2000 report, she did not explain several inconsistencies between her February 15, 2000 report and her agreement with Dr. Thompson's March 29, 2000 report. In her February 15, 2000 report, Dr. Walther said that claimant's work injury had caused a tearing of the anteromedial joint structures that resulted in a large scar ball. (Ex. 14-1). On the other hand, Dr. Walther concurred with Dr. Thompson's March 29, 2000 report, which found it implausible that the "scar ball" could have developed in one month between the injury and the surgery. (Ex. 20-5).

On February 15, 2000, Dr. Walther found that the work injury had caused an injury to the lateral aspect of claimant's knee that resulted in a large fissure in the articular surface of the lateral tibial plateau, as well as a chondral defect on the lateral aspect of her patella. (Ex. 14-1). Dr. Walther also said that the chondral lesion of the lateral tibial plateau in combination with a chondral lesion of the undersurface of the patella required a lateral release and "was primarily caused by her accident." (Ex. 14-2).

Conversely, Dr. Walther concurred with Dr. Thompson's March 29, 2000 report that expressly rejected Walther's statement that the work injury had caused a large fissure in the articular surface of the lateral tibial plateau. (Ex. 20-6). Dr. Thompson said it was "inexplicable" that the findings of the lateral joint could be related to the work incident, based on Dr. Walther's clinical findings when she first saw claimant. (*Id.*) Dr. Thompson also specifically rejected Dr. Walther's statement that the injury had caused the chondral defect on the lateral aspect of the patella to this injury. (*Id.*) He noted that Dr. Walther had not described any complaints referable to the patella at the time of her initial examination. (*Id.*)

Furthermore, in his March 29, 2000 report, Dr. Thompson said that claimant's preexisting patellofemoral malalignment or patellofemoral dysplasia were *not* related to the industrial injury, nor were those conditions the major factor in her need for surgery. (Ex. 20-5, -7). He explained that claimant's ongoing symptoms were "referable to the treatment of the patellar malalignment, *i.e.*, the lateral retinacular release, as well as some infrapatellar tendinitis which I do not believe is related to the injury." (Ex. 20-7). In his April 26, 2000 report, Dr. Thompson again stated that claimant's ongoing symptoms were referable to the patellar malalignment. (Ex. 23-2).

Dr. Walther initially concurred with both reports. Although she later explained on July 31, 2000 that she did not agree with the April 26, 2000 report that claimant's preexisting condition was the major contributing cause of her problem (Ex. 31), she provided no response to her earlier agreement with Dr. Thompson that claimant's current symptoms were referable to the patellar malalignment. Moreover, although Dr. Walther agreed on July 31, 2000 that claimant's work incident was the major contributing cause of the "combined condition" (Ex. 31), she did not explain what condition(s) she believed were causing claimant's current left knee symptoms.

We find that, because Dr. Walther did not explain the inconsistencies and her change of opinion, her opinion on causation is entitled to little weight. *Compare Kelso v. City of Salem*, 87 Or App 630 (1987) (medical opinion that provided a reasonable explanation for the change of opinion was persuasive). We also find that Dr. Walther's opinion is not persuasive because it is conclusory and lacks adequate explanation. We conclude that Dr. Walther's opinion is insufficient to establish that the compensable injury is the major contributing cause of claimant's need for medical treatment or disability of her current left knee condition.

There are no other medical opinions that establish compensability. Dr. Thompson believed that claimant's ongoing symptoms were related to preexisting patellar malalignment, which was not related to the work injury. (Exs. 20-7, 23-2). He felt that claimant's symptoms from the October 1999 injury had resolved within six to eight weeks after the November 23, 1999 surgery. (Ex. 23-2). Similarly, Dr.

Schilperoort found that claimant's sprain from the injury had resolved and her current diagnoses of preexisting patellofemoral malalignment and grade III patellofemoral chondromalacia were not causally related to the work injury. (Ex. 12A-3, -4). Under these circumstances, we conclude that the medical evidence does not establish compensability of claimant's current left knee condition. We therefore reverse the ALJ's order.

ORDER

The ALJ's order dated September 15, 2000 is reversed. SAIF's denials of claimant's current left knee condition are reinstated and upheld. The ALJ's attorney fee is also reversed.

January 30, 2001 Cite as 53 Van Natta 118 (2001)

In the Matter of the Compensation of
CATHRYN DODGENS, Claimant
WCB Case Nos. 00-03682 & 98-07856
ORDER ON REVIEW
Linerud Law Firm, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's chronic cervical strain condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

On December 12, 1997, claimant tripped and fell at work, striking her head, left shoulder and arm against a solid wooden object. (Exs. 1, 2, 4). She sought emergency room treatment on December 16, 1997 for headache and visual difficulties. (Ex. 1). Examination showed no neck stiffness. *Id.*

On December 19, 1997, she was treated by Dr. Richards. He noted that her headaches and visual problems were improving. His examination found claimant's neck to be supple. (Ex. 5).

On December 24, 1997, the insurer accepted a disabling head contusion. (Ex. 7).

On February 5, 1998, claimant returned to Dr. Richards complaining of pain on the right side of her neck, which she stated that she had had since her injury. (Ex. 10). She noted that she had pain radiating down the right arm that seemed to start at the base of the neck lateral to the midline on the right side and was worsened by having to work with her neck flexed in the same position for prolonged periods. Dr. Richards found tenderness at T6-7, in the perispinous muscles on the right, and in the neck with flexion. *Id.* He diagnosed a neck injury precipitated by her fall.

On February 18, 1998, claimant returned to Dr. Richards complaining of severe headache and neck pain that she related to her modified work duties. (Ex. 14A). Dr. Richards took claimant off work.

February 18, 1998 x-rays revealed facet hypertrophy on the left at C5-6 and C6-7. (Ex. 13).

On February 26, 1998, claimant reported considerable improvement after being off work, although she noted stiffness in the right trapezius. (Ex. 14). On March 5, 1998, claimant reported pain at the base of the skull and the back of the upper neck that was unrelated to activity or rest. Dr. Richards released claimant to regular work. (Ex. 15). Claimant sought no further medical treatment until July 1998.

On July 24, 1998, the insurer issued a Notice of Closure that awarded temporary but no permanent disability. (Ex. 21).

On July 30, 1998, claimant returned to Dr. Richards, complaining of increased pain in the right trapezius muscle. Dr. Richards diagnosed a right trapezius/deltoid muscle strain and prescribed physical therapy. (Ex. 22). On August 7, 1998, Dr. Richards repeated his evaluation of claimant's shoulder and occasional numbness and tingling in the 4th and 5th fingers. (Ex. 23). An MRI revealed disc bulges at C5-6 on the left and C6-7 and C7-T1 on the right. (Ex. 24).

On August 20, 1998, claimant returned to Dr. Richards with tingling and weakness in her right hand. Dr. Richards referred claimant to Dr. Verska, neurosurgeon, for evaluation. (Ex. 25). Dr. Verska concluded that claimant did not have a symptomatic herniated disc and referred her to Dr. Green for consultation regarding the cause of her right arm complaints. *Id.* Dr. Green, neurologist, concluded after EMG studies that claimant was negative for neurological disorders and that the changes seen in the MRI were due to wear and tear. He diagnosed claimant with a cervical strain, "probably with facet joint and/or muscular/ligament strain." (Ex. 29).

On September 28, 1998, claimant sought treatment from Dr. Puziss, orthopedist, for complaints of neck and lower posterior area pain. Dr. Puziss diagnosed chronic cervical strain. (Ex. 29C).

On March 18, 1999, claimant was examined by Dr. Grimm, neurologist. (Ex. 33).

A March 24, 1999 MRI revealed no findings of disc protrusion nor nerve root impairment. (Ex. 34).

Dr. Brown examined claimant for the insurer on February 15, 2000.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant had established the compensability of her chronic neck strain condition. On review, the insurer argues that claimant's chronic neck strain is not compensable, because she did not report any neck symptoms until almost two months after her slip and fall incident, and because she sought no treatment for her neck for a five-month period, which was followed by an unexplained worsening of her condition.

In order to establish compensability of her chronic cervical strain, claimant must prove that it is materially related to her December 12, 1997 work accident. ORS 656.005(7)(a); ORS 656.266. Alternatively, if the strain combined with any preexisting conditions, claimant must prove that the compensable injury is the major cause of her disability or need for treatment of the combined condition. ORS 656.005(7)(a)(B). Because of the gaps in medical treatment, the issue of the cause of claimant's chronic cervical strain condition presents a complex medical question that must be answered by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993). In evaluating the medical evidence concerning causation, we rely on those opinions which are both well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986).

Here, opinions were provided by Dr. Richards, Dr. Verska, Dr. Green, Dr. Brown, Dr. Puziss, Dr. Grimm and Dr. Bachman.

Dr. Richards, claimant's treating family doctor, is the only doctor who saw claimant shortly after the accident and treated her for an extended period (from December 1997 until August 1998). Dr. Richards' initial opinion attributed claimant's chronic cervical strain to the December 1997 work injury without explanation. Moreover, although an MRI had revealed disc bulges in the neck that Dr. Green had attributed to "wear and tear," Dr. Richards indicated that the effect of the preexisting conditions was "unknown." (Ex. 38).

Ultimately, however, Dr. Richards concluded that claimant's cervical strain was not related to her December 1997 work injury. (Ex. 40-20). This changed opinion was based on his review of and deference to the expert opinions of Dr. Verska, neurosurgeon, and Dr. Green, neurologist, whose reports concluded that claimant's neck condition was not related to the December 12, 1997 injury because of the 55-day delay before claimant sought treatment for neck symptoms,[1] and his new understanding that claimant did not initially complain of neck symptoms. (Exs. 40-5, 30, 31). Because Dr. Richards' changed opinion is based on more accurate and complete information, we find it more persuasive than his earlier, conclusory "check-the-box" opinion.

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[1] Although claimant testified that, among other symptoms, she had neck stiffness from the moment of her injury that never went away, she did not allege any neck injury in the medical records, her First Medical Report form, 801 form or at her first visit with Dr. Richards a week after the injury, when he found that her neck remained supple. *See* Exs. 1 through 5. Dr. Richards diagnosed a post-traumatic headache and released her to work on December 28, 1997. The medical record is silent for more than a month. On February 5, 1998, 55 days after the injury, claimant returned to Dr. Richards indicating the presence of neck pain since the injury. (Ex. 10).

Dr. Brown, who performed a medical records review and examination of claimant, also initially thought that claimant had suffered a cervical strain in the December 12, 1997 accident. (Ex. 40A-12). He admitted, however, that his initial review was focused on claimant's inner ear complaints. (Ex. 42). When provided additional information from Dr. Verska and Dr. Green that suggested that some of claimant's cervical spine injury may have been preexisting, Dr. Brown was no longer able to say with reasonable medical probability whether claimant's neck condition was related to her work injury. *Id.* As with Dr. Richards, Dr. Brown's changed opinion was based on more accurate and complete information and is, therefore, more persuasive than his earlier opinion.

Dr. Puziss, who concluded that claimant's neck strain was work related, provided no persuasive explanation for his conclusion, nor did he persuasively address the problem of claimant's initial delay in reporting her neck symptoms. In attempting to explain that delay, Dr. Puziss indicated that claimant probably damaged her cervical discs, the symptoms of which may not have manifested immediately. (Ex. 31A). Dr. Puziss also stated that claimant probably aggravated her preexisting disc bulges by the sudden twisting of her neck. (Ex. 36A). Dr. Puziss later stated that claimant's (noncompensable) headaches, bulging discs and inner ear concussion syndrome were all related to her cervical strain. (Ex. 36B). But Dr. Puziss never distinguished the symptoms of the alleged disc condition, headaches and inner ear condition from the alleged cervical strain. Without such an explanation, it is unclear whether Dr. Puziss has actually diagnosed an independent, work-related cervical strain. Because Dr. Puziss' opinion is conclusory and unexplained, it is not persuasive.

Likewise, Dr. Grimm's opinion does not persuasively address the initial delay in reporting neck symptoms, nor does he clearly distinguish between the noncompensable disc condition, the noncompensable inner ear condition and the cervical strain.

Dr. Grimm initially diagnosed a stiff neck secondary to a mild inner ear concussion syndrome and a herniating disc. (Ex. 33). In his next report, he confirmed that claimant had an inner ear injury that accounted for some of her symptoms and further indicated that claimant may have a cervical nerve root injury. (Ex. 35). Later, Dr. Grimm indicated that the improvement shown in a comparison of the 1998 and 1999 MRIs showed that claimant had disc findings caused by the work injury. (Ex. 37). But Dr. Grimm failed to distinguish the symptoms of the (noncompensable) inner ear and disc/nerve root injuries from the cervical strain. Without such a distinction, it is unclear whether he thought that claimant had a cervical strain caused by work and independent of the other noncompensable conditions.

Finally, Dr. Grimm's final "check-the-box" opinion is entirely unpersuasive, as it provides no analysis and indicates that: (1) claimant did not have a preexisting condition; (2) the work injury was the major contributing cause for the pathological worsening of the preexisting condition; and (3) the injury was the major contributing cause of the treatment or disability for the combined condition.

The opinion provided by Dr. Bachman is also unpersuasive. In the final analysis, Dr. Bachman stated only that it was "plausible that [claimant] could have a delayed reaction to [the work] accident," and that claimant's diagnosis of chronic cervical strain "could be" attributed to the work injury. (Exs. 39, 41-15, -16). These statements of possibility are not sufficient to establish compensability. *See Gormley v. SAIF*, 52 Or App 1055 (1981) (a possibility of a causal relationship is insufficient to meet claimant's burden of proof).

In sum, after our *de novo* review of the medical record, we find that the preponderance of the persuasive medical evidence establishes that claimant has failed to carry her burden to prove compensability of her cervical strain condition under either a material or major contributing cause standard. Therefore, we reverse the ALJ's opinion.

ORDER

The ALJ's order dated September 29, 2000 is reversed in part and affirmed in part. That portion of the order that set aside the insurer's denial of claimant's chronic cervical strain is reversed and the insurer's denial is reinstated and upheld. The ALJ's attorney fee is also reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
KEITH B. FISHER, Claimant
WCB Case Nos. 00-02940 & 00-02477
ORDER ON REVIEW
Heather Holt, Claimant Attorney
Julie Masters (Saif), Defense Attorney
VavRosky, et al, Defense Attorney

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

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside SAIF's denial, on behalf of Tidewater Contractors Incorporated, of claimant's aggravation claim for a thoracic strain; and (2) upheld Cambridge Integrated Services' (CIS) denial, on behalf of Rogue Truck Body, of claimant's "new injury" claim for the same condition. In his respondent's brief, claimant contests the ALJ's refusal to assess SAIF a penalty for allegedly unreasonable claim processing. On review, the issues are responsibility and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings."

CONCLUSIONS OF LAW AND OPINION

Claimant injured his back on December 14, 1998, when he swung a 20 pound sledge hammer awkwardly and felt a "tearing" pain in his mid back. SAIF accepted claimant's injury claim for a thoracic strain. A March 3, 1999 Notice of Closure closed the claim with no award of permanent disability.

Claimant returned to work, with continuing mid-back soreness. On December 3, 1999 (under CIS' coverage), he felt the onset of mid-back pain while restocking steel bar in an overhead rack at work. Dr. Brown limited claimant to light work and prescribed conservative treatment.

Claimant filed an aggravation claim with SAIF and a "new injury" claim with CIS. SAIF did not respond. CIS denied compensability and responsibility, but withdrew its compensability denial before hearing. (Ex. 44; Tr. 2). At hearing, the parties litigated responsibility and penalty issues.

Responsibility

The ALJ found SAIF responsible for claimant's current thoracic strain condition, under ORS 656.308(1). The ALJ reasoned that SAIF previously accepted the same condition and the 1999 injury under CIS' coverage was not the major contributing cause of claimant's need for treatment or disability for his current condition. We agree and adopt the ALJ's reasoning and conclusions on this issue, beginning with the first full paragraph on page four, with the following supplementation.

Even if claimant's 1999 symptoms were not in "exactly" the same location as his 1998 symptoms, we nonetheless find that the 1999 thoracic strain is the same thoracic strain condition that SAIF previously accepted. We further find that the medical evidence establishes that the 1998 injury, not the 1999 injury, was the major contributing cause of claimant's current strain. We reach these conclusions based on the opinions of Dr. Brown, former treating physician, Dr. Mullarky, current treating physician, and Drs. Maukonen and Smith, examining physicians.[1] (Exs. 43, 45, 47, 56B, 57, 58).

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[1] We do not find Dr. Donahoo's contrary opinion persuasive, because it is based largely on an inaccurate history that claimant's 1998 symptoms resolved. (Ex. 54-9-10). Claimant explained that he still had thoracic soreness whenever he worked, after the 1998 injury. (Tr. 7-8).

Penalties

The ALJ found that claimant perfected his aggravation claim less than 90 days before the August 2, 2000 hearing. Reasoning that SAIF's failure to accept or deny did not constitute untimely claim processing, the ALJ declined to assess a penalty on that basis. We assess a penalty, based on the following reasoning.

Under ORS 656.273(3), there are two essential elements for a "claim for aggravation:" a completed Director's aggravation form and an accompanying attending physician's report establishing by written medical evidence supported by objective findings that the claimant has suffered a worsened condition attributable to the compensable injury. *Charles L. Chittim, Jr.*, 51 Van Natta 764 (1999). When an aggravation claim is perfected, the carrier must accept or deny the claim within 90 days or risk penalty assessment for unreasonable or untimely claim processing. *See* ORS 656.262(6)(a); 656.262(11)(a).

Claimant is entitled to a penalty if the carrier "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim[.]" ORS 656.262(11)(a). The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. *International Paper Co. v. Huntley*, 106 Or App 107 (1991). If so, the carrier's conduct 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).

In this case, we find that no claim was perfected by SAIF's receipt of claimant's December 3, 1999 claim form and his nurse practitioner's chart note (of the same date) or Dr. Brown's June 7, 2000 letter. (Exs. 21-23, 57). Dr. Brown's letter is insufficient to perfect the claim because it did not "accompany" the claim form. *See Chittim*, 51 Van Natta at 765 n.2. The December 3, 1999 chart note is insufficient to perfect the claim, because it does not say that claimant had suffered a worsened condition attributable to the compensable injury. *See* ORS 656.273(1).

Claimant also argues that he filed an aggravation claim in April 2000, based on Dr. Mullarky's April 5, 2000 chart note and an accompanying claim form. (Exs. 46, 47).[2] SAIF apparently received these documents on April 12, 2000, more than 90 days before the August 2, 2000 hearing. (*See* Ex. 47-2). Therefore, the question is whether SAIF had a legitimate doubt that the chart note constituted "written medical evidence supported by objective findings that [] claimant has suffered a worsened condition attributable to the compensable injury." *See* ORS 656.273(1).

Dr. Mullarky's April 5, 2000 chart note described objective findings upon examination, stating that claimant "does have some tenderness in the midline of his back at T7-8 with paraspinal spasm" and "[s]pasm is palpable and somewhat visible." (Ex. 47). In addition, Dr. Mullarky described a "back injury which occurred one year ago in December of 1998, with exacerbation in December of 1999," followed by "constant pain in that area of his back with occasional exacerbations." (Ex. 47-1). Based on her examination and claimant's history, Dr. Mullarky ultimately assessed a "Mid thoracic strain which seems to have a history in 12/98, with aggravation in 12/99." (*Id.*).

The above-described medical report, in conjunction with the accompanying Director's aggravation claim form, satisfied the statutory requirements of ORS 656.273(1). Under such circumstances, SAIF did not have a legitimate doubt about its duty to accept or deny the claim within 90 days, upon receipt of these documents.[3] Accordingly, we conclude that SAIF's failure to timely process the claim was unreasonable and claimant is entitled to a penalty on this basis.

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[2] SAIF argues that we should not consider claimant's contention that he filed a second aggravation claim in April 2000, because it is raised for the first time on review. As a general rule, we do not consider issues that are raised for the first time on review. However, alternative legal theories may be considered for the first time on Board review if there is no prejudice to the adverse party. *See Daniel B. Covert, on recon*, 52 Van Natta 2066 (2000). Here, the issue underlying the request for a penalty at hearing was whether (or when) claimant had perfected an aggravation claim. Thus, claimant's arguments on review regarding the date of claim perfection present a new theory, not a new issue. Moreover, because the claim perfection issue was litigated at hearing, we conclude that SAIF has not been prejudiced by the new theory. *See id.*

[3] SAIF's arguments about the accuracy and completeness of Dr. Mullarky's history and the forcefulness of her assessment go the merits of the claim, not the sufficiency of SAIF's notice.

Claimant's attorney is entitled to an assessed fee for services on review 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 $1,200, 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. Finally, we have not considered claimant's counsel's services on review devoted to the penalty issue.

ORDER

The ALJ's order dated August 30, 2000 is reversed in part and affirmed in part. Claimant is awarded a penalty equal to 25 percent of the amounts due as of the date of hearing (as a result of the ALJ's order), payable by the SAIF Corporation, to be shared equally by claimant and his counsel. The remainder of the ALJ's order is affirmed. For services on review, claimant is awarded a $1,200 attorney fee, payable by SAIF.

Board Member Phillips Polich concurring.

I agree with the majority that SAIF is responsible for claimant's current thoracic condition and claimant is entitled to a penalty based on SAIF's unreasonable failure to process his aggravation claim. However, I would find that the claim was perfected, and SAIF's duty to process was triggered, long before April 12, 2000.

SAIF's conduct was clearly unreasonable and it does not escape "penalty-free." Nevertheless, I write separately to express my concern that our hypertechnical interpretation of ORS 656.273(3) unnecessarily invites unreasonable claim processing such as claimant experienced in this case.

A majority of the Board has held that an aggravation claim is not perfected under the statute unless the completed Director's aggravation claim form physically accompanies a medical report establishing a *prima facie* aggravation claim at the very moment the carrier receives them. *E.g., Charles L. Chittim, Jr.*, 51 Van Natta 764 (1999); *compare Laticia R. Tate*, 52 Van Natta 1952 (2000) (Board Member Biehl, dissenting). And the carrier is not required to process the claim until these stringent requirements are satisfied, no matter how much "noncomplying notice" it otherwise receives.

The particular circumstances of this case illustrate how the majority's interpretation of ORS 656.273(3), a "notice statute," essentially allowed SAIF to ignore claimant's aggravation claim for over a year.

Beginning in December 1999, claimant sent SAIF numerous documents, including two completed Director's aggravation claim forms--but SAIF did not accept or deny the claim before the August 2, 2000 hearing. (*See* Exs. 21, 22, 23, 46, 47, 57). SAIF was notified that claimant was filing an aggravation claim when it received the first claim form. And claimant's medical professionals (her treating nurse practitioner and physician) submitted consistent supporting reports with the first form *and* with a second form--after SAIF did nothing for over a year after receiving the first form. I would hold that the exact timing of the carrier's receipt of the "claim perfection" documentation is not determinative, when a reasonable carrier would know that a written aggravation claim was filed. When a carrier unreasonably ignores information it has, as SAIF did in this case, I would find claimant entitled to a penalty based on "amounts due" during the entire period of the unreasonable conduct. *See Jeffrey D. Dennis*, 43 Van Natta 857, 858 (1991) (the delay period is the "then" in "amounts then due" under ORS 656.262(11)(a)). Accordingly, although I agree with the majority's conclusion regarding SAIF's conduct, I write separately to highlight this unreasonable claims processing.

In the Matter of the Compensation of
STACY FRIERSON, Claimant
WCB Case No. 98-03225
ORDER ON REMAND
Hollander & Lebenbaum, Claimant Attorney
Reinisch, et al, Defense Attorney

Reviewed by Board Members Biehl, Bock, and Haynes.

This matter is before the Board on remand from the Court of Appeals. *Labor Force of Oregon v. Frierson*, 169 Or App 573 (2000). The court has reversed our prior order, *Stacy Frierson*, 51 Van Natta 331 (1999), that affirmed an Administrative Law Judge's (ALJ's) order affirming an Order on Reconsideration that awarded 9 percent (28.8 degrees) unscheduled permanent disability for a low back injury. Reasoning that the basis for our ruling regarding the application of OAR 436-035-0007(28) was unclear, the court has remanded for reconsideration.

FINDINGS OF FACT

We continue to adopt the ALJ's "Findings of Fact," but do not adopt the "Ultimate Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

We begin by briefly recounting the factual and procedural background of the case, as set forth in the court's opinion. Claimant suffered a compensable lumbar strain while lifting heavy metal tubes. He requested reconsideration and an examination by a medical arbiter after his claim was closed with no award of permanent disability. To determine the extent of claimant's impairment, the medical arbiter, Dr. Bald, performed range-of-motion measurements.[1] Dr. Bald recorded his measurements on a standardized form, listing five categories of different movements. In each category, the form asked "[a]re measurements within +/10 [percent] or five [degrees] (whichever is greater)" and provided a box for the arbiter to check "yes" or "no."

On two of the five categories, Dr. Bald checked "no." These pertained to lumbar flexion and lumbar left lateral flexion. (Ex. 19-6). On three of the five categories, Dr. Bald checked "yes" (these categories were lumbar extension, passive straight leg raising and lumbar right lateral flexion). He left one subcategory (the "straight leg raising validity check") blank.

As part of his report, Dr. Bald also answered specific questions. The fifth question stated: "If any findings are considered invalid, provide rationale and detailed reasoning in accordance with Bulletin 239 and the AMA Guides[.]" (Ex. 19-7). Dr. Bald responded: "Today's findings are fraught with significant inconsistencies. However, I do feel that they are a reasonable description of the claimant's current level of function." (Ex. 19-4). Based on Dr. Bald's report, an Order on Reconsideration awarded claimant 9 percent unscheduled permanent disability. (Ex. 20).

The employer requested a hearing. Relying on OAR 436-035-0007(28), the employer argued that Dr. Bald's findings were invalid because they did not satisfy the AMA criteria. The ALJ disagreed, reasoning that Dr. Bald was aware of significant inconsistencies regarding claimant's range of motion findings. In particular, the ALJ noted that, after performing three separate measurements for lumbar extension and five separate measurements for lumbar flexion, and after a comprehensive examination of claimant and preparation of a thorough medical arbiter evaluation report, Dr. Bald had concluded that his range of motion findings were a reasonable description of claimant's current level of function (permanent impairment). Thus, the ALJ concluded the range of motion findings were valid and supported claimant's permanent disability award. The employer requested Board review.

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[1] The Workers' Compensation Division describes the relevant validity criterion for those measurements:

"The AMA's Guides state that 'Reproducibility of abnormal motion is currently the only known criterion for validating optimum effort. The examiner must take at least three consecutive measurements of mobility which must fall within plus or minus ten percent or five degrees (whichever is greater) of each other to be considered consistent.'" Workers' Compensation Division Bulletin No. 242 (Feb. 1, 1995).

We adopted and affirmed the ALJ's opinion and affirmed. *Stacy Frierson*, 51 Van Natta at 331 (Board Member Moller dissenting). The employer requested judicial review.

Before the court, the employer argued that we incorrectly applied OAR 436-035-0007(28).[2] The court noted that it had held, under a former version of this rule, that findings of impairment that do not meet AMA validity criteria may not be used to rate a claimant's impairment. *See Roseburg Forest Products v. Clemons*, 169 Or App 231, 240 (2000) (interpreting *former* OAR 436-035-0007(27) (1996), renumbered as OAR 436-035-0007(28) (1998). The court further noted that, under the amended rule, we potentially had to resolve two issues in this case. The first issue was whether Dr. Bald's findings of impairment satisfied the AMA criteria. If they did not, the second was whether Dr. Bald's explanation met the standard stated in OAR 436-035-0007(28). That is, whether Dr. Bald's statement--"I do feel that [the findings] are a reasonable description of the claimant's current level of function"-- constituted a "written rationale, based on sound medical principles, explaining why the findings are valid."

The court stated that the ALJ's opinion, which we had adopted, did not specifically address either issue. Before it could address the employer's arguments that we had failed to apply the administrative rule properly, the court noted that it must be able to ascertain the basis of our ruling. Because it could not, the court reversed and remanded for further proceedings, citing *SAIF v. Brown*, 159 Or App 440 (1999), and *Armstrong v. Asten-Hill Co.*, 90 Or App 200 (1988).

In accordance with the court's opinion, we first examine whether Dr. Bald's impairment findings satisfy AMA criteria. We find that the measurements for lumbar extension and lumbar right lateral flexion did satisfy AMA validity criteria, while the measurements for lumbar flexion and lumbar left lateral flexion did not. (Ex. 19-6). The left and right lateral flexion measurements are not of any consequence since the measurements do not result in permanent impairment under the standards, regardless of whether they satisfy AMA criteria. *Id.* However, the lumbar extension and lumbar flexion measurements would qualify for permanent impairment, assuming they were valid. Since the lumbar extension measurements meet AMA validity criteria, we find that this impairment finding (22 degrees) establishes that claimant has permanent impairment due to the compensable injury.[3]

On the other hand, the lumbar flexion measurements do not meet AMA validity criteria because the measurements were not within plus or minus ten percent or five degrees of each other. (Ex. 19-6). Because of this, we must determine whether Dr. Bald's statement that his findings were a reasonable description of claimant's current level of function constitutes a "written rationale, based on sound medical principles, explaining why the findings are valid."

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[2] That rule provides:

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

[3] We acknowledge Dr. Bald's statement that claimant's findings were "fraught with significant inconsistencies." This leads to the question of whether the lumbar extension measurements can be considered. *See Luzviminda P. Anonuevo*, 52 Van Natta 1656 (2000) (physician's range of motion findings that were within validity criteria not used to rate the claimant's permanent impairment because the physician provided a written opinion based on sound medical principles explaining why the impairment findings were invalid). Having reviewed Dr. Bald's report, we conclude that Dr. Bald was not referring to his lumbar extension findings because those findings satisfied the AMA validity criteria. Instead, we interpret Dr. Bald's "fraught with inconsistencies" comment as being directed to the findings that did not satisfy the AMA validity criteria. Because there is no written opinion explaining why the lumbar extension measurements were invalid, we consider them in rating the extent of claimant's permanent impairment.

Having considered Dr. Bald's statement, we conclude that it does not constitute a written rationale "based on sound medical principles" explaining why the lumbar flexion findings are valid. Instead, we find that this comment is conclusory and does not sufficiently explain why the lumbar flexion measurements should be considered valid, particularly in light of Dr. Bald's previous statement that claimant's findings were "fraught with significant inconsistencies."[4]

Accordingly, we find that claimant is entitled to impairment of 1.2 percent for reduced range of lumbar extension under OAR 436-035-0360(20), which would be rounded to 1 percent. No party disputes the reconsideration order's finding that the value for claimant's social and vocational factors is 4. Therefore, when this value is added to the impairment value (1), claimant's unscheduled permanent disability is 5 percent.

Therefore, on reconsideration of, and in lieu of, our prior order, the ALJ's order is modified. In lieu of the ALJ's and the Order on Reconsideration's award of 9 percent (28.8 degrees) unscheduled permanent disability, claimant is awarded 5 percent (16 degrees) unscheduled permanent disability. Because we have reduced claimant's award of permanent disability as a result of the employer's request for hearing, we also reverse the ALJ's attorney fee award pursuant to ORS 656.382(2).[5]

IT IS SO ORDERED

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[4] We have recently addressed similar issues in two cases. In *Leland J. Wilson*, 52 Van Natta 1963 (2000), we agreed with an ALJ that the reasons set forth by an arbiter constituted a written rationale, based on sound medical principles, explaining why impairment findings were valid. Specifically, the arbiter reported that, while the claimant had failed a validity check by only two degrees, the claimant had given good effort with all muscle testing and had been very cooperative during the examination.

In *Luzviminda P. Anonuevo*, a physician expressly indicated his range of motion findings were not valid for impairment rating purposes, based on the discrepancy between the claimant's active and passive ranges of motion as well as her diffuse giveway in musculature in the upper extremity not involved in her impingement problems. Because the physician had provided a written opinion based upon sound medical principles explaining why his impairment findings were invalid, we concluded that those findings could not be used to rate the claimant's impairment. 52 Van Natta at 1656. In contrast to both those cases, Dr. Bald's opinion in this case is conclusory and, therefore, not based on "sound medical principles."

[5] Our prior assessed attorney fee awarded under ORS 656.382(2) is also eliminated.

Board Member Haynes dissenting in part.

The majority finds that measurements for lumbar right and left lateral flexion do not result in impairment, whether or not they meet AMA validity criteria. The majority also concludes that lumbar flexion measurements do not meet AMA validity criteria and, because Dr. Bald did not provide a "written rationale, based on sound medical principles, explaining why the findings are valid," claimant is not entitled to impairment for these measurements. Finally, the majority finds that lumbar extension measurements satisfy AMA validity criteria and awards claimant 1 percent impairment for reduced lumbar extension.

I disagree only with the last finding. The majority acknowledges Dr. Bald's statement that claimant's impairment findings were "fraught with significant consistencies" but decides that Dr. Bald was referring only to those measurements that did not meet AMA validity criteria. Finding "no written opinion explaining why the lumbar extension measurements were invalid," the majority concludes that they should be used to rate impairment.

When Dr. Bald indicated that claimant had "significant inconsistencies," he was answering the following question: "If any findings are considered invalid, provide rationale and detailed reasoning in accordance with Bulletin 239 and the AMA Guides; include anatomic findings if applicable." Dr. Bald's complete response was: "Today's findings are fraught with significant inconsistencies. However, I do feel that they are a reasonable description of claimant's current level of function." (Ex. 19-4).

I find Dr. Bald's response to be ambiguous and difficult to interpret. By indicating that claimant's findings were "fraught with significant inconsistencies," Dr. Bald suggests that he considered

them invalid.[1] Dr. Bald, however, does not "provide [a] rationale and detailed reasoning in accordance with Bulletin 239 and the AMA Guides" to explain why they are invalid, stating only that they are "a reasonable description of claimant's current level of function."

It is claimant's burden to prove entitlement to impairment. *See* ORS 656.266. Claimant's attending physician reported that claimant had no

> "permanent impairment as a result of this incident. On the April 3, 1997 visit, I was unable to find any objective limitations in strength or range of motion, and I was unable to elicit any neurological deficit. Although [claimant] consistently reports only 1-2 hours of relief following treatment, he is able to climb up and down a steep embankment to his favorite fishing hole and he reports playing basketball, although not as long a he usually does." (Ex. 12-2).

In light of Dr. Bald's indication that findings were "fraught with significant inconsistencies," I do not find that his report is sufficiently persuasive to establish a different level of impairment from that of the attending physician. In sum, based on the attending physician's opinion that claimant has no impairment from the compensable injury and the defects in Dr. Bald's report, I would conclude that claimant did not carry his burden of proving any permanent disability.

Because the majority comes to a different conclusion, I dissent from that portion of its opinion.

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[1] Although ambiguous, I was not persuaded by the majority's interpretation of Dr. Bald's response as discussing only those findings that did not satisfy AMA validity criteria. Dr. Bald universally referred to "findings" without giving any indication that he was distinguishing between any of his measurements.

In the Matter of the Compensation of
VERNON L. MIKESELL, Claimant
WCB Case No. 00-03573
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorney
Bottini, Bottini & Oswald, Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the insurer's denial of his low back injury claim. On review, the issue is compensability.

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

The ALJ upheld the insurer's denial. In doing so, the ALJ reasoned that claimant had failed to sustain his burden of proving the compensability of a "combined condition" consisting of preexisting degenerative disc disease and work activity on November 27, 1999 that resulted in a herniated lumbar disc. *See* ORS 656.005(7)(a)(B). We agree with the ALJ's assessment of the medical evidence and his reasoning on the compensability issue.

On review, claimant contends, however, that the medical opinions on whom the insurer relied (Drs. Schilperoort, Fuller and Dickerman) addressed the major contributing cause of the herniated disc, but not the major contributing cause of the disability or need for treatment for the "combined condition." *See SAIF v. Nehl*, 148 Or App 101 *on recon* 149 Or App 309 (1997). Thus, claimant contends that the physicians who support compensability are more persuasive because they spoke to that issue. We disagree.

The medical evidence establishes that the disc herniation at L4-5 was the cause of the disability or need for treatment. Thus, we conclude that the major contributing cause of the disc herniation would necessarily be the major contributing cause of the disability or need for treatment of the "combined

condition," *i.e.*, the disc herniation. Thus, we are not persuaded that the major contributing cause of the need for treatment in this case is different from the major cause of the disc herniation. *See Robinson v. SAIF*, 147 Or App 157, 162 (1997). Because of this, we do not discount the persuasiveness of Drs. Schilperoort, Fuller and Dickerman on the basis of claimant's Nehl argument.

Alternatively, claimant contends that his low back condition is compensable as an occupational disease. We are not inclined to address this issue because it was raised for the first time on review. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247, 252 (1991). However, even if we did address the issue, we would find that claimant failed to prove a compensable occupational disease.

The medical evidence does not establish that claimant's work activities were the major contributing cause of his herniated disc or of his degenerative disc disease. *See* ORS 656.802(2)(a). In addition, if claimant's occupational disease claim is based on the worsening of preexisting degenerative disease, the medical evidence does not show that work activities were the major contributing cause of the "combined condition" and of a pathological worsening of the preexisting disease or condition. *See* ORS 656.802(2)(b).

Accordingly, we find that claimant has failed to prove compensability under either an injury or occupational disease theory. Thus, we affirm.

ORDER

The ALJ's order dated August 31, 2000, as republished on September 28, 2000, is affirmed.

January 30, 2001 Cite as 53 Van Natta 128 (2001)

In the Matter of the Compensation of
BETTY J. MOEN, Claimant
Own Motion No. 00-0365M
OWN MOTION ORDER
Scott M. McNutt, Sr., Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for claimant's back condition. Claimant's aggravation rights have expired. The insurer opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force.

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

On January 4, 2000, claimant underwent low back surgery. Thus, we conclude that claimant's compensable condition worsened requiring 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,[1] the "date of disability" is the date she is hospitalized due to a worsening of her

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[1] The Board in its Own Motion jurisdiction can only authorize temporary disability from the time of surgery or hospitalization. *See* ORS 656.278(1)(a).

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 she was in the work force is the time prior to her January 4, 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).

The insurer contends that claimant was not in the work force at the time of the current disability. In response to the insurer's contentions, claimant has submitted her January 8, 2001 affidavit, with attachments.

Claimant contends that she satisfies the third *Dawkins* criterion. As explained above, in order to satisfy that criterion, claimant must establish both that: (1) although not working, she is willing to work; and (2) she is not seeking work because her work-related injury has made any reasonable work search efforts futile. *Dawkins*, 308 Or at 258.

Based on claimant's January 4, 2001 affidavit, we find that she is willing to seek employment. Specifically, claimant attested that she has not returned to work, but that "when I am physically able I am interested in doing so."

Claimant also asserted that she would "still be in the work force," but for her compensable work-related injury. However, in order to prove that she is a member of the work force, claimant must also satisfy the "futility" factor of the third *Dawkins* criterion. Based on the following reasoning, we are not satisfied that the "futility" factor has been satisfied.

In April 1998, Dr. Boye, claimant's attending physician, reported that claimant had been advised that she could not work, but that she had gone to work against his advice. Noting that her worsened pain had convinced claimant that she could not continue to work, Dr. Boye concluded that she should be "on absolute light duty and off her feet for a significant amount of time each day in the next few weeks." Because Dr. Boye specified that claimant's work restrictions were limited to a "few weeks," we conclude that these restrictions were temporary in nature.

Dr. Boye further recommended referral to "her medical doctor and consider[ation of] getting an MRI scan and possible neurological evaluation." The record before us does not demonstrate that claimant sought further medical treatment as recommended by Dr. Boye.

As explained above, the relevant time period for the purpose of determining whether claimant was in the work force is the time prior to her January 2000 hospitalization. Dr. Boye's April 1998 chart notes (prepared some 20 months before claimant's January 2000 surgery) do not address claimant's ability to work and/or seek work at the relevant time, *i.e.* the time prior to the January 2000 surgery.

Further, claimant submits a January 4, 2000 report from Dr. Bert, her attending surgeon. Although Dr. Bert indicates that claimant has had "episodes" where she had been off work due to the "significance of her pain" over the years since her 1993 injury, he does not address claimant's ability to work and/or seek work prior to the January 2000 surgery.

In conclusion, the record does not establish that, at the time of her January 2000 surgery, it would have been futile for claimant to seek work due to her compensable condition. Consequently, the "futility" standard of the third Dawkins criterion has not been satisfied. Therefore, we conclude that claimant was not in the work force at the time of the January 2000 worsening of her compensable condition.

Accordingly, claimant's request for temporary disability compensation is denied. Claimant's entitlement to medical expenses pursuant to ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
SANDRA R. WALLWORK, Claimant
WCB Case No. 00-02013
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorney
Cummins, Goodman, et al, Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's consequential condition claim for wrist and elbow conditions. On review, the issue is compensability.

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

The ALJ set aside the insurer's denial based on the opinion of claimant's treating physician, Dr. Puziss. On review, the insurer contends that the ALJ overlooked or misinterpreted certain evidence. We disagree. Claimant contends that she developed carpal tunnel syndrome and cubital tunnel syndrome conditions as a consequence of her compensable right shoulder injury. Claimant must therefore prove that her compensable injury is the major contributing cause of her consequential conditions. ORS 656.005(7)(a)(A); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992).

The relation of claimant's carpal tunnel and cubital tunnel conditions to her compensable shoulder condition 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 rely on the opinion of claimant's treating physician. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find no persuasive reasons not to defer to claimant's treating physician and surgeon, Dr. Puziss.

The insurer first contends that the ALJ improperly disregarded the opinion of Dr. Scheinberg, who examined claimant at the request of the insurer. While conducting an examination primarily directed at claimant's right shoulder, Dr. Scheinberg noted that "In addition [claimant] may well have some nonwork-related mild right-sided carpal tunnel syndrome." (Ex. 23-5). The ALJ did not expressly consider Dr. Scheinberg's opinion. However, we find that Dr. Scheinberg's opinion is entirely conclusory, and therefore unpersuasive. *Blakely v. SAIF*, 89 Or App 653, *rev den* 305 Or 972 (1988); *Paul R. Grasham*, 52 Van Natta 385 (2000).

Next, the insurer contends that the ALJ failed to consider the opinion of Dr. Long, who examined claimant once at the request of Dr. Puziss and performed nerve conduction studies. (Ex. 65). The insurer notes that Dr. Long felt that claimant's "peripheral nerve lesions" preexisted her June 3, 1998 compensable injury. (Ex. 65-4). However, Dr. Long also diagnosed "Work injury, June 3, 1998, with right shoulder derangement, intermittent right median and ulnar nerve lesions, secondarily symptomatic." (*Id.*) The most reasonable inference from that statement is that claimant's nerve lesions are symptomatic due to the compensable injury. Magic words are not necessary to sustain a statutory burden of proof. *McClendon v. Nabisco*, 77 Or App 412 (1986). In any event, even if Dr. Long's opinion is considered to be non-supportive of claimant's consequential condition claim, we do not find it sufficiently compelling to overcome the persuasive opinion presented by Dr. Puziss.

Finally, the insurer contends that Dr. Puziss' opinion is inconsistent regarding claimant's May 1999 non-work injury catching her child. We disagree. Dr. Puziss acknowledged that the May 1999 injury may have had a significant contribution to claimant's cubital tunnel condition, and materially worsened her underlying condition. (Ex. 88-32, -45). However, ultimately Dr. Puziss stated that, even considering the "child grabbing" incident, claimant's compensable injury remained the major contributing cause of her conditions.[1] (Ex. 88-46).

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[1] Accordingly, we do not adopt the ALJ's conclusion that Dr. Puziss believed claimant's compensable injury to be the "sole cause" of her conditions. (O&O at 3). Nevertheless, we are satisfied that Dr. Puziss considered both claimant's preexisting nerve lesions and her May 1999 non-work injury in reaching his opinion on causation. (Ex. 88-30, -46). *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 321 Or 416 (1995) (in determining the major contributing cause of a condition, persuasive medical opinion must evaluate the relative contribution of different causes and explain why work injury or exposure contributes more to the claimed condition than all other causes or exposures combined).

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 insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and claimant's attorney's uncontested attorney fee request), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated September 6, 2000 is affirmed. For services on review, claimant's attorney is awarded $2,000, payable by the insurer.

January 30, 2001 Cite as 53 Van Natta 131 (2001)

In the Matter of the Compensation of
CHARLES G. SAYLER, Claimant
WCB Case Nos. 00-03893 & 00-01299
ORDER ON REVIEW
Brownstein, Rask, et al, Claimant Attorney
Julie Masters (Saif), Defense Attorney
Meyers, Radler, et al, Defense Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) upheld the SAIF Corporation's denial of his claimant for a left knee condition; and (2) upheld Argonaut Insurance Company's denial of the same condition. On review, the issues are compensability and responsibility.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated August 23, 2000 is affirmed.

Board Member Phillips Polich dissenting.

The majority affirms the ALJ's conclusion that claimant failed to establish that his left knee condition is compensable. Because I believe that the persuasive medical record establishes a sufficient causal relationship, I respectfully dissent.

Claimant testified that on August 2, 1999, his left boot caught in a grating causing him to twist his left knee and fall onto his right knee. (Tr. 14). Although he experienced left knee pain at that time, the back pain that claimant experienced was more significant. (*Id.*). Dr. Weirich, M. D., who performed the left knee surgery, indicated that it was medically probable that claimant most likely tore the lateral meniscus during the August 2, 1999 work incident. (Ex. 44A). In his deposition, Dr. Weirich reiterated that it was probable that claimant had a meniscus tear as a result of the August 2, 1999 work incident that eventually required surgery. (Ex. 47-10). Dr. Weirich further indicated that the mechanism of the August 2, 1999 work incident was of the type that would cause a meniscus tear. (Ex. 47-11).

Although Dr. Weirich does not specifically quantify his opinion in terms of "major cause," it is clear from the context of his opinions that Dr. Weirich believed that claimant suffered the torn meniscus as a result of the August 2, 1999 work incident. This is sufficient to carry claimant's burden of proof. *See Worldmark the Club v. Travis*, 161 Or App 644 (1999); *SAIF v. Strubel*, 161 Or App 516 (1999). Because Dr. Wierich treated claimant and performed the left knee surgery, he is in a better position to offer an opinion on causation. *See Argonaut Ins. Co. v. Mageske*, 93 Or App 698, 702 (1988).

For these reasons, I would find that claimant has established that the August 2, 1999 work incident was the major contributing cause of the left knee meniscus tear. Therefore, I would reverse the ALJ's order to the extent that it upholds the SAIF Corporation's denial.

In the Matter of the Compensation of
CALVIN A. KAEO, Claimant
WCB Case No. 00-03730
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
Julie Masters (Saif), Defense Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) Fitzwater's order that: (1) upheld the SAIF Corporation's denial of his current combined condition; and (2) declined to assess penalties for an allegedly unreasonable denial. On review, the issues are compensability and penalties.

We adopt and affirm the ALJ's order with the following supplementation. A prior ALJ found that claimant's December 1997 injury, as opposed to his preexisting degenerative disc disease, was the major contributing cause of the need for treatment of the combined low back condition and set aside SAIF's March 1998 denial. The Board affirmed the prior ALJ's order.

In March 1999, SAIF accepted "lumbar strain/sprain." In January 2000, SAIF issued a modified notice of acceptance indicating that claimant's lumbar sprain/strain injury combined with claimant's "preexisting S1 left compression secondary to lateral recess stenosis at the L5-S1 level." On April 26, 2000, SAIF denied claimant's current combined condition on the grounds that the compensable injury was no longer the major contributing cause of the current condition. Claimant requested a hearing and the ALJ upheld the denial on the merits after finding that the denial was not procedurally invalid.

Claimant continues to argue on review that SAIF's denial of his current combined condition is procedurally invalid and that SAIF was required to instead issue a partial denial. Claimant does not cite any direct authority in support of his argument that SAIF's current combined condition denial is procedurally invalid and we are aware of none.

ORS 656.262(6)(c) allows an insurer or self-insured employer which has accepted a combined condition to deny the condition if the otherwise compensable injury ceases to be the major contributing cause of the combined condition. The preponderance of the evidence in this record supports a conclusion that claimant's compensable injury combined with his preexisting condition and that the injury is no longer the major contributing cause of the condition. Moreover, we agree with the ALJ's reasoning that the denial is of the entire current combined condition and is therefore not a partial denial. Under such circumstances, we reject claimant's argument regarding the procedural validity of the denial.

Regarding the merits, claimant argues that SAIF failed to "recite the actual modified acceptance in the information" given to Dr. White, an examining physician. (App. Br. at 4). We interpret claimant's argument to be that Dr. White did not understand what the accepted "combined condition" was and that consequently, his opinion regarding the major contributing cause of that condition is unpersuasive. As the ALJ noted, however, there is no persuasive evidence that the compensable injury remains the major contributing cause of the disability or need for treatment of the current condition. In reaching this conclusion, the ALJ found the opinion of the only physician supporting compensability, Dr. Van Pett, unpersuasive. Thus, even assuming that Dr. White's opinion is also unpersuasive, claimant still has not met his burden of proof to establish compensability.

ORDER

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

Board Member Phillips Polich dissenting.

Claimant argues that the carrier's denial should be treated as a partial denial because claimant was awarded permanent disability and the permanent disability remained a compensable part of the claim. On this basis, claimant argues that the denial is procedurally invalid, because it does not comply with the administrative rule regarding partial denials, OAR 438-005-0065. That rule requires that the denial shall set forth with particularity the injury, condition, benefit or service for which liability is denied and the factual and legal reasons therefor. In essence, claimant argues that any subsequent combined condition denial is invalid because permanent disability is attributable to the compensable condition. Because I agree with claimant's arguments and would find the denial to be procedurally invalid, I dissent from the majority's opinion.

In the Matter of the Compensation of
DARCIE A. HOWARD, Claimant
WCB Case No. 00-03873
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that affirmed an Order on Reconsideration that did not award any unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability.

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

Claimant argues that the ALJ erred by relying on the findings from the medical arbiter panel in determining her impairment. Claimant contends that the arbiter panel failed to provide a valid explanation as to why her lumbar range of motion measurements were invalid.

Claimant has an accepted lumbar strain resulting from her August 19, 1998 injury. (Exs. 9, 10). 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).

Although claimant relies on the opinion of her attending physician, Dr. Karasek, we find that his opinion is inconsistent and unpersuasive. Claimant contends that Dr. Karasek ratified the November 29, 1999 range of motion findings provided by physical therapist Rider.

On November 29, 1999, Ms. Rider, PT, reported that claimant's lumbar extension was 13 degrees, lumbar extension was 42 degrees, and left/right lateral flexion were 20 degrees. (Ex. 49-3). That document was not signed by Dr. Karasek. In a January 8, 2000 concurrence letter from SAIF, however, Dr. Karasek was asked the following question:

> "In your October 4, 1999 chart note you stated [claimant] has normal range of motion. Based on the Oregon Standards for rating impairment the range of motion findings in the November 29, 1999 evaluation by Janice Rider, P.T. these would not be considered normal for the general population. Do you consider these findings to represent the 'normal' for this individual with no loss as a result of the accepted lumbar strain?" (Ex. 53).

Dr. Karasek responded by checking the "no" box. (*Id.*) He indicated that claimant's impairment was related 60 percent to the lumbar strain and 40 percent to other factors. (*Id.*)

Even if we assume, without deciding, that Dr. Karasek "ratified" Ms. Rider's November 29, 1999 range of motion findings, we find that his conclusory and unexplained answer of "no" in the January 8, 2000 letter is not persuasive because it is inconsistent with his October 1999 reports. On October 4, 1999, Dr. Karasek reported that claimant had normal range of motion. (Ex. 44). He diagnosed: "[p]ainful ligamentous strain in the back? I am unable to clearly identify a pain generator." (*Id.*) On October 8, 1999, Dr. Karasek wrote to SAIF, stating that claimant had "persistent back pain which she finds moderate and somewhat limiting." (Ex. 46). He explained:

> "She does not have objective findings other than chronic pain with reported tenderness over the paraspinous musculature of the lumbar spine.
>
> "I do not believe that this patient's back pain is diagnosable at this time. My feeling is that she should have an evaluation by Injured Workers Program for work hardening and return to work. This evaluation should be prompt." (*Id.*)

We find that Dr. Karasek's agreement that Ms. Rider's measurements were not "normal" for claimant is inconsistent with his own findings, one month before, that claimant had normal range of motion and he was unable to identify a pain generator. (Ex. 44). Furthermore, Dr. Karasek reported on October 8, 1999 that claimant did not have objective findings other than chronic pain. (Ex. 46). In addition, we find that Dr. Karasek's January 8, 2000 characterization of claimant's impairment as 60 percent related to the lumbar strain is inconsistent with his October 8, 1999 statement that claimant's back pain was not "diagnosable at this time." (Exs. 46, 53). Because Dr. Karasek did not explain his change of opinion, his opinion is entitled to little weight.

For the following reasons, we find that the medical arbiter panel provided the most thorough, complete and well-reasoned evaluation of claimant's impairment. In addition, because the arbiter panel's April 26, 2000 exam was performed much closer in time to the May 15, 2000 Order on Reconsideration than Dr. Karasek's January 8, 2000 report, we find that the medical arbiter panel's report is more persuasive. *See, e.g., Kelly J. Zanni*, 50 Van Natta 1188 (1998).

The medical arbiter panel (Drs. Denekas, Tiley and Vessely) reported claimant's lumbar ranges of motion as follows: lumbar flexion 55 degrees, lumbar extension 15 degrees, right lateral flexion 20 degrees, left lateral flexion 22 degrees. (Ex. 55-4). They found that the straight leg raising validity check was invalid. (*Id.*) The panel explained that claimant had no objective findings associated with the accepted condition. (Ex. 55-5). They noted that two MRIs, a bone scan and discograms had been "completely normal" and a CT scan performed after a discogram was negative. (*Id.*) In response to a question regarding validity of the findings, the arbiter panel explained:

> "Even though the ranges of motion do not come up to the normal guidelines, we feel that these are normal for [claimant] and that there is no valid loss of motion in the lumbar spine from the accepted condition. It is to be noted that all objective examinations in this case are negative. Also, her ranges of motion have varied by different examiners and the straight leg raising did not validate the lumbar spine motion. We feel that [claimant] does not have any valid loss of motion from the accepted condition of lumbar strain." (Ex. 55-6).

OAR 436-035-0007(28) (WCD. Admin Order No. 98-055) provides:

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

In *Labor Force of Oregon v. Frierson*, 169 Or App 573 (2000), the court interpreted OAR 436-035-0007(28) and found that the Board potentially had to resolve two issues. The first issue was whether the physician's findings of impairment satisfied the AMA criteria. *Id.* at 577. If they did not, the second was whether the explanation given by a physician met the standard stated in OAR 436-035-0007(28), *i.e.*, whether it constituted a "written rationale, based on sound medical principles, explaining why the findings are valid." *Id.*

Here, the medical arbiter panel specifically found the straight leg raising validity check was invalid. (Ex. 55-4). In the worksheet attached to the report, they indicated that claimant's range of motion finding for lumbar flexion was invalid. (Ex. 55-8). OAR 436-035-0007(28) provides that when findings are determined invalid, they shall receive a value of zero. We conclude that claimant is not entitled to a rating for lumbar flexion.

The medical arbiter panel found that, although claimant's lumbar range of motion findings did not meet the normal guidelines, the findings were "normal for [claimant] and that there is no valid loss of motion in the lumbar spine from the accepted condition." (Ex. 55-6). In reaching that conclusion, the panel explained that "all objective examinations in this case are negative." (*Id.*) Earlier in their report, they explained that claimant had no objective findings associated with the accepted condition. (Ex. 55-5). They said that claimant's two MRIs, a bone scan and discograms had been completely normal and a CT scan performed after a discogram was negative. (*Id.*) They also noted that claimant had been diagnosed with fibromyalgia. (Ex. 55-3). In finding that claimant's ranges of motion were invalid, the panel also explained that claimant's ranges of motion had varied by different examiners and the straight leg raising did not validate the lumbar spine motion. (Ex. 55-6). They concluded that claimant did not have any valid loss of motion from the accepted condition of lumbar strain. (*Id.*)

We find that the medical arbiter panel provided a persuasive written opinion, based on sound medical principles, explaining why claimant's lumbar range of motion findings were invalid. *See* OAR 436-035-0007(28). Based on the panel's conclusion that claimant's range of motion findings were "normal" for her, we find that they did not relate her restricted lumbar range of motion to the compensable injury. *See Beverly B. Stigall*, 52 Van Natta 1892 (2000) (medical arbiter characterized range of motion as "normal for this person"); *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). Based on the medical arbiter panel's report, claimant has no impairment related to the accepted lumbar strain.

Finally, claimant argues that, based on its January 24, 2000 Notice of Closure that awarded 9 percent unscheduled permanent disability, SAIF may not now allege that she has no impairment. Claimant argues that SAIF's Notice of Closure acted much like an official or judicial admission. We note that claimant requested reconsideration from the Notice of Closure and claimant requested a hearing regarding the May 15, 2000 Order on Reconsideration that awarded no permanent disability. Claimant is also the party who requested a hearing and Board review. Thus, based on the procedural posture of this case, claimant has the burden of establishing error. *See Callow v. Marvin Wood Products*, 171 Or App 175 (2000) (party seeking affirmative relief on appeal or review must identify an error in the decision and must do so persuasively). In any event, we need not specifically address claimant's argument because, even if we completely disregarded SAIF's arguments at hearing or its brief on review, the problem for claimant is that the medical evidence is insufficient to establish that she is entitled to an award for unscheduled permanent disability.[1] We therefore affirm the ALJ's order.

ORDER

The ALJ's order dated October 11, 2000 is affirmed.

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[1] We note that because the Order on Reconsideration reduced claimant's unscheduled permanent disability award as granted by the Notice of Closure, SAIF can defend that order. *See Guilebaldo G. Ramirez*, 50 Van Natta 654, *on recon* 50 Van Natta 863 (1998); *Kathleen S. Schultz*, 48 Van Natta 2518 (1996).

In the Matter of the Compensation of
MILAN P. SHUBERT, Claimant
WCB Case No. 94-08858
SECOND ORDER ON REMAND (REMANDING)
Preston, Bunnell, et al, Claimant Attorney
Julene M. Quinn (Saif), Defense Attorney

On October 31, 2000, we issued an Order on Remand that remanded claimant's "temporary rule" request to the Director for further proceedings consistent with the Supreme Court's decision in *Shubert v. Blue Chips*, 330 Or 554 (2000). In that case, the court had held that the Director must promulgate a temporary rule that addressed claimant's particular impairment. On January 12, 2001, the Director adopted a temporary rule.

We have previously determined that, when remanding to the Director for the adoption of a temporary rule, it is likewise appropriate to remand the case to the Hearings Division. *See Stanley M. Shaw*, 51 Van Natta 2020 (1999), *on recon* 52 Van Natta 75 (2000) (Board remanded case to the Hearings Division to hold in abeyance awaiting Director action regarding promulgation of a temporary rule). In this way, the litigants will be able to present their respective arguments regarding the extent of a claimant's permanent disability to an Administrative Law Judge (ALJ) once the Director completes the "temporary rule" review. Thereafter, any party dissatisfied with the ALJ's order may request Board review. This procedure is consistent with a policy of attempting to resolve disputes at the lowest possible appellate level when possible.

Here, in remanding this matter to the Director for promulgation of a temporary rule, our October 31, 2000 order neglected to also remand the case to the ALJ to await the Director's action regarding the temporary rule. Nonetheless, because our prior order neither finally fixed the amount of, or claimant's entitlement to, compensation, it is not a final order. *Scott D. Dorry*, 52 Van Natta 2178 (2000); *Merry E. Franklin*, 46 Van Natta 1637 (1994). In light of such circumstances, we retain authority to reconsider our October 31, 2000 decision.

Therefore, on reconsideration of our October 31, 2000 order, we supplement our decision to remand this case to ALJ Lipton. The parties are directed to notify ALJ Lipton of their respective positions concerning the effect of the Director's temporary rule. ALJ Lipton shall then conduct further proceedings in any manner that the ALJ deems will achieve substantial justice. Thereafter, the assigned ALJ shall proceed to resolve the remaining issues and issue a final, appealable order.

Accordingly, as supplemented herein, our October 31, 2000 order is republished.

IT IS SO ORDERED.

February 2, 2001 Cite as 53 Van Natta 136 (2001)

In the Matter of the Compensation of
KENNETH W. STOCKAMP, Claimant
WCB Case No. 99-08454
ORDER ON RECONSIDERATION
VavRosky, et al, Defense Attorney

Claimant, *pro se*, has requested reconsideration of our January 4, 2001 order that adopted the Administrative Law Judge's order upholding the self-insured employer's denial of claimant's occupational disease claim for an upper respiratory and gastrointestinal condition.[1]

In his request for reconsideration, claimant states that he was referred to an occupational specialist who did not help him. Claimant's letter then refers to Dr. Green. It is unclear whether claimant is seeking remand for additional evidence from Dr. Green or is seeking reconsideration of Exhibit 117 which is a report from Dr. Green's office indicating that spores were found in a sample.

Assuming that claimant's request is a motion for remand, we deny the motion for the following reasons. Our review is limited to the record developed at hearing. ORS 656.295(5). We may only remand to the ALJ should we find that the hearing record has been "improperly, incompletely or otherwise insufficiently developed." *Id.* Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

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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 1-800-927- 1271 (V/TTY) (within the State of Oregon), or write to:

WORKERS' COMPENSATION OMBUDSMAN
350 WINTER ST NE, ROOM 160
SALEM OR 97301-3878

Here, there has been no showing that additional evidence from Dr. Green was unobtainable with due diligence at the time of the hearing or that the evidence would be reasonably likely to affect the outcome of the case.

It is possible that claimant is requesting that we reconsider our decision based on Exhibit 117, a lab report from Dr. Green's office that indicates that mold from claimant's place of employment was capable of causing symptoms. The report, however, does not state that claimant's symptoms were probably caused by the molds. Claimant has the burden to compensability of his occupational disease claim by a preponderance of the evidence. ORS 656.266. He must prove that his work activities are the major contributing cause of the disease. ORS 656.802(2)(a). Because causation of claimant's condition presents a complex medical question, expert medical opinion is necessary to establish causation. *See Uris v. Compensation Department*, 247 Or 420 (1967). Claimant must prove to a reasonable medical probability that his work activities caused his disease. *See, e.g., Gormley v. SAIF*, 52 Or App 1055 (1981) (a possibility of a causal relationship is insufficient to meet a claimant's burden of proof).

As the ALJ noted, at most the lab report from Dr. Green's office suggests a possibility that the molds contributed to claimant's symptoms. Thus, the lab report is insufficient to meet claimant's burden of proof.

Our January 4, 2001 order is withdrawn. On reconsideration, as supplemented herein, we republish our January 4, 2001 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

February 5, 2001 Cite as 53 Van Natta 137 (2001)

In the Matter of the Compensation of
DAVID J. GAMBELL, Claimant
WCB Case No. 99-05969
ORDER ON REVIEW
Mitchell & Guinn, Claimant Attorney
Breathouwer & Gilman, Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Tenenbaum's order that upheld the self-insured employer's denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the second paragraph of the "Findings of Ultimate Fact." We supplement and summarize the pertinent facts as follows.

Claimant compensably injured his low back in May 1998. The employer accepted a disabling "lumbar strain." (Ex. 9). Claimant was diagnosed with a disc protrusion at L4-5 on the left. (Exs. 7, 8, 11, 13).

On February 26, 1999, the employer issued an Updated Notice of Acceptance that identified the accepted condition as "lumbar strain." (Ex. 14). A Notice of Closure of the same date awarded temporary but no permanent disability. (Ex. 15).

On May 11, 1999, Dr. Davidson filed an aggravation claim. (Ex. 16). In a May 31, 1999 letter, Dr. Davidson reported that claimant had no objective findings of a worsening. (Ex. 17). Drs. Laycoe and Watson examined claimant on June 16, 1999. They, too, found no objective findings of a worsened condition. (Ex. 18). Based on their reports, the employer denied claimant's aggravation claim. (Ex. 21).

On August 12, 1999, claimant requested amendment of the Notice of Acceptance to include the L4-5 disc protrusion as a result of the May 6, 1998 incident. (Ex. 23).

CONCLUSIONS OF LAW AND OPINION

The ALJ found the L4-5 disc protrusion compensable as a "new medical condition" and ordered the employer to amend its acceptance to include that condition and process the claim under *Fleetwood Homes of Oregon v. Vanwechel*, 164 Or App 637 (1999).

The ALJ then reasoned that, because the insurer had acknowledged that the L4-5 disc protrusion had been accepted *ab initio*, the aggravation of claimant's L4-5 disc protrusion was ripe for evaluation on the merits. The ALJ concluded that claimant failed to establish an "actual worsening" of his low back condition because there was no medical evidence of "objective findings."

On review, we affirm the ALJ's order, but we base our decision on the following reasons.

A new medical condition claim is distinct from an initial claim or an aggravation claim and must be processed as any other claim under ORS 656.262 and 656.268. *See Johansen v. SAIF*, 158 Or App 672, 680-681 (1998), *on recon* 160 Or App 579, *rev den* 329 Or 527 (1999). Moreover, although a new medical condition claim is related to an initial claim, it is distinct and must be processed independently of the initial claim. *Id.* at 679-681.

In *John R. Graham*, 51 Van Natta 1740 (1999), we held that, where a "new medical condition" claim is accepted after claim closure, the claim must be reopened under ORS 656.262(7)(c) for the payment of benefits (including the payment of temporary disability benefits under ORS 656.262 and claim closure under ORS 656.268), even where the claimant's aggravation rights had expired on the original claim. *See also Robert A. Olson*, 52 Van Natta at 1541; *Larry L. Ledin*, 52 Van Natta at 684.

Here, even if the insurer acknowledged that it had "accepted" the "new medical condition" *ab initio*,[1] it had not modified its original notice of acceptance or clarified the accepted conditions at the time of the February 26, 1999 claim closure by issuing an updated notice of acceptance that included the L4-5 condition, as permitted under ORS 656.262(7)(c) and ORS 656.262(6)(b)(F).[2] See *Michael T. Bergmann*, 52 Van Natta 1931 (2000) (construing these statutes). Thus, because the ALJ found that claimant's "new medical condition" claim for an L4-5 disc protrusion was compensable after claim closure, the claim must be reopened under ORS 656.262(7)(c) for the payment of benefits for the "new condition" (including claim closure under ORS 656.268).

Although we agree that the L4-5 disc condition is properly processed under ORS 656.262(7)(c) that does not end the inquiry. The employer issued a formal denial of claimant's aggravation claim. Inasmuch as claimant's accepted lumbar strain condition is not a "new medical condition," the issue becomes whether claimant's accepted condition has worsened.

On this record, we agree with and adopt the ALJ's conclusion that neither Dr. Davidson, claimant's attending physician, nor any of the examining physicians have documented any objective findings of a worsening of claimant's lumbar strain condition. (See Exs. 17, 18, 19, 20, 26-7 through 9). Consequently, we affirm the ALJ's opinion on the aggravation issue insofar as it relates to a worsening of claimant's accepted lumbar strain.

In conclusion, although we have modified the ALJ's reasoning with regard to claimant's aggravation claim, the ALJ's order simply upheld the self-insured employer's denial. Consequently, as supplemented herein, we affirm the ALJ's order.

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[1] The employer contends on review that claimant's disc condition has never been denied, nor is there any evidence that it refused to pay any medical bills for treatment of the disc condition. First, payment of compensation is not considered acceptance of a claim. ORS 656.262(10). Moreover, claimant specifically sought written acceptance of the L4-5 disc condition. Because the employer did not respond to claimant's request timely, he requested a hearing on a "de facto" denial of the claim. For purposes of an attorney fee award under ORS 656.386(1), the employer's failure to timely respond to a claim for compensation for a "new medical condition" condition is considered to be a "denied claim." ORS 656.386(1)(b)(C).

[2] 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."

ORDER

The ALJ's order dated August 11, 2000 is affirmed.

February 5, 2001 Cite as 53 Van Natta 139 (2001)

In the Matter of the Compensation of
CHARLES R. GODE, Claimant
WCB Case No. 00-06287
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Herman's order that affirmed an Order on Reconsideration's award of 38 percent (121.6 degrees) unscheduled permanent disability for claimant's head injury. On review, the issue is extent of unscheduled permanent disability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the exception of the last paragraph of findings.

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable head injury on September 4, 1997, when struck in the left temple and on top of the head by a large piece of wood. After the injury, claimant complained of intense headaches with nausea that would occur after a couple hours of computer drafting. Claimant also experienced hearing loss and ringing in the ears, among other symptoms.

The claim was closed by Notice Of Closure of April 3, 2000, which awarded 25 percent scheduled permanent disability for loss of hearing in the left ear. Claimant requested reconsideration, to include an arbiter examination and promulgation of a temporary rule to rate impairment due to chronic and disabling headaches. (Ex. 14B).

The Department issued its reconsideration order on July 20, 2000. Relying on the report of the medical arbiter, Dr. Syna, and based on the temporary rule, the reconsideration order awarded 38 percent unscheduled permanent disability for a concussion syndrome with headaches. The reconsideration order also reduced the scheduled permanent disability award to 15 percent.[1] SAIF requested a hearing, seeking to reduce claimant's unscheduled permanent disability award to zero.

The ALJ affirmed the Order on Reconsideration, finding that claimant was entitled to permanent impairment under the temporary rule promulgated by the Department to address claimant's alleged permanent disability due to his headaches. In so doing, the ALJ rejected SAIF's argument that there were no "objective findings" of permanent impairment due to claimant's reported headaches. After reviewing the medical evidence from Dr. Weller, an examining physician, with whom the attending physician, Dr. Stiger, had concurred, and Dr. Syna, the medical arbiter, the ALJ concluded that claimant had sufficiently demonstrated verifiable indications of injury or disease. Therefore, the ALJ found that claimant's impairment value under the temporary rule was 30 and, when added to the uncontested value (8) for the social/vocational factors, that his unscheduled permanent disability was 38 percent, the same amount awarded by the reconsideration order.

On review, citing *SAIF v. Lewis*, 170 Or App 201 (2000), SAIF contends that the ALJ incorrectly affirmed the reconsideration order's unscheduled permanent disability award because the record does not establish that claimant's headache condition resulted in permanent impairment established by medical evidence based on "objective findings." SAIF asserts that, while the medical arbiter and other physicians apparently believed claimant's description of his headaches as disabling, none of them employed an independent process to verify claimant's subjective complaints. For the following reasons, we find SAIF's contentions persuasive.

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[1] Extent of scheduled permanent disability is not at issue on review.

ORS 656.283(7) requires that "[a]ny finding of fact regarding the worker's impairment must be established by medical evidence that is supported by objective findings." *See also* ORS 656.726(3)(f)(B) ("[i]mpairment is established by a preponderance of medical evidence based upon objective findings"); OAR 436-035-0010 ("all disability ratings * * * shall be established on the basis of medical evidence that is supported by objective findings"). ORS 656.005(19) defines objective findings as "verifiable indications of injury or disease." The statute further provides that "'objective findings' does not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable."

In *SAIF v. Lewis*, 170 Or App at 203, 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." 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." 170 Or App at 212.

Here, we agree with SAIF the alleged impairment due to claimant's headaches is not based on findings made by a medical expert on the basis of a verification process involving trained observation, examination, or testing. Dr. Syna, the medical arbiter, reported that claimant "*describes* the headaches as occurring after one to two hours of computer-aided drafting." (Ex. 15-1, emphasis supplied). Dr. Syna's arbiter's report, however, does not indicate that he engaged in any independent verification process that produced physical or subjective responses that were witnessed, measured or could be reproduced.

In *Larry J. Morgan*, 51 Van Natta 1448, *on recon* 51 Van Natta 1840 (1999), *on recon* 52 Van Natta 4 (2000), we found that the claimant was not entitled to a permanent partial disability award for a head/brain injury based on a medical arbiter's report. One of the reasons we cited was that the arbiter's opinion that the claimant had a head/brain injury was based solely on the claimant's report of headaches, rather than any objective examination findings. 51 Van Natta at 1450. Likewise, in this case, the medical arbiter's opinion that claimant has permanent impairment is based solely on claimant's report of headaches rather than any objective examination findings. Thus, we conclude that Dr. Syna's impairment finding (Class II head/brain injury impairment) based on claimant's subjective description of his headaches is not supported by "objective findings" within the meaning of ORS 656.005(19).

We now turn to Dr. Weller's opinion.[2] Dr. Weller concluded that there was no way of objectively verifying claimant's headache disorder. Specifically, Dr. Weller stated:

> "The claimant complains of intermittent left periorbital headaches as a consequence of utilizing a computer screen during which he must concentrate in order to accomplish his usual activities as an engineer. Such activities reliably and always reproduce headache which prevents his ability to do his work *by his report. Objective tests for such a history are not available.*" (Ex. 6-6, emphasis added).

Elsewhere in his report, Dr. Weller further emphasized the lack of objective means to verify claimant's symptoms. Dr. Weller stated that "there is no availability of tests to objectify the primary disabling issue of headaches." (Ex. 6-7). According to Dr. Weller, "there is no objective evidence available for his complaints of headache and, therefore, this cannot be strictly stated to be 'objectified.'" (Ex. 6-7). Finally, Dr. Weller observed that "there are no objective findings capable of verifying his complaint of headache; this is no way refuting the apparent fact that he does have headaches in a reliable and historically consistent fashion." (Ex. 6-8). Dr. Stiger, claimant's attending physician, concurred with Dr. Weller's report. (Ex. 7-2).

Having considered the medical evidence from Drs. Syna, Weller and Stiger, we conclude that claimant's alleged impairment is not established by medical evidence that is supported by "objective

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[2] We may consider Dr. Weller's opinion on the permanent impairment issue because the attending physician concurred with it. *See Tektronix, Inc. v. Watson*, 132 Or App 483 (1995); *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994).

findings."[3] Thus, we find that the Order on Reconsideration incorrectly awarded unscheduled permanent disability based on impairment for claimant's headache condition. Therefore, we modify the Order on Reconsideration to eliminate the 38 percent unscheduled permanent disability award.

ORDER

The ALJ's order dated November 8, 2000 is reversed in part and affirmed in part. That portion of the ALJ's order that affirmed the Order on Reconsideration's award of 38 percent unscheduled permanent disability is reversed. The Order on Reconsideration is modified to reduce the award of unscheduled permanent disability to zero. The ALJ's assessed attorney fee is also reversed. The remainder of the ALJ's order is affirmed.

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[3] Claimant contends that his headaches are reproducible, measurable or observable based on our decisions in *Wayne W. Bowers*, 52 Van Natta 963 (2000), and *Krisha L. Gruenhagen*, 51 Van Natta 1888 (1999). Thus, he contends that there are "objective findings" that verify his impairment.

In *Bowers*, we found that the claimant's pain and tenderness in the coccyx area were reproducible and constituted a valid objective finding based on physical examinations conducted by various physicians. 52 Van Natta at 970. In *Gruenhagen*, we found that the claimant's pain and tenderness in the scapula area were reproducible and constituted valid objective findings. Again, this conclusion was based on the reports of clinical examinations performed by physicians. 51 Van Natta at 1888.

Thus, in both *Bowers* and *Gruenhagen*, the findings were made by medical experts on the basis of a verification process involving trained observation, examination, or testing that produced results -- either physical or subjective responses -- that were witnessed, measured, or reproduced. By contrast, in this case, the alleged impairment findings were based entirely on claimant's description of his symptoms. Such findings do not constitute "objective findings." *See Lewis*, 170 Or App at 203.

February 5, 2001 Cite as 53 Van Natta 141 (2001)

In the Matter of the Compensation of
STAN L. LILLIBRIDGE, Claimant
WCB Case No. 99-09952
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Biehl, Bock and Haynes.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Mongrain's order that set aside its denial of claimant's occupational disease claim for bilateral rotator cuff tears. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

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 October 4, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the insurer.

Board Member Haynes concurring in part and dissenting in part.

Although I agree with the majority that claimant has not established compensability of his bilateral A/C arthritis, I dissent from that portion of the majority's order that finds that claimant's bilateral rotator cuff tears are compensable. In adopting and affirming the ALJ's order, the majority holds that claimant's shoulder symptoms developed without a discrete event and that Dr. Schwartz's opinion is sufficient to establish compensability. Because the majority's conclusion is not supported by claimant's testimony or persuasive medical evidence, I respectfully dissent.

The insurer argues that claimant's testimony supports an injury theory, not an occupational disease theory. The insurer contends that neither Dr. Schwartz nor Dr. James had an accurate history of claimant's shoulder symptoms. For the following reasons, I would find that, even if this case is properly characterized as an occupational disease, Dr. Schwartz had an inaccurate understanding of claimant's shoulder symptoms and his opinion is entitled to little weight.

Claimant, a truck driver, began working for the employer in April 1998. (Tr. 6, Ex. 1). Before working for the employer, claimant did not have any problems with either shoulder. (Tr. 8). Claimant's work with the employer involved flatbed trucks, and was much more physical than his previous work because it involved reaching and overhead use of his arms to tarp and secure the loads. (Tr. 6-7, 24-26).

Claimant testified that his left shoulder pain began after working for the employer for two to three months. (Tr. 9). He experienced a specific event in which he thought he had pulled a muscle getting down off the trailer and he "extended it." (Tr. 9, 10). Claimant explained the left shoulder incident:

> "Well, I don't jump anymore off of anything. I'm getting too old. But I sit down on the side of the trailer, and as I was easing myself down I had my - my left hand on the trailer, and the trailer has got aluminum decking, and it was - it rained, and it was damp. And as I put my weight on to get down off, my hand - my arm slid, and it extended a whole lot farther than God meant it to do, I think. And I just - I thought I'd pulled a muscle or whatever." (Tr. 21).

Claimant said that was the first time he had left shoulder pain and it kept hurting thereafter. (*Id.*) After that incident, claimant said his shoulder "lost strength" and kept getting sorer so he went to see Dr. Solkovits, who referred him to Dr. Schwartz. (Tr. 9, 10).

Claimant testified that his right shoulder problems started about three to four months after his left shoulder problems. (Tr. 13-15). Claimant said he could "document the time when I injured it[,]" and he explained:

> "Well, I was loading big PVC pipe in the Sacramento area, and it was a big high load. And you have to really, really haul back and throw the straps high in the air to get them over the top of the load. And when I tossed it and extended my arm, I just - just fell right up against the trailer and went down on the ground. I just felt like I throwed my arm plumb up and over the - the trailer. And it - for about three days it just - having to practically use my left hand to move it around. And - and from then on it just got worse and worse." (Tr. 14).

Claimant said that incident was the first time he had pain in his right shoulder. (Tr. 22).

Claimant relies on the opinion of Dr. Schwartz, his treating physician and surgeon, to establish compensability. Dr. Schwartz examined claimant on August 19, 1998 and referred to the following history:

> "[Claimant] relates a several year history of intermittent shoulder pain mostly in the anterior part of his shoulder which occasionally radiates all the way to his hand. He has associated weakness and stiffness, which are also progressively worsening and has got significantly worse over the last several months. * * * He does not recall a history of any traumatic injuries to his left shoulder." (Ex. C).

At hearing, claimant specifically denied having a several year history of intermittent shoulder pain. (Tr. 8-9).

Dr. Schwartz understood that claimant's shoulder problems had a gradual onset and progressive worsening. (Exs. C, 3A, 4C). He performed surgery on claimant's right shoulder on November 30, 1999, and the left shoulder on January 11, 2000. (Exs. 3B, 4D).

In a deposition, Dr. Schwartz said that claimant developed AC joint arthritis and rotator cuff tendonitis/tear because of his work activities. (Ex. 7-7). He believed that claimant's work caused "50 percent or more" of his rotator cuff difficulties. (Ex. 7-8). He felt that the development of claimant's rotator cuff symptoms correlated "pretty clearly" with his change of driving a flatbed, which involved chaining and tarping and loading. (*Id.*) Dr. Schwartz explained that rotator cuff disease can be injury-induced, but a more common scenario is a repetitive injury that causes a tendonitis, which causes a rotator cuff tendonopathy and develops into a full thickness tear. (Ex. 7-10). He relies on a patient's history in assessing causation. (Ex. 7-12). When the insurer's attorney asked if claimant had an injury with the employer, Dr. Schwartz responded:

> "Again, I have some minor things. I have in one note from a physical therapist about him tarping up and having some increased pain at that particular episode. But there was no major injury to his shoulder. It was simply, in my opinion, the change in the work activities to using his shoulders in a substantially heavier manner that generated his, generated his rotator cuff difficulties." (Ex. 7-13).

Claimant's testimony is inconsistent with Dr. Schwartz's understanding of the onset of claimant's shoulder pain. Dr. Schwartz's initial history was that claimant had a "several year history of intermittent shoulder pain" and claimant did *not* recall a history of any traumatic injuries to his left shoulder. (Ex. C). Dr. Schwartz understood that claimant's shoulder problems had a gradual onset. (Exs. C, 3A, 4C). As discussed earlier, claimant specifically denied having a several year history of intermittent shoulder pain. (Tr. 9). Moreover, claimant testified that his left shoulder pain began, for the first time, after a work incident as his left arm slipped as he was getting down from a trailer. (Tr. 9, 10, 21). Claimant said that his right shoulder pain began, for the first time, when he was loading PVC pipe and was throwing straps. (Tr. 14, 22).

Based on claimant's testimony, Dr. Schwartz did not have an accurate understanding of the onset of claimant's left and right shoulder symptoms. Consequently, I believe that Dr. Schwartz's opinion is entitled to little weight. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) (medical opinions based on incomplete or inaccurate information are not persuasive).

The ALJ (and the majority) responded to the "history problem" as follows:

> "As I see it, this case must be analyzed as an occupational disease. Although the claimant mentioned two separate work incidents of increased left and right shoulder pain, the history given to most of the physicians is that the pain developed gradually over a period of time without a discrete onset. Indeed, the history recorded by Dr. James is that the two incidents occurred 'well after the onset of his difficulties.' Therefore, I do not accept [Liberty's] invitation to analyze the claim as involving accidental injuries for which no timely claim was ever filed." (Opinion and Order at 3).

Thus, the ALJ and the majority apparently solve the inconsistencies between claimant's testimony and the medical opinions by simply ignoring claimant's testimony. I find that disposition particularly curious in light of the ALJ's express finding that claimant testified in a "straightforward, nonevasive and thoroughly credible manner."

Claimant argues on review that since Dr. Schwartz had read Dr. James' report, Dr. Schwartz was well aware of the incidents where claimant felt severe right shoulder pain after throwing a tarp and felt left shoulder pain after his hand slipped. I believe that claimant's reliance on Dr. James' report to resolve the "history problem" is misplaced.

Dr. James reported that claimant began to experience left shoulder problems after driving a flatbed and he "did not recall any specific injury at the onset and stated he just thought it was a change in his job requirements, which were more vigorous than he had experienced in the past, along with his age and poor conditioning." (Ex. 2-1). He said that claimant began to experience right shoulder pain shortly after the left shoulder problems began. (Ex. 2-2). Dr. James explained:

> "He can recall earlier this year in throwing a tarp over a load he had severe right shoulder pain for about three days. There was also a somewhat similar incident at work when his left hand slipped getting down off the truck bed and he had severe left shoulder pain, but this was *well after the onset of his difficulties.*" (Id.; emphasis supplied).

Dr. James' understanding of the onset of claimant's left and right shoulder symptoms is inconsistent with claimant's testimony at hearing. Consequently, I would reject claimant's assertion that Dr. Schwartz had an accurate history because he had read Dr. James' report.

Although it is possible that Dr. Schwartz would reach the same conclusion about causation if he had an accurate history of claimant's shoulder symptoms, there is no basis, on this record, to reach that conclusion. 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 about causation 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").

I do not understand how the majority can find that Dr. Schwartz's opinion is persuasive when it is clear that he did *not* have an accurate history of the onset of claimant's shoulder problems. There are no other medical opinions that support compensability. Under these circumstances, claimant has failed to sustain his burden of proving compensability of his bilateral rotator cuff tears. Because the majority decides otherwise, I dissent.

In the Matter of the Compensation of
COLIN L. SPENCER, Claimant
Own Motion No. 00-0078M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Cole, Cary, et al, Claimant Attorney
Hettle & Martin, Defense Attorney

Claimant requests reconsideration of our January 8, 2001 Own Motion Order on Reconsideration, which adhered our March 15, 2000 order that declined to authorize the reopening of his 1991 claim because he was not in the work force at the time of his current worsening. Claimant contends that the Board erred regarding its decision on the "futility" criterion. On reconsideration we continue to adhere to our prior order with the following supplementation.

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

It is undisputed that claimant's compensable condition has worsened requiring surgery or hospitalization. Nevertheless, 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; (2) not employed, but willing to work <u>and</u> is seeking work; or (3) not working but willing to work, <u>and</u> 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,[1] is the date he enters the hospital for the proposed surgery

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[1] The Board in its Own Motion jurisdiction can only authorize temporary disability from the time of surgery or hospitalization. *See* ORS 656.278(1)(a).

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 May 13, 1999 hospitalization when his condition worsened requiring 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).

In our prior orders, we found that claimant had not met his burden of proof regarding the work force issue. Specifically, we concluded that the record did not establish claimant's *willingness* to work.

On reconsideration, claimant argues that his May 2000 affidavit should take precedence over his August 13, 1999 unsworn taped interview because it carries a "guarantee of veracity" and it addresses his willingness to work during the "relevant time period." Therefore, relying on his May 2000 affidavit together with his attending physician's opinion that it was futile for him to work and/or seek work during the "relevant time period," claimant argues that he has met the third *Dawkins* criterion. We disagree.

Although claimant's attending physician's opinion, which concludes it would have been futile for claimant to work and/or seek work from January 1999 through June 1999, may satisfy the "futility" standard, 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 Stephen v. Oregon Shipyards*, 115 or App 521 (1992); *Judith R. King*, 48 Van Natta 2303 (1996); *Marlene J. Andre*, 48 Van Natta 1859 (1996).

In this regard, the issue of whether a work-related injury makes efforts to seek work futile presents a medical question that must be answered by expert medical opinion; however, the issue of *willingness* to work does not present a medical question. Instead, willingness to work is established by a preponderance of the evidence based on the whole record.

Here, we remain unpersuaded that claimant has satisfied the "willingness" test set forth in *Dawkins*. This conclusion is based on the following reasoning. Claimant was found medically stationary and released to work in December 1994. A "return-to-work" program in February 1995 was terminated because of claimant's lack of participation. Claimant has not worked or sought work since his return-to-work program was terminated in February 1995.

In claimant's May 11, 2000 affidavit, he represented that he was unable to work due to his "on-the-job injury" from January 1, 1999 to May 13, 1999. Claimant further stated that he was "willing to look for gainful employment." However, the record does not support claimant's implication that it was futile for him to seek work from February 1995 until he became "disabled" from work in January 1999. Additionally, the record does not establish that claimant sought any work at all since he was released to work in 1994.

Because we are not persuaded that it was futile for claimant to work from February 1995 until his condition worsened in January 1999, nor that he sought any type of work during that time, we are likewise not persuaded by claimant's sworn statement that he was *willing* to work at the time of disability. Claimant's actions (or lack thereof) in seeking work from February 1995 until January 1999 suggest that he was unwilling to attempt to work within the limitations to which he had been released in December 1994. *See Marlene J. Andre*, 48 Van Natta at 1860; *Martin L. Moynahan*, 48 Van Natta 103 (1996).

Accordingly, our prior January 8, 2001 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our January 8, 2001 order in its entirety.[2] The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

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[2] In light of this decision, claimant is not entitled to temporary disability compensation. Consequently, claimant's requests for penalties and attorney fees have been rendered moot.

Board Member Biehl dissenting.

Because I disagree with the majority's conclusion that claimant has not demonstrated a willingness to work, and because I believe the majority unfairly discounts the unrebutted opinion of claimant's treating physician on the issue of futility, I respectfully dissent.

Initially, I note that the relevant time period, as the majority notes, is prior to claimant's May 13, 1999 hospitalization and surgery. The preponderance of persuasive evidence from this time period demonstrates that claimant was willing to work, but that any such efforts would have been futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

On May 11, 2000, claimant averred in an affidavit that he was willing to look for gainful employment from January 1, 1999 through May 13, 1999, but was "not in the workforce" due to his on-the-job injury. Claimant's affidavit is supported by his attending physician's uncontradicted statement that "It would have been futile for [claimant] to seek employment from 1/99 through mid June 1999 due to disability and pain from his disc herniation and subsequent recovery from surgery." *See Forrest N. Stalnaker*, 52 Van Natta 2238 (2000) (unrebutted attending physician's opinion on futility found persuasive).

Instead of properly taking into consideration the above evidence, the majority focuses on a broader, and far less relevant, time period encompassing five years prior to claimant's date of disability. The majority also relies on claimant's statements in an earlier unsworn statement to a representative of the insurer instead of the later, sworn affidavit. I would find claimant's affidavit more persuasive due to its recency and greater indicia of reliability.

Finally, contrary to the majority's reasoning, I believe that the fact that claimant abandoned his vocational retraining program in 1995 is even further evidence of his inability to work more than four years later, not evidence of a current unwillingness to work. This is especially true in light of the majority's acknowledgement that it is undisputed that claimant's compensable condition has *worsened*, (by implication, since the time of the vocational program) requiring hospitalization and surgery. In other words, claimant's failure to complete vocational retraining four years prior to his May 13, 1999 hospitalization and surgery is barely relevant to his willingness to work in the time period prior to his current disability. If anything, it is additional proof of the futility of claimant's return to work efforts over time.

For the above reasons, I respectfully dissent from the majority's refusal to reopen claimant's claim for the payment of temporary disability.

February 6, 2001 Cite as 53 Van Natta 146 (2001)

In the Matter of the Compensation of
JERRY L. JOHNSON, Claimant
Own Motion No. 01-0032M
OWN MOTION ORDER

The self-insured employer has submitted claimant's request for temporary disability compensation for a right shoulder condition. Claimant's aggravation rights have expired. The employer recommends that claimant's 1992 claim be reopened.[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.*

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[1] The employer notes that two surgical procedures are proposed. First, a right shoulder arthroscopic acromioplasty, which it relates to claimant's 1992 right shoulder claim. And second, a distal clavicle resection, which is currently in "deferred status" as a "new claim." In light of such circumstances, we limit our current review to the undisputed acromioplasty.

On January 10, 2001, Dr. Baertlein, claimant's attending surgeon, recommended that claimant undergo a right shoulder arthroscopic acromioplasty. 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 1992 injury claim to provide temporary disability compensation beginning the date claimant is hospitalized for the right shoulder arthroscopic acromioplasty. When claimant's condition related to the right shoulder arthroscopic acromioplasty is medically stationary, the employer 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 distal clavicle resection and its relationship, if any, to claimant's 1992 right shoulder claim.

February 6, 2001 Cite as 53 Van Natta 147 (2001)

In the Matter of the Compensation of
VICTORIA L. SEABOURN, Claimant
WCB Case No. 00-04194
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Nichols' order that upheld the insurer's denial of her low back injury claim. On review, the issue is compensability.

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

The ALJ upheld the insurer's denial, finding that clamant had failed to prove that an alleged injury on March 2, 2000 was the major contributing cause of her need for medical treatment. *See* ORS 656.005(7)(a)(B). Among claimant's contentions on review is her assertion that the ALJ applied the wrong legal standard when she at one point stated that claimant must prove that the alleged March 2, 2000 injury was the major contributing cause of "her current condition *and* need for treatment."

Under ORS 656.005(7)(a)(B), claimant must prove that an otherwise compensable injury is the major contributing cause of the disability or need for medical 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). Thus, claimant is correct that the ALJ did not accurately state the legal standard under ORS 656.005(7)(a)(B).

However, we are not persuaded that the ALJ *applied* an incorrect legal standard, for she ultimately found that the opinion of the attending physician, Dr. Kulus, did not prove that the alleged new injury in March 2000 was the major contributing cause of claimant's need for treatment. (O&O p. 5). Moreover, we agree with the ALJ's analysis of medical evidence and conclude that the March 2, 2000 injury was not the major contributing cause of the need for medical treatment or of the disability of the "combined condition."

Thus, claimant failed to prove a compensable injury claim under ORS 656.005(7)(a)(B). Accordingly, we affirm.

ORDER

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

In the Matter of the Compensation of
MITCHELL B. BLACK, Claimant
WCB Case Nos. 00-04719 & 00-04187
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of those portions of Administrative Law Judge Howell's order that: (1) upheld the SAIF Corporation's denial of his claim for an L4-5 disc bulge; (2) declined to award temporary disability between March 16, 2000 and May 3, 2000; and (3) declined to assess a penalty or penalty-related attorney fee for SAIF's allegedly unreasonable delay in processing his claim for omitted conditions. On review, the issues are compensability, temporary disability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the fifth full paragraph on page 3, we delete the second sentence.

CONCLUSIONS OF LAW AND OPINION

We adopt and affirm sections A, B and D of the ALJ's order with the following change. On page 4, we delete the seventh paragraph.

Section C pertains to claimant's entitlement to temporary disability for his compensable L5-S1 disc condition. The parties do not challenge the ALJ's conclusion that claimant is entitled to temporary disability compensation from December 22, 1999 to March 16, 2000, less any time worked. We adopt and affirm section C on page 5 of the ALJ's order, with the following change. In the last paragraph on page 5, we change the first sentence to read: "Dr. Powell was claimant's attending physician beginning December 22, 1999."

We replace the first two paragraphs on page 6 with the following:

Claimant argues that he is entitled to temporary disability compensation between March 16, 2000 and May 3, 2000. He relies on Dr. Powell's December 22, 1999 report that he could not perform regular work and the fact that Dr. Powell never released him to work or found that he was no longer eligible for temporary disability.

On review, SAIF agrees that claimant is entitled to time loss benefits for the period between March 16, 2000 and May 3, 2000. SAIF agrees that Dr. Powell was claimant's attending physician beginning on December 22, 1999 and SAIF does not contest the ALJ's conclusion that claimant was entitled to temporary disability benefits beginning on that date. Under these circumstances, we find that claimant is entitled to temporary disability between March 16, 2000 and May 3, 2000.

Claimant is entitled to an out-of-compensation attorney fee of 25 percent of any increased temporary disability compensation created by this order, payable directly to claimant's counsel. However, the total "out-of-compensation" fee granted by the ALJ's order and this order shall not exceed $5,000. *See* ORS 656.386(2); OAR 438-015-0055(1).

ORDER

The ALJ's order dated October 31, 2000 is affirmed in part and modified in part. That portion of the ALJ's order that declined to award temporary disability between March 16, 2000 and May 3, 2000 is reversed. SAIF is directed to pay temporary disability benefits for that time period. Claimant's attorney is awarded an attorney fee of 25 percent of the additional temporary disability compensation awarded by this order. However, the total "out-of-compensation" fee granted by the ALJ's order and this order shall not exceed $5,000. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
ROBERT E. CHARBONNEAU, Claimant
WCB Case Nos. 00-06072 & 00-04227
ORDER ON REVIEW
Coughlin, Leuenberger & Moon, Claimant Attorney
Lundeen, et al, Defense Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Liberty Northwest Insurance Corporation, on behalf of Gyllenberg Construction, Inc. (Gyllenberg), requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) set aside its denials of claimant's occupational disease claim for a cervical condition; and (2) upheld the SAIF Corporation's denial, on behalf of Michael A. Becker General Contractor (Becker), of the same condition. In its respondent's brief, SAIF contests that portion of the ALJ's order that set aside the compensability portion of its denial of the same condition. On review, the issues are compensability and responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the last paragraph, and the "Findings of Ultimate Fact," except for the third paragraph.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the ALJ's reasoning and conclusions regarding the compensability of claimant's cervical degenerative condition, except for the paragraph running from page 9 to page 10.[1] In addition, we offer the following supplementation.

We find Dr. Sandefur's causation opinion persuasive, because it is well-reasoned and based on an accurate and complete history. Dr. Sandefur opined that claimant's cervical condition was due to primarily to years of heavy construction work, with lesser contributions from his November 1998 and September 1999 work injuries. The doctor reasoned that claimant's work activities were the sort that could cause cervical degeneration and claimant's degeneration was significantly more severe than expected for his age. Dr. Sandefur's reasoning in this regard is consistent with the record and essentially unchallenged.[2]

The ALJ found that Dr. Sandefur changed his opinion, but adequately explained the changes. We do not find that Dr. Sandefur changed his opinion. Instead, we find the doctor's opinion consistent over time, throughout the record, when we consider his statements in their immediate and overall contexts. *See SAIF v. January*, 166 Or App 620 (2000) (inconsistencies may not exist when circumstances are better understood); *SAIF v. Strubel*, 161 Or App 516 (1999).

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[1] We agree with the ALJ that this claim is properly analyzed as an occupational disease, because claimant's degenerative condition arose gradually over time, rather than suddenly. *See Mathel v. Josephine County*, 319 Or 235, 240 (1994); *Active Transportation Co. v. Wylie*, 159 Or App 12 (1999).

[2] As the ALJ noted, the contrary opinions are inadequately explained and they failed to consider claimant's years of heavy, repetitive, and traumatic work activities.

Dr. Sandefur has consistently opined that claimant's heavy construction work activities could and probably did cause most of his cervical degeneration.[3] The doctor stated:

> "The cervical spondylosis, disc degeneration and disk prolapse, while it is a pre-existing condition, is most likely due to [claimant's] repetitive work that is involved as a construction worker * * * . I believe that his neck condition has progressed due to repetitive occupational duties of his job as a construction worker, and it was aggravated by the one discrete injury[.]." (Ex. 19-2; *see* Exs. 10, 15).

Dr. Sandefur also agreed with claimant's counsel's statement that claimant's construction work activities for Liberty's insured were the major contributing cause of his cervical degeneration, further commenting:

> "[Claimant] most likely had some early degenerative disc disease but I believe that the severity of the findings as well as his complaints were due to repetitive construction work." (Ex. 21A-1).

Based on these statements and the opinion as a whole (as well as the doctor's statements in isolated contexts, *see* note 2), we conclude that Dr. Sandefur's opinion is consistent over time and well-reasoned. Consequently, we rely on Dr. Sandefur's opinion and conclude, as did the ALJ, that claimant's occupational disease claim is compensable.

Responsibility

We adopt the ALJ's opinion on this issue up to, but not including the last sentence on page 11. In addition, we offer the following reasoning and conclusions.

Responsibility for claimant's compensable cervical condition shifts forward, from Liberty/Gyllenberg to SAIF/Becker, under the last injurious exposure rule, if the "later employment contributed independently to the cause or worsening" of the condition. *MacMillan Plumbing v. Garber*, 163 Or App 165, 170 (1999), *see Bracke v. Baza'r*, 293 Or 239, 250 (1982) (once assigned, responsibility may shift forward if later work activities "contribute to the cause of, aggravate, or exacerbate the underlying disease").

The ALJ found no evidence to support shifting responsibility. We disagree.

As we explained above, Dr. Sandefur's persuasive opinion establishes that claimant's construction work was the major cause of his condition. Claimant performed construction work for Becker after he stopped working for Gyllenberg. Furthermore, Dr. Sandefur examined claimant regarding new symptoms after claimant lifted a heavy generator on the Becker job, in September 1999.

Claimant's counsel asked Dr. Sandefur if it was "correct" or "incorrect" that:

> "Specifically, you do not believe that the degenerative changes or the disc prolapses at [claimant's] C3-4, C4-5 and C5-6 were pathologically worsened *at all* as a result of [claimant's] September 1999 lifting incident while working for Becker Construction." (Exs. 21A-4, emphasis added).

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[3] Although the doctor sometimes referred to the degeneration as "preexisting," those references are found in responses to questions about the November 1998 lifting *injury*. (See Exs. 9B, 10). For example, claimant's counsel asked the doctor what injury claimant had with the first employer (question 2), then, whether the preexisting condition combined with the injury (question 3). Dr. Sandefur's response to the latter question about the November 1998 lifting *injury*, indicates that claimant's degeneration preceded *that event*. (Ex. 10; see Ex. 21A-2). Next, responding to the same question, the doctor stated that it would be "difficult" to say whether "work activities" were the major cause, because he did not see claimant until almost 8 months after the *injury*. (*Id*). Although the doctor's uncertainty referenced "work activities," we believe that he was actually referring to the 1998 injury, because his comments responded to questions about the injury specifically --not claimant's overall work activities. In other words, we read Dr. Sandefur's conclusions to indicate uncertainty about the injury's contribution, *not* the contribution of the years of work activities. This reading is consistent with Dr. Sandefur's subsequent chart note reiterating that he had difficulty relating claimant's cervical degeneration "completely back to just one work incident." (Ex. 15; *see* Ex. 21A-4-5). It is also consistent with the doctor's August 21, 2000 letter explaining that by "preexisting," he meant that claimant's MRI changes "did not occur as the result of the work injury." (Ex. 19-1; *see* Ex. 21A-2-3).

Dr. Sandefur checked a box indicating that statement was "incorrect," and commented: "[Claimant's] work at Becker Construction contributed to his symptoms but the vast majority of his findings are due to his work at Gyllenberg Construction." (*Id*). Thus, although Dr. Sandefur opined that claimant's later work contributed to his symptoms, he did not agree that it caused no pathological worsening "at all." Considering these statements in light of the doctor's prior opinions that claimant's years of heavy construction, *including* his work for Becker, caused his condition, we find it more likely than not that claimant's work for Becker independently contributed to his condition.[4] (*See* Ex. 10). Accordingly, on this record, we conclude that responsibility shifts from Liberty/Gyllenberg to SAIF/Becker.

Finally, because there is no evidence that prior employment was the sole cause of claimant's condition or that claimant's work for SAIF's insured could not cause it, we conclude that responsibility remains with SAIF.

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 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 October 27, 2000, is reversed in part, modified in part, and affirmed in part. That portion of the order that set aside Liberty Northwest Insurance Corporation's denial is reversed. The denial is reinstated and upheld. That portion of the order that upheld the SAIF Corporation's denial is reversed. The denial is set aside and the claim is remanded to SAIF for processing according to law. The ALJ's attorney fee awards are payable by SAIF, rather than Liberty. For services on review, claimant is awarded a $1,500 attorney fee, payable by SAIF. The remainder of the ALJ's order is affirmed.

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[4] We acknowledge Dr. McNeill's opinion that claimant's work for SAIF's insured did not contribute to his condition. We find that opinion unpersuasive because it is completely unexplained. (*See* Ex. 17).

February 7, 2001 Cite as 53 Van Natta 151 (2001)

In the Matter of the Compensation of
CLIFFORD L. COZART, Claimant
Own Motion No. 99-0422M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's December 4, 2000 Notice of Closure which closed his claim with an award of temporary disability compensation from December 13, 1999 through November 20, 2000. SAIF declared claimant medically stationary as of November 20, 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 December 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). 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 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 SAIF's December 4, 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 conclusion that claimant was medically stationary at the time of closure and temporary disability compensation was appropriately terminated.

On October 27, 2000, claimant was examined by Dr. Weston, a consulting physician, who reports that claimant was "medically stationary practically speaking at this point for workmans' compensation concerns." On November 20, 2000, Dr. Waller, claimant's attending physician, concurred with Dr. Weston's assessment. These opinions are unrebutted.

Based on the uncontroverted medical evidence, we find that claimant was medically stationary on November 20, 2000. Inasmuch as temporary disability benefits were paid through November 20, 2000, and the claim was closed on December 4, 2000, we conclude that claimant is not entitled to additional temporary disability and that SAIF's claim closure was proper.

Accordingly, we affirm SAIF's December 4, 2000 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARIA D. MEZA, Claimant
WCB Case No. 99-09292
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Johnson's order that dismissed her request for hearing as untimely. On review, the issue is the propriety of the ALJ's dismissal of the hearing request.

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

The ALJ dismissed claimant's hearing request regarding the insurer's March 27, 2000 denial. In so doing, the ALJ found that claimant had failed to establish "good cause" for her failure to timely file a hearing request by the 60th day after mailing of the denial. *See* ORS 656.319(1)(b).

On review, claimant contends that the ALJ's dismissal of the entire matter was too broad because the Hearings Division still had jurisdiction to determine compensability issues by reason of her November 18, 1999 request for hearing that had raised the issue of "de facto" denial. Alternatively, claimant contends that she established "excusable neglect" for her failure to timely request a hearing from the March 27, 2000 denial.

In response, the insurer asserts that claimant agreed at hearing that, if the ALJ found that she failed to establish "good cause" for failure to timely appeal the March 27, 2000 denial, the entire matter would be dismissed. Thus, the insurer contends that claimant's argument that the formal written denial of March 27, 2000 did not subsume the issues raised in her prior hearing request is an attempt to raise a "new issue" on review. Therefore, the insurer urges us not to consider it. *See Stevenson v. Blue Cross of Oregon*, 180 Or App 247 (1991).

To decide this issue, we examine the transcript of the preliminary discussions at the hearing. There, the insurer's counsel moved for a "bifurcated" hearing. Specifically, the insurer requested that the issue of the timeliness of the hearing request be decided first so that the parties could avoid the time and expense of depositions associated with litigation of the compensability issues if the ALJ determined that the hearing request should be dismissed. Thus, pursuant to the insurer's request, the ALJ was to proceed first with a determination of whether claimant established good cause for failure to timely appeal the March 27, 2000 denial and, if so, to advise the parties to proceed with depositions. (Tr. 5). Claimant's counsel responded to the insurer's counsel's remarks by stating that "[t]he issues are correct for today." *Id.*

The ALJ then summarized his understanding of the issue to be litigated. The ALJ stated:

> "* * * so we will just limit our testimony and evidence to the particular procedural question whether there's been a timely filing of a Request for Hearing. And then I will issue an order within the normal 30 day time period. If it should be that I do find that there has been a timely filing, I will just issue an interim order advising the parties of that and then we'll go on in the rest of the case preparation and reconvene for any testimony *et cetera* on the merits. *If I should find that there has not been a timely appeal filed then I will issue a final order dismissing the matter and then the Board can deal with it from that point on, so. We'll proceed under that format then.*" *Id.* (emphasis added).

Claimant's attorney did not disagree with the ALJ 's understanding of how the matter was to be litigated. Just prior to testimony, the insurer's counsel reiterated her understanding of the procedural posture of the case. She stated: "So, it's our position that the new conditions have all been formally denied. There was no timely appeal of the denial. The burden of proof is now on claimant to establish good cause for failure to appeal in a timely manner. And I understand that's the issue we'll address today." (Tr. 10). Again, claimant's counsel did not disagree with the insurer's understanding of the procedural posture of the case.

Having reviewed the "pre-testimony" discussions, we are persuaded that the parties agreed that litigation of compensability issues was dependent on the outcome of the timeliness issue. Thus, we find that any compensability issues raised by the November 1999 hearing request concerning a "de facto" denial were subsumed by the subsequent formal written denial of March 27, 2000. Accordingly, when the ALJ determined that claimant had failed to establish "good cause" for her failure to timely appeal the March 27, 2000 denial, his dismissal of claimant's hearing request disposed of all issues potentially subject to litigation, including those raised by the November 1999 hearing request regarding a "de facto" denial.

In conclusion, we disagree with claimant's contention that the Hearings Division had jurisdiction over the compensability issues even if she did not establish "good cause" for failure to timely appeal the March 27, 2000 denial. Moreover, we agree with the ALJ's reasoning that claimant did not establish "good cause" for failure to timely request a hearing from that denial. Thus, we find that the ALJ properly dismissed claimant's hearing request. Therefore, we affirm.

ORDER

The ALJ's order dated October 12, 2000 is affirmed.

In the Matter of the Compensation of
GARY NORED, Claimant
WCB Case No. 99-05211
ORDER ON REVIEW
Scott M. McNutt, Sr., Claimant Attorney
Hoffman, et al, Defense Attorney

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its denial of claimant's low back injury claim; and (2) awarded a $5,100 assessed attorney fee. On review, the issues are compensability and attorney fees.

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

In January 1989, claimant underwent L5-S1 percutaneous discectomy. Following the surgery, claimant had no further back symptoms until March 30, 1999.

Claimant works for the employer as a telephone service technician. On March 30, 1999, he crawled under a mobile home on his hands and knees to repair a telephone line. He felt a sharp pain in his low back. The next day, he had pain radiating down the right leg. Claimant saw Dr. Givens who diagnosed "probable lumbar disc compression, recurrent" and referred him to Dr. Gallo, a neurosurgeon, for treatment. (Ex. 3). Dr. Gallo performed a right lumbosacral discectomy at L5-S1.

The employer denied the claim on June 22, 1999 on the ground that the major cause of the current L5-S1 herniation was a previous herniation at the same level. Claimant requested a hearing from the denial.

A hearing was held on September 30, 1999. The ALJ subsequently issued an order that set aside the employer's denial of claimant's low back condition. The ALJ reasoned that the March 30, 1999 injury was the major contributing cause of claimant's herniated disc at L5-S1. The ALJ relied on Dr. Gallo's opinion. The ALJ also declined the employer's request to admit into evidence proposed Exhibits 10 and 11, a September 9, 1999 letter from claimant's attorney to Dr. Gallo and Dr. Gallo's post-hearing response dated October 4, 1999.

On Board review, we vacated the ALJ's order and remanded for admission of the disputed exhibits and to consider any other evidentiary matters resulting from our decision. *Gary Nored,* 52 Van Natta 920 (2000).

On remand, the ALJ issued an order that admitted Exhibits 11 and 12 into evidence and also admitted Exhibit 13, Dr. Gallo's deposition and Exhibit 14, a record review by Dr. Williams, neurosurgeon, on behalf of the employer. On reconsideration, the ALJ again relied on the opinion of Dr. Gallo and set aside the employer's denial of claimant's low back injury claim.

After reviewing the medical evidence, we agree with the ALJ that Dr. Gallo's opinions, as clarified, in her deposition, persuasively establish compensability of the claim. In this regard, Dr. Gallo testified that she was aware that claimant's prior surgery was at the L5-S1 level. She opined that the March 1999 injury probably caused a tear in the annulus of the disc. She also opined that the March 1999 injury combined with the prior condition at L5-S1 and was the major contributing cause of the need for treatment after March 30, 1999. (Ex. 12-10).

At the time she rendered her opinion, Dr. Gallo was aware of and had considered all of the factors that contributed to the cause of the condition. In this regard, Dr. Gallo considered the prior surgery, claimant's many years after 1989 with no symptoms, and the mechanism of the March 1999 injury. After considering all of these factors, Dr. Gallo concluded that the March 30, 1999 injury was the major contributing cause of claimant's combined condition and need for surgery. (Ex. 12-10). Because Dr. Gallo performed claimant's surgery, offered a persuasively reasoned opinion and is in the best position to comment on the cause of the disc condition, we agree with the ALJ that Dr. Gallo's opinion is entitled to deference. Accordingly, we conclude that claimant has met his burden of proof.

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

ORDER

The ALJ's order dated October 3, 2000 is affirmed. For services on Board review, claimant's attorney is awarded $1,000, payable by the employer.

February 8, 2001 Cite as 53 Van Natta 155 (2001)

In the Matter of the Compensation of
JAMES V. OXLEY, Claimant
WCB Case Nos. 00-02350 & 99-05414
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorney
Bostwick, et al, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Johnston and Culberson, Inc. (JCI), the claim processing agent for the noncomplying employer, requests review of the portion of Administrative Law Judge (ALJ) Mongrain's order that: (1) set aside its denial of responsibility for claimant's current low back condition; and (2) upheld ESIS's responsibility denial of claimant's claim for the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following correction. The first sentence is corrected to reflect that claimant's injury at Salvage-One occurred in April 1985.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his low back in April 1985 while working for the noncomplying employer. A left-sided L5-S1 disc herniation was diagnosed. SAIF, as the then-processing agent for the noncomplying employer, accepted a low back strain and possible ruptured disc. Claimant had laminectomy and discectomy surgery at L5-S1 in September 1985.

In October 1993, claimant experienced "heaviness" in the right leg while working as a parcel pick-up driver. MRI and CT scans revealed postoperative changes at L5-S1 with no recurrent disc herniation. A lumbar strain was accepted.

In October 1998, claimant experienced back and left leg symptoms after four hours of shoveling gravel. An MRI showed disk bulges at L4-5 and L5-S1. The MRI report indicated that very mild impingement of the traversing left S-1 root might be present. The report also indicated that there might be mild impingement of the exiting L-5 roots. Dr. Ampel treated claimant for left-sided lumbosacral radiculopathy. ESIS accepted a lumbar strain.

The claim was closed July 1, 1999 by a Notice of Closure that awarded temporary disability only. Also on July 1, 1999, ESIS denied claimant's current condition. Claimant requested reconsideration. A September 13, 1999 Order on Reconsideration affirmed the Notice of Closure.

On December 6, 1999, claimant's attorney requested that JCI accept an L5-S1 disc herniation under the noncomplying employer claim. On May 19, 2000, ESIS accepted lumbosacral strain superimposed upon preexisting lumbar degenerative disc disease. The claim was closed the same day with no award of temporary or permanent disability. On the same day, ESIS issued a denial on the ground that the preexisting degenerative disease was no longer the major contributing cause of claimant's disability and need for treatment. A September 14, 2000 Order on Reconsideration affirmed the May 19, 2000 Notice of Closure.

Claimant appealed a "de facto" denial by JCI of treatment for lumbar degenerative disc disease and S1 nerve root irritation and ESIS' formal denial of the same condition. The ALJ found that the combined condition accepted by ESIS as a result of the October 14, 1998 injury was not the same condition that was accepted in 1985 under the noncomplying employer claim. On this basis, the ALJ concluded that JCI, the claim processing agent for the noncomplying employer claim, remained responsible for claimant's medical treatment.

We agree with the ALJ that the October 1998 injury did not involve the same condition as the 1985 claim. In this regard, ORS 656.308(1) only applies if the 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). Where, as here, the second claim is accepted as a combined condition, the second 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).

We agree with the ALJ that the ESIS injury did not involve the same condition as the 1985 injury because it does not have the earlier compensable injury within or as part of itself. Based on the opinions of Drs. Donahoo, Williams, Gripekoven and Rischitelli, we conclude that the strain caused by the 1998 injury and the preexisting degenerative disease and scarring from the 1985 surgery were brought into a close relationship, but did not integrate. We also conclude that Dr. Ampel's opinion supports this conclusion. Although Dr. Ampel believed that the 1998 injury involved a new nerve root injury, his opinion also suggests that he did not believe that the 1985 and 1998 conditions had integrated. Since ORS 656.308(1) does not apply, and if the 1985 and 1998 injuries involve the same body part, the last injury rule applies to determine responsibility. *See Emmett G. Dehart*, 52 Van Natta 2243 (2000). ESIS argues that the 1998 and 1985 injuries do not involve the same body part. Specifically, ESIS argues that the 1985 claim involved a herniated disc at L5-S1 and the 1998 injury involved a lumbar strain. We conclude that the lumbar disc and the lumbar strain both involve the same body part: the low back. *See Sisters of Providence v. Ridenour*, 162 Or App 467 (1999) (substantial evidence supported Board's conclusion that L4-5 disc herniation and lumbar strain were injuries to the same body part). Based on this record, we conclude that the 1985 and 1998 injuries were successive injuries to the same body part. Thus, the last injury rule applies.

Because the 1985 and 1998 injuries are "successive injuries" involving the same body part, responsibility is determined under the "last injury rule." *See James A. Hoyt*, 52 Van Natta 346 (2000). In addition, because the successive injuries to the same body part are accepted, the presumption in *Industrial Indemnity v. Kearns*, 70 Or App 583 (1984) applies. *Kearns* created a rebuttable presumption that, in the context of successive accepted injuries involving the same body part, the last carrier with an accepted claim remains responsible for subsequent conditions involving the same body part. 70 Or App at 585-87. Encompassed in the "*Kearns* presumption" is the "last injury rule," which fixes responsibility based on the last injury to have independently contributed to the claimant's current condition. *Id.* at 587. The carrier with the last accepted injury can rebut the *Kearns* presumption by establishing that there is no causal connection between the claimant's current condition and the last accepted injury. *Id.* at 588.

Here, based on the preponderance of the medical evidence, we are unable to conclude that there is no causal connection between claimant's current condition and the 1998 injury. In this regard, Dr. Rischitelli opined that each of claimant's low back injuries probably contributed to a progression of his degenerative changes and that each injury results in inflammation, scarring and increased susceptibility to future injury. (Ex. 103-17). Dr. Ampel believed that claimant suffered nerve root injury, as well as muscle strains, during the October 1998 injury and that this was caused by a new lumbar disc injury. (Ex. 104-2). Dr. Donahoo believed that claimant's October 1998 injury combined with his preexisting degenerative condition to cause and/or prolong his disability. (Ex. 94-3). Drs. Williams and Gripekoven believed that the October 1998 injury caused a lumbosacral strain; however, Dr. Gripekoven later concurred with Dr. Donahoo's opinion that the strain combined with the preexisting condition to cause or prolong claimant's disability.

We conclude, based on the preponderance of the medical evidence, that the October 1998 injury independently contributed to claimant's condition. Thus, we conclude that responsibility rests with ESIS.

By virtue of our *de novo* review authority regarding the ALJ's order, compensability was potentially at risk on Board review. Accordingly, claimant's attorney is entitled to a fee under ORS 656.382(2) for services on Board review. *See Dennis Uniform Manufacturing v. Teresi*, 115 Or App 252-53 (1992), *mod* 119 Or App 447 (1993). 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 ESIS. 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 24, 2000 is reversed. JCI's denial of responsibility is upheld. ESIS' denial is set aside and the claim is remanded to ESIS for processing according to law. For services on Board review, claimant's attorney is awarded $1,000, payable by ESIS.

February 8, 2001 Cite as 53 Van Natta 157 (2001)

In the Matter of the Compensation of
TONY M. THOMPSON, Claimant
WCB Case Nos. 00-02863, 00-01196, 99-09433 & 00-00518
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorney
Terrall & Terrall, Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Marshall's order that: (1) declined to admit Exhibits 15a-c into the record; (2) awarded claimant interim compensation at a temporary disability rate greater than zero; and (3) assessed a penalty for the employer's allegedly unreasonable claim processing. Claimant moves to strike the employer's appellant's brief as untimely filed. On review, the issues are motion to strike, the ALJ's evidentiary ruling, interim compensation, and penalties. We deny the motion to strike and affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Claimant moves to strike the employer's appellant's brief as untimely filed. Pursuant to OAR 438-011-0020(2), a party's appellant's brief must be filed within 21 days after the date of mailing of the transcript to the parties. 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). An attorney's certificate that a thing was deposited in the mail on a stated date is proof of mailing on that date. *Id.*

Here, the Board's revised briefing schedule indicated that the employer's appellant's brief was due on November 10, 2000, which was a Friday. The employer filed its appellant's brief by mailing the brief by certified mail, on Monday, November 13, 2000. However, Friday, November 10, 2000 was Veteran's Day, a state holiday. ORS 187.010(1)(h); ORS 187.010(2) (November 11, 2000 was a Saturday; each time a holiday falls on a Saturday, the preceding Friday shall be a legal holiday). In addition, all Sundays are legal holidays. ORS 187.010(1)(a).

In *Sandy K. Preuss*, 50 Van Natta 1028 (1998), we held that, when the last day of an appeal deadline falls on a state holiday, the appeal period "runs until the end of the next day that is not a Saturday or legal holiday." 50 Van Natta at 1028. Here, Monday, November 13, 2000, was the next day

(after November 10, 2000) that was not a Saturday or legal holiday. The employer's appellant's brief was timely filed.[1] Accordingly, we deny claimant's motion to strike.

Evidentiary Issue

The ALJ excluded Exhibits 15a through 15c from the record because they were not timely disclosed to claimant's attorney. On review, the employer contends that the ALJ abused his discretion in excluding the documents. We disagree.

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). OAR 438-007-0018(1) mandates that the carrier provide the claimant, 28 days before hearing, legible copies of all documents that are relevant and material to the matters in dispute at the hearing. Pursuant to OAR 438-007-0018(4), the ALJ has the discretion to admit or exclude documents that have not been disclosed pursuant to this rule. In the exercise of this discretion, the ALJ must determine whether material prejudice has resulted from the timing of the disclosure, and, if so, whether there is good cause for the failure to timely disclose the documents which outweighs any prejudice to the other party. OAR 438-007-0018(4).

Here, the employer generated Exhibits 15a-c in November 1999, eight months prior to hearing.[2] However, the documents had not been disclosed to claimant's attorney until the day of the hearing. (Tr. 4). The documents were integral to the issue of the employer's compliance with a modified duty job offer in relation to the issue of claimant's entitlement to interim compensation. Compliance with the requirements of offering a modified duty job is very specific and detailed. *See* OAR 436-060-0030(5). Thus, the failure to disclose the documents was prejudicial to claimant's preparation for that issue at hearing. For instance, due to the untimely disclosure of Exhibits 15a-c, claimant's attorney was unable to confer with claimant or his attending physician regarding the modified job description and the attending physician's approval. (Tr. 6).

It is not sufficient that Exhibit 15, a letter to Dr. Morley seeking approval for a modified duty position referred to the excluded documents, and therefore allegedly put claimant "on notice" of the additional documents (Exhibits 15a-15c), as the employer contends. The employer must strictly comply with all of the elements of OAR 436-060-0030(5). *See Eastman v. Georgia Pacific*, 79 Or App 610 (1986); *Trevor E. Shaw*, 46 Van Natta 1821, *on recon* 46 Van Natta 2168 (1994). Therefore, the specific contents of the excluded documents were relevant and material to the issues at hearing. Such circumstances support the ALJ's conclusion that claimant would be prejudiced by their late disclosure.

Finally, the employer has not offered any basis for a finding of "good cause" for failure to disclose the documents which might outweigh any prejudice to claimant. OAR 438-007-0018(4). In these circumstances, we find that the ALJ did not abuse his discretion in declining to admit the documents.

Interim Compensation

Finding that the employer did not strictly comply with the administrative rule to cease the payment of interim compensation, the ALJ awarded claimant temporary partial disability from November 15, 1999 through February 7, 2000.

"Interim compensation" is paid upon receipt of notice of a claim until the claim is accepted or denied. *Jones v. Emanuel Hospital*, 280 Or 147 (1977). 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); *Teri L. Bernloehr*, 52 Van Natta 144 (2000).

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[1] *Corrie M. Harp*, 50 Van Natta 212 (1998), cited by claimant, is distinguishable. In Harp, we granted a motion to strike an appellate brief that was untimely because it was not filed (placed in the mail), on Columbus Day, which is a federal holiday, but not a state holiday. 50 Van Natta at 212 n1. However, as we discussed above, Veteran's Day, in contrast to Columbus Day, is a state holiday. In *Sandy K. Preuss*, we specifically noted that we would not apply our holding in *Connie M. Harp* to situations where the last day of an appeal deadline falls on a state holiday. 50 Van Natta at 1028.

[2] Exhibit 15a is a "job description/job analysis" for a "radio auditor" modified -duty position at the employer. Exhibit 15b is Dr. Dean's approval of this position. Exhibit 15c is apparently duplicative of Exhibit 15a.

The first installment of temporary disability compensation shall be paid no later than the 14th day after the employer has notice or knowledge of the claim, if the attending physician has authorized the payment of temporary disability compensation. ORS 656.262(4)(a). Moreover, the attending physician's authorization must relate the claimant's inability to work to the job-related injury. *Robert W. Fagin*, 50 Van Natta 1680, 1681 (1998).

Here, as the ALJ correctly noted, claimant has never been temporarily totally disabled. Instead, claimant's attending physician released him to modified work with regard to his wrist condition on November 13, 1999, the day after the on-the-job injury. (Ex. 12). Accordingly, the statutes and rules regarding when temporary total disability can be reduced to temporary partial disability are not applicable. *Audrey L. McDaniel*, 50 Van Natta 1423, 1424 (1998). Rather, the issue is the rate of temporary partial disability from November 15, 1999 (the date the employer received claimant's claim for the wrist injury) through February 7, 2000 (the date of the employer's denial). (Exs. 16, 35).

Temporary partial disability is determined by a comparison of a worker's post-injury wages with the worker's at-injury wages. *See* OAR 436-060-0030(2); *Lonnie L. Dysinger*, 47 Van Natta 2282, 2283 (1995). Here, claimant was suspended and then terminated following his injury for reasons unrelated to the injury. He therefore did not begin modified work. Accordingly, the employer could determine claimant's "post-injury" wages by using the wages claimant could have earned by accepting a modified duty job offer, *if* the employer otherwise has complied with OAR 436-060-0030(5). OAR 436-060-0030(10).

In light of our decision to affirm the ALJ's evidentiary ruling excluding Exhibits 15a-15c, we agree with the ALJ that the employer did not strictly comply with OAR 436-060-0030(5), which would allow the employer to offset wages claimant could have made by accepting the modified job offer. Specifically, the record does not contain a statement of the wages of the modified job, nor "an accurate description of the physical requirements of the job." OAR 436-060-0030(5)(c).

In any event, even if Exhibits 15a-c had been admitted, we agree with the ALJ that there is no evidence that claimant's attending physician, Dr. Morley, ever approved a modified job description. OAR 436-060-0030(5)(a) and (b). Instead, Dr. Dean, who apparently practices in the same office as Dr. Morley but has never examined claimant, approved claimant for unspecified "modified work." (Ex. 15).[3] Therefore, on that alternate basis, we find that the employer did not strictly comply with OAR 436-060-0030(5). The employer must calculate claimant's rate of temporary partial disability benefits based on a comparison of his wage at injury and (actual) post-injury wages, if any. OAR 436-060-0030(2).

Penalties

We adopt and affirm the ALJ's order on the issue of penalties for the employer's failure to pay interim compensation. In this regard, we note that the employer's only argument on review for avoidance of a penalty is that it did comply with OAR 436-060-0030(5). We have found otherwise. We therefore find that a penalty was appropriately assessed.

Attorney fee

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. We further note that claimant's attorney is not entitled to a fee for services devoted to the penalty issue. *Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986). In addition, services regarding claimant's unsuccessful motion to strike have also not been considered.

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[3] The employer contends that, because Dr. Dean and Dr. Mortley practice in an Urgent Care facility, physicians necessarily "fill in" for each other on a regular basis, including answering inquiries regarding approval of modified positions. (*See* Ex. 33). However, a hospital's internal practices cannot override the express statutory requirement.

ORDER

The ALJ's order dated August 7, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the self-insured employer.

February 8, 2001 Cite as 53 Van Natta 160 (2001)

In the Matter of the Compensation of
CHARLES M. WHITEHEAD, Claimant
WCB Case No. 00-02636
ORDER ON REVIEW
Preston, Bunnell & Stone, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) directed it to reopen and process claimant's "new medical condition" claim for a left knee arthritis condition pursuant to ORS 656.262 and ORS 656.268; and (2) awarded a penalty for the insurer's allegedly unreasonable claims processing. On review, the issues are claims processing and penalties.

We adopt and affirm the order of the ALJ with the following modification.

We note that, following the insurer's request for Board review of this matter, which was filed on November 1, 2000, the ALJ issued an "Amended Opinion and Order" dated November 6, 2000. The amended order essentially republished the ALJ's original October 5, 2000 order, but it also awarded an attorney fee for claimant's counsel's services at hearing.

Because the ALJ's amended order did not issue until after the insurer's request for Board review was filed, the ALJ did not have jurisdiction over the case and the "amended" order was not valid. *See Mach II*, 45 Van Natta 526, 527 (1993). Nevertheless, on *de novo* review, we find that the insurer's failure to process the claim constituted an unreasonable resistance to the payment of compensation. Therefore, an assessed attorney fee for claimant's counsel's services at hearing is appropriate.

After applying the factors set forth in OAR 438-015-0010(4), we conclude that an assessed attorney fee of $2,500 is a reasonable fee for claimant's counsel's services at hearing. In reaching our conclusion, we have considered the time devoted to the issue (as represented by the record), the complexity of the issue involved, the value of the interest involved, the skill of the attorneys, the nature of the proceedings, the benefits secured for the represented party, and the risk that claimant's counsel's efforts might go uncompensated.

Claimant's attorney is also entitled to an assessed fee for services on review regarding the claims 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 claims processing issue is $1,200, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the claims processing issue (as represented by that portion of claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant's attorney is not entitled to an attorney fee for services on review regarding the penalty issue.

ORDER

The ALJ's order dated October 5, 2000 is affirmed, as modified. For services at hearing and on review, claimant's counsel is awarded a total assessed attorney fee of $3,700, to be paid by the insurer.

In the Matter of the Compensation of
JIMMIE C. PEDERSON, Claimant
WCB Case No. 00-04735
ORDER ON REVIEW (REMANDING)
Bischoff, Strooband & Ousey, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Johnson's order that affirmed an Order on Reconsideration that set aside a Notice of Closure as prematurely issued. On review, the issues are premature closure and remand. We reverse the ALJ's order and remand.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

On October 17, 1999, claimant injured his low back, which resulted in his claim being accepted for an "L5-S1 disc herniation." Dr. Fridinger has been claimant's treating physician. On March 8, 2000, Dr. Fridinger declared claimant medically stationary. He noted that claimant's examination revealed full range of motion with minimal tenderness to palpation overlying the spine at belt level. Dr. Fridinger reported that claimant's discomfort in his back was not of any functional significance and was not coming from his ruptured disc. Dr. Fridinger permanently limited claimant's lifting to 25 pounds. Although Dr. Fridinger had not received notice regarding a closing examination from SAIF, he stated that "as far as I am concerned, this is [claimant's] closing exam." (Ex. 16).

On March 29, 2000, SAIF issued a Notice of Closure that awarded temporary but no permanent disability. Claimant requested reconsideration, raising only impairment findings and asking for a medical arbiter examination. (Ex. 23).

An Order on Reconsideration issued on May 26, 2000. It rescinded the Notice of Closure as having improperly closed the claim for lack of adequate closing information pursuant to OAR 436-030-0020(4)(a). The Appellate Review Unit (ARU) made the following statements: "While [the attending physician] reported lumbar spine ranges of motion as 'full', this is insufficient information to determine impairment;" and "[the attending physician] has only provided work restrictions." (Ex. 26-2). *See* ORS 656.268(1)(a). SAIF requested a hearing.

The ALJ found that the Department properly rescinded SAIF's closure notice. Specifically, the ALJ noted that the Department has promulgated OAR 436-030-0020(3), (4) and (6), which defines "sufficient information" upon which to close a claim includes the information required by OAR 436-030-015(2) and (4) and OAR 436-010-0280 and OAR 436-035-0001 *et seq*, the Disability Rating Standards. The ALJ agreed with claimant's argument that Dr. Fridinger's statement that claimant has "full range of motion of his lumbar spine" is not sufficiently precise to allow application of the Standards.

On review, SAIF contends that our recent decision in *Gloria Garibay*, 52 Van Natta 2251 (2000) governs this case. We agree.

In *Garibay*, a decision issued subsequent to the ALJ's order, 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 contained sufficient information to determine permanent impairment.

Here, at the closing examination, Dr. Fridinger found claimant to be asymptomatic in regard to his ruptured disc. He noted claimant's full range of motion, a negative result on the straight leg raising test, and no neurological deficits. Finally, Dr. Fridinger attributed the only positive finding, that of tenderness "at the belt line," as "[not] coming from his ruptured disc."[1]

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[1] Although Dr. Fridinger permanently limited claimant's lifting to 25 pounds, a lifting restriction alone does not qualify as "impairment." *Jeffrey V. Collado*, 50 Van Natta 2075 (1998).

After our review of Dr. Fridinger's report, we conclude that Dr. Fridinger's closing examination report contained sufficient information for SAIF to determine impairment. Consequently, we find that the Department improperly rescinded SAIF's closure notice.

Finally, because the closure notice was improperly rescinded and because claimant specifically requested an arbiter during the reconsideration proceeding, the claim should be remanded to the ALJ so that the parties can ask the Director to schedule a medical arbiter's examination. *See Katherine M. Tofell*, 51 Van Natta 1845 (1999); *compare Raymond L. Harris*, 52 Van Natta 1357 (2000) (where the claimant had not requested a medical arbiter examination, it was not necessary to remand to the ALJ for deferral pending receipt of a medical arbiter's report).

As we explained in *Tofell*, we have fashioned a remedy that accommodates both our lack of authority to remand this claim to the Director, *Pacheco-Gonzalez v. SAIF*, 123 Or App 312 (1993), and claimant's statutory entitlement to a medical arbiter report. Specifically, while we are remanding this case to the ALJ, the parties are directed to seek a medical arbiter examination through the Director. Once that examination is conducted and an arbiter report issues, the parties may notify the ALJ, who can then proceed to review the extent of disability issue.

Accordingly, we 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 on claimant's challenges to the Notice of Closure (including consideration of the medical arbiter's report), they shall contact the ALJ. Thereafter, the ALJ shall conduct further proceedings in any manner that achieves substantial justice.

ORDER

The ALJ's order dated November 3, 2000 is reversed. The Order on Reconsideration's rescission of the Notice of Closure is reversed. The ALJ's attorney fee award is reversed. This matter is remanded to ALJ Johnson for urther proceedings consistent with this order.

February 9, 2001 Cite as 53 Van Natta 162 (2001)

In the Matter of the Compensation of
VICKIE R. LARSON, Claimant
WCB Case No. 00-02233
ORDER ON REVIEW
John C. Dewenter, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Nichols' order that: (1) found that claimant's claim should be reclassified as disabling, whereas an Order on Reconsideration had found the claim non disabling; and (2) awarded 5 percent (16 degrees) unscheduled permanent disability. On review, the issue is claim processing.[1] We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for left rhomboid strain. An Order on Reconsideration dated February 28, 2000 affirmed a Determination Order that found that claimant's claim was correctly classified as nondisabling. Based on Exhibit 21, a document prepared by claimant's attending physician, Dr. Foreman, and based on a physical capacities evaluation approved by Dr. Foreman that listed claimant's physical limitations, the ALJ found that claimant had a 1 percent loss of range of motion in the thoracic spine. In addition, the ALJ awarded claimant 5 percent unscheduled permanent disability

[1] Claimant filed a cross-request for review, but withdrew the cross-request in her brief.

for a chronic condition limiting repetitive use of her shoulder/lower thoracic area. Based on this evidence, the ALJ found that claimant would be entitled to an award of permanent disability benefits and that her claim should be reclassified as disabling.

A "disabling compensable injury" entitles the worker to compensation for disability or death, whereas an injury is not disabling if no temporary disability benefits are due and payable, unless there is a reasonable expectation that permanent disability will result from the injury. ORS 656.005(7)(c). Here, claimant's rhomboid strain claim is disabling only if there is proof of a reasonable expectation of permanent disability. In construing ORS 656.005(7)(c) and determining whether a compensable injury is disabling, we require expert medical opinion indicating that a permanent disability award is likely or expected. *See, e.g., Thomas G. Dobson*, 50 Van Natta 2390, 2391, *on recon* 51 Van Natta 297 (1999); *Gerasimos Tsirimiagos*, 50 Van Natta 1627 (1998).

SAIF argues that the compensable injury involved a rhomboid strain and did not involve the thoracic spine and that no evidence establishes that the loss of range of motion in the thoracic spine is due to the injury. Assuming without deciding that there is insufficient evidence to establish that claimant's loss of thoracic range of motion is due to the compensable injury, there is also medical evidence suggesting a chronic condition limiting repetitive use of the shoulder/lower thoracic area.

The ALJ concluded that claimant was entitled to 5 percent unscheduled permanent disability for a chronic condition limiting repetitive use of the shoulder/lower thoracic area. The ALJ based this conclusion on Dr. Foreman's permanent restriction on claimant's ability to repetitively reach overhead and forward. Pursuant to OAR 436-035-0320(5), a worker may be entitled to unscheduled chronic condition impairment where a preponderance of medical opinion establishes that the worker is unable to repetitively use a body area due to a chronic and permanent medical condition. In this regard, the physical capacities evaluation signed by Dr. Foreman indicates that claimant is restricted in her ability to reach overhead and forward. (Ex. 18-2). In addition, the physical capacities evaluation approved by Dr. Foreman states that left reach is limited by left rhomboid and lower trapezius weakness, and complaints of increased pain in the left scapular area. The evaluation further indicates that left reaching more than once every 5-10 minutes increases symptoms.[2] *Id.*

Based on his signature and approval of the physical capacities evaluation and permanent restrictions, we conclude that Dr. Foreman agreed with the findings. In addition, Dr. Foreman indicated that the restrictions were permanent. (Ex. 18-3). Under these circumstances, we find that claimant has established a reasonable expectation that permanent disability will result from the injury. See ORS 656.005(7)(c). Accordingly, we agree with the ALJ that the claim should be reclassified as disabling.

In addition to finding that the claim should be classified as disabling, the ALJ actually awarded permanent disability benefits for a chronic condition limiting repetitive use of the shoulder/lower thoracic spine. SAIF contends that the ALJ's determination of permanent disability was premature because the claim has not yet been processed to closure. We agree that the issue of extent of permanent disability is not yet ripe. The issue litigated by the parties was whether the claim should be reclassified as disabling, not the extent of any permanent disability that might exist. To show that a claim should be classified as disabling, the statute requires only a reasonable expectation that permanent disability will result. It is not necessary to establish entitlement to an award. Accordingly, we reverse that portion of the ALJ's order that awarded permanent disability benefits.

Claimant's attorney is entitled to an assessed fee for services on review. *See Ben E. Conradson*, 52 Van Natta 893 (2000); 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 classification issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

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[2] We have previously interpreted language similar to that in OAR 436-035-0230(5) requiring that a worker be "unable" to repetitively use a body part to require that there must be medical evidence of at least a partial loss of ability to repetitively use the body part. *Donald E. Lowry*, 45 Van Natta 749, *on recon* 45 Van Natta 1452 (1993); *see Weckesser v. Jet Delivery Systems*, 132 Or App 325, 328 (1995) (court relied on Board's interpretation of *former* OAR 436-35-010(6) as requiring at least a partial loss of ability to repetitively use the body part to establish chronic condition impairment). Here, the medical evidence establishes a partial loss of ability to repetitively use the left shoulder/lower thoracic area. Thus, we are persuaded that claimant is reasonably likely to receive a permanent disability award.

ORDER

The ALJ's order dated October 18, 2000 is affirmed in part and reversed in part. The portion of the ALJ's order that awarded permanent disability benefits is reversed. The ALJ's award of an "out-of-compensation" attorney fee is also reversed. The remainder of the ALJ's order is affirmed. For services on Board review, claimant's attorney is awarded $1,000, payable by SAIF.

February 9, 2001 Cite as 53 Van Natta 164 (2001)

In the Matter of the Compensation of
STACEY A. PENDERGAST, Claimant
WCB Case No. 00-00035
ORDER ON REVIEW
Coughlin, Leuenberger & Moon, Claimant Attorney

Reviewed by Board Members Haynes and Bock.

Johnston and Culbertson Insurance Company (JCI), the statutory assigned claims agent for a noncomplying employer, requests review of those portions of Administrative Law Judge (ALJ) Podnar's order that: (1) awarded an $8,000 attorney fee under ORS 656.386(1); and (2) assessed a penalty for JCI's allegedly unreasonable denial. In her respondent's brief, claimant requests an additional attorney fee for services on review pursuant to ORS 656.382(2) and seeks sanctions pursuant to ORS 656.390 for a frivolous appeal. On review, the issues are attorney fees, penalties and sanctions. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact with the addition of the following facts.

On March 28, 2000, the parties proceeded to hearing on the issues of JCI's denial of claimant's injury claim for a back condition. The one-day hearing lasted more than four hours. The issues at hearing involved compensability, penalties for an allegedly unreasonable denial, and attorney fees under ORS 656.386(1). The parties called six witnesses, two on behalf of claimant. The transcript of the hearing consisted of 187 pages. The admitted exhibits totaled 65, 11 of which were originally submitted by claimant's attorney. One physician deposition was conducted, requested by JCI. Claimant's attorney spent significant "post-hearing" time subpoenaing the employer's business records. These efforts included seeking and securing an ALJ's order directing the disclosure of such records.

After the hearing, claimant's attorney submitted a statement of services detailing 40.9 hours of time. The statement did not differentiate between time expended for the compensability issue and the penalty/attorney fee issue. Claimant's attorney requested a fee of $8,000, reflecting an hourly rate of $150 plus a "contingency factor" for the risk of not prevailing over the denial.

CONCLUSIONS OF LAW AND OPINION

Attorney Fees

Considering all of the factors in OAR 438-015-0010(4), the ALJ awarded claimant's counsel $8,000 for services rendered at the hearing level in overturning JCI's denial. In determining the amount of the attorney fee, the ALJ noted that claimant's attorney worked in an expeditious fashion, in light of the necessity to develop all aspects of the claim. The ALJ further acknowledged JCI's argument that the benefit to claimant was "*de minimus*," but noted that the benefit secured is but one of the factors to be considered. The ALJ also took into account the risk of claimant's counsel going uncompensated, given the "vigorous defense" mounted by JCI.

In determining a reasonable attorney fee, we apply the factors set forth in OAR 438-015-0010(4). Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses. *See Schoch v. Leupold & Stevens*, 162 Or App 242 (1999) (the Board must explain the reasons why the factors considered lead to the conclusion that a specific fee is reasonable).

On review, we find that the time devoted to the compensability dispute[1] and the nature of the proceedings were more extensive than those generally presented to the Hearings Division for resolution. The four-hour hearing involved six witnesses and 65 exhibits (including a "post-hearing" deposition). In addition, significant services were provided after the hearing involving the disclosure of business records from the employer. Both counsel presented their respective positions in a skillful and professional manner.

Considering disputes generally litigated before the Hearings Division, the issues in this case were of above-average complexity (both legally and factually). In reaching this conclusion, we note the involvement of the NCE, the "post-hearing" deposition, and the unusual "subpoena" issue, as well as strongly contested issues of both credibility and medical causation.

Next, we acknowledge that the benefit secured for claimant was relatively small given the nature of her injury (thoracic strain). Nonetheless, we do not consider it to be "*de minimus.*" In other words, as a result of claimant's attorney's efforts in overturning the denial of her injury claim, claimant secured the benefits of an accepted claim with lifetime rights to medical services, rights to temporary disability and "five-year" aggravation rights, as well as the potential for future benefits such as permanent disability and vocational assistance.

The risk of claimant's counsel going uncompensated was significant given the multi-faceted defense mounted by JCI, especially on the "credibility" issue. However, we have often stated that we do not apply a "contingency factor" or multiplier in a strict mathematical sense. *Kimberley R. Rice*, 52 Van Natta 138 (2000); *Karen M. Stone*, 51 Van Natta 1560 n1 (1999). The ALJ did not expressly apply a contingency factor, but rather increased the fee to account for the risk of going uncompensated given the "vigorous defense" of this claim. We agree with the ALJ that consideration of the risk of going uncompensated (but not a mathematically calculated "contingency factor" as requested by claimant's counsel) is appropriate here. Finally, we find that there were no frivolous defenses asserted.

Based on application of each of the previously enumerated rule-based factors and considering the parties' arguments, we find that $6,000 is a reasonable attorney fee for services at the hearings level regarding the compensability issue. Accordingly, we modify the ALJ's attorney fee award.

Penalties

The ALJ awarded a penalty for JCI's unreasonable denial, finding that JCI did not have a legitimate doubt as to the compensability of claimant's claim at the time of its denial. ORS 656.262(11)(a).

On review, JCI first contends that the ALJ did not make a finding as to what evidence JCI had at the time of its denial, citing to *Brown v. Argonaut Insurance Co.*, 93 Or App 588 (1988). We disagree. The ALJ stated that JCI had no medical evidence refuting the fact that claimant had suffered a work-related thoracic strain at the time of its December 21, 1999 denial. (Ex. 47). (O&O at 3). The ALJ specifically noted that Dr. Sandefur's initial response to JCI indicating that the thoracic strain was not related to the work incident was not received by JCI until after the issuance of its denial. (Ex. 50).

In any event, based on our *de novo* review of the record, we find that JCI had no legitimate doubt as to the compensability of this claim as of the date of its denial. *Brown v. Argonaut Insurance Co.*, 93 Or App at 592. In this regard, we note that claimant's injury was witnessed by a coworker and claimant reported the injury to another coworker that same day. (Tr. 57, 74). There is also no

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[1] Claimant's counsel submitted a statement of services detailing 40.9 hours of time expended at the hearings level. However, claimant's counsel did not separate the time spent on the compensability issue as opposed to the penalty issue. The ALJ's and our authority to award an assessed attorney fee under ORS 656.386(1) is for services devoted to the compensability issue only; *i.e.* overturning the denial. *See Pamela J. Peacock*, 52 Van Natta 835 n4 (2000). The statute does not provide an attorney fee for services directed to the penalty issue. Instead, claimant's counsel receives one-half the penalty based on 25 percent of the compensation "then due" as a result of the unreasonable claims processing issue. ORS 656.262(11). Because claimant's counsel's statement of services does not apportion services between the compensability and penalty/attorney fee issues, a portion of such services cannot be considered in determining a reasonable attorney fee for prevailing over the compensability denial. Based on the record, we conclude that the portion of claimant's counsel's services devoted to the penalty/attorney fee issue were minimal; *i.e.* no more than 10 percent.

preexisting condition in the record to which JCI could allege that claimant's back condition is related.[2] Moreover, claimant's condition, diagnosed as "thoracic strain," was supported by the objective findings of marked spasm of the thoracic spine. (Ex. 43). Finally, claimant consistently reported to her treating physicians that her injury hitting her back on a cooler handle happened at work. Claimant reported this same history from her first visit with Dr. Kehr on May 26, 1999 (five days after the work injury) although at the time she chose not to "turn it in" as a workers' compensation matter. (Ex. 14B-3). Accordingly, we agree with the ALJ that a penalty was appropriate. ORS 656.262(11)(a).

Sanctions

Claimant seeks sanctions for JCI's allegedly frivolous request for review. Pursuant to ORS 656.390(1), the Board may impose a sanction against the attorney filing a request for review if we determine that the appeal 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 the matter is initiated without reasonable prospect of prevailing. ORS 656.390(2). We decline to award sanctions for the following reasons.

On the issue of attorney fees, JCI presented arguments that resulted in a reduction in the amount of the ALJ's award. The fact that JCI was successful on one aspect of its request for review indicates that its request for review on that issue was not frivolous. Therefore, JCI's entire request for review is not frivolous. *See Arlene J. Bond*, 50 Van Natta 2426, 2427 (1998). Moreover, although we have affirmed the ALJ's assessment of a penalty, we find that JCI presented a colorable argument for the reversal of the penalty award. Consequently, the request for sanctions is denied.

ORDER

The ALJ's order dated September 7, 2000 is affirmed in part and modified in part. In lieu of the ALJ's $8,000 attorney fee award, claimant's attorney is awarded $6,000 for services at the hearing level, payable by JCI. The remainder of the order is affirmed.[3]

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[2] Claimant's scoliosis condition was determined to be "posttraumatic" in nature. (Exs. 51, 52).

[3] Claimant's attorney is not entitled to an additional fee for services on review as the only issues on review were attorney fees and penalties. *Dotson v. Bohemia*, 80 Or App 233, *rev den* 302 Or 35 (1986); *Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986).

In the Matter of the Compensation of
CHRISTOPHER M. VANDEHEY, Claimant
WCB Case No. 00-08278
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that upheld the SAIF Corporation's denial of his aggravation claim for a low back condition. On review, the issue is aggravation.

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

Claimant has an accepted claim for low back strain and L4-5 disc herniation conditions. (Ex. 8). SAIF issued a Notice of Closure on June 9, 1999, awarding claimant 14 percent unscheduled permanent disability and four percent scheduled permanent disability for loss of use or function of the left leg. (Ex. 9). Claimant was awarded values for a low back surgery and for the adaptability "factors," but was not awarded any value for loss of range of motion in his lumbar spine, based on the May 12, 1999 "closing examination" findings of his attending physician, Dr. Niles. (Ex. 6).

On July 16, 1999, Dr. Niles noted increased pain in claimant's low back and legs, as well as loss of circumference in claimant's left thigh and calf, "more marked" since the closing examination. (Ex. 12-1). Dr. Niles then ordered an MRI scan and referred claimant to neurosurgeon Dr. Mason. (Ex. 15). Dr. Mason evaluated claimant on July 30, 1999 and requested a lumbar myelogram to determine the possible necessity of additional surgery. (Ex. 18-2).

Claimant requested reconsideration of the Notice of Closure with a medical arbiter panel. On August 21, 1999, the medical arbiter examiners found decreased range of motion in his lumbar spine. (Ex. 21-6). The arbiters, however, noted that claimant was "under active evaluation for [his low back condition] with a pending myelogram, and we believe this should be completed before any impairment or residual functional capacity limitation is determined." (Ex. 21-8). An Order on Reconsideration affirmed SAIF's Notice of Closure with regard to permanent disability. (Ex. 26).

Claimant then filed a claim for aggravation, which was denied by SAIF. (Exs. 30, 34). In upholding SAIF's denial, the ALJ found that claimant had not met his burden of proving an "actual worsening" of his compensable condition. The ALJ reasoned that Dr. Niles ultimately concluded that claimant had experienced only a "waxing and waning" of his symptoms, as opposed to an actual worsening. (Ex. 32).

On review, claimant contends that the medical evidence from Dr. Niles and the medical arbiters establishes that he suffered at least a temporary "actual worsening" of his compensable low back condition to support a valid aggravation. ORS 656.273. We disagree.

To establish a compensable aggravation claim, claimant must prove an "actual worsening" of his 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); *Norma L. Lamerson*, 52 Van Natta 1086 (2000).

Here, Dr. Niles at one time opined that claimant's increased symptoms and temporarily-increased restrictions in his low back "merit reopening" of his claim. (Ex. 19). Dr. Niles also agreed that, at the time of claimant's medical arbiter examination, his low back condition was worse than it had been at the time of closure. (Ex. 41-14). However, Dr. Niles' ultimate opinion is that claimant suffered only a "waxing and waning" of the symptoms related to his compensable low back condition, as opposed to an "actual worsening."[1] (Exs. 32, 41-9); ORS 656.273(8). Dr. Niles reached this conclusion after reviewing claimant's September 14, 1999 myelogram and reports from Dr. Mason, the consulting neurosurgeon. (Exs. 27, 31). Dr. Niles did not have this additional information at the time she stated her initial opinion on "reopening."

Claimant also contends that the medical arbiters' examination findings provide objective evidence of a worsened condition. We disagree. The medical arbiters were charged with determining the extent of permanent impairment attributable to claimant's compensable conditions. The arbiters did not address the specific requirements of the aggravation statute, *i.e.* whether or not claimant's findings constituted an "actual worsening" (Ex. 21). ORS 656.273. Consequently, the medical arbiters' findings are not probative on the aggravation issue.

ORDER

The ALJ's order dated October 24, 2000 is affirmed.

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[1] Dr. Niles' final opinion was that *at no time since closure* did claimant suffer an "actual worsening" of his low back condition, not that claimant suffered a temporary "actual worsening," as claimant contends. (Ex. 41-30); *see Roland A. Walker*, 52 Van Natta 1018 (2000) (*Walker* on remand). Consequently, we are not persuaded that Dr. Niles' ultimate conclusion supports the compensability of claimant's aggravation claim.

In the Matter of the Compensation of
JAMES K. McVEY, Claimant
Own Motion No. 00-0280M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests review of the insurer's November 6, 2000 Notice of Closure, which closed his claim with an award of temporary disability compensation from June 7, 2000 through July 21, 2000.[1] The insurer declared claimant medically stationary as of July 21, 2000.

In his request for review, claimant contends that the June 2000 surgery left him "totally disabled" from work and that his condition continues to worsen. We interpret such a contention to mean that claimant was not medically stationary at claim closure.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981).

The propriety of the closure turns of whether claimant was medically stationary at the time of the November 6, 2000 Notice of Closure, considering claimant's condition at the time 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 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 additional benefits because his surgery disabled him from work and he continues to worsen. We interpret claimant's request as a challenge to the "closure" and timeloss awarded. The evidence in the record supports the conclusion that claimant was medically stationary at the time of closure and temporary disability compensation was appropriately terminated.

In a July 21, 2000 chart note, Dr. Chiu, claimant's attending physician, recommended a neurosurgical evaluation, which claimant was apparently interested in pursuing. Noting that no further follow-up visits would be scheduled, Dr. Chiu reported that claimant would be seen on an "as-need-basis."

On August 2, 2000, Dr. Chiu agreed that claimant's condition had reached medically stationary status. In a September 13, 2000, Form 827, based on his July 21, 2000 examination, Dr. Chiu declared claimant medically stationary.

These opinions are unrebutted. Thus, based on uncontroverted medical evidence, we find that claimant was medically stationary on the date his claim was closed. We further conclude claimant is not entitled to additional temporary disability benefits.

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[1] Claimant's May 14, 1985 claim was accepted as a disabling claim and was first closed on August 16, 1986. Thus, claimant's aggravation rights expired on August 16, 1991. ORS 656.273(4)(a). When claimant's condition worsened requiring surgery in June 2000, claimant's claim was under our Own Motion jurisdiction. ORS 656.278(1)(a). Consistent with our statutory authority, on September 15, 2000, we issued our Own Motion Order authorizing the payment of temporary disability compensation and noted that when claimant was medically stationary, the insurer should close the claim pursuant to OAR 438-012-0055.

In his request for review, claimant notes that he is "totally disabled" and that Dr. Chiu agrees that he would be permanently impaired. To the extent that claimant is seeking a permanent disability award, we are without authority to grant such benefits. In other words, the legislature has not authorized the Board to grant permanent disability compensation for an Own Motion claim. *Independent Paper Stock v. Wincer*, 100 Or App 625 (1990).[2]

In conclusion, based on the uncontroverted medical evidence, we find that claimant was medically stationary on the date his claim was closed. Therefore, the insurer's closure was proper.

Accordingly, we affirm the insurer's November 6, 2000 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[2] It appears from claimant's request 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 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
NICK J. MARTIN, Claimant
WCB Case No. 00-05239
ORDER ON RECONSIDERATION
Brian L. Pocock, Defense Attorney

We have received correspondence from claimant requesting "more time for my appeal." We treat this as a request for reconsideration of our January 24, 2000 Order on Review that affirmed the Administrative Law Judge's (ALJ's) order upholding the insurer's denial. We withdraw our prior order and proceed with our reconsideration.

After reviewing claimant's reconsideration request, it appears that he desires more time to obtain additional information regarding his case. Our review, however, is limited to the record developed before the ALJ. *See* ORS 656.295(5). Having considered that record, we previously concluded that the ALJ's decision was proper. We do not have statutory authority to lengthen the appeal period or to allow additional evidence to be considered. Instead, as explained in the section marked "Notice to All Parties," claimant's option (if dissatisfied with this decision) is to petition the Court of Appeals for judicial review of our order.

Accordingly, we withdraw our January 24, 2000 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
KATHLEEN A. ROBINSON, Claimant
WCB Case No. 93-02515
ORDER ON REMAND
Welch, Bruun & Green, Claimant Attorney
VavRosky, MacColl, et al, Defense Attorney

This matter is before the Board on remand from the Supreme Court. *Robinson v. Nabisco, Inc.*, 331 Or 178 (2000). The Supreme Court has reversed the Court of Appeals decision, 143 Or App 59 (1996), that had affirmed our prior order, *Kathleen A. Robinson*, 46 Van Natta 833, *on recon* 46 Van Natta 1677 (1994), that had upheld the self-insured employer's partial denial of claimant's low back disc herniation injury claim which had resulted from her employer-arranged medical examination for a compensable low back strain injury. Reasoning that claimant's prior compensable low back strain injury (the claim under which the medical examination had been based) was not the major contributing cause of the disc herniation, we had concluded that the claim was not compensable as a "consequential condition" under ORS 656.005(7)(a)(A). Concluding that claimant's injury during the employer-arranged medical examination arose out of and in the course of her employment, the Court determined that the injury was compensable under ORS 656.005(7)(a) and, as such, the limitation in ORS 656.005(7)(a)(A) was not applicable. Accordingly, the Supreme Court has remanded for further proceedings.

As previously noted, the Supreme Court has held that claimant's low back herniated disc injury is compensable due to its connection to work. Because the Court has ruled that claimant's injury arose of and in the course of her employment, the employer's denial is set aside and the claim is remanded to the employer for further processing in accordance with law.

Where a claimant finally prevails after remand from the Supreme Court, the Board shall approve or allow a reasonable attorney fee for services before every prior forum. ORS 656.388(1); *Mark L. Hadley*, 47 Van Natta 725 (1995). Because claimant did not finally prevail over the employer's denial until the issuance of this Order on Remand, the Court "conditionally" granted claimant a $28,735 fee for her attorney's services. After considering the factors set forth in OAR 438-015-0010(4), we find that the Court's $28,735 award represents a reasonable fee for claimant's counsel's services performed at hearing, on Board review, on Board reconsideration, and before the Court of Appeals and the Supreme Court.

Accordingly, the ALJ's order dated June 24, 1993 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the employer for further processing according to law. For services at all levels, claimant is awarded $28,735, to be paid by the employer.

IT IS SO ORDERED.

In the Matter of the Compensation of
GLENN A. BURKS, Claimant
WCB Case Nos. 00-05592, 00-05591, 00-04042, 00-03844, 00-03503 & 00-01247
ORDER ON REVIEW
Myrick, Seagraves, Claimant Attorney
Julie Masters (Saif), Defense Attorney
Hornecker, Cowling, et al, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

SIMS, on behalf of Barrett Business Services/Furniture Crafters, requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its responsibility denial of claimant's occupational disease claim for his right carpal syndrome condition; and (2) upheld the SAIF Corporation's responsibility denial, on behalf of Wildwood Cabinets, Inc., of claimant's claim for the same condition. On review, the issue is responsibility.

We adopt and affirm the order of the ALJ with the exception of the last partial paragraph on Page 4 and the remainder of that paragraph on the top of Page 5 of the Opinion and Order. We substitute the following reasoning.

SIMS argues that there is no evidence that claimant established a pathological worsening of his carpal tunnel syndrome condition during his employment with its insured, Furniture Crafters. As the ALJ acknowledged, no doctor specifically used the words "pathological worsening" in addressing the effect of claimant's work at Furniture Crafters on his carpal tunnel condition. Nevertheless, we conclude that the medical opinions are sufficient to establish that claimant's condition pathologically worsened.

In *Linda M. Hansen*, 51 Van Natta 1253 (1999), we noted that the claimant's treating doctor did not expressly state that her work-related activities were the major contributing cause of the pathological worsening of her preexisting condition. However, the doctor had explained that the claimant's dysfunction was progressive and that work had exacerbated the condition. Relying on *Freightliner Corp. v. Arnold*, 142 Or App 98 (1996), we found that "magic words" were not required and the doctor's opinion established that work activities were the major cause of the pathological worsening of claimant's condition.

Here, Dr. Schilperoort reported that there was "significant contribution" from claimant's work at Furniture Crafters and it was likely that the "normal course of [claimant's] work has continued to worsen the condition." (Ex. 14-7). Dr. Appleby reported that claimant's work for Furniture Crafters which was continually "stressful to his hands has been the most important specific period relative to his right hand symptoms." (Ex. 17-2). Dr. Appleby also stated that claimant's prior problems had completely resolved and his work for SIMS' insured in a job that was highly repetitive had had "its effect on him." Finally, Dr. Marble reported that claimant's work for Furniture Crafters was the major contributing cause of claimant's need for treatment. (Ex. 40-7).

Accordingly, on this record, we conclude that the medical evidence establishes that claimant's work at Furniture Crafters pathologically worsened his carpal tunnel condition. Therefore, the ALJ properly shifted responsibility from Wildwood/SAIF to Furniture Crafters/SIMS.

ORDER

The ALJ's order dated October 11, 2000 is affirmed.

In the Matter of the Compensation of
FRED A. WRIGHT, Claimant
WCB Case No. 00-04960
ORDER ON REVIEW
Walsh & Associates, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that reversed an Order on Reconsideration finding that claimant's back and right elbow injury claim was prematurely closed. On review, the issue is premature closure.

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

On March 8, 2000, claimant's treating physician completed a "Closing Report Form" indicating that: (1) claimant's condition was medically stationary; (2) claimant was released for regular work; and (3) claimant did not have permanent impairment. (Ex. 6). Acting on that information, the insurer requested that the Department issue a Determination Order. (Ex. 7).

On March 24, 2000, a Determination Order awarded temporary disability, but no permanent disability. Claimant requested reconsideration contending (among other things) that the claim was prematurely closed. (Ex. 12). Thereafter, an Order on Reconsideration found that the claim had been prematurely closed, and rescinded the March 24, 2000 Determination Order. (Ex. 14-2). The insurer requested a hearing.

The ALJ determined that claimant's condition was stationary at the time of claim closure. Consequently, the ALJ concluded that the claim had not been prematurely closed. Accordingly, the ALJ reversed the Order on Reconsideration and reinstated the Determination Order.

On review, claimant does not contest his medically stationary status. Rather, claimant asserts that because no "detailed medical report" was supplied by the insurer to the Department, pursuant to OAR 436-030-0015(2)(c), claim closure was improper under the terms of OAR 436-030-0030. We disagree.

OAR 436-030-0030 sets forth the requirements of claim closure by the Department.[1] In particular, OAR 436-030-0030(2) provides:

> "Unless the worker is actively engaged in training, the insurer shall request determination for those claims it elects not to close within 14 days after the worker becomes medically stationary and sufficient information is available to determine the extent of disability pursuant sections 030-0015(2) and (4) of these rules."

OAR 436-030-0015(2) describes the materials which an insurer is required to provide the Department in order to request determination. Those materials include: "A closing medical examination report which describes in detail all permanent residuals attributable to the accepted condition(s) pursuant to OAR 436-010-0280 and OAR 436-035."[2] OAR 436-030-0015(2)(c).

Here, the "closing report" provides that: (1) claimant is no longer treating for the accepted injury; (2) the last date of treatment was January 17, 2000; (3) claimant was released for regular work on January 18, 2000; (4) claimant's condition is medically stationary; and (5) claimant has no permanent impairment attributable to the accepted condition. (Ex. 6). Although Dr. Humphrey's (attending physician) report does not record specific range of motion measurements, it does state that claimant has no permanent residuals. Consequently, the closing report satisfies the terms of OAR 436-030-0015(2)(c). *See Gloria Garibay*, 52 Van Natta 2251 (2000) (although lacking specific range of motion findings, closing report contained sufficient information to close claim).

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[1] As of January 1, 2001, all claim closures are by Notice of Closure. Section 16(3), chapter 313, Oregon Laws 1999.

[2] OAR 436-010-0280 and OAR 436-030-0001 *et seq*, are the Disability Rating Standards.

Thus, because claimant was medically stationary, and the Department had sufficient information available to determine the extent of claimant's disability (none) we conclude that the March 24, 2000 Determination Order was properly issued. Consequently, we agree with the ALJ's conclusion that the claim was not prematurely closed.

ORDER

The ALJ's order dated October 16, 2000 is affirmed.

February 14, 2001 Cite as 53 Van Natta 173 (2001)

In the Matter of the Compensation of
PATRICIA A. BOYD, Claimant
WCB Case Nos. 00-01853 & 99-09795
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorney
Hornecker, Cowling, et al, Defense Attorney
Bostwick, et al, Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

Johnston & Culbertson, Inc., (JCI) requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order that: (1) set aside its compensability/responsibility denial of claimant's "new injury" claim for a left shoulder condition; and (2) upheld EBI Insurance Companies' (EBI) responsibility denial for the same condition. On review, the issues are compensability and responsibility.

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

Claimant compensably injured her left shoulder as the result of a fall in February 1999 while working for EBI's insured. The accepted condition was "left shoulder strain."[1] (Ex. 28A). Claimant's pain from this injury subsided in April 1999. (Tr. 16).

In July 1999, while working for JCI's insured as a chemical applicator, claimant had the sudden onset of pain at the top of her left shoulder, immediately after lifting and pulling on a long hose. (Tr. 12). The pain following this episode was more severe and in a different location than the pain from the February 1999 injury (the top of the shoulder as opposed to the top of the biceps). (Tr. 14, 16).

The ALJ, relying on the opinions of Drs. Melson and Geist (EBI-arranged examiners), determined that claimant's work injury of July 1999 was the major contributing cause of claimant's disability or need for treatment for her left shoulder condition.[2] Consequently, the ALJ concluded that claimant's July 1999 work injury was compensable.

JCI, relying on the opinion of Dr. Schilperoort, acknowledges that the July 1999 work precipitated claimant's shoulder symptoms. Nonetheless, JCI contends that the work injury is not the major contributing cause of claimant's disability or need for treatment of the left shoulder condition. Rather, JCI asserts that claimant's preexisting type II or type III acromion process is the major contributing cause of her disability or need for treatment of her left shoulder condition.

The parties agree that the major contributing cause standard applies to this claim. In order to satisfy the "major contributing cause" standard, claimant must establish that her work injury of July 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

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[1] Dr. Srch, the attending physician at that time, diagnosed "left shoulder subluxation" and "strain of left biceps tendon." (Ex. 7-1).

[2] The opinion of Drs. Melson and Giest is supported by Dr. Wenner, who was initially a consulting orthopedist but became the attending physician after Dr. Laubengayer retired. (Ex. 31A).

disability or need for treatment of the claimed condition and deciding which is the primary cause. *Dietz v. Ramuda,* 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). The fact that a work event precipitated the symptoms or need for treatment of a condition does not necessarily mean that the work incident was the major contributing cause of the condition or its need for treatment. *Dietz,* 130 Or App at 401; *see also Robinson v. SAIF,* 147 Or App 157, 162 (1997); *Elaine M. Baxter,* 51 Van Natta 1898 (1999).

Because of the possible alternative causes for the left shoulder 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).

Initially, Dr. Schilperoort noted claimant's acromion condition, but opined that as a result of the July 1999 work incident, claimant "sustained an acute biceps tendinitis involving the shoulder." (Ex. 20-6). In rendering his opinion, Dr. Schilperoort specifically noted tenderness compatible with biceps tendinitis as an objective finding. (Ex. 20-7).

Later, after reviewing MRI scans, Dr. Schilperoort indicated that the July 1999 work incident caused either: (1) an acute bicipital tendinitis; or (2) an impingement problem (type II or type III acromion) to become symptomatic. (Ex. 34-24). In assessing the probabilities for each diagnosis, Dr. Schilperoort opined that: (1) the likelihood that the July 1999 work incident caused an acute bicipital tendinitis was 48 percent; and (2) the likelihood that the July 1999 work incident caused a preexisting impingement to become symptomatic was 52 percent. (Ex. 34-37).

During Dr. Schilperoort's deposition the following exchange took place:

"Q. If we're looking at the impingement syndrome, except for the possibility of the July 26th incident making that symptomatic, it preexisted and was unrelated to either incident; is that correct?

"A. I need to expand on that just a minute.

"* * * * *

"A. And that is subacromial impingement syndrome, the term 'syndrome' is a collection of symptoms generally associated with the particular pathologic problem. That's why they call it carpal tunnel syndrome, for instance. One can have subacromial impingement often times for years before it becomes symptomatic. Once it becomes symptomatic, it then becomes subacromial impingement syndrome. There is evidence that subacromial impingement had been present for a very long time period and clearly preceded both of the injury events that were present. In fact, far more commonly than not, there is a mild to moderate episode that occurs that causes the chronic subacromial impingement to tip over and become symptomatic and, therefore, becomes subacromial impingement syndrome. I apologize for splitting hairs, but the importance is significant." (Ex. 34-19-20).

We conclude from Dr. Schilperoort's remarks that there is a medical distinction between subacromial impingement and subacromial impingement syndrome. We further conclude that Dr. Schilperoort is of the opinion that claimant's current shoulder condition is subacromial impingement syndrome (a symptom complex) that was caused in major part (52 percent) by claimant's work injury of July 1999. Consequently, contrary to JCI's assertions, we interpret the whole of Dr. Schilperoort's opinion as supporting the compensability of the July 1999 work incident. *See Teledyne Wah Chang v. Vorderstrasse,* 104 Or App 498, 501 (1990); *Georgia Pacific Corp. v. Warren,* 103 Or App 275, 278 (1990), *rev den* 311 Or 60 (1991); *Robert W. Fagin,* 50 Van Natta 1680, 1683 (1998) (if medical evidence establishes the symptoms are the disease, a worsening of symptoms that is caused, in major part, by work conditions may be compensable).

In contrast to Dr. Schilperoort, Drs. Melson and Geist opined that the July 1999 work incident caused a rotator cuff injury. (Ex. 32-6). Additionally, Drs. Melson and Geist noted claimant's preexisting acromion, but opined that the July 1999 work incident was the major contributing cause of

the current left shoulder condition and her need for treatment. (Ex. 32-6). In rendering their opinion, Drs. Melson and Geist took into account: (1) claimant's employment history and employment duties; (2) claimant's off-the-job activities and family history; (3) the preexisting acromion condition; (4) the February 1999 work injury; and (5) the prior medical records. Their opinion appears well reasoned.[3]

A specific diagnosis is not required to establish compensability; instead, the issue is whether claimant's condition is work-related, whatever the diagnosis. *See Boeing Aircraft Co. v. Roy*, 112 Or App 10, 15 (1992); *Tripp v. Ridge Runner Timber Services*, 89 Or App 355 (1988); *Vicky C. Shaw*, 52 Van Natta 1077 (2000). Consequently, based upon the above-listed medical opinions, we conclude that claimant's left shoulder condition is compensable, whether the actual diagnosis is a rotator cuff problem or subacromial impingement syndrome.

The ALJ determined that the February 1999 work injury did not involve the same condition as the July 1999 work injury. Consequently, the ALJ determined that ORS 656.308(1) was not applicable, and concluded that JCI was responsible for claimant's current left shoulder condition.[4]

JCI asserts that, if claimant's left shoulder condition is compensable, then ORS 656.308(1) is applicable, and that a correct analysis under that statute assigns responsibility to EBI.

EBI contends that, because the July 1999 work injury is the major contributing cause of claimant's disability or need for treatment of the left shoulder condition, responsibility rests with JCI, even if ORS 656.308(1) is applicable.

ORS 656.308(1) only applies if the later injury involves the same condition as did the earlier accepted claim. *Sanford v. Balteau Standard*, 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). Under ORS 656.308(1), 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, JCI is responsible for claimant's current left shoulder condition only if the July 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.

Based on Drs. Melson and Giest's persuasive opinion, we conclude that claimant's July 1999 work injury for JCI's insured was the major contributing cause of claimant disability or need for treatment of her current left shoulder condition. Consequently, regardless of whether claimant's current left shoulder condition is the same condition for which EBI was initially responsible, responsibility for claimant's current left shoulder condition rests with JCI.[5]

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[3] We acknowledge JCI's argument that Drs. Melson and Geist did not assign a specific percentage contribution to the preexisting acromion condition, and that they indicated: "How much a role they are playing is unknown." (Ex. 32-6). However, because they specifically indicated the acromion condition was considered and because they specifically indicated that the contribution of the July 1999 work injury was greater than 51 percent, we are not persuaded that their failure to attribute a specific percentage contribution to the acromion condition renders their opinion unpersuasive.

[4] ORS 656.308(1) provides:

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

[5] EBI accepted a "left shoulder strain." That is not the same condition as claimant's current rotator cuff problem. Therefore, ORS 656.308(1) is not applicable. However, even if the two conditions were the same and ORS 656.308(1) did apply, the result would be the same.

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 JCI. 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 September 5, 2000 is affirmed. For services on review, claimant is awarded a $1,200 attorney fee, payable by JCI.

February 15, 2001 Cite as 53 Van Natta 176 (2001)

In the Matter of the Compensation of
GALE F. FARRESTER, Claimant
WCB Case No. 00-02386
ORDER ON REVIEW
Doblie & Associates, Claimant Attorney
Terrall & Terrall, Defense Attorney

Reviewed by Board Members Biehl and Meyers.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hoguet's order that set aside its denial of claimant's injury claim for a back condition. On review, the issue is compensability.[1]

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

The ALJ set aside the employer's denial based on the "material contributing cause" standard, relying on the reports of claimant's treating physician, Dr. Niles. On review, the employer contends that the ALJ erred in failing to apply the "major contributing cause" standard, because claimant had a "preexisting condition" which combined with his work injury to cause his disability or need for treatment for a combined low back condition. ORS 656.005(7)(a)(B). We disagree.

For the "combined condition" statute to apply, there must be medical evidence that a preexisting condition combined with claimant's work injury to create a "combined condition." *Michael A. Kreger*, 52 Van Natta 2201 (2000). Here, although claimant had several prior injuries to his back, both on and off work, there is no medical evidence establishing the existence of a "combined condition," *i.e.* two conditions that "merge or exist harmoniously." *Luckhurst v. Bank of America*, 167 Or App 11, 16-17 (2000) (discussing *Multifoods Specialty Distribution v. McAtee*, 164 Or App 654 (1999). Accordingly, we find that the ALJ properly declined to apply the "major contributing cause" standard to this case. ORS 656.005(7)(a)(B).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4), and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by the 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 July 12, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the self-insured employer.

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[1] The employer initially moved to strike claimant's respondent's brief as untimely filed. However, when it learned that claimant's brief had been received by the Board (and not returned for postage), the employer withdrew its objection.

In the Matter of the Compensation of
VINCENT R. KIRCHER, Claimant
WCB Case No. 98-09401 & 98-03802
ORDER ON REVIEW
Fox & Olson, Claimant Attorney
Jerry Keene, Defense Attorney

Reviewed by Board Members Haynes, Bock, and Biehl.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Johnson's order that: (1) found that claimant's 1997 injury claim was filed timely; (2) set aside its denials of claimant's right lunate necrosis (avascular necrosis) condition; and (3) awarded a $17,250 attorney fee. On review, the issues are timeliness, compensability and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the last paragraph on page 3, we change the date in the first sentence to "February 1997." In the second paragraph on page 4, we replace the second sentence with the following:

> "Dr. Sanford reported that claimant had right hand pain, radiating into the wrist. (Ex. 3). Claimant thought he had injured it two weeks ago while pushing boxes. (*Id.*) Dr. Sanford noted: 'Had pain in hand before that incident.' (*Id.*) He found that claimant was 'tender (R) dorsum wrist over the mid joint space' and he diagnosed 'wrist pain.' (*Id.*)"

On page 4, we replace the third paragraph with the following:

> "Mr. Lazarus, claimant's supervisor, testified that he first saw claimant wearing a wrist splint in early 1997. (Tr. 219, 220). Lazarus said he asked claimant how he was injured and claimant responded that he was not sure, but he was 'leaning towards possibly hurting himself on the job.' (Tr. 219). Lazarus said he gave claimant an accident report in early 1997, but claimant did not return it to him. (Tr. 222-23, 225, 242, 255). Lazarus testified that he saw claimant wearing his splint for about two to three months. (Tr. 226).

In the fifth paragraph on page 4, we change the citation to "(Ex. 7)." In the last paragraph beginning on page 4, we change the fourth sentence to read: "This may represent healing phase of avascular necrosis of the lunate (Kienbock disease) or degenerative changes secondary to prior trauma and continued ligamentous instability." In the second full paragraph on page 8, we change the citation after the third sentence to "(Ex. 29-14)."

In the last two paragraphs on page 9, regarding Dr. Thompson's deposition testimony, we make the following changes. In the first paragraph of that section, we change the last sentence to read: "Dr. Thompson said there was a distinct possibility that claimant had only one source of vascularization of his lunate. (Ex. 34-14, -15)." We delete the last sentence on page 9.

In the first full paragraph on page 11, we change the fourth sentence to read: "Dr. Wilson acknowledged that if claimant had wrist pain before the February 1997 incident, it could change his opinion on causation. (Tr. 91-93)." In the same paragraph, we delete the last sentence.

In the last paragraph on page 11 regarding Dr. Button's deposition, we change all the citations to "Ex. 50" rather than "Ex. 38." We change the last sentence in that paragraph to read: "Dr. Button continued to believe that claimant's condition was idiopathic. (Ex. 50-29)."

CONCLUSIONS OF LAW AND OPINION

Timeliness - 1997 Injury

The ALJ found that, almost immediately after the February 1997 incident, claimant prepared an injury report regarding that incident and placed it in his mailbag, which he then delivered to the

employer's office. The ALJ found that claimant's tender of the mailbag constituted notice to the employer as much as if he had formally mailed the notice. The ALJ also found that Mr. Lazarus, claimant's supervisor, had knowledge of the February 1997 incident within 90 days after that incident.

The insurer argues that claimant did not timely file a claim for the February 1997 incident. The insurer relies on Mr. Lazarus' testimony that he never received a claim for that incident and it contends that, because no claim was filed within 90 days or one year after the incident, the claim is barred as untimely. According to the employer, no written claim was filed regarding the 1997 incident until November 1998, when claimant's attorney submitted a signed "801" form. The record includes an undated "801" form signed by claimant that refers to a wrist injury sustained in January 1997 when he was unloading a trailer. (Ex. 3A).

Although the parties focus on whether the employer had "knowledge" of the injury, we first determine whether claimant gave "notice" pursuant to ORS 656.265 within one year after the 1997 incident. ORS 656.265(1) provides that notice of an accident shall be given to the employer no later than 90 days after the accident. ORS 656.265(2) provides that the notice shall be in writing "and shall apprise the employer when and where and how an injury has occurred to a worker." ORS 656.265(3) provides:

> "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."

Claimant does not assert that he submitted notice of the February 1997 injury to the employer by mail. Rather, he contends that he fulfilled the requirements of ORS 656.265 when he filled out a workers' compensation injury form provided by the employer, put it in his mailbag and delivered it to his employer on the day after the 1997 injury.

At hearing, claimant, a truck driver, testified that he injured his right wrist at work when he was pushing a large box along the floor of the truck and it jammed on a metal plate. (Tr. 132, 133, 137). He was not sure of the precise date of the incident, but he believed it occurred about two weeks before February 28, 1997, when he sought treatment for right wrist pain from Dr. Sanford. (Tr. 135, Ex. 3). Claimant testified that, at the end of the day of injury, he called the employer's secretary and asked her to put an injury report form in his mail bag. (Tr. 139). He explained that, although no one is usually in the office when he arrives at work, the paperwork for his deliveries is ready for him in the morning. (Tr. 141-42). Mr. Lazarus, claimant's supervisor, said that the drivers pick up "mail bags" in the morning that include various documents, including bills of lading and delivery receipts. (Tr. 217).

Claimant said that an injury form was included in his paperwork the next day when he arrived at work to pick up the truck. (Tr. 140). He testified that he filled out the injury form the day after the incident and he turned in the form to the secretary that day by leaving it on her desk. (Tr. 140, 141, 143, 176). He did not remember if the secretary was present at the time or if he simply turned in the form. (Tr. 143). He explained that he did not personally hand the form to Mr. Lazarus. (Tr. 146).

ORS 656.265(1) provides that notice of an accident shall be given to the employer not later than 90 days after the accident. ORS 656.265(3) provides that the notice "shall" be given "by personal delivery to the employer or to a foreman or other supervisor of the employer." For the following reasons, we find that, even if we assume claimant obtained and prepared an injury claim form related to the February 1997 injury in early 1997, the evidence is not sufficient to establish that notice to the employer was given by "personal delivery" within the required time. Claimant said that he left the document on the secretary's desk, but he could not recall if she was there or not. The secretary did not testify at hearing. Furthermore, claimant testified that he did not personally hand the document to Mr. Lazarus.

Nevertheless, claimant relies on the ALJ's finding that ORS 656.265 appears to "contemplate that 'mere' secretarial personnel can form a vital link in the 'chain of notice.'" (Opinion and Order at 13). The ALJ reasoned that if the worker mailed a notice to the employer, that constitutes valid notice and

implicit in that is the understanding that, in many offices, a secretary opens the envelopes. The ALJ concluded that when claimant tendered the mailbag to someone in the office or left it in its customary place, that constituted sufficient notice to the employer. Claimant argues that the ALJ correctly decided that the procedure followed by claimant constituted notice to the employer as much as if he had mailed the notice in a stamped envelope addressed to the employer. We disagree.

If the notice of an accident is not given to the employer by mail, ORS 656.265(3) requires that the notice "shall be given" by personal delivery to "the employer or to a foreman or other supervisor of the employer." In construing ORS 656.265(3), our task is to discern legislative intent. ORS 174.020. We examine the text and context of the statute. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610 (1993). The context includes other provisions of the same statute and other related statutes. *Id.* at 611.

The language of ORS 656.265(3) specifically requires that the notice by personal delivery is limited "to the employer or to a foreman or other supervisor of the employer." Claimant testified that he left the injury form on the secretary's desk, but he could not recall if she was there or not. He testified that he did not personally hand the form to his supervisor, Mr. Lazarus. We are not persuaded that Lazarus' testimony and his statement to the investigator establishes that claimant provided notice by personal delivery "to the employer or to a foreman or other supervisor of the employer."

Furthermore, there is nothing in the text of ORS 656.265(3) to support claimant's argument that leaving an injury form on a secretary's desk constitutes "personal delivery." Even if we assume that the employer's secretary received the form, there is no evidence that she had any supervisory authority over claimant. *See Colvin v. Industrial Indemnity*, 301 Or 743, 747 (1986) ("in order that knowledge be imputed to the employer, the person receiving it must be in some supervisory or representative capacity").

In *Orr v. City of Eugene*, 151 Or App 541, 545 (1997), the court held that notice to a legal secretary was not "actual notice" under the Oregon Tort Claims Act. The court explained that ORS 30.275(6) provides that, in the absence of formal notice, a tort claim against a public body may proceed if the plaintiff has given the public body actual notice. Actual notice may be communicated to any of the parties listed in ORS 30.275(5)(b): "[t]o the public body at its principal administrative office, to any member of the governing body of the public body, or to an attorney designated by the governing body as its general counsel." The plaintiff argued that the court should interpret the phrase "to an attorney" as meaning "to an attorney or that attorney's agent." The court rejected that argument, reasoning that the statute specifically required notice "to an attorney." In reaching its conclusion, the court found nothing in the statutory context to support the plaintiff's argument. The court explained:

> "Exploration of related statutory provisions--those which govern notice of claims and service to particular parties--demonstrates that the legislature knows how to unambiguously express the intention to allow notice to be given to office personnel like clerks and secretaries. *See, e.g.*, ORCP 7 D(3)(b)(i) (allowing service 'upon any clerk on duty in the office * * *'). If the legislature had intended to allow tort claim notice to be given to legal secretaries, it would simply have said so, as it has in other statutes." 151 Or App at 545.

We reach a similar conclusion in this case. Although the statute at issue in this case is different, ORS 656.265(3) specifically requires that the notice by personal delivery "shall" be given "to the employer or to a foreman or other supervisor of the employer." There is nothing in the text of ORS 656.265(3) to support a conclusion that a claimant may comply with that statute by providing notice via personal delivery by giving the form to a secretary or leaving the form on a secretary's desk. In construing statutory language, we are not permitted to omit what has been inserted or insert what has been omitted. ORS 174.010.

We find that claimant has not established that he provided notice of the February 1997 injury "by personal delivery to the employer or to a foreman or other supervisor of the employer." Furthermore, claimant did not provide notice to the employer by mail and there is no evidence he provided notice to the Director of DCBS pursuant to ORS 656.265(3). We conclude that claimant did not satisfy the notice requirements of ORS 656.265(3).

ORS 656.265(4) provides:

"Failure to give notice as required by this section bars a claim under this chapter unless the notice is given within one year after the date of the accident and:

"(a) The employer had knowledge of the injury or death; or

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

Thus, ORS 656.265 requires a written request in order to perfect the claim. *Simmons v. Lane Mass Transit Dist.*, 171 Or App 268 (2000) ("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"). Under ORS 656.265(4), failure to give the notice bars a claim unless the notice is given within one year after the accident and the employer knew of the injury or death or the worker died within 180 days of the accident. *McPhail v. Milwaukie Lumber Co.*, 165 Or App 596, 604 (2000). The effect of ORS 656.265 is to make an accident claim void in the absence of the written notice within the times that the statute describes. *Id.* Claimant must prove by a preponderance of the evidence that the insurer received written notice of the claim within one year of the accident. *See James J. Lascari*, 51 Van Natta 965, 966 (1999).

Here, even if we assume that the insurer had "knowledge" of the injury, we find that claimant has failed to prove by a preponderance of the evidence that he provided notice to the insurer within one year of the February 1997 accident pursuant to ORS 656.265. *See Buzz Vsetecka*, 53 Van Natta 57 (2001) (the claimant's written reports of injury did not adequately apprise the employer of when and where and how the injury occurred); *Lascari*, 51 Van Natta at 966 (the claimant failed to prove that the employer received some form of written notice of the claim within one year of the accident). We agree with the employer that claimant's 1997 claim is barred as untimely.

Compensability

The insurer argues that, if the 1997 claim is barred, claimant cannot establish compensability of his avascular necrosis condition because no persuasive medical opinion establishes that his 1998 work incident was the major contributing cause of his current disability or need for treatment. For the following reasons, we agree with the insurer.

The only medical opinion that supports compensability is from Dr. Wilson, claimant's attending physician and surgeon. At hearing, Dr. Wilson testified that claimant's 1997 injury was the major contributing cause of his avascular necrosis. (Tr. 50-51, 56, 58). Because Dr. Wilson believed that the 1997 injury caused the avascular necrosis, his opinion indicates that the avascular necrosis "preexisted" claimant's February 1998 work injury.

ORS 656.005(7)(a)(B) provides that 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 if the injury is the major contributing cause of the disability or need for treatment of the combined condition. Dr. Wilson felt that claimant's February 1998 injury caused a worsening and change in the underlying pathology. (Tr. 56-57). He believed that the February 1998 injury probably further disrupted the blood supply in the lunate and knocked off whatever collateral was there. (Tr. 57). We interpret Dr. Wilson's opinion to mean that claimant's preexisting avascular necrosis from the 1997 injury combined with the February 1998 injury to cause his disability or need for treatment. Consequently, ORS 656.005(7)(a)(B) applies to this case. Dr. Wilson's opinion, however, does not support the conclusion that the February 1998 injury was the major contributing cause of claimant's disability or need for treatment. As discussed above, he testified that claimant's *1997* injury was the major contributing cause of his disability and need for treatment.

There are no other medical opinions that establish that claimant's 1998 work incident is the major contributing cause of his avascular necrosis. We agree with the insurer that claimant has failed to sustain his burden of proving compensability. We therefore reverse the ALJ's order.[1]

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[1] In light of our conclusion, we need not address the insurer's argument that the attorney fee award at hearing was excessive.

ORDER

The ALJ's order dated August 11, 2000 is reversed in part and affirmed in part. The insurer's denials of claimant's right lunate necrosis condition are reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

Board Member Biehl dissenting.

The majority finds that claimant failed to prove that he provided notice to the insurer within one year of the February 1997 accident and it concludes that claimant's 1997 claim is barred as untimely. Because I disagree with the majority's analysis, I respectfully dissent.

I agree with claimant that he fulfilled the requirements of ORS 656.265(1) and (2) when he filled out the workers' compensation injury form provided by the employer, put it in his mailing bag and delivered it to his employer on the day after the 1997 injury occurred. The ALJ correctly determined that claimant had filed his accident report almost immediately and the claim was timely. I believe the procedure followed by claimant constituted notice to the employer as much as if he had sent the notice in the mail.

Furthermore, I agree with the ALJ that the employer had knowledge of the February 1997 injury shortly after it occurred. The ALJ found, and I agree, that Mr. Lazarus, claimant's supervisor, had joked with claimant about the injury and he understood that it had occurred when claimant was pushing boxes at work. As claimant points out, in early 1997 Mr. Lazarus knew that: (1) claimant's trailer had a defect that caused jamming of boxes when he moved them; (2) claimant's wrist was injured; and (3) claimant believed that the jamming of the boxes was the mechanism of the injury. Moreover, Mr. Lazarus' statements to Ms. Redman, the investigator, indicated that he believed claimant had returned the injury form to him. Under these circumstances, the majority errs by determining that claimant's 1997 claim was untimely.

In addition, I agree with the ALJ that Dr. Wilson's persuasive opinion establishes that claimant's 1997 work injury was the major contributing cause of his right lunate avascular necrosis. The ALJ's order should be affirmed.

February 13, 2001 Cite as 53 Van Natta 181 (2001)

In the Matter of the Compensation of
NATHAN T. WARK, Claimant
WCB Case No. 00-05726
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Meyers, et al, Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that declined to assess an attorney fee pursuant to ORS 656.382(1) for the self-insured employer's failure to reopen the claim. On review, the issue is attorney fees.

We adopt and affirm the ALJ's order with the following supplementation. The ALJ found that the claim must be reopened under ORS 656.262(7)(c) because additional conditions were accepted after claim closure, but he declined to assess penalties or fees because there were no "amounts then due" on which to base a penalty. We agree that the record contains no evidence of "amounts then due" on which to base a penalty and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee. *See Boehr v. Mid-Willamette Valley Food*, 109 Or App 292 (1991).

ORDER

The ALJ's order dated November 28, 2000 is affirmed.

In the Matter of the Compensation of
DARREN C. LANEY, Claimant
WCB Case No. 00-04947
ORDER ON REVIEW
Charles Robinowitz, Claimant Attorney
Atwood & Associates, Defense Attorney

Reviewed by Board Members Biehl and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that decreased his unscheduled permanent disability award for a cervical and thoracic spine condition from 40 percent (128 degrees), as awarded by an Order on Reconsideration, to zero. On review, the issue is unscheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant injured his neck and upper back in May 1998 while operating a front end loader. (Ex. 1). The claim was initially denied, but eventually found to be compensable by a prior ALJ's April 1999 order. (Ex. 23). Pursuant to the prior ALJ's order, the insurer issued a Notice of Acceptance, accepting, among other things, a "cervical and thoracic condition."[1] (Ex. 28).

On February 23, 2000, the insurer issued its Notice of Closure, which did not award permanent disability. Claimant requested reconsideration. (Ex. 49).

As a part of the reconsideration process, a medical arbiter's exam was performed by Dr. Berselli. (Ex. 54). Relying on the medical arbiter's report, the Appellate Review Unit issued an Order on Reconsideration awarding claimant 40 percent (128 degrees) unscheduled permanent disability. (Ex. 57). The insurer requested a hearing challenging the Order on Reconsideration.

As a result of the compensable injury, claimant retains 14 degrees of flexion; 8 degrees of extension; 10 degrees of right lateral flexion; 12 degrees of left lateral flexion; 12 degrees of right rotation; and 10 degrees of left rotation in the cervical spine. In addition, as a result of the compensable injury, claimant retains 2 degrees of flexion; 10 degrees of right rotation; and 12 degrees of left rotation in the thoracic spine.

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that Dr. Gilbert (the attending physician) had ratified the evaluation of Drs. Fuller and Radecki (insurer-arranged examiners). Consequently, the ALJ concluded that the preponderance of the medical evidence as determined by the findings of Dr. Fuller and Radecki established that claimant's permanent disability award should be reduced to zero.

Claimant contends that: (1) the medical arbiter's report was more persuasive than the report ratified by the attending physician; (2) the "attending physician-ratified" report contains an inaccurate history; and (3) the "attending physician-ratification" is inconsistent the physician's prior opinion and chart notes. We agree with claimant'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. Where a preponderance establishes a different level of impairment, the impairment is established by the preponderance of evidence. OAR 436-035-0007(14) (WCD Admin Order No. 98-055).

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[1] Because the insurer had requested review of the prior ALJ's order, the insurer's Notice of Acceptance contained language indicating that acceptance was contingent on the outcome of the case on Board review. (Ex. 28-2). The Board affirmed the prior ALJ's order in November 1999. (Ex. 45). *Darren C. Laney*, 51 Van Natta 1855 (1999).

Here, the medical arbiter, Dr. Berselli, found that claimant had restricted ranges of motion in his cervical and thoracic spine, noted that his findings were valid according to AMA guidelines, and opined that the findings were attributable to the accepted condition. (Ex. 54-3; 54-4; 56). He further opined that as a result of the work injury, claimant had a chronic condition and a partial loss of the ability to repetitively use the cervical and thoracic spine area. (Ex. 54-2). Consequently, Dr. Berselli's range of motion measurements are to be used to rate impairment, unless the preponderance of medical evidence establishes otherwise. OAR 436-035-0007(14) (WCD Admin Order No. 98-055). For reasons explained below, we are not persuaded that the medical evidence establishes that Dr. Berselli's range of motion measurements should not be used to rate claimant's impairment.

Drs. Fuller and Radecki (insurer-arranged examiners) measured and reported in specific detail claimant's cervical range of motion.[2] (Ex. 47-6). They also measured and reported in specific detail the range of motion of claimant's shoulders. They did not report measuring the range of motion of claimant's thoracic spine.[3] Ultimately, they opined that the range of motion measurements were invalid for rating purposes, due to claimant's self-limiting (to the point of malingering) pain behavior. (Ex. 47-12). Because their comments about claimant's self-limiting pain behavior were inconsistent with their findings of claimant's normal scapulothoracic range of motion, we do not find Dr. Fuller's and Dr. Radecki's report well reasoned or persuasive. *See Somers v. SAIF*, 77 Or App 259, 263 (1986).

In February 2000, Dr. Gilbert concurred with the "findings" of Drs. Fuller and Radecki in a "check-the-box" type concurrence letter.[4] (Ex. 48). To begin, because we do not consider Drs. Fuller and Radecki's report persuasive, we likewise do not find Dr. Gilbert's concurrence with those "findings" to be persuasive. Furthermore, we note that Dr. Gilbert's concurrence is inconsistent with her chart notes. Specifically, her unexplained "concurrence" is inconsistent with her charting of claimant's ongoing pain and her observations of "significant muscle spasms."[5] (Ex. 32-1; 42-1). We also note that Dr. Gilbert has not questioned the authenticity of claimant's pain complaints. Because Dr. Gilbert's "concurrence" is inconsistent with her chart notes and her referral of claimant to Dr. Lorish, we give it little weight. Moreover, because Dr. Gilbert's "concurrence" is unexplained and because of the aforementioned inconsistencies, we are unable to discern which "findings" (by Drs. Fuller and Radecki) Dr. Gilbert concurs with. As a result, Dr. Gilbert's "concurrence" does not render the report of Drs. Fuller and Radecki persuasive.

Finally, we note that Dr. Berselli's medical arbiter examination was performed within 30 days of the Order on Reconsideration while the examination by Drs. Fuller and Radecki was performed about 5 months before the Order on Reconsideration. *See 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. Berselli, the medical arbiter.

Based on Dr. Berselli's findings, claimant's impairment associated with loss of range of motion of the cervical spine is 25 percent (24.83 percent rounded). *See* OAR 436-035-0360(13). Additionally, his impairment associated with the loss of range of motion of the thoracic spine is 8 percent (7.53 percent rounded). *See* OAR 436-035-0360(8). Pursuant to OAR 436-035-0007(15) through (18), the impairment values for the cervical spine and the thoracic spine are combined, which results in a final impairment

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[2] Because Dr. Gilbert, the attending physician, concurred with their findings, Drs. Fuller and Radecki's findings can be used to rate impairment. *Tektronix Inc. v. Watson*, 132 Or App 483, 486 (1995).

[3] Rather they report, without recording measurements, that claimant's "scapulothoracic" was normal with no medial scapular impingement. (Ex. 47-6).

[4] The report of Drs. Fuller and Radecki does not contain a section entitled "findings." (Ex. 47).

[5] Because of Drs. Fuller and Radecki's comments regarding malingering, Dr. Gilbert's concurrence is also inconsistent with her recommendations for additional physical therapy, her referral of claimant to Dr. Lorish for pain management, and her indication that claimant may require surgery. (Ex,. 35-1; 38-1).

value of 31 percent of the cervical/thoracic spine.[6] Assembling claimant's impairment and his vocational factors (determined to be 9, and not challenged on Board review) we conclude that claimant is entitled to 40 percent unscheduled disability (128 degrees), as previously determined by the Department's Order on Reconsideration.

Accordingly, the order of the ALJ is reversed, and the Department's Order on Reconsideration is reinstated and affirmed.

Because our order results in increased compensation, claimant's counsel is entitled to an "out-of-compensation" attorney fee equal to 25 percent of the increased compensation, not to exceed $5,000. ORS 656.386(2); OAR 438-015-0055.

ORDER

The ALJ's order dated September 21, 2000 is reversed. The Order on Reconsideration dated June 1, 2000 is reinstated and affirmed. For services on review, claimant is awarded "out-of-compensation" attorney fee equal to 25 percent of the increased compensation, not to exceed $5,000, payable directly to claimant's attorney.

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[6] Because claimant has more than 5 percent impairment, he is not entitled to an additional impairment value for a chronic condition. OAR 436-035-0320(5)(a).

In the Matter of the Compensation of
EDGAR L. TJADEN, Claimant
WCB Case No. 99-08179
ORDER ON RECONSIDERATION
Ransom & Gilbertson, Claimant Attorney
Jerald Keene, Defense Attorney

On December 28, 2000, we abated our December 5, 2000 order that reversed an Administrative Law Judge's (ALJ's) order that set aside the self-insured employer's denial of claimant's occupational disease claim for a mental disorder. We took this action to consider the parties'settlement.

The parties have now submitted a "Disputed Claim Settlement" that is designed to resolve all issues raised or raisable between them. Pursuant to the agreement, claimant agrees that the employer's denial "shall remain affirmed and the matter shall be dismissed with prejudice."

We have approved the settlement, thereby resolving the parties' dispute. Accordingly, on reconsideration, this matter is dismissed with prejudice.

IT IS SO ORDERED.

In the Matter of the Compensation of
ELLA L. LAVERY, Claimant
WCB Case No. 00-00184
ORDER ON REVIEW
Jean M. Fisher, Claimant Attorney
Scheminske, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Black's order that set aside its denial of claimant's occupational disease claim for a right shoulder tendinitis condition. On review, the issue is compensability. We affirm in part and reverse in part.

FINDING OF FACT

We adopt the ALJ's "Findings of Fact" with the following changes and supplementation. On page 2, in the first full paragraph after the quoted section, we replace the first sentence with the following: "Although some of claimant's job duties involved inspection work, she was frequently interrupted to fill in at other positions, including the cabinet shop, work with the cane saw, molding work and cutting formica. (Tr. 11, 31, 33)."

After the fourth full paragraph on page 3, we add the following: "Dr. Ballard concurred with Dr. McColl's February 23, 2000 report. (Ex. 14)."

CONCLUSIONS OF LAW AND OPINION

Right Shoulder Tendinitis

We adopt and affirm the ALJ's order concerning compensability of claimant's right shoulder tendinitis with the following change and supplementation.

In the last paragraph on page 4 that continues on page 5, we delete the fourth sentence and replace the sixth sentence with the following:

> "Claimant testified that during the last six months that the old plant was opened, she was frequently transferred to help in the cabinet shop and in molding and she rarely got a break to perform inspection work. (Tr. 11). Claimant's job duties included covering for missing employees and helping if they were behind. (Tr. 7, 33)."

We write only to address the employer's argument that ORS 656.802(2)(b) applies to that condition. According to the employer, claimant had a "fully developed disorder" at the time her symptoms worsened about four months before she filed the claim and, therefore, ORS 656.802(2)(b) applies.

To establish a compensable occupational disease, claimant must prove that her employment conditions were the major contributing cause of her right shoulder condition. ORS 656.802(2)(a). 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). In *SAIF v. Cessnun*, 161 Or App 367, 371 (1999), the court held that, in occupational disease cases, a disease or condition is "preexisting" only if it both contributes or predisposes the claimant to disability or a need for treatment and precedes either the date of disability or the date when medical treatment is first sought, whichever occurs first.

Here, claimant first sought treatment for her right shoulder condition from Dr. McColl on August 17, 1999. (Ex. 2). Dr. McColl reported that claimant did not have a specific injury, but her right shoulder and right arm had been painful for nearly a year. (*Id.*) Similarly, Dr. Ballard reported that claimant had experienced right shoulder problems for about one year. (Ex. 12). Neither Dr. McColl nor Dr. Ballard diagnosed claimant with a preexisting disease or condition related to her right shoulder.

On November 8, 1999, Dr. Gripekoven examined claimant on behalf of the employer. He reported that there was no specific, traumatic event and claimant felt that the discomfort had been "building up" for about two years. (Ex. 9-1). He diagnosed upper extremity pain, possible deltoid

sprain. (Ex. 9-4). In response to the employer's question whether there were any preexisting conditions, pre-dispositions or congenital abnormalities that caused or contributed to claimant's condition, Dr. Gripekoven responded: "There is no history of any preexisting conditions or congenital anomalies which are contributing to her present condition." (Ex. 9-5).

In sum, we find no medical evidence that establishes that claimant had a preexisting right shoulder disease or condition that contributed or predisposed her to disability or a need for treatment and preceded August 17, 1999, when she first sought medical treatment from Dr. McColl. Under these circumstances, we do not agree that ORS 656.802(2)(b) applies to the right shoulder tendinitis condition. We adopt and affirm the ALJ's order that found claimant's right shoulder tendinitis condition compensable under ORS 656.802(2)(a).

Right Carpal Tunnel Syndrome

In her brief, claimant contends that the issue on review includes compensability of her right carpal tunnel syndrome (CTS). Although she asks the Board to affirm the ALJ's order, she argues that her work was the major contributing cause of her arm and shoulder conditions *and* the pathological worsening of her carpal tunnel syndrome. (Claimant's brief at 12).

The ALJ found that claimant's carpal tunnel syndrome was "not in issue here." (Opinion and Order at 1). The ALJ set aside the employer's denial and directed the employer to accept a right shoulder tendinitis condition. (Opinion and Order at 5). Thus, the ALJ found only that claimant's right shoulder tendinitis condition was compensable.[1]

The employer responds that, to the extent claimant is attempting to establish compensability of her CTS, the medical evidence is insufficient. For the following reasons, we agree with the employer.

At hearing, claimant testified that she had been diagnosed and treated for CTS 10 to 15 years ago. (Tr. 21). She had nerve conduction studies that confirmed the CTS diagnosis. (Tr. 39). She testified that her previous doctor said she would probably always have problems with that condition. (Tr. 21). When claimant began having right shoulder problems, she thought it might be CTS. (Tr. 15-16, 23). Her right hand symptoms worsened during the same period that she was having right shoulder and arm symptoms. (Tr. 22-23).

Dr. McColl's August 17, 1999 chart note referred to the fact that claimant had been diagnosed with right CTS 10 to 15 years ago. (Ex. 2). During the August 17, 1999 exam, claimant complained that her hand was painful and occasionally numb in the palm. (*Id.*) Dr. McColl's diagnoses included right CTS. (*Id.*)

Based on claimant's testimony and Dr. McColl's report, we find that claimant had a right CTS condition that preceded August 17, 1999, when Dr. McColl first treated her for that condition. Dr. McColl concluded that claimant's work was the major contributing cause of "an aggravation of the previously known carpal tunnel syndrome in the right wrist." (Ex. 13-2). Based on her report, we find that claimant had a preexisting right CTS condition that contributed or predisposed her to disability or a need for treatment. Therefore, we find that claimant's claim for right CTS is based on the worsening of a preexisting disease/condition and she must prove that her employment conditions were the major contributing cause of her combined condition and a pathological worsening of the disease. *See* ORS 656.802(2)(b).

We agree with the employer that there is no medical evidence sufficient to meet that standard. Although Dr. McColl said that claimant's work "aggravated" her preexisting CTS, her conclusory opinion is not sufficient to prove that claimant had experienced a pathological worsening of her CTS. At a deposition, Dr. McColl explained that the "problem with carpal tunnel is that people do have repetitive episodes and some new activity often brings the symptoms back[.]" (Ex. 15-8). Dr. McColl's testimony indicates that claimant had a symptomatic worsening of her CTS condition. We find that Dr.

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[1] Because neither party agrees with the ALJ's finding that claimant's CTS was "not in issue" and because the employer's denial expressly referred to the CTS condition, we have addressed the compensability of that condition on review.

McColl's opinion lacks adequate explanation and is not sufficient to establish a pathological worsening of the CTS condition, particularly in light of claimant's testimony that she had "always had" CTS and that she "just accepted" that she was always going to have problems with that condition. (Tr. 21). There are no other medical opinions that support a conclusion that claimant's CTS condition has pathologically worsened. We note that neither Dr. Gripekoven nor Dr. Ballard diagnosed a current CTS condition. (Exs. 9, 12).

Claimant's attorney is entitled to an assessed fee for services on review regarding the right shoulder tendinitis 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 regarding the right shoulder tendinitis condition is $1,200, 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), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated October 16, 2000 is affirmed in part and reversed in part. Insofar as the employer's denial pertains to claimant's CTS condition, the denial is reinstated and upheld. The remainder of the ALJ's order is affirmed. For services on review regarding the right shoulder tendinitis condition, claimant's attorney is awarded $1,200, payable by the self-insured employer.

February 15, 2001 Cite as 53 Van Natta 187 (2001)

In the Matter of the Compensation of
JOHN W. WILLIAMS, SR., Claimant
WCB Case No. 00-06548
ORDER ON REVIEW
Scott M. McNutt, Jr., Claimant Attorney
Brownstein, Rask, et al, Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that dismissed his request for hearing on the basis that the Hearings Division lacked jurisdiction over the matter. On review, the issue is jurisdiction.

We adopt and affirm the ALJ's order with the following exception and correction.[1] We do not adopt the second and third sentences of the fourth paragraph of the ALJ's order. We replace those sentences with the following. In *Mary Mitchell*, 47 Van Natta 300 (1995), relying on *Howard v. Liberty Northwest Ins.*, 94 Or App 283, 286-87 (1988), the Board held that relief payable under a Disputed Claim Settlement (DCS) did not constitute "compensation" under ORS 656.005(8).

ORDER

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

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[1] Claimant alleges that the Director refused jurisdiction of his request for assessment of a penalty under ORS 656.262(11) for untimely payment of DCS proceeds. We take administrative notice of the Director's November 16, 2000 Proposed and Final Order regarding this matter and note that claimant misreads the Director's order. In that order, the Director accepted jurisdiction of this penalty issue pursuant to ORS 656.262(11). However, *on the merits*, the Director found that claimant was not entitled to a penalty under ORS 656.262(11). In making this finding, the Director explained that DCS proceeds are not considered "compensation" as defined by ORS 656.005(8) and, thus, late payment of DCS proceeds would not support a penalty under ORS 656.262(11), which only allows a penalty to be assessed on late payment of "compensation."

In the Matter of the Compensation of
MORGAN S. CAGLE, Claimant
WCB Case Nos. 00-01236 & 99-06444
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorney
Julie Masters (Saif), Defense Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Liberty Northwest Insurance Corporation (Liberty) (on behalf of Sunburst Contemporary Homes) requests review of those portions of Administrative Law Judge (ALJ) Martha Brown's order that: (1) set aside its denial of claimant's "new injury" claim for a low back condition; and (2) upheld the *de facto* denial of claimant's aggravation claim for the same condition by the SAIF Corporation (on behalf of Superior Steel Fabrication). SAIF cross-requests review of that portion of the ALJ's order that assessed a penalty for allegedly unreasonable claim processing. On review, the issues are compensability, responsibility, and penalties.

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

Claimant compensably injured his low back in February 1997 while working for SAIF's insured, Superior Steel. As a result of that injury, claimant underwent a left L4-5 partial hemilaminectomy and diskectomy performed by Dr. Van Pett. In July 1998 the claim was closed by Notice of Closure that awarded (among other things) 24 percent unscheduled permanent disability.[1]

Claimant began working as a service technician for Liberty's insured, Sunburst, in the fall of 1998. On April 6, 1999, as a part of his work for Sunburst, claimant and a co-worker were requested to repair a leaking roof. Claimant carried bundles of shingles, weighing about 90 pounds per bundle, up a ladder onto the roof. Near the end of the day, claimant advised his boss that his back had become sore. Claimant was unable to work the following day.

On April 29, 1999, after two weeks of back pain, claimant sought treatment from Dr. Wilson. (Ex. 43, 44) As a result, a "new injury" claim was filed with Liberty. (Ex. 44-2). On August 6, 1999, Liberty issued its compensability/responsibility denial. (Ex. 55). Claimant requested a hearing.

The ALJ, relying on the opinions of Dr. Wilson and Dr. Van Pett, determined that claimant had incurred a "new" soft tissue injury as the result of his work activities on April 6, 1999. The ALJ then reasoned that, under the "last injury rule," responsibility for claimant's condition rested with Liberty.

Liberty contends that Dr. Wilson's deposition testimony regarding the compensability of claimant's "new injury" represents an unexplained change in his prior opinion, and thus Dr. Wilson's deposition testimony is not persuasive. Consequently, Liberty asserts that claimant has failed to establish the compensability of his "new injury." We disagree.

Only two doctors, Drs. Wilson and Van Pett, offered opinions regarding causation of claimant's "new injury." Dr. Van Pett opined that the major cause of claimant's current condition and need for treatment was the April 1999 work incident. (Ex. 59). Because we find Dr. Van Pett's opinion sufficient to carry claimant's burden of proof, the compensability of claimant's "new injury" does not rest on the persuasiveness of Dr. Wilson's opinion.[2] Consequently, even if we found Dr. Wilson's opinion unpersuasive, we would still conclude that claimant's current low back condition is compensable.

Liberty contends that, because the 1997 injury (SAIF's responsibility) represents a substantial preexisting condition, proper application of the "last injury rule" requires more than an independent contribution by the 1999 injury to make it responsible for claimant's current low back condition. We disagree.

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[1] About two weeks later, the Board approved a Claim Disposition Agreement (in the amount of $17,500), in which claimant released his released his rights to workers' compensation benefits, other than medical services.

[2] We acknowledge Liberty's argument that Dr. Van Pett's opinion rests on an incorrect history. However, for the reasons stated by the ALJ, we reject this argument.

Because the 1997 and 1999 injuries were "successive injuries" involving the same body part (*i.e.*, low back), responsibility is determined under the "last injury rule." *James A. Hoyt*, 52 Van Natta 346 (2000); *see John J. Saint*, 46 Van Natta 2224, 2226 (1994). The 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)."

Nothing in the above-quoted rule requires more than an independent contribution by the second injury to place full responsibility upon the carrier covering the risk at the time of the most recent injury. Because we have determined that claimant's 1999 injury while working for Liberty's insured contributed independently to his low back condition, responsibility for the low back condition rests with Liberty.[3]

Penalties

The ALJ determined that SAIF had not issued an acceptance or denial within 90 days of the time SAIF had notice of the claim as required by ORS 656.262(6)(a).[4] As a result, the ALJ concluded that SAIF's delay in issuing its denial was unreasonable, and assessed a penalty of 25 percent of the amounts due claimant by Liberty.

A carrier is liable for a penalty when it "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). "Unreasonableness" is to be considered in light of all the evidence available at the time of the denial. *Brown v. Argonaut Insurance Company*, 93 Or App 588, 591 (1988); *Eric M. Challbury*, 52 Van Natta 972 (2000).

Here, SAIF stipulated that it had notice of the claim on August 19, 1999. Nonetheless, it failed to accept or deny either the compensability of, or the responsibility for, the claim before March 14, 2000 (the day of the hearing). Additionally, SAIF offered no explanation for its failure to accept or deny the claim within the time mandated by ORS 656.262(6)(a). Accordingly, we conclude that SAIF's conduct was unreasonable. *See Rosa Chavez*, 52 Van Natta 833 (2000).

SAIF does not dispute the existence of precedent for assessing a penalty against a non-responsible carrier. *See SAIF v. Whitney*, 130 Or App 429 (1994) (a penalty could be imposed against a non-responsible carrier for its own unreasonable claim processing). Rather SAIF asserts that in those cases where such a penalty has been assessed, the delay by the non-responsible carrier had also delayed the issuance of a "307" order, thereby delaying a claimant's receipt of compensation. SAIF points out that because Liberty denied compensability, the Department was prohibited from issuing a "307" order. Thus SAIF argues its delay in issuing a denial did not deprive or delay compensation to claimant. In such circumstances, SAIF contends that a penalty is not warranted, *i.e.* "no harm, no foul." We disagree.

In upholding the assessment of penalties against two insurers, even though only one was responsible for the claim, the *Whitney* court said: "[i]f two insurers, or for that matter, four insurers, act unreasonably, we see no reason why they should not each be liable for a penalty of up to 25 percent." *Whitney*, 130 Or App at 432. Although the *Whitney* court was relying on *former* ORS 656.262(10)(a), the statutory language on which the court relied remains in the current version of the statute, ORS

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[3] We note that the two injuries do not involve the "same condition." Consequently, responsibility is not determined by ORS 656.308(1). *See Sanford v. Balteau Standard*, 140 Or App 177, 181 (1996).

[4] SAIF's denial was a *de facto* denial. SAIF did not clarify the scope of its denial (responsibility only) until the start of the hearing. (Tr. 2).

656.262(11)(a), which 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 then due."

The express terms of ORS 656.262(11)(a) do not limit its application to only those claims in which a carrier's delay in issuing its acceptance prevents the Department from designating a paying agent pursuant to the terms of ORS 656.307(1)(a)(C). Consequently, because SAIF unreasonably delayed processing the claim, we conclude that a penalty is warranted. Accordingly, we affirm the ALJ's assessment of a penalty against SAIF in the amount of 25 percent of the compensation due claimant from Liberty, through October 16, 2000 (the day the hearing record closed).

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 Liberty. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. Claimant is not entitled to an attorney fee for his counsel's services on review regarding the penalty issue. *Saxton v. SAIF*, 80 Or App 631 (1986).

ORDER

The ALJ's order dated November 13, 2000 is affirmed. For services on review, claimant is awarded a $1,200 attorney fee, payable by Liberty.

February 16, 2001 Cite as 53 Van Natta 190 (2001)

In the Matter of the Compensation of
AMANDA D. SMITH, Claimant
WCB Case No. 00-02594
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorney
Jerald Keene, Defense Attorney

Reviewed by Board Members Meyers and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the insurer's denial of claimant's occupational disease claim for left wrist and right elbow conditions. On review, the issue is compensability.

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

In concluding that the claim was not compensable, the ALJ found Dr. Schilperoort's opinion to be more persuasive than that of Dr. Puziss. Claimant argues that Dr. Schilperoort's opinion is unpersuasive because his testimony and report are in conflict. We disagree.

Although Dr. Schilperoort testified that claimant's work activities, in conjunction with her congenital lack of pronation, caused pain, his report concludes that he could not relate the onset of the discomfort "as a direct cause and effect relationship creating any pathological problem to either the left wrist or right elbow." We read Dr. Schilperoort's report as indicating that the work did not cause any pathologic condition to develop and that the pain resulted from the congenital condition. We do not find this inconsistent with his testimony that claimant's work activities cause pain because of the congenital lack of pronation.

Claimant relies on the opinion of Dr. Won in addition to that of Dr. Puziss. Dr. Won's opinion is conclusory and is therefore not persuasive. *See Moe v. Ceiling Systems, Inc.*, 44 Or App 429 (1980).

ORDER

The ALJ's order dated October 18, 2000 is affirmed.

In the Matter of the Compensation of
ARTHUR C. COLLIER, Claimant
WCB Case No. 00-00607
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

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

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that awarded $7,000 in assessed attorney fees pursuant to ORS 656.386(1).[1] On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following summary and supplementation.

Claimant, who has preexisting back conditions, compensably injured his low back on December 12, 1998. SAIF originally accepted the claim as a lumbar strain, but later modified its acceptance to accept a combined condition. (Exs. 12, 30).

On December 1, 1999, SAIF denied compensability of claimant's current low back condition. (Ex. 30). Claimant requested a hearing to appeal the denial. Claimant's current low back condition causing his symptoms and need for treatment was a disc bulge at L4-5 with a tear of the annulus fibers. (Exs. 33, 34).

On April 12, 2000, claimant's attorney requested SAIF to amend its Notice of Acceptance to include a disc bulge with a tear of the annulus fibers. (Ex. 32). SAIF did not respond to that request.

At hearing, the parties agreed that the issues included: (1) compensability of claimant's current low back condition, appealing SAIF's December 1, 1999 denial; and (2) compensability of SAIF's "de facto" denial of a disc bulge with a tear of the annulus fibers. (Tr. 7-8).

By order dated August 22, 2000, the ALJ set aside both denials and assessed attorney fees of $3,500 per denial, for a total award of $7,000 for services at hearing. Following SAIF's request for reconsideration, the ALJ abated his order. On reconsideration, the ALJ adhered to and republished the August 22, 2000 order in its entirety.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside SAIF's current condition denial and its "de facto" denial of claimant's L4-5 disc bulge with an annulus tear. He also assessed attorney fees of $3,500 per denial, for a total award of $7,000 for services at hearing. On review, SAIF makes several arguments that there was only one denial at issue at hearing. Therefore, SAIF argues, claimant is entitled to only one assessed attorney fee. Based on the following reasoning, we find that there were two denials.

SAIF contends that there was no "de facto" denial. This contention is contrary to the parties' agreement at hearing, where the parties explicitly agreed that claimant was appealing two denials, SAIF's written current condition denial and its "de facto" denial of the disc bulge with a tear of the annulus fibers. (Tr. 7-8). In addition, SAIF's contention is contrary to the facts of the case. In this regard, claimant's attorney made a written request that SAIF amend its Notice of Acceptance to include a disc bulge with a tear of the annulus fibers. (Ex. 32). Pursuant to ORS 656.262(6)(d), SAIF had 30 days to respond in writing to that request. SAIF did not respond. Therefore, SAIF "de facto" denied the claim. Thus, we find that there were two denials at issue at hearing: (1) SAIF's written current condition denial; and (2) its "de facto" denial of claimant's claim for a disc bulge with a tear of the annulus fibers. (Exs. 30, 32).

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[1] In relevant part, ORS 656.386(1)(a) provides that in cases involving denied claims where a claimant finally prevails against the denial in a hearing before an ALJ, the ALJ shall allow a reasonable attorney fee.

Alternatively, SAIF argues that, if there are two denials and each entitles claimant to a separate attorney fee, then the ALJ's total award of $7,000 is excessive. SAIF argues that the same condition was at issue for both denials; therefore, claimant's counsel did not have to develop a separate record or perform additional work for the "de facto" denial. SAIF argues that, on this record, a total fee of $3,500 is reasonable.

Claimant responds that, because he did not request a specific fee at hearing, SAIF is not entitled to object to the fee awarded by the ALJ. We disagree with claimant's contention.

Claimant cites OAR 438-015-0003 *et seq.* in support of his contention. OAR 438-015-0003 *et seq.* provides our rules for awarding attorney fees pursuant to ORS 656.307, 656.382, and 656.386. Nothing in OAR 438-015-0003 *et seq.* prohibits a carrier from contending attorney fees awarded by an ALJ are excessive in absence of a request for a specific fee from claimant.

OAR 438-015-0029[2] allows, on Board review, a claimant's attorney to file a request for a specific fee for services at the hearing level and/or for services on Board review. *See William F. Davis*, 51 Van Natta 257 (1999). Citing OAR 438-015-0029(3) and (4), claimant contends that, to the extent that our rules allow a process for objecting to a specific fee, SAIF's objection does not comply with those procedures and shall not be considered. Claimant does not explain how SAIF's objection does not comply with our procedures. In any event, as claimant acknowledges, he did not request a specific fee. Thus, by its terms, OAR 438-015-0029 does not apply.

Moreover, contrary to claimant's contentions, our statutory authority and case law support a finding that SAIF is not precluded from appealing the ALJ's attorney fee award. In this regard, the scope of our *de novo* review encompasses all issues considered by the ALJ, and we are authorized to modify or supplement the ALJ's findings and conclusions. *See* ORS 656.295(6); *Destael v. Nicolai*, 80 Or App 723 (1986).

In addition, in *Anthony Foster*, 45 Van Natta 1647, 1781, 1997, 2055 (1993), relying on *former* OAR 438-15-029(4),[3] we held that, because the carrier did not submit a timely response to the claimant's counsel's statement of services, we would not consider its motion for reconsideration insofar as it

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[2] OAR 438-015-0029 provides:

"(1) On Board review of an Administrative Law Judge's order, to assist the Board in determining the amount of a reasonable assessed fee for services at the hearing level and/or for services on Board review, a claimant's attorney may file a request for a specific fee, which the attorney believes to be reasonable.

"(2) The request shall be considered by the Board if:

"(a) The request is filed within 14 days from the date of filing of the last appellate brief under OAR 438-011-0020;

"(b) The request describes in detail the manner in which the factors set forth in OAR 438-015-0010(4) specifically apply to the case, as well as any other information deemed relevant; and

"(c) A copy of the request is simultaneously served upon the other parties and their attorneys who appeared at hearing and on Board review in the manner provided in OAR 438-005-0046(2)(a) and proof of such service is provided in accordance with OAR 438-005-0046(2)(b).

"(3) A written response raising objection to the request shall be considered by the Board if:

"(a) The response is filed within 14 days from the date of filing of claimant's attorney's request for a specific fee under subsection (2)(a) of this rule; and

"(b) A copy of the request is simultaneously served upon the other parties and their attorneys who appeared at hearing and on Board review in the manner provided in OAR 438-005-0046(2)(a) and proof of such service is provided in accordance with OAR 438-005-0046(2)(b).

"(4) A request or response that does not comply with this rule shall not be considered by the Board in determining the amount of a reasonable assessed fee."

[3] We note that, although the current version of *former* OAR 438-15-029(4) has been renumbered as OAR 438-015-0029(4), the relevant language is the same.

pertained to specific objections to representations offered in the claimant's counsel's attorney fee request. Nevertheless, because the carrier had timely requested reconsideration of our order and raised the issue of the attorney fee award amount, we found it appropriate to reexamine that attorney fee award without considering the carrier's untimely contentions regarding particular portions of the claimant's counsel's statement of services.

Moreover, relying on *Foster*, we have held that a carrier can challenge an ALJ's attorney fee award even though the carrier failed to timely challenge the claimant's attorney's statement of services under the rules. *See Laura M. Rodello*, 51 Van Natta 406 (1999). Likewise, we have held that a claimant may raise the issue of the adequacy of an attorney fee award even though the claimant did not submit a request for a specific assessed fee. *See Robert E. Ralph*, 49 Van Natta 1341 (1997) (although the claimant's attorney did not timely file a request for assessed fees under OAR 438-015-0029(1), because the claimant sought reconsideration of a Board order awarding an attorney fee, we reconsidered our attorney fee award based solely on reexamination of the record and the appellate briefs); *Robert M. Mitchell*, 46 Van Natta 1284 (1994) (same).

Here, SAIF timely appealed the ALJ's order and contested the assessed attorney fee award, an issue that was before the ALJ. Therefore, even though claimant chose not to file a request for a specific fee, the attorney fee issue is properly before us. *See Hays v. Tillamook County General Hospital*,160 Or App 55 (1999).

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.

There were four issues at hearing, and claimant prevailed on three of them. Claimant did not prevail on his contention that SAIF had issued an impermissible "back-up" denial. In addition, although claimant prevailed on the penalty issue, he is not entitled to attorney fees regarding the penalty assessment. *See Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986). The remaining two issues were compensability of claimant's current condition, which SAIF denied on December 1, 1999, and compensability of the disc bulge at L4-5 with a tear of the annulus fibers, which SAIF "de facto" denied.

After *de novo* review of the record, we find that both denials dealt with the same condition, *i.e.*, claimant's disc bulge at L4-5 with a tear of the annulus fibers. As explained by Dr. Olson, treating orthopedist, and Dr. Bolin, treating chiropractor, the compensable injury caused the disc bulge at L4-5 with a tear of the annulus fibers, which caused claimant's current condition and need for treatment, including symptoms of swelling of the nerve with radiculitis. (Exs. 33, 34). Thus, both denials involved the same condition. As a result, the same evidence supported setting aside both denials. (Exs. 33, 34).

The record consists of 46 exhibits, 10 of which were generated by claimant's attorney, including the causation opinions from Drs. Olson and Bolin that established compensability of the L4-5 disc bulge/annulus tear condition and current condition. There were no depositions. The hearing lasted 50 minutes, and the hearing transcript consists of 17 pages. Claimant was the only witness. The closing arguments were oral, not written.

We find the legal, medical, and factual issues, when compared to compensability disputes generally presented to the Hearings Division, to be of average complexity. We find the value of the claim and the benefits secured to be 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, there was a risk that claimant's counsel's efforts might have gone uncompensated.

After considering the parties' respective arguments in light of the factors set forth in OAR 438-015-0010(4) and applying them to this case, we conclude that $4,000 is a reasonable attorney fee under ORS 656.386(1) for services at the hearings level regarding the compensability issue and setting aside the two denials. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the hearing record), the complexity of the issue, the value of the interests involved, the skill of the attorneys, the nature of the proceedings, and the risk that counsel may go uncompensated. We modify the ALJ's attorney fee award accordingly.

Finally, we note that 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).

ORDER

The ALJ's order dated September 19, 2000 is affirmed in part and modified in part. In lieu of the ALJ's assessed attorney fee award, claimant's attorney is awarded an assessed fee of $4,000, payable by SAIF directly to claimant's attorney. The remainder of the ALJ's order is affirmed.

Board Member Phillips Polich dissenting.

I agree with the ALJ's reasoning and conclusions that $7,000 is a reasonable fee for claimant's counsel's services at hearing for prevailing over two separate denials. Therefore, I would affirm the ALJ's assessed fee award of $7,000. In addition, claimant's counsel should not be penalized for engaging in administrative economy. In other words, this matter dealt with two denials but was heard in a single hearing, which preserves administrative resources. By reducing the ALJ's attorney fee award, the majority encourages bifurcation when multiple denials are at issue, which will result in multiple hearings and wasted administrative resources. For all of these reasons, I respectfully dissent.

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

Claimant requests reconsideration of our January 30, 2001 order that upheld the SAIF Corporation's denials of her current left knee condition. Specifically, claimant argues that SAIF's denials are not supported by the medical evidence for several reasons. First, claimant 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.

In order to further consider this matter, we withdraw our January 30, 2001 order. SAIF is granted an opportunity to respond. To be considered, SAIF's response must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHARLES M. HANEY, Claimant
Own Motion No. 98-0360M
SECOND OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Saif Legal Department, Defense Attorney

On December 13, 2000, we withdrew our November 14, 2000 Own Motion Order Reviewing Carrier Closure on Reconsideration, which had adhered to our August 17, 2000 Own Motion Order, that had affirmed the SAIF Corporation's February 1, 2000 Notice of Closure. We took this action to consider claimant's submission of a report from Dr. Heath, one of his treating physicians, in support of claimant's contention that he was not medically stationary when SAIF closed his claim.

In our prior orders, we concluded that, although there were various medical opinions regarding claimant's need for surgery, those opinions focused on claimant's current need for treatment, and not claimant's medically stationary status at the time of closure. Dr. Funk, claimant's former attending physician, provided the only medical report regarding claimant's medically stationary status at closure. He opined that claimant was medically stationary on January 28, 2000 and that he would achieve no further improvement. Accordingly, we affirmed SAIF's February 1, 2000 Notice of Closure. In response to claimant's request, SAIF submitted an October 26, 2000 medical report prepared by an insurer-arranged medical examiner, Dr. James. Dr. James concurred with Dr. Funk's opinion that claimant was stationary on January 28, 2000 and that no further treatment was recommended.

In addition, SAIF contends that because Dr. Heath "cannot be" claimant's attending physician, his opinion regarding claimant's medically stationary status is questionable. Notwithstanding SAIF's assertion, it is well settled that for purposes of determining whether a claimant is medically stationary at the time of closure, we rely upon all competent medical evidence and not just the opinion of the attending physician. *See Patricia M. Knupp*, 46 Van Natta 2406 (1994); *Francisco Villagrana*, 45 Van Natta 1504 (1993); *Timothy H. Krushwitz*, 45 Van Natta 158 (1993). Additionally, we generally defer to the opinion of a claimant's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). We also give the most weight to opinions that are both well reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259 (1986).

Here, we previously found Dr. Funk's unrebutted opinion more persuasive. He was the only physician to render an opinion regarding claimant's medically stationary status at closure. All other medical opinions referred to claimant's current need for treatment. In addition, SAIF submitted the IME physician's concurrence with Dr. Funk's opinion regarding claimant's medically stationary status. Based on the following reasoning, we continue to find that claimant was medically stationary when his claim was closed.

On reconsideration, claimant submitted a December 4, 2000 medical report from Dr. Heath, one of his treating physicians. Dr. Heath opined that during the time period between February 2000 to May 2000, claimant was "disabled and unable to work." In a handwritten addendum to the report, Dr. Heath further opined that claimant was "not medically stable in this time period." However, a review of the record demonstrates that claimant was referred to Dr. Heath for "chronic pain management." In a November 1999 chart note, Dr. Heath explained that he was treating claimant "to increase his functionality by decreasing his pain." He further explained that his goal "was not one of surgery or not surgery but rather one of function versus lack of function." We have previously found that when treatment is designed to primarily improve a claimant's functional abilities, and not to improve his compensable condition, such treatment is not determinative when establishing his medically stationary status under ORS 656.005(17). *Kelly J. Trussell*, 47 Van Natta 121 (1995); *Frank M. Douglas*, 46 Van Natta 1445 (1994).

Here, Dr. Heath was treating claimant for pain management to improve his functionality. However, as noted above, functional improvement alone is not pertinent to his medically stationary status. Instead, the deciding factor is that there is evidence that such treatment is prescribed to improve claimant's compensable condition, *i.e.* his right leg and knee conditions. Without such evidence, and given Dr. Funk's unrebutted opinion that claimant was medically stationary as of January 28, 2000, we continue to find that claimant was medically stationary when SAIF closed his claim. Therefore, we conclude SAIF's closure was proper.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our August 17, 2000 order, as reconsidered on November 14, 2000, in its entirety. The parties' rights of

appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

Board Member Phillips Polich dissenting.

Because I disagree with the majority's evaluation of the evidence on claimant's medically stationary status, I respectfully dissent. I begin by noting that Dr. Heath is under the mistaken assumption that he would not qualify as claimant's "attending physician" because, in Texas, a "treating physician" apparently cannot also function as the "attending physician." (*See* Dr. Heath's April 28, 2000 handwritten note). Oregon law recognizes no such distinction. In any event, as the majority notes, we are not bound by the opinion of claimant's treating physician. Instead, we may consider any competent medical evidence. In this regard, I believe the majority fails to properly consider relevant and persuasive evidence from Dr. Heath and from Dr. Randell, a consulting physician.

Dr. Heath specifically stated that "I would agree that [claimant] was not medically stable in this time period [February 2000 through May 2000]." Although Dr. Heath made this statement in December, 2000, it expressly addresses claimant's condition at the time of closure (February 1, 2000). In addition, I believe a better reading of Dr. Heath's opinion is that claimant's *compensable condition* would improve through further pain management treatment, not just that claimant's "functional abilities" would improve. In *Kelly J. Trussell*, cited by the majority, we were conscious of situations, as here, where a physician's prescribed treatment, "although nominally to improve a claimant's 'functional abilities,' is actually designed to improve a claimant's underlying condition." 47 Van Natta at 122.

Moreover, it is well settled that 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). This rule applies equally in an "Own Motion" context where the issue is the propriety of a carrier's closure order. *See Michael Stewart*, 52 Van Natta 1437 (2000). On March 30, 2000, Dr. Randell recommended physical therapy and work hardening, and suggested that claimant undergo an arthroscopy "to assess whether this patient has significant degenerative changes and problems that would require any further type of surgery." Although he does not specifically use the term "(not) medically stationary," Dr. Randell's statements demonstrate that he has a reasonable expectation that claimant's condition would improve after physical therapy and the suggested arthroscopic surgery. ORS 656.005(17). I consider Dr. Randell's letter, authored less than two months after closure, to be persuasive evidence relating to claimant's condition at closure. In my view, the majority errs by failing to properly consider it.[1]

For all of these reasons, I would set aside SAIF's February 1, 2000 Own Motion Notice of Closure. I respectfully dissent.

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[1] I recognize that we addressed Dr. Randell's reports in our initial Own Motion Order Reviewing Carrier Closure. Nevertheless, I find it currently relevant and persuasive.

In the Matter of the Compensation of
CHRISTOPHER J. WEHREN, Claimant
WCB Case Nos. 00-01180 & 99-01486
ORDER OF ABATEMENT
Black, Chapman, et al, Claimant Attorney
Cummins, Goodman, et al, Defense Attorney

The self-insured employer requests abatement and reconsideration of our January 23, 2001 Order on Review that affirmed the Administrative Law Judge's (ALJ's) order that set aside its denial of claimant's injury claim for a cervical condition. In order to consider this matter, we withdraw our January 23, 2001 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

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 197-254 WITH WORKERS' COMPENSATION BOARD ORDERS THROUGH MARCH 2, 2001. THESE PAGES SHOULD BE INSERTED INTO YOUR CURRENT *VAN NATTA'S* BINDER, VOLUME 53, JANUARY-MARCH 2001.

In the Matter of the Compensation of
DALE E. HOLDEN, Claimant
WCB Case No. 00-00288
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorney
Hitt, et al, Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) set aside its denial of claimant's current right knee condition; and (2) set aside its denial of claimant's new medical condition claims for additional right knee conditions. On review, the issue is compensability.

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

The ALJ set aside the employer's current condition denial based on the opinion of Dr. Mohler. On review, the employer contends that Dr. Mohler relied on an inaccurate history, and that his opinion is therefore unpersuasive. Based on the following analysis, we need not examine the relative persuasiveness of Dr. Mohler's opinion.

Instead, we find that, because the employer was ordered through earlier litigation to accept claimant's right knee chondromalacia condition, (which the medical evidence indicates is the same condition as claimant's current chondromalacia condition), it cannot now deny this same condition. *See Robert S. Wigget*, 49 Van Natta 1307 (1997). In other words, there is no "preexisting condition;" only claimant's chondromalacia condition, which is compensable as a matter of law. Therefore, ORS 656.005(7)(a)(B) does not apply to require that claimant prove that his compensable 1990 injury remains the major contributing cause of his current chondromalacia condition.[1] *Ronald L. Ledbetter*, 47 Van Natta 1461 (1995).

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 insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and claimant's attorney's uncontested attorney fee request), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated October 23, 2000 is affirmed. For services on review, claimant's attorney is awarded $2,000, payable by the self-insured employer.

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[1] We acknowledge the employer's argument that the earlier litigation order setting aside its May 25, 1990 denial specifically referred to ORS 656.005(7)(a)(B). (Ex. 22-3). Nevertheless, subsequent to the order, the employer unambiguously accepted "right knee chondromalacia." (Exs. 25, 28). It did not accept a "combined condition" as a result of the litigation order. *See Blamires v. Clean Pak Systems*, 171 Or App 263 (2000) (acceptance of a combined condition must precede a denial of a combined condition). Similarly, because it has not accepted a "combined condition," the employer cannot deny the claim on the basis that claimant's preexisting "patellofemoral malalignment" condition has combined with claimant's compensable chondromalacia condition. *Id.*

In the Matter of the Compensation of
DALE E. HOLDEN, Claimant
Own Motion No. 99-0410M
OWN MOTION ORDER
Cole, Cary, et al, Claimant Attorney
Hitt, et al, Defense Attorney

The self-insured employer submitted claimant's request for temporary disability compensation for his right knee condition. Claimant's aggravation rights on that claim have expired.

On November 8, 1999, the employer denied the compensability of claimant's current condition. In addition, the employer opposed reopening the claim on the grounds that: (1) it is not responsible for claimants current condition; (2) surgery or hospitalization is not reasonable and necessary for the compensable condition; and (3) claimant was not in the work force at the time of disability. Claimant requested a hearing. (WCB Case No. 00-00288). On January 20, 2000, we consolidated the Own Motion matter with the pending litigation. The Administrative Law Judge (ALJ) was requested to take evidence and provide a recommendation as to whether claimant was in the work force at the time of disability, if claimant's current condition was found compensable.

Thereafter, ALJ Spangler set aside the employer's denial. In doing so, ALJ Spangler found that claimant's current condition was causally related to the April 1990 work injury. The ALJ also noted that the parties had stipulated at hearing that: (1) the proposed surgery was reasonable and necessary; and (2) claimant was in the work force at the time of disability. The employer requested Board review of ALJ Spangler's order, and, by an order issued on today's date, we have affirmed ALJ Spangler's October 23, 2000 order.

Under ORS 656.278(1)(a), we may exercise our Own Motion authority to reopen a claim for temporary disability compensation when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization.

On June 7, 1999, Dr. Mohler, claimant's attending physician, recommended right knee surgery. In addition, based on the parties' stipulation, we are persuaded that claimant's 1990 right knee work injury worsened requiring surgery. Finally, again based on the parties' stipulation, the record establishes that claimant was in the work force at the time of his disability. *SAIF v. Blakely*, 160 Or App 242 (1999); *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

Accordingly, we authorize the reopening of claimant's 1990 injury claim for the employer to provide temporary disability compensation beginning the date claimant is hospitalized for the proposed surgery. When claimant is medically stationary, the employer shall close the claim pursuant to OAR 438-012-0055.

Claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,500, payable by the employer directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

In the Matter of the Compensation of
ARDELLE C. CARLTON, Claimant
WCB Case No. 99-05153
ORDER ON REVIEW
Brothers & Ash, Claimant Attorney
Lundeen, et al, Defense Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the insurer's denial of claimant's right shoulder impingement syndrome condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated September 18, 2000 is affirmed.

Board Member Phillips Polich dissenting.

I disagree with the majority's order adopting and affirming the ALJ's order. The ALJ found that the opinion of claimant's current treating physician, Dr. Walther, did not carry claimant's burden of proof because he thought that Dr. Walther relied only on a "temporal coincidence of the onset of symptoms."

A review of Dr. Walther's opinion shows that she based it on more than a temporal relationship. First, Dr. Walther noted that the mechanism of the December 27, 1998 injury was consistent with her diagnosis of "multidirectional instability." Dr. Walther ruled out off-work activities and noted that claimant's disability and need for medical treatment commenced at the time of the injury. Finally, Dr. Walther indicated that other individuals with the same relatively mild preexisting condition would be expected to remain asymptomatic in the absence of an injury event. Thus, Dr. Walther concluded that the December 27, 1998 injury was the major cause of calimant's disability and need for treatment.

Given this analysis, Dr. Walther is entitled to deference as the treating physician. *See Weiland v. SAIF*, 64 Or App 810 (1983). Because Dr. Walther provided the most persuasive medical opinion, claimant proved compensability. *See* ORS 656.005(7)(a)(B). Therefore, I dissent from the majority's contrary conclusion.

In the Matter of the Compensation of
LORAN O. BANEK, Claimant
WCB Case No. 00-02870
ORDER ON REVIEW
Scott M. McNutt, Jr., Claimant Attorney
Scheminske, et al, Defense Attorney

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Lipton's order that: (1) found claimant had given timely notice of an injury claim; and (2) set aside its denial of claimant's injury claim for a left eye laceration, petit mal seizures, a chest contusion and a third degree heart block. Claimant cross-requests review of that portion of the ALJ's order that declined to assess a penalty for the employer's allegedly unreasonable denial. On review, the issues are timeliness, compensability and penalties.

We adopt and affirm the ALJ's order with the following supplementation. We write only to address the employer's argument that claimant's injury did not arise out of the course and scope of his employment.

Claimant was injured in a motor vehicle accident on December 10, 1999, which occurred shortly after his work shift ended as he was pulling out of a parking spot at the employer's parking lot. Relying on *Fred Meyer, Inc. v. Hayes*, 325 Or 592 (1997), the ALJ found that claimant's injury occurred in the course of his employment. The ALJ also determined that claimant had satisfied the "arising out of" employment element.

On review, the employer acknowledges that claimant's injury arguably occurred in the course of his employment, but it argues that element was weak. The employer contends that claimant has failed to show a causal link between the injury and his employment.

For an injury to be compensable under the workers' compensation law, it must "aris[e] out of" and occur "in the course of employment[.]" ORS 656.005(7)(a). The "arise out of" prong of the compensability test requires that a causal link exist between the worker's injury and his or her employment. *Hayes*, 325 Or at 596. The requirement that the injury occur "in the course of" the employment concerns the time, place, and circumstances of the injury. *Id.* Both prongs of the work-connection test must be satisfied to some degree; neither is dispositive. *Id.* The work-connection test may be satisfied if the factors supporting one prong of the statutory test are minimal while the factors supporting the other prong are many. *Id.*

Ordinarily, an injury sustained while a worker is going to or coming from work is not considered to have occurred "in the course of" employment and is not compensable. *Krushwitz v. McDonald's Restaurants*, 323 Or 520, 526 (1996). One exception to the "going and coming" rule is the "parking lot" exception. *Hayes*, 325 Or at 597. Under that exception, injuries sustained on the employer's premises while the worker is going to or coming from work have a sufficient work-connection to be considered to have occurred "in the course of" employment. *Id.* at 597-98. The "parking lot" exception is a recognition that the parking lot over which an employer exercises control is a part of the worker's employment environment. *Id.* at 598 n.10.

We first address the issue whether claimant's injury occurred "in the course of" his employment. That inquiry tests the time, place, and circumstance of the injury. In *Hayes*, the claimant suffered a compensable injury after her work shift ended while going to her car, which was parked in the employer's parking lot. The Supreme Court explained:

> "An injury occurs 'in the course of' employment if it takes place within the period of employment, at a place where a worker reasonably may be expected to be, and while the worker reasonably is fulfilling the duties of the employment or is doing something reasonably incidental to it. *'In the course of' employment also includes a reasonable period of time after work for the worker to leave the employer's premises, including the employer's parking lot.*" 325 Or at 598 (emphasis supplied).

Here, we agree with the ALJ that claimant was injured in the course of his employment on December 10, 1999. Claimant's work hours were 7:00 a.m. to 3:30 p.m. (Tr. 28). On December 10, 1999, he "clocked out" and went to the employer's parking lot to get into his car. (Tr. 28-29). He arrived at his car about 5 to 15 minutes after clocking out. (Tr. 29). Claimant put his seat belt on, pulled out "frontwards" and started to drive away. (Tr. 37). After he pulled out of his parking spot, he turned to the left and was hit by a pickup truck and seriously injured. (Tr. 37). The injury occurred in the employer's parking lot. (Tr. 29).

We find that the injury occurred at the employer's parking lot, at a reasonable interval after working hours. Based on the time, place and circumstances of the injury, we agree with the ALJ that claimant was injured in the "course of" his employment.

Claimant must also establish a causal connection between the injury and the employment, *i.e.*, that the injury arose "out of" his 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. *Hayes*, 325 Or at 601. A claimant need not prove that he or she was exposed to any "peculiar" or "increased" risk by the employment. *Id.* To the contrary, an injury that arises from a neutral risk of the employment arises out of the employment. *McTaggart v. Time Warner Cable*, 170 Or App 491, 500 (2000).

Here, we find no evidence that claimant's motor vehicle accident was caused by a person known to claimant or that it arose out of any animosity. In other words, there is no evidence that the risk of a motor vehicle accident was personal to claimant. As discussed earlier, the "parking lot" exception to the going and coming rule is a recognition that the parking lot over which an employer exercises control is a part of the worker's employment environment. *Hayes*, 325 Or at 598 n.10. Claimant's supervisor testified that the accident occurred in late afternoon, and it was overcast and "kind of twilight." (Tr. 10). Claimant believed that the other driver was going too fast for a parking lot. (Tr. 42). Under these circumstances, we find that the risk of injury resulted from some risk to which the work environment exposed claimant. *See Hayes*, 325 Or at 601-02. We therefore conclude that claimant's injury "arose out of" his employment. In summary, we agree with the ALJ that claimant's injury arose out of and in the course of his employment.

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 issue, and the value of the interest involved. Claimant's attorney is not entitled to an attorney fee for services concerning the penalty issue. *See Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986).

ORDER

The ALJ's order dated October 23, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the self-insured employer.

February 20, 2001 Cite as 53 Van Natta 201 (2001)

In the Matter of the Compensation of
WILLIAM F. DAVIS, Claimant
Own Motion No. 98-0193M
OWN MOTION ORDER OF DISMISSAL
Ransom & Gilbertson, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requested review of the SAIF Corporation's January 12, 2001 Notice of Closure. In response to claimant's request, SAIF announced that the January 12, 2001 Notice of Closure "was issued in error." We interpret SAIF's statement to mean that it has rescinded its January 12, 2001 Notice of Closure.[1]

[1] SAIF explained that the January 12, 2001 Notice of Closure was void because "the worker's claim was not reopened under the Board's [Own Motion] jurisdiction."

Inasmuch as SAIF has withdrawn its January 12, 2001 Notice of Closure, the request for review is dismissed.[2]

IT IS SO ORDERED.

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[2] We note that claimant also sought a penalty for "unreasonable claim processing of a new medical condition." Because our authority under ORS 656.278 is limited to issues arising from the processing of Own Motion claims, we are with our authority to consider claimant's penalty request concerning the processing of a new medical condition. *Craig J. Prince*, 52 Van Natta 108 (2000).

February 22, 2001 Cite as 53 Van Natta 202 (2001)

In the Matter of the Compensation of
DELORIS E. GEMOETS, Claimant
WCB Case No. 00-03416
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order that: (1) declined to admit into the record Exhibits A, B, and C, which relate to lottery receipts/activity at the employer's business on the night of the alleged injury; and (2) set aside its denial of claimant's left knee and low back injury claim. On review, the issues are evidence and compensability.

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

At hearing, the insurer submitted Exhibits A, B, and C, which dealt with the employer's two lottery machines, an all game machine and a video poker machine. (Tr. 69-73).[1] Prior to submitting these exhibits for admittance into the record, Mr. Cook, the employer's administrator, testified as to what the exhibits showed. (Tr. 69-73). When the insurer offered these exhibits into the record, claimant's attorney objected on the grounds that they were not good quality copies, it was difficult to read some of the numbers on the exhibits, and they were not the "best evidence." (Tr. 75). The ALJ deferred ruling on the objection pending the insurer providing the original documents either to the forum or to claimant's attorney. (Tr. 76). The insurer was unable to obtain the original documents. Instead, the insurer provided the copies from which Exhibits A, B, and C were made and provided a statement from a public affairs representative from the Oregon Lottery. The ALJ declined to admit the proffered exhibits, finding that claimant should have the opportunity to review the original exhibits.

On review, the insurer argues that the ALJ abused his discretion in declining to admit these exhibits, including the statement from the Oregon Lottery representative. We disagree.

ALJs are not bound by common law or statutory rules of evidence or by technical or formal rules of procedure and may conduct the hearing in any manner that will achieve substantial justice. ORS 656.283(7); *Armstrong v. SAIF*, 67 Or App 498 (1984). We review the ALJ's evidentiary ruling for abuse of discretion. *Rodney D. Jacobs*, 44 Van Natta 417 (1992); *Renia Broyles*, 42 Van Natta 1203 (1990).

We find no abuse of discretion in refusing to admit the exhibits in question. As the insurer notes, the ALJ relied on the testimony of Mr. Cook in explaining what the exhibits represented to find that the timing of claimant's alleged accident was called into question. The ALJ noted that Mr. Cook's testimony suggested that the Lodge was not closed at the time of the alleged accident, and tended to

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[1] Exhibit A is a copy of the January 31, 2000 lottery work sheet showing the "beginning bank" amounts and with spaces for "ending totals." Exhibit B is a copy of January 31, 2000 printouts for the employer's two lottery machines. Exhibit C is a copy of a bill acceptance log and a cash ticket log from the employer's video poker machine that Mr. Cook, the employer's administrator, printed out on February 1, 2000. The bill acceptance log shows money deposited into the employer's video poker machine from 7:07 p.m. through 10:46 p.m. on January 31, 2000. (Ex. C-1).

contradict claimant's testimony that she was alone in the bar at the time of her injury. Thus, the substance of the proffered exhibits was admitted into the record without objection through Mr. Cook's testimony. Therefore, we find that substantial justice was achieved and we do not find that the ALJ abused his discretion in refusing to admit the exhibits.

Nevertheless, although considering the inconsistency in claimant's report of the timing of the injury and the possibility that someone else was in the Lodge at the time the incident occurred, based on claimant's testimony, as corroborated by the testimony of her witnesses, the ALJ found that claimant's injury occurred at work in the way she described. We agree with the ALJ's reasoning and conclusions on this issue.

In addition, claimant testified that on February 1, 2000, Mr. Ward, her domestic partner, notified the employer that claimant injured herself the night before when she fell off a chair at work while turning off lights. (Tr. 29, Ex. 3). The employer's 801 form corroborates claimant's testimony by noting that the employer first knew of the claim on February 1, 2000. (Ex. 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 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 value of the interest involved and the complexity of the issue.

ORDER

The ALJ's order dated November 1, 2000 is affirmed. For services on Board review, claimant's attorney is awarded $1,200, payable by the insurer.

February 22, 2001 Cite as 53 Van Natta 203 (2001)

In the Matter of the Compensation of
ALVARO MACHUCA-RAMIREZ, Claimant
WCB Case No. 00-01419
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Johnson's order that awarded 28 percent (89.6 degrees) unscheduled permanent disability for claimant's low back condition, whereas an Order on Reconsideration awarded none. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant had back pain sporadically beginning in 1995. He filed earlier claims for two low back injuries, in October 1997 and May 1998, and a prior carrier accepted the latter claim as a nondisabling lumbar strain. X-rays revealed low back degeneration. (Exs. 7, 15).

The present claim stems from a December 2, 1998 low back injury and an exacerbation in April 1998. The insurer accepted claimant's claim for a disabling lumbar strain. (*See* Exs. 14, 31, 40, 52).

Dr. Tsang, attending physician, provided conservative treatment.

Drs. Woodward and Williams examined claimant on September 21, 1999 and found him medically stationary. They diagnosed chronic recurrent lumbosacral strain and lumbar spondylosis (the latter based on claimant's CT scan). (Ex. 50-5). The examiners measured claimant's lumbar range of motion, found the lumbar flexion measurement invalid, and stated that they were unable to "explain" claimant's reduced lumbar motion. (*Id.* at 6).

Dr. Tsang concurred with the examiner's report on October 7, 1999. (*See* Ex. 53-2).

An October 21, 1999 Notice of Closure closed the claim with a 28 percent unscheduled permanent disability award. Claimant requested reconsideration and a medical arbiter examination.

Dr. Vessely, medical arbiter, examined claimant on January 12, 2000 and reported claimant's history that his back pain had worsened since he stopped working in November 1999. Dr. Vessely found the examination extremely compromised by pain magnification and functional interference. Claimant's range of motion measurements were inconsistent, indicating a lack of cooperation, and Dr. Vessely did not complete three sets of tests. Dr. Vessely concluded that the examination was "almost totally invalid." (Ex. 57-6).

A February 18, 2000 Order on Reconsideration reduced claimant's unscheduled permanent disability award to zero, based on the arbiter's report. Claimant requested a hearing.

The ALJ reinstated the Notice of Closure's award of 28 percent unscheduled permanent disability, based on Dr. Tsang's concurrence with the examiners' September 21, 1999 findings. The ALJ reasoned that the examiner's findings constituted a preponderance of medical evidence regarding claimant's permanent impairment. In this regard, the ALJ found the examiners' measurements intrinsically persuasive because their findings were based on three measurements for each range of motion finding, whereas the arbiter "gave up" after attempting one set of measurements. The ALJ also found it "important" that three experts agreed regarding the earlier findings. The ALJ further reasoned that, if claimant's condition worsened after claim closure but before reconsideration, it would be appropriate to rely on findings made at closure, before such worsening.

We conclude that claimant has not established permanent impairment, based on the following reasoning.[1]

On reconsideration, where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. OAR 436-035-0007(14) (WCD Admin. Order 98-055). This preponderance of medical opinion 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 rely on the most thorough, complete, and well-reasoned evaluation of claimant's injury-related impairment. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

The medical arbiter's report does not support a conclusion that claimant has injury-related impairment. Therefore, the remaining question is whether the examiners' September 21, 1999 report (with which Dr. Tsang concurred) establishes injury-related impairment and if so, whether that report constitutes a preponderance of the medical evidence. *See* ORS 656.726(4)(f)(B).

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[1] We acknowledge claimant's contention that the insurer may not contest its own Notice of Closure award (*i.e.*, 28 percent unscheduled permanent disability). However, the issue before the ALJ and the Board on review is the propriety of the change the Order on Reconsideration made in claimant's award (*i.e.*, reduction to zero). The insurer is not precluded from defending the change made by the reconsideration order. *See Christine M. Flaherty*, 51 Van Natta 1971 (1999) (carrier not precluded from defending reconsideration order's permanent disability award where extent issue was raised on reconsideration and preserved at hearing) (applying *Duncan v. Liberty Northwest Ins. Corp.*, 133 Or App 605 (1995)).

We also acknowledge claimant's contention that the insurer is precluded from arguing that claimant's condition is not injury-related because it did not issue a preclosure "combined condition" denial. However, for the reasons expressed in this order, this record does not support a conclusion that claimant has sustained permanent impairment; *i.e.* claimant's impairment findings are either invalid or unreliable. In any event, because the insurer did not accept a combined condition, it 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); *compare SAIF v. Belden*, 155 Or App 568 (1995) (where the insurer accepted a combined condition but did not issue a denial of the combined condition, entire combined condition properly rated); *see also Croman Corp. v. Serrano*, 163 Or App 136 (1999) (ORS 656.262(6)(c) and ORS 656.262(7)(b), inapplicable unless accepted condition is a combined condition).

The examiners diagnosed "[c]hronic recurrent lumbosacral strain" and "[l]umbar spondylolysis, by CT scan report."[2] (Ex. 54-5). They commented that claimant "had recurrent attacks of low back pain for more than two years and can be expected to have them in the future." (*Id*). When asked to identify the major contributing cause of claimant's current condition, the examiners responded: "[f]rom the examinee's history it would seem that the major contributing cause is his recurrent low back pain." (Ex. 50-6). When asked to provide all objective findings and indicate whether objective findings support objective complaints, the examiners responded:

> "The examinee has a normal neurologic examination and has no neurologic symptoms. The examinee's range of motion has been restricted according to all evaluators. We cannot explain this loss of lumbar range of motion. We cannot explain the marked loss of lumbar extension and lateral flexion on the basis of the examinee's imaging studies and history." (*Id*).

Thus, the examiners not only failed to relate claimant's impairment findings to the accepted strain injury, but they were also unable to explain those findings. Under these circumstances, we do not find that Dr. Tsang's concurrence with the examiners' report supports a conclusion that claimant's impairment findings are injury-related. Accordingly, on this record, claimant has not established entitlement to permanent disability compensation for his accepted strain. *See* ORS 656.214(5).

ORDER

The ALJ's order dated November 9, 2000 is reversed. The Order on Reconsideration is reinstated and affirmed. The ALJ's attorney fee award is reversed.

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[2] The cover letter attached to the examiners' report states, "This document describes only the reported injury." (Ex. 50-1). However, the accepted condition is a lumbar strain and the examiners diagnosed a strain *and* spondylolisis. Because the examiners did not relate claimant's impairment findings to either diagnosis, we are not persuaded that the findings are limited to the accepted strain condition.

February 22, 2001 Cite as 53 Van Natta 205 (2001)

In the Matter of the Compensation of
JOSE C. MARTINEZ, Claimant
WCB Case No. 00-04955
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

The SAIF Corporation requests review of Administrative Law judge (ALJ) Crumme's order that set aside its denial of claimant's occupational disease claim for a right shoulder condition. On review, the issues are claim preclusion and compensability.

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

The ALJ found that claimant's current occupational disease claim for right shoulder acromioclavicular (AC) joint arthritis was not barred by a final January 15, 1998 Opinion and Order that had upheld SAIF's previous denial of an occupational disease claim based in part on a bilateral shoulder condition. On review, SAIF contends that claimant's current right shoulder AC joint arthritis condition is the same condition that was determined not compensable in the prior order and, thus, cannot be relitigated in these proceedings. We disagree.

Although there was X-ray evidence of bilateral AC joint arthritis in 1995, the diagnoses of claimant's bilateral shoulder condition consisted of myofascial pain and fibromyalgia when the prior occupational disease claim was filed. Although the prior order was somewhat unspecific as to the exact shoulder "condition" that was being litigated, the ALJ in his prior order extensively discussed the medical opinion of Dr. Maier regarding the cause of claimant's fibromyalgia. (Ex. 25-4). Having reviewed the prior order as a whole, we are persuaded that compensability of claimant's AC joint

arthritis was not at issue in that case and, therefore, that claimant's current right shoulder condition is not the same one that was previously determined not compensable.

Accordingly, we find that the ALJ properly rejected SAIF's claim preclusion argument. We now address SAIF's substantive arguments regarding the medical evidence that the ALJ determined was sufficient to prove the compensability of claimant's current occupational disease claim for AC joint arthritis.

The ALJ found that claimant proved that his work activities over 26 years of employment, almost entirely as a bus driver, were the major contributing cause of his AC joint arthritis condition. In so doing, the ALJ found the opinion of Dr. Davis, whom the ALJ considered the current attending physician, to be more persuasive than that of Dr. Lantz, who examined claimant on several occasions in 1995 and on one occasion in March 2000.

SAIF contends that Dr. Lantz's opinion is more persuasive than Dr. Davis's opinion because the latter doctor did not address the proper legal standard, had an incomplete history, and issued a conclusory opinion. By contrast, SAIF argues that Dr. Lantz's opinion benefits greatly from his having examined claimant in both 1995 and in March 2000. Having considered SAIF's contentions, we do not find them persuasive.

SAIF correctly notes that claimant must prove that his work activities are the major contributing cause of the AC joint arthritis condition, not just the symptoms or the need for treatment. *See* ORS 656.802(2)(a); *David E. Belton*, 52 Van Natta 2250 (2000); *Tammy L. Foster*, 52 Van Natta 178 (2000). SAIF focuses on Dr. Davis' statement that the primary "aggravation" to claimant's shoulders and the cause of the "need for treatment" were claimant's work activities. (Ex. 42). Standing alone, this statement does not satisfy claimant's burden of proof.

However, Dr. Davis also noted that AC joint arthrosis can occur over a long period in response to chronic stress/strain to the region. Dr. Davis opined that 25 years was sufficient to cause AC joint arthrosis. *Id.* Having reviewed Dr. Davis' opinion as whole, and keeping in mind that "magic words" are not necessary to establish causation, we are persuaded that Dr. Davis' opinion is sufficient to establish that claimant's entire employment of 26 years is the major contributing cause of the right shoulder arthritis 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. Davis' opinion satisfies the correct legal standard and is not conclusory.

SAIF also argues that Dr. Davis' opinion is flawed because he was unaware that claimant developed right shoulder symptoms in conjunction with doing push-ups in the Army reserve in 1994. While Dr. Davis' reports do not evidence an awareness of this history, we are not persuaded that it fatally flaws his opinion. In this regard, we note that the physician on whom SAIF relies, Dr. Lantz, does not identify the "push-ups" as a causal factor in the AC joint condition. Thus, we conclude that this gap in Dr. Davis' history is not sufficient for us to discount his opinion.

Moreover, we are not persuaded that Dr. Lantz' opinion is more reliable, despite his perspective on the claim, because his causation opinion only focuses on claimant's work activities since 1998. (Ex. 41A). Because we have determined that the prior litigation has no preclusive effect on the current occupational disease claim, we consider claimant's entire 26 year employment in determining the cause of the AC joint condition. When the entire employment is considered, we agree with the ALJ that claimant has proved the compensability of the occupational disease claim. Thus, 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 October 30, 2000 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by SAIF.

In the Matter of the Compensation of
STEPHANIE A. DYS-DODSON, Claimant
WCB Case Nos. 00-03498 & 00-02158
ORDER ON REVIEW
Willner, Wren, Hill & Uren, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of those portions of the order of Administrative Law Judge (ALJ) Poland that: (1) affirmed an Order on Reconsideration finding that claimant's right thumb/wrist injury claim was prematurely closed; and (2) set aside the Director's order suspending claimant's benefits for failing to attend or cooperate with an insurer-arranged medical examination. On review, the issues are premature closure and the propriety of the Director's suspension order.[1] We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Premature Closure

Claimant has an accepted claim for "right thumb tendinitis" as the result of a July 7, 1999 injury to her right thumb and wrist.[2] (Ex. 1; 6; 7). Claimant's condition has been diagnosed as both right thumb tendinitis and de Quervain's tenosynovitis. (Exs. 2; 4; 5; 8;11A; 13; 34). On January 5, 2000 Dr. Buehler (the attending physician at that time), indicated there was nothing more he could do for claimant. On January 21, 2000, Dr. Buehler confirmed that claimant was medically stationary with no permanent impairment from the accepted claim. (Ex. 24). On January 24, 2000, Dr. Buehler released claimant to regular work.

The insurer issued a February 3, 2000 Notice of Closure, listing January 5, 2000 as the medically stationary date. (Ex. 32). Claimant requested reconsideration, raising (among other issues) premature claim closure. (Ex. 35).

The Order on Reconsideration determined that the Notice of Closure had been improperly issued because: (1) there was insufficient information to determine the extent of disability from the accepted condition; and (2) the medically stationary status of claimant's condition was in doubt. (Ex. 38-2). The insurer requested a hearing.

The ALJ determined that there was insufficient information to determine the extent of disability from the accepted condition. Consequently, the ALJ affirmed the Order on Reconsideration.

The insurer asserts that, when the February 3, 2000 Notice of Closure was issued, Dr. Buehler had indicated that claimant was medically stationary with no permanent impairment from the accepted claim. Consequently, the insurer reasons that its claim closure was proper, and that the Notice of Closure should be reinstated. We agree.

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[1] In its reply brief, the insurer argued that the holding in *Ball v. The Halton Company*, 167 Or App 468 (2000), was controlling. In response, claimant moved to strike that portion of the insurer's reply, contending that *Ball* is no longer viable due to the 1999 amendments to ORS 656.268(1). Although characterized as a "motion to strike," claimant's response is really a substantive response to the insurer's argument. Because the insurer could make an argument based on *Ball*, we deny claimant's "motion." However, we decide this issue based upon the current version of ORS 656.268(1)(a) (which was not applicable in the *Ball* case) and our recent decision in *Gloria Garibay*, 52 Van Natta 2251 (2000). In other words, *Ball* is distinguishable.

[2] Both the initial Notice of Acceptance and the Notice of Acceptance at Closure list the accepted condition as "right thumb tendinitis." (Exs. 6; 27).

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 436-030-015(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), a decision issued subsequent to the ALJ's order, 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.

Here, claimant was not engaged in training at the time of claim closure. Additionally, the attending physician had opined that claimant had no permanent impairment attributable to the accepted claim. Based on that opinion, we conclude that sufficient information existed to rate the extent of claimant's permanent disability as zero. Consequently, following our reasoning in Garibay, we conclude that the Notice of Closure was properly issued, provided that claimant was medically stationary at the time.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). The propriety of the closure turns on whether claimant was medically stationary at the time of the February 2000 Notice of Closure, considering claimant's condition at the time of closure and not 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, the record establishes that, on January 21, 2000, Dr. Buehler indicated that claimant's condition was stationary. (Ex. 24). Later, on January 24, 2000, Dr. Buehler indicated that claimant had been released to regular duty work. (Ex. 26).

Although the record establishes that claimant is now under the care of Dr. Layman, and that claimant needed additional treatment and was restricted from working beginning March 30, 2000, the record does not indicate that either Dr. Layman or Dr. Buehler disagree with Dr. Buehler's previous finding that claimant's condition was stationary as of January 21, 2000. Consequently, based on this record, we conclude that the February 3, 2000 Notice of Closure was properly issued.

Accordingly, that portion of the ALJ's order that affirmed the Order on Reconsideration is reversed.[3] The insurer's Notice of Closure is reinstated. Inasmuch as claimant did not raise permanent disability as an issue during the reconsideration preceding and does not challenge the temporary disability granted by the Notice of Closure, we affirm the Notice of Closure.

Suspension of Benefits

We adopt and affirm this portion of the ALJ's order.

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 in this case for claimant's attorney's services on review regarding the "suspension" issue is $700, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

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[3] Because of our decision, we also reverse the ALJ's attorney fee award under ORS 656.382(2).

ORDER

The ALJ's order dated July 28, 2000 is affirmed in part and reversed in part. That portion of the ALJ's order that affirmed the April 11, 2000 Order on Reconsideration is reversed. The ALJ's $2,500 insurer-paid attorney fee award is also reversed. The February 3, 2000 Notice of Closure is reinstated and affirmed. The remainder of the ALJ's order is affirmed. For services on review, claimant is awarded a $700 attorney fee, payable by the insurer.

February 22, 2001 Cite as 53 Van Natta 209 (2001)

In the Matter of the Compensation of
ROBERT A. ROGERS, Claimant
WCB Case No. 00-02272
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorney
Julie Masters (Saif), Defense Attorney

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

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Nichols' order that directed it to accept claimant's severe post-traumatic disc degeneration and soft tissue stenosis as new medical conditions. In his brief, claimant requests sanctions under ORS 656.390 based on SAIF's allegedly frivolous argument regarding claim preclusion. On review, the issues are scope of acceptance and sanctions.

We deny claimant's motion for sanctions and adopt and affirm the ALJ's order, with the following supplementation.[1]

The ALJ directed SAIF to accept claimant's disc degeneration and soft tissue stenosis as new medical conditions. Although the ALJ did not specifically direct SAIF to process claimant's claim for those "post-closure" conditions under ORS 656.262(7)(c), an ALJ has jurisdiction over such a matter and a carrier is obligated to process such conditions under that statute. ORS 656.283(7); *Larry L. Ledin*, 52 Van Natta 682, 683 (2000); *Craig J. Prince*, 52 Van Natta 108 (2000).

In his respondent's brief, claimant asks for sanctions, alleging that SAIF's "claim preclusion" defense is frivolous. Pursuant to ORS 656.390(1), 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, SAIF has presented colorable arguments on review regarding the "new medical condition" issue that are sufficiently developed so as to create a reasonable prospect of prevailing on the merits. While the arguments on review did not ultimately prevail (including the argument cited by claimant), we cannot say SAIF's request for review was "frivolous." *Jack B. Hooper*, 49 Van Natta 669 (1997); *Donald M. Criss*, 48 Van Natta 1569 (1996). Accordingly, we deny claimant's request for sanctions.

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 $2,500, 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. Claimant is not entitled to an attorney fee for his counsel's services devoted to the sanctions issue.

ORDER

The ALJ's order dated November 8, 2000 is affirmed. For services on review, claimant's attorney is awarded $2,500, payable by the SAIF Corporation.

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[1] We need not address the parties' arguments regarding burden of proof, because, regardless of who has the burden of proof, the persuasive medical evidence establishes that SAIF's 1993 acceptance of claimant's L4-5 herniated disc did not "reasonably apprise" the worker and medical providers of the nature of the "post-closure" medical conditions.

Board Member Meyers dissenting.

The majority finds that Dr. Lewis' medical opinion establishes that SAIF's acceptance of an L4-5 herniated disc did not "reasonably apprise" claimant and his medical providers of the nature of the severe post-traumatic disc degeneration and soft tissue stenosis. I disagree with their analysis, particularly in light of the fact that each physician who provided an opinion in this case explained that the later-developing conditions appeared as a natural and anticipated result of the herniated disc, and, from a medical perspective, nothing need be added to the acceptance of a herniated disc to further describe the condition as including severe post-traumatic disc degeneration and soft tissue stenosis.

Most importantly, I think good public policy requires that that portion of ORS 656.262(7)(a) at issue in this case[1] should be liberally construed to include naturally occurring and anticipated results of surgery for a compensable condition. Otherwise, all anticipated sequelae from surgery will of necessity result in either the requirement that examiners be clairvoyant of such sequelae or an increase in litigation of "new medical conditions" and the reopening and reprocessing of claims many years subsequent to the original claim acceptance. This reopening and reprocessing of claims will result in additional and unnecessary burdens to the system in at least the following areas:

(a) workers will experience uncertainty and inefficiencies in receiving needed care resulting from already determined compensable claims;

(b) medical providers will also face similar confusion in providing such reasonably necessary care, the prime evidence of which can be found in Dr. Lewis' deposition responses in this case;

(c) insurers and self-insured employers will, in turn, be faced with the incorporation of those increased costs into the stream of commerce; and, finally,

(d) as explained in the special concurrence by Member Haynes in *Larry L. Ledin*, 52 Van Natta 682 (2000), such costs were never contemplated in the prediction of reserve amounts, loss development, or rating structure of Oregon's workers' compensation system.

For these reasons, I respectfully dissent.

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[1] ORS 656.262(7)(a) states in relevant part:

"The insurer or self-insured employer is not required to accept each and every diagnosis or medical condition with particularity, so long as the acceptance tendered reasonably apprises the claimant and medical providers of the nature of the compensable conditions."

In the Matter of the Compensation of
LORNA J. SANTANGELO, Claimant
WCB Case No. 00-00317
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorney
Terrall & Terrall, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Davis's order that upheld the self-insured employer's denials of her claims for her right first carpometacarpal joint degenerative arthritis, right tenosynovitis, right trapezoid bone stress fracture and carpal tunnel syndrome conditions. With her appellant's brief, claimant has submitted medical records not admitted at hearing. We treat the submission as a motion for remand. On review, the issues are remand and compensability. We deny the motion for remand and affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Remand

With her appellant's brief, claimant has submitted numerous "post-hearing" medical reports. Claimant argues that the reports establish that her disability is due to a newly diagnosed condition. Consequently, claimant contends that this matter should be remanded to the ALJ for consideration of the additional documents.

Our review must be based on the record certified to us. ORS 656.295(5). Consequently, we treat claimant's submission of evidence as a motion to remand to the ALJ for the taking of additional evidence. *Judy A. Britton*, 37 Van Natta 1262 (1985). We consider the proffered evidence only for the purpose of determining whether remand is appropriate.

We may remand to the ALJ if the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of hearing. *Compton v. Weyerhaeuser Co.*, 301 Or 641 (1986). Although evidence that is not generated until after the hearing is "unavailable," it may still have been "obtainable" at the time of hearing. *Compton*, 301 Or at 648-49. *See also James E. Gore*, 45 Van Natta 1652 (1993) (evidence is not newly discovered merely because it was generated after the hearing).

Here, there has been no showing that the "new" diagnosis of reflex sympathetic dystrophy (RSD) was based on evidence generated after the hearing. *See, e.g., Kienow's Food Stores v. Lyster*, 79 Or App at 420 (where a new medical report was based on information available before the hearing, it was merely an attempt to explain a changed opinion and there was no compelling reason to remand). Furthermore, although the diagnosis differs from those provided by prior doctors, claimant has not explained why a report from Dr. Anderson was not obtained prior to the hearing. Finally, we are not convinced that Dr. Anderson's subsequent diagnosis of RSD is necessarily more persuasive than the diagnosis offered by claimant's treating doctor. Consequently, we find no compelling reason to remand.

Because we have found that the information claimant's new medical report was based on was available prior to hearing, and because it has not been shown that the outcome of this matter would be affected, we find that the record has been properly developed. Therefore, claimant's motion for remand is denied.

Compensability

We adopt and affirm the ALJ's Conclusions of Law and Opinion on the issue of compensability.

ORDER

The ALJ's order dated October 31, 2000 is affirmed.

In the Matter of the Compensation of
WILLIAM A. STRODE, Claimant
WCB Case No. 98-10183
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Kekauoha's order that: (1) set aside its denial of claimant's occupational disease claim for a right wrist condition; and (2) awarded an assessed fee of $9,240 for services at hearing. On review, the issues are compensability and attorney fees.

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

We agree with the ALJ that ORS 656.802(2)(a) applies under the facts of this case. In this regard, claimant's theory of compensability is not based on a worsening of a preexisting condition. Thus, ORS 656.802(2)(b) does not apply.[1] *See Ron L. Merwin*, 49 Van Natta 1801 (1997) (ORS 656.802(2)(b) not applicable where the claimant's theory of compensability was not based on a worsening of a preexisting condition). Therefore, pursuant to ORS 656.802(2)(a), claimant must prove that his work activities are the major contributing cause of the disease itself (diagnosed as bone marrow edema and/or avascular necrosis of the capitate bone), not just the disability or treatment associated with it. *See Tammy L. Foster*, 52 Van Natta 178 (2000). We agree with the ALJ's reasoning and conclusions that claimant met his burden of proof.

Regarding the attorney fee issue, the ALJ awarded a $9,240 assessed attorney fee to claimant's counsel for prevailing over the employer's denial to the extent that it denied claimant's occupational disease claim for bone marrow edema and avascular necrosis of the capitate in the right wrist. On review, the employer contests the amount of the attorney fee, arguing that it is excessive and should be "reduced considerably."

We review the attorney fee issue *de novo*, considering the specific contentions raised on review, in light of the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that any attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses. *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).

Following the hearing, the parties submitted written closing arguments and claimant's attorney submitted an affidavit seeking a $9,240 fee, stating that he had spent 56 hours preparing and litigating this case. After considering the factors in OAR 438-015-0010(4), the ALJ concluded that the requested amount of $9,240 was reasonable. We agree.

On review, the employer argues that some of the 56 hours claimant's attorney reported should not be considered in determining a reasonable attorney fee, speculating that some of that time was spent on the issue of compensability of the left hand condition, an issue claimant withdrew at hearing. However, in a separate affidavit, claimant's attorney attested that none of the reported 56 hours was spent on the compensability of the left hand condition. Based on that sworn representation, the record supports a conclusion that claimant's counsel expended 56 hours at the Hearing level regarding the right wrist condition.

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[1] ORS 656.802(2)(b) provides:

"If the occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005(7), the worker must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease."

The hearing lasted two hours and 15 minutes, and three witnesses testified, all called by claimant. The witnesses included claimant, his wife, and his supervisor. The record contains 146 exhibits, four of which were submitted by claimant's attorney. Claimant's attorney took the statement of Dr. Balkovich, consulting plastic surgeon, which was completed in about ten minutes. (Ex. 151). Depositions were also taken of Dr. Balkovich, Dr. Thrall, treating internist and occupational medicine specialist, and Dr. Long, treating hand surgeon. (Exs. 153, 154, 155). These depositions ranged from almost an hour to an hour and a half.

The legal issue regarding compensability of an occupational disease was of average complexity. However, the medical causation issue was of greater than normal complexity, given claimant's history and the nature of the bone edema/avascular necrosis condition. The value of the interest involved and the benefits secured is average in that claimant will receive medical treatment and possibly other benefits for his bone edema/avascular necrosis condition. The attorneys were skilled and presented their positions in a thorough manner, including written closing arguments. No frivolous issues or defenses were raised. Given the differing medical opinions regarding causation, there was substantial risk that claimant's attorney might go uncompensated.

Based on our application of the factors set forth above and considering the parties' arguments, we find that an attorney fee of $9,240 is reasonable for claimant's counsel's services in this particular case regarding compensability at the hearing level. 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 (146 exhibits, a 2-hour hearing, and three depositions), 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 compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4), and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and 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 August 17, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the employer.

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[2] Claimant's attorney attested to spending 12.5 hours preparing his Respondent's Brief and requested a fee of $2,062.50 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 compensability issue is $1,500.

In the Matter of the Compensation of
STANLEY W. TALLEY, Claimant
WCB Case No. 96-09870
ORDER ON REVIEW
Schneider, et al, Claimant Attorney
Reinisch, et al, Defense Attorney
Donald M. Hooton, Attorney

Reviewed by Board Members Haynes, Bock, and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Johnson's order that dismissed his hearing request from a "post-Authorized Training Program" Notice of Closure for lack of jurisdiction. On review, the issues are jurisdiction, claim processing and, potentially, permanent disability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," but summarize the facts pertinent to our review.

Claimant suffered a compensable injury to his low back on March 14, 1977. The claim was initially closed by Determination Order dated October 19, 1978. (Ex. 1). Claimant's 5-year aggravation rights expired on October 19, 1983.

By Order on Review of December 21, 1989, the Board affirmed: (1) a prior ALJ's determination that claimant became medically stationary on May 7, 1987; and (2) a prior ALJ's determination that claimant was entitled to an award of 60 percent (192 degrees) unscheduled permanent partial disability.[1] (Ex. 14).

On November 29, 1991, the self-insured employer approved claimant's participation in an authorized training program (ATP) and voluntarily reopened the claim. (Ex. 24). The ATP ended in March 1993. Thereafter, on March 17, 1993, the insurer issued a Notice of Closure awarding temporary disability from December 21, 1991 through February 9, 1993 (the time period corresponds to the start of the ATP and the end of claimant's vocational eligibility), but no additional award of permanent disability. (Ex. 71). The Notice of Closure indicates it was filed "to close following a vocational training program." (*Id.*) The notice further advised claimant as follows:

> "You have the right to request a Reconsideration on this Notice of Closure by the Appellant Unit of the Department of Insurance and Finance, Labor & Industries Building, Salem Oregon 97310. Your written request for a Reconsideration must be received within the 180 days allowed from the mailing date of this notice. If you are dissatisfied with the Reconsideration decision you also have the right to request a hearing within that same 180-day period." (*Id.*)

Rather than request reconsideration, claimant filed his request for hearing on the Notice of Closure, contending, among other things, entitlement to permanent and total disability, or in the alternative, an increased award of permanent partial disability.[2] (Ex. 74A-4).

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that, because claimant's aggravation rights had expired on October 19, 1983, jurisdiction of this matter was exclusively within the Board's "Own Motion" jurisdiction. Consequently, the ALJ dismissed claimant's request for hearing for lack of jurisdiction.

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[1] These determinations arose out of a July 7, 1987 Determination Order. (Ex. 8).

[2] Because claimant has been medically stationary since May 7, 1987 (before the effective date of 1995 legislative amendments) the method of appeal from a "post-ATP" Determination Order or Notice of Closure is to request a hearing (not reconsideration) within 180 days from the date the order or notice was mailed. *See David F. Corn*, 50 Van Natta 951 (1998); *Richard La France*, 48 Van Natta 427 (1996).

Claimant contends that the insurer reopened the claim for the sole and express purpose of providing vocational assistance benefits pursuant to ORS 656.340. Because those benefits consisted of an ATP, claimant asserts that claim closure is not governed by ORS 656.278 (the Board's "Own Motion" jurisdiction), but by ORS 656.268(9).[3] Consequently, claimant reasons that he is entitled to have his permanent disability redetermined. We disagree.

The Board has previously held that where a carrier voluntarily reopens a claim for an ATP, the claimant is entitled to a redetermination of permanent disability even though the claimant's aggravation rights had expired. *Dannie W. Crawley*, 45 Van Natta 491 (1993); *see also Clifford A. Bettin*, 44 Van Natta 2455 (1992).

However, after those cases were decided, the court determined that a claimant whose claim was in Own Motion status and whose aggravation rights had expired was not eligible for an award of vocational assistance. *Harsch v. Harsco Corporation*, 123 Or App 383 (1993). Later, following the court's holding in *Harsch*, the Board determined that a claimant whose claim is in "Own Motion" status is not substantively entitled to vocational assistance. *Donald D. Hilliard*, 46 Van Natta 2264 (1994). Consequently, as a result of *Harsch* and *Hilliard*, we conclude that the holdings of *Crawley* and *Bettin* are not controlling.

After the expiration of a claimant's aggravation rights under ORS 656.273(4), any additional compensation falls under the Board's "Own Motion" authority pursuant to ORS 656.278. *Mark D. Stapleton*, 51 Van Natta 1779, 1780 (1999). Under ORS 656.278(5), a carrier may voluntarily reopen any claim to provide benefits. In such circumstances, claim closure is governed by OAR 438-012-0055, which provides in pertinent part:

> "(1) Except as provided in section (2) of this rule, when a claim has been voluntarily reopened or ordered reopened by the Board but not simultaneously closed by the Board and the medical reports indicate to the insurer that the claimant's condition has become medically stationary, the claim shall be closed by the insurer without the issuance of a Board order. In all such cases the insurer shall issue a Notice of Closure (Form 2066) to the claimant with copies to the claimant's attorney, if any, and Benefits Section. * * *.
>
> "(2) When an own motion claim has been reopened for the payment of temporary disability compensation, and the Board approves a claim disposition agreement under ORS 656.236 by which the claimant releases his right to further payment of temporary disability compensation, the claim shall be closed administratively by the Board."

Here, because the Board did not simultaneously close the claim upon reopening, and because claimant's condition is medically stationary, the employer was required to issue a Notice of Closure.[4] Moreover, because the benefits voluntarily provided to claimant were vocational assistance benefits, and because the Board's "Own Motion" jurisdiction does not extend to vocational assistance benefits (*see* ORS 656.278(2)), neither the Hearings Division nor the Board on review of the ALJ's order have jurisdiction over the employer's claim closure. Accordingly, we affirm the ALJ's order.

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[3] ORS 656.268(9) provides:

"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. Permanent disability compensation shall be redetermined for unscheduled disability only. If the worker has returned to work or the worker's attending physician has released the worker to return to regular or modified employment, the insurer or self-insured employer shall again close the claim. This notice of closure may be appealed only in the same manner as are other notices of closure under this section."

[4] Because the claim was reopened after expiration of claimant's aggravation rights, the carrier is required to issue a Notice of Closure of Own Motion claim with appeal rights to Board's Own Motion under ORS 656.278. *See* OAR 438-012-0055.

ORDER

The ALJ's order dated July 10, 2000 is affirmed.

Board Member Biehl dissenting.

Because I conclude that claimant has an independent right (beyond the Board's Own Motion jurisdiction) under ORS 656.268(9) to have the extent of his unscheduled permanent disability redetermined following participation in an ATP, I respectfully dissent.

Relying on *Harsch v. Harsco Corporation*, 123 Or App 383 (1993), and *Donald D. Hilliard*, 46 Van Natta 2264 (1994), the majority determines that the Board's previous holdings in *Dannie W. Crawley*, 45 Van Natta 491 (1993), and *Clifford A. Bettin*, 44 Van Natta 2455 (1992), are not controlling. In so reasoning, the majority overlooks that neither *Harsch* nor *Hilliard* discuss a carrier voluntarily reopening a claim to provide vocational assistance. Because nothing in either *Harsch* or *Hilliard* precludes a carrier from such a voluntary reopening, I conclude that *Harsch* or *Hilliard* are distinguishable, and that *Crawley* and *Bettin* are still controlling.

In other words, I conclude that once a carrier voluntarily reopens a claim to provide an ATP, it must close the claim pursuant to ORS 656.268, even if the claim is otherwise in "Own Motion" status. Consequently, because I have determined that claimant's entitlement to a redetermination of permanent disability following an ATP is independent of the Board's exclusive "Own Motion" jurisdiction under ORS 656.278, I conclude that the ALJ had jurisdiction to consider the matter.[1] *Crawley*, 45 Van Natta at 491; *Bettin*, 44 Van Natta at 2456.

Having concluded that the ALJ had jurisdiction to consider the issues presented pursuant to claimant's request for hearing, I now examine the issues arising out of the Notice of Closure.

At the time the Notice of Closure was issued, redetermination following an ATP was governed by ORS 656.268(8) which provided:

> "If, after the determination made or notice of closure issued pursuant to this section, the worker becomes enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, any permanent disability payments due under the determination or closure shall be suspended, and the worker shall receive temporary disability compensation while the worker is enrolled and actively engaged in the training. When the worker ceases to be enrolled and actively engaged in the training, the Department of Consumer and Business Services shall reconsider the claim pursuant to this section unless the worker's condition is not medically stationary. If the worker has returned to work, the insurer or self-insured employer may reevaluate and close the claim without the issuance of a determination order by the Department of Consumer and Business Services."

Here, claimant was medically stationary when the ATP terminated. Additionally, claimant did not return to work after ATP termination. As a result, the statutory precedent necessary for the insurer to issue a Notice of Closure (claimant's return to work) was not satisfied at the time the insurer closed the claim. Consequently, I conclude that under the terms of ORS 656.268(8), the insurer did not have

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[1] The insurer cites *Mark D. Stapleton*, 51 Van Natta 1779 (1999) (a carrier's voluntary reopening of the claimant's aggravation claim after the expiration of the claimant's "aggravation rights" is within the Board's "Own Motion" jurisdiction), and *Carl C. Clayton*, 47 Van Natta 1069 (1995) (reopening of a "non-disabling" claim after expiration of five year "aggravation rights" was within the Board's "Own Motion" jurisdiction), in support of its position that jurisdiction is exclusively within the Board's "Own Motion" authority under ORS 656.278. However, both *Stapelton* and *Clayton* involve a claim for "aggravation" following the expiration of the claimant's "aggravation" rights. Here, the claim was not reopened to provide temporary disability benefits resulting from a worsened compensable condition, as was the case in both *Stapleton* and *Clayton*. Rather the present claim was voluntarily reopened to provide temporary disability during claimant's participation in an ATP. Pursuant to ORS 656.263(8), the claim must be submitted to the Director for closure once claimant's participation in the ATP has ceased. Consequently, I find *Stapleton* and *Clayton* are distinguishable.

authority to issue its Notice of Closure; rather, reevaluation and claim closure had to be performed by the Department.[2] Accordingly, I find that the Notice of Closure is a nullity. *See Herbert L. Lockett*, 51 Van Natta 1349 (1999).

Because I have determined that the Notice of Closure is a nullity, I further determine that the claim remains open. Accordingly I would remand to the insurer for further processing according to law.

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[2] Redetermination following an ATP is currently governed by ORS 656.268(9), which now requires that such redetermination be performed by the carrier, not the Department.

In the Matter of the Compensation of
DELVIN W. VANDETTA, Claimant
WCB Case Nos. 00-05315 & 00-04376
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 those portions of Administrative Law Judge (ALJ) Johnson's order that: (1) deferred ruling on compensability of claimant's L5-S1 disc condition; and (2) deferred ruling on claimant's entitlement to interim compensation. In the event we do not affirm the ALJ's deferral decisions, claimant cross-requests review on the issues of: (1) compensability of the L5-S1 disc condition; (2) entitlement to interim compensation; and (3) penalties for an allegedly unreasonable failure to pay interim compensation. On review, the issues are the ALJ's procedural ruling, compensability, interim compensation and penalties. We reverse the ALJ's deferral ruling and proceed to determine the remaining issues on the merits.

FINDINGS OF FACT

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

At hearing, the issues before the ALJ included a "de facto" denial of proposed medical services (a facet block at L5-S1), penalties and attorney fees for a "de facto" denial of medical services, compensability of claimant's L5-S1 disc condition, penalties for an allegedly unreasonable denial, interim compensation, and penalties and attorney fees for an allegedly unreasonable failure to pay compensation.

CONCLUSIONS OF LAW AND OPINION

Deferral

The ALJ set aside SAIF's "de facto" denial of the proposed L5-S1 facet block, awarded an assessed attorney fee for prevailing over that denial and declined to assess penalties and attorney fees for an allegedly unreasonable denial. On review, the parties do not contest those portions of the ALJ's order.

On his own motion, however, the ALJ also deferred the remaining issues for resolution at some future date after the L5-S1 facet block was performed. In doing so, the ALJ assigned the remaining issues a new case number and held that claimant's pending request for hearing regarding the compensability denial remained viable and could be determined in a future hearing.

On review, SAIF contends that the ALJ did not have authority to defer a decision on the issues raised by the parties at hearing. For the following reasons, we agree with SAIF's contention.

At hearing, no party requested deferral of the issues of compensability, interim compensation and penalties and attorney fees concerning the facet block, if that treatment was found compensable.

Rather, the transcript reflects that the parties were prepared to litigate those issues and proceeded to do so at hearing. Accordingly, we conclude that the ALJ should not have deferred a decision on those issues.[1] *See, e.g., Boise Cascade Corp. v. Katzenbach*, 307 Or 391 (1989); *Gonzalo M. Cervantes*, 44 Van Natta 1840 (1992). Because we find that the record was sufficiently developed at hearing, we now proceed to determine the deferred issues on review. ORS 656.295(5).

Compensability/L5-S1 disc condition

Claimant's accepted claim following the 1998 injury included a left scapula fracture, fourth and fifth rib fractures, and an L1-2 vertebral endplate fracture. The claim was closed in February 1999, but in September 1999, claimant returned to treat with Dr. Coe, primarily for left shoulder pain, but also for low back pain. Dr. Coe referred claimant to Dr. Kendrick, neurosurgeon, for treatment of his low back condition.

To establish compensability of his L5-S1 disc condition, claimant relies on the opinion of Dr. Kendrick, his treating neurosurgeon. Claimant argues that, although Dr. Kendrick acknowledged that his chronic pain since the injury was due to his compression fracture at L1-2, he further stated that the L5-S1 disc was also capable of generating pain. (Ex. 37). Claimant contends that, while he had L5-S1 degenerative changes prior to the 1998 compensable injury, his heavy work as a logger could have caused degenerative changes at that level.

To establish compensability under ORS 656.005(7)(a)(B), claimant must prove that the June 1998 injury was the major contributing cause of the disability or need for treatment of the combined condition. To satisfy the "major contributing cause" standard, claimant must establish that the 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 L5-S1 disc condition and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

With regard to the issue of causation, Dr. Kendrick first reported that, if claimant was having low back pain from degenerated disc levels at L5-S1, it "would not be due to his industrial injury." (Ex. 37). However, Dr. Kendrick subsequently reported that the injury specifically caused claimant to seek treatment for his current condition. (Ex. 40-1). Dr. Kendrick agreed that the industrial injury was the "main reason" claimant needed treatment at the present time because claimant had been asymptomatic for some period of time following the injury. (Ex. 38A-1; 40).

To the extent that Dr. Kendrick's final report could be construed to support compensability of claimant's L5-S1 condition, we do not find it persuasive. First, we find that Dr. Kendrick's report represents an unexplained change of opinion from his prior report that stated that the L5-S1 condition was not due to the compensable injury. *See Kelso v. City of Salem*, 87 Or App 630 (1987). Moreover, Dr. Kendrick's final report does not evaluate the relative contribution of claimant's preexisting L5-S1 degenerative condition and the work injury. Rather, it is based on "but for" reasoning, *i.e.*, claimant was asymptomatic and did not need treatment for at least three years before the work injury, and therefore, the work injury caused claimant to seek treatment for his current condition. Accordingly, we find persuasive reasons not to defer to Dr. Kendrick's opinion.[2]

Finally, on review, claimant argues that his heavy labor as a logger could cause degenerative changes at the L5-S1 level. SAIF contends that claimant did not raise the issue of an occupational disease at hearing and, therefore, should not be permitted to make such an argument on review.

We need not determine whether the issue of occupational disease was raised for the first time on review. We conclude that, even if the issue was properly before us, the record does not support compensability of claimant's L5-S1 disc condition as an occupational disease. To establish compensability of his condition, claimant must prove that his work activities are the major contributing cause of the disease. ORS 656.802(2)(a).

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[1] Additionally, we disagree with the ALJ's conclusion that the deferred issues could not be determined without the results of the L5-S1 facet block. Dr. Kendrick, claimant's treating neurosurgeon, had already explained that, if claimant's pain was coming from that level, it would not be due to his work injury. (Ex. 37).

[2] Dr. Coe, claimant's initial treating doctor, deferred questions of causation to Dr. Kendrick. (Ex. 39).

Here, only Dr. Kendrick has addressed the issue of an occupational disease. (Ex. 40-2). However, Dr. Kendrick reported that he could state "with some reservation only that it is possible to sustain advanced degenerative changes given the fact that [claimant] did work on vibratory heavy equipment as well as his logger position requiring a lot of physical labor." Dr. Kendrick felt that it was "possible" that such activities contributed to claimant's degenerative changes. (Ex. 40-2). Because an opinion couched in terms of medical possibility rather than medical probability is not sufficient, *see Gormley v. SAIF*, 52 Or App 1055 (1981), we conclude that claimant has not met his burden of proof in establishing a compensable occupational disease.

Interim compensation/L5-S1 disc condition

On review, SAIF contends that no interim compensation is due because claimant failed to perfect an aggravation claim under ORS 656.273. While we agree that the evidence does not establish that claimant perfected such a claim, the issue at hearing and on review was not entitlement to interim compensation based on an aggravation claim. Rather, the issue was claimant's entitlement to interim compensation relative to the new claim regarding the L5-S1 disc condition. (Tr. 3).

"Interim compensation" is temporary disability payments made between the employer's notice of the injury and the acceptance or denial of the claim. *Bono v. SAIF*, 298 Or 405, 407 n.1 (1984). A worker is entitled to interim compensation if the worker has suffered a loss of earnings as a result of a work-related injury. *RSG Forest Products v. Jansen*, 127 Or App 247 (1994). Such entitlement includes new medical condition claims. *Labor Ready, Inc. v. Mann*, 158 Or App 666, 669, *on recon* 160 Or App 576, *rev den* 329 Or 479 (1999). A worker's entitlement to interim compensation is triggered by the attending physician's authorization relating the claimant's inability to work to the job-related injury. *Teri L. Bernloehr*, 52 Van Natta 144 (2000).

Claimant contends that Dr. Coe's notation of light duty on September 30, 1999 established his right to interim compensation. (Ex. 26). We disagree. The chartnote cited by claimant only dealt with the left shoulder condition and specifically released claimant to light duty. However, as explained above, the claim is not for interim compensation based on an aggravation claim, and claimant has not perfected an aggravation claim related to his accepted conditions.

Claimant also relies on reports from Dr. Kendrick to establish entitlement to interim compensation. SAIF argues that Dr. Kendrick is not claimant's attending physician and his reports do not relate any ability to work to the job-related injury. Because we agree with SAIF's second contention, we need not address its argument regarding Dr. Kendrick's status.

Claimant relies on Dr. Kendrick's notation that claimant was unable to work because of his pain. (Exs. 27, 29, 32, 36). Claimant also argues that Dr. Kendrick explained in letters to SAIF that claimant's condition correlated with his previously accepted condition, i.e., a vertebral endplate fracture. (Exs. 32, 34, 37, 40).

We find that the exhibits referenced by claimant do not indicate that the L5-S1 disc condition was related to claimant's work injury. (Exs. 27, 29). While Dr. Kendrick's subsequent reports provide that claimant continued to complain of low back pain and listed his work status as "disabled," Dr. Kendrick also stated that he had no way of knowing whether the pain was coming from the compression fracture of the L5-S1 level. (Ex. 34).

Accordingly, although Dr. Kendrick stated that claimant was "disabled," he did not relate the disability to a job-related L5-S1 injury. To the contrary, Dr. Kendrick reported that if claimant's pain was coming from that level, it would not be due to the work injury. (Ex. 37). Therefore, on this record, we find that claimant has not established an entitlement to interim compensation.

Penalties/failure to pay interim compensation

Because we have found that claimant is not entitled to interim compensation, SAIF's failure to pay interim compensation was not unreasonable. Therefore, no penalties are due.

ORDER

The ALJ's order dated October 17, 2000 is reversed in part and affirmed in part. That portion of the order that declined to decide issues regarding compensability, interim compensation, and penalties is

reversed. The SAIF Corporation's July 12, 2000 denial of claimant's L5-S1 disc condition is upheld. Claimant's requests for interim compensation and penalties based on this issue are denied. The remainder of the order is affirmed.

February 22, 2001 Cite as 53 Van Natta 220 (2001)

In the Matter of the Compensation of
JEFF E. WHITE, Claimant
WCB Case No. 99-09807
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by the Board en banc.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Howell's order that set aside its denial of claimant's "combined" low back condition as procedurally invalid. On review, the issue is the procedural validity of SAIF's denial. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

On December 2, 1999, in a document entitled "Notice of Modified Acceptance and Denial," SAIF accepted, effective September 19, 1998, a "combined condition," consisting of the compensable September 19, 1998 injury and a preexisting L3-4 and L4-5 degenerative condition. In that document, SAIF also denied the same combined condition effective November 18, 1999. Claimant did not contest the denial on the merits, but instead requested a hearing challenging its procedural validity.

The ALJ determined that the denial portion of the "Notice of Modified Acceptance and Denial" was procedurally invalid under ORS 656.262(6)(c).[1] The ALJ concluded that the statute requires that a denial of a "combined condition" be later in time than an acceptance of a combined condition, and that the statutory requirement is not satisfied by a single notice that simultaneously accepts and denies a "combined condition." In reaching this conclusion, the ALJ interpreted the word "later" as used in ORS 656.262(6)(c) to mean "following another event in time" and synonymous with "subsequently" or "afterward." The ALJ further stated that "later" was not susceptible to a meaning of "at the same time" or "simultaneously." Moreover, the ALJ reasoned that the statutory context of ORS 656.262(6)(c) supported an interpretation that simultaneous acceptance and denial of a "combined condition" was impermissible.

On review, SAIF contends that its combined condition denial was procedurally valid. For the following reasons, we agree with SAIF.

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

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[1] ORS 656.262(6)(c) provides:

"An insurer's or self-insured employer's acceptance of a combined or consequential condition under ORS 656.005(7), whether voluntary or as a result of a judgment or order, shall not preclude the insurer or self-insured employer from later denying the combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition."

ORS 656.262(6)(c) provides that a carrier's acceptance of a "combined" or "consequential" condition, whether voluntary or as a result of a judgment or order, shall not preclude the carrier from "later" denying the combined or consequential condition, if the otherwise compensabe injury ceases to be the major contributing cause of the combined or consequential condition. The issue in this case is whether the legislature's use of the word "later" in ORS 656.262(6)(c) prohibits a carrier from simultaneously accepting and denying a "combined condition" in one document.

To begin, because this precise question has not been previously addressed, there is no express precedent for the Board to follow. Nonetheless, the appellate courts have previously recognized the validity of a document containing an acceptance and a denial. *See Johnson v. Spectra Physics*, 303 Or 49, 58 (1987) (the court stated that "the insurer may partially deny a claim if it specifies which injuries or conditions it accepts and which it denies" and that "such specificity, which promotes timely closure of accepted conditions and prompt appeals of denied conditions, is the essence of a partial denial"); *Barnes v. SAIF*, 115 Or App 564 (1992); *Weyerhaeuser Co. v. Warrilow*, 96 Or App 34, *rev den* 308 Or 184 (1989).

Admittedly, the aforementioned case holdings have pertained to claim processing actions prior to the enactment of ORS 656.262(6)(c). Nevertheless, because the statute itself does not expressly prohibit a simultaneous acceptance and denial, the existing case precedent validating such conduct is supportive of SAIF's actions in this case.

Moreover, we acknowledge the ALJ's interpretation of the word "later" in the statute to mean some action subsequent to or after the acceptance of a "combined condition." The statute's use of the general term "later," however, is sufficiently broad to include both the issuance of separate documents evidencing the acceptance and denial of a "combined condition," as well as the acceptance and "later" denial of a "combined condition" in the same document.[2] In the absence of a clear legislative intention (as manifested in the statutory language of ORS 656.262(6)(c)) to require separate acceptances and denials of "combined conditions" or to prohibit a so-called "simultaneous" acceptance/denial of "combined conditions" (as of a date "later" than the acceptance date), we are not prepared to extend the statute beyond its parameters. For this reason, we decline to do so.[3]

Accordingly, we conclude that a denial of a "combined condition" issued subsequent to an acceptance of the "combined condition" is procedurally permissible under ORS 656.262(6)(c). In addition, where an acceptance and denial of a "combined condition" occurs in the same document, this is also procedurally valid under the statute, provided that the period of acceptance is specific and that the date of the "later" denial is likewise explicit.[4]

Applying our analysis of the statute to the case at hand, we find SAIF's December 2, 1999 denial (which first accepted claimant's "combined condition" as of the date of his September 19, 1998 injury

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[2] Indeed, under the statutory scheme, it would appear that a denial issued a day, an hour or even a minute after an acceptance would be "later" and, thus, satisfy the requirements of ORS 656.262(6)(c). In other words, as long as an acceptance (*i.e.*, a period of compensability) is identified in the document and precedes the date of denial, an acceptance and denial in the same document satisfies the statute.

[3] In support of his interpretation of ORS 656.262(6)(c), the ALJ cited the statutory context. Specifically, the ALJ noted that ORS 656.262(7)(b) allows a carrier to issue a pre-closure combined condition denial, "[o]nce a worker's claim has been accepted." The ALJ reasoned that this provision did not necessarily preclude a simultaneous acceptance and denial, but suggested or was entirely consistent with an interpretation of ORS 656.262(7)(c) that requires first an acceptance and then a "later" denial. As the ALJ himself acknowledged, however, ORS 656.262(7)(b) does not necessarily prohibit SAIF's simultaneous acceptance and denial of the "combined condition." Thus, we do not view the statutory context of ORS 656.262(6)(c) as presenting a significant hurdle to our holding that a carrier may accept and deny a "combined condition" in one document, especially in light of the case authority that has previously allowed the practice.

[4] The dissent cites *Blamires v. Clean Pak Systems, Inc.*, 171 Or App 163 (2000), and *Croman Corp. v. Serrano*, 163 Or App 136 (1999), in support of the argument that it is the act of accepting or denying, as opposed to accepting or denying as of a particular date, that is crucial. We disagree with the dissent's argument. Acceptance in this case did "precede" denial in terms of a period of acceptance followed by a "later" denial. Accordingly, we believe our decision is compatible with *Blamires* and *Serrano*.

and "later" denied the "combined condition" as of a subsequent date, November 18, 1999) to be procedurally valid.[5] Accordingly, based on the aforementioned reasoning, we reverse the ALJ's order.

Because claimant does not contest SAIF's denial on substantive grounds, the denial is reinstated and upheld.

ORDER

The ALJ's order dated is reversed in part and affirmed in part. That portion of the ALJ's order that set aside SAIF's Notice of Modified Acceptance and Denial of claimant's combined condition is reversed. SAIF's denial is reinstated and upheld in its entirety. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

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[5] Unlike the ALJ, we are not convinced that issuance of two separate documents provides greater clarity for a claimant than a single, all-inclusive notice outlining accepted and denied conditions. One can easily envision a claimant receiving both an acceptance and a notice of denial in certified mail dated the same day, but, believing the latter to merely be a duplication of the former (as commonly occurs with insurance medical examination notices), deciding not to retrieve the certified mail. Claimant, therefore, may never receive actual notice of nor timely appeal the partial denial. *See Ivan R. McDaniel, Jr.*, 51 Van Natta 967 (1999) (failure to retrieve certified mail after receiving notice does not constitute due diligence). Further, from a claims administration standpoint, one document would avoid the extensive and complex language necessary to clearly cross-reference the various documents and director-mandated forms.

Board Members Phillips Polich and Biehl dissenting in part and concurring in part.

The majority reverses the ALJ's determination that the denial portion of SAIF's "Notice of Modified Acceptance and Denial" was procedurally invalid under ORS 656.262(6)(c).[1] Because we disagree with the majority's action, we respectfully dissent.

Our analysis of the statutory language of ORS 656.262(6)(c) provides support for the ALJ's conclusion that SAIF's simultaneous acceptance and denial of a "combined condition" in one document is invalid. In this regard, we note that ORS 656.262(6)(c) has several components: (1) a carrier's acceptance of a "combined or consequential condition" (whether voluntarily or by judgment or order); (2) an otherwise compensable injury that "ceases" to be the major contributing cause of the "combined or consequential condition;" and (3) a "later" denial should the "ceases" event occur. Accordingly, we conclude, unlike the majority, that the statute is focused on the *act* of accepting or denying as opposed to accepting or denying as of a particular date (retroactively). We also believe the Court of Appeals' decision in *Blamires v. CleanPak Systems, Inc.*, 171 Or App 163 (2000) supports this view. There, the court held that, under the wording of ORS 656.262(6)(c), the acceptance of a combined condition must precede the denial of a combined condition. *Id.* at 267; *see also Croman Corp. v. Serrano*, 163 Or App 136 (1999).

In addition, the statute premises the "later" denial on a specific event: "if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition." In other words, the statute is written in a prospective manner, such that, following the acceptance of a combined or consequential condition, a carrier may "later" deny the condition when there is a change in the condition; *i.e.*, medical evidence indicates that the compensable injury "ceases" to be the major contributing cause of the previously accepted combined or consequential condition.

The ALJ also interpreted the word "later" as used in ORS 656.262(6)(c) to mean "following another event in time" and synonymous with "subsequently" or "afterward." The ALJ further stated that "later" was not susceptible to a meaning of "at the same time" or "simultaneously."

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[1] ORS 656.262(6)(c) provides:

"An insurer's or self-insured employer's acceptance of a combined or consequential condition under ORS 656.005(7), whether voluntary or as a result of a judgment or order, shall not preclude the insurer or self-insured employer from later denying the combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition."

Although the ALJ did not cite any authority for this interpretation, we believe that such authority does exist. Webster's *Third New International Dictionary* (1993) does not directly define the word "later," but does note that it can be used in an adverb form of the word "late," which is defined as "at or to a distant or advanced point in time: far into the night, day, week, or other period." We find that this definition is consistent with the ALJ's interpretation of "later" as not meaning "simultaneously" or "at the same time." Accordingly, we would conclude the ALJ's determination that an acceptance and a denial of "combined condition" cannot occur in the same document is compatible with the statutory language of ORS 656.262(6)(c).

The majority finds, however, that the denial was later in time than its acceptance because SAIF's "Modified Notice of Acceptance and Denial" accepted the combined condition as of September 19, 1998 and denied the combined condition effective November 18, 1999. While the effective date of the "acceptance" preceded the effective date of the "denial" by more than a year, the fact remains that the notice of acceptance and notice of the denial occurred simultaneously. Such simultaneous acceptance and denial is incompatible with the language of ORS 656.262(6)(c) which requires that a carrier "later" deny a "combined condition." In addition, as previously noted, the statute is premised on the *act* of acceptance or denial, not the effective dates of any acceptance or denial. *See Blamires*, 171 Or App at 267.

The majority, like SAIF, also contends that the ALJ's decision was improper because the court has held in cases such as *Barnes v. SAIF*, 115 Or App 564 (1992), that an acceptance and denial may be contained in the same document. We do not find that case, or the others cited by the majority, very helpful, because they did not concern the statute at issue in this case: ORS 656.262(6)(c). As previously noted, that statute requires that a "combined condition" denial be issued *later than, not simultaneously with*, acceptance of a combined condition.

SAIF cites our decision in *Gary F. Blaske*, 52 Van Natta 259 (2000), in which the carrier accepted a "combined condition" and issued a current condition denial on the same day. In that case, we concluded, based upon the medical information at the time of the current condition denial, that "it would appear that the denial was procedurally valid." *Id.* at 261. Nonetheless, we noted that we need not conclusively resolve this question because we had set the denial aside on substantive grounds. *Id.* Thus, our comments on the procedural validity of the carrier's denial in *Blaske* were *dicta*. Moreover, the precise issue in this case (whether an acceptance and denial of a "combined condition" may occur simultaneously) was not presented in *Blaske*. For these reasons, we conclude that *Blaske* is not controlling.

Finally, SAIF asserts that its denial was proper because the language of its acceptance and denial notice indicates the acceptance portion of the document preceded the denial portion and, thus, that the combined condition was "later" denied. We are not persuaded by SAIF's assertion that the acceptance and denial were not simultaneous. While the acceptance language may have preceded the denial language in the document itself, such a narrow interpretation of the document does not dissuade us from concluding that the acceptance and denial were simultaneous and, therefore, in contravention of the express language of ORS 656.262(6)(c), which requires first an acceptance and then a "later" denial of the combined condition.

In conclusion, we do not find persuasive any of the majority's or SAIF's arguments in opposition to the ALJ's holding. Accordingly, we would affirm the ALJ's finding that SAIF's denial was procedurally improper.[2] Because the majority reaches the opposite conclusion, we dissent.

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[2] Although we are persuaded that the language of ORS 656.262(6)(c) requires the result reached by the ALJ, we, like the majority, are not convinced that issuance of two separate documents provides greater clarity for a claimant than a single, all-inclusive notice outlining accepted and denied conditions. Thus, we concur with the majority's footnote regarding this issue. Nevertheless, because we believe that we are constrained to follow the language of the statute, we would affirm the ALJ's decision setting aside the denial as procedurally invalid. We urge the legislature, however, to reexamine the wording of ORS 656.262(6)(c).

In the Matter of the Compensation of
KEVIN J. NETTLES, Claimant
WCB Case No. 00-00205
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorney
Reinisch, et al, Defense Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that upheld the self-insured employer's denial of an L4-5 disc herniation. On review, the issue is the scope of acceptance.

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

Claimant filed a claim for back pain on November 26, 1996. The claim was accepted for a disabling right thigh strain on February 25, 1997. The employer issued an updated Notice of Acceptance at Claim Closure accepting right thigh strain and low back strain on February 12, 1998. On the same day, a Notice of Closure issued that closed the claim. On February 17, 1998, claimant's attorney requested acceptance of right lower extremity sciatica and disc herniation at L4-5 and L5-S1.

On November 17, 1998, an ALJ approved a Stipulated Order of Dismissal in which the carrier agreed to accept "right lower extremity sciatica due to low back strain." (Ex. 60). Soon after, on December 9, 1998, the employer issued an Updated Notice of Acceptance at Claim Closure and accepted "low back sciatica symptoms." (Ex. 61).

A December 30, 1998 Corrected Notice of Closure awarded temporary disability only. (Ex. 63). Claimant requested reconsideration and a March 9, 2000 Order on Reconsideration awarded 16 percent unscheduled permanent disability. The employer requested a hearing regarding the Order on Reconsideration. The parties subsequently entered into a claim disposition agreement (CDA) that listed the accepted condition as "right thigh strain, low back strain and right lower extremity sciatica due to low back strain." Following the Board's approval of the CDA, an ALJ dismissed the employer's request for hearing regarding the Order on Reconsideration on June 10, 1999.

Dr. Miller filed an aggravation claim on August 10, 1999. Dr. Miller attributed claimant's pain to a herniated disc at L4-5, as did examining physicians, Drs. Denekas and Woodward. (Exs. 79; 80). The employer issued a responsibility denial for claimant's current need for medical treatment and explained that because of the prior CDA, benefits under ORS 656.273 were not available. (Ex. 82). Claimant requested a hearing.

At the hearing, the parties stipulated that the employer's denial was amended to deny L4-5 disc herniation. Claimant argued that the employer's December 9, 1998 acceptance of "low back sciatica symptoms" amounted to an acceptance of the condition causing the symptoms.[1] Claimant relied on *Georgia Pacific Corp. v. Piwowar*, 305 Or 494 (1988), in making his argument that by accepting sciatica symptoms, the employer had accepted the L4-5 disc herniation.

The ALJ agreed with claimant that the employer's acceptance of "low back sciatica symptoms" constituted an acceptance of the condition causing the symptoms under *Piwowar*. However, the ALJ held that the June 4, 1999 CDA, which provided that the accepted conditions were right thigh strain, low back strain and right lower extremity sciatica due to low back strain, superceded the December 9, 1998 Updated Notice of Acceptance and limited the accepted conditions to those specified in the CDA. On this basis, the ALJ concluded that claimant could not contend that his disc herniation was an accepted part of the claim.

On Board review, claimant argues that the employer expressly accepted "low back sciatica symptoms" in its December 9, 1998 Updated Notice of Acceptance at Claim Closure. Claimant relies on *Piwowar* and Board cases following *Piwowar* to argue that by accepting symptoms, the employer accepted the condition causing the symptoms (in this case the L4-5 disc herniation). Claimant further argues that

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[1] There appears to be no dispute between the parties that the condition causing the radicular or sciatic symptoms is the L4-5 disc herniation.

the employer's denial of the L4-5 disc herniation amounts to an improper "back-up" denial under ORS 656.262(6)(a). The employer argues that the language of the stipulation and the CDA limit the acceptance to the conditions set forth in those agreements. Alternatively, the employer argues that the record does not establish that the disc herniation existed and caused claimant's symptoms at the time of the December 9, 1998 acceptance. On this basis, the employer argues that it did not accept the L4-5 herniation under the holding of *Piwowar*.

We agree with the ALJ's decision to uphold the employer's denial, but we base this conclusion on the following reasoning.

Here, just prior to the December 9, 1998 Updated Notice of Acceptance at Claim Closure, the parties had entered into a Stipulated Order of Dismissal that was approved by an ALJ on November 17, 1998. In this stipulation, the parties indicated that the employer would accept "right lower extremity sciatica due to low back strain" in addition to the previously accepted right thigh strain and low back strain. The stipulation noted that claimant had requested a hearing alleging "de facto" denials of disc herniations at L4-5 and L5-S1. Claimant in turn agreed to withdraw his request for hearing. (Ex. 60-1). Soon thereafter, on December 9, 1998, the carrier issued an Updated Notice of Acceptance at Claim Closure and accepted right thigh strain, low back strain and "low back sciatica symptoms."

The scope of an acceptance is a factual determination. *SAIF v. Tull*, 113 Or App 449 (1992). Based on the parties' stipulation that accepted right lower extremity sciatica due to low back strain, we conclude that this was the condition that the parties intended to have accepted. To the extent that the Updated Notice of Acceptance, which issued soon after the stipulation, listed only sciatica symptoms, we are persuaded, based on the stipulation that preceded the notice that the employer agreed to accept sciatica due to the accepted strain and did not agree to accept a disc herniation or sciatica in general.

This conclusion is confirmed by the contemporaneous medical evidence from 1998, which does not support the existence at that time of a disc herniation at L4-5 or a herniated disc-related sciatica. Dr. Matteri had opined in July 1998 that claimant did not have any significant disc herniation. (Ex. 56). In a January 1998 report, Drs. Edmonds and Arbeene opined that claimant's then-current condition and need for treatment was due to degenerative disc disease that preexisted the November 1996 compensable injury. (Ex. 39-8). Thus, the medical evidence preceding the November 1998 stipulation and the December 1998 Updated Notice of Acceptance, does not support the existence of an L4-5 disc herniation.

After reviewing the evidence at the time of the December 1998 Updated Notice of Acceptance, we conclude that the acceptance was limited to sciatica caused by the accepted strain and not caused by a disc herniation or the preexisting degenerative disc disease.

Finally, we do not agree that the CDA, by listing the accepted conditions, superceded or modified the prior acceptances. In this regard, it is well-settled that the function of a CDA is not to accomplish claim processing functions under ORS 656.262 or otherwise resolve compensability issues. *See Lynda J. Thomas*, 45 Van Natta 894 (1993). In other words, a CDA cannot be used to accept a condition or modify a prior acceptance. Thus, the CDA had no effect on the prior acceptances in this claim.

ORDER

The ALJ's order dated August 22, 2000 is affirmed.

Board Member Phillips Polich dissenting.

On December 9, 1998, the employer issued an Updated Notice of Acceptance at Claim Closure and accepted "low back sciatica symptoms." This notice was issued after the parties' Stipulated Order of Dismissal that accepted "right lower extremity sciatica due to low back strain." The updated acceptance notice functioned to modify the previous acceptance. *See* ORS 656.262(6)(b)(F) (the notice of acceptance shall be modified from time to time as medical or other information changes a previously issued notice of acceptance). The employer freely issued the Updated Notice of Acceptance that explicitly accepted low back sciatica symptoms. Based on this Notice of Acceptance, I agree with claimant that when it accepted sciatica "symptoms," it also accepted the condition causing the symptoms. *See Georgia Pacific v. Piwowar*, 305 Or 494 (1988).

In *Piwowar*, the carrier accepted a claim for a "sore back." Medical evidence showed that a preexisting disease (ankylosing spondylitis) caused the sore back, and the carrier denied compensability of that condition. 305 Or at 497. The Supreme Court concluded that, because the carrier had accepted a claim for a symptom of the underlying disease, and not a separate condition, its denial of the preexisting condition constituted a "back-up" denial. *Id.* at 501-02. The carrier was precluded from denying the underlying condition.

Here, the employer accepted "sciatica symptoms" without qualification. The sciatica symptoms accepted are caused by the L4-5 disc herniation. Once the condition was accepted, the employer could not legally deny the condition unless it issued a "back-up" denial that meets the criteria of ORS 656.262(6)(a). Thus, I disagree with the majority's conclusion and would conclude that by accepting the sciatica symptoms, the employer also accepted the L4-5 disc condition causing the sciatica. The majority finds that the contemporaneous medical evidence does not support the existence of a disc herniation at L4-5 at the time the December 9, 1998 Updated Notice of Acceptance at Claim Closure issued. However, a disc bulge was present at L4-5 on an MRI as early as December 30, 1996. (Ex. 9). The same MRI report indicates that the disc protrusions are probably clinically significant. Based on this record, I would conclude that the acceptance of the sciatica symptoms amounted to an acceptance of the disc herniation at L4-5.

As the majority notes, the CDA had no effect on the prior acceptances in this claim because a CDA may not be used to accomplish claim processing functions. *Lynda J. Thomas*, 45 Van Natta 894 (1993). Thus, I would conclude that the December 9, 1998 Updated Notice of Acceptance at Claim Closure accepting "low back sciatica symptoms" was an acceptance of the L4-5 disc herniation that caused the symptoms. In addition, the CDA, which is not a claim processing document, did not affect or modify the acceptance. For these reasons, I disagree with the majority and conclude that the acceptance of low back sciatica symptoms was an acceptance of the disc herniation that caused the symptoms.

In the Matter of the Compensation of
QUINNA J. NOLAN, Claimant
WCB Case No. 00-00954
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

The insurer requests review of Administrative Law Judge (ALJ) Thye's order that affirmed an Order on Reconsideration that awarded 35 percent (52.5 degrees) scheduled permanent disability for loss of use or function of the right leg (knee), whereas a Notice of Closure awarded no permanent disability. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following supplementation and summary.

Several years ago claimant underwent surgery on her *left* knee following a ski injury. On February 8, 1999, claimant twisted her *right* knee while helping to subdue a violent resident while working for the employer as a nurse. Claimant initially sought medical treatment on February 10, 1999, and a right knee sprain was diagnosed. (Exs. 2, 4-2).

Subsequently, claimant underwent a MRI that indicated mild degeneration of the medial meniscus. (Ex. 4-2). By March 23, 1999, claimant began treating with Dr. Hering, orthopedist, who ordered a second MRI, which showed a possible horizontal tear of the posterior horn of the medial meniscus. (Ex. 4-2, -3). On April 21, 1999, Dr. Hering recommended a diagnostic arthroscopy.

On May 4, 1999, Dr. Tesar, orthopedist, examined claimant on behalf of the insurer. (Ex. 4). He diagnosed a sprain of the right knee, with possible tear of the medial meniscus. (Ex. 4-5). He noted

that claimant's history of the right knee injury was the type of injury that could result in a tear of the medial meniscus and her MRI showed objective findings of a possible medial meniscus tear. (Ex. 4-6). Dr. Tesar recommended a diagnostic arthroscopy to rule out a medial meniscus tear. (*Id.*).

On May 10, 1999, the insurer accepted the February 1999 injury claim as a disabling "medial meniscus tear right knee." (Ex. 5).

On May 13, 1999, Dr. Hering performed an arthroscopy. (Exs. 6, 7). Although the preoperative diagnosis was a suspected torn medial meniscus, no tear of the meniscus was found. (Ex. 7). Instead, Dr. Hering found severe articular cartilage damage of the medial femoral condyle, which he debrided. (Ex. 7-1). He also found significant patellofemoral chondromalacia. (*Id.*). Dr. Hering found the medial meniscus intact and stated that claimant's "pain no doubt was due not to the meniscus which appeared normal, but to articular damage to the femoral condyle." (*Id.*).

Following rehabilitation at the Northwest Occupational Medicine Center (NOMC), claimant was found medically stationary as of October 1, 1999. (Ex. 9). The discharge summary noted that the arthroscopy with debridement of articular cartilage of the medial femoral condyle was considered to be related to the strain injury, although patellofemoral chondromalacia and degenerative joint disease of the right knee were considered unrelated. (Ex. 9-1). Right knee range of motion was measured at 90 degrees flexion and -7 degrees extension. (Ex. 9-3).

Dr. Hering concurred with the NOMC discharge summary. (Ex. 10). He also concurred with a statement that the limited ranges of motion and all other mentioned restrictions were related to preexisting conditions, not the industrial injury. (Ex. 10-1).

On October 15, 1999, the insurer issued an Updated Notice of Acceptance at Closure that again accepted "medial meniscus tear right knee." (Ex. 12). That same date, the insurer issued a Notice of Closure that awarded temporary disability, but no permanent disability. (Ex. 13).

Claimant requested reconsideration. On October 28, 1999, claimant was examined by a medical arbiter panel consisting of Drs. Denekas, neurologist, Steele, orthopedist, and Tiley, orthopedist, with Dr. Tiley dictating the report. (Ex. 15). The accepted condition was listed as medial meniscus tear, right knee. However, Dr. Tiley noted that the arthroscopy showed no meniscal pathology and, instead, showed a femoral condylar articular cartilage traumatic lesion that required debriding. (Ex. 15-2). He also noted that "the accepted condition of medial meniscus tear is not really the injury of question here." (Ex. 15-3).

A January 24, 2000 Order on Reconsideration awarded 35 percent scheduled permanent disability for loss of use or function of the right leg (knee). (Ex. 17).

CONCLUSIONS OF LAW AND OPINION

Citing *Granner v. Fairview Center*, 147 Or App 406 (1997), and finding that the insurer accepted a condition that claimant was ultimately determined not to have, the ALJ determined the compensability of claimant's right knee conditions and affirmed the Order on Reconsideration's award of 35 percent scheduled permanent disability award. We disagree.

The issue at hearing and on review is extent of scheduled permanent disability benefits, not compensability of claimant's right knee conditions. We have found that the statutory scheme set out in ORS 656.262(7) and 656.283(7) limits compensability litigation in the "extent" rating process. *See Julio C. Garcia-Caro*, 50 Van Natta 160 (1998) (statutory scheme contemplates that compensability determinations will be made separately from extent determinations); *Robin W. Spivey*, 48 Van Natta 2363, 2366 (1996).

In addition, both the administrative rules and case law hold that extent of permanent disability benefits is limited to permanent impairment caused by *accepted* conditions or direct medical sequelea of *accepted* conditions. OAR 436-035-007(1);[1] *Julio C. Garcia-Caro*, 50 Van Natta at 162-63 (the accepted

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[1] With certain exceptions not applicable here, OAR 436-035-0007(1) provides:

"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."

condition determines what is included in rating permanent disability of a claim); *see also 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 await the reopening and processing of the claim for that new condition); *James L. Mack*, 50 Van Natta 338, 339 (1998) (same).

Moreover, applying ORS 656.268(14),[2] we have determined that permanent disability caused by direct medical sequelea is limited to direct medical sequelea of *accepted* conditions. *See Julio C. Garcia-Caro*, 50 Van Natta at 161-63; *Donald D. Davis*, 50 Van Natta 357 (1998) (although the medical evidence showed that the claimant's epicondylitis condition was a sequela of the accidental *injury*, that condition was not a "direct medical sequela" of the *accepted* condition of left elbow contusion; therefore, the claimant was not entitled to impairment for the epicondylitis condition under *former* ORS 656.268(16)); *see also Colleen M. Conner*, 52 Van Natta 1464 (2000) (where the insurer had accepted a thoracic sprain, without accepting any condition involving the left shoulder and cervical spine, impairment in those areas found not currently ratable because the claimant failed to show the unaccepted conditions were a direct medical sequelae of the accepted conditions); *Robert A. Moon*, 51 Van Natta 242 (1999) (the claimant was not entitled to disability based on laxity of the medial collateral ligament where no condition involving the medial collateral ligament was accepted and the claimant failed to show the unaccepted condition was a direct medical sequelae of the accepted condition).

Granner, relied on by the ALJ, does not extend compensability determinations into the arena of extent determination. In *Granner*, the carrier accepted a "right patella dislocation." The issue was whether the claimant's preexisting knee condition was within the scope of the carrier's acceptance. If it was, then the carrier was precluded from denying compensability of the claimant's current condition. The *Granner* court rejected the claimant's interpretation of *Georgia-Pacific v. Piwowar*, 305 Or 494 (1988), and explained that *Piwowar* and its progeny stood for the proposition that a carrier is precluded from denying compensability of a claimant's underlying condition where the carrier's acceptance listed symptoms rather than separate conditions. The *Granner* court also noted that the question of the scope of the carrier's acceptance was a question of fact for the Board. 147 Or App at 411. The *Granner* court concluded that the Board's conclusion that the carrier accepted a separate condition, rather than a symptom, was supported by substantial evidence. Therefore, the court held that the Board correctly concluded that the carrier did not accept the claimant's preexisting condition.

On review, claimant argues that the ALJ correctly decided the matter, contending that, because the scope of the insurer's acceptance is a question of fact, the Board must determine what the compensable condition is. We agree that the scope of a carrier's acceptance may come into play in determining extent of disability where there is a dispute over what conditions were encompassed in the carrier's acceptance. *See Roseburg Forest Products v. Clemons*, 169 Or App 231 (2000) (accepted claim for "left-sided sciatica" included neurological symptoms of foot weakness; therefore, scheduled permanent disability award for foot weakness appropriate). However, claimant actually argues for going beyond simply determining the scope of the insurer's acceptance and determining the compensability of claimant's right knee condition in an extent setting. As explained above, an extent determination is not the proper setting to determine compensability.

As for the scope of acceptance issue, an acceptance of a claim encompasses only those conditions specifically or officially accepted in writing. *Johnson v. Spectra Physics*, 303 Or 49, 56 (1987). Whether an acceptance occurs is a question of fact. *SAIF v. Tull*, 113 Or App 449, 454 (1992).

Here, the insurer specifically accepted a disabling medial meniscus tear in the right knee. (Exs. 5, 12). *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, even though no physician had diagnosed a knee strain at the time of acceptance); *compare Fred L. Dobbs*, 50 Van Natta 2293, 2295 (1998) (when the carrier does not identify the specific condition accepted, we look to the contemporaneous medical records to

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[2] ORS 656.268(14) provides that "[c]onditions 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."

determine what condition was accepted), *aff'd SAIF v. Dobbs*, 172 Or App 446 (2001). Because the insurer accepted a specific condition rather than a symptom, the reasoning in *Piwowar* does not apply to determine the scope of acceptance. Instead, the insurer's acceptance is limited to the condition it specifically accepted in writing, *i.e.*, a disabling medial meniscus tear in the right knee. The fact that the meniscus condition had been eliminated by the time of the pre-closure updated notice of acceptance does not change the scope of acceptance.[3] In determining compensability of claimant's right knee conditions, the ALJ went beyond determining the scope of the insurer's acceptance.

Thus, here, the accepted condition is a medial meniscus tear of the right knee. (Exs. 5, 12). Therefore, any impairment due to this accepted condition is currently ratable. The insurer has not accepted (nor does the record reflect that claimant has requested that the insurer accept) any other condition involving the right knee, including the articular damage to the medial femoral condyle discovered in the May 13, 1999 arthroscopy. Therefore, any impairment due to femoral condyle damage is not currently ratable unless claimant can establish that the unaccepted femoral condyle condition is a direct medical sequela of the accepted condition medial meniscus tear. *See Davis*, 50 Van Natta at 357; *see also Donald A. Westlake*, 50 Van Natta 1213 (1998) (where the medical evidence failed to show that the claimant's distal clavicle condition was accepted or that it constituted direct medical sequelae to the accepted condition of acute impingement syndrome, the claimant was not entitled to a permanent disability award based on the distal clavicle resection).

We do not find that either Dr. Hering's opinion or the medical arbiter panel's reports support a finding of impairment due to the accepted condition of a right knee medial mensicus tear. All of these physicians acknowledge that the arthroscopy showed no medial meniscus tear condition. (Exs. 7-1, 15-2, -3). In addition, Dr. Hering stated both that claimant's pain was due not to the meniscus (which was normal) but to articular damage to the femoral condyle, and that all restrictions after claimant became medically stationary were due to preexisting conditions, not the work injury. (Exs. 7-1, 10-1).

While we find the medical arbiter panel's report and Dr. Tiley's supplemental report more complete than Dr. Hering's "check-the-box" concurrence, those reports also do not support claimant's position. The panel clearly understood that the accepted condition was a medial meniscus tear in the right knee, a condition they explained claimant did not have, specifically noting that "the accepted condition of medical meniscus tear is not really the injury of question here." (Ex. 15-3). Moreover, they do not explain how a condition that claimant does not have can cause impairment. Given this, we do not find their opinion establishes that the accepted condition resulted in impairment. Instead, they relate the impairment to the femoral condyle condition. (Exs. 15-2, -3, -4).

However, while their opinions may support the position that the femoral condyle condition is the result of the *work injury*, they do not establish that the unaccepted femoral condyle condition is a direct medical sequelae of the *accepted* medial meniscus tear condition. (Exs. 15, 16). In the absence of such evidence, claimant is not entitled to a scheduled permanent disability award for impairment related to the femoral condyle condition. In order for claimant to be entitled to permanent disability for any injury to her femoral condyle, it would be necessary for her to make a claim for that condition (*see* ORS 656.262(6)(d), (7)(a)), and for the condition to be found compensable and the claim reopened (under ORS 656.262(7)(c)). We note that such a claim may be made at any time. ORS 656.262(6)(d), (7)(a).

We acknowledge that, under *SAIF v. Danboise*, 147 Or App 550, *rev den* 325 Or 438 (1997), we may conclude that certain impairment findings are due to the compensable injury where the medical arbiter rates impairment and describes it as "consistent with" the compensable injury and the record discloses no other possible source of impairment.[4] Here, given the consistent medical opinions of the

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[3] Instead, as addressed below, claimant's remedy lies in either contesting the notice of acceptance or requesting acceptance of a new medical condition. ORS 656.262(6)(d), (7)(a).

[4] In *SAIF v. Alton*, 171 Or App 491 (2000), the court discussed a claimant's burden of proof in the context of an extent of permanent disability case and explained that, in *Danboise*, 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." 171 Or App at 499.

medical arbiter panel and Dr. Hering that claimant does not have a medial meniscus tear, we do not find that those opinions describe the impairment as "consistent with" the accepted condition. In cases such as this, where the medical evidence does not address whether the impairment is consistent with, or does not indicate that the impairment is a direct medical sequelae of, an accepted condition, claimant has not sustained her burden of proof.[5] *See David D. Couture*, 50 Van Natta 1181 (1998) (finding that, in the absence of any evidence that loss of cervical range of motion is consistent with a low back injury, *Danboise* is inapplicable).

ORDER

The ALJ's order dated August 3, 2000 is reversed. The Notice of Closure's award of zero scheduled permanent disability for the right leg (knee) is reinstated and affirmed. The ALJ's assessed attorney fee award is reversed.

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[5] Because we are not an agency with specialized medical expertise entitled to take official notice of technical facts within our specialized knowledge, we must have medical evidence that the impairment is consistent with, or a direct sequelae of, the accepted condition. *See, e.g., SAIF v. Calder*, 157 Or App 224 (1998).

Board Member Phillips Polich concurring.

While I agree with the reasoning and conclusions in the lead opinion, I find that the current state of the workers' compensation law presents a hyper-technical trail that unsuspecting claimants must traverse to secure their rights. As the law becomes ever more complex, it is increasingly difficult for workers to handle their claims without representation and still have a reasonable chance of securing the benefits to which they are entitled now and in the future.

Regarding the issue currently before us, I am concerned that the burden to insure the correctness of a carrier's acceptance has shifted from the carrier to the injured worker, who generally is not as experienced in workers' compensation matters and may not be aware of the importance of an accurate acceptance.

In the Matter of the Compensation of
WILLIAM I. SERGEANT, Claimant
WCB Case No. 99-10066
ORDER ON REVIEW
Daniel Snyder, Claimant Attorney
Jerry Keene, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Herman's order that affirmed an Order on Reconsideration that declined to reclassify his claim as disabling. In its brief, the self-insured employer argues that the ALJ did not have jurisdiction to consider the claim classification dispute. On review, the issues are jurisdiction and claim classification. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. We change the first sentence on page 2 to read: "Claimant was employed by Kelly Services." In the last paragraph of the findings of fact on page 3, we change the date in the last sentence to "December 23, 1999."

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The employer argues that the ALJ erred by finding that the Hearings Division had jurisdiction to consider the classification dispute. The employer contends that, under *amended* ORS 656.277, claimant's appeal must first go through the Director, not the Board.

We begin by reviewing the procedural history. Claimant compensably injured his neck on November 12, 1998. (Ex. 1). The employer accepted a nondisabling cervical strain on December 4, 1998. (Ex. 6). Claimant requested that the claim be reclassified as disabling. (Ex. 30a). At that time, *former* ORS 656.277(1) provided:

> "If within one year after the injury, the worker claims a nondisabling injury originally was or has become disabling, the insurer or self-insured employer, upon receiving notice or knowledge of such a claim, shall report the claim to the Director of the Department of Consumer and Business Services for determination pursuant to ORS 656.268."

The employer complied with *former* ORS 656.277(1) when it submitted the claim to the Department of Consumer and Business Services ("Department"). (Ex. 30a). The employer, however, said it did not believe the claim should be classified as disabling. (*Id.*) An August 12, 1999 Determination Order found that the claim remained classified as nondisabling. (Ex. 31). The Determination Order stated that any party to the claim had a right to request reconsideration for a period of 60 days from the mailing date of the order. (Ex. 31-1). Claimant requested reconsideration.

At the time claimant requested reconsideration of the Determination Order, *former* ORS 656.268(5)(b) provided:

> "If the worker, the insurer or self-insured employer objects to a determination order issued by the department, the objecting party must first request reconsideration of the order. The request for reconsideration must be made within 60 days of the date of the determination order."

Claimant complied with *former* ORS 656.268(5)(b) by requesting reconsideration within 60 days of the August 12, 1999 Determination Order. The Department began reconsideration on September 21, 1999. (Ex. 35). A December 9, 1999 Order on Reconsideration affirmed the Determination Order and concluded that the claim would remain classified as nondisabling. (Ex. 35). The Order on Reconsideration stated, in part:

> "Any party to the claim has the right to request a hearing for a period of 30 days from the date of this Order on reconsideration. A hearing request must be sent in writing to the Workers' Compensation Board, 2601 25th Street SE, Suite 150, Salem, Oregon 97302-1282." (Ex. 35-3).

ORS 656.268(6)(g) provides:

"If any party objects to the reconsideration order, the party may request a hearing under ORS 656.283 within 30 days from the date of the reconsideration order."

Claimant complied with ORS 656.268(6)(g) by requesting a hearing regarding the Order on Reconsideration on December 23, 1999.

The employer's jurisdictional argument is based on the 1999 amendments to ORS 656.277, which were effective on October 23, 1999. We have determined that those amendments do not apply retroactively. *See, e.g., Jon O. Norstadt*, 52 Van Natta 1627 (2000). The problem in this case, however, is that the statutory amendments were effective *after* claimant requested reconsideration of the Determination Order, but *before* the Order on Reconsideration issued on December 9, 1999.

As discussed earlier, claimant properly complied with *former* ORS 656.268(5)(b) when he requested reconsideration within 60 days of the August 12, 1999 Determination Order. Senate Bill 220 eliminated *former* ORS 656.268(5)(b), effective October 23, 1999. Or Laws 1999, ch 313, Sec. 1. The 1999 legislature amended several statutes, including ORS 656.277, which pertains to claim classification. The employer relies on *amended* ORS 656.277 to argue that claimant's appeal must first go through the Director, not the Board. ORS 656.277(1) now provides:

"A request for reclassification by the worker of an accepted nondisabling injury that the worker believes was or has become disabling must be submitted to the insurer or self-insured employer. The insurer or self-insured employer shall classify the claim as disabling or nondisabling within 14 days of the request if the request is received within one year after the date of acceptance. A notice of such classification shall be mailed to the worker and the worker's attorney if the worker is represented. The worker may ask the Director of the Department of Consumer and Business Services to review the classification by the insurer or self-insured employer by submitting a request for review within 60 days of the mailing of the classification notice by the insurer or self-insured employer. If any party objects to the classification of the director, the party may request a hearing under ORS 656.283 within 30 days from the date of the director's order."

Thus, ORS 656.277(1) now requires that the worker first submit a request for reclassification to the carrier. If a worker is dissatisfied, he or she may request review of the classification by the Director. If either party objects to the Director's decision, the party may request a hearing under ORS 656.283.

Section 16 of Oregon Laws 1999, chapter 313 (SB 220) provides:

"(1) The Director of the Department of Consumer and Business Services shall phase out the claim closure activities of the Department of Consumer and Business Services in a manner that minimizes disruption for workers, insurers and self-insured employers to the greatest extent practicable.

"(2) The director may:

"(a) After providing reasonable written notice, require insurers and self-insured employers to assume claim closure responsibilities by a date certain for all claims or specific kinds of claims.

"(b) Take other reasonable steps as may be necessary to implement this section and the amendments to ORS 656.206, 656.218, 656.262, 656.268, 656.270, 656.273, 656.277, 656.283, 656.295, 656.307, 656.726, 657.170 and 659.455 by sections 1 to 10 and 13 to 15 of this 1999 Act.

"(3) Notwithstanding subsection (2) of this section, the director shall cease all claim closure activities and insurers and self-insured employers shall assume the responsibility for closing all workers' compensation claims not later than June 30, 2001."

Although the effective date of Senate Bill 220 was October 23, 1999, section 16 provides that the Director is to cease claim closure activities "not later than June 30, 2001." Furthermore, section 16 provides that the Director is to phase out claim closure activities in a manner that "minimizes disruption." In addition, section 16 indicates that "reasonable steps" are to be taken to implement the statutory amendments.

Effective January 1, 2001, the Director amended the administrative rules pertaining to claim classification. (WCD Admin. Order No. 00-058). The amended rules, however, pertain only to claims with dates of injury on or after October 23, 1999. OAR 436-030-0003(3)(b). Claimant's date of injury was November 12, 1998. OAR 436-030-0003(3)(b) provides that for claims with dates of injury *before* October 23, 1999, the provisions of OAR 436-030-0045 in WCD Administrative Order 97-065 "shall apply until the industry is notified otherwise by the director."

Former OAR 436-030-0045(12) (WCD Admin. Order No. 97-065) provided that if a party objected to the determination of the worker's disabling/nondisabling status by the department, that party "must request reconsideration by the department in accordance with ORS 656.268 before requesting a hearing pursuant to ORS 656.283." Here, claimant properly requested reconsideration and complied with *former* ORS 656.268(5)(b), as well as *former* OAR 436-030-0045(12), which still applies to his claim. *See* OAR 436-030-0003(3)(b) (WCD Admin. Order No. 00-058). Based on the aforementioned statutes, section 16 of Senate Bill 220, and the administrative rules, we agree with the ALJ that the Hearings Division has jurisdiction in this case.[1]

Claim Classification

Claimant argues that his claim should be reclassified as disabling and he should be paid temporary disability benefits from December 4, 1998 through January 18, 1999. Claimant contends that temporary disability was authorized by Drs. Kingston and Carvalho.

ORS 656.005(7)(c) provides:

> "A 'disabling compensable injury' is an injury which entitles the worker to compensation for disability or death. An injury is not disabling if no temporary benefits are due and payable, unless there is a reasonable expectation that permanent disability will result from the injury."

There is no argument that claimant has a reasonable expectation of permanent disability. Therefore, the claim classification issue depends on whether there are temporary disability benefits due and payable. ORS 656.262(4)(a) and (h) provide that temporary disability compensation shall be paid if authorized by the attending physician. ORS 656.245(2)(b)(B) provides that "[a] medical provider who is not an attending physician cannot authorize the payment of temporary disability compensation."

Claimant argues that Dr. Kingston authorized temporary disability on December 8, 1998. He relies on his testimony that Dr. Kingston authorized temporary disability on his second appointment on December 8, 1998, as well as Dr. Kingston's December 4, 1998 letter. (Tr. 11-12, Ex. 8).

Dr. Kingston first examined claimant on December 4, 1998. (Exs. 7, 9, 10). His December 4, 1998 chart notes did not indicate that he had authorized time loss for claimant. (Exs. 9, 11-3).

Claimant filled out an "827" form on December 4, 1998, which was signed by Dr. Kingston, but not dated by him. (Ex. 7). Dr. Kingston checked the box that stated "[r]eleased for regular work" and he wrote "no time loss." (*Id.*) Dr. Kingston indicated that he had first examined claimant on December 4, 1998 and claimant's next appointment was on December 8, 1998. (*Id.*) Although Dr. Kingston did not date the "827" form, we infer that he signed it between December 4, 1998 and December 8, 1998.

On the other hand, the record includes a letter from Dr. Kingston "To Whom It May Concern" dated December 4, 1998. (Ex. 8). That letter stated, in part: "[claimant] was in a lot of pain, so I authorized time loss from December 4, 1998 until January 12, 1999." (*Id.*)

Claimant testified[2] that Dr. Kingston ordered him not to return to work, and on his next visit, Dr. Kingston gave him a letter to that effect. (Tr. 11, 12). He said that he received Dr. Kingston's December 4, 1998 letter on his second appointment on December 8, 1998. (Tr. 12).

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[1] We find that the employer's reliance on *Jeffrey J. McHenry*, 52 Van Natta 2187 (2000), is misplaced. In that case, there was no discussion as to which version of ORS 656.277(1) applied. Instead, the issue in *McHenry* was whether ORS 656.283(1) gave a worker an alternative, discretionary course of action in claim classification disputes.

[2] We note that neither party challenges the ALJ's September 1, 2000 interim order, which determined that claimant was allowed to testify at the reclassification hearing. Under such circumstances, such evidence has been considered. *See Fister v. South Hills Health Care*, 149 Or App 214 (1997).

The ALJ found that Dr. Kingston's December 4, 1998 letter was actually written much later than that date. Even if we assume, however, that Dr. Kingston wrote that letter on December 4, 1998, we find that the evidence is not sufficient to establish whether he authorized time loss on that date. Dr. Kingston's December 4, 1998 letter (Ex. 8) is inconsistent with the "827" form he signed, in which he checked the box that stated "[r]eleased for regular work" and he wrote "no time loss." (Ex. 7). Furthermore, Dr. Kingston's December 8, 1998 letter to claimant made no mention of time loss. (Ex. 14). On this record, in light of Dr. Kingston's inconsistencies, we are unable to determine whether Dr. Kingston authorized temporary disability on either December 4, 1998 or December 8, 1998, notwithstanding claimant's testimony.

We turn to Dr. Kingston's January 27, 1999 letter "To Whom it May Concern" which stated that he treated claimant from December 11, 1998 to January 12, 1999 and claimant was "off work from November 12, 1998 to January 8, 1999." (Ex. 24). ORS 656.262(4)(g) provides that no authorization of temporary disability compensation by the attending physician shall be effective to retroactively authorize the payment of temporary disability more than 14 days prior to its issuance. Thus, Dr. Kingston's January 27, 1999 letter could arguably authorize time loss beginning on January 13, 1999. However, Dr. Kingston was not claimant's attending physician on either January 13, 1999 or January 27, 1999. On January 8, 1999, claimant signed a "change of attending physician" form naming Dr. Carvalho as his attending physician. (Ex. 16). Under these circumstances, we agree with the ALJ that the record is insufficient to establish that Dr. Kingston authorized temporary disability.

Claimant also argues that Dr. Carvalho authorized temporary disability. Dr. Carvalho first examined claimant on January 8, 1999. (Ex. 17). As mentioned above, claimant signed a "change of attending physician" form naming Dr. Carvalho as his attending physician on that date. (Ex. 16). Also on January 8, 1999, Dr. Carvalho authorized time loss from January 8, 1999 to January 18, 1999. (Ex. 17). Dr. Carvalho reported that claimant had muscle spasms in his neck and mid back and he had some limited ranges of motion. (Ex. 18-3).

The employer argues that Dr. Carvalho was not an "attending physician" and could not authorize time loss. The employer contends that Dr. Carvalho was a non-approved provider and claimant had been notified that he had a duty to treat with an approved "MCO" doctor.

Claimant responds that it was the employer's fault that he did not see an "MCO" physician. He contends that the employer's December 28, 1998 letter erroneously told him that he was to seek medical care from an MCO list of physicians in Eugene, even though he lives in Portland. Claimant argues that, at the time he saw Dr. Carvalho, he had not received the employer's January 4, 1999 letter that referred to a new MCO list of Portland physicians.

On December 4, 1998, the employer accepted a nondisabling cervical strain. (Ex. 6). The notice of acceptance provided, in part:

> "Your attending physician must provide the insurer with time-loss authorization before your insurer is required to make a payment of temporary disability to you. If your attending physician tells you that you are unable to work as a result of your injury, you should ask your physician at each visit if time loss authorization has been provided to the insurer." (Ex. 6-1).

On December 28, 1998, the employer sent claimant three letters pertaining to his medical providers. (Ex. 14C-1, -2, -3). One of the letters stated, in part:

> "Your employer is covered by a managed care agreement between [OHS and Riskco]. This means the medical care you are receiving for the above injury is now subject to the provisions of that managed care agreement. * * *
>
> "If you are in need of additional medical care, the enclosed pamphlet explains in detail how you may receive medical services, and under which circumstances you may be allowed to treat with a non-OHS provider. A list of OHS providers is also enclosed for your convenience.
>
> "I have no record of a primary care physician who is authorized to treat you within MCO guidelines. Therefore, you must choose an attending physician from the attending physicians on the enclosed list of OHS providers." (Ex. 14C-2).

The list of OHS providers referred only to physicians in the Eugene, Oregon area. (Ex. 14C-4, -5, -6, -7).

The other two December 28, 1998 letters from the employer pertained to claimant's treatment with Dr. Kingston and Dr. Wei.[3] (Ex. 14C-1, -3). Those letters provided, in part:

> "Under the managed care agreement, you must receive care from an MCO provider, or from your family physician if they qualify as a primary care physician under Oregon Law, and agree to abide by the MCO guidelines.
>
> "Our records indicate that the above provider either is not an MCO provider, does not meet the criteria of primary care physician, has declined to treat under the terms and conditions of the MCO, or does not qualify for out-of-panel treatment. Treatment from this provider beyond 14 days from the date of this letter will not be considered compensable. We suggest that you transfer care to a provider who has contracted with OHS. A provider list was previously sent to you at the time of enrollment." (Ex. 14C-1, -3).

On December 30, 1998, claimant's attorney wrote to the employer regarding the MCO provider list sent to claimant that referred to physicians in Eugene. (Ex. 14D). The letter stated, in part:

> "Please promptly provide my client with the correct list of doctors in Portland if you want him to see physicians in your MCO. Otherwise, I will assume that he is free to receive care from any medical doctor he wishes to receive care from. (*Id.*)

On January 4, 1999, the employer prepared a letter to claimant, which included a corrected list of OHS providers in the Portland area. (Ex. 14E). Dr. Carvalho's name was not included on that list.

Claimant testified that he did not have any transportation as a result of the accident and could not afford to get to Eugene for medical treatment. (Tr. 14, 15, 23-24). Instead, he sought treatment from Dr. Carvalho, who had been referred by Dr. Kingston. (Tr. 14). He testified that when he saw Dr. Carvalho on January 8, 1999, he had not received the employer's list of Portland physicians. (Tr. 15, 21). After he received the list of Portland providers, he chose a physician from that list. (Tr. 15).

On cross-examination, claimant explained that the employer's letters indicated that he needed to see a provider from the employer's list, but at the same time, he felt he needed treatment immediately. (Tr. 18). He believed the list they gave him would have required him to go to Eugene. (*Id.*) Claimant testified that, at the time, he was confused about what an MCO was and he thought that he just needed to be referred by a physician and Dr. Kingston had referred him to Dr. Carvalho. (Tr. 19, 20). When he went to Dr. Carvalho, he was not sure if she was an approved MCO physician. (Tr. 22). Claimant thought that he just needed to have a referral from a physician. (*Id.*)

As discussed earlier, ORS 656.262(4)(a) and (h) provide that temporary disability compensation shall be paid if authorized by the "attending physician." ORS 656.005(12)(b) provides, in part:

> "Except as otherwise provided for workers subject to a managed care contract, 'attending physician' means a doctor or a physician who is primarily responsible for the treatment of a worker's compensable injury[.]"

ORS 656.260(13) provides:

> "Notwithstanding ORS 656.005(12) or subsection (4)(b) of this section, a managed care organization contract may designate any medical service provider or category of providers as attending physicians."

ORS 656.245(4)(a) provides, in part:

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[3] We note that there is no evidence that Dr. Wei treated claimant. Rather, he interpreted claimant's lumbosacral and cervical spine x-rays. (Exs. 12, 13).

"Those workers who are subject to the [managed care organization] contract shall receive medical services in the manner prescribed in the contract. * * * A worker becomes subject to the contract upon the worker's receipt of actual notice of the worker's enrollment in the managed care organization, or upon the third day after the notice was sent by regular mail by the insurer or self-insured employer, whichever event first occurs. * * * A worker shall not be subject to a contract if the worker's primary residence is more than 100 miles outside the managed care organization's certified geographical area. * * * However, a worker may receive immediate emergency medical treatment that is compensable from a medical service provider who is not a member of the managed care organization. Insurers or self-insured employers who contract with a managed care organization for medical services shall give notice to the workers of eligible medical service providers and such other information regarding the contract and manner of receiving medical services as the director may prescribe."

Claimant did not recall when he received the employer's December 28, 1998 letters. (Tr. 13). However, his attorney wrote to the employer on December 30, 1998, questioning whether claimant was required to treat with Eugene physicians. (Ex. 14D). In any event, based on ORS 656.245(4)(a), claimant became subject to the MCO contract "upon the third day after the notice was sent by regular mail by the insurer or self-insured employer[.]" In light of claimant's attorney's December 30, 1998 letter, we find that claimant was subject to the MCO contract by the time he sought treatment from Dr. Carvalho on January 8, 1999. Dr. Carvalho's name was not included in the employer's January 4, 1999 provider list of physicians in Portland. (Ex. 14E).

ORS 656.245(4)(a) provides that a worker may receive "immediate emergency medical treatment" from a medical service provider who is not a member of the MCO. Although claimant testified that he needed care "[i]mmediately" (Tr. 18), Dr. Carvalho's January 8, 1999 chart note did not refer to an emergency situation and does not establish that her treatment constituted "emergency medical treatment." (Ex. 18). Furthermore, even if Dr. Carvalho's treatment was deemed to be "compensable" under ORS 656.245(4)(a), the record is not sufficient to establish that she was an "attending physician" who may authorize time loss.

OAR 436-015-0070 (WCD Admin. Order No. 98-061) pertains to primary care physicians who are not MCO members. Section 1 provides that the MCO shall authorize a physician who is not a member of the MCO to provide medical services to an enrolled worker if the physician qualifies as a primary care physician. For the purposes of OAR 436-015-0070(1), the physician must, among other things:

"(a) Qualify in accordance with ORS 656.005(12) as an attending physician and must be a general practitioner, a family practitioner, or an internal medicine specialist.

"* * * * *

"* * * * *

"(d) Agree to comply with all terms and conditions regarding services governed by the MCO. For purposes of this section, the phrase 'all terms and conditions regarding services governed by the MCO' means MCO treatment standards, protocols, utilization review, peer review, dispute resolution, billing and reporting procedures, and fees for services in accordance with OAR 436-015-0090[.]"

There is no evidence that Dr. Carvalho met the criteria to qualify as a primary care physician with the MCO. Consequently, we are not persuaded that Dr. Carvalho qualified as an "attending physician" pursuant to ORS 656.005(12)(b). Under these circumstances, we agree with the ALJ that claimant has not established that he is entitled to temporary disability. ORS 656.005(7)(c) provides, in part, that an injury is not disabling if no temporary benefits are due and payable. Accordingly, we agree with the ALJ that the claim should remain classified as nondisabling.

ORDER

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

In the Matter of the Compensation of
JEFFREY S. SORN, Claimant
WCB Case Nos. 99-09865 & 99-05945
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Lundeen, et al, Defense Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock, and Biehl.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Black's order that: (1) found "good cause" for claimant's untimely hearing request regarding SAIF's denial of claimant's "new injury" claim for a low back condition; and (2) set aside SAIF's denial. On review, the issue is timeliness of the hearing request and, potentially, responsibility. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

SAIF denied responsibility for claimant's December 28, 1998 low back injury on February 24, 1999. (Ex. 20).

On July 25, 1999, claimant requested a hearing from the denial. He stated that he would have made this request within 60 days, but for his understanding that Liberty Northwest Insurance Corporation (Liberty), rather than SAIF, was "liable." (Ex. 23A). At hearing, claimant testified that a SAIF claims examiner contacted him after he filed his 1998 injury claim and he understood from that conversation that SAIF was a state agency that investigated workers' compensation claims. Claimant stated that he told SAIF's claims examiner that he had injured his back previously under Liberty's coverage. Then, shortly before the denial, SAIF's claims examiner called claimant and informed him that his claim was compensable, but the other insurance company was responsible for it. (*See* Tr. 24-27; 55-58).

Claimant received SAIF's denial about a week later. He did not request a hearing for almost six months, because he "didn't think it was necessary." (Tr. 27).

The ALJ found that claimant established "good cause" for his untimely request for hearing, based on a misunderstanding about the process that was "abetted" by the two "insurer-instigated" conversations with SAIF's claims examiner. The ALJ reasoned that claimant was misled by the claims examiner's failure to advise him that responsibility for his claim might be disputed and he needed to appeal SAIF's denial "in order to stay in the game." We disagree.

It is undisputed that claimant requested a hearing from SAIF's denial more than 60 days and less than 180 days after the mailing of the denial. Consequently, the hearing request confers jurisdiction only if claimant had "good cause" for the late filing. ORS 656.319(1); *Tracie L. Salustro*, 52 Van Natta 1420 (2000).

Mistake, inadvertence, surprise or excusable neglect, as those terms are used in ORCP 71B(1), constitute "good cause." *Hempel v. SAIF*, 100 Or App 68, 70 (1990); *Anderson v. Publishers Paper Co.*, 78 Or App 513, 517, *rev den* 301 Or 666 (1986). Claimant has the burden of proving good cause. *Cogswell v. SAIF*, 74 Or App 234, 237 (1984). Lack of diligence does not constitute good cause. Id.

Confusion regarding the contents of a denial does not, without reasonable diligence, constitute good cause. *See Debra A. Gould*, 47 Van Natta 1072 (1995) (a claimant confused by a carrier's simultaneous denial of a condition as a new occupational disease and reopening of an accepted claim did not have good cause for untimely hearing request because there was no evidence that the claimant had exercised any diligence in resolving confusion); *Mary M. Schultz*, 45 Van Natta 571 (1993) (confusion regarding status of claim caused by receipt of interim compensation insufficient to prove good cause; further, lack of diligence in clearing up confusion also prevented finding of good cause).

Here, SAIF's letter was not expressly entitled a "denial." Nonetheless, the letter clearly provided, in pertinent part, in capital letters:

> "If you think this *denial* is not right, within 60 days after the date of this letter you must file a letter with the Workers' Compensation Board * * *. If you do not file a request within 60 days, you will lose any right you may have to compensation unless you can show good cause for delay beyond 60 days. After 180 days all your rights will be lost." (Ex. 20-1). (Emphasis supplied.)

We are not persuaded that claimant relied on SAIF's representation that his claim was compensable. As we have explained, the denial included clear appeal rights. Under these circumstances, we conclude that claimant's failure to follow the instructions on the denial amounted to a lack of due diligence and, therefore, claimant has not established good cause for his untimely request for hearing. *See Jack L. Barbee*, 48 Van Natta 1855 (1996) (the claimant's mistaken belief that the claim would be covered by another carrier did not constitute good cause). Accordingly, the ALJ's order is reversed, SAIF's denial is reinstated, and claimant's request for hearing is dismissed.

ORDER

The ALJ's order dated October 20, 2000 is reversed in part and affirmed in part. The SAIF Corporation's denial is reinstated. The ALJ's attorney fee award is reversed. Claimant's request for hearing from SAIF's denial is dismissed. The remainder of the ALJ's order (that portion that found that Liberty was not responsible for claimant's low back condition) is affirmed.

Board Member Biehl dissenting.

The majority reasons that SAIF's "denial" clearly apprised claimant of his appeal rights and any confusion claimant had about those rights therefore did not amount to "good cause" for his failure to timely request a hearing. The majority summarily dismisses uncontradicted evidence of SAIF's *prior* misleading and unsolicited assurances and claimant's reasonable reliance on those assurances.

It is well settled that reasonable reliance on misleading assurances by a carrier's claims representative *can* constitute "good cause." *See Voorhies v. Wood, Tatum, Mosser*, 81 Or App 336, *rev den* 302 Or 342 (1986). Here, it is undisputed that claimant relied on misleading, albeit well-meaning, assurances by SAIF's claims examiner. Moreover, these assurances and the plain language of the "denial" clearly establish that claimant's reliance was reasonable and his late request for hearing was due to excusable neglect.

Claimant testified that SAIF's claims examiner *called him* "shortly before" the denial, "a little concerned that [he] might take it [the denial] the wrong way." She stated that she "wasn't denying [his] benefits, [they] were available from somebody else" and claimant needed to pursue his claim with the other insurance company. (Tr. 26). Later, claimant explained that it was his understanding that SAIF would not be accepting the claim and Liberty Northwest was liable. (Ex. 32A). Claimant's representations are unrebutted.

Within a week of the claims examiner's unsolicited telephone advice to claimant, claimant received a letter from SAIF. The letter did *not* say that it was a denial. On the contrary, it stated, "Your injury appears to be work related and compensable against a subject Oregon employer." Although the letter announced that SAIF was "unable" to accept the claim, it also informed claimant that, "in order to protect the right to obtain benefits on the claim," he should file claims against other insurers. (Ex. 20). Thus, the contents of the denial were entirely consistent with the claims examiner's prior communication: Claimant reasonably understood that his claim was compensable and he should file a claim with Liberty, which he did. Claimant explained that he "didn't think it was necessary to file an appeal" from SAIF's denial because the claims examiner told him he had a "valid claim" and another insurer was responsible for it. (Tr. 26).

Thus, by assuring claimant that his claim was compensable, the claims examiner clearly induced and abetted claimant's belief that his claim was in order and he had done everything necessary to protect his right to compensation. SAIF does not argue that these events occurred other than as claimant describes them.

Finally, although the "denial" concludes with the boilerplate "appeal rights" paragraph quoted by the majority, the import of that paragraph is inconsistent with the preceding contents of the letter *and* the claims examiner's prior assurances. Moreover, the inconsistent boilerplate paragraph is the *only* place the word "denial" appears.

I agree with the ALJ that this evidence establishes that claimant reasonably relied on SAIF's assurances when he neglected to request a hearing within 60 days of SAIF's "denial." Even though the claims examiner probably did not intend to mislead claimant, her assurances were nonetheless misleading and claimant's reliance on them was no less detrimental to him because she meant well. Finally, because the claims examiner's advice was unsolicited and claimant had no reason to doubt its authority, claimant's reliance on that advice was eminently reasonable. Under these circumstances, claimant's late response to the denial was "excusable neglect" and he clearly had "good cause" for the delay. Therefore, I must respectfully dissent.

February 26, 2001 Cite as 53 Van Natta 239 (2001)

In the Matter of the Compensation of
CLANCY WHITTEN, Claimant
Own Motion No. 00-0372M
OWN MOTION ORDER ON RECONSIDERATION
Dale C. Johnson, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

On February 2, 2001, we withdrew our January 3, 2001 Own Motion Order, which denied claimant's request for Own Motion relief on the ground that he was not in the work force at the time of his current worsening. We took this action to consider claimant's submission of an affidavit, a light duty questionnaire and medical report in support of his contention that he was in the work force. Having received the insurer's response, we proceed with our reconsideration.

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

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work *and* is seeking work; or (3) not working but willing to work, *and* is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 OR 254, 258 (1989).

The "date of disability" for the purpose of determining whether claimant is in the work force, under the Board's Own Motion jurisdiction,[1] is the date he enters the hospital for the proposed surgery 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 December 26, 2000 surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; *SAIF v. Blakely*, 160 Or App 242 (1999); *Paul M. Jordan*, 49 Van Natta 2094 (1997).

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 Stephen v. Oregon Shipyards*, 115 Or App 521 (1992); *Judith R. King*, 48 Van Natta 2303 (1996).

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[1] The Board in its Own Motion jurisdiction can only authorize temporary disability from the time of surgery or hospitalization. *See* ORS 656.278(1)(a).

On reconsideration, claimant submitted an affidavit stating that he has "been willing to work, but I have not been looking for work, because my compensable low back condition made it impossible." Based on claimant's unrebutted assertion, we are persuaded that claimant is willing to work.

Claimant must also satisfy the "futility" standard of the third Dawkins criterion, in order to be found in the work force. Claimant indicated that the January 15, 2000 "light duty" questionnaire demonstrates that he was in the work force in January 2000, but has "been unable to work due to my low back condition since." The insurer contends that claimant removed himself from the work force in January 2000 and there is no evidence that he was unable to work or was seeking work from January 2000 until Dr. Chesnut's January 2001 report from. Under such circumstances, the insurer argues that claimant was not in the work force at the time of the current worsening. Based on the following reasoning, we disagree with the insurer's assertion.

As noted above, the relevant time period for which claimant must show that it was futile for him to work and/or seek work was prior to December 26, 2000. Dr. Chesnut, claimant's attending physician, opined that claimant was not "able to seek work on or about the day of surgery" because the compensable injury made it futile for him to work and/or seek work. In the absence of persuasive evidence to the contrary, we interpret Dr. Chesnut's reference to "on or about" to mean that it was futile for claimant to work prior to and on the date of surgery, *i.e.* December 26, 2000. Consequently, claimant has satisfied the "futility" standard of the third *Dawkins* criterion.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning the date he is hospitalized for surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,500, payable by the insurer directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

February 27, 2001 Cite as 53 Van Natta 240 (2001)

In the Matter of the Compensation of
LEONA M. CLARK, Claimant
Own Motion No. 01-0038M
OWN MOTION ORDER
Jon C. Correll, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for her 1983 low back claim. Claimant's aggravation rights have expired. SAIF opposes authorization of temporary disability compensation, contending that: (1) claimant's current condition does not require surgery and/or hospitalization; (2) the current condition is not causally related to the accepted condition; (3) SAIF is not responsible for claimant's current condition; (4) surgery or hospitalization is not reasonable and necessary for the compensable injury; and (5) claimant was not in the work force at the time of the 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.*

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. Claimant has not responded to SAIF's contention. Claimant has the burden of proof on this issue and must provide evidence, such as copies of paycheck stubs, income tax forms, unemployment compensation records, a list of employers where claimant looked for work and dates of contact, a letter from the prospective employer, or a letter from a doctor stating that a work search would be futile because of claimant's compensable condition for the period in question. As a result, we are not authorized to grant claimant's request to reopen the claim.[1]

Accordingly, we deny the request for Own Motion relief. *Id.*

IT IS SO ORDERED.

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[1] As presently developed, the record does not establish that claimant's current condition is causally related to her compensable injury or that a proposed surgery will be authorized. In this particular case, these matters need not be conclusively resolved because even if each issue was found in claimant's favor, the record would still be insufficient to establish her entitlement to temporary disability benefits.

February 28, 2001 Cite as 53 Van Natta 241 (2001)

In the Matter of the Compensation of
JAN L. HUTCHISON, Claimant
WCB Case No. 00-05086
ORDER ON REVIEW
Holly J. Somers, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock, and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) set aside its denial of claimant's bilateral upper extremity overuse condition; and (2) awarded an assessed attorney fee of $4,250. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ relied on Dr. Sullivan and Dr. Goslin to conclude that claimant had established compensability of her bilateral upper extremity overuse conditions as an occupational disease. SAIF argues that the opinions of Dr. Sullivan and Dr. Goslin are unpersuasive because they do not evaluate the contribution from claimant's gender, age and weight.

Because claimant seeks to establish the compensability of her bilateral upper extremity condition as an occupational disease, she must prove that her work activities are the major contributing cause of the disease. ORS 656.802(2)(a). To satisfy the "major contributing cause" standard, claimant must prove 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. *Stacy v. Corrections Div.*, 131 Or App 610, 614 (1994); *see Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

Four physicians addressed the cause of claimant's condition. Dr. Bell, a neurologist, examined claimant on behalf of SAIF. Dr. Bell could not identify the major contributing cause of claimant's upper extremity conditions. (Ex. 19-9). She felt that claimant had predisposing factors of body habitus, gender, age and previous similar work activities while self-employed, all of which could be contributing to a greater degree than her brief history of working for the employer as manager of the employer's delicatessen.

Dr. Button, a hand surgeon, saw claimant in consultation and opined that claimant's work was a contributing cause to her condition, but that the major cause was her gender, age and weight and possible psychosocial issues. (Ex. 28-2).

Dr. Goslin, a neurologist, and Dr. Sullivan, claimant's family physician, believed that claimant's upper extremity conditions were related in major part to her work activities for the employer. (Exs. 25; 26).

Dr. Goslin and Dr. Sullivan ruled out diabetes and thyroid disease as possible causes of claimant's entrapment neuropathies, but they did not address the opinions of Drs. Button and Bell that claimant's weight, age and gender contributed more to the condition than claimant's work activities. Because they did not rebut or address the possible contribution from the factors cited by the other physicians, we are unable to find the opinions of Drs. Sullivan and Goslin persuasive. In short, we find that Drs. Sullivan and Goslin failed to evaluate the relative contribution of all of the different causes of claimant's disease to decide which was the primary cause. Accordingly, we conclude that claimant has failed to establish compensability based on this record.

ORDER

The ALJ's order dated November 3, 2000 is reversed. The June 29, 2000 denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

Board Member Biehl dissenting.

I disagree with the majority's interpretation of the medical evidence and would affirm the ALJ's order that set aside SAIF's denial of claimant's bilateral upper extremity conditions. The ALJ relied upon claimant's treating physicians, Dr. Sullivan and Dr. Goslin. I agree with the ALJ's conclusion that Drs. Sullivan and Goslin provide the most thorough and logical explanation for claimant's condition.

The majority finds the opinions of the treating doctors unpersuasive on the ground that they do not address the opinions of Drs. Bell and Button that the factors of age, gender and weight contribute in major part to claimant's upper extremity conditions. I do not agree that the opinions of Drs. Sullivan and Goslin can be discounted on this basis. These physicians were clearly aware of claimant's age, gender and weight and did not attribute her upper extremity conditions to these factors. Moreover, the doctors ruled out other potential causes of claimant's condition such as diabetes, off work activities, arthritis and thyroid problems. Dr. Goslin noted that claimant's work involves frequent repetitive use of her hands and arms. She concluded that claimant's entrapment neuropathies were likely secondary to claimant's work activities. Dr. Sullivan likewise attributed claimant's upper extremity conditions to her work activities. Based on the persuasive evidence from claimant's treating physicians, I would affirm the ALJ's order setting aside the denial. For this reason, I dissent from the majority's opinion.

In the Matter of the Compensation of
JOHN E. KIRWIN, Claimant
WCB Case No. 99-07040
ORDER ON REVIEW
Schneider, et al, Claimant Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order that affirmed an "out-of-compensation" attorney fee granted by an Order on Reconsideration. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant's claim was closed by a June 29, 1999 Notice of Closure. A September 23, 1999 Order on Reconsideration awarded temporary disability and directed the noncomplying employer's processing agent to pay claimant's attorney 10 percent of any additional compensation awarded, but "not more than the maximum attorney fee allowed in OAR 438-015-0040(1)(2) and OAR 438-015-0045." (Ex. 1-2); *see* OAR 436-030-0050(14).

Claimant requested a hearing, contending that the limitation in the Worker's Compensation's Division (WCD's) rule was contrary to ORS 656.268(6)(c). The ALJ affirmed the Order on Reconsideration, reasoning that the Hearings Division lacked the authority to modify the attorney fee award.

On review, claimant argues that the Order on Reconsideration's limit on attorney fees is inappropriate, citing *Timothy W. Krushwitz*, 47 Van Natta 2207 (1995). We agree.

In *Krushwitz*, we concluded that *former* ORS 656.268(6)(a) (now ORS 656.268(6)(c)) provides that WCD, in any reconsideration proceeding, shall order the carrier to pay the attorney 10 percent of any additional compensation awarded to the worker, but imposes no maximum award. 47 Van Natta at 2208. We further concluded that, because there is no authority that requires the Director to adopt the Board's rules concerning attorney fees, which do impose maximum awards, we would give no effect to WCD's rule. We therefore reversed the reconsideration order's imposition of a maximum attorney fee award. *Id; see also Theresa G. Peterson*, 48 Van Natta 1825 (1996); *Rodney V. Boqua*, 48 Van Natta 357 (1996).

The cases cited by the ALJ are distinguishable. In *Shook v. Pacific Communities Hospital*, 159 Or App 604 (1999), for instance, WCD had held that the claimant's back surgery was appropriate and that the carrier was liable for the surgery, but did not award the claimant attorney fees. The claimant then requested a hearing before the Board's Hearings Division, asserting entitlement to an attorney fee pursuant to ORS 656.386(2). *Id.* at 606, 607. The ALJ and the Board declined to award attorney fees in those circumstances. The court affirmed. The court reasoned that the services were rendered solely at WCD and that the subject of the representation was a matter uniquely within WCD's review jurisdiction. Accordingly, relying on ORS 656.385(5) and ORS 656.388(1), the court held that the Board was "preempted and precluded" from awarding "out-of-compensation" fees. *Id.* at 609.

However, here, the issue is not *entitlement* to an "out-of-compensation" attorney fee for services performed in another forum, but rather the statutory limit for a claimant's "out-of-compensation" attorney fee award arising from an Order on Reconsideration under ORS 656.268(6)(c).

Moreover, in *Glen A. Bergeron*, 51 Van Natta 900 (1999), we held that an ALJ lacked the authority to award an "out-of-compensation" attorney fee under ORS 656.386(2) for a claimant's counsel's services performed before WCD in obtaining reclassification of the claimant's nondisabling claim to disabling. ORS 656.385(5); 51 Van Natta at 901. *Bergeron* likewise did not involve the application of ORS 656.268(6)(c) to a "maximum" attorney fee already awarded by WCD. It is likewise distinguishable.

Accordingly, claimant's attorney is entitled to an "out-of-compensation" attorney fee equal to 10 percent of the temporary disability compensation resulting from the Order on Reconsideration. *Timothy W. Krushwitz*, 47 Van Natta at 2208.

ORDER

The ALJ's order dated November 21, 2000 is reversed. The Order on Reconsideration's "out-of-compensation" attorney fee is modified. In lieu of that award, claimant's attorney is awarded an "out-of-compensation" fee equal to 10 percent of the disability compensation resulting from the Order on Reconsideration.

In the Matter of the Compensation of
WILLIAM M. BETTIS, Claimant
WCB Case Nos. 98-05795 & 98-02745
ORDER ON REVEIW
Michael A. Bliven, Claimant Attorney
Mannix, et al, Defense Attorney

Reviewed by Board Members Meyers and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Poland's order that: (1) set aside its denial of claimant's current head, left shoulder and cervical conditions;[1] (2) set aside an Order on Reconsideration as "premature"; and (3) remanded the claim to the insurer for further processing. Claimant cross-requests review of that portion of the ALJ's order that found that the insurer's denial was procedurally proper. On review, the issues are propriety of the denial, compensability and, if the claim is compensable, premature closure or extent of permanent disability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the last paragraph.[2]

CONCLUSIONS OF LAW AND OPINION

Claimant sustained compensable head, neck and left shoulder injuries on July 10, 1996. The insurer accepted claimant's claims for "closed head injury, cervical & left shoulder strain." (Exs. 11, 22, 49; *see* Ex. 77).

Claimant treated conservatively and his symptoms resolved except for neck pain and headaches. On March 2, 1998, the insurer denied claimant's current head injury and cervical and left shoulder strains, based on evidence that the conditions had "resolved fully without any further residuals." (Ex. 76).

On March 3, 1998, a Notice of Closure closed claimant's claim with awards of temporary, but not permanent, disability. (Ex. 78). Claimant requested reconsideration.

After a medical arbiter's examination, an Order on Reconsideration affirmed the Notice of Closure. Claimant requested a hearing.

The ALJ found that the insurer's preclosure current condition denial was procedurally proper. We adopt and affirm the ALJ's opinion in this regard, with the following supplementation.

Although claimant had preexisting cervical degeneration, there is no evidence that it combined with the work injury to cause claimant's subsequent disability or need for treatment. (*See* Exs. 64, 70-5, 89-1-2). On the contrary, the medical evidence uniformly describes claimant's cervical degeneration as separate and distinguishable from his accepted cervical strain. Moreover, because there is no claim or denial of a combined condition and the insurer closed claimant's injury claim within two days of its current condition denial, we agree with the ALJ that the denial was procedurally proper.[3]

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[1] We note that, although the ALJ found that claimant failed to establish "a compensable claim for any current head injury or left shoulder condition," she nonetheless set aside the insurer's current condition denial in its entirety. (Opinion and Order, pp. 6, 10). Claimant does not argue that he currently has injury-related head or shoulder conditions. In any event, we conclude that claimant's entire current condition is not compensable, as explained herein.

[2] We note the Notice of Closure incorrectly identified claimant's medically stationary date as February 10, 1998. (Ex. 78-1). Because the remainder of the record establishes that claimant was medically stationary on February 10, 1997, we conclude that the 1998 date was a scrivener's error. (*See* Exs. 78-3, 83-2).

[3] The preclosure denial was not authorized under ORS 656.262(7)(b) because there is no accepted combined condition. *See Croman Corp. v. Serrano*, 163 Or App 136 (1999). However, the denial is nonetheless procedurally proper because claimant's current condition is medically separate from his accepted condition. *See Shawn E. Morgan*, 52 Van Natta 2112, 2114 (2000) ("Generally, preclosure denials are disfavored but, if they pertain to a condition separate or severable from the accepted condition, they are procedurally valid.").

We also agree with the ALJ that the insurer's denial of claimant's current head and left shoulder conditions is supported by an absence of medical evidence relating any such conditions to the accepted injury. However, we disagree with the ALJ's conclusion regarding claimant's cervical condition.

The ALJ found claimant's current cervical condition compensable, based on the opinion of Dr. Swartz, treating physician. We find Dr. Swartz' opinion inadequately reasoned, in light of the contrary medical evidence and the absence of objective findings supporting a relationship between claimant's current symptoms and his work injury.

Drs. Reimer and Fuller examined claimant on February 10, 1997 and found his "subjective complaints of pain unsupported by any abnormality[.]" (Ex. 37-4-5). Dr. Anderson examined claimant on September 2, 1997 and found no objective evidence of injury at that time. (Exs. 80, 87-13-14).

Drs. Reimer and Marble examined claimant on January 5, 1998 and found:

> "a rather profound discrepancy that is obvious during the interview and on direct examination because at that time we note that he has a great deal of cervical motion, particularly flexion and lateral rotation. However, on direct examination, he appears to have marked volitional inhibition of his cervical motion with severe limitations recorded with inclinometer technique." (Ex. 70-4).

The examiners reasoned that claimant's cervical range of motion findings were invalid when measured, because they "appeared to be quite normal" on indirect observation. (Ex. 70-5). Therefore, they concluded that claimant's subjective complaints were "grossly out of proportion to any objective findings and in fact [they felt] that [claimant was] grossly functional in presenting objective loss of [cervical spine] motion." (Ex. 70-5-6; *see* Ex. 86-17-21; *see also* Ex. 84-54).

On June 8, 1998, Dr. Staver indicated that claimant's current condition was not related to his work injury. (Ex. 81). He explained that claimant's subjective complaints did not reveal their cause, but the cervical strain should have resolved and claimant's ongoing symptoms were probably due to his preexisting degeneration. (Ex. 85-19-15 *see* Ex. 86-25).

Dr. Swartz examined and treated claimant on numerous occasions. He opined that claimant's 1996 work injury was a material contributing cause of claimant's "chronic cervical strain" and the major contributing cause of claimant's current treatment and/or disability. (Ex. 89-1-2). However, we find no persuasive evidence that the doctor relied on anything other than claimant's subjective complaints in forming his causation opinion. In fact, Dr. Swartz identified no objective findings supporting his diagnosis or his causation opinion. Moreover, Dr. Swartz failed to address the numerous inconsistencies reported by examining physicians, except to say the he did not believe claimant was malingering. Under these circumstances, we find Dr. Swartz' opinion unpersuasive and we decline to rely on it.[4]

Accordingly, on this record, we conclude that claimant's compensable conditions resolved before claim closure and the insurer's current condition denial was procedurally and substantively proper. (*See* Ex. 86-27; 86-49; 87-14). In addition, because claimant's accepted conditions were medically stationary as of claim closure and claimant had no injury-related permanent disability as of reconsideration, we also reinstate and affirm the Order on Reconsideration.

ORDER

The ALJ's order dated September 9, 2000 is reversed in part and affirmed in part. That portion of the order finding the denial procedurally proper is affirmed. The remainder of the order is reversed. The insurer's denial is reinstated and upheld. The Order on Reconsideration is affirmed. The ALJ's attorney fee award is reversed.

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[4] To the extent that Dr. Aversano's opinion supports the claim, we find it unpersuasive because it is inconsistent. (*See* Exs. 86A, 86B, 90).

In the Matter of the Compensation of
RONALD R. GILDEROY, Claimant
Own Motion No. 95-0617M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Malagon, Moore, et al, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requested review of the SAIF Corporation's June 23, 1999 Notice of Closure, which closed his claim with an award of temporary disability compensation from January 17, 1998 through June 11, 1999. SAIF declared claimant's condition medically stationary as of June 11, 1999. Claimant seeks entitlement to benefits beyond June 11, 1999.

Claimant has requested that his current psychological condition be accepted as a compensable portion of his 1978 claim. SAIF denied the compensability of claimant's current psychological condition, on which claimant filed a request for hearing. (WCB Case No. 00-00118). We postponed action on the Own Motion matter pending resolution of the litigation before the Hearings Division.

On September 20, 2000, Administrative Law Judge (ALJ) Peterson approved the parties' disputed claim settlement. Pursuant to that settlement, claimant agreed that the SAIF Corporation's December 28, 1999 denial of his current psychological condition would remain in full force and effect. In addition, the settlement provided that claimant's request for hearing "shall be dismissed with prejudice," and that the settlement resolved "all issues raised or raisable."

The dispute regarding the compensability of claimant's current psychological condition has been resolved. Because SAIF's denial was upheld, claimant's current psychological condition is not a compensable portion of his 1978 claim. In light of such circumstances, we now turn to claimant's request for review of SAIF's closure of his claim.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the July 23, 1999 Notice of Closure, considering claimant's condition at the time of closure and not subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 or App 7, 12 (1980).

In support of its closure, SAIF relies on a June 11, 1999 letter submitted by Dr. Morland, claimant's attending physician, who last examined claimant on June 3, 1999. Dr. Morland opined that claimant's condition was medically stationary, but would "require palliative care for the time being."

On January 14, 2000, Dr. Morland withdrew his prior opinion regarding claimant's medically stationary status. Dr. Morland explained that, following his June 11, 1999 letter, claimant had obtained a second opinion and ultimately had a Morphine pump surgically implanted. Under such circumstances, Dr. Morland opined that SAIF's June 23, 1999 closure was "premature" because claimant had not reached medically stationary status at that time.

Evidence that was not available at the time of closure may be considered to the extent that the evidence addresses the condition at the time of closure. *Scheuning v. J.R. Simplot & Co.*, 84 Or App 622, 625 (1987). Here, Dr. Morland retracted his earlier opinion that claimant was medically stationary in June 1999. Because of a second opinion which led to claimant's receiving an Morphine pump implant, Dr. Morland concluded that claimant's condition had not been medically stationary in June 1999.[1]

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[1] Dr. Morland's January 2000 report is sufficiently explained to overcome his initial June 1999 opinion. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of physician's opinion found unpersuasive).

Based on Dr. Morland's unrebutted opinion, we conclude that claimant was not medically stationary on June 23, 1999 when his claim was closed. Therefore, we set aside SAIF's June 23, 1999 Notice of Closure. The claim is remanded to SAIF to recommence temporary disability benefits as of the date it previously terminated such benefits and to continue the payment of these benefits until they can be lawfully terminated. When it is appropriate, the claim shall be closed by SAIF 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.

March 1, 2001 Cite as 53 Van Natta 247 (2001)

In the Matter of the Compensation of
KENNETH W. STOCKAMP, Claimant
WCB Case No. 99-08454
SECOND ORDER ON RECONSIDERATION
VavRosky, et al, Defense Attorney

Claimant, *pro se,* has requested reconsideration of our February 2, 2001 Order on Reconsideration.[1]

Specifically, on reconsideration, claimant questions our standard of "due diligence" and asserts that the worker's compensation system and the HMO system have failed to provide him with the medical care he needs. Claimant raises issues beyond the scope of our review - such as malpractice and other issues with his HMO. It is clear that claimant believes that his concerns have not been heard by the Board. Because claimant is pro se , the Board chooses to emphasize to this claimant that our review is impartial and the workers' compensation system is a "no fault" system. Claimant should not interpret anything in our orders as assigning blame to claimant nor any party, but must understand that it is our responsibility to impartially and consistently apply the legal standards set forth in the law.

In this case, the evidence is not sufficient to establish compensability. After reviewing claimant's motion, we conclude that our prior orders and the Administrative Law Judge's order adequately explained the basis for our decision. Claimant raises no arguments regarding the compensability of his workers' compensation claim that have not been addressed.

Accordingly, we withdraw our prior orders. As supplemented herein, we republish our January 4, 2001 order, as reconsidered February 2, 2001. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] Claimant's motion states that the Workers' Compensation Ombudsman has been unavailable due to illness. We note, however, that the Ombudsman's office has other staff who can assist claimant.

In the Matter of the Compensation of
JAMES R. JENKINS, Claimant
WCB Case Nos. 00-03859, 00-03414, 99-04069 & 99-00166
ORDER ON REVIEW
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
Bottini, et al, Defense Attorney
Steven T. Maher, Defense Attorney
Wallace, Klor & Mann, Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

Liberty Northwest Insurance Corporation (Liberty), on behalf of its insured, Crown Pacific Ltd., requests review of those portions of Administrative Law Judge (ALJ) Kekauoha's order that: (1) set aside its compensability/responsibility denial of claimant's occupational disease claim for binaural hearing loss; (2) upheld Geisy Greer & Gunn's responsibility denial, on behalf of Diamond International (Diamond/GGG), for the same condition; (3) upheld Geisy's responsibility denial, on behalf of Brooks Scanlon (Brooks/GGG), for the same condition; and (4) upheld Fremont Indemnity Company's responsibility denial, on behalf of DAW Forest Products (DAW), for the same condition. Claimant cross-requests review of that portion of the ALJ's order that: (1) declined to award an attorney fee payable by GGG for rescission of its compensability denials at hearing; and (2) awarded an attorney fee of $3,500, payable by Liberty. On review, the issues are compensability, responsibility and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

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

From 1966 to 1994, claimant was employed by the same sawmill in Bend. Geisy Greer and Gunn (GGG) was third party administrator (TPA) for employers Brooks Scanlon and Diamond International during the period of claimant's employment from January 1, 1976 through May 6, 1984. Employer DAW Forest Products was insured by Industrial Indemnity, now Fremont Indemnity, during the period of employment from May 7, 1984 through December 31, 1986. Employer Crown Pacific was insured by Liberty during the period of employment from January 1, 1987 through January 7, 1994. Claimant was laid off in 1994 when the mill closed.

From 1966 until some time in 1985, claimant worked in the woods, primarily operating heavy equipment such as CATs and skidders. During the first few years, the skidders had no mufflers and were very loud; claimant wore no hearing protection. Subsequently, when foam rubber earplugs were issued, he began wearing them about 95 percent of the time. (Exs. 13-18, 27-1). In 1985, the woods operation was shut down by DAW and claimant began working in the sawmill powerhouse where he operated CATs to gather fuel for the mill. The CAT exhausts were very loud and the fuel generated steam, which leaked and created loud noise. Claimant was next assigned to monitor and adjust fuel and water gauges on boilers in a separate plant where there was constant loud noise from the metal conveyor chains.

Claimant's baseline hearing was tested in 1966, when he began working for Brooks Scanlon. (Exs. 1-3, 2). This baseline audiogram revealed a slight mild hearing loss in the left ear and a mild noise-induced hearing loss in the right ear. (Ex. 14-4). Audiograms were repeated in 1976, 1979, 1991 and 1993, and in each of those years, plus 1980, claimant was told that he had bilateral hearing loss and might benefit from seeking medical advice. He was also told that he needed to protect his hearing and agreed to do so. (Exs. 2, 4, 6, 7, 10, 11).

Claimant did not become disabled due to his hearing loss. In 1997, claimant went to a hearing aid specialist and was fitted with hearing aids. (Ex. 13-18). In 1998, claimant filed an occupational disease claim for binaural hearing loss against Liberty. (Ex. 12). On October 12, 1998, Dr. Hodgson, otolaryngologist, examined claimant on behalf of Liberty. (Ex. 14). The examination included an audiogram. (*Id.*)

On December 7, 1998, Liberty denied compensability and responsibility. (Ex. 15). Claimant filed claims against other employers/insurers.

On January 11, 1999, Dr. Lee, otolaryngologist, examined claimant, reviewed his medical records, and obtained an audiogram. (Exs. 16, 18).

On May 17, 1999, GGG denied compensability and responsibility on behalf of Brooks Scanlon and Diamond. (Ex. 22).

On March 26, 2000, Mr. Fairchild, audiologist, reviewed claimant's medical records for Diamond/GGG. (Ex. 27).

On May 8, 2000, Fremont denied responsibility on behalf of DAW. (Ex. 28).

CONCLUSIONS OF LAW AND OPINION

Timeliness

Insofar as Liberty has raised the issue of the timeliness of claimant's claim, we address it on review because of its jurisdictional implications. An occupational disease claim must be filed within one year from the date a physician suggests that the condition was due to work activities. *See* ORS 656.807(1)(b). Here, claimant filed his occupational disease claim against Liberty on June 23, 1998, after visiting an audiologist who prescribed hearing aids. (Tr. 15). Claimant first treated with a physician for hearing loss on January 11, 1999, after he had filed his workers' compensation claim. Accordingly, we conclude that claimant has timely filed an occupational disease claim against Liberty, and may proceed to prove compensability of an occupational disease against it. *See* ORS 656.807(1).

Compensability

The ALJ applied the last injurious exposure rule of proof and concluded that claimant had established that his progressive hearing loss was caused in major part by employment-related exposure and was, therefore, compensable. We adopt and affirm the ALJ's reasoning and conclusions regarding this issue and write only to address Liberty's argument on review.

Liberty asserts that, because claimant had a hearing loss that preexisted his employment that was not worsened by claimant's employment at Liberty's insured, claimant's condition is not compensable to Liberty. Liberty cites *SAIF v. Cessnun*, 161 Or App 367 (2000) and *Dora R. Redding*, 52 Van Natta 1067 (2000) in support of its argument. We find that Liberty's reliance on those cases is misplaced.

Here, claimant invoked the last injurious exposure rule to establish a compensable occupational disease. In *Roseburg Forest Products v. Long*, 325 Or 305, 309 (1997), the Court described the last injurious exposure rule:

> "[The last injurious exposure rule] imposes full responsibility on the last employer, from the time of the onset on the disability, if the claimant was exposed there to working conditions that could have caused the type of disease suffered by the claimant. The last injurious exposure rule is a rule of proof and a rule of assignment of responsibility.
>
> "As a rule of proof, the last injurious exposure rule allows a claimant to prove the compensability of an injury *without having to prove the degree, if any, to which exposure to disease-causing conditions at a particular employment actually caused the disease. The claimant need prove only that the disease was caused by employment-related exposure.*" (Citations omitted; emphasis added).

Here, Dr. Hodgson took into account the hearing loss that preceded claimant's employment, as well as other non-occupational factors, when he opined that the major contributing cause of claimant's hearing loss was due to occupational factors. (Ex. 26-9). Thus, claimant has proven that his hearing loss was caused by employment-related exposure, which is sufficient to establish compensability under the last injurious exposure rule of proof.

Finally, because claimant invoked the last injurious exposure rule to establish a compensable occupational disease, Liberty's reliance on *SAIF v. Cessnun* and *Dora R. Redding* is inapposite.

In *Cessnun*, the claimant had a preexisting, noncompensable bone spur that contributed to the causation of the rotator cuff tear for which he was seeking compensation. In *Redding*, the claimant had a preexisting, noncompensable carpal tunnel syndrome when she filed a claim for a worsening of that preexisting condition. Neither of those cases involved the last injurious exposure rule. Rather, in *Cessnun*, the issue resolved by the court involved "preexisting" conditions in relation to initial claims and aggravation claims. In commenting on the distinction made between the two, the court stated:

> "Our holding does not affect the extent to which, in cases involving the last injurious exposure rule, a claimant may rely on the entirety of his or her prior employment in proving that an occupational disease was caused by employment-related exposure." *Cessnun*, 161 Or App at 373 n. 2.

Thus, because claimant in this case relied on the last injurious exposure rule, *Cessnun* and *Redding* are inapplicable.

Responsibility

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

Attorney Fee-GGG

Claimant contends that he is entitled to an assessed fee under ORS 656.386(1) for GGG's rescission of its compensability denials. We agree.

ORS 656.386(1)(a) in relevant part provides that, "[i]n such cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge, a reasonable attorney fee shall be allowed." Based on such language, we have held that a nonresponsible carrier is liable for an attorney fee award for rescinding a compensability denial. *Elizabeth H. Nutter*, 49 Van Natta 829 (1997). The record establishes that GGG, on behalf of Diamond and Brooks Scanlon, initially denied compensability, but conceded the issue at the beginning of the hearing. (Ex. 22; Tr. 3, 4).

Based on our review of the record, and 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 in obtaining the rescission of the compensability denials issued by GGG/Diamond/Brooks prior to a decision by the ALJ is $1,000, payable by GGG/Diamond/Brooks. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record, including the hearing request filed by claimant's attorney), the complexity of the compensability issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. Claimant's counsel is not entitled to an attorney fee for services rendered subsequent to the rescission of the compensability denial. *See Amador Mendez*, 44 Van Natta 736 (1992).

Attorney Fee-Liberty

The ALJ awarded claimant an assessed fee in the amount of $3,000 under ORS 656.386(1), and an additional fee of $500 under ORS 656.308(2)(d). Claimant seeks attorney fee awards greater than those awarded by the ALJ. Claimant argues that the ALJ's award is inconsistent with the fee awarded in *Carrie Newton*, 50 Van Natta 1750 (1998), and requests a fee in the amount of $5,340 for services at hearing pursuant to ORS 656.386(1) and a greater fee under ORS 656.308(2)(d).

While comparing and contrasting other cases can be of some assistance in determining a reasonable fee, each case must ultimately be evaluated based on its own particular circumstances. *Ben Conradson*, 51 Van Natta 851, 852 n. 4 (1999).

Here, after considering the particulars of the case attested to by claimant's counsel, and based on the factors set forth in OAR 438-015-0100(4), we find that $3,500 is a reasonable fee for the compensability and responsibility issues at hearing. Therefore, the ALJ's attorney fee awards, payable by Liberty, are affirmed.

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 $1,500, payable by Liberty. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's counsel's statement of services and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

Furthermore, claimant's attorney is entitled to a fee under ORS 656.308(2)(d) for prevailing against Liberty's responsibility denial. Claimant neither asserts nor do we find "extraordinary circumstances" warranting an attorney fee in excess of the statutory maximum $1,000 attorney fee. Therefore, after considering the factors set forth in OAR 438-015-0010(4), claimant's counsel is awarded a $500 attorney fee for services on review, payable by Liberty. *See Foster-Wheeler Constructors, Inc. v. Smith*, 151 Or App 155 (1997).

ORDER

The ALJ's order dated September 1, 2000 is modified in part and affirmed in part. For services in obtaining the rescission of Geisy, Greer & Gunn's denials prior to hearing, claimant's attorney is awarded $1,000, payable by GGG. The remainder of the ALJ's order is affirmed. For services on review, under ORS 656.382(2) and ORS 656.308(2)(d), claimant's attorney is awarded $2,000, payable by Liberty Northwest Insurance Corporation.

March 2, 2001 Cite as 53 Van Natta 251 (2001)

In the Matter of the Compensation of
LADDIE R. TOFELL, Claimant
WCB Case Nos. 00-04271 & 00-04270
ORDER ON REVIEW
Mustafa T. Kasubhai, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) found that ORS 656.802 violated the federal Age Discrimination in Employment Act; (2) set aside SAIF's denial of claimant's occupational disease claim for a left medial meniscus tear; and (3) awarded an attorney fee of $5,000. Claimant cross-requests review of that portion of the ALJ's order that found his employment conditions were only a material cause of his left knee condition. We reverse.

FINDINGS OF FACT

Claimant's job duties as a maintenance worker and welder involved heavy lifting, bending, squatting, twisting, crawling and kneeling. He compensably injured his right knee in September 1992. Dr. Balme diagnosed a torn right medial meniscus and performed surgery on September 23, 1992. (Ex. A3). SAIF accepted a disabling bucket-handle tear of the medial meniscus of the right knee. (Ex. A10). Claimant continued to have right knee problems. In May 1994, Dr. Weinman reported that claimant's April 1994 right knee MRI findings reflected a combination of post-surgical degenerative change and/or a recurrent or residual tear. (Ex. A25). An August 18, 1994 Order on Reconsideration awarded 31 percent scheduled disability for loss of use or function of claimant's right knee. (Ex. A26).

Claimant testified that his right knee pain continued and he tried to use his left knee and leg instead. (Tr. 12-13). On December 1, 1999, he sought treatment from Dr. Balme for right and left knee pain. (Ex. B2). A left knee MRI on March 6, 2000 showed a complex tear of the medial meniscus. (Ex. B4). Dr. Balme recommended surgery. (Ex. B5).

Claimant filed a claim for his left and right knee conditions on March 15, 2000.[1] (Ex. B6).

In April 2000, Dr. James examined claimant on behalf of SAIF and issued two reports. (Exs. B13, -14).

In May 2000, Dr. Schmitz treated claimant's knee problems. (Ex. A42). He performed left knee surgery on May 30, 2000. (Ex. B16). His post-operative diagnoses were left knee medial meniscus tear, left knee grade I and II chondral changes of the patellofemoral joint, and diffuse synovitis predominantly about the medial aspect of the knee. (Ex. B16-1).

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[1] In May 2000, SAIF recommended that the Board reopen claimant's right knee claim for Own Motion time loss benefits. (Ex. A45). The right knee claim is not at issue in this proceeding.

SAIF denied claimant's left knee claim on the basis that his work was not the major contributing cause of his left knee condition and his left knee claim did not arise out of and in the course of his employment. (Ex. B15). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Relying on the Age Discrimination in Employment Act (ADEA), 29 USC section 623, the ALJ found that, by applying ORS 656.802, claimant was denied benefits because his employment was only a material and not the major cause of his occupational disease. The ALJ concluded that the occupational disease statute violated the federal statute and, as applied to this case, was invalid. The ALJ determined that the standard of proof was material cause and he relied on Dr. Schmitz' opinion to find claimant's left knee claim compensable. On review, SAIF argues that the ALJ erred by applying a material cause standard and finding the claim compensable.

SAIF relies on *Wantowski v. Crown Cork & Seal*, 164 Or App 214 (1999), and argues that ORS 656.802(2)(a) does not discriminate on the basis of age because all workers, regardless of age, are subject to the major contributing cause standard for occupational diseases. In *Wantowski*, 164 Or App 214 (1999), the claimant filed an occupational disease claim for hearing loss. Among other things, the claimant argued that the Board erred in taking into account his age-related hearing loss, which conflicted with the ADEA. The court rejected that argument:

> "Claimant's hearing loss is treated as a disease under the workers' compensation statutes. Under ORS 656.802(2)(a), '[t]he worker must prove that employment conditions were the major contributing cause of the disease.' Nothing in the statute expressly or implicitly limits the Board's authority to consider the effect of age-related causes in evaluating whether occupational conditions constitute the major cause of a disease." *Id.* at 218.

In *Wantowski*, the court also discussed *Brown v. A-Dec, Inc.*, 154 Or App 244 (1998). In *Brown*, the court rejected the claimant's argument that her degenerative cervical condition could not properly be considered a preexisting condition because, having been caused by the natural process of aging, it was not an "injury" or "disease" that may be considered a preexisting condition under ORS 656.005(24). The court explained that there was nothing in ORS 656.005(24) that evinced an intention to exclude "naturally occurring" conditions from the meaning of the term "disease." *Wantowski*, 164 Or App at 218.

Based on *Wantowski*, we agree with SAIF that there is nothing in ORS 656.802 that limits our authority to consider the effect of age-related causes in evaluating the major contributing cause of an occupational disease.

Furthermore, in *Gary W. Benson*, 48 Van Natta 1161 (1996), we held that we did not have jurisdiction to consider the claimant's ADEA argument. In that case, the claimant argued that the major contributing cause standard in ORS 656.005(7)(a)(B) violated the ADEA because it imposed the "major contributing cause" standard on claimants who suffer from a preexisting degenerative condition. Specifically, the claimant argued that his preexisting degenerative low back condition developed as part of the aging process, and but for his age, he would not have the preexisting condition with which his compensable injury combined. We rejected the claimant's arguments, explaining:

> "29 U.S.C. section 623(a) provides that it is unlawful for an employer to discriminate against any individual because of such individual's age. We conclude, for the reasons articulated in *Sandra J. Way*, [45 Van Natta 876 (1993), *aff'd on other grounds Way v. Fred Meyer, Inc.*, 126 Or App 343 (1994)], that we similarly lack jurisdiction to consider claimant's ADEA challenge. As with the ADA, the Equal Employment Opportunity Commission (EEOC) is the agency responsible for investigating and enforcing the provisions of the ADEA. *See* 29 U.S.C. section 626. To the extent claimant contends the ADEA preempts ORS 656.005(7)(a)(B) or that his employer unlawfully discriminated against him by relying on this statute, we find that claimant's complaint falls within the jurisdiction of the EEOC and/or the courts, but not the Board." *Id.* at 1163.

Here, claimant's argument involves ORS 656.802, the occupational disease statute, rather than ORS 656.005(7)(a)(B). Nevertheless, we reach the same conclusion. Even if we assume that ORS

656.802 somehow limits our authority to consider the effect of age-related causes in evaluating the major contributing cause of an occupational disease, we do not have jurisdiction to address claimant's ADEA argument.[2]

We turn to the merits of claimant's case. To establish a compensable occupational disease claim, claimant must prove that his employment conditions were the major contributing cause of his left medial meniscus tear. *See* ORS 656.802(2)(a). Claimant relies on the opinion of Dr. Schmitz, who performed his left knee surgery.

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). Here, however, the record indicates that Dr. Schmitz apparently examined claimant on only one occasion before performing his left knee surgery. (Exs. A42, B16). Under these circumstances, we find that Dr. Schmitz's opinion is not entitled to any particular deference as a treating physician.

On May 8, 2000, Dr. Schmitz reported to SAIF that he concurred with Dr. James' report about claimant's left knee "diagnosis, findings, test and opinions and discussion." (Ex. A42-2). Dr. James diagnosed a complex tear of the medial meniscus of the left knee, probably degenerative in nature. (Ex. B13-8). Dr. James found that claimant's work activities were only a material cause of his left knee condition and he explained that medical literature did not support work-related conditions as being a significant factor in the development of osteoarthritis or degenerative lesions of the menisci. (Ex. B13-8, -9). Dr. James explained:

> "I feel that his work exposure in regard to his left knee is a material contributing cause but not the major contributing cause to his current left knee condition. Without a specific injury to this knee, we cannot clearly state that his work condition caused his meniscal lesion noted on the MRI. Certainly, his work requirements could have materially contributed to this, but the literature simply does not support occupational environment and conditions, namely that of work at the medium or heavy work category with a bent knee, as a significant risk factor for degenerative conditions of the menisci or the knee." (Ex. B13-10).

In a later concurrence letter from claimant's attorney, Dr. Schmitz changed his opinion. Dr. Schmitz agreed that claimant's complex medial tear was consistent with the cumulative effect of the weight bearing forces involved in his work activities, and in particular because he had been favoring his right knee since the 1992 surgery. (Ex. B19-2). Dr. Schmitz agreed with the following:

> "After considering the relative contribution of [claimant's] age and work activities you opined that while it was a 'close call' in your medical opinion (based both on your expertise and training in orthopedic surgery and clinical experience), the work activities over the last several years brought the pathological changes in the left knee which led to the meniscal tear. The work activities were 51% of the cause of those pathological changes and age was the other contributing cause." (*Id.*)

Dr. Schmitz did not explain the inconsistencies between his concurrence with Dr. James' report and his later concurrence with claimant's attorney's letter. In particular, Dr. Schmitz did not explain why he no longer agreed with Dr. James that the medical literature did not support work-related conditions as being a significant factor in the development of osteoarthritis or degenerative lesions of the menisci. Under these circumstances, Dr. Schmitz's opinion is entitled to little weight. Compare *Kelso v. City of Salem*, 87 Or App 630 (1987) (medical opinion that provided a reasonable explanation for the change of opinion was persuasive). We conclude that Dr. Schmitz's conclusory opinion is insufficient to establish that claimant's employment conditions were the major contributing cause of his left medial meniscal tear.

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[2] On review, claimant argues that ORS 656.802 violates ORS 659.030, which also prohibits age discrimination. Because there is no evidence that claimant raised this issue at hearing, we decline to address it. *See Stevenson v. Blue Cross*, 108 Or App 247 (1991).

Aside from Dr. James' opinion that claimant's work activities were only a material cause of his left knee condition, the only other opinion on causation is from Dr. Balme. On March 31, 2000, Dr. Balme reported that claimant felt his left knee problems were related to his work activities. (Ex. B9). Dr. Balme noted that claimant's work involved repetitive squatting, crawling and twisting and he explained that "in spite of the fact he has had no specific injury to his left knee, *I suspect* that his problem in the left side is related to the demands of his job." (*Id.*; emphasis supplied). Dr. Balme's opinion is not persuasive because it supports only a possibility that claimant's left knee condition was related to his work activities. *See Gormley v. SAIF*, 52 Or App 1055, 1060 (1981) (persuasive medical opinions must be expressed in terms of medical probability). Because there are no other medical opinions that support compensability of the medial meniscus tear as an occupational disease, we reverse the ALJ's order.

We note that claimant also relied on a "consequential condition" theory at hearing, *i.e.*, he argued that his left knee condition was a consequential condition arising out of a right knee injury. The ALJ found that there was no persuasive proof that claimant's left medial meniscal tear was a consequence of the compensable right knee injury. We agree.

To establish a compensable consequential condition under ORS 656.005(7)(a)(A), claimant must prove that the compensable right knee injury was the major contributing cause of the left knee medial meniscal tear. The only opinion that arguably supports compensability under this theory is from Dr. Schmitz. In a concurrence letter from claimant's attorney, Dr. Schmitz agreed that claimant's complex medial tear was consistent with the cumulative effect of the weight bearing forces involved in his work activities, "and in particular because of his favoring of the right knee." (Ex. B19-2). For the reasons discussed earlier, we do not find Dr. Schmitz's opinion persuasive because he did not explain his change of opinion. Moreover, we find that his opinion lacks adequate explanation and is insufficient to establish that claimant's right knee injury was the major contributing cause of his left knee condition.[3] We agree with the ALJ that claimant has failed to establish a compensable consequential condition.

ORDER

The ALJ's order dated October 11, 2000, as reconsidered on October 23, 2000, is reversed in part and affirmed in part. SAIF's denial of claimant's occupational disease claim for a left knee medial meniscal tear is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the ALJ's order is affirmed.

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[3] In light of our conclusion that claimant has failed to establish compensability, we need not address SAIF's argument that the ALJ's attorney fee award was excessive.

March 2, 2001 Cite as 53 Van Natta 254 (2001)

In the Matter of the Compensation of
CALVIN A. KAEO, Claimant
WCB Case No. 00-03730
ORDER OF ABATEMENT
Dale C. Johnson, Claimant Attorney
Julie Masters (Saif), Defense Attorney

On January 31, 2001, we affirmed an Administrative Law Judge's (ALJ's) order that: (1) upheld the SAIF Corporation's denial of claimant's current combined condition; and (2) declined to assess penalties for an allegedly unreasonable denial. Contending that our decision "inadvertently creates more problems and promotes additional litigation," claimant seeks abatement and reconsideration of our order.

In order to consider claimant's contentions, we withdraw our January 31, 2001 order. SAIF is granted an opportunity to respond. To be considered, SAIF's response must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

VAN NATTA'S
WORKERS' COMPENSATION REPORTER
1017 Parkway Drive N.W.
Salem, Oregon 97304
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UPDATE PAGES

ENCLOSED ARE *VAN NATTA'S* PAGES 255-326 WITH WORKERS' COMPENSATION BOARD ORDERS THROUGH MARCH 16, 2001. THESE PAGES SHOULD BE INSERTED INTO YOUR CURRENT *VAN NATTA'S* BINDER, VOLUME 53, JANUARY-MARCH 2001.

In the Matter of the Compensation of
JAMES R. ANDREWS, Claimant
WCB Case No. 99-08705
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of that portion Administrative Law Judge (ALJ) Davis' order that upheld the self-insured employer's denial of claimant's occupational disease claim for a bilateral epicondylitis 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. Williams (an employer-arranged examiner), concluded that claimant had failed to establish the compensability of his bilateral epicondylitis condition. Claimant contends that the opinions of Drs. Ackerman, Greeder, and Nolan establish the compensability of his bilateral epicondylitis. We disagree.

Because claimant seeks to establish the compensability of his bilateral epicondylitis condition as an occupational disease, 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 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. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). Because of the possible alternative causes for his bilateral epicondylitis 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).

Five doctors provided opinions regarding the cause of claimant's epicondylitis problem.[1] The opinions of Drs. Ackerman, Greeder, and Nolan support compensability, while the opinions of Drs. Woodward and Williams do not.[2]

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). 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).

The dispute here centers primarily on the evidentiary weight given a videotape of an individual (not claimant) performing the assembly line functions that claimant asserts caused his epicondylitis. Claimant contends that very little, if any, weight should be given the videotape as it was not personal to claimant. While we agree that the videotape would be more probative if it was personal to claimant, under the circumstances here, we cannot conclude that it has no value to a doctor assessing the cause of claimant's epicondylitis condition.

Here, the videotape does not purport to precisely replicate all of claimant's work functions; it does, however, show the use of the same tools (air wrench and screw gun) that claimant used.[3] (Tr. 29). Therefore, because the videotape reasonably depicts the use of the tools required by claimant's work, and because the record contains medical evidence that the body mechanics required to use those

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[1] The doctors are in agreement that claimant has bilateral epicondylitis, but they disagree over the cause of that condition.

[2] Dr. Ackerman is the attending physician. Drs. Greeder and Nolan are consulting physicians. Drs. Woodward and Williams are employer-arranged examiners.

[3] When asked if there was anything that claimant normally did that was not shown on the tape, he replied: "No, I just do a different system, but it's the same thing." (*Id.*).

tools are not severe enough to cause epicondylitis, we conclude that, in this case, viewing the videotape is a part of the doctors' evaluation of causation. We, therefore, rely upon the following medical opinions regarding the cause of claimant's epicondylitis condition.[4]

As a part of his examination, Dr. Williams took a detailed history from claimant that included claimant's description of drilling, riveting, fastening bolts, attaching fenders, pulling cabs, sanding cabs, using power air wrenches, using power air drills and screw guns. (Ex. 25-7). Based on that description, Dr. Williams opined that the described activities did not produce sufficient loads on the elbow or forearm to be the major cause of claimant's lateral epicondylitis. (*Id.*). After viewing the videotape, Dr. Williams opined: "There is nothing in the video that I reviewed to demonstrate to me a repetitive force placed on the lateral epicondyle or the extensor forearm bundle to produce lateral epicondylitis." (Ex. 26-2). We find his opinion persuasive, based upon both claimant's description of the work activities and the videotape.

In contrast to Dr. Williams, Dr. Ackerman indicated: "Although the activities did not seem unduly stressful, I believe it is conceivable that one could develop lateral epicondylitis from such workplace activities." (Ex. 27-1). In light of those remarks, we find that Dr. Ackerman's causation opinion is based upon a possibility, rather than a medical probability. *See Norma J. Neilsen*, 51 Van Natta 244, 245 (1999) (doctor's comment that it was "very conceivable" that the claimant's work activities "could have contributed" to the claimed medical condition, established only possibility of causal connection between work and the condition). Consequently, we conclude that Dr. Ackerman's opinion is insufficient to meet claimant's burden of proof. *See Gormley v. SAIF*, 52 Or App 1055 (1981) (a claimant must prove more than just a possibility of a causal connection between the work-related accident and the disability to establish compensability).

Claimant's counsel sent Dr. Greeder a copy of the videotape to review and specifically asked if the videotape changed his previously stated opinion of February 9, 2000, that claimant's work was the major contributing cause of the epicondylitis condition. (Ex. 30). Dr. Greeder's short response indicated (without additional explanation) that he continued to adhere to his previous opinion. (Ex. 30-2). The ALJ reasoned that it was not clear that Dr. Greeder had reviewed the videotape because Dr. Greeder failed to refer to the videotape in his response to claimant's counsel's inquiry. (O&O, 5). Regardless of whether Dr. Greeder viewed the videotape, we find his opinion is not sufficiently persuasive to establish the compensability of claimant's epicondylitis condition.

Although Dr. Greeder opined that claimant's work activities were the major contributing cause of the epicondylitis condition, his opinion appears to rest on the fact that claimant's work activities were merely repetitive in nature. (Ex. 26A-2). He offered no explanation or evaluation regarding the work activities ability to place force or stress on the lateral epicondyle or the extensor forearm bundle. Therefore, Dr. Williams' opinion in that regard has not been rebutted. Without such an explanation or comment, we find Dr. Greeder's opinion conclusory and, as such, less persuasive than the opinion offered by Dr. Williams. *See Moe v. Ceiling Systems, Inc.*, 44 Or App 429, 433 (1980).

Accordingly, we agree with the ALJ's conclusion that the medical record does not establish the compensability of claimant's epicondylitis condition.

ORDER

The ALJ's order dated September 13, 2000 is affirmed.

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[4] Of the doctors rendering opinions on causation, only Dr. Williams, Ackerman, and Greeder viewed the videotape.

In the Matter of the Compensation of
TED BRENNER, JR., Claimant
WCB Case No. 00-00233
ORDER ON REVIEW
Kryger, et al, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that determined that claimant's rate of temporary partial disability (TPD) was zero for the periods from December 17, 1999 to December 20, 1999 and from January 7, 2000 to January 20, 2000. The SAIF Corporation cross-requests review of those portions of the ALJ's order that: (1) directed it to pay temporary total disability (TTD) from December 21, 1999 to January 6, 2000; and (2) assessed a 25 percent penalty for SAIF's allegedly unreasonable claim processing. On review, the issues are temporary disability and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Rate of Temporary Disability

On October 13, 1999, claimant, a truck driver for a welding supply company, compensably injured his left arm. Claimant's attending physician authorized TTD on December 10, 1999, but released claimant for modified work on December 14, 1999. The employer offered claimant physician-approved modified work for another employer (Project Advantage), but claimant declined the offer on December 16, 1999.

After another period of total disability, claimant's attending physician released claimant for modified work and the employer offered physician-approved modified work for another employer (S & J Thrift Shop) beginning January 7, 2000. Claimant declined this offer as well.

On or about January 20, 2000, claimant returned to regular work as a truck driver. During the periods that claimant was partially disabled but had declined modified work for employers other than his at-injury employer, SAIF paid TPD at the rate of zero. Claimant requested a hearing seeking temporary disability payments at the TTD rate for the periods in which he declined modified work at alternative work sites, arguing that work at those sites did constitute proper modified employment.

Framing the issue as whether claimant must accept an offer of physician-approved modified work as a "loaned" employee, the ALJ found that claimant must do so. In making this finding, the ALJ reasoned that no statute or administrative rule limits modified employment to the employer at injury. Thus, the ALJ concluded that modified employment may be at an alternative work site and that the at-injury employer may "loan" an injured worker to another employer. Accordingly, the ALJ held that claimant was entitled to TPD at the rate of zero for those periods in which he was released for modified work but declined such work at alternative work sites for other employers.

On review, citing the legislature's use of the word "return" in ORS 656.268(4), and *Christine M. Mulder*, 50 Van Natta 521 (1998), and *Douglas B. Organ*, 49 Van Natta 198 (1997), claimant contends that the ALJ incorrectly determined that his TPD rate was zero. Claimant asserts that modified work for other employers provided no benefit to his at-injury employer and that this work was not related in any way to the work he performed for the employer at injury, a welding supply company. Claimant argues that this employment does not constitute appropriate modified employment. We disagree.

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. *See generally Anthony R. Holder*, 50 Van Natta 1760 (1998). Here, the issue is whether the modified work offered to claimant qualifies as "modified employment" within the meaning of ORS 656.268(4)(c).

Focusing first on claimant's statutory construction argument, the word "return" is not defined in chapter 656. Therefore, we turn to the text and context of the statute. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-11 (1993). The word "return" is a term of common usage that should be given its "plain, natural, and ordinary meaning." *See PGE*, 317 Or at 611.

As a verb, "return" means: "to bring, send, or put (a person or thing) back to or in a former position" or "to restore to a former or to a normal state." *Webster's Third Int'l Dictionary*, 1941 (unabridged ed. 1993) (usage examples omitted). Thus, based on the dictionary definition of "return," use of that term means to bring a person (the claimant in this context) back to or in a former position or restore the person to a former or normal state. This could, as claimant contends, mean that he must be returned to his former position or normal state, *i.e.*, his employment at injury.[1]

However, "return" refers to the phrase "modified employment" in ORS 656.268(4)(c) and the phrase "regular or modified employment" in ORS 656.268(4)(a). There is no dispute that the employment offered claimant was "modified" from what he performed as part of his "regular" employment as a truck driver. Moreover, claimant does not contend that the employment offered him did not involve services in exchange for remuneration subject to the direction and control of "an" employer. Thus, we conclude that the modified work offered claimant was "employment." *See* ORS 656.005(30) (defining "worker" as any person who engages to perform services for a remuneration subject to the direction and control of "an employer").

Therefore, having reviewed the text and context of ORS 656.268(4)(c), we conclude that provision does not necessarily require that claimant "return to modified work" for the employer at injury. In addition, the cases cited by claimant do not require a different result.

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.

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 Project Advantage was not part of a training program, but rather consisted of actual work raising money for charities over the telephone, greeting people, stuffing envelopes, folding flyers and performing office cleaning duties. At S &J Thrift Center, claimant's modified work was also not part of a training program, but rather claimant was to perform work as a customer service associate, which included sorting donations, reorganizing books, organizing clothes on racks, greeting customers and operating a cash register. In addition, vocational evidence was admitted into evidence that indicated that the modified work offered claimant was legitimate employment. (Ex. 29AA-4).

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. 51, 53, 70, 82). Furthermore, the

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[1] On the other hand, when claimant was released for modified work, he had not previously performed modified work. Therefore, he arguably could not be brought to a former position or restored to a former or a normal state. In light of this, we believe it makes more sense to consider the broader statutory context, rather than to focus entirely, as claimant does, on the word "return."

employer's controller testified that modified work, such as what was offered claimant in this case, assists the employer because injured workers who come back to work sooner are more easily reintegrated into the workforce. (Tr. 54).

Under these circumstances, we conclude that the modified work offered to claimant at alternative work sites was appropriate "modified employment" and that the ALJ correctly determined that claimant's TPD rate was "zero." Thus, we affirm that portion of the ALJ's order.

SAIF's Cross Request

The ALJ directed SAIF to pay TTD from December 21, 1999 to January 6, 2000 and assessed a 25 percent penalty for its failure to pay temporary disability during that period. SAIF alleges, however, that the only issue at hearing was the appropriateness of the alternative work sites and, thus, that the ALJ incorrectly decided issues regarding claimant's entitlement to TTD during the above period and to a penalty.

Claimant does not dispute SAIF's description of the issue and specifically agrees that the only issue was the appropriateness of the alternative work sites. Under such circumstances, we reverse the ALJ's award of TTD during the period from December 21, 1999 to January 6, 2000, as well as a penalty assessment. *See Jeffrey D. Ward*, 45 Van Natta 1513 (1993) (ALJ's review limited to issues raised by the parties).

ORDER

The ALJ's order dated July 19, 2000 is reversed in part and affirmed in part. Those portions of the ALJ's order that awarded TTD from December 21, 1999 to January 6, 2000 and assessed a 25 percent penalty are reversed. The ALJ's "out-of-compensation" attorney fee is also reversed. The remainder of the ALJ's order is affirmed.

Board Members Phillips Polich and Biehl dissenting.

The majority concludes that modified work offered to claimant at alternative work sites was appropriate "modified employment" and that the ALJ correctly determined that claimant's TPD rate was "zero." Because we disagree with the majority's conclusions, we dissent.

Claimant asserts that the offers of alternative modified work were extended with nothing more in mind than to give him compelling reasons to quit so that temporary disability obligations would cease. As we view this record, we are hard pressed to disagree. Claimant, a truck driver able to transport hazardous materials for a welding supply company, was required by his "modified employment" to raise money over the telephone for a now-defunct company and later to work as a customer service associate for a thrift store, performing duties such as sorting donations, reorganizing books, organizing clothes on racks, greeting customers and watching for shoplifters. Considering that this work was not remotely relevant to his at-injury work and was to be performed for employers other than the at-injury employer, we can certainly understand why claimant believed this "modified employment" was unsuitable.

Moreover, we are persuaded by claimant's argument that the legislature's use of the word "return" in ORS 656.268(4) indicates that it was the legislature's intent that an injured worker be returned to his employment at injury. Black's Law Dictionary (6th ed. 1990) defines "return" to mean "[t]o bring, carry or send back; * * * 'return' means that something which has had a prior existence will be brought or sent back." The majority's definition of "return," gleaned from another dictionary, is very similar. Considering the plain meaning of the word "return," it is reasonable to conclude that the legislature intended that an injured worker be returned to his employment at injury.

Finally, the "modified employment" offered claimant provided no more than minimal benefit to the at-injury employer and provided with claimant with no job skills relevant to his regular job.[1] Unlike the majority, we would find *Douglas B. Organ*, 49 Van Natta 198 (1997), controlling and conclude that the "modified employment" offered claimant was not legitimate. Because the majority reaches the opposite conclusion and approves the highly questionable practice of "loaning" injured workers to other employers, we must dissent.

[1] Apart from these concerns, we are also troubled by other issues that could arise when modified work is performed at alternative work sites. Most importantly, there is the question of employer control of the work area. It is unclear which employer (the at-injury employer or the alternative-work site employer) would be responsible should claimant injure himself while performing modified work. Although these concerns are not directly at issue in this case, to us, they provide an additional reason to reject the majority's reasoning in this case.

March 5, 2001 Cite as 53 Van Natta 260 (2001)

In the Matter of the Compensation of
LEWIS C. LYONS, Claimant
WCB Case No. 00-07406
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that determined that claimant's rate of temporary partial disability (TPD) was zero effective May 4, 2000. On review, the issue is temporary disability.

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

On May 2, 2000, claimant compensably injured his right foot.[1] (Ex. 2). He was treated that day by Dr. Watson and released for modified work. (Ex. 5). The work restrictions as of that date were for a "sit-down job only with ability to elevate his leg at all times while working." (*Id.*)

Also on May 2, 2000, the employer offered and claimant accepted modified employment as a "market researcher" beginning on May 4, 2000.[2] (Ex. 4). A description of the modified employment had been reviewed and approved by Dr. Watson. (Ex. 6A).

The job at injury was located in Eugene, close enough to claimant's home that he used a bicycle for transportation to and from work.[3] The modified employment was located in Springfield. Because of the injury, claimant was precluded from riding his bicycle. (Tr. 32). Additionally, claimant felt precluded from using public transportation because he was supposed to keep his foot elevated, and putting his foot down caused pain. (Tr. 33). Consequently, claimant did not report for modified work as scheduled. As a result, SAIF did not pay temporary disability benefits.

The ALJ determined that while the doctor's restrictions limited claimant's transportation options, those restrictions (absent the transportation issues) did not prevent claimant from performing the modified job as offered by the employer. Consequently, the ALJ determined that claimant's TPD rate was zero effective May 4, 2000.

[1] The claim was accepted on May 5, 2000 as a nondisabling "fracture of the second, third and fourth metatarsals right foot." (Ex. 9).

[2] The modified employment was for the hours of 8:30 AM to 5:00 PM, Monday through Friday. The wage was to be $7.50 per hour (the same as the job of injury). (Ex. 4; Tr. 33).

[3] At the time of the injury, claimant did not own a car or have a driver's license. (Tr. 31).

Claimant contends that the physical restrictions from the compensable injury prevented him from getting to the location of the modified job. Hence, claimant argues he should be entitled to TPD benefits at the rate of TTD benefits. We disagree.

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, claimant was offered and accepted a modified job that had been approved by the attending physician. When claimant failed to begin the modified employment, SAIF was entitled to cease paying TTD and begin paying TPD. Because the wages for the modified job was the same as the job at injury, claimant's TPD rate is zero. *See* OAR 436-060-0030(5)(a).

We acknowledge that claimant had some transportation problems that interfered with his ability to get to the modified employment. Nonetheless, we have previously held that a limitation on driving or the need for transportation to the job location is not a work-related restriction because it does not pertain to matters directly affecting claimant's performance of the modified job while on the work site. *See Paul H. McNeil,* 51 Van Natta 711 (1999); *Robert E. Dixon,* 48 Van Natta 46 (1996); *Rhonda Stockwell,* 46 Van Natta 446 (1994).

Here, claimant's restrictions affected his ability to get to the place of his modified work, but did not otherwise affect his ability to physically perform the modified work. Consequently, we conclude that SAIF was entitled to cease paying TTD and begin paying TPD as described in OAR 436-060-0030(5). Accordingly, we agree with the ALJ that claimant's TPD rate was zero effective May 4, 2000.

ORDER

The ALJ's order dated November 3, 2000 is affirmed.

Board Member Biehl concurring.

Were I deciding this case with a clean slate, my resolution of this issue would be different. In my view, it makes no sense to ignore the physical requirements of getting to the job site in the ultimate determination of whether an injured worker can perform a modified job. Nonetheless, I am compelled by the principles of stare decisis to follow the Board's previous holdings in *Paul H. McNeil,* 51 Van Natta 711 (1999); *Robert E. Dixon,* 48 Van Natta 46 (1996); *Rhonda Stockwell,* 46 Van Natta 446 (1994). Consequently, I affirm the ALJ's order.

In the Matter of the Compensation of
KATRINA S. MACLAUGHLAN, Claimant
WCB Case No. 99-06376
ORDER ON REVIEW
Lawrence A. Castle, Claimant Attorney
Scheminske, et al, Defense Attorney

Reviewed by Board Members Biehl and Meyers.

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

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant began working at the employer's manufactured home facility in 1998.

On March 3, 1999, claimant was experiencing low back, right flank, and abdominal pain, due to an undiagnosed kidney infection. She fell at work that day, landing on her buttocks and back, and experienced immediate additional low back pain. Despite her abdominal and low back pain, claimant was able to finish working her shift and work at least three full days thereafter.

On April 1, 1999, claimant sought treatment for ongoing pain. Dr. Smucker diagnosed pyelonephritis (a kidney infection) and took claimant off work.

Claimant took a 30-day leave of absence from work. During that time, the kidney infection resolved with treatment, but claimant's low back symptoms increased.

An April 27, 1999 MRI disclosed an L5-S1 herniated disc.

Claimant filed an injury claim for her low back condition on April 30, 1999. The employer denied the claim and claimant requested a hearing.

The ALJ set aside the employer's denial. We reach the opposite result, based on the following reasoning.

Claimant bears the burden of proving that the claimed March 3, 1999 injury was a material cause of her low back condition. ORS 656.005(7)(a). Because of the multiple possible causes of claimant's need for treatment,[1] and considering the passage of time since the injury,[2] we find that this case presents a complex medical question that depends on expert medical analysis for its resolution. *See Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279 (1993). Accordingly, claimant's lay testimony is "probative but not dispositive." *See Moe v. Ceiling Systems*, 44 Or App 429, 433 (1980).

Drs. Smucker, Keenan, Sotta, Rich, and Marble treated or examined claimant after she fell at work on March 3, 1999. Neither Dr. Sotta nor Dr. Keenan, treating surgeon, expressed an opinion about the cause of claimant's disc herniation. Drs. Rich and Marble stated that they had "no reason [] to dispute [claimant's] description of her slip-and-fall," and the incident "*could have* produced some damage to her L5-S1 disc." (Ex. 30-6, *emphasis added*). Dr. Smucker opined that claimant's pyelonephritis "could" have masked some of her low back pain. (Ex. 34). *See Gormley v. SAIF*, 52 Or App 1055 (1981) (medical opinion expressed as mere possibility insufficient to prove claim).

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[1] Claimant had low back pain due to a preexisting kidney infection that could have "masked" symptoms of her lumbar disc condition. (*See* Ex. 34). She also had a painful lipoma on her right upper buttock. (Ex. 16-1).

[2] Claimant's medical records do not mention the claimed March 3, 1999 incident for almost two months. (*See* Ex. 16).

Thus, the medical reports indicate that claimant related her back pain to her fall at work and there is evidence that claimant's fall at work *could* have caused her disc condition. However, no doctor expressly attributed claimant's low back condition to a fall at work (or concluded that the fall caused the condition if her history was truthful).

As we have explained, claimant's testimony is insufficient to prove this medically complex case. *See, e.g., Moreno v. Menlo Logistics*, 171 Or App 675, 676 (2000). Accordingly, because no doctor relates claimant's disc condition to the work injury (except as a mere possibility), we conclude that the claim must fail.[3] Consequently, we reverse the ALJ's order.

ORDER

The ALJ's order dated August 21, 2000 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[3] Medical certainty is not required. *Robinson v. SAIF*, 147 Or App 157, 160 (1997). Instead, a preponderance of evidence may be shown by medical probability. *Gormley v. SAIF*, 52 Or App at 1060.

In the Matter of the Compensation of
GREGORY McKEEN, Claimant
WCB Case No. 00-05221
ORDER ON REVIEW
Kryger, et al, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the SAIF Corporation's denial of claimant's claim for a C6-7 disc condition. On review, the issue is compensability.

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

Claimant relies upon the opinions of Drs. Dorsen and Throop to establish compensability of his C6-7 disc condition. We are unpersuaded by the opinions of Dr. Dorsen and Dr. Throop. In this regard, both physicians attributed claimant's problems to a herniated disc at C6-7. However, based upon Dr. Dorsen's operative report and Dr. Courogen's review of the operative report, it does not appear that a herniated disc existed at C6-7.

In addition, Dr. Dorsen believed that claimant had no preexisting conditions. (Ex. 26A). However, the remainder of the medical evidence suggests the existence of at least some preexisting degenerative disease in the cervical spine. (Exs. 9; 13; 19). Moreover, given that the operative report does not appear to support the existence of a disc herniation, Dr. Dorsen's opinion (Ex. 26A) that claimant's C7 radiculopathy secondary to a disc herniation is compensable is conclusory and unexplained. *See Moe v. Ceiling Systems, Inc.*, 44 Or App 429, 433 (1980).

In addition, Dr. Throop had apparently not seen Dr. Dorsen's surgical findings at the time he rendered his opinion regarding the cause of claimant's condition. (Ex. 26). Thus, we are not persuaded that he based his opinion upon a complete history. At best, the medical opinions from Dr. Throop and Dr. Dorsen are confusing regarding the nature of claimant's condition and its relationship to the injury.

ORDER

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

In the Matter of the Compensation of
ROXANNE M. RUHL, Claimant
WCB Case No. 00-04178
ORDER ON REVIEW
Mustafa T. Kasubhai, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order set aside its denial of claimant's occupational disease claim for a right shoulder tendinitis condition. On review, the issue is compensability.

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

The ALJ first determined that claimant's tendinitis condition was an occupational disease. Then, relying upon the opinion of Dr. Wenner, a consulting orthopedist, the ALJ concluded that claimant had established the compensability of the tendinitis condition.

On review, the employer argues that claimant's symptoms had a sudden onset in the summer of 1998, and thus the right shoulder condition is an injury, not an occupational disease.[1] The employer also contends that Dr. Coletti's (an employer-arranged examiner) opinion persuasively establishes that claimant's shoulder condition is the result of a preexisting instability problem. We disagree.

The distinction between occupational diseases and occupational injuries is usually drawn along the lines that occupational diseases are gradual rather than sudden in onset. *Fuls v. SAIF*, 321 Or 151 (1995); *Mathel v. Josephine County*, 319 Or 235, 240 (1994); *James v. SAIF*, 290 Or 343, 348 (1981); *Weyerhaeuser v. Woda*, 166 Or App 73, 79-80 (2000).

Here, claimant had some initial pain symptoms after lifting freight in the summer of 1998. (T. 12; Ex. 6). Claimant did not seek medical attention at that time, but chose instead to self medicate with ibuprofen. (Tr. 13). After a couple of weeks of the ibuprofen therapy, claimant felt fine. (*Id.*). A few months thereafter, the pain began again and progressively worsened such that claimant eventually sought medical treatment from Dr. Ross in January 2000. (Tr. 13, 14; Ex. 1). Such a history establishes that the condition is gradual in onset. Consequently, we conclude that claimant's shoulder condition should be analyzed as an occupational disease rather than as an injury.

Claimant seeks to establish the compensability of the tendinitis condition as an occupational disease. Therefore, she must prove that her 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. *Stacy v. Corrections Div.*, 131 Or App 610, 614 (1994); *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). 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).

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[1] The employer alleges that claimant did not give notice of an accident resulting in injury within 90 days of the onset of her arm pain as required by ORS 656.265(1), and that therefore, the claim is time barred pursuant to ORS 656.265(4). (Ex. 12). Because we agree with the ALJ that the claim is for an occupational disease, the applicable claim filing requirements are set forth in ORS 656.807(1). Inasmuch as claimant was informed by a physician that she was suffering from a work related condition on January 20, 2000, her claim (which was filed on January 26, 2000) was timely. (Ex. 1-2; 3).

The record contains the opinions of only two doctors regarding the cause of claimant's shoulder condition. One opinion is from Dr. Wenner, a consulting orthopedist. The other opinion is from Dr. Coletti, an employer-arranged examiner. Dr. Wenner's opinion supports compensability, while Dr. Coletti's opinion does not.[2]

Dr. Wenner opined that the major contributing cause of claimant's tendinitis condition (an inflammation of tendons and supporting structures of the shoulder) was her work activities which involve overhead lifting.[3] (Ex. 13). In rendering his opinion, he considered claimant's history, her preexisting multidirectional shoulder instability, and the MRI findings of testing performed in April 2000. (*Id.*). Because of its thoroughness, we find Dr. Wenner's opinion well reasoned and persuasive.[4]

The employer contends that Dr. Wenner's opinion is not persuasive because it is based upon an incomplete understanding of claimant's work activities. Specifically, the employer asserts that claimant's work activities were not as strenuous as Dr. Wenner assumed.[5] We disagree.

Dr. Wenner reported that: (1) claimant began noticing pain in her right shoulder over a year ago while lifting items overhead at work; (2) claimant noticed the pain increasing and becoming worse when she was working on the employer's loading dock; and (3) when claimant first sought medical treatment she was performing duties on the loading dock. (Ex. 13-1).

Claimant's supervisor testified that: (1) prior to October 1999, claimant would work two freight shifts per month; (2) starting in October 1999, the frequency of claimant's freight shifts (each shift is 8 hours) increased to one to two per week; (3) in January 2000, the frequency of claimant's freight shifts increased to two to three per week; (4) a freight shift is labor intensive and fast paced with a worker's objective to "cut" (unstock) 60 cases an hour; and (5) the excess stock is placed on racks, the top shelf of which is 8 feet high.[6] (Tr. 30, 33-35). The supervisor's testimony is not incompatible with Dr. Wenner's understanding of claimant's work. Consequently, we disagree with the employer's assertion that Dr. Wenner had an inadequate understanding of the physical nature of claimant's work.

In contrast to Dr. Wenner, Dr. Coletti did not diagnose tendinitis, but rather opined that claimant's shoulder problem was entirely due to a preexisting multidirectional instability. (Ex. 11-4). However, unlike Dr. Wenner, Dr. Coletti did not review the MRI nor the accompanying report by Dr. Tamplen before rendering his opinion.[7] (Ex. 11-2). Under such circumstances, we conclude that Dr.

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[2] We acknowledge the employer's argument that Dr. Ross offered an opinion which supports the opinion of Dr. Coletti. However, we disagree with the employer's interpretation of Dr. Ross' writings. While Dr. Ross did indicate he agreed with Dr. Coletti's findings of shoulder instability, he also indicated that claimant had tendinitis. (Ex. 9, 14, 15). Moreover, Dr. Ross did opine that claimant's work precipitated the shoulder condition. (Ex. 14; 15). Consequently, we do not find that Dr. Ross's overall opinion necessarily supports the opinion of Dr. Coletti.

[3] Although Dr. Ross, the attending physician, did not offer an opinion on causation, he did opine that claimant was suffering from "supraspinatus tendonitis," a diagnosis he felt was confirmed by MRI. (Ex. 9).

[4] The employer suggests that pursuant ORS 656.802(2)(b), claimant must prove a "pathological worsening" of her shoulder instability problem in order to establish the compensability of her tendinitis condition. We disagree. Claimant is not attempting to establish the compensability of her shoulder instability problem; rather, she is attempting to establish the compensability of a tendinitis condition. (Respondent's Brief, 4). Hence, ORS 656.802(2)(b) does not apply, and claimant need not prove a "pathological worsening" of that condition. *See Michael D. Cessnun*, 51 Van Natta 1737 (1999). Based upon Dr. Wenner's opinion, which we find persuasive, we conclude that claimant's tendinitis condition is compensable.

[5] The employer states that Dr. Coletti and Dr. Ross shared the same misunderstanding of claimant's work activities. (Appellant's Brief, 9).

[6] Claimant is 5' 3" tall. (Tr. 36). Claimant estimated that 40 percent of her freight duties required overhead lifting. (Tr. 37).

[7] As reported by Dr. Tamplen, the MRI shows "possible tendinitis at the insertion site of the supraspinatus tendon." (Ex. 8).

Coletti is not in as advantageous a position as Dr. Wenner to render an opinion regarding the nature and cause of claimant's shoulder condition. Accordingly, we do not find Dr. Coletti's opinion as persuasive as Dr. Wenner's opinion.[8]

Based upon the opinion of Dr. Wenner, which we find to be the most persuasive in this record, we conclude that claimant has established the compensability of her right shoulder tendinitis condition as an occupational disease.

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 insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated October 10, 2000 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the employer.

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[8] The employer asserts that Dr. Wenner's opinion as expressed in Exhibit 13 represents an unexplained change of what appears in his chart note in Exhibit 12A. In particular, the employer argues that the Exhibit 12A indicates that work merely caused the need for treatment of the tendinitis, whereas Exhibit 13 states that work caussed the tendinitis. Again, we disagree with employer's contention.

Exhibit 12A is a chart note entry documenting that Dr. Wenner and claimant's counsel had a telephone conversation regarding claimant's condition. As a part of that chart note entry, Dr. Wenner very briefly listed the various aspects of that conversation. In contrast, Exhibit 13 is a two page letter setting forth in detail Dr. Wenner's opinion and the items he considered in arriving at that opinion. Under these circumstances, we are not persuaded that the differences between the two documents, to the extent that there are any, equate to unexplained inconsistencies rendering Dr. Wenner's opinion unpersuasive.

In the Matter of the Compensation of
MARVIN H. BENZ, Claimant
WCB Case No. 98-04562
ORDER ON REMAND
Swanson, Lathen, et al, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *Benz v. SAIF*, 170 Or App 22 (2000). The court has reversed our prior order, *Marvin H. Benz*, 51 Van Natta 288 (1999), that had upheld the SAIF Corporation's denial of claimant's occupational disease claim for a bilateral hearing loss condition. In reaching our conclusion, we had found that an unrebutted physician's opinion (which had supported a connection between claimant's employment exposures and his hearing loss) was not persuasive because it was based on an inaccurate work history. Determining that our decision that claimant had no history of exposure to harmful noise levels at his previous employment exposures was not a reasonable inference that could be drawn from the available medical evidence, the court held that substantial evidence did not support our conclusion that "claimant's testimony and the history he gave Audiologist Rheinfelder and Ediger do not support Frink's assumed history of exposure to harmful noise levels." Consequently, the court has remanded for further consideration.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant, an electrician, filed a claim for bilateral hearing loss, which was denied by SAIF. Claimant requested a hearing. The ALJ upheld SAIF's denial, finding claimant's treating audiologist Mr. Frink's opinion unpersuasive.

On review, we affirmed the ALJ's order based on different reasoning from that expressed by the ALJ; *i.e.* that Mr. Frink had an inaccurate history of claimant's work activities. The court reversed our order, holding that our finding regarding Mr. Frink's inaccurate work history was not supported by substantial evidence. On remand, we proceed with our review.

In our original order, we affirmed the ALJ's order on an alternative basis; *i.e.*, that Mr. Frink's opinion rested on an inaccurate work history. However, the ALJ had rejected Mr. Frink's opinion based on questions regarding Mr. Frink's methodology and reasoning. Specifically, the ALJ noted that Mr. Frink's opinion rested on the speculative assumption that claimant had a noise-induced "notching" pattern to his hearing loss at age 40. The ALJ also found that Mr. Frink's opinion improperly discounted claimant's preexisting presbycusis condition, contrary to Board caselaw. *See Henry F. Downs*, 48 Van Natta 2094 (1996). Accordingly, questioning Mr. Frink's methodology and the legal sufficiency of his opinion, the ALJ discounted Mr. Frink's conclusion that claimant's work exposure was the major contributing cause of his hearing loss condition.

On remand, in lieu of our prior decision, we adopt the ALJ's reasoning regarding the relative persuasiveness of Mr. Frink's opinion based on his faulty methodology and reasoning. We supplement the reasoning as follows.

In order to establish this claim as an occupational disease, claimant must prove that his work exposure was the major contributing cause of his bilateral hearing loss condition. ORS 656.802(2)(a). 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, 263 (1986).

Here, we find that Mr. Frink's opinion as to the effect of time on claimant's "notched" pattern of hearing loss rests on speculation and thus is unpersuasive. Mr. Frink opined that claimant's continued exposure to noise after age 40 (he was 62 at the time of hearing) "flattened" the demarcations on either side of the "notch" and made them less discernible. (Ex. 15-3). However, the record contains no evidence of claimant's pattern of hearing loss at age 40. We find Mr. Frink's opinion on this issue speculative and therefore unpersuasive.

Moreover, we find that Mr. Frink did not properly consider claimant's preexisting "presbycusis" (age-related hearing loss) condition. In *Henry F. Downs*, 48 Van Natta 2094, 2096 (1996), we stated that "Claimant is not permitted to extract a portion of the disease (hearing loss) and claim that only that portion is caused in major part by work exposure. Pursuant to ORS 656.802(2)(a), claimant must prove that the major contributing cause of his overall hearing loss was work-related noise exposure." *See also Philip Taylor*, 51 Van Natta 898 (1999).

Here, Mr. Frink acknowledged that presbycusis is "a factor" in claimant's overall hearing loss. (Ex. 15-5). This case is therefore distinguishable from *Downs*, where the claimant attempted to seek compensation only for the noise-induced portion of his hearing loss, after subtracting for presbycusis. 48 Van Natta at 2095.

However, Mr. Frink discussed claimant's work exposure in terms of a percentage of the cause of claimant's hearing loss in comparison to a bilateral 100-decibel deduction for presbycusis (as determined by claimant's age and OAR 436-035-0250). (*See* Ex. 15-5, -6). We agree with SAIF that the 100-decibel deduction for presbycusis is applicable only at the extent of permanent disability stage; *i.e.*, after the claim has been determined compensable. *See* OAR 436-035-0250. Because the disputed issue pertains to the compensability of claimant's hearing loss claim, we consider this basis for Mr. Frink's opinion also to be poorly reasoned and unpersuasive.

Consequently, we find that claimant has not met his burden of proving the compensability of his bilateral hearing loss condition based on Mr. Frink's opinion. ORS 656.266. Accordingly, on remand, the ALJ's order dated October 5, 1998 is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
GENE L. GRENZ, Claimant
WCB Case No. 00-04240
ORDER ON REVIEW
Brian L. Pocock, Claimant Attorney
Meyers, Radler, et al, Defense Attorney

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

The self-insured employer requests review of Administrative Law Judge (ALJ) Howell's order that: (1) admitted "post-reconsideration" documents into evidence; (2). set aside an Order on Reconsideration that awarded no permanent disability; and (3) remanded the claim to the Director. On review, the issues are the ALJ's evidentiary ruling, extent of scheduled permanent disability, and (potentially) remand. We reverse and reinstate the Order on Reconsideration.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant filed an occupational disease claim for tinnitus and hearing loss that the employer initially denied. After a prior ALJ set aside the denial, the employer accepted the claim, which was closed by a December 1999 Determination Order. That order did not award any permanent disability.

Claimant requested reconsideration, including promulgation of a "special rule" to cover his hearing loss condition. As part of the reconsideration proceedings, a medical arbiter examination was performed by Dr. Scott. Dr. Scott found that claimant had noise-induced hearing loss in the right ear due to his employment.

On May 5, 2000, an Order on Reconsideration issued. The Appellate Review Unit (ARU) rejected claimant's request for a temporary rule, finding that the "standards" addressed claimant's disability due to the accepted right ear hearing loss and tinnitus. (Ex. 5-3). In addition, the reconsideration order made no award of scheduled permanent disability. In declining to award permanent disability, ARU determined that claimant had 155 decibels of hearing loss, but, after deducting 93 decibels for presbycusis (age related hearing loss) pursuant to OAR 436-035-0250(4)(c), found that the remaining level of hearing loss (62 decibels) did not reach the minimum threshold level (151 decibels) for an award of permanent disability. *Id.*

Claimant requested a hearing and offered into evidence proposed Exhibits A through E, 3A, and 6 through 10. The employer objected to the admission of these exhibits, with the exception of 3A, on the ground that they were not submitted during the reconsideration proceedings. Claimant conceded that the disputed exhibits were not part of the reconsideration proceedings, but argued that they should nevertheless be admitted.

The ALJ agreed with claimant. Noting that, while *former* ORS 656.283(7) had provided that evidence not submitted at reconsideration on an issue regarding a Notice of Closure or a Determination Order was not admissible at hearing, the ALJ observed that the legislature in 1999 had removed the words "determination order" from the current version of ORS 656.283(7). Thus, the ALJ reasoned that the evidentiary restrictions in ORS 656.283(7) did not apply to Determination Orders, such as the one that had closed this claim. Therefore, the ALJ admitted the disputed exhibits.

Turning to the permanent disability issue, the ALJ agreed with the reconsideration order's conclusion that claimant was not entitled to scheduled permanent disability under the "standards." The ALJ, however, agreed with claimant that OAR 436-035-0250 was invalid.

The ALJ reasoned that the record as a whole established that claimant's right ear hearing loss in excess of presbycusis was compensable noise-induced hearing loss, noting that no other cause for the hearing loss had been identified. The ALJ then determined that OAR 436-035-0250 was contrary to ORS 656.214(2)(f), because the rule failed to award permanent disability in proportion to the ratio of the compensable monaural hearing loss to normal hearing. Because there was no valid standard by which claimant's permanent disability could be determined, and lacking the authority to adopt such a standard, the ALJ remanded the claim to the ARU for adoption of a standard or amendment of an

existing standard so that claimant's permanent disability could be evaluated consistent with ORS 656.214(2)(f).

On review, the employer contends that the ALJ incorrectly admitted the disputed exhibits and determined that OAR 436-035-0250 was invalid. We need not decide, however, whether the ALJ improperly admitted the "post-reconsideration" evidence. That is, even if we considered the disputed exhibits, we would still conclude that the reconsideration order correctly determined that, under OAR 436-035-0250, claimant was not entitled to scheduled permanent disability for his hearing loss.

The Director has broad authority to adopt disability standards pursuant to ORS 656.726(3)(f)(A). *See Schultz v. Springfield Forest Products*, 151 Or App 727 (1997) (so long as Director prescribed a method within the delegation by the legislature, Board may not substitute its own judgment regarding the method of computation). In *Milan F. Shubert*, 47 Van Natta 1297 (1995), pursuant to the Board's order remanding the claim, the Director promulgated a temporary rule to address a surgical procedure but, after applying the rule, found that claimant was not entitled to an impairment value for the surgery. We found that the Hearings Division and Board lacked jurisdiction to declare a temporary rule invalid and that our review was limited to applying the Director's "standards." *Id.* at 1298. We also noted that the Director's action was not inconsistent with ORS 656.726(3)(f)(C) since "not all impairment necessarily results in a worker receiving an impairment value under the 'standards.'" We specifically noted that a worker is not entitled to an impairment value for all range of motion losses. Rather, the lost range of motion must meet the requisite level established by the Director's "standards." *Id.*

Likewise, in this case, there is no dispute that claimant has hearing loss after the deduction of prebycusis. However, that residual hearing loss does not meet the threshold level for impairment under the relevant standard. In accordance with our reasoning in *Shubert*, we again recognize the principle that not all impairment results in an impairment value under the disability standards.[1]

Indeed, we recently applied this principle in *Scott D. Dorry*, 52 Van Natta 2178 (2000), *on recon* 53 Van Natta 27 (2001). In that case, the ARU made an express finding that the claimant's disability relating to his "right facial nerve, frontal zygomatic branch" condition was addressed by the standards. Nevertheless, the claimant contended that the standards did not address his motor loss attributable to the right facial nerve.

We agreed with the ARU that the claimant's impairment was addressed by the existing standards. We also noted that the applicable administrative rule provided a value for "complete" motor loss on either side of the face. *See* OAR 436-035-0390(6). Because the standard contemplated the "complete" motor loss on either or both sides of the face, we reasoned that, by implication, any impairment of the facial nerve that was less than "complete" was addressed by the standards, but did not meet the level required for an impairment value. Because there was no evidence that the claimant's facial nerve loss was "complete" on either or both sides of the face, the threshold for impairment contemplated by the administrative rule was not satisfied. 52 Van Natta at 2180.

Likewise, in this case the "standards" do address the impairment due to claimant's hearing loss. However, as was true in *Dorry*, claimant's hearing loss after deduction of presbycusis does not meet the threshold for impairment contemplated by the administrative rule. Thus, the reconsideration order properly declined to award scheduled permanent disability.[2]

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[1] We acknowledge that our decision in Shubert was ultimately reversed in *Shubert v. Blue Chips*, 330 Or 554 (2000). In that case, the Supreme Court held that a temporary rule, which does not address the claimant's personal circumstances, is "unresponsive as a matter of law" and contrary to ORS 656.726(4)(f)(C). 330 Or at 561. The Court specifically stated that "[i]f the Director finds that a worker suffers from an impairment that results in disability and that disability is not addressed by existing standards, then the Director must promulgate a rule that addresses the worker's particular impairment." *Id* at 560-561. However, the court agreed that the Director could adopt a temporary rule that assigns an impairment value of zero. Thus, while the *Shubert* court reversed our decision, it did so on other grounds and did not reject our reasoning that not all impairment results in an impairment value under the "standards."

[2] The "post-reconsideration" evidence submitted by claimant questions the scientific validity of the administrative rules pertaining to the rating of hearing loss and the method of deducting presbycusis values. Nevertheless, because the Director is given broad discretion to adopt disability standards pursuant to ORS 656.726(3)(f)(A), we decline to substitute our judgment regarding the method of computing hearing loss for the Director's. *See Hadley v. Cody Hindman Logging*, 144 Or App 157, 160 (1996) (so long as the Director prescribed a method that is within the delegation by the legislature, neither the court nor the Board may substitute its own judgment regarding the method of computation).

ORDER

The ALJ's order dated November 9, 2000 is reversed. The May 5, 2000 Order on Reconsideration is reinstated and affirmed.

Board Member Phillips Polich dissenting.

The majority reverses the ALJ's order finding that OAR 436-035-0250 is invalid because it is contrary to ORS 656.214(2)(f). In so doing, it reinstates an Order on Reconsideration that failed to award permanent disability for claimant's right ear hearing loss. Because I agree with the ALJ's analysis of the validity of the administrative rule, and with his decision to remand the case to the Director, I dissent.[1]

As the majority notes, claimant has 155 decibels of hearing loss, but, after deducting 93 decibels for presbycusis (age related hearing loss) pursuant to OAR 436-035-0250(4)(c), the ARU found that the remaining level of hearing loss (62 decibels) did not reach the minimum threshold level (151 decibels) for an award of permanent disability. There is no dispute that, under the "standards," claimant is not entitled to a permanent disability award. However, this does not resolve the permanent disability issue. With respect to monaural hearing loss, ORS 656.214(2)(f) provides:

> "For partial or complete loss of hearing in one ear, that percentage of 60 degrees which the hearing loss bears to normal monaural hearing."

Noting that "normal hearing" is not defined, the ALJ observed that OAR 436-035-0250(4)(b) provides a table of values for hearing loss due to age-related hearing loss (presbycusis). Further noting that the rule states that the values represented the total decibels of hearing loss in six standard frequencies which "normally" result from aging, the ALJ concluded that OAR 436-035-0250(4)(b) established "normal monaural hearing" for an individual of a given age or sex.

Therefore, the ALJ reasoned that, because presbycusis was the only identified cause of "normal" hearing loss, any hearing loss in excess of presbycusis is necessarily abnormal. Because "normal" hearing for claimant is a total loss of 93 decibels in one ear due to presbycusis, the ALJ properly reasoned that any loss in excess of that amount was not normal for claimant. Therefore, claimant had 62 decibels of hearing loss in the right ear in excess of "normal" hearing loss, and because no other cause for the hearing loss than employment had been identified, the ALJ correctly found that claimant had compensable noise induced hearing loss.

Under ORS 656.214(2)(f), claimant is entitled to a scheduled permanent disability award for the partial loss of hearing in his right ear due to his compensable condition, and the amount of that award must be in proportion to the ratio his hearing loss bears to normal monaural hearing. Because claimant has some compensable loss of monaural hearing, the ratio of hearing loss to normal monaural hearing cannot be zero, even though that is the value assigned by the "standards" to claimant's compensable hearing loss.

Because of this, I agree with the ALJ's conclusion that OAR 436-035-0250 may not define claimant's hearing loss as abnormal, but fail to award permanent disability in proportion to the ratio of the compensable monaural hearing loss to normal hearing. To the extent that it does so, the ALJ properly ruled that the administrative rule is contrary to statute and invalid.[2]

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[1] Although the validity of the administrative rule does not turn on the ALJ's evidentiary ruling, I, nevertheless, agree with the ALJ's reasoning that, under the current version of ORS 656.283(7), the evidentiary restrictions under that statute do not apply to Determination Orders. Therefore, I believe the ALJ properly admitted the disputed exhibits.

[2] Although the majority reasons that not all impairment results in disability under the standards, the precedent on which it relies did not concern a situation, such as here, where the applicable administrative rule is clearly contrary to statute and is, therefore, invalid.

This leaves the issue of an appropriate remedy. The ALJ recognized the dilemma of having no valid "standard" by which disability could be determined, but also lacking the authority to adopt a "standard." Under these circumstances, the ALJ appropriately remanded to the Director for adoption of a standard or amendment of an existing standard so as to evaluate claimant's permanent disability consistent with the statute. Although the majority does not reach this issue, I believe that the ALJ's decision was the proper one under these circumstances.

In conclusion, I agree with the ALJ's well-reasoned opinion regarding the validity of OAR 436-035-0250 and would find that remand to the Director was the proper remedy under these circumstances. Because the majority reaches the opposite conclusion, I respectfully dissent.

March 6, 2001 Cite as 53 Van Natta 271 (2001)

In the Matter of the Compensation of
JOHN F. RAANES, SR., Claimant
WCB Case No. 00-05610
ORDER ON REVIEW
Holly J. Somers, Claimant Attorney
Hitt, et al, Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order that upheld the self-insured employer's partial denial of claimant's injury claim for a left elbow condition. On review, the issue is compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact with the addition of the following facts.

Claimant, an appliance repairman, was involved in a compensable motor vehicle accident on July 23, 1999. In the impact from the rear-end collision, claimant struck his left elbow on the door lock button. (Tr. 8). Claimant drove himself to a chiropractor's office that day, where x-rays were taken of his left elbow and shoulder, among other views. (Ex. 2). On July 28, 1999, Dr. Olenick noted the presence of a "bruise- [left] upper arm." (Ex. 5).

CONCLUSIONS OF LAW AND OPINION

Left Elbow Contusion

The ALJ upheld the employer 's denial of claimant's left elbow condition claim, characterizing the claim as one for left elbow bursitis. However, the ALJ's order neglected to address claimant's separate claim for a left elbow contusion condition arising from the same work injury. (*See* Tr. 1). The employer does not dispute that the contusion condition was a separate issue at hearing, but contends that the condition is not compensable. On *de novo* review, we set aside the employer's denial of the left elbow contusion condition.

To establish a compensable injury claim, claimant must prove that he sustained 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). The claim must be established by medical evidence supported by objective findings. *Id.*

"Objective findings" are verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength and palpable muscle spasm. ORS 656.005(19). "Objective findings" do not include "physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable." *Id. See SAIF v. Lewis*, 170 Or App 201, 212 (2000) (requirement of objective findings not satisfied by reports of symptoms not presently verifiable by the physician).

Here, claimant had no prior injuries or treatment for his left elbow. (Tr. 13). After the July 23, 1999 injury, claimant immediately sought medical treatment, complaining, *inter alia*, of left elbow pain. (Exs. 3, 3A, 3C). Claimant testified that he observed a bruise on his left elbow just after the compensable injury. (Tr. 10, 29). On July 28, 1999, claimant's former treating physician, Dr. Olenick, noted a "bruise - [left] upper arm." (Ex. 5).[1] Dr. Olenick thus presently verified claimant's left elbow contusion five days after his compensable motor vehicle accident. *See SAIF v. Lewis*, 170 Or App at 212. Accordingly, we find that claimant's left elbow contusion condition is supported by objective findings.

Claimant's treating physician and surgeon, Dr. Cook, stated that claimant's motor vehicle accident was the major contributing cause of his left elbow contusion. (Ex. 39). Dr. Duff, who examined claimant at the request of the employer, stated that "it is clear from the medical record that there was at least a contusion of the left elbow sustained in the motor vehicle accident of July 23, 1999." (Ex. 30-4). Based on these unrebutted opinions, coupled with claimant's testimony and the objective evidence of a left elbow bruise verified by Dr. Olenick, we are satisfied that claimant sustained a compensable left elbow contusion. In other words, claimant's work injury was a material contributing cause of his need for medical treatment or disability for his left elbow contusion condition. We therefore set aside the employer's June 20, 2000 denial insofar as it denied a left elbow contusion condition.

Left Elbow Bursitis

The ALJ upheld the employer's denial of a left elbow bursitis condition based on the opinion of Dr. Duff. On review, claimant contends that Dr. Duff's opinion is internally inconsistent and relies on a "precipitating cause" analysis. We need not examine the relative persuasiveness of Dr. Duff's opinion, however, because we agree with the ALJ that Dr. Cook's opinion is unpersuasive.

Claimant contends that his bursitis condition is a direct result of the July 23, 1999 injury. (Tr. 5). Claimant must prove that his bursitis condition arose out of and in the course of employment and required medical services or resulted in disability or death. ORS 656.005(7)(a). The claim must be established by medical evidence supported by objective findings. *Id.*

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 to do otherwise, we defer to the opinion of claimant's treating physician. *Weiland v. SAIF*, 64 Or App 810 (1983).

Dr. Cook concluded that claimant's motor vehicle accident was the major contributing cause of his left elbow chronic bursitis condition and related need for treatment. (Exs. 39, 40). However, Dr. Cook's opinion is entirely conclusory. As such, we find it unpersuasive. *See Elyata J. Guritz*, 52 Van Natta 1958 (2000). In addition, Dr. Cook failed to consider the potential effect of claimant's "post-back surgery" elbow activity, when claimant was required to lift his body using his elbows following a non-work related back surgery. We consider such an omission to be significant, in light of Dr. Duff's opinion attributing claimant's bursitis condition to this activity. (Ex. 30-4). Thus, even assuming that Dr. Cook relied on a complete and accurate history, as claimant contends, we find Dr. Cook's opinion unpersuasive on these bases.

Claimant has failed to meet his burden of proving the compensability of his left elbow bursitis condition through Dr. Cook's opinion. *See* ORS 656.266. Consequently, it is unnecessary to compare the relative persuasiveness of Dr. Duff's opinion. Accordingly, we affirm the ALJ's order on this issue.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding the compensability of the left elbow contusion 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 regarding compensability of the left elbow contusion claim is $3,000, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record, claimant's appellate briefs and his counsel's attorney fee requests), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

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[1] A "contusion" is "Any mechanical injury (usually caused by a blow) resulting in hemorrhage beneath unbroken skin. See also *bruise*." (Emphasis in original). *Stedman's Medical Dictionary*. *See SAIF v. Calder*, 157 Or App 224, 227 (1999) (Board may resort to medical dictionary to define medical terms as they are facts that are "capable of accurate and ready determination"); *Rebecca R. Collins*, 52 Van Natta 2123 (2000).

ORDER

The ALJ's order dated November 22, 2000 is reversed in part and affirmed in part. The employer's June 20, 2000 denial, insofar as it denied a left elbow contusion condition, is set aside and the claim is remanded to the self-insured employer for processing according to law. For services at hearing and on review, claimant's attorney is awarded $3,000, payable by the employer. The remainder of the ALJ's order is affirmed.

March 6, 2001 Cite as 53 Van Natta 273 (2001)

In the Matter of the Compensation of
ELISEO ROMAN, Claimant
WCB Case No. 00-03534
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Tenenbaum's order that increased claimant's total scheduled permanent disability award for the loss of use and function of his left little finger from 57 percent (3.42 degrees) to 74 percent (4.44 degrees). On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant's February 11, 1998 injury claim was accepted for "crush injury, left fifth finger." (Ex. 5). Dr. Balkovich performed surgery to amputate the fingertip, repair the lacerations, and to cover the amputated fingertip with the remaining tissue. (Ex. 4). Subsequently, Dr. Balkovich further shortened the amputation to the distal interphalangeal joint and re-covered the fingertip. (Ex. 7). Claimant was declared medically stationary on February 8, 1999. (Ex. 8). SAIF issued an "Updated Notice of Acceptance at Closure" that indicated the accepted condition was "crush injury, left fifth finger." (Ex. 9).

SAIF issued a February 26, 1999 Notice of Closure that awarded 57 percent scheduled permanent disability for claimant's left little finger for amputation, reduced range of motion (ROM) and sensory loss. The Notice of Closure also awarded 5 percent for the left thumb. (Ex. 10). After a medical arbiter panel examination, a June 23, 1999 Order on Reconsideration affirmed. (Ex. 13). The Order on Reconsideration was not contested by either party and became final.

By an August 11, 1999 Stipulation, SAIF agreed to accept "laceration on ulnar side of left fifth finger." SAIF issued a Modified Notice of Acceptance to include that condition and reopened the claim pursuant to ORS 656.262(7)(c).

Dr. Balkovich reexamined claimant's left little finger on November 23, 1999. (Ex. 17). He made findings regarding the amputation, ROM and lost sensation. He noted "[o]ther laceration healing well." He also found that claimant remained medically stationary from his injury. *Id.*

After redetermining the extent of permanent disability for claimant's left little finger based on Dr. Balkovich's November 23, 1999 findings, SAIF issued a December 23, 1999 Notice of Closure that awarded an additional 5 percent scheduled permanent disability, for a total award of 62 percent for the left little finger. (Ex. 21).

On March 18, 2000, Drs. Denekas, Tiley, and Vessely performed a medical arbiter examination. (Ex. 24). An April 13, 2000 Order on Reconsideration redetermined claimant's permanent disability under OAR 436-035-0007(9)(c), finding permanent impairment of 56 percent for the left little finger and 5 percent for the left thumb. Because the last arrangement of compensation prior to reopening (*i.e.*, the June 1999 Order on Reconsideration) awarded 57 percent scheduled permanent disability for the left little finger, the ARU found that no reduction was appropriate under OAR 436-035-0007(12). Accordingly, the ARU's redetermination resulted in a total award of 57 percent scheduled permanent disability award for the left little finger. (Ex. 25).

Claimant requested a hearing, contending that the Notice of Closure 62 percent award for the left little finger should be reinstated.

CONCLUSIONS OF LAW AND OPINION

Relying on Dr. Denekas' November 1999 report, the ALJ redetermined claimant's left little finger impairment and increased claimant's scheduled permanent disability award from 57 percent to 74 percent. On review, SAIF makes several arguments. First, relying on our opinion in *Rodrigo R. Mancilla*, 51 Van Natta 692 (1999), SAIF argues that the ALJ erred by redetermining the scheduled permanent disability award for the left little finger. SAIF reasons that our opinion in *Mancilla* established that the processing of a "new medical condition" does not include "reprocessing" or "redetermination" of the original claim. Second, SAIF argues that the medical evidence does not establish additional impairment due to the newly-accepted condition.

Claimant, citing *Remiro Pelayo*, 52 Van Natta 363 (2000), responds that SAIF should be precluded from affirmatively seeking a reduction below the 62 percent it awarded in its own Notice of Closure because SAIF did not request reconsideration. Alternatively, claimant argues that the ALJ properly considered the entire medical record to establish a total impairment value of 74 percent.

We begin our analysis by looking at the medical evidence to determine whether any of claimant's impairment is due to his newly accepted ulnar laceration condition. We conclude that it is not.

When Dr. Balkovich reexamined claimant's left little finger in November 1999 in regard to the newly-accepted ulnar laceration, he provided the same impairment findings that he had provided for the previously accepted "crush injury" condition. However, he failed to attribute any of these impairment findings to the newly accepted laceration condition. Rather, Dr. Balkovich recorded, "Other laceration healing well." (Ex. 16).

The medical arbiter panel, which noted that its examination was to address the newly accepted condition only (the laceration on the ulnar side of the left fifth finger), reported that the laceration was part of the original crush injury and was "repaired at the time of the initial surgery." (Ex. 24).

Like Dr. Balkovich, the arbiter panel evaluated the same body part as had been evaluated previously in relation to claimant's left fifth finger crush injury. The panel provided impairment findings for the left fifth finger based on amputation of the finger tip, lost ROM, and lost sensation. There is no evidence that these impairment findings are a result of the new medical condition. The panel stated: "All findings are related to the traumatic incident of February 12, 1998, and the injury on this date was a crush injury of the left fifth digit with a laceration associated with this crush injury *that was repaired at the time of the original amputation.*" (Emphasis added.) The arbiter panel did not specifically attribute any additional impairment to the ulnar laceration. Consequently, based on the medical evidence, we conclude that claimant is not entitled to additional permanent disability due to the newly-accepted ulnar laceration condition. However, our analysis does not end here.

Although the evaluation of conditions accepted after claim closure is limited to the newly accepted condition(s), both SAIF, in its Notice of Closure, and the Department, in its Order on Reconsideration, redetermined the extent of permanent disability, as did the ALJ. OAR 436-035-0007(9)(c) requires redetermination of the extent of permanent disability under certain limited circumstances if a claim has multiple compensable conditions that are either newly accepted since the last arrangement of compensation and/or that have actually worsened. *See, e.g., Clara J. Scurlock*, 52 Van Natta 1926 (2000). If a condition is unchanged or improved, there shall be no redetermination, and, if a condition has not actually worsened, the impairment value shall continue to be the same impairment values that were established at the last arrangement of compensation. OAR 436-035-007(9)(c).[1]

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[1] We are cognizant that we held in *Mancilla* that nothing in the text or context of ORS 656.262(7)(c) suggests that processing of a "new medical condition" claim includes "reprocessing" or "redetermination" of the initial claim. In *Mancilla*, however, the Director's rule regarding redetermination of the extent of permanent disability was not before us. Thus, the reasoning expressed in *Scurlock* is not inconsistent with our holding in *Mancilla*.

Therefore, we must first establish whether claimant's crush injury condition is unchanged, improved, or actually worsened. Claimant sought no additional medical treatment after the June 23, 1999 Order on Reconsideration that closed claimant's original "left fifth finger crush injury" claim. In December 1999, Dr. Balkovich determined that claimant remained medically stationary and had returned to his regular work. Although Dr. Balkovich thought it was possible that claimant might require medical treatment in the future, depending on how durable the amputation stump remained, he did not indicate that there was any actual worsening of claimant's condition. (Ex. 17). Likewise, the medical arbiter panel noted that Dr. Balkovich had shortened the amputated finger with flap revision, "which has gone on to heal well." (Ex. 24). Based on these medical opinions, we conclude that claimant's crush injury condition is either unchanged or improved. Therefore, under these circumstances, redetermination is not appropriate.

Finally, we turn to claimant's argument that SAIF is precluded from affirmatively seeking a reduction below the 62 percent permanent disability it awarded in its own Notice of Closure. As noted above, claimant cited *Ramiro Pelayo* in support of its position. For the reasons discussed below, we conclude that *Pelayo* is inapposite under the circumstances of this case.

In *Pelayo*, although the claimant objected to the carrier's Notice of Closure that awarded 11 percent unscheduled permanent disability, he challenged only the age, education and adaptability figures used in rating his unscheduled permanent disability. The claimant did not object to the impairment findings. The carrier requested a medical arbiter examination and the claimant objected to the carrier's request. A medical arbiter report issued, and, based on that report, the Order on Reconsideration reduced the claimant's unscheduled permanent disability award to zero.

Relying on ORS 656.268(6), the ALJ found that the carrier was without statutory authority to request appointment of a medical arbiter. Accordingly, the medical arbiter's report was stricken from the record. Finding that the claimant's highest SVP in the past 5 years was 2, the ALJ amended the Order on Reconsideration to award 20 percent unscheduled permanent disability.

On appeal, we determined that there was no statutory procedure by which a carrier may challenge its own Notice of Closure, either directly or by cross-request. Thus, we further reasoned, a carrier cannot request a medical arbiter to challenge a Notice of Closure. We accordingly determined that, because the carrier could not cross-request review of its own Notice of Closure, the only issue before the ALJ was the value for SVP and we affirmed the ALJ's award.

Here, in contrast to *Pelayo*, claimant objected to the Notice of Closure's impairment findings and a medical arbiter panel was appointed. Thus, the issue of impairment was properly raised on reconsideration. The Order on Reconsideration in this case reduced SAIF's Notice of Closure's award from the additional 5 percent scheduled permanent disability to zero, based on the medical arbiters' impairment findings.

Claimant requested a hearing seeking restoration of the additional 5 percent award (thus preserving the issue of impairment at hearing). Therefore, in contrast to *Pelayo*, SAIF was not precluded from the defending the Order on Reconsideration's reversal of the additional 5 percent scheduled permanent disability award at hearing. *See Christine M. Flaherty*, 51 Van Natta 1971 (1999) (carrier not precluded from defending reconsideration order's permanent disability award on review, where issue was raised on reconsideration and preserved at hearing; applying *Duncan v. Liberty Northwest Ins. Corp.*, 133 Or App 605 (1995) and *Guilebaldo G. Ramirez*, 50 Van Natta 654, *recon* 50 Van Natta 863 (1998)).

In summary, we conclude that the 57 percent award for claimant's little finger stands, as the June 1999 Order on Reconsideration was not appealed. Claimant receives a rating of zero for his laceration condition, a "post-closure" new medical condition, because the medical evidence does not support impairment for that condition. There is also no medical support for worsening or change in the previously accepted crush injury condition; consequently, redetermination is not appropriate.

Therefore, rather than "increasing" claimant's permanent disability from 57 percent to 62 percent, SAIF's second Notice of Closure, in effect, awarded an additional 5 percent permanent disability. The Order on Reconsideration eliminated that 5 percent award. Nevertheless, SAIF could defend the Order on Reconsideration at hearing. Finally, because claimant has not established entitlement to permanent disability for his "new medical condition," we reinstate the Order on Reconsideration that awarded no additional permanent disability for claimant's ulnar laceration condition.

ORDER

The ALJ's order dated September 22, 2000 is reversed. The April 13, 2000 Order on Reconsideration that did not award claimant additional scheduled permanent disability beyond the 57 percent (3.42 degrees) previously granted for his left little finger is affirmed. The ALJ's "out-of-compensation" attorney fee award is also reversed.

March 6, 2001 Cite as 53 Van Natta 276 (2001)

In the Matter of the Compensation of
JENNIE L. SEIBEL, Claimant
WCB Case No. 00-02331
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorney
Terrall & Terrall, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Johnson's order that upheld the self-insured employer's denial of her low back injury claim. On review, the issue is compensability.[1]

We adopt and affirm the ALJ's order with the following changes. In the first paragraph on page 5, we change the last sentence to read: "An April 3, 2000 lumbar MRI showed that claimant had a central disc bulge at L3-4 and degenerative disc disease at L4-5. (Ex. 22)." In the last paragraph on page 6, we delete the last sentence.

We change the first citation on page 8 to read: "*Luckhurst v. Bank of America*, 167 Or App 11 (2000)." Also on page 8, we delete the three paragraphs of the "Major Cause" section and replace them with the following:

> "An April 3, 2000 lumbar MRI showed that claimant had a central disc bulge at L3-4 and degenerative disc disease at L4-5. (Ex. 22). In a June 15, 2000 report, Dr. Lorish explained that claimant's history was most consistent with irritating her preexisting lumbar condition. (Ex. 26-1). Based on those reports, we find that claimant's preexisting lumbar degenerative disease combined with her February 1, 2000 injury to cause her disability or need for treatment. Therefore, under ORS 656.005(7)(a)(B), she must establish that the February 2000 injury was the major contributing cause of her disability or need for treatment."

In the last full paragraph on page 8, we change the citation to "(Ex. 27)."

ORDER

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

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[1] When an Appellant's brief was not received, we proceeded with our review. After completing our review, the employer requested an extension of the briefing schedule to file its respondent's brief. Under these circumstances, the employer's request has become moot.

In the Matter of the Compensation of
JOHN R. GRAHAM, Claimant
WCB Case No. 98-07038
ORDER ON REMAND
Michael A. Bliven, Claimant Attorney
Jerald Keene, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. On August 29, 2000, the court granted the parties' motion to remand this matter for our consideration of their proposed settlement. In dismissing the self-insured employer's petition for judicial review, the court also granted "leave to seek reinstatement [of judicial review] if the Board should fail to approve the settlement."

The parties have announced that a settlement will not occur. Pursuant to the court's remand order, our authority is limited to consideration of the parties' proposed settlement. Furthermore, in the event that Board approval of the settlement is not granted, the court has expressly provided the parties with a remedy. Specifically, leave to seek reinstatement of the petition for judicial review has been offered to the parties. Under such circumstances, in accordance with the court's August 29, 2000 order, the parties are authorized to seek reinstatement of the judicial review which was previously pending before the court.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN R. GRAHAM, Claimant
WCB Case No. 98-08943
ORDER ON REMAND
Michael A. Bliven, Claimant Attorney
Jerald Keene, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. On August 29, 2000, the court granted the parties' motion to remand this matter for our consideration of their proposed settlement. In dismissing claimant's petition for judicial review, the court also granted "leave to seek reinstatement [of judicial review] if the Board should fail to approve the settlement."

The parties have announced that a settlement will not occur. Pursuant to the court's remand order, our authority is limited to consideration of the parties' proposed settlement. Furthermore, in the event that Board approval of the settlement is not granted, the court has expressly provided the parties with a remedy. Specifically, leave to seek reinstatement of the petition for judicial review has been offered to the parties. Under such circumstances, in accordance with the court's August 29, 2000 order, the parties are authorized to seek reinstatement of the judicial review which was previously pending before the court.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN R. GRAHAM, Claimant
WCB Case No. 98-0240M
OWN MOTION ORDER ON REMAND
Michael A. Bliven, Claimant Attorney
Jerald Keene, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. On August 29, 2000, the court granted the parties' motion to remand this matter for our consideration of their proposed settlement. In dismissing the self-insured employer's petition for judicial review, the court also granted "leave to seek reinstatement [of judicial review] if the Board should fail to approve the settlement."

The parties have announced that a settlement will not occur. Pursuant to the court's remand order, our authority is limited to consideration of the parties' proposed settlement. Furthermore, in the event that Board approval of the settlement is not granted, the court has expressly provided the parties with a remedy. Specifically, leave to seek reinstatement of the petition for judicial review has been offered to the parties. Under such circumstances, in accordance with the court's August 29, 2000 order, the parties are authorized to seek reinstatement of the judicial review which was previously pending before the court.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES W. GRIFFIN, Claimant
WCB Case No. 00-03370
ORDER ON REVIEW
Bottini, Bottini & Oswald, Claimant Attorney
Jerry Keene, Defense Attorney

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

The insurer requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's cervical condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

On March 26, 1999, claimant, a mechanic, injured his left shoulder when he slipped off a tire and fell, grabbing a hold of a machine and hyperextending his left arm and shoulder. Claimant did not obtain medical treatment until April 26, 1999, when he reported persistent left shoulder pain to Dr. Brown, who diagnosed "left shoulder pain, status post fall." (Ex. 4). Dr. Brown's chart note indicates that claimant's cervical spine was examined and reported to be "supple."

On April 27, 1999, Dr. Casey, a naturopath, noted that claimant had "a little bit of pain radiating up into the left cervical spine area but his main complaint is he's quite tender over his left AC joint and into the deltoid region." Dr. Casey diagnosed a "left shoulder injury. Rule out internal derangement." (Ex. 7-2).

An April 28, 1999, MRI scan revealed a rotator cuff tear. (Ex. 8). Dr. Hanley, an orthopedic surgeon, began treating claimant in May 1999. On May 11, 1999, Dr. Hanley reported that claimant denied neck pain, although he was experiencing persistent pain and weakness in the left shoulder. On examination of the cervical spine, Dr. Hanley noted negative cervical compression, cervical "bounce" and "Spurling's" tests. (Ex. 10-1). Dr. Hanley recommended physical therapy, during which it was reported that claimant had pain "into neck." (Ex. 13).

Dr. Hanley eventually performed a rotator cuff repair of the left shoulder on July 7, 1999. (Ex. 21). On July 20, 1999, the insurer accepted the claim for a left rotator cuff tear. (Ex. 22).

On July 27, 1999, a physical therapy chart note indicated that claimant had fallen at home over the weekend and caught himself with his left arm. (Ex. 23). On September 2, 1999, "some swelling" was reported in the neck area. (Ex. 31). A September 21, 1999 physical therapy note describes claimant's pain as shifting to his deltoids and "into neck." (Ex. 32-1). On September 28, 1999, another physical therapy note reported that claimant was having pain in the right neck down into right upper extremity of 5 days duration. *Id.*

Claimant continued to be followed by Dr. Hanley and received physical therapy for his left shoulder condition. On March 9, 2000, Dr. Hanley reported that claimant had been noticing numbness and tingling in the right arm, along with tightness in the neck and intrascapular pain. Physical examination of the cervical spine now showed positive "Spurling's," cervical compression and cervical "bounce" tests. (Ex. 49a). An MRI scan was ordered, which revealed a broad-based disc and spur complex at C4-5. Dr. Hanley referred claimant to a neurosurgeon, Dr. Brett, for an evaluation of the cervical spine condition. (Exs. 49a, 50).

Dr. Brett opined that claimant had a disc protrusion at C4-5 superimposed on preexisting cervical spondylosis, with possible contusion and nerve entrapment of the C6 nerve root. (Ex. 50A-2). According to Dr. Brett, the March 1999 injury was the major contributing factor in claimant's cervical condition.

On March 31, 2000, a cervical myelogram revealed degenerative disc disease with an anterior bulge on the thecal sac at C4-5 and "mass effect" on the left C5 and right C6 nerve roots. (Ex. 53). Dr. Brett recommended surgery, which was performed on May 15, 2000.

On April 21, 2000, Drs. Radecki and Sacamano examined claimant on the insurer's behalf. They attributed claimant's cervical condition and need for surgery to preexisting cervical spondylosis and the reported at-home injury in July 1999. (Ex. 55-6). The insurer then denied the cervical condition on April 27, 2000. (Ex. 56). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the insurer's denial, applying ORS 656.005(7)(a)(B) and concluding that a preponderance of the medical evidence established that the March 26, 1999 injury was the major contributing cause of claimant's need for treatment of his "combined" cervical condition. Specifically, the ALJ found the medical opinions of Dr. Brett and Dr. Gritzka, an examining physician who also related claimant's cervical condition in major part to the March 1999 injury, more persuasive than those of Drs. Hanley, Dr. Radecki and Dr. Sacamano.

On review, the insurer contends that the medical opinions of Drs. Brett and Gritzka are not persuasive because they relied on an inaccurate history that claimant experienced constant cervical pain since the March 1999 left shoulder injury and because they failed to sufficiently weigh the relative contribution of the various possible causes of claimant's cervical condition, including the preexisting degenerative condition, and the July 1999 off-the-job injury. The insurer urges us to rely instead on the opinions of Drs. Hanley, Radecki and Sacamano. For the following reasons, we find that claimant failed to sustain his burden of proving the compensability of his cervical condition.

The parties do not dispute, and we find, that ORS 656.005(7)(a)(B) applies to this claim. Therefore, in order to establish that his cervical condition is compensable, claimant must show that his work injury was the major contributing cause of the disability or need for treatment of the "combined" cervical condition. *See 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 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). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's cervical condition and deciding which is the primary cause. *See Dietz v. Ramuda*, 130 Or App 397 (1994), rev dismissed 320 Or 416 (1995).

The ALJ found no persuasive reasons not to follow the opinion of claimant's current treating physician, Dr. Brett. Although we generally defer to the conclusions of a treating physician, we do not do so when, as here, there are persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810, 814 (1983).

First, Dr. Brett did not begin treating claimant until a year after the compensable injury. Thus, his status as the current attending physician does not place him in an advantageous position on which to comment on causation. *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). In contrast, Dr. Hanley began treating claimant less than two months after the compensable injury. Dr. Hanley opined that it was unlikely that the compensable injury in March 1999 caused the symptoms of numbness and tingling that claimant first reported in March 2000. (Ex. 62).

The ALJ also cited the fact that Dr. Brett performed claimant's cervical surgery as support for his conclusion that Dr. Brett's opinion was persuasive. *See Argonaut Insurance Company v. Mageske*, 93 Or App 968 (1988). We disagree with this rationale because Dr. Brett never explained how his surgical observations assisted him in evaluating the cause of claimant's cervical condition. Indeed, it appears that Dr. Brett's opinion was based largely on claimant's history of immediate and persistent neck discomfort after the March 1999 injury. (Exs. 50A-1, 63). Having reviewed this record, we are not persuaded that it establishes that claimant experienced immediate and consistent neck symptoms after

the March 1999 incident of injury. When claimant first sought treatment, a month after the March 26, 1999 injury, he reported no neck symptoms. In fact, claimant's neck was described on examination as "supple." (Ex. 4). On May 11, 1999, claimant specifically denied neck pain. In addition, examination of claimant's cervical spine that day was entirely negative. (Ex. 10-1).

The ALJ cited chart notes of April 27,1999 and May 12, 1999 as evidence of consistent neck pain since the injury. However, the first chart note indicates that claimant's pain, described as a "little bit," was "radiating up into the left cervical spine area." (Ex. 7-1). The second chart note of May 12, 1999 also describes the pain as "into neck." (Ex. 13). Neither chart note establishes a neck injury. The implication from both chart notes is that the pain radiating "into" the cervical region was referred from elsewhere. Dr. Radecki elaborated as follows on this point:

> "[P]ain radiating towards a point does not indicate that that point is injured. For instance, one can have a pinched nerve in the back, and get sciatica down the leg to the foot, but no one would propose that it is the foot that was injured because the pain was radiating towards the foot. It is obviously the person's back that is hurt, causing the nerve root compression and sciatica to the foot, not the foot being hurt causing the problem of sciatica. Thus, pain radiating into an area does not indicate that that is the area which is hurt." (Ex. 66-3).

Neither Dr. Brett nor Dr. Gritzka rebutted Dr. Radecki's opinion, which we find persuasive on this point. The ALJ, however, cited claimant's and his wife's testimony in support of his conclusion that Drs. Radecki and Sacamono had an erroneous history that claimant developed neck symptomatology primarily after the July 1999 off-the-job incident in which claimant fell at home. Claimant testified that he had an "extreme" amount of neck pain shortly after the March 1999 left shoulder injury and that he had neck pain "all along." (Trs. 10, 19). Claimant's wife testified that claimant had neck pain after the March 1999 injury. (Tr. 27). The ALJ found claimant to be a credible witness. (O&O p. 2).

Although finding claimant to be a credible witness, the ALJ did not state that this conclusion was based on demeanor. Thus, we understand that the ALJ assessed credibility based on the substance of claimant's testimony, rather than demeanor. When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. *Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987).

Having considered the medical reports in which claimant either denied neck pain or failed to report cervical discomfort, in combination with the specific negative examinations of claimant's cervical spine, we do not find claimant's testimony to be credible. Moreover, even if the ALJ's credibility determination was based on demeanor, we would still find the inconsistencies in the record sufficient to cast doubt on the reliability of claimant's testimony. *See Gail A. Albro*, 48 Van Natta 41, 42 (1996) (inconsistencies in the record may be a sufficient basis to disagree with the ALJ's credibility finding if the inconsistencies raise such doubt that we are unable to conclude that material testimony is credible); *Angelo L. Radich*, 45 Van Natta 45 (1993).

Accordingly, we conclude that Dr. Brett's opinion is not persuasive because he did not base it on an accurate history and he failed to discuss the contemporaneous medical records cited above. In addition, we conclude that Dr. Gritzka's opinion also suffers from similar weaknesses.

Claimant reported to Dr. Gritzka that he had neck pain following the March 26, 1999 accident, but that he could not distinguish neck pain from the shoulder pain. (Ex. 64-3). However, for the reasons previously discussed, we find the history of consistent neck pain from March 1999, as well any assumption that claimant's neck was injured at the time of that accident, questionable. Moreover, Dr. Gritzka concluded that the mechanism of injury could reasonably be expected to cause a disc herniation in the cervical spine, but Dr. Gritzka fails to explain how. (Ex. 64-8). We find this lack of explanation particularly troubling in light of the negative examinations of claimant's cervical spine in contemporaneous medical records and the delayed onset of radicular symptoms of numbness and tingling. Finally, Dr. Gritzka does not discuss the contemporaneous medical records in concluding that the March 1999 injury is the major contributing cause of claimant's cervical condition.[1] *Id.*

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[1] In the "Present Medical History" portion of his report, Dr. Gritzka does refer to some of the contemporaneous reports that we have discussed. (Ex 64-1,2). However, conspicuously absent from Dr. Gritzka's review are references to those portions of the records concerning claimant's cervical spine.

In conclusion, we do not find the medical evidence from Drs. Brett and Gritzka persuasive. Inasmuch as Drs. Hanley and Radecki offer contrary medical opinions more persuasive than Drs. Gritzka and Brett, we conclude that claimant failed to prove compensability under ORS 656.005(7)(a)(B). Thus, we reverse.

ORDER

The ALJ's order dated October 23, 2000 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

Board Member Phillips Polich dissenting.

Reversing the ALJ's order, the majority concludes that claimant failed to prove compensability of his cervical condition under ORS 656.005(7)(a)(B). Unlike the majority, I believe that the medical evidence from Drs. Brett and Gritzka establishes that the March 1999 injury is the major contributing cause of claimant's disputed cervical condition. For this reason, I would find the claim compensable. Therefore, I dissent.

At the outset, I am mindful that the ALJ determined that claimant was a credible witness, a finding to which we should defer. *See Coastal Farm Supply v. Hultberg*, 84 Or App 282, 285 (1987). Claimant testified that he experienced neck pain ever since the March 26, 1999 injury. In light of that credible testimony, Dr. Brett, claimant's attending physician for the cervical condition, had an accurate history on which to base his causation opinion. Moreover, Dr. Brett, who performed claimant's cervical surgery and personally observed the degenerative disease and cervical conditions, opined that the March 1999 injury is the major contributing cause of the combined cervical condition. That opinion is the most persuasive, having come from both the attending physician for the cervical condition and claimant's surgeon. *See Argonaut Ins. Co. v. Mageske*, 93 Or App 698, 702 (1988); *Weiland v. SAIF*, 64 Or App 810 (1983). The ALJ correctly concluded that there were no persuasive reasons not to defer to Dr. Brett's opinion, which is supported by Dr. Gritzka.

Dr. Gritzka noted that claimant had no cervical spondylosis symptoms prior to the compensable March 26, 1999 injury. Dr. Gritzka persuasively reasoned that it made no sense to opine that a previously asymptomatic cervical spondylosis worsened and became symptomatic coincidentally to and after the March 1999 injury. According to Dr. Gritzka, it was much more likely that the March 1999 injury was the major contributing cause of a pathological worsening of the preexisting condition and the intervertebral disc herniations for which Dr. Brett operated. (Ex. 64-8). I agree with the ALJ that this analysis makes sense and is, therefore, also persuasive on the causation issue.

The majority relies on Drs. Radecki, Sacamano and Dr. Hanley. However, the ALJ properly discounted those opinions. Drs. Radecki and Sacamano assumed an incorrect history that claimant developed neck symptoms after an off-the-job incident in July 1999 when claimant slipped and fell at home. As previously noted, claimant credibly testified that he had cervical symptoms all along, although they were initially masked by shoulder pain. Moreover, claimant's credible testimony is supported by contemporaneous medical records that indicate that claimant had neck pain on April 27, 1999 and May 12, 1999, well prior to the July 1999 slip and fall. (Exs. 7, 13). As for Dr. Hanley, he did not treat the cervical condition, but rather referred claimant to Dr. Brett for cervical treatment. Moreover, Dr. Hanley's opinion that claimant's need for neck treatment was not likely due to the original compensable injury lacks explanation. (Ex. 62). For this reason, it is not persuasive. *See Moe v. Ceiling Systems*, 44 Or App 429 (1980).

Accordingly, based on my review of the medical evidence and claimant's credible testimony, I would conclude that the opinions of Drs. Brett and Gritzka are the most persuasive on this record. The majority errs in not deferring to their well-reasoned and persuasive opinions. Thus, I respectfully dissent.

In the Matter of the Compensation of
NANCY J. STRATTON, Claimant
WCB Case No. 00-05973
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability.

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

The ALJ stated that the issue in this occupational disease claim was whether work trauma was "the major contributing cause of the need for medical services or disability." The correct legal standard for an occupational disease claim, however, is whether work activity was the major contributing cause of the disease itself, not just the medical services or disability. *See* ORS 656.802(2)(a); *David E. Belton*, 52 Van Natta 2250 (2000); *Tammy L. Foster*, 52 Van Natta 178 (2000).

Notwithstanding this clarification, we nevertheless agree with the ALJ's reasoning that the opinion of the attending physician, Dr. Karty, is more persuasive than that of the examining physician, Dr. Williams. Thus, we find that claimant has proved that her work activity is the major contributing cause of her carpal tunnel disease.[1] Thus, we agree with the ALJ that claimant has established a compensable 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 $1,000, 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 November 17, 2000 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by SAIF.

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[1] Noting the ALJ's comment that no compelling explanation supported either Dr. Karty's or Dr. Williams' position, SAIF argues that the medical evidence is in "equipoise" and, therefore, that claimant cannot sustain her burden of proof. We disagree. Although the ALJ's comment may have implied that the medical evidence was equally balanced, it is clear from the remainder of his order that the ALJ found Dr. Karty's opinion was more persuasive. We agree with the ALJ's reasoning and conclude that claimant sustained her burden of proof.

In the Matter of the Compensation of
MARYAM HOSSEINI, Claimant
WCB Case No. 99-02726
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorney
Stoel, Rives LLP, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Fulsher's order that set aside its partial denial of claimant's injury claim for a left lower back condition (subcutaneous mass lesion). On review, the issue is compensability.

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

In May 1997, claimant was compensably injured in a fall. (Ex. 8; Tr. 6). The accepted conditions at closure were: (1) concussion; (2) cervical sprain/strain; and (3) right trapezius muscle strain. (Ex. 99).

In June 1998, claimant noticed a lump on her low back located near the L4 vertebrae on the left. (Ex. 90; Tr. 7). The lump (subcutaneous mass lesion) was surgically removed on August 10, 1998, by Dr. Minami. (Ex. 95). It is the compensability of the subcutaneous mass lesion that is at issue.

The ALJ, relying upon the opinion of Dr. Minami, determined that the subcutaneous mass lesion was caused by blunt trauma to claimant's back during the May 1997 fall at work. Consequently, the ALJ concluded that the subcutaneous mass lesion was compensable.

The employer contends that: (1) the major contributing cause standard applies to this claim;[1] (2) Dr. Minami's opinion is insufficient to meet claimant's burden of proof; and (3) the opinions of Drs. Baumeister, Barnhouse, and Gambee are more persuasive than the opinion of Dr. Minami. As explained below, we disagree with each of the employer's contentions.

The parties agree that the resolution of the cause of the subcutaneous mass lesion 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). Additionally, if the opinion of the treating physician is based upon his actual surgical findings, the opinion is generally entitled to great weight. *Argonaut Ins. Co. v. Mageske*, 93 Or App 698, 702 (1988).

The mechanism of injury, according to Dr. Minami, was blunt trauma to claimant's back from the fall at work in May 1997. The trauma, as explained by Dr. Minami, caused the death of fat cells in the subcutaneous layer at the site of the trauma.[2] The dead cells then hydrolyzed into glycerol and fatty acids, gradually producing a mass of scar tissue. (Ex. 117-1).

The employer asserts that claimant's fall at work did not result in blunt trauma to the left portion of claimant's back. Therefore, the employer argues that because Dr. Minami's opinion rests on an incorrect history (the occurrence of blunt trauma to claimant's back), the opinion is not persuasive,

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[1] Because we find that claimant's fall at work in May 1997 is the sole cause of her subcutaneous mass lesion, we conclude that the condition is compensable under either a material contributing cause standard or the major contributing cause standard. Consequently, we need not decide which standard is appropriate. Nonetheless, we note that the probative evidence suggests that claimant's condition is attributable to the May 1997 fall at work. Thus, we would likely conclude that the appropriate standard is material contributing cause. *See* ORS 656.005(7)(a); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992).

[2] According to Dr. Minami, examples of the type of blunt trauma sufficient to cause fat necrosis include: (1) a fall and direct pressure on the soft tissue; (2) a punch; and (3) running or bumping into an object. (Ex. 118-7 & 8).

and as such is insufficient to carry claimant's burden of proof. Consequently, before we address the persuasiveness of Dr. Minami's opinion, we must first determine whether the preponderance of the evidence supports a finding that claimant received blunt trauma to her left low back during the May 1997 fall at work.

Claimant testified that on May 8, 1997, she was carrying a bucket of urine to a sink to empty, when her feet caught on a floor mat causing her to fall. (Tr. 6, 9). Claimant remembers nothing further of that event until she opened her eyes and discovered people around her. (Tr. 6). When claimant opened her eyes, she found herself lying up "against a counter on her right-hand side."[3] (Tr. 9). After the incident, claimant was seen at the emergency room and diagnosed with headache and muscle aches post contusion. (Ex. 11). In the days following the incident, claimant was seen for medical follow up with complaints of headache, neck pain, right shoulder pain, left mid back pain, and left leg pain.[4] (Ex. 11, 13, 14, 15). Between the May 1997 fall and the June 1998 discovery of the mass lesion, there is no evidence of any other blunt trauma to claimant's left low back.

Based upon the foregoing, especially considering claimant's complaints of pain in the left mid back area, we conclude it is more probable than not that, as a result of the fall, claimant received a blunt trauma to the area of her back where Dr. Minami removed the subcutaneous mass lesion. Having thus concluded that Dr. Minami's history of blunt trauma to the back was correct, we now examine the balance of his opinion to determine if it is persuasive.

On August 10, 1998, Dr. Minami surgically removed the mass.[5] (Ex. 95; 118-7). Pathology confirmed the mass to be fat necrosis, which Dr. Minami explained is basically scar tissue due to injury to the fatty tissue. (Ex. 118-7). According to Dr. Minami, such a mass is almost always caused by trauma; the force of the trauma damages the blood supply to the tissue, the tissue dies, and scar tissue settles in. (Ex. 117-1; 118-8). Dr. Minami explained that such a mass develops within a few days to few weeks after the trauma, while symptoms from the mass itself (pain) may not start until months or years later. (Ex. 118-8 & 9). In claimant's particular case, Dr. Minami opined that trauma from the 1997 fall at work caused the mass, and that the mass went unnoticed until June 1998 when the mass itself began to cause pain.[6] We find Dr. Minami's opinion well reasoned and persuasive.

In contrast to Dr. Minami's opinion are the opinions of Dr. Barnhouse (initial attending physician), Dr. Baumeister (attending physician for claimant's headaches) and Dr. Gambee (employer-arranged medical record reviewer). In indicating that the 1997 fall did not cause the mass lesion, Drs. Barnhouse, Baumeister, and Gambee assume that the lesion did not develop until June 1998. (Ex. 111-1; 114; 115). They did not consider, and were not asked to consider the scenario, as did Dr. Minami, that the mass formed shortly after the accident, but was not discovered until June 1998. Consequently, we find their opinions conclusory, and as such, not persuasive. *Moe v. Ceiling Systems, Inc.*, 44 Or App 429 (1980).

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[3] The ALJ did not make an express finding regarding claimant's credibility. The employer does not contend that claimant lacks credibility. Rather, the employer asserts there is no evidence that claimant was unconscious following the fall. However, the occupational injury clinic note indicating loss of consciousness - 2 minutes, suggests otherwise. (Ex. 15). So too does the history of the June 17, 1997, outpatient referral stating claimant had been informed by co-workers that she had lost consciousness. (Ex. 20).

[4] We acknowledge the employer's assertion that claimant's pain was right sided and that therefore she suffered no blunt trauma to her left back as a result of the 1997 fall. We note however, that claimant's complaint of left sided mid back pain shortly after the May 8, 1997 fall suggests otherwise. (Ex. 15).

[5] Prior to surgery, the mass was described as a 1 cm nodule. (Ex. 90).

[6] We acknowledge that during his deposition, Dr. Minami learned for the first time that about ten years prior to the May 1997 fall claimant had a chair pulled out from under her as she attempted to sit down. As a result of that incident, claimant landed on her buttocks and required some physical therapy. (Tr. 11). After obtaining the description of the event and after being apprised that claimant's prior medical records (1991 until May 1997) do not disclose the presence of a left low back mass lesion, Dr. Minami opined that it was unlikely for the mass lesion to predate the May 1997 fall. (Ex. 118-27). The record contains no opinion to the contrary. In light of such circumstances, we disagree with the employer's contention that Dr. Minami's opinion was based upon an inaccurate history.

Additionally, we note that neither Dr. Barnhouse nor Dr. Baumeister appear to be aware that claimant reported pain in her left back area. (Ex. 15). Their opinions assume all of claimant's pain was right-sided. Consequently, in addition to being conclusory, their opinions are also based upon complete information, and as such, are not persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977); *William R. Ferdig*, 50 Van Natta 442, 443 (1998).

In conclusion, we find that claimant incurred blunt trauma to her left back resulting in the subcutaneous mass lesion that Dr. Minami surgically removed in August 1998. Accordingly, regardless of whether the appropriate standard of proof is material or major contributing cause, we agree with the ALJ that claimant established the compensability of the subcutaneous mass lesion.

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.

ORDER

The ALJ's order dated October 27, 2000 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,200, to be paid by the self-insured employer.

March 8, 2001 Cite as 53 Van Natta 285 (2001)

In the Matter of the Compensation of
CATHRYN DODGENS, Claimant
WCB Case Nos. 00-03682 & 98-07856
ORDER DENYING RECONSIDERATION
Linerud Law Firm, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Claimant requests reconsideration of our January 30, 2001 Order on Review that reversed the Administrative Law Judge's (ALJ's) order and upheld the insurer's denial of claimant's chronic neck strain claim. Because we find that our prior order has become final, we lack authority to reconsider the Order on Review.

A Board order is final unless, within 30 days after the date of mailing copies of the order, one of the parties files a petition for judicial review with the Court of Appeals. ORS 656.295(8). The time within which to appeal an order continues to run unless the order had been "stayed," withdrawn or modified. *International Paper Co. v. Wright*, 80 Or App 444 (1986); *Fischer v. SAIF*, 76 Or App 656, 659 (1986).

Here, the 30th day following our January 30, 2001 Order on Review was March 1, 2001. Claimant mailed a request for reconsideration to the Board on March 2, 2001. The Board did not receive claimant's motion until March 6, 2001. Thus, before claimant mailed her request and before we could respond to claimant's motion, the 30-day period of ORS 656.295(8) had expired. Because our January 30, 2001 order has not been stayed, withdrawn, modified or appealed within 30 days of its mailing to the parties, we are without authority to alter our prior decision. *See* ORS 656.295(8); *International Paper Co. v. Wright*, 80 Or App at 447; *Fischer v. SAIF*, 76 Or App at 659; *Paul D. Hamilton*, 52 Van Natta 1063, 52 Van Natta 1251 (2000) (Second Order Denying Reconsideration); *Darlene E. Parks*, 48 Van Natta 190 (1996); *see also Barbara J. Cuniff*, 48 Van Natta 1032 (1996) (although motion was hand-delivered to the Board's Portland office on the 30th day, the statutory period had expired by the time the motion was brought to the Board's attention). Consequently, claimant's motion for reconsideration is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHAEL D. LITTLEFIELD, Claimant
Own Motion No. 99-0428M
OWN MOTION ORDER
Furniss, Shearer & Leineweber, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted a request for temporary disability compensation for claimant's low back condition. Claimant's aggravation rights have expired. SAIF agreed that claimant's current low back condition was causally related to his accepted condition and that it is responsible for claimant's current condition. However, SAIF opposed reopening on the grounds that: (1) surgery was proposed by a non-managed care organization (MCO) physician; (2) the proposed surgery was not reasonable or necessary; and (3) claimant was not in the work force at the time of his disability.

FINDINGS OF FACT

In April 1993, claimant sustained a compensable low back injury. That claim was first closed on April 12, 1994. Thereafter, claimant underwent two low back surgeries.

Claimant experienced relative pain relief until January 1999, when he sustained an unrelated left leg injury. Claimant's initial complaints were left hip, knee and leg pain. A new injury claim was filed and accepted for his left leg condition. The January 1999 claim was closed on June 14, 1999, with approximately four and one-half months with temporary disability.

While treating for the injuries sustained in his January 1999 work incident, claimant experienced low back pain. He sought treatment with Dr. Meigs, a long-time treating physician, who referred him to Dr. Hill for further evaluation. Dr. Hill recommended further low back surgery, which received Dr. Meigs' concurrence.

On November 24, 1999, SAIF submitted its Own Motion recommendation to deny reopening of claimant's 1993. Noting that Dr. Hill was not an MCO provider, SAIF contended that he could not treat claimant. In addition to challenging the propriety of the surgery request, SAIF asserted that claimant was not in the work force at the time of the current disability.

In response to SAIF's contentions, claimant submitted various medical reports and a January 4, 2000 affidavit. Claimant also announced that Dr. Hill was attempting to become MCO certified but, if he was unsuccessful, claimant had an alternate MCO physician, Dr. Grewe.

On February 15, 2000, Dr. Grewe concurred with Dr. Hill's assessment and opined that claimant required surgery for his low back condition. Dr. Grewe requested pre-authorization from the MCO panel. The MCO panel disapproved Dr. Grewe's request on the grounds that the requested surgery was not medically necessary or appropriate.

On May 17, 2000, the Joint Medical Committee (JMC) panel upheld the MCO disapproval. Claimant appealed the JMC's decision to the Director. On July 20, 2000, we postponed action on the Own Motion matter pending resolution of the matter before the Director.

On September 7, 2000, the Director decided that no further action would be taken on claimant's request for review of the JMC's denial until new diagnostic test were obtained. These were taken and Dr. Grewe again requested pre-certification of the recommended surgery.

The MCO panel, after review of the new diagnostic tests, continued to conclude that the requested surgery was inappropriate treatment for claimant and disapproved Dr. Grewe's request. Claimant appealed that decision. On January 19, 2001, the JMC "determined to overturn the initial disapproval and precertify the requested procedure as medically necessary and appropriate." That decision was not appealed.

CONCLUSIONS OF LAW

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 proposed surgery was found to be medically necessary and appropriate treatment for claimant's compensable condition. However, SAIF also opposed reopening of the Own Motion claim on the ground that claimant was not in the work force at the time his condition worsened requiring surgery.

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 is 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,[1] 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). In other words, the relevant time period for which claimant must establish he was in the work force is the time prior to when his compensable condition worsened requiring surgery and/or inpatient hospitalization. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; *SAIF v. Blakely*, 160 Or App 242 (1999); *Paul M. Jordan*, 49 Van Natta 2094 (1997); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997).

Here, on May 3, 1999, Dr. Hill recommended that claimant undergo surgery on his lower back (that surgery has been subsequently found to be appropriate treatment for claimant's compensable low back condition). At that time, claimant was receiving temporary disability under an accepted left leg claim with another carrier. Since claimant was receiving temporary disability compensation in another workers' compensation claim at the time of his disability in this claim, he is considered to be in the work force. *See Harry R. Bostwick*, 49 Van Natta 490 (1997); *Michael C. Johnstone*, 48 Van Natta 761 (1996); *William L. Halbrook*, 46 Van Natta 79 (1994).

Therefore, we conclude that claimant did not voluntarily remove himself from the work force, but, rather, was disabled due to another compensable injury which prevented him from working at the time of his current worsening. Consequently, we find that claimant has established that he was in the work force at the time of disability, *i.e.* May 3, 1999.

Accordingly, we authorize the reopening of claimant's 1993 claim to provide temporary disability compensation beginning the date he is hospitalized for the proposed surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,500, payable by SAIF directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

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[1] 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 the Matter of the Compensation of
JAMES V. OXLEY, Claimant
WCB Case Nos. 00-02350 & 99-05414
ORDER OF ABATEMENT
Bischoff, Strooband & Ousey, Claimant Attorney
Bostwick, et al, Defense Attorney

Claimant and ESIS have requested reconsideration of our February 8, 2001 order that set aside ESIS' responsibility denial. Claimant has requested clarification of our order to indicate that the ALJ's compensability finding has been affirmed and to clarify which carrier is responsible for the attorney fees awarded by the ALJ's order. ESIS seeks reconsideration of our determination regarding responsibility. Specifically, ESIS argues that its denial was permitted by ORS 656.262(6)(c) 656.262(7)(b).

In order to allow sufficient time to consider the motions, we withdraw our February 8, 2001 order. Claimant and JCI/WCD are granted an opportunity to respond to ESIS' motion.[1] To be considered, the parties' responses must be filed within 14 days of the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

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[1] We have already received JCI's response to claimant's motion. Should ESIS wish to respond to claimant's motion, it may do so within 14 days of the date of this order.

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

Reviewed by the Board en banc.

Claimant requests review of Administrative Law Judge (ALJ) Martha Brown's order that: (1) found that the self-insured employer was authorized to deduct 50 percent of claimant's temporary disability payments, based on previously overpaid permanent disability and unpaid child/spousal support; and (2) declined to award a penalty based on allegedly unreasonable claim processing. On review, the issues are offset and penalties. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Stipulated Facts" and "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

The parties agree that the employer reduced claimant's temporary disability payments by a total of 50 percent, with 25 percent offset to recover overpaid permanent disability and 25 percent withheld pursuant to a child support enforcement order.

Claimant requested a hearing, contending that only one 25 percent deduction from claimant's temporary disability should be allowed and the support obligation should take precedence over recovery of the overpayment. The ALJ held that both deductions were statutorily authorized.

On review, claimant argues that no more than 25 per cent of his temporary disability may be deducted, "no matter how many obligations are valid." Alternatively, claimant contends that, even if the employer properly deducted child/spousal support, subsequent offset of overpaid permanent disability should be limited to 25 percent of the balance payable to claimant *after* deduction of child support.[1]

The employer argues that the two statutes each authorized a 25 percent deduction. Consequently, the employer asserts that the 50 percent it withheld was proper and reasonable.

The issue is whether the legislature intended the deductions in ORS 656.268(13)(a) and 656.234(3)(a) to be alternative, concurrent, or otherwise interrelated. More precisely, the question is how claimant's temporary disability payments are calculated, considering the employer's prior overpayment and the child support order.

Thus, the sole issue is a legal one that requires us to construe the two statutes to determine how much is properly deducted from claimant's temporary disability payments. In making that determination, we apply the methodology established by the Supreme Court in *PGE v. Bureau of Labor and Industries*, 317 Or 606 (1993).

Under that methodology, we first examine the text and context of a statute because a statute's wording "is the best evidence of the legislature's intent." *Id.* at 610. Related to that principle is a rule of textual construction that governs the scope of our first-level inquiry. That rule limits our role in construing a statute

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[1] The employer argues that we should not address this argument because it is raised for the first time on review. As a general rule, we do not consider issues that are raised for the first time on review. However, alternative legal *theories* may be considered for the first time on Board review if there is not prejudice to the adverse party. *See Daniel B. Covert, on recon*, 52 Van Natta 2066 (2000). Here, the substantive issue at hearing was how much of claimant's benefit payment the employer was authorized to deduct. Thus, claimant's arguments on review regarding the proper amount of the deduction present a new theory, not a new issue. Moreover, because the deduction issue was litigated at hearing, we conclude that the employer has not been prejudiced by the new theory. *See id.*

"simply to ascertain and declare what is, in terms or in substance, contained therein, not to insert what has been omitted, or to omit what has been inserted [.]" ORS 174.010; *PGE*, 317 Or at 611.

The context of a statute relevant at the first level of analysis may include other provisions of the same statute and related statutes, *id.* at 610-11, prior enactments and judicial interpretations of those and related statutes, *Owens v. Maass*, 323 Or 430, 435 (1996), and the historical context of the relevant enactments, *Goodyear Tire & Rubber Co. v. Tualatin Tire and Auto*, 322 Or 406, 415 (1995), *on recon* 325 Or 46 (1997).

If, but only if, the intent of the legislature is not clear from the first level of analysis may legislative history be considered. *PGE*, 317 Or at 611. If that inquiry fails to yield an unambiguous result, then consideration may be given to pertinent maxims of construction. *Id.* at 612.[2]

Here, ORS 656.268(13)(a), regarding offset of overpayments, 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).

ORS 656.234, regarding child support taken from workers' compensation, provides:

"(1) *No moneys payable* under this chapter on account of injuries or death are subject to assignment prior to their receipt by the beneficiary entitled thereto, nor shall they pass by operation of law. All such moneys and the right to receive them are exempt from seizure on execution, attachment or garnishment, or by the process of any court.

"(2) Notwithstanding any other provision of this section:

"(a) *Moneys payable* pursuant to ORS 656.210 and 656.212 are subject to an order to enforce child support obligations, and spousal support when there is a current support obligation for a joint child of the obligated parent and the person to whom spousal support is owed, pursuant to ORS 25.378; and

"(b) *Moneys payable* pursuant to ORS 656.206, 656.214, 656.236 and 656.289 (4) are subject to an order to enforce child support obligations pursuant to ORS 25.378.

"(3) Notwithstanding the provisions of ORS 25.378 and 25.414, the amount of child support obligation subject to enforcement shall not exceed:

"(a) One-fourth of *moneys paid* under ORS 656.210 and 656.212 or the amount of the current support to be paid as continuing support, whichever is less, or, if there is no current support obligation and the withholding is for arrearages only, 15 percent of the moneys paid under ORS 656.210 and 656.212 or the amount previously paid as current support, whichever is less;

"(b) One-fourth of *moneys paid* under ORS 656.206, 656.214 and 656.236; or

"(c) One-fourth of the net proceeds paid to the worker in a disputed claim settlement under ORS 656.289 (4).

"(4) Notwithstanding any other provision of this section, when withholding is only for arrearages assigned to this or another state, the Department of Human Services may set a lesser amount to be withheld if the obligor demonstrates the withholding is prejudicial to the obligor's ability to provide for a child the obligor has a duty to support." (Emphasis added).

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[2] *See Young v. State*, 161 Or App 32, 35-36 (1999) (discussing "*PGE*" analysis).

Thus, ORS 656.234 authorizes a deduction for a support obligation from "moneys paid" and "moneys payable" as workers' compensation -- here, temporary total disability benefits. Under the statute, the amount withheld for this obligation shall not exceed "one-fourth of the moneys *paid* under ORS 656.210 and 656.212[.]" ORS 656.234(3)(a) (emphasis added).

ORS 656.268 authorizes offset of overpaid permanent disability against "any compensation *payable* to the worker to recover an overpayment[,]" not to exceed 25 percent of the *payment*.[3] ORS 656.268(13)(a) (emphasis added).

The terms and substance of the two statutes are similar in some respects and different in others. Both authorize deductions from benefits and both limit the respective deductions to 25 percent -- of "compensation payable" (for the overpayment) and 25 percent of "moneys paid" or "moneys payable" (for child support). Because both statutes independently provide for "deductions," we agree with the ALJ that deductions are authorized under both statutes. *See NW Alliance for Market Equality v. Department of Rev.*, 318 Or 129, 133 (1993) (if possible, we adopt "a construction that will give effect to all provisions of a statute"). However, it does not necessarily follow that the two deductions are taken from the same basis amount. In fact, the opposite inference arises, because the statutes describe that amount differently. *See, e.g., Perlenfein and Perlenfein*, 316 Or 16, 22-23 (1993) (legislature's use of a particular term in one provision of a statute and omission of that term in a related provision leads to a conclusion that the legislature did not intend that the term apply in the provision from which it is omitted).

The basis amount for purposes of recovering an overpayment is "compensation payable" and the subject amount for purposes of assigning claimant's support obligation to his or her obligee is "moneys paid" or "moneys payable." Paid, payable, and moneys are all words of common usage.[4] Nothing about either statute suggests that the legislature's usage here differs from common usage.

Compensation, on the other hand, is defined for purposes of the Workers' Compensation Statutes as including "all benefits, including medical services, provided to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to this chapter." ORS 656.005(8).

The significance of the different terms in the two statutes is not apparent from the text and context of the statutes. There are at least three plausible interpretations: both deductions are taken from the same amount; the offset is subtracted first, reducing the basis for the support obligation; or the support obligation is subtracted first, reducing the basis for the offset.[5] Because there is more than one plausible interpretation, the terms of the statutes are ambiguous. *See Young v. State*, 161 Or App 32, 34 (1999) (*PGE* requires a finding of at least two plausible interpretations before ambiguity may be deduced). Therefore, we turn to the legislative history of the enactments to determine the intent of the statutes.

The legislative history regarding recovery of overpayments does not shed light on the ambiguity or the question before us. However, the legislative history regarding ORS 656.234 indicates that the very question here was raised to the drafters, but not addressed, in committee discussion before enactment.

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[3] Based on the emphasized language, claimant contends that, because only 75 percent of his benefits remain payable to him after the support deduction, the offset for overpayment should only by 25 percent of the remaining 75 percent (rather than 25 percent of the amount payable to him before the support deduction). The parties do not consider the conclusion we reach -that the support deduction is taken from "moneys paid" *after* the offset.

[4] Moneys is the plural form of money, which is defined in pertinent part, as "anything that serves as a medium of exchange for goods and services[.]" Webster's *Third Int'l Dictionary*, 644 (unabridged ed. 1993). Payable and paid (past participle of pay) are used as adjectives modifying the moneys and compensation. Payable means "that must, should, or may be paid." *Id.* at 738. In this context, pay means "to give [someone] money owed or due." *Id.* at 737. *See PGE*, 317 Or at 611 (Words of common usage should be given their "plain natural and ordinary" meanings). The dictionary definitions do not help us resolve the statutes' ambiguity, as explained herein.

[5] *Compare, e.g., Hughes v. State of Oregon*, 314 Or 1, 28 (1992) (where one provision of statute referred to past and present benefits and another provision of the same statute to past, present and future taxes, court concluded that legislature "knew how to refer to the future").

House Bill 2461 was introduced in 1989 to amend ORS 656.234 and allow child support deduction from workers' compensation benefits. Representative Edmunson was on the House Judiciary Subcommittee on Family Justice that ultimately recommended passing the bill. On February 24, 1989, he described the bill to the subcommittee as "a major policy question," noting that the deduction would be from payments that were already just two-thirds of the worker's gross wages, while support payments were based on full salary before the disability. (Tape 37, Side B at 052). Representative Edmunson envisioned that support payments could take all the disability benefits. The bill's sponsor responded that the deduction was limited to 25 percent.

Representative Edmunson then asked the question presented in this case: "How do you deal with claims when temporary disability paid is in error?" He noted that carriers recover such payments, commonly at claim closure. (*Id.* at 111). The sponsor responded, "Not prepared to address technicalities." (*Id.*)

Then, on March 21, 1989, on the committee record, Representative Edmunson commented that he had attempted to "work through the amendments" with the Department of Justice, but had been "disappointed to learn" that the Department "stayed with" the original language of the bill. Representative Edmunson moved to delete the support deduction, but the motion failed and the committee voted 6-0 to recommend "Do Pass."

On May 5, 1989, Senator Bradbury described the support collection from workers' compensation in House Bill 2461 as "an excellent compromise with Senate Bill 510 that will allow 25 percent attachment rate on wage replacement benefits coming from Workers' Compensation[.]" (Tape Recording, Senate Judiciary Committee, HB 2461, May 5, 1989, Tape 160, Side A.) The bill passed and, as of 1989, support obligations may be deducted from workers' compensation payments. However, the legislative history does not indicate whether or how the authorized "deductions" in ORS 656.268(13) and ORS 656.234 affect each other.

Because the text, context, and legislative history do not answer the question presented, we must proceed to general maxims of statutory construction. *PGE*, 317 Or at 612. First and foremost, we must do our best to "determine how the legislature would have intended the statute to apply had it considered the issue." *Westwood Homeowners Assn. v. Lane County*, 318 Or 146, 158 (1993).

We read the statutes as consistent with one another and determine the legislature's intent by evaluating how this claim must be processed to give effect to both statutes. *See* 174.010.

Under ORS Chapter 656 the insurer or self-insured employer is responsible for computation of workers' compensation benefits in the first instance. ORS 656.262(1). ORS 656.210 and 656.212 provide the statutory basis for the temporary disability payments to injured workers. The Workers' Compensation Division provides rules for implementing these statutes, including calculation of temporary disability benefits. *See* OAR 436-060-0020, 436-060-0025, 436-060-0030. In addition, the calculation may include offset for recovery of previously overpaid benefits, as authorized by ORS 656.268(13)(a). *See* 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"); OAR 436-030-0580(15) ("[t]he insurer may allow overpayments made on a claim with the same insurer to be deducted from compensation to which the worker is entitled but has not yet been paid"); *see also* OAR 436-030-0580(14). Under the statutes and rules, logically, and as a practical necessity, amounts payable are determined before moneys are paid.

This reasoning is supported by the rules promulgated pursuant to ORS 25.275. These rules set out the method for calculating the amount of an obligor's support obligation. *See* OAR 461-195-0185. This obligation is determined based on the obligor's "gross income," which is defined to include workers' compensation benefits. OAR 137-050-0340. Thus, because the support obligation depends in part on the obligor's workers' compensation "income," workers' compensation benefits payable must be calculated before the amount of the child support obligation can be determined. In other words, the child support obligation is determined *after* determining "gross income," based in part on inclusion of workers' compensation "income." Because that income does not include the offset for recovery of the prior overpayment, the offset must precede the support assignment. Stated differently, the overpayment amount is not part of claimant's income, so it cannot be "moneys paid" or "moneys payable" for purposes of the support obligation. ORS 656.234.

Based on this reasoning, we conclude that the employer should first deduct 25 percent from claimant's temporary disability payment to recover its overpayment, then, from the remaining 75 percent balance, the employer should "divert" 25 percent as directed by the support order. The ALJ's order is modified accordingly.

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

Here, we find that the terms of ORS 656.268(13) and 656.234, standing alone, are reasonably understood to separately authorize 25 percent "deductions" from the same subject amount. Under these circumstances, we cannot say that the employer's 50 percent "deduction" amounted to unreasonable claim processing. Therefore, we conclude that the employer had a legitimate doubt regarding its computation of claimant's benefits and no penalty is appropriate.

ORDER

The ALJ's order dated October 10, 2000 is modified in part and affirmed in part. The claim is remanded to the self-insured employer for recalculation of claimant's temporary disability payment, consistent with this order. The remainder of the order is affirmed.

March 12, 2001 Cite as 53 Van Natta 293 (2001)

In the Matter of the Compensation of
KATHY M. CLEARY, Claimant
WCB Case No. 99-07496
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorney
Hornecker, Cowling, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Myzak's order that: (1) set aside its denial of claimant's injury claim for a bilateral wrist condition; and (2) assessed a penalty for the employer's allegedly unreasonable denial. 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.

CONCLUSIONS OF LAW AND OPINION

Compensability

The ALJ set aside the employer's denial of claimant's injury claim[1] for a "combined" bilateral carpal tunnel syndrome condition based on the opinions of Drs. Parvin and Bernstein. On review, the employer contends that Drs. Parvin and Bernstein's opinions are not persuasive for several reasons.

The causation of claimant's combined carpal tunnel syndrome condition represents a complex medical question, given the many potential causative factors in the record, including claimant's preexisting carpal tunnel syndrome condition (which, the medical evidence proves, contributed to her "combined" carpal tunnel syndrome condition). Accordingly, expert medical opinion is required. *Barnett v. SAIF*, 122 Or App 279 (1993).

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[1] The ALJ also upheld the employer's oral denial of claimant's occupational disease claim for the same condition.

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, 263 (1986). In addition, we generally rely on the opinion of claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810 (1983).

Here, we agree with the ALJ that claimant has established the compensability of her bilateral carpal tunnel syndrome condition as a "combined condition." ORS 656.005(7)(a)(B). Under the "combined condition" standard, claimant must prove that her work injury is the major contributing cause of her disability or need for treatment for her combined carpal tunnel syndrome condition. *SAIF v. Nehl*, 148 Or App 101, *on recon*, 149 Or App 309 (1997), *rev den* 326 Or 389 (1998).

In reaching this conclusion, however, we decline to rely on the opinion of Dr. Bernstein because we cannot discern from his opinion whether he has implicated claimant's work injury, as opposed to her "preexisting carpal tunnel syndrome," as the major contributing cause of her disability and need for treatment for the combined carpal tunnel syndrome condition. (*See* Ex. 37). In response to claimant's counsel's inquiry, Dr. Bernstein stated that "[I]t is medically probable that there is a combination between her medical injury and the carpal tunnel syndrome. I further agree that it is medically probable that the major cause of her need for treatment is the combination of her pre-existing carpal tunnel syndrome and her spine injury, with the former not becoming symptomatic until the point of her spine injury." (Ex. 37). From this statement, it is ambiguous whether Dr. Bernstein determined that the work injury or the "preexisting carpal tunnel syndrome" condition is the major contributing cause of claimant's need for treatment for the resultant combined condition. Accordingly, we find Dr. Bernstein's opinion unpersuasive.

Instead, we rely on the opinion of Dr. Parvin. Dr. Parvin, who examined claimant on referral from her treating physician Dr. Bach, concluded that "the major cause of [claimant's] current need for treatment relative to her carpal tunnel syndrome is the March 17, 1999, industrial injury." (Ex. 38-2).

The employer contends that Dr. Parvin identified many possible contributors to claimant's carpal tunnel syndrome condition, but did not identify any one cause as the major contributing cause. We disagree. Although Dr. Parvin identified claimant's work injury, her September 1999 motor vehicle accident, her degenerative cervical spondylosis and cervical disc herniation, her predisposition to develop carpal tunnel, and her work activities as possible contributing factors, he ultimately concluded that claimant's work injury was the major contributing cause of claimant's need for treatment for the combined condition. (Exs. 30, 38). Dr. Parvin's opinion therefore satisfies the *SAIF v. Nehl* standard stated above. Based on this persuasive opinion, we agree with the ALJ's conclusion that claimant's bilateral wrist condition is compensable.

Penalties

The ALJ also assessed a penalty for the employer's denial of claimant's "combined condition" claim, finding that there was no contrary medical opinion to that of Drs. Bernstein and Parvin, and that, therefore, the employer had no legitimate doubt about the compensability of the need for treatment and disability for claimant's combined carpal tunnel syndrome condition.

On review, the employer contends that the ALJ erred in assessing a penalty. The employer contends it had a legitimate doubt as to the compensability of claimant's carpal tunnel syndrome condition given claimant's various theories of compensability and in light of the conflicting medical opinions on causation. We agree.

In determining whether a delay or refusal to pay compensation is unreasonable, the question is whether the carrier had a legitimate doubt as to its liability at the time of the denial. *Brown v. Argonaut Insurance Co.*, 93 Or App 588, 591 (1988); *Errol L. Schrock*, 52 Van Natta 1888 (2000). Here, at the time of the employer's July 30, 1999 denial of claimant's injury claim, the employer had obtained the June 17, 1999 report of Dr. Grant, who initially diagnosed claimant's carpal tunnel syndrome condition, but stated that the condition was "definitely * * * not related to this work injury of 3/17/99." (Exs. 20-4, 25). The employer also had claimant's treating physician Dr. Bach's July 6, 1999 concurrence with Dr. Grant's report at the time of its denial. (Ex. 23).

Although Dr. Grant did not state his opinion precisely in terms of the "combined condition" standard, Dr. Grant's opinion is that claimant's carpal tunnel syndrome is a preexisting condition, and that her March 17, 1999 work injury at most precipitated claimant's symptoms. (Ex. 20-4). Claimant later developed persuasive medical evidence supportive of her carpal tunnel syndrome condition as a "combined condition," as explained above. However, Dr. Grant's opinion by itself would not have satisfied claimant's burden of proof. Even reading Dr. Grant's opinion in the most advantageous manner for claimant's claim, it rests on a "precipitating cause" analysis that has been found unpersuasive. *Deitz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed*, 321 Or 416 (1995); *Steven M. Kenimer*, 53 Van Natta 6 (2001).

Based on those circumstances, we find that the employer had a legitimate doubt as to the compensability of claimant's carpal tunnel syndrome as an injury or "combined condition" claim at the time of its July 30, 1999 denial. Accordingly, we reverse the ALJ's assessment of a penalty under ORS 656.262(11).

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 concerning the compensability issue is $1,250, 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), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 13, 2000 is affirmed in part and reversed in part. That portion of the order that assessed a penalty is reversed. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded $1,250, payable by the self-insured employer.

In the Matter of the Compensation of
JOSEPH M. HAMILTON, Claimant
WCB Case No. 00-04867
ORDER ON REVIEW
Gayle A. Shields, Claimant Attorney
Jerry Keene, Defense Attorney

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

The insurer requests review of that part of Administrative Law Judge (ALJ) Davis' order that set aside its partial denial of claimant's claim for loose bodies in his left ankle. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exception and correction. We do not adopt the second sentence of the ALJ's findings of ultimate fact. The insurer closed the accepted disabling left ankle sprain injury claim by Notice of Closure on March 8, 2000. (Ex. 40).

CONCLUSIONS OF LAW

On August 14, 1998, claimant tripped coming down the ramp of a delivery truck while working for the employer. The insurer accepted the claim as a disabling left ankle sprain. Prior to this injury, claimant had a long history of injuries to his left ankle and foot, including a motor vehicle accident that resulted in left-foot drop, a possible breaking of the left ankle in 1979, and a history of repeated left ankle strains/sprains. By letter dated May 24, 2000, claimant's attorney requested the insurer to accept the condition of "loose bodies and osteophytosis, lateral aspect of the left ankle." (Ex. 40C). On June 23, 2000, the insurer denied compensability of these conditions. (Ex. 41).

We adopt the ALJ's reasoning and conclusions that the work injury combined with claimant's preexisting left ankle condition. Claimant does not dispute this conclusion. Therefore, under the "combined condition" statute, claimant must prove that his August 1998 left ankle sprain was the major contributing cause of his disability or need for treatment for his combined left ankle condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 301, *on recon*, 149 Or App 309 (1997).

When determining major contributing cause in a "combined condition" context, a persuasive medical opinion must evaluate the relative contribution of different causes of claimant's disability or need for treatment for the combined condition and decide which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397, 401-402 (1994), *rev dismissed* 320 Or 416 (1995). The fact that a work event precipitated the symptoms or need for treatment of a condition does not necessarily mean that the work incident was the major contributing cause of the condition or its need for treatment. *Id.* at 401; *see also Robinson v. SAIF*, 147 Or App 157, 162 (1997).

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).

Here, two physicians render causation opinions. Dr. Farris, orthopedist, examined claimant on behalf of the insurer. (Exs. 27, 38). He opined that, as a result of the work injury, claimant had a soft tissue injury that was superimposed on a significant preexisting condition in the left ankle. (Ex. 27-7). He opined that this soft tissue injury should have resolved and it was medically probable that claimant's preexisting condition was the major contributing cause of claimant's current left ankle condition. (*Id.*). After reviewing the operative report, Dr. Farris maintained his opinion that claimant's primary problem was one of chronic degenerative change rather than an acute injury. (Ex. 38-1).

Dr. Greenleaf first examined claimant on April 8, 1999, at which time he noted that claimant's history was "[s]ignificant for previous lower extremity trauma, with a resultant partial left footdrop." (Ex. 22). At that time, Dr. Greenleaf suspected scar tissue formation or a loose body in the lateral gutter of the left ankle and recommended an ankle arthroscopy.

On July 27, 1999, Dr. Greenleaf performed an arthroscopy. (Ex. 29). In the operative report, Dr. Greenleaf noted that there were some moderate osteophytes at the tibia and that the lateral gutter had significant scar tissue formation with several loose bodies. The arthroscopy included: (1) debridement of the lateral aspect of the left ankle; (2) debridement of osteophytes from the left fibula; and (3) removal of loose bodies from the lateral gutter in the left ankle. (Ex. 29).

Dr. Greenleaf's operative report and his chart notes before and after this surgery did not discuss the cause of claimant's left ankle condition. (Exs. 22, 26, 29, 30, 36). Instead, Dr. Greenleaf's causation opinion is contained in a conversation summary in which he stated that he believed that the "loose bodies" removed during surgery were pieces of osteophyte that were broken off during the work injury. (Ex. 40A-1). He also stated that, although claimant had a preexisting condition in that at least some of the osteophytes were probably formed before the accident, the work accident was the major contributing cause of a pathological worsening of the preexisting condition. Finally, he stated that the work injury was the major contributing cause of the combined condition, the need for treatment of the combined condition, and the resulting disability of the combined condition. (*Id.*).

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, 263 (1986). Absent persuasive reasons to the contrary, we generally rely on the opinion of claimant's treating physician. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to claimant's current treating physician, Dr. Greenleaf.

Although Dr. Greenleaf acknowledged some contributory role from claimant's preexisting left ankle condition to his disability and need for treatment, he did not weigh or analyze its relative contribution. (Ex. 40A). *Dietz v. Ramuda*, 130 Or App at 401-402. Instead, Dr. Greenleaf made a conclusory statement that the work injury was the major contributing cause of claimant's disability and need for treatment.

Claimant argues that we should defer to Dr. Greenleaf because he had the opportunity to observe claimant's left knee during surgery. Generally, deference is given to the treating physician who was able to observe the affected body part during surgery. *See Argonaut Insurance Company v. Mageske*, 93 Or App 698, 702 (1988). However, although Dr. Greenleaf performed claimant's surgery, he does not

relate any surgical observations to his causation opinion. *Compare Mageske*, 93 Or App at 702 (treating surgeon's opinion found persuasive where he was able to observe the claimant's shoulder during surgery and indicated that there was no evidence that the claimant's condition was due to congenital defect); *Givens v. SAIF*, 61 Or App 490, 494 (1983) (treating surgeon's opinion found persuasive where he indicated that he saw no evidence during surgery that the claimant's that the claimant's thoracic outlet syndrome was the result of a congenital defect or a compressed artery).

Accordingly, on this record, we find that claimant failed to meet his burden of proving that the work injury was the major contributing cause of the disability or need for treatment of the combined left knee condition. ORS 656.005(7)(a)(B).

ORDER

The ALJ's order dated October 30, 2000, as amended November 27, 2000, is reversed. The insurer's partial denial is reinstated and upheld. The ALJ's assessed attorney fee award is reversed.

Board Member Phillips Polich dissenting.

For the reasons given by the ALJ, I would rely on the opinion of Dr. Greenleaf, claimant's treating surgeon. Specifically, although claimant has a history of injury to his left ankle, he was functional prior to the current work injury. Furthermore, after that injury he had ongoing problems until the surgery performed by Dr. Greenleaf. As a result of performing this surgery, Dr. Greenleaf is in a better position to provide an opinion as to the cause of claimant's left ankle condition. Dr. Greenleaf opines that several loose bodies were broken off during claimant's work injury and the underlying condition was pathologically worsened. (Ex. 40A-1). Dr. Greenleaf also opines that the work injury was the major contributing cause of the combined condition, disability, and need for treatment. (*Id.*).

Contrary to the majority's opinion, I see no reason not to rely on Dr. Greenleaf's causation opinion. In addition, the opinion of Dr. Farris, examining orthopedist, is unpersuasive. In this regard, Dr. Farris simply stated that claimant only sustained a soft tissue injury as a result of the work injury, without explaining why the work injury did not also cause osteophytes in the left ankle to break off and cause the loose bodies that required surgical treatment. On this record, I would affirm the ALJ's order and find the loose body condition in claimant's left ankle compensable. Because the majority disagrees, I respectfully dissent.

In the Matter of the Compensation of
LONNY L. POPE, Claimant
WCB Case No. 99-05769
ORDER ON RECONSIDERATION
Thomas J. Dzieman, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorney

On January 26, 2001, we abated our January 11, 2001 order that affirmed an Administrative Law Judge's (ALJ's) order that set aside the insurer's denial of claimant's right index finger injury claim and awarded an insurer-paid attorney fee. We took this action to consider the insurer's motion for reconsideration. Having received claimant's response, we proceed with our reconsideration.

The ALJ found that the insurer's guaranty contract remained in effect as of June 28, 1999, the date of claimant's injury, because it was not canceled under either ORS 656.423 or ORS 656.427. In our initial order, we found that the insurer provided coverage to the employer as of the date of claimant's injury on the additional basis that the employer had not canceled its guaranty contract by providing notice to the Director, as required by ORS 656.423(1). On reconsideration, the insurer contends that its liability was automatically terminated as of the effective date of the subsequent insurer's guaranty contract, pursuant to OAR 436-050-0100(4). We agree.

ORS 656.419(5) provides that "[c]overage of an employer under a guaranty contract continues until canceled or terminated as provided by ORS 656.423 or 656.427." ORS 656.423 provides the mechanism for cancellation of coverage by the employer. ORS 656.427 provides for termination of guaranty contracts by the insurer.

Pursuant to ORS 656.427, the insurer may terminate its liability by giving notice to the employer and to the Director of the Department of Consumer and Business Services (the Director). ORS 656.427(1). An employer may terminate coverage by an insurer by giving the insurer 30 days notice, or by providing other coverage or becoming a self-insured employer. ORS 656.423(1) and (3). Cancellation under ORS 656.423(3) is effective immediately upon the effective date of the other coverage or the effective date of certification as a self-insured employer. ORS 656.423(3).

Here, the insurer filed a notice of termination with the Director, but not until after claimant's date of injury. (Ex. 14-4). There is no evidence that the insurer ever gave notice of termination to the employer. We are therefore persuaded that the insurer did not terminate coverage pursuant to ORS 656.427 prior to the date of claimant's injury. In other words, referencing only ORS 656.427, the insurer's guaranty contract was still in effect as of the date of claimant's injury.

However, the employer contracted with a subsequent insurer to provide coverage, with an effective date of February 3, 1998. (Ex. 14-2). Therefore, there were two guaranty contracts in effect with the Director for the same period of time. OAR 436-050-0005(13) defines "double coverage" as "more than one guaranty contract in effect with the Director for the same period of time." Thus, there was a "double coverage" situation from February 3, 1998 through at least the date of claimant's injury.[1] OAR 436-050-0100(4) provides that "[w]hen there is a double coverage situation, the preceding insurer's responsibility will terminate with the effective date of a guaranty contract issued by the subsequent insurer."[2]

We therefore conclude that the insurer's responsibility terminated on February 3, 1998, the effective date of the guaranty contract issued by the subsequent insurer. OAR 436-050-0100(4).

Claimant contends that the subsequent insurer's guaranty contract was not filed with the Director until after claimant's date of injury, and has no effect until after it was filed. We disagree. ORS 656.423(3) provides that "[a] cancellation under this section [*e.g.*, the employer's providing other coverage] is effective *immediately upon the effective date* of the other coverage[.]" (Emphasis added). *See also* OAR 436-050-0100(1); *D Maintenance Co. v. Mischke*, 84 Or App 218, 222, *rev den* 303 Or 483 (1987). Here, the effective date of the subsequent insurer's coverage was February 3, 1998. (Ex. 14-2).[3]

We also reject claimant's contention that the insurer was obligated to comply with the cancellation requirements of ORS 656.427 in order to terminate its coverage. First, we note that ORS 656.419(5) provides that coverage of an employer under a guaranty contract can be terminated pursuant to ORS 656.427 or ORS 656.423. Moreover, ORS 656.427(1) uses the permissive language "[a]n insurer * * * *may* terminate its liability [by giving written notice to the employer and to the Director.]" In other words, ORS 656.427 does not expressly preclude other methods of cancellation or termination.

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[1] We note that claimant settled his claim with the subsequent insurer.

[2] OAR 436-050-0100(5) provides that "[a]n insurer, whose coverage responsibility is terminated by the filing of a guaranty contract by a subsequent insurer, must file a notice of termination as required by ORS 656.423 or 656.427 within 30 days after becoming aware of the need to terminate the guaranty contract." Although this subsection requires the insurer to file a guaranty contract after "becoming aware of the need" to terminate its contract, the language of the rule suggests that the insurer's responsibility has already been (automatically) terminated by the filing of a guaranty contract by the subsequent insurer. We also note that the Director is authorized to assess civil penalties for a carrier's violation of its rules, *e.g.* ORS 656.745(2)(b). However, the insurer is not thereby precluded from taking advantage of the effect of other rules, *i.e.*, OAR 436-050-0100(4).

[3] We reject claimant's argument that the insurer must comply with ORS 656.423(4) in order to terminate its responsibility where the employer has terminated its old coverage by providing new coverage. ORS 656.423(4) requires the insurer to send a copy of the notice of cancellation to the Director "within 10 days after receiving notice of cancellation [from the employer] under this section." However, ORS 656.423(3) does not require the employer to send notice of cancellation to the prior insurer in order to complete the cancellation of coverage. Instead, that subsection provides that cancellation is "effective immediately upon the effective date of the other coverage." Even if ORS 656.423(3) only shortens the 30-day notice requirement of ORS 656.423(1), and therefore requires that notice be given to the insurer for cancellation to be effective, there would still be two guaranty contracts on file with the Director as of claimant's date of injury, a "double coverage" situation. OAR 436-050-0100(4) would then automatically terminate the first insurer's responsibility as of the effective date of the second insurer's guaranty contract.

Similarly, we decline claimant's invitation to find OAR 436-050-0100 inconsistent with ORS 656.423 or 656.427, and therefore exceeding the Director's authority. Both ORS 656.423 and ORS 656.427 utilize the same permissive language, and are thus not inconsistent with the administrative rule.

In *Wausau v. Walker*, 155 Or App 231 (1998), the court held that an insurer could not cancel its guaranty contract pursuant to ORS 656.427(1) without providing written notice to the Director. *Id.* at 236. We therefore agree with claimant that notice to the Director is not merely a "procedural nicety," *if* the insurer wishes to cancel coverage pursuant to ORS 656.427. However, *Walker* did not address the effect of ORS 656.423 or OAR 436-050-0100 when there is a "double coverage" situation, as here. *Walker* is therefore distinguishable.

Accordingly, on reconsideration, we withdraw our January 11, 2001 order. In lieu of that order, the ALJ's order setting aside the insurer's denial is reversed. The insurer's denial is reinstated and upheld. The ALJ's assessed attorney fee award is also reversed. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

March 12, 2001 Cite as 53 Van Natta 299 (2001)

In the Matter of the Compensation of
SUZANNE J. SILLER, Claimant
WCB Case No. 00-05797
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) declined to grant claimant's request to continue the hearing for the admission of additional medical reports (proposed Exhibits 48 and 49); (2) declined to reopen the record to admit the aforementioned medical reports; (3) found that the insurer's denial of claimant's occupational disease claim for a low back condition pertained to both legal and medical causation; and (4) upheld the insurer's denial of the claim.[1] On review, the issues are the ALJ's procedural and evidentiary rulings and compensability.

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

Claimant filed the claim for her low back condition on April 20, 2000, alleging an onset date of March 1, 2000. (Ex 6). On July 11, 2000, the insurer issued a denial stating in pertinent part:

> "You stated 5/9/00 there was no specific injury. You're [*sic*] lower back hurt when you sat down or when you walked and when you stand up. You further stated to me that you hurt your back at home while you were cleaning. And in fact you could not work Monday 5/1/00.
>
> "We received an 827 First Medical Report 5/11/00 with Diagnosis of lower back pain.
>
> "After review of your claim and completion of my investigation I find there is insufficient evidence of an on the job injury.
>
> "Therefore, without waiving further questions of compensability, we respectfully issue this denial of compensability and responsibility for any treatment or disability in connection with your Low Back Condition[.]" (Ex 39-1).

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[1] The ALJ determined that claimant was seeking to establish the compensability of her low back condition as an occupational disease, rather than as an occupational injury. Claimant does not assert otherwise. Consequently on review, we analyze the compensability of claimant's low back pursuant to ORS 656.802.

At the commencement of the hearing, claimant attempted to limit litigation to course and scope of employment, asserting that the "insufficient evidence of a job injury" language in the denial limited the compensability issue to legal causation only. (Tr. 2). The insurer objected, maintaining that both legal and medical causation remained in issue.

The ALJ, relying on *Mary K. Phillips*, 50 Van Natta 519 (1998) (denial stating that injury did not occur in "course and scope" of employment included defense of medical causation), determined the insurer's reference to "on the job injury" raised the issue of claimant's work activities causing a low back condition in the same way that a reference to "course and scope" includes medical causation. Consequently, the ALJ sustained the insurer's objection and declined to limit the litigation to legal causation.

In response to the ALJ's ruling, claimant sought a continuance to obtain additional medical evidence. (Tr. 2). The ALJ sustained the insurer's objection to a continuance, but did allow claimant until the close of the hearing to submit additional medical evidence. (*Id.*) No additional medical evidence was submitted before the close of the hearing.

Five days later, claimant submitted proposed Exhibits 48 and 49. The ALJ sustained the insurer's objection to the proffered evidence and declined to admit those exhibits.

Claimant contends that the ALJ erred in: (1) declining to grant a continuance: and (2) in declining to admit proposed Exhibits 48 and 49. As a result of the alleged error, claimant seeks remand for the admission of proposed Exhibits 48 and 49. We review both rulings for abuse of discretion.[2] Because claimant also seeks remand for the admission of the aforementioned proposed exhibits, we examine the proposed exhibits to determine if remand is appropriate.

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). For the reasons stated below, we conclude that the admission of the proposed exhibits will not likely affect the outcome of the case.

Claimant ultimately seeks to establish the compensability of her low back condition as an occupational disease. Therefore, she must prove that her 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).

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[2] An ALJ may continue a hearing for further proceedings for any party to respond to an issue raised for the first time at hearing. OAR 438-006-0091(c). Because the language of the continuance rule is permissive (*i.e.*, "may") and delegates to the ALJ a range of discretion in granting a continuance, we review an ALJ's ruling (on a continuance motion) for abuse of discretion. *See Georgia-Pacific Corp. v. Kight*, 126 Or App 244, 246 (1994); *David E. Collins*, 49 Van Natta 561, 562 (1997).

Additionally, 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).

Here, after considering the circumstances and arguments presented at the time of the hearing (as well as those raised following the hearing), we are not inclined to find that the ALJ's rulings constitute an abuse of discretion. However, we need not conclusively resolve that question because, even if the excluded exhibits were considered, they would not alter the ultimate outcome of claimant's occupational disease claim for the reasons expressed above.

Here, the proffered exhibits consist of "check-the-box" letters from Dr. Carlson and Dr. Larsen stating simply that claimant's low back condition "arises out of her working activities." At best the proposed exhibits establish only that claimant's low back condition was caused, in part, by her work activities; they do not establish that claimant's work activities were the major contributing cause of the low back condition. Consequently, even if the proposed exhibits were admitted, the medical record would still be insufficient to establish the compensability of claimant's low back condition as an occupational disease.

Because we have concluded that the admission of the proposed exhibits will not change the outcome of claimant's occupational disease claim, we conclude that there is no compelling reason to remand for the admission of the proposed exhibits. Accordingly, with the aforementioned supplementation, we affirm the ALJ's order.

ORDER

The ALJ's order dated November 15, 2000 is affirmed.

March 13, 2001 Cite as 53 Van Natta 301 (2001)

In the Matter of the Compensation of
FRANK W. BOLLINGER, Claimant
WCB Case No. 00-04136
ORDER ON REVIEW
Schneider, et al, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order that declined to award temporary disability compensation for the period from October 17, 1997 through October 26, 1998. On review the issue is temporary disability.

We adopt and affirm the ALJ's order.

ORDER

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

Board Member Phillips Polich concurring.

I acknowledge that claimant and his family have suffered devastating financial hardship with the injury-related loss of twelve months of income. However, I am constrained to follow ORS 656.262(4)(g) and *Fred Meyer, Inc. v. Bundy*, 159 Or App 44, *rev dismissed*, 329 Or 503 (1999): Temporary disability is simply not due unless the worker's attending physician authorizes time loss within 14 days of the loss claimed. Because there is no such contemporaneous medical authorization for most of the lost work time in this case, there is no legal remedy for claimant's hardship.

In the Matter of the Compensation of
VIRGINIA E. BRAY, Claimant
WCB Case No. C010459
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Welch, Bruun & Green, Claimant Attorney
VavRosky, et al, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

On February 27, 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 released rights to future workers' compensation benefits, except medical services, for the compensable injury. For the following reasons, we approve the proposed disposition.

The CDA provides in an attached addendum: "...Therefore, the parties agree that the February 8, 2001 Order on Reconsideration will be rescinded, the September 19, 2000 Notice of Closure will be affirmed in its entirety, and the claim will be processed pursuant to paragraph 8 of the original CDA."

We have held that it is impermissible for a CDA to accomplish claim processing functions, such as determining whether a claimant is medically stationary or awarding permanent partial disability, because it is not one of the objectives to be resolved with such an agreement. *E.g., Kenneth R. Free*, 47 Van Natta 1537 (1995); *Debbie K. Ziebert*, 44 Van Natta 51 (1992). The function of a claim disposition agreement is to dispose of an accepted claim, with the exception of medical services, as the claim exists at the time the Board received the CDA. *See* ORS 656.236(1).

Here, however, we do not interpret the present CDA as impermissibly attempting claim processing functions. Instead, we consider the so-called "rescission" of the Order on Reconsideration as, in effect, an agreement between the parties that the proceeds of the CDA are in lieu of the benefit awarded by the Order on Reconsideration.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHAEL J. CROUCH, Claimant
WCB Case No. 00-04921
ORDER ON REVIEW
Bottini, et al, Claimant Attorney
Reinisch, et al, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the insurer's denials of his injury claim for L4-5 and L5-S1 disc conditions. On review, the issue is compensability.

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

In the fifth paragraph on page 2, we change the second sentence to read: "He reported that claimant had resolution of all low back discomfort and leg complaints, except for minor low back discomfort with overexertion and occasional stiffness. (Ex. 16)." After the fifth paragraph on page 2, we add the following:

> "Dr. Brett reported on October 3, 1997 that claimant was 'doing very nicely with resolution of all complaints and no residual discomfort.' (Ex. 20). Claimant's lumbar range of motion was unimpaired without pain or muscle spasm and Dr. Brett reported that claimant was 'extremely pleased' with his progress. (*Id.*)"

After the first paragraph on page 4, we add the following: "Dr. Bernier concurred with Dr. Gritzka's report. (Ex. 53)." On page 4, we replace the third paragraph with the following:

> "On September 14, 2000, Drs. Fuller and Reimer examined claimant on behalf of the insurer. (Ex. 54). They diagnosed preexisting, progressive degenerative discopathy at L4-5 and L5-S1 with facet arthropathy. (Ex. 54-10). They found no evidence of a discogenic or annular injury in 1997. (Ex. 54-10, -12, -15). In addition, they found no relationship between claimant's 1997 injury and his need for surgery in July 2000. (Ex. 54-13)."

In the last paragraph on page 4, we delete the first sentence and change the beginning of the second sentence to read "Dr. Gritzka" rather than "He."

For the following reasons, we agree with the ALJ that the medical evidence is insufficient to establish compensability of claimant's L4-5 and L5-S1 disc conditions.

The ALJ was not persuaded by Dr. Gritzka's opinion that claimant suffered a torn annulus at the time of the July 1997 injury because that finding was not supported by any of the imaging studies or by the surgical findings. The ALJ also found that Dr. Gritzka relied on an inaccurate history that claimant had a healthy back prior to 1997.

On review, claimant argues that the ALJ erred by discounting Dr. Gritzka's opinion. Claimant contends that Dr. Gritzka's opinion was the most comprehensive and accurate. We disagree.

Dr. Gritzka found that claimant had a "remarkably healthy-appearing back" and that his July 1997 work injury did not combine with or worsen any preexisting low back condition. (Ex. 52-10). In addition, he did not believe that claimant's x-rays showed any change that could be deemed degenerative arthritis or significant lumbar spondylosis. (Ex. 52-8).

Unlike Dr. Gritzka, Drs. Brett, Smith, Fuller and Reimer found that claimant had a preexisting degenerative condition at L4-5 and L5-S1 that combined with his July 1997 injury. (Exs. 37, 39, 50, 52A, 54). After performing claimant's low back surgery, Dr. Brett diagnosed his condition as preexisting lumbar spondylotic disease and some congenital smallness of the spinal canal with a superimposed disc protrusion at L4-5 with nerve root impingement. (Ex. 52A). Because Dr. Brett was the treating surgeon,

we find his diagnosis of preexisting lumbar spondylitic disease more persuasive than Dr. Gritzka's finding that claimant had no significant lumbar spondylosis. In addition, Drs. Fuller and Reimer explained that claimant had preexisting degenerative discopathy at L4-5 and L5-S1 with facet arthropathy that combined with the July 1997 work injury. (Ex. 54-10, -13). Based on the contrary and persuasive medical evidence, Dr. Gritzka's opinion that claimant's July 1997 work injury did not combine with a preexisting low back condition is entitled to little weight.

Moreover, we find that Dr. Gritzka did not have an accurate understanding of claimant's July 3, 2000 surgery. Dr. Gritzka opined that "[claimant's] L4-5 and/or L5-S1 condition pathologically worsened subsequent to claim closure in 1997 with the disc protrusion slowly worsening over time, resulting finally in the need for surgery at the L4-5 and at the L5-S1 levels[.]" (Ex. 52-10). Dr. Brett, however, did not perform surgery at L5-S1. Rather, he performed a bilateral L4-5 keyhole laminectomy and foraminatomy. (Ex. 47). Although Dr. Brett felt that claimant's L4-5 disc had worsened, he found no new pathology at L5-S1. (Ex. 52A). In sum, we find that Dr. Gritzka's report is based on an inaccurate information and is poorly reasoned. We agree with the ALJ that Dr. Gritzka's opinion is not persuasive. Similarly, because Dr. Bernier concurred with Dr. Gritzka's opinion, we find that his opinion is entitled to little weight.

Claimant also relies on Dr. Brett's opinion to establish compensability. Dr. Brett agreed with Dr. Gritzka's report that "the 7-8-97 industrial injury is the major contributing cause of [claimant's] current low back condition and/or need for treatment." (Ex. 52A). Based on the aforementioned inconsistencies between Dr. Gritzka's report and Dr. Brett's reports regarding the nature of the preexisting condition and the surgery performed, we find that Dr. Brett's agreement with Dr. Gritzka's report is inadequately explained and unpersuasive.

Furthermore, although Dr. Brett said that claimant sustained an "annular injury at L4-5 or L5-S1" in 1997 (Ex. 39), he had reported on October 3, 1997 that claimant had "resolution of all complaints and no residual discomfort." (Ex. 20). Dr. Brett did not adequately explain his opinion, particularly in light of Drs. Fuller and Reimer's well-reasoned, contrary opinion. Drs. Fuller and Reimer found no support in the contemporaneous MRI studies or Dr. Brett's surgical findings to establish that claimant had a discogenic or annular injury in 1997. (Ex. 54-10, -12, -15). They explained why they did not agree with the theory that claimant tore some annular fibers in 1997:

> "This panel does not agree with this highly speculative conclusion - since nothing in the factual medical records supports this speculation. First of all there was no bright spot on the MRI in 1997 consistent with a fresh annular tear. If the annulus is torn or compromised, generally a progressive disc protrusion occurs. Since there was no change on comparison of any of the imaging studies, over a three year time frame, no such progression is documented, nor is a traumatic discopathy described. Furthermore, there was no narrowing or compromise or change in the disc spaces, over a three year period that would suggest a traumatic insult to either the L4-5 or L5-S1 discs.
>
> "Finally, Dr. Brett did not find any disc pathology at the time of surgery when he directly visualized the L4-5 disc, not only on the right but also on the left. He found the 'annulus firmly bulging diffusely across the entire disc space without focal herniation or sequestered fragment.' In other words, he found an entirely normal annulus given that [claimant] had pre-existing age-related degeneration, without any annular tear." (Ex. 54-15).

We conclude that Dr. Brett's opinion is not persuasive because it lacks adequate explanation and is not well-reasoned. We agree with the ALJ that the medical evidence is not sufficient to establish that claimant's July 1997 injury was the major contributing cause of his need for medical treatment or disability for his L4-5 or L5-S1 disc conditions.

ORDER

The ALJ's order dated December 13, 2000 is affirmed.

In the Matter of the Compensation of
MICHAEL E. FULLER, Claimant
WCB Case Nos. 99-08163 & 99-07797
ORDER ON REVIEW
Welch, et al, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Meyers and Bock.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Lipton's order that: (1) set aside its denials of claimant's "new injury" claim for a low back condition; and (2) upheld Liberty Northwest Insurance Company's (Liberty's) denial of claimant's aggravation claim for the same condition. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the last paragraph of findings.

CONCLUSIONS OF LAW AND OPINION

At all relevant times, claimant worked for the employer, an electrical contractor. Liberty provided workers' compensation coverage through September 30, 1998 and SAIF's coverage began October 1, 1998.

Claimant has a history of back problems that began at age 15. On October 16, 1995, when Liberty was on the risk, claimant sustained a compensable nondisabling low back strain injury. (Exs. 1 through 5). Dr. Foresman declared him medically stationary on October 18, 1995, and released him to regular work. (Ex. 6). Claimant returned for flare-ups of low back symptoms in April 1996, September and October 1997, and February 1998. Claimant also regularly self-medicated with an over-the-counter analgesic.

On November 6, 1998, claimant developed an ache in his low back while carrying a 70-80 pound load of supplies at work. Two days later, when he straightened up from bending over, his back began to spasm. His condition worsened and he consulted Dr. Mick, his family physician, on November 9, 1998. (Ex. 11). Dr. Mick noted that claimant was moving with difficulty and needed assistance. On physical examination, Dr. Mick found that claimant's reflexes were adequate and leg strength good, but that he had pain with extension of his legs at the knee. Dr. Mick diagnosed a lumbosacral strain and recurrent strain. (*Id.*) On November 12, 1998, claimant returned to Dr. Mick for follow up. Upon physical examination, Dr. Mick found tenderness and muscle tension in the low back. (Ex. 12).

On March 29, 1999, claimant returned to Dr. Mick complaining of increased low back pain. Physical examination revealed muscle spasm and pain in the lower lumbar area. (Ex. 14).

Claimant continued to experience low back pain. On May 19, 1999, Dr. Mick referred him to Dr. Schmidt, neurosurgeon, for a surgical assessment. (Ex. 16). On May 28, 1999, Dr. Mick filed a claim for aggravation. (Ex. 17).

On June 14, 1999, claimant filed an 801 form. (Ex. 18).

Dr. Schmidt examined claimant on June 22, 1999. Dr. Schmidt found reduced range of motion, back tightness, reduced straight leg raising, some possible give away of toe flexors bilaterally, and decreased sensation. (Ex. 21). He diagnosed low back pain with bilateral lower extremity paresthesias of unclear etiology, rule out significant spinal lesion. Dr. Schmidt reviewed an MRI scan as showing nothing significant. (Ex. 25A).

On July 29, 1999, claimant was examined for Liberty by Drs. Gardner and Woodward. (Ex. 27).

On August 10, 1999, Liberty denied claimant's aggravation claim. (Ex. 27B).

On August 18, 1999, claimant was examined for SAIF by Drs. Reimer and McKillop. (Ex. 29).

On August 23, 1999, SAIF denied claimant's claim on the basis that his injury was not the major cause of his need for treatment and disability. (Ex. 30). On November 23, 1999, SAIF denied claimant's claim on the basis that he did not give timely notice to his employer; SAIF also denied responsibility. (Ex. 32A). On March 1, 2000, SAIF amended its denial to include compensability. (Ex. 34).

The ALJ concluded that claimant experienced a compensable low back strain on November 6, 1998, while SAIF was on the risk. On review, SAIF contends that claimant's low back strain is not compensable for two reasons. First, citing *SAIF v. Lewis*, 170 Or App 201 (2000), SAIF contends that there are no "objective findings" to support a compensable injury; and, second, that claimant's degenerative disc disease is the major contributing cause of his need for treatment and disability.

We need not resolve the "objective findings" question because, even if the claim is supported by "objective findings," we are not persuaded that the major contributing cause of claimant's disability/need for medical treatment was a work injury at SAIF's insured. We base this conclusion on the following reasoning.

The ALJ relied on the opinion of Drs. Gardner and Woodward to conclude that claimant's low back strain was caused by his lifting at work. SAIF contends that the opinions of Dr. Mick and Drs. Reimer and McKillop are more persuasive. We agree.

At hearing, claimant testified that he bent down at home and felt something "give way" in his back two days after the November 6, 1998 work incident. Based on claimant's history of recurrent back symptoms dating back to at least 1993 (and evidence of diffuse degenerative disc disease at L2-3 and L4-5), Drs. Reimer and McKillop opined that claimant's condition could best be explained on the basis of a symptomatic flare-up of his underlying, preexisting low back condition. Noting that no acute injury or incident was reported on November 6, 1998, and that claimant's acute symptoms did not develop until November 8, 1998, they opined that that sequence of events would also appear to be more compatible with a symptomatic flare-up. Finally, they concluded that the major contributing cause of claimant's low back strain condition was his preexisting condition. (Ex. 29).

Although Dr. Mick initially supported compensability, he withdrew his support at the deposition. He explained that, at the time of his initial opinion, he was unaware that two days had passed before claimant experienced severe back pain. After taking that information into account and reviewing in detail the two insurer-obtained medical reports, Dr. Mick opined that, when claimant's severe pain started two days after the work incident, claimant may have experienced a strain. But, like Drs. Reimer and McKillop, Dr. Mick opined that claimant had not experienced a "new injury" on Friday, November 6, 1998, and that the major cause of his strain was his preexisting condition. (Ex. 37).

Drs. Gardner and Woodward also noted claimant's long history of recurrent episodes of low back pain, sometimes work-related, sometimes not. They also noted that claimant's degenerative disc disease was more likely to expose claimant to back pain and possibly to low back strain episodes. However, their opinion that the November 1998 injury was probably the major contributing cause of claimant's low back pain for weeks or months, after which claimant experienced intermittent low back pain and then a gradual worsening, is conclusory and unexplained. Moreover, they opined that the November 1998 injury was no longer the major contributing cause of claimant's ongoing low back pain or need for treatment, and that claimant's current low back pain and need for treatment was probably due to his preexisting degenerative condition. (Ex. 27).

We find Drs. Gardner and Woodward's opinion less persuasive than those of Drs. Reimer and McKillop and Dr. Mick for several reasons. First, they did not discuss the import of the hiatus between claimant's work incident and the acute flare up after bending two days later. Moreover, they did not evaluate the relative contribution of the preexisting condition and the November 1998 work incident, as is required under *Dietz v. Ramuda*, 130 Or App 297, 401 (1994), *rev dismissed* 320 Or 416 (1997).

Consequently, based on the persuasive opinions of Drs. Reimer and McKillop, as well as that of Dr. Mick, we conclude that claimant has not established that his low back injury is compensable. *Somers v. SAIF*, 77 Or App 259 (1986) (we generally give greater weight to those opinions that are well-reasoned and based on complete information).

ORDER

The ALJ's order dated September 15, 2000 is reversed in part and affirmed in part. That portion of the order that set aside the SAIF Corporation's denial is reversed. SAIF's denial is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

March 13, 2001 Cite as 53 Van Natta 307 (2001)

In the Matter of the Compensation of
MONA L. McPHERSON, Claimant
WCB Case No. 00-01320
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorney
Meyers, Radler, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Mongrain's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," but only accept finding number one of the "Ultimate Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the employer's denial, finding that claimant, a stockbroker, sustained her burden of proving that work activities were the major contributing cause of her bilateral carpal tunnel syndrome. In making this finding, the ALJ analyzed medical evidence provided by Dr. Carlini, a consulting physician, and examining physicians, Drs. Melson and Neumann. The ALJ reasoned that Dr. Carlini's opinion was not persuasive because he at one point indicated that he could not identify the major factor in claimant's bilateral wrist condition, but later agreed in a concurrence letter that work was the major contributing cause of the carpal tunnel condition. (Exs. 11, 13). Concluding that Dr. Carlini's opinion could not establish a compensable claim, the ALJ then turned to the Melson/Neumann panel's opinion.

The ALJ noted that this panel had identified numerous factors that contributed to claimant's condition: employment-related computer work, claimant's sleeping position, motorcycle riding, sewing, "bucking" hay, age, gender and her weight. Based on claimant's and her husband's testimony, the ALJ, however, determined that the off-the-job factors of motorcycle riding, sewing, haying, and sleeping position did not exist. Moreover, the ALJ discounted the risk factors of age, gender and weight, finding that these were no more than statistical risk factors and, thus, could not constitute a persuasive basis for concluding that non-work factors were the major contributing cause of the carpal tunnel condition. *See Catherine Grimes*, 46 Van Natta 1861 (1994).

After eliminating all non-work related factors from the causation calculus, the ALJ found that work activity was the only identified factor left to explain the carpal tunnel condition. Although the Melson/Neumann panel had opined that work activity was not the major contributing cause of claimant's carpal tunnel condition, the ALJ, nevertheless, concluded that work activity must be the major contributing cause of the disputed condition because it was the only legitimate, medically identified cause remaining. Thus, the ALJ determined that claimant had sustained her burden of proving a compensable occupational disease claim.

On review, the employer contends that the ALJ's order must be reversed because he improperly converted an opinion unfavorable to compensability into one supporting compensability, thereby substituting his opinion for the Melson/Neumann panel. We agree.

In order to establish a compensable occupational disease claim, claimant must prove that employment conditions were the major contributing cause of her bilateral carpal tunnel syndrome. ORS 656.802(2)(a). Because of multiple potential causal factors, the causation question is medically complex

and requires expert medical opinion to resolve. *Barnett v. SAIF*, 122 Or App 279, 282 (1993); *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985). It is claimant's burden to prove that her alleged occupational disease is compensable. ORS 656.266.

To begin, we agree with the ALJ's reasoning for finding Dr. Carlini's opinion unpersuasive. *See Kelso v. City of Salem*, 87 Or App 630 (1987). Drs. Melson and Neumann provided the remaining opinions on causation. Both doctors opined that work activities are not the major contributing cause of claimant's bilateral carpal tunnel condition. (Exs. 8-3, 12-21, 14-14). Thus, there is no persuasive medical evidence that claimant's work activities are the major contributing cause of the carpal tunnel condition. Therefore, claimant cannot sustain her burden of proving a compensable occupational disease under ORS 656.802(2)(a).

The ALJ, however, construed the Melson/Neumann panel's opinion that claimant's work activity was a contributing factor as satisfying claimant's burden of proving major causation by eliminating all off-the-job or idopathic factors from the casual equation. While the ALJ's reasoning may have some superficial appeal, neither Dr. Melson nor Dr. Neumann opined that work activities are the major contributing cause of the bilateral carpal tunnel condition (in fact, they reached just the opposite conclusion). Perhaps they may have reached such a conclusion if they had been asked to assume that all off-the-job or idiopathic factors they had identified were non-existent or invalid. However, we cannot make such an assumption.

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 about causation 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 our conclusion about medical causation without medical evidence that persuasively establishes that work activities are the major contributing cause of claimant's bilateral carpal tunnel condition. *See Barry M. Grigsby*, 49 Van Natta 695, 696 (1997) (not appropriate to substitute our lay opinion in place of a medical opinion).

Therefore, even assuming that the ALJ correctly determined that all the off-the-job or idiopathic factors identified by Drs. Melson and Neumann were nonexistent or invalid, neither we nor the ALJ is free to substitute our opinion for the medical evidence. Because Drs. Melson and Neumann did not opine that work activities were the major contributing cause of claimant's bilateral carpal tunnel condition, and because the opinion of Dr. Carlini is unpersuasive, the medical evidence does not satisfy claimant's burden of proof under ORS 656.802. Accordingly, we reverse.

ORDER

The ALJ's order dated November 15, 2000 is reversed. The employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

March 12, 2001 Cite as 53 Van Natta 308 (2001)

In the Matter of the Compensation of
JAMES E. SMITH, Claimant
WCB Case No. 00-02797
ORDER ON REVIEW
Arthur P. Klosterman, Claimant Attorney
Breathouwer & Gilman, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that upheld the self-insured employer's denial of claimant's injury or 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.

We reach the same result under ORS 656.802, because, in light of claimant's lack of credibility and unreliable medical histories, the record does not persuasively establish that claimant's work activities were the major contributing cause of his low back condition.

ORDER

The ALJ's order dated December 4, 2000 is affirmed.

March 13, 2001 Cite as 53 Van Natta 309 (2001)

In the Matter of the Compensation of
LORNA J. SANTANGELO, Claimant
WCB Case No. 00-00317
ORDER ON RECONSIDERATION
Hollander & Lebenbaum, Claimant Attorney
Terrall & Terrall, Defense Attorney

Claimant requests reconsideration of that portion of our February 22, 2001 order that denied her request for remand to the Administrative Law Judge (ALJ). Specifically, claimant argues that, although we found that there was no explanation for her failure to obtain a report from Dr. Anderson prior to the hearing date, claimant did not treat with that doctor until after the hearing. Accordingly, claimant contends that there was no possibility of obtaining a report from him before the hearing.

After reviewing claimant's motion for reconsideration, we adhere to our previous conclusion. As we explained in our prior order, although evidence that is not generated until the hearing is "unavailable," it may still have been "obtainable" at the time of hearing. *Compton v. Weyerhaeuser Co.*, 301 Or 641 (1986). Claimant has not provided reasons or explained why she was not able to treat with and/or obtain a report from Dr. Anderson until after the hearing. Consequently, for this reason and the remaining reasons expressed in our order,[1] we continue to conclude that there is no compelling reason to remand.

Accordingly, our February 22, 2001 order is withdrawn. On reconsideration, as supplemented, we republish our February 22, 2001 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] As noted in our Order on Review, we found no reason to accept Dr. Anderson's subsequent diagnosis rather than the diagnosis offered by claimant's treating doctor. Because we are not persuaded by Dr. Anderson's report, therefore, even if it was considered we would find no compelling reason to remand.

In the Matter of the Compensation of
HILARY D. SHAPIRO, Claimant
WCB Case No. 00-04191
ORDER ON REVIEW
Richard Alan Stout, Claimant Attorney
Schwabe, et al, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order that upheld the self-insured employer's denial of her injury claim. On review, the issue is compensability.

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

The ALJ concluded that claimant's injury was not compensable because it occurred during a recreational or social activity she was performing primarily for her own personal pleasure. See ORS 656.005(7)(b)(B). We agree with and adopt the ALJ's reasoning, but we conclude that even if the exclusion from compensability of ORS 656.005(7)(b)(B) did not apply, we would still conclude that the claim did not arise in the course and scope of employment.

To be compensable, an injury must arise out of and in the course of a worker's employment. ORS 656.005(7)(a). The Supreme Court has interpreted this rule as a unitary test consisting of two prongs, the goal of which is to determine whether a claim is sufficiently work-related to merit compensability. *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366 (1994). Under the "arises out of" prong, the question is whether the injury is sufficiently causally related to the claimant's employment. The "in the course of" prong requires that the time, place and circumstances of the employee's injury justify connecting the injury to the employment. *Norpac Foods, Inc. v. Gilmore*, 318 Or at 366. Although neither requirement is determinative, both must be satisfied to some degree. *Id.*

In the present case, we conclude that the "in the course of" element is absent. Claimant's injury occurred when she was involved in a motor vehicle accident with a police car while going from her home to a costume shop to pick up an Easter Bunny costume. It was her day off work. Claimant, who was a front office manager for the employer, a hotel, had volunteered to play the Easter Bunny at an Easter brunch the following day (Easter Sunday) at the hotel. Although the employer assigned the "Easter Bunny" duties to claimant, the record does not establish that such an assignment included making rental and transportation arrangements regarding the "Easter Bunny" costume. Consequently, when claimant was injured on her day-off, while driving to the costume shop, she was not explicitly or implicitly required nor expected by her employer to take such an action.

We acknowledge that, because the costume shop was only open for a short time on Saturday, claimant wanted to make sure that the costume was picked up so she decided to get it herself. We also recognize that she left a message for the person who she thought was supposed to pick up the costume and was involved in the accident on the way to the costume shop. Nonetheless, the indisputable fact remains that she was never required nor expected by her employer (explictly or implicitly) to travel to the costume shop (on her day-off).

Under such circumstances, we conclude that the "in the course of" element has not been satisfied. Because both prongs of the unitary test must be satisfied at least to some degree and because the "in the course of" element has not been satisfied, we agree with the ALJ that the injury did not occur within the course and scope of employment.

ORDER

The ALJ's order dated September 29, 2000 is affirmed.

In the Matter of the Compensation of
STEVEN L. SUSTICH, Claimant
WCB Case No. 00-02250
ORDER ON REVIEW
Baxter & Baxter, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock, and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) set aside its denial of claimant's injury claim; and (2) awarded an assessed attorney fee of $4,500. On review, the issues are course and scope of employment and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact, with the exception of the last paragraph in that section.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant, who was employed as a mechanic, was injured in the course and scope of his employment. At the time he was injured, claimant was accompanying two other employees in an automobile that had been brought to the employer, a car dealership, for a trade-in. The employee driving the car was Matthew Dean, another mechanic. While merging onto the highway, Mr. Dean lost control of the vehicle, clipped a tractor-trailer rig, and spun into a barrier.

The ALJ found that, under the "dual purpose" doctrine, the claim was compensable because, even though claimant was interested in how the car (a "supercharged" BMW) handled, claimant reasonably believed that there was a legitimate purpose for driving the car, *i.e.*, a road test. The ALJ also found that claimant reasonably believed that Mr. Dean was authorized to take the vehicle for a road test. We disagree.

First, we find that claimant's injury is not compensable under the "dual purpose" doctrine. Because claimant's injury was neither associated with going to nor coming from his employment, that doctrine is not applicable. *See, e.g., Barbara A. Nathan*, 52 Van Natta 1092 (2000).

For an injury to be compensable under workers' compensation law, it must arise out of and occur in the course of employment. ORS 656.005(7)(a). Compensability of an injury depends on whether, considering all relevant factors, the activity causing the injury was sufficiently connected to work. *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366 (1994); *Rogers v. SAIF*, 289 Or 633, 642 (1980).

Here, SAIF does not dispute that claimant was in the course of employment when injured. Rather, SAIF argues that claimant was engaged in prohibited conduct when he was injured.

In *Andrews v. Tektronix*, 323 Or 154 (1996), the Court held that the fact that an employer had instructed a worker to avoid certain work, and that the worker's injury occurred when he or she disregarded that instruction, were only two of many factors that must be considered in determining work-connectedness. The Court determined that, among the additional factors were the degree of connection between what the worker was authorized to do and was forbidden to do, the degree of judgment and latitude normally given the worker, workplace customs and practices, and the relative risk to the worker when compared to the benefits to the employer. Finally, the Court reasoned that, when a worker's failure to follow a work-defining instruction was taken into consideration, the manner in which the instruction was conveyed, and the worker's consequent perception of the instructions' purpose and scope, also must be considered. *Id.* at 165.

Here, the employer's handbook provided that employees must drive safely and should not exhibit speed or recklessness. Customer owned vehicles could be operated for test driving but the handbook provided that when driving a customer vehicle, it should be done "in a careful and safe manner abiding by all of the laws applicable thereto." The handbook further provided that a "serious accident resulting from your negligent operation of a motor vehicle in connection with your employment may lead to disciplinary action up to and including termination." (Ex. C).[1]

[1] Claimant acknowledged that he had received and reviewed the handbook. (Ex. A).

At hearing, claimant's coworkers testified that it was the employer's policy that test drives would be performed by the mechanic/technician assigned to the particular car. (Tr. 131). Coworkers also testified that it was unusual for three workers to test drive a car. (Tr. 90, 97, 132).

Claimant's coworkers were aware that the car had been assigned to Sam Williamson and not to Matthew Dean. (Tr. 131). One of claimant's coworkers, John Isai, testified that the car was taken in the following manner:

> "The car was parked somehow in the shop, not in the stall, just in the shop, and I remember they couldn't find the keys somehow, and then Matt [Dean] found the keys, came in, and he was going to go for a ride. And [claimant] said he was going. Zeb [Gregory] said he was going. I said I was going. And they all got in the car, and they - Matt or [claimant] said like three is enough or something. And then when I went to go grab the door handle, Tony [Criado] called me back and said hey, you know, get back over here. He said that's nothing but trouble, just hang tight, you know." (Tr. 128).

Mr. Isai further testified that the mechanics (including himself) were getting in the car "to see what the car could do." (Tr. 128.) He agreed that, in this case, the car was being taken out for "hot rodding," "high rpms" and "[t]hings like that." (Tr. 134-135). Zeb Gregory, who did get in the car with claimant and Mr. Dean, agreed that it was an "unauthorized drive." (Tr. 149).

Based on the testimony from his co-workers, we are persuaded that, at the time of his injury, claimant was engaging in conduct that was neither authorized by his employer nor consistent with the employer's express policy. Therefore, we find that claimant was engaged in prohibited conduct when he was injured.

Moreover, we do not find that claimant had a reasonable belief that the car was being taken for an authorized purpose; *i.e.* a "road test." Claimant agreed it was "unusual" for more than two mechanics to test drive a car. (Tr. 21). Claimant also conceded that he was "partially" along for the ride because he thought it would be fun to get in the car and see how it handled. (Tr. 45). Additionally, claimant later signed an action plan and wrote that the car had been taken off of the lot without authorization. Claimant wrote that he would no longer ride in another car "unless needed to be there and authorized to do so." (Ex. 3A-2).[2]

In light of claimant's awareness of the employer's policies, and his co-workers' testimony that the car was being taken out for "hot rodding," we conclude that claimant did not have a reasonable belief that the car was being driven for purposes of a vehicle inspection. Accordingly, we conclude that, after applying the criteria set forth in *Andrews*, claimant failed to prove a sufficient work connection between his injury and his employment. Therefore, claimant's injury did not arise out of and in the course of employment. Thus, we reverse the ALJ's order.

ORDER

The ALJ's order dated October 5, 2000 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[2] At hearing, claimant testified that he merely completed the employer's plan so that he could go back to work. However, because we question claimant's testimony that he believed that use of the car was authorized, we similarly question his testimony that his statements following the accident were written solely for purposes of remaining with the employer.

Board Member Biehl dissenting.

For the following reasons, I disagree with the majority's opinion that claimant's injury was not within the course and scope of his employment. First, I disagree with the majority's finding that claimant could not have reasonably believed that Mr. Dean was authorized to test drive the vehicle involved in the accident. While the ALJ did not make a specific credibility finding, it is obvious that he found claimant credible as he accepted claimant's testimony regarding the circumstances of the accident. After reviewing the record and the testimony at hearing, I find no reason to reject claimant's testimony.

Claimant testified that it was standard for inspections to be performed on cars that were brought into the employer's dealership. Claimant also testified that test drives were routinely done either before or after such inspections. (Tr. 18). Furthermore, claimant and other witnesses testified that it was not unusual for two workers to go on such a test drive. (Tr. 18, 19, 89).

Claimant testified at hearing that Mr. Dean, who was also a mechanic, requested that he accompany him on a test drive that day. Claimant's testimony is supported by Mr. Dean's testimony. (Tr. 20, 65, 80).

Accordingly, I disagree with the majority's conclusion that claimant was aware or should have been aware that Mr. Dean was not authorized to test drive the car. Claimant is being penalized because he participated in a test drive of a "supercharged" car. However, claimant's actions that day were consistent with the duties expected of mechanics. Moreover, as the ALJ noted, even if claimant's motivation that day was due in part to his interest in the car, an injury may not be excluded merely because the activity was somewhat for his personal pleasure. The court has held that the inquiry should focus on the primary purpose of the activity at the time of the injury. *Kaiel v. Cultural Homestay Institute*, 129 Or App 471, 478, *rev den* 320 Or 453 (1994).

Here, in light of the evidence concerning the past practices of the employer and considering claimant's reasonable belief that his coworker was authorized to take the vehicle that day, I find that claimant's primary purpose was to accompany the others on a legitimate test drive. Therefore, because the purpose of the activity was work-related and the injury occurred during regular work hours, I would conclude that it occurred within the course and scope of claimant's employment. Consequently, I respectfully dissent from the majority's opinion.

In the Matter of the Compensation of
ROBERT W. SMITH, Claimant
WCB Case No. 99-04007
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
Hitt, et al, Defense Attorney

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Otto's order that: (1) set aside its denial of claimant's current left shoulder condition and thoracic outlet syndrome; and (2) awarded a $10,000 attorney fee. On review, the issues are compensability and attorney fees.

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

The insurer argues that the ALJ's award of a $10,000 attorney fee was excessive. We review the attorney fee issue *de novo* applying the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the 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.

Here, the issue at the hearing was whether claimant had thoracic outlet syndrome that was compensably related to his work injuries. After the first hearing and claimant's appeal of the ALJ's non-compensability decision, claimant's attorney moved for remand for additional evidence regarding claimant's post-hearing surgery. We remanded to the ALJ for further development of the record regarding claimant's post-hearing surgery.

The first hearing lasted approximately 1 hour resulting in 27 pages of transcript. The second hearing lasted one hour. Claimant was the only witness to testify at the hearings. Approximately 60 exhibits were admitted, including 11 exhibits submitted by claimant on remand. The record also contains a deposition of Dr. Irvine and at least two other exhibits submitted by claimant. Some of the medical reports submitted by claimant were of significant probative value in establishing the compensability of his claim.

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 surgery. Based on the record, claimant's attorney devoted a substantial amount of time to the case. 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 employer's vigorous defense.

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $10,000 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 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 also 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 $1,300, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and claimant's attorney's statement of services),[1] the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 30, 2000 is affirmed. For services on Board review, claimant's attorney is awarded $1,300, payable by the employer.

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[1] In reaching this conclusion, we note that claimant's counsel submitted a statement of services requesting a $1,450 attorney fee on Board review. However, these services included services devoted to defending the ALJ's attorney fee award on review. Claimant's attorney is not entitled to a fee for services related to the attorney fee issue. *Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986). Accordingly, we conclude that a $1,300 fee is reasonable.

In the Matter of the Compensation of
JOBE W. SAYLOR, Claimant
WCB Case No. 00-04746
ORDER ON REVIEW
John C. Dewenter, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that: (1) awarded no unscheduled permanent disability, whereas an Order on Reconsideration had awarded 11 percent (35.20 degrees) unscheduled permanent disability benefits; and (2) approved an offset of temporary disability benefits against unemployment benefits received by claimant. On review, the issues are unscheduled permanent disability and offset.

We adopt and affirm the ALJ's order with the exception of the second full paragraph on page 5 and with the following supplementation.

Given claimant's complicated medical situation, including claimant's chronic pain and addiction to narcotics, we agree with the ALJ that claimant's attending physician, Dr. Schulte, is more familiar with claimant's condition than the arbiter panel and is in the best position to give an opinion regarding

impairment due to the compensable injury.[1] Thus, we agree with the ALJ that, based on Dr. Braun's report, as concurred with by Dr. Schulte, claimant has not established entitlement to an unscheduled permanent disability award.

With regard to the offset issue, the ALJ cited *Wells v. Pete Walker's Auto Body*, 86 Or App 739, *rev den* 304 Or 406 (1987), to conclude that the insurer was entitled to offset temporary disability benefits it paid against unemployment benefits claimant received during the same period. Claimant argues that the insurer should not be allowed an offset because the Employment Department has determined that claimant was not entitled to the unemployment benefits and is attempting to recover them.

The record in this case does not reflect that claimant has repaid any of the unemployment benefits. Under the *Wells* holding, the insurer can offset temporary disability payments it has made against the unemployment benefits claimant received. Here, however, the insurer has not yet taken an offset and claimant has apparently not repaid any of the unemployment benefits. Given these circumstances, we view the issue claimant raises as not yet being ripe for adjudication. At this point, there is no current dispute because, as explained above, claimant has not repaid any of the unemployment benefits and the insurer has not yet offset temporary disability benefits against unemployment benefits that have been repaid by claimant. Thus, claimant is in effect requesting an advisory opinion regarding a potential future dispute. As we have done in the past, we decline to issue an advisory opinion. *See, e.g., Greg Harsha*, 53 Van Natta 4 (2001).

ORDER

The ALJ's order dated November 28, 2000 is affirmed.

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[1] Although claimant asserts that Dr. Schulte only examined claimant four times, we still conclude that he was more familiar with claimant than the arbiter panel who saw claimant only once.

In the Matter of the Compensation of
GALE F. FARRESTER, Claimant
WCB Case No. 00-02386
ORDER ON RECONSIDERATION
Doblie & Associates, Claimant Attorney
Terrall & Terrall, Defense Attorney

The self-insured employer requests reconsideration of our February 15, 2001 Order on Review that affirmed the Administrative Law Judge's (ALJ's) order that set aside its denial of claimant's injury claim for a back condition.

Specifically, the employer contends that we failed to address its argument that claimant was not credible. We supplement our initial order as follows.

At hearing, the employer offered videotape evidence depicting claimant's activities outside of his home two weeks after his work injury. (Ex. 80). On the videotape, claimant works on his automobile, bending over to change the oil and various auto parts. The employer contends that this evidence contradicts claimant's testimony that he did not work on his car during this period of time, due to his work-related back injury. (Tr. 154-156).

However, we agree with the ALJ that, given the timing of the videotape (approximately two weeks after the work injury), this evidence is more relevant to the severity of claimant's injury, rather than to the issue of compensability. Moreover, to the extent that the videotape impeaches claimant's testimony (that he did not work on his car) such evidence impeaches claimant only on that collateral issue, not the central issue of whether he was injured at work on January 28, 2000. *See Greg T. Smith*, 52 Van Natta 273 (2000) (evidence that claimant had a reputation for stretching the truth and for telling "untruths" found collateral to the issue of whether the claimant was hurt on the job). Here, the videotape does not directly dispute that claimant was injured at work on January 28, 2000.

In addition, even assuming that we find claimant not to be credible or truthful regarding his testimony about working on his car, we still find that the remainder of the record supports the compensability of the claim for the reasons expressed by the ALJ. *See Westmoreland v. Iowa Beef Processors*, 70 Or App 642 (1984), *rev den* 298 Or 597 (1985); *Victor J. Cervantes*, 51 Van Natta 1343 (1999) (even if a claimant lacks credibility with regard to certain matters, he can still meet his burden of proof where the remainder of the record supports his claim).

Finally, because we have found that claimant does not have a "preexisting condition" that contributed to his disability and need for treatment for his low back condition, we agree with the ALJ that claimant's (inaccurate) denial of prior injuries on his 801 and 827 claim forms is not material to Dr. Niles' understanding of claimant's history on the issue of compensability. In this regard, we agree with the ALJ that the record supports the fact that claimant's prior back injuries had resolved and that claimant was working at his regular job without problems prior to his work injury. (Tr. 92). Claimant had not sought medical treatment since December 1997, more than two years prior to the January 2000 work injury. (Ex. 38).

Therefore, on reconsideration, we continue to find that the evidence supports a conclusion that claimant's work injury was a material contributing cause of his need for medical treatment or disability for his back condition.

Accordingly, we withdraw our February 15, 2001 order. On reconsideration, as supplemented herein, we adhere to and republish our February 15, 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
GAYLYN FENN, Claimant
WCB Case No. 00-04469
ORDER ON REVIEW
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
Meyers, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Johnson's order that set aside its denial of claimant's injury claim for a left leg and/or low back/left hip condition. With her respondent's brief, claimant contests that portion of the ALJ's order that declined to assess a penalty for allegedly unreasonable claim processing. On review, the issues are compensability and penalties.

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

Claimant contends that she compensably injured her left leg and/or low back/left hip on February 4, 2000 while moving a magazine tote from a pallet to a cart.[1]

The ALJ determined that claimant was "totally credible," and concluded that the opinions of Drs. Mullins, Houts, and to some extent Woodward supported the compensability of claimant's condition. Consequently, the ALJ reasoned that claimant had established the compensability of her left leg and/or low back/left hip condition.

The employer contends that: (1) claimant is not credible; and (2) the medical evidence is insufficient to meet claimant's burden of proof. We disagree with each of the employer's contentions.

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[1] Claimant's job involved arranging magazine displays at various supermarkets. A part of that job required her to lift and move plastic "totes" of magazines weighing between 30 and 50 pounds. (Tr. 9-15).

Here, as noted, the ALJ concluded that claimant was "totally credible." Based upon our review of the record, we find no reason to disturb the ALJ's credibility finding. Thus, we conclude that claimant is credible regarding the lifting incident at work. In other words, we are persuaded that claimant experienced left leg/low back pain as a result of performing her work activities on February 4, 2000. We now proceed to address the issue of "medical" causation.

To establish that her left leg/low back condition is compensable, claimant must prove that her February 4, 2000 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). 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). 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. Mullins, the initial treating physician, diagnosed lumbosacral strain and S.I. joint dysfunction and attributed the problem to claimant's work activities in February 2000, which he felt were cumulative in nature. (Ex. 12).

Subsequently, Dr. Houts treated claimant for left leg pain which Dr. Houts felt might be work related, but opined that a causation conclusion depended upon an accurate and complete history. (Ex. 7; 13).

In August 2000, Dr. Woodward examined claimant at the employer's request. By that time, claimant had not required medical treatment since May 2000, and had returned to her regular duty work. (Ex. 11-3). Dr. Woodward was unable to provide an orthopedic diagnosis, but he did indicate that claimant had no preexisting conditions, and that it was possible claimant had sustained a minor lumbar strain from picking up a heavy tote. (Ex. 11-6, 7, 8). Such an opinion is not inconsistent with the opinion of Dr. Mullins.

Based upon the record as a whole, including claimant's testimony (which we have concluded is credible), and the medical opinion of Dr. Mullins, which is not contradicted by the opinions of Drs. Houts and Woodward, we conclude that claimant's left leg/low back condition is compensable.

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. 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 August 14, 2000 is affirmed. For services on review, claimant is awarded a $1,200 attorney fee, payable by the employer.

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[2] The ALJ concluded that the material contributing cause standard applied to this claim. The employer does not challenge that conclusion. Consequently, we apply the material contributing cause standard on review.

In the Matter of the Compensation of
THOMAS L. GREEN, Claimant
WCB Case No. 01-01423, 00-00470 & 00-00467
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Lundeen, et al, Defense Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that: (1) upheld the SAIF Corporation's denial on behalf of Hank Kliever's Floor Covering, Inc. (SAIF/Kliever) of claimant's occupational disease claim for a low back condition; (2) upheld the SAIF's denial on behalf of James W. Fowler Company (SAIF/Fowler) for the same occupational disease claim; and (3) upheld Liberty Northwest Corporation's *de facto* denial on behalf of James W. Fowler Company (Liberty/Fowler)[1] for the same occupational disease claim. On review, the issues are compensability and responsibility.[2]

We adopt and affirm the ALJ's order with the following exception and supplementation. We do not adopt the second sentence of the second full paragraph on page eight of the ALJ's opinion.

Dr. Rosenbaum, neurologist, examined claimant on behalf of Liberty/Fowler primarily regarding a March 16, 1999 low back injury that allegedly occurred while Liberty/Fowler was on the risk. (Exs. 28, 29). Dr. Rosenbaum opined that, given the lack of contemporaneous report of the alleged injury and the significant lumbar disc pathology that existed prior to this alleged injury, the March 16, 1999 event was not a significant factor to claimant's lumbar disc condition and eventual need for treatment and surgery. (Ex. 29-3). Claimant withdrew his request for hearing regarding this specific injury claim and proceeded on the issues of compensability of and responsibility for the low back condition under an occupational disease theory. (Tr. 6-7).

Dr. Scheinberg, orthopedist, performed a record review on behalf of SAIF. (Exs. 35, 38). Dr. Scheinberg found that claimant had multilevel degenerative arthritis and degenerative disc disease and an L4-5 disc herniation. He opined that claimant's low back condition was due to a natural degenerative/aging process that began in the 1970's, if not before.

Dr. Young, radiologist, performed a record and imaging study review on behalf of Liberty/Fowler. (Exs. 35, 36). Dr. Young opined that claimant had advanced multilevel degenerative disease involving the entire lumbar spine that probably started in claimant's teenage years. He found that this degenerative disease probably combined with claimant's work activities throughout the years but the contribution of the work exposure was minor. He opined that the major contributing cause of claimant's low back condition was the degenerative condition, which was genetically mediated and related to accumulated age related wear and tear.

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[1] Claimant worked for Hank Kliever's Floor Covering, Inc. [Kliever's] from about 1972 until February 28, 1974. During that period, Kliever's was insured by SAIF. On March 1, 1974, claimant began to work for James W. Fowler Company [Fowler]. As of the date of hearing, claimant remained employed by Fowler. SAIF insured Fowler from July 1, 1985 through September 30, 1996, and from October 1, 1999 through the present. (Ex. 37). Liberty Northwest insured Fowler during the interim period from October 1, 1996 through September 30, 1999. (*Id.*).

[2] Claimant also requested a hearing regarding Liberty's "denial of a claim for a specific injury on 3/16/99 and the denial of a claim dated August 5, 1998." Claimant subsequently withdrew that hearing request, which resulted in an Order of Dismissal. WCB Case No. 99-08162. That order has not been appealed. In withdrawing his prior hearing request, claimant also requested a hearing from Liberty's *de facto* denial of an occupational disease claim against Liberty/Fowler. That issue was addressed and resolved in the ALJ's order that is currently on review. Because the ALJ's order in WCB Case No. 99-08162 (the unappealed order) dismissed the only WCB Case Number that pertained to claimant's claim with Liberty/Fowler, another WCB Case Number (01-01423) (one that coincides with claimant's occupational disease claim with Liberty/Fowler) has been added to this order.

Only Dr. Rand, treating surgeon, supports compensability of claimant's degenerative low back condition as an occupational disease. (Exs. 31, 39). Dr. Rand opined that changes in the spine over time are related to several things, including genetic composition of the structure, the process of normal aging, and the stresses applied to it during this time of aging. Dr. Rand opined that another significant factor influencing disc degeneration and overall wear of the spine are outside influences due to cyclic loading and deformation. He opined that the highest load the disc experiences comes with rotation and compression simultaneously, which he considered claimant to have performed repetitively to continuously throughout his work career at high levels of physical demand. (Ex. 39-3). Based on this, Dr. Rand concluded that claimant's work activities were the major contributing cause for his disc degeneration and need for treatment, and that the genetic make up and aging process were insignificant in comparison. (*Id.*).

The problem with Dr. Rand's opinion is that it is based on an inaccurate history of claimant's work activities. In this regard, Dr. Rand understood that claimant worked for some 26 years, 60-70 hours per week, performing work in the woods that involved packing in oxygen tanks weighing 100 pounds and acetylene tanks weighing 70 pounds, repairing disabled equipment, and packing his equipment back out. (Ex. 39-1). Dr. Rand understood that, more recently, claimant has been working in the shop doing welding, which requires mechanically poor body postures during the course of the day and repetitively lifting up to 250 pounds in the course of this work. (Ex. 39-1-2).

At hearing, claimant described his work duties over the years. (Tr. 11-29). From 1972 through February 1974, claimant worked at Kliever's installing flooring, which involved carrying flooring to and from the truck and doing a lot of work on his knees.

On March 1, 1974, claimant began working for Fowler, which entailed several jobs over the years. Claimant started out driving a "swamp buggy," which was used to apply chemicals to farm fields in the spring and fall. (Tr. 17-20). Liquid chemicals were kept in 55 gallon drums and five gallon containers. Claimant would mix the liquid chemicals by tipping the drums. An auger was used to load dry fertilizers into the swamp buggy. Claimant also did maintenance on the swamp buggy. After the spring and fall chemical spraying was finished, claimant would operate and maintain a Caterpillar, performing ground clearing, road building, farm pond construction, etc. (Tr. 20).

In 1980, Fowler sold the swamp buggy business and went into heavy construction, building forest, county, and state roads. (Tr. 22, 23). At that time, claimant started running and maintaining a big excavator - a backhoe on tracks. From 1980 through 1990, claimant was supervising a lot of jobs in addition to running the excavator. (Tr. 23).

In 1990, claimant transferred to the shop and began doing maintenance on the equipment full time, which involved bending, crawling, and pushing and pulling on parts. (Tr. 24-27). About 1994, claimant began working as a fabricator/welder and did welding full time, which involved a lot of bending. (Tr. 27-28). Sometimes, claimant worked on big items, including bulldozer blades and excavator buckets. (Tr. 28).

As summarized above, Dr. Rand's understanding of claimant's work activities does not correspond to claimant's testimony. As the ALJ found, the work exposure set out in Dr. Rand's opinion is "overdone." Because Dr. Rand does not base his causation opinion on an accurate history, we do not find it persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) (medical opinions based on incomplete or inaccurate information are not persuasive).

ORDER

The ALJ's order dated November 28, 2000 is affirmed.

In the Matter of the Compensation of
RONALD C. GROAT, Claimant
WCB Case No. 00-04050
ORDER ON REVIEW
Arthur P. Klosterman, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Black's order that: (1) found that claimant was a subject worker; and (2) upheld the SAIF Corporation's "subjectivity" denial of claimant's injury claim for a left foot condition. On review, the issue is subjectivity.

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

Salem Indoor Soccer (SIS), is a private business that operates an indoor playing facility with a pro shop that sells supplies, soccer uniforms, and equipment. To facilitate use of its indoor "fields," SIS organized leagues for all ages of participants and, to some extent, organized "house" teams.

SIS maintains a pool of referees to officiate the games played at its "fields." (Tr. 46). Referees are recruited and trained by SIS. (*Id.*) After a referee has been certified by SIS, the referee is eligible to officiate at the SIS facilities. The referees are assigned to the games by SIS.[1] (*Id.*) Claimant is one of the above-described soccer referees.[2]

Claimant developed a left foot condition (metatarsalgia or Morton's neuroma) as the result of running (a function of his duties as a soccer referee) on the artificial turf at the SIS facilities. Claimant contends that he is the employee of SIS and, thus, reasons that his left foot condition, which is the result of his duties as a soccer referee, is compensable.

The ALJ determined that claimant was not a subject worker. Consequently, the ALJ upheld SAIF's denial. Claimant challenges the ALJ's determination.

When deciding whether a claimant comes under workers' compensation law, the first inquiry is whether the claimant is a "worker" under ORS 656.005(30) and the judicially created "right to control" test. *See S-W Floor Cover Shop v. Natl. Council on Comp. Ins.*, 318 Or 614, 630-631 (1994). If the relationship between the parties cannot be established by the "right to control" test, it is permissible to apply the "nature of the work" test. *Id.* at 622 n. 6.

The principal factors considered under the "right to control" test are: (1) direct evidence of the right to, or the exercise of control; (2) the method of payment; (3) the furnishing of equipment; and (4) the right to fire. *See Castle Homes, Inc. v. Whaite*, 95 Or App 269, 272 (1989). None of these factors are dispositive; rather, they are viewed in their totality. *See Cy Investment, Inc. v. Natl. Council on Comp. Ins.*, 128 Or App 579, 583 (1994).

Here, although SIS assigned the games claimant was to officiate, we find that there is very little evidence showing a direct right to control. Claimant's primary function was to use his judgment to enforce the game rules for indoor soccer matches. The "rules of the game" are not SIS's rules, but are instead rules for indoor soccer that are essentially the same for all indoor games, regardless of where the game is played.[3] (Tr. 77-78). Claimant's authority to "call the game" was absolute. There is no evidence that either the games claimant officiated, or his performance, was monitored by SIS.

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[1] By the end of 1999, the referees received their game assignments via the SIS web site. (Tr. 9).

[2] Claimant is also a certified referee with OISA, FEFA, and OSAA for outdoor soccer games. (Tr. 15). Claimant stipulated that he was an independent contractor with regard to his officiating activities for those organizations. (Tr. 6).

[3] We recognize that there may be "ground rules" that are unique to a particular indoor facility. Here, for example, SIS had a ceiling net above the field to prevent the ball from hitting the lights. When a ball came into contact with the net, it was judged "out of bounds." (Tr. 11). However, except for the local "ground rules," the rules for indoor soccer are the same at SIS as they are in facilities in Corvallis, Springfield, or Portland. (Tr. 77-78).

Claimant received either $12 or $14 per game as remuneration for his referee services.[4] (Tr. 10). However, the monies received by claimant for these services were not paid by SIS, but rather by the coaches of the teams which were the recipients of claimant's services. (*Id.*) SIS did not provide claimant with either a W-2 or a 1099 for his tax records.[5] (Tr. 36). Such circumstances do not support a conclusion that SIS had a right to control.

Regarding equipment, SIS furnished a time clock and game report forms. (Tr. 15). Claimant furnished his own uniform. (*Id.*) The game ball was provided by one of the teams in the game being officiated. (*Id.*) These circumstances are not indicative of a right to control by SIS.

Finally, although SIS could, based upon coaches' complaints, cease assigning games to an individual referee, thereby effectively firing that referee, SIS has never done so. (Tr. 57).

Under the circumstances, after considering all the factors discussed above, we conclude that SIS did not have the right to control claimant's work.[6] Therefore, we agree with the ALJ that claimant is not a subject worker and is not entitled to benefits under the Workers' Compensation Law.[7]

ORDER

The ALJ's order dated December 1, 2000 is affirmed.

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[4] The rate was dependent upon the age group of the teams involved in the game being officiated.

[5] Claimant did receive a 1099 from OSAA and OISA for monies received officiating games for those organizations. (Tr. 17).

[6] We acknowledge claimant's argument that having the coaches pay the referees was merely an artificial accounting arrangement designed to keep those funds off SIS's books. However, even if SIS paid claimant for his refereeing services, we would still find that there was insufficient control for claimant to be considered a subject worker of SIS.

[7] In light of our conclusion that there was no "right to control" and claimant was not a subject worker, we do not address the "nature" of claimant's work.

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

The insurer has submitted claimant's request for temporary disability compensation for claimant's left knee condition. Claimant's aggravation rights have expired. The insurer opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force.

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

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

Here, the insurer contends that claimant was not in the work force at the time of his current disability. In response to the insurer's contention, claimant has submitted copies of his 2000 1099 Forms and a copy of his January 2001 paystub.[1] Based on claimant's submission, we find that he was in the work force at the time of his current worsening which required surgery.[2]

Accordingly, we authorize the reopening of claimant's claim, for the insurer to provide temporary disability compensation beginning the date he is hospitalized for surgery. 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] As it is unclear whether claimant mailed a copy to the insurer, a copy of claimant's submission is enclosed with the insurer's copy of this order.

[2] 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).

In the Matter of the Compensation of
CALVIN A. KAEO, Claimant
WCB Case No. 00-03730
ORDER ON RECONSIDERATION
Dale C. Johnson, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Claimant requests reconsideration of our January 31, 2001 order that affirmed the Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's denial of claimant's current combined condition and declined to assess penalties for an allegedly unreasonable denial.

On March 2, 2001, we abated our order to allow sufficient time to consider claimant's motion. Having received SAIF's response to claimant's motion, we proceed with reconsideration.

As we noted in our prior order, a previous ALJ found that claimant's December 1997 injury, as opposed to his preexisting degenerative disc disease, was the major contributing cause of the need for treatment of the combined low back condition and set aside SAIF's March 1998 denial. On Board review, we affirmed the prior ALJ's order. In March 1999, SAIF accepted "lumbar strain/sprain." In January 2000, SAIF issued a modified notice of acceptance indicating that claimant's lumbar sprain/strain injury combined with claimant's "preexisting S1 left compression secondary to lateral recess stenosis at the L5-S1 level."

On April 26, 2000, SAIF denied claimant's current combined condition on the grounds that the compensable injury was no longer the major contributing cause of the current condition. Claimant requested a hearing and the ALJ upheld the denial on the merits after finding that the denial was not procedurally invalid.

In our January 31, 2001 order, we rejected claimant's argument that SAIF's denial of his current combined condition was procedurally invalid and that SAIF was required to instead issue a partial denial. We noted that ORS 656.262(6)(c) allows a carrier that has accepted a combined condition to deny the condition if the otherwise compensable injury ceases to be the major contributing cause of the combined condition. We concluded that the evidence established that the compensable injury was no longer the major contributing cause of the condition. We also concluded that SAIF's denial was a denial of the entire current combined condition and was therefore not a partial denial.

On reconsideration, claimant argues that the prior litigation established compensability of his "lumbar laminectomy" surgery and that permanent impairment exists from the laminectomy. Claimant argues that SAIF's current combined condition denial cannot extinguish the claim.

In the prior litigation regarding compensability, we affirmed the prior ALJ's order that found claimant's low back injury claim compensable as a combined condition. (Exs. 46; 47). The combined low back condition, not "lumbar laminectomy" surgery, was found compensable. The statutory scheme allows carriers to issue denials when the compensable injury is no longer the major contributing cause of the combined condition. ORS 656.262(6)(c); 656.262(7)(b). That is what occurred here. Although claimant continues to argue that the denial was improper, the current statutes permit such a denial.[1]

As supplemented herein, we republish our January 31, 2001 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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[1] Claimant appears to contend that a carrier cannot issue a current condition denial where an accepted claim has resulted in a permanent disability award. Claimant does not cite any authority for this position and we are not aware of any. A current condition denial does not "extinguish" a prior, final permanent disability award. Just because a current condition denial has issued does not mean that there was never any accepted condition or that any final permanent disability awards are "wiped out." We disagree with claimant's arguments to the contrary and we note that claimant fails to cite any statutory or other legal authority to support his position.

Board Member Phillips Polich dissenting.

I continue to disagree with the majority's opinion and would conclude that any subsequent combined condition denial is invalid in this case because there is permanent disability attributable to the compensable condition. For this reason, I disagree with the majority's conclusion.

In the Matter of the Compensation of
SHARLOTTE E. PLOG, Claimant
WCB Case Nos. 00-05652, 00-03208, 00-02663, 00-02662 & 00-00227
ORDER ON REVIEW
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
William J. Blitz, Defense Attorney
Lundeen, et al, Defense Attorney
Cavanagh & Zipse, Defense Attorney
Sather, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

EBI Companies[1], on behalf of Sunriver Living Centers, requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) set aside its denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome (CTS) condition; and (2) upheld the denials of Liberty Northwest Insurance Corporation, on behalf of Bend Villa Court, the SAIF Corporation, on behalf of Bachelor Butte, and Farmers Insurance Group, on behalf of Westview Cafe (Farmers), of the same condition. On review, the issues are compensability and responsibility. We modify in part and affirm in part.

FINDINGS OF FACT

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

Dr. Ponte informed claimant that her work activities were causing her bilateral CTS problems in early 1998. (Ex. 58-2; *see* Tr. 57-60).

Claimant filed an occupational disease claim with Farmers in January 2000. (Ex. 46A).

CONCLUSIONS OF LAW AND OPINION

We adopt and affirm the ALJ's "Opinions and Conclusions," with the following exception and modification.

We do not adopt the last paragraph on page 6.[2] Instead, we find that claimant's claim against Farmers is void because it was filed over a year after Dr. Ponte informed claimant that she had work-related CTS. (*See* Exs. 46A, 58-2; Tr. 57-60). Accordingly, claimant's request for hearing regarding Farmers' denial is dismissed. *See* ORS 656.807.[3] *See also Liberty Northwest Ins. Corp. v. Meeker*, 106 Or App 411, 414-15 (1991). The ALJ's order is modified accordingly.[4]

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[1] Royal and Sunalliance is now processing the claim for EBI. However, for purposes of this order we refer to "EBI."

[2] We do not adopt the duplicate sentence in the second paragraph on page 14.

[3] ORS 656.807(1) provides:

"(1) All occupational disease claims shall be void unless a claim is filed with the insurer or self-insured employer by whichever is the later of the following dates:

"(a) One year from the date the worker first discovered, or in the exercise of reasonable care should have discovered, the occupational disease; or

"(b) One year from the date the claimant becomes disabled or is informed by a physician that the claimant is suffering from an occupational disease."

[4] Neither this conclusion nor the fact that claimant sought treatment for right CTS symptoms in 1987 affects our holding that EBI is responsible for claimant's compensable condition, because we agree with the ALJ that all claimant's work activities contributed to her CTS. (*See* Exs. 38, 58; *see also* Exs. 47, 51A-5, 61; Tr. 50, 60-61, 66-67).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $750, payable by EBI. 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 October 28, 2000 is modified in part and affirmed in part. Claimant's request for hearing regarding Farmers Insurance Group's denial, on behalf of Westview Cafe, is dismissed. The remainder of the order is affirmed. For services on review, claimant is awarded a $750 attorney fee, payable by EBI Companies, on behalf of Sun River Living Center.

March 16, 2001 Cite as 53 Van Natta 325 (2001)

In the Matter of the Compensation of
CHARLES M. HANEY, Claimant
Own Motion No. 98-0360M
THIRD OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our August 17, 2000 Own Motion Order Reviewing Carrier Closure, as reconsidered on November 14, 2000 and February 16, 2001. Our prior orders affirmed the SAIF Corporation's February 1, 2000 Notice of Closure which closed his claim with an award of temporary disability August 18, 1998 through January 28, 2000. SAIF declared claimant medically stationary as of January 28, 2000.

In his most recent request, claimant contends that the opinions of his three treating physicians, two of which are Drs. Funk and Heath should be relied upon when reviewing SAIF's closure and not the independent insurer-arranged medical examiners' (IME) opinions. In addition, claimant argues that "[u]nder Oregon Administrative Rules the attending doctor must evaluate the worker's condition at the time of closure." Claimant explained that Dr. Funk was his attending physician, but had not "examined" him for a "period of months." Since Dr. Funk referred claimant to Dr. Heath, and Dr. Heath was attending him at the time SAIF closed his claim, claimant contends that Dr. Heath's opinion should be deferred to when considering his condition at closure.

As explained in our prior orders, it is well settled that for purposes of determining whether a claimant is medically stationary at the time of closure, we rely upon all competent medical evidence and not just the opinion of the attending physician. *See Patricia M. Knupp*, 46 Van Natta 2406 (1994); *Francisco Villagrana*, 45 Van Natta 1504 (1993).

Additionally, we generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). We give the most weight to the opinions that are both well reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259 (1986). In this case, we have found Dr. Funk's opinion more persuasive. Dr. Funk, who was claimant's attending physician at the time SAIF closed his claim, opined that claimant was medically stationary on January 28, 2000. Dr. Funk further concluded that claimant would achieve "no further improvement." His opinion is unrebutted.

In contrast to Dr. Funk's opinion, as explained in our prior orders, the opinions of Drs. Randell and Hendrix focused on claimant's *current* need for treatment. In other words, those opinions did not address his medically stationary status at closure.

Finally, we previously noted that, although Dr. Heath opined that claimant was "not medically stable in this time period" (referring to the period between February 2000 and May 2000), he was treating claimant for pain management to improve his functionality. Reasoning that functional improvement alone was not pertinent to claimant's medically stationary status, we found Dr. Heath's opinion to be insufficient to establish that claimant's condition was not medically stationary.

After considering claimant's arguments on reconsideration, we adhere to our prior conclusions. Consequently, we continue to affirm SAIF's Notice of Closure.

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

IT IS SO ORDERED.

Board Member Phillips Polich dissenting.

I continue to disagree with the majority's opinion and would set aside SAIF's February 1, 2000 Own Motion Notice of Closure because both Dr. Heath and Dr. Randell persuasively explain that with further treatment, claimant's medical condition would materially improve. These opinions, although rendered after claim closure, addressed claimant's condition at closure. For this reason, I disagree with the majority's conclusion.

In the Matter of the Compensation of
COLIN L. SPENCER, Claimant
Own Motion No. 00-0078M
OWN MOTION ORDER DENYING RECONSIDERATION
Cole, Cary, et al, Claimant Attorney
Hettle & Martin, Defense Attorney

Claimant requests reconsideration of our February 5, 2001 Second Own Motion Order on Reconsideration, which denied his request for reopening of his 1991 injury claim for the payment of temporary disability benefits. We took this action because claimant failed to establish he was in the workforce at the time of the current worsening.

Pursuant to OAR 438-012-0065(2), a reconsideration request must be filed within 30 days after the mailing date of the order, or within 60 days after the mailing date if there was good cause for the failure to file within 30 days. Filing of a document other than a request for hearing or a request for review of an Administrative Law Judge's order or Director's order, may be accomplished by mailing within the prescribed time accompanied by an attorney's certificate that it was deposited on the stated date. OAR 438-005-0046(1)(c).

Here, claimant's request for reconsideration (which was dated March 7, 2001, the 30th day from our February 5, 2001 order) was not mailed by certified mail, and was received by the Board on March 8, 2001. Claimant's request for reconsideration did not contain an attorney's certificate that the request was deposited in the mail on a stated dated. In light of such circumstances, we are inclined to deny the request as untimely filed. *See Joe C. Capron*, 50 Van Natta 2143 (1998). Nonetheless, we need not conclusively resolve this issue because, even if we were to accept claimant's request for reconsideration as timely filed, he has not provided any new evidence or argument which would persuade us to reach a different conclusion. In other words, we have nothing further to add to the finding and reasoning set forth in our January 8, and February 5, 2001 orders.[1]

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).

IT IS SO ORDERED.

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[1] We acknowledge claimant's request for *en banc* review. Because we do not consider the issues presented in this case to warrant such a review, the request has been denied. *Denice K. Drushella*, 52 Van Natta 940 (2000); *Dale F. Cecil*, 51 Van Natta 1010 (1999).

VAN NATTA'S
WORKERS' COMPENSATION REPORTER
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UPDATE PAGES

ENCLOSED ARE *VAN NATTA'S* PAGES 327-396 WITH WORKERS' COMPENSATION BOARD ORDERS THROUGH MARCH 31, 2001. THESE PAGES SHOULD BE INSERTED INTO YOUR CURRENT *VAN NATTA'S* BINDER, VOLUME 53, JANUARY-MARCH 2001.

In the Matter of the Compensation of
MODESTA GABRIEL, Claimant
WCB Case No. 00-02073
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Johnson's order that "vacated" a "Stipulation and Order." On review, the issue is jurisdiction. We vacate the ALJ's order and dismiss claimant's request for hearing.

FINDINGS OF FACT

On March 15, 2000, claimant requested a hearing, raising claim classification, penalties and attorney fees as issues. A hearing date was set. Before the scheduled hearing, the Workers' Compensation Division (WCD) reclassified claimant's claim.

Thereafter, the parties submitted a stipulation (signed by SAIF's claims examiner and trial counsel as well as claimant's attorney) whereby SAIF agreed to pay a $500 penalty. (The agreement also noted that the only issue remaining for resolution prior to the hearing was claimant's entitlement to a penalty.)

The ALJ initially approved the stipulation, but subsequently vacated the approval based on SAIF's contention that the stipulation was invalid because claimant did not sign it. Claimant requested Board review.

CONCLUSIONS OF LAW AND OPINION

A threshold issue concerns the Hearings Division's subject matter jurisdiction. *See Southwest Forest Industries v. Anders*, 299 Or 205, 208 (1985) (Court raised want of jurisdiction on its own motion); *Schlect v. SAIF*, 60 Or App 449 (1982) (subject matter jurisdiction may be raised at any time).

Here, claimant's request for hearing raised claim classification, penalty, and attorney fee issues. However, prior to the scheduled hearing, WCD reclassified claimant's claim and the sole remaining issue was claimant's entitlement to a penalty.

Under ORS 656.262(11)(a), the Director has "exclusive jurisdiction" over proceedings where entitlement to a penalty is the sole issue. *See Corona v. Pacific Resource Recycling*, 125 Or App 47 (1993); *Raymond J. Dominiak*, 48 Van Natta 108 (1996) (where the claimant seeks only a penalty, not benefits under a stipulation, the Director has exclusive jurisdiction over the issue). Therefore, once the classification and related fee issues ceased to exist, the Hearings Division lacked subject matter jurisdiction, and the ALJ lost authority to resolve the remaining penalty issue. *See Francisco J. Martinez*, 52 Van Natta 666 (2000).

Under these circumstances, the ALJ's order must be vacated and claimant's request for hearing dismissed. *E.g., Hill v. Oland*, 52 Or App 7891, 794 (1981) (even if a party does not raise a jurisdictional issue, "if we are without jurisdiction to hear [an] appeal, we must dismiss it sua sponte[.]"); *Lushona K. Icenhower*, 52 Van Natta 886 (2000).

ORDER

The ALJ's order dated October 31, 2000 is vacated. Claimant's request for hearing is dismissed.

In the Matter of the Compensation of
PAMELA M. HATSTAT, Claimant
WCB Case No. 00-02453
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
Cummins, Goodman, et al, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) upheld the self-insured employer's partial denial of her injury claim for neck, upper back and bilateral shoulder conditions; and (2) declined to assess a penalty or penalty-related attorney fees for the employer's allegedly unreasonable denial. On review, the issues are compensability, penalties and penalty-related attorney fees.

We adopt and affirm the ALJ's order with the following changes and supplementation. In finding of fact #9 on page 4, we change the first sentence to read: "In September 1999, claimant resumed chiropractic treatment for her neck, upper back and shoulders, and she began physical therapy in November 1999." In finding of fact #13 on page 4, we change the citation "Ex. 9-2" to read "Ex. 98-2." In the citations in the last paragraph on page 5, we add "Ex. 111."

On page 7, we replace the fourth full paragraph with the following:

"We find, however, that the opinions of Drs. Blum and Colfer are not persuasive because they did not have an accurate understanding of the hours claimant worked or the amount of time she spent removing covers from the promotional booklets. Claimant worked 30 to 40 hours a week in May 1999. (Ex. 41-4). She performed the activity of tearing the covers off promotional booklets from about May 10, 1999 until early June. (Exs. 31, 41-9). During that time, she spent 50 to 60 percent of her time tearing the covers off the booklets and she performed other clerical duties during the rest of the time. (Ex. 50-3). In June, claimant reduced her hours to twenty hours a week and in early July, she worked ten hours a week. (Exs. 41-4, 50-3).

"Dr. Colfer incorrectly understood that claimant removed the covers from the booklets during her entire shift and she was not aware that claimant's work hours changed between May 10, 1999 and July 12, 1999. (Ex. 115-11, -12). Dr. Blum was not aware how much time per day claimant spent removing the covers from the booklets and she did not know whether claimant's work hours had changed between May and July 1999. (Ex. 116-28, -29). Because the causation opinions from Drs. Colfer and Blum were based on incomplete information, we do not find them persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977)."

ORDER

The ALJ's order dated November 20, 2000 is affirmed.

In the Matter of the Compensation of
EDDARINE ROACH, Claimant
WCB Case No. 99-09094
ORDER ON REVIEW
Westmoreland & Mundorff, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Biehl, Bock, and Meyers.

The insurer requests review of Administrative Law Judge (ALJ) Hazelett's order that set aside its partial denials of claimant's "new medical condition" claims for left knee patellofemoral chondritis and post traumatic patellar instability. On review, the issue is compensability. We reverse in part, modify in part, and affirm in part.

FINDINGS OF FACT

Claimant injured her left knee at work on December 7, 1997. The insurer accepted a disabling left knee contusion. The claim was closed in May 1998, with no permanent disability award. Claimant requested reconsideration and Dr. Ho performed a medical arbiter's examination. Dr. Ho suspected that claimant's ongoing left knee pain may be due to patellofemoral chondritis.

An Order on Reconsideration awarded scheduled permanent disability, but an Opinion and Order reduced the award to zero and an Order on Review affirmed the Opinion and Order.

Dr. Neitling first examined claimant on January 13, 2000. Based on his examination findings and the mechanism of claimant's injury, Dr. Neitling diagnosed post-traumatic patellar subluxation and chronic patellofemoral arthralgia (pain).

Claimant filed "new medical condition" claims for patellofemoral chondritis and post traumatic patellar instability, which the insurer denied. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ stated that the "issue is the compensability of claimant's current left knee condition which may be patellofemoral chondritis or patellar instability." The ALJ reasoned that the opinions of Drs. Ho and Neitling establish that "something" is wrong with claimant's knee and claimant is not required to establish a specific diagnosis if her condition is injury-related. Therefore, the ALJ set aside the insurer's denials of claimant's "new medical condition" claims.

The insurer argues that it did not deny claimant's "current condition," only her "new medical condition" claims for patellofemoral chondritis and patellar instability. We agree.[1] (*See* Exs. 17, 26). *See Birrer v. Principal Financial Group*, 172 Or App 654 (2001); *Patricia N. Hall*, 40 Van Natta 1873 (1988) (an insurer's denial frames the issues for hearing).

Because claimant filed specific "new medical condition" claims for patellofemoral chondritis and post traumatic patellar instability, she must establish that she has these conditions, by a preponderance of persuasive medical evidence. *See Elvira Gonzales*, 52 Van Natta 954, 958 n. 1 (2000). In addition, claimant must prove the claimed conditions are work-related, based on medical evidence supported by objective findings. *See* ORS 656.005(7)(a).

Drs. Ho and Neitling provide the only medical evidence arguably indicating that claimant has left knee patellofemoral chondritis. Dr. Ho examined claimant once and opined that she had "findings suggesting patello-femoral chondritis which may account for [her symptoms]." (Ex. 9-2). Later, he stated, "I believe that the patello-femoral chondritis is a direct sequela of the accepted left knee contusion." (Ex. 10).

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[1] We note that the parties did not expand the scope of issues to be litigated at hearing beyond the compensability of the expressly denied "new medical condition" claims for left knee patellofemoral chondritis and post traumatic patellar instability. (*See* Tr. 1-2).

Dr. Neitling initially opined that claimant has patellar chondritis, chondrosis, or chondromalacia (one or a combination), but the only way to determine the type and nature of such cartilage damage would be arthroscopy (which he recommended). (Ex. 23). Later, Dr. Neitling stated, without further explanation, "I do not believe that I have opined that [claimant] has a chondritis." (Ex. 29-2).

We find both opinions inadequately explained regarding this diagnosis. Dr. Ho did not explain how his possible chondritis diagnosis evolved into an actual diagnosis. And Dr. Neitling did not explain why he initially thought that claimant had cartilage damage (*e.g.*, chondritis), then inconsistently reported that he did not say that. Absent further explanation, we conclude that claimant has established, at most, the possibility that she has left knee chondritis. (*See* Ex. 29-2; *see also* Exs. 16, 21-4-5, 26A-7). Under these circumstances, we reinstate the insurer's partial denial of claimant's "new medical condition" claim for left knee patello-femoral chondritis. *See Gormley v. SAIF*, 52 Or App 1055, 1060 (1981) (opinion in terms of medical possibility rather than medical probability is unpersuasive).

We reach a different result regarding the claim for post traumatic patellar instability, based on the following reasoning.

Claimant's left knee functioned "normally" until her work injury, but not thereafter. There is no evidence that claimant had a contributory preexisting left knee condition. However, by the time Dr. Neitling saw her in January 2000, claimant had suffered two years of "post injury" left knee pain. In addition, claimant's left knee "gave out on her" frequently and she often fell when that happened. (Ex. 18-1).

Dr. Neitling examined claimant and noted an increased "Q-angle" and lateral tracking of the left patella, "with a moderate tilt." He also reported peripatellar tenderness, pain "with vertical compression," tenderness over the mid and lower patellar tendon, as well as inferomedial retinacular tenderness. (Ex. 18-1-2). In addition, Dr. Neitling recorded "apprehension with the patellar subluxation maneuver," noting claimant's history that this test reproduced the "feeling of 'slipping' that she feels when the knee wants to give out." (Ex. 18-2).

X-rays showed "lateral tilt of the patella with lateral tracking of same. There is widening of the medial joint space." (*Id.*). Dr. Neitling explained:

> "In my opinion, she had a blow to the knee which stretched the medial retinacular structures, rending the patella unstable. This would explain the persistence of pain despite [lack of] evidence of any obvious internal derangement early on after the injury. With pain, there is guarding and favoring the knee, which leaves the quadriceps weakening. This results in further laterally-directed forces on the patella, contracture in the lateral retinaculum, and further stretching of the medial structures. We now have a situation where there is mechanically abnormal patellofemoral tracking * * *. All clinical findings suggest patellofemoral malalignment and chronic pain on that basis." (Ex. 18-2).

Accordingly, based on claimant's history, examination findings, x-rays, and the mechanism of her injury, Dr. Neitling diagnosed post traumatic patellar subluxation[2] and concluded, "The major contributing cause of her present condition is the work-related injury that occurred in December of 1997." (Ex. 18-3; *see* Exs. 20, 23).

The contrary medical evidence is provided by examining physicians who offered no explanation for claimant's ongoing left knee pain and give-way or her x-ray findings. (*See* Exs. 21, 22, 23, 25, 26A). In particular, the examining physicians disagreed with Dr. Neitling's diagnosis because they found no evidence of patellar instability. (*See id.*; Exs. 28, 30).

Dr. Neitling responded to the examiners' lack of findings, explaining that the knee joint has soft tissue restraints and when these restraints are stretched, as claimant's were with her injury, a "dynamic" instability may occur. When the instability occurs, the patella subluxes easily, under stress, "when forces are placed across the patellofemoral joint as with quadriceps setting or with heavy bent-knee activities." (Ex. 29-2). Dr. Neitling explained that the "cardinal findings" implicating claimant's "dynamic patellar instability" diagnosis were ongoing pain and irritability in the medial retinacular area. (*Id*). He noted that Dr. Scheinberg found claimant's knee alignment "satisfactory." However, Dr. Neitling further noted that Dr. Scheinberg did not comment

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[2] Subluxation is defined as: "An incomplete luxation or dislocation; though a relationship is altered, contact between joint surfaces remains." *Stedman's Electronic Medical Dictionary* v. 4.0 (1998).

"regarding the actual tracking of that structure, and whether there is any lateral thrust toward terminal extension when the quad is set. These are all important findings that would relate to [claimant's] ongoing pathologic problems."[3] (Ex. 29-1).

Thus, Dr. Neitling explained, a patella may track normally, except under certain stress, when a subluxation (or even dislocation) may occur because of the prior stretching injury. Accordingly, considering claimant's findings and the nature of her injury, Dr. Neitling concluded that the work injury caused claimant's current patellofemoral instability condition. (Ex. 29-2).

We find Dr. Neitling's opinion regarding claimant's left knee patellar instability condition persuasive because it is well-reasoned and based on an accurate and complete history.[4] Accordingly, based on Dr. Neitling's diagnosis and reasoning, we conclude that claimant's work injury was the major contributing cause of her current left knee patellar instability condition.[5]

Claimant's attorney is entitled to an assessed fee for services at hearing and on review for services regarding the compensable left knee patellar instability condition. ORS 656.386(1); 656.382(2). Claimant is not entitled to an attorney fee award for her counsel's services rendered at the hearing and Board review levels regarding the chondritis condition. Consequently, we award an attorney fee, in lieu of the ALJ's award.

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 patellar instability issue is $3,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate 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 November 22, 2000 is reversed in part, modified in part, and affirmed in part. That portion of the order that set aside the insurer's denial of claimant's claim for left knee chondritis is reversed. That denial is reinstated and upheld. In lieu of the ALJ's attorney fee award, claimant is awarded an attorney fee of $3,500, payable by the insurer. The remainder of the order is affirmed.

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[3] Although Dr. Scheinberg tested claimant's patellar tracking "with the patient sitting and actively extending her knees," there is no indication that he or any other examining physician evaluated it under stress "when the quad is set," as described by Dr. Neitling. (*See* Exs. 21-4, 26A-6, 30). Therefore, Dr. Neitling's reasoning--that the abnormal tracking occurs under stress in claimant's case--is unrebutted. (*See* Ex. 29).

[4] We have previously found Dr. Neitling's opinion regarding the claimed patellofemoral chondritis condition unpersuasive because it was inadequately explained and inconsistent over time. For the reasons expressed above, we find Dr. Neitling's opinion concerning the patellar instability condition to be thorough, well-explained, and persuasive.

[5] We also find that claimant's "new medical condition" claim for left knee patellar instability is established by medical evidence supported by objective findings, including Dr. Neitling's x-rays, claimant's "apprehension with the patellar subluxation maneuver," and her "pain with vertical compression." (*See* Ex. 18-2). *See* ORS 656.005(19).

Board Member Meyers concurring in part and dissenting in part.

The majority upholds the insurer's denial of claimant's claim for patellofemoral chondritis, but sets aside its denial of her claim for patellar instability. I agree with the former decision, but disagree with the latter, based on the following reasoning.

First, Dr. Neitling is the only physician who believes that claimant has left knee patellar instability. Three other physicians, Drs. Grewe, Duff, and Scheinberg, examined or treated claimant and found no evidence of patellar instability. Not only do these three experts agree, but they are also orthopedic specialists, well qualified to determine the nature and etiology of claimant's left knee

condition. Dr. Neitling's credentials, on the other hand, are not apparent in the record. Under these circumstances, I would rely on the three qualified experts who agree that claimant has no findings of left knee patellar instability. (*See* Exs. 21-2, -5, 25, 26A-7-8, 28; *see also* Ex. 4A).

I also note that claimant has contralateral findings in her uninjured *right* knee that suggest that her similar left knee abnormalities are not injury related. In this regard, Dr. Duff reported that *both* patellae are malaligned, (Ex. 21-3). Because a preponderance of the qualified persuasive expert evidence clearly indicates that claimant has no left knee patellar instability, I would uphold the insurer's denial of claimant's claim for such a condition. Consequently, I must respectfully dissent from the contrary portion of the majority's decision.

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

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, in its recommendation form, the insurer indicates that claimant is represented. Based on such a reference, claimant's attorney may be entitled to a reasonable attorney fee, payable out of the increased compensation awarded by this order. However, on this record, we cannot approve such a fee because: (1) no current retainer agreement has been filed with the Board (*see* OAR 438-015-0010(1)); and (2) no evidence demonstrates that claimant's attorney was instrumental in obtaining increased temporary disability compensation. OAR 438-015-0080.

Consequently, no "out-of-compensation" attorney fee award has been granted. In the event that a party disagrees with this decision, that party may request reconsideration and submit information that is currently lacking from this record. Because our authority to further consider this matter expires within 30 days of this order, any such reconsideration request must be promptly filed.

IT IS SO ORDERED.

In the Matter of the Compensation of
RAYMOND ALDINGER, Claimant
WCB Case No. 00-05568
ORDER ON REVIEW

Reviewed by Board Members Haynes and Bock.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Lipton's order that declined to award temporary disability benefits. On review, the issue is temporary disability.

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

A claimant must be in the work force to be entitled to temporary disability. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989); *Doyce G. Prince*, 52 Van Natta 1883 (2000). Work force status is determined at the time of disability. *Id.*; *Weyerhaeuser Co. v. Kepford*, 100 Or App 410, 414, *rev den* 310 Or 71 (1990). A claimant is deemed to be in the work force if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is making reasonable efforts to obtain employment; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. *Dawkins*, 308 Or at 258.

As the ALJ explained, claimant is not working and is not seeking work. Thus, he must prove that he is not seeking work because such efforts would be futile. The record indicates that claimant is receiving social security retirement benefits. (Ex. 17). The record contains no medical, vocational or other evidence establishing that it is futile for claimant to seek work.[1] Under such circumstances, claimant has not established that he remains in the work force. Consequently, temporary disability benefits cannot be awarded.

ORDER

The ALJ's order dated November 2, 2000, as corrected on the same date, is affirmed.

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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 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
RAYMOND E. ALDINGER, Claimant
Own Motion No. 00-0289M
OWN MOTION ORDER

The self-insured employer submitted claimant's request for temporary disability compensation for his right ear and shoulder condition. Claimant's aggravation rights on that claim have expired. The employer opposed reopening on the ground that claimant was not in the work force at the time of his current disability.

FINDINGS OF FACT

On December 31, 1998, the employer denied the compensability of claimant's current right ear condition. Claimant requested a hearing before the Hearings Division. (WCB Case No. 99-01674). On October 29, 1999, Administrative Law Judge (ALJ) Otto set aside the employer's denial and remanded the claim to the employer for "acceptance and processing according to Oregon's Workers' Compensation Laws." That order was not appealed.

On July 14, 2000, the employer modified its Notice of Acceptance to include claimant's right inner ear condition (*i.e.* tympanic membrane perforation). On July 17, 2000, claimant requested another hearing before the Hearings Division, raising the issue of entitlement to temporary disability compensation beginning November 15, 1998, the date the employer terminated his timeloss following its closure of the 1989 Own Motion reopening. (WCB Case No. 00-05568).

On September 19, 2000, the employer submitted an Own Motion recommendation. The employer opposed reopening, contending that claimant was not in the work force at the time of the current worsening. The Board deferred action on the Own Motion matter pending resolution of the litigation before the Hearings Division.

Thereafter, a hearing in WCB Case No. 00-05568 was held. In his November 2, 2000 Opinion and Order, ALJ Lipton found that claimant's current right ear condition must be processed as a "newly accepted" condition. ALJ Lipton further concluded that claimant was not entitled to timeloss benefits as a result of the prior ALJ's October 29, 1999 order.

Claimant requested Board review of ALJ Lipton's order. In a separate order issued today, we have affirmed ALJ Lipton's November 2, 2000 order.

CONCLUSIONS OF LAW AND OPINION

A new medical condition claim qualifies for reopening and closure under ORS 656.268 pursuant to ORS 656.262(7)(c), even if the initial claim is in Own Motion jurisdiction. *Dave A. Humphrey*, 52 Van Natta 2212 (2000); *Robert A. Olson*, 52 Van Natta 1540 (2000); *John R. Graham*, 51 Van Natta 1740 (1999). On the other hand, the Board, in its Own Motion capacity under ORS 656.278, does not have authority to direct a carrier to process a claim under ORS 656.262(7)(c). *Craig J. Prince*, 52 Van Natta 108, 110 (2000). Instead, that issue is a "matter concerning a claim," under the jurisdiction of the Hearings Division, and not under the Board's Own Motion jurisdiction. ORS 656.708; *Dave A. Humphrey*, 52 Van Natta at 2213, citing *Camilla S. Kosmoski*, 52 Van Natta 1573, 1574 n2 (2000).

Here, claimant's "new condition" claim qualifies for reopening and closure under ORS 656.268 pursuant to ORS 656.262(7)(c). However, the Board has no authority, in its Own Motion capacity under ORS 656.278, to order such reopening. *Craig J. Prince*, 52 Van Natta at 110. Accordingly, we deny the request for Own Motion relief.[1]

IT IS SO ORDERED.

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[1] In other words, because we lack authority to issue an order on the merits of claimant's claim for temporary disability in our Own Motion capacity, this order neither awards, nor declines to award, temporary disability. Instead, our Order on Review, issued this same date, addresses claimant's entitlement to temporary disability.

In the Matter of the Compensation of
MICHAEL C. KERSHAW, Claimant
WCB Case No. 00-05222
ORDER ON REVIEW
Edward J. Harri, Claimant Attorney
James B. Northrop (Saif), Defense Attorney
Kryger, et al, Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) Black's order that found that the SAIF Corporation's termination of temporary disability benefits was proper. On review, the issue is temporary disability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

On September 27, 1999, claimant, who drove dump trucks and/or trailer combinations for the employer, a trucking company, compensably injured his right shoulder and neck and fractured his left fourth metacarpal bone in a motor vehicle accident. Claimant also suffered post-traumatic anxiety syndrome as a result of the compensable injury. (Ex. 24).

On April 14, 2000, claimant was released to modified work. The employer, through an employee leasing and temporary worker company, arranged a physician-approved job as a helper at a thrift store, to be paid at an hourly rate of $9.57 per hour. (Exs. 18, 19). Claimant was to work eight hours a day from 8:00 a.m. to 4:30 p.m., Tuesdays through Saturdays. His duties included picking up and replacing fallen items, performing minor repair work, measuring items, spotting shoplifters, sorting clothing and placing items on hangars, stuffing envelopes and performing other clerical duties, dusting, and cleaning the lunch room. (*Id.*) Claimant began work at the thrift store on April 25, 2000. It was claimant's responsibility to call the work site, the employee leasing company, and the employer if he was sick. (Tr. 13, 14; Ex. 12A).

On June 13, 2000, SAIF informed the employer that claimant had not shown up for work. (Ex. 2; Tr. 31). Claimant was also not at work on June 14, 2000. (Ex. 2). On June 14, 2000, the employer terminated claimant's employment for his alleged failure to report to work without calling in. (Ex. 21; Tr. 14). Thereafter, claimant requested a hearing, seeking temporary disability benefits that SAIF had terminated based on claimant's failure to perform modified work.

At hearing, claimant argued that he did not violate the employer's work rules and that, in any case, any violation of work rules did not affect his entitlement to time loss because the alternate work bore no relationship to the "at injury" employer's business or economic interests. After discussing *Douglas B. Organ*, 49 Van Natta 198 (1997), *Christine Mulder*, 50 Van Natta 521 (1998), and *Paul H. McNeil*, 51 Van Natta 711 (1999), the ALJ concluded that there is no requirement that modified work be with the "at injury" employer. The ALJ further found that claimant had not called in on June 13 or 14, 2000, and was therefore terminated for violation of work rules or other disciplinary reasons under ORS 656.325(5)(b).

On review, claimant contends that he was not in violation of work rules when he failed to report for work on June 13 and 14, 2000. Thus, he asserts that SAIF improperly ceased payment of temporary disability under ORS 656.325(5)(b). Claimant also argues that, in any event, the modified work at the thrift store did not constitute appropriate "modified employment" under ORS 656.268(4).

After *de novo* review of the record, we begin by adopting and affirming the ALJ's reasoning and conclusions that claimant was terminated for violation of work rules or other disciplinary reasons.

Claimant nevertheless contends that SAIF has the duty to pay temporary partial disability compensation pursuant to ORS 656.325(5)(b)[1] after the employer terminated his employment. We conclude that ORS 656.325(5)(b) is inapplicable in this case, for the following reasons.

Temporary disability benefits are intended to provide replacement for wages lost due to a compensable injury. *Cutright v. Weyerhaeuser Co.*, 299 Or 290, 296 (1985); *Roseburg Forest Products v. Wilson*, 110 Or App 72, 75 (1991); *see also Madrigal v. J. Frank Schmidt & Son*, 172 Or App 1 (2001) (ORS 656.212(2) requires payment of temporary disability benefits only for wages lost due to the compensable injury, not due to the worker refusing to accept modified work). Where a worker leaves work for reasons other than an inability to work as a result of the compensable injury, the worker is not entitled to temporary disability benefits. *Noffsinger v. Yoncalla Timber Products*, 88 Or App 118, 121 (1987); *Lino Villa-Acosta*, 51 Van Natta 211 (1999); *compare Peggy J. Baker*, 49 Van Natta 40 (1997) (claimant entitled to temporary disability when terminated, at least in part, because of inability to perform regular work due to compensable injury).

Here, claimant left his modified work on June 14, 2000, when he was discharged for a violation of work rules. The record does not establish that claimant left work due to an inability to work as a result of his compensable injury. Therefore, claimant is not entitled to resumption of temporary total disability benefits after June 14, 2000. *See Michael D. Wingo*, 48 Van Natta 2477 (1996), *aff'd Wingo v. DPR Construction*, 153 Or App 237 (1998), *Patricia K. Stodola*, 48 Van Natta 613 (1996).

Moreover, if claimant was earning the same wage he earned at the time of injury when he was performing modified work, he was not entitled to receive any temporary partial disability benefits, because he was not sustaining wage loss as a result of the compensable injury. *See Madrigal*, 172 Or App at 3 (the amount of the temporary partial disability benefit is determined by the "loss of wages" due to the compensable injury).

It is claimant's burden to prove that SAIF incorrectly calculated his temporary partial disability. *See Coombe v. SAIF*, 111 Or App 71, 75 (1992); *Oscar J. Myers*, 48 Van Natta 1283, 1284 (1996).[2] Here, the record does not establish that the wages claimant earned at modified employment were less than his "at-injury" wages. *See* ORS 656.212(2); *Lonnie L. Dysinger*, 47 Van Natta 2282, 2283 (1995). Under such circumstances, claimant's temporary partial disability rate was zero.

Accordingly, claimant's loss of wages after termination of his modified job was not due to the compensable injury. Instead, it was due to his violation of work rules when he failed to call in when he was sick. Therefore, after claimant was terminated for violation of work rules, he lost no wages due to the work injury and his temporary partial disability rate remained zero.[3]

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[1] ORS 656.325(5)(b) provides:

"(5) Notwithstanding ORS 656.268:

"(b) If the worker has been terminated for violation of work rules or other disciplinary reasons, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 and commence payments pursuant to ORS 656.212 when the attending physician approves employment at a modified job that would have been offered to the employer if the worker had remained employed, provided that the employer has a written policy of offering modified work to injured workers."

[2] In *Coombe*, the claimant argued that the rate at which the carrier paid his temporary disability benefits for a second injury was incorrect. The court agreed with the Board's conclusion that, on the basis of information provided by the employer and the claimant regarding his wages, the claimant had not met his burden to show that his benefits should be more than the weekly rate that had been paid by the carrier.

Likewise, in *Oscar J. Myers*, the claimant presented no evidence to support his argument that the carrier incorrectly calculated his temporary disability rate based on his average earnings over the 26-week period prior to the date of injury, rather than the 52-week period prior to the injury date. Absent such evidence, we concluded that the claimant failed to meet his burden in that case.

[3] In other words, when a worker is terminated for violation of work rules, and therefore will not be receiving any wages from that modified employment, the insurer shall cease paying temporary total disability benefits and pay temporary partial disability benefits. However, if the modified work paid the at-injury wage, the worker's loss of wages is not due to the compensable injury, but is due to his or her violation of work rules (or other disciplinary measures). Under such circumstances, the temporary partial disability rate would be zero. *Madrigal*, 172 Or App at 3.

Finally, because claimant was not receiving (and was not entitled to receive) temporary total disability benefits at the time of his termination, ORS 656.325(5)(b) does not apply. *See, e.g., George B. Orazio*, 49 Van Natta 1982 (1997).[4]

We next address claimant's alternative argument that the modified work at the thrift store did not, in any case, constitute appropriate "modified employment" under ORS 656.268(4).

Subsequent to the ALJ's order, we addressed whether a claimant must accept an offer of physician-approved modified work as a "loaned" employee in *Ted Brenner, Jr.*, 53 Van Natta 257 (2001). In *Brenner*, the claimant had declined modified work at alternative work sites, arguing that work at those sites did not constitute proper modified employment. We began our analysis by deciding whether the modified work offered to the claimant qualified as "modified employment" within the meaning of ORS 656.268(4)(c). After reviewing the text and context of the statute, we concluded in *Brenner* that the statute does not necessarily require that the claimant return to modified work for the "at injury" employer.

We then discussed *Organ* and *Mulder*. In *Mulder*, we had found that the light duty research position offered in that case was a legitimate modified job, as distinguished from our finding in *Organ* that the "skills-center program" offered in that case did not qualify as "modified employment." We concluded in *Brenner* that, unlike the training program in *Organ*, the claimant's modified work at the alternative work site was not part of a training program, but, as in *Mulder*, consisted of actual work.

In this case, as in *Brenner*, we conclude that ORS 656.268(4)(c) does not necessarily require that "modified employment" be performed at the employer-at-injury's job site. In addition, claimant's modified work that he performed at the alternative work site (which included picking up and replacing fallen items, performing minor repair work, measuring items, spotting shoplifters, sorting clothing and placing items on hangars, performing clerical duties, dusting, and cleaning the lunch room) was actual work and, as such, constituted "modified employment."

ORDER

The ALJ's order dated October 10, 2000 is affirmed.

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[4] In *Orazio*, the claimant sustained a compensable injury and was earning his at-injury wage while performing modified work when he was discharged for disciplinary reasons. We determined that ORS 656.325(5)(b) did not apply because the claimant was not entitled to receive temporary total disability at the time of termination. In addition, we found that the claimant was not entitled to temporary disability benefits after he was discharged from employment because temporary disability benefits were intended to replace wages lost due to a compensable injury. Because the claimant did not leave work due to an inability to work as a result of his compensable injury, but left work because he was discharged for disciplinary reasons, we concluded that the claimant was not entitled to temporary disability benefits after the date he was discharged.

Board Member Phillips Polich dissenting.

For the reasons expressed in my dissent in *Ted Brenner, Jr.*, 52 Van Natta 257 (2001), I continue to disagree with the majority in *Brenner* who concluded that modified work offered to claimants at alternative work sites is appropriate "modified employment." Similarly, in this case, I would find that the modified work offered to claimant at an alternative work site is not appropriate "modified employment" and that the ALJ's determination that claimant's temporary disability was "zero" was incorrect. Accordingly, I respectfully dissent.

In the Matter of the Compensation of
BARBARA A. MORRIS, Claimant
WCB Case No. 00-03919
ORDER ON REVIEW
McGinty & Belcher, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that: (1) increased claimant's unscheduled permanent disability for a left shoulder injury from 24 percent (76.8 degrees), as awarded by an Order on Reconsideration, to 28 percent (89.6 degrees); and (2) reduced claimant's scheduled permanent disability award for loss of use or function of her left hand from 13 percent (19.5 degrees) to zero. On review, the issue is extent of permanent disability, scheduled and unscheduled.[1]

We adopt and affirm the ALJ's order.[2] *See Donald A. Westlake,* 50 Van Natta 1213 (1998) (where the medical evidence failed to show that the claimant's distal clavicle condition was accepted or a direct medical sequela of the accepted impingement condition, no permanent disability award was granted based on the clavicle condition).[3]

ORDER

The ALJ's order dated November 13, 2000 is affirmed.

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[1] Alternatively, claimant requests remand for the ALJ to make findings and conclusions regarding whether the brachial nerve injury condition diagnosed by the medical arbiter is a direct medical sequela of the accepted left rotator cuff strain and impingement syndrome conditions. However, given our *de novo* review, we are equally empowered to make the findings and conclusions proposed by claimant (should the evidence support such a conclusion). Because there is no medical evidence indicating that the brachial nerve injury is a sequela of the accepted conditions, we reject claimant's request (on the procedural "remand" issue, as well as the substantive "sequela" issue).

[2] We acknowledge claimant's contention that SAIF may not contest its own Notice of Closure award (*i.e.*, 31 percent unscheduled permanent disability). However, the issue before the ALJ and the Board on review is the propriety of the *change* the Order on Reconsideration made in claimant's award (*i.e.*, reduction to 24 percent). The insurer is not precluded from defending the change made by the reconsideration order. *See Christine M. Flaherty,* 51 Van Natta 1971 (1999) (carrier not precluded from defending reconsideration order's permanent disability award where extent issue was raised on reconsideration and preserved at hearing and applying *Duncan v. Liberty Northwest Ins. Corp.*, 133 Or App 605 (1995)).

[3] Because we are not an agency with specialized medical expertise entitled to take official notice of technical facts within our specialized knowledge, we must have medical evidence that the impairment is consistent with, or a direct sequela of, the accepted condition. *See SAIF v. Calder,* 157 Or App 224 (1998). However, our holding does not mean that a claim for the unaccepted conditions cannot be made and, if accepted or determined to be compensable, rated for permanent disability in the future. *See* ORS 656.262(6)(d), (7)(a).

In the Matter of the Compensation of
MARK MOSER, Claimant
WCB Case No. 00-05367
ORDER ON REVIEW
Parker, et al, Claimant Attorney
Reinisch, et al, Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that upheld the insurer's partial denial of claimant's injury claim for an L4-5 disc condition. On review, the issue is compensability.

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

Claimant injured his back September 8, 1999, while carrying a concrete form. As a result of the insurer's back injury claim denial, claimant requested a hearing. (Ex. 16). On November 5, 1999, a prior ALJ's order determined that the injury was compensable and remanded the claim to the insurer for processing. (Ex. 29).

Following the prior ALJ's order, the claim was accepted as a nondisabling "upper thoracic strain."[1] (Ex. 30). A few days later, claimant requested that the insurer accept and process an L4-5 disc herniation. (Ex. 30A).

On July 14, 2000, the insurer issued a partial denial declining to accept the L4-5 disc. Claimant requested a hearing. At hearing, the parties agreed that the insurer's denial encompassed both legal and medical causation. (Tr. 2). Additionally, the parties agreed that claimant was contending the L4-5 disc was compensable as either an omitted condition or a new condition. (Tr. 3).

The ALJ determined that claimant was not a credible witness. The ALJ based her determination on claimant's demeanor, responsiveness, hesitations while testifying, and internal inconsistencies in medical histories. After reviewing the medical and lay evidence, the ALJ concluded that claimant had failed to establish the compensability of his L4-5 disc condition.

Claimant contends that: (1) the ALJ erred in finding him not credible; and (2) notwithstanding the ALJ's credibility finding, the medical evidence demonstrates that his disc condition is compensable. We disagree.

We generally defer to an ALJ's demeanor-based credibility findings, and after reviewing the record, we do so here. *See Bush v. SAIF*, 68 Or App 230, 233 (1984). Based largely upon claimant's presentment at hearing, the ALJ found several reasons to distrust him. (O&O pg. 3). Because the ALJ had the opportunity to observe the claimant's testimony, she is in a much better position to assess his credibility and her determination is entitled to considerable weight. *See Sherri L. Williams*, 51 Van Natta 75, 77 (1999). After reviewing claimant's arguments and the record, we find no reason to disturb the ALJ's credibility finding.

We acknowledge claimant's argument that in certain cases the Board has held that even if a worker lacks credibility in certain respects, he may still establish the compensability of a claimed condition where the remainder of the record supports his claim. *See Westmoreland v. Iowa Beef Processors*, 70 Or App 642 (1984); *Greg T. Smith*, 52 Van Natta 273 (2000); *Victor J. Cervantes*, 51 Van Natta 1343 (1999). However, here, the medical opinions regarding the cause of claimant's low back condition are dependent on claimant's history (a history that inaccurately portrays the level of claimant's physical activity from the date of his September 1999 work injury to the onset of his low back pain). Consequently, the remainder of the record is insufficient to support a finding that claimant's low back condition was caused by the work injury as opposed to some other event. Accordingly, we conclude that claimant has failed to establish the compensability of his low back condition.

ORDER

The ALJ's order dated December 29, 2000 is affirmed.

[1] On July 24, 2000, the insurer reclassified the accepted thoracic strain as disabling. (Ex. 32).

In the Matter of the Compensation of
STEPHANIE A. DYS-DODSON, Claimant
WCB Case Nos. 00-03498 & 00-02158
ORDER ON RECONSIDERATION
Willner, Wren, Hill & Uren, Claimant Attorney
Lundeen, et al, Defense Attorney

Claimant requests reconsideration of that portion of our February 22, 2001 order that reversed the Administrative Law Judge's (ALJ's) award of an insurer-paid attorney fee under ORS 656.382(2). Specifically, claimant contends that: (1) the ALJ's attorney fee award "was not before the Board on review"; and (2) the Board lacks authority to reverse an ALJ's attorney fee award, even if the basis for the ALJ's award no longer exists.[1] After considering the employer's arguments, we continue to adhere to our prior order with the following supplementation.

On August 15, 2000, the insurer filed its "Request for Review" in which it expressly "requests review pursuant to ORS 656.295 of Judge Kathryn Poland's order dated July 28, 2000." The "Request for Review" unequivocally requested review of the ALJ's order, which necessarily included the ALJ's attorney fee award. Furthermore, although the insurer only specifically addressed the premature closure issue in its appellant's brief, it expressly "request[ed] that the ALJ's decision be reversed." Under these circumstances, we were authorized to consider the ALJ's attorney fee award. *See* ORS 656.295(6).

We turn to claimant's second contention. 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, 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 set by the Administrative Law Judge, 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."

Here, the insurer requested a hearing challenging ARU's Order on Reconsideration decision that the Notice of Closure had prematurely closed claimant's claim. The ALJ affirmed the Order on Reconsideration, and because the insurer's request for hearing did not result in a reduction of claimant's benefits, awarded claimant an insurer-paid attorney fee under ORS 656.382(2). The insurer requested Board review. On review, we reversed the ALJ's order, and reinstated the Notice of Closure, thereby reducing benefits otherwise payable to claimant pursuant to the Order on Reconsideration.

Claimant, relying on *Santos v. Carryall Transport*, 171 Or App 467 (2000), contends that notwithstanding that the insurer was ultimately successful in challenging the Order on Reconsideration, he is still entitled to the attorney fee awarded by the ALJ for services rendered at the hearing. In *Santos*, the court held ORS 656.382(2) did not authorize an appellate attorney fee award for a claimant who initiated and prevailed on his petition for Judicial review before the court, even though the carrier had initiated appeal to the Board and prevailed at that level. *Santos*, 171 Or App at 474. As a part of its decision in explaining the applicability of ORS 656.382(2) the court said:

> "As the emphasized language makes clear, when the employer initiates a review and compensation is not disallowed or reduced *at that level of review*, the employer must pay the claimant's attorney fees in an amount set by the reviewing body for that level of review and for prior levels of review." (emphasis in original). *Santos*, 171 Or App at 511.

Claimant argues that the word "must" in the above-quoted language requires that the ALJ's attorney fee award be upheld, even if later the insurer successfully obtains a reduction in claimant's benefits. We disagree with claimant's assertion.

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[1] Claimant does not seek reconsideration of that part of our order that reversed the ALJ and reinstated the Notice of Closure. Rather claimant contends he is entitled to the attorney fee awarded by the ALJ, regardless of the outcome on Board Review.

Santos did not involve the reversal of an ALJ's attorney fee award following a carrier's successful challenge of the ALJ's "on the merits" decision regarding a claimant's compensation award. Consequently, *Santos* is distinguishable.

Here, the insurer requested Board review of the ALJ's order and was successful in obtaining a reinstatement of its Notice of Closure; *i.e.*, a reduction in claimant's benefits awarded by the Order on Reconsideration that had set aside the Notice of Closure as premature. Because our order replaces the ALJ's order, it necessarily follows that claimant is not entitled to an insurer-paid fee for services at the hearing. *See Lorenzo K. Kimball*, 52 Van Natta 633 (2000); *Patricia L. McVay*, 48 Van Natta 317 (1996).

Accordingly, our February 22, 2001 order is withdrawn. On reconsideration, as supplemented herein, we republish our February 22, 2001 order in its entirety. The parties' rights of appeal shall begin to run form the date of this order.

IT IS SO ORDERED.

March 22, 2001 Cite as 53 Van Natta 341 (2001)

In the Matter of the Compensation of
DELORIS E. GEMOETS, Claimant
WCB Case No. 00-03416
ORDER ON RECONSIDERATION
Cole, Cary, et al, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorney

The insurer requests reconsideration of that portion of our February 22, 2001 Order on Review that adopted and affirmed, with supplementation, an Administrative Law Judge's (ALJ's) order that set aside its denial of claimant's left knee and low back injury claim. Having received claimant's response to the insurer's motion, we proceed with our reconsideration.

At hearing and on review, the insurer argued that testimony from its witness regarding lottery machine printouts showing lottery activity until almost 11:00 p.m. the night of January 31, 2000, brings into question claimant's report of being injured around 8:00 p.m. while closing the Lodge on January 31, 2000. The ALJ addressed this argument. While finding that claimant and her witnesses were credible based on their demeanor at hearing, the ALJ found that the above testimony from the insurer's witness tended to contradict claimant's testimony that she was alone in the bar at the time of her injury. Because claimant failed to explain this inconsistency during her testimony, the ALJ construed it against her.

Nevertheless, because this inconsistency was collateral in nature, the ALJ found that it did not defeat claimant's claim. The ALJ found that, even if claimant's injury occurred at a different time the night of January 31, 2000 from that to which she and her witnesses testified, and even if she was not alone in the Lodge at the time the incident occurred, it was more likely than not that claimant was injured in the way she described, based on her witnesses' testimony.

On review, we adopted and affirmed the ALJ's order with supplementation. Specifically, we agreed with the ALJ's reasoning and conclusions as summarized above. In addition, we noted that claimant testified that her domestic partner notified the employer the next day that claimant injured herself the night before when she fell off a chair at work while turning off lights. (Tr. 29, Ex. 3). We also found that the employer's 801 form corroborated claimant's testimony by noting that the employer first knew of the claim on February 1, 2000. (Ex. 3). Thus, we agreed with the ALJ that the insurer's denial should be set aside.

In its motion for reconsideration, the insurer repeats its argument that its witness's testimony discredits claimant's and her witnesses' report of an injury occurring at work the night of January 31, 2000. In addition, the insurer asserts that we did not address that argument on review. We disagree. As summarized above, by adopting and supplementing the ALJ's order, we adequately addressed the insurer's argument in our initial Order on Review. *See Jorge Pedraza*, 49 Van Natta 1019 (1997). After reconsideration, we have nothing further to add.

Claimant's attorney is entitled to an additional assessed attorney fee for his 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 concerning the compensability issue is $100, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the 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.

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our February 22, 2001 order effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

March 22, 2001 Cite as 53 Van Natta 342 (2001)

In the Matter of the Compensation of
CHARLES A. GOULD, Claimant
Own Motion No. 01-0083M
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.*

On January 18, 2001, Dr. Grewe, claimant's attending surgeon, recommended that claimant undergo a left knee arthroscopy and ligamentous reconstruction. 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 1985 injury claim to provide temporary disability compensation beginning the date claimant is hospitalized for the left knee arthroscopy and ligamentous reconstruction. When claimant's condition related to the left knee arthroscopy and ligamentous reconstruction is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[1] SAIF notes that two surgical procedures are proposed. First, a left knee arthroscopy and ligamentous reconstruction, which it relates to claimant's 1985 left knee claim. And second, a left knee open-wedge varus-producing osteotomy with iliac crest bone graft, which it contends is not related to his 1985 left knee claim. In light of such circumstances, we limit our current review to the undisputed arthroscopy and ligamentous reconstruction.

[2] This conclusion should not be interpreted as a decision, in any manner, regarding claimant's left knee open-wedge varus-producing osteotomy with iliac crest bone graft and its relationship, if any, to claimant's 1985 left knee claim.

In the Matter of the Compensation of
DEBRA D. OSLER, Claimant
WCB Case No. 00-03464
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
VavRosky, et al, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) awarded claimant additional temporary total disability; and (2) assessed a penalty for allegedly unreasonable claim processing. In its appellant's brief, the employer seeks "administrative notice" of a "post-hearing" Order on Reconsideration. In her respondent's brief, claimant seeks additional temporary disability and challenges the employer's "administrative notice" request.[1] On review, the issues are administrative notice, temporary disability, and penalties. 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, a dental assistant, initially filed her bilateral carpal tunnel syndrome claim in June 1999. (Ex. 4). The employer issued its denial in August 1999. (Ex. 16). Claimant requested a hearing.

On March 17, 2000, a prior ALJ's order found the claim compensable and remanded it to the employer's processing agent for "acceptance, payment of benefits and processing in accordance with law." (Ex. 34-5). The employer requested Board review. On June 7, 2000, the Board affirmed the prior ALJ's order.[2] *Debra D. Osler*, 52 Van Natta 977 (2000).

In a June 19, 2000 letter to claimant's attorney, Dr. McMillan, claimant's attending physician, indicated that if claimant was unable to hold dental instruments, she would be unable to perform her work as a dental assistant. (Ex. 44). In her June 27, 2000 chart note, Dr. McMillan opined that claimant was unable to return to work as a dental assistant and further indicated that she was withdrawing as claimant's attending physician.[3] (Ex. 45). When the employer did not commence temporary disability payments, claimant requested a hearing.

The ALJ interpreted Dr. McMillan's June 27, 2000 chart note as an authorization of temporary disability benefits and concluded that claimant had established an entitlement to temporary total disability (TTD). Additionally, finding that the employer had not processed the claim since the prior ALJ's order, the ALJ assessed the employer a 25 percent penalty.

The employer does not challenge the ALJ's interpretation of Dr. McMillan's chart note as an authorization of TTD. Rather, the employer contends that, because Dr. McMillan withdrew as the attending physician on June 27, 2000, Dr. McMillan's authorization of TTD benefits expired on that date. Consequently, the employer argues that claimant is not entitled to TTD after June 27, 2000.

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[1] Because we conclude that the admission of the "post-hearing" Order on Reconsideration will not alter our ultimate decision, we need not address the employer's "administrative notice" request.

[2] The Board's Order on Review was not appealed.

[3] Dr. McMillan was treating claimant for some noncompensable conditions in addition to the carpal tunnel syndrome. Apparently, claimant's private health coverage changed, which necessitated a change in physicians for the non-work related conditions. (Ex. 45).

In contrast, claimant contends that Dr. McMillan's June 19, 2000 letter is an authorization for TTD. Consequently, claimant asserts that the ALJ's order should be modified such that TTD commences on June 19, 2000, rather than June 27, 2000.[4]

A claimant is entitled to temporary disability for those periods of time for which there is authorization from an attending physician. ORS 656.262(4) (a), (g). Additionally, TTD shall continue until whichever of the following events 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." ORS 656.268(4).

Here, it is undisputed that Dr. McMillan authorized TTD on June 27, 2000. (Ex. 44). Because the resignation of the attending physician is not one of the events enumerated in ORS 656.268(4), we disagree with the employer's assertion that claimant's entitlement to TTD ended when Dr. McMillan ceased to be the attending physician.[5]

We now turn to the issue of penalties. A carrier is liable for a penalty when it "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). The standard for determining unreasonableness is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. *International Paper Co. v. Huntley*, 106 Or App 107 (1991). "Unreasonableness" is to be considered in light of all the evidence available at the time of the denial. *Brown v. Argonaut Insurance Company*, 93 Or App 588, 591 (1988); *John G. Bachman, Jr.*, 52 Van Natta 1450 (2000).

The ALJ assessed a penalty for the employer's failure to process the claim in the five month period since the prior ALJ's order. As examples, the ALJ noted the employer's failure to: (1) pay TTD, or alternatively take lawful efforts to terminate TTD; (2) obtain a closing examination; or (3) close the claim. With regard to claim closure issues, we note that there is no indication that claimant's condition was medically stationary. ORS 656.268(1)(a). Lacking such evidence, the record does not support a conclusion that the employer was obligated to seek a closing examination or that it unreasonably failed to close the claim.

With regard to the TTD issue, we note that Dr. McMillan's chart notes give the impression that she was resigning as the attending physician in March 2000.[6] Although we have found to the contrary,

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[4] We disagree with claimant's interpretation of the June 19, 2000 letter. Because of Dr. McMillan's use of the word "if" and because Dr. McMillan had not seen claimant since May 31, 2000, we consider Dr. McMillan's letter as merely a statement of what might be confirmed at claimant's next appointment. It was not until June 27, 2000, upon examination of claimant, that Dr. McMillan was able to confirm her previous supposition and authorize TTD. Notwithstanding this subsequent confirmation, Dr. McMillan did not retroactively extend the June 27, 2000 TTD authorization to June 19, 2000.

[5] The employer contends that Dr. McMillan ceased being the attending physician in March 2000, rather than on June 27, 2000. However, because Dr. McMillan continued to follow claimant for the carpal tunnel syndrome condition after March 2000, we conclude that Dr. McMillan remained claimant's attending physician until June 27, 2000. (Ex. 47-19).

[6] Dr. McMillan's March 31, 2000 chart note indicates that she had been instructed by claimant's lawyer to no longer evaluate or treat claimant for carpal tunnel syndrome. (Ex. 36).

we find such evidence provided the employer with a legitimate doubt as to its duty to pay TTD authorized by Dr. McMillan after March 2000. Consequently, we conclude that under all the circumstances presented here, a penalty is not warranted. Accordingly, we reverse the ALJ's penalty assessment.

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 temporary disability issue is $1,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee 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 November 15, 2000 is affirmed in part and reversed in part. That portion that assessed a penalty is reversed. The remainder of the order is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the employer.

March 20, 2001 Cite as 53 Van Natta 345 (2001)

In the Matter of the Compensation of
GEORGE D. HILTON, Claimant
WCB Case No. 01-0073M
AMENDED OWN MOTION ORDER
Liberty Northwest Ins. Corp., Insurance Carrier

It has come to our attention that our prior Own Motion Order referenced claimant's accepted *left knee condition*. The order should have referred to claimant's *low back condition*. In order to correct this oversight, we withdraw our prior order. In its place, as supplemented herein, we adhere to and republish our prior order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
BARRY M. BROWN, Claimant
Own Motion No. 01-0019M
OWN MOTION ORDER
Hollander & Lebenbaum, Claimant Attorney

The insurer has submitted claimant's request for temporary disability compensation for his low back condition. Claimant's aggravation rights have expired. The insurer agrees that: (1) claimant's current low back condition is causally related to his accepted condition; (2) the insurer is responsible for the current low back condition, which requires surgery; and (3) claimant was in the work force at the time of his current disability. However, the insurer opposes reopening the claim, contending that claimant is not entitled to temporary disability compensation because his low back surgery was performed on an outpatient basis. The insurer offers no support for this contention. Based on the following reasoning, we find that neither statutory nor case law supports the insurer's contention.

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

"Surgery" is an invasive procedure undertaken for a curative purpose, which is likely to temporarily disable the worker. *Fred E. Smith*, 42 Van Natta 1538 (1990). Moreover, ORS 656.278(1)(a) explicitly states that a worsening of the compensable injury requiring "either inpatient *or* outpatient surgery *or* other treatment requiring hospitalization" allows the Board to "authorize the payment of temporary disability from the time the worker is actually hospitalized *or* undergoes outpatient surgery." (Emphasis added). Because the language of the statute is written in the disjunctive, meeting any one of the listed requirements is sufficient. *See Roy G. Wells*, 49 Van Natta 1557 (1997) (ORS 656.278(1) does not require that a claimant both undergo outpatient surgery and be hospitalized as an inpatient; invasive outpatient procedure resulting in temporary disability sufficient); *Gary L. Dobbins*, 49 Van Natta 88 (1997) (outpatient surgery that was invasive and resulted in temporarily disabling the claimant satisfied ORS 656.278(1)(a)).

On September 27, 2000, Drs. Carden and Tepper, claimant's attending physicians, performed outpatient surgery to implant a spinal cord stimulator in claimant's low back. This procedure involved: (1) an incision at T11 and T12; (2) a left-sided interlaminar laminotomy (lamina dissected); (3) the placement of twin electrode paddle-leads; and (4) wound coverage with multiple sutures and staples. Furthermore, Dr. Tepper, in several subsequent progress reports (November and December 2000 and January 2001), noted that claimant was released from work.

On this record, we are persuaded that claimant's condition worsened to the extent that he underwent an invasive procedure that resulted in temporary disability, which qualifies as "surgery" under ORS 656.278. *See Fred E. Smith*, 42 Van Natta at 1538. Claimant does not also have to establish that he was "hospitalized." *See* ORS 656.278(1)(a); *Roy G. Wells*, 49 Van Natta at 1557; *Gary L. Dobbins*, 49 Van Natta at 88. Under such circumstances, we conclude that authorization of temporary disability compensation is appropriate.

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[1] ORS 656.278(1)(a) 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:

"(a) There is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, the board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the board[.]

Accordingly, we authorize the reopening of claimant's 1979 injury claim to provide temporary disability compensation beginning September 27, 2000, the date claimant underwent surgery. When claimant's condition is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,500, payable by the insurer directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

March 23, 2001 Cite as 53 Van Natta 347 (2001)

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

Claimant requested review of the SAIF Corporation's November 16, 2000 "Notice of Closure Board's Own Motion Claim" that closed his claim with an award of temporary disability compensation from September 4, 1998 through November 6, 2000. SAIF declared claimant medically stationary as of November 7, 2000.

Claimant requested review as a "protective" measure pending resolution of his request that SAIF accept "a new condition that is intimately involved with the open period of this Notice of Closure." SAIF submitted copies of the documents it considered in closing the claim as well as a copy of a February 7, 2001 modified notice of acceptance.

In response to SAIF's submission, claimant announced that the "Own Motion Notice of Closure is appropriate."[1] We interpret claimant's announcement as a withdrawal of his request for Board review of SAIF's November 16, 2000 Notice of Closure.

Accordingly, claimant's request for review is dismissed.

IT IS SO ORDERED.

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[1] Claimant also noted that "the claim should be processed pursuant to ORS 656.262 and 656.268." We have previously found that a new medical condition claim qualifies for reopening and closure under ORS 656.268 pursuant to ORS 656.262(7)(c), even if the initial claim is in Own Motion jurisdiction. *Dave A. Humphrey*, 52 Van Natta 2212 (2000); *Robert A. Olson*, 52 Van Natta 1540 (2000); *John R. Graham*, 51 Van Natta 1740 (1999). On the other hand, the Board, in its Own Motion capacity under ORS 656.278, does not have authority to direct a carrier to process a claim under ORS 656.262(7)(c). *Craig J. Prince*, 52 Van Natta 108, 110 (2000). Instead, that issue is a "matter concerning a claim," under the jurisdiction of the Hearings Division, and not under the Board's Own Motion jurisdiction. ORS 656.708; *Dave A. Humphrey*, 52 Van Natta at 2213, citing *Camilla S. Kosmoski*, 52 Van Natta 1573, 1574 n2 (2000).

Consistent with the aforementioned point and authorities, our review is limited to SAIF's November 16, 2000 Notice of Closure Board's Own Motion Claim." Because claimant states that the closure notice was "appropriate," there are no issues remaining for our Own Motion review.

In the Matter of the Compensation of
SANTANA JAIMEZ, Claimant
WCB Case No. 00-06651
ORDER ON REVIEW
Arthur P. Klosterman, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a bilateral wrist condition. On review, the issue is compensability.

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

Claimant is a sewing machine operator who makes furniture cushions. Claimant contends that her work activities as a sewing machine operator caused a bilateral wrist condition (overuse syndrome and/or carpal tunnel syndrome).

After watching claimant demonstrate her sewing activities, the ALJ determined that claimant held her hands flat as the material being sewn was automatically pulled through the sewing machine. Consequently, the ALJ concluded that claimant's work did not require constant gripping of the material as she pushed and pulled the material through the machine. Based on that conclusion, the ALJ found that the opinions of attending physicians, Drs. Isaacson and Gail, did not establish the compensability of claimant's bilateral wrist condition as their opinions were based upon a misunderstanding of the physical requirements of claimant's work.

Claimant asserts that the opinions of Drs. Isaacson and Gail establish the compensability of claimant's bilateral wrist condition. We disagree.

Because claimant seeks to establish the compensability of her bilateral wrist condition as an occupational disease, she must prove that her 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. *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).

Four doctors provided opinions regarding the cause of claimant's bilateral wrist problem. The opinions from attending physicians Drs. Isaacson and Gail support compensability, while the opinions of insurer-arranged examiners, Drs. Nolan and Thompson do not.

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). 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, however, persuasive reasons exist to discount the opinions of Drs. Isaacson and Gail.

Dr. Isaacson opined that the major contributing cause of claimant's bilateral wrist condition was claimant's work. Dr. Isaacson's opinion is based upon a belief that claimant's work required "a lot of gripping, pulling and pushing." (Ex. 15, 18). In a similar manner, Dr. Gail's opinion that the major contributing cause of claimant's bilateral wrist condition was claimant's work is based upon a belief that claimant's work involved repetitive type gripping.[1] (Ex. 20).

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[1] Additionally, we note that neither physician discusses claimant's use of scissors that claimant testified caused her the greatest discomfort.

However, as found by the ALJ, claimant's own at-hearing demonstration of her work established that her work activities do not require either "a lot of gripping, pulling and pushing" or repetitive type gripping. Consequently, we conclude that neither Dr. Isaacson nor Dr. Gail had a complete or accurate understanding of the physical nature of claimant's work. Accordingly, their opinions are not persuasive and we do not rely on them. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977); *William R. Ferdig*, 50 Van Natta 442, 443 (1998).

Because the opinions of Drs. Isaacson and Gail are the only opinions in this record to support compensability, and because we have found their opinions not persuasive, we conclude, as did the ALJ, that claimant has failed to establish the compensability of her bilateral wrist condition.

ORDER

The ALJ's order dated December 11, 2000 is affirmed.

March 23, 2001 Cite as 53 Van Natta 349 (2001)

In the Matter of the Compensation of
CHARLES E. HOWELL, Claimant
Own Motion No. 00-0325M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

On November 21, 2000, we issued an Own Motion Order that authorized the SAIF Corporation to reopen claimant's claim for the provision of temporary disability compensation beginning August 28, 2000. SAIF has now submitted an amended Own Motion recommendation requesting that claimant's compensation begin November 9, 1999, the date he was hospitalized for an epidural catheter placement.

A request for reconsideration of an Own Motion order must be filed within 30 days after the date the order was mailed, or within 60 days after the mailing date if the requesting party establishes good cause for failing to file the request within 30 days after the mailing date. OAR 438-012-0065(2). In extraordinary circumstances, however, we may, on our Own Motion, reconsider a prior order. OAR 438-012-0065(3).

Here, the request for reconsideration was received March 16, 2001, more than 60 days after the issuance of our November 21, 2000 order. Consequently, the record must support a conclusion that extraordinary circumstances warrant the reconsideration of our November 21, 2000 order. Based on the following reasoning, we conclude that extraordinary circumstances have been established.

SAIF has acknowledged that claimant *first* worsened requiring inpatient hospitalization in November 9, 1999. SAIF further stipulates that he satisfied the criteria for reopening of his claim for the payment of temporary disability compensation beginning on that date. These determinations are supported by the reports and other documents SAIF has submitted, which it represents that it only "recently" received. After considering this record, we conclude that extraordinary circumstances warrant the reconsideration of our prior order. Therefore, we conclude that modification of our prior order is justified. *Leslie D. Marcum*, 51 Van Natta 862 (1999) ("extraordinary circumstances" were allowed because of a "post-Own Motion Order" determination that claimant's current condition was compensable under a subsequent 1998 claim). Consequently, we modify our November 21, 2000 order as follows.

We are persuaded that claimant's compensable injury has worsened requiring inpatient hospitalization. Accordingly, we authorize the reopening of the claim for SAIF to provide temporary total disability compensation beginning November 9, 1999, the date claimant was hospitalized. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

Accordingly, our November 21, 2000 is withdrawn. On reconsideration, as supplemented and modified herein, we republish our November 21, 2000 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
ERWIN D. THOMAS, Claimant
Own Motion No. 00-0200M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Saif Legal Department, Defense Attorney

Claimant requested review of the SAIF Corporation's January 24, 2001 Notice of Closure which closed his claim with an award of temporary disability compensation from June 14, 2000 through October 2, 2000.[1] SAIF declared claimant medically stationary as of December 11, 2000.

In his request for review, claimant contends that he did not "realize" his claim had been "fully closed" because he kept up with his "re-checks." He asserts that upon our review, we "may find that further compensation is due." We interpret such statements as a contention that claimant was either not medically stationary at claim closure or that he is entitled to additional temporary disability.

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 claim was medically stationary at the time of the January 24, 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 requested review because he believes he is entitled to further compensation. We interpret claimant's request for review as a challenge to the "closure" and timeloss awarded. The evidence in the record supports the conclusion that claimant was medically stationary at the time of closure and temporary disability compensation was appropriately terminated.

In a December 11, 2000 chart note, Dr. Dodd, claimant's attending physician, opined that claimant was medically stationary. Dr. Dodd reported that claimant had not suffered any permanent impairment and had a "satisfactory" return to his normal work duties. He noted that claimant had some mild residual soreness with hand usage but expected it to gradually fade over time. This medical opinion is unrebutted. Thus, based on the uncontroverted medical evidence, we find that claimant was medically stationary on the date his claim was closed. We further conclude claimant is not entitled to additional temporary disability benefits.

Claimant also notes that he "didn't understand that [the claim] being opened as a Boards Own Motion Claim meant no further Compensation would be awarded." He requested we "reconsider the need for further compensation." To the extent that claimant is seeking a permanent disability award, we

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[1] Claimant's June 2, 1992 claim was as a nondisabling claim. Thus, claimant's aggravation rights expired on June 2, 1997. ORS 656.273(4)(a). When claimant's condition worsened requiring surgery in June 2000, claimant's claim was under our Own Motion jurisdiction. ORS 656.278(1)(a). Consistent with our statutory authority, on June 13, 2000, 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.

are without authority to grant such benefits. In other words, the legislature has not authorized the Board to grant permanent disability compensation for an Own Motion claim. *Independent Paper Stock v. Wincer*, 100 Or App 625 (1990).[2]

In conclusion, based on the uncontroverted medical evidence (i.e. the opinion of his attending physician), we find that claimant was medically stationary on the date his claim was closed. Therefore, SAIF's closure was proper.

Accordingly, we affirm SAIF's June 5, 2000 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
ROBIN C. RYERSE, Claimant
Own Motion No. 00-0097M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Linerud Law Firm, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requested review of the SAIF Corporation's December 6, 2000 Notice of Closure which closed his claim with an award of temporary disability compensation from March 6, 2000 through July 28, 2000. SAIF declared claimant medically stationary as of November 14, 2000. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his 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 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 December 6, 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).

On November 14, 2000, Dr. Edelson, claimant's attending physician, performed a closing evaluation. Dr. Edelson noted that, although claimant had a slight limited range of motion, he was "doing quite well." Dr. Edelson declared claimant to be medically stationary and noted that he would see him on an "as-need-basis." This opinion is unrebutted.

Based on the uncontroverted medical evidence, we find that claimant was medically stationary when SAIF closed his claim. Therefore, we conclude that SAIF's closure was proper.

Accordingly, we affirm SAIF's December 6, 2000 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD A. VENNER, Claimant
WCB Case Nos. 00-00639, 00-00563 & 00-00135
ORDER ON REVIEW
Kryger, et al, Claimant Attorney
Cummins, Goodman, et al, Defense Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Meyers and Bock.

The RSK Company (RSKCo), on behalf of Transportation Insurance, requests review of those portions of Administrative Law Judge (ALJ) Black's order that: (1) set aside its responsibility denial of claimant's L4-5 herniated disc condition; and (2) upheld the SAIF Corporation's responsibility denial of the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

At all relevant times, claimant worked for the employer, a metallurgical plant. On March 30, 1998, claimant injured his low back while lifting and weighing barrels. At that time, the employer was insured by Transportation Insurance, administered by RSKCo. RSKCo accepted a nondisabling lumbar strain. (Ex. 6). Dr. Swan subsequently determined that claimant had completely recovered from the March 30, 1998 injury. (Ex. 8-1).

On August 28, 1998, claimant again injured his low back when a valve he was turning suddenly released. Dr. Swan diagnosed a low back strain and restricted claimant to light duty. (*Id.*) Claimant filed a claim and RSKCo accepted a nondisabling low back strain. (Ex. 8B).

On September 16, 1998, claimant sought treatment from Dr. Ferguson for increased back and right leg pain. Dr. Ferguson diagnosed an acute sacroiliac strain. (Ex. 9). By October 1, 1998, Dr. Ferguson noted some components of nerve root irritation. (Ex. 10). The employer reclassified claimant's claim as a disabling acute sacroiliac strain. (Ex. 10A). An October 21, 1998 MRI revealed a focal central disc protrusion at L4-5 with mass effect on the thecal sac and some bilateral foraminal stenosis from hypertrophic facet changes. (Ex. 12).

On November 1, 1998, SAIF became the employer's workers' compensation insurance carrier. (Ex. 30J-1).

Claimant continued to treat for low back and right leg symptoms. After examining claimant in February 1999, Dr. Ferguson reinstituted physical therapy and pain control medication after concluding that claimant had sciatic nerve irritation. (Ex. 14). On May 25, 1999, RSKCo issued an Updated Notice of Acceptance at Closure for an "acute sacroiliac strain." (Ex. 15A). On June 3, 1999, Dr. Ferguson declared claimant medically stationary, and a June 9, 1999 Determination Order closed the claim with an award of temporary but no permanent disability. (Exs. 16, 16A).

Claimant continued to have intermittent low back and leg symptoms, which Dr. Ferguson attributed to continued sacroiliac joint irritation. (Exs. 17, 18; Tr. 16, 17).

On November 5, 1999, claimant was opening a butterfly valve that stuck. The next day his low back and right leg symptoms returned and worsened. Dr. Ferguson took him off work. (Ex. 19). A November 19, 1999 MRI revealed mild spinal stenosis at L4-5 with a prominent right paracentral disc protrusion with mass effect on the L5 nerve root. (Ex. 23).

On December 1, 1999, claimant filed a claim for back strain with possible ruptured disc. (Ex. 26). On December 2, 1999, Dr. Dorsen diagnosed right L5 radiculopathy, secondary to an L4-5 disc herniation. (Ex. 27). On December 27, 1999, Dr. Dorsen performed a right L4-5 laminectomy and discectomy. (Ex. 29a).

SAIF and RSKCo each denied responsibility for claimant's L4-5 disc herniation. (Exs. 30, 30B, 30C). On February 23, 2000, a "307" order issued, designating RSKCo as the paying agent. (Ex. 30Ga).

On March 23, 2000, Drs. Fuller and Snodgrass examined claimant for SAIF. (Ex. 31).

The parties stipulated at hearing that claimant's L4-5 disc herniation and radiculopathy were work related and that the only issue to be decided was responsibility. The ALJ determined that, for purposes of responsibility analysis, claimant's August 1998 (acute sacroiliac strain) and November 1999 (L4-5 disc herniation with radiculopathy) work injuries involved the "same condition" because they involved the same body part. Applying ORS 656.308(1) and 656.005(7)(a)(B), the ALJ concluded that, because claimant did not experience a "new injury" when SAIF was on the risk, RSKCo was responsible for claimant's current low back condition.

RSKCo agrees that ORS 656.308(1) applies to this case, but contends that a correct analysis under that statute assigns responsibility to SAIF. RSKCo also contends that, because SAIF did not deny compensability of the L4-5 disc herniation, it cannot now argue that no new injury occurred in November 1999. SAIF also agrees that ORS 656.308(1) and ORS 656.005(7)(a)(B) apply to this case, but argues that the medical evidence is insufficient to shift responsibility from RSKCo. Alternatively, SAIF argues that, if ORS 656.308(1) does not apply, then claimant did not sustain a new injury in November 1999. SAIF further argues that a "responsibility-only" denial implicitly preserves the compensability issue, and that, therefore, it is not prohibited from defending its responsibility denial for lack of causation.

We agree that SAIF can defend its responsibility denial by asserting that actual responsibility lies with another employer or insurer. *See, e.g., Kristin Montgomery*, 47 Van Natta 961 (1995). Moreover, although we agree with the ALJ's conclusion that RSKCo is the responsible employer, we provide the following analysis.

The ALJ found that claimant's August 1998 (acute sacroiliac strain) and November 1999 (L4-5 disc herniation with radiculopathy) work injuries involved the "same condition." In reaching this conclusion, the ALJ relied on *Sisters of Providence v. Ridenour*, 162 Or App 467 (1999). However, the issue in *Ridenour* was whether an *accepted* L4-5 herniated disc condition and an *accepted* "low back" condition were the same body part under *Industrial Indemnity Co. v. Kearns*, 70 Or App 583 (1984).[1] Here, in contrast to Ridenour, RSKCo is the only carrier with an accepted claim. When only one accepted claim is involved, the Kearns presumption does not apply. *See Daral T. Morrow*, 47 Van Natta 2384 (1995), *aff'd mem Barrett Business Services v. Morrow*, 142 Or App 311 (1996); *Brian A. Bergrud*, 50 Van Natta 1662, 1663 (1998); *Lynnette D. Barnes*, 44 Van Natta 993 (1992).

Moreover, we disagree that RSKCo's acceptance included anything other than an acute sacroiliac strain, regardless of the contemporary medical evidence. *See Kim D. Wood*, 48 Van Natta 482, 484, *aff'd mem*, 144 Or App 486 (1996) (because there is a specific acceptance, the contemporaneous medical records were not considered to determine what condition was accepted). In addition, the likelihood that claimant did not have a sacroiliac strain at the time of the acceptance[2] neither changes the condition accepted nor does it make RSKCo liable for conditions other than that specifically accepted in writing. *Id.* Consequently, because there is no accepted L4-5 disc herniation condition, responsibility for that condition is not determined under ORS 656.308(1). *See SAIF v. Yokum*, 132 Or App 18 (1994) (ORS

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[1] In *Kearns*, the court held:

"'Where there are multiple accepted injuries involving the same body part, we will assume that the last injury contributed independently to the condition now requiring further medical services or resulting in additional disability, and the employer/insurer on the risk at the time of the most recent injury has the burden of proving that some other *accepted* injury last contributed independently to the condition which presently gives rise to the claim for compensation; *e.g.*, that its *accepted* injury caused only symptoms of the condition or involved a different condition affecting the same body part.'" (Emphasis added.)

[2] Drs. Fuller and Snodgrass determined that, rather than "lumbar strain," claimant's 1998 condition should have been diagnosed as "L4-5 central disc protrusion." (Ex. 31-8). They did not indicate that claimant's "lumbar/sacroiliac strain" condition combined with the L4-5 disc condition. Dr. Ferguson agreed with their assessment of the diagnosis. (Ex. 32-1).

656.308(1) does not apply to initial claim determinations).[3] Instead, in cases where there is no accepted condition, responsibility is generally determined under the last injurious exposure rule. *Yokum*, 132 Or App at 24; *Bennett v. Liberty Northwest Ins. Corp.*, 128 Or App 71, 75 n. 1 (1994).

Where actual causation is established with respect to a specific employer, a carrier may assert the 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). Here, we find Drs. Fuller and Snodgrass' opinion persuasive, because it is well-reasoned and based on an accurate and complete history. *Somers v. SAIF*, 77 Or App 259, 263 (1986). The doctors opined that claimant's disc condition was caused by the August 1998 work injury and that, based on a comparison of the October 1998 and November 1999 MRIs, the development of the acute herniation was the result of the natural progression of the 1998 L4-5 disc bulge and not the November 5, 1999 work incident. They explained that claimant's symptoms had waxed and waned prior to the November 5, 1999 work incident, and that true neurological deficits, indicative of an acute disc herniation, did not immediately appear at the time of the November 5 incident. Finally, after more closely considering the gap between the November 5, 1999 work incident and claimant's presentation on November 15, 1999, Dr. Fuller opined that any material worsening of claimant's disc condition was not attributable to the November 5, 1999 work incident.

Moreover, although we find that Dr. Ferguson's initial opinions are confusing, in his deposition he agreed that claimant had sustained an initial annular injury in 1998 that had progressed to the nerve root effacement found at surgery.[4]

The persuasive medical opinions establish not only that the November 5, 1999 incident while SAIF was on the risk did not materially worsen claimant's disc condition, but that the development of the acute herniation was the result of the natural progression of the 1998 L4-5 disc bulge and not the November 5, 1999 work incident. Moreover, there is no persuasive medical evidence that the November 5, 1999 work incident independently contributed to claimant's herniated disc. Thus, we conclude that the November 5, 1999 incident did not independently contribute to claimant's herniated disc.

Accordingly, actual causation has been established with respect to RSKCo, and, because the November 5, 1999 incident when SAIF was on the risk did not independently contribute to claimant's disc condition, we need not resort to the last injurious exposure rule to determine responsibility. *See Victoria*, 154 Or App at 577. Therefore, RSKCo is responsible for claimant's L4-5 disc condition.

ORDER

The ALJ's order dated November 3, 2000 is affirmed.

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[3] 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). 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). As we noted in footnote 2, the medical evidence does not establish that claimant's herniated disc is a "combined condition."

[4] As the ALJ noted, Dr. Dorsen's opinion is primarily predicated on the increase in the disc pathology seen on the 1999 MRI. However, Dr. Dorsen failed to consider the length of time between the November 5, 1999 incident and the first development of claimant's neurological problems on November 15, 1999. Moreover, as the ALJ also noted, Dr. Dorsen did not weigh the relative contribution of the various factors (including claimant's preexisting degenerative disc condition) in his opinion.

In the Matter of the Compensation of
GREGORY S. ALTON, Claimant
WCB Case No. 98-04318
ORDER ON REMAND
Preston, Bunnell & Stone, Claimant Attorney
David L. Runner (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *SAIF v. Alton*, 171 Or App 491 (2000). The court reversed our prior order, *Gregory S. Alton*, 51 Van Natta 225 (1999), that affirmed an Administrative Law Judge's order that awarded claimant 74 percent (236.8 degrees) unscheduled permanent disability for a head injury. The court concluded that the Board's reasoning for inferring a causal relationship between claimant's compensable injury and his impairment was insufficient and it has 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

We begin by recounting the background of the case, as set forth in the court's opinion and supplemented.

Claimant was compensably injured in August 1995, suffering injuries to his face and head as a result of a fall. SAIF accepted a nasal fracture, non-displaced left zygomaticomaxillary complex fracture, basilar skull fracture, mild closed head injury and bilateral periorbital ecchymosis. (Ex. 10). Following treatment of his physical injuries, claimant complained of, among other problems, headaches, moodiness, dizziness, and memory problems.

In June 1996, claimant was examined by a psychiatrist, Dr. Bellville. Bellville noted that claimant had just been released from a 140-day court-mandated alcohol treatment program and that he was still consuming alcohol. (Ex. 21-7, -8). Bellville suspected that claimant had a history of alcohol abuse and mild to moderate depression; he was uncertain of the extent to which claimant's "intellectual complaints" were due to "pre-injury, longstanding emotional or personality issues" or alcohol, rather than to his injury. (Ex. 21-10, -11). He recommended that claimant receive neuropsychological testing to rule out mental disorders related to his injury. (*Id.*)

Also in June 1996, claimant was examined by a neurologist, Dr. Bell. Bell noted claimant's apparent mental deficits, stated that it was "difficult" to determine the extent to which they were due to his injury, and recommended further testing, including a neuropsychological evaluation and an EEG. (Ex. 21-3, -4).

In December 1997, Dr. Binder conducted a neuropsychological evaluation of claimant. Binder noted claimant's history of alcohol abuse, including court-mandated treatment. (Ex. 30-2). Claimant reported that, four days before the examination, he had consumed six to 10 beers. (Ex. 30-3). Except for alcohol treatment, claimant denied any previous history of psychiatric problems or treatment. (Ex. 30-4). Based on claimant's performance on the neuropsychological tests, which generally was worse than that of persons with "well-documented" brain dysfunction and "more serious traumatic brain injuries," Binder concluded that the results of the tests were invalid, due to lack of effort and "poor motivation" on claimant's part. (Ex. 30-5 to -8). Binder declined to estimate the likely outcome from claimant's injury because, according to the doctor, it was a type of injury "from which full recovery sometimes occurs and sometimes does not occur." (Ex. 30-8). Binder stated: "When people do not fully recover, the residual is mild or minimal in terms of Oregon Workers' Compensation definitions of disability attributable to brain injury." (*Id.*) He opined that it was "likely" that claimant was an "alcohol abuser" and that he suffered from antisocial personality disorder. (*Id.*) Binder concluded that he was unable to determine whether a neuropsychological condition related to claimant's injury "continues to exist"; that he did not know if claimant "has any permanent impairment"; and that claimant's "probable impairment is nil, minimal, or mild." (*Id.*) Claimant's treating physician, Dr. Potter, concurred in Binder's findings. (Ex. 32).

A February 23, 1998 Notice of Closure awarded temporary disability but no permanent disability. (Ex. 33). Claimant requested reconsideration. (Ex. 35). The Department of Consumer and Business Services (DCBS) appointed three medical arbiters, including an ear, nose, and throat specialist and a neurosurgeon, and submitted medical information and written questions to each arbiter, as appropriate to the arbiter's medical specialty. (Ex. 40-7 to -14).

In his May 1998 report, the ear, nose, and throat specialist, Dr. Holden, described claimant's nasal fracture and other physical injuries, referred to his residual nasal deformity, and noted that the latter may have been the result of claimant's noncompliance and interference with his treatment "along with alcohol abuse." (Ex. 41-1). Holden said that, although claimant's fractures had healed, he had "persistent symptoms of headache, dizziness, imbalance and problems with short term memory and cognition along with psychosocial problems of depression and inadequacy[.]" (Ex. 41-2). Holden reported that claimant was a "chronic alcoholic with moods of depression[.]" (*Id.*) He concluded:

> "My sense is that [claimant] will remain dependent upon society for his care and support and I do not see any likely alternative.
>
> "I am also concerned about his brain/possible inner ear injury * * *, short term memory and cognition problems, drug abuse of alcohol and aspirin and social inadequacy. * * *
>
> " * * * Since I suspect that [claimant] has a post-traumatic inner ear concussion syndrome it would be advisable to have him tested * * * to further clarify his functional capacity mentally and physically." (*Id.*)

Dr. Williams, the neurosurgeon, took a medical history of claimant's injury and conducted a neurological examination. In his May 1998 report, Williams stated:

> "It is my opinion that the patient is ADL [activities of daily living] assisted, being limited with cognitive impairment and psychological impairment.
>
> "It is my opinion that the patient in the head/brain injury impairment section functions as a Rancho-Los-Amigos Scale of Class III. He is alert and oriented. His behavior is appropriate for the most part. He does have impaired judgment and mild memory deficit. His language is mildly affected. He has noted personality changes. He does describe sleep disorders. I would not consider the worker safe to operate industrial machinery." (Ex. 40-4).

On reconsideration, DCBS determined that, based on claimant's invalid neuropsychological test results, no impairment rating was due. (Ex. 42). DCBS modified the award of temporary disability and affirmed the award of no permanent disability. It did not consider Holden's and Williams' reports because those reports had not been completed as of the time of the Order on Reconsideration.

Claimant requested a hearing. The record was supplemented with Holden's and Williams' reports. *See* ORS 656.268(6)(f). The ALJ relied on Dr. Williams' report to find that claimant was entitled to an unscheduled permanent disability award of 74 percent. Citing *Kim E. Danboise*, 47 Van Natta 2163, *on recon* 47 Van Natta 2281 (1995), *aff'd sub nom SAIF v. Danboise*, 147 Or App 550, *rev den* 325 Or 438 (1997), the ALJ reasoned that Williams had not attributed claimant's condition to anything other than the compensable injury. The ALJ concluded that claimant had met his burden of proving that his post-injury condition was the result of his compensable injury. The Board affirmed the ALJ's order and adopted the ALJ's reasoning and conclusion that Williams' opinion established claimant's entitlement to the permanent disability award.

On appeal, SAIF argued that none of the medical experts determined the cause of claimant's impairment or expressly found that it was consistent with the compensable injury. SAIF contended that because the record disclosed other possible sources of claimant's impairment, the record legally was inadequate to permit a factual inference that the compensable injury caused his permanent impairment.

In *Alton*, the court discussed its decision in *Danboise*, which had 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. 171 Or App at 499. The court explained that, unlike *Danboise*, the record in this case contained evidence that claimant's impairment

may be due to other possible causes. *Id.* at 500-01. The court found that the Board had inferred causation from two facts: (1) Dr. Williams was aware of possible noncompensable causes for claimant's condition; and (2) he did not say that claimant's impairment was attributable to those other possible causes. *Id.* at 501. Concluding that the Board's reasoning for inferring causation was insufficient, the court remanded for reconsideration.

Under OAR 436-035-0007(13) (WCD Admin. Order 96-072), impairment is established by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. Claimant relies on the opinion of Dr. Williams, the medical arbiter, to establish his impairment.

After reconsidering the medical evidence, we find that it is insufficient to establish that claimant's mental impairment is "consistent with" the compensable injury. Although Dr. Williams opined that claimant had mental impairment, he did not discuss the cause of his impairment. Furthermore, Dr. Williams did not indicate that claimant's impairment was attributable to or "consistent with" or "due to" the compensable injury and his report does not support such a conclusion.

We acknowledge that the medical arbiter questions from DCBS included instructions that "[t]he enclosed medicals, which may include information concerning unrelated or preexisting conditions, are to be reviewed for determining impairment due to the accepted condition(s), including any direct medical sequelae." (Ex. 40-12). We have considered the possibility that, in light of these instructions, Dr. Williams' failure to relate claimant's impairment to anything other than the compensable injury meant that he believed that the injury was the cause of claimant's current condition. We do not believe that is a reasonable inference, however, based on the conclusory nature of Dr. Williams' report and because it is unclear which of claimant's previous medical records Dr. Williams had reviewed. In light of the other possible sources of claimant's mental impairment, including his alcohol abuse and psychological problems as reported by Dr. Binder,[1] we conclude that Dr. Williams' report is insufficient to establish that claimant's impairment is due to his compensable injuries. There is no other medical evidence that rated claimant's mental impairment and described it as "consistent with" or "due to" the compensable injury. Under these circumstances, we conclude, on reconsideration, that claimant has failed to establish that he is entitled to a permanent disability award.[2]

Thus, on reconsideration, and in lieu of our prior order, we reverse the ALJ's order dated September 25, 1998. The Order on Reconsideration is affirmed. The ALJ's "out-of-compensation" attorney fee award is reversed.

IT IS SO ORDERED.

---

[1] We note that Dr, Potter, claimant's treating physician, concurred in Binder's findings. (Ex. 32).

[2] In light of our disposition, we need not address claimant's previous argument on review that he is entitled to a Class IV rating.

Board Member Biehl dissenting.

The majority errs by concluding that claimant has failed to establish that he is entitled to a permanent disability award for his mental impairment. Instead, I agree with the ALJ that claimant is entitled to an unscheduled permanent disability award of 74 percent for his head injury.

I believe that Dr. Williams' report, when considered in light of the medical arbiter questions from DCBS, supports the conclusion that claimant is entitled to an unscheduled permanent disability award. The medical arbiter questions included the following instructions:

> "The enclosed medicals, which may include information concerning unrelated or preexisting conditions, are to be reviewed for determining impairment due to the accepted condition(s), including any direct medical sequelae. If you disagree with any of these or feel they are incomplete, please provide your comments.
>
> "Please perform a complete examination of the basil skull fracture and mild closed head injury, and describe any objective findings of permanent impairment resulting from the <u>accepted condition(s)</u> including, but not limited to, the following:

"BASIL SKULL FRACTURE AND MILD CLOSED HEAD INJURY

"1. Please review the existing records and perform a complete neuropsychological examination and report any objective permanent impairment resulting from the accepted condition only. For injury to the brain, classify claimant's impairment using the criteria below." (Ex. 40-12; underline in original).

Thus, the arbiter instructions informed Dr. William about what conditions had been accepted and instructed him to review "[t]he enclosed medicals" to determine "impairment due to the accepted condition(s), including any direct medical sequelae." (Ex. 40-12). Dr. Williams was specifically asked to describe "any objective findings of permanent impairment resulting from the accepted condition(s)" and he was asked to "report any objective permanent impairment resulting from the accepted condition only." (*Id.*; underline in original).

Dr. Williams, neurosurgeon, performed a physical examination and found that claimant seemed to have a significant gap in his past recent memory and at times had difficulty performing tasks. (Ex. 40-3). He explained that claimant could read before the accident, but after the injury he had to read an item two or three times to understand it. (*Id.*) He noted that claimant had been told that he had a personality change after the accident. (*Id.*) Claimant could no longer work on motorcycles because he gets confused and has difficulty. (*Id.*)

Dr. Williams concluded that claimant was ADL assisted and was limited with cognitive impairment and psychosocial impairment. (Ex. 40-4). He explained that claimant had Class III impairment, noting that he had impaired judgment and mild memory deficit, and his language was mildly affected. (*Id.*) In addition, Dr. Williams did not consider claimant safe to operate industrial machinery. (*Id.*)

In discussing claimant's impairment, Dr. Williams did not refer to any unrelated or preexisting conditions. In light of the medical arbiter instructions from DCBS, it is reasonable to infer that Dr. Williams' failure to relate claimant's mental impairment to anything other than the compensable injury meant that he believed that the impairment was due to the accepted condition. I agree with the ALJ that, based on Dr. Williams' report, claimant is entitled to an unscheduled permanent disability award of 74 percent for his head injury. The majority errs by concluding otherwise.

March 26, 2001 Cite as 53 Van Natta 358 (2001)

In the Matter of the Compensation of
ENRIQUE A. GONZALEZ, Claimant
WCB Case No. 00-04672
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that increased claimant's scheduled permanent disability award for loss of use or function of the right arm from 20 percent (38.4 degrees), as awarded by the Order on Reconsideration, to 26 percent (49.92 degrees). On review, the issue is extent of scheduled permanent disability.

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

Claimant sustained a compensable fracture of the right radius and right ulna. Claimant contends that, based on a response from Dr. Casey, his attending physician, he is entitled to a "chronic" condition award. We agree with the ALJ that claimant failed to establish entitlement to a "chronic" condition award.

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 listed body part, including the forearm and the arm. OAR 436-035-0010(5)(c) and (d).

Claimant did not request appointment of a medical arbiter; therefore, we may only consider impairment findings rendered by his attending physician in determining his impairment. As part of the reconsideration process, claimant requested Dr. Casey's opinion regarding the chronic condition impairment issue.[1] (Ex. 74). Specifically, claimant explained that, under Department standards, "a worker is entitled to additional disability compensation for a 'significant' loss of the ability to repetitively use his right arm." (Ex. 74-1). Considering that standard, Dr. Casey was asked whether claimant was "unable to perform repetitive heavy work such as lifting and carrying, pushing or pulling with the right arm." (Ex. 74-2). Dr. Casey left blank both the box indicating "yes" and the box indicating "no." Instead, he responded that claimant "can do pushing & pulling & lifting with right up to 25 [pounds]." (*Id.*). In addition, Dr. Casey checked the "yes" box in response to claimant's question as to whether he considered this loss to be a "significant loss" considering that claimant "is employed as a farm laborer for which heavy work is a regular component of employment, and that [claimant's] level of education and related factors make it unlikely that he will readily obtain employment outside the area of manual labor." (*Id.*).

Based on the following reasoning, we do not find that Dr. Casey's opinion establishes entitlement to an award for chronic condition impairment. Although Dr. Casey's response to claimant's first question might indicate some limitation in repetitive use of the right arm, it does not indicate "significant" limitation, as required under OAR 436-035-0010(5). In this regard, we have found that indications of "some limitation" 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).

In addition, claimant's second question essentially asked Dr. Casey to consider various social and vocational factors in rendering an opinion as to whether claimant's loss was "significant." (Ex. 74-2). However, social and vocational factors are not considered in rating scheduled permanent disability, which is limited to the permanent loss of use or function of a body part due to the industrial injury. ORS 656.214(2); OAR 436-035-0010(2). Consistent with this, OAR 436-035-0010(5) only applies 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. Thus, the rule is limited to the determination of a physical impairment, *i.e.*, loss of repetitive use of a body part, and does not extend to consideration of social and vocational factors.[2]

ORDER

The ALJ's order dated December 1, 2000 is affirmed.

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[1] The Appellate Review Unit also requested Dr. Casey's opinion regarding the chronic condition issue. (Exs. 80-2, 81-4). However, no response to that inquiry is in the record.

[2] We note that determination of unscheduled permanent disability benefits may include consideration of social and vocational factors. *See* ORS 656.214(5) (criteria for rating of unscheduled permanent disability shall be the permanent loss of earning capacity due to the compensable injury calculated pursuant to standards enacted by the Director); OAR 436-035-0290 (age factor), 436-035-0300 (education factor), 436-035-0310 (adaptability to perform a given job factor). Nevertheless, even the rule providing for chronic condition impairment for unscheduled permanent disability focuses solely on physical impairment, without consideration of social and vocational factors. *See* OAR 436-035-0320(5). Claimant does not contend that he is entitled to unscheduled permanent disability benefits for his right arm injury.

In the Matter of the Compensation of
HERB A. KETELSON, Claimant
WCB Case Nos. 00-05115 & 00-02780
ORDER ON REVIEW
Linerud Law Firm, Claimant Attorney
VavRosky, et al, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Crumme's order modifying an Order on Reconsideration to affirm a Notice of Closure that had closed the claim based on claimant's failure to seek treatment for 30 days. On review, the issue is the propriety of the claim closure.

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

The ALJ affirmed the self-insured employer's February 7, 2000 Notice of Closure that had closed the claim pursuant to ORS 656.268(1)(c) and OAR 436-030-0034(1) for claimant's failure to seek medical treatment for 30 days.[1] In so doing, the ALJ rejected claimant's argument that he responded to the employer's January 11, 2000 letter (warning claimant that the claim may be closed for failure to seek medical treatment) by seeking medical treatment with a physician's assistant on January 31, 2000.

The ALJ reasoned that the treatment did not negate the fact that claimant did not seek treatment for a period of more than 30 days between June 2, 1999 and January 31, 2000; that there was nothing to indicate that the failure to treat was with the approval of the attending physician or was for reasons beyond the worker's control; and that the appointment with a physician's assistant was not an appointment with an attending physician under the offer in the employer's January 11, 2000 letter. Finally, the ALJ reasoned that claimant did not advise the employer of the January 31, 2000 appointment until months later.

On review, claimant contends that the closure would have been proper had the claim been closed prior to the care claimant received on January 31, 2000. Because the closure did not occur until after the January 31, 2000 treatment with the physician's assistant, claimant asserts that the February 7, 2000 closure is invalid. We disagree.

In *Tat Hueng*, 50 Van Natta 2205 (1998), the insurer wrote to the claimant on June 12, 1997, advising that current medical information indicated that her compensable condition was medically stationary. (Ex. 13). On July 2, 1997, the employer advised the claimant that it was planning to obtain administrative closure of the claim because she had not sought treatment for more than 30 days. The letter asked the claimant or her physician to respond within two weeks; otherwise, the employer would assume that she had completely recovered. By letter dated July 7, 1997, the claimant's counsel responded that the claimant had not recovered and would be seeking further treatment. The letter also requested that the claim not be administratively closed.

Thereafter, on July 21, 1997, the claimant sought treatment from a new physician, who indicated that the claimant was not medically stationary. On July 25, 1997, having not yet received the July 21, 1997 medical report, the insurer requested administrative closure on the basis the claimant was presumed medically stationary. On August 5, 1997, the Department issued a Determination Order finding that the claim qualified for closure on June 4, 1997 pursuant to OAR 436-030-0034.

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[1] ORS 656.268(1)(c) instructs a carrier to close a worker's claim and determine the extent of permanent disability upon the occurrance of certain triggering conditions, one of which is a worker's failure to seek medical treatment for a period of 30 days or to attend a closing examination, unless the worker affirmatively establishes that such failure was attributable to reasons beyond the worker's control. OAR 436-030-0034(1)(a) provides that a carrier may close a claim when the worker is not medically stationary and when the worker has not sought medical care for a period in excess of 30 days, without approval of the attending physician, for reasons within the worker's control, provided that the carrier has notified the worker after the close of that 30-day period, by certified letter, that claim closure may result for failure to seek medical treatment for a period of 30 days.

We held in *Hueng* that, upon receiving appropriate notice from the insurer and an opportunity to respond, the claimant did not affirmatively establish that her failure to seek treatment was attributable to reasons beyond her control. Therefore, we determined that the administrative closure was procedurally valid under ORS 656.268(1)(b) (even though the claimant received treatment prior to the administrative claim closure) because the claimant previously failed to seek treatment for a period in excess of 30 days without the approval of her attending physician. 50 Van Natta at 2206.

As was true in *Hueng*, claimant here sought care prior to claim closure.[2] However, as was also true in *Hueng*, claimant in this case failed to seek treatment for a period in excess of 30 days without the approval of his attending physician. Upon receiving appropriate notice from the employer and an opportunity to respond, claimant did not affirmatively establish that his failure to seek treatment was attributable to reasons beyond his control. Therefore, as the ALJ found, the administrative closure was procedurally valid. Thus, we affirm.

ORDER

The ALJ's order dated December 27, 2000 is affirmed.

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[2] We note, however, that claimant's January 31, 2000 visit to the physician's assistant was "primarily for discussion of chronic low back pain." (Ex. 26-1). Even if this office visit constitutes medical "treatment," we would still approve the administrative claim closure as valid.

In the Matter of the Compensation of
JULIE SWANSON, Claimant
WCB Case No. 00-03374
ORDER ON REVIEW
Ransom, et al, Claimant Attorney
Reinisch, et al, Defense Attorney

Reviewed by Board Members Meyers and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's "new medical condition" claim for a right shoulder 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 worked as a Certified Nurse Assistant (CNA), compensably injured her right shoulder on December 17, 1998. The insurer accepted a nondisabling "right shoulder strain." On December 30, 1998, Dr. Rose declared claimant's strain resolved and released her to regular work.

Claimant continued working, but had intermittent shoulder aching. On July 29, 1999, claimant sought medical treatment, complaining of persistent pain that had become worse over the prior three weeks. Dr. Carlson noted crepitation posteriorly over her scapula with range of motion. X-rays were negative. Dr. Carlson treated claimant conservatively with medication and physical therapy. On August 17, 1999, claimant was released to regular work.

On November 26, 1999, claimant sought treatment for pain in the right shoulder over the rotator cuff area. She was treated by Dr. Moede, who injected her, but she had no sustained improvement. On January 10, 2000, Dr. Carpenter found limited range of motion and a positive impingement test. He diagnosed chronic impingement syndrome and recommended an impingement release.

Drs. Tesar and Farris examined claimant for the insurer on March 2, 2000, with Dr. Tesar dictating the reports. X-rays revealed a type 2 acromion.

On August 1, 2000, Dr. Carpenter performed impingement release surgery on claimant's right shoulder.

On August 14, 2000, claimant wrote to the insurer and requested that the right shoulder impingement syndrome be accepted as a part of the original December 17, 1998 injury claim. On October 20, 2000, the insurer denied compensability of that condition. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's right shoulder impingement syndrome arose directly from her December 17, 1998 injury and, applying a material contributing cause standard, found it compensable. On review, the insurer argues that the claim must be analyzed under the major contributing cause standard. For the following reasons, we conclude that claimant's right shoulder impingement syndrome is not compensable, whether analyzed under a major or material contributing cause standard.

It is claimant's burden to prove compensability by a preponderance of the evidence. ORS 656.266. Dr. Tesar took x-rays that revealed that claimant had a type 2 to 3 acromion, the bony overhang above the rotator cuff. Dr. Tesar explained that, with a type 2 to 3 acromion, the space between the acromion and the rotator cuff is narrowed, which predisposes one to developing an impingement syndrome. Dr. Tesar concluded that claimant's strain injury (an injury to muscle) had healed, based on Dr. Rose's examination of December 30, 1998. In regard to causation, Dr. Tesar opined that the development of shoulder pain seven months after the strain injury had resolved was related to claimant's preexisting type 2 to 3 acromion, which predisposed her to the impingement syndrome, and not to the resolved December 1998 injury.

Because of the possible alternative causes for the right shoulder impingement 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).

Here, Dr. Carpenter's opinion is conclusory because he failed to explain the basis for his opinion. Dr. Carpenter opined that the sole cause of claimant's right shoulder impingement syndrome was the December 1997 on-the-job incident. But his opinion was based solely on "but for" reasoning; *i.e.*, claimant did not experience shoulder pain prior to the December 1998 work injury and experienced pain at the time of the injury, and, therefore, the work injury was the cause of her impingement syndrome. (Ex. 23). Dr. Carpenter did not explain the relationship of the impingement syndrome and the accepted right shoulder strain condition, nor did he discuss the seven month hiatus in treatment after Dr. Rose found that claimant's shoulder strain resolved, nor the potential predisposing factor of a type 2 or 3 acromion. Under such circumstances, we do not find Dr. Carpenter's cursory and conclusory opinion persuasive. Consequently, we conclude that claimant has failed to prove that her right shoulder impingement condition is compensable.

ORDER

The ALJ's order dated December 11, 2000 is reversed in part and affirmed in part. That portion of the order that set aside the insurer's denial of a right shoulder impingement syndrome is reversed. The denial is reinstated and upheld. The attorney fee is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
CHRISTOPHER J. WEHREN, Claimant
WCB Case Nos. 00-01180 & 99-01486
ORDER ON RECONSIDERATION
Black, Chapman, et al, Claimant Attorney
Cummins, Goodman, et al, Defense Attorney

On February 14, 2001, we abated our January 23, 2001 order that affirmed the Administrative Law Judge (ALJ's) order that set aside the self-insured employer's denial of claimant's injury claim for a cervical condition. We took this action to consider the employer's motion for reconsideration. Having received claimant's response, we proceed with our reconsideration.

Specifically, the employer contends that we failed to explain our finding that Dr. Grant relied on a complete and accurate history and that our order failed to address its argument that Dr. Grant did not weigh all potentially contributory factors to the development of claimant's myofascial pain syndrome condition.

First, the employer contends that Dr. Grant did not rely on a complete and accurate history, as we found in our initial order. We disagree. During Dr. Grant's May 27, 1999 examination of claimant, he took a correct history of "initial problems" beginning with claimant's 1992 compensable injury "digging post holes in granite." (Ex. 116-1). Dr. Grant also noted "recurrent symptoms in 1994 associated with some heavy work activities." (*Id.*) Finally, Dr. Grant reported a history of "recurrent symptoms beginning 9/14/98" again associated with vigorous work activity. (*Id.*) Claimant's counsel later provided Dr. Grant with medical records surrounding claimant's 1993 suicide attempt. (Exs. 124, 125). We therefore find that Dr. Grant had a complete history of claimant's various potentially-causative neck injuries.

Similarly, we acknowledge the employer's argument that Dr. Grant referenced "recurrent symptoms" in 1994 and 1998, whereas claimant's neck and shoulder symptoms in fact have "migrated" from side to side. We interpret Dr. Grant's statement as merely noting the general recurrence of upper extremity symptoms relating to claimant's myofascial pain syndrome. Dr. Grant did not distinguish between the exact location of the symptoms, and there is no indication that the precise location was critical to his opinion.

Instead, Dr. Grant focused on the "myofascial cycle" of the syndrome, beginning with an "acute injury" or a "chronic overuse type of injury." (*Id.*) Dr. Grant noted that it was common to see "myofascial difficulties" in the musculature of the upper back, neck, and shoulder areas -- in other words, in all of the areas where claimant has reported pain over the years since 1992. (Ex. 125-1; Tr. 17). This opinion is consistent with claimant's testimony that he had pain in his neck and both shoulders constantly since 1992. (Tr. 17). Accordingly, we continue to find that Dr. Grant relied on an accurate history.

Second, the employer contends that we failed to address its argument that Dr. Grant did not weigh all potential contributing factors to claimant's myofascial pain syndrome, pursuant to *Dietz v. Ramuda*, 130 Or App 497 (1994), *rev dismissed* 321 Or 416 (1995). On reconsideration, we find that Dr. Grant considered all potential contributing factors, based on the following reasoning.

Dr. Grant agreed with the statement that "based on the history contained in your report of May 27, 1999, you felt the original work injury in 1992 was the major cause of [claimant's] post traumatic pain syndrome in his neck. Your opinion was based on the fact that [claimant's] history indicated no prior problems before 1992 and sporadic problems since that time." (Exs. 124-1, 125). As explained above, Dr. Grant's May 27, 1999 report contained an accurate recitation of claimant's history including potentially contributory 1994 and 1998 work activity (minus the 1993 suicide attempt, which history was later provided). Dr. Grant agreed with the above statement; *i.e.*, that he reached his opinion after considering these various activities noted in his initial history as well as the 1993 suicide attempt.

Dr. Grant's opinion was that, despite these intervening incidents, claimant's 1992 injury was the cause of the "myofascial cycle," resulting in his myofascial pain problems. (Ex. 125). Dr. Grant also agreed with the reasoning expressed in claimant's attorney's letter that claimant's descriptions of pain in

1999 were similar to those noted in 1992. (Exs. 124-1, 125). We therefore disagree with the employer's contention that Dr. Grant's conclusions lack reasoning. Consequently, on reconsideration, we find that Dr. Grant's opinion considers all potentially causative factors and is persuasive.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our January 23, 2001 order. The parties' rights of appeal shall begin to run from the date of this order.

Claimant's attorney is entitled to an assessed fee for services on reconsideration. 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 $750, 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 response to the employer's reconsideration request), the complexity of the issues, and the value of the interest involved.

IT IS SO ORDERED.

Board Member Meyers dissenting.

Because I agree with the employer that Dr. Grant's opinion is not persuasive, on reconsideration, I would reverse our initial order and find claimant's claim noncompensable. Accordingly, I respectfully dissent.

In my view, the majority's opinion glosses over significant omissions and misunderstandings in Dr. Grant's history of claimant's symptoms. It follows that Dr. Grant's opinion is fundamentally flawed and unpersuasive. Dr. Grant examined claimant only once, on May 27, 1999, more than six years after claimant's 1992 compensable injury. As the employer correctly notes, there is no evidence that Dr. Grant ever reviewed claimant's prior medical records. This defect is important, for the following reasons.

Although Dr. Grant appears to have been made aware of some, but not all, of claimant's intervening injuries, the details of these injuries and claimant's varying symptoms over time are important to a correct understanding of claimant's history. For example, although Dr. Grant vaguely describes "recurrent symptoms" in both 1994 and 1998, a close review of the record reveals that the location of claimant's symptoms has varied over the years.

In the form 801 associated with claimant's 1992 compensable injury, claimant described left-sided neck complaints. (Ex. 5). Dr. Weinman, claimant's then-attending physician, treated claimant for left-sided neck pain, radiating into his left arm. (Ex. 3-1). At that point, claimant was thought to have a "probable herniation of C6-7 disk, left." *Id.*

Then, on 801 and 827 forms associated with claimant's 1994 injury, claimant reported *right*-sided symptoms . (Ex. 23, 24). Claimant was diagnosed with a "right rhomboid strain." (Ex. 22). Missing entirely from Dr. Grant's history is that claimant also treated several times for his neck in 1995, by which time claimant's symptoms had returned to the left side. (Exs. 52, 53, 58, 59, 60, 67). Finally, in 1998, claimant again complained of right-sided neck and shoulder pain. (Ex. 91).

The above chronology demonstrates to my satisfaction that Dr. Grant had neither a "complete" nor "accurate" history. We do not know whether Dr. Grant would have reached the same opinion on causation if he had been provided with a complete and accurate history. Therefore, I would find that claimant has not met his burden of proof through Dr. Grant's opinion. Accordingly, on reconsideration, I would reverse that portion of the ALJ's order that set aside the employer's denial of claimant's cervical condition.

In the Matter of the Compensation of
MATTHEW J. DEAN, Claimant
WCB Case No. 00-02284
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the SAIF Corporation's denial of his injury claim. On review, the issue is course and scope of employment. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's injury did not "arise out of" his employment and was, therefore, not compensable. We agree; however, we apply the following analysis.

Claimant worked for the employer, an auto dealership, as a mechanic. On February 28, 2000, during working hours, claimant and two coworkers took a "supercharged" BMW off the employer's premises for a drive. Claimant, who was driving the vehicle, lost control of the car while attempting to merge with highway traffic. The car clipped a trailer truck and spun into a barrier. Claimant sustained a closed head injury/concussion and scalp laceration.

On review, SAIF asserts, as it did at hearing, that claimant was engaged in an unauthorized and prohibited activity when he was injured. Alternatively, SAIF contends that claimant was driving the vehicle primarily for his personal pleasure.[1]

For an injury to be compensable under workers' compensation law, it must arise out of and occur in the course of employment. ORS 656.005(7)(a). Compensability of an injury depends on whether, considering all relevant factors, the activity causing the injury was sufficiently connected to work. *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366 (1994); *Rogers v. SAIF*, 289 Or 633, 642 (1980).

In *Andrews v. Tektronix*, 323 Or 154 (1996), the Court held that the fact that an employer had been instructed to avoid certain work, and that the worker's injury occurred when he or she disregarded that instruction, were only two of many factors that must be considered in determining work-connectedness. The Court stated that, among the additional factors were the degree of connection between what the worker was authorized to do and was forbidden to do, the degree of judgment and latitude normally given the worker, workplace customs and practices, and the relative risk to the worker when compared to the benefits to the employer. Finally, the Court reasoned that, when a worker's failure to follow a work-defining instruction was taken into consideration, the manner in which the instruction was conveyed, and the worker's consequent perception of the instruction's purpose and scope, also must be considered. 323 Or at 165.

Here, the employer's handbook provided that employees must drive safely and should not exhibit speed or recklessness. Customer owned vehicles could be operated for test driving, but the handbook provided that when driving a vehicle, it should be done "in a careful and safe manner abiding by all of the laws applicable thereto." The handbook further provided that a "serious accident resulting from your negligent operation of a motor vehicle in connection with your employment may lead to disciplinary action up to and including termination." (Exs. C; AB). Claimant acknowledged that he had received the handbook and that he would comply with it. (Ex. A).

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[1] Claimant argues that SAIF's alternative theory may not be raised for the first time on review. However, because we agree with SAIF's contention that claimant's actions were not authorized, we do not address its alternative argument.

Claimant's job description required him to perform "assigned" vehicle repairs and maintenance and to follow correct safety practices.[2] (Ex. AC). At hearing, David Whitman, a dispatcher for the employer, testified that the work policy normally involved one person taking a car for a test drive, and that person was the one who was working on the car. (Tr. 89).

On review, claimant argues that he was given permission or authorization to take the vehicle for a test drive. Claimant further contends that whether or not he was expressly authorized to take the car, the circumstances surrounding his actions support a finding that he was acting within the course and scope of his employment when he was injured. Specifically, claimant argues that the coworker assigned to the vehicle pointed out the location of the keys to him and, when asked if he could perform the inspection was told, "well, whatever...". (Tr. 64).

After reviewing the record, we do not accept claimant's testimony that he was given permission to take the car. Claimant's testimony that his coworker, Sam Williamson, pointed out the keys to him and responded, "whatever," is not consistent with Mr. Williamson's testimony. Mr. Williamson testified that the car had been assigned to him and that he did not point out the keys to claimant or give him permission to take the car. (Tr. 117, 120, 123). Mr. Williamson's testimony is consistent with his previous statement that was taken the day after the accident. (Ex. 7).

Claimant also testified that he asked the dispatcher, Mr. Whitman, whether he could do the vehicle inspection on the car and was told that he would have to talk to Mr. Williamson. (Tr. 63). However, Mr. Whitman testified that claimant did not talk to him about working on the car. (Tr. 88).

Finally, claimant's coworkers testified that they were aware that the car had not been assigned to him and that it was not being taken out for a routine inspection. (Tr. 131, 149). Claimant's coworkers also testified that they believed that claimant's use of the car was not authorized. (Tr. 92).

After reviewing the record and having rejected claimant's testimony, we conclude that claimant's use of the vehicle was not authorized. The employer's policies regarding working only on authorized vehicles was clear. We find no reliable evidence that claimant was given permission or could have reasonably believed that he was permitted to take the car that had been assigned to Mr. Williamson. Moreover, we are unable to find any benefit to the employer by claimant driving the car, as opposed to Mr. Williamson. If we were able to identify such a benefit, we would find that the relative risk to the worker by performing a drive in such a manner far outweighs any possible benefit to the employer.

Accordingly, after having applied the criteria set forth in *Andrews*, we conclude that claimant disregarded the employer's policies and procedures and his injury occurred as a result. Therefore, claimant has failed to prove a sufficient work connection between his injury and his employment. Consequently, because claimant's injury did not arise out of and in the course of his employment, we affirm the ALJ's order.

ORDER

The ALJ's order dated October 5, 2000 is affirmed.

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[2] Claimant signed his job description and indicated that he understood the requirements of the position. (Ex. AC).

Board Member Phillips Polich specially concurring.

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

The ALJ made no credibility findings in this case. After reviewing the testimony, I am unable to find any reasons to reject the testimony of either claimant and his witnesses, or the employer's witnesses. Accordingly, I would conclude that all witnesses in this case are credible.

Having made such a finding, I must acknowledge that the testimony given by claimant and his coworkers cannot be reconciled. That is, claimant testified that he was given permission to take the car for a test drive, whereas his coworkers have testified that permission was not granted and that everyone concerned knew that the car was being taken for a "joy ride." There is also contradictory testimony regarding the employer's practices and policies.

Here, I find that the inconsistencies in the testimony are material ones as the issue of whether claimant was acting within his employment must be determined by considering whether claimant disregarded instructions, what authorization he had been given to do such work, and practices of the workplace. With regard to each of these issues, claimant's testimony is not consistent with the testimony provided by the employer's witnesses.

Accordingly, as I have found no reason to reject the testimony in this case, the evidence is, at best, in equipoise. Therefore, claimant cannot prevail. For these reasons, I agree with the ALJ and the majority that this claim is not compensable.

March 27, 2001 Cite as 53 Van Natta 367 (2001)

In the Matter of the Compensation of
TRACY A. HUGHES, Claimant
WCB Case No. 00-04698
ORDER ON REVIEW
Mustafa T. Kasubhai, Claimant Attorney
Terrall & Terrall, Defense Attorney

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Johnson's order that affirmed an Order on Reconsideration that awarded 16 percent (24 degrees) scheduled permanent disability for loss of use or function of claimant's right hand. 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

In August 1999, claimant filed a claim for right wrist, elbow and shoulder symptoms. (Ex. 3). She was treated by Dr. Fridinger. The employer accepted disabling right wrist tendinitis. (Ex. 15). A January 18, 2000 Notice of Closure awarded temporary disability but no permanent disability. (Ex. 22). Claimant requested reconsideration and Dr. Lowengart performed a medical arbiter examination in May 2000. (Exs. 22A, 22B). A May 18, 2000 Order on Reconsideration awarded 16 percent scheduled permanent disability for loss of use or function of her right hand. (Ex. 23). The employer requested a hearing. The ALJ relied on the medical arbiter's findings and affirmed the Order on Reconsideration.

The employer argues that we should rely on Dr. Fridinger's opinion in determining claimant's impairment. The employer contends that Dr. Lowengart's opinion is not persuasive because she referred to several unaccepted conditions and did not explain which findings were related to the *accepted* condition.

On reconsideration, where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. OAR 436-035-0007(14) (WCD Admin. Order 98-055). This preponderance of medical opinion 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 rely on the most thorough, complete, and well-reasoned evaluation of claimant's injury-related impairment. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

Claimant relies on the opinion of Dr. Lowengart, the medical arbiter, to establish that she is entitled to a scheduled permanent disability award of 16 percent. She contends that the ALJ properly relied on Dr. Lowengart's findings in determining impairment. The ALJ affirmed the Order on Reconsideration, which relied on Dr. Lowengart's report and awarded 1 percent scheduled permanent disability for reduced range of motion in the right wrist, 5 percent for chronic condition impairment and 11 percent for reduced sensation along the thenar eminence of the right palm, for a combined value of 16 percent. (Ex. 23).

ORS 656.214(2) provides that "the criteria for the rating of scheduled disability shall be the permanent loss of use or function of the injured member *due to the industrial injury*." (Emphasis supplied). OAR 436-035-0007(1) provides, in 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 [sic]. Unrelated or noncompensable impairment findings shall be excluded and shall not be valued under these rules."

In May 2000, Dr. Lowengart performed a medical arbiter examination and found that claimant's right wrist range of motion was 18 degrees for radial deviation and 68 degrees for palmar flexion. (Ex. 22B-5). *See* OAR 436-035-0080(3), (5). Regarding claimant's wrist ranges of motion, Dr. Lowengart explained:

> "All ranges of motion are within normal limits, with the exception of radial deviation, which lack 2 [degrees]. There is a discrepancy between motion on the right and left, right being somewhat less than left. There is segmental restriction noted at the scapholunate junction of the right wrist, not present on the left. This is consistent with a partial subluxation of the lunate, which can go along with symptoms of carpal tunnel syndrome." (Ex. 22B-2).

Later in the report, Dr. Lowengart referred to a "diagnosis of lunate subluxation" (Ex. 22B-3), and said that the subluxation of claimant's right wrist had not been adequately addressed. (Ex. 22B-4).

Dr. Lowengart concluded that the findings of wrist motion were "due to the accepted condition." (Ex. 22B-3). That statement is inconsistent with her discussion of the wrist ranges of motion, which referred to segmental restriction at the scapholunate junction of the right wrist that was consistent with a partial subluxation of the lunate and symptoms of carpal tunnel syndrome. (Ex. 22B-2). Thus, Dr. Lowengart apparently associated the reduced range of motion, at least in part, with the segmental restriction/partial subluxation of the lunate/carpal tunnel syndrome, none of which are accepted conditions. Rather, the only accepted condition was right wrist tendinitis. Dr. Lowengart did not explain how claimant's decreased range of motion could be consistent with subluxation of the lunate and carpal tunnel syndrome, but nevertheless be "due to" the accepted tendinitis condition. We find that Dr. Lowengart's inconsistent comments regarding wrist range of motion findings are confusing and her conclusions are not adequately explained or well-reasoned.

Moreover, OAR 436-035-0007(1) provides that a worker is entitled to a value under the rules "only for those findings of impairment that are permanent[.]" Dr. Lowengart's comment that the subluxation of claimant's right wrist had not been adequately addressed (Ex. 22B-4), suggests that claimant's wrist range of motion will improve with further treatment, and is therefore not permanent. We conclude that Dr. Lowengart's report is not sufficient to establish that claimant's reduced right wrist ranges of motion are "due to" the accepted tendinitis condition.

Regarding claimant's sensation loss, Dr. Lowengart found:

> "Sensation of the palmar surface of the hand is reduced to two-point discrimination to 14 mm in a palmar thenar eminence distribution *consistent with partial median nerve injury*." (Ex. 22B-3; emphasis supplied).

Later in the report, however, Dr. Lowengart said that claimant's numbness was "due to the accepted condition." (*Id.*) That conclusion is inconsistent with her comment that claimant's sensation loss in the palmar thenar eminence distribution was "consistent with partial median nerve injury." (*Id.*) Although Dr. Lowengart related claimant's sensation loss to a "partial median nerve injury," no such condition was accepted. Rather, as noted above, the only accepted condition was right wrist tendinitis. We find that Dr. Lowengart's report lacks adequate explanation and is not sufficient to establish that claimant's reduced sensation is "due to" the accepted tendinitis condition.

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. Lowengart explained:

> "4. This worker is significantly limited in the ability to repetitively use her right hand, wrist and forearm due to the diagnosed chronic and permanent medical condition *arising out of the accepted condition of right wrist tendinitis and diagnosis of lunate subluxation or wrist strain related to the 08/11/99 injury.*
>
> "5. *However, there are limitations also related to her undiagnosed condition of cervical problems,* see end of this discussion. It is my impression that her inability to grip strongly, dorsiflex the wrist and use the thumb is due to the work-related condition. The inability to use the shoulder, elbow, neck and remainder of the forearm would be related to the neck condition, etiology of which has not been determined." (Ex. 22B-3; emphasis supplied).

Although Dr. Lowengart found that claimant was significantly limited in the ability to repetitively use her right hand, wrist and forearm, she attributed that limitation to "the accepted condition of right wrist tendinitis and diagnosis of lunate subluxation or wrist strain related to the 08/11/99 injury[,]" and she also noted that claimant had limitations related to undiagnosed cervical problems. (Ex. 22B-3). Dr. Lowengart found "unequivocal evidence that her neck is contributing to her arm and shoulder pain," and she also suspected that claimant had hyperinsulinemia that contributed to her overall pain condition. (*Id.*)

It is unclear from Dr. Lowengart's report what condition was causing claimant's significant limitations in her ability to repetitively use her right wrist. As noted above, the only accepted condition is right wrist tendinitis. Under OAR 436-035-0007(1), unrelated or noncompensable impairment findings shall be excluded and shall not be valued under these rules. Dr. Lowengart's report refers to several possible conditions other than the right wrist tendinitis, including partial subluxation of the lunate, de Quervain's tendinitis, partial median nerve injury, wrist strain, cervical problems and hyperinsulinemia. Dr. Lowengart's report also suggests that claimant has several conditions that require treatment, including a neck condition, hyperinsulinemia and subluxation of the wrist. We find that Dr. Lowengart's report does not adequately address whether claimant is significantly limited in the repetitive use of her right wrist "due to" the accepted right wrist tendinitis condition.

In *SAIF v. Danboise*, 147 Or App 550, 553, *rev den* 325 Or 438 (1997), the Court of Appeals held that

> "when the record discloses no other possible source of impairment, medical evidence that rates the impairment and describes it as 'consistent with' the compensable injury supports a finding that the impairment is due to the compensable injury."

In *Danboise*, the court relied on the fact that the record identified no noncompensable factors that may have contributed to the claimant's impairment. 147 Or App at 553. Here, unlike *Danboise*, Dr. Lowengart referred to several unaccepted conditions that could be causing claimant's impairment findings, including partial subluxation of the lunate, partial median nerve injury, wrist strain, cervical problems and hyperinsulinemia. Although Dr. Lowengart made the conclusory statement that claimant's "findings of wrist motion and numbness are due to the accepted condition" (Ex. 22B-3), the rest of her report suggests that those findings were also related to other conditions, as discussed previously.

Because the medical evidence discloses other possible sources of claimant's impairment and there is no medical evidence that rates claimant's range of motion impairment and describes it as "consistent with" or "due to" the compensable injury, we conclude that the holding in *Danboise* does not apply. *See SAIF v. Alton*, 171 Or App 491 (2000); *SAIF v. Gaffke*, 152 Or App 367 (1998); *Kenneth C. Molz*, 52 Van Natta 1306 (2000).

There is no other medical evidence that supports claimant's entitlement to permanent disability. To the contrary, claimant's attending physician, Dr. Fridinger, found no objective findings of any pathological process and he questioned the significance of claimant's subjective complaints. (Ex. 19).

In sum, we conclude that claimant is not entitled to an award of scheduled permanent disability for loss of use or function of her right hand. We therefore reverse the ALJ's order and the Order on Reconsideration award of 16 percent scheduled permanent disability.[1]

ORDER

The ALJ's order dated November 28, 2000 is reversed. In lieu of the ALJ's and Order on Reconsideration's scheduled permanent disability award, the January 18, 2000 Notice of Closure is reinstated and affirmed. The ALJ's attorney fee award is also reversed.

[1] Our holding, however, does not mean that a claim for the unaccepted conditions cannot be made and, if accepted or determined to be compensable, rated for permanent disability in the future. *See* ORS 656.262(6)(d), (7)(a).

In the Matter of the Compensation of
RANDY G. MYERS, Claimant
Own Motion No. 01-0092M
OWN MOTION ORDER
Cole, Cary, et al, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for a left ankle condition. Claimant's aggravation rights have expired. SAIF 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 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, consistent with claimant's counsel's request, claimant's attorney is allowed an approved fee in the amount of 10 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,500, payable by the carrier directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.[1]

IT IS SO ORDERED.

[1] In light of claimant's attorney's express request for a reduced percentage of attorney fees from 25 percent to 10 percent, we have so reduced the percentage award of the "out-of-compensation" attorney fee, not to exceed $1,500.

In the Matter of the Compensation of
RANDALL L. NUNNENKAMP, Claimant
WCB Case No. 99-07681
ORDER DENYING RECONSIDERATION
Shelley K. Edling, Claimant Attorney
Cummins, Goodman, et al, Defense Attorney

The self-insured employer requests reconsideration of our May 31, 2000 order that affirmed an Administrative Law Judge's (ALJ's) order that affirmed an Order on Reconsideration award of 32 percent (48 degrees) scheduled permanent disability for claimant's right knee condition. The employer requests remand for the admission of additional exhibits.

The employer filed a petition for judicial review of our decision on June 21, 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 employer asks that we exercise our authority to withdraw the appealed order in order to reconsider our decision in light of new evidence. *See* ORS 183.482(6); ORAP 4.35. Specifically, the employer contends that new evidence shows that the medical arbiter incorrectly diagnosed a patellar defect and the arbiter erred in finding that the patellar defect arose out of the accepted conditions. For the following reasons, we deny the employer's motion for reconsideration and remand.[1]

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). A compelling reason exists when the new evidence (1) concerns disability; (2) was not obtainable at the time of the hearing; and (3) is reasonably likely to affect the outcome of the case. *Id.; Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986).

Here, the remand issue is complicated by the statutory requirements pertaining to admissibility of evidence.[2] ORS 656.283(7) provides that "[e]vidence on an issue regarding a notice of closure that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing[.]" ORS 656.268(7)(h) provides that, after reconsideration, "no subsequent medical evidence of the worker's impairment is admissible * * * for purposes of making findings of impairment on the claim closure."

In *Marvin Wood Products v. Callow*, 171 Or App 175, 183 (2000), the court explained that, under the current statutory scheme, the hearing before the ALJ is on the reconsideration record made before the Department of Consumer and Business Services and is limited to the issues raised on reconsideration. The record may be supplemented only with a medical arbiter report that was not prepared in time for use in the reconsideration process, ORS 656.268(6)(f), and the issues may be expanded only to consider those "aris[ing] out of the reconsideration order itself." ORS 656.283(7).

The employer refers to ORS 656.268(7)(h), asserting that medical evidence deemed "related to impairment" that was not considered on reconsideration is not admissible. Nevertheless, the employer attempts to distinguish the proffered medical evidence on the basis that it relates solely to the non-existence of the condition "mistakenly" diagnosed by the arbiter. In addition, the employer contends that new "non-medical" evidence exists in the form of "admissions against interest" by claimant that will allow the ALJ to correct the "mistake" made in the Order on Reconsideration.

The new medical evidence proffered by the employer, as well as the new "non-medical" evidence, was not submitted on reconsideration and indeed, was not available at that time. Thus, the proffered evidence is "[e]vidence on an issue regarding a notice of closure" that was not submitted at

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[1] In reaching this decision, we note that 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).

[2] We note that this case does not involve permanent total disability benefits. *See Koskela v. Willamette Industries, Inc.*, 331 Or 362 (2000) (statutory scheme for assessing whether a worker should receive permanent total disability benefits failed to satisfy procedural due process requirements).

reconsideration and would therefore not be admissible at hearing, pursuant to ORS 656.283(7). Moreover, we find that the proffered medical evidence constitutes "medical evidence of the worker's impairment" that is to be used for "purposes of making findings of impairment on the claim closure." *See* ORS 656.268(7)(h). As such, the evidence would not be admissible.

Because the evidence offered by the employer was not submitted at reconsideration and made part of the reconsideration record regarding the August 24, 1999 Order on Reconsideration, it would not be admissible at hearing.[3] Consequently, there is no compelling reason for remand to the ALJ for the taking of additional evidence. *See Juana M. Lopez*, 52 Van Natta 1654 (2000) (because the medical report submitted by the claimant was not in the reconsideration record, it would not be admissable at hearing and there was no compelling reason to remand); *James E. Craft*, 52 Van Natta 2048 (2000) (no abuse of discretion where ALJ declined to admit an exhibit that was not part of the reconsideration record; Board denied the claimant's request for remand). We deny the employer's request for reconsideration and request for remand.

IT IS SO ORDERED.

[3] To the extent that the employer requests that we take administrative notice of the proffered agency orders involving this claim, we decline to do so. Because the proffered agency orders were not in existence at the time of the reconsideration proceeding and are not a part of the reconsideration record, we may not consider them as evidence on any issue regarding the Notice of Closure in this case. *See* ORS 656.283(7); *Salvador Guevara-Morales*, 52 Van Natta 1427 (2000); *Tony D. Houck*, 51 Van Natta 1301 (1999) (Board did not consider an administrative order concerning a medical treatment dispute as evidence because it could have impacted Board's decision about premature closure).

In the Matter of the Compensation of
RONALD A. CARNAGEY, Claimant
WCB Case Nos. 00-01643 & 99-07852
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorney
William J. Blitz, Defense Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

The SAIF Corporation, on behalf of its insured, Oregon Woodwork (OWW), requests review of those portions of Administrative Law Judge (ALJ) Kekauoha's order that: (1) set aside its "de facto" denial of compensability and responsibility for an L4-5 annular tear; (2) upheld SAIF's compensability and responsibility denial of the same condition, issued on behalf of Jefferson School District No. 509J (Jefferson); and (3) directed SAIF/OWW to pay temporary disability under a "new medical condition" claim for the L4-5 annular tear. Claimant cross-requests review of that portion of the ALJ's order that assigned responsibility for the L4-5 annular tear to SAIF/OWW. On review, the issues are compensability, responsibility and temporary disability.

We adopt and affirm the ALJ's order with the following supplementation regarding the temporary disability issue.

The ALJ found that SAIF/OWW was responsible for claimant's "new medical condition" claim for an annular tear at L4-5 under its 1960 low back injury claim. Applying *John R. Graham*, 51 Van Natta 1740 (1999), the ALJ then determined that SAIF/OWW was required to pay any procedural temporary disability due with respect to the "new medical condition" claim.

On review, SAIF/OWW contends that, once claimant's aggravation rights expired in 1967, his claim was in "own motion" status, and, therefore, benefits could only be awarded under ORS 656.278. SAIF/OWW further contends that, pursuant to the Board's "Own Motion" order postponing action on a request for relief, the Board intended that the case would return to the Board for a determination of "Own Motion" relief in the event responsibility was assigned to SAIF/OWW. Finally, SAIF/OWW asserts that *Graham* was wrongly decided and should be reconsidered. For the following reasons, we do not find these contentions persuasive.

Although SAIF/OWW contends that the Board lacks jurisdiction to direct processing under ORS 656.262(7)(c) once a claim is in "Own Motion" status, in previous cases, we have concluded that the ALJ had jurisdiction over the matter because the claimant's request pertained to the carrier's duty to process his or her claim under ORS 656.262(7)(c). *Michael T. Bergmann*, 52 Van Natta 1931 (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). We reach the same conclusion in this case.

SAIF/OWW argues, however, that ORS 656.262(7)(c) applies only to conditions in existence and omitted at closure, and does not apply to new medical conditions under ORS 656.262(7)(a). We rejected that argument in *Michael T. Bergmann*, 52 Van Natta at 1931, concluding that ORS 656.262(7)(c) was intended to apply to all conditions found compensable after claim closure. We continue to follow our reasoning in *Bergmann*. *See Dave A. Humphrey*, 52 Van Natta 2212, 2213 (2000).

We now turn to SAIF/OWW's argument that *Graham* was wrongly decided. After considering SAIF's arguments, we adhere to our decision in that case and continue to rely on it. *See Humphrey*, 52 Van Natta at 2214 (declining to overrule *Graham*).

Finally, we reject SAIF's argument that our order postponing action in the "Own Motion" claim precluded the ALJ from awarding temporary disability. Our previous order only postponed action on the "Own Motion" claim. It did not deprive the ALJ of authority under *Graham* and its progeny to award temporary disability under the "new medical condition" claim.

Because we have not reduced claimant's compensation as a result of SAIF/OWW's request for review, claimant's attorney is entitled to an assessed fee for services on review regarding the compensability 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 is $1,000, payable by SAIF/OWW. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated November 2, 2000 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by SAIF/OWW.

In the Matter of the Compensation of
RONALD A. CARNAGEY, Claimant
Own Motion No. 66-0470M
OWN MOTION ORDER
Malagon, Moore, et al, Claimant Attorney
William J. Blitz, Defense Attorney
Julie Masters (Saif), Defense Attorney

The SAIF Corporation submitted claimant's request for medical and temporary disability benefits relating to claimant's compensable 1960 low back injury. SAIF recommended against reopening this "pre-1966 injury" claim under our Own Motion authority on the grounds that: (1) surgery or hospitalization had not been recommended; (2) claimant's current condition was not causally related to his 1960 work injury; and (3) SAIF is not responsible for claimant's current low back condition.

In addition, SAIF noted that claimant had sustained a new injury in November 1998 with a different employer. That claim was accepted for a lumbar strain; however, a responsibility denial issued regarding claimant's current low back condition. Claimant filed a request for hearing with the Hearings Division regarding, among other issues, the responsibility for his current low back condition. (WCB Case No. 99-07852). In light of such circumstances, we postponed action on the Own Motion matter pending resolution of the litigation before the Hearings Division.

By order dated November 2, 2000, Administrative Law Judge (ALJ) Kekauoha set aside SAIF's "de facto" denial of claimant's current low back condition as it related to his 1960 claim. The ALJ also remanded claimant's "new condition" claim to SAIF for "acceptance and processing according to law, including, but not limited to, the payment of temporary disability benefits." SAIF requested Board review of the ALJ's order. In a separate order issued today, we have affirmed the ALJ's order. Having decided the responsibility issue, we now proceed with our review of the request for Own Motion relief.

Inasmuch as claimant sustained a compensable injury prior to January 1, 1966, he does not have a lifetime right to medical benefits pursuant to ORS 656.245. *See William A. Newell*, 35 Van Natta 629 (1983). However, the Board may exercise its Own Motion authority to authorize medical services and temporary disability compensation for compensable injuries occurring before January 1, 1966. ORS 656.278(1)(b).

Here, as noted above, claimant's current condition has been ordered to be accepted as a "new condition" in his 1960 claim. Based on the following reasoning, we find that claimant's "new condition" claim is not within our Own Motion jurisdiction under ORS 656.278(1)(b).

The Board's Own Motion jurisdiction extends only to claims for which the claimant's aggravation rights have expired. *Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988); ORS 656.278(1)(a). Here, the aggravation rights expired on claimant's initial claim on January 5, 1967. In addition, a "new medical condition claim" is not entitled to a separate 5-year aggravation rights period. Instead, the 5-year aggravation rights period is determined by the initial injury claim. *Susan K. Clift*, 51 Van Natta 646 (1999).

Nevertheless, a new medical condition claim qualifies for reopening and closure under ORS 656.268 pursuant to ORS 656.262(7)(c), even if the initial claim is in Own Motion jurisdiction. *Dave A. Humphrey*, 52 Van Natta 2212, 2213 (2000); *Robert A. Olson*, 52 Van Natta 1540 (2000); *John R. Graham*, 51 Van Natta 1740 (1999). On the other hand, the Board, in its Own Motion capacity under ORS 656.278, does not have authority to direct a carrier to process a claim under ORS 656.262(7)(c). *Craig J. Prince*, 52 Van Natta 108, 110 (2000). That issue is a "matter concerning a claim," under the jurisdiction of the Hearings Division, and not under the Board's Own Motion jurisdiction. ORS 656.708; *Dave A. Humphrey*, 52 Van Natta at 2213, citing *Camilla S. Kosmoski*, 52 Van Natta 1573, 1574 n2 (2000).

Here, claimant's "new condition" low back claim has been ordered to be accepted and processed according to law pursuant to the ALJ's November 2000 order, which we have affirmed. Likewise, the condition for which SAIF has submitted a request for Own Motion relief is claimant's "new condition." As explained above, claimant's "new condition" claim qualifies for reopening and closure under ORS 656.268 pursuant to ORS 656.262(7)(c). However, the Board has no authority in its Own Motion

capacity to order such reopening. *Craig J. Prince*, 52 Van Natta at 110. Accordingly, we deny the request for Own Motion relief.

IT IS SO ORDERED.

March 28, 2001 Cite as 53 Van Natta 375 (2001)

In the Matter of the Compensation of
DENNIS M. GETZ, Claimant
WCB Case No. 97-00652
ORDER ON REVIEW
Myrick, Seagraves, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by the Board *en banc*.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that upheld the insurer's denial of his left hip injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the following additional finding. On January 9, 1997, the insurer denied the compensability of an alleged hip injury that took place in a physical capacities evaluation (PCE) on the grounds that: (1) the left hip injury did not arise out of and in the course of the original June 26, 1993 injury; and (2) that the June 1993 injury was not a major contributing factor to claimant's current left hip injury. (Ex. 23).

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable right shoulder and elbow injury on June 26, 1993. On March 8, 1996, Dr. Chamberlain, the attending physician, found claimant's condition to be medically stationary. In May 1996, Dr. Chamberlain requested that a PCE be performed. After some delay due to claimant's high blood pressure, the PCE was completed on August 16, 1996. Claimant later alleged that he sustained a left hip injury after being placed in a "lunging type position" with the left leg during the PCE. The insurer denied the left hip injury claim on January 9, 1997. Claimant requested a hearing.

Applying ORS 656.005(7)(a)(A), the ALJ upheld the insurer's denial of claimant's alleged left hip injury. In doing so, the ALJ reasoned that this injury did not result directly from the compensable injury or from medical treatment for that injury. The ALJ also concluded that the circumstances of claimant's injury were nearer to *Robinson v. Nabisco, Inc.*, 143 Or App 59 (1996) (holding injury sustained during insurer-arranged medical examination was not compensable as a "consequential condition" under ORS 656.005(7)(a)(A)), and *Kephart v. Green River Lumber*, 118 Or App 76 *rev den* 317 or 272 (1993) (upholding denial of shoulder injury sustained in the course of vocational rehabilitation; the compensable injury was not the major contributing cause of shoulder injury), than they were to *Barrett Business Services v. Hames*, 130 Or App 190, *rev den* 320 Or 492 (1994) (where reasonable and necessary treatment for a compensable injury is the major contributing cause of a new injury, the compensable injury itself is properly deemed the major contributing cause of the consequential condition for purposes of ORS 656.005(7)(a)(A)).

After claimant requested review of the ALJ's decision, the parties agreed to suspend the briefing schedule pending the Supreme Court's decision in *Robinson*. The Court has rendered its opinion in that case. *Robinson v. Nabisco Inc.*, 331 Or 178 (2000). Having considered the parties' arguments based on the *Robinson* rationale, we now analyze the compensability issue in this case.[1]

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[1] The Supreme Court's decision in *Robinson* substantially limits the applicability of ORS 656.005(7)(a)(A). However, it would appear that the legislature intended that statute to apply in cases such as this. *See Barrett Business Services v. Hames*, 130 Or App 190, *rev den* 320 Or 492 (1994) (discussing legislative history concerning ORS 656.005(7)(a)(A)); *Hicks v. Spectra Physics*, 117 Or App 293 (1992) (also discussing legislative history concerning that statute). Accordingly, the legislature may wish to revisit this area of workers' compensation law in the wake of *Robinson*.

To be compensable under ORS 656.005(7)(a), claimant's injury must arise out of and in the course of employment. In Robinson, the Supreme Court reversed the Court of Appeals' decision that had affirmed our order in *Kathleen A. Robinson*, 46 Van Natta 833, *on recon* 46 Van Natta 1677 (1994), upholding a carrier's partial denial of the claimant's disc herniation injury claim resulting from her carrier-arranged medical examination. Reasoning that the claimant's prior compensable low back strain injury (the claim on which the medical examination had been based) was not the major contributing cause of the disc herniation, we had concluded that the claim was not compensable as a "consequential condition" under ORS 656.005(7)(a)(A). Before the Supreme Court, the claimant contended that her injury resulting from the "compelled-medical examination" (CME) under ORS 656.325(1) arose out of the course of and within the course of her employment and, as such, was compensable pursuant to ORS 656.005(7)(a).

The Supreme Court agreed with the claimant's contention. After reviewing the text of ORS 656.005(7)(a), the Court determined that the first question was whether the claim concerned an accidental injury that "aris[es] out of and in the course of employment * * *."

Turning to the two-prong work-connection test as described in *Krushwitz v. McDonald's Restaurants*, 323 Or 520, 526 (1996), the Court first applied the "arising out of" prong (*i.e.*, whether some causal link existed between the injury and her employment). After reviewing the characteristics of the CME conducted under ORS 656.325(1), the Court determined that some causal link existed between the claimant's "CME" injury and a risk connected to a condition of her employment. Reasoning that the claimant's fulfillment of her statutory obligation to submit to the CME exposed her to the risk that produced her injury, the Supreme Court stated that there was a sufficient work connection to justify the conclusion that her injury arose out of her employment under ORS 656.005(7)(a).

Addressing the question of whether the injury occurred "in the course of" her employment (*i.e.*, the time, place and circumstances under which the accident took place), the Court determined that the CME served the interest of the carrier by providing it with pertinent information about the claimant's compensable injury. Applying *Fred Meyer, Inc. v. Hayes*, 325 Or 596, 598 (1997), the Supreme Court concluded that the claimant's CME injury occurred in the course of her employment.

Because the circumstances of the claimant's CME injury satisfied, at least to some degree, each prong of the test stated in ORS 656.005(7)(a), the Court further concluded that the relationship between the claimant's injury and her employment was sufficient to justify compensation. In addition, because the claimant's injury was compensable due to its connection to work, the Court reasoned that the "consequential condition" limitation in ORS 656.005(7)(a)(A) was not applicable.

Turning to this case, the insurer denied the left hip injury claim on course and scope of employment grounds. Thus, the first question is whether the claim concerned an accidental injury that arises out of and in the course of employment. If the circumstances of claimant's PCE injury satisfy, at least to some degree, each prong of the test stated in ORS 656.005(7)(a), the relationship between the claimant's injury and his employment is sufficient to justify compensation. In addition, if claimant's injury is compensable due to its connection to work, we need not address the "consequential condition" limitation in ORS 656.005(7)(a)(A). *Robinson*, 331 Or at 190.

As previously noted, the Supreme Court views the two prongs of the compensability test as two parts of a unitary "work-connection" inquiry that asks whether the relationship between the injury and the employment is sufficiently close that the injury should be compensable. *Krushwitz*, 323 Or at 526. According to the Court, although the "arising out of" and "in the course of" prongs provide guidance, the unitary work-connection test does not supply a mechanical formula for determining whether an injury is compensable. We evaluate those factors in each case to determine whether the circumstances of a claimant's injuries are sufficiently connected to employment to be compensable.

Claimant's PCE injury must satisfy both prongs of the work-connection test to some degree; neither prong is dispositive. *Krushwitz*, 323 Or at 531. However, if many facts support one element of that test, fewer facts may support the other. *Redman Industries, Inc. v. Lang*, 326 Or 32, 35 (1997). The Supreme Court has explained that the "arising out of" prong of the compensability test in ORS 656.005(7)(a) requires that "some causal link exist" between the worker's injury and his or her employment. *Krushwitz*, 323 Or at 525-26. The "in the course of" employment prong requires that the time, place, and circumstances of the injury justify connecting the injury to the employment. *Id.* at 526.

In accordance with the above legal precedent, we begin our analysis of the work-connection test by applying the "arising out of" prong to claimant's PCE injury. Claimant's injury arises out of employment if employment exposed him to some risk from which the injury originates. *Fred Meyer, Inc. v. Hayes*, 325 Or at 601.

OAR 436-009-0070(4)(b) explains that a "Second Level PCE," such as what was performed in this case, is requested by an insurer or attending physician to measure general residual functional capacity to perform work or provide general evaluation information, including musculoskeletal information. According to the rule, the PCE may also be used to establish Residual Functional Capacities for claim closure. OAR 436-010-0005(32) defines a PCE as "an objective, directly observed, measurement of a worker's ability to perform a variety of physical tasks combined with subjective analyses of abilities by worker and evaluator."

Having considered these rules, we conclude that the predicate for any PCE is a work-related injury or disease that entitles the worker to receive compensation. Thus, like the "CME" in *Robinson*, a PCE is a condition of the employment relationship -- specifically, an injury or disease that occurs on the job.

However, the circumstances surrounding the PCE in this case differ in some significant respects from the "CME" in *Robinson*. The injured worker in *Robinson* was required to comply with a request for a "CME" or face suspension of the right to compensation. The *Robinson* Court noted that, in no sense, was the claimant's participation in a "CME" a voluntary act carried out for personal reasons.

Unlike the "CME" in *Robinson*, the PCE in this case lacked the compulsory aspects important to the Court's decision in *Robinson*. Here, there is no statutory obligation comparable to that imposed by ORS 656.325(1) that compelled claimant to attend the "CME." The evidence in this case does not establish that claimant was required to attend the PCE or face suspension of his right to compensation. Moreover, unlike *Robinson*, where the claimant's employer requested the "CME," and the employer's chosen medical examiner controlled completely the examination procedures and the conditions that led to the claimant's injury, the insurer in this case did not request the PCE or the medical examiners who performed the evaluation. Rather, the record simply indicates that claimant's attending physician requested the PCE.

The foregoing discussion of the characteristics of the PCE in this case demonstrates that, while some causal link does exist between claimant's injury during the PCE and a risk connected to a condition of employment, that connection is very weak.

We now turn to the "course of employment" prong. As explained above, "in the course of" factor "'point[s] to the time, place and circumstance under which the accident takes place.'" *Rogers*, 289 Or at 639 (quoting *Larson v. State Ind. Acc. Com.*, 135 Or 137, 139-40 (1931)).

Here, unlike the carrier in *Robinson*, the insurer did not exercise control over claimant at the time of his "PCE injury." The insurer did not choose the time, place, and circumstances of claimant's PCE, direct claimant to attend, or control the circumstances of the PCE that led to claimant's injury. As previously noted, the PCE was conducted at the attending physician's request. The record does not establish that the insurer benefited from information supplied by the PCE.[2]

In light of these circumstances, we conclude that the record is devoid of evidence that claimant's PCE injury occurred in the course of employment. Because the circumstances of claimant's injury do not satisfy, at least to some degree, each prong of the test stated in ORS 656.005(7)(a), we conclude that the relationship between claimant's injury and employment is insufficient to justify compensation.

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[2] The insurer wrote Dr. Chamberlain to ask him whether he concurred with the PCE. (Ex. 20). However, the record does not indicate whether or how the insurer used information from the PCE. Therefore, we are unable to conclude from this record that the insurer or employer benefited from the PCE. This fact is significant because the *Robinson* Court noted that, in determining whether an injury occurs in the course of employment, the proper focus is whether the activity promotes some interest of the employer. *Robinson*, 331 Or at 189.

Accordingly, we hold that claimant's 1996 PCE injury did not arise out of and in the course of employment.[3] It was not, for that reason, a compensable injury under ORS 656.005(7)(a). However, the PCE injury may still be compensable under ORS 656.005(7)(a)(A) as a consequence of the compensable 1993 injury. Accordingly, consistent with the *Robinson* rationale, we must now determine whether the compensable 1993 injury was the major contributing cause of the 1996 PCE injury.

As previously noted, the ALJ determined that claimant's left hip injury incurred during the PCE was not a compensable consequential condition. The ALJ reasoned that the PCE was an evaluation performed by other than an attending or consulting physician and was not recommended as treatment of the compensable 1993 right shoulder and elbow injury. The ALJ further noted that the lunge activity that caused the left hip injury was not directly related to claimant's compensable shoulder/elbow injury and that the PCE was an assessment of claimant's injury after claimant had been declared medically stationary and after Dr. Chamberlain had provided what medical treatment he reasonably could. Accordingly, the ALJ found that the PCE injury did not result directly from the compensable injury or from medical treatment for that injury. Under such circumstances, the ALJ concluded that the left hip injury was not a compensable consequential condition under ORS 656.005(7)(a)(A).

Having considered this record, we adopt the ALJ's reasoning and conclude that claimant has not proved that the compensable 1993 injury is the major contributing cause of the 1996 left hip injury. *See Kephart v. Green River Lumber*, 118 Or App at 79.[4] Thus, we find that claimant has failed to prove compensability under either ORS 656.005(7)(a) or ORS 656.005(7)(a)(A). Accordingly, we affirm.

ORDER

The ALJ's order dated May 22, 1997 is affirmed.

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[3] Our decision in this case should not be construed as stating that no injury occurring during a PCE can ever be compensable. To the contrary, such an injury may be compensable under the appropriate circumstances. Here, however, we do not find sufficient facts to support extending the *Robinson* rationale to cover this PCE injury.

[4] We recognize that, in light of the Supreme Court's analysis in *Robinson*, the analytical framework of the Court of Appeals' decisions in cases such as *Kephart* and *Hames* is questionable (*i.e.*, applying ORS 656.005(7)(a)(A) rather than ORS 656.005(7)(a)). However, the Court's decision in *Robinson* does not cause us to question the *substance* of the Court of Appeals' application of the consequential condition statute. Accordingly, because we do not find that claimant's 1996 PCE injury resulted directly from the compensable 1993 injury, we agree with the ALJ that this injury is not compensable as a consequential condition under ORS 656.005(7)(a)(A).

In the Matter of the Compensation of
VERGIL E. MEIER, Claimant
WCB Case No. 00-07316
ORDER ON REVIEW
Popick & Merkel, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that upheld the SAIF Corporation's denial of claimant's injury and occupational disease claims for a cervical strain condition. On review, the issue is compensability.

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

The ALJ characterized claimant's claim as one for an occupational disease, rather than for an injury. The ALJ then upheld SAIF's denial, finding that claimant had not proved that his work activities were the major contributing cause of his cervical condition, or of a "pathological worsening of the underlying condition." ORS 656.802(2)(a) and (b).

On review, claimant first contends that the ALJ erred in applying ORS 656.802(2)(b) to this case where the claim is not based on a "worsening" of any preexisting condition. We agree with claimant that ORS 656.802(2)(b) does not apply to this case. Nevertheless, we agree with the ALJ that claimant has not met his burden of proving the compensability of his condition (whether the standard is "material" or "major" contributing cause).

At hearing, the issue was identified as the compensability of a cervical strain condition. (Tr. 1). The ALJ specifically noted that claimant was not making a claim for any degenerative cervical condition. (O&O at 1). Therefore, although claimant has a preexisting degenerative cervical condition, his cervical strain claim is not "based on the worsening" of any such condition. *See* ORS 656.802(2)(b); *William A. Strode*, 53 Van Natta 212 (2001); *Ron L. Merwin*, 49 Van Natta 1801 (1997). Furthermore, there is no medical evidence that claimant's cervical strain "combined with" any preexisting condition. Accordingly, claimant need not prove that his employment conditions were the major contributing cause of a combined condition and pathological worsening of the disease. *Id.*; *Tony D. Houck*, 48 Van Natta 2443 (1996), *aff'd mem Atlas Bolt & Screw v. Houck*, 151 Or App 200 (1997).

To prove the compensability of his cervical strain condition as an injury, claimant must prove that his condition was related in material part to a work injury. ORS 656.005(7)(a); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992). To establish his claim as an occupational disease, claimant must prove that his work activities were the major contributing cause of his cervical strain condition. ORS 656.802(2)(a). However, we need not resolve the issue of whether claimant's claim is an injury or occupational disease because we find that claimant has not met his burden of proving either theory of compensability.[1]

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, 263 (1986). Absent persuasive reasons to do otherwise, we defer to the opinion of claimant's treating physician. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to the opinion of claimant's treating physician, Dr. Wong.

Dr. Wong concluded that "[claimant's] onset of symptoms initiated during the activity of operating a piece of heavy equipment. The relationship to the work activities is a temporal related causation." (Ex. 22). Such an analysis, standing alone, is generally not persuasive. *See Allie v. SAIF*, 79 Or App 284 (1987).

Dr. Prideaux, a chiropractor who treated claimant several times, stated that claimant's cervical strain was a direct result of claimant's "operating heavy equipment and the major contributing cause of his need to seek treatment." (Ex. 23-2). However, Dr. Prideaux's opinion on causation is unexplained and conclusory. As such, we find the opinion unpersuasive. *Moe v. Ceiling Systems, Inc.*, 44 Or App 429 (1980); *Amanda D. Smith*, 53 Van Natta 190 (2001). Moreover, Dr. Prideaux's opinion would not satisfy claimant's burden of proof in an occupational disease context, because he concluded that claimant's work activity was the major contributing cause of his need to seek treatment, as opposed to the major contributing cause of his condition. (Ex. 23-2); *see Tammy L. Foster*, 52 Van Natta 178 (2000).

Dr. Vessely, who examined claimant at the request of SAIF, concluded that claimant's neck pain was related to his preexisting degenerative changes and not to any work activity. (Ex. 18-6). Dr. Vessely described claimant's degenerative changes as "longstanding," and reasoned that claimant's type of work activities would not be associated with that degree of degeneration. (Ex. 18-5, -6). Dr. Vessely further reasoned that any occurrence of neck pain while at work would be purely coincidental. (Ex. 18-6). We find Dr. Vessely's opinion to be well-reasoned and therefore persuasive. Based on Dr. Vessely's persuasive opinion, we conclude that the denial was correctly upheld.

ORDER

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

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[1] Nevertheless, claimant's claim is more likely an occupational disease due to the absence of an identifiable event which caused claimant's disability and need for treatment. *See Valtinson v. SAIF*, 56 Or App 184 (1982).

In the Matter of the Compensation of
WILLIAM A. RUTTEN, JR., Claimant
WCB Case No. 00-04466
ORDER ON REVIEW
Arthur P. Klosterman, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

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

Claimant requests review of that portion of Administrative Law Judge (ALJ) Johnson's order that upheld the SAIF Corporation's denial of claimant's injury claim for a right shoulder condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

On July 2, 1999, claimant, the food services manager for Union Gospel Mission, participated in a bike ride outing arranged for resident program members of the Gospel Mission. During the outing, claimant fell off his bike, fracturing his right clavicle. The ALJ upheld SAIF's denial, concluding that the injury did not arise out of and in the course of employment under ORS 656.005(7)(a).

On review, claimant contends that his injury occurred within the course and scope of employment and that his primary reason for going on the bike ride was to benefit the employer by distributing the food he had prepared and engaging in fellowship with program members. Thus, claimant asserts that ORS 656.005(7)(b)(B) does not preclude a finding that his injury is compensable.

Under ORS 656.005(7)(b)(B), a "compensable injury" does not include any injury incurred while engaging in recreational activity primarily for the worker's personal pleasure. *See Julie A. Garcia*, 48 Van Natta 776 (1996); *Michael W. Hardenbrook*, 44 Van Natta 529, *aff'd mem Hardenbrook v. Liberty Northwest Insurance Corporation*, 117 Or App 543 (1992). However, the statute does not automatically exclude those recreational activities that have a close work nexus and are not performed "primarily" for the worker's personal pleasure. *Humberto F. Nambo*, 51 Van Natta 773 (1999); *Garcia*, 48 Van Natta at 776.

The statutory exclusion analysis under ORS 656.005(7)(b)(B) must precede any unitary work connection analysis. *Hardenbrook*, 44 Van Natta at 530; *see Andrews v. Tektronix, Inc.*, 323 Or 154, 161 n. 1 (1996) ("Paragraph (7)(a) [of ORS 656.005] is the primary definition of compensability. Paragraph (7)(b) states grounds for exclusion that are additional to those that are inherent in the primary definition found in paragraph (7)(a)"); *see also Theodore A. Combs*, 47 Van Natta 1556, 1557 (1995) (where the claim was not compensable under ORS 656.005(7)(b)(B), Board did not reach the "work connection" test). "The proper inquiry under ORS 656.005(7)(b)(B) is, what is the primary purpose of the activity [at the time of injury]?" *Kaiel v. Cultural Homestay Institute*, 129 Or App 471, 478 (1994); *Nambo*, 51 Van Natta at 773. The fact that a worker derives pleasure from a work activity does not necessarily mean that the worker engages in the activity primarily for personal pleasure. *Kaiel*, 129 Or App at 478; *Mike R. Armstrong*, 50 Van Natta 54, 55 (1998).

Claimant's written job description makes him responsible for daily operations of all food service areas. (Ex A). The written job description notes that "food services is a complex area of service, touching many areas of the Mission." (*Id.*) Over and above the specific written job description, claimant, along with all of the employer's workers, was considered part of the ministry staff. (Tr. 38). Consequently, anyone who works at the Mission is supposed to relate to and have fellowship with the people that are involved in the Mission's programs. (*Id.*) There is no indication that claimant either requested or his employer granted "vacation leave" for the time he was participating on the outing.

Claimant is a salaried employee, who normally works from 8:00 AM to 4:30 PM. (Tr. 29). If claimant had not participated in the bicycle outing, he would have been performing his normal food service duties on the employer's premises. (Tr. 22). Claimant was paid for time on the outing. (*Id.*)

When the time came to organize the outing, Mr. Heibert, the men's director and the supervisor in charge of the outing, asked claimant if he wanted to participate, so that claimant could be included in the headcount for the lunches.[1] (Tr. 63). Claimant and Heibert were the only staff people to accompany the program members during the cycling portion of the outing. Heibert expected claimant to assist in the supervision of the program members if the need arose. (Tr. 64).

Although he was not required to do so, claimant had planned to assist with the lunch by handing out the box lunches he had personally prepared for this outing. (Tr. 29, 31). He was there to enjoy the day, which included fellowship and bonding with the program members and to offer general assistance to anyone who might have bicycle problems. (Tr. 31).

While claimant anticipated deriving pleasure from the "outing," we find that his participation was primarily work-related in that he planned to distribute the lunches as well as provide general assistance and fellowship to the program members. Consequently, claimant's situation is analogous to that of the claimant in *Ester E. Edwards*, 44 Van Natta 1065 (1992). There, the claimant was injured participating in an employer-sponsored volleyball game, the purpose of which was to build morale among the employer's staff. Under the circumstances presented there, we held that the claimant's participation in the game was not an activity performed "primarily" for claimant's personal pleasure. *Edwards*, 44 Van Natta at 1066.

Here, we recognize that claimant would derive personal pleasure from enjoying the day with program members during the outing. However, we are persuaded that claimant's participation was primarily work related in that, in addition to "bonding" with the program members and offering them general assistance (if needed), he would be distributing the box lunches to the program members and enhancing their outing experience with his fellowship. Consequently, we find that ORS 656.005(7)(b)(B) does not preclude claimant from establishing the compensability of his injury.

Having concluded that ORS 656.005(7)(b)(B) does not preclude claimant from establishing the compensability of his injury, we now must determine whether claimant's injury is compensable under ORS 656.005(7). To do so, we analyze the two parts of a unitary "work-connection" test that asks whether the relationship between the injury and the employment is sufficiently close that the injury should be compensable. *Robinson v. Nabisco, Inc.*, 331 Or 178, 185 (2000); *Krushwitz v. McDonald's Restaurants*, 323 Or 520, 526 (1996). Although the "arising out of" and "in the course of" prongs provide guidance, the unitary work-connection test does not supply a mechanical formula for determining whether an injury is compensable. Rather, we evaluate those factors on a case by case basis to determine whether the circumstances of a claimant's injuries are sufficiently connected to employment to be compensable. *Robinson*, 331 Or at 185.

> " 'The statutory phrase "arising out of and in the course of employment" must be applied in each case so as to best effectuate the socio-economic purpose of the Worker's Compensation Act: the financial protection of the worker and his/her family from poverty due to injury incurred in production, regardless of fault, as an inherent cost of the product to the consumer. 1 Larson, Workmen's Compensation Law, section 2.20.' " *Id.* (citations omitted).

Claimant's injury must satisfy both prongs of the work-connection test to some degree; neither is dispositive. *Robinson*, 331 Or at 186; *Krushwitz*, 323 Or at 531. However, if many facts support one element of that test, fewer facts may support the other. *Robinson*, 331 Or at 186; *Redman Industries, Inc. v. Lang*, 326 Or 32, 35 (1997).

The "arising out of" prong requires that "some causal link exist" between the worker's injury and his or her employment. *Robinson*, 331 Or at 186; *Krushwitz*, 323 Or at 525-26. The "in the course of" prong requires that the time, place, and circumstances of the injury justify connecting the injury to the employment. *Robinson*, 331 Or at 186; *Krushwitz*, 323 Or at 526.

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[1] We acknowledge that the dissent determines that claimant initiated his participation on the bicycle outing. We note, however, that in addition to the testimony on which the dissent relies, Heibert also testified he could not remember who initiated claimant's participation. (Tr. 63). We also note that claimant testified that Heibert initially inquired if claimant wished to participate on the outing. (Tr. 25). Based upon the entire testimony of both Heibert and claimant, we conclude, contrary to the dissent, that Heibert initiated claimant's participation.

We begin our analysis of the work-connection test by applying the "arising out of" prong to claimant's injury. Claimant's injury arises out of employment if the employment exposes him to some risk from which the injury originates. *Robinson*, 331 Or at 186; *Fred Meyer, Inc. v. Hayes*, 325 Or 592 (1997); *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366 (1994).

Here, the employer sponsored a bicycle outing for program members. Although claimant was not required to participate on this particular outing, the employer generally encouraged claimant's participation in such outings through its policy of considering all of its employees part of the ministry staff, and thus responsible for promoting fellowship among program participants. Consequently, we conclude that claimant was engaged in an activity within the boundaries of his work when he was injured. Under these circumstances, we are satisfied that a sufficient causal link exists between claimant's injury and a risk connected with employment to justify the conclusion that claimant's injury arose out of employment under ORS 656.005(7)(a).

We now turn to the "in the course of" factor of the work-connection test. As explained above, that factor points to the time, place and circumstances under which the accident takes place. *Robinson*, 331 Or at 186; *Krushwitz*, 323 Or at 526.

> "An injury occurs 'in the course of' employment if it takes place within the period of employment, at a place where a worker reasonably may be expected to be, and while the worker reasonably is fulfilling the duties of the employment or is doing something reasonably incidental to it." *Robinson*, 331 Or at 189.

Here, claimant was injured during the hours of his normal work day at a place he could reasonably have expected to be, given the employer's encouragement to participate in program outings. In participating in the outing, claimant was reasonably fulfilling the fellowship duties of his employment. Applying the above-listed criteria, we conclude that claimant's injury occurred in the course of employment. Because the circumstances of claimant's injury satisfy, at least to some degree, each prong of the test stated in ORS 656.005(7)(a), we also conclude that the relationship between claimant's injury and employment is sufficient to justify compensation. *Robinson*, 331 Or at 190; *see Andrews*, 323 Or at 162.

Accordingly, we reverse the ALJ's order and set aside SAIF's denial.

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 SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated October 11, 2000 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant is awarded a $4,500 attorney fee, to be paid by SAIF.

Board Member Meyers dissenting.

Because I conclude that claimant's primary purpose in participating on the bicycle outing was his own personal pleasure, I respectfully dissent.

This particular outing had been on the employer's calendar of events the entire summer. (Tr. 66). According to Mr. Heibert, the outing coordinator, claimant initiated his participation by expressing a desire to go along. (Tr. 65). Additionally, claimant testified that he was on the outing voluntarily and he was there to "enjoy the day and have fun with the program members." (Tr. 29, 31).

All staff supervision on the outing was to be handled by the outing coordinator (Mr. Heibert) and the Mission chaplain (Mr. Swan). (Tr. 63). It had been prearranged that the lunches were to be transported to the outing and given to the program members by Mr. Swan. (Tr. 36, 52). In short, there was nothing of a work related nature expected of claimant when he was on this particular outing.

While claimant may have been motivated to some extent by a contemporaneously unexpressed desire to pass out the box lunches to the program members and enhance their experience with his fellowship during the outing, I conclude, based upon claimant's own testimony (which the majority too easily discounts), the testimony of Mr. Heibert, and the testimony of Mr. Swan that claimant's personal pleasure was the *primary* purpose for his participation on the bicycle outing. Consequently, I find that claimant's right clavicle injury is excluded from the definition of compensable injuries under ORS 656.005(7)(b)(B).[1]

Accordingly, I would affirm the ALJ's order.

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[1] I also infer from the testimony of Mr. Swan, that claimant fell off his bicycle attempting to jump over a mound of dirt clearly marked with orange and white barricades. (Tr. 15; 52). However, based upon a stipulation by the parties, I will not address "horseplay" as part of a "course and scope" analysis.

March 28, 2001 Cite as 53 Van Natta 383 (2001)

In the Matter of the Compensation of
JOHN J. SHULTS, Claimant
WCB Case No. 00-04358
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that upheld the insurer's denials of his preexisting lumbar degenerative disc disease and facet arthropathy and his current low back condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

On March 4, 1999, claimant was working for the employer as a machinist. When he was lifting a 30-40 pound spindle, he developed low back and right leg pain. (Ex. 4). Dr. Delgado diagnosed an L5-S1 strain with right sciatica, for which he prescribed physical therapy and anti-inflammatory medications. (Ex. 6). After three weeks, claimant returned to regular work. (Ex. 13-2). On March 30, 1999, he reinjured his low back while performing the same maneuver. (*Id.*) He was diagnosed with an L5-S1 strain with left sciatica. Dr. Delgado placed claimant on modified work. That same day, the insurer accepted a disabling "left lumbar sacroiliac strain." (Ex. 11).

On June 3, 1999, Dr. Henderson evaluated claimant for Dr. Delgado. Dr. Henderson diagnosed his condition as mechanical back pain and mild sciatica and recommended an MRI. (Ex. 12).

On June 9, 1999, Drs. Schilperoort and Williams, who examined claimant for the insurer, declared claimant medically stationary and concluded that his condition had resolved without impairment. (Ex. 13).

On July 8, 1999, an MRI revealed disc dessication and bulge at L4-5, bulge at L5-S1 and mild facet arthrosis. (Ex. 14). Dr. Delgado diagnosed a persistent pattern of musculoskeletal lumbosacral pain with a discogenic component, possible right nerve root impingement and intermittent left-sided sciatic symptoms, possibly associated with a discogenic component. (Ex. 15).

Dr. Williams subsequently reviewed the MRI, which he thought showed no convincing evidence of neurological impingement or an explanation for claimant's right or left lower extremity symptoms. After review of the MRI, their prior examination and Dr. Henderson's report, Drs. Schilperoort and Williams declined to change their opinion. (Ex. 16).

In early August 1999, claimant developed increased low back and left leg symptoms. (Ex. 18). On September 2, 1999, Dr. Kirkpatrick evaluated claimant for Dr. Delgado. (*Id.*) A second MRI was unchanged from the previous study. (Ex. 19). Dr. Kirkpatrick did not think that claimant was a surgical candidate and was, at that time, essentially medically stationary. (Ex. 21). Claimant sought no further medical treatment.

On February 23, 2000, Drs. Bald and Farris examined claimant for the insurer. They diagnosed a disc bulge at L4-5, degenerative disc disease of the lumbar spine with disc space dessication, osteophyte formation and facet arthropathy that predated the March 4, 1999 work injury. (Ex. 25). They opined that claimant's lumbar strain combined with his preexisting degenerative disease and facet arthropathy and that the major contributing cause of claimant's combined condition was the March 4, 1999 injury, up until the time he was found medically stationary. They further opined that the major contributing cause of claimant's combined condition since that time, *i.e.*, current condition, was the preexisting degenerative disc disease and facet arthropathy. (*Id.*) Dr. Delgado concurred in their opinion. (Ex. 26).

On April 12, 2000, the insurer issued a modified notice of acceptance, accepting left lumbar sacroiliac strain combined with preexisting and non-compensable lumbar degenerative disc disease and facet arthropathy, so long as and to the extent that the injury is and remains the major contributing cause of the disability or of the need for treatment of the combined condition. (Ex. 27).

On the same date, the insurer issued a denial of claimant's current low back condition on the basis that the March 4, 1999 injury no longer remained the major contributing cause of his need for treatment or disability of the combined condition, and a denial of claimant's preexisting degenerative disc disease and facet arthropathy. (Ex. 28).

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant argued that there was insufficient evidence to find that the insurer issued its denial after its acceptance of the combined condition because the insurer issued both notices on April 12, 2000. The ALJ concluded that, because the insurer's April 12, 2000 denial referred to the acceptance of the combined condition, the insurer had already accepted the combined condition. Claimant raises the same argument on review, contending that the insurer's April 12, 2000 denial should be set aside pursuant to *Croman Corp. v. Serrano*, 163 Or App 136 (1999), because a combined condition must be accepted before it can be denied under ORS 656.262(6)(c).[1]

We begin by reviewing the procedural posture of this case. On March 4, 1999, claimant compensably injured his low back. On June 3, 1999, the insurer accepted a disabling "left lumbar sacroiliac strain." On April 12, 2000, the insurer issued a letter to claimant entitled "MODIFIED NOTICE OF ACCEPTANCE." (Ex. 27). In this letter, the insurer identified the accepted conditions as:

> "[L]eft lumbar sacroiliac strain combined with pre-existing and non-compensable lumbar degenerative disc disease and facet arthropathy, so long as and to the extent that the injury is and remains the major contributing cause of the disability or of the need for treatment of the combined condition." (*Id.*; underlining in original).

Also on April 12, 2000, the insurer issued a letter that stated, in part:

> "While employed by [the insured], you filed a claim for a left lumbar sacroiliac strain sustained on March 4, 1999 that combined with pre-existing non-compensable lumbar degenerative disc disease and facet arthropathy. That claim has been accepted so long as and to the extent that the left lumbar sacroiliac strain injury is and remains the major contributing cause of your disability or need for treatment of the combined condition. * * *

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[1] ORS 656.262(6)(c) provides:

"An insurer's or self-insured employer's acceptance of a combined or consequential condition under ORS 656.005(7), whether voluntary or as a result of a judgment or order, shall not preclude the insurer or self-insured employer from later denying the combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition."

"Medical information in your file shows that your injury of March 4, 1999 no longer remains the major contributing cause of the disability of your combined condition or the major contributing cause of the need for treatment of your combined condition. Furthermore, medical evidence shows that the major contributing cause of your disability and need for treatment is the pre-existing non-compensable conditions.

"Therefore, without waiving further questions of compensability, pursuant to ORS 656.262(7)(b) we respectfully submit this denial of your combined condition as well as your pre-existing lumbar degenerative disc disease and facet arthropathy. * * * " (Ex. 28).

The issue is whether the insurer's April 12, 2000 denial, which was issued the same day as the April 12, 2000 "combined condition" acceptance, is procedurally valid. In *Croman Corp.*, the court stated that: [w]hen ORS 656.005(7)(a)(B) is read with the language of ORS 656.262(6)(c), it is clear that the combined condition must have been accepted before it may be denied under the statute." 163 Or App at 141.

In *Blamires v. Clean Pak Systems*, 171 Or App 263, 267 (2000), the court explained that "[t]he rule of *Croman Corp.* is that, under the wording of ORS 656.262(6)(c), the acceptance of a combined condition must precede the denial of a combined condition."

Here, the insurer issued an acceptance of claimant's "left lumbar sacroiliac strain" on June 3, 1999. Ten months later, on April 12, 2000, the insurer issued an amended acceptance accepting "left lumbar sacroiliac strain combined with a pre-existing and non-compensable lumbar degenerative disc disease and facet arthropathy, so long as and to the extent that the injury is and remains the major contributing cause of the disability or of the need for treatment of the combined condition." On the same day, the insurer issued a denial of compensability of claimant's "combined condition" on the basis that claimant's March 4, 1999 injury no longer remained the major contributing cause of his disability or need for treatment.

The question, then, is whether a denial issued on the same day as an acceptance is "later in time" than an acceptance of a combined condition. We recently addressed a similar issue in *Jeff E. White*, 53 Van Natta 220 (2001).

In *White*, the carrier simultaneously accepted and denied a "combined condition" in one document. We concluded that the word "later" in ORS 656.262(6)(c) is sufficiently broad to include both the issuance of separate documents evidencing the acceptance and denial of a "combined condition," as well as the acceptance and "later" denial of a "combined condition" in the same document. We further concluded that, in the absence of a clear legislative intention (as manifested in the statutory language of ORS 656.262(6)(c)) to require separate acceptances and denials of "combined conditions" or to prohibit a so-called "simultaneous" acceptance/denial of "combined conditions" (as of a date "later" than the acceptance date), we were not prepared to extend the statute beyond its parameters. Finally, we concluded that a denial of a "combined condition" issued subsequent to an acceptance of the "combined condition" is procedurally permissible under ORS 656.262(6)(c).

Applying the *White* analysis of the statute to this case, we agree with the ALJ's conclusion. Even though both notices were issued on April 12, 2000, the denial refers to the acceptance of the combined condition.[2] Contrary to claimant's argument that because both notices were issued the same date they were "simultaneous" and thus impermissible under ORS 656.262(6)(c), we find the denial's reference to the acceptance of the combined condition to be sufficient evidence to sustain the inference

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[2] By modifying the original acceptance without specifying a date different from the date of the initial acceptance, the modified acceptance reverts back to the June 3, 1999 acceptance, superceding and augmenting the initial acceptance of the left lumbar sacroiliac strain. In other words, modification of the previously accepted condition does not constitute a "new" acceptance as of April 12, 2000. *See* ORS 656.262(6)(b)(F) (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").

that the insurer had already accepted the combined condition.[3] Thus, because the insurer's denial of a "combined condition" issued subsequent to its acceptance of the "combined condition," it is procedurally valid.

We next turn to the compensability issue(s). We adopt and affirm the ALJ's opinion on this issue, with the following supplementation to address the arguments claimant raises on review.

First, claimant contends that the medical records do not establish that he had a combined condition prior to the determination that he was medically stationary, and that he received no medical treatment for his preexisting condition. After *de novo* review of the medical evidence, we disagree.

In July 1999, after evaluation of claimant's continuing pain by Dr. Henderson, Dr. Delgado diagnosed claimant with "persistent pattern of low back LS pain with musculoskeletal source, diskogenic component with possible nerve root impingement right sided and occasional left sided intermittent sciatic sx possibly associated with diskogenic component." (Ex. 15). This condition was treated conservatively. In November 1999, Dr. Delgado continued to diagnose claimant with a lumbar strain with evidence of "discogenic disease, previous moderate disk dessication, midline bulge L4-L5 though w/o herniation evident." (Ex. 21).

Moreover, in their February 23, 2000 report, Drs. Bald and Farris opined that claimant had lumbar degenerative disc disease and facet arthropathy that preexisted his March 4, 1999 work injury (which was established by x-ray and MRI evidence). (Exs. 14, 19, 25, 29). They also opined that claimant's complaints related to his low back and left leg were the result of a lumbosacral strain superimposed on preexisting degenerative disc disease. Dr. Kirkpatrick, who had evaluated claimant's condition for Dr. Delgado, concurred with Drs. Bald and Farris' opinion. There is no contrary opinion.[4] Consequently, based on this medical evidence, we find that claimant experienced a "combined condition" and that combined condition was the subject of claimant's medical treatment.

Finally, claimant argues that the denial should be overturned as an impermissible prospective denial. Claimant reasons that, because a carrier's acceptance of a "resolved" condition is an impermissible denial of future benefits, and the statutory language "for so long and to the extent that * * *" does not differ from the use of the word "resolved," the insurer's denial is, in effect, an impermissible prospective denial. We do not agree.

First, we do not find that the phrase "so long and to the extent that * * *" is equivalent to the word "resolved." The phrase appears in ORS 656.005(7)(a)(B), which 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.*" (Emphasis added).

The statute establishes that a combined condition is compensable only under certain circumstances, namely, during the period that the work injury is the major contributing cause of the disability or need for treatment of the combined condition. In other words, a combined condition is compensable only during the period that the work injury is the major contributor to the disability or need for treatment of the combined condition. When the contribution by the work injury changes so that it is no longer the major contributing cause of the disability or need for treatment of the combined condition, the combined condition itself then becomes noncompensable.

In contrast, to "resolve" means "to restore to the normal state after some pathologic process."[5]

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[3] Moreover, under *White*, even if a denial was "simultaneous" with the acceptance, the denial would be for a "subsequent period" as long as an acceptance is identified in the document and precedes the date of denial. *See White*, 52 Van Natta at 221 n 2.

[4] Apparently Dr. Delgado provided some sort of correspondence dated March 15, 2000, regarding Drs. Bald and Farris' February 23, 2000 evaluation, according to Dr. Bald's July 18, 2000 addendum to the February 23, 2000 evaluation. Dr. Delgado's March 15, 2000 correspondence is not a part of the record.

[5] *Dorland's Illustrated Medical Dictionary*, Twenty-fifth Ed., 1974, p. 1346.

There is nothing in the language of the statute to indicate that the change in the relative contribution by the work injury to the disability or need for treatment of the combined condition is equivalent to the resolution of the combined condition; *i.e.*, that the combined condition has become restored to its normal state. Rather, the pathologic process of the combined condition may continue; it is only the relative amount of the contribution to the disability or the need for treatment of the combined condition that has changed. Thus, we conclude that the insurer's "current condition" denial is not an impermissible prospective denial.

ORDER

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

Board Member Phillips Polich specially concurring.

I agree with the outcome reached by the lead opinion, and find it consistent with my discussion of the statutory language of ORS 656.262(6)(c) in my dissent in *Jeff E. White*, 52 Van Natta at 222 (with the exception of footnote 3). As I stated in *White*, simultaneous acceptance and denial is incompatible with the language of ORS 656.262(6)(c), which requires that a carrier "later" deny a "combined condition." Here, the lead opinion found that, even though both notices were issued the same day, the insurer's denial of the "combined condition" issued subsequent to its acceptance of the "combined condition" and was, therefore, procedurally valid. Consequently, in accord with my discussion in *White*, the "combined condition" denial was premised on a "later" event, namely, that there was a change in the medical condition indicating that the compensable injury had "ceased" to be the major contributing cause of the previously accepted combined or consequential condition. For these reasons, I respectfully specially concur.

March 29, 2001 Cite as 53 Van Natta 387 (2001)

In the Matter of the Compensation of
GEORGE E. DUARTE, JR., Claimant
WCB Case No. 00-03067
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Meyers and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the SAIF Corporation's denial of his occupational disease claim for a positive tuberculosis (TB) test. On review, the issue is compensability.

We adopt and affirm the ALJ's order on this issue, with the following supplementation.

The ALJ upheld SAIF's denial, concluding that claimant failed to prove that his positive TB test arose out of the course of employment. In reaching this conclusion, the ALJ reasoned that claimant failed to affirmatively prove that his occupational disease was related to his employment. *See* ORS 656.266; *see also Rhonda L. Hittle*, 47 Van Natta 2124 (1995) (an increased risk of exposure to TB at work was insufficient evidence of actual exposure to the disease); *Tamara Hergert*, 45 Van Natta 1707 (1993) (same).

On review, claimant contends that Dr. Gilmour's opinion is sufficient to establish compensability and requests that we reexamine our position in the above-cited cases in light of the medical evidence that meets the standard of proof by a preponderance of evidence based on medical probability.

We need not address our rulings in the above-cited cases because, for the reasons explained below, we agree with the ALJ that claimant's claim is not compensable.

Claimant has the burden to prove the compensability of his occupational disease claim by a preponderance of the evidence. ORS 656.266. He must prove that his work activities are the major contributing cause of the disease. ORS 656.802(2)(a). Because causation of claimant's condition presents a complex medical question, expert medical opinion is necessary to establish causation. *See Uris v. Compensation Department*, 247 Or 420 (1967). Claimant must prove to a reasonable medical probability that his work activities caused his disease.

The issue in this case is whether Dr. Gilmour's opinion is sufficient to establish the necessary causal relationship between claimant's positive TB test and his work exposure. We conclude that it is not.

Claimant is a ground ambulance paramedic who transports civilian patients from all walks of life. Claimant relies on the opinion of Dr. Gilmour. Dr. Gilmour stated that it was "medically probable that the exposure which resulted in the positive PPD test occurred within the course and scope of his employment as a paramedic. This opinion is based on [my] knowledge of the potential for exposure as a health care professional versus exposure in the general population." (Ex. 6).

There is no documented evidence that claimant was actually exposed on the job to a person infected with TB. Moreover, the record is silent regarding the incidence of TB in the population with which claimant came into contact. Dr. Gilmour stated that he based his opinion that claimant was exposed to TB at work on a statistical analysis. However, when questioned regarding the statistical likelihood of claimant's being exposed at work, he was unable to do so. (Ex. 7-4, -10, -11). Instead, Dr. Gilmour admitted that, when he stated that it was medically probable that claimant's exposure came at work, what he was really doing was ruling out other likely exposures by engaging in deductive reasoning.

Not only is Dr. Gilmour's unsupported statistical analysis unpersuasive, but he admitted that his opinion that claimant's positive TB test was probably due to his work was based on deductive reasoning; *i.e.*, because it was not proven that claimant's exposure to active TB was due to other causative agents, the positive TB test must have been caused by the work environment. Taken together, Dr. Gilmour's reports are inadequate to establish more than a possible exposure to TB at work.

Consequently, claimant has failed to prove compensability by a preponderance of the evidence. ORS 656.266; *Lenox v. SAIF*, 54 Or App 551 (1981) (claimant must prove claim by preponderance of the evidence); *Gormley v. SAIF*, 52 Or App 1055 (1981) (a possibility of a causal relationship is insufficient to meet a claimant's burden of proof). Accordingly, we affirm the ALJ's decision upholding SAIF's denial of claimant's occupational disease claim for TB exposure.

ORDER

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

Board Chair Bock concurring.

I agree that statistics cannot be used in this case to establish compensability any more than in other cases. However, nothing precludes the legislature from determining that it would be good public policy to create legal presumption of compensability for certain diagnoses or exposures for emergency medical technicians and other health care workers, similar to the presumption of compensability for lung, respiratory, hypertension or cardiovascular diseases suffered by fire fighters.

In the Matter of the Compensation of
ANTHONY L. ST. JULIEN, Claimant
WCB Case No. 00-05022
ORDER ON REVIEW
Nicholas M. Sencer, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Mills' order that declined to award temporary disability benefits from July 28, 1999 through December 12, 1999. On review, the issue is temporary disability.

We adopt and affirm the ALJ's order with the following supplementation. We write only to address claimant's argument that the insurer's continued payment of time loss compensation should be construed as a "waiver" of any objection to the sufficiency of the authorization. We disagree.

Waiver is "the intentional relinquishment of a known right." *Wright Schuchart Harbor v. Johnson*, 133 Or App 680, 685 (1995) (quoting *Drews v. EBI Companies*, 310 Or 134, 150 (1990)). Waiver must be plainly and unequivocally manifested, either "in terms or by such conduct as clearly indicates an intention to renounce a known privilege or power." *Id.* (quoting *Great American Ins. v. General Ins.*, 257 Or 62, 72 (1970)). We find no persuasive evidence that the insurer intended to relinquish its right to challenge the propriety of the authorization for time loss. Moreover, ORS 656.262(10) provides, in part:

> "Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability, nor shall mere acceptance of such compensation be considered a waiver of the right to question the amount thereof."

We are not persuaded by claimant's argument that the insurer's continued payment of time loss compensation constitutes a "waiver" of its right to challenge the sufficiency of the time loss authorization.

ORDER

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

March 29, 2001 Cite as 53 Van Natta 389 (2001)

In the Matter of the Compensation of
DELINDA S. FRENCH-DAVIS, Claimant
WCB Case No. 00-04541
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 declined to direct the insurer to close her lumbar strain injury claim. Claimant also requests that we award an assessed fee under ORS 656.382(1) for the insurer's allegedly unreasonable claim processing. In its respondent's brief, the insurer requests that we dismiss the hearing request as untimely under ORS 656.319(6). On review, the issues are claim processing, attorney fees, and the timeliness of claimant's hearing request challenging the insurer's claim processing. We vacate the ALJ's order and dismiss the hearing request.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the exception of the "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

The ALJ declined claimant's request that the insurer be ordered to close her lumbar strain condition. That condition was accepted after a February 8, 1994 Notice of Closure had closed the originally accepted left knee portion of the claim. The ALJ reasoned that a May 1995 stipulation, whereby the insurer had agreed to accept and process the lumbar strain condition, constituted the acceptance of the lumbar condition, rather than a December 16, 1997 Notice of Acceptance that formally accepted the condition. Because the law in 1995 did not require reopening of a claim after "post-closure" acceptance of a new condition, the ALJ determined that the insurer was under no obligation to reopen and re-close the lumbar claim. Given this finding, the ALJ declined to address the insurer's argument that the two-year statute of limitations provided in ORS 656.319(6) barred claimant from litigating the claim processing issue.

On review, claimant contends that the lumbar strain acceptance did not occur until the Notice of Acceptance was issued in December 1997, at which time the insurer was obligated to reopen the claim for processing of the claim under ORS 656.262(7)(c). Moreover, claimant asserts that, even if the lumbar strain condition was accepted in May 1995, the 1997 amendments to ORS 656.262(7)(c) were fully retroactive and required the insurer reopen the claim for processing of the lumbar strain component under cases such as *Fleetwood Homes of Oregon v. Vanwechel*, 164 Or App 637 (1999); *Mario R. Castaneda*, 49 Van Natta 2135 (1997); and *Ronald G. Smith, Sr.*, 49 Van Natta 1807 (1997). Finally, arguing that the

insurer's claim processing was unreasonable, claimant requests that we award an assessed fee under ORS 656.382(1) for the insurer's allegedly unreasonable resistance to the payment of compensation.

The insurer responds by contending that the ALJ correctly determined that the lumbar strain condition was accepted by stipulation in 1995 and that, under the prevailing legal authority at the time of acceptance, a carrier was under no legal obligation to reopen a claim after a "post-closure" acceptance of a new condition. Moreover, the insurer argues that, if we determine that claim acceptance did not occur until December 1997, claimant's June 2000 hearing request was untimely under ORS 656.319(6) because it occurred more than two years after the acceptance. Claimant responds to the insurer's timeliness argument by asserting that her hearing request was within two years of the insurer's failure to process the lumbar strain condition, pointing to letters her counsel wrote to the insurer in October 1998 and April 2000, both of which were within two years of her hearing request and which requested that the insurer process the lumbar strain condition.

For the following reasons, we agree with claimant that acceptance of her lumbar strain condition occurred in December 1997. Nevertheless, we conclude that claimant's hearing request was untimely under ORS 656.319(6) and, therefore, dismiss the hearing request.

The May 1995 stipulation provided that the insurer "agrees to accept claimant's claim for lumbar strain and will process according to Oregon Workers' Compensation law." (Ex. 23-2). As a general rule, whether an acceptance occurs is a question of fact. *SAIF v. Tull*, 113 Or App 449, 454 (1992). Here, we conclude that, as a factual matter, the May 1995 stipulation did not accept the lumbar strain condition. The agreement merely provided that the insurer agreed to accept and process the lumbar strain condition, implying that the actual acceptance and processing would happen at a future date. The actual acceptance did not occur until December 1997, when the insurer issued its Notice of Acceptance of the lumbar condition.[1]

However, the exact date of the acceptance is not crucial to our resolution of this dispute. That is because we conclude that, regardless of when the lumbar condition was accepted (May 1995 or December 1997), claimant's hearing request was more than two years after the insurer's failure to process the claim. Thus, claimant's hearing request is time-barred.

ORS 656.319(6) provides:

> "A hearing for failure to process or an allegation that the claim was processed incorrectly shall not be granted unless the request for hearing is filed within two years after the alleged action or inaction occurred."

Under that statute, claimant's hearing request is time-barred unless it was within two years of the alleged inaction, *i.e.*, the failure to process. The alleged inaction may have occurred in December 1997, when the insurer issued its acceptance notice. This was after the 1997 amendments to ORS 656.262(7)(c) that required a carrier to reopen a claim for processing after a "post-closure" acceptance of a new condition. If this is the case, the June 2000 hearing request would have been more than two years after the alleged inaction.

On the other hand, the alleged inaction may have been after claimant specifically requested processing of the lumbar strain condition in October 1998 and in April 2000. In either of those instances, the alleged inaction would have been within the two-year time frame of ORS 656.319(6).

After considering the issue, we find that, under these particular circumstances, 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. At that time, ORS 656.262(7)(c) unambiguously provided that, if, as in this case, a condition was found compensable after claim closure, the insurer "shall" reopen the claim for processing. Given the mandatory language of the statute, we conclude that the insurer's duty of reopening the claim for processing of the lumbar condition arose upon its acceptance of that condition in December 1997. Because the insurer failed to comply with that duty, it was that inaction that ultimately led to claimant's subsequent requests for processing in October 1998 and April 2000.

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[1] Our order should not be construed as holding that a stipulation can never be an acceptance. Rather, under the circumstances of this case, we have interpreted this stipulation as stating that the carrier would issue an acceptance in the future.

Claimant cites *Camilla S. Kosmoski*, 52 Van Natta 1573 (2000), and *Robert A. Olson*, 52 Van Natta 1540 (2000), as support for her argument. In *Olson*, the alleged claims processing violation was the carrier's failure to process the claimant's February 2, 2000 omitted medical condition claim. In *dicta*, we determined that the period between the alleged failure to process the medical meniscus and patellar conditions under ORS 656.262(6)(d) and the claimant's request for hearing was well within the two year limitation of ORS 656.319(6). *Olson*, 52 Van Natta at 1541. In *Kosmoski*, we also found in *dicta* that the period between the alleged failure to process the claim under ORS 656.262(7)(c) and the request for hearing was less than four months, which was well within the two year statutory period allowed under ORS 656.319(6). 52 Van Natta at 1574 n. 3.

However, as claimant concedes, neither case is directly on point. In *Olson*, we were not required to make a determination of the timeliness issue since the issue was not properly raised at hearing. 52 Van Natta at 1541. In *Kosmoski*, the timeliness issue was also not properly raised. Nevertheless, it is unclear what date was used to determine the triggering of the two-year limitations period in ORS 656.319(6). 52 Van Natta at 1574 n. 3.

Accordingly, we conclude that neither of these cases precludes us from finding that claimant's June 2000 hearing request contesting the insurer's failure to process the lumbar condition was untimely because it was more than two years after the insurer's inaction in December 1997. Therefore, we dismiss the hearing request under ORS 656.319(6).[2]

ORDER

The ALJ's order dated October 26, 2000 is vacated. Claimant's hearing request is dismissed.

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[2] Given our resolution of this case, we need not address the attorney fee issue.

March 29, 2001 Cite as 53 Van Natta 391 (2001)

In the Matter of the Compensation of
JORGE A. SARAVIA, Claimant
WCB Case No. 00-05304
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Sather, et al, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that affirmed an Order on Reconsideration awarding no unscheduled permanent disability for a low back injury. On review, the issue is extent of unscheduled permanent disability.

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

Claimant, a welder, compensably injured his low back in August 1998 while lifting a long, heavy pipe. (Ex. 2-1). The claim was accepted in September 1998 as a disabling L4-5 disc herniation with left L5 radiculopathy. (Ex. 32). In February 2000 the insurer issued a Notice of Closure that awarded 20 percent (64 degrees) unscheduled permanent disability. (Ex. 34).

Claimant requested reconsideration, challenging, among other things, the medical impairment findings used to rate disability. (Ex. 137). Following a medical arbiter's exam performed by Dr. Berquist, an Order on Reconsideration reduced claimant's unscheduled permanent disability award to zero. (Ex. 140). Claimant requested a hearing.

The ALJ relied on Dr. Berquist's medical arbiter exam and determined that claimant had no permanant impairment as the result of the accepted disc condition. Consequently, the ALJ affirmed the Order on Reconsideration.

On review, claimant contends: (1) the preponderance of the evidence supports a finding that claimant has measurable impairment as a result of his herniated disc condition; and (2) the insurer is precluded in benefiting from a reduction in permanent disability awarded by its own Notice of Closure. We disagree with claimant's assertions.

We address the preclusion issue first. We recently addressed this issue in *Eliseo Roman*, 53 Van Natta 273 (2001). In *Roman*, we held that when a carrier issued a Notice of Closure and the claimant subsequently requested reconsideration, after which an Order on Reconsideration reduced the Notice of Closure's award, the carrier was not precluded from defending the Order on Reconsideration. The procedural facts in *Roman* are identical to those presented here. Consequently, for the reasons stated in *Roman*, we conclude that the insurer is not precluded from defending the Order on Reconsideration.

Having concluded that the insurer is not precluded from defending the Order on Reconsideration, we now evaluate the extent of claimant's unscheduled permanent disability. 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 evidence establishes a different level of impairment, the impairment is established by the preponderance of evidence. (*Id.*)

Here, medical arbiter Berquist found claimant had restricted ranges of motion, but opined that those restrictions were not the result of the accepted herniated disc, but from degenerative disc disease.[1] (Ex. 139-2). Dr. Berquist's opinion is based in part on the December 9, 2000 MRI and myelogram ordered by Dr. Brett (attending physician at closure) showing "no evidence of nerve impingement" and "only minimal disc bulging at L4-5 and L5-S1 and minor degenerative changes."[2] (Ex. 132; 139-2).

Because Dr. Berquist's opinion that claimant's accepted condition (herniated L4-5 disc) had resolved is compatible with Dr. Brett's findings that the L4-5 disc evidenced only minimal bulging, we find Dr. Berquist's impairment findings persuasive. Therefore, we conclude that claimant's reduced ranges of motion are not the result of the accepted disc condition.[3] Consequently, we conclude that the preponderance of the medical evidence does not establish a different level of impairment than that determined using the medical arbiter exam.[4] Accordingly, we agree with the ALJ that the Order on Reconsideration should be affirmed.

ORDER

The ALJ's order dated December 20, 2000 is affirmed.

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[1] Dr. Berquist opined that the herniated disc had resolved. (Ex. 139-2).

[2] The quoted material is Dr. Brett's interpretation of the MRI and myelogram testing. (Ex. 132).

[3] We acknowledge claimant's argument that in accepting a L4-5 herniated disc, the insurer necessarily accepted any preexisting degenerative disc disease at that level as part of a "combined condition." We note however, that the insurer specifically and unambiguously accepted "disc herniation, L4-5, w/ left L5 radiculopathy." (Ex. 32-1). It did not accept the L4-5 disc as a "combined condition." Nor did it accept degenerative disc disease as a "combined condition." Consequently, we find the insurer did not accept a "combined condition." *See Jose L. Rios*, 52 Van Natta 1873, 1874 (2000).

[4] We also note that Dr. Brett's closing examination does not appear to be complete. In particular, we note that he indicated claimant had minor degenerative changes at L4-5 and L5-S1, but he did not indicate what effect, if any, the degenerative changes had on claimant's reduced ranges of motion. Consequently, we consider Dr. Brett's opinion regarding impairment attributable to the accepted condition, conclusory, and, as such, not persuasive. *See Moe v. Ceiling Systems, Inc.*, 44 Or App 429, 433 (1980).

In the Matter of the Compensation of
RONALD G. COX, Claimant
WCB Case No. 00-03726
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Howell's order that upheld the insurer's denial of his claim for degenerative disc disease, degenerative joint disease, lumbar degeneration, spondylosis and chronic back pain. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following change and supplementation. In the fifth paragraph on page 2, we change the date to "March 5, 1999."

On review, we write only to address claimant's alternative argument that the insurer should reopen and process his claim for L5-S1 degenerative disc disease under ORS 656.262(7)(c). Claimant contends that, because the ALJ found that he had a combined condition at L5-S1, that necessarily involves setting aside the insurer's denial of his L5-S1 degenerative disc disease. He requests an attorney fee for prevailing over a denied claim.

The insurer relies on the ALJ's conclusion that its acceptance of a left protruding disc at L5-S1 was adequate. The insurer contends that claimant's request that it accept a protruding disc at L5-S1 combined with preexisting degenerative disease is merely a "word game."

The ALJ explained that the insurer had accepted a "protruding disc at L5-S1, left" and that was the condition identified by Drs. Denekas and Scheinberg as a "combined condition." The ALJ determined that the record did not establish the existence of any broader combined condition than that specifically accepted by the insurer and, therefore, the insurer's denial was upheld. For the following reasons, we agree with the ALJ.

In May 2000, Drs. Denekas and Scheinberg examined claimant on behalf of the insurer. They diagnosed degenerative lumbar spondylosis, "[c]hronic back pain and left leg pain, etiology unknown[,]"degenerative disc disease and degenerative joint disease. (Ex. 22-5). They found that the cause of claimant's ongoing complaints was unclear because there were multiple nonorganic features in his examination and he had no response to treatment of any kind. (Ex. 22-6). They did not believe claimant's current treatment was a direct result of the October 1998 injury. (Ex. 22-7). In response to the insurer's question as to whether claimant's work exposure had worsened the underlying pathology or merely exacerbated his symptoms, they responded:

> "If one assumes that the disk protrusion at the L5-S1 level was produced by his work activities, then we would feel that the work activity is the major contributing cause of his disk protrusion at the L5-S1 level. Other non-work factors would include the preexisting degenerative changes as outlined above. The disk protrusion at the L5-S1 level is secondary to the work exposure, in a previously degenerative disk. This would be considered a worsening of the pathology of the disk." (Ex. 22-7, -8).

Drs. Denekas and Scheinberg concluded that claimant's L5-S1 disc protrusion had received adequate treatment and other factors were causing his ongoing complaints. (Ex. 22-8).

Based on the report from Drs. Denekas and Scheinberg, we agree with the ALJ that the condition identified as a combined condition is the "protruding disc at L5-S1, left," which has already been accepted by the insurer. In other words, the "worsening pathology" of the degenerative disc at L5-S1 was the protrusion at L5-S1, which has already been accepted. We agree with the ALJ that the medical evidence does not establish the existence of any broader combined condition than that specifically accepted by the insurer.

ORDER

The ALJ's order dated December 1, 2000 is affirmed.

In the Matter of the Compensation of
CARL A. NOTTAGE, Claimant
WCB Case Nos. 00-04893 & 00-03316
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
VavRosky, et al, Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order that set aside a portion of its denial of multiple physical and mental conditions. In his brief, claimant contends that: (1) the ALJ incorrectly upheld the employer's denial to the extent that it denied visual disturbances; and (2) that the ALJ incorrectly set aside an Order on Reconsideration rescinding a Notice of Closure as prematurely issued. On review, the issues are compensability and premature claim closure.[1] We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt and affirm the ALJ's reasoning and conclusions.

Premature Claim Closure

The employer issued a Notice of Closure on March 3, 2000, from which claimant requested reconsideration, raising, among other issues, premature closure. On June 8, 2000, a reconsideration order rescinded the closure notice as prematurely issued.

The Appellate Review Unit (ARU) reasoned that the record lacked "sufficient information" to determine permanent impairment. *See* ORS 656.268(1)(a). Specifically, the ARU noted that the attending physician, Dr. Goering, had not concurred with the medical report on which the closure was based, a February 9, 2000 report from a panel of examining physicians (Drs. Duncan and Reimer). (Ex. 169-2). Moreover, the ARU concluded that the February 9, 2000 medical report, itself, contained insufficient information to determine impairment.

Applying *Ball v. The Halton Company*, 167 Or App 464 (2000), the ALJ set aside the reconsideration order, finding that the employer's closure notice was not improper. The ALJ reasoned that, because the record established that claimant's accepted conditions were medically stationary and that claimant was released for modified work, the closure was statutorily valid. *See former* ORS 656.268(4)(a) and (b).

On review, the Department observes that, under *amended* ORS 656.268, a claim may now be closed when a worker is medically stationary and there is "sufficient information" to determine permanent impairment. *See* ORS 656.268(1)(a). Noting that the amended statute applies to this claim that was closed after the effective date (October 23, 1999) of the 1999 amendments to ORS 656.268, the Department asserts that the ALJ improperly relied on the former statute, which required that a worker be medically stationary and released for regular or modified work. *Former* ORS 656.268(4)(a) and (b). Moreover, the Department argues that the case on which the ALJ relied (*Ball*) is not applicable because it interpreted the former statute. Thus, the Department contends the ALJ erred in setting aside the reconsideration order.

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[1] The Department has participated in this proceeding under ORS 656.726(4)(h), challenging that portion of the ALJ's order that set aside the reconsideration order and reinstated the closure notice.

At the outset, we agree with the Department's reasoning that the 1999 amendments to ORS 656.268 apply to this claim. ORS 656.268(1)(a) now 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 436-030-015(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), a decision issued subsequent to the ALJ's order, 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.

Here, claimant was not engaged in training at the time of claim closure. However, unlike *Garibay*, there was no information in this case to determine permanent impairment. The employer's closure was based on the February 9, 2000 report of impairment findings by examining physicians Reimer and Duncan. (Ex. 159). However, 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).

Moreover, we have previously held that, to be consistent with ORS 656.245(2)(b)(B) and ORS 656.268(7), the "preponderance of medical evidence" standard prescribed by the disability standards to determine a worker's level of impairment is limited to the above three medical sources. *Adam J. Delfel*, 50 Van Natta 1041, 1043 (1998). Thus, consideration of an examining physician's opinion regarding a worker's impairment is not appropriate, unless that opinion has been concurred with by the worker's attending physician. Therefore, in this case, because the attending physician, Dr. Goering, did not concur with the Reimer/Duncan report, that report could not legally be used to determine impairment.[2]

Because Dr. Goering, himself, did not provide any information regarding claimant's permanent impairment and, in fact, believed that claimant's medical conditions were not medically stationary prior to the claim closure (Ex. 161), we conclude that there was not "sufficient information" available to the employer to determine impairment when it closed the claim on March 2, 2000. Accordingly, we conclude that the reconsideration order correctly rescinded the Notice of Closure. We, therefore, reverse this portion of the ALJ's order. We further reinstate and affirm the Order on Reconsideration.

Attorney Fees

Because we have affirmed that portion of the ALJ's order that set aside a portion of the employer's denial, 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 $1000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

Claimant's attorney is also entitled to an "out-of-compensation" fee for his services at hearing and on review regarding the premature claim closure 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 the employer directly to claimant's counsel. OAR 438-015-0055(1).

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[2] The employer cites medical evidence from other physicians (Drs. Arbeene, Mitchell and Davidson) as providing "sufficient information" to close the claim. However, Dr. Goering did not concur with those reports, either.

ORDER

The ALJ's order dated October 24, 2000 is reversed in part and affirmed in part. That portion of the ALJ's order that set aside the Order on Reconsideration and reinstated the Notice of Closure is reversed. The Order on Reconsideration is reinstated and affirmed. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the employer. Claimant's attorney is also 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.

March 29, 2001 Cite as 53 Van Natta 396 (2001)

In the Matter of the Compensation of
LARRY THUROW, Claimant
WCB Case Nos. 00-01370 & 00-00234
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorney
Jerry Keene, Defense Attorney

The self-insured employer requests reconsideration of our March 9, 2001 order that affirmed an Administrative Law Judge's (ALJ's) order that: (1) set aside its partial denial of claimant's injury claim for an L2-3 disc condition; (2) affirmed a Department order classifying the claim as disabling; and (3) awarded an attorney fee under ORS 656.382(2) regarding the classification issue.

The employer argues that we erred in evaluating the medical evidence. Having considered the employer's arguments, the record, and our prior order (that adopted the ALJ's order), we conclude that our prior order adequately explained why Dr. Misko's opinion is persuasive and the contrary opinions are not persuasive.

The employer also argues that the claim for an L2-3 disc condition should be classified separately from the accepted low back strain claim, under *Johansen v. SAIF*, 158 Or App (1999). We find *Johansen* distinguishable, because it involved a "new medical condition" claim under ORS 656.262(7)(a). A "new medical condition" is one that arises after claim acceptance. *See Johansen*, 158 Or App at 679. In this case, the persuasive medical evidence indicates that claimant's L2-3 disc condition arose before, not after, claim acceptance. Therefore, this is not a "new medical condition" claim and *Johansen* is not controlling. Accordingly, we continue to conclude that claimant's July 12, 1999 injury claim was properly reclassified as disabling, based on Dr. Misko's time loss authorization.

Finally, we continue to find claimant entitled to an attorney fee for prevailing on the classification issue, as explained in our initial order.

Accordingly, our March 9, 2001 order is withdrawn. On reconsideration, we republish our March 9, 2001 order, as supplemented herein. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

WORKERS' COMPENSATION CASES

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Cite as 331 Or 362 (2000) December 14, 2000

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of George D. Koskela, Claimant.

GEORGE D. KOSKELA, Petitioner on Review,
v.
WILLAMETTE INDUSTRIES, INC., Respondent on Review.
(WCB 95-08576; CA A97325; SC S46351)

En Banc
On review from the Court of Appeals.*
Argued and submitted January 6, 2000.
David W. Hittle, Burt, Swanson, Lathen, Alexander, and McCann, Salem, argued the cause and filed the brief for petitioner on review.
David L. Johnstone, VavRosky, MacColl, Olson, Bush & Pfeifer, P.C., Portland, argued the cause and filed the brief for respondent on review.
Julene M. Quinn, Salem, filed a brief on behalf of *amici curiae* SAIF Corporation and South Hills Health Care Center.
Phil Goldsmith, Portland, filed a brief on behalf of *amici curiae* Oregon Trial Lawyers Association, Legal Aid Services of Oregon, Oregon Advocacy Center, Oregon Law Center, and Oregon AFL-CIO. With him on the brief was Lake James H. Perriguey.
LEESON, J.
The decision of the Court of Appeals is reversed. The order of the Workers' Compensation Board is reversed. The case is remanded to the Workers' Compensation Board for further proceedings.

* Judicial Review from the Workers' Compensation Board. 159 Or App 229, 978 P2d 1018 (1999).

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331 Or 365> The underlying issue in this workers' compensation proceeding is whether claimant is permanently totally disabled.[1] The Workers' Compensation Board (Board) held that claimant is only permanently partially disabled. The Board rejected claimant's assertion that the post-1995 process for determining whether a worker should receive an award of permanent total disability (PTD) benefits facially is invalid under the Due Process Clause of the Fourteenth Amendment to the United States Constitution.[2] In a split, en banc decision, the Court of Appeals affirmed. *Koskela v. Willamette Industries, Inc.*, 159 Or App 229, 978 P2d 1018 (1999). We allowed claimant's petition for review, and, for the reasons that follow, we reverse the decision of the Court of Appeals and the order of the Board. We remand the case to the Board for further proceedings.

The facts relevant to claimant's challenge are not in dispute. Claimant began working for Willamette Industries in 1965. In 1986 and 1989, claimant suffered compensable injuries to his jaw while he was working as a scrubber. Claimant already had an extensive history of medical problems with his temporomandibular joint (TMJ). In June 1994, after multiple surgeries, claimant's treating physician declared claimant medically stationary,[3] but he noted that claimant continued to experience facial swelling and pain when engaged in physical activities.

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[1] An injured worker receives "permanent total disability" (PTD) benefits if the worker is permanently incapacitated "from regularly performing work at a gainful and suitable occupation." ORS 656.206(1)(a). PTD benefits consist of payments in the amount of 66-2/3 percent of the worker's wages, ORS 656.206(2), and are intended to compensate for the wages the worker loses permanently as a consequence of a compensable injury. *See Tee v. Albertsons, Inc.*, 314 Or 633, 640, 842 P2d 374 (1992) (so stating).

[2] The Fourteenth Amendment provides, in part, that no state shall "deprive any person of * * * property, without due process of law[.]"

[3] ORS 656.005(17) provides:

"'Medically stationary' means that no further material improvement would reasonably be expected from medical treatment, or the passage of time."

The declaration that claimant was medically stationary triggered the claim closure process conducted by the Department of Consumer and Business Services (DCBS) for **<331 Or 365/366>** determining the extent of claimant's permanent disability. *See former* ORS 656.268(2)(a) (1993) *renumbered* as ORS 656.268(1)(a) (1999) (claim closure begins after claimant "has become medically stationary"). As part of the claim closure process, claimant underwent three medical examinations that his self-insured employer had ordered. ORS 656.325(1)(a). Employer's medical examiners conducted physical examinations of claimant and reviewed a "surveillance videotape" that employer had made, showing, among other things, claimant mowing his lawn, chopping wood, fishing, and driving his truck. The medical examiners concluded that claimant was capable of performing at least sedentary work. Claimant's physician also reviewed the videotape and agreed that claimant was capable of performing the physical activities depicted on it, but he questioned whether claimant could perform such activities on a regular basis. In October 1994, after reviewing the medical reports from employer's medical examiners and claimant's treating physician, DCBS issued a determination order that awarded claimant 14 percent permanent partial disability (PPD) benefits. *See* ORS 656.268(2) and (5) (1993) (describing DCBS review).

Claimant sought reconsideration, and the matter was assigned to the appellate review unit (ARU) of DCBS. ORS 656.268(5), (6)(a) (1993). When claimant sought reconsideration, ORS 656.283(7) (1993) provided, in part:

> "Nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present evidence at hearing and to establish by a preponderance of the evidence that the standards * * * for evaluation of the worker's permanent disability were incorrectly applied in the reconsideration order pursuant to ORS 656.268."

The Court of Appeals had construed that wording as permitting a party to introduce evidence at hearing that it had not introduced previously at reconsideration. *Safeway Stores, Inc. v. Smith,* 122 Or App 160, 163, 857 P2d 187 (1993).

In the reconsideration proceeding, claimant bore the burden of proving the extent of his disability. ORS 656.266. Claimant sought to prove that he was permanently totally disabled. To prove that he should receive PTD benefits, **<331 Or 366/367>** claimant had to demonstrate: (1) "permanent total disability status," that is, that his disability permanently prevented him from regularly performing work at a gainful and suitable occupation, (2) that he was willing to seek regular gainful employment, and (3) that he had made reasonable efforts to obtain such employment. *See* ORS 656.206(3) (describing claimant's burden).

In July 1995, the ARU issued an order on reconsideration rejecting claimant's contention that he was permanently totally disabled, but increasing his permanent disability rating from 14 percent to 29 percent PPD. Claimant requested a hearing before an administrative law judge (ALJ). *Former* ORS 656.268(6)(b) (1993) *renumbered* as ORS 656.268(6)(g) (1999); ORS 656.283(1) (1993).

At outset of the hearing, on October 16, 1995, claimant stated that he planned to introduce testimonial evidence from himself, his family physician, a vocational expert, and lay witnesses who knew him. That testimony would regard the extent of his permanent disability, whether suitable sedentary employment was available, his willingness to work, and his efforts to find suitable work. However, on June 7, 1995, while claimant's case was pending before the ARU, a legislative amendment to ORS 656.283(7) took effect. See Or Laws 1995, ch 332, section 69 (providing for effective date of amendment to ORS 656.283(7)). That amendment modified the sentence in ORS 656.283(7), set out above, regarding the rights of the parties to introduce evidence at hearing. The amendment also added a sentence, which we discuss in more detail later in this opinion, that prohibits the introduction of new evidence at hearing and limits the issues that may be considered at hearing to those that have been raised at reconsideration. Relying on the new statutory restrictions, the ALJ refused to admit any additional evidence or testimony in support of claimant's contention that he should receive an award of PTD benefits.

In response to the ALJ's ruling, claimant argued that the 1995 amendments to the claim closure process violated the Due Process Clause of the Fourteenth Amendment, because they deprived him of an oral evidentiary hearing, including the right to appear, to present live testimony, and **<331 Or 367/368>** to cross-examine adverse witnesses in meeting his burden of proof and persuasion regarding

an award of PTD benefits. The ALJ rejected that argument. She then held that, based on the written record that had been compiled during the reconsideration process, claimant had failed to meet his burden of showing that he is permanently and totally disabled. That record contained no evidence about whether suitable sedentary work was available to claimant, no evidence that claimant had searched for work, and no showing that, were it not for his compensable TMJ condition, claimant would be willing to work. Accordingly, the ALJ affirmed the ARU's order on reconsideration that had awarded claimant 29 percent PPD benefits. As noted, the Board affirmed.

Before the Court of Appeals, claimant contended that the 1995 amendments to ORS Chapter 656 violate the Due Process Clause, because they provide no opportunity for a worker who is seeking PTD benefits thoroughly to present evidence on all the elements on which the worker bears the burden of proof and persuasion, and they deny the worker the opportunity to rebut adverse evidence or to cross-examine adverse witnesses. The Court of Appeals' majority weighed claimant's private interest in PTD benefits; the risk of an erroneous deprivation of that interest through the procedures provided for determining the extent of permanent disability and the value, if any, of added or substitute procedural safeguards; and the government's interest, including the fiscal and administrative burdens of additional or substitute procedures. *Koskela*, 159 Or App at 235; *see Mathews v. Eldridge*, 424 US 319, 335, 96 S Ct 893, 47 L Ed 2d 18 (1976) (identifying three-factor test in due process challenges, hereafter "*Mathews* factors"). It then held that "due process principles do not entitle a claimant [seeking PTD benefits] to present evidence through in-hearing testimony rather than through written reports and sworn affidavits." *Koskela*, 159 Or App at 251.

Judge Edmonds concurred. He argued that, because ORS 656.283(7) authorizes the ALJ to "conduct the hearing in any manner that will achieve substantial justice[,]" claimant's facial due process challenge must fail, but that claimants still could bring an "as applied" challenge if an ALJ **<331 Or 368/369>** denied a worker the opportunity for oral presentation of evidence when due process required such an opportunity. *Id.* at 251-52 (quoting ORS 656.283(7)).

Judges De Muniz and Wollheim dissented. They argued, among other things, that determining whether a worker should be awarded PTD benefits necessarily includes an assessment of the worker's credibility and veracity, which requires an ALJ to observe credibility and veracity first hand, and on the record. *Id.* at 255 (De Muniz, J., dissenting), and at 260 (Wollheim, J., dissenting).

We review for errors of law. ORS 656.298(7). However, before addressing claimant's due process challenge to ORS 656.283(7), we must consider a threshold issue that employer argues disposes of this matter. The Due Process Clause of the Fourteenth Amendment applies to state action that deprives a person of a protected property interest.[4] *Cleveland Bd. of Educ. v. Loudermill*, 470 US 532, 538, 105 S Ct 1487, 84 L Ed 2d 494 (1985). Property includes state-created benefits to which a person has become entitled. *Board of Regents v. Roth*, 408 US 564, 577, 92 S Ct 2701, 33 L Ed 2d 548 (1972). A person who has established an entitlement to a state-created benefit has a property interest in the continued receipt of that benefit. *See, e.g., Mathews*, 424 US at 332 (property interest in continued receipt of Social Security disability benefits); *Goldberg v. Kelly*, 397 US 254, 261-62, 90 S Ct 1011, 25 L Ed 2d 287 (1970) (property interest in continued receipt of welfare benefits). Before the Board and the Court of Appeals, employer did not challenge whether claimant had a protected property interest in disability benefits. However, after the case had been submitted to the Court of Appeals, the United States Supreme Court issued an opinion that, in employer's view, calls into question whether claimant has a protected property interest in disability benefits. *American Mfrs. Mut. Ins. Co. v. Sullivan*, 526 US 40, 119 S Ct 977, 143 L Ed 2d 130 (1999). The Court of Appeals did not address **<331 Or 369/370>** that issue, because it determined that ORS 656.283(7) does not violate due process. *See Koskela*, 159 Or App at 234 n 3 ("Given our rejection of the due process challenge, we need not consider *Sullivan's* implications for this case.").

Before this court, employer asserts that *Sullivan* provides the proper basis for resolving this case, because *Sullivan* held that a workers' compensation claimant does not have a property interest in disability benefits. In employer's view, there is no due process constraint on the legislature of the kind that claimant asserts.

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[4] The parties do not dispute that the Board's action in rejecting claimant's claim for PTD benefits was state action for purposes of a federal procedural due process challenge. *See Adickes v. S. H. Kress & Co.*, 398 US 144, 152 90 S Ct 1598, 26 L Ed 2d 142 (1970) ("The involvement of a state official * * * plainly provides the state action essential to show a direct violation of [the] Fourteenth Amendment[.]").

In *Sullivan*, the Court held that, under Pennsylvania's workers' compensation act, claimants do not have a property interest in payments for medical treatments for which they are *eligible* but to which they are not yet *entitled*. *Sullivan*, 526 US at 61.[5] The Court explained that, under Pennsylvania law, workers' compensation claimants seeking payment for medical treatments must "clear two hurdles." *Id.* at 60-61. First, claimants "must prove that an employer is liable for a work-related injury[.]" *Id.* at 61. Second, claimants "must establish that the particular medical treatment at issue is reasonable and necessary." *Id.* The Court concluded that the claimants in that case had cleared the first hurdle but not the second one: "While they indeed have established their initial *eligibility* for medical treatment, they have yet to make good on their claim that the particular medical treatment that they received was reasonable and necessary." *Id.* (emphasis in original). Accordingly, the Court held, the claimants had not established a property interest in payments for medical treatments that had "yet to be found reasonable and necessary." *Id.*

According to employer, workers' compensation claimants in Oregon do not have a protected property interest in permanent disability benefits until they establish through the claim closure process that they are entitled to receive such benefits. Underlying employer's argument is the **<331 Or 370/371>** assumption that workers have no property interest in benefits until they meet their burden of demonstrating the extent of their permanent disability. See ORS 656.266 (setting out burden). That assumption misapprehends the nature of a worker's property interest and the purpose of the claim closure process.

In Oregon, apparently unlike in Pennsylvania, a claimant needs to clear only one hurdle to establish entitlement to compensation benefits. Acceptance of a claim signifies that the worker has met the burden of proving a compensable injury. ORS 656.266; see ORS 656.262(2) ("The compensation due under this chapter *shall* be paid * * * to the person entitled thereto * * * except where the right to compensation is denied" (emphasis added)). The claim closure process begins after a claim has been accepted and a claimant has been declared medically stationary. ORS 656.268(1)(a). The purpose of claim closure is to "determine the extent of the worker's permanent disability," ORS 656.268(1) (emphasis added), not, as employer would have it, the worker's *entitlement* to compensation. Because a claimant whose claim has been accepted is entitled to receive workers' compensation benefits, that claimant has a protected property interest in receiving compensation. *See Roth*, 408 US at 577 ("To have a property interest in a benefit, a person clearly must have * * * a legitimate claim of entitlement to it."). *Sullivan* is not a barrier to reaching claimant's constitutional challenge in this case.

To assess claimant's constitutional challenge, it first is necessary to describe in detail the post-1995 statutory process for determining the extent of a worker's permanent disability. The first step is claim closure. Under ORS 656.268, claim closure is authorized when the worker's condition becomes "medically stationary," as occurred in this case, or when certain other events occur. ORS 656.268(1), (2)(a), (4)(a). DCBS, the insurer, or the self-insured employer is responsible for claim closure. ORS 656.268(1) (1995).[6]

331 Or 372> An insurer or self-insured employer that closes the claim must make findings regarding the extent of the worker's permanent disability by applying standards that are prescribed by DCBS. ORS 656.268(4)(b) (1995) *renumbered as* ORS 656.268(5)(a)) (1999). Those findings are made solely based on medical and vocational reports. The insurer or self-insured employer then must issue a notice to the worker, to the worker's attorney if the worker is represented, and to DCBS stating whether the worker should receive an award of PTD benefits or, if the worker is not determined to be permanently totally disabled, the percentage of permanent partial disability benefits the worker should receive. Id. If an insurer or self-insured employer does not elect to close the claim, then DCBS must determine the extent of the worker's permanent disability and issue a determination order. ORS 656.268(5)(a) (1995).

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[5] The Pennsylvania act provides that: "'All payments to providers for treatment * * * shall be made within thirty (30) days of receipt of such bills and records *unless the employer or insurer disputes the reasonableness or necessity of the treatment*[.]'" Sullivan, 526 US at 60 (quoting 77 Pa Stat Ann section 531(5) (Purdon Supp 1998)) (emphasis in original).

[6] In 1999, the legislature amended ORS 656.268(1) to require the Director of DCBS to "phase out the claim closure activities of [DCBS]" by "not later than June 30, 2001." Or Laws 1999, ch 313, section 16. After that date, insurers or self-insured employers will have sole responsibility for claim closure.

A notice of closure or a determination order must inform the parties of their right to seek reconsideration of the finding regarding the extent of an injured worker's permanent disability and the amount of the disability award. ORS 656.270; *see also* ORS 656.268(4)(b) (1995) *renumbered* as ORS 656.268(5)(a) (A) (1999) (requiring notice of closure to inform workers of right to seek reconsideration within 60 days of the notice of closure). The notice or order also must notify the injured worker of the right to consult with the ombudsman for injured workers[7] and to be represented by an attorney at reconsideration. ORS 656.270.

If a party is dissatisfied with a notice of closure or a determination order, then that party may request reconsideration. ORS 656.268(5)(b) (1995) *renumbered* as ORS 656.268(5)(c) (1999). The reconsideration process may occur only once on each notice of closure or determination order. **<331 Or 372/373>** ORS 656.268(6)(a). A request for reconsideration must include, among other things, a statement "[w]hether there is disagreement with the specific impairment findings used to determine permanent disability at the time of claim closure and if so, an explanation * * * of the specific areas of disagreement[.]" OAR 436-030-0125(6).[8] The reconsideration process begins when DCBS receives the request for reconsideration. OAR 436-030-0115(2). At reconsideration, the worker has the burden of proof. ORS 656.206(3); ORS 656.266.

Like claim closure, reconsideration is conducted entirely on a written record.[9] Either party, in writing, may correct erroneous information in the record and submit medical evidence that should have been but was not submitted by the claimant's attending physician at the time of claim closure. ORS 656.268(6)(a). The parties also may submit written responses to the other side's documentary evidence, as well as written arguments, statements, and sworn affidavits. OAR 436-030-0115(4).

A party that is dissatisfied with an order on reconsideration may request a hearing under ORS 656.283. ORS 656.268(6)(f) (1995) *renumbered* as ORS 656.268(6)(g) (1999); **<331 Or 373/374>** ORS 656.283(1). The Board refers hearings to an ALJ. ORS 656.283(4).

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[7] ORS 656.709(1) provides:

"The office of ombudsman for injured workers is created in the Department of Consumer and Business Services. The ombudsman shall report directly to the Director of the Department of Consumer and Business Services. The ombudsman shall act as an advocate for injured workers by accepting complaints concerning matters related to workers' compensation, investigating them and attempting to resolve them. The ombudsman shall also provide information to injured workers to enable them to protect their rights in the workers' compensation system."

[8] If a worker who is not represented by an attorney files a request for reconsideration, then

"the department shall assist the worker in developing a completed request; inform the worker of the right to consult with the ombudsman or an attorney; and mail a copy to the insurer. Notwithstanding any other provision of this rule, the department may extend any nonstatutory time frames or request any information deemed necessary to assure the unrepresented worker's reconsideration request is complete."

OAR 436-030-0135(2).

[9] OAR 436-030-0115(3) provides, in part:

"For the purpose of these rules, 'reconsideration proceeding' means the procedure established to reconsider a Notice of Closure or Determination Order and *does not include personal appearances by any of the parties to the claim or their representatives, unless requested by the department*. All information to correct or clarify the record and any medical evidence regarding the worker's condition as of the time of claim closure that should have been but was not submitted by the physician serving as the attending physician at the time of claim closure and all supporting documentation must be presented during the reconsideration proceeding."

The 1995 amendments to ORS 656.268 and ORS 656.283(7) changed the evidence that an ALJ may consider at a hearing on an order on reconsideration and how the ALJ shall conduct those hearings.[10] ORS 656.268(7)(g) (1995) *renumbered as* ORS 656.268(7)(h) (1999), now provides that, after reconsideration, "*no* subsequent medical evidence of the worker's impairment is admissible * * * for purposes of making findings of impairment on the claim closure." (Emphasis added.) The ALJ may consider at hearing only issues that a party raised and preserved at reconsideration, or that arise out of the reconsideration order itself. ORS 656.268(8). As amended, ORS 656.283(7) provides, in part:

> "*Except as otherwise provided in this section* and rules of procedure established by the board, the Administrative Law Judge is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, and may conduct the hearing in any manner that will achieve substantial justice. Neither the board nor an Administrative Law Judge may prevent a party from withholding impeachment evidence until the opposing party's case in chief has been presented, at which time the impeachment evidence may be used. * * * Evaluation of the worker's disability by the Administrative Law Judge shall be as of the date of issuance of the reconsideration order pursuant to ORS 656.268. Any finding of fact regarding the worker's impairment must be established by medical evidence that is supported by objective findings. The Administrative Law Judge shall apply to the hearing of the claim such standards for evaluation of disability as may be adopted by the director pursuant to ORS 656.726. *Evidence on an issue regarding a notice of closure that was not submitted at the reconsideration required by ORS 656.268 is not admissible* **<331 Or 374/375>** *at hearing, and issues that were not raised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself. However, nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present the reconsideration record at hearing to establish by a preponderance of that evidence that the standards adopted pursuant to ORS 656.726 for evaluation of the worker's permanent disability were incorrectly applied in the reconsideration order pursuant to ORS 656.268.* * * *."

(Emphasis added.)

Before the 1995 amendments, ORS 656.283(7) had permitted the ALJ to conduct a hearing "in any manner that will achieve substantial justice." The 1995 amendments limited the ALJ's authority regarding the conduct of hearings on orders on reconsideration by adding the phrase, "[e]xcept as otherwise provided in this section * * *." With respect to hearings on orders on reconsideration, other amendments to ORS 656.283(7), emphasized above, specifically limit the evidence that is admissible to what was presented in writing at reconsideration or that arises out of the reconsideration order.

In other words, the post-1995 statutory scheme specifically restricts an ALJ's authority regarding the conduct of hearings on orders on reconsideration regarding the extent of a worker's permanent disability. The 1995 amendments to ORS 656.268(7)(h), ORS 656.268(8), and ORS 656.283(7) make clear that a worker must submit *all* evidence of the extent of disability in writing at reconsideration.[11]

The Court of Appeals' majority held that a written record is adequate under due process standards for determining whether a worker should receive an award of PTD benefits. Nonetheless, it asserted that, as it previously had held in *Rogue Valley Medical Center v. McClearen*, 152 Or App 239, 952 P2d 1048 (1998), the statutory scheme affords parties a limited right to cross-examine medical and vocational experts at hearing. *Koskela*, 159 Or App at 238.

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[10] Before the 1995 amendments, claimants could request an oral evidentiary hearing before an ALJ following reconsideration. In 1993, this court characterized the hearing before an ALJ as a contested-case hearing similar to the kind of evidentiary hearing provided by the Administrative Procedures Act (APA). *See Colclasure v. Wash. County School Dist. No. 48-J*, 317 Or 526, 533, 857 P2d 126 (1993) ("There can be no doubt that the proceeding before the [ALJ] is a classic contested case."). As noted, in 1993, the Court of Appeals had construed ORS 656.283(7) (1993) as permitting a claimant to introduce new evidence at hearing that had not been introduced at reconsideration. *Safeway Stores*, 122 Or App at 163.

[11] A medical arbiter's report is admissible at hearing "even if the report is not prepared in time for use in the reconsideration proceeding." ORS 656.268(6)(e) (1995) *renumbered* as ORS 656.268(6)(f) (1999).

331 Or 376> In *McClearen*, the Court of Appeals had held that, in cases involving issues of loss of earning capacity, vocational evidence may be admitted at hearing under ORS 656.287(1), so long as the insurer or self-insured employer had submitted the reports to the worker ten days before hearing and made the writer of the report available for testimony and cross-examination at hearing. *McClearen*, 152 Or App at 245. In *Koskela*, the majority cited OAR 438-007-0005(3) for the proposition that the contents of medical, surgical, and hospital reports are admissible at hearing if the doctor rendering the medical and surgical reports submits to cross-examination. 159 Or App at 238. OAR 438-007-0005(3), in turn, implements ORS 656.310(2), which provides, in part:

> "The contents of medical, surgical and hospital reports presented by claimants for compensation shall constitute prima facie evidence as to the matter contained therein; so, also, shall such reports presented by the insurer or self-insured employer, provided that the doctor rendering medical and surgical reports consents to submit to cross-examination."

The 1995 amendments to ORS 656.268 and ORS 656.283(7) focus on claim closure and reconsideration, which are the processes for determining the extent of an injured worker's permanent disability. Those amendments explicitly limit the evidence that can be admitted at a hearing on an order on reconsideration to the written reconsideration record. Allowing oral testimony and cross-examination at hearing would introduce new evidence. *See, e.g., State v. Stevens*, 328 Or 116, 133, 970 P2d 215 (1998) (cross-examination introduces new evidence). To the extent that ORS 656.287(1) and ORS 656.310(2) would permit the introduction of evidence at a hearing on the extent of an injured worker's permanent disability, and permit even limited cross-examination, they are inconsistent with the specific evidentiary limitations imposed by the 1995 amendments to ORS 656.268 and ORS 656.283(7). When statutes are inconsistent, the legislature has prescribed that the particular provision "is paramount" to the general provision. ORS 174.020; *see also Smith v. Multnomah County Board of Commissioners*, 318 Or 302, 309, 865 P2d 356 (1994) (in conflict **<331 Or 376/377>** between statutes, special provisions must prevail over general provisions). Although the provisions of ORS 656.287(1) and ORS 656.310(2) remain applicable in *other* kinds of hearings provided for in chapter 656, they no longer apply to hearings on orders on reconsideration. As we have explained, the post-1995 statutory scheme for determining the extent of an injured worker's permanent disability does not permit the introduction of evidence through oral testimony or cross-examination at hearing. Rather, the process consists entirely of written submissions, from which the decision-maker determines whether the worker has met the burden of proof and persuasion with respect to PTD benefits.

To summarize: Under the 1995 amendments to ORS 656.268 and ORS 656.283(7), a worker, insurer, or self-insured employer who is dissatisfied with a notice of closure or determination order may request reconsideration by the ARU of DCBS. The worker has the burden of proof and persuasion. If the worker is seeking PTD benefits at reconsideration, then the worker must prove that he or she permanently is prevented from regularly performing work at a gainful and suitable occupation, is willing to seek regular gainful employment, and has made reasonable efforts to seek such employment. Like the process that led to the notice of closure or the determination order, the reconsideration record consists solely of written submissions. The parties may submit written evidence and affidavits, and the worker may rebut in writing evidence that the insurer, self-insured employer, or DCBS relied on in issuing the notice of closure or determination order.

A party that is dissatisfied with an order on reconsideration may request a hearing. The parties are not permitted to introduce any other new evidence, such as presenting oral testimony, cross-examining adverse witnesses, or presenting rebuttal evidence. In short, under the 1995 amendments to ORS 656.268 and ORS 656.283(7), the record on which a decision is made regarding an award of PTD benefits -- or any permanent disability benefits -- consists solely of the parties' written submissions.

With that understanding of the post-1995 statutory scheme, we turn to the merits of claimant's constitutional **<331 Or 377/378>** challenge. *See Loudermill*, 470 US at 541 ("[O]nce it is determined that the Due Process Clause applies, 'the question remains what process is due.'") (quoting *Morrissey v. Brewer*, 408 US 471, 481, 92 S Ct 2593, 33 L Ed 2d 484 (1972)).

As a matter of procedural due process, it is well established that the state may not deprive a person of life, liberty, or property without "notice and opportunity for hearing appropriate to the nature

of the case." *Mullane v. Central Hanover Tr. Co.*, 339 US 306, 313, 70 S Ct 652, 94 L Ed 865 (1950). An appropriate hearing is one that is provided "at a meaningful time and in a meaningful manner." *Armstrong v. Manzo*, 380 US 545, 552, 85 S Ct 1187, 14 L Ed 2d 62 (1965); *see State ex rel Juv. Dept. v. Geist*, 310 Or 176, 189-90, 796 P2d 1193 (1990) (so stating). The opportunity to be heard must be tailored to the capacities and circumstances of those who are to be heard. *Goldberg*, 397 US at 269. When important decisions turn on assessments of credibility and veracity, written submissions are "wholly unsatisfactory." *Id.* The purpose of due process requirements is to provide a "safeguard against mistake." *Mathews*, 424 US at 345.

In this case, claimant does not object to the notice or to the timing requirements contained in the post-1995 procedures for establishing the extent of a worker's permanent disability. He argues only that the evidentiary restrictions imposed by the process constitutionally are inadequate, because they prevent a worker seeking PTD benefits, who bears the burden of proof and persuasion, from participating meaningfully in the process. Whether a process is meaningful under the Due Process Clause turns on the three *Mathews* factors. *Mathews*, 424 US at 335. We address each factor in turn, beginning with the private interest that will be affected by a determination that a worker should not receive PTD benefits. *See id.* (private interest first factor in test).

Without wage-replacement benefits, a permanently totally disabled worker risks losing his or her economic self-sufficiency. The United States Supreme Court has recognized that the loss of a person's livelihood is a severe deprivation. Continued employment is such an important interest that it "ought not be interrupted without substantial justification." *Federal Deposit Ins. Corp. v. Mallen*, 486 US 230, **<331 Or 378/379>** 243, 108 S Ct 1780, 100 L Ed 2d 265 (1988); *see also Loudermill*, 470 US at 543 ("We have frequently recognized the severity of depriving a person of the means of livelihood"; citing cases).

The purpose of PTD benefits is to provide permanently totally disabled workers with the equivalent of continued employment in the form of lifetime wage replacement, thereby restoring them to economic self-sufficiency. ORS 656.012(2)(c); *see Tee v. Albertsons, Inc.*, 314 Or 633, 640, 842 P2d 374 (1992) (award of permanent disability benefits "aims to compensate an injured worker for *permanently* lost earning capacity, thereby promoting the goal of returning the worker to economic self-sufficiency" (emphasis added)). The importance of economic self-sufficiency, both for permanently totally disabled workers and their dependents, is self-evident. *See* ORS 656.012(2)(a) (Workers' Compensation Law to provide adequate and reasonable income benefits to injured workers and dependents).

The possible length of a wrongful deprivation of benefits also is an important factor in assessing the private interest at stake. *Fusari v. Steinberg*, 419 US 379, 389, 95 S Ct 533, 42 L Ed 2d 521 (1975). If the deprivation of benefits is merely temporary, for example, and prompt and adequate procedures exist to correct errors in the eligibility determination, then the private interest is not as great as it is if the determination is final. *Id.*

Under the Oregon workers' compensation statutes, the determination that a worker is *not* eligible for PTD benefits is final. Considering both the importance of economic self-sufficiency and the finality of an adverse determination, we hold that a permanently totally injured worker's interest in receiving PTD benefits is great.[12]

331 Or 380> We turn to the second *Mathews* factor, which is whether the process adequately safeguards a worker's private interest in PTD benefits from an erroneous deprivation and the probable value, if any, of added or substitute procedural safeguards. *See Mathews*, 424 US at 335 (describing second factor). As we have explained, ORS 656.206(3) requires a worker seeking PTD benefits to prove that he or she permanently is incapacitated from regularly performing work at a gainful and suitable occupation, is willing to seek regular gainful employment, and has made reasonable efforts to gain such employment. The decision-maker determines whether a worker has satisfied the burden of proof and persuasion after evaluating the parties' competing evidence. The post-1995 statutory scheme limits the worker to a written record at every stage of the process in meeting the burden of proof and persuasion.

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[12] Even if a worker is awarded PTD benefits, that award is subject to review every two years, and the award may be reduced to PPD if the claimant subsequently is found to be capable of working. ORS 656.206(5). In employer's view, the fact that an award of PTD benefits is not final, because of the two-year review provision, means that a worker's private interest is not as great as the state's interest. That argument misses the point that, under the workers' compensation scheme, a permanently injured worker is entitled to disability benefits that are intended to maintain his or her economic self-sufficiency.

In *Goldberg*, the Supreme Court explained that written submissions are an "unrealistic option" for individuals who lack the educational attainment necessary to write effectively and who cannot obtain professional assistance. 397 US at 269. For purposes of this analysis, however, we assume without deciding that all PTD claimants are able to retain counsel and that a written record would suffice for determining whether a worker permanently is incapacitated from regularly performing work at a gainful and suitable occupation.

However, that is not the only issue in a proceeding of this kind. A worker seeking PTD benefits also must prove that he or she is willing to work and has made reasonable efforts to find suitable employment. The worker's credibility directly is at issue with respect to willingness to work and reasonable efforts to find suitable employment. In situations requiring the decision-maker to apply a broad standard that includes subjective assessments of, among other things, a person's credibility and veracity, due process requires "personal contact between the recipient and the person who decides his case." *Califano v. Yamasaki*, 442 US 682, 697, 99 S Ct 2545, 61 L Ed 2d 176 (1979). What is more, when, as here, the decision-maker must resolve factual disputes involving credibility and veracity, due process requires an opportunity for at least some kind of an oral evidentiary hearing. *Goldberg*, 397 US at 268.

331 Or 381> As we have explained, the post-1995 statutory scheme for determining whether a worker should receive an award of PTD benefits provides no opportunity for a worker to have an oral evidentiary hearing. Because two of the three elements that the worker seeking PTD benefits must prove require a judgment about the worker's credibility and veracity, and the resolution of factual disputes, the probable value of at least some opportunity for the presentation of evidence at an oral hearing is substantial. *See Mathews*, 424 US at 335 (requiring inquiry into value of additional or substitute procedural safeguards).

The final *Mathews* factor is the state's interest and the cost of added procedural safeguards. 424 US at 335. The 1995 amendments reflect the state's interest in the development of a complete record at an early stage of the process, and preventing the introduction of additional evidence after reconsideration. There is no doubt that restricting the record at hearing to the record that was developed at reconsideration makes the process more efficient. However, efficiency is not an end in itself. The Supreme Court has explained that

> "the Constitution recognizes higher values than speed and efficiency. Indeed, one might fairly say of the * * * Due Process Clause in particular, that [it was] designed to protect the fragile values of a vulnerable citizenry from the overbearing concern for efficiency and efficacy that may characterize praiseworthy government officials no less, and perhaps more, than mediocre ones."

Stanley v. Illinois, 405 US 645, 656, 92 S Ct 1208, 31 L Ed 2d 551 (1972) (footnote omitted). The Oregon legislature also has recognized that the state has an interest in the fair and accurate resolution of workers' compensation disputes, because the purpose of the workers' compensation statutes is to ensure that insurers and self-insured employers, rather than taxpayers, will carry the burden of returning permanently injured workers to an economically self-sufficient status. *See* ORS 656.012(2)(a), (b), (c) (objectives of Workers' Compensation Law are to provide workers and dependents adequate and reasonable income benefits, access to fair and just administrative system for delivery of financial benefits, and to restore workers to economically self-sufficient status). **<331 Or 381/382>** Efficiency does not trump the basic constitutional right to a minimally adequate hearing.

Allowing a worker who is seeking PTD benefits an opportunity at some stage of the process to have some kind of an oral evidentiary hearing will not impede significantly the state's ability to resolve those disputes efficiently. Administrative law judges are expert, neutral decision-makers who can control the extent and length of testimony and can work with the parties to limit the record to written submissions when doing so is appropriate. The additional cost of providing PTD claimants with the opportunity for at least some kind of oral evidentiary hearing is minimal given the magnitude of the private interest that is at stake.

Having considered the three *Mathews* factors, we conclude that the post-1995 statutory scheme for assessing whether a worker should receive an award of PTD benefits fails to satisfy procedural due process requirements. A worker's private interest in PTD benefits, which are intended to restore

permanently injured workers to economic self-sufficiency through lifetime wage-replacement benefits, is great. The worker seeking PTD benefits has the burden of proof and persuasion. The determination that a worker should receive an award of PTD benefits is final. That determination requires the decision-maker to resolve factual disputes and to make judgments about the credibility and veracity of a worker's claim that he or she is willing to work and has made reasonable efforts to find suitable gainful employment. Under the statute, the worker must meet the burden of proof and persuasion based entirely on a written record. At no stage of the process is the worker afforded any opportunity to have an oral evidentiary hearing. Because the worker does not have the opportunity to make a meaningful record on elements of proof that are necessary for the worker to meet the burden of proof and persuasion, we hold that the post-1995 statutory process does not provide adequate safeguards against mistake. *Mathews*, 424 US at 345. Allowing a worker, at some meaningful stage of the process, an opportunity for at least some kind of oral evidentiary hearing will not significantly impede the state's interest in providing a cost-effective process, because hearings can be conducted in a manner that achieve both fairness and efficiency.

331 Or 383> The decision of the Court of Appeals is reversed. The order of the Workers' Compensation Board is reversed, and the case is remanded to the Workers' Compensation Board for further proceedings.

Cite as 331 Or 665 (2001) March 15, 2001

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Benny H. Rash, Claimant,

BENNY H. RASH, Petitioner on Review,
v.
MCKINSTRY COMPANY and LIBERTY NORTHWEST INSURANCE CORPORATION, Respondents on Review.
(WCB TP-97009; CA A100576; SC S46514)

On review from the Court of Appeals.*
Argued and submitted January 7, 2000.
Meagan A. Flynn, Preston, Bunnell & Stone, LLP, Portland, argued the cause for petitioner on review. Robert K. Udziela, Pozzi Wilson Atchison LLP, Portland, filed the petition.
Alexander D. Libmann, Liberty Northwest Insurance Corp., Portland, argued the cause and filed the brief for respondents on review.
Before Carson, Chief Justice, and Gillette, Durham, Kulongoski, Leeson, and Riggs.**
RIGGS, J.
The decision of the Court of Appeals is reversed. The order of the Workers' Compensation Board is reversed, and the case is remanded to the Board with instructions to dismiss the petition of respondents on review.

* Judicial Review from the Workers' Compensation Board. 160 Or App 131, 981 P2d 343 (1999).

** 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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331 Or 667> In this workers' compensation case, claimant seeks review of a Court of Appeals' decision affirming a Workers' Compensation Board (Board) order. The Court of Appeals held that, notwithstanding ORS 656.236(1)(a) (set out below), the statutory lien rights of Liberty Northwest Insurance Corporation (insurer) on claimant's third-party settlement proceeds survived the parties' Claim Disposition Agreement (CDA). *Rash v. McKinstry Co.*, 160 Or App 131, 137, 981 P2d 343 (1999). We review for errors of law. *See* ORS 656.298(7) (providing that review of Board order shall be as provided in ORS 183.482); ORS 183.482(8)(a) (providing for review for errors of law). We reverse the decision of the Court of Appeals and the order of the Board.

We take the following undisputed facts from the Court of Appeals' opinion:

> "On June 16, 1994, claimant injured his neck and back while in the course and scope of his employment. Employer's insurer accepted the neck and back injuries as work related and provided benefits to claimant. In July 1996, after claimant began a tort action against a third party involved in the cause of the injuries, insurer and claimant entered into a CDA. The CDA did not specifically preserve insurer's lien rights against any recovery that claimant might receive in the tort action. After claimant settled with the third party for $400,000, insurer sought to recover $124,716.73 from the proceeds, the amount that it had paid on claimant's claim."

Rash, 160 Or App at 133.

When claimant refused to pay insurer's demand of $124,716.73, insurer petitioned the Board to resolve the parties' dispute. *See* ORS 656.593(3) (providing that any conflict between claimant and paying agency concerning "just and proper" distribution of third-party proceeds shall be resolved by Board); ORS 656.576 (defining "paying agency" as "the self-insured employer or insurer paying benefits to the worker or beneficiaries"). Claimant argued that, under ORS 656.236(1)(a), insurer waived its statutory lien rights when it **<331 Or 667/668>** failed to preserve them expressly in the CDA. ORS 656.236(1)(a) provides, in part:

> "The parties to a claim, by agreement, may make such disposition of any or all matters regarding a claim, except for medical services, as the parties consider reasonable, subject to such terms and conditions as the Workers' Compensation Board may prescribe. For the purposes of this section, 'matters regarding a claim' includes the disposition of a beneficiary's independent claim for compensation under this chapter. *Unless otherwise specified, a disposition resolves all matters and all rights to compensation, attorney fees and penalties potentially arising out of claims, except medical services, regardless of the conditions stated in the agreement.* Any such disposition shall be filed for approval with the board. If the worker is not represented by an attorney, the worker may, at the worker's request, personally appear before the board. Submission of a disposition shall stay all other proceedings and payment obligations, except for medical services, on that claim. * * *"

(Emphasis added.) The Board considered the phrase "matters regarding a claim," which appears in the first sentence of the statute, in resolving the dispute. For interpretive guidance, the Board looked to ORS 656.704(3)(a), a workers' compensation statute that describes the scope of the authority of the Department of Consumer and Business Services over workers' compensation matters. ORS 656.704(3)(a) provides, in part:

> "For the purpose of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under this chapter, and for determining the procedure for the conduct and review thereof, *matters concerning a claim under this chapter are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue.* * * *"

(Emphasis added.) Applying that definition to ORS 656.236(1)(a), the Board concluded that "all matters and all rights to compensation" referred only to a *claimant's* -- not an insurer's -- rights to compensation. Accordingly, the Board ruled that the parties' CDA did not extinguish insurer's statutory lien. The Board ordered claimant to pay $124,716.73 to insurer.

331 Or 669> Claimant sought judicial review in the Court of Appeals. *See* ORS 656.298(1) (providing for Court of Appeals review of Board orders). The court examined the text, context, and legislative history of ORS 656.236(1)(a) and concluded, as the Board had, that a CDA presumptively resolves only a claimant's right to compensation. *Rash,* 160 Or App at 135-37. The court's reasoning differed from the Board's, in that the court found that the workers' compensation statutes generally make a distinction between damages recovered against third parties and benefits received by a worker under the workers' compensation system. Specifically, the court found that the statutes relating to third-party recovery use the words "proceeds" and "action." *See, e.g.,* ORS 656.593 ("proceeds"); ORS 656.580 ("action"); ORS 656.587 (same); ORS 656.591(1) (same). Because ORS 656.236(1)(a) does not contain either the word "proceeds" or the word "action," the court concluded that the phrase "all matters and all rights to compensation" did not encompass third-party recovery. *Rash,* 160 Or App at 136. Consequently, the court determined that the parties' CDA did not extinguish insurer's statutory lien, and it affirmed the Board order.

In a dissent to the Court of Appeals' majority opinion, one judge concluded that the meaning of the statute was plain from its text: The legislature intended that a CDA extinguish an insurer's statutory lien -- a "matter[] * * * potentially arising out of claims" -- unless the parties provided otherwise. *Rash,* 160 Or App at 137-38 (Armstrong, J., dissenting). The dissent was "at a loss to see how the phrase 'all matters,' given its plain, natural and ordinary meaning, * * * could be read to mean anything other than *all* matters." *Id.* at 138 (Armstrong, J., dissenting) (emphasis in original).

We allowed claimant's petition for review. Claimant argues that the dissenting opinion correctly construed the meaning of the phrase "all matters" in ORS 656.236(1)(a): An insurer's statutory lien rights are resolved by a CDA, unless the parties in the CDA provide otherwise. For its part, insurer argues that the definition of "matters concerning a claim" in ORS 656.704(3) controls the interpretation of the word "matters" in ORS 656.236(1)(a). Because that statutory **<331 Or 669/670>** definition pertains only to a *claimant's* right to compensation, insurer continues, its statutory lien right is not a "matter[]" within the meaning of ORS 656.236(1)(a). Accordingly, insurer concludes, its lien survives the CDA. For the reasons that follow, we conclude that the phrase "all matters * * * potentially arising out of claims" in ORS 656.236 encompasses an insurer's statutory lien.

Before discussing the merits, we outline briefly for background purposes the statutory scheme that gave rise to the events in this case. A worker who receives an injury that arises out of and in the course of employment may file a claim for compensation from the employer or, as in this case, from the employer's insurer. *See* ORS 656.005(7)(a) (defining "compensable injury"); ORS 656.005(6) (defining "claim," in part, as "a written request for compensation from a subject worker"); ORS 656.202(1) (providing that injured worker "shall receive compensation as provided in this chapter"). If the claimant's injury was caused by the negligence of a third party, as claimant alleges in this case, then the claimant also may elect to recover damages from the third party. ORS 656.154; ORS 656.578.[1] If a claimant so elects, then the entity that paid the claim (the "paying agency") has a lien against the claimant's action against the third party that is second only to the cost of recovering those damages. ORS 656.580(2).[2] If that claimant ultimately recovers money from **<331 Or 670/671>** the third party, then a paying agency also has a lien against those proceeds. ORS 656.593(1).[3] In this case, insurer is a paying agency, because it provided claimant compensation for his injury. *See* ORS 656.576 (including insurer that pays benefits to worker within definition of "paying agency"). Because claimant received $400,000 in settlement of his claim against a third party, ORS 656.593(1) granted insurer a lien against the settlement.

We turn to the disputed statute, ORS 656.236. In determining the meaning of that statute, we employ the now-familiar methodology outlined in *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993) (stating that court first examines text and context of statute to determine legislative intent). We begin with the statutory text, which is the best evidence of the legislature's intent. *Id.*

ORS 656.236 governs claim disposition agreements, or settlement agreements, of a claimant's claim. As noted, paragraph (1)(a) of that statute provides, in part:

> "* * * Unless otherwise specified, a disposition resolves all matters and all rights to compensation, attorney fees and penalties potentially arising out of claims, except medical services, regardless of the conditions stated in the agreement. * * * "

The lien at issue here is not an "attorney fee[]" or a "penalt[y]." Therefore, we focus our attention on the statutory wording "all matters and all rights to compensation." As a matter of grammar, we first determine that, contrary to the Court of Appeals' majority's conclusion, the phrase "to compensation" qualifies only the word "rights" and not the word "matters." That distinction is relevant, because ORS 656.005(8) defines "compensation" for purposes of the workers' compensation statutes as including:

> **331 Or 672>** "all benefits, including medical services, provided for a compensable injury *to a subject worker* or the worker's beneficiaries by an insurer or self-insured employer pursuant to this chapter."

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[1] ORS 656.154 provides:

"If the injury to a worker is due to the negligence or wrong of a third person not in the same employ, the injured worker, or if death results from the injury, the spouse, children or other dependents, as the case may be, may elect to seek a remedy against such third person."

ORS 656.578 provides, in part:

"If a worker of a noncomplying employer receives a compensable injury in the course of employment, or if a worker receives a compensable injury due to the negligence or wrong of a third person (other than those exempt from liability under ORS 656.018), entitling the worker under ORS 656.154 to seek a remedy against such third person, such worker or, if death results from the injury, the other beneficiaries shall elect whether to recover damages from such employer or third person. * * *"

[2] ORS 656.580(2) provides:

"The paying agency has a lien against the cause of action as provided by ORS 656.591 or 656.593, which lien shall be preferred to all claims except the cost of recovering such damages."

[3] ORS 656.593(1) provides, in part:

"* * * The proceeds of any damages recovered from an employer or third person by the worker or beneficiaries [of the worker] shall be subject to a lien of the paying agency for its share of the proceeds as set forth in this section. * * *"

(Emphasis added.) Thus, by definition, the phrase "all rights to compensation" in ORS 656.236(1)(a) relates only to a *worker's* right to benefits and does not include an insurer's statutory lien, which is a benefit to the insurer.

We turn to the meaning of the phrase "all matters," considering first the word "all." The plain and unambiguous meaning of the word "all" is "every." *See Webster's Third New Int'l Dictionary*, 55 (unabridged ed 1993) (defining "all," in part, as "every member or individual component of"). As used in the disputed part of the statute, the word "all" appears to have a sweeping meaning. We also note that the statute excludes only "medical services" from the issues that a CDA resolves. That sole and express exclusion bolsters the sweeping meaning that we ascribe to the word "all," in that it demonstrates that the legislature knew how to prevent a CDA from resolving a particular issue.

Similarly, the word "matters" is a general and broad term. *See Webster's Third New Int'l Dictionary* at 1394 (defining "matters," in part, as "the event or circumstances of a particular but [usually] unspecified situation, occurrence, or relation"). The definition of "matters" in the disputed sentence is informed by the two other references to that word in ORS 656.236(1)(a). Specifically, the first sentence of the statute describes the universe of issues that can be the subject of a CDA as "any or all matters regarding a claim." The second sentence of paragraph (1)(a) also contains the phrase "matters regarding a claim." As noted, insurer argues that the definition of "matters concerning a claim" in ORS 656.704(3) applies to ORS 656.236(1)(a). See ORS 656.704(3) (defining phrase as relating to matters affecting worker's right to receive compensation). Insurer's argument only goes so far, however.

Even if the phrases "matters concerning a claim" and "matters regarding a claim" have the same meaning, the wording in the disputed third sentence of ORS 656.236(1)(a) is markedly different. Specifically, the phrase "potentially **<331 Or 672/673>** arising out of claims" appears in the middle of the third sentence. Because of the previous modifications of "matters" with the phrase "regarding a claim," we conclude that the wording "potentially arising out of claims" also modifies the phrase "all matters." Accordingly, the relevant wording is: "all matters * * * potentially arising out of claims." That wording casts a wider net than the phrases "matters regarding" or "matters concerning" a claim. The addition of the word "potentially" means that a CDA resolves all matters that, in the future, could arise out of a claim, not merely the matters currently known to arise out of a claim.

We turn to the facts of this case. The type of lien at issue arises only if a number of contingencies occur, namely, that the insurer pays benefits on a claim for compensation to a claimant, that the claimant elects to proceed against a third party, and that the third party pays a sum of money to the claimant. But for the claimant's filing of a claim, the lien cannot arise. Thus, we hold 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). Accordingly, as that lien was not mentioned in the parties' CDA, the lien was "resolved," or extinguished, by the CDA.

The decision of the Court of Appeals is reversed. The order of the Workers' Compensation Board is reversed, and the case is remanded to the Board with instructions to dismiss the petition of respondents on review.

Cite as 171 Or App 467 (2000) December 20, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Benjamin G. Santos, Claimant.

BENJAMIN G. SANTOS, Petitioner,

v.

CARYALL TRANSPORT and SAIF CORPORATION, Respondents.

(96-01407; CA A99312)

En Banc

Judicial Review from Workers' Compensation Board.

On respondents' Motion for Reconsideration filed February 4, 2000. Order filed January 21, 2000. Taken en banc August 8, 2000.

David L. Runner for the motion.

Donald M. Hooton and Merrill Schneider *contra.*

Before Deits, Chief Judge, and Edmonds, Landau, Haselton, Armstrong, Linder, Wollheim, Kistler and Brewer, Judges.

DEITS, C. J.

Reconsideration allowed; order withdrawn and request for attorney fees denied.

Armstrong, J., concurring.

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171 Or App 469> Employer petitions for reconsideration of our order awarding claimant attorney fees under ORS 656.382(2). We grant the petition, withdraw the order, and deny claimant's request for attorney fees.

Claimant worked as a transport driver for employer. He injured his lower back in 1991 when he slipped and fell on ice in a hospital parking lot. The fall occurred in the course of his employment. Before claimant received a final award on his claim for injuries from the fall, the legislature amended ORS 656.214(6) to increase the amount of money to be awarded for each degree of disability for injuries that occurred before January 1, 1992. The amendment applied retroactively to all claims that were not final as of its effective date. When employer failed to pay claimant at the new disability rate, claimant sought a hearing before an administrative law judge (ALJ) on that failure. The ALJ ordered employer to recalculate claimant's permanent partial disability award according to the new rate.

Employer requested review before the Workers' Compensation Board. The Board held that the amendment applied retroactively, but that claimant had failed to preserve his claim to be paid at the new rate because he had not raised the issue on reconsideration. On claimant's petition, we reversed in a per curiam decision citing to *Crowder v. Alumaflex*, 163 Or App 143, 986 P2d 1269 (1999), in which we held that the amendment was retroactive but that the claimant was not required to raise the rate issue on reconsideration, because the amendment had been adopted after reconsideration. *Santos v. Caryall Transport*, 163 Or App 414, 987 P2d 1271 (1999). We remanded for recalculation of the amount of permanent partial disability.

After prevailing on that issue, claimant sought an award of attorney fees under ORS 656.382(2) for his attorney's services in this court. Employer objected to an award on the ground that the statute authorizes attorney fees only when the employer or insurer is the party that *initiated* the review at the level at which the award is requested. We **<171 Or App 469/470>** awarded fees. On reconsideration, we conclude that employer was correct and withdraw our order awarding fees.

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, 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 set by the Administrative Law Judge, 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." (Emphasis added.)

As the emphasized language makes clear, when the employer initiates a review and compensation is not disallowed or reduced *at that level of review*, the employer must pay the claimant's attorney fees in an amount set by the reviewing body for that level of review and for prior levels of review. We have long adhered to the view that ORS 656.382(2) requires that the employer or insurer initiate review at the particular stage at which attorney fees are sought in order for attorney fees to be available under the statute. *See Gainor v. SAIF*, 51 Or App 869, 870, 627 P2d 41 (1981); *Bailey v. Morrison-Knudsen*, 5 Or App 592, 598-600, 485 P2d 1254 (1971). Here, employer initiated the appeal to the Board and prevailed at that level. Claimant then initiated and prevailed on his petition for review before us. Under these circumstances, the statute simply does not authorize fees for claimant.

Claimant argues that a 1983 amendment to the statute eliminated the requirement that the employer or insurer initiate the review at the particular level at which attorney fees are sought. We disagree. In 1983, the legislature inserted the words "prior to" in describing the services for which fees are to be awarded once the statutory entitlement to fees is triggered. Or Laws 1983, ch 568, section 1. The amendment made it clear that fees can be awarded for legal services rendered at prior proceedings. However, the amendment did not change the language of the statute on which our above **<171 Or App 470/471>** interpretation of ORS 656.382(2) was based. Furthermore, neither we nor the Supreme Court has ever interpreted the 1983 amendment in the manner urged by claimant. Both courts have continued to require that, in order to be entitled to fees under ORS 656.382(2), the employer must have initiated the review *at the level at which fees are sought*.

The reason for the requirement has been described by the Supreme Court. In *Bracke v. Baza'r*, 294 Or 483, 487, 658 P2d 1158 (1983), the court described the purpose of ORS 656.382(2), as explained in the legislative history:

> "During the testimony before legislative committees considering the 1965 revision, opponents of HB 1001 (the vehicle for revision) expressed fear that the adversarial position of the employer or SCD [State Compensation Department] * * * and the claimant * * * might result in the former pursuing appeals at each level for the purpose of wearing down or harassing claimants. The answer was to provide that where the employer or SCD initiated 'a request for hearing, request for review or court appeal' and the claimant successfully defended his award, the employer or SCD, as the case might be, would become liable for reasonable attorney fees in addition to the award of benefits. Or Laws 1965, ch 285 section 42(2)."

In *SAIF v. Curry*, 297 Or 504, 686 P2d 363 (1984), the court similarly focused on the issue of wearing down or harassing the claimant. ("One purpose of the statute is to discourage employers or their insurers from wearing down claimants with harassing and frivolous appeals. The statute does this by providing for an award of attorney fees to the claimant if an employer or insurer initiates a higher level examination of the case and does not win a reduction or elimination of the claimant's award.") In *Shoulders v. SAIF*, 300 Or 606, 615, 716 P2d 751 (1986), the court analyzed both ORS 656.382(2) and ORS 656.386(1), and described what it considered to be the primary distinction between the statutes: Under ORS 656.382(2), the claimant is entitled to fees if the insurer appeals and compensation is not reduced; under ORS 656.386(1), attorney fees are available when the claimant appeals and finally prevails. In *Short v. SAIF*, 305 Or 541, 546, 754 P2d 575 (1988), the court adhered to that analysis:

> **171 Or App 472>** "Where the claimant appeals the amount of liability or extent of disability, as in the present case, he or she concurrently may seek review of the attorney fee award *in the forum in which the merits are presented*. In such case, there is no statutory provision providing for circuit court review of that forum's determination of the appropriate attorney fee award. Where the insurer appeals the compensability of a claim or the amount or extent of liability, as the insurer did in this case before the board, the insurer is liable for attorney fees under ORS 656.382(2)." (Emphasis added.)

Again, in *Greenslitt v. City of Lake Oswego*, 305 Or 530, 535, 754 P2d 570 (1988), the court said:

> "ORS 656.382(2) provides for attorney fees to a claimant in an employer-initiated review or appeal where compensation is not reduced or disallowed."

Further, as mentioned above, our case law since the 1983 amendment adheres to our earlier reading of ORS 656.382(2) that the employer must have initiated review at the particular level where attorney fees are sought. In *Weyerhaeuser Co. v. Roller*, 85 Or App 500, 737 P2d 625 (1987), the employer requested a hearing as to the award of permanent partial disability in a determination order. The referee reduced the claimant's award. On the claimant's appeal, the Board reversed the referee, holding that the referee had no jurisdiction to consider the request for hearing. On judicial review, the Court of Appeals affirmed the Board. The claimant sought attorney fees under ORS 656.382(2) for services before the Board, reasoning that the statute authorized fees based on the employer's original challenge of the determination order. We rejected the contention, holding:

> "ORS 656.382(2) authorizes an award of insurer-paid attorney fees if the claimant prevails on an appeal initiated by the insurer or the employer. Here, *claimant* initiated the appeal to the Board. He is not entitled to attorney fees under ORS 656.382, or under any other section." *Roller*, 85 Or App at 504 (emphasis in original).

Our analysis in *Roller* is consistent with our earlier decisions and requires the conclusion that a prerequisite to the recovery of attorney fees under ORS 656.382(2) is that the employer initiate the appeal or review at the level at which attorney fees are sought.

171 Or App 473> We have continued to recite the prerequisites to recovery of attorney fees under ORS 656.382(2) to include an employer-initiated proceeding to obtain a disallowance or reduction in the claimant's award. *Deaton v. Hunt-Elder*, 145 Or App 110, 928 P2d 992 (1996) ("An award of attorney fees under [ORS 656.382(2)] requires (1) that an employer initiate a request for a hearing to obtain a disallowance or reduction in a claimant's award of compensation; (2) that the claimant's attorney perform legal services in defending the compensation award; and (3) that the ALJ find on the merits that the claimant's award of compensation should not be disallowed or reduced."); *Strazi v. SAIF*, 109 Or App 105, 107-108, 817 P2d 1348 (1991) ("There are three things that a claimant must prove to get attorney fees under [ORS 656.382(2)]: first, that the employer initiated a request for a hearing to obtain a disallowance or reduction in the claimant's award of compensation or filed a cross-appeal to do so, *Dotson v. Bohemia, Inc.*, 80 Or App 233, 236, 720 P2d 1345, *rev den* 302 Or 35[, 302 Or 461] (1986); second, that the claimant's attorney performed legal services in defending the compensation award, *Mobley v. SAIF*, 58 Or App 394, 396, 648 P2d 1357 (1982); and third, that the referee found on the merits that the claimant's award of compensation should not be disallowed or reduced. *Liberty Northwest Ins. Corp. v. McKellips*, 100 Or App 549, 550, 786 P2d 1321 (1990); *Agripac, Inc. v. Kitchel*, 73 Or App 132, 135, 698 P2d 69 (1985)."); *Ray Schulten's Ford v. Vijan*, 105 Or App 294, 297, 804 P2d 1196 (1991) ("We have held that, in order to recover attorney fees under [ORS 656.382(2)], the claimant must have prevailed in a proceeding in which he risked the loss of or reduction in compensation."). In summary, the text of ORS 656.382(2) and the courts' previous interpretations of that language compel the conclusion that fees simply are not available here for claimant.

The concurrence agrees that ORS 656.382(2) does not authorize an award of fees by this court. The concurrence expresses the view, however, that even though this court lacks authority under the statute to award fees, on remand from this court, it is arguably correct that the Board has the authority to make an award of attorney fees. As the concurrence recognizes, the first and most serious problem with its **<171 Or App 473/474>** position is that the question of the Board's authority to award fees on remand from this court is not before us. Accordingly, we do not address the issue at this time. Further, we note that the discussion included in the concurrence regarding this issue is the view of the concurring judges only and would not necessarily reflect the position of a majority of this court.

It could be said that there is a "gap" in the statutes authorizing attorney fees in workers' compensation cases. Under ORS 656.386(1), the claimant is entitled to fees on his or her own appeal only if the compensability of the claim is at issue. Under ORS 656.382(2), the claimant is entitled to fees only if the employer initiates the appeal or review. Neither statute allows the claimant to recover fees if the compensability of the claim is not at issue (*i.e.*, the only issue is the amount of liability or the extent of disability) and it is the claimant's appeal. In that circumstance, attorney fees must be paid out of the increased award, as provided in ORS 656.386(2) ("In all other cases, attorney fees shall be paid from the increase in the claimant's compensation"). If this situation is one that should be remedied, it is a task for the legislature, not this court.

Reconsideration allowed; order withdrawn and request for attorney fees denied.

ARMSTRONG, J., concurring.

I agree with the majority that we erred in awarding attorney fees under ORS 656.382(2) to claimant for his attorney's work in our court to reverse an erroneous Workers' Compensation Board decision. Whether the Board can award attorney fees to claimant on remand and whether it can include in its award fees for the work before us are issues that have not been raised or argued by the parties. Consequently, the court cannot now decide them. I note, however, that ORS 656.382(2) arguably could provide authority for the Board to award fees to claimant for the work before us when the Board later affirms the administrative law judge's award to claimant on insurer's request for review.

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 **<171 Or App 474/475>** the Supreme Court is initiated by an employer or insurer, and the Administrative Law Judge, 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 set by the Administrative Law Judge, 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."

After a hearing, an administrative law judge (ALJ) increased claimant's compensation award. Insurer requested review by the Board of the ALJ's decision. On review, the Board reversed the ALJ. Claimant then sought review by us, and we reversed the Board. The effect of our decision is that, on remand, the Board will enter an order that affirms the ALJ's prior award. *See Santos v. Caryall Transport*, 163 Or App 414, 987 P2d 1271 (1999); *Crowder v. Alumaflex*, 163 Or App 143, 986 P2d 1269 (1999).

By entering that order, the Board will have found that the compensation awarded to claimant by the ALJ "should not be disallowed or reduced." It will make that determination on an insurer-initiated review to the Board, so claimant apparently will be entitled to an award of attorney fees under ORS 656.382(2) from the Board.[1] In making that award, the Board is to include attorney fees incurred "prior to the * * * review." ORS 656.382(2). The attorney fees incurred on review to us were incurred prior to the Board's final decision on review, so the statute may provide authority for the Board to include those fees in its award of fees on remand.

Wollheim, J., joins in this concurrence.

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[1] Our decision returned the case to the Board and, but for our decision, there would be nothing pending before the Board. However, the matter that the *Board* must address on remand is the proper disposition of the insurer-initiated review of the ALJ's decision. The Board's decision on remand will be to affirm the ALJ in that matter, which is to say that it will dispose of the insurer-initiated request for review, not our remand order. Our decision simply tells the Board how to resolve an issue that will be back before the Board on the insurer-initiated review.

Cite as 171 Or App 491 (2000) December 20, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Gregory S. Alton, Claimant.

SAIF CORPORATION and SNYDER ROOFING & SHEET METAL, INC., Petitioners - Cross-Respondents,

v.

GREGORY S. ALTON, Respondent - Cross-Petitioner.

(WCB 98-04318; CA A105614)

En Banc

Judicial Review from Workers' Compensation Board.

Argued and submitted March 29, 2000; resubmitted en banc September 20, 2000.

Jerome P. Larkin argued the cause for petitioners - cross-respondents. With him on the petitioners' brief was David L. Runner. On the cross-respondents' brief was Jerome P. Larkin.

Megan Flynn argued the cause for respondent - cross-petitioner. On the brief were John S. Stone and Pozzi Wilson Atchison, LLP.

Before Deits, Chief Judge, Edmonds, Landau, Haselton, Armstrong, Linder, Wollheim, Kistler and Brewer, Judges.

LINDER, J.

On petition, reversed and remanded for reconsideration; affirmed on cross-petition.

Armstrong, J., concurring.

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171 Or App 493> SAIF Corporation and Snyder Roofing and Sheet Metal, Inc. (SAIF) petition for review of an order of the Workers' Compensation Board (Board), contending that the evidence on which the Board relied in affirming an award to claimant of permanent partial disability (PPD) was legally insufficient to satisfy claimant's burden of proof. Claimant cross-petitions, seeking review of the Board's classification of his disability. We reverse the award of PPD and therefore do not reach claimant's assignment of error regarding the classification of his disability.

Claimant was compensably injured in August 1995, suffering injuries to his face and head as a result of a fall.[1] Following treatment of his physical injuries, claimant complained of, among other problems, headaches, moodiness, dizziness, and memory problems.

In June 1996, claimant was examined by a psychiatrist, Dr. Bellville. Bellville noted that claimant had just been released from a 140-day court-mandated alcohol treatment program and that he was still consuming alcohol. Bellville suspected that claimant had a history of alcohol abuse and mild to moderate depression; he was uncertain of the extent to which claimant's "intellectual complaints" were due to "pre-injury, longstanding emotional or personality issues" or alcohol, rather than to his injury. He recommended that claimant receive neuropsychological testing to rule out mental disorders related to his injury.

Also in June 1996, claimant was examined by a neurologist, Dr. Bell. Bell noted claimant's apparent mental deficits, stated that it was "difficult" to determine the extent to which they were due to his injury, and recommended further testing, including a neuropsychological evaluation and an EEG.

In December 1997, Dr. Binder conducted a neuropsychological evaluation of claimant.[2] Binder noted claimant's history of alcohol abuse, including court-mandated **<171 Or App 493/494>** treatment. Claimant reported that, four days before the examination, he had consumed six to 10 beers. Claimant denied any previous history of psychiatric problems or treatment. Based on claimant's performance on

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[1] Among other injuries, claimant suffered a skull fracture, a mild closed-head injury described as a "small epidural hematoma at the anterior left temple region," and nasal and facial fractures.

[2] The 18-month delay in conducting a neuropsychological examination apparently was due in part to claimant's incarceration for 10 months during 1997.

the neuropsychological tests administered to him, which generally was worse than that of persons with "well-documented" brain dysfunction and "more serious traumatic brain injuries," Binder concluded that the results of the tests were invalid, due to lack of effort and "poor motivation" on claimant's part. Binder declined to estimate the likely outcome from claimant's injury because, according to the doctor, it was a type of injury "from which full recovery sometimes occurs and sometimes does not occur." Binder stated: "When people do not fully recover, the residual is mild or minimal in terms of Oregon Workers' Compensation definitions of disability attributable to brain injury." He opined that it was "likely" that claimant was an "alcohol abuser" and that he suffered from antisocial personality disorder. Binder concluded that he was unable to determine whether a neuropsychological condition related to claimant's injury "continues to exist"; that he did not know if claimant "has any permanent impairment"; and that claimant's "probable impairment is nil, minimal, or mild." Claimant's treating physician, Dr. Potter, concurred in Binder's findings.

In February 1998, SAIF closed claimant's claim with an award of temporary disability but no award of permanent disability. Claimant requested reconsideration by the Department of Consumer and Business Services (DCBS). DCBS appointed three medical arbiters including, as pertinent here, an ear, nose, and throat specialist and a neurosurgeon, and submitted medical information and written questions to each arbiter, as appropriate to the arbiter's medical speciality. *See* OAR 436-030-0155(1); OAR 436-030 0165(3).

In his May 1998 report, the ear, nose, and throat specialist, Dr. Holden, described claimant's nasal fracture and other physical injuries, noted his residual nasal deformity, and noted that the latter may have been the result of claimant's noncompliance and interference with his treatment "along with alcohol abuse." Holden noted that, although claimant's fractures had healed, he had "persistent symptoms of headache, dizziness, imbalance and problems **<171 Or App 494/495>** with short term memory and cognition along with psychosocial problems of depression and inadequacy * * *." Holden reported that claimant was a "chronic alcoholic with moods of depression." He concluded:

> "My sense is that [claimant] will remain dependent upon society for his care and support and I do not see any likely alternative.
>
> "I am also concerned about his brain/possible inner ear injury * * *, short term memory and cognition problems, drug abuse of alcohol and aspirin and social inadequacy. * * *
>
> " * * * Since I suspect that [claimant] has a post-traumatic inner ear concussion syndrome it would be advisable to have him tested * * * to further clarify his functional capacity mentally and physically."

Dr. Williams, the neurosurgeon, took a medical history of claimant's injury and conducted a neurological examination. In his May 1998 report, Williams stated:

> "It is my opinion that the patient is ADL [activities of daily living] assisted, being limited with cognitive impairment and psychological impairment.
>
> "It is my opinion that the patient in the head/brain injury impairment section functions as a Rancho-Los-Amigos Scale of Class III. He is alert and oriented. His behavior is appropriate for the most part. He does have impaired judgment and mild memory deficit. His language is mildly affected. He has noted personality changes. He does describe sleep disorders. I would not consider the worker safe to operate industrial machinery."

On reconsideration, DCBS determined that, based on claimant's invalid neuropsychological test results, no impairment rating was due. DCBS modified the award of temporary disability and affirmed the award of no permanent disability. It did not consider Holden's and Williams's reports because those reports had not been completed as of the time of the order on reconsideration.

Claimant requested a hearing. The record was supplemented with, as pertinent here, Holden's and Williams's reports. In the Conclusions and Opinion section of his order **<171 Or App 495/496>** after hearing, the administrative law judge (ALJ) stated, in part:

> "There is no question that claimant had preinjury psychosocial problems, including alcohol abuse. However, the evidence preponderates in favor of finding that claimant's ability to function was diminished post-injury.
>
> "The most that the attending physician could say, concurring in the report of the neuropsychologist, was that the etiology of claimant's then current condition could not be determined because of the invalidity of the test results. Although arbiter Holden noted claimant's difficulties in dealing with life prior to the injury, he concluded that claimant would be dependent on society for his support and care after the injury, and suspected an inner ear concussion syndrome as a result of the injury. Dr. Williams based his opinion of claimant's impairment on the post-injury condition of claimant, noting the post-injury changes. Presumably, Dr. Williams had reviewed claimant's medical records, and he did not attribute claimant's condition to anything other than the compensable injury. The neuropsychologist indicated that claimant's symptoms could be consistent with his head injury."

Citing *Kim E. Danboise*, 47 Van Natta 2163, *on recons* 47 Van Natta 2281 (1995), *aff'd sub nom SAIF v. Danboise*, 147 Or App 550, 937 P2d 127, *rev den* 325 Or 438 (1997), the ALJ concluded that claimant had met his burden of proving that his post-injury condition was the result of his compensable injury. The ALJ awarded claimant 74 percent unscheduled PPD. The Board affirmed the ALJ's award, specifically adopting the ALJ's reasoning and conclusion that Williams's opinion established claimant's entitlement to the disability award.

In its assignment of error, SAIF argues that the Board erred as a matter of law in concluding that the medical opinions in this case satisfy claimant's burden of proving that his permanent impairment is due to the compensable injury. According to SAIF, Williams merely measured the extent of claimant's impairment; neither he nor any other medical expert determined the cause of claimant's impairment nor expressly found that it was consistent with the **<171 Or App 496/497>** compensable injury. SAIF urges that, because this record "abundantly discloses other possible sources of claimant's impairment," the record legally is inadequate to permit a factual inference that the compensable injury caused claimant's permanent impairment.

Claimant responds that, under this court's opinion in *SAIF v. Danboise*, a claimant can meet his or her burden of establishing impairment due to a compensable injury by presenting the report of a medical arbiter that (1) contains impairment findings that are consistent with the compensable injury, and (2) does not attribute the impairment to causes other than the compensable injury. Claimant argues that the Board's application of the described test was legally correct and that, as a factual matter, substantial evidence in the record supports the Board's order.

We begin with a brief review of the principles relevant to the burden of proof in this context. The burden of proving that an injury or occupational disease is compensable, and of proving the nature and extent of any disability resulting therefrom, is on the claimant. ORS 656.266. The claimant must meet his or her burden by a preponderance of the medical evidence. *See, e.g., Barnett v. SAIF*, 122 Or App 279, 282, 857 P2d 228 (1993). OAR 436-035-0005(10)[3] is instructive in regard to the type and quality of medical evidence that is required to meet the applicable burden of proof. It defines "preponderance of medical evidence" as follows:

> "'Preponderance of medical evidence' or 'opinion' does not necessarily mean the opinion supported by the greater number of documents or greater number of concurrences; rather it means the more probative and more reliable medical opinion based upon factors including, but not limited to, one or more of the following:
>
> "(a) The most accurate history;
>
> "(b) The most objective findings;
>
> "(c) Sound medical principles; or
>
> "(d) Clear and concise reasoning."

[3] The rule was promulgated by the Workers' Compensation Division of DCBS.

171 Or App 498> *See also* ORS 656.005(19) ("'Objective findings' in support of medical evidence are verifiable indications of injury * * * 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.") Those provisions indicate that, in order for a workers' compensation claimant to meet the applicable burden of proof, the evidence put forth by the claimant ordinarily must be comprised of express findings, opinions, and reasoning of the treating physicians or medical arbiters. *See SAIF v. Gaffke*, 152 Or App 367, 954 P2d 179 (1998) (in that case, "the question of causation is a complex one, requiring expert medical opinion"); *Barnett*, 122 Or App at 282 (particularly where a claimant's injuries are complex in nature, expert medical evidence is necessary to meet the burden of proof).

With those evidentiary principles in mind, we turn to the issue raised in this case. The starting point is our decision in *Danboise*, upon which both parties rely. In *Danboise*, the medical arbiters found that the claimant had cervical impairment but did not expressly attribute the impairment to the compensable injury. The Board affirmed the award of PPD, stating in part:

> "We agree that claimant has the burden of establishing that his cervical impairment is due to his compensable injury. Claimant may, however, meet that burden by presenting a treating physician's or medical arbiter's report that: (1) contains impairment findings that are consistent with [his or her] compensable injury; and (2) does not attribute those findings to causes other than the compensable injury."

Danboise, 147 Or App at 552 (quoting Board's order; internal quotation marks omitted; emphasis omitted). The employer appealed, contending that the Board applied an incorrect standard of proof. This court determined that

> "the Board's explanation of the evidence that claimant was required to produce was correct. As the Board found, the record in this case identifies no noncompensable factors that may have contributed to claimant's impairment. The Board is correct that, *when the record discloses no other possible source of impairment, medical evidence that rates the* **<171 Or App 498/499>** *impairment and describes it as 'consistent with' the compensable injury supports a finding that the impairment is due to the compensable injury.*"

Id. at 553 (emphasis added). We concluded that the findings made by the Board met that standard and that they were supported by substantial evidence in the record. *Id.*

As those two quoted portions of our opinion reveal, there is a subtle but significant difference between the Board's and this court's articulation of how the claimant in that case satisfied her burden to prove permanent impairment in the absence of a medical opinion making express findings that the impairment was due to a compensable injury. The Board's order in *Danboise* stated that claimant satisfied her burden with evidence (1) that the physician or arbiter made impairment findings consistent with the compensable injury, and (2) that the same physician or arbiter did not attribute those findings to any other cause. In affirming the Board, our emphasis was somewhat different. We agreed that, in rating the impairment, the medical evidence expressly described the impairment as "consistent with" the compensable injury. Furthermore, we considered it significant that nothing in the record disclosed any other possible source for the impairment, not just that the medical experts failed expressly to attribute the impairment to other possible causes.

Properly understood, *Danboise* is an application of the principles that apply to factual inferences in administrative cases. Evidence to support a finding of fact ordinarily can include reasonable inferences derived from facts expressly adduced, as long as the facts on which the inference is based are themselves supported by substantial evidence in the record and as long as there is a "basis in reason" for connecting the inference to the facts from which it is derived. *See City of Roseburg v. Roseburg City Firefighters*, 292 Or 266, 271, 639 P2d 90 (1981) (so explaining). In *Danboise*, we 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. The logic **<171 Or App 499/500>** underlying the inference was: claimant has an impairment consistent with the compensable

injury; there is no evidence of any other cause for the impairment; therefore, the impairment is due to the compensable injury.[4]

Here, as SAIF points out, the record contains extensive evidence that claimant's impairment may be due to other possible causes. Indeed, those other possible causes were the reason that several of the medical experts expressly declined to attribute claimant's impairment to the compensable condition. Thus, this case is distinguishable from *Danboise*. Distinguishing *Danboise* does not end the inquiry, however. The fact that we agreed that an inference of causation could be made on the record in *Danboise* does not establish that, on this different set of facts, the inference cannot be drawn.

In this case, the Board expressly adopted "the ALJ's reasoning and conclusion that the opinion of Dr. Williams * * * establishes that claimant was entitled to an unscheduled permanent disability award." The ALJ had inferred causation from Williams's arbiter's report because Williams "presumably" had reviewed claimant's medical records and nevertheless did not attribute claimant's condition to anything other than the compensable injury. In essence, Williams's silence on causation was the "fact" from which the Board inferred that he formed a medical opinion that claimant's impairment was, to a medical probability, attributable to the compensable injury.

We agree with SAIF that the limited facts on which the Board relied will not bear the weight of the inference that the Board drew. As SAIF correctly points out, the record here **<177 Or App 500/501>** contains significant medical evidence of at least one noncompensable factor that may have caused claimant's impairment--namely, claimant's alcohol abuse. The record suggests other noncompensable factors as well--*i.e.*, that claimant was suffering from or has a history of depression and possibly other mental disorders that may be responsible for his impairment, and that the tests of the extent of claimant's impairment were influenced by his lack of effort and poor motivation. Moreover, no medical expert offered a direct opinion that claimant's impairment is attributable to the compensable condition. Nor did any medical expert even offer an express opinion that the impairment "is consistent with" the compensable condition.[5] Thus, the facts from which the Board inferred causation reduce to these two: (1) Williams was aware of possible noncompensable causes for claimant's condition; (2) Williams did not say that claimant's impairment was attributable to those other possible causes. From those two facts alone, the Board inferred that Williams must have concluded that the compensable conditions, rather than the noncompensable ones, caused the impairment.

The Board's reasoning appears to be: if Williams knew about other possible causes, and if he did not say that claimant's impairment was attributable to the other causes, then he must have concluded that claimant's impairment was not attributable to those causes. That reasoning simply is faulty. No principle in logic declares that if several things are possible, and none is selected as being probable, then a **<171 Or App 501/502>** specific one of the possible things must be more probable than the others.

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[4] As a syllogism, the logic is flawed: the conclusion that the impairment is due to the compensable injury does not invariably flow from the factual premises--*i.e.*, that the impairment is consistent with the compensable injury and that there is no evidence of other possible causes. The conclusion is not compelled because the mere absence of evidence of any other cause does not affirmatively establish that there is no other cause. As a result, the conclusion to be inferred--*i.e.*, that the impairment is due to the compensable injury--at most is a permissible one. Consistent with that observation, *Danboise* does not hold that the inference of causation *must* be drawn, only that it *may* be.

[5] The ALJ expressly relied on Binder's arbiter's report, characterizing it as containing a conclusion that claimant's impairment "could be consistent" with the compensable injury. The Board, however, declined to adopt the ALJ's reliance on Binder's report. The contents of that report suggest why. Rather than observe that claimant's impairment was or could be consistent with the compensable injury, Binder observed only that claimant's injury was such that "full recovery sometimes occurs and sometimes does not." That is an equivocal statement at best. Moreover, it cannot be viewed in isolation from the rest of Binder's reported medical opinion. Binder found that his examination was invalid and explained why (*e.g.*, that certain test scores were not consistent with the injury claimant had suffered; that certain of the neurological test results were inconsistent in ways that suggested they were invalid; that claimant was poorly motivated). The invalid testing, together with the existence of other potential causes for claimant's impairment, caused Binder expressly and directly to state that he could not make a diagnosis regarding the presence or absence of residual consequences due to claimant's injury. Binder ended his report stating: "I do not know if [claimant] has any permanent impairment because of the invalid test results."

It may be that the Board considered some additional unarticulated fact or presumption in drawing an inference of causation in this case. For example, the Board's inference might have a greater "basis in reason" if it could be presumed that a medical arbiter's findings of impairment always relate only to the compensable condition. In prior cases, however, the Board has rejected that presumption. *See Julie A. Widby*, 46 Van Natta 1065 (1994) (there is no requirement that a medical arbiter report only impairment findings that are due to the compensable injury); *see generally Kim E. Danboise*, 47 Van Natta 2281-82 (discussing cases). In all events, however, our review is limited to the Board's stated rationale. As the Supreme Court has explained:

> "Sometimes a rational nexus between an evidenced fact and an inference drawn from it is obvious from common experience (*e.g.*, we may infer from the fact of a wet street that it recently rained). In other cases, however, and particularly in cases involving expertise, the reasoning is not obvious (*e.g.*, we may infer from present meteorological conditions that it will snow tomorrow). In such an inference, we will not assume the existence of a rationale. Rather, we look to the order to state the rational basis of the agency's inference. The explanation need not be complex, but it should be sufficient to demonstrate the existence of a rational basis and to allow for judicial review."

Roseburg City Firefighters, 292 Or at 271-72 (footnote omitted). If the Board had additional facts or presumptions in mind when it drew the inference that it did, the Board did not tell us what those were. As to the explanation that the Board gave, the Board's reasoning for inferring causation in this case is insufficient.[6]

171 Or App 503> In sum, claimant presented no direct medical testimony to establish that his impairment is due to the compensable injury. Nevertheless, the Board inferred such causation from Williams's arbiter's report. The Board's stated rationale, however, does not provide a sufficient basis in reason for any such inference. Consequently, we reverse the Board's disability award and remand for reconsideration.

On petition, reversed and remanded for reconsideration; affirmed on cross-petition.

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[6] If the concurring opinion's basic point is that experts generally need not express themselves with particular word-choices, we agree, at least as a general proposition. *See Freightliner Corp. v. Arnold*, 142 Or App 98, 105, 919 P2d 1192 (1996) ("expert's testimony need not be ignored merely because it fails to include 'magic words'"). That does not mean, however, that the Board's factfinding role extends to supplying a medical opinion when the substance of the opinion is significantly in doubt because of the expert's failure to articulate it. *See SAIF v. Calder*, 157 Or App 224, 228, 969 P2d 1050 (1998) ("The Board is not an agency with specialized medical expertise entitled to take official notice of technical facts within its specialized knowledge"); *Rolfe v. Psychiatric Security Review Board*, 53 Or App 941, 951, 633 P2d 846, *rev den* 292 Or 334 (1981) ("It is one thing, however, to say that an agency may employ its experience and expertise to evaluate and understand evidence and quite another to allow it to use its special knowledge as a substitute for evidence presented at a hearing"). The fact remains that, in the workers' compensation area, the legislature expressly requires compensability and extent determinations to be made based on *preponderant medical* evidence. To meet that standard, a medical opinion must be expressed by the medical expert, even if less-than-artfully, rather than divined by the factfinder. *See generally Uris v. State Compensation Department*, 247 Or 420, 424, 427 P2d 753 (1967) (endorsing the "settled rule" that where a worker's injuries are of such character as to require skilled and professional persons to determine the cause and extent thereof, the question is one of science and must necessarily be determined by testimony of skilled, professional persons). We endorse no more liberal standard of proof or liberal view of the Board's factfinding role in these cases.

ARMSTRONG, J., concurring

I agree with the majority that we must remand this case to the Workers' Compensation Board for reconsideration. I write separately because there are two points that I think deserve particular emphasis.

First, the majority makes it clear that, contrary to SAIF's argument, our decision in *SAIF v. Danboise*, 147 Or App 550, 937 P2d 127, *rev den* 325 Or 438 (1997), does not state a rule of law of what constitutes legally sufficient evidence to prove that a claimant's injury caused his or her current condition. Rather, *Danboise* is simply one example, out of many possible examples, of how evidence may be sufficient to prove that connection. All we did in *Danboise* was to determine both that there was substantial evidence to support the inferences that the Board drew in that case and that its reasoning in that case satisfied the substantial reason test. It remains the Board's responsibility to examine the evidence in each case in order to determine what inferences it will draw and to explain its rationale for drawing them. Indeed, the **<171 Or App 503/504>** problem with this case, as the majority describes it, is primarily one of the Board's failure to give an adequate explanation for the result that it reached, not one of the evidence being legally insufficient.

My second point concerns the Board's options in reexamining the record on remand. The problem that it will face in this and other cases comes from the fact that witnesses, treating physicians, independent experts, medical arbiters, and others do not necessarily express themselves in the precise words that the Board might prefer. Thus, part of the Board's responsibility in finding the facts is to determine the meaning of the evidence before it--that is, what the witnesses and authors of reports intended to convey by the words that they used.[1] In this case, the Board must review a number of opinions in order to draw a conclusion about the relationship between claimant's injury and his current condition, and it must understand those opinions in their proper context. Thus, before Dr. Williams, the neurosurgeon, examined claimant, DCBS told him that "[t]he enclosed medicals, which may include information concerning unrelated or preexisting conditions, are to be reviewed for determining impairment due to the accepted condition(s), including any direct medical sequelae." It may be that the Board will conclude that, in light of those instructions, Williams's failure to relate claimant's condition to anything other than the compensable injury meant that he believed that the injury was the cause of claimant's current condition and that his report embodied that opinion. Whether the Board reaches that conclusion on remand, and, if it does, what weight it gives Williams's opinion in light of the rest of the record, are, of course, matters for it, not for us. I point out the possibility simply to illustrate why it would seriously distort the factfinding process to follow SAIF's suggestion in this case and treat the question as one of law.

171 Or App 505> With those understandings, I concur in the majority's decision to reverse the Board and remand the case for reconsideration.

Wollheim, J., joins in this concurrence.

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[1] I do not mean, as the majority seems to suggest, that the Board may create a medical opinion out of thin air. Rather, the Board has the responsibility to determine what the medical expert meant, and that includes determining the meaning of something that may be inartfully expressed.

Cite as 171 Or App 526 (2000) December 27, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jack B. Roy, Claimant.

JACK B. ROY, Petitioner,
v.
MCCORMACK PACIFIC COMPANY and SAIF CORPORATION, Respondents.
(97-00659; CA A105275)

Judicial review from Workers' Compensation Board.
Argued and submitted May 12, 2000.
Donald M. Hooton argued the cause and filed the brief for petitioner.
Jerome Patrick Larkin argued the cause and filed the brief for respondent.
Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.
EDMONDS, P. J.
Reversed and remanded for reconsideration.

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171 Or App 528> In this workers' compensation case, claimant seeks judicial review of an order of the Board, in which the Board upheld SAIF's denial of compensation for claimant's current condition and consequential injury. We reverse.

Claimant was injured twice. In August 1996, he suffered a torn meniscus in his left knee in a work-related accident (the August injury). The torn portion of the meniscus was surgically removed on October 1, 1996. SAIF determined that claimant's August injury and his resulting condition were compensable. It accepted a "left knee strain and contusion," and "a grade 3 tear of the posterior horn of the medial meniscus, repaired on October 1, 1996, as a result of the work-related injury of August 14, 1996." Claimant began to recover and was engaged in physical therapy when he injured the same knee again by falling on his way across a parking lot after a physical therapy appointment on October 25 (the October injury). SAIF became aware of the October injury through reports of claimant's treating physician about the new injury and not because of any action on claimant's part.

Before the October injury occurred, claimant's physician had anticipated that claimant would be released for light-duty work in a few days and that he would be medically stationary by January or February 1997. After it occurred, the physician determined that the October meniscus tear was distinct from the August meniscus tear and that claimant's fall was only partially caused by the weakened state of his knee from the August injury. The physician reported that the August injury and claimant's resulting condition was only a 25 percent factor in causing claimant to fall in October and that the October fall itself was the major cause of the October injury and claimant's current condition.

When SAIF learned of the October injury, it determined that it had caused a "consequential condition."[1] SAIF **<171 Or App 528/529>** concluded that because the October injury was caused only in minor part by the residual weakness remaining after the August injury, claimant's current condition was no longer compensable. SAIF wrote claimant and denied coverage for his October injury and his post-October 25 condition, stating:

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[1] *See* ORS 656.005(7)(a)(A) ("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."). We have defined a "consequential" injury or condition in past cases, by comparing a consequential injury with an initial compensable injury. In *Albany General Hospital v. Gasperino*, 113 Or App 411, 415, 833 P2d 1292 (1992), we said,

> "The distinction is between a condition or need for treatment that is caused by the *industrial accident*, for which the material contributing cause standard still applies, and a condition or need for treatment that is caused in turn by the *compensable injury*. It is the latter that must meet the major contributing cause test."

> "We have recently received information that you sustained a new off work injury to your left knee on October 25, 1996. The new injury has been diagnosed as a Grade III retear of the posterior horn of the medial meniscus. Since your accepted claim is not the major cause of this new consequential injury, and since the new injury is the major cause of the your current disability and need for medical treatment, the new injury and your current condition on and after October 25, 1996 are not compensable in this claim.
>
> "Therefore, we must issue this denial of your new consequential injury and current condition. SAIF Corporation will continue to provide medical benefits related to your accepted left knee strain and contusion."

Claimant requested a hearing on the denial before the hearings division. He argued that his current condition was not a consequential injury and thus, not subject to a major contributing cause standard. He also argued that

> "[t]he original injury cannot be denied by way of a current condition denial so long as that material relationship is present, and the claim has not been closed. The denial in this case, occurred prior to claim closure. *See* ORS 656.262(7)(b) and *Michael C. Leggett*, 50 Van Natta 151 (1998) (preclosure denial not permitted unless insurer has accepted a combined condition.)."

The administrative law judge (ALJ) upheld SAIF's denial, as did the Board on appeal by claimant. The Board specifically held that the October injury was a consequential **<171 Or App 529/530>** injury, that claimant's current condition was therefore subject to the major contributing cause standard of proof, ORS 656.005(7)(a)(A), and that the evidence failed to show that the August injury was the major contributing cause of claimant's post-October 25 condition. Its order states:

> "We affirm the ALJ's conclusion that claimant's new meniscus tear is a noncompensable consequential condition under ORS 656.005(7)(a)(A). It, therefore, follows that claimant's 'current condition' is not compensable so long as the new meniscus tear remained the major contributing cause of claimant's disability and need for treatment. To conclude otherwise would circumvent the legislature's intent in enacting ORS 656.005(7)(a)(A).
>
> "Finally, we note that our decision does not effect [sic] SAIF's continued responsibility for any future treatment and disability that is compensably related to the accepted August 14, 1996 injury."

Claimant now concedes that his October injury was a new, consequential injury, rather than a worsening or aggravation of the August injury or a new medical condition. However, he argues that: (1) the Board erred when it upheld the denial that SAIF issued without first closing the accepted claim, and (2) the Board erred when it failed to address the ruling of the ALJ that excluded two exhibits from the record. We address the latter issue first.

At the hearing before the ALJ in April 1997, claimant's counsel requested that the record be left open for the specific, limited purpose of the admission of a later-scheduled deposition of Dr. Witczak. Claimant was granted leave to submit that deposition testimony when it was procured. SAIF submitted the transcript of Dr. Witczak's deposition. On January 5, 1998, the ALJ scheduled closing arguments to occur in the following weeks. On January 19, 1998, claimant offered a medical arbiter's report dated July 1, 1997, and a hearings division December 31, 1997 opinion and order on claimant's extent of disability from the August injury into evidence. After SAIF objected, the ALJ entertained arguments on the admissibility of the exhibits and ruled, denying claimant's request to reopen the record for the admission of the exhibits. The ALJ reasoned that the medical arbiter's report had been in existence for several months before it was **<171 Or App 530/531>** offered and that claimant offered no explanation for that delay. He also concluded that SAIF would be prejudiced by the admission of the report because it would not be able to cross-examine the physician who had prepared the report. As to the opinion and order regarding claimant's permanent disability rating, the ALJ reasoned that it was inadmissible because it was then being challenged by claimant, and therefore was not a final order. Having ruled on claimant's evidentiary request, the ALJ stated, "The issues are compensability, attorney fees, and penalties for what claimant contends is an unreasonable denial." The ALJ ultimately held that SAIF's denial was proper.

Claimant moved for reconsideration of the ALJ's decision on May 7, 1998. He did not request reconsideration of the ALJ's ruling as to the admissibility of the evidence. SAIF's response also did not address that issue. The ALJ's order on reconsideration stated, "The parties' arguments on reconsideration have been reviewed. This review leads me to conclude that there have been no errors of fact or law and the April 16, 1998, Opinion and Order shall be republished as written by incorporation herein." Claimant appealed the order on reconsideration to the Board.

In lieu of submitting a new brief to the Board, claimant submitted the closing arguments that he had submitted to the ALJ before his motion for reconsideration. As we have stated, his initial closing argument discussed the evidentiary issue. However, in his cover letter to the Board, claimant said

> "Claimant contends the ALJ erred in assessing the standard of proof required to establish an injury to be a compensable consequence of the original injury. As it happens, this issue was throughly briefed to the Judge at hearing; he simply made the wrong decision."

The Board adopted the ALJ's findings and decision. The Board's order said, "On review, the issue is compensability." Its order made no mention of the evidentiary issue.

In light of the foregoing procedural history of the evidentiary issue, we are not persuaded that claimant put the Board on notice that it was being asked to decide the evidentiary issue. Claimant did not raise the issue in his request for **<171 Or App 531/532>** reconsideration by the ALJ, and although the argument was incorporated into claimant's closing argument to the Board because it had been included in the argument to the ALJ, counsel's cover letter to the Board did not mention it. Instead, the letter focused the Board's attention on the substantive issue of the standard to be applied to claimant's claim. Moreover, claimant did not seek reconsideration of the Board's order when it failed to address the issue. An argument that is not raised to the Board is deemed waived. *See Oregon Lox Co. v. Nichols*, 151 Or App 531, 949 P2d 741 (1997) (employer waived and failed to preserve its claim that Appellate Review Unit had lacked authority to increase workers' compensation claimant's scheduled disability awards where employer did not raise such issue at hearing before administrative law judge or Workers' Compensation Board). Consequently, we decline to consider claimant's evidentiary issue argument on review. ORAP 5.45(2).

Claimant's final argument has both procedural and substantive aspects. He argues that SAIF's denial was procedurally premature because the condition caused by his August injury was not yet medically stationary; it follows, according to claimant, that the consequential condition arising from that condition could not have been properly denied absent closure of the accepted claim. He concludes, based on the perceived procedural error, that the Board should have applied a material contributing cause standard rather than a major contributing cause standard to medical treatment for the August injury.[2] Our first inquiry, as it was with the preceding issue, is whether the issue was raised to the Board.

Claimant's contention is, at times, unclear, but he argued throughout his submissions to the Board that, "The Board erred when it affirmed a premedically stationary and preclosure denial * * *." The cover letter to the Board, as referred to above, directed the Board's attention to the merits of the case, not to any procedural error. However, claimant's closing argument to the Board reads in part:

> **171 Or App 533>** "The original injury cannot be denied by way of a current condition denial so long as that material relationship is present, and the claim has not been closed. The denial in this case[] occurred prior to claim closure. *See* ORS 656.262(7)(b) and *Michael C. Leggett*, 50 Van Natta 151 (1998) (preclosure denial not permitted unless insurer has accepted a combined condition.)."

We conclude that claimant's brief to the Board was sufficient to put it on notice as to the issue.

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[2] For example, claimant argued to the Board, "ORS 656.273(1) and the major contributing cause standard for intervening injuries discussed there, do not apply to this claim, since at the time of the October 25, 1996 injury that claimant had not yet reached a medically stationary status and the claim had not been closed."

The Board did not respond to the procedural aspect of claimant's argument. It ruled that claimant's current condition was a consequential condition, applied a major contributing cause standard and found that it had not been met. It stated,

> "We affirm the ALJ's conclusion that claimant's new meniscus tear is a noncompensable consequential condition under ORS 656.005(7)(a)(A). It, therefore, follows that claimant's 'current condition' is not compensable so long as the new meniscus tear remained the major contributing cause of claimant's disability and need for treatment. To conclude otherwise would circumvent the legislature's intent in enacting ORS 656.005(7)(a)(A).
>
> "Finally, we note that our decision does not effect [*sic*] SAIF's continued responsibility for any future treatment and disability that is compensably related to the accepted August 14, 1996 injury."

Thus, although the Board reached the merits of the claim, it failed to address the procedural issues raised by claimant that could have affected the claim. Although the order purports to maintain claimant's accepted claim in open status, it effectively prohibits compensation from being paid for claimant's current condition. The failure of the Board to address claimant's argument in its entirety renders its order insufficient for our review.

The applicable statutes frame the issue for the Board to decide on remand.[3] ORS 656.268(1) (1997), provides, in part:

> **171 Or App 534>** "Claims shall not be closed if the worker's condition has not become medically stationary unless:
>
> "(a) The 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) and the worker is not enrolled and actively engaged in training. When the claim is closed because the accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions, the likely impairment and adaptability that would have been due to the current accepted condition shall be estimated."

ORS 656.268(2)(a) (1997) provides:

> "Unless the insurer or self-insured employer has elected to close the claim pursuant to this section, when the injured worker's condition resulting from an accepted disability injury has become medically stationary or the accepted injury is no longer the major contributing cause of the worker's combined or consequential condition pursuant to ORS 656.005(7), unless the injured worker is enrolled and actively engaged in training, *the insurer or self-insured employer shall so notify the Department of Consumer and Business Services, the worker, and the employer, if any, and request the claim be examined and further compensation, if any, be determined.*" (Emphasis added.)

ORS 656.268(4)(a) (1997) provides:

> "When the worker's condition resulting from an accepted disability injury has become medically stationary, and the worker has returned to work or the worker's attending physician releases the worker to return to regular or modified employment, or when the worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005(7), the claim may be closed by the insurer or self-insured employer, without the issuance of a determination order by the Department of Consumer and Business Services."

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[3] Many of the provisions relevant in this case were amended in 1999. *See* Or Laws 1999, ch 313, section 1.

SAIF did not elect to close claimant's accepted claim at the time that it issued its denial, as it could have done under ORS 656.268(4)(a) (1997). It was therefore required by the mandatory language of ORS 656.268(2)(a) (1997) to refer the claim to the department for further examination and a **<171 Or App 534/535>** determination of further compensation. When the claimant's condition is a combined condition, ORS 656.262(7)(b) addresses this procedural issue.[4] Here, however, claimant's current condition is not a combined condition, but a consequential condition. We are unaware of any statute that authorizes an insurer to deny a consequential claim without also closing the underlying accepted claim. Moreover, we cannot discern from the record before us what effect, if any, SAIF's failure to close the accepted claim had on the payment of compensation for the accepted condition. Under the circumstances, the Board in the first instance must make the initial determination about the effect of SAIF's erroneous failure to close the August injury claim.

Reversed and remanded for reconsideration.

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[4] ORS 656.262(7)(b) provides that

"[o]nce a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim can be closed." *See also SAIF v. Belden*, 155 Or App 568, 964 P2d 300 (1998), *rev den* 328 Or 330 (1999).

Cite as 171 Or App 569 (2000) December 27, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Margaret L. Evans, Claimant.

FRED MEYER, INC., Petitioner,
v.
MARGARET L. EVANS, Respondent.
(98-07413; CA A107200)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 1, 2000.
Deborah L. Sather argued the cause for petitioner. With her on the brief were Tracy J. White and Sather, Byerly & Holloway, LLP.
Charles R. Mundorff argued the cause for respondent. With him on the brief was Westmoreland & Mundorff.
Before Landau, Presiding Judge, and Brewer, Judge, and Ceniceros, Senior Judge.
LANDAU, P. J.
Affirmed.

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171 Or App 571> Employer seeks review of an order of the Workers' Compensation Board (Board) upholding the compensability of claimant's neck surgery. Its principal contention on review is that the Board applied the wrong standard of proof by treating claimant's case as a claim for a "combined condition" instead of a "consequential condition." We affirm.

The following facts are not in dispute. Claimant worked as a receiving clerk for employer. In 1992, she was hit by a forklift while working. Employer accepted claimant's claim for shoulder, knee, and foot injuries. When other symptoms occurred, claimant submitted a claim for injuries to her neck.

In 1993, Dr. Wayson reported that claimant had degenerative disc disease in her neck that preexisted her injury and evidence of disk herniation at C5-6. In March of 1994, Wayson performed an anterior C5-6 and C6-7 discectomy and interbody fusion. Employer ultimately amended its acceptance to include a herniated disc at C5-6, but not the preexisting condition. In November 1994, employer closed the claim with an award of unscheduled disability for the neck.

In 1997, claimant returned to Wayson with complaints of numbness, tingling, and weakness in her arms. Wayson found foraminal stenosis, or narrowing of the apertures in the vertebrae. Wayson concluded that claimant required a foraminotomy, a surgical enlargement of the intervertebral foramina. Claimant underwent the surgery in 1998 and submitted a claim for "C5-6 foraminal stenosis as a consequence of compensable herniated disc." Employer denied the claim, asserting that the herniated C5-6 was not the major contributing cause of the foraminal stenosis.

At the hearing on the denial, the medical evidence concerning causation was divided. Employer's independent medical examiners took the view that the major contributing cause of claimant's need for surgery was her preexisting degenerative disc disease, while Wayson took the view that:

> **171 Or App 572>** "[W]hat has gone on is that with scarring and progressive calcification secondary to the degeneration at that level, in part related to the injury and part related to the subsequent surgery, has led to progressive compromise of the nerve root foramen. * * * I do believe the original industrial injury and subsequent need for surgery at C5-6 and C6-7 and the subsequent degeneration that was exacerbated and caused by that original injury and surgery is the major cause for the current need for medical services."

The ALJ found Wayson's opinion most persuasive and set aside the denial. The Board affirmed. The Board concluded that, based on the medical evidence, claimant's condition is properly viewed as a combined condition, thus triggering the standard of proof expressed in ORS 656.005(7)(a)(B):

> "If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition."

The Board then found, based on Wayson's opinion, that claimant had demonstrated that the major contributing cause of her need for treatment was the 1992 compensable injury and the resulting 1994 surgery.

On review, employer contends that the Board erred in concluding that claimant's condition is properly viewed as a combined condition. According to employer, it is more accurate to view claimant's condition as a consequential condition, which triggers the standard of proof expressed in ORS 656.005(7)(a)(A):

> "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."

As employer sees it, the standard applicable to combined conditions is less demanding, as it requires only that the major cause of the "need for treatment" be the compensable injury, while the standard applicable to consequential conditions **<171 Or App 572/573>** requires that the major cause of the consequential condition itself be the compensable injury.

In this case, employer argues, claimant's condition should be viewed as a consequential condition. Employer reasons that the combined condition standard applies only when a preexisting condition makes a compensable injury worse, and this is the reverse situation, that is, claimant's compensable injury made a preexisting condition worse. Such a case, employer concludes, must be subject to the standard that applies to consequential conditions. Claimant argues that it makes no sense to suggest that the worsened degenerative condition that preexisted the compensable injury can be regarded as a consequence of it. We agree with claimant.

ORS 656.005(7)(a)(B), the standard for combined conditions, applies when a "compensable injury combines at any time with a preexisting condition" to cause a disability or need for treatment. The statute contains no wording that limits its applicability to cases in which a preexisting condition makes a compensable injury worse, and not vice versa. It simply requires that the compensable injury and the preexisting condition "combine[] at any time" to create a disability or need for treatment. The operative principle is that multiple conditions combine to create a disability or need for treatment, not that one condition makes another one worse. *Lockhurst v. Bank of America,* 167 Or App 11, 16-17, 1 P3d 1031 (2000). In contrast, under ORS 656.005(7)(a)(A), 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 back strain." *Fred Meyer, Inc. v. Crompton,* 150 Or App 531, 536, 946 P2d 1171 (1997).

In this case, the Board found that claimant's compensable 1992 injury, the surgery that followed, and the preexisting degenerative condition *combined* to bring about claimant's need for further surgery. That is precisely the sort of condition to which the combined condition standard of ORS 656.005(7)(a)(B) applies. Claimant's condition is not a separate condition that arose from the compensable injury; it preexisted and combined with it. The consequential condition standard of ORS 656.005(7)(a)(A), therefore, does not apply.

171 Or App 574> We conclude that the Board did not err in applying the combined condition standard of ORS 656.005(7)(a)(B).

Employer's other arguments do not require discussion.

Affirmed.

Cite as 171 Or App 675 (2000) December 27, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Luis G. Moreno, Claimant.

LUIS G. MORENO, Petitioner,
v.
MENLO LOGISTICS, INC., Respondent.
(WCB 98-03849; CA A107054)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 14, 2000.
R. Adian Martin argued the cause and filed the brief for petitioner.
Kenneth Kleinsmith argued the cause for respondent. With him on the brief was Meyers, Radler, Replogle, Roberts & Miller.
Before De Muniz, Presiding Judge, and Haselton and Wollheim, Judges.
WOLLHEIM, J.
Reversed and remanded for reconsideration.

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171 Or App 677> Claimant seeks review of an order of the Workers' Compensation Board reversing an order of the Administrative Law Judge (ALJ) and upholding employer's denial of a claim for low back strain due to lack of proof of medical causation. We reverse the Board and remand the case for reconsideration.

The facts, for purposes of the issues presented for review, are largely undisputed. The Board found that claimant fell at work on April 21, 1998, when his right foot caught on the lip of a trailer that he had been unloading and his left leg went down in the space between the dock and the trailer. On April 22, 1998, claimant sought treatment at an urgent care clinic for complaints of pain involving the upper back, neck, and lower back. On a Form 827, filed with employer on April 22, claimant described his symptoms as "back of my neck left side and lower back hurt." Claimant again visited the urgent care clinic on April 27, 1998, and the admitting nurse wrote: "Was in on 4/22 with neck and back injury. Neck pain improved but continues to have left lower back and hip pain." The physician noted on the same form that claimant "[h]ad neck, shoulder stiffness that has improved with rest." The physician noted that claimant reported "lumbar pain with numbness left lat thigh and painful gait." The doctor diagnosed "lumbar strain with left radiculopathy."

Claimant saw Dr. Pierson on April 29, 1998, who noted that claimant had reported falling at work and straining his neck. "He was seen in the Urgent Care the same day and was mainly complaining of left neck and upper back pain." Pierson further reported:

> "The neck gradually improved, however, over the ensuing days he has developed pain in the low back and around the left hip area with numbness in the anterior left thigh. * * *
>
> "Presently, he continues to have numbness in the anterior left thigh, but no real radiation of pain down the leg. He basically points around the left hip region as the area of discomfort and toward the low back."

Pierson diagnosed a cervical strain, lumbar strain, and probable hip strain. Neither the ALJ nor the Board described in **<171 Or App 677/678>** detail the medical record before claimant's visit to Pierson, other than to note that "[t]he diagnoses made at the urgent care facility were cervical strain (trapezius) and lumbar strain."

On May 5, 1998, claimant gave a statement to an investigator for employer's insurer, saying that immediately after falling he felt a little bit of pain in the hip at the outside surface, but that at night after the fall he experienced "shocking pain" on the inside of his hip. He made no mention of neck or low back pain. On May 8, 1998, employer denied a claim for low back injury, stating that "[t]here is

insufficient evidence that your employment at Menlo Logistics either caused or contributed to your low back condition."

Claimant testified at the August 10, 1998, hearing regarding his symptoms immediately after the fall:

> "Q: All right. Can you tell us the kind of problems you were having at that time?
>
> "A: Mainly it was the soreness of my hip and--from the impact, it was probably with--probably three or four days my neck was hurting, but mainly, mainly was my--my injury on my--on my--on my hip."

The Board understood claimant's testimony to be inconsistent with his description of the injury given earlier to Pierson. It accepted claimant's testimony as the definitive description of his symptoms.

In discussing the question of medical causation, the Board noted that Pierson had been asked in his deposition about objective findings of injury and that his testimony was directed to that issue. He offered no express opinion addressing medical causation. The Board said, "[a]pparently, claimant is relying on Dr. Pierson's diagnoses of cervical strain, lumbar strain, and left hip strain as evidence that he sustained such conditions as a result of the work incident." The Board said that, "[w]hether or not diagnoses, by themselves, can establish medical causation," it did not find Pierson's opinion sufficient in light of the discrepancies between the symptoms claimant described at hearing and those on which **<171 Or App 678/679>** Pierson had relied. It held that claimant had failed to establish the compensability of his claim because he had not shown medical causation.

Initially, we reject claimant's contention that the Board could not address the question of medical causation in its order because employer waived the issue. We have examined the record and conclude that there was no waiver.

We next address claimant's contention that medical causation of claimant's low back injury is so readily apparent that it need not be established by expert opinion. *Uris v. Compensation Dept.*, 247 Or 420, 426, 427 P2d 537 (1967); *Barnett v. SAIF*, 122 Or App 279, 283, 857 P2d 228 (1993). The relevant factors for determining whether expert opinion on medical causation is required are: (1) whether the situation is complicated; (2) whether the symptoms appeared immediately; (3) whether the worker reported the occurrence to a superior; (4) whether the worker previously was free from disability of the kind involved; and (5) whether there was any expert opinion that the alleged precipitating event could not have been the cause of the injury. *Uris*, 247 Or at 426.

The question of whether medical causation can be determined without an expert opinion is a close one, but we conclude that the situation here is too complicated to be within that category. In the first place, although the Board apparently found that claimant's symptoms "arose at the same time as the fall," there was some inconsistency in the record as to the onset of claimant's symptoms. Furthermore, the relation between the mechanism of the injury and the diagnoses are not so obvious as to eliminate the necessity of expert opinion.

The Board determined that it could not rely on Pierson's opinion to support a finding of medical causation, because Pierson "did not rely on an accurate history." Specifically, the Board focused on what it considered to be the inconsistency between Pierson's statement that claimant's low back and hip symptoms arose "over the ensuing days" and claimant's testimony that he felt hip pain immediately after the fall. The Board said:

> **171 Or App 680>** "In this regard, Dr. Pierson relied on a history that the onset of claimant's low back and left hip pain was a few days *after* the work incident; as claimant's statement and testimony shows, his symptoms, *and in particular the left hip pain,* arose at the same time as the fall. *Because Dr. Pierson did not rely on an accurate history, we do not find his chart note establishes causation.*" (Emphasis added.)

We conclude, for several reasons, that the Board has not adequately explained to its rejection of Pierson's opinion. First, we do not read Pierson's report to be that hip and low back symptoms had their *onset* a few days after the incident. Pierson said that the symptoms arose "over the ensuing days," which means in the days following the injury. Secondly, we do not understand how the discrepancy is material to the question of medical causation of the low back strain. It is undisputed that in the days after his injury, claimant had pain in his low back. Six days after his injury, a nurse at the urgent care clinic noted that claimant "continues to have left lower back and hip pain." The physician on duty at the urgent care clinic reported "lumbar pain with numbness left lat thigh and painful gait." Pierson's report that claimant complained *mainly* of neck and upper back pain immediately after the injury is not inconsistent with those medical notes. Additionally, claimant's statement to the investigator and his testimony at hearing that it was his hip that hurt most after the injury is not necessarily inconsistent with a low back strain.

In summary, the Board has not adequately explained 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. *SAIF v. Grant*, 135 Or App 293, 297, 897 P2d 1200 (1995). Accordingly, we remand the claim to the Board 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.

Reversed and remanded for reconsideration.

Cite as 172 Or App 1 (2001) January 17, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Sergio Madrigal, Claimant.

SERGIO MADRIGAL, Petitioner,

v.

J. FRANK SCHMIDT & SON and LIBERTY NORTHWEST INSURANCE CORP., Respondents.

(98-04937; CA A106313)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 3, 2000.
Max Rae argued the cause and filed the brief for petitioner.
David O. Wilson argued the cause and filed the brief for respondents.
Before Landau, Presiding Judge, and Linder and Brewer, Judges.
LANDAU, P. J.
Affirmed.

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172 Or App 3> Claimant seeks review of an order of the Workers' Compensation Board (Board) upholding employer's calculation of benefits for temporary partial disability compensation. We affirm.

The relevant facts are not in dispute. In early January 1996, claimant compensably injured his ankle. His physician treated him and, on January 24, 1996, released him to modified work. Employer immediately offered claimant a light-duty job, beginning January 29, 1996, at the same wage as claimant's wage at the time of injury. Claimant did not report for the job and, in fact, did not communicate with employer until February 7, 1996. Meanwhile, employer paid claimant temporary partial disability benefits through January 28, 1996, the day before the modified work would have commenced. On May 18, 1996, claimant's physician released him to regular employment.

On August 12, 1996, claimant's claim was closed by a determination order awarding him temporary partial disability through January 29, 1996. Claimant requested reconsideration, contending that he was entitled to partial disability payments at the full rate for temporary total disability through May 17, 1996, the day before he was released to regular employment. The Board ultimately reversed the determination order, holding that, because claimant was not released to regular employment until May 18, 1996, he was, at least "theoretical[ly]," entitled to receive temporary partial disability benefits until that time. The question remains, the Board held, precisely how much claimant is entitled to receive. According to the Board, "if claimant was to receive his regular wage or more for performing modified work, [temporary partial disability benefits] would be zero."

Neither party sought judicial review of the Board's order. Employer then calculated claimant's temporary partial disability benefits for the period from January 30, 1996, through May 17, 1996, to be zero. Employer reasoned that, because claimant had turned down the offer of modified work at the same wage as his wage at the time of injury, he suffered no "loss" of wages due to his compensable condition. **<172 Or App 3/4>** Claimant requested a hearing, arguing that he is entitled to temporary partial disability benefits at the full temporary total disability rate regardless of his failure to accept the offer of modified work.

The administrative law judge (ALJ) concluded that employer correctly calculated petitioner's rate of disability benefits. The ALJ relied on OAR 436-060-0030(5), which provides that payments at the temporary total disability rate cease when the worker fails to begin modified work approved by the attending physician. The ALJ further concluded that petitioner's reading of the applicable law

> "would necessarily require the factfinder to conclude that the * * * Legislature intended to compel [insurers] to pay time loss to workers who: (1) refused valid offers of return to work; and (2) were then terminated for reasons unrelated to their work injury. I do not believe that such a construction of Chapter 656 was intended by the Legislature. ORS 656.212(1) (requiring a loss of wages to be the result of a compensable injury), 656.268(3)(c), and 656.325(5)(a) & (b) (mandating that a worker shall no longer receive temporary total disability if he, like this claimant, refuses a valid offer of modified work)."

The Board affirmed, adopting the opinion of the ALJ.

On review, claimant argues that the Board erred in upholding employer's calculation of his benefits at zero. He argues that OAR 436-060-0030(5) is invalid because it is inconsistent with ORS 656.212, which he reads as requiring the payment of temporary partial disability benefits at the full temporary total disability rate regardless of a refusal to begin modified work. Employer responds that the statute requires payment of temporary disability benefits only for wages lost due to the compensable injury, not due to the worker refusing to accept modified work. We agree with employer.

We review the Board's construction of the applicable statute as a matter of law, looking first to the text of the statute in context and then, if necessary, to legislative history and other aids to construction. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993).

172 Or App 5> Temporary disability benefits generally are intended to provide replacement for wages lost due to a compensable injury. *Cutright v. Weyerhaeuser Co.*, 299 Or 290, 296, 702 P2d 403 (1985). As this court held in *Roseburg Forest Products v. Wilson*, 110 Or App 72, 75, 821 P2d 426 (1991), "[i]n the absence of a legislative direction to the contrary, [temporary disability benefits] are not available if the loss results from other than the compensable injury." The question in this case is whether there is any "legislative direction to the contrary."

ORS 656.210 provides for the payment of time loss benefits when the worker suffers a temporary total disability. Under that statute, the worker is entitled to 66-2/3 percent of wages at the time of the injury, not to exceed 100 percent of the average weekly wage. When the disability becomes only partial in character, ORS 656.212 provides that:

> "(1) No disability payment is recoverable for temporary disability suffered during the first three calendar days after the worker leaves work or loses wages as a result of the compensable injury. If the worker leaves work or loses wages on the day of the injury due to the injury, that day shall be considered the first day of the three-day period.
>
> "(2) The payment of temporary total disability pursuant to ORS 656.210 shall cease and the worker shall receive that proportion of the payments provided for temporary total disability which the loss of wages bears to the wage used to calculate temporary total disability pursuant to ORS 656.210."

Thus, under subsection (2), when a temporary disability becomes partial in character, the worker's benefit is calculated as a percentage of the temporary total disability benefits. In turn, that percentage is the "loss of wages" divided by the wage used to calculate the temporary total disability.

At issue in this case is the meaning of the "loss of wages" component of the fraction. Claimant contends that it means whatever wage he is not making following the compensable injury, regardless of the reason for that loss. In claimant's view, because he did not work after his injury, his "loss of wages" is the full amount of the wages earned at the **<172 Or App 5/6>** time of injury and used to calculate his temporary total disability; the fraction thus equals "1," and he is entitled to full temporary total disability benefits. Employer argues that the "loss of wages" refers to wages lost *as a result* of the compensable injury. In this case--because it is undisputed that the wages were lost solely because claimant refused to accept modified work--the "loss of wages" component of the fraction is zero, and thus he is entitled to zero times the temporary total disability benefits, or zero.

We begin by noting that, under the ordinary meaning of the term "loss," claimant's reading of the statute is unlikely. "Loss" generally refers to "the act or fact of losing." *Webster's Third New Int'l Dictionary*, 1338 (unabridged ed 1993). To "lose" generally means "to suffer deprivation of : part with esp. in an unforeseen or accidental manner." *Id.*; *see also Black's Law Dictionary*, 945 (6th ed 1990) (defining "lose" as "to suffer the loss of; to be deprived of; part with, especially in an accidental or unforeseen manner; as to lose an eye"). That would suggest that a "loss of wages" within the meaning of ORS 656.212(2) refers to a deprivation of wages as a result of an accidental or unforeseen compensable injury.

The manner in which the term is used elsewhere in the same section confirms that "loss of wages" was intended to mean what its ordinary wording suggests. Subsection (1) of ORS 656.212 spells out the timing of temporary partial disability benefits. The first of two sentences provides that, when a temporary disability becomes partial in character, the worker may not recover any benefits during the first three days after the worker "leaves work or *loses wages as a result of the compensable injury.*" (Emphasis added.) The loss of wages is explicitly causally connected with the compensable injury. ORS 656.212(1). The second sentence then provides that, if the worker "leaves work or loses wages on the day of the injury due to the injury," that day commences the three-day period. *Id.* That sentence, too, explicitly connects the loss of wages with the compensable injury.

Subsection (2) of ORS 656.212 then describes the amount of the temporary partial disability benefit. It declares that, after that three-day period, the amount of the **<172 Or App 6/7>** benefit is determined by the aforementioned formula, a component of which is "*the* loss of wages." The use of the definite article--"the loss of wages"--indicates that the phrase refers to the same loss of wages that is mentioned in the preceding two sentences. *See, e.g., Anderson v. Jensen Racing, Inc.*, 324 Or 570, 578-79, 931 P2d 763 (1997) (use of the definite article is an indicator of statute's intended meaning). Thus, it refers to the loss of wages due to the compensable injury.

To read the statute otherwise would require the same wording to mean two different things in the same statutory section. Nothing in the text of the statute suggests that the legislature intended that unlikely construction. *See PGE*, 317 Or at 611 (citing presumption that the "use of the same term throughout a statute indicates that the term has the same meaning throughout the statute").

Moreover, claimant's construction of ORS 656.212(2) cannot be reconciled with the general obligation of the worker to mitigate his or her losses. Under ORS 656.325(2), for example, a worker's benefits may be suspended if he or she commits acts that "imperil or retard recovery" or if the worker "refuses to submit to such medical or surgical treatment as is reasonably essential to promote recovery." Closer to the point, under ORS 656.325(5), when a worker receiving temporary total disability benefits refuses modified employment for which he or she is qualified, the worker is no longer entitled to those benefits. ORS 656.268(3)(c) similarly provides that temporary total disability benefits must cease if, after being released to modified work, a worker refuses to accept an offer of such work. As the Supreme Court observed in *Nelson v. EBI Companies*, 296 Or 246, 252, 674 P2d 596 (1984), such statutes indicate that a "claimant who has suffered personal injury has a duty to minimize his or her damages." Claimant's suggestion that, under ORS 656.212(2), a partially disabled worker may receive temporary total disability benefits merely by refusing to take a valid offer of modified work clearly is at odds with that duty.

We conclude that the Board correctly upheld employer's calculation of claimant's temporary partial disability benefits to be zero.

172 Or App 8> Claimant advances other arguments for reversal of the Board, but they do not require discussion.

Affirmed.

Cite as 172 Or App 233 (2001) January 31, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Conrid J. Paxton, Claimant.

RLC INDUSTRIES, Petitioner,

v.

SUN STUDS, INC./SAIF CORPORATION; WOOLLEY ENTERPRISES/SAIF CORPORATION; and CONRID PAXTON, ALLER & MORRISON/SAIF CORPORATION, Respondents.

(95-00537, 94-13809 and 94-10357; CA A103762)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 1, 1999.

Charles E. Bolen argued the cause for petitioner. With him on the brief was Hornecker, Cowling, Hassen & Heysell.

William Blitz argued the cause and filed the brief for respondent Woolley Enterprises.

David L. Runner waived appearance for respondents SAIF Corporation and Sun Studs, Inc.

No appearance for respondents Conrid Paxton and Aller & Morrison.

Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.

ARMSTRONG, J.

Reversed and remanded.

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172 Or App 235> This case is before us on review for the second time. *See SAIF Corporation v. Paxton*, 154 Or App 259, 959 P2d 634 (1998). In the current proceeding, RLC Industries (RLC) seeks reversal of an order of the Workers' Compensation Board that assigned responsibility for claimant's hearing loss to it under the last injurious exposure rule. We reverse.

Claimant is a heavy equipment maintenance worker. He worked for Woolley Enterprises (Woolley) from 1977 to January 1981, for RLC from January 1981 to October 1991, and for Sun Studs, Inc. (Sun Studs) after 1991. Claimant's first hearing test, which was conducted for RLC on June 4, 1981, showed substantial hearing loss. Although claimant's subsequent hearing tests were somewhat inconsistent, the two doctors whose opinions the Board credited concluded that claimant's occupational hearing loss occurred before June 4, 1981. The Board nonetheless assigned responsibility for the entire hearing loss to Sun Studs under the last injurious exposure rule.

In our prior review, we held that the Board had erred in assigning responsibility to Sun Studs because the medical evidence showed that that employment could not have contributed to the hearing loss. On remand, the Board assigned responsibility to RLC, once again relying on the last injurious exposure rule. RLC argues on review that responsibility cannot be assigned to it because OAR 436-035-0250(2) allows an employer to absolve itself of responsibility for a hearing loss by documenting the loss within the first 180 days of a claimant's employment, and RLC documented claimant's loss within the first 180 days of his employment with RLC.[1] Although OAR 436-035-0250(2) concerns the rating of a hearing disability rather than the assignment of responsibility for it, and therefore is not strictly applicable to this case, see OAR 436-035-0003, we conclude that RLC has proved that it could not have caused the loss. Responsibility **<172 Or App 235/236>** for claimant's injuries therefore shifts to Woolley under the last injurious exposure rule.

When there is a dispute about which of several employers is responsible for an occupational disease or injury, the last injurious exposure rule "assigns initial responsibility for the claimant's occupational [condition] to the last employer for whom the claimant worked before the claimant became disabled by or sought treatment for the [condition] whose work conditions could have caused the [condition]." *MacMillan Plumbing v. Garber*, 163 Or App 165, 170, 986 P2d 1275 (1999). "The last insurer can transfer liability to a previous insurer by establishing that it was impossible for its employer to have caused the condition or that a prior period of employment was the sole cause of the condition." *Reynolds Metals v. Rogers*, 157 Or App 147, 153, 967 P2d 1251 (1998), *rev den* 328 Or 365 (1999) (citations omitted).

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[1] The rule deals with tests conducted within 180 days of assignment "to a high noise environment." OAR 436-035-0250(2). There is no dispute that claimant's employment with RLC involved employment in a high noise environment, so we will refer to the test as having been conducted within 180 days of claimant's employment with RLC.

Further, if the medical evidence is such that causation is easily apportioned among employers, we have held that the last injurious exposure rule does not apply: "[W]hen injuries are so distinct that it is possible to segregate them in terms of causation, responsibility for the injuries can and will be apportioned between or among the employers." *James River Corp. v. Green*, 164 Or App 649, 652-53, 993 P2d 157 (1999) (citations and internal quotation marks omitted).[2] That exception to the last injurious exposure rule accords with its dual purposes, which are administrative efficiency and precision in the assignment of responsibility. *See Runft v. SAIF*, 303 Or 493, 502, 739 P2d 12 (1987). Under the principles outlined above, we conclude that RLC has shown that it was impossible for it to have caused claimant's loss.

Claimant had worked for RLC for about five months before his first hearing test revealed his injury. Thus, under the last injurious exposure rule, the liability for claimant's hearing loss falls on RLC unless it can prove that it was impossible for it to have caused the condition or that another employer was solely responsible for it. *See Reynolds Metals*, 157 Or App at 153. Here, the use of multiple audiograms **<172 Or App 236/237>** allows RLC to prove that it could not have caused claimant's injury. Based on the audiograms, both of the doctors whose opinions the Board credited concluded that claimant's entire work-related hearing loss occurred before the June 4, 1981, hearing test conducted for RLC. RLC argues that, in conjunction with the medical evidence, OAR 436-035-0250(2)[3] establishes that claimant's hearing loss occurred before his employment with RLC, which began in January 1981.[4] We agree with RLC that, by absolving employers from the obligation to compensate claimants for preexisting losses that are documented within the first 180 days of employment, the rule indirectly establishes that RLC could not have caused claimant's hearing loss.

Although the rule was created for use in rating a claimant's disability, ignoring it in the responsibility context could lead to troubling results. For instance, claimant joined all three potentially responsible employers as parties at the outset of the case. If we were to ignore the principle of causation implicit in OAR 436-035-0250(2) and simply apply the last injurious exposure rule without reference to it, responsibility for claimant's hearing loss would fall on RLC. However, when RLC closed claimant's claim and calculated his disability award, the principle of causation in OAR 436-035-0250(2) apparently could allow RLC to offset 100 percent of claimant's hearing loss. Claimant would then be left with no compensation because both of the other potentially responsible employers, Woolley and Sun Studs, would already have been absolved of responsibility under the last injurious exposure rule. That result, which is precisely the type that the last injurious exposure rule was designed to prevent, *see Runft*, 303 Or at 502, militates against applying the rule without **<172 Or App 237/238>** reference to the methods by which disability awards are calculated. Accordingly, we reject that approach and apply the last injurious exposure rule in light of OAR 436-035-0250(2), which means that responsibility for claimant's loss shifts to Woolley.

Woolley argues that RLC is precluded from attempting to shift responsibility to it under ORS 656.308(2) (1990) because, when RLC initially disclaimed responsibility, it failed to list Woolley as a potentially responsible employer. Under the circumstances of this case, we reject Woolley's argument.

ORS 656.308(2) (1990) provided that

> "[n]o employer or insurer shall be joined in any workers' compensation proceeding unless the worker has first filed a timely written claim for benefits against the employer or insurer * * *. Any employer or insurer which intends to disclaim responsibility for a given injury or disease claim on the basis of an injury or exposure with another employer or insurer shall mail a written notice to the worker as to this position within 30 days of actual knowledge of being named or joined in the claim. The notice shall specify

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[2] We also noted in *James River Corp.* that hearing loss is one of the conditions for which it often is possible to segregate injuries in terms of causation. *James River Corp.*, 164 Or App at 653.

[3] OAR 436-035-0250(2) provides that

> "[c]ompensation may be given only for loss of normal hearing which results from an on-the-job injury or exposure. * * * [H]earing loss which existed before this injury or exposure will be offset against hearing loss in the claim, if adequately documented by a baseline audiogram obtained within 180 days of assignment to a high noise environment."

[4] Although OAR 436-035-0250 technically deals with rating a claimant's disability compensation, and therefore comes into play only after responsibility has been assigned, we have previously applied the rule to apportion responsibility. *See Green*, 164 Or App at 653.

> which employer or insurer the disclaiming party believes is responsible for the injury or disease. The worker shall have 60 days from the date of mailing of the notice to file a claim with such other employer or insurer. Any employer or insurer against whom a claim is filed may assert, as a defense, that the actual responsibility lies with another employer or insurer, regardless of whether or not the worker has filed a claim against that other employer or insurer, if that notice was given as provided in this subsection."

RLC mailed two versions of the required written notice to claimant, both within 30 days. The first did not list any other employer or insurer as the responsible party; the second listed only Sun Studs.

Based on our decisions in *Gosda v. J. B. Hunt Transportation*, 155 Or App 120, 962 P2d 777 (1998), *Garibay v. Barrett Business Services*, 148 Or App 496, 941 P2d 1036 (1997), and *Farmers Ins. Group v. Huff*, 149 Or App 298, 942 P2d 853 (1997), Woolley argues that RLC's failure to name **<172 Or App 238/239>** Woolley in the disclaimer precludes RLC from arguing on appeal that Woolley is the responsible party. We disagree.

In *Garibay*, the employer sought to shift responsibility without having disclaimed responsibility at all. As a consequence of that failure, the claimant did not join the other potentially responsible employers. *Garibay*, 148 Or App at 500-01. The employer's utter lack of compliance with 656.308(2) (1990) in *Garibay* and the claimant's resultant failure to join the other potentially responsible employers distinguish that case from this one. In *Gosda*, we applied the 1995 version of ORS 656.308(2) and merely discussed the circumstances of *Garibay* in our analysis. *Gosda*, 155 Or App at 124. Nothing that we said in *Gosda* broadens our holding in *Garibay*.

Finally, in *Farmers Ins. Croup*, one of two insurers had issued an untimely disclaimer. The claimant nonetheless joined both insurers in the proceeding, and the Board absolved from responsibility the insurer that had entered an untimely disclaimer and held the other insurer responsible. We affirmed, noting that the one insurer's untimely disclaimer did not bar the claimant from proving his case against the other insurer. *Farmers Ins. Group*, 149 Or App at 305-07. Although the Board in *Farmers Ins. Group* found that the claimant had elected to pursue his claim against the complying employer,[5] it specifically declined to require "that there be a special effort or preference exhibited by a claimant before there can be a finding that a claimant has 'actively pursued' a claim against a carrier." *Joseph R. Huff*, 48 Van Natta 731, 734 (1996). We affirmed the Board's determination that the claimant in *Farmers Ins. Group* had pursued a claim against the complying employer in spite of the fact that the claimant had done little more than join that employer in the proceeding.[6] *Farmers Ins. Group*, 149 Or at 306-07. This **<172 Or App 239/240>** case is similar to *Farmers Ins. Group* in that both of the relevant employers were parties from the beginning. This case is also similar to *Farmers Ins. Group* in that claimant, by joining Woolley, has elected to pursue his claim against it. In addition, like the claimant in *Farmers Ins. Group*, claimant has proven his claim against a complying employer, Woolley.

Our conclusion is bolstered by the purpose of the disclaimer requirement in ORS 656.308(2) (1990), which is to protect the claimant from being left without compensation if she fails to identify all of the potentially responsible employers. *See, e.g., Garibay*, 148 Or App at 501. It does that by denying the noncomplying employer a responsibility defense against the claimant, thereby allowing *the claimant* to recover against a noncomplying employer in the event that the other potentially responsible employers have not been joined. Here, because all of the potentially responsible employers were joined, there is no danger of claimant being left without a remedy from the responsible employer for a compensable claim. We conclude, therefore, that the Board erred in assigning responsibility to RLC under the last injurious exposure rule.

Reversed and remanded.

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[5] In this case, we use the adjectives "complying" and "noncomplying" to refer to the employer's compliance or lack of compliance with the requirements of ORS 656.308(2) (1990), rather than with the coverage requirements of the Workers' Compensation Law.

[6] The Board in *Farmers Ins. Group* pointed to only one piece of evidence, other than the claimant's joining the complying employer, that indicated that the claimant was actively pursuing a claim against the complying employer: the fact that the claimant's counsel replied in the affirmative when the ALJ asked whether the claimant was actively pursuing a claim against the complying employer. *Joseph R. Huff*, 48 Van Natta at 734.

Cite as 172 Or App 446 (2001) February 14, 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.
(WCB 97-09540, 97-09535, 97-07489 & 97-02870; CA A104744)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 24, 1999.
Jenny Ogawa argued the cause for petitioners - cross-respondents. With her on the briefs was Kevin L. Mannix, P.C.
Thomas M. Cary argued the cause for respondent - cross-petitioner. With him on the brief was Cole, Cary, Wing & Bloom, P.C.
Julene M. Quinn argued the cause and filed the brief for respondents SAIF Corporation/Sherman Brothers.
David O. Wilson filed the brief for respondents Liberty Northwest Insurance Corporation/Sherman Brothers.
John Snarskis argued the cause and filed the brief for respondents Industrial Indemnity/Kwik Kafe of Oregon.
Haselton, Presiding Judge, and Deits, Chief Judge,* and Wollheim, Judge.
WOLLHEIM, J.
Affirmed on petition and on cross-petition.

*Deits, C. J., *vice* De Muniz, J., resigned.

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172 Or App 449> The primary issue in this workers' compensation case is which of claimant's multiple employers is responsible for his current low back condition. The Workers' Compensation Board assigned responsibility to Jerry and Jean Trucking and its insurer, SAIF Corporation (SAIF/J&J). They sought review of the Board's order, and claimant cross-petitioned from the Board's order, asserting that under ORS 656.308 or *Industrial Indemnity Co. v. Kearns*, 70 Or App 583, 690 P2d 1068 (1984), claimant's subsequent employer, SAIF/Sherman Brothers, is responsible. Claimant also seeks attorney fees in his cross-petition. We affirm the Board on both the petition and cross-petition.

In May 1978, claimant sustained a low back injury while working for Kwik Kafe, which was insured by Industrial Indemnity (II/Kwik Kafe). Testing revealed that claimant had degenerative changes in his low back. Claimant underwent a lumbar laminectomy. In December 1978, the claim was closed with an award of 15 percent unscheduled permanent partial disability (PPD). In June 1980, claimant underwent another lumbar laminectomy. The claim was again closed in July 1981 with an award of an additional 10 percent unscheduled PPD.

In July 1983, claimant sustained another back injury while working for Jerry & Jean Trucking. SAIF/J&J accepted the claim but did not specify what condition it accepted. This claim was closed in February 1984 with an award of 15 percent unscheduled PPD.

In the mid-1980s, claimant began working as a truck driver for Sherman Brothers, which was then insured by Liberty Northwest Insurance Corporation (LNW/Sherman). In February 1987, claimant sustained a back and shoulder injury. LNW/Sherman accepted the claim but did not specify what condition it accepted. This claim was closed in April 1987 without an award of any PPD.

In September 1994, claimant sustained yet another low back injury while working for Sherman Brothers. At that time, Sherman Brothers was insured by SAIF (SAIF/**<172 Or App 449/450>** Sherman). SAIF/Sherman accepted a non-disabling claim for a lumbosacral/cervical strain.

While still working for Sherman Brothers, claimant sustained his most recent low back injury in November 1996. SAIF still insured Sherman Brothers at the time of this injury. On February 7, 1997, SAIF/Sherman accepted a claim for a non-disabling lumbar strain.

Claimant's condition continued to be symptomatic, and his attending physician recommended additional surgery. In April 1997, SAIF/Sherman issued a compensability denial of claimant's current condition, stating:

> "Your accepted lumbar strain *combined with* one or more pre-existing condition(s). However, on March 17, 1997, your lumbar strain has ceased to be the major cause of the treatment and disability of the *combined condition.*" (Emphasis added.)

In May 1997, SAIF/Sherman issued a disclaimer of responsibility but did not request a paying agent order pursuant to ORS 656.307. Soon thereafter, II/Kwik Kafe, SAIF/J&J, and LNW/Sherman also disclaimed responsibility for claimant's current condition.

The administrative law judge (ALJ) set aside SAIF/Sherman's compensability and responsibility denial and upheld the responsibility denials of the other insurers. On review, the Board reversed that part of the ALJ's order that set aside SAIF/Sherman's compensability and responsibility denials and concluded that SAIF/J&J was responsible for claimant's current low back condition.

The focus of the Board's analysis was on which insurer remained responsible for claimant's current low back condition under ORS 656.308(1).[1] The Board first examined **<172 Or App 450/451>** whether claimant's current low back condition was a condition previously accepted by SAIF/Sherman in 1994 or 1996. The Board found that SAIF/Sherman's prior acceptances were limited to "a nondisabling lumbar strain and a nondisabling lumbosacral/cervical strain." The Board then concluded that claimant's current low back condition included "degeneration of the lumbar spine and spinal stenosis[.]" The Board reasoned that because claimant's current low back condition did not involve the same condition previously accepted by SAIF/Sherman, ORS 656.308(1) did not apply. *See Multifoods Specialty Distribution v. McAtee*, 164 Or App 654, 993 P2d 174 (1999). The Board upheld SAIF/Sherman's denials.

Next, the Board found that claimant's current low back condition was the same condition accepted by SAIF/J&J in 1983. Accordingly, the Board held that SAIF/J&J was responsible for claimant's current low back condition.

The scope of SAIF/J&J's acceptance is a question of fact. *SAIF v. Tull*, 113 Or App 449, 832 P2d 1271 (1992). The Board's order determining that claimant's current low back condition is the same condition accepted by SAIF/J&J but not the same condition accepted by SAIF/Sherman is supported by substantial evidence. We therefore affirm the Board's determination that SAIF/J&J is responsible for claimant's current condition.

In his cross-petition, claimant contends, among other things, that he is entitled to attorney fees from SAIF/Sherman under ORS 656.386(1). In light of our determination affirming the Board's order upholding SAIF/Sherman's compensability denial, we reject the contention. We also reject claimant's remaining assignments of error without further discussion.[2]

Affirmed on petition and cross-petition.

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[1] ORS 656.308(1) 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. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer."

[2] We asked the parties for additional briefing to address the application of *Croman Corp. v. Serrano*, 163 Or App 136, 986 P2d 1253 (1999). We are persuaded that that decision is inapplicable here, primarily because no party has challenged the procedural propriety of SAIF/Sherman's denial.

Cite as 172 Or App 470 (2001) February 14, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

SOMMUANG PANPAT, as Personal Representative for the ESTATE OF ACHARA TANATCHANGSANG, Respondent,

v.

OWENS-BROCKWAY GLASS CONTAINER, INC., a Delaware corporation, Appellant, and STANLEY-SMITH SECURITY, a Texas corporation, dba Wallace Security; WALLACE PRINCE, individually and in his capacity as Security Supervisor; and A. J. CAMPBELL, individually and in his capacity as a Security Officer, Defendants.

OWENS-BROCKWAY GLASS CONTAINER, INC., a Delaware corporation, Third-Party Plaintiff,

v.

ESTATE OF CHRIS A. BLAKE, Third-Party Defendant.

(9708-06234; CA A104501)

Appeal from Circuit Court, Multnomah County.

Michael H. Simon, Judge pro tempore.

Argued and submitted May 2, 2000.

Lee Ann Huntington argued the cause for appellant. With her on the briefs were Stephen M. Hankins, Charles F. Adams, Andrew R. Gardner, Morgenstein & Jubelirer LLP and Stoel Rives LLP.

Jana Toran argued the cause for respondent. With her on the brief was James Patrick McHugh, Jr.

Before Haselton, Presiding Judge, and Linder and Kistler, Judges.

KISTLER, J.

Order granting a new trial as to Owens-Brockway Glass Container, Inc., reversed; otherwise affirmed.

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172 Or App 473> Employer[1] appeals from an order granting plaintiff's motion for a new trial in this wrongful death action. We reverse the order as to employer and remand with instructions to enter judgment in employer's favor.

Chris Blake and Achara Tanatchangsang worked on the same shift in employer's Portland manufacturing plant. Blake and Tanatchangsang were also involved in a romantic relationship that ended in November 1995. In January 1996, Blake told employer's plant superintendent that he was having difficulty coping with the breakup and that he did not want to work the same shift as Tanatchangsang. Employer's plant superintendent approached Tanatchangsang and offered to transfer her to a different shift. Tanatchangsang did not want to be transferred, however. In January 1996 and again in March 1996, Tanatchangsang reported to her supervisor that Blake had called her derogatory names. At some point after the March 1996 incident, Blake was placed on medical leave.

In April 1996, while still on medical leave, Blake entered employer's manufacturing plant and shot and killed Tanatchangsang while she was at work. He then killed himself. Tanatchangsang's estate brought this wrongful death action against employer, alleging that it had failed to provide security in the workplace that would have protected Tanatchangsang from Blake and that employer's "conduct was a substantial factor in causing the death of Tanatchangsang." Specifically, plaintiff alleged that employer had negligently

"created a foreseeable risk of harm to Tanatchangsang in the following particulars:

"(a) In failing to instruct security officers to refuse entry to Blake;

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[1] Plaintiff sued Owens-Brockway Glass Container, Inc., Stanley-Smith Security, and two of Stanley-Smith's security officers. The trial court granted summary judgment in favor of all four defendants. Plaintiff moved for a new trial. The trial court granted plaintiff's new trial motion and Owens-Brockway has appealed from that ruling. *See Carter v. U. S. National Bank*, 304 Or 538, 546, 747 P2d 980 (1987). On appeal, we refer to Owens-Brockway as employer.

172 Or App 474> "(b) In failing to provide training to security officers regarding [employer's] policies;

"(c) In failing to provide Tanatchangsang security despite knowledge that Blake posed a substantial risk of harm to her;

"(d) In failing to intervene when notified Tanatchangsang was being held at gunpoint;

"(e) In allowing a visibly intoxicated person to enter the facility; and, or

"(f) After observing Blake's presence, by failing to direct him to exit the premises."[2]

Employer moved for summary judgment on three grounds: (1) that it had no notice of the need to control Blake; (2) that Blake's criminal act was not foreseeable; and (3) that the Oregon workers' compensation system provides the exclusive remedy for plaintiff's claim. The trial court granted employer's summary judgment motion because "plaintiff ha[d] failed to present a genuine issue for trial concerning [employer's] knowledge of the need to control Chris Blake." The trial court entered judgment in employer's favor.

Plaintiff moved for a new trial because it had discovered a workplace violence policy that employer had promulgated. Plaintiff argued that, once Blake called Tanatchangsang derogatory names in the workplace, the workplace violence policy required employer to "'take steps based on *available information* to address to the extent possible the risk of reoccurrence of such incident or of *further violence*.'" (Emphasis in original.) The court granted plaintiff's new trial motion, and employer appeals from that ruling. On appeal, employer argues that, because the workplace violence policy was a subsequent remedial measure, it was inadmissible and could not provide a basis for granting a new trial. Employer also argues that plaintiff's wrongful death "is barred by the exclusive remedy provision of the workers' compensation law." Plaintiff responds that the court correctly granted its new trial motion based on newly discovered evidence and that, in any event, the court could have granted the new trial **<172 Or App 474/475>** motion because the court had erred initially in granting employer's summary judgment motion.

We begin with employer's summary judgment motion and its argument that the workers' compensation system provides plaintiff's exclusive remedy. *See Krushwitz v. McDonald's Restaurants*, 323 Or 520, 525, 919 P2d 465 (1996) (considering that issue as a defense to a wrongful death claim). ORS 656.018 provides that, if a worker's injury "aris[es] out of and in the course of employment," a worker may not bring a tort action against the employer; rather, the worker is limited to his or her remedy under the workers' compensation laws.[3] Because this case arises on summary judgment, employer can prevail on its workers' compensation defense only if the facts, taken in the light most favorable to plaintiff, show that the injury that produced Tanatchangsang's death arose out of and in the course of her employment. *See Krushwitz*, 323 Or at 526, 532-33.

In this case, there is no dispute that the injury that caused Tanatchangsang's death occurred in the course of her employment. The question is whether that injury arose out of her employment. The Oregon Supreme Court has explained that the question whether an injury arises out of employment "tests the causal connection between [a] claimant's injury and a risk connected with her employment." *Fred Meyer, Inc. v. Hayes*, 325 Or 592, 601, 943 P2d 197 (1997). A claimant need not show that the risk was peculiar to the work or that the work quantitatively increased the risk of injury. *Id.* "Rather, 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." *Id.*

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[2] Plaintiff did not allege that employer was negligent in failing to warn Tanatchangsang.

[3] ORS 656.018 is subject to certain exceptions that are not applicable here. We also note that the Supreme Court has held that applying the workers' compensation exclusivity provisions to a negligent wrongful death claim does not violate Article I, section 10, of the Oregon Constitution. *Kilminster v. Day Management Corp.*, 323 Or 618, 627-28, 919 P2d 474 (1996). Plaintiff accordingly has not raised a constitutional challenge to employer's assertion that workers' compensation provides plaintiff's exclusive remedy.

In *Redman Industries, Inc. v. Lang*, 326 Or 32, 40, 943 P2d 208 (1997), the court explained that the risk of assault by a coworker in the workplace ordinarily "is a risk to **<172 Or App 475/476>** which the work environment exposes an employee" and thus arises out of work. *Id.* However, that is not always true. *Id.* "When the motivation for an assault by a coworker is an event or circumstance pertaining to the assailant and the claimant that originated entirely separate from the workplace, and the only contribution made by the workplace is to provide a venue for the assault," the assault does not arise out of employment. *Id.*; *see also Robinson v. Felts*, 23 Or App 126, 133, 541 P2d 506 (1975). The court noted, as an example, that "where two employees had a romantic relationship outside of work and a workplace assault by one on the other was based on an event unique to that relationship and was not fueled, in part, by any workplace event," the assault would not arise out of employment. *Redman*, 326 Or at 41.

On appeal, plaintiff argues that Blake's assault on Tanatchangsang was motivated purely by personal reasons and thus fits squarely within the example noted in *Redman*. It follows, plaintiff reasons, that Tanatchangsang's injury did not arise out of work and that the workers' compensation statutes do not bar its negligence claim against employer. Employer responds that plaintiff faces a dilemma. If Blake's personal animosity were the sole cause of Tanatchangsang's death, as plaintiff argues, plaintiff has not stated a negligence claim against employer. In order to state a negligence claim against it, employer reasons, plaintiff must allege that employer's conduct was a substantial factor in causing Tanatchangsang's death. *See Purcell v. Asbestos Corp., Ltd.*, 153 Or App 415, 421, 959 P2d 89, *on recons* 155 Or App 1, 963 P2d 729 (1998), *rev den* 325 Or 438 (1999).

Employer notes that plaintiff has alleged, presumably to supply the necessary causal link for its negligence claim, that employer's failure to take steps in the workplace to protect Tanatchangsang from foreseeable injury was a "substantial factor in [her] death[.]" Employer argues that, while that allegation supplies the necessary causal link for plaintiff's negligence claim, it also establishes that Tanatchangsang's death arose in substantial part from a risk to which the work environment exposed her. *See Fred Meyer, Inc.*, 325 Or at 601-02. Employer concludes that, to the extent that a risk to which the workplace exposed Tanatchangsang **<172 Or App 476/477>** was a substantial factor in causing her death, workers' compensation provides the exclusive remedy for the injury that Tanatchangsang suffered.

Employer's argument potentially raises two issues. The first issue is whether an allegation that an employer's conduct was a substantial factor in causing a worker's injury (the causal test for negligence) always establishes that the injury resulted from a risk to which the workplace exposed the worker (the causal test for workers' compensation).[4] We need not decide that broad issue to resolve this case, however. In this case, plaintiff's six specifications of negligence either allege that the injury that Tanatchangsang suffered resulted from a risk to which the workplace exposed her or fail to state a claim for negligence.

Five of plaintiff's six specifications of negligence allege that employer failed to provide a secure workplace. Plaintiff alleges, for example, that employer was negligent "[i]n failing to provide training to security officers regarding [employer's] policies" and "[i]n allowing a visibly intoxicated person to enter the facility." The failure to provide increased or better security in the workplace is functionally no different from the failure in *Fred Meyer, Inc.* to provide increased or better lighting in the employee parking lot. Both actions resulted in workplace conditions that exposed an employee to a risk of assault. *See* 325 Or at 601-02. As the court explained in *Fred Meyer, Inc.*, requiring the claimant to park on the fringes of a poorly lit parking lot "'made [her] vulnerable to an attack' and created the risk that such an attack would occur." *Id.* at 602. According to plaintiff's complaint, employer's failure to provide better security in the workplace made Tanatchangsang vulnerable to an attack and was a substantial factor in creating the risk that Blake would assault her.

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[4] In *Fred Meyer, Inc.*, the court explained that "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." 325 Or at 601. We focus on the latter part of that causal test for workers' compensation because there is no claim that Tanatchangsang's injury resulted from the nature of her work.

172 Or App 478> The fourth specification presents a potentially different issue. It alleges that employer "fail[ed] to intervene when notified Tanatchangsang was being held at gunpoint[.]" That specification can be read in one of two ways. To the extent that it alleges that every bystander should intervene to protect a person being held hostage, that theory of negligence might not be subject to the workers' compensation statutes, but it fails to state a claim for relief. A bystander who fails to come to another's aid is not negligent. *See Sullenger v. Setco Northwest*, 74 Or App 345, 348, 702 P2d 1139 (1985); *Restatement (Second) of Torts* section 314 (1965). To the extent that the fourth specification alleges that employer had a duty, arising out of its status as an employer, to intervene to protect its employees in the workplace, the risk arising from the failure to comply with that duty, if it exists, arises out of employment and is no different from the risk posed by plaintiff's five other specifications of negligence.

We accordingly conclude that, if the allegations that are a prerequisite to plaintiff's negligence claim are true, a substantial factor in causing Tanatchangsang's death was a risk to which the workplace exposed her. The remaining question is what effect that factor has when combined with the motive for Blake's assault. Because this case arises on summary judgment, we view the facts in the light most favorable to plaintiff and assume that Blake's decision to assault Tanatchangsang was based solely on his disappointment over the course of their personal relationship and was not engendered or exacerbated by their employment. As noted above, however, plaintiff has also alleged that employer's failure to provide a secure workplace "created a foreseeable risk of harm to Tanatchangsang" and was a substantial factor in causing her death. In other words, to the extent that plaintiff has alleged a negligence claim against employer, we must assume that two factors caused Tanatchangsang's death: One factor was wholly personal and unrelated to work while the other resulted from a risk to which the workplace exposed her.

The court has explained that "[w]hen the motivation for an assault by a coworker is an event or circumstance pertaining to the assailant and the claimant that originated **<172 Or App 478/479>** entirely separate from the workplace, and the only contribution made by the workplace is to provide a venue for the assault," then the assault does not arise out of employment. *Redman Industries, Inc.*, 326 Or at 40 (emphasis added). Conversely, when a risk in the workplace contributes to the assault, then the resulting injury arises out of employment. See Arthur Larson and Lex K. Larson, 1 *Larson's Workers' Compensation Law* section 8.02[1][c] (2000). As Larson explains:

> "When it is clear that the origin of the assault was purely private and personal, and that the employment contributed nothing to the episode, whether by engendering or exacerbating the quarrel or facilitating the assault, the assault should be held noncompensable even in states fully accepting the positional-risk test[.]"

Id. (footnotes omitted). In this case, plaintiff's specifications of negligence establish that the employment facilitated the assault even though we assume, on employer's motion for summary judgment, that it did not engender or exacerbate it. Plaintiff's allegations also establish that the employment conditions were not an incidental or *de minimis* cause of Tanatchangsang's death; rather, plaintiff has alleged that they were a substantial factor in causing her death.

We recognize that the personal motivation for Blake's assault on Tanatchangsang would ordinarily be sufficient for an agency or a court to say that Tanatchangsang's injury did not result from a risk in the workplace. *See* 1 *Larson's Workers' Compensation Law* section 8.02[1][c]. In this case, however, plaintiff has alleged that employer's failure to provide a secure workplace was a "substantial factor in causing the death of Tanatchangsang." That allegation, which is an essential element of plaintiff's negligence claim, takes this case out of the class of cases in which the workplace only provides a venue for the assault and brings it within the class of cases for which workers' compensation provides the exclusive remedy.

Because the injury that led to Tanatchangsang's death arose out of and in the course of her employment, the workers' compensation system provides plaintiff's exclusive remedy. *See* ORS 656.018. The trial court correctly granted employer's summary judgment motion. The court, however, **<172 Or App 479/480>** erred in allowing plaintiff's motion for a new trial as to employer. Even if employer had a workplace violence policy that pre-existed Tanatchangsang's injury, that policy provides no basis for avoiding workers' compensation exclusivity.

Order granting a new trial as to Owens-Brockway Glass Container, Inc., reversed; otherwise affirmed.

Cite as 172 Or App 484 (2001) February 21, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Wayne A. Dillon, Claimant.

WAYNE A. DILLON, Petitioner,

v.

WHIRLPOOL CORP., Respondent.

(99-07184, 99-03655; CA A111025)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 17, 2001.

Michael Strooband argued the cause for petitioner. With him on the brief was Bischoff, Strooband & Ousey, P.C.

Jerald P. Keene argued the cause and filed the brief for respondent.

Before Landau, Presiding Judge, and Linder and Brewer, Judges.

LANDAU, P. J.

Affirmed.

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172 Or App 486> Claimant seeks review of an order of the Workers' Compensation Board (Board) affirming employer's denial of his claim for injury to his lower back. Claimant argues that the Board erred as a matter of law in failing to defer to the opinion of the treating physician as to the compensability of his claim and as a matter of fact in finding that he had failed to establish compensability. We affirm.

We take the facts from the findings of the Board. Claimant worked for employer as an appliance repair person. He had a prior history of injuries to his lower back. On July 1, 1998, in the course of his employment, claimant bent to pick up some appliance parts and experienced pain from his neck down to his lower back. He continued working for several weeks, but eventually sought chiropractic treatment and filed a report of occupational injury with employer. Claimant was treated by several physicians and ultimately was referred to a neurosurgeon, Dr. Gallo, who diagnosed back and leg pain due to a disc herniation and recommended surgery. Gallo operated on claimant's back, performing an L4-5 fusion.

Meanwhile, Dr. Thompson examined claimant for employer. Thompson obtained an accurate history and concluded that claimant suffered from lumbar and cervical strains and longstanding L4-5 degenerative disc disease. Employer issued a partial denial, accepting the strains but denying the herniated disc.

At hearing, both Gallo and Thompson agreed that claimant suffered from a preexisting condition, that is, L4-5 degenerative disc disease, before the July 1998 injury. The physicians also agreed that the preexisting condition combined with the July 1998 injury to create the current disability or need for treatment. Gallo, however, concluded that the 1998 injury was the major contributing cause of the combined condition, while Thompson concluded that the preexisting condition was the major contributing cause.

The administrative law judge (ALJ), and later the Board, found Gallo's opinion unpersuasive because of certain **<172 Or App 486/487>** errors in the medical history on which she relied and concluded that claimant failed to establish the compensability of the claim.

On review, claimant first urges that the Board erred:

> "As both the ALJ and the Board failed to either give the treating neurosurgeon deference or provide justification for not giving deference, the Board's order is contrary to law and must be reversed."

In support of his contention, claimant relies on *Argonaut Insurance Company v. Mageske*, 93 Or App 698, 763 P2d 1202 (1988), which he reads to require the fact finder to give "special deference" to opinions of treating physicians.

Employer responds that there is no such rule of law. According to employer, *Mageske* and other cases do not stand for a rule of law that the opinions of treating physicians must receive greater weight, but rather merely reflect the practices of this court during an era in which it reviewed workers' compensation decisions on a *de novo* basis. Under current law, employer argues, the findings of the

Board must be affirmed on review if they are supported by substantial evidence. We agree with employer.

Before 1987, this court reviewed findings of the Board *de novo*; indeed, under the statutes applicable during that time, this court could take additional evidence. ORS 656.298(6) (1985). In the context of that *de novo* review, we noted in a number of decisions a tendency to give greater weight to the opinion of a treating physician in cases in which the medical evidence was divided, because the record revealed that the treating physician had more complete knowledge of the relevant facts. It bears emphasis that we have never announced a rule of law that we, the Board, or any other finder of fact *must* give greater weight to the opinions of treating physicians under any circumstances.

Mageske illustrates the prior practice. In that case, we reviewed the employer's denial of the claimant's claim for thoracic outlet syndrome (TOS). The claimant's physician, Dr. Silver, concluded that the claimant's condition was the **<172 Or App 487/488>** result of a work-related injury, while the employer's physicians testified to the contrary. On *de novo* review, we concluded that:

> "Silver's testimony established that claimant's injury was compensable. Although there was contradictory medical evidence, even the physicians who did not agree with Silver's theory testified that he is a qualified physician held in high regard in the medical community. They also conceded that TOS is an area of medical science where there is considerable controversy among experts. Silver was claimant's treating physician for a substantial time and, as the treating physician, was able to observe claimant's shoulder during surgery. * * * Because of his first-hand exposure to and knowledge of claimant's condition, we give his opinion great weight."

93 Or App at 702. Thus, we did not give weight to Silver's opinion merely because he claimed the label "treating physician," but because the record showed that, as the treating physician, Silver had better information about the claimant's condition.

To similar effect is our opinion in *Weiland v. SAIF*, 64 Or App 810, 669 P2d 1163 (1983). In that case, we noted our tendency to give greater weight to the opinions of treating physicians in the absence of persuasive reasons not to do so. *Id.* at 814. We then explained that we gave greater weight to the treating physician in that particular case because he had the opportunity to see the claimant between 80 and 90 times and therefore "had a much better opportunity to evaluate claimant's condition than either of [the employer's] doctors, who examined him on a very limited basis." *Id.*

In 1987, the legislature amended ORS 656.298 to eliminate de novo review of Board decisions. Or Laws 1987, ch 884, section 12a; *see Garcia v. Boise Cascade Corp.*, 309 Or 292, 295, 787 P2d 884 (1990). We are now required to affirm the Board's findings of fact when the record, viewed as a whole, would permit a reasonable person to make such a finding. ORS 656.298(7); ORS 183.482(8). As we explained in *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206, 752 P2d 312 (1988):

> **172 Or App 489>** "[I]n a context which is likely frequently to occur in workers' compensation cases, if there are doctors on both sides of a medical issue, whichever way the Board finds the facts will probably have substantial evidentiary support. We would not need to choose sides. * * * [T]he substantial evidence test * * * will be decisive only when the credible evidence apparently weighs overwhelmingly in favor of one finding and the Board finds the other without giving a persuasive explanation."

Thus, while under the previous standard of review, divided medical opinion led us as finders of fact frequently to give greater weight to the opinions of treating physicians, under the current standard of review that prior tendency is irrelevant. We no longer review Board decisions de novo. Under the current statutory scheme, divided medical opinion leaves the Board in the position of evaluating the evidence. The Board properly may or may not give greater weight to the opinion of the treating physician, depending on the record in each case. On review, we will affirm the Board's findings so long as substantial evidence supports them. *Winters v. Woodburn Carcraft Co.*, 142 Or App 182, 187, 920 P2d 1118 (1996); *Queener v. United Employers Ins.*, 113 Or App 364, 367, 832 P2d 1265, *rev den* 314 Or 176 (1992).

In the alternative, claimant argues that, even assuming that the Board did not err as a matter of law, its findings as to the conflicting medical evidence are not supported by substantial evidence. We have reviewed the record as a whole and conclude that the Board's findings are amply supported.

Affirmed.

Cite as 172 Or App 654 (2001) February 28, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Corinne L. Birrer, Claimant.

CORINNE L. BIRRER, Petitioner,
v.
PRINCIPAL FINANCIAL GROUP and JOHNSTON & CULBERSON, INC., Respondents.
(98-01138, 98-01097, 98-01095; CA A106163)

Judicial review from Workers' Compensation Board.
Argued and submitted August 1, 2000.
Donald M. Hooton argued the cause and filed the brief for petitioner.
Richard D. Barber, Jr. argued the cause for respondents. With him on the brief was Sheridan, Bronstein & Levine, LLP.
Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.
EDMONDS, P. J.
Reversed and remanded for reconsideration.

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172 Or App 656> Claimant petitions for review of an order of the Workers Compensation Board that upheld both employer's denial of the continued compensability of injuries to her right and left wrists and its contemporaneous closure of the claim without an award of permanent disability. She argues that the Board improperly allowed employer to raise a ground for the denials that it did not mention in the denial letter and that it should have required a medical arbiter's report before deciding the extent of her left wrist disability. We reverse and remand.

The issues in this case are primarily procedural. We state the facts as the Board found them, supplemented with undisputed evidence in the record. Claimant works for employer as a medical claims data processor. At the time of the hearing, she had worked in data entry for over 25 years. She filed claims for left wrist tendinitis in January 1996 and for right wrist tendinitis in August 1996. Employer accepted both claims, giving each a separate claim number. It accepted the left wrist condition as nondisabling and the right wrist condition as disabling. In August 1996, claimant's physician concluded that the left wrist condition was medically stationary; employer closed that claim soon afterwards. Despite the closure, claimant's left wrist continued to bother her, and in April 1997 she had surgery for left wrist intersection syndrome. Because her physician concluded that the left and right wrist conditions were related, employer, rather than reopening the closed left wrist claim, treated the left wrist condition as part of the open right wrist claim. On October 29, 1997, it closed that claim so far as the right wrist condition was concerned; claimant sought reconsideration of the closure.[1] ORS 656.268(5)(c).

On January 28, 1998, employer formally modified its acceptance to cover both the disabling right wrist tendinitis and the left wrist tendinitis/intersection syndrome. On the **<172 Or App 656/657>** same day, employer denied the claim that it had just accepted, explaining to claimant that "the information we have received indicates that your compensable injury no longer remains the major contributing cause of your disability and need for treatment for your left wrist condition. ORS 656.005(7)(a)(B)." On February 2, employer amended both the acceptance and the denial. The only substantive change was that the denial now included a statement that it might lead to closure of the claim. On the same day, employer closed the claim. Claimant thereafter sought reconsideration of the February 2 closure.

Also on February 2, Dr. Peter Nathan conducted a medical arbiter's examination of claimant's right wrist as part of the evaluation of her request for reconsideration of the October closure. ORS 656.268(7)(a). At that time, claimant had not sought either reconsideration of the February 2 closure of the left wrist claim or a medical arbiter's examination of it. Nathan, thus, was not aware of the left

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[1] In September 1997, claimant filed an aggravation claim based on her physician's conclusion that problems that she experienced with her right elbow were related to her work. She does not challenge the Board's decision upholding employer's denial of that claim.

wrist closure and did not examine claimant with that claim in mind. He did give some attention to the left wrist as well as the right during the examination, noting a reduced range of motion in the left wrist compared to the right. However, Nathan evaluated only the right wrist in his report, finding no significant limitations as a result of the accepted condition.

After receiving Nathan's report, the appellate reviewer for the Department of Consumer and Business Services told him about the accepted left wrist condition and asked him to answer questions concerning it based on his February 2 examination. In response, Nathan stated that his examination of the left wrist had been more general than that of the right wrist. He explained that, although he had found no objective findings of anything that was a direct residual of the intersection syndrome, he had not attempted to determine the source of the reduced range of motion in the left wrist. Still, it did not appear to him that there was any significant limitation in claimant's ability to use her left hand and wrist due to a chronic and permanent condition arising out of the accepted condition. Nathan concluded by saying that he would need to see claimant again to give more detailed information because her left wrist was not the primary focus of his examination.

172 Or App 658> On February 23, the Department issued an order affirming the October closure. On March 5, it issued a second order affirming the February 2 closure. Claimant sought a hearing on each order. After the consolidated hearings, the Administrative Law Judge concluded that employer's denial of claimant's current left wrist condition was improper because there had been no acceptance of a preexisting condition or a combined condition before the closure occurred. The ALJ also held that claimant was entitled to a complete medical arbiter's examination of her left wrist. He therefore set aside the March order affirming the February 2 closure in those respects and affirmed all other aspects of both orders.

Claimant did not appeal to the Board on the issues that she lost. On the employer's appeal, the Board reversed the ALJ's decision and affirmed the Department's orders in their entirety. It concluded that employer had not shown that claimant had a combined condition, primarily because employer had not identified any other condition that could be responsible for her condition. However, the Board then found that the preponderance of the medical evidence showed that claimant's current condition was not related to her accepted injury. Claimant sought reconsideration, arguing that the Board decided the case on an issue not framed by the denials, but the Board adhered to its conclusion.[2]

In her first assignment of error, claimant asserts that the Board erred by affirming the January 28 and February 2 denials on a ground other than the one that employer identified in the denials. The stated ground for the denials was that the accepted condition was no longer the major contributing cause of claimant's disability, and the denials **<172 Or App 658/659>** expressly referred to the statute concerning combined conditions. However, the Board affirmed the denials on the ground that there was no relationship between claimant's current condition and the accepted injury. The ALJ did not discuss that issue in his order. Rather, he decided that employer's combined condition denial was not procedurally proper, because employer had not accepted a combined condition before denying the continuing compensability of the left wrist claim. In denying claimant's motion for reconsideration on the ground asserted in this assignment of error, the Board found that claimant should have known that employer's denials put in issue whether claimant's current condition was related to the accepted conditions.

Claimant does not assert on review that the record is factually insufficient to support the Board's finding that her current condition is not related to her accepted injury.[3] Rather, she reiterates that the Board erred in going beyond employer's denial after it concluded that there was no combined condition

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[2] A "combined condition" occurs when a work-related injury combines with a preexisting unrelated condition to cause the claimant's current condition. In order for a combined condition to be compensable, the work-related injury must be the major contributing cause of the current condition. ORS 656.005(7)(a)(B). It is implicit in a combined condition denial that the employer treats the accepted injury as a material factor in the claimant's current condition, even though it is no longer the major contributing cause. In contrast, a current condition denial involves an assertion that the accepted injury is *not* a material factor in the claimant's current condition. Thus, each kind of denial involves an assertion about the causation of the claimant's current condition, but the assertion in each case is significantly different.

[3] Claimant *does* assert that, if she had known that employer would argue that it had made a current condition denial, she would have tried her case differently.

for employer to deny. She emphasizes that the only issue that employer raised on appeal to the Board was whether its denials were procedurally improper. Claimant says that she was not given the opportunity to litigate the issue decided by the Board. Employer argued to the Board that the Board's decision in *Tracey A. Blamires*, 50 Van Natta 1793 (1998), allowed it to deny a combined condition under ORS 656.262(7)(b) without having first accepted it under ORS 656.005(7)(a)(B). However, as claimant points out, the Board's holding in Blamires is inconsistent with our subsequent decision in *Croman Corp. v. Serrano*, 163 Or App 136, 986 P2d 1253 (1999). After this case was submitted, we reversed the Board's decision in *Blamires v. Clean Pak Systems, Inc.*, 171 Or App 263, 15 P3d 101 (2000).[4] Employer next argues that, regardless of the fact that the Board may have incorrectly decided this case based on its ruling in *Blamires*, it correctly reached the issue of whether claimant's **<172 Or App 659/660>** current condition is related to her accepted injury, and it correctly found that her current condition was not related to her accepted injury. As to claimant's argument that the Board went beyond the scope of employer's denials, employer argues that substantial evidence supports the Board's decision that claimant "had notice of the alternate theory."

We agree with claimant that the Board went beyond the express scope of the denials when it concluded that claimant's current condition is not related to her accepted injury. The Board's response on reconsideration to claimant's argument that it decided the case on an issue that was not before it is puzzling. In its opinion on reconsideration, the Board referred to the issue as the "Zora Ransom" issue.[5] It noted that the ALJ's opinion stated that employer contended that the denials were procedurally proper, citing the Ransom case. It then concluded:

> "The ALJ's order indicates that the parties had raised the issue of whether the employer's preclosure denials were procedurally valid, which included whether claimant's current left wrist condition was or was not related to the accepted left wrist condition. On Board review, claimant did not contest the ALJ's summary of the parties' respective positions. Under these circumstances, we find that claimant was adequately apprised of the * * * issue at hearing and we find no evidence that she objected."

In a footnote, the Board explained that the claimant's argument on reconsideration came too late. It then said that if it were to consider claimant's argument, it would find that claimant implicitly agreed to try the issue before the ALJ.

An 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. The Board does not explain how employer's reliance on the *Ransom* case and claimant's "failure to object" to that reliance constitutes an implicit agreement by claimant to try an issue outside the express terms of the denials. To adopt the Board's reasoning apparently would mean that every time a party cites a case in an argument, the **<172 Or App 660/661>** failure of the other party to respond constitutes an agreement that the issue in the cited case is also an issue in the case at bar.[6]

As to the timeliness of claimant's argument, it could be untimely only if claimant had notice of the issue in the proceeding before the ALJ and the ALJ had decided the issue. If the Board's rejection of claimant's argument is based on the finding that the issue was decided by the ALJ and that claimant failed to raise it on appeal, it is not apparent what evidence supports that finding. The Board refers to the ALJ's summary of the parties' respective positions, but it is unclear to what portion of the ALJ's order the Board is referring. We find no express reference in the ALJ's opinion to the issue decided by the Board, and the ALJ ruled that employer's denials were procedurally improper because there was no

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[4] The rule of *Croman Corp.* is that, under the wording of ORS 656.262(6)(c), the acceptance of a combined condition must precede the denial of a combined condition. Here, the ALJ found that there never was an acceptance of a combined condition.

[5] The reference is to a Board decision, *Zora Ransom*, 46 Van Natta 1287 (1994).

[6] Claimant did in fact object to employer's attempt to raise the current condition argument during its oral argument before the ALJ. Because the ALJ did not decide that issue, and employer did not raise it before the Board until its reply argument, claimant had no reason to discuss it until after the Board's decision.

accepted preexisting condition or combined condition before closure occurred. Thus, we are unable to discern from the Board's explanation of how it reached its conclusion that there was no procedural defect in employer's denials. On remand, the Board must provide a sufficient explanation to demonstrate that its conclusion is based on substantial evidence and substantial reason. *See SAIF v. Leland*, 160 Or App 480, 486-87, 982 P2d 48 (1999). *See also Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206, 752 P2d 312 (1988).

In her third assignment of error,[7] claimant asserts that the Board erred in holding that the ALJ was without authority to remand the case to the Department for a full medical arbiter examination of her left wrist before determining the extent of her disability. The Board reversed the ALJ's decision on this point primarily because it found that the medical evidence in the record showed that the compensable injury was no longer related, in major or material part, to the accepted left wrist tendinitis/intersection syndrome condition. It noted that Nathan expressly said that there were no objective findings from the left wrist intersection **<172 Or App 661/662>** syndrome. Although Nathan did not comment about the left wrist tendinitis, claimant's treating physician testified that he was not certain that claimant still had a tendinitis condition or that her work activities were a material factor in her current condition. Based on those reports, the Board concluded that the preponderance of the evidence established that claimant has no impairment from her accepted left wrist condition.

Claimant points out that 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 the disability, "the director *shall* refer the claim to a medical arbiter appointed by the director." (Emphasis supplied.) A medical arbiter examination, thus, is mandatory. Although Nathan gave the best opinion that he could based on the limited examination that he conducted, he emphasized that he had not examined claimant in order to determine the causation of her left wrist condition or its residual effects. He specifically did not express any opinion about the reasons for the reduced range of motion in her left wrist. Even if the Board properly accepted his tentative conclusion concerning the residual effect of the intersection syndrome, Nathan did not foreclose the possibility that the reduced range of motion was the result of the tendinitis. Claimant, in short, has not had the medical arbiter examination of her left wrist that the statute requires before the Department or the Board rates her permanent disability. Consequently, we reject employer's argument that the record before the Board was sufficient to make a decision on impairment.

The Board also noted that it had previously held that an ALJ does not have the authority to remand a case for a medical arbiter examination. *Dennis R. Loucks*, 50 Van Natta 1779 (1998). However, in *Loucks* and other cases, the Board adopted alternative remedies to provide for such an examination before the ALJ rules on the case. *See, e.g., Vicky L. Woodard*, 52 Van Natta 796 (2000). There is no apparent reason why the Board lacks authority to adopt those alternative remedies if it chooses to employ them on remand.

Reversed and remanded for reconsideration.

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[7] Our resolution of the first assignment of error makes it unnecessary to consider the second.

Cite as 172 Or App 663 (2001) February 28, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jack B. Roy, Claimant.

JACK B. ROY, Petitioner,

v.

McCORMACK PACIFIC COMPANY and SAIF CORPORATION, Respondents.

(97-00659; CA A105275)

Judicial review from Workers' Compensation Board.

On respondents' petition for reconsideration filed January 10, 2001; and on petitioner's response and cross-petition for reconsideration filed January 24, 2001. Opinion filed December 27, 2000. 171 Or App 526, ___ P3d ___.

Jerome P. Larkin, Salem, for respondents.

Donald M. Hooton, Milwaukie, for petitioner.

Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.

EDMONDS, P. J.

On SAIF's petition, reconsideration allowed; opinion adhered to as modified. On claimant's petition, reconsideration allowed; opinion adhered to.

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172 Or App 665> SAIF petitions for reconsideration of our opinion in this workers' compensation case, *Roy v. McCormack Pacific Co.*, 171 Or App 526, ___ P3d ___ (2000). Claimant also cross-petitions for reconsideration. We allow reconsideration on both petitions, modify our opinion, and adhere to our previous disposition.

Claimant sought judicial review of an order of the Workers' Compensation Board upholding SAIF's denial of compensation for claimant's current condition and consequential injury. SAIF had originally accepted claimant's condition consisting of a left knee strain and contusion and a tear of the medial meniscus. Several weeks later, claimant suffered a new injury to the same knee, an injury of which SAIF became aware through a report from claimant's treating physician. As a result of that information, SAIF issued a denial of compensability for the new injury and for claimant's post-injury condition without first closing the accepted claim. Ultimately, the Board upheld the denial. On review, we reversed the Board's ruling and remanded for reconsideration, reasoning that there is no statutory authority for the denial of a consequential injury claim unless the underlying, accepted claim is also closed. We observed, "we cannot discern from the record before us what effect if any, SAIF's failure to close the accepted claim had on the payment of compensation for the accepted condition." *Roy*, 171 Or App at 535.

In its petition for reconsideration, SAIF argues that the record shows that it issued a notice of closure of the accepted claim four calendar days and two business days after it issued the denial. Relying on our holding in *Chaffee v. Nolt*, 94 Or App 83, 764 P2d 600 (1988), for the first time on reconsideration, SAIF argues that there was no erroneous failure to close the accepted claim in light of the proximity of its closure to the issuance of its denial and the fact that the accepted claim had been closed before the Board upheld the denial. SAIF did not rely on *Chaffee* until this petition for reconsideration as a justification for the fact that its closure did not occur before the denial. Our initial opinion did not discuss whether the accepted claim had been closed before the Board's order upholding SAIF's denial. To the extent that our **<172 Or App 665/666>** original opinion suggests that it had not, it is modified accordingly.

The question then becomes whether, under *Chaffee*, SAIF is entitled to have the Board's order upholding its denial affirmed. In *Chaffee*, the claimant sought review of an order of the Board finding that the claimant's compensable back injury was medically stationary without permanent disability at the time that the employer issued its notice of closure. We affirmed the Board's order, writing only to address a procedural issue raised by the claimant. Three days before the employer issued its notice of closure, it sent the claimant a letter informing him that it was denying "any psychological condition as not related to your condition." At the hearing, employer's counsel stated that the letter was intended as a denial of future benefits for the back condition. Because the denial was in effect a prospective denial of an accepted condition, we held it to be procedurally improper. However, we also held:

> "[I]n view of employer's prompt closure of the claim immediately after the issuance of the denial, it does not appear that its conduct was intended to shortcut the ordinary process of claim closure or was otherwise unreasonable." *Chaffee*, 94 Or App at 85.

In this case, claimant expressly argued to the Board that the procedural error of denying an accepted claim occurred before the claim was closed, but the Board did not respond to that argument. As a result of that failure, we said that we could not discern from the record before us what effect, if any, SAIF's procedural error had on the payment of compensation for the accepted claim and concluded that the failure of the Board to address claimant's argument rendered its order insufficient for our review. It is that perception that distinguishes this case from *Chaffee*, in which this court made a ruling that was tantamount to a ruling of harmless error on the facts of that case. As we stated in our initial opinion, the more prudent course of action on the record before us is to permit the Board to make the determination of the effect of SAIF's error in the first instance.

In claimant's petition for reconsideration, he requests that the Board's order be reversed on the ground **<172 Or App 666/667>** that it failed to address an evidentiary ruling of the administrative law judge (ALJ). In our initial opinion, we held that claimant had not shown that he put the Board on notice that the evidentiary ruling was an issue on appeal to the Board. In his petition for reconsideration, claimant points to the language of the letter of request for Board review in which he said, "Review is requested on each and every issue raised at hearing." However, as we stated in our opinion, the letter focused the Board's attention on the issue of compensability and did not expressly refer to any evidentiary ruling. In lieu of submitting a brief on appeal to the Board, claimant submitted a copy of the closing argument that he had submitted to the ALJ. The review by the Board resulted in an order that stated: "On review, the issue is compensability." Thereafter, claimant did not correct the Board's understanding by requesting the Board to consider the evidentiary ruling on reconsideration. To adopt claimant's argument under these circumstances would result in a reversal on judicial review on the ground that the Board is required to review every ruling in the record made before the ALJ, even though the Board has not been put on explicit notice as to the issue before it. For obvious reasons, we decline claimant's invitation to promulgate such a principle of law. There is no apparent reason that would have prevented claimant from alerting the Board to the evidentiary issue in the way that he alerted it to the procedural error.

On SAIF's petition, reconsideration allowed; opinion adhered to as modified. On claimant petition, reconsideration allowed; opinion adhered to.

Cite as 172 Or App 738 (2001) February 28, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of George A. MacDonald, Claimant.

C.W. McCALLEN CONSTRUCTION CO., INC., and TIG INSURANCE COMPANY, Petitioners,
v.
GEORGE A. MACDONALD, Respondent.
(98-04744; CA A106403)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 12, 2000.
Jerald P. Keene argued the cause and filed the brief for petitioners.
Ernest M. Jenks argued the cause and filed the brief for respondent.
Before Haselton, Presiding Judge, and Wollheim, Judge, and Ceniceros, Senior Judge.
WOLLHEIM, J.
Affirmed.

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172 Or App 740> In this Workers' Compensation case, C.W. McCallen Construction, Inc., (employer) seeks judicial review of an order of the Workers' Compensation Board (Board), in which the Board held that claimant's injury was not excluded from compensability under ORS 656.005(7)(b)(A). The issue is whether claimant was an "active participant" in an assault or combat. We review for errors of law, ORS 183.482(8), and affirm.

The material facts are undisputed. The Board adopted the administrative law judge's (ALJ) opinion and order:

> "Claimant is [a] 52-year-old man. At times relevant to this proceeding, he was working for the employer as a dump-truck driver.
>
> "March 11, 1998 was a rainy, muddy day. The employer's foreman arrived at an employer work site at about 6 or 6:30 a.m. The dump truck that claimant ordinarily drove was on the site. Claimant was not yet on duty, and the foreman chose to drive the truck and went back and forth on a side road. At some point the truck became mired in some mud and the foreman and apparently some other crew members used chains to hook a bulldozer to the truck.
>
> "At approximately that time, claimant drove up the road to the site. He stopped on the road prior to reaching the dump-truck location and spoke to the foreman's son, who also worked for the employer. He asked the son why the truck was stuck.
>
> "Claimant parked his vehicle and approached the foreman in a rapid and excited manner. He was apparently upset that the foreman had been using the truck and indicated that he needed the truck right away for a job. He questioned the foreman's authority to use the truck. Claimant was also concerned that the chaining of the truck to the bulldozer had been done improperly and would damage the truck. Claimant was also angry at the foreman because claimant believed the foreman had previously thrown away the truck's registration paper and insurance card. Claimant's language was abusive and he [made] use of a well-know[n] obscenity. The foreman apparently responded with **<172 Or App 740/741>** a certain amount of salty language as well. Claimant did not threaten to strike the foreman, nor did the foreman fear that claimant would do so. They did engage in a debate in close proximity to one another.
>
> "At some point, the foreman grabbed claimant's jacket with both hands. There was a chain apparently suspended between posts behind the foreman's legs. Claimant pulled his right hand back in self-defense. The foreman pulled back on claimant with a motion to the left and both of their legs reached the chain and they went over it. They fell down together in the dirt, but claimant also rolled down a small slope.

"The foreman got up promptly. Claimant appeared surprised and fumbled quite a bit.

"When claimant stood up, he threatened to have the foreman arrested. Claimant got inside the truck to make a phone call to the employer. The foreman ordered him out of the truck, and claimant ran to an office and used the phone in there.

" * * * * *

"Claimant reported to a hospital emergency room on the date of injury, where a doctor observed large linear abrasions across both popliteal surfaces. The doctor noted slight paracervical tenderness and minimal paralumbar tenderness. The doctor diagnosed bilateral popliteal abrasions, low-back pain exacerbation, and neck strain.

"Claimant later saw Dr. Gundry, who took him off work.

"On June 8, 1998 the insurer denied the claim on the grounds that claimant was an active participant in the altercation with the foreman."

The ALJ set aside employer's denial of compensability, finding that claimant was not an active participant in an assault or combat under ORS 656.005(7)(b)(A). The Board affirmed and adopted the ALJ's order.

On judicial review, employer assigns error to (1) the Board's conclusion that claimant was not an active participant in an assault or combat under ORS 656.005(7)(b)(A),[1] **<172 Or App 741/742>** and (2) the Board's conclusion that the assault or combat between claimant and the foreman was connected to claimant's job assignment.[2]

An injury is compensable if it "aris[es] out of and in the course of employment[.]"[3] ORS 656.005(7)(a). However, ORS 656.005(7)(b)(A) "excludes from compensability injuries from assaults (1) to an active participant in the assault *and* (2) when the assault is not connected to the job assignment and amounts to a deviation from customary duties. Unless both of those elements are met, the exclusion does not apply." *Redman Industries, Inc. v. Lang*, 326 Or 32, 38, 943 P2d 208 (1997) (emphasis in original).

Employer argues that *Kessen v. Boise Cascade Corp.*, 71 Or App 545, 693 P2d52 (1984), in which we held that the claimant's injury was not compensable because he was an active participant in an assault or combat, is nearly identical to this case. We disagree. In *Kessen*, the claimant, also a truck driver, became very angry when his supervisor refused to give him the night off from work after attending a funeral for a co-worker to be held earlier that afternoon. *Id.* at 547. The claimant stormed out of his supervisor's office and slammed the door behind him. The supervisor then called the claimant back and told him to "close the door right." *Id.* That further compounded the claimant's anger so that he began to "tell off" the supervisor by claiming that day-shift drivers were being favored and job assignments were being made unfairly. The claimant then directed his anger to a nearby co-worker by "pointing and shaking his finger" at him, speaking in a loud voice and accusing him of being one of the favored drivers. *Id.* The claimant then "grabbed [his co-worker's] wrapped and bandaged left arm, which had only recently been removed from a cast." *Id.* The co-worker got up and "nailed claimant with a right to the jaw[.]" We found that **<172 Or App 742/743>** the claimant was an active participant in the altercation because "he was the one who, because of his anger, vocal tirade and threatening gestures, actually *initiated the fight*." *Id.* at 548 (emphasis added). Employer argues that the key language in which we should focus in *Kessen* is the claimant's "anger, vocal tirade and threatening gestures" because that is similar to what claimant did here. We disagree and instead find the key language of the opinion to be the italicized portion--*initiated the fight*.

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[1] ORS 656.005(7) provides, in part:

"(b) 'Compensable injury' does not include:

"(A) Injury to any active participant in assaults or combats which are not connected to the job assignment and which amount to a deviation from customary duties[.]"

[2] Because we hold that claimant was not an active participant in an assault or combat, we need not address his second assignment of error.

[3] The parties do not dispute that claimant's injury arose out of and in the course of his employment.

To be an active participant in an assault or combat requires more than just a heated exchange of words. There must either be a physical altercation initiated by the claimant--*see, e.g., Kessen,* 71 Or App 545 (claimant *grabbed* co-workers sore arm); *Donald Converse,* 50 Van Natta 1830 (1998) (claimant yelled and swore at assailant and *hit his safety glasses out of his hands* provoking assailant to assault the claimant)--or, if a claimant initiates a verbal altercation, it must incite or invite a physical response. *See, e.g., Irvington Transfer v. Jasenosky,* 116 Or App 635, 640, 842 P2d 454 (1992) (the claimant held not to be an active participant because he "did not have an opportunity to withdraw from the situation and he did not *voluntarily assume an active or aggressive role in the altercation.*" (emphasis added)); *Lang,* 326 Or at 42 (holding that claimant was not an active participant despite the fact that he angered assailant by making derogatory racial remarks to him because ORS 656.005(7)(b)(A) "require[s] more than that a claimant anger an assailant in such a way that the assailant later assaults the claimant").

Here, although claimant was very upset when he approached the foreman and was yelling obscenities, the Board found that "claimant did not threaten to strike the foreman, nor *did the foreman fear that claimant would do so.*" (Emphasis added.) The Board further found that,

> "[a]fter the foreman had used both his hands to grab claimant, claimant did likely bring back his right arm in an effort at self-defense. The foreman's action in grabbing claimant was quite threatening and aggressive. Claimant had no opportunity to withdraw from the physical contact. I cannot conclude that because claimant momentarily sought to act **<172 Or App 743/744>** in self-defense that he was an active participant in the combat."

Similar to *Jasenosky,* claimant had no opportunity to withdraw from the altercation once the foreman grabbed him and they fell over the chain. Nor does the record suggest that claimant, by his words, incited or invited the physical response by the foreman. Rather, the foreman himself testified that he grabbed claimant "*to make him 'wake up and smell the roses'*" and to "*shake [him] up.*" (Emphasis added.)

Therefore, we hold that the Board did not err in holding that claimant was not an active participant in an assault or combat under ORS 656.005(7)(b)(A).

Affirmed.

Cite as 173 Or App 29 (2001) March 14, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Johnny R. Richey, Claimant.

JOHNNY R. RICHEY, Petitioner,
v.
BARRETT BUSINESS SERVICES, Respondent.
(99-02426; CA A110039)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 14, 2001.
Donald E. Beer argued the cause for petitioner. With him on the brief was Popick & Merkel.
Scott H. Terrall argued the cause for respondent. With him on the brief was Terrall & Terrall.
Before Landau, Presiding Judge, and Linder and Brewer, Judges.
LANDAU, P. J.
Reversed and remanded for reconsideration.

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173 Or App 31> Claimant seeks review of an order of the Workers' Compensation Board (Board) upholding employer's denial of his lower back injury claim. Claimant argues that the Board applied an incorrect legal standard. We agree and reverse and remand for reconsideration.

The relevant facts are not in dispute. Claimant worked as a "leased employee" whom employer assigned out to other employers. While working as a construction laborer on a residential work project, claimant slipped and fell. He did not feel immediate pain; rather, pain in his lower back came on gradually over the next few days. Three days after the accident he sought treatment for the pain and filed a claim for injury to his lower back.

Employer denied the claim. Claimant was examined by a number of physicians, including Dr. Grossman, his current treating physician. All noted that claimant suffers from a preexisting degenerative disc disease and has had other back injuries, but none concluded that either the preexisting disease or the prior injuries combined with the work injury to cause his current back condition. The Board upheld the denial. Because the claim does not involve a combined condition, the Board concluded that claimant was required to show that his work injury was a material contributing cause of his need for treatment or disability. The Board further concluded that, because the claim involved complex medical questions, expert medical opinions were required. The Board then commented that

> "[t]he expert medical opinion must evaluate the relative contribution of each cause. *Dietz v. Ramuda*, 130 Or App 397[, 882 P2d 616] (1994), *rev dismissed* 321 Or 416 (1995)."

The Board noted that it generally deferred to the claimant's treating physician, but in this case, it said, it found persuasive reasons to do otherwise. Among other things, the Board found that

> "Dr. Grossman did not properly weigh the relative contribution of each cause. Dr. Grossman's opinion does not mention claimant's degenerative disc disease or discuss the effect or lack of effect of claimant's other back injuries."

173 Or App 32> In consequence, the Board concluded that claimant failed to establish that his work activities were a material contributing cause of his need for treatment.

On review, claimant argues that the Board erred in requiring that experts evaluate the relative contribution of each cause in a case that does not involve a combined condition and to which the material contributing cause standard applies. According to claimant, *Dietz* described what must be proved in a combined condition case, in which it must be shown that the compensable injury is the *major* contributing cause of the disability or need for treatment. In that context, it is necessary for experts to weigh the relative contribution of each cause in order to arrive at a conclusion as to the *major* contributing cause. In this context, argues claimant, the *material* contributing cause standard applies, and requiring experts to weigh relative causes is unnecessary.

Employer concedes that the Board described and applied an incorrect standard in evaluating Grossman's testimony. It insists, however, the Board's ultimate finding that his testimony is not persuasive is so amply supported by evidence in the record that the error is of no consequence.

Claimant is correct that the Board applied the wrong legal standard in evaluating Grossman's testimony. We decline to accept employer's invitation to speculate that the error was of no consequence to the Board's evaluation of that testimony.

Reversed and remanded for reconsideration.

Cite as 173 Or App 82 (2001) March 14, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Daniel S. Kaleta, Claimant.

LIBERTY NORTHWEST INSURANCE CORPORATION and DAVIDSON'S MASONRY, INC., Petitioners - Cross-Respondents,

v.

DANIEL S. KALETA, Respondent - Cross-Petitioner, and SAIF CORPORATION and PARDUE RESTORATION, Respondents - Cross-Respondents.

(WCB 98-03898, 98-02289; CA A105641)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 25, 2000.

Alexander D. Libmann argued the cause and filed the briefs for petitioners - cross-respondents.

Edward J. Harri argued the cause for respondent - cross-petitioner Daniel S. Kaleta. With him on the brief was Glen Lasken.

Jerome P. Larkin argued the cause and filed the briefs for respondents - cross-respondents SAIF Corporation and Pardue Restoration.

Before Haselton, Presiding Judge, and Deits, Chief Judge, and Wollheim, Judge.

WOLLHEIM, J.

Affirmed on petition and cross-petition.

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173 Or App 84> In this workers' compensation case, Davidson's Masonry (Davidson's) seeks review of a Workers' Compensation Board order setting aside its denial of responsibility for claimant's bilateral carpal tunnel syndrome. Davidson's argues that the Board erred in its application of the last injurious exposure rule to determine responsibility. Claimant cross-petitions for review and argues that the Board erred in awarding attorney fees under ORS 656.308(2)(d) rather than ORS 656.307(5). We affirm on the petition and the cross-petition.

The facts are not in dispute. Claimant worked as a caulker for Pardue Restoration (Pardue) in its masonry business from 1994 to September 1997. His job duties included caulking, masonry restoration, and masonry concrete work. His work at Pardue required him to use manual caulking guns and power tools involving significant vibration. While working at Pardue, claimant occasionally experienced numbness in his hands, but he never sought treatment nor missed work due to his hands.

In September 1997, Pardue loaned claimant to Davidson's to help it with a masonry job at the Lincoln County jail. Claimant performed essentially the same duties for Davidson's as he had performed at Pardue. Claimant's employment with Davidson's lasted approximately four weeks. However, during those four weeks, claimant's symptoms worsened. He also began getting a painful burning sensation in his fingers. Claimant decided to seek medical treatment for his symptoms when his four weeks of employment with Davidson's ended and he could return home.

On October 20, 1997, claimant went back to work for Pardue. His symptoms remained the same but did not worsen during that one day. After work that same night, claimant sought medical treatment. He was diagnosed with bilateral carpal tunnel syndrome. Claimant filed workers' compensation claims

with both Pardue and Davidson's. Pardue twice denied responsibility for claimant's bilateral carpal tunnel syndrome, once in January 1998 and again in February 1998. Davidson's also denied responsibility for that **<173 Or App 84/85>** condition in May 1998. Both Pardue and Davidson's specifically requested the designation of a paying agent under ORS 656.307;[1] however, one was never issued.

Claimant sought review of the insurers' denials of responsibility for his bilateral carpal tunnel syndrome. The administrative law judge (ALJ) concluded that, under the last injurious exposure rule, Pardue was initially responsible. The ALJ further concluded that Pardue could not shift responsibility backwards because Pardue could not prove (1) that claimant's four weeks at Davidson's were the sole cause of his condition, or (2) that it was impossible for claimant's one day of work at Pardue to have contributed to his condition. Therefore, the ALJ set aside Pardue's denial and upheld Davidson's denial. The ALJ also held that attorney fees were proper under ORS 656.307(5)[2] and not ORS 656.308(2)(d),[3] despite the absence of a 307 order.[4]

Pardue sought review by the Board of that order. The Board reversed the decision of the ALJ, set aside Davidson's denial and upheld Pardue's denial. In doing so, the Board stated:

> "We also agree with the ALJ that, because claimant sought first sought treatment while working for Pardue, SAIF is initially responsible. *Timm* [*v. Maley*], 125 Or App [396], 401[, 865 P2d 1315 (1993), *rev den* 319 Or 81 (1994)]. **<173 Or App 85/86>** Only Dr. Gardner and Dr. Weller assess contribution between claimant's 1994-97 employment with Pardue, Davidson's, and the subsequent single day of work at Pardue. Because both physicians indicate that the October 20 employment at Pardue did not 'pathologically worsen' claimant's condition, we find their opinions sufficient to establish that prior employment with Davidson and the 1994-97 exposure with Pardue was the sole cause of claimant's carpal tunnel syndrome. Thus, responsibility shifts from [Pardue] to [Davidson's]. *See Roseburg Forest Products v. Long*, 325 Or 305, 313[, 937 P2d 517] (1997)."

The Board also reversed the part of the ALJ's order awarding attorney fees under ORS 656.307(5). The Board based its decision on the fact that there was no 307 order and, thus, ORS 656.307(5) did not apply. Rather, the Board awarded a $1,000 attorney fee under ORS 656.308(2)(d), because claimant's attorney finally prevailed against Davidson's responsibility denial and actively and meaningfully participated in the proceeding.

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[1] Pardue's first denial in January 1998 expressly opposed the designation of a paying agent. However, in February 1998, it issued an amended denial that expressly requested a paying agent.

[2] ORS 656.307(5) provides:

"The claimant shall be joined in any proceeding under this section as a necessary party, but may elect to be treated as a nominal party. If the claimant appears at any such proceeding and actively and meaningfully participates through an attorney, the [ALJ] may require that a reasonable fee for the claimant's attorney be paid by the employer or insurer determined by the [ALJ] to be the party responsible for paying the claim."

[3] ORS 656.308(2)(d) provides:

"Notwithstanding ORS 656.382(2), 656.386 and 656.388, a reasonable attorney fee shall be awarded to the injured worker for the appearance and active and meaningful participation by an attorney in finally prevailing against a responsibility denial. Such a fee shall not exceed $1,000 absent a showing of extraordinary circumstances."

[4] A "307" order is shorthand terminology commonly used to refer to an order issued pursuant to ORS 656.307.

On review, Davidson's contends that the Board applied the wrong legal test for shifting responsibility under the last injurious exposure rule. "As a rule of assignment of responsibility, the last injurious exposure rule assigns full responsibility to the last employer that could have caused the claimant's injury." *Long*, 325 Or at 309. "[T]he function of the last injurious exposure rule is to 'spread[ ] liability fairly among employers by the law of averages and * * * reduc[e] litigation.'" *Id.* at 314, *citing Bracke v. Baza'r*, 293 Or 239, 248, 646 P2d 1330 (1982). However,

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

Davidson's argues that the Board erred when it applied a "pathological worsening" standard, and we should remand to the Board with instructions to apply the impossibility standard for determining whether claimant's one day at work with Pardue contributed to his bilateral carpal tunnel syndrome. We disagree.

173 Or App 87> The Board correctly determined that Pardue was initially responsible under the last injurious exposure rule because claimant first sought treatment after working at Pardue on October 20, 1997. *Timm*, 125 Or App at 401 ("If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date that the claimant first began to receive treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim, unless the subsequent employment contributes independently to the cause or worsening of the condition."). We also agree with Davidson's that the standard for determining whether responsibility shifts backwards under the last injurious exposure rule to a previous employer required Pardue to prove it was either (1) impossible for claimant's one day at Pardue to have caused claimant's bilateral carpal tunnel syndrome or (2) that claimant's bilateral carpal tunnel syndrome was caused solely by conditions at one or more previous employments. *Reynolds Metals v. Rogers*, 157 Or App 147, 153, 967 P2d 1251 (1998), *rev den* 328 Or 365 (1999). We also agree that it was inaccurate for the Board to have interjected the *pathological* worsening language into its opinion. However, despite that inaccuracy, it is not necessary to remand to the Board for reconsideration. Although *pathological* worsening is not taken into account when determining whether responsibility should shift under the last injurious exposure rule, the Board's use of the term pathological worsening, albeit improper, did not compromise the correctness of its resolution of the case.

The Board properly and consistently with *Long* determined that claimant's prior employments from 1994-97 with both Davidson's and Pardue were the *sole cause* of his bilateral carpal tunnel syndrome. Thus, it necessarily follows that claimant's one day of work at Pardue on October 20 did not cause claimant's condition, because his previous employments were the sole cause of his condition. Whether the sole cause of claimant's injury was from claimant's previous employments is a question of fact that we review for substantial evidence. *SAIF v. Paxton*, 154 Or App 259, 959 P2d 634 (1998); ORS 183.482(8)(c). We hold that substantial evidence supports that finding.

<173 Or App 87/88> Further supporting our conclusion is the fact that the Board, after shifting responsibility to Davidson's, analyzed whether responsibility should further be shifted backwards to SAIF as the carrier for claimant's employment with Pardue from 1994 to 1997. In doing so, the Board held that

> "[b]ecause we find no evidence that this exposure was the sole cause of claimant's carpal tunnel syndrome condition or that it was impossible for claimant's employment with [Davidson's] to have contributed to that condition, responsibility remains with [Davidson's]."

That language shows that the Board knew what the standard under *Long* was for shifting responsibility backwards under the last injurious exposure rule. Remanding the case to the Board for it to reach the same result solely because of ill-placed language in the order would do neither the parties nor the Board justice. The Board did not err in its application of the last injurious exposure rule.

We now address claimant's cross-petition for review. Claimant contends that the Board erred in awarding attorney fees to claimant's attorney under ORS 656.308(2)(d) rather than under ORS 656.307(5). Claimant argues that ORS 656.307 provides a mechanism for resolving initial determinations of responsibility, whereas ORS 656.308 provides "for a mechanism of allocating or assessing subsequent responsibility after there is an *accepted claim.*" (Emphasis added.) Therefore, because both Pardue and Davidson's were disputing responsibility of an initial claim, neither had accepted the claim and neither assumed responsibility for payment of compensation, ORS 656.308 is inapplicable. We disagree.

In *Dean Warren Plumbing v. Brenner*, 150 Or App 422, 946 P2d 356 (1997), *rev dismissed* 327 Or 174 (1998), we interpreted both ORS 656.308(2)(d) and ORS 656.307(5) and held that

> "ORS 656.307(5) specifically authorizes attorney fees under specific circumstances; that is fees for legal services before an ALJ *in a proceeding under ORS 656.307* where *only* responsibility is disputed. ORS 656.308(2)(d), on the other hand, authorizes attorney fee awards in responsibility cases in a number of contexts. The authorization of fees in **<173 Or App 88/89>** the particular circumstances identified in ORS 656.307(5) is more specific and, under the rules of statutory construction, that statute should control over the more general language of ORS 656.308(2)(d). ORS 174.020." *Id.* at 427 (first emphasis added, second emphasis in original).

No 307 order was issued here. Thus, the proceeding before the ALJ was not decided under the rules that govern ORS 656.307. Therefore, under *Brenner*, attorney fees cannot be awarded under ORS 656.307. Instead, the applicable statute for determining the amount of attorney fees is ORS 656.308(2)(d).

> "By adopting ORS 656.308(2)(d) the legislature has made the policy decision to limit claimant's attorney fees in a dispute over responsibility. * * * The text of the statute does not limit its application to cases where responsibility is the only issue." *Foster-Wheeler Constructors, Inc. v. Smith*, 151 Or App 155, 158, 947 P2d 1144 (1997).

Furthermore, "ORS 656.308(2) applies to *any* responsibility denial, except for one falling under ORS 656.307(5) * * *." *Id.* at 158 n 3 (emphasis in original). ORS 656.307(5) is inapplicable and thus, claimant's argument that ORS 656.308(2)(d) applies only if there is an already accepted claim is incorrect. Because claimant successfully overturned Davidson's responsibility denial, we hold that the Board did not err in awarding attorney fees under ORS 656.308(2)(d).

Affirmed on petition and cross-petition.

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